CONCEPTS OF FAMILY AND ROLE PERCEPTIONS OF COMMUNITY HEALTH NURSES IN THE STATE OF OKLAHOMA

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This manuscript is dedicated to my beloved sister, Patricia, whose love, encouragement, and eternal optimism have seen me through the most trying times and to my late husband, Gene, who taught me the true meaning of Love and Family.

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CHAPTER I

INTRODUCTION

The Problem and Its Setting

As the health services move strongly into a systems organization the blurring of professional lines is inescapable and a clear definition of practice for any group becomes difficult. Preventive nursing may be hard to distinguish from preventive medicine and nursing consultation from health education or social work. Freeman and Heinrich (1981) contend that responsibilities and roles change so rapidly that any definition is obsolete before it is generally accepted.

There are unique differences between community health nursing and nursing in other settings. These differences are in patterns of practice, in the relative emphasis, and in the nature of the caseload. Studies show that early socialization and academic preparation focus upon care of individuals as a major function of the nurse. Talbot (1983), on the other hand, states that public health nursing is based upon the premise of caring for populations whether these be families or specified groups in the community. She also contends that principles of community health nursing practice include nursing the family as a unit. Community health nursing practice differs from other specialty nursing practice because it focuses on whole populations rather than on single individuals who are in need of care.

Since this study focuses upon the community health nurse and the practice of family centered nursing it is important to explore the general goal of community health nursing related to families. This goal, according to Freeman and Heinrich (1981), is to enable families to manage their health problems, both existing and anticipated, while at the same time preserving family functioning.

The nurse, in order to be effective in family nursing, must have an understanding of family organization and functioning. She must also understand how the organization and functioning of the family affect individual, family, and community health. In planning services for the family the community health nurse must work within the framework of the whole family structure.

The nurse often comes from a background in which her family experiences were very different from the population with whom she must work. The practice of basing treatment on individuals as separate entities rather than as members of a family system may be well established from previous educational and professional experiences.

All of these factors influence the nurse's concept of family and her perception of her role in working with families. Role theory provides a framework for examining the performance expectations and attitudes which serve to define the role of the community health nurse.

Significance of the Study

From the beginning of modern nursing, nurses have entered homes to help persons manage their health care needs concentrating on teaching principles of personal and environmental health and assisting families toward independence. The goal was, and still is, development

of an optimal plan of health care congruent with individual and family life situations. Community health nurses have performed in the roles of case finder, referral agent, teacher, counselor, provider of care, and mobilizer of community resources.

Programs in which community health nursing is practiced have grown tremendously in the past decade. Medicare, Medicaid, family planning, mental health, chronic disease, home health, occupational health, school health, children and youth, adult health, and gerontology programs have proliferated, so that few regions of the country are without them. Federal, state, and local tax money as well as regulations have accompanied these programs (Talbot, 1983). These programs, each with different data and accountability requirements and regulations as to who may be served, are causing changes in community health nurses. These changes require increased interaction between the nurse and families of the individual who is the primary recipient of care. Expectations that the role of the community health nurse will include increased interaction with families suggests the need for more information about the concepts of family which nurses hold and their perceptions of their roles in working with total families as opposed to individual patients. Such information is particularly pertinent for those who are planning learning experiences and curriculum for nursing education programs preparing nurses to work with the families in the current health care arena.

A search of the literature did not reveal studies done in relation to how community health nurses perceive families or how they perceive their roles in working with families. This study provides data related to how community health nurses working in staff positions in local

health departments view families and how they perceive that their roles should ideally be performed and how they are actually performed.

Statement of the Problem

This study focused on concepts of family and role perceptions held by a group of community health nurses. Knowing how nurses employed in local health departments in one region perceive families and how they perceive their role in working with families, both actual and ideal, will provide a base for generalizing to other nurses in similar positions in the same region and will assist in developing family centered nursing programs.

Purpose of the Study

This study was designed to identify concepts of family and role perceptions held by community health nurses working in staff positions in local health departments. In addition, the study attempted to identify discrepancies between how the nurses perceived roles should be performed ideally and actually are performed by community health nurses.

The specific goals of the study were:

I. To identify community health nurses' concepts of family by:
   A. determining the level of importance community health nurses placed on 15 family concepts which are considered important in carrying out the nursing process.
   B. determining if educational background is associated with the level of importance community health nurses place on these family concepts.

C. determining if amount of experience is associated with the level of importance community health nurses place on these family concepts.

II. To identify how community health nurses perceive their roles in working with individuals and families in actual practice by:

A. identifying how community health nurses rank the roles of casefinder, referral agent, teacher, counselor, and caregiver, as being performed in actual practice.

B. determining if educational background is associated with how the community health nurse perceives roles in actual practice.

C. determining if amount of experience is associated with how the community health nurse perceives roles in actual practice.

III. To identify how community health nurses perceived their roles should ideally be performed in working with individuals and families by:

A. identifying how community health nurses rank the roles of casefinder, referral agent, teacher, counselor, and caregiver, according to how they should ideally be performed.

B. determining if educational background is associated with how the community health nurse perceives roles should ideally be performed.

C. determining if amount of experience is associated with how the community health nurse perceives roles should ideally be performed.

IV. To identify discrepancies between how community health nurses perceive their roles to be actually performed and ideally performed by comparing how they perceive the roles of casefinder, referral agent, teacher, counselor, and caregiver are actually performed and how they perceive these roles should be ideally performed.

V. To determine if community health nurses are more individual-care oriented or family-care oriented by:

A. comparing responses reflecting individual care orientation versus family care orientation.

B. determining if educational background is associated with individual or family care orientation.

C. determining if amount of experience is associated with individual or family care orientation.

VI. To determine if there is a relationship between community health nurses' concepts of family and role perceptions by educational background and amount of experience.

Each of the goals of the study will be achieved in part through describing the responses of the subjects and in part through analyzing the responses for significance of associations or correlations in the data. Specific operationally defined null hypotheses for these comparisons may be found in Chapter IV.

In order to meet the objectives of the study, information was gathered through a survey of community health nurses in the State of Oklahoma. These nurses were asked to respond to an instrument devised by the researcher to assess importance attached to concepts of family and perceptions of whether certain roles were actually being performed or should ideally be performed by community health nurses in carrying

out the nursing process when caring for individuals and families. Respondents were asked to report their perceptions of the importance of concepts of family and of the performance, actual and ideal, of nursing roles on Likert-type items which did not imply right or wrong answers.

Questions to be Answered

1. Can 15 concepts of family identified in the literature as related to the nursing process be rank ordered on the basis of response to a 5-point Likert-type scale of degree of importance?

2. Is educational background of the respondents associated with responses?

3. Is amount of experience in community health nursing associated with responses?

4. Can community health nurses' perception of the actual performance of five roles of the community health nurse be rank ordered on the basis of responses of agreement that the role is being performed?

5. Is educational background associated with responses?

6. Is amount of experience associated with responses?

7. Can community health nurses' perceptions of ideal performance of five roles of the community health nurse be rank ordered on the basis of responses to a 5-point Likert-type scale indicating degrees of agreement that the role should ideally be performed?

8. Is educational background associated with responses?

9. Is amount of experience associated with responses?

10. Are there discrepancies between perceptions held by public health nurses of actual performance and ideal performance of their roles?

11. Can public health nurses be identified as oriented more toward individuals or toward families in carrying out their roles in the nursing process?

12. Is educational background associated with orientation?

13. Is amount of experience associated with orientation?

14. Is there a correlation between concepts of family and perceptions of role performance by community health nurses on the basis of educational background and experience?

These 14 research questions present a complex problem which can be approached only through more than one basic method of research. Descriptive, comparative, and correlational methods were used in the study.

Assumptions

The following assumptions have been made in designing this study:

1. Information about perceptions of importance of family concepts and performance of roles can be gathered through a pencil and paper inventory distributed as a survey.

2. Anonymity of respondents will increase the potential for obtaining valid responses.

3. The subjects identified will find personal relevance in the content of the survey, thereby increasing the response rate from that usually expected for a survey.

4. Community health nurses in local health departments which operate outside of metropolitan areas in the geographical region including Oklahoma, Arkansas, Louisiana, Texas, New Mexico, and Colorado have similar expectations for performance and similar ranges of educational background.

Limitations

One serious limitation of the current study is the lack of instrumentation available for assessing perceptions of concepts of family as applied in nursing practice and perceptions of performance of community health nursing roles. Initial stages of instrument development can yield only limited information which can be generalized or used for purposes of prediction. Reliability and validity measures are tenuous in the early stages of instrument development.

The resources available to a single graduate student without external support place restrictions on sampling and on refining the instrument. This study must, therefore, be considered an exploratory study which may suggest directions for further investigation and cannot be expected to provide definitive, predictive information.

Delimitations

The scope of this study is limited to perceptions of a limited number of family concepts which may be applied in nursing practice and to certain specific roles performed by community health nurses. Other concepts of family might be studied as well as the roles performed by those with other specializations among nurses.

The subjects of this study are limited to those nurses who hold similar job titles, with similar agency expectations, in one state. The influence of some uncontrolled variables may be minimized in this way.

Definition of Terms

Community Health Nurse was defined for the purpose of this study as a nurse who is licensed to practice professional nursing and employed by a local health department.

Community Health Nursing was defined as a synthesis of nursing practice and public health practice applied to preserving the health of populations.

Community Health Nursing Roles were defined for the purpose of this study as casefinder, caregiver, teacher, counselor, and referral agent.

Local Health Department was defined for the purpose of this study as a county health department operated under the direction of the State Department of Health.

Nursing Process was defined as a designated series of actions including assessment, diagnosis, planning, implementation, and evaluation intended to fulfill the purpose of nursing.

Public Health Nurse was used interchangeably with the term community health nurse.

Role was defined as a patterned sequence of learned actions or deeds performed by a person in an interaction situation (Sarbin, 1968).

Organization of the Study

This research study is presented in five chapters. Chapter I introduces the study, discusses the significance of the study and explains the problem, purpose, objectives, assumptions, limitations, delimitations, and definition of terms. Chapter II presents a review of the literature related to concepts of family, role theory, and

community health nursing. Chapter III presents the methodology of the study including subjects, instrumentation, and collection and treatment of the data. Chapter IV identifies specific hypotheses to be tested and describes the findings of the study. Chapter V includes a summary, conclusion, and recommendations for further research.

CHAPTER II

REVIEW OF THE LITERATURE

The conceptual framework chosen for this study was role theory. The study focuses upon the role of the community health nurse in caring for families in the community setting and the nurses' concept of family. The review of the literature includes definition of family, role theory, role theory and the family, and role theory and community health nursing. Reinhardt and Quinn (1977) state that the major focus and priority for the community health nurse is working with the family and individual members concerning each member's relationship to the family as a unit and to the community. The concept of family that the nurse has affects her ability to function and identify her role with families.

Winch (1952) defines the family as a group of two or more persons, joined by ties of marriage, blood or adoption who constitute a single household, who interact with each other in their respective familial roles, and who create and maintain a common culture. Goode (1965) cites functions of the family as 1) reproduction, or replacement of members of society, 2) status placement, 3) biological and emotional maintenance, 4) socialization and care of children, and 5) social control. Throughout history, the family has been the basic unit in society. Families shape the direction of society through values, beliefs, and customs. Alterations in role expectations are also shaped by these same factors in society.

Tackett (1981) offers a very fluid definition of family.

> The family unit is a living, open system of interacting persons who group themselves together with a central purpose to create and maintain a common culture which promotes progressive and holistic development of each of its members (p. 5).

Friedman (1981) describes the primary functions of the family as being 1) care and rearing of children, 2) socialization and social placement, including transmission of cultural values and/or rituals from one generation to another, 3) provision of physiologic needs, 4) effective functioning (personality maintenance), and 5) family coping.

Despite the magnitude of changes occurring in family values and behavior and the changes in traditional family patterns, Americans consistently report that a happy marriage and a good family life are the most important aspects of life. Some of the factors influencing the changes in the family cited by Thornton and Friedman (1983) are:

1. Fifty-six percent of women aged 20-24 in 1983 have never been married compared to 36 percent of women this age in 1970.

2. The number of unmarried couples living together has more than tripled since 1970 to nearly 1.9 million in 1983.

3. Half of all recent first marriages will end in divorce if current rates continue, and up to one half of all children will experience living in a fatherless family before they reach age 18.

4. Currently 19 percent of households with children under 18 are headed by a woman with no husband present.

5. Over one half (51 percent in 1982) of all married women now hold a paid job outside the home, including 49 percent of married mothers of preschool children.

6. Median income for married-couple families with a working wife was $30,300 in 1982 compared to $21,300 where only the husband worked.

7. Young white women now in the prime childbearing ages of the twenties say they expect to have an average of two children but are delaying the start of their families to the

extent that nearly 30 percent of them could end up childless.

8. Eighteen percent of all births in 1980 were out of wedlock (p. 3).

These trends affecting family patterns have had major repercussions on many aspects of family life. Hofferth and Moore (1983) in their study of women's employment and marriage revealed that there was not a clear relationship between the employment of wives and marital satisfaction. Cherlin and Barnhouse (1978) in their study of male and female sex role attitudes found that growing involvement in paid employment outside the home has been accompanied by a shift in attitudes toward appropriate roles for men and women.

Glick (1984) discusses American household structure in transition, stating that most Americans still live in married-couple households. The number of households consisting of unmarried couples was the fastest growing group in the population between 1970 and 1983. It is significant to note that 96 percent of the entire population lives in households with the remaining four percent living in group quarters, such as mental and penal institutions, college dormitories, military barracks, rooming houses, convents, and monasteries. Glick goes on to report that the rate of cohabitation of women under age 45 with an unrelated man has increased more than 700 percent since 1970.

Chinn (1979) states that the stereotypical family is less dominant now than it once was in American family life, but the stereotype continues to exert a significant influence on the expectations that people hold for normal family life. The transfer of culture and socialization has been one of the primary functions of the family. Ideally, roles of family members have been described and proclaimed through the culture of the family.

Jurich and Jurich (1975) present an interesting view of preferences of different types of family forms of people who were not practicing alternative life styles. The subjects chosen had chosen a traditional lifestyle and were not personally involved in different lifestyles. This is especially relevant to community health nurses since needed information can be gained and perhaps some understanding can come about as to why different lifestyles are chosen.

Cook and Dreyer (1984) present a new approach to the analysis of family-dyadic interaction by providing therapists a much needed new method of studying family interaction through the use of the "Social Relations Model." Kandzari and Howard (1981) point out that if the nurse is to be successful with the family she must look for patterns and trends in the family's interactional system. It is through these systems that clues arise about the changing family. With these changes in family systems new beliefs about health and illness emerge. Family and individual history include translation of personal attitudes, values, and beliefs into health behavior. Pratt (1976) presented evidence that health practices and illness behavior in a family are related to family interaction patterns.

Role Theory

The concept of role is useful when exploring how the community health nurse perceives activities in providing care to individuals and families since it offers a means of studying both the individual and the collectivity within a single conceptual framework (Gorden, 1966).

A review of the literature reveals that it was not until the 1930s in this country that the term role was used technically in

writings on role problems. Biddle and Thomas (1966) report that Mead, Moreno, and Linton were some of the early contributors to the concept of role. Mead employed the concept of "role taking" along with the related ideas of the "generalized other," the "self," the "I" and "me," and "audience." Since the introduction of role into behavioral science there has been a diffusion of role concepts.

The interdisciplinary study of role has resulted in many definitions of role. Linton (1936) wrote, what was considered by some, the most quoted definition of role. He states that a role represents the dynamic aspect of a status. The individual is socially assigned to a status and occupies it with relation to other statuses. He is performing a role when he puts the rights and duties which constitute the status into effect.

Gorden (1966) states that role theory embraces reciprocal action between persons and that the interaction of role and self marks role theory as a unique social psychological formulation. This idea of integration of self and role closely resembles Parsons' idea of need dispositions and role expectations.

Biddle and Thomas (1966) address the influence of role upon human behavior. Individuals in society occupy positions and their role performance is determined by social norms, demands and rules, by role performance of others, and by the individual's capabilities and personality.

According to Sarbin and Allen (1968), Newcomb explained role as the ways of behaving expected of any individual who occupies a certain position which constitute the role associated with that position. Sarbin and Allen (1968) in their study of role somewhat agree with

Newcomb. They defined role as a cognitive set of expectations. They also stated that role expectations are comprised of rights and privileges as well as duties and obligations.

Spiegel (1960) describes roles as culturally patterned ways of unthinking interaction. Cues are often offered and accepted as to the behavior expected. This automatic function of the role system is necessary for economy of effort. It saves making endless decisions. As long as members retain their role functions there arises no conflict as to who is to do what: complementarity of roles is not disturbed. When expected role functions are not maintained disequilibrium ensues. Self-consciousness and self-guarding enter the scene along with role conflict, all of which raise the number of decisions which must be made. As long as complementarity is maintained at high levels of equilibrium, decisions are decentralized. They are taken care of by the system of role relations rather than by the persons acting in a self-conscious manner. Equilibrium is not maintained long in family affairs because circumstances, tasks, and people change. Complementarity fails and members must try to adjust roles so as to regain balance. Bernard (1981) discusses the good provider role and different ways of being a good provider.

Scanzoni and Fox (1980) in their review of the decade of the 1970s sum up sex role studies. They also include suggestions for increasing the sophistication of the next decade's sex role studies.

It appears from the literature that changing roles within the family are well studied but application to the study of family has been slow. Role concepts are included in a large number of family studies.

Many concepts of role were examined. Since this research was directed toward the family and the community health nurse's role in working with families a review of role theory and how it relates to families and nursing was also done.

Role Theory and the Family

In Role Structure and Analysis of the Family, Nye (1976) reviews the role concept. He quotes other authors such as Linton (1936) and describes role sets, role sectors, and role clusters. The consensus seems to be that the father occupies a number of positions such as provider, disciplinarian, playmate, etc., and opts for a number of roles in each position. Drawing from other authors Nye also describes the delineation of family roles. He describes eight roles in the position of spouse, parent, or both. These are provider, housekeeper, child care, child socialization, sexual, recreational, therapeutic, and kinship. Traditionally, housekeeper, child care, and sexual roles have been assigned by the norms to the wife, with provider role assigned to the husband, and kinship and child socialization to both roles.

There has been a tendency in recent years for shared role enactment on the part of both spouses. The extent to which spouses feel roles should be shared between spouses and other family members will influence the research task in determining role enactment by all family members (Nye, 1976).

Robischon and Smith (1977) discuss how role theory is used in family assessment to focus on how family members integrate their role relationships and on family intragroup and intergroup relationships. Family members occupy positions and along with these positions there

are roles which are defined by patterns of wants and goals, beliefs, attitudes, feelings, values, and actions expected of occupants of the position. Roles within the family prescribe expected behaviors. As the family system evolves role changes occur, thus changing the family as a unit.

The literature abounds with studies on the changing roles within the family. Bird, Bird, and Scruggs (1983) discovered that there was a significant difference in the use of role-management strategies by husbands and wives in two earner families.

Pleck (1984) analyzes aspects of what he called "work-family role systems." He used male work role, female work role, male family role, and female family role as a category system for organizing research about the relations among these roles and analysis of the roles.

The literature shows that family roles encompass the essential activities of family. Family roles are delineated and appropriate role enactment by all family members provides equilibrium in the family unit. Burgess (1971) describes role as a cluster of interpersonal behaviors, attitudes, and activities that are associated with an individual in a certain situation or position. Role activities are governed by expectations of those outside the individual and are learned through a process of socialization. Each family must define its role in the community and the roles of its individual members. These roles are learned through interaction and imitation.

Hill (1958) suggests that in a period of crisis such as that caused by illness of a family member, the family structure is modified and members' capability to perform their usual roles is temporarily reduced. The family is in a state of disequilibrium until equilibrium

is established. The equilibrium is a readjustment of power and relationships within the family system. Roles are not static. Roles change from time to time as events and circumstances precipitate a change.

Role Theory and Community Health Nursing

Nursing as a profession is based on theory, practice, and research, and strives to meet the health needs of individuals and society. The discipline of nursing is defined and implemented within the framework of the role of the nurse. The nursing setting and people to be served may specify the elements of the role to be carried out by the nurse. Dohney, Cook, and Stopper (1982), in describing the discipline of nursing, describe those elements as caregiver, patient advocate, counselor, educator, coordinator, collaborator, consultant, and change agent. These elements are interrelated and serve to define the role of the nurse. Within nursing there are varying degrees of involvement and expertise in the use of these elements. This level of involvement is influenced by educational background and the position of the nurse.

Intrinsic to all elements of the nursing role are two integrating processes, the nursing process and the interpersonal process. In order to understand the role of the nurse there are certain role concepts which must be considered. The literature emphasizes that there is a strong diversity in the meaning of role but there are certain prevalent commonalities of role theory which apply to nursing. According to Conley (1974) some of these commonalities include the fact that roles have behavioral references concerned with standards of expected behavior or judgments about behaviors. They reflect goals, values, and sentiments operating in a given situation. Roles involve the individual

in social locations behaving with reference to these expectations as well as their own feelings. A role involves an action of an individual in a particular setting with some identified expectations.

These concepts of role apply to nursing in a complex manner according to Dohney, Cook, and Stopper (1982). Due to the social nature of nursing, people have different concepts and expectations of the role of the nurse. A patient may expect one set of behaviors from a nurse such as direct care, the family may expect knowledge and understanding of the situation the patient is experiencing and the physician may expect a totally different set of behaviors such as carrying out prescribed orders. Other allied health professionals have other sets of role expectations. It is the responsibility of the nurse to interpret these varying expectations within the framework of nursing theory and research.

Reinhardt and Quinn (1977) explain how the nurse uses role theory in family assessment to focus on how family members integrate their role relationships and in understanding family intragroup and intergroup relationships. Thompson, Miller, and Bigler (1975) describe the role of the professional as a sociological concept which helps in understanding human behavior in social situations. A role, sociologically speaking, is the behavior prescribed for and expected of all persons who perform certain functions. The role tells us what our duties are, what our obligations are, and what our rights and privileges are. The professional code is part of the role.

Individuals occupy many roles and the community health nurse has certain prescribed roles as described throughout the literature. Clements and Roberts (1983) state that role theory has many implications

for community health nursing and nursing in general and can be very useful in guiding nursing intervention.

Summary of Selected Family Concepts

A review of the literature has provided definitions of family and concepts of family which explain the changing family and influence the care of the family in health and illness. Those concepts presented in the literature which seem to be relevant to family studies as well as to community health nursing are presented in the following section.

Family History includes translations of personal attitudes, values, and beliefs into behaviors. It reveals to the professional providing care to the family clues about the changing family and provides personal and family health background.

Family Function reflects the five main functions of the family which are important in viewing the family as the basic unit in society. These functions are 1) reproduction, 2) status placement, 3) biological and emotional maintenance, 4) socialization and care of children, and 5) social control. The family offers a foundation for the present and continuity and stability through time.

Holistic Approach to Family reflects the major focus and priority for the community health nurse which is working with the entire family in a holistic manner. The family must be considered as a group of individuals, with individual needs, contributing to the family as a unit.

Power in the Family reflects the three domains of family power which are presented in the literature. These are bases of power, power processes, and power outcomes. This family concept also deals with

certain aspects of these domains in relation to family work, sex roles, and decision making. Although this is an important aspect of family study it is a difficult area to validate in terms of measurement. It is also an important area to consider in family health care due to the importance of decision making about health care choice.

Family Strengths may be assessed through role theory. This concept is used to assess how family members integrate their role relationships. Roles within the family prescribe expected behaviors. As the family system evolves, changes occur, thus changing the family as a unit.

Emotional and Social Development is the title used to reflect the concept that each family must define its role in the community and the roles of its individual members. The study of family demands that the worker understand that role activities are governed by expectations of those outside the individual and are learned through a process of socialization. The emotional and social development of individual members of the family determine the level of development of the family as a unit and offer indicators of individual and family needs for adequate socialization and emotional development.

Family Rights and Responsibilities reflects the concept that family roles encompass the essential activities of families. Family roles are delineated and each individual is responsible for appropriate role enactment. This provides equilibrium in the family. Not only do individuals have a responsibility for appropriate role enactment, they have the right to carry out that responsibility. The family also has the right and the responsibility to set norms for their own family. It is important that outside forces such as the community health nurse or family worker do not usurp that right but that they also assist the

family in logically exercising those rights and responsibilities.

Family Culture reflects the concept that health care is based not only on the physical causes of disease but also on sociocultural influences. Culture enables us to interpret our surroundings and to behave in ways that make sense. Culture consists of standards for deciding what is, how one feels about it, and how to go about doing it. Some anthropologists conceive of culture as a set of rules with each culture providing the individual with a set of rules for behaving and interpreting the behavior of others.

Work of the Family reflects the concept that the effects of work and family influence are closely related. The social status of the family is often judged by work of the father. The work role of the father often influences the occupation choices of the children and determines the status and role of the father within the family. The work of the mother has increased in the past few years and produces profound effects upon the family. Role conflict for the mother often occurs as a result of too many duties to perform between work outside of the house and the need to be available to the children in the house. These factors often affect the stability of the marriage and the family and the health and well-being of the mother. The economic need of the family is often the determining factor in whether the woman works, and there is an increasing number of two-earner families.

Beliefs about Health and Illness reflects the concept that beliefs are what an individual holds true and may or may not be based on fact. Culture influences beliefs because they are based on cultural factors and the meanings that individuals attach to these factors. The behavior of individuals and families in regard to health and illness can

be better understood by knowing about their beliefs and values. These beliefs and values influence the kind of health care considered acceptable and desirable and provide motivation and standards for behavior on the part of the individual and family.

Sex Roles in the Family reflects the concept that there is a close tie between men's and women's roles and family structure. Most individuals at some time perform the roles of worker, parent, and spouse. Each involves activities, identities, obligations, and relationships with others. Work-family interference occurs when conflicting demands make it difficult to fulfill the requirements of both work and family roles. Family role allocation may be either traditional with the husband as breadwinner and the wife performing family work or symmetrical with an interchangeable division of labor in which both husband and wife work outside the home and share family work. These varying patterns of work/family role allocation result from negotiation using criteria such as sex-role norms, ability and competence, time and availability, and perceived equity.

Family Communication Patterns reflects the concept that communication is the actual information that is transmitted through messages sent and received between individuals. All human interactions take place through verbal and nonverbal messages communicated from one person to another. When assessing family communication patterns frequency of communication, variety of communication, openness and humor of communication, depth and time of communication, clarity and empathy, and whether communication is understood need to be observed. Observation of communication patterns is the most effective way to evaluate patterns rather than having families to describe their communication patterns.

Family Life Style is the title used to reflect the concept that life styles greatly affect the development of the family. The way in which a family accomplishes daily living reflects highly individualized styles of living, none of which are necessarily superior to another. There are many family forms. Few individuals over a lifetime remain in a single type of family structure. The most prominent traditional types of family structures are the nuclear family, the nuclear dyad, single-parent family, single adult living alone, middle-aged or elderly couple, and the kin network. Emerging structures include the communal family, unmarried parent and child family, unmarried couple, and homosexual couple. It is becoming more common for individuals to move from one family form to another either because of design or circumstances.

Developmental Stages of Family Members reflects the concept that each member of a family is faced with developmental stages. There is a responsibility to guide the internalization of increasingly mature and acceptable patterns of physical, intellectual, and emotional-social behavior in each member and to be able to recognize the stages of development. Expanding independence, ability to solve problems, and adjustment to one's changing body are functions which are accomplished with varying degrees according to the family's socioeconomic status, cultural orientation, and where the family is in its life cycle.

Definition of Family reflects the concept that there are many definitions of family, most of which include family functions and characteristics. These definitions are frequently conceptualized in relation to the discipline represented by the definer. Definitions of the family range from viewing the family as having one structure

exclusively to perceiving the family as a household unit representative of various types of family structures.

CHAPTER III

PROCEDURES

Introduction

The purpose of this study was to investigate community health nurses' concepts of family and their perceptions of ideal and actual roles in working with individuals and families. A three-part questionnaire was developed and distributed to all staff nurses in local health departments under the supervision of the Oklahoma State Department of Health. It should be noted that public health nurses in the two metropolitan areas of the state were not included in this study since these health departments are not under the direct supervision of the State Department of Health.

The programs in the local health departments which are under supervision of the State Department of Health are fairly uniform throughout the state, whereas the health departments in the two metropolitan areas are autonomous and develop their own programs. In order to exert some control over variables involved, the nurses working in these autonomous units were not included as subjects. The questionnaires were distributed to the staff nurses by district nursing supervisors, completed by the staff nurses, and returned to the investigator by mail in a stamped, self-addressed envelope.

New developments in health care in the United States and changes in accreditation guidelines for the preparation of professional nurses

make urgent demands on both nursing and family study areas to become increasingly aware of common interests. Evidence of response to this demand is an increase in the emphasis on family-centered health care in programs preparing professional nurses. Other evidence may be found in the inclusion of sections related to family health in the programs of recent conferences of the National Council on Family Relations.

Methodological Approach

Efforts to examine some of these common interests led the investigator to develop a schematic presentation of the conceptual base for this study (Figure 1). In this conceptual base, philosophy, theory, and research led to the identification of concepts of family which may be influenced by education and experience. Perhaps other unidentified variables will also be influenced. The nursing process has been described traditionally as consisting of five identifiable steps. The behavior of any community health nurse will probably be influenced by how the nurse perceived her role in carrying out the nursing process and by the orientation of that nurse toward emphasizing care of the individual or care of all of those in the family milieu.

The 14 questions identified for study present a complex problem which can be approached only through more than one basic method of research. Descriptive, comparative, and correlational methods were used. Descriptive data were collected by questionnaire which described the subjects being studied, providing demographic data including education and experience. Selected concepts of family and role perceptions of the subjects were also determined using descriptive data.

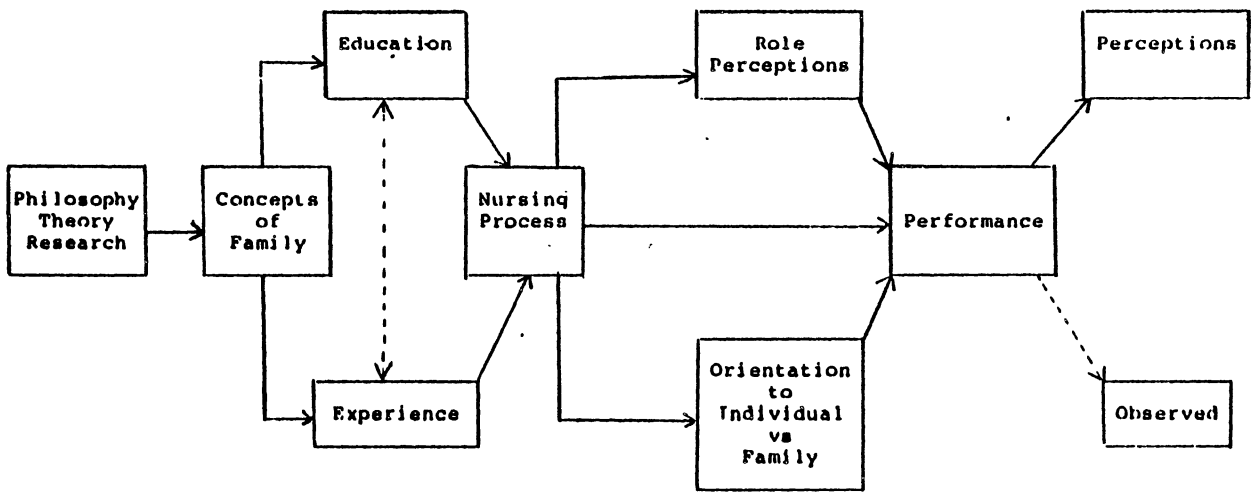

Figure 1. Conceptual Base for Study

Comparative data collection methods were used to determine the influence of education and experience of the subjects on their concepts of family and role perceptions. Comparative methods were also used to determine orientation to individual-centered versus family-centered care. Correlational methods were used to collect data which determined relationships between the subjects' family concepts and role perception by education and experience.

Conceptual Definitions

Definitions for the components of the conceptual base for the study were developed. They are described in the following section.

Concepts of family were developed from the literature found in both nursing and family studies. Concepts were identified for use in this study which appeared in writings in both areas and seemed to be related to the practice of nursing with particular emphasis on a family-centered approach. Fifteen concepts were selected for study. A detailed discussion of these concepts may be found in Chapter II.

Education was selected as component of this study and reflects the educational background in professional preparation for nursing. Only the categories of Associate degree, Baccalaureate degree, and Diploma were considered in this study. These categories were treated as nominal level with no inference of order.

Experience reflects the total years of experience in public health nursing. Categories of 1) less than or equal to one year, 2) more than one year but less than or equal to five years, 3) more than five years but less than or equal to nine years, and 4) more than nine years were used for analysis of the responses.

Nursing process reflects the steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. These were used as an organizing construct in developing statements used in the research instrument to reflect the family concepts studied.

Role perceptions reflect the roles commonly used in nursing. These are casefinder, referral agent, teacher, counselor, and caregiver. Respondents rated both actual performance and ideal performance of these roles through responses to three items related to each of the five roles.

Orientation in this study reflects the orientation toward giving major attention to the individual patient or toward caring for the whole family. Information about this component was gathered through the items seeking role perceptions. Each of the role perception items reflected an orientation toward individual or family as well as reflecting one of the five roles identified above.

Performance of roles was considered in terms of actual performance of the roles of the community health nurse and ideal performance of these roles as perceived by the respondents. Responses were measured by the degree (level) of agreement that the role described in each item 1) was being performed and 2) should be performed.

Subjects

The subjects chosen for this study were community health nurses in one state who were representative of community health nurses employed in local health departments under the supervision of State Departments of Health in the Southwest. It was assumed that these subjects were also a sample representative of the total population of

community health nurses employed by local health departments under the supervision of State Departments of Health across the country. The results of the study can be generalized only to those community health nurses with like educational and experiential backgrounds and is not intended to be representative of those nurses who have practitioner or clinician status or those nurses who work in private practice or in nongovernmental agencies.

The subjects for the study were 217 community health nurses working in staff positions in local health departments. All local health departments were under the supervision of the Oklahoma State Department of Health. The subjects were identified by the Chief of Nursing and District Nursing Supervisors of the Oklahoma State Department of Health and represented all staff nurses working under the supervision of the State Department of Health.

Instrumentation

A search of the literature yielded information for the development of an instrument which would identify various concepts of families and community health nurses' perceptions of roles, both ideal and actual, in working with families. A questionnaire format was selected as the method of choice because it provides an efficient and fairly objective method of collecting information. The questionnaire provides greater uniformity in the manner in which questions can be posed, thereby ensuring greater comparability in the answers. Another advantage in the questionnaire method is that it provides for anonymity of the respondent allowing the respondent the opportunity to answer as honestly as she or he desires (Babbie, 1979). The questionnaire was developed in

three sections to address demographic assessment, family concept assessment, and nursing role assessment.

Demographic Assessment

The first section of the instrument contains items for gathering demographic data. Items include primary job title of the nurse, major area of responsibility, highest degree held, public health nursing experience, length of time in present job, age, family of origin type, number of children in nuclear family, personal birth order, number of siblings (including adopted, step, and foster), marital status, and number of children.

Family Concept Assessment

Part II of the instrument was used to identify the level of importance placed on 15 selected concepts of family in carrying out the nursing process. These 15 concepts were presented in Chapter II. One statement was developed relating to each concept--family history (CF item #1), family function (CF item #3), holistic approach to family (CF item #5), power in the family (CF item #7), family strengths (CF item #9), emotional and social development (CF item #11), family rights and responsibilities (CF item #12), family culture (CF item #13), family work (CF item #14), family beliefs about health and illness (CF item #15), sex roles in the family (CF item #16), family communication patterns (CF item #17), family life style (CF item #18), developmental stages of family members (CF item #19), and definition of family (CF item #20).

The five steps of the nursing process, assessment, diagnosis, planning, implementation, and evaluation were used as an organizing construct in developing these 15 statements by relating three items to each of the five steps in the nursing process. The section of the instrument assessing importance placed on 15 concepts of family might also be divided into five subscales reflecting the five steps in the nursing process. Subscale 1, assessment, includes CF items 1, 11, and 20; subscale 2, diagnosis, includes CF items 3, 13, and 15; subscale 3, planning, includes CF items 5, 12, and 14; subscale 4, implementation, includes CF items 7, 16, and 19; and subscale 5, evaluation, includes CF items 9, 17, and 18.

Five items taken from Porter's Job Satisfaction Scale were used as distractors and were not included in the data analysis. They appear as items 2, 4, 6, 8, and 10 in the family concept section of the instrument. Distractor items were utilized to prevent response-set, which is a general tendency of respondents to agree or disagree with questionnaire items, regardless of their content (Kerlinger, 1964). The respondents were asked to rate each of the items using a 5-point Likert-type response from very important to very unimportant. Very important was assigned a value of "5" with values of 4, 3, 2, and 1 assigned to the decreasing ratings of importance.

Nursing Role Assessment

Part III of the instrument consisted of 15 items which assessed what the nurse perceived her role to be both ideally and in actual practice. The items also identified whether the nurse was more family-centered or more individual-centered in her practice.

Each item was constructed to describe a hypothetical situation in which a community health nurse might find herself/himself. There were two subsets for each item. The first subset addressed the extent to which the nurse thinks the situation should be practiced in community health nursing (ideal), and the other, the extent to which the respondent perceives it is actually practiced in community health nursing (actual). The items were divided into two subscales, one set of items reflecting individual orientation to the nursing role and the other subscale reflecting a family-centered orientation to the nursing role. These items sought information about perceptions of community health nursing roles identified in the literature (casefinder, referral agent, teacher, counselor, and caregiver) and about the orientation, individual or family, of the community health nurse. Identification of the orientation of each of the 15 role perception items is presented in Figure 2.

Role	Orientation	
	Individual Item	Family Item
Casefinder	3	1 and 2
Referral Agent	4 and 6	5
Teacher	7 and 9	8
Counselor	11	10 and 12
Caregiver	13 and 24	15

Figure 2. Role/Orientation of Items

The third section of the instrument was adapted from the role perception scale developed and used by Pieta (1979) in studying role perceptions of senior nursing students and their faculties. The format was modified by rearranging the questions and response column. New situation descriptions were developed which would be definitive for community health nursing. Situations are based on the literature and previous experience of the researcher. Each item required a response on a 5-point Likert-type scale. Since a higher numerical value is usually associated with higher positive response, the data were coded for statistical analysis so that 1=strongly disagree, 2=disagree, 3=undecided, 4=agree, and 5=strongly agree. See Appendix F for complete instrument.

Content Validity

Content validity was addressed by giving a panel of three nursing faculty with experience in community health nursing material which included nursing definitions of family concepts and role concepts and a list of the questions in random order. All three members agreed that the items measured the concepts for which they were designed. In addition, two members of the Family Relations and Child Development faculty reviewed the questions.

The questionnaire was administered to 11 senior nursing students. They were asked to validate clarity of questions by verbally reporting whether or not they thought the questions were clearly stated. All 11 students reported that the statements were clearly stated. The instrument was also administered to 16 district nursing supervisors. Clarity of questions was confirmed by all 16 subjects through verbal

communication. Results from the panel of experts and student review demonstrated the data collection instrument did have content validity.

Reliability

Reliability refers to the dependability, stability, consistency, or predictability of a measure. According to Kerlinger (1964), reliability is the accuracy or precision of a measuring instrument. A test may measure reliably at one level of performance and unreliably at another level. Items too difficult for some respondents may cause them to guess, yielding "reliable" but chance results; items too easy for others also provide "reliable" but nondiscriminatory information. The difficulty level of a test must be adjusted to the purpose of the testing (Isaac and Michael, 1983). According to Nunnally (1967), coefficient alpha measures the reliability based on the average correlation among items. Highest possible alpha is determined by identifying the best combinations of items within each scale. Items which lower the overall reliability should be removed to increase the scale reliability. Although multiple methods of calculating reliability coefficients may be used to allow comparison, coefficient alpha (Cronbach, 1951) is considered to be one of the most useful assessments for new measurement techniques. Nunnally (1967, p. 196) refers to alpha as "so pregnant with meaning that it should be routinely applied to all new tests." Since the research instruments used in this study are new, Cronbach's coefficient alpha was used to determine internal consistency. Reliability measures are discussed in detail in Chapter IV.

Pilot Study

The original instrument was administered to four staff nurses employed by the local County Health Department. The staff of this County Health Department was chosen because of their representativeness of the population to be studied and their accessibility to the researcher.

The questionnaire was administered following a meeting with the nurses. Their recommendations, along with those of the faculty members resulted in the addition of more demographic data items and a section related to family concepts to the instrument.

Collection of Data

The final instrument was distributed to public health staff nurses employed in local health departments under the supervision of the Oklahoma State Department of Health. Questionnaires for all 217 staff nurses employed in local health departments were distributed to district supervisors at a supervisors' meeting. The supervisors were instructed by the researcher and by a cover letter (Appendix D) to distribute a questionnaire to each nurse who worked in a staff position in her/his district.

A cover letter (Appendix E) with each questionnaire explained the purpose of the study and solicited the nurses' support by completing the questionnaire. Written instructions for completing the questionnaire were given along with instructions to place the completed questionnaire in the self-addressed, stamped envelope, and return it to the researcher.

The cover letter assured anonymity, requesting the nurse to place the completed questionnaire in the return envelope, seal it, and put it in the mail. The subject was requested not to sign his/her name to

the questionnaire. Confidentiality was assured through these procedures.

Treatment of Data

The statistical procedures used for the analysis of data came from the Statistical Analysis System (SAS) package (SAS Introductory Guide, 1983). In analyzing the data presented in this study frequency distributions for family concepts and role perceptions were calculated. All responses from all respondents are presented in Table XVI, Appendix A, and Table XVII, Appendix B. Since the educational levels used for comparisons in this study were limited to Diploma, Baccalaureate degree, and Associate degree, responses from those holding Master's degrees (n=5) and those who did not report their level of education (n=4) were dropped from all other statistical analysis.

Frequency distributions, measures of central tendency, percentages of responses, and rank order were calculated in relation to the descriptive objectives of the study. In order to analyze the data obtained each research question was stated as an hypothesis. In order to identify the relative importance attached to family concepts mean ratings were calculated and a rank ordering of these means was established (Hypothesis I).

An analysis of variance and Duncan's multiple-range test were used through the SAS statistical package to compare importance scores for family concepts and compute the F ratio of differences in order to determine if community health nurses' scores of the importance of each of 15 family concepts differed significantly according to educational background (Hypothesis II). The same procedure was used to determine

if experience in community health nursing and community health nurses' scoring of the importance of each of 15 family concepts were significantly different (Hypothesis III). A significant F ratio indicated important differences among ratings. The one-way analysis of variance is used to determine overall significance of difference and has a more accurate estimation of population variance than most other tests, since it can base its estimation on all sample data.

Mean scores were calculated in order to determine how respondents perceived community health nursing roles in terms of actual performance (Hypothesis IV). Analysis of variance and Duncan's multiple-range test were used to compare means and compute the F ratio of the difference in the rating of actual performance of roles according to education (Hypothesis V) and actual performance of roles according to experience (Hypothesis VI).

Means of scores were also calculated in order to determine how respondents viewed community health nursing roles in terms of ideal performance (Hypothesis VII). Composite scoring of the three items related to each role was computed as well as mean scores for each item to describe the perceptions of roles reported.

Analysis of variance and Duncan's multiple-range test were utilized to compare means and compute the F ratio of the difference between the groups to determine if there was a significant difference in how community health nurses perceived ideal performance of roles according to education (Hypothesis VIII) and according to experience (Hypothesis IX).

A t test was used to determine significance of difference between how the respondents perceived their roles to be performed in actual practice and how they should be ideally performed. The t test was used

to determine the significance of difference between the two sample means, ideal and actual (Hypothesis X). A *t* test was also used to test significance of difference in perceptions of roles reported by community health nurses in relation to individual care orientation and family care orientation in their nursing practice (Hypothesis XI) since this test is appropriate for testing significance of difference between two sample means.

Analysis of variance was utilized to test significance of difference in how respondents perceived roles in terms of individual versus family care orientation (Hypothesis XII). Analysis of variance was also used to determine the significance of differences in perception of roles in relation to individual and family care orientation according to experience in public health nursing (Hypothesis XIII).

The purpose of the Pearson product-moment correlation coefficient (*r*) is to describe a linear relationship between two continuous variables, therefore the Pearson *r* was utilized in data analysis to examine the relationship between community health nurses' family concepts and their role perceptions (Hypothesis XIV).

Reliability measures were calculated for each of the items in the instrument using coefficient alpha. Family concept items were also analyzed according to subscales reflecting the steps of the nursing process, assessment, diagnosis, planning, implementation, and evaluation. Role perception items were also analyzed by subscales reflecting the community health nursing roles of caregiver, referral agent, teacher, counselor, and caregiver; by the subscales reflecting actual and ideal performance of roles; and by the subscales reflecting individual or family orientation to care. Coefficient alpha was calculated by

using the variances generated through the SAS package and applying the formula for alpha developed by Cronbach (1951).

Results and discussion of the calculated measures of reliability (coefficient alpha) may be found in Chapter IV. The individual hypotheses tested with related results and discussion are also presented in Chapter IV.

CHAPTER IV

ANALYSIS OF DATA

This study was designed to examine community health nurses' concepts of family and their role perceptions in working with families both ideally and in actual practice. The first section of Chapter IV describes background information and characteristics of the subjects. The second section summarizes the analysis of data related to the objectives of the study. The data were analyzed by descriptive techniques, analysis of variance and Pearson product-moment correlation. Due to the complexity of the data much of the information is presented in table form.

Sample

Data were collected from a sample of community health nurses employed in local health departments under the supervision of the Oklahoma State Department of Health. From a group of 217 nurses, 161 responded to the questionnaire, resulting in a response rate of 74.2 percent. According to Babbie (1979, p. 335) a response rate of 70 percent or more is "very good." Five of the respondents held master's degrees and four of the respondents did not state their level of education. For the purpose of statistical analysis these two groups were dropped from the study leaving a sample of 152 individuals (N = 152).

The sample consisted of all females. Their ages ranged from 21 years to 66 years with the largest group (38.2%) being in the age range from 30 years to 39 years. The mean age was 39 years.

The highest level of education in nursing held by the respondents was reported to be Associate degree for 64, Baccalaureate degree for 31, and Diploma for 57. The largest number of respondents reported the Associate degree as their highest level of education (n=64, 42.8%).

All 152 respondents included in the study were staff nurses with experience in public health nursing ranging from less than one year to 31 years in their present position. The largest number of respondents had between one and five years (n=83, 54.6%) experience in their present position. The mean years in their present position was 4.9 years. Two of the respondents reported more than 20 years of experience in their present position and 26 of the respondents stated that they had less than one year total experience in their present position (n=26, 17.1%).

Five of the respondents (3.3%) had less than one year total experience in public health nursing, with the greatest number (n=90, 59%) having one to five years total experience in public health nursing. Four (2.6%) had more than 20 years experience in public health nursing. The mean years of total experience in public health nursing was six years. Table I contains additional data concerning characteristics of the subjects.

Reliability and Validity

External validity of the design was addressed in the planning of the study. Subjects were selected who represent community health nurses in Oklahoma and are likely to be fairly representative of nurses

TABLE I

CHARACTERISTICS OF SUBJECTS

Characteristic	N	Percent
Age Range (yrs.) $\bar{X}$ = 39		
20 - 29	25	16.5
30 - 39	58	38.2
40 - 49	36	23.7
50 - 59	23	15.1
60 - 69	8	5.3
Missing	2	1.3
Highest Level of Nursing Education		
Diploma	57	37.5
Associate Degree	64	42.8
Baccalaureate	31	20.4
Total Years Experience in P.H.N. $\bar{X}$ = 6		
Less than 1 year	5	3.3
1 - 5	90	59.2
6 - 10	33	21.7
11 - 15	8	5.3
16 - 20	12	7.9
Over 20 years	4	2.6
Experience in P.H.N. Other than Current Position		
Yes	40	26.3
No	110	72.4
Missing	2	1.3
Family of Origin (Parents)		
Natural	138	90.8
Adopted	1	0.7
Single-divorce	4	2.6
Single-death	6	3.9
Other	1	0.7
Missing	2	1.3
Number of Children Family $\bar{X}$ = 3.8		
1 - 2	47	30.9
3 - 4	61	40.1
5 - 6	26	17.1
7 - 8	12	8.0
9 - 10	3	2.0
11 - 12	2	1.3
Over 12	1	0.7
Years of Experience at Present Position $\bar{X}$ = 4.9		
Less than 1 year	26	17.1
1 - 5	83	54.6
6 - 10	24	15.8
11 - 15	8	5.3
16 - 20	9	5.9
Over 20 years	2	1.3

Characteristic	N	Percent
Birth Position		
1	65	42.8
2	40	26.3
3	18	11.8
4	16	10.5
5	6	4.0
6	2	1.3
7	3	2.0
8	1	0.7
9	1	0.7
Adopted Brothers or Sisters		
Yes	2	1.3
No	148	97.4
Missing	2	1.3
Step Brothers or Sisters		
Yes	12	7.9
No	138	90.8
Missing	2	1.3
Foster Brothers or Sisters		
Yes	2	1.3
No	148	97.4
Missing	2	1.3
Marital Status		
Single	3	2.0
Married	124	81.6
Divorced	17	11.2
Widowed	8	5.3
Respondent's Number of Natural Children $\bar{X}$ = 1.9		
None	22	14.5
1 child	36	23.7
2 children	52	34.2
3 children	26	17.1
4 children	13	8.6
5 children	3	2.0
Respondent's Number of Adopted Children		
None	143	94.0
1 child	3	2.0
2 children	6	4.0
Respondent's Number of Step Children		
None	142	93.5
1 child	4	2.6
2 children	4	2.6
3 children	2	1.3

Note. N = 152

working in the same kinds of agencies in the same geographical region. There was no interactive effect of pretesting these subjects nor were there any reactive effects of the data gathering procedures.

Content validity was addressed in the construction of the instrument through review by a panel of specialists (nursing faculty). In addition, pretesting with two groups, nursing students and supervisors, was part of the construction process.

One way of explaining internal consistency reliability is to say that it is based on the average correlation among items within a test and the number of items. Coefficient alpha (Cronbach, 1951) is used for determining internal consistency reliability. It is an especially effective method when the number of items is low. Other methods of obtaining a measure of reliability (test-retest and alternate forms) were not possible in this study. In order to establish a measure of internal consistency reliability measures were calculated for all items of the instrument. Means and variances were calculated by utilizing the SAS package. Coefficient alpha was calculated from the variances by using the formula for alpha. The formula is as follows:

$$\text{alpha } (\alpha) = \left(\frac{K}{K - 1}\right) \left[1 - \left(\frac{\Sigma V \text{ items}}{V \text{ total}}\right)\right]$$

where K = the number of items in the scale

ΣV items = sum of all item variances

V total = variance of the total scores on the scale

Coefficient alpha was calculated for the total score of the family concept scale, Part II of the research instrument, using the formula above. In addition, coefficient alpha was calculated for each of the

concept of family (CF) subscales which were designated according to the steps of the nursing process; assessment (CF items 1, 11, and 20), diagnosis (CF items 3, 13, and 15), planning (CF items 5, 12, and 14), implementation (CF items 7, 16, and 19), and evaluation (CF items 9, 17, and 18).

Role conception (RC) items in Part III of the research instrument were organized into the following subscales: casefinder (RC items 1, 2, and 3), referral agent (RC items 4, 5, and 6), teacher (RC items 7, 8, and 9), counselor (RC items 10, 11, and 12), caregiver (RC items 13, 14, and 15), actual performance (all RC items), ideal performance (all RC items), individual-orientation (RC items 3, 4, 6, 7, 9, 11, 13, and 14), and family-orientation (RC items 1, 2, 5, 8, 10, 12, and 15). Coefficient alpha was calculated for all subscales using the variances calculated by the SAS package and the formula for alpha.

It was determined that role items demonstrated a greater degree of consistency than the family concept items; however, both meet minimum standards for research purposes. In contrast, subscales assessing the steps in the nursing process demonstrated very low reliabilities and must be interpreted with caution. The results are presented in Appendix C. Since this is a new instrument further study of reliability is needed.

Examination of Research Questions and Hypotheses

In order to analyze the data obtained each research question was stated as an hypothesis. Those hypotheses subjected to statistical analysis were stated in the null form. The following section identifies

the specific hypotheses, reports the results of analysis of the data, and presents discussion of the results.

Hypothesis I. Community health nurses will not differ in importance scores attached to each of 15 family concepts related to carrying out the nursing process.

Testing of this hypothesis served to identify the relative importance of 15 concepts of family as perceived by the community health nurse in carrying out the nursing process. Part II of the research instrument contained one item for each of the family concepts. Items 2, 4, 6, 8, and 10 were distractor items and were not included in the data analysis.

Mean scores of importance community health nurses attached to each family concept were calculated and a rank ordering of these means was established. This information is presented in Table II.

In order to examine in greater depth the level of importance attached to each of the family concepts the ratings were compressed into two categories identified as "not important" and "important." The rating of "undecided" was placed with "unimportant" responses. Since the instrument presented only one item for each family concept it is possible that this one item may be eliciting responses which reflect the value attached to more than the family concept identified by the researcher.

Table III presents the family concepts from the instrument with frequency of ratings in the two compressed categories and the results of a binomial comparison of the frequencies. The items are presented in order of rank according to importance as calculated by combining "very important" and "important" responses.

TABLE II

IMPORTANCE OF FAMILY CONCEPTS

Family Concepts in Nursing Process	Item Number	Mean Rating[a]	Rank[b]
Family History	1	4.67	1
Family Function	3	3.44	10
Holistic Approach to Family	5	3.74	8
Power in Family	7	4.02	5
Family Strengths	9	2.68	13
Emotional and Social Development	11	4.29	3
Family Rights and Responsibilities	12	1.77	15
Family Culture	13	3.48	9
Family Work	14	4.16	4
Beliefs About Health and Illness	15	4.44	2
Sex Roles in Family	16	2.70	12
Family Communication Patterns	17	3.89	6
Family Life Styles	18	2.59	14
Development Stages of Family Members	19	3.87	7
Definition of Family	20	3.23	11

Note. N = 152.

[a]Possible ratings range from 1=very unimportant to 5=very important.

[b]1=most important; 5=least important.

TABLE III

RELATIVE IMPORTANCE OF FAMILY CONCEPTS

Family Concept	N	Rank	Rating NI[a]	Rating IM[b]	z	p
Family History	152	1	0	152	15.19	.0001
Beliefs About Health-Illness	151	2	1	150	14.88	.0001
Family Work	152	3	6	144	14.11	.0001
Emotional and Social Development	152	4	9	143	13.61	.0001
Power in Family	152	5	27	125	10.63	.0001
Developmental Stages of Family Members	150	6	28	122	10.33	.0001
Family Communication Patterns	152	7	33	119	9.64	.0001
Holistic Approach to Family	151	8	46	105	7.40	.0001
Family Culture	148	9	60	88	4.83	.0001
Family Function	148	10	67	81	3.65	.0002
Definition of Family	149	11	72	77	2.90	.0020
Family Life Styles	147	12	104	43	-2.66	.0040
Sex Roles in Family	145	13	107	38	-3.39	.0004
Family Strengths	152	14	113	39	-3.61	.0002
Family Rights and Responsibilities	149	15	147	2	-9.63	.0001

Note. N = Less than 152 indicates missing values.

[a]NI = Not important. [b]IM = Important.

As shown in Table II, five (33%) of the family concepts received mean scores of 4.0 or more and were judged to be "important" to "very important" in the analysis of individual concepts. The concept Family History received the highest mean score which indicates it was first in level of importance. This finding is not unexpected since most patient records require a family history as a part of assessment and is emphasized both in educational programs and in agency expectations.

The concept Beliefs about Health and Illness was ranked as second in importance by the respondents. This finding was expected since both education and experience in community health nursing emphasizes importance of beliefs about health and illness. A common value taught is that illness can be prevented through promotion of health.

Emotional and Social Development ranked third in importance. The individual nature of this concept corresponds with the individual role orientation of the subjects and may contribute to the high ranking of the concept.

Family Work was ranked fourth in importance with a mean score of 4.16. Work of the family is an important concept held by the majority of the respondents. Power in the Family was ranked fifth in importance with a mean score of 4.02. It was anticipated that work and power would be ranked closely since income from work plays a significant part in determining assignment of power in the family. Power is also closely related to decision making in relation to planning for care of the family. This is an important factor in implementing family health care when including the family in decision making.

The compressed categories, as indicated in Table III, resulted in the same five concepts ranking in the top five positions but in a

different order. Family Work ranked third and Emotional and Social Development ranked fourth whereas they were reversed in the 5-point scale ranking. The placing of "undecided" responses with "unimportant" responses may account for some of the difference.

The concepts Developmental Stages of Family Members, Family Communication Patterns, and Holistic Approach to Family were relatively high in numbers of respondents reporting the concepts were important (Table III). There was a sudden drop in the z score of Family Culture, Function, and Definition of Family, with Definition of Family having a z score of 2.90. Family Life Styles, Sex Roles in the Family, Family Strengths, and Family Rights and Responsibilities have negative z scores indicating these four concepts were thought to be unimportant.

It should be noted that in the 5-point scale ranking of the concepts Developmental Stages of Family Members and Communication Patterns were reversed in mean rating from those in the compressed categories but Holistic Approach to Family, Family Culture, Family Function and Definition of Family are ranked in the same order in both rankings.

The four concepts which are ranked unimportant and have negative z scores in the compressed categories are the same as those concepts in the 5-point scale ranking which have the four lowest mean ratings but they are not in the same order. The low ranking of the concepts of Family Life Style, Sex Roles in the Family, Family Strengths, and Family Rights and Responsibilities may indicate that the respondents are not familiar with the concepts to the same extent as those more concrete concepts which they ranked higher in importance. The possibility that the items may not have clearly identified concepts must be considered.

Based on the binomial comparisons of the importance scores for the family concepts the null hypothesis that community health nurses will not differ in importance attached to the 15 family concepts considered important in carrying out the nursing process was rejected.

Hypothesis II. There will be no significant difference among importance scores attached to each of 15 family concepts by community health nurses according to educational background.

Analysis of variance and Duncan's multiple-range test were used to test Hypothesis II. Results are presented in Table IV.

When comparing responses according to three categories of educational background significant differences were found in the concepts Family Culture ($p<.01$) and Sex Roles in the Family ($p<.01$). Since both of the items related to these concepts were negative statements a lower rating is equated with a stronger ranking of importance. Baccalaureate graduates had a mean of 2.8 ($n=29$, $\overline{X}=2.8$) compared to a mean of 3.7 ($n=56$, $\overline{X}=3.7$) for Diploma graduates and a mean of 3.6 ($n=63$, $\overline{X}=3.6$) for Associate degree graduates indicating the Baccalaureate graduates tend to place more importance on cultural beliefs when making a family diagnosis than the Associate degree and Diploma graduate. When considering Sex Roles in the Family the Baccalaureate graduate had a mean of 2.1 ($n=28$, $\overline{X}=2.1$) compared to a mean of 2.9 ($n=56$, $\overline{X}=2.9$) for Diploma graduates and a mean of 2.7 ($n=61$, $\overline{X}=2.7$) for Associate degree graduates indicating that the Baccalaureate graduates tended to place more importance on consideration of sex roles ascribed to in the family when carrying out the nursing process than did the Associate degree or Diploma graduate. Based on these results,

TABLE IV

IMPORTANCE SCORES FOR FAMILY CONCEPTS
BY EDUCATIONAL BACKGROUND

Family Concept	Educational Background: Diploma n	Diploma $\bar{X}$	Baccalaureate Degree n	Baccalaureate Degree $\bar{X}$	Associate Degree n	Associate Degree $\bar{X}$	F	p
Family History	57	4.6	31	4.7	64	4.7	0.10	.90
Family Function	56	3.5	30	3.5	62	3.4	0.24	.78
Holistic Approach to Family	57	3.9	31	3.7	63	3.6	1.45	.24
Power in Family	57	4.2	31	3.9	64	3.9	1.76	.18
Family Strengths	57	2.9	31	2.6	64	2.5	2.49	.08
Emotional and Social Development	57	4.3	31	4.4	64	4.3	0.52	.59
Family Rights and Responsibilities	57	4.3	31	4.4	64	4.3	0.52	.59
Family Culture	56	3.7	29	2.8	63	3.6	6.05	.01
Family Work	57	4.0	31	4.2	64	4.2	1.44	.24
Beliefs about Health Illness	57	4.3	31	4.5	63	4.5	2.49	.08
Sex Roles in Family	56	2.9	28	2.1	61	2.7	5.43	.01
Family Communication Patterns	57	3.9	31	3.9	64	3.9	0.10	.91
Family Life Styles	57	2.8	28	2.1	62	2.6	2.28	.11
Developmental Stages of Family Members	56	3.8	31	3.9	63	3.9	0.58	.56
Definition of Family	56	3.3	30	3.1	63	3.1	0.44	.65

even though there are only two concepts which show a significant difference, the null hypothesis can be partially rejected.

Hypothesis III. There will be no significant difference among the importance scores attached to each of 15 family concepts by community health nurses according to experience.

Analysis of variance and Duncan's multiple-range test were used to test Hypothesis III. Results are presented in Table V.

When comparing responses according to four categories of experience in public health nursing the concept of Beliefs about Health and Illness ($p<.01$) and the concept of Family Communication Patterns ($p<.01$) showed significant difference. The experience group of more than nine years indicated a tendency to place more importance on family communication patterns and on beliefs about health and illness than did the other experience groups. Due to two concepts showing significant differences the null hypothesis can be partially rejected.

Hypothesis IV. There is no difference in perception scores of actual performance of the nursing roles of casefinder, referral agent, teacher, counselor, and caregiver.

Means of scores for the "B" response to each item (perceptions of actual performance) in Part III of the research instrument were calculated to determine how respondents viewed community health nursing roles in actual practice. A value of 5 was assigned to the response indicating strong agreement that the role was important, with a value of 1 indicating strong disagreement that the role is important in carrying out the nursing process. Table VI presents composite scores for the three items related to each role as well as mean scores for each item.

TABLE V

IMPORTANCE SCORES FOR FAMILY CONCEPTS BY EXPERIENCE IN PUBLIC HEALTH NURSING

Family Concept	Experience in Community Health Nursing 1[a]		2[b]		3[c]		4[d]			
	n	$\bar{X}$	n	$\bar{X}$	n	$\bar{X}$	n	$\bar{X}$	F	p
Family History	34	4.74	61	4.59	27	4.74	30	4.70	1.04	.37
Family Function	34	3.41	60	3.42	25	3.48	29	3.62	0.34	.80
Holistic Approach to Family	34	3.74	60	3.80	27	3.63	30	3.73	0.18	.91
Power in Family	34	3.94	61	4.00	27	3.93	30	4.23	0.78	.51
Family Strength	34	2.44	61	2.67	27	2.93	30	2.73	1.13	.34
Emotional and Social Development	34	4.44	61	4.31	27	4.26	30	4.10	1.84	.14
Family Rights and Responsibilities	34	1.97	60	1.75	26	1.77	29	1.59	1.59	.19
Family Culture	34	3.62	58	3.59	26	3.15	30	3.40	0.92	.44
Family Work	34	4.26	61	4.16	27	4.11	30	4.10	0.63	.60
Beliefs about Health-Illness	34	4.65	60	4.48	27	4.41	30	4.17	6.31	.01
Sex Roles in Family	34	2.71	59	2.53	24	2.79	28	2.96	1.12	.35
Family Communication Patterns	34	4.21	61	3.84	27	4.04	30	3.53	3.77	.01
Family Life Styles	34	2.53	58	2.52	26	2.69	29	2.72	0.23	.88
Developmental Stages of Family Members	34	4.03	60	3.83	27	3.96	29	3.66	1.64	.18
Definition of Family	33	3.09	60	3.32	26	3.23	30	3.23	0.34	.82

[a]1 = Experience less than or equal to one year. [b]2 = More than one year; less than or equal to five years. [c]3 = More than five years; less than or equal to nine years. [d]4 = More than nine years.

TABLE VI

PERCEPTIONS OF ACTUAL ROLE PERFORMANCE

Role Name	Item Number	Item $\overline{X}$	Role $\overline{X}$	Rank of Roles
Casefinder			3.20	4
	1	3.05		
	2	2.78		
	3	3.69		
Referral Agent			3.59	3
	4	4.31		
	5	2.56		
	6	3.89		
Teacher			3.82	1
	7	4.08		
	8	2.87		
	9	4.41		
Counselor			3.74	2
	10	2.79		
	11	4.09		
	12	4.32		
Caregiver			3.17	5
	13	3.81		
	14	3.03		
	15	2.65		

The role of teacher ranked number one in actual performance. The role of counselor ranked as number two, the role of referral agent ranked number three, the role of casefinder ranked number four, and the role of caregiver ranked number five.

The ranking of roles may be due in part to services offered by the agency and agency expectations. This is in keeping with Sarbin's definition of role expectations which states that role expectations are comprised of rights and privileges and duties and obligations of any occupant of a social position in relation to other persons occupying other positions in the social structure. The position the nurse occupies may be filled over a period of time by many nurses but the fulfillment of the duties applies to any nurse who at any time is assigned the role. The agency has certain assigned roles and expectations which the nurse must accept and perform accordingly. The results show that there is a difference in how this group of community health nurses perceived their roles to be performed in actual practice. (See Table VI.)

Hypothesis V. There is no significant difference in the scores reflecting perceptions of actual role performance according to education.

Analysis of variance and Duncan's multiple-range test were used to test Hypothesis V. None of the responses reflecting actual performance of roles showed a significant difference when responses were analyzed according to education, indicating that education does not have a strong influence on how these community health nurses perceived the ranking of roles in actual practice. The results are presented in Table VII. The null hypothesis is not rejected.

TABLE VII

PERCEPTIONS OF ACTUAL ROLE PERFORMANCE
BY EDUCATIONAL BACKGROUND

Role Name	Item Number	Educational Background: Diploma n	Diploma $\bar{X}$	Baccalaureate Degree n	Baccalaureate Degree $\bar{X}$	Associate Degree n	Associate Degree $\bar{X}$	F	p
Casefinder	1	51	3.26	31	2.74	63	3.03	2.33	.10
	2	51	2.78	31	2.58	63	2.87	1.04	.36
	3	55	3.73	31	3.77	64	3.63	0.33	.72
Referral Agent	4	55	4.33	31	4.36	64	4.28	0.17	.84
	5	54	2.80	31	2.39	64	2.45	2.27	.11
	6	55	3.89	31	4.00	64	3.83	0.34	.71
Teacher	7	55	4.13	31	4.29	63	4.18	0.51	.60
	8	55	2.93	31	2.71	63	2.89	0.48	.62
	9	56	4.34	31	4.52	63	4.43	1.04	.36
Counselor	10	55	2.69	31	3.07	63	2.75	1.01	.37
	11	56	4.05	31	4.07	63	4.13	0.11	.89
	12	55	4.29	31	4.29	64	4.36	0.24	.79
Caregiver	13	52	3.88	31	3.65	64	3.83	0.59	.55
	14	52	3.31	31	2.81	64	2.91	2.29	.11
	15	53	2.43	31	2.68	64	2.81	2.27	.11

Hypothesis VI. There is no significant difference in the perception scores of actual role performance according to experience.

Analysis of variance and Duncan's multiple-range test indicated that one item of the three related to the caregiver role showed a significant difference ($p<.02$) (Table VIII). These results indicate that experience was not important in how the responding community health nurses perceived roles. The null hypothesis is not rejected.

The absence of significant differences in the relationship of education and experience to how the community health nurse perceives roles in actual practice is important since this study seeks to determine if these two factors are relevant to how community health nurses perceive their roles. If these factors are not the contributing factors other studies must be done in order to ascertain what accounts for the differences in how roles are perceived.

Hypothesis VII. There is no difference in the perception scores of ideal performance of the roles of casefinder, referral agent, teacher, counselor, and caregiver as reported by the community health nurse.

Means of scores for the "A" response to each item (ideal performance of roles) in Part III of the research instrument were calculated to determine how respondents perceived ideal performance of community health nursing roles. Table IX presents composite scores of the three items related to each role as well as mean scores for each item. The respondents indicated that ideally the role of teacher should be second, casefinder third, counselor, fourth, and caregiver fifth. This rank order differs somewhat from perception of the actual roles performed as presented in Table VI. The respondents did differ in their perceptions of ideal role performance.

TABLE VIII

PERCEPTIONS OF ACTUAL ROLE PERFORMANCE BY EXPERIENCE IN PUBLIC HEALTH NURSING

Role Name	Item Number	Experience in Public Health Nursing 1[a] n	$\bar{X}$	2[b] n	$\bar{X}$	3[c] n	$\bar{X}$	4[d] n	$\bar{X}$	F	p
Casefinder	1	32	2.94	57	3.05	26	3.15	30	3.07	0.20	.89
	2	33	2.73	56	2.88	27	2.85	29	2.59	0.71	.55
	3	33	4.36	58	4.24	26	4.42	30	4.37	0.39	.76
Referral Agent	4	33	4.48	59	4.47	27	4.59	30	4.30	1.15	.33
	5	34	3.53	60	3.43	26	3.65	30	3.67	0.44	.73
	6	33	4.18	59	4.32	27	4.15	30	4.27	0.42	.75
Teacher	7	33	4.52	59	4.34	27	4.41	30	4.40	0.52	.67
	8	34	3.59	60	3.77	27	3.52	30	3.40	1.00	.40
	9	33	4.52	59	4.49	27	4.33	30	4.50	1.45	.23
Counselor	10	34	3.50	59	3.19	27	3.44	30	3.30	0.50	.68
	11	33	4.18	59	4.12	27	4.33	30	4.53	1.88	.13
	12	34	4.47	59	4.47	27	4.22	30	4.43	1.64	.18
Caregiver	13	33	3.91	59	3.83	26	3.62	29	3.83	0.46	.72
	14	34	3.35	59	2.98	26	3.27	29	3.10	0.78	.51
	15	34	3.41	69	3.66	26	3.42	29	2.97	3.21	.02

[a]1 = Experience less than or equal to one year. [b]2 = More than one year; less than or equal to five years. [c]3 = More than five years; less than or equal to nine years. [d]4 = More than nine years.

TABLE IX

PERCEPTIONS OF IDEAL ROLE PERFORMANCE

Role Name	Item Number	Item $\bar{X}$	Role $\bar{X}$	Rank of Roles
Casefinder			4.05	3
	1	3.99		
	2	3.81		
	3	4.33		
Referral Agent			4.09	2
	4	4.46		
	5	3.54		
	6	4.25		
Teacher			4.16	1
	7	4.40		
	8	3.61		
	9	4.51		
Counselor			4.00	4
	10	3.33		
	11	4.26		
	12	4.42		
Caregiver			3.46	5
	13	3.81		
	14	3.14		
	15	3.43		

Hypothesis VIII. There is no significant difference in the scores reflecting perceptions of ideal performance of roles according to education.

Analysis of variance and Duncan's multiple-range test were used to test Hypothesis VIII. Mean scores for ideal performance of roles according to education showed a significant difference on only one of the 15 items. This item was in the referral agent subscale and reflected a family orientation. These results show that education is not significantly associated with how community health nurses perceived that roles should ideally be performed. Table X presents the results of this analysis. The null hypothesis is not rejected.

Hypothesis IX. There is no significant difference in the scores reflecting perceptions of ideal performance of roles according to experience.

Analysis of variance and Duncan's multiple-range test were used to test Hypothesis IX. Mean scores for ideal role performance according to experience showed a significant difference in only one of the 15 items. This item was in the caregiver subscale and reflected a family orientation. These results show that experience is not significantly associated with how this group of community health nurses ranked roles in their perceptions of ideal performance; therefore, the null hypothesis is not rejected. Results of this analysis may be found in Table XI.

Hypothesis X. There is no significant difference in how community health nurses perceive their roles to be ideally performed and actually performed.

TABLE X

PERCEPTIONS OF IDEAL ROLE PERFORMANCE
BY EDUCATIONAL BACKGROUND

Role Name	Item Number	Educational Background: Diploma n	Diploma $\bar{X}$	Baccalaureate Degree n	Baccalaureate Degree $\bar{X}$	Associate Degree n	Associate Degree $\bar{X}$	F	p
Casefinder	1	55	3.95	31	3.97	63	4.95	0.19	.83
	2	52	3.75	31	3.94	63	3.79	0.67	.51
	3	52	4.29	31	4.29	64	4.38	0.21	.81
Referral Agent	4	54	4.41	31	4.48	64	4.50	0.36	.70
	5	55	3.64	31	3.84	64	3.31	2.98	.05
	6	54	4.28	31	4.35	64	4.17	0.65	.52
Teacher	7	54	4.33	31	4.61	64	4.36	2.13	.12
	8	56	3.45	31	3.87	64	3.63	1.81	.17
	9	54	4.46	31	4.55	64	4.53	0.33	.72
Counselor	10	55	3.16	31	3.68	64	3.30	1.60	.21
	11	54	4.19	31	4.29	64	4.30	0.30	.74
	12	55	4.35	31	4.48	64	4.45	0.92	.40
Caregiver	13	52	3.48	31	3.65	64	3.83	0.59	.55
	14	53	3.42	31	3.00	64	2.98	2.11	.12
	15	53	3.21	31	3.58	64	3.53	1.97	.14

TABLE XI

PERCEPTIONS OF IDEAL ROLE PERFORMANCE BY EXPERIENCE IN PUBLIC HEALTH NURSING

Role Name	Item Number	Experience in Public Health Nursing 1[a] n	$\bar{X}$	2[b] n	$\bar{X}$	3[c] n	$\bar{X}$	4[d] n	$\bar{X}$	F	p
Casefinder	1	34	4.00	58	3.97	27	4.07	30	3.97	0.09	.95
	2	34	3.76	57	3.88	26	3.88	29	3.66	0.75	.53
	3	33	4.36	58	4.24	26	4.42	30	4.37	0.39	.76
Referral Agent	4	33	4.48	59	4.47	27	4.59	30	4.30	1.15	.33
	5	34	3.53	60	3.43	26	3.65	30	3.67	0.44	.73
	6	33	4.18	59	4.32	27	4.15	30	4.27	0.42	.75
Teacher	7	33	4.52	59	4.34	27	4.41	30	4.40	0.52	.67
	8	34	3.59	60	3.77	27	3.52	30	3.40	1.00	.40
	9	33	4.52	59	4.49	27	4.33	30	4.50	1.45	.23
Counselor	10	34	3.50	59	3.19	27	3.44	30	3.30	0.50	.68
	11	33	4.18	59	4.12	27	4.33	30	4.53	1.88	.13
	12	34	4.47	59	4.47	27	4.22	30	4.43	1.64	.18
Caregiver	13	33	3.91	59	3.83	26	3.62	29	3.83	0.46	.72
	14	34	3.35	59	2.98	26	3.27	29	3.10	0.78	.51
	15	34	3.41	69	3.66	26	3.42	29	2.97	3.21	.02

[a]1 = Experience less than or equal to one year. [b]2 = More than one year; less than or equal to five years. [c]3 = More than five years; less than or equal to nine years. [d]4 = More than nine years.

A *t* test was used to determine significance of difference between how the respondents perceived their roles to be performed in actual practice and how they should ideally be performed. All items related to the casefinder, referral agent, teacher, and counselor roles show significance of difference ($p<.01$). (See Table XII.) Only one item of the three related to the caregiver role showed a significant difference between perceptions of actual and ideal role performance. The caregiver role is the one role in which the respondents perceive fewer differences between actual and ideal practice. The null hypothesis is rejected.

Hypothesis XI. There is no significant difference in perceptions of roles reported by community health nurses in relation to individual-care orientation and family-care orientation.

Each of the 15 items used to identify role performance was stated to reflect either an individual or a family orientation to performing the role. Specific identification of the orientation for each item is presented in Table XIII.

Mean scores for the 15 items in Part III of the research instrument were calculated in order to determine if nurses were more individual-care oriented or family-care oriented. Mean scores are reported for both actual and ideal performance of roles in Table XIII. It should be noted that the mean scores for items reflecting individual orientation are both higher than the means for items reflecting family orientation. It should also be noted that those items reflecting an individual orientation for both ideal and actual performance rank 1 and 2, while those items reflecting a family orientation for ideal and actual performances rank 3 and 4. The

TABLE XII

DIFFERENCES BETWEEN PERCEPTIONS OF ACTUAL AND IDEAL PERFORMANCES OF ROLES

Role Name	Item Number	Performance Ideal $\bar{X}$	Performance Actual $\bar{X}$	t	p
Casefinder	1	3.99	3.05	11.17	.01
	2	3.81	2.78	13.14	.01
	3	4.33	3.69	9.49	.01
Referral Agent	4	4.46	4.31	4.36	.01
	5	3.54	2.56	10.50	.01
	6	4.25	3.89	5.58	.01
Teacher	7	4.40	4.18	4.90	.01
	8	3.61	2.87	9.51	.01
	9	4.51	4.41	3.58	.01
Counselor	10	3.33	2.79	7.94	.01
	11	4.26	4.09	4.35	.01
	12	4.42	4.32	3.38	.01
Caregiver	13	3.81	3.81	0.00	---
	14	3.14	3.03	1.68	.09
	15	3.43	2.65	9.07	.01

TABLE XIII

ORIENTATION OF PUBLIC HEALTH NURSES IN IDEAL AND ACTUAL ROLE PERFORMANCE

Group	$\overline{X}$	Rank	t	p
Individual Orientation/ Ideal Performance (RC Items 3B, 4B, 6B, 7B, 9B, 11B, 13B, and 14B)	4.13	1		
Family Orientation/ Ideal Performance			10.05	.01
(RC Items 1B, 2B, 5B, 8B, 10B, 12B, and 15B)	3.73	3		
Individual Orientation/ Actual Performance (RC Items 3A, 4A, 6A, 7A, 9A, 11A, 13A, and 14A)	3.93	2		
Family Orientation/ Actual Performance			24.4	.01
(RC Items 1A, 2A, 5A, 8A, 10A, 12A, and 15A)	3.01	4		

results of analysis show that respondents have a stronger individual-care orientation in their perceptions of both ideal and actual practice. A *t* test was applied to test the significance of the apparent differences. The null hypothesis is rejected.

Hypothesis XII. There is no significant difference in perception of roles in relation to individual- versus family-care orientation reported by community health nurses according to education.

Analysis of variance indicated that there is no significant difference in how the respondents perceive roles in terms of individual- versus family-care orientation according to education. It was found in testing Hypothesis XI that the respondents, in general, were more individual-care oriented than family-care oriented and when education was added as a variable it made no overall difference. It was found, however, that when each educational level was analyzed separately the Baccalaureate graduates were slightly more family-care oriented in their perceptions of ideal practice ($\overline{X}$=3.90, p<.07) but were less family-centered in their perceptions of actual practice ($\overline{X}$=2.92, p<.57). It is possible that a trend is suggested by this result which should be investigated further. Differences were not great enough to result in an overall significance of difference; therefore, the null hypothesis is not rejected. A summary of the results of this comparison may be found in Table XIV.

Hypothesis XIII. There is no significant difference in perception of roles in relation to individual- versus family-care orientation according to experience in public health nursing.

TABLE XIV

FAMILY VERSUS INDIVIDUAL ORIENTATION
BY EDUCATION

Orientation	Diploma		Baccalaureate Degree		Associate Degree			
	n	$\bar{X}$	n	$\bar{X}$	n	$\bar{X}$	F	p
Family								
Ideal	56	3.63	31	3.90	64	3.72	2.62	.07
Actual	55	3.04	31	2.92	64	3.03	.57	.57
Individual								
Ideal	55	4.12	31	4.15	64	4.13	.03	.97
Actual	56	3.96	31	3.93	64	3.90	.30	.74

TABLE XV

FAMILY VERSUS INDIVIDUAL ORIENTATION
BY EXPERIENCE

Orientation	Experience 1[a] n	$\bar{X}$	2[b] n	$\bar{X}$	3[c] n	$\bar{X}$	4[d] n	$\bar{X}$	F	p
Family										
Ideal	34	3.75	60	3.77	27	3.74	30	2.62	0.49	.69
Actual	33	2.95	60	3.09	27	2.99	30	2.93	0.90	.45
Individual										
Ideal	34	4.13	59	4.11	27	4.15	30	4.17	0.09	.97
Actual	34	3.97	60	3.96	27	3.84	30	3.89	0.57	.63

[a]1 = less than or equal to 1 year. [b]2 = More than 1 year; less than or equal to 5 years.

[c]3 = More than 5 years; less than or equal to 9 nines. [d]4 = More than 9 years.

There was no significant difference in the responses according to experience when comparing for individual-care orientation versus family-care orientation. It is interesting to note that some differences in means did appear but an analysis of variance revealed no significant differences when both within group and between group variances were considered. Based on the statistical analysis using analysis of variance and Duncan's multiple-range test the null hypothesis is not rejected. (See Table XV.)

Hypothesis XIV. There will be no significant relationship between community health nurses' importance of family concept scores and their perception of actual role performance by education and experience.

Analysis of data used Pearson's product-moment correlation with family concept scores as the dependent variable compared with role perception scores. Respondents were placed into six groups:

1. Associate degree graduates with years of experience equal to or greater than the median of five years.

2. Associate degree graduates with years of experience less than the median of five years.

3. Baccalaureate graduates with years of experience equal to or greater than the median of three years.

4. Baccalaureate graduates with years of experience less than the median of three years.

5. Diploma graduates with years of experience equal to or greater than the median of five years.

6. Diploma graduates with years of experience less than the median of five years.

This grouping facilitated data analysis to show the impact a combination of education and experience might have on the correlation between perceptions of actual role performance and importance of family concepts.

The correlation matrix of family concepts and role perceptions of Associate degree graduates with equal to or greater than five years experience showed only three *r*'s (4%) with $p<.05$. These indicated a positive correlation between the caregiver role and the family concept Holistic Approach to Family (CF item 5), and significant negative correlations between the roles of both teacher and counselor and the family concept Family Strengths (CF item 9). (See Table XVIII, Appendix G.)

The responses of Associate degree graduates with less than five years of experience indicated only four (5%) significant correlations. Positive correlations were found between the casefinder role and the concept of Family Communication Patterns (CF item 17) and between the counselor role and the concepts of Power in the Family (CF item 7). A negative correlation was indicated between the teacher role and the concept of Family Rights and Responsibilities (CF item 12) and the counselor role and the concept of Family Strengths (CF item 9). (See Table XIX, Appendix G.)

For Baccalaureate graduates with equal to or more than median years of experience (Mdn=3) only two (2.5%) significant positive correlations were found between the referral agent role and the concept of Family Culture (CF item 13) and between the counselor role and the concept of Family Culture. (See Table XX, Appendix G.)

For Baccalaureate graduates with less than the median years of experience (Mdn=3) only four (5%) significant correlations were found.

These were the casefinder role and the concept of Family Communication Patterns (CF item 17), the casefinder role and the concept of Family Life Styles (CF item 18), and the referral agent role and the concept of Family Strengths (CF item 9). There was a significant negative relationship between the counselor role and the concept of Family Function (CF item 3) in this group. (See Table XXI, Appendix G.)

The responses of Diploma graduates with equal to or more than the median years of experience (Mdn=5) showed significant positive correlations between the referral agent role and the concepts of Family History (CF item 1), Family Work (CF item 14), Sex Roles in Family (CF item 16), and Family Communication Patterns (CF item 17). There was also a significant positive correlation between the teacher role and the concept of Emotional and Social Development of Individuals in the Family (CF item 11). (See Table XXII, Appendix G.)

The responses of Diploma graduates with less than the median years of experience (Mdn=5) showed 12 (15%) significant correlations. These were found in three concepts, each of which correlated significantly and positively with four of the five roles. Positive correlations were between the casefinder role and the concept of Developmental Stages (CF item 19); the caregiver role and the concepts of Emotional and Social Development of Individuals (CF item 11), Family Work (CF item 14), and Developmental Stages of Family Members (CF item 19); the role of referral agent and the concepts of Emotional and Social Development and Family Work; the teacher role and the concepts of Emotional and Social Development, Family Work, and Developmental Stages of Family Members; the counselor role and the concepts of Emotional and Social Development, Family Work, and Developmental Stages of Family

Members. (See Table XXIII, Appendix G.) Since there is a limited degree of significant correlation demonstrated for all educational levels the null hypothesis is partially rejected.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The area of Family Studies is increasing to include almost every area of family life. One area that shows increased interest is the area of health care and the family demonstrated by the inclusion of sections related to family health in the programs of the recent annual conference of the National Council on Family Relations. Changes in the health care system and the increased emphasis on family-centered care by nurses practicing in the community setting make it imperative that the common interests of Community Health Nursing and Family Studies be explored. It was with that need in mind this study was conducted.

Limited research has been done on roles of community health nurses and a search of the literature did not reveal information on family concepts held by community health nurses. Nurses working with individuals and families in their homes and in the community environment have a unique opportunity to interact with families on a more intimate basis than any other professional group. This unique opportunity for nurse-family interaction and the lack of information about this interaction make it important to investigate community health nurses' concepts of family and perceptions of roles in working with families.

Nurses working in the community health setting come from varying education and experience backgrounds. The community health nurse may be a graduate from an Associate degree or Diploma program in nursing or have a Baccalaureate Degree in Nursing. These programs have varied amounts of family content in the curriculum. Not only is it important to know how community health nurses perceive families and their roles in working with families, it is also important to know if education and experience are related to these perceptions. It is also important to know if the nurses are more individual centered in relating to clients or do they see the family as a whole as their client.

The purpose of this study was to examine community health nurses' concepts of family and their role perceptions both ideal and actual. Attempts were made to identify the effects of experience and education upon these concepts and role perceptions. Attempts were also made to determine if there is a difference in how community health nurses perceive their roles to be in actual practice and how they should be ideally performed and to determine if they are more individual-care oriented or family-care oriented. Finally, efforts were made to determine if there is a relationship between the community health nurses' concepts of family and how community health nurses perceive their roles.

The subjects for this study were 217 community health nurses employed in local health departments under the supervision of the Oklahoma State Department of Health. One hundred sixty one or 74.2 percent returned the research instrument questionnaires. Of the group returned five held Master's degrees and four failed to state years of experience resulting in the exclusion of nine respondents from the

study leaving a total of 152 usable questionnaires. All 161 questionnaires were, however, included in the frequency responses but nine were excluded from statistical analysis when testing hypotheses. A questionnaire was distributed by district nursing supervisors and returned to the researcher by mail. The three-part questionnaire consisted of: 1) background information, 2) family concepts, and 3) the respondent's conception of roles.

Role theory was chosen as the conceptual framework for the study. A search of the literature gave many definitions of role. Thompson, Miller, and Bigler (1975) described the role of the professional as a sociological concept which helps to understand human behavior in social situations. It is the behavior prescribed for and expected of all persons who perform certain functions and it tells us what our duties, obligations, rights, and privileges are. Individuals occupy many roles.

Experts in the field of community health nursing have long emphasized the importance of education and experience upon this area of nursing practice to the extent that very often job descriptions and criteria for promotion are based upon years of experience and education. This study attempted to determine if the two factors, education and experience, did have an effect on how community health nurses perceive roles resulting in certain behaviors and the performance of certain functions in the roles they occupy.

Summary of Findings

The subjects of the study were all females with a mean age of 39 years. The largest number reported the Associate Degree as their

highest level of nursing education (42.8%). All 152 respondents included in the study were staff nurses with years of experience in public health nursing ranging from less than one year to more than 20 years. The mean years reported in their present position was 4.9 years.

A total of 14 hypotheses were tested in the study. Statistical analysis of the data revealed that according to this study community health nurses do, in general, place varying degrees of importance on the 15 concepts of family included in the study and that they rank ordered them according to perceived importance. Educational background and experience were related in a limited way to how the concepts were perceived.

Analysis of the data showed that the respondents did perceive roles to differ in actual performance. The role of teacher ranked number one in performance and the role of caregiver ranked number five in performance. Education and experience did not affect the perceptions of actual role performance by the respondents.

The respondents also differed significantly in how they perceived roles should be ideally performed, but education and experience were not associated with how they perceived the roles related to ideal performance.

The respondents were more individual-care oriented than family-care oriented in both ideal and actual practice. When education and experience were added as variables there was no significant difference overall as a result of either variable. When education was looked at separately the baccalaureate graduates were more family centered in ideal practice than the diploma and associate degree graduates but were less family centered in actual practice than the other two groups.

The baccalaureate graduates were more individual-care centered than family-care centered overall and ranked very close to the other two groups in both ideal and actual practice.

There was a limited correlation between family concepts and role perceptions by education groups and experience groups. Diploma graduates with less than three years of experience showed the highest number of significant correlations between concepts of family and perceptions of actual role performance.

Conclusions

The following conclusions were reached as a result of the study:

1. The respondents viewed the 15 family concepts to be significantly different according to perceived importance of the concepts. Education and experience, when added as variables, made no significant difference and apparently are not associated with how the respondents perceive the concepts. Including only one question relating to each concept may have limited the reliability of the responses to the concepts.

2. Perceptions of roles in the nursing process differed significantly between actual and ideal practice. Since education and experience are not significant in how the roles were perceived, the responses may be due to job descriptions and agency expectations based upon services offered within the agency.

3. The findings indicate that there are differences between perceptions held by public health nurses of actual performance and ideal performance of their roles. These findings indicate that the respondents think the roles are not being performed as they should ideally be

performed. Further study needs to be done in order to determine reasons for perceived differences and whether these differences are more strongly influenced by individual background or by agency expectations.

4. The respondents were more individual-care oriented than family-care oriented. When looking at the education groups individually it was found that the baccalaureate graduates were slightly more family-care oriented in ideal practice and less family-care oriented in actual practice than the other two groups. Analysis of responses by education groups presents findings which suggest a need for further investigation.

5. There is limited correlation between concepts of family and perceptions of role performance by community health nurses according to education and experience. The diploma graduates with less than three years of experience showed the highest number of significant correlations of the education groups. On the basis of the data it cannot be positively concluded that role perceptions and family concepts are correlated.

6. The results of this study indicate that graduates of the three types of nursing education programs studied are more alike than they are different in terms of their concepts of family and their perceptions of roles in the community health setting.

7. The questionnaire needs to be reworded and expanded to assure clarity of questions and to assure that the information needed is being obtained. Additional items need to be added so that family concepts are based on more than one item. Reliability needs to be further established.

Recommendations

Based on this study the following recommendations are made:

1. In order to better study concepts of family and role perceptions of community health nurses, a revision of the instrument to make it more reliable should be done.

2. Studies of comparable groups should be done in order to determine if the results can be generalized to the total population of community health nurses.

3. A study should be done in an effort to ascertain perceptions of the community health nurse's role held by other health care workers in local health departments, especially public health administrators.

4. In light of the fact that, according to this study, present levels of education and experience make limited significant difference in community health nurses' concepts of family and role perceptions, further study needs to be done in order to determine factors which do make a difference and whether specific curriculum and/or experience can modify perceptions.

5. Further study needs to be done to determine why community health nurses perceive they are not performing their roles as they ideally should be performed.

The purpose of this study was accomplished in that it examined education and experience as factors contributing to concepts of family and role perceptions of community health nurses. It also determined how nurses perceive their roles, both ideal and actual, and increased the knowledge available to educators and administrators concerning the orientation of community health nurses. It is hoped that this study may stimulate interest in pursuing the study of family concepts and

role perceptions of community health nurses and of family studies curriculum in nursing preparation programs. It is also hoped that requirements for level of preparation for entry into the practice of community health nursing with strong emphasis on family content will be a consideration for future study and practice.

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APPENDIXES

APPENDIX A

FREQUENCY RESPONSE - FAMILY CONCEPTS

TABLE XVI

FREQUENCY RESPONSE - FAMILY CONCEPTS

Family Concept Number (CF)	Rankings					
	Very Unimportant	Unimportant	Undecided	Important	Very Important	No Answer
1	0	0	0	52	109	0
Percentage	0	0	0	32.1	67.8	0
2	4	23	46	68	16	4
Percentage	2.5	14.3	28.6	42.2	9.9	2.5
3	4	18	26	79	33	1
Percentage	2.5	11.2	16.2	49.1	20.5	0.6
4	o	o3	o5	87	45	0
Percentage	0.6	8.1	9.3	54.0	28.0	0
5	19	60	41	36	4	1
Percentage	11.8	37.3	25.5	22.4	2.5	0.6
6	0	1	8	97	55	0
Percentage	0.0	0.6	5.0	60.2	34.2	0.0
7	57	79	19	2	0	4
Percentage	35.4	49.1	11.8	1.2	0.0	2.5
8	13	27	22	59	34	6
Percentage	8.1	16.8	13.7	36.6	21.1	3.7
9	1	0	6	120	33	1
Percentage	0.6	0.0	3.7	74.5	20.5	0.6
10	0	0	1	87	71	2
Percentage	0.0	0.0	0.6	54.0	44.1	1.2
11	22	51	39	34	7	8
Percentage	13.7	31.7	24.2	21.1	4.3	5.0
12	2	11	21	93	33	1
Percentage	1.2	6.8	13.0	57.8	20.5	0.6
13	41	40	27	32	15	6
Percentage	25.5	24.8	16.8	19.9	9.3	3.7
14	0	11	18	109	19	4
Percentage	0.0	6.8	11.2	67.7	11.8	2.5
15	6	47	23	68	13	4
Percentage	3.7	29.2	14.3	42.2	8.1	2.5

Note. N = 161 and includes all responses.

APPENDIX B

FREQUENCY RESPONSE - ROLE PERCEPTIONS

TABLE XVII

FREQUENCY RESPONSE - ROLE PERCEPTION

Role		Rankings					
		Very Unimportant	Unimportant	Undecided	Important	Very Important	No Answer
1	A[a]	2	15	7	91	43	3
	Percentage	1.3	9.3	4.4	56.5	26.7	1.9
	B[b]	4	55	32	51	12	7
	Percentage	2.5	34.2	19.9	31.7	7.5	4.3
2	A	1	7	30	98	19	6
	Percentage	0.6	4.3	18.6	60.9	11.8	3.7
	B	7	61	44	38	4	7
	Percentage	4.3	37.9	27.3	23.6	2.5	4.3
3	A	2	3	9	71	71	5
	Percentage	1.2	1.9	5.6	44.1	44.1	3.1
	B	3	17	29	87	23	2
	Percentage	1.9	10.6	18.0	54.0	14.3	1.2
4	A	0	2	3	74	79	3
	Percentage	0.0	1.2	1.9	46.0	49.1	1.9
	B	0	3	3	94	59	2
	Percentage	0.0	1.9	1.9	58.4	36.6	1.2
5	A	9	15	40	70	25	2
	Percentage	5.6	9.3	24.8	43.5	15.5	1.2
	B	20	70	38	25	5	3
	Percentage	12.4	43.5	23.6	15.5	3.1	1.9
6	A	0	7	10	80	61	3
	Percentage	0.0	4.4	6.2	49.7	37.9	1.9
	B	2	15	25	77	40	2
	Percentage	1.2	9.3	15.5	47.8	24.9	1.2
7	A	1	1	4	81	71	3
	Percentage	0.6	0.6	2.5	50.3	44.1	1.9
	B	1	4	9	95	49	3
	Percentage	0.6	2.5	5.6	59.0	30.4	1.9
8	A	5	19	37	72	27	1
	Percentage	3.1	11.8	23.0	44.7	16.8	0.6
	B	7	63	43	35	10	3
	Percentage	4.4	39.1	26.7	21.7	6.2	1.9
9	A	0	1	0	76	81	3
	Percentage	0.0	0.6	0.0	47.2	50.3	1.9
	B	0	1	2	87	69	2
	Percentage	0.0	0.6	1.2	54.0	42.9	1.2
10	A	17	30	22	60	30	2
	Percentage	10.6	18.6	13.7	37.3	18.6	1.2
	B	21	54	33	35	15	3
	Percentage	13.0	33.5	20.5	21.7	9.3	1.9

TABLE XVII (Continued)

Role		Rankings					
		Very Unimportant	Unimportant	Undecided	Important	Very Important	No Answer
11	A	1	7	9	75	66	3
	Percentage	0.6	4.4	5.6	44.6	41.0	1.9
	B	2	9	14	80	54	2
	Percentage	1.2	5.6	8.7	49.7	33.5	1.2
12	A	0	0	2	89	68	2
	Percentage	0.0	0.0	1.2	55.3	42.2	1.2
	B	0	2	4	95	58	2
	Percentage	0.0	1.2	2.5	59.0	36.0	1.2
13	A	1	21	29	66	39	5
	Percentage	0.6	13.0	18.0	41.0	24.2	3.1
	B	1	21	29	66	39	5
	Percentage	0.6	13.0	18.0	41.0	24.2	3.1
14	A	10	53	20	49	25	4
	Percentage	6.2	32.9	12.4	30.4	15.6	2.5
	B	15	49	25	49	18	5
	Percentage	9.3	30.4	15.5	30.4	11.2	3.1
15	A	3	31	36	69	18	4
	Percentage	1.9	19.3	22.4	42.9	11.2	2.5
	B	9	77	39	25	7	4
	Percentage	5.6	47.8	24.2	15.5	4.3	2.5

Note. N = 161 and includes all responses.

[a]A = Ideal. [b]B = Actual.

APPENDIX C

RELIABILITY MEASURES

Reliability Measures

Scales	Number of Items	alpha
Family concepts	15	.64
Nursing process		
Assessment	3	.23
Planning	3	.20
Diagnosis	3	.51
Implementation	3	.11
Evaluation	3	.27
Nursing role		
Casefinder	6	.83
Referral agent	6	.77
Teacher	6	.86
Counselor	6	.59
Caregiver	6	.78
Role performance		
Actual	15	.89
Ideal	15	.90
Orientation		
Family	14	.79
Individual	16	.90

APPENDIX D

INSTRUCTIONS FOR SUPERVISORS

September 13, 1984

Dear Supervisor:

Thank you for assisting me in collecting data for my dissertation.

Please provide one of the enclosed questionnaires to each staff nurse in your area. Nurse practioners and clinicians are not included in the study.

When the nurse has completed the questionnaire she will place it into the self-addressed, stamped envelope and mail it to me. It should take approximately 35 minutes to answer the questions.

All responses will be kept strictly confidential and no one will be identified as an individual. An abstract of findings will be furnished upon request.

Your time and effort are greatly appreciated.

Sincerely,

Ella Herriage

Ella Herriage, RN., MPH
3113 Raintree
Stillwater, OK 74074

APPENDIX E

COVER LETTER

September 13, 1984

Dear Public Health Nurse:

I am doing my dissertation as a part of the requirements for a Ph.D. at Oklahoma State University and I need your help.

I am interested in learning more about Public Health Nurses' concept of family and how the nurse perceives his/her role in working with families. Your assistance by responding to my questionnaire would be greatly appreciated.

Please take a few minutes to complete the attached questionnaire giving your personal response to the questions. There are no right or wrong answers, just your opinion.

Your responses will be kept strictly confidential and in no way will you be identified as an individual. Do not write your name on the questionnaire. Each questionnaire has been assigned a number in order that I may know which ones have not been returned.

When you have completed the three parts of the questionnaire please place it in the self-addressed, stamped envelope and drop it in the mail no later than October 15, 1984.

An abstract of the findings will be furnished to you upon request. Thank you for your time and effort. Your participation will be greatly appreciated.

Sincerely.

Ella Herriage

Ella Herriage, RN., MPH

APPENDIX F

DATA COLLECTION INSTRUMENT

Part I

Demographic Data

Instructions:

Please either circle the choice which best describes you or fill in the blank.

1. My primary job title is_____.

2. I spend the majority of my time in the area of:

   01. child health
   02. maternal health
   03. communicable disease
   04. home health
   05. chronic disease
   06. other, (specify)_____.

3. The highest degree that I hold in nursing is:

   01. Diploma _____ (Year) _____ (School) _____ (State).

   02. AD _____ (Year) _____ (School) _____ (State).

   03. BSN _____ (Year) _____ (School) _____ (State).

   04. Masters in Nursing _____ (Year) _____ (School) _____ (State).

4. Have you worked in public Health nursing other than in your present position?

   01. yes

   02. no

5. If the answer to question number four is yes please complete the following. List only Public Health Nursing experience.

   Areas of responsibility
   1 = child health
   2 = maternal health
   3 = communicable disease
   4 = home health
   5 = chronic disease
   6 = other (specify)_____.

Area of responsiblility Last job before this one	Place employed	Years at job
Area of responsibility previous job	Place employed	Years at job

Area of responsibility previous job	Place employed	Years at job
Area of responsibility previous job	Place employed	Years at job

6. I have been in my present job _____years.

7. My total number of years of experience in Public health nursing is_____years.

8. My age is_____years.

9. In my family of origin my parents are:

   01. my natural parents
   02. adopted parents
   03. single parent due to divorce
   04. single parent due to death of one parent
   05. other (specify)_____.

10. There were_____(number) children in my nuclear family.

11. My birth order is (were you born first, second, third, ect?)_____.

12. Do you have

   01. yes 02. no adopted brothers or sisters?
   01. yes 02. no step brothers or sisters?
   01. yes 02. no foster brothers or sisters?

13. What is your marital status?

   01. single never married
   02. married
   03. divorced
   04. widow

14. How many children do you have?

   01. ____natural
   02. ____adopted
   03. ____stepchildren
   04. ____total number of children

Part II

Concept of Family

Instructions:

This section consists of a list of 20 statements which the nurse may consider when providing care to the family in the community health setting.

Please read each statement and indicate if you think it is important or unimportant in carrying out the nursing process. Give your opinion: there are no "wrong" answers.

Indicate the degree to which you think the statements are important or unimportant by checking one of the alternative answers ranging from: VERY IMPORTANT, IMPORTANT, UNDECIDED, UNIMPORTANT, VERY UNIMPORTANT.

HERE IS AN EXAMPLE	Very Important	Important	Undecided	Unimportant	Very Unimportant
The community Health Nurse responds with sensitivity and warmth toward all family members.	___	✓	___	___	___

	Very Important	Important	Undecided	Unimportant	Very Unimportant
1. A family history is obtained on every client receiving prenatal care.	___	___	___	___	___
2. The nurse must have a feeling of prestige in the community health agency.	___	___	___	___	___
3. The nurse must be careful not to assign roles to family members when making a family nursing diagnosis.	___	___	___	___	___
4. The nurse must always have an opportunity for independent thought and action when working with families.	___	___	___	___	___
5. A nursing care plan is developed for all, family members receiving care from the public health nurse.	___	___	___	___	___
6. A position in the community health agency must provide an opportunity for the nurse to give help to other people.	___	___	___	___	___
7. When implementing a plan of care the nurse must find out who has the power in the family.	___	___	___	___	___

	Very Important	Important	Undecided	Unimportant	Very Unimportant
8. The nurse must always be consulted before new policies and procedures are put into force in the agency.	___	___	___	___	___
9. The nurse always views the family from a perspective of how a traditional family should function when evaluating care.	___	___	___	___	___
10. The nurse must be careful not to develop close friendships in the work setting.	___	___	___	___	___
11. Emotional and social development is always included in Individual Assessment.	___	___	___	___	___
12. The nurse should make all appointments for the family to be seen for health care relieving the family of this responsibility.	___	___	___	___	___
13. The nurse should not let a family's cultural beliefs cloud her judgement when making a family diagnosis.	___	___	___	___	___
14. The development of a family care plan always takes into consideration the work status of the mother and father.	___	___	___	___	___
15. The nurse is prepared to encounter differences in beliefs and behaviors related to health and illness when determining individual problems.	___	___	___	___	___
16. The nurse must remember that sex roles ascribed to in a family's particular culture are a private matter and should not be a part of nursing care.	___	___	___	___	___
17. Family communication patterns must be the first thing a nurse considers when evaluating the care given to the family.	___	___	___	___	___
18. The nurse evaluates care of all families in the same way regardless of alternative life style such as; single parent, step parent, communal family homosexual parents, and others.	___	___	___	___	___
19. The nurse knows the developmental stages of each of the family members when implementing a plan of care.	___	___	___	___	___
20. The nurse must know a formal definition of a family when assessing a family.	___	___	___	___	___

Part III

Community Health Nursing Role Conceptions

Instructions:

This section consists of a list of 15 situations in which a community health nurse might find herself. You are asked to indicate both:

(A) The extent to which you think the situation should be the ideal for nursing.

(B) The extent to which you think the situation actually exists in the community health agency.

Notice that there are two answers for each situation. Consider the statements of what should be the case and of what is actually the case separately; try not to let your answer to one statement influence your answer to the other statement. Give your opinions: there are no "wrong" answers.

Indicate the degree to which you agree or disagree with the statement by checking one of the alternative answers ranging from: STRONGLY AGREE, AGREE, UNDECIDED, DISAGREE, and STRONGLY DISAGREE.

STRONGLY AGREE	indicates that you agree with the statement with almost no exceptions.
AGREE	indicates that you agree with the statement with some exceptions.
UNDECIDED	indicates that you could either "agree" or disagree with the statement with about an equal number of exceptions in either case.
DISAGREE	indicates that you disagree with the statement with some exceptions.
STRONGLY DISAGREE	indicates that you disagree with the statement with almost no exceptions.

HERE IS AN EXAMPLE

Registered nurses in community health agencies consider the entire family when developing a plan of nursing care.

A. This is what the nurse should do.

B. This is what the nurse actually does.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1) A.		✓			
(2) B.				✓	

Be sure to place a check mark after both statements A and B according to you degree of agreement with it.

Situation:

1. The community health nurse made an appointment to see the entire family on her first home visit to a patient with tuberculosis.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

2. A community health nurse planned and carried out a family screening program for health risk factors in her area.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

3. One community health nurse, while working with young mothers, noted that one of the mothers was rejecting her baby. The nurse developed a plan to determine the parenting skills of the young mother.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

Situation:

4. A nurse discovered that a 2 year old child had a hearing impairment. Her main function was to act as a resource to refer the child to an agency for care.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

5. Public Health Nurses in agency Y meet routinely with other agencies in the community to discuss families with problems.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

6. A nurse who was working with Mrs. A discovered she was being abused by her husband. She referred Mrs. A to a shelter for battered wives.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

Situation:

7. One community health nurse developed a teaching plan for a diabetic patient to be implemented in the home.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

8. A nurse, as a part of her nursing intervention, discussed with the family the impact of an unplanned pregnancy upon each member of the family.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

9. A nurse working in a local health department developed a plan to teach a home health patient to care for her own colostomy.

   A. This is what the nurse should do.

   B. This is what the nurse actually does.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

Situation:

10. A nurse working in public health agency Z received a referral from a school nurse reporting that child abuse was suspected in the case of a 3rd grade girl. The nurse made a home visit and as a part of her assessment she attempted to help the family identify family stresses which might lead to abusive behaviors.

    A. This is what a nurse <u>should</u> <u>do</u>.

    B. This is what a nurse <u>actually</u> <u>does</u>.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

11. A nurse working in an adolescent health clinic discovered that a 13 year old female was sexually active. She assured the teenager that all information is confidential and encouraged her to discuss the matter with her parents.

    A. This is what a nurse <u>should</u> <u>do</u>.

    B. This is what a nurse <u>actually</u> <u>does</u>.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

12. A nurse counsels a family about available community resources which may help them to meet their health care needs.

    A. This is what a nurse <u>should</u> <u>do</u>.

    B. This is what a nurse <u>actually</u> <u>does</u>.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

Situation:

13. A nurse visits a 96 year old woman in her home on a daily basis in order to change her dressings.

    A. This is what a nurse <u>should</u> <u>do</u>.

    B. This is what a nurse <u>actually</u> <u>does</u>.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

14. A community health nurse in agency Y is assigned to work in the immunization clinic giving immunizations to infants and preschoolers on a full time basis.

    A. This is what a nurse <u>should</u> <u>do</u>.

    B. This is what a nurse <u>actually</u> <u>does</u>.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

15. The nurse caring for Mrs. G. in the family planning clinic asked that Mr. G. accompany her on her next visit to the clinic to discuss future plans for contraception.

    A. This is what a nurse <u>should</u> <u>do</u>.

    B. This is what a nurse <u>actually</u> <u>does</u>.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	A					
(2)	B					

APPENDIX G

CORRELATION MATRIX

TABLE XVIII

CORRELATION MATRIX FOR ASSOCIATE DEGREE WITH EXPERIENCE ≤ MEDIAN: FAMILY CONCEPTS AND ROLES

Concept Item	Role				
	Case-finder	Care-giver	Referral Agent	Teacher	Counselor
1	-.19	.03	.36	.18	.24
3	-.22	.24	.15	.01	.10
5	-.14	.40	.13	.16	.13
7	.14	.06	.16	.06	.31
9	-.04	.06	.04	-.53	-.52
11	.10	.13	.10	.27	.09
12	.08	.25	.18	-.09	-.24
13	-.07	-.01	.28	-.22	-.14
14	.03	-.03	-.13	-.16	-.04
15	-.17	.29	.04	-.02	.16
15	-.24	.08	.07	-.34	-.25
17	-.08	.01	.14	-.07	-.13
18	.10	.15	.21	-.13	-.22
19	-.09	.14	-.16	.10	.05
20	.08	.24	-.09	-.24	-.29

Note. Concept item numbers refer to the research instrument, Part II, Concept of Family. Roles reflect 3-item subscales in Part III Nursing Role Conceptions. n=28; df=26; Mdn=5; Significant r=.37, p<.05.

TABLE XIX

CORRELATION MATRIX FOR ASSOCIATE DEGREE WITH EXPERIENCE < MEDIAN: FAMILY CONCEPTS AND ROLES

Concept	Role				
	Case-finder	Care-giver	Referral Agent	Teacher	Counselor
1	.25	.14	-.01	-.04	.02
3	-.07	-.18	.26	-.07	.06
5	.18	.03	-.02	.21	.21
7	.04	.28	.29	.27	.39
9	-.05	-.14	-.18	-.12	-.45
11	.07	-.05	-.03	.17	.22
12	-.16	-.22	-.19	-.38	-.26
13	.15	-.01	.03	.06	.12
14	.07	.20	.17	.21	.26
15	.03	.11	.10	.20	.21
16	-.16	-.20	-.18	-.19	.21
17	.46	.18	.07	.35	.29
18	-.16	.05	-.06	.05	.00
19	.07	.25	-.06	.15	.24
20	.18	.25	.14	.18	.18

Note. Concept item numbers refer to the research instrument, Part II, Concept of Family. Roles reflect 3-item subscales in Part III, Nursing Role Conceptions. n=29; df=27; Mdn=5; Significant r=.36, p<.05.

TABLE XX

CORRELATION MATRIX FOR BACCALAUREATE WITH EXPERIENCE ≧ MEDIAN: FAMILY CONCEPTS AND ROLES

Concept Item	Role				
	Case-finder	Care-giver	Referral Agent	Teacher	Counselor
1	-.01	-.03	.14	-.10	-.19
3	.15	-.27	-.10	.06	-.17
5	.05	-.41	-.11	-.01	-.16
7	-.28	-.21	-.19	-.21	-.40
9	.39	.17	-.20	-.32	-.11
11	-.10	-.45	-.03	-.22	-.11
12	-.05	.30	-.30	.05	.25
13	.38	.19	.63	.29	.78
14	.30	.35	.12	.09	.27
15	.06	-.01	-.04	-.06	-.02
16	-.33	-.27	-.21	-.23	-.00
17	-.27	-.04	-.46	-.27	-.38
18	-.35	.41	-.03	.14	.21
19	.03	-.16	-.49	-.41	-.25
20	-.01	-.05	.21	.30	.08

Note. Concept item numbers refer to the research instrument, Part II, Concept of Family. Roles reflect 3-item subscales in Part III, Nursing Role Conceptions. n=15; df=13; Mdn=3; Significant r=.51, p<.05.

TABLE XXI

CORRELATION MATRIX FOR BACCALAUREATE WITH EXPERIENCE < MEDIAN: FAMILY CONCEPTS AND ROLES

Concept Item	Role				
	Case-finder	Care-giver	Referral Agent	Teacher	Counselor
1	.17	.15	.16	-.02	.19
3	-.01	-.17	-.33	.23	-.56
5	-.25	.16	.05	-.40	.16
7	-.15	-.34	.28	.35	-.14
9	.10	-.44	.71	-.42	-.16
11	-.11	.37	.36	.04	-.06
12	-.08	.05	.01	-.30	-.14
13	.04	.16	-.08	.31	-.34
14	.21	.21	.36	.25	-.28
15	-.22	-.13	.09	.15	-.26
16	.38	.29	.02	-.27	-.11
17	.58	.30	.19	-.08	.17
18	.51	.20	.15	.04	.04
19	.44	.34	.19	.17	-.35
20	.29	-.24	-.30	-.14	-.16

Note. Concept item numbers refer to the research instrument, Part II, Concept of Family. Roles reflect 3-item subscales in Part III, Nursing Role Conceptions. n=16; df=14; Mdn=3; Significant r=49, p<.05.

TABLE XXII

CORRELATION MATRIX FOR DIPLOMA WITH EXPERIENCE ≧ MEDIAN: FAMILY CONCEPTS AND ROLES

Concept Item	Role				
	Case-finder	Care-giver	Referral Agent	Teacher	Counselor
1	.01	.01	.37	.13	.07
3	-.22	-.07	-.07	-.01	.16
5	.08	.02	.19	.13	.07
7	-.18	-.15	.01	-.01	.06
9	.22	.11	.07	-.06	.32
11	.01	.06	.24	.39	-.17
12	.07	-.26	-.01	-.11	-.22
13	-.03	.17	.07	.15	.28
14	.25	.19	.42	.28	.09
15	.24	-.05	.13	.36	-.25
16	.24	-.08	.38	.15	.09
17	-.06	.07	.42	.10	.01
18	-.17	-.02	-.09	-.35	-.15
19	-.34	-.23	-.01	-.12	-.01
20	.09	.16	.32	.31	.34

Note. Concept item numbers refer to the research instrument, Part II, Concept of Family. Roles reflect 3-item subscales in Part III, Nursing Role Conceptions. n=28; df=26; Mdn-5; Significant r=.37, $p<.05$.

TABLE XXIII

CORRELATION MATRIX FOR DIPLOMA WITH EXPERIENCE
< MEDIAN: FAMILY CONCEPTS AND ROLES

Concept Item	Role				
	Case-finder	Care-giver	Referral Agenr	Teacher	Counselor
1	-.12	.00	-.04	-.00	.11
3	-.13	.14	.04	.03	-.07
5	.11	.09	.09	.12	.12
7	.00	.19	.16	.13	.15
9	-.11	.25	.00	.25	.00
11	.19	.34	.32	.33	.34
12	.08	.23	.04	.06	.01
13	.09	.04	.17	.27	.10
14	.30	.49	.37	.55	.39
15	-.22	.18	.26	.27	.20
16	.09	-.14	-.26	-.17	-.02
17	.02	.20	-.05	-.02	-.02
18	-.06	.09	-.07	.03	.03
19	.38	.55	.31	.48	.40
20	.26	.35	.15	.47	.14

Note. Concept item numbers refer to the research instrument, Part II, Concept of Family. Roles reflect 3-item subscales in Part III, Nursing Role Conceptions. n=36; df=34; Mdn=5; Significant r-.32, $p<.05$.

2

VITA

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