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AN EXPLORATORY STUDY OF THE ATTITUDES OF PUBLIC HEALTH NURSES TOWARD GROUP WORK WITH IMPLICATIONS FOR CURRICULUM DEVELOPMENT

by

Marion Isabel Murphy

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in the
University of Michigan
1958

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M.I.M.

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CHAPTER I

THE NATURE OF THE PROBLEM

Group work in public health nursing is not new but its relative importance as a way of giving service to people has been emphasized in recent years, particularly in official health agencies. There is a resultant need for each university program of study preparing nurses for the public health field to re-examine its curriculum objectives and offerings in the group work area. Such curriculum study would be greatly facilitated were information available from public health nurses in the field as to how they look upon group work, what skills they feel are involved, and how they think they learned what they know. It is such a group of public health nurses who will be the subjects for this study in the hope that a "field approach" will give increased vitality and reality to academic preparation for the group work function.

Definition of the Problem and Method of Approach

The problem of the study is to explore the attitudes of a sample of health department nurses toward group work, to study the relationships between attitudes and nursing background, and to point up any possible implications for public health nursing education.

The selection of a method of approach to this type of problem posed several questions. Although the problem was in the realm of education and might thereby be expected to be formalized by statements of hypotheses, this was not found to be possible. The study attempts to relate curriculum content to public health nursing practice but

neither the elements of preparation nor the aims of practice were sufficiently standardized to allow for very rigorous conclusions concerning the relationship. After considering several hypotheses, such as that preparation in public health nursing would result in certain skills, or that attitudes could be tested using preparation or lack of it as the main variable, it was concluded that the study must be considered exploratory and descriptive rather than more definitive and theoretical. Rather than allowing complete freedom, the writer found that the exploratory approach imposed responsibility for specifying what relationships were under scrutiny, which interrelationships could be analyzed, and how each was a part of the central problem.

Subheadings of Problem and Objectives

For further clarification, the problem was divided into three subheadings with objectives developed for each part. The first of these subheadings was: How a selected group of health department nurses feel about the importance of group work in public health nursing. Specific objectives here were as follows:

1. To learn what the nurse believes is the relative importance of group work as part of her job.
2. To learn how the nurse differentiates between working with existing community groups or organizing new groups.
3. To learn how the nurse differentiates between her roles as a group member, resource person, discussion leader, and "teacher".
4. To learn in which type of group activity the public health nurse believes that she makes her best and poorest contribution and why.
5. To learn if there are difficulties or barriers commonly encountered by public health nurses in working with groups.

The second subheading was: How the nurses in the study group feel that preparation for group work can best be obtained. Specific objectives were:

1. To learn what experiences the nurses in the study group had found most helpful in preparing for four specific group work roles.

2. To learn which factors these nurses consider to be most important in preparing public health nurses to do any type of group work in public health nursing.

The third subheading of the problem was: How the feelings that these nurses have toward group work might be related to their preparation and experience in public health nursing. One objective relating to this was divided into two parts:

1. To learn if their attitudes toward group work seem to be related to:

   a. Academic preparation in public health nursing or lack of it.

   b. Length of experience in public health nursing.

These three subheadings of the problem will be referred to as Parts I, II, and III throughout the study.

Justification for the Study

There seems to be considerable difference of opinion on the part of public health nurses and other workers in the public health field as to what constitutes "group" activity, what is involved in the preparation for group work and how one grows in group work skills. This situation is complicated by the fact that the public health nurse may be a participant in many groups, a resource person in some, a leader or a "teacher" in others. These differences of opinion have been reflected to some extent in degree of emphasis on the group work function in the approved programs of study which are preparing nurses for beginning positions in public health nursing. How much these variations have affected field practice in public health nursing is not known, and might be difficult to estimate since, in the country as a whole, only approximately a third of the nurses working in public health

have completed a year or more of approved university preparation. Even in Michigan, where in 1953, the ratio was somewhat better than the national average, approximately 50 percent[1] of the nurses currently employed in public health had completed a year or more of preparation.

In considering what preparation for group work might be, it seemed important to review many related factors. In a sense, group work could not be separated from the whole unique segment of the health services known as public health nursing. The development of the public health nurse as a group leader is closely related to her development as a professional person, as a practitioner with individual patients and families, and as a member of an agency staff. Certainly the types of groups with which nurses are identified are related to services rendered by the health department in the community. In her work with groups, as in her work with families, she probably reflects much of herself and of the atmosphere of the agency she represents. It is hoped that this study will show certain ways in which practitioners are identifying themselves with group work within the agency and community framework in which they operate, and that such findings will contribute to curriculum planning for public health nursing.

A question might well be raised, "Can such information concerning feelings and attitudes be obtained? Do we have means of getting at such data and will the returns be worth the effort? Likert, in speaking before a public health audience, compared other types of governmental survey problems with those in public health in a way which the writer found encouraging.

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[1] Annual Census of Nurses Employed for Public Health Work, (Washington, D.C.: U. S. Dept. of Health, Education and Welfare, Public Health Service, 1953), Table III.

He said,

> I am confident that it is possible to obtain similar data to yield insights into the motivations of people with regard to health behavior and to learn about people's attitudes and level of information regarding health problems. These are fundamental facts required along with other data for an intelligent analysis of the nature of the health problems of the nation and for the planning of activities to improve health.[1]

Timeliness of Study

With the publication of the Public Health Nursing Curriculum Guide[2] in 1942, the need for including preparation for group work in public health nursing education received support from within the profession. While there were programs of study which included some group work emphasis before the publication of the Curriculum Guide, it is safe to say that emphasis increased thereafter, particularly in the development of special courses for nurses, many times under a "teaching methods" title.

In Chapter III under the heading Review of Literature, the writer will use as a point of departure the group work objectives from the Curriculum Guide. Related public health and public health nursing literature prior to and following its publication will be briefly reviewed to see to what extent it seems to reflect the emphasis in the Guide. The writer also will review this same literature as well as a representative bit from the group dynamics field in order to establish any possible relationships with the objectives of this study.

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[1] Rensis Likert and Stanley Seashore, "The Sample Survey", Proceedings for Second Conference on Public Health Statistics, (Ann Arbor: School of Public Health, University of Michigan, 1952), p. 25.

[2] The Public Health Nursing Curriculum Guide, (New York: National League for Nursing, 1942).

The writer has included in the Appendix[1] a list of suggested objectives for group work in the public health nursing curriculum. These are not presented as a suggested revision of the Curriculum Guide material but rather as a possible outline for a resource unit on group work in public health nursing. While drawn to some extent from the writer's own experience in teaching a group work course, as well as from her agency experience, these objectives also reflect suggestions and contributions from a number of professional colleagues. They are included in this study simply as additional evidence as to what has been happening in the development of education for group work in public health nursing and perhaps will pull together and crystallize information supplied by the review of literature.

This effort seems especially timely today when basic collegiate schools of nursing are being encouraged to include preparation for public health nursing as part of the four year degree program. The public health nursing profession is being asked to supply an answer to controversial questions: What is distinctive about group work in public health nursing - what are some of the group work skills required and how did today's practitioners learn them? How do "prepared" public health nurses feel about the preparation for working with groups which they received in a university program? What weight do they attach to such preparation as compared to inservice education in the job setting? To what extent are the attitudes of the "prepared" nurses toward group work different from those of the "unprepared"? To what extent does public health nursing experience seem to influence the attitudes of both groups of nurses?

The need for such information presents a challenge. Before university programs of study can consider whether to add more hours or different

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[1]These suggested objectives may be found in Appendix A.

learning activities to group work preparation, the question needs to be raised, "More of what?" "Why?" It is hoped that this study can contribute at least a small bit of much needed information which will help answer these questions.

Definition of Terms

Attitude - The term "attitude" as used in this study refers to an individual's tendency to think and feel in a certain way about something. Newcomb describes an attitude as a person's "predisposition to perform, perceive, think, and feel"[1] in relation to the subject. Krech and Crutchfield say, "An attitude can be defined as an enduring organization of motivational, emotional, perceptual, and cognitive processes with respect to some aspect of the individual's world".[2]

Group. While in the opinion of experts, there is no acceptable definition of a group which can be said to supersede all others, the writer feels that the following quotation from Cattell represents an inclusive point of view which covers well the types of groups concerned in this study. "A group is a collection of organisms in which the existence of all (in their given relationships) is necessary to the satisfaction of certain individual needs in each."[3] In other words, "The group is an instrument toward the satisfaction of needs in the individual."[4] Individuals find certain satisfactions in belonging to a group which, at least for them, had not been as

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[1]Theodore M. Newcomb, Social Psychology. (New York; Dryden Press, 1950), p. 118.

[2]David Krech and Richard S. Crutchfield, Theory and Problems of Social Psychology, (New York: McGraw-Hill Book Co., 1948), p. 152.

[3]Raymond B. Cattell, "New Concepts for Measuring Leadership, in Terms of Group Syntality", Group Dynamics, ed. by Dorwin Cartwright and Alvin Zander (Evanston, Ill.: Row-Peterson and Co., 1953), 20.

[4]Ibid.

readily accessible in another way. It will be noted that such a definition does not describe groups only in terms of interaction or common norms although these characteristics may be essential to some types of groups.

Differentiation between group and organization seems necessary also since the latter term describes some of the environment in which the public health nurse operates. In speaking of social organization, Stogdill[1] points out that while a group may or may not have leaders, when it does it is an organization. Similarly, if group members have mutual responsibilities for a common task then the group is an organization - a particular kind of group.

Group work. As used in this study, the term group work will include all the agency and community group or organization activities in which the nurse functions either as a member or non-member. Within these groups or organizations she might perform certain roles such as participant, discussion leader, resource person, speaker, or "teacher".

Some of these community groups encountered by public health nurses in their work are well established and highly cohesive in character, while others may be simply people who happened to come to a certain meeting, clinic or class. According to the previous definition, the former would be termed organizations while the latter would not meet criteria for the "group" category. As a representative of a community service agency, the public health nurse would, in the first instance, contribute to helping the members carry out their responsibilities toward the achievement of goals. In the case of the "audience" type of gathering, she would utilize whatever group methods seemed favorable to stimulating learning on the part of the members. The latter type of meeting is included under the group work

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[1]Ralph M. Stogdill, "Leadership, Membership and Organization", Group Dynamics, op. cit., p. 41.

heading in this study since it is rather prevalent in public health nursing practice. Its limitations are recognized by the writer.

Class, organized class, or health class as used hereafter will designate groups which are organized and hold a series of meetings for the express purpose of learning about a selected area of health content - classes for expectant mothers or parents and home nursing classes are perhaps the best examples of these. A community or school group which invites the nurse in to "talk" at a particular meeting is not a class in this sense and would fall under the broader "group work" category. Again, it seems important to point out that the cohesiveness of class groups will vary greatly. For example, in mothers' classes the only common factor may be pregnancy; the extent to which these group members band together or "organize" may be limited. While the group may serve as "an instrument toward the satisfaction of needs in the individual"[1] it is well to recognize that this too, is apt to vary in degree.

Approved program of study in public health nursing[2] refers to either one of two types of collegiate preparation which have been approved by the Accrediting Service of the National League for Nursing. The two types are:

a. A collegiate basic nursing program leading to a baccalaureate degree. Public health and public health nursing content is included with clinical instruction and additional public health courses prepare students for at least eight weeks of public health nursing field experience in the senior year, or such courses are

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[1]Cattell, op. cit., p. 20.

[2]Completion of an Educational Program in Nursing Approved for Public Health Nursing, Publication No. 557 (New York: National League for Nursing, 1951).

offered concurrently with field experience. The collegiate program generally covers four calendar years and its graduates are eligible for licensure. As of 1953, 14 of the 97 approved collegiate basic nursing programs in the United States had this "extra" approval to prepare nurses for the field of public health nursing.

b. A program for graduate nurses leading to a baccalaureate or higher degree with a major in public health nursing. This is a program for nurses who have graduated from a three-year course in a hospital school of nursing. These nurses have a diploma from their schools and have passed state licensing examinations; they are commonly referred to as "graduate" or "registered" professional nurses. When this nurse enters a college or university program in nursing she receives approximately one year of credit for her three-year nursing course. The college or university offers a program of about three years which combines general and professional education. The professional major in this program requires at least one school year and includes three or four months of field practice.

Because of the need in the public health field for "prepared" nurses many colleges and universities have allowed students to enroll directly in the professional portion of the program prior to taking any general education courses. Thus, a public health nurse might have been enrolled in an approved program of study but lack the "rounding-out" influence of general education. While this is a controversial issue in nursing education, it is not relevant to this study. As of 1953, 35 approved programs offering a major in public health nursing as part of a baccalaureate degree curriculum existed in colleges and universities in the United States.

A third category known as a "general" or "pre-specialization" program in nursing for graduate nurses will not be defined here except to say that public health nursing content is included in approximately the same amount as in the collegiate program. Only one such program has been approved by the Accrediting Service as of 1953, and it was not felt that this type of preparation was a significant factor in describing public health nursing preparation in Michigan at this time.

A "prepared" public health nurse is difficult to define with exactness today. For purposes of this study, a nurse will be considered "prepared" in public health nursing if she is a graduate of an approved collegiate basic program as described above (a) or if, as a graduate nurse, she has completed one school year of public health nursing preparation in an approved program as described above (b). Although completion of the major in public health nursing in many university programs requires more than an academic year, the Public Health Service[1], in its annual count, divides public health nurses into those having "completed one or more academic years" of study from those with less preparation. There may be nurses practicing public health nursing today who have had a year of preparation but no specific preparation for group work since such courses are apt to be offered toward the end of the program. Completion of an approved program of study, or in many agencies, a year of study, means that the college and/or the agency considers that a nurse is ready for a staff position in a public health nursing agency under nursing supervision. Graduate nurses who have completed the public health nursing major in an approved program, regardless of degree status, are

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[1]Annual Census of Nurses, op. cit., Table III.

usually considered "prepared" in terms of civil service or other employment regulations.

This discrepancy in agreement on a standard of preparation for public health nursing is a puzzling situation, since presumably both parties (Public Health Service and universities) are concerned with high standards of practice. However, it is not relevant to the purposes of this study except to help define what apparently escapes clear definition, namely preparation for public health nursing.

Inservice education as used here refers to educational activities undertaken "on-the-job" which have as their purpose improvement in knowledge, understanding, or skill in group work. Such activities would be sponsored or approved by the employing agency and the group might be composed of agency staff or wider community, regional, or state membership. An in-service education project on group work shared by health workers, school, social agency, or other personnel would also come within the scope of this definition.

A health department is an organized branch of government financed by tax funds and charged with certain responsibility for protection of the people's health. Broadly speaking, these responsibilities are carried out through activities directed toward the prevention and control of disease, and measures which contribute to maintenance of positive health in individuals and groups within the population. The jurisdiction of a "local" department may cover a city, a county, a city and county, or a district made up of several counties. Traditionally, public health nursing in a health department has been identified with prevention, "teaching", or educational aspects rather than with the giving of nursing care to patients at home. This is changing in recent years, especially in areas where the health department is the only public health agency and the need for home nursing

among certain population groups is more acute.

A voluntary public health nursing agency is one which does not receive tax support. Its funds may come from a number of sources such as contributions or subscriptions, "Community Chest" or other organized fund appeals, fees for service, other voluntary agencies like a Cancer Society, etc. The voluntary or "private" agency in public health nursing is characterized by a board of representative citizens who administer its business affairs and serve as an interpretive group to the community. The most common name for this type of agency is visiting nurse service or visiting nurse association. Traditionally its program has been home care of the sick but with prevention of disease and health teaching emphasized also. Formerly, in many communities, a visiting nurse service rather than a health department was responsible for health education activities in the maternal and child health field on a demonstration basis. These activities often included expectant mothers' classes. In recent years, health departments have assumed increased responsibility for such programs although, for the country as a whole, the picture would be spotty.

Combination agency refers to a "service that is jointly administered by both governmental and voluntary agencies; financed by tax funds, earnings, and contributions; and in which all field services offered by the participating agencies are rendered by a single staff of public health nurses"[1]. While there were only two agencies of this type in Michigan, it seemed necessary to distinguish them from health departments for the purpose of this study.

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[1] A Study of Combination Services in Public Health Nursing (New York: National League for Nursing, 1950), p. 1.

CHAPTER II

THE METHOD OF INVESTIGATION

The Study Design

The survey method, based as it is upon clearly defined objectives, seemed most appropriate for this study. The development of a survey design suitable for the exploration of the problem called for very careful planning of each step. Moreover, each step had to be tested out in terms of the objectives to be sure that, in so far as possible, extraneous material was excluded, and even more important, gaps were closed and essential information included. The pages which follow in Chapter II will attempt to show, at times in considerable detail, how the survey method was followed. It is hoped that this illustration of method in this as well as in later chapters will lend support to the much quoted characteristic of survey research "the objectives write the report."

Further Development of Objectives

The initial introduction of the objectives for the study on page 2 showed that they had been developed in relation to the three parts of the problem. Next it was necessary to elaborate further on the objectives, through a number of subheadings each of which served as a basis for one or more questionnaire[1] items. To clarify this step further the main objectives with their subheadings follow with specific relationships to questionnaire items shown by Arabic numerals in the left margin. Further discussion of the questionnaire will be found on page 16.

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[1]A copy of the questionnaire may be found in Appendix B.

Part I of the Problem: How a selected group of health department nurses feel about the importance of group work in public health nursing.

Objectives:

1. To learn what the nurse believes is the relative importance of group work as a part of her job. Is it:

1, 17 a. Basic to her concept of health education service to the community?
17, 17a b. Her feeling that the group experience contributes to effectiveness of health education?
4, 5 c. A part of her work requiring additional skills than individual health counseling?
5, 10, 18 d. The same process, in terms of skills involved, whether in agency or community situations?
2 e. Her preferred method of giving service?

2. To learn how the nurse differentiates between working with existing community groups and organizing new groups - in terms of:

13, 14, 15 a. Skills involved in group organization.
11, 12 b. Whether group is sponsored by health department or other community agency.
16 c. Time involved in group organization vs. time saved in reaching more people.

3. To learn how the nurse differentiates between her roles as a group member, resource person, discussion leader, and "teacher" - in terms of:

6, 7 a. Identification of skills of resource person and discussion leader.
8, 9 b. Any additional time involved in preparing for responsibilities as a resource person, discussion leader, or "teacher".

4. To learn in which type of group activity the public health nurse believes that she makes her best and poorest contribution.

Is her feeling related to:

a. Whether it is an agency or community group?

18 b. Whether she is a participant, resource person, discussion leader, speaker, or "teacher"?

10 c. A desirable sequence for learning about group work?

25 5. To learn if there are difficulties or barriers commonly encountered by public health nurses in working with groups.

Part II of the Problem: How the nurses in the study group feel that preparation for group work can best be obtained.

Objectives:

1. To learn what experience the nurses in the study group have found most helpful in preparing for the following:

20, 20a a. Being a participant in group discussions in agency or community.
21, 21a b. Being a health resource person at school or community meetings.
22, 22a c. Being a discussion leader in agency or community groups.
23, 23a d. Being a teacher for an organized series of health classes.

2. To learn which factors these nurses consider to be the most important in preparing public health nurses to do any type of group work in public health nursing - in terms of:

24 a. University courses relating to group work.
19 b. Inservice education designed to improve group work skills.
3 c. Membership and participation in a wide number of groups.
26 d. Other influences such as supervision, common purposes.

Part III of the Problem: How the feelings that these nurses had toward group work might be related to their preparation and experience in public health nursing.

Objectives:

1. To learn if their attitudes toward group work are related to:

30, 24 a. Academic preparation in public health nursing or lack of it.
29, 2 b. Length of experience in public health nursing.

The Questionnaire[1]

A mail questionnaire was developed from the objectives set for the study. Writing the questions presented many difficulties, the greatest of which was communicating a feeling of interest in the respondents-to-be and a warm regard for the value of their answers. With this in mind, many of the questions first were written in open-end interview form and later re-adjusted into poll-type questions and checklists.[2] In some instances, the

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[1] Ibid.

[2] Paul Lazarsfeld, "The Controversy over Detailed Interviews", Public Opinion Quarterly, VIII (1944), 38-60.

leads purposely were left rather long and conversational in style. Even at the danger of lengthening the questionnaire, this opportunity for clarification and interpretation of the questions could not be disregarded.

Many of the problems associated with the use of this type of fact-finding instrument were explored and fully appreciated by the writer. The length of the questionnaire (33 questions, 11 pages) in the opinion of some authors[1] would be a negative factor. The form of some of the questions, asking respondents to rank their responses or fill in reasons, was a known risk. It was a calculated risk, however, because in the opinion of the writer, such questions seemed to be the best way of securing certain information sought by the objectives. Because of several limitations, but mainly time, a mail questionnaire seemed to be the only choice open to the writer.

Aside from the above problems, it was possible to formulate questions which seemed to express the intent and philosophy of the objectives. In translating objectives into questionnaire items, care was taken in the phrasing so that questions would not reflect any specific curriculum emphasis or seek approval for one type of group work practice over another. In an effort to check on internal consistency in an individual's responses, in most instances two and occasionally three questions were asked relative to the same sub-objective.[2] While questions were developed following the order of the objectives, in the final version of the questionnaire, the 33 questions were rearranged in what seemed to be the most free-flowing, acceptable sort of sequence.

Pretesting of the questionnaire was carried out with a selected group of public health nursing students enrolled in the School of Public

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[1]Mildren B. Parten, Survey, Polls, and Samples (New York: Harper and Brothers, 1950), p. 385.

[2]Supra, pp. 14-15.

Health at the University of Michigan, and in the Washtenaw County Health Department located in Ann Arbor, Michigan. Follow-up interviews with pretest subjects were done to determine any points of difficulty in interpretation, clarity of subject matter, and the best sequence. This proved to be a most helpful step and, in general, the results were reassuring to the writer.

Plan for Coding

Before each item was approved for inclusion in the questionnaire, a plan was made for its coding. Coding of the pretest responses sometimes resulted in the structure of a question being changed or directions being made more specific. Since IBM analysis of data was planned, the code for each question was arranged under column headings with 0 designated for "no response" and the 1 - 9 spaces for alternative replies.

Provision for coding answers to open-end questions, such as reasons for a certain response, was made by using 2 columns, the first classifying the response and the second designating the more specific reason. In questions requiring a 1 - 2 - 3 or other amount of ranking of relative importance of response, a separate column was used for each possible choice. In one or two questions where multiple responses were requested, coding was set up by columns so that each answer would be available independently.[1]

In the opinion of the writer, this preliminary effort, while time-consuming and often tedious in nature, greatly increased the objectivity of the data. It also proved to be an essential step in relating objectives to questions and later to tables.

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[1]A copy of the code developed for this study may be found in Appendix C.

Plan for Tables

Tentative preliminary tables were made in open block form, following closely the three subheadings of the main problem and then the individual objectives. Planning for tables at this point was an essential step in preparing the data for IBM analysis. It was necessary to decide in advance what data should be tabulated from each card, and, in terms of the remaining columns available, what should follow. Thus, the items from the code were grouped under card headings according to the way in which they were expected to be used in the tables.

Because of this, a decision was made that the first 35 columns of every IBM card would contain the background data found on page 11 of the questionnaire (questions 27 - 33) plus question 18, which classified the respondent's group work experience. The remaining 45 columns on each card were available for whatever data the writer planned to tabulate in relation to the foregoing questions. After considerable experimentation, it was decided that four IBM cards (for each questionnaire) would include all the combinations of data needed for analysis and tables.

Plan for Sampling

Health department nurses in the state of Michigan made up the universe from which the sample was drawn. A decision was made to select separate samples from the Outstate area and from within the Detroit Department of Health, that is, to consider Detroit and the rest of the State as two sub-universes for sampling. This decision was based in part on the necessity of working with two separate agencies, the Michigan Department of Health and the Detroit Department of Health in securing accurate listings of public health nurses currently employed. Another consideration was that the Detroit staff constituted a large homogeneous group (approximately 31 percent of the total universe) from which it seemed proper to draw a smaller sample than

from the more heterogeneous remaining Outstate group. This reasoning is supported by Neiswanger[1] and other authorities.

While a study including all members of the selected universe was first considered by the writer, sampling was decided upon because of time and cost factors as well as ease in handling the data. In speaking of sampling, Mainland[2] describes random samples as those whose differences in composition are determined solely by chance. He goes on to offer two equivalent definitions:

1. A sample chosen in such a way that all individuals in the population have an equal opportunity of being selected.
2. A sample chosen according to a rule that is completely independent of the observations to be made on the sample.[3]

Systematic sampling, sometimes called restricted random sampling, is described as the selection of the k^{th} item with a random start.[4] This method was chosen by the writer as the simplest and most practical way of securing an objective, non-biased study group. While systematic sampling is not unrestrictedly random sampling[5], it is probability sampling since theoretically the sampling variation can be determined. Because systematic sampling is not unrestrictedly random, care must be exercised to avoid bias or excess

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[1]William B. Neiswanger, Elementary Statistical Methods (rev. ed.: New York: The MacMillan Co., 1956), 114.

[2]Donald Mainland, Elementary Medical Statistics (Philadelphia: W. B. Saunders Co., 1952), 52.

[3]Ibid.

[4]Neiswanger, op. cit., p. 122.

[5]Robert E. Patton, "The Sampling of Records", Public Health Reports, LXVII (1952), 1013.

sampling error. When sampling from a classified or stratified list the sampling error may be less than that of random sampling, if due attention is given to avoiding periodicities in the classification. This may be done by using higher sampling rates where the classes have a size rather larger than the sampling interval.

The size of the two samples was set at 50 percent of the Outstate group and 25 percent of the Detroit Department of Health nurses. This decision, as pointed out previously, was based upon the greater variation existing within the Outstate group as compared to the more homogeneous Detroit staff. While warning that composition of a sample is more important than size, several authors[1] explain how errors in sampling may be reduced by increasing the number of observations. However, since neither of the samples used in this study could be considered small in relation to the sub-universe represented, the element of size did not pose a special problem.

But how good is a sample? How well does it represent the universe from which it was drawn? The writer found Mainland's[2] discussion of this most helpful. In seeking the true or "population value", he points out, we assume that we would approach it more and more closely by taking repeated samplings. Any one sample, or even the mean of several samples, is only an estimate and that is why it is necessary to find out what allowance to make for random errors. In further discussing levels of confidence,[3] he explains that when the "95 percent Band", or confidence interval is selected, we mean that in the long run, 95 percent of our judgments will be correct and 5 percent will be wrong. In a specific sample therefore, we

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[1]Mainland, op. cit., p. 86, and Neiswanger, op. cit., p. 116.

[2]Mainland, op. cit., p. 31.

[3]Ibid, p. 54.

can say that the odds are 95 to 5, i.e., 19 to 1 that it will be correct; or that there is one chance in 20 of its being wrong. Since the sample used in this study was not unrestrictedly random, and departs from this in the direction of smaller sampling variance, the confidence limits obtained from tables calculated under the assumption of unrestrictedly random samplings will be somewhat too broad. As a result, significance tests will indicate lack of attainment of a given level of significance a bit more frequently than would be generally true.

To illustrate confidence limits further, Mainland gives an example of a surgeon who wished to know the significance of two failures in 20 operations[1]. If the 95 percent confidence interval is used, "the standard of precision that is commonly recognized as the minimum standard", 2 failures out of 20 operations will not mean ten percent failures but something between 1.2 and 31.7 percent failures. In discussing probability[2], P, in relation to the same illustration, Mainland says that instead of referring to "5 percent of the total random samples", we can say that with a population percentage of 31.7 the probability, P, of finding samples as rare as, or rarer than, our observed sample is 5/100, i.e., 0.05.

It is recognized that the 31.7 percent refers to the remaining proportion of a normal distribution of which 68.27 percent represents the rest and that the latter zone will include 95.45 percent of repeated samplings. Neiswanger[3] illustrates the same point in describing how, when the mean of a group of samples is known, confidence intervals can be established with known probability of including the population mean. Thus, it is possible to say that when a sample is selected by a probability method, it

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[1] Ibid, p. 55.

[2] Ibid, p. 57.

[3] Neiswanger, op. cit., p. 345.

can be determined within what levels it represents the universe from which it was drawn.

Sources of Data

Plans were made with the Chief of the Public Health Nursing Section, Michigan Department of Health, to use the official file of public health nurses employed in health departments outside Detroit. Similar arrangements were completed with the Director of the Public Health Nursing Division in the Detroit Department of Health.

The selection of a study group in Michigan was influenced by the writer's familiarity with the program and personnel, particularly in the area of the State outside Detroit. This greatly facilitated interpretation of the plan for the study to the people involved. The writer met with the administrative and consultant staff in the State Public Health Nursing Section to explain the study and type of information needed. By so doing it was hoped that the public health nursing consultants, who were not included in the study, might be able to answer field nurses' questions and generally encourage nurses in their respective districts to respond. Just prior to the mailing of the questionnaire, the Interdepartmental Circular, a publication of the Michigan Department of Health which reached all health departments and potentially all health department nurses in the area outside Detroit, carried an announcement concerning the study and asked for cooperation in responding to the questionnaires. Mention of this was made in the letter which accompanied the questionnaire to the state group.[1]

The writer also met with the administrative staff of the Public Health Nursing Division of the Detroit Department of Health, securing full cooperation for sending the questionnaire to a selected sample of nurses. A separate introductory letter was prepared for this group.[2]

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[1] A copy of this letter may be found in Appendix B.

[2] A copy of this letter may be found in Appendix B.

Limitations of Sources of Data

This study is limited by the fact that public health nurses in only one state, Michigan, participated. Moreover, Michigan is not a typical or average state in the numbers of public health nurses employed or in their qualifications. According to the 1950 United States Census, Michigan ranked seventh in population among the states. In 1953, the state was outranked by seven others in total number of public health nurses employed, but ranked fifth in number of nurses employed in official agencies (health departments). In qualifications of public health nurses, Michigan ranked twelfth among the states and territories, with 51.8 percent of its nurses employed in public health having completed a year or more in an approved public health nursing program. This percentage compared favorably with that of 36.8 percent of all states and territories.[1]

Thus, Michigan had more nurses employed in public health work than the average state, many more employed in health departments, and qualifications above the national average. Without further studies of this general type in other states, it would not be possible to assume that findings from a Michigan study would apply to a wider area. However, since it is possible to relate the findings of this study to such specific factors as preparation and experience, the significance of Michigan nurses' attitudes about group work could be said to have broader implications at least in relation to these factors.

A second limitation was the selection of only health department nurses for the study. Omitting non-official agency nurses did not mean that they were not concerned with group work. Indeed, it could be shown that certain voluntary agencies had taken considerable leadership in this

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[1]Annual census of Nurses, op. cit., Table III.

field. There seems to be evidence, however, that as health departments have expanded and increased the scope of their programs, they have become concerned with group work to a greater extent than agencies whose major function is bedside nursing. This point will be explored further in Chapter III. In considering numbers of nurses involved, nationally and in Michigan, the ratio of official to voluntary agency nurses is approximately two to one.

Establishment of a Study Group - Outstate Area

The Public Health Service count showed 546 nurses employed in local official agencies in Michigan as of January 1, 1953.[1] Since, according to State records, 167 of these nurses were known to be employed in the Detroit Department of Health, this left 379 in local official agencies in the Outstate area.

However, by the time the Michigan Department of Health had prepared and published a mimeographed directory of public health nurses for use in the State, additional nurses had been employed with the result that 383 names were available for the Outstate study group. This number was checked with the Public Health Nursing Section in April 1953 and was accurate as of that time. Only nurses who were employed in city, county, city-county or district health departments were included. Nurses in the two combination agencies[2] also were included since their work encompassed the usual health department nursing responsibilities.

Fifteen additional nurses whose names appeared on the State list were not included in the study group. Five of these additional nurses were employed by county boards of supervisors in counties without organized

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[1] Ibid. Tables VII and VIII.

[2] A combination agency is a merger of two or more public health agencies, usually a health department and a visiting nurse service. See page 13.

health departments, while others worked as township or community nurses. While broadly categorized as "local official" in terms of the Public Health Service count, in the opinion of the Public Health Nursing Section, the work of these nurses varied considerably from that of nurses in organized health departments. While health department programs are known to vary considerably also, according to personnel and resources, there is a common base which is lacking in the unorganized counties or when nurses work alone in other positions. To this extent, these nurses seemed different from others in the Outstate study group. No part-time nurses were included.

A word should be added to explain what seems to be a discrepancy in numbers in that the list published by the Michigan Department of Health included more nurses than were counted by the Public Health Service. The difference is one of time. Tabulations for the Public Health Service are commonly made in December while the State Department of Health list is likely to be published a month or so later. Since this list serves as a directory of public health nurses for the rest of the year, changes are made up until the time of publication. Thus, the State list, although usually dated January 1, might obtain more or less names than are indicated in the Public Health Service tabulations as of the same date.

In arrangement, the list of 383 names followed the pattern used by the State directory, which was alphabetical by counties. Nurses were listed alphabetically under each health department with the exception that supervisory personnel in order of rank, headed the staff lists. Where a city and a county health department were listed separately under a county heading (Example, Grand Rapids City Health Department and Kent County Health Department) both lists were used exactly as they appeared in the State directory. Nurses who were employed in district health departments were listed under the county served rather than the county where the central office for the district was located, again following the State pattern.

Selection of Sample - Outstate Area

The study plan called for the selection of a 50 percent sample of the nurses in the Outstate group who were sent the questionnaire. This was accomplished by dividing the list of 383 names into two alternate groups according to odd and even numbers. The odd-number group, consisting of 192 names, was selected for study by random method. According to the study plan, nurses in this group received follow-up notices if they failed to return the questionnaire in a specified time.

Nurses in the even-number group were sent the questionnaire but no follow-up was done. The question of whether to send questionnaires to the entire list of 383 or only to the odd-number group was given careful consideration. A decision was made to send to all because the writer felt that by so doing there might be greater acceptance on the part of a typical nursing staff. For instance, if all four or eight nurses in an office received the questionnaire, it was felt that there might be fewer questions raised as to selectivity, criteria for choice, etc. The fact that the writer knew quite a number of the nurses and was known to more of them by name and position also made it seem more important to depersonalize the selection process.

Table 1. offers a comparison between the proportion of nurses and supervisors in the Outstate group before the sample was selected and in the sample itself.

Table 1. Comparison of Composition of Universe and Fifty Percent Sample: Outstate Nurses

Categories	Outstate Universe Number	Outstate Universe Percent	Outstate Sample Number	Outstate Sample Percent
Administrators or Supervisors	60	15.7	32	16.7
Public health (staff) nurses	323	84.3	160	83.3
Total	383	100.0	192	100.0

Establishment of a Study Group - Detroit Department of Health

The directory of public health nurses published early in 1953 by the Michigan Department of Health listed a total of 167 nurses employed by the Detroit Department of Health. However, by the time final arrangements were completed for the participation of the Detroit staff in the study, (April 30, 1953) the writer was furnished with a corrected list containing 159 names. In order to have consistency in the composition of the State and Detroit lists, the Director and Assistant Director of the Public Health Nursing Division and seven specialized consultant nurses were omitted since comparable personnel were not part of the Outstate group. This left a list of 150 names.

The Detroit list, thus established, included five District Supervisors[1] whose positions were considered comparable to nursing directors in the larger health departments in the Outstate group. It also included nineteen Supervising Public Health Nurses. Nine of these were generalized supervisors serving at the five health stations and the other ten supervised specialized activities such as the tuberculosis clinic or the social hygiene program. The 126 remaining names were the Public Health Nurses, of which group 108 or 85 percent were assigned to the health stations while 18 served in specialized fields.

The writer questioned the desirability of including supervisors or staff nurses whose work responsibilities were different from those of the generalized public health nurse assigned to a health center. After considerable discussion and exploration of the matter, however, a decision was reached to include these nurses in the list for the following reasons. All who were classified as Supervisors or Public Health Nurses had met certain requirements for employment and all had functioned, usually for a

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[1]Official civil service titles will be used in referring to categories of nurses on the Detroit list hereafter.

period of years, as generalized public health nurses. Staff nurses and supervisors could apply for and transfer to a specialized program or return to generalized work as openings occurred. Thus, the supervisors and nurses who served in specialized assignments at the time of the study were not specialists in a permanent sense or because of specialized preparation. Moreover, all Divisions of the Health Department operated under common policies and were closely united by common program objectives.

Selection of Sample - Detroit Department of Health

The list of 150 names furnished by the Detroit Department of Health had been arranged alphabetically under the headings, District Supervisors, Supervising Public Health Nurses and Public Health Nurses. The study plan specified (1) the selection of a 25 percent sample from the established list, (2) sending the questionnaire to the sample group only, (3) follow-up of the entire sample. With the aid of a table of random numbers, the number two was designated as a starting point for selecting names from the list. Thus, beginning with the second name under the District Supervisor heading, every fourth name was selected, resulting in a sample of 38 names.

Table 2 gives a comparison of how typically the Detroit sample represented the universe from which it was drawn.

Table 2. Comparison of Composition of Universe and Twenty-five Percent Sample: Detroit Nurses

Categories	Detroit Universe		Detroit Sample	
	Number	Percent	Number	Percent
District Supervisors	5	3.3	1	2.6
Supervising public health nurses	19	12.7	5	13.2
Public health (staff) nurses	126	84.0	32	84.2
Total	150	100.0	38	100.0

Plan for Evaluation of Data

The process of establishing the validity of survey findings requires careful analysis and search for related criteria. This is especially true in the case of an exploratory study, for if acceptable measurement of the characteristics being studies existed, the type of study needed would be altered. In this study, testing for internal consistency of responses should help validate findings. For instance, how many respondents who reacted in a certain way to one phase of group work have actually had experience with this phase? Another procedure which points toward validity or lack of it is the extent of the "no response" replies.

The reliability of the data are, to a considerable extent, dependent upon the reliability of each step in the survey procedure. The way in which the sample was drawn, the questionnaire arranged and pretested, and the objectivity of the coding, all contribute directly to reliability. Comparison of the two samples (Outstate and Detroit) should provide another measurement.

In terms of statistical interpretations, common means of measurement which would apply in this study in varying degrees are percentages, frequencies or counts, and the chi-square test for significance where two or more sets of responses are concerned. As has been pointed out previously, since the systematic samples used in this study cannot be regarded as unrestricted random samples, statistical tests based upon the assumption of unrestricted random sampling are not exact. Since there is reason to believe that the sampling error may have been less than that of unrestrictedly random sampling, the tests are conservative in the sense of indicating a somewhat higher likelihood of error than is true. This carries the implication that some comparisons which were rejected as "not significant at the 5% level" may in fact have been beyond that level.

Collection of Data

On May 7, 1953, questionnaires were mailed to the list of 383 Outstate nurses and to 38 nurses in the Detroit sample. Approximately two weeks following the mailing of the questionnaire, the first postcard[1] reminder was sent to those who had not responded in the Outstate odd-number group and the Detroit sample. A second postcard reminder was sent in another two weeks and a third after three more weeks had elapsed.

The timing of the follow-up notices was guided mainly by the principle of diminishing returns - when responses had dwindled to a small number per day or when a day was skipped. Another procedure which Parten[2] quotes from Lindsay, would be to send the first reminder at the end of 16 days, a second one week after the first and a third two weeks after the second. The theory behind the close spacing of the first and second follow-up letters apparently is to strengthen recall soon after the original reminder and to repeat this at gradually increasing intervals. In this study, the first follow-up coincided rather closely to Lindsay's pattern and resulted in a good number of returns. One wonders if a shorter interval between the next two follow-up notices might have increased the rather negligible number of responses received.

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[1] Copies of the follow-up notices may be found in Appendix B.

[2] Parten, op. cit., p. 398.

Tables 3 and 4 show the responses of the Outstate nurses.

Table 3. Final Response to Questionnaire: Outstate Nurses

	Odd-Number Group (with follow-up)		Even-number Group (no follow-up)		Total	
	Number	Percent	Number	Percent	Number	Percent
Questionnaires returned	157	81.8	122	63.9	279	72.8
Questionnaires not returned	35	18.2	69	36.1	104	27.2
Total sent	192	100.0	191	100.0	383	100.0

Table 4. Initial Returns and Effect of Follow-Up: Outstate Nurses

	Odd-Number Group		Even-Number Group		Total	
	Number	Percent	Number	Percent	Number	Percent
Questionnaires returned without follow-up	81	42.1	122	63.9	203	53.0
Questionnaires returned with follow-up	76	39.6	-	-	76	19.8
No response	35	18.3	69	36.1	104	27.2
Total	192	100.0	191	100.0	383	100.0

A first glance at Table 4 raised a puzzling question in the mind of the writer. Why was the initial response in the even-number group better than the odd-number group? Did this mean that the 64 percent who responded in the even-number group with no follow-up were more receptive to the questionnaire and more willing to participate than were the 42 percent who responded in the odd-number group? Did the final returns of 82 percent in the odd-number group mean that some of these respondents had been "hounded" into returning the questionnaire by repeated follow-up notices?

Fortunately, review of the numbering system for returned questionnaires helped to throw light on these questions. All returned questionnaires (Odd and Even Outstate groups and the Detroit group) had been numbered in sequence. Thus it was possible, through checking the return numbers of those in the odd-number group who had received the first follow-up notice,

to determine that returns in the even-number group continued to come in throughout the period when the odd-number group was being followed. Further study of the returns revealed that actually only 60 questionnaires or 49 percent of the 122 responses in the even-number group had come in at the two-week period when the first follow-up notice was sent to the odd-number group. Additional responses in the even-number group continued to come in, tapering off with time but with a few paralleling the six returns to the third postcard notice sent to the odd-number and Detroit groups. See Table 7.

While this review of returns in both Outstate groups does not entirely answer the question as to rate or proportion of responses, it does suggest that the groups probably are not too dissimilar. One wonders to what an extent proximity was a factor influencing members in the even-number group to respond. For instance, if a nurse at a nearby desk or in the same office received a follow-up notice, did her colleague who had not received a similar reminder get busy anyhow and return the questionnaire?

Table 5. Final Response to Questionnaire: Detroit Nurses

	Number	Percent
Questionnaires returned	28	73.7
Questionnaires not returned	10	26.3
Total sent	38	100.0

Table 6. Initial Returns and Effect of Follow-up of Entire Sample: Detroit Nurses

	Number	Percent
Questionnaires returned without follow-up	15	39.5
Questionnaires returned with follow-up	13	34.2
No response	10	26.3
Total	38	100.0

Table 7. Comparison of Results of Follow-up in Both Samples: Outstate and Detroit

	Questionnaires Returned			
	Outstate Sample		Detroit Sample	
	Number	Percent	Number	Percent
Response with no follow-up	81	51.6	15	53.6
Response to 1st postcard	51	32.5	10	35.7
Response to 2nd postcard	20	12.7	2	7.1
Response to 3rd postcard	5	3.2	1	3.6
Total returns	157	100.0	28	100.0

Additional Information on "No Response" Category

Information was received from or about six additional nurses in the Outstate odd-number and Detroit groups who had been sent questionnaires. However, since these communications did not result in data which could be tabulated under specific questionnaire items, they fell into the "no response" category.

In two instances, one Outstate and one Detroit, nurses returned the questionnaire with the first page or a few items on the first several pages filled in but with the personal data sheet and over three-fourths of the questionnaire items unanswered. A decision was made not to include these

questionnaires in the coding. An "unprepared" Outstate nurse returned the questionnaire unanswered but wrote a note explaining that because of recency of employment and total unfamiliarity with group work she did not feel capable of responding. She added her good wishes for the success of the study.

In another instance, information was received from a supervisor as to termination of a staff member's employment just prior to the time the questionnaire was received. A friend of another nurse wrote to say that the nurse in question was on an extended leave of absence because of illness. Another "no response" occurred when a questionnaire from a supervisor apparently was lost in the mail. She responded to the first follow-up by explaining that she had returned the questionnaire and did not complete the second questionnaire that was sent to her. This is understandable but two staff nurses whose questionnaires also were "apparently lost" volunteered to fill in another copy and did so. Information similar to the above was received from or about four nurses in the even-number group also.

Table 8 provides for comparison between the returns from the Outstate and Detroit samples and provides a summary of basic data upon which further analysis in the next chapters will be based.

Table 8. Comparison Between Questionnaire Returns: Outstate and Detroit Samples with Same Follow-up.

	Analysis of Returns					
	Outstate		Detroit		Total	
	50 percent sample		25 percent sample			
	Number	Percent	Number	Percent	Number	Percent
Questionnaires returned	157	81.7	28	73.7	185	80.4
Questionnaires not returned	35	18.3	10	26.3	45	19.6
Total sent	192	100.0	38	100.0	230	100.0

Coding of Questionnaires for IBM Analysis

With advice and assistance from the Tabulating Research Laboratory at the University of Minnesota, code sheets[1] were devised upon which all questionnaire responses could be reduced to numerical form. Since four IBM cards were needed to tabulate the data from one questionnaire, separate mimeographed code sheets were made, marked Card 1, Card 2, etc. Numbered blocks on each card indicated the columns and the 0 - 9 responses were tabulated in the blocks quite easily.

When all of the data had been transcribed from the questionnaires to the code sheets, the latter were used by the IBM operator in punching the permanent cards. The finished cards were then sorted so as to differentiate responses in terms of Outstate or Detroit, preparation and experience. Further breakdowns suggested themselves as the writer considered the data in the light of the objectives for the study and other relationships were analyzed.

Summary of Study Design

A mail questionnaire was developed incorporating 33 questions, the responses to which, it was hoped, would supply information needed to meet the objectives for the study. Plans for coding of responses and the use of data in tables were worked out in some detail. The size and form of the sample was determined.

After pretesting, the questionnaire was mailed to a list of 383 nurses employed in official health agencies in Michigan outside Detroit. A 50 percent systematic sample of this list was followed further by sending three reminder postcards over a period of eight weeks to those who had not returned the questionnaire. This 50 percent (the odd-number group) became the Outstate sample referred to throughout the study.

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[1]Copies of these sheets may be found in Appendix C.

Simultaneously, the questionnaire was mailed to a sample of 38 Detroit Department of Health Nurses. This sample, also selected by the systematic method, constituted 25 percent of the total staff and was followed up in a manner similar to the Outstate sample. These nurses are referred to as the Detroit sample hereafter in the study.

Plans were made for evaluation of the data and, tentatively, for the application of a limited number of statistical procedures. Total returns from both samples amounted to 185 questionnaires or 80 percent of the total sent. The Outstate sample returned 157 questionnaires or 82 percent of those sent while 28 or 74 percent of the Detroit sample responded. Data used in this study, therefore, are based upon the responses of a total of 185 nurses.

Data from the questionnaires were transcribed to numerical code sheets which were used as a basis for IBM tabulations. The IBM cards, when completed, were sorted in accordance with previously made plans for tables. Results of the tabulations will appear in following chapters.

In the study design the writer has attempted to carry out the planning in the manner as described by Campbell as follows:

> The first essential for efficient research is adequate planning. Surveys are intensely interconnected. Each phase of a survey project follows from a preceding phase. The original statement of objectives is translated into an elaboration of the specific data needed, so that we have, in fact, the titles of the tables that are going to appear in the final report before we write the questionnaire. The questionnaire is simply a device for getting the information that should appear in those tables. It follows directly from the preceding step. The coding, or content analysis, comes directly out of the objectives as expressed through the questionnaires. The IBM analysis which follows simply carries out what has been planned from the very beginning.[1]

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[1]Angus Campbell, "Criteria for the Conduct of Sample Surveys", Proceedings for Second Conference on Public Health Statistics (Ann Arbor: School of Public Health, University of Michigan, 1952), p. 13.

CHAPTER III

A REVIEW OF RELATED LITERATURE

Many problems were encountered in exploring possible sources of information concerning the topic under investigation. As stated in Chapter I, the writer had two main purposes in mind. She wished to identify previous studies or other reference materials in nursing, public health, or the group dynamics field which were related to the objectives for this study. A second purpose was to learn how public health and public health nursing literature might have been influenced by the group work objectives in the Curriculum Guide[1].

A search for previous research projects or studies dealing with any aspects of group work in public health nursing prior to 1953 proved to be fruitless. However, since the completion of this study has been delayed several years, it seemed permissible to note one project, publicized in 1955, which in the writer's opinion had a direct relationship to the study problem. For this reason, the training project in group leadership which was set up by the Child Study Association for a group of public health nurses in New York State will be reviewed toward the latter part of this chapter.[2]

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[1]Curriculum Guide, op. cit., p. 160.

[2]Aline B. Auerbach, "Public Health Nursing and Parent Education: A Pilot Project of Training for Parent Group Leadership", American Journal of Public Health, XLV (1955), 1578-1589.

Literature Prior to the Curriculum Guide

Early Period

Undoubtedly, most widely used by early university programs and agencies alike was Gardner's Public Health Nursing, first published in 1916. While the author listed the teaching function of the public health nurse as her second fundamental principle[1], she dwelt mostly upon teaching of individual patients and families usually in the home situation. She maintained in her second edition that, "Indeed it is principally as a teacher that the public health nurse has justified her existence", but almost no reference was made to group teaching situations[2]. The only mention of the preparation of the nurse for group teaching (in a school situation) was a negative one, ". . . as few nurses have had pedagogical training they are rarely successful as group teachers[3]. .."While considerable support could be found for the position that the teacher rather than the nurse should be responsible for organized health instruction in the school, the assumption that the nurse could not teach successfully seems unfounded.

The Maternity Center Association of New York, founded in 1918, published its first "Routines" or teaching guide in 1920. This pamphlet[4] underwent many editions and probably exerted a very real influence on content and method for expectant mothers' classes throughout the country.

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[1]Mary S. Gardner, Public Health Nursing, (2nd ed.; New York: Macmillan Co., 1930), 42.

[2]Ibid., p. 305.

[3]Ibid., p. 327.

[4]Maternity Center Association, Routines for Maternity Nursing and Briefs for Mothers' Club Talks, (4th ed.; New York: Maternity Center Association, 1935).

A woman physician was responsible for the promotion of the "Little Mothers' Leagues" by the New York City Department of Health[1]. "The purpose was to enlist the cooperation and interest of girls in the baby - saving campaign and at the same time to give to these little mothers who had to care for their younger brothers and sisters the information whereby such care might be made safe[2]. Public health nurses were responsible for teaching these groups. Baker describes them thus: "At each meeting of the league. . .the nurse should speak from ten to fifteen minutes about some special topic of baby care and then give an actual demonstration of the methods to be followed"[3]. The "Little Mothers' Leagues" spread to other cities during the twenties and references to them can be found in public health nursing literature.

But not all group teaching developments of this period were in large cities. The Bureau of Public Health Nursing of the American Red Cross established many public health nursing services in smaller cities and rural areas in the years following World War I. These were essentially demonstrations and many of them later became part of governmental health agencies. The teaching of home nursing procedures to groups of women and high school girls usually was a recognized part of the Red Cross nursing service. In describing this total development, Roberts says, "Some of the nurses found that the teaching of classes in 'Home Hygiene and Care of the Sick' could be fitted into their programs very effectively"[4].

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[1]S. Josephine Baker, Child Hygiene, (New York: Harper and Brothers, 1925), 230.

[2]Ibid.

[3]Ibid, p. 234.

[4]Mary M. Roberts, American Nursing-History and Interpretation, (New York: Macmillan Company, 1954), 193.

Another teaching guide somewhat similar to the Red Cross Home Nursing textbook, which seemed to have rather wide use in the late thirties and early forties had a subheading "A Teaching Guide for Rural Classes"[1]. This publication, in two volumes, dealt in great detail with: the family in health, the family in illness, and the family and public health. It contained detailed lesson plans, suggestions for projects and other aids for the instructor.

The Survey of Public Health Nursing, published in 1934, covered 68 public health nursing agencies in 28 communities. This report stated that 11 agencies in the study group (7 public health nursing associations and 4 departments of health) were offering group instruction to expectant mothers[2]. Other types of group teaching were not mentioned. Of perhaps greater significance, however, was the finding that, in general, the teaching aspect of the nurses work was the part of her performance which was rated lowest[3]. A four way classification was used for evaluating the work of the nurse in homes and schools; approach, technique, teaching, and adequacy of care. Since a separate rating did not seem to be available on teaching in the mothers' classes it was not possible to trace a clear relationship. However, the Survey showed that in general nurses' teaching was distinctly better in the prenatal care service than in any other area.[4] Recent emphasis on maternal and infant mortality and availability of educational guides for the nurse were thought to be responsible factors. The reference to the Survey is used here, not because the findings related particularly to group

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[1]Elma Rood and Gertrude Lingham, Taking Care of the Family's Health, (Madison College, Tennessee: The Rural Press, 1938), I and II.

[2]National Organization for Public Health Nursing, Survey of Public Health Nursing, (New York: Commonwealth Fund, 1934), 161.

[3]Ibid., p. 207.

[4]Ibid., p. 35.

teaching but rather to point out that they did not. The Survey does, however, give some information as to the type of class and frequency with which such classes were included in the programs of some typical agencies of the period.

In summarizing this section, it seems clear that public health nurses have been involved in certain types of group teaching situations at least since the early twenties. The literature suggests, however, that these were class situations where the nurse was responsible for teaching a specific body of content such as maternity care or home nursing. The motivating forces behind such classes seemed closely related to major public health problems of the period. Available guides which were reviewed seemed to emphasize specific content and methodology.

Literature around 1940.

The writer also was interested in learning more about what types of groups were discussed in public health nursing literature just prior to or about the time of the publication of the Curriculum Guide. Did the literature show any evidence of a sequential experience pattern, i.e., was the public health nurse expected to gain skill in her contacts with individual patients before attempting to work with groups? Should every nurse on a staff be expected to do group teaching? Was thought given to the types of intra-agency group experiences which might help prepare the nurse for group work in the community? The foregoing review of earlier literature had not supplied answers to these questions.

Gilbert[1], one of the first to present what might be called the "mental health approach" in public health nursing, spoke of the nurse's relationship with groups as a teacher, leader, or member as part of her

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[1]Ruth Gilbert, The Public Health Nurse and Her Patient, New York: Commonwealth Fund, 1940, p. 182.

job. While cautioning that there were technical aspects of the emerging field of group work with which the nurse would not be expert, it seemed clear that the public health nurse would be expected to assume some responsibility and to work as constructively as possible. Classes for antepartal patients---"mothers clubs" were described by Gilbert as the best established, and the type of group which the public health nurse might encounter most frequently. A sizable section of Part III of the first edition of her book was devoted specifically to the role of the public health nurse with this type of class.[1]

Gilbert's discussion implied that the nurse who led the mothers' class also carried a district and was well versed in other types of nursing service rendered by the agency. A question was raised as to whether the group experience was more successful when members knew the leader as a district nurse prior to the organization of the group. She suggested further that nurses who led mothers' classes and similar groups increasingly regarded them as a beginning, or a continuation of work with mothers and fathers, rather than an end in themselves.[2]

Another author[3], representing one of the pioneer urban health demonstrations, strongly agreed with the point of view expressed above. In speaking of the maternity class as the nurse's initial venture in group leadership, Benjamin felt that it was the nurse's experience in working with families over a period of years, knowing and observing parents as they prepared for the child, which helped her to focus attention on the parents' goal and the parents themselves. According to this author, the nurse's

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[1] Ibid., 191-205.

[2] Ibid., 205.

[3] Frances H. Benjamin, "Leading the Maternity Group", Public Health Nursing, XXXI (1939), 292-297.

understanding of people and their motivations seemed to be the key to successful group experience rather than the employment of any specific devices to stimulate group discussion. In a section entitled "Leader's Relationship to Group", she says

> The leader must not only be sensitive but she should be informed about the different ways in which individuals relate themselves to the group and in particular to her. The leader's understanding of her relationship to the group is so important that there is need to learn how to use it for the greatest service to the group members and for her own growth. What her relationship to the group shall be lies more directly within her control than any one factor in the group situation.[1]

While this point of view concerning group leadership would seem to fit as comfortably into the literature ten years later, it should be remembered that the East Harlem Nursing and Health Service in New York City represented a demonstration where the education and experience levels of the staff were considerably above that found in an average agency. Nevertheless, the publication of this article in 1939 and Gilbert's book in 1940 presented a feeling about group work in public health nursing that was not readily discernible in the Curriculum Guide section on Group Learning. Perhaps the fact that the latter was in outline form hampered this but a statement such as "Discuss why standard patterns of group discussions may retard growth"[2], seemed so detached that it presented a rather theoretical concept to the reader.

Gilbert presented evidence to show that public health nursing agencies gradually had abandoned the idea that every staff nurse should have the experience of leading a group.[3] She felt that this was a sound move in that it acknowledged individual differences and allowed each nurse

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[1] Ibid., 294.

[2] Curriculum Guide, op. cit., p. 163.

[3] Gilbert, op. cit., p. 196.

to make a special contribution in her own way. She was critical of past practice in agencies where nurses often were expected to rotate through a group teaching assignment.

> We remember the agonies some of these nurses have experienced--the midnight oil they burned and the pale courage with which they approached the waiting group of patients. ------- we would emphasize here the lack of economy and what approaches cruelty when the discipline is imposed upon those who are not fitted for it.[1]

Gilbert cautioned further that some nurses liked to lead groups because it gave them opportunity to talk. This rather limited approach to group teaching was interpreted as potentially dangerous. Rather, she suggested, the skillful nurse should be able to lay her material before a group "suggestively, modestly, and briefly", thus becoming a "group builder" rather than a "group compeller"[2].

Two other authors presented articles in Public Health Nursing in 1942 which, using the "teaching methods" approach, illustrated how public health nurses might be flexible in employing sound teaching techniques. Dunlap[3] of the University of Chicago showed how, through first learning about her group, their interests and problems, a nurse could organize a course of study. She cautioned against attempting to use a fixed plan or a plan made by someone else for another group. The second article[4] mentioned above dealt with the evaluation of class achievement in a somewhat more formalized teaching situation.

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[1] Ibid.

[2] Ibid., p. 197.

[3] Mary M. Dunlap, "Group Teaching by the Nurse", Public Health Nursing, XXXIV (1942), 627-29.

[4] Anna C. Gring, "To Help You Teach Home Nursing", Public Health Nursing, XXXIV (1942), 315.

The writer was unable to assemble any very conclusive evidence from early literature showing emphasis on group experiences within the agency setting which might help the nurse with group work in the community. Gilbert[1] mentioned these activities (group organization for staff education, staff council, supervisor's meetings and case conferences) in defining what she considered to be the scope of group work in public health nursing but did not develop the idea further. However, many of the articles on in-service education, included in the ten year review of literature which follows, implied that group work on the part of the staff was involved.

The Influence of the Curriculum Guide

The reason for using this publication as a focus in reviewing literature was that it was thought likely that emphasis in the Guide had affected what had been taught to nurses who had completed approved preparation for the public health nursing field. Also, it seemed probable that the same emphasis might have affected agency practice through inservice educatior programs, thus indirectly reaching nurses who had not been enrolled in programs of study. The writer wished to study how the group work suggestions in the Guide had been reflected in the literature and to what extent changes in emphasis had occurred since its publication in 1942 and the year the data were collected, 1953.[2]

Part Four of the Guide was entitled "Methods of Learning Health as Related to Public Health Nursing"[3]. It was subdivided into three units, A. Individual Learning, B. Group Learning, and C. Community Learning. The central objective of Unit B, Group Learning, was entitled "Understanding of

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[1]Gilbert, op. cit., p. 182.

[2]Curriculum Guide, op. cit., p. 160.

[3]Ibid., page 163.

and ability to apply the technique of the group approach in promoting community health". A review of the contributory objectives showed acceptance and support of the idea that working with a number of community groups was an important phase of public health nursing practice. However, the emphasis seemed to be on the nurse as a full-fledged competent group worker without mention of the evolutionary process through which she herself must develop such skills. The nurse was asked to "consider the kinds of meetings you might be expected to plan as a health worker, and how to build attendance at meetings."[1] One objective dealt with group discussion and one with selection, preparation, and utilization of health education materials and media which might aid in group learning. This latter theme was further elaborated in Unit C, Community Learning, which follows.

Unit C had as its central objective "Understanding of the importance of and ability to assist in coordinating the health efforts of all agencies in order to realize a community-wide health program".[2] While some basic understanding as expressed here and in the contributory objectives which followed would seem a legitimate goal for a public health nursing student, the manner in which this unit was developed in the Curriculum Guide would also seem appropriate for a graduate course in health education. Understanding and, to some extent, ability in use of the newspaper, radio, motion picture, film strips, exhibits, and literature as media for health education were suggested as goals for learning experiences.

A column headed "Suggestions" did not include mention of the fact that the beginning staff nurse was expected to be working under supervision, or seem to give recognition to the availability of supervisory and special

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[1] Ibid.

[2] Ibid., page 164.

consultant assistance in carrying out such suggestions as "Plan an annual publicity calendar for a public health nursing service" or "List the points to be considered in planning a local movie".

In summary, the writer acknowledges that Part Four of the Curriculum Guide brought together a wealth of ideas and suggestions for involving the public health nurse in group work in her community. However, she questions the implication that a staff nurse should be prepared to function on the levels suggested and feels that her preparation would, at best, be superficial.

Ten-year review of three periodicals

In the following pages, the writer will present a brief analysis of literature from two nursing and one public health journal for the ten year period 1943 through 1952 using the central objectives from the units on group and community learning in the Curriculum Guide as a basis for classification.

The three journals selected were: Public Health Nursing[1], the American Journal of Nursing, and the American Journal of Public Health. It was believed that these three represented periodicals most available to and probably most widely read by nurses employed in the public health field and also in use in universities where nurses might have studied. The three differ markedly in purpose and scope, however. Public Health Nursing, as the official publication of the National Organization for Public Health Nursing[2] carried articles on literally any matters of concern to public health nursing agencies, board members, employees, universities preparing public health nurses, or students. The American Journal of Nursing, the

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[1]Ceased publication in 1952; merged with new publication Nursing Outlook in 1953.

[2]Since 1953, part of the National League for Nursing.

official organ of the American Nurses' Association, is concerned with all nursing, of which public health nursing is but one rather small part. The American Journal of Public Health serves the interests of all public health workers; health officers, epidemiologists, laboratory workers, engineers, health educators, public health nurses, and others. Articles in this Journal are largely published papers from the annual meeting of the American Public Health Association and therefore represent a cross-section of public health interests.

As would be suspected from the above, Public Health Nursing provided more specific content relating to the Curriculum Guide objectives in question. In considering articles from the American Journal of Nursing, only those were included which were specifically about public health nursing situations, or readily applicable to a community group situation in which a public health nurse might be involved. This arbitrary decision eliminated much material having to do with curriculum and teaching methods in schools of nursing whose relationship to community classes was acknowledged, but not very strongly, by the writer. Likewise, the American Journal of Public Health carried little material relating to the group learning objective but a great many general articles which the writer classified under the heading of community organization or community planning. In regard to the latter two, an arbitrary decision was made that articles dealing with health councils or definite step-by-step reviews of community action for health, i.e., McClusky's[1] description of block organization, would be tabulated as community organization, while the more general descriptive or theoretical articles would go under the community planning category. It is realized that this is a thin line of demarcation and that alternative groupings also

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[1]Howard Y. McClusky, "Block Organization for Health Education", American Journal of Public Health, XXXIV (1944), 648.

might have been considered. Also, at times it was difficult to determine whether an article fitted best under a group learning or community learning category but here again, arbitrary decisions were made. While the writer was diligent about checking the journals in question for articles in the desired categories, it is possible that a few were missed. Summaries of the two categories follow.[1]

Analysis of "Group Learning" articles. A glance at the totals in Table 9 shows that while articles describing group discussion methods increased most sharply in the five-year period 1948-52, nearly all other categories showed increases also. The group discussion category included articles on group dynamics, workshops, role playing, sociodrama, and planning group meetings so as to involve the members in new methods of participation. Articles on inservice education were included under the Group Learning Category since this type of intra-staff planning also showed evidence of use of the group process. It is apparent that articles on mothers' or parents' classes increased as those describing Red Cross Home Nursing classes remained about the same. It should be remembered that the ten year period covered in this review included some of the war and immediate postwar years and in this sense was not a normal period for health agency activities. To what extent this affected the type of articles published during this period is not known.

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[1] A listing of articles included in the ten year review of three periodicals may be found in Appendix D.

Table 9. Summary - Articles Related to the Group Learning Objective from the Curriculum Guide, 1943-1952 in Three Journals.

Category	P.H.N.[1] 1943-1947	P.H.N.[1] 1948-1952
Group discussion methods	2	6
Inservice education-agency and other	1	8
Mothers' or Parents' Classes	1	8
Red Cross Home Nursing Classes	5	2
School centered groups	3	4
Other classes; diabetics, baby sitters, etc.	1	3
Group work in general (or as part of the nurse's work)	1	
Totals	14	31

[1] Public Health Nursing.

Table 9 - Continued

A.J.N.[1]		A.J.P.H.[2]		Total	
1943-1947	1948-1952	1943-1947	1948-1952	1943-1947	1948-1952
	10	1		3	16
2			2	3	10
1	1		2	2	11
3	4		1	8	7
				3	4
	1			1	4
	1	1	1	2	2
6	17	2	6	22	54

[1] American Journal of Nursing.

[2] American Journal of Public Health.

Table 10. Summary - Articles Related to the Community Learning Objective from the Curriculum Guide 1943-1952 in Three Journals.

Category	P.H.N.	
	1943-1947	1948-1952
Community organization	1	6
Community planning for health education	2	2
Exhibits	6	1
Publicity (written)	3	1
Films, radio, television	3	2
Other audio-visual methods	1	4
Talks - speeches	2	1
Health education as a process and role of health educator	1	
Nurses' participation in community activities		
Totals	19	17

Table 10 - Continued

A.J.N.		A.J.P.H.		Total	
1943-1947	1948-1952	1943-1947	1948-1952	1943-1947	1948-1952
2		5	2	8	8
2		5	4	9	6
	2	*	*	6	3
		*	*	3	1
		4		7	2
			1	1	5
	1	*	*	2	2
		1	3	2	3
	2				2
4	5	15	10	38	32

* Articles grouped under other headings, i.e., community planning or other audio-visual methods also contained material relating to the starred items but were classified according to the most general theme.

Analysis of Community Learning articles. This is a more difficult category to analyze since the emphasis from the two journals making the major contribution is quite different. In the case of articles from Public Health Nursing, the illustrations are from nursing, i.e., how a nurse arranged a successful health exhibit for a store window or planned a successful radio script. While articles in the American Journal of Public Health refer to some of the same activities, they usually involve the whole agency program and, in many instances the key person involved is the professional public health educator. Nevertheless, it is likely that the latter articles also affected public health nursing practice. Certainly the use of a health education expert as a resource person is supported by the public health profession as a whole. Probably the most significant comment on this table in relation to the Community Learning objective is the faithful way in which the Public Health Nursing articles seem to be based on topics set by the Curriculum Guide. Further comment will be made in regard to a few of the specific items in this category in later pages.

Texts in common use during 1943-52 period. A review of some books, in addition to Gilbert, which were quite widely used as public health nursing texts during the 1943-52 period did not reveal much additional information relative to the above questions. Wales[1] mentioned mothers' classes and school groups in illustrating public health nursing practice and implied that these activities were part of the public health nurse's job. Grant[2] mentioned classes along the same lines and, in a chapter devoted to staff

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[1]Marguerite Wales, The Public Health Nurse in Action, New York: Macmillan Company, 1941.

[2]Amelia Howe Grant, Nursing: A Community Health Service, Philadelphia: W. B. Saunders Co., 1942.

education[1], suggested that staff nurses should be given responsibility for preparing for the meetings, presenting certain materials, etc. Freeman's book on supervision[2] pulled together some of the materials on group leadership and techniques in a manner which related them to use in a public health nursing agency. Her chapter entitled "Group Procedures" undoubtedly was a contribution in that it helped public health nurses to better understand a rather controversial topic.

Other Related Developments

Adult education.

Among the influences which undoubtedly have had some effect on the development of group work in public health nursing was adult education. Indeed, some forms of group work in which public health nurses have been engaged are a typical part of a community adult education program. The teaching of Red Cross Home Nursing to various groups of women, for instance, or the nurse's contribution, perhaps with other resource people, to a mothers' study group at a YWCA are examples of this.

The work of one well-known author[3] from the adult education field is listed among group work references in the Curriculum Guide. It seems likely that material from Bryson such as "How Adults Can Be Taught"[4] was incorporated into group work courses for public health nurses.

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[1]Ibid., p. 148.

[2]Ruth B. Freeman, Techniques of Supervision in Public Health Nursing, Philadelphia, W. B. Saunders Co., 1944.

[3]Lyman Bryson, Adult Education, (New York: American Book Co., 1936).

[4]Ibid., p. 71.

Another author from the adult education field whose work has appeared on various reference lists in public health nursing texts and periodicals is Mueller[1]. This author's chapters on various group work methods seem to have served as a resource for the development of materials specifically for public health nursing.

Group organization.

This telescopic view of some of the earlier writings on group work in public health nursing would not be complete without a look at group organization. Dunlap[2] mentioned the differences in working with an existing group and organizing a new one and the other authors previously cited implied that the nurse usually had a role in organizing classes for expectant mothers. A specialist in the field of health education[3], writing in 1934, gave strong support to the values of organizing new groups for health teaching rather than relying upon existing clubs and organizations. She cited Detroit's experience in organizing classes on health subjects such as community health, communicable disease, child hygiene, and home care of the sick. The public health nurse who had preparation for teaching, in Connolly's opinion, was best fitted to conduct such classes, "because of her experience in the homes of many". While the "Health Guilds" of the Detroit Department of Health were a rather special development, the article illustrated a strong belief in the importance of neighborhood or small group organization specifically for health teaching which has broader implications.

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[1]A. D. Mueller, Principles and Methods in Adult Education, (New York: Prentice-Hall, 1940).

[2]Dunlap, op. cit., p. 626.

[3]Mary P. Connolly, "Organization of Adult Groups for Health Education", American Journal of Public Health, XXIV (1934), 571-575.

Another publication which considered many aspects of community organization for health was Hiscock's Ways to Community Health Education[1] which appeared in 1939. This book, probably widely used as a text by nurses and other public health students, is listed in the bibliography to the "Methods of Learning Health" section of the Curriculum Guide. Chapter XIV[2] entitled "Teaching People How to Live" contained several illustrations of the public health nurse's role in group organization.

The role of the professional health educator.

While not spelled out specifically in the study objectives, the role of the health education consultant is implied at several points and is mentioned in some of the questionnaire items. For this reason it seemed important to learn what had been available in the literature which might have helped public health nurses understand this person's role.

Review of public health nursing literature prior to 1942 did not reveal many references to the specialist in health education as a professional colleague of the public health nurse and a regular member of the public health family. Where such references were identified, the health educator seemed most likely to be part of a school health program or employed by a specialized health agency. This does not mean, however, that literature in the general field of public health had overlooked the field of health education. Hiscock's[3] Community Health Organization first published in 1927, and other references on public health administration gave recognition to the need for health education as a division of a health department, headed by a qualified person. Such statements, however, were apt to emphasize administrative

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[1]Ira V. Hiscock, Ways to Community Health Education, New York: Commonwealth Fund, 1939.

[2]Ibid., p. 225-262.

[3]Ira V. Hiscock, Community Health Organization, New York: American Public Health Association, 1927.

matters and methodology rather than the interrelated nature of certain agency personnel functions.

One of the first clear statements describing how public health nurses and a health educator might work constructively together on a health department staff came from Lifson and Wilson[1] in 1946. These authors described the role of the public health nurse in health education as one of organization, interpretation, and teaching in relation to on-going day-to-day activities in a local nursing district. Thus the public health nurse might organize and teach an expectant mothers' class or a home nursing class; she might enlist the aid of interested citizens to do volunteer work at her well child conferences; she might interpret to individuals and groups in her district the need for certain changes in the health program. In general, however, the authors point out, the public health nurse is concerned with the health education needs of individuals and families who are in her case load rather than with the development of broader sustained programs involving the whole community.

In contrast, health educators were described as workers who were "primarily concerned with the development of programs which make it possible for the adults in the community to take the responsibility for discovering the health problems of the community, and with technical guidance from health department personnel to obtain the facts, plan a solution, and then put the plan into action. Plans so developed are not lightly set aside because the people themselves have had a hand in creating them"[2]. Examples were given which illustrated how the public health nurse and the health educator could share in many aspects of the health department program to

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[1]S. S. Lifson and Alberta B. Wilson, "Health Education" in the Health Department", Public Health Nursing, XXXVIII (1946), 421.

[2]Ibid., p. 421.

the end that people in the community better understand and utilize health services.

As mentioned in commenting on the ten year review of literature, many of the articles in the American Journal of Public Health which the writer placed under the Community Learning category further illustrated the role of the health education specialist in relation to other health workers and to the whole community health program. One of these, a report of a symposium entitled "What is Health Education"[1] contained statements from fourteen experts from various fields of public health including a public health nurse. Another, in editorial form[2], conveyed strong feeling that emphasis in health education and in all public health had changed from giving information to people to other techniques which aimed at working out programs with people. This philosophy, while significant for all aspects of public health programs, seems especially pertinent as a common base upon which both health educator and public health nurse could develop group teaching.

Public Health nursing participation in community affairs.

The writer was interested in any information concerning the public health nurse's activity as a citizen or as a member of non-professional groups which might possibly relate to her role as a group worker on the job. Since the nursing profession as a whole had done some soul-searching along these lines in postwar years, available publications were reviewed with the above theme in mind. Bernays[3] reported on a study in 1946 in which community group leaders were asked their opinions on certain characteristics of the nursing profession. The results showed that public health nursing agencies

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[1]"What is Health Education", American Journal of Public Health, XXXVII (1947), 641.

[2]Ed. "Health Education As a Two-Way Process", American Journal of Public Health, XLII (1952), 74.

[3]Edward L. Bernays, "Nursing and Community Groups", American Journal of Nursing, XLVI (1946), 297.

were considered "liberal" in their social influence by approximately 50 percent of the respondents. Professional nursing organizations, schools of nursing, and individual nurses were ranked only half as high (approximately 25 percent liberal) on the same scale, and in general, were considered conservative.

The same study pointed up real feelings on the part of community leaders that they needed to know more about nursing and that nurses themselves must take more responsibility for publicizing their work. A plea in the same direction was made by a rural extension expert from the United States Department of Agriculture[1] who felt that nurses had such a wealth of human experience to draw upon but sometimes lacked the "know-how" to explain their contribution to others. The same author suggested that nursing education and nursing organizations needed to give more than lip service to community participation and utilize many ways to know the consumers of nursing service--the general public and one's specific neighborhood--on a more personalized basis.

Two other studies offer some comparative information concerning the participation of public health nurses. In seeking information as to the political activities of nurses, Herz[2] found that 74 percent of the public health nurses in her study group of 185 could invariably be counted on to vote. This was true of only 56 percent of the institutional nurses in the group. Public health nurses also ranked higher in knowing the names of Washington representatives and in the number of newspapers and political periodicals read.

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[1]Elin L. Anderson, "Community Nursing--The Challenge of Nursing Education", Public Health Nursing, XXXVIII (1946), 637.

[2]Zipporah Herz, "Do Public Health Nurses Take More Interest in Political Activities Than Institutional Nurses", American Journal of Nursing, XLIX (1949), 133.

Harris[1] found that public health nurses ranked highest of five nursing groups in participation in civic organizations, with nurse educators and administrators ranking second. This study also showed a positive relationship between years of experience in nursing and participation in civic affairs. In all instances, the nurse who was a college graduate participated to a greater extent than the graduate nurse without a degree.

Thus, while there is some evidence that public health nurses stood out favorably in their participation in community affairs, the overall picture for nursing in general still could be improved. The writer was unable to find evidence which would establish, except by implication, any relationship between participation in community affairs and the nurse's role as a group worker in public health nursing.

Research in Group Dynamics

The next section of this chapter will be devoted to comments on the growth of research in group dynamics and implications for group work in public health nursing. The ten year review of literature related to the Group Learning section of the Curriculum Guide presented previously showed quite a sharp rise in articles dealing with various aspects of the group process in the five year period 1948-1952. However, except for an occasional reference, the writer prefers to go behind these, and explore more original sources.

Bradford and French[2], after presenting a group of articles under the heading "The Dynamics of the Discussion Group", concluded that the method of group discussion was an extremely complex educational process. Group

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[1]Elizabeth F. Harris, "A Study of Nurses' Participation in Community Affairs", American Journal of Nursing, LI (1951), 518.

[2]Leland P. Bradford and John R. P. French, ed., Journal of Social Issues, IV (1948) 70-73.

discussion, so conceived, the authors pointed out, must be differentiated from the utilization of a bag of tricks or devices which might contribute toward limited purposes. The important skills and techniques involved were further described in this issue under the role of the leader, the group member, and the productivity observer.

Unfortunately, considerable confusion grew up around the term "group dynamics". It tended to be grasped at by the insecure as an answer to all group problems and scoffed at by others as "old stuff under a new name". Articles such as Jenkins[1] which explained in simple terms that group dynamics was not something which could be turned off or on in a group seem elementary in retrospect and yet did much to remove the aura of mystery.

However, the neophyte in group work, thrilled by the new term and the meanings he attached to it, probably felt baffled at the explanation that "the dynamics of the group described the forces in the group situation which are determining the behavior of the group and its members"[2]. To learn that the use of a process observer, post-reaction sheets, or role-playing were simply techniques which might or might not be appropriate to a certain meeting seemed particularly deflating since such activities, to the novice, were linked with "a group dynamics approach".

Gradually, although perhaps painfully, the nurse or educator whose interest in the possibilities of group dynamics persevered beyond the frustration of the "bag of tricks" phase made a discovery. This discovery, more important because of the confusion which preceded it, was a growing appreciation that group dynamics was a science--and, like any other science, something

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[1]David H. Jenkins, "What Is Group Dynamics", Adult Education Journal, I (1950), 54-60.

[2]Ibid., 54.

that was constantly being tested and tried by research methods.

Thus, the learner came to appreciate that many aspects of groups had been the subject of intensive study. Bales[1] had classified group phenomena under two headings, action or interaction and situation. Festinger[2] reported on sources of attraction to groups, pointing out how differences in levels of satisfaction with group membership affected the cooperation within a community. Coch and French[3] presented findings from industry illustrating how resistance to change could be modified by effective group communication between management and labor. Of particular interest to public health nurses were Lewin's[4] studies of group decision involving the effect of different group patterns in changing food habits. These illustrations as well as some on research in the group leadership area which follow were drawn from the same source by the writer since this one volume contained carefully selected literature arranged around central problems. In this sense the book Group Dynamics could be said to present representative research reports linked together in a meaningful pattern by the editors.

Probably one of the most helpful instances of putting a new idea and new terminology into action with a group of public health nurses was the Conference on Mental Hygiene Education for Nurses at which Herrold[5] served

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[1]Robert F. Bales, "A Theoretical Framework for Interaction Process Analysis", Group Dynamics, ed. by Dorwin Cartwright and Alvin Zander (Evanston, Ill.: Row-Peterson and Co., 1953), p. 29.

[2]Leon Festinger, "Group Attraction and Membership", Group Dynamics, op. cit., p. 92.

[3]Lester Coch and John R. P. French, Jr., "Overcoming Resistance to Change", Group Dynamics, op. cit., p. 257.

[4]Kurt Lewin, "Studies in Group Decision", Group Dynamics, op. cit., p. 287.

[5]Kenneth F. Herrold, "Conference Planning and Action Through Use of the Group Process", Public Health Nursing, XLII (1950), 199-206.

as conference leader. In addition to the large group of conference participants, the step-by-step description which later was circulated in reprint form, served to give an orientation to a much wider audience. Another article[1] which had meaning for public health nurses because of their familiarity with community adult education programs[2], showed how methodology in this field had been affected by research in group dynamics. The authors suggested that adults attending community classes had personal and social goals as well as goals for specific learning and that attention to the former as well as the latter would result in rich dividends to the group and community.

Group Leadership

This topic has been separated out from the general area of research in group dynamics because of its importance and its bearing on the problem of this study. Cartwright and Zander[3] have pointed out that while nearly everyone has an opinion as to what leadership "ought" to be, it is much more difficult to separate out ideological assumptions and bias so as to approach such study objectively.

For instance, it is apt to be taken for granted that a true leader exerts more influence on the group and its activities than does the average member.[4] But is this really true--or always true? Cattell took an opposite stand believing that any member of a group exerts leadership to the extent that the properties of the group are modified by his presence.[5] Following

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[1]Malcolm S. Knowles and Leland P. Bradford, "Group Methods in Adult Education", Journal of Social Issues, VIII (1952), 11-22.

[2]Supra, p. 56.

[3]Group Dynamics, op. cit., p. 535.

[4]Ibid., p. 538.

[5]Ibid., p. 538.

along this line of thought would mean that leadership is something which a person might show to varying degrees—in other words, any group member, under certain circumstances might possess qualities of leadership appropriate for a given situation confronted by the group.

Other researchers[1], dissatisfied with so broad a scope, have limited leadership to a certain category of functions, usually related to a rather authoritarian role. However, when the two basic types of group functions[2] are examined carefully, both of these (a) the achievement of some specific group goal and (b) the maintenance or strengthening of the group itself, necessitate action on the part of members which cross over into "leader territory". Thus a concept of leadership has evolved which implies that important group functions may, in principle, be distributed in many ways among the members of a group.[3] While no claim can be made that this can be regarded as a final answer to the problem, nevertheless it is heartening to realize that further research concerning the functions of leadership is underway. The editors close their introductory chapter in the leadership section of Group Dynamics with these words:

> Finally, it is becoming evident that problems of leadership cannot be safely separated from problems of membership. As our understanding of the nature of groups becomes broadened, the mystery of leadership disappears.[4]

In an effort to try to learn what might have influenced public health nurses' concepts of leadership roles, the writer searched for information

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[1]Krech, David and Crutchfield, R.S. cited by D. Cartwright and A. Zander in Group Dynamics, op. cit., p. 539.

[2]Group Dynamics, op. cit., p. 541.

[3]Ibid., p. 543.

[4]Ibid., p. 550.

under the "discussion methods" category in the ten-year review of literature. Many of the articles under this category dealt with specific group methods on situations such as the use of role playing or how to plan a workshop. The Herrold[1] article, referred to previously, seemed to give the clearest concept of the type of leader-member relationships described above and this was in rather brief form. The "inservice education" category yielded some kernels of support for "democratic leadership" but only as part of the total setting. Since much of the reported research in group dynamics was rather new in 1953 it seems unlikely that it had come to the attention of many nurses in the study group except perhaps for those who might have been enrolled in university courses or certain adult education classes in recent years. Another possible source of help which might have reached public health nurses were several articles on leadership which appeared in Adult Leadership[2] in 1952 and 1953.

One other thought as to what factors might have influenced public health nurses' concepts of group leadership is suggested by the emphasis on the teaching of organized adult health classes as revealed in the ten-year review of literature. Did this emphasis, plus that from the earlier approach which tended to formalize both content and method, give the word "teaching" an authoritarian flavor? Did the nurse perhaps fear that she would fall from a pedestal of "expertness" if she tried new and less formal methods? It seems probable that the usual staff nurse might have been rather confused at the wide variety of group leadership roles she was expected to assume.

However, prior to 1953, it seems likely to the writer that public health nurses might have been more influenced by "lesson plans" and course

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[1]Herrold, op. cit., p. 203.

[2]"Sharing the Leadership Load", (based on materials prepared in consultation with Ronald Lippitt and Alvin Zander. Adult Leadership I (1952).

outlines for organized classes than by the newer thinking concerning the interactions in groups.

Studies Since 1953

A Pilot project in group leadership

This project[1], referred to in the introduction to this chaper, is included here because of its relevance to the problem of this study although it is apparent from the date of publication (1955) that the findings could not have influenced either the writer or the responses of the nurses who participated.

As described by Auerbach, the program was undertaken to give a group of fifteen public health nurses training in newer methods of educational group work with parents. All of the nurses in the experimental group had had approved preparation for public health nursing and all had at least two years of experience. It was thought that the project might provide help on problems of selection for leadership, "the special assets and limitations of the public health nurse for this type of work, and the possible significance of these implications for nursing education"[2].

Auerbach makes a differention in group method which the writer found interesting. In separating parent group education from "group dynamics", she explains that parent group leaders make use of many concepts of group process and interaction developed and identified by the group dynamics field. However, "parent group education sees its function primarily as that of helping parents to become better parents, rather than better group members; it concentrates on the specific concern which brings parents to such groups . . .

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[1]Auerbach, op. cit., p. 1578.

[2]Ibid.

rather than on the nature of their participation or their role in the group."[1]

The program consisted of two parts, a 13 week theoretical period and a following period of field work practice in which trainees conducted parent discussion groups under the auspices of their local health departments but with supervision from the training staff of the Child Study Association. The theoretical sessions covered content for parent group education and techniques of leadership. A seminar was included to which trainees could bring questions or problems growing out of either the theoretical sessions or their concurrent observation of parent groups led by Association staff. A special research committee of the Association planned for and conducted evaluation procedures designed to measure growth and movement of the trainees before, during, and after training.

The results were extremely interesting to the writer since they suggested some of the same problem areas with which she has been concerned. In general the trainees accepted the content material on growth and development and normal behavior well and showed quite a bit of familiarity with some of the concepts reviewed. However, many showed much less readiness to handle group discussion on these topics in the practice sessions suggesting that their backgrounds might have lacked depth or conviction.

The trainees did not show special interest in theoretical concepts of group method which were presented, moving rather quickly to practical questions of group leadership--how the leader gets the group to talk, etc. Yet during their later practice periods, many had real problems in the role of leadership, how the leader used her activity, her role in giving information, or how to suggest that certain problems might be explored further in individual settings.

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[1] Ibid., p. 1581.

The trainees' reactions to the seminar which accompanied the theoretical phase of training seemed to confirm impressions of some of their difficulties. The seminar had been planned as a "free" period in which trainees might ask questions and clarify problem areas but the nurse trainees showed much less readiness to use it than had other professional groups trained by the Association staff. While some progress was made, it seemed significant that the trainees themselves apparently were not comfortable under the type of leadership which they were preparing to give to parent groups. How much any previous group experience in which the leader presented structured didactic material affected their responses in this situation can only be surmised.

On the whole, the results of the experimental project were positive. There was considerable evidence of growth, much more on the part of some individuals than others. The project threw light on some rather serious problems suggesting that public health nurses needed greater depth in related content areas, in understanding the dynamics of behavior, and in practical application of group techniques. Both this and a later project[1] carried out under the same auspices suggested that not every public health nurse had the skills and abilities needed for working in this type of group relationship.

While the author stated that the research study which accompanied the projects was not conclusive, one of the measures used seems worthy of mention here. In two of three groups of nurse-trainees there was a high degree of correlation between the ranking given the nurses by members of the Child Study Association staff and their relative scores on a test which measured

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[1]Aline B. Auerbach, "New Approaches to Work with Expectant Parent Groups", American Journal of Public Health, XLVII (1957), 189-191.

authoritarian attitudes[1]. The findings with a third group of trainees were not as clear in this respect.

Study of professional nursing

One other development which has emerged and crystallized to some extent in the years since the data for this study were collected is fairly intensive research about what is professional nursing. While concerned primarily with the nursing care of individual patients, this development also has implications for nurses who work with groups of patients as in a public health agency setting. Nursing practice of truly professional caliber, Kreuter stated, ". . . is comprehensive, is patient-centered, and takes into consideration the long-term social value that should accrue to the patient."[2]

While Kreuter was of the opinion that this concept of nursing practice is beyond that usually found, she categorized nursing care of patients into three types, elementary care, technical care, and comprehensive or fully professional care. While all three levels were professional to a greater or lesser degree, there seemed to be considerable evidence[3] that much nursing practice could be classified on an elementary or technical level and probably could be rendered as well by a practical nurse.

The three levels further defined were[4]: Elementary care was described as giving care "to" the patient using standard procedures and teaching

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[1] Ibid., p. 188.

[2] Frances R. Kreuter, "Evolving Concepts of Professional Nursing", Minutes of the Conference of the Council of Member Agencies of the Department of Baccalaureate and Higher Degree Programs, Chicago, January 12-14, 1956 (New York: National League for Nursing, 1956), 1-7.

[3] Ibid., p. 7.

[4] Ibid., p. 6.

was limited to simple directions; technical care was giving care "for" and treatments "to" a patient while teaching consisted of answering questions, telling facts, demonstrating, and encouraging self-help; comprehensive professional care was described as a situation in which the nurse shared "with" the patient, using discriminative judgment and devising and inventing new measures; teaching was based upon an understanding of the motivation of the learner; there was interaction between the nurse and patient which had knowingly been established by the nurse and which grew out of an understanding of the natural and behavioral sciences; the patient's involvement in his own plan for care, rehabilitation, and if possible, recovery was paramount in the professional care category.

The writer has interjected this material because she believes that it contains a challenge which is confronting public health nursing practice including the group work aspects of such practice. While it can readily be shown, as previous sections of this chapter demonstrate, that public health nursing has identified itself with the teaching role from early days, should a question be raised as to the quality of teaching involved? Was the teaching only telling? Did the nurse teach what she (and perhaps the agency) thought patients should be taught -- for their own good? In a group teaching situation, would we characterize the nurse's dependence upon a fixed lesson plan as an elementary type of practice? In contrast, would we call the type of group leadership promoted by Auerbach and others, which "concentrates upon the specific concern which brings the parents to such groups - their parenthood and their children", as comprehensive and professional in character?

It seems to the writer that the inclusion of these last two studies, even though they took place after the plan for her research was underway, adds support to the reasons why she chose the problem. They also suggest

intense interest on the part of others as to what nurses are doing in their daily practice and what factors have influenced their performance.

Summary - Chapter III

To summarize this chapter is to attempt to pull together many threads, and, lest the proximity result in tangled confusion, try to weave them into a reasonably smooth fabric. To begin, it seems clear from early literature that the concept of teaching was a fundamental part of public health nursing. Where group teaching developed, emphasis seemed to be on definite content material and rather formal method. The group work objectives in the Curriculum Guide undoubtedly gave impetus to group work as a recognized part of the public health nurses' responsibility. The writer questioned whether the level of expected performance was realistic for the beginning or average staff nurse, and was concerned that the type of philosophy expressed by Gilbert and others in the years preceding the Guide seemed lacking. The ten year review of related articles in three journals showed considerable relationship between the Curriculum Guide objectives and the type of article published, especially in the case of Public Health Nursing. Emphasis on the teaching of organized community health classes was foremost in the Group Learning section although group discussion methods placed second in number of articles.

There seemed to be acceptance, prior to the Curriculum Guide, that the public health nurse was expected to have experience with individual patients before serving as a group leader as in a mothers' class; mention was made of intra-agency group work experiences but the writer could find no evidence of any thinking that these and other group experiences of increasing complexity might precede serving as a fullfledged leader or teacher in a class. Thus the idea of a sequential arrangement of learning experiences

through which a nurse might gain group work skill was not apparent in the literature reviewed. One author felt strongly that every public health nurse should not be expected to be able to lead groups. The nurse's involvement with group organization seemed apparent.

Specific illustrations as to how public health nurses and health educators might work together on a health department staff seemed to be more apparent in literature since the mid-forties, or roughly, the postwar period. Studies of the role of the nurse as a participant in community affairs were found during the same period. While public health nursing rated favorably in these, as compared to other fields, there was no evidence that activity in community affairs was directly related to the nurses' participation in group work in public health nursing.

With a few exceptions, the ten year review of literature showed that articles in the group dynamics field were of the methodology or techniques type and did not go very deeply into underlying philosophy. Again, with a few exceptions, there was little emphasis on the scope of research underway in the group dynamics area. This seemed particularly true in regard to the leadership role. The writer wondered whether this lack, plus the emphasis on the nurse as a teacher of community health classes which was apparent in the literature, might have given nurses a rather skewed perspective on the functions of leadership.

Two studies which were completed since the data for this project were collected in 1953 showed interesting developments in defining depth and comprehensiveness of the nurse's contribution. Auerbach's training projects suggested that many public health nurses had much potential and could develop real skill in working with parents' groups. However, it seemed clear that they needed considerable extra preparation, some of which was common with the needs of other professional workers and some seemingly

related to previous factors in the nursing background. Kreuter presented findings which raised questions concerning how much of nursing practice was comprehensive and professional in nature. Implications for public health nursing and for group work practice were apparent. In the writer's opinion, there was a parallel between the two studies above, both of which had concerned themselves with definition of quality and means of achieving it.

CHAPTER IV

A DESCRIPTION OF THE RESPONDENTS

Chapter II has shown that the design for the study called for samples of two sub-universes, one from the Outstate area in Michigan and the second from Detroit. Procedures followed in the selection of the two samples were reviewed, and some evidence was presented (Tables 1 and 2) to show that the two samples quite closely resembled the groups from which they were drawn in terms of one characteristic, the proportion of supervisors and staff nurses in the parent group. Table 8 showed that there were 157 returns from the Outstate sample and 28 from the Detroit sample. Data contained in the questionnaire replies from these 185 public health nurses will therefore become the basis for various types of analysis throughout the study.

Data presented as total responses represent replies from all of the 185 nurses who participated in the study. However, since two samples were involved, and observations were made at different sampling rates, the total responses represent weighting of data in the smaller sample. Specifically, the Detroit data were weighted by two so as to make the relative proportion of the universe sampled the same as in the Outstate group. Or:

Estimate for						
Outstate responses	+	Detroit responses	x	2	=	Total responses
157	+	28	x	2	=	213

This, it will be recognized, is in reality a short-cut procedure for an estimate of the population as 426. In other words, instead of weighting (multiplying) the Detroit data by four and the Outstate by two, the former were weighted by two and the latter by one with the same results. However,

the total number of cases (respondents) remains 185 individuals and this number (n = 185) will be carried on subsequent tables even though the percentages are based on a total weight of 213.

Presentation of Outstate and Detroit Responses - Statistical Significance

In many instances, in the analysis which follows in this and later chapters, data are presented so as to show responses of the Outstate and Detroit samples as well as of the total State sample. Although originally consideration of differences which might exist between the Outstate group and Detroit was not an objective of this study, as analysis proceeded it seemed desirable to explore the meaning of such differences, if only as a basis for later analysis of the total group. Accordingly, in Chapter V, the chi-square test was applied to data in Tables 19 through 33 and to Table 40. The chi-square procedure with multinomial samples was used with the number of independent pieces of information which contributed to the estimate determining the degrees of freedom[1]. The degrees of freedom will be indicated on tables by df hereafter. The 5 percent level of significance (P = 0.05) is considered an adequate standard of precision in considering these types of data obtained through a random sample.[2] Although the sample was not unrestrictedly random, the departure is probably small and in the conservative direction. That is to say, a value indicated to be significant at the 5 percent level probably is so at, let us say, the 4 percent level. According to Mainland, in speaking of fourfold tables, "in random sampling from the same population, 95 percent of the chi-square values would be below 3.841; 5 percent would be above 3.841; and one percent would be above 6.635. Using P, the probability -- we say that for chi-square = 3.841, P = 0.05, and for

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[1]Mainland, op. cit., p. 279.

[2]Ibid, p. 56.

the chi-square = 6.635, P = 0.01. We thus define P for any particular value of chi-square as the probability of finding, by random sampling, values of chi-square greater than that particular value".[1]

It should be pointed out here, however, that chi-square only tests whether or not the observed differences are the result of sampling error. If the differences are "significant" at the 5 percent level (P = 0.05 or less), that is, the likelihood of obtaining a certain response differs for Outstate and Detroit respondents more than would be expected 5 percent of the time in repeated samplings, then we speak of a relationship, i.e., difference, between Outstate and Detroit since it is unlikely to be a chance effect. Conversely, when chi-square results are less than those indicated at the 5 percent level in a chi-square probability table, (P = more than 0.05) the differences can be said to be due to chance sampling fluctuations and the two groups not significantly different with respect to the particular measure under investigation. The limitations of using the chi-square results as "proof" in dealing with these types of data will be discussed further in relation to specific tables.

Occupational Status

Table 11 shows that 15.5 percent of the total respondents were supervisors and 84.5 percent staff nurses. These results compare favorably with expectations set forth in Tables 1 and 2 where it was shown that 13.5 percent of the Outstate sample and 15.8 percent of the Detroit sample were supervisors.

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[1] Ibid., p. 99.

Table 11. Proportion of Supervisors and Staff Nurses Responding to Questionnaire - Total State Sample

Occupational Category	Outstate n = 157 Percent	Detroit n = 28 (56)[1] Percent	Total State n = 185 (213)[1] Percent
Supervisors	14.6	17.9	15.5
Staff	85.4	82.1	84.5
No response	-	-	-
Total	100.0	100.0	100.0

[1]See page 76 for description of weighting.

Place of Occupation

Table 12 shows the proportion of rural respondents to be slightly higher than that of urban nurses.

Table 12. Place of Occupation of Respondents

Type of Agencies	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
City Health Department	31.0	100.0	41.8
Rural health department (County and District)	65.0		47.9
City-county and combination agency	14.0		10.3
No response	-	-	-
Total	100.0	100.0	100.0

The city-county health department respondents and those from combination agencies were combined since only 3.7 percent of the total were from the latter type of agency. Moreover, the largest agency coming under the combination agency category covered both city and county and, in this sense, also

could have been grouped as a city-county health department. Assuming that the 10.3 percent might also represent both urban and rural respondents, the total sample could be said to contain nearly equal numbers from these two groups.

While the Detroit sample represented nurses in only one agency, further analysis of this group brought to light some interesting information. The method of selection, based upon an alphabetical list, resulted in great variation in the proportion of nurses in the sample from several work assignment categories within the agency. For example, 15.4 percent of the nurses assigned to Herman Kiefer Health Center were included in the sample while 45.8 percent of the staff at Northeast Health Center were included. These and other variations are shown in Table 13. It can be noted that 78.6 percent of the nurses assigned to health centers responded as compared to 60.0 percent of those with other assignments. However, this difference is not statistically significant since the chi-square is 1.35 with 1 degree of freedom. The chi-square value would have to be 3.84 to be significant at the 5 percent level.

Table 13. Analysis of Detroit Sample and Questionnaire Returns by Place of Work Assignment

Work Assignment Categories	Total Nurses Assigned
Bruce Douglas Health Center	22
Gratiot Health Center	31
Herman Kiefer Health Center	13
Northeast Health Center	24
Northwest Health Center	18
Communicable Disease Division	2
Special Investigation Division	2
Nursing Administration* Division	1
Nursing Records* Division	1
Social Hygiene Division	13
Tuberculosis Division	13
Industrial Hygiene Division	1
Field-Hospital Division Coordination	6
Maternal, Child, and School Health	3
Total staff group from which sample was drawn	150

*Staff nurses assigned to central office to carry out specific duties.

Whether or not drawing a sample from nurses working in health centers only and omitting those on special assignments would have resulted in a higher proportion of responses is not known. As explained in Chapter II (page 28) the decision to draw from the total staff seemed best at the time for the reasons given.

Table 13 - Continued

How Sample Represented Work Assignment Categories		Returns by Place of Work Assignment	
Number in Sample	Percent of Category Represented in Sample	Number of Responses	Percent of Sample Category Represented in Responses
4	18.2	3	75.0
6	19.4	6	100.0
2	15.4	1	50.0
11	45.8	8	72.7
5	27.8	4	80.0
0	-	-	-
1	50.0	-	-
1	100.0	1	100.0
0	-	0	-
2	15.4	0	-
3	23.1	2	66.7
0	-	0	-
2	33.3	2	100.0
1	33.3	1	100.0
38	-	28	-

Experience in public health nursing

Nearly one-half of the total sample had had over ten years of experience in public health nursing and of these 23 percent had been employed for twenty-one years or more. Only 8.4 percent had worked for less than a year in this field and an additional 10.3 percent had been employed from one to ten years.

Table 14. Length of Time Respondents Had Been Employed in Public Health Nursing

Number of Years	Outstate n = 157	Detroit n = 28	Total State n = 185
	Percent	Percent	Percent
Under 1 years	10.2	3.6	8.4
1 - 2 years	10.2	10.7	10.3
3 - 5 years	18.5	14.3	17.4
6 - 10 years	21.0	7.1	17.4
11 - 20 years	25.5	17.9	23.5
21 years or more	14.6	46.4	23.0
No response	-	-	-
Total	100.0	100.0	100.0

Age of Respondents

As would be expected from the experience data, the majority of the sample were in what might be called a "middle-age" group. Approximately 20 percent were under thirty years of age and an equal proportion were over fifty. The greatest extremes in age were found in the Detroit sample. To what extent the age distribution of the sample might affect responses is a matter of conjecture. One might raise a question as to whether younger nurses might have been exposed to more of the modern group dynamics emphasis than nurses in their forties or fifties. This question, it should be re-

membered, might also be related to recency of educational preparation, or to specific inservice education.

Table 15. Age of Nurses in Total Sample

Age in Years	Outstate n = 157	Detroit n = 28	Total State n = 185
	Percent	Percent	Percent
21 - 25 years	5.7	14.3	8.0
26 - 30	10.8	14.3	11.7
31 - 40	25.5	7.1	20.7
41 - 50	37.6	42.9	39.0
51 - 60	17.2	10.7	15.5
Over 60	1.9	10.7	4.2
No response	1.3	-	.9
Total	100.0	100.0	100.0

Marital Status

Slightly less than one-half of the sample had never been married. Approximately 10 percent (9.4 percent) had been married but classified themselves as "widowed or other" and the rest were married at the time of filling in the questionnaire. Thus, the total sample was almost equally divided between single nurses or those who were or had been married.

Table 16. Married Status of Respondents

Marital Status	Outstate n = 157	Detroit n = 28	Total State n = 185
	Percent	Percent	Percent
Never married	44.6	60.7	48.8
Now married	42.7	39.3	41.8
Widowed or other	12.7	-	9.4
No response	-	-	-
Total	100.0	100.0	100.0

Status as to Dependents

The responses to this question indicate that nearly 40 percent of the nurses had children or other dependents living in their homes. The responses of the two samples showed that this was true to a greater extent for the Outstate group than in Detroit.

Table 17. Proportion of Nurses in Samples Who Had Dependents in The Home

Children or Other Dependents at home	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Yes	45.9	21.4	39.4
No	51.6	78.6	58.7
No response	2.5	-	1.9
Total	100.0	100.0	100.0

Responsibility for children or other dependents in the home would seem to bear at least a potential relationship to extra preparation time for group work activities or to evening meetings in school or community which nurses might attend. This comment would apply to marital status also (Table 16) but might be a more acute issue in the case of dependents.

Preparation for Public Health Nursing

Sixty-nine percent of the total respondents had had one year or more of university preparation for public health nursing. As anticipated, the proportion of prepared nurses was higher in the Detroit sample where 89.3 percent of those responding were prepared as compared to 62.8 percent in the Outstate sample. The three nurses in the Detroit sample who had less than a year of preparation were all under thirty years of age and had been employed less than three years. These findings are consistent with the writer's understanding of personnel policies in that agency, under which

nurses are expected to complete preparation within a given period of time.

Table 18. Status of Respondents' Preparation in Public Health Nursing[1]

Status of Preparation	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent	
No public health nursing courses	19.1	-	14.1	31.0 percent unprepared
Less than one school year of preparation	19.1	10.7	16.9	
One or more years but not degree	29.3	57.1	36.6	69.0 percent prepared
Bachelor's degree including public health nursing	26.8	32.2	28.2	
Master's degree including public health nursing	5.7	-	4.2	
No response	-	-	-	
Total	100.0	100.0	100.0	

[1]The "unprepared categories are summarized above the dotted line and the "prepared" below.

While the question relating to preparation (Q.30) broke down replies into quite detailed categories, these were later combined into two groups, prepared and unprepared. As defined in Chapter I, a prepared nurse was one who had completed one school year of public health nursing preparation in an approved program of study, or was a graduate of an approved basic collegiate program.

In reviewing the findings it is interesting to recall that slightly more than one-half (54.0 percent) of the nurses in the total universe from which both samples were drawn were in the prepared category. However, Chapter II (page 26) describes how, in establishing an Outstate list from which a 50 percent sample could be drawn, a decision was made to include

only nurses who were employed by organized health departments or combination agencies. This decision omitted fifteen nurses from the master list who were employed by other "local official" auspices and almost entirely unprepared. How much this affected the proportion of prepared nurses who later made up the Outstate sample is not known.

The writer's unofficial estimate, from reviewing the names of the nurses which appeared on the sample lists, would be that approximately 60 percent of the entire sample had completed preparation. While no conclusions can be drawn from this kind of evidence, it perhaps is helpful in understanding the difference between the proportion of prepared (54 percent) in the total universe and the proportion of preparation among the respondents (69 percent). Moreover, if the 185 individuals who returned questionnaires are considered as one group rather than two samples, 122 individuals or 66 percent would be classified as prepared. In other words, the 69 percent is derived from weighting the Detroit responses while the 54 percent refers to the total universe from which the two samples were drawn.

It is clear however, that even though the 230 nurses who made up both samples had equal opportunity to respond to the questionnaire, the responses indicated that those with preparation took somewhat greater advantage of the opportunity. An unofficial review of the status of preparation of the forty-five nurses who did not respond showed that approximately 42.0 percent were in the prepared group.

Summary of Characteristics of Respondents

The typical respondent had approximately an equal chance of being employed in an urban or rural health department. If employed in Detroit, the chances were three out of four that she was assigned to a district health center.

Six to ten years of experience as a public health nurse was the median range for the respondents and the typical respondent was between forty-one and fifty years of age. However, variations as shown in Tables 14 and 15 are perhaps more significant than these generalizations. Approximately one-half of the group were single nurses. Forty percent of the respondents had children or other dependents living in their homes.

Approximately two-thirds of the sample had completed one year or more of university preparation for public health nursing while 14.1 percent had had no university courses. Fifteen percent of the sample were supervisors and 84 percent staff nurses.

CHAPTER V

HOW A SELECTED GROUP OF HEALTH DEPARTMENT NURSES FELT ABOUT THE IMPORTANCE OF GROUP WORK IN PUBLIC HEALTH NURSING

Chapter V begins the analysis of the data relating to the three parts of the study problem. Data relating to Parts I and II of the problem will be assembled around individual objectives and findings relating to each objective will be discussed under a topical heading. Interrelatedness of responses will be checked and questions raised as to meaning. Part I will be discussed in this chapter and Part II in Chapter VI.

Information gained from open-end questions, usually in the form of reasons for certain responses, will be included only when they seem to add emphasis or present a new idea. Even though a full review of all of the reasons for responses will not be given, the writer believes that the data contained in them has shown that the respondents understood the questions and wanted to explain their responses as fully as possible. Illustrations of this occur in the presentation of data in this and later chapters.

Part III of the problem will be treated somewhat differently. Findings in relation to each objective in Parts I and II of the problem will be reexamined, considering the effect of two variables, preparation and experience. While the interrelatedness of these two factors in their influences on nurses' responses to questions about group work may hamper such analysis, an attempt will be made to show possible relationships which may exist. Part III will be discussed in Chapters VII and VIII.

Since the over-all objective of Part I was to learn as much as possible about the importance of group work to public health nurses, any conclusions from Chapter V necessarily will be limited to this. It is realized that importance can be estimated mainly from the nurses' replies to a number of specific questions relating to on-the-job situations with which they are familiar. It is hoped also that the way in which nurses related themselves to the study, i.e., their cooperation in supplying answers to open-end questions, will assist with an estimation of importance. However, it is necessary to stress that this chapter, through presenting an analysis of replies to specific questions, can only offer evidence as to how the nurses in this sample responded. Until these findings are further analyzed in terms of possible relationships to a common variable such as the status of preparation for public health nursing, they should not be applied to other groups of nurses.

How Important is Group Work?

The first objective under this chapter heading sought to learn the relative importance of group work as a part of the public health nurses' job. Two questions were asked in an effort to learn whether or not group work was basic to her concept of health education service to the community. Tables 19 and 20 show these results.

It is apparent from Table 19 that the total State responses indicate a high value placed on meetings and classes as a means of health education in the community. Chief reasons given to support the "more" answers were that the sharing of experience was valuable (43 percent of "more" respondents) and that more people could be reached in this way (25 percent). A question might be raised as to the soundness of comparing group work to home and clinic visits since the value of either could be termed nebulous and

standardization is not possible. Nevertheless, the familiarity of the home visit, especially to any public health nurse, made it seem a fair basis for comparison with another technique for reaching people. The chi-square value would have to have been 9.48 or higher to rule out chance at the 5 percent level.

Table 19. Health Education Values of Meetings or Classes as Compared to the Individual Home or Clinic Visit

Meetings or Classes Offer	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
More opportunity	40.1	42.8	40.8
Same opportunity	23.6	10.7	20.2
Less opportunity	23.6	35.7	26.8
Can't tell	10.8	7.2	9.9
No response	1.9	3.6	2.3
Total	100.0	100.0	100.0

Chi-square = 3.94, df = 4, P = .406. Differences in Outstate and Detroit responses not significant at 5 percent level.

Table 20. Does Group Experience Offer "Plus Values" in Terms of Health Education as Compared to Individual Visits?

"Plus Values"	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Yes	86.0	89.3	86.9
No	.6	-	.4
Don't know	8.9	10.7	9.4
No response	4.5	-	3.3
Total	100.0	100.0	100.0

Chi-square = 1.66, df = 3, P = .572. Differences in Outstate and Detroit responses not significant at 5 percent level.

Table 20, in one sense, presents another reason to support the nurses' feelings about the importance of group work. While related to some later objectives also, these findings are presented here since they seem most closely associated with the nurses' feelings about the reasons group work was important.

However, the writer wonders if the wording of the question might have been a conditioning factor. Nurses were asked (Q 17) if they thought that the group experience itself - as in a mothers' class - might be a "plus value" in health education. A question could be raised as to whether the term "health education" was apt to be linked with groups in the nurse's mind while "health teaching" was related more to individual visits. The rather overwhelming affirmative responses made the writer wonder if a different response would have been elicited had the question been asked with clearer definitions.

If nurses regard group work as a highly valuable phase of their community service, then it seemed important to learn if they thought that any extra skills were involved over and above those employed in individual visits with patients. Table 21 reports on this.

Table 21. Does Group Work Within the Agency Require Different Skills than Home Visiting?

Skills Required are	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Same	43.9	42.8	43.7
Different	50.3	53.6	51.2
Can't tell	2.6	3.6	2.8
No response	3.2	-	2.3
Total	100.0	100.0	100.0

Chi-square = 1.08, df = 3, P = .801. Differences in Outstate and Detroit responses not significant at 5 percent level.

Reasons listed by respondents to support their answers were as follows: In the group who felt that the skills were the same, 35 percent gave reasons which could be classified under the category "Skills were more alike than different". Of those who responded that different skills were involved, 67 percent gave reasons indicating that they felt that more skill was involved in group work while 12 percent said that home visiting required more skill. It should be remembered that this question limited group work to that which took place within the agency. A question could be raised as to whether part of the difference might also be related to the situation itself. In the instance of group work within the agency, other professional people would be involved while in home visiting the nurse would be working with lay people.

The question which followed took the next step and sought information as to whether the nurses felt that group work in the community required more skill than that within the agency. These findings are shown in Table 22.

Table 22. Is More Skill Required in Working with Community Groups Than With Agency Groups?

Skill required	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
More	47.1	17.9	39.4
Same	40.1	35.7	39.0
Less	3.2	10.7	5.2
Can't tell	7.0	32.1	13.6
No response	2.6	3.6	2.8
Total	100.0	100.0	100.0

Chi-square = 22.2, df = 4, P = .001. Differences in Outstate and Detroit responses are significant.

While there is considerable difference between the proportion of "more" responses in the two samples, the reasons listed for their choices did not seem to differ. Those who felt that working with community groups required more skill on the part of the nurse said that it was necessary to know how to work with people with different backgrounds and interests (27 percent) and that broader preparation in terms of varied subject matter was required than in agency group work (28 percent). Of the Outstate nurses who responded that the same skills were involved whether in agency or community groups, 17 percent commented that the basic elements of group work were the same. While 36 percent of the Detroit nurses felt that the same skills were required in either agency or community groups, no reasons were given.

The factors responsible for the differences in responses from the Outstate and Detroit nurses are not very clear. Approximately two-thirds of the latter group either felt that community and agency group work required the same skills or gave a "can't tell" response. This, when coupled with the 10 percent who felt that community groups required less skill might mean rejection of the question as trivial or inconsequential by approximately three-fourths of the Detroit respondents. In contrast, in the Outstate group, 87 percent were nearly evenly divided between the "more" and "same" variables. It is possible, too, that the types of community groups with which public health nurses had contact in Detroit differed considerably from those encountered by Outstate nurses. At least this type of possible difference suggests that the factors in nurses' backgrounds which influence their replies may be very complex and not subject to clear-cut analysis by statistical procedures which are practical for this type of study.

One other question (Q 2) originally classified by the writer as relating to Part III of the problem, upon further analysis, also seemed to belong in Part I. This question asked nurses if they had preference between

working in a one-to-one relationship with individuals and working with "any groups that are related to your job." The results are presented in Table 23 as additional testimony concerning the nurses' feelings about the importance of group work in public health nursing.

Table 23. Nurses' Preferences Concerning Working With Individuals or Groups

Preferences Expressed	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Prefer working with individuals	28.0	32.2	29.1
Prefer working with groups	12.7	21.4	15.0
Either way - doesn't matter	54.8	39.3	50.7
Not sure	1.9	7.1	3.3
No response	2.6	-	1.9
Total	100.0	100.0	100.0

Chi-square = 5.42, df = 4, p = .243. Differences in Outstate and Detroit responses not significant at 5 percent level.

It is of interest that nearly twice as many nurses in the Detroit sample indicated that they preferred working with groups rather than with individuals as compared with the responses of the Outstate nurses. A review of the reasons for this response indicated that 40 percent stated that group work saved the nurse's time and allowed her to reach more people. Other reasons were scattered and did not add to the total picture. Of the nurses who preferred working with individuals, the chief reasons given were that the nurse was more at ease (22 percent) and did not feel secure in a group situation (27 percent). The interrelatedness of these two reasons is recognized by the writer. Nurses who reported that they were ambivalent supported this response by saying that they enjoyed both types of experiences and felt that both were necessary in public health nursing.

Summary

In summarizing "How Important is Group Work", the data show that nearly one-half of the respondents (40.8 percent), felt that group meetings or classes offered more opportunity for health education than did individual home or clinic visits. Another 20 percent said that the two activities offered the same opportunity. A very large majority felt that the group experience itself offered "plus values" in health education as compared to individual contacts. Opinion was quite evenly divided as to whether group work within the agency or individual contacts with people required the same or different skills on the part of the nurse. Total responses were also almost evenly divided on the question of whether working with community groups required more or the same skills on the part of the nurse as working with professional groups within the agency. However, there were wide differences in the proportion of Outstate and Detroit nurses who replied in the "more" category. Nearly one-half (47.1 percent) of the former felt that community groups required more skill as compared to 17.9 percent of the Detroit nurses. Whether this difference is related to experience and preparation of the Detroit sample is not known. While a higher proportion of Detroit nurses expressed a preference for working with groups, the difference between their responses and those of the Outstate nurses was not statistically significant.

Group Organization

The second objective considered in this chapter sought to learn how the nurse differentiated between working with existing community groups (such as a PTA Health Committee or a YWCA Mothers' Study Club) and organizing new groups. Examples of the latter might be an Expectant Prents' class or group meetings for diabetics organized under health department auspices. Table 24 shows how the nurses felt about this and the extent of difference

in their replies.

Table 24. Preference for Working With Organized Groups or Organizing New Ones

Preferences Expressed	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
To meet with organized groups, contributing to their programs	32.5	28.6	31.5
To organize or assist with organizing groups directly related to the health department program	14.6	21.4	16.4
No preference - work with both kinds	51.0	46.4	49.8
No response	1.9	3.6	2.3
Total	100.0	100.0	100.0

Chi-square = 1.22, df = 3, P = .801. Differences in Outstate and Detroit responses not significant at 5 percent level.

It seems clear that approximately 50 percent of the nurses in both samples had no preference as to whether they worked with existing groups or helped organize new ones. Nurses in both samples who said that they preferred working with existing groups gave as their most common reason (30 percent) a feeling of inadequacy in organizing a new group. However, an additional 18 percent said that organizing new groups took more time and because of the nursing shortage this was not possible. A question could be raised also as to whether reluctance to organize new groups was related to belief on the nurses' part that this was not a nursing function.

The most common reason expressed in the total sample for preferring to organize new groups was that it was possible to know such groups better and give better service. The nurses who had no preference as to type of group supported their choice by saying that, if approached properly, both experiences could be helpful in terms of community health education (49

percent) and that each type of experience was a learning experience for the nurse (12 percent).

Since the nurse's readiness to work with groups may be related to her feelings about group organization, a series of questions was asked concerning this. Tables 25 and 26 show the results.

Table 25. How Much Initiative Should the Public Health Nurse Take in Organizing Groups - Such as Expectant Parents' Class?

Action Nurses Would Take	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Wait for request to come to health department	3.2	3.6	3.3
Take beginning steps such as discussing matter with Supervisor	84.1	89.3	85.4
Go ahead and explore interest of community group concerned	10.8	7.1	9.9
No response	1.9	-	1.4
Total	100.0	100.0	100.0

Chi-square = 1.01, df = 3, P = .801. Differences in Outstate and Detroit responses not significant at 5 percent level.

Even though 30 percent of the total sample had expressed feelings of inadequacy in terms of organizing a new group, Table 25 shows that a large majority of the nurses reported that they would exercise some initiative when confronted with a community situation. However, the fact that the step they would take was in the direction of securing assistance or approval for such a venture may be significant. Less than 10 percent of the total sample reported that they would independently go ahead and explore community interest. However, it is only fair to add that, in the case of staff nurses who comprise the majority of the sample, seeking supervisory assistance would be the acceptable public health nursing practice.

Table 26. Skills in Group Organization Ranked in Order of Importance

Skills Listed	Percentage Making This Choice First	Second	Third	n = 185
	Percent	Percent	Percent	
Skill in interpreting community situations and readiness for organization	34.3	11.7	7.0	
Skill in presenting ideas clearly	19.7	16.0	11.7	
Skill in getting people to want to work together	14.5	22.5	21.1	
Skill in picking key people to help	14.1	26.8	14.1	
Skill in group dynamics	8.5	5.2	8.5	
Skill in helping groups think through and adopt action	7.0	16.0	34.3	
No response	1.9	1.8	3.3	
Total	100.0	100.0	100.0	

Chi-square = 3.03, df = 6, P = .809. Difference in Outstate and Detroit responses (1st choice only) not significant at 5 percent level.

This question (Table 26) attempted to learn how much the nurses knew about some of the problems of group organization. Perhaps because of this, its design is rather hazy and unnecessarily detailed. For instance, the first, third, and fourth responses could be considered as one since all deal with sensitivity in understanding a given community and its responses. The last two items could be said to relate primarily to group process rather than to group organization. However, skill in the use of the group process could be an important factor in the nurse's approach and manner of working through a problem of this sort. The item "skill in group dynamics" was introduced to see to what extent the respondent might grasp at a familiar but not well understood term. This apparently did not happen except for a small proportion of responses (8.5 percent). It might be said also that the second and third items, which seemed to the writer to be the most manipulative, were

selected less frequently. Perhaps it is not sound to claim more for these findings, however, than that the respondents showed considerable understanding of certain important concepts in group organization.

If group organization is a problem and the nurse wishes to do a good job but also to conserve time, where would she turn for assistance with this phase of her work? Table 27 shows how the group responded to this question.

Table 27. Where Public Health Nurses Would Turn for Help in Group Organization

Sources of Help	Percentage Making This Choice* First Percent	Second Percent	Third Percent	Fourth Percent	n = 185
Key people in community with organization experience	30.5	24.9	26.2	7.0	
Specialist in health education	33.3	36.6	11.7	4.4	
Supervisor or consultant	28.2	27.2	27.0	7.0	
Themselves - more familiar with situation	4.2	1.9	16.9	36.6	
Other	.5	-	.4	.9	
No response	3.3	9.4	17.8	44.1	
Total	100.0	100.0	100.0	100.0	

*Responses ranked 1-2-3 in order of importance.
Chi-square = 3.80, df = 5, P = .549. Differences in Outstate and Detroit responses (1st choice only) not significant at 5 percent level.

In this question (Q 15) the nurses were asked to whom they would go for help if they wished to organize a group but wanted to conserve time in so doing. In a sense this carried the implication of expertness which may, in part, account for the high proportion of "specialist" responses. This rather surprised the writer, for except in Detroit, it seems unlikely that many of the respondents would have worked with a health education specialist. In the Detroit sample, 46.4 percent of the respondents gave this as their first choice as compared to 28.7 percent of the Outstate nurses. Were the

nurses in the Outstate sample answering from a theoretical base, i.e., they thought that it would be the best way even though such a resource was not available? The choices in the fourth column are weakened by the large proportion of no response answers but it might be said that the nurses would look primarily to others for help in group organization and to themselves as a last resort.

One additional question dealt with the nurse's feelings about preparation for group organization. This time they were asked to consider, if several methods of preparation were equally available, which one they would choose. Respondents also were given opportunity to indicate that they felt adequately prepared for this responsibility at the present time. The results are presented in Table 28.

Table 28. What Nurses Said Would Best Prepare Them for Organizing Groups; Percentage Who Did Not Need Help

Items Checked Most Important	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
University courses relating to group organization	16.5	39.3	22.5
Inservice education relating to group organization	33.1	17.9	29.1
Assistance from supervisor or consultant	15.3	17.9	16.0
Observing how another nurse organized a group	15.3	14.3	15.0
Did not need help with group organization	15.3	3.5	12.2
No response	4.5	7.1	5.2
Total	100.0	100.0	100.0

Chi-square = 10.7, df = 5, P = .051. Differences in Outstate and Detroit are significant at 5 percent level.

It seems apparent that responses of the Detroit and Outstate nurses differed quite sharply in regard to the value of a university course concerned with group organization. Nearly 40 percent of the Detroit nurses rated this as the most important factor in preparing to organize a group while only 16.5 percent of the Outstate nurses gave this response. In this instance the chi-square value of 10.7 nearly approaches 11.0, the point on the probability table at which it could be said to be significant at the 5 percent level.

In reviewing the above data, the writer wondered if the higher proportion of preparation in the Detroit sample was not a contributing factor to this response. A question might be raised also as to whether specific course work relating to group organization might have been available to Detroit nurses to a greater extent than to Outstate nurses, thus constituting a common factor which affected responses.

Similarly, Outstate nurses may have had more opportunities to attend workshops and discussion meetings which might have tended to influence their responses as to the values of inservice education. The higher proportion of Outstate nurses who felt adequate in the group organization area (15.3 percent of the Outstate nurses as compared to 3.5 percent of the Detroit sample) might be related to more direct experience with this type of responsibility. While both groups had indicated (Table 27) that they considered the health education specialist the best source of help, it seems likely that Outstate nurses might have had to participate in group organization more actively as specialists were less apt to be available.

A final question in this series on group organization asked, perhaps needlessly, whether the nurses felt that group work saved the nurse's time - for example, did a group class with ten expectant mothers take less time than making home visits to the same patients. While this has at times been a controversial issue in public health nursing practice, it was difficult to

phrase a question here which could be considered objectively, since the whole emphasis of the questionnaire was on group work. How much the setting influenced the responses shown in Table 29 can only be estimated.

Table 29. Does Group Work Save the Nurse's Time?

Save Time	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Yes	67.5	92.8	74.3
No	15.3	3.6	12.2
Uncertain	14.6	3.6	11.7
No response	2.6	-	1.8
Total	100.0	100.0	100.0

Chi-square = 7.47, df = 3, P = .059. Differences in Outstate and Detroit responses are significant at 5 percent level.

Reasons for the "yes" replies were headed by the argument that while both group work and home visits required preparation, the same amount of preparation on the part of the nurses would reach more people in a class situation (39 percent of "yes" respondents). Another 15 percent said that group work saved the nurse considerable travel time and 8 percent pointed out that the nurse's time was saved in a class in that people helped to answer each other's questions. A small number (4 percent) qualified their responses by saying that time might not be saved if it were the nurse's first experience in teaching a class. In the writer's opinion a question might be raised here as to any significance in the terminology used by the respondents. The question was about group work but comments were limited to class situations. Does this mean that the nurses' ideas about "group work" were primarily related to classes?

Among the "No" respondents, 35 percent maintained that preparation for classes really took longer, especially if more than one class was

involved. Another 15 percent said that mothers' classes often resulted in "case-finding" in the sense that home visiting seemed indicated for individual problems, thus increasing the demands on the nurse's time.

It is apparent that nearly all (92.8 percent) of the Detroit nurses were of the opinion that group work saved the nurse's time as compared to approximately two-thirds (67.5 percent) of the Outstate nurses. This difference is supported by the chi-square value of 7.47 which approaches 7.81, the point on the probability table at which it becomes significant at the 5 percent level. How much this response on the part of the Detroit nurses is related to their longer years of experience and the fact that nearly 90 percent of the sample were "prepared" for public health nursing can only be estimated. It is likely, moreover, that this response, as in other instances where there was a significant difference between the Detroit and Outstate groups, represents a complex grouping of interactions.

Summary - Group Organization

Approximately one-half of the respondents had no preference with regard to working with health groups already organized in the community or organizing new groups affiliated with the health department. Another one-third preferred to work with already organized groups and slightly more than one-sixth preferred to organize new groups. A large majority, however, felt that the nurse might take some initiative in exploring plans for group organization rather than waiting for the request to be brought to the health department.

Skill in interpreting readiness for organization, knowing how to select key people to help, and skill in helping groups think through and adopt action were rated in a 1-2-3 order as most important for the nurse in group organization. A specialist in health education was thought to be

the best source of help in organizing groups, followed by the nursing supervisor and/or consultant, and the nurse herself as a last resort.

Inservice education on group organization was considered the most helpful experience in preparing a nurse to organize a group although the Outstate and Detroit groups approached the 5 percent level in terms of significance of difference in this response, i.e., the two samples gave almost opposite preferences between inservice education and a university course. A university course on group organization placed second as a total response. A small proportion of the respondents (12.2 percent) reported that they felt adequately prepared for this responsibility. Approximately three-fourths of the total respondents said that group work saved the nurses' time. Here again, the Outstate and Detroit responses approached the 5 percent level thus implying that this difference would hold for the entire universe of nurses.

Concepts of Leadership Roles

A third objective sought to learn how the nurses regarded certain leadership roles which they might be expected to fill. Questions were asked about two roles, serving as a health resource person, i.e., a representative of the health department at school or community meetings, and being a group leader. Tables 30 and 31 show the results.

Table 30. Skills Thought to be Most Important in Serving as Health Resource Person at Community Meetings

Important Skills	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Understanding when and how to contribute	89.2	82.1	87.3
Finding ways of introducing description of health department program	3.2	7.2	4.2
Estimating situation but not talking unless called upon	7.0	10.7	8.0
No response	.6	-	.5
Total	100.0	100.0	100.0

Chi-square = 1.73, df = 3, P = .572. Difference in Outstate and Detroit responses not significant at 5 percent level.

While a large majority of nurses in the sample (87.3 percent) identified with the first response, the writer feels that the phrasing of the alternative could have been improved. "Understanding when and how to contribute" is quite general and perhaps does not show sufficient delineation of the resource role except as it is separated from the other two alternatives. However, since the lead in the question (Q 6) presented considerable background information, perhaps it could be assumed that, in responding thus, the majority showed sensitivity to the group situation which the question described. A desire to understand how and when to contribute might also be said to imply conscientiousness on the part of the respondents, in contrast to choosing a "pat" answer such as the second alternative.

The results of the next question (Q 7) presented in Table 31 seem to provide a clue to one of the problems which public health nurses encounter in group work.

Table 31. Nurses' Opinions Concerning Group Leadership as Compared to Group Membership

Comparison of Leadership and Membership	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Leader carries most of the responsibility	56.0	78.6	62.0
The two roles are more alike than different	38.9	14.3	32.4
Group participant does not carry much responsibility	3.2	7.1	4.2
No response	1.9	-	1.4
Total	100.0	100.0	100.0

Chi-square = 7.59, df = 3, P = .057. Differences in Outstate and Detroit responses are significant at 5 percent level.

Again, the writer feels that the alternatives shown in Table 31, of which the respondents were asked to check one, might be open to question. The lead in the question had attempted to show group work as an evolutionary process with progression described as "committee chairmanship, or discussion leader" after the nurse had been a member of the groups concerned. This explanation seemed important in setting the stage for the question so that the nurses could not confuse it with group leadership in the sense of teaching a class. The latter activity, it was felt by the writer, might more easily be interpreted by the nurses as a situation in which they carried major responsibility. Further analysis of the nurses' problems with the leadership role will be presented in discussion of later objectives.

It is apparent that the Detroit respondents identified more closely with the concept of the leader as the person carrying major responsibility (78.6 percent) as compared with the Outstate respondents (56.0 percent). The chi-square value of 7.59 is sufficient to be regarded as significant at the 5 percent level, thus indicating that factors other than chance

influenced the responses.

Another aspect of the leadership problem was approached by asking the nurses if leadership roles required extra preparation time on their part and if so, how did they feel about this. Tables 32 and 33 show the replies.

Table 32. Do Group Leadership Roles (Health Resource Person, Leader, or Teacher) Require Extra Preparation Beyond Working Hours?

Extra Preparation Required	Estimate for Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Yes	82.2	60.7	76.5
No	7.6	28.6	13.2
Can't tell	7.0	7.1	7.0
No response	3.2	3.6	3.3
Total	100.0	100.0	100.0

Chi-square = 11.2, df = 3, P = .011. Differences in Outstate and Detroit responses are significant at 5 percent level.

In giving reasons for the "yes" response, 29 percent said that that time was involved in looking up material or doing research on the subject matter involved, 9 percent mentioned that preparation in group work techniques involved extra time and another 8 percent said that the agency work load was too heavy to allow for any such preparation during working hours.

A review of the Outstate and Detroit responses indicates a marked difference in the feelings of the two groups with regard to extra time involved for certain group work roles. A large majority of the Outstate group (82.2 percent) felt that extra time was involved as compared to 60.7 percent of the Detroit nurses. Moreover, three times as many of the Detroit group felt that no extra time was involved in preparing for group leadership. While the chi-square value indicates that these differences are due to factors other than chance, it is likely that these responses reflect a

number of related factors such as agency policy, experience and preparation, and liking for group work.

Table 33. If Leadership Roles Involve Extra Preparation Time Beyond Working Hours, What Should Be Done?

Suggested Course of Action	Estimate for Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Nurse should consider this part of her professional responsibility	8.3	7.2	7.9
Agency should allow time for preparation during working hours	24.2	46.4	30.1
Combination of above	64.9	39.3	58.2
No response	2.6	7.1	3.8
Total	100.0	100.0	100.0

Chi-square = 7.50, df = 3, P = .059. Differences in Outstate and Detroit responses are significant at 5 percent level.

The fact that roughly one-half (58.2 percent) of the nurses in the total sample selected a compromise answer would seem to indicate that this type of overtime was not regarded as a burning issue by this proportion of respondents. The difference in the way in which the two samples responded to the second item might be related to differences in age and experience between the two groups and perhaps also reflects the influence of environmental factors, attitudes, and interpretation of personnel policy by the Detroit group. Again, in this instance, the chi-square value barely approached the 5 percent level of significance.

Summary

A large majority of respondents felt that understanding when and how to contribute was the most important skill when serving as a health resource person at a community meeting. Over one-half of the group were of the

opinion that the discussion leader carried most of the responsibility while approximately one-third said that the roles of participants and discussion leader were more alike than different.

Approximately three-fourths of the respondents said that preparation for group leadership roles involved time beyond working hours. Approximately one-third felt that the agency should allow for this preparation time and slightly over one-half of the group said that the nurse and the agency both should share in this responsibility. Chi-square tests showed that the responses of the Detroit and Outstate nurses were significantly different at the 5 percent level in Tables 31, 32 and 33.

How Nurses Ranked Their Group Work Contributions

A fourth objective under this chapter heading was concerned with how the nurse felt about her own abilities in the group work area. Specifically, nurses were asked to rank what they felt were their contributions to various group work categories and activities using best, medium-good, or poorest as a rating scale. (Q. 18) This rather complicated device was used in asking for information about group work experience because it was felt that the nurses could respond best in terms of a specific experience, i.e., being a discussion leader at a joint meeting between teachers and nurses, rather than being a discussion leader in general.

It seemed important also to know what proportion of the nurses responding had actually had experience in the various group work roles. It was hoped that the provision of a "no experience" or "no response" category in the question would contribute to the accuracy of the responses. The rather painstaking way in which the majority of the respondents tried to classify their feelings about these group work roles would seem to add support to the validity of the question. Tables 34 to 37 present the

findings. Each will be discussed separately and the comments then summarized.

Table 34. Professional Public Health Meetings - How Nurses Ranked Their Contributions to Group Work

Total Sample n = 185

Types of Activity	Best Percent	Medium-Good Percent	Poorest Percent	No Experience Percent	No Response Percent
Public health nursing staff meetings - inservice education and committees					
Participant	44.6	39.0	.9	3.3	12.2
Discussion leader	8.9	27.2	8.5	14.6	40.8
General Agency staff meeting					
Participant	31.5	36.2	8.5	7.9	15.9
Discussion leader	3.3	14.1	8.4	29.1	45.1
Regional or statewide workshops					
Participant	23.9	27.7	10.3	22.1	16.0
Discussion leader	.5	8.4	7.5	39.4	44.1

Agency Versus Community Setting

One interesting aspect of the nurses' ranking of their group work abilities was whether or not there would be differences relating to agency or community setting. Table 34 indicates that the nurses' feelings about their contributions as participants was highest for public health nursing meetings (44.6 percent), slightly lower for general agency staff meetings (31.5 percent) and still lower (23.9 percent) for regional or state meetings. Nevertheless, nurses in the sample apparently did not consider that they functioned this well as participants in group discussion in school or community groups. (Tables 35 and 36) Here the proportion of "Bests" receded from 20.2 percent for participation at social work meetings to 11.7

percent for both PTA and other community health groups.

Table 35. School Meetings Attended as Part of Job - How Nurses Ranked Their Contributions to Group Work

Total Sample n = 185

Types of Activity	Best Percent	Medium-Good Percent	Poorest Percent	No Experience Percent	No Response Percent
Joint meetings between teachers and nurses					
Participant	19.7	30.1	4.2	8.0	38.0
Health resource person	49.3	19.3	2.8	8.4	20.2
Discussion leader	2.0	23.0	9.4	18.3	42.3
PTA meetings					
Participant	11.7	25.8	2.4	20.2	39.9
Health resource person	36.2	20.6	1.4	15.5	26.3
Discussion leader	5.6	11.3	5.6	29.1	48.4
Speaker	9.9	26.3	8.5	16.4	38.9

Table 36. Other Community Meetings Attended as Part of Job - How Nurses Ranked Their Contributions to Group Work

Total Sample n = 185

Types of Activity	Best Percent	Medium-Good Percent	Poorest Percent	No Experience Percent	No Response Percent
Joint meetings between nurses and social workers					
Participant	20.2	27.7	2.8	20.7	28.6
Health Resource person	22.5	22.1	1.8	20.7	32.9
Discussion leader	3.3	10.8	8.9	30.1	46.9
Other Community groups (Tbc Ass'n, Polio Chapter, Child Study Clubs)					
Participant	17.4	14.5	2.8	34.3	31.0
Health resource person	17.8	23.0	1.4	20.7	37.1
Discussion leader	4.7	11.7	5.6	28.7	49.3
Speaker	4.7	11.7	6.6	28.6	48.4

The Discussion Leader Role

The role of the discussion leader was rated as a "Best" by a very small proportion of the respondents. Only 8.9 percent felt that their best contribution was as discussion leader at public health nursing staff meetings and the proportion of "Bests" in the discussion leader role was reduced by approximately one-half in the other settings listed. See Tables 34, 35 and 36. The writer wonders if perhaps the very low proportion of nurses who felt that they made their best contribution as discussion leader in any situation may be part of a rather complicated problem involving the nurses' concepts of leadership and their expectations of this role.

Moreover, in reviewing Tables 34 to 36, it is obvious that something happened when the nurses checked responses to "discussion leader" on the questionnaire. The proportion of "no responses" doubled or tripled in each instance (a range of from 40.8 percent to 49.3 percent) as compared with the "no response" answers in other group work categories. The proportion of "no experience" as discussion leader usually was higher also, a range of from 14.6 percent to 39.4 percent but this in itself does not seem unreasonable. Did nearly one-half of the nurses block or react so negatively to the term discussion leader that they failed to record any response to this item wherever it appeared in question 18? A question could be raised also as to the need for a clear definition of "discussion leader" in the questionnaire. In considering the "no response" category in Tables 34, 35 and 36 it might be well to keep in mind the possibility of several contributory factors; lack of opportunity to be a discussion leader, limited experience or feelings of inadequacy about a few experiences, and confusion as to the definition of discussion leader.

On the brighter side, it should be pointed out that the nurses' ratings of themselves as discussion leaders rose appreciably when asked to

indicate the group work roles where they felt that they made a "Medium-good" contribution. Whether the marked difference between the "Best" and "Medium-good" ratings in the discussion leader category in Tables 34 to 36 are due to modesty or reluctance to over-rate themselves is, of course, not known. Perhaps at least, those nurses who rated their contribution as discussion leaders as "Medium-good" offer encouragement in a situation which, when all data dealing with group leadership are analyzed, does not seem too encouraging. The data presented in Tables 34 to 36 will be analyzed further in relation to the preparation and experience of the nurses in Chapter VI, VII and VIII.

The Role as Health Resource Person

Tables 35 and 36 seem to indicate that the respondents were more satisfied with their contributions as health resource persons at school or community meetings. Approximately one-half (49.3 percent) felt they made their "Best" group work contribution in this role at meetings with teachers, and approximately one-third reported similar ratings for PTA. (36.2 percent) Contributions as a health resource person at other community meetings were not rated as highly (17.8 percent "Best") and the "no experience" and "no response" responses also were highest in this category. The latter would seem to indicate that meetings of this type were less frequent and not of as much interest to the respondents as, for instance, meetings with teachers where only 8.4 percent reported no experience as a health resource person.

With the exception of other community meetings, where the combined "Best" and "Medium-good" ratings amounted to 40.8 percent, approximately one-half of the respondents could be said to rate their contributions as a health resource person "Best" or "Medium-good".

A question might be raised as to what extent these findings relate to and support those of Table 30, which suggested a conscientious attitude on the part of the nurses toward the role of health resource person and some understanding of its purpose. It would seem proper to say that approximately one-half of the respondents had sufficient experience in this role with various community groups to feel that their contribution was in the "Best" or "Medium-good" category. It can be pointed out also that, in the four types of meetings listed in Tables 35 and 36, the health resource person role could be said to be the most popular, judging from the number of times it was checked as a "Best" contribution.

In this connection, another question arises and this relates to the fact that, in general, the responses of the nurses showed that they preferred to be a health resource person rather than a participant. Does the rather low number of "Best" responses to the participant role at school or community meetings mean that the nurses did not consider participation important? Also, in this sense, do these findings relate to the responses in Table 31 where 62.0 percent felt that the leader carried most of the responsibility? Another, perhaps more realistic explanation could be that when the public health nurse attends a teachers' meeting or other meeting of the type listed, she may be the only representative of her professional group present and, to varying degrees, the group itself uses her as a special resource person rather than as a general participant. To what extent the nurses' expectations as to her role in the group influence this, of course, is open to question and would need further exploration before conclusions could be drawn. One other possibility which should not be overlooked is that the respondents perhaps were not quite sure what the term participant meant when used in this question. (Q. 18) While participant was intended to describe the group member role, as different from resource person or leader, this difference may not have

been clear to the nurses in the sample.

Being a Speaker

In two instances, PTA and other community meetings, the nurses were asked to rate their contributions as speakers. Tables 35 and 36 indicate that approximately twice as many nurses felt that they did a better job as a speaker at PTA meetings than in other community groups although, even in this instance (PTA), only a minority (9.9 percent) felt that it was their "Best" group work role. These responses are the more interesting when related to experience since only 16.4 percent reported no experience as a PTA speaker while 28.6 percent had no experience in speaking to other community groups. These findings will be analyzed further in relation to a speech class as a factor in preparation in Chapters VI and VII.

The Nurse as a Teacher

Table 37. Community Classes - How Nurses Ranked Their Contributions

Total Sample n = 185

Types of Classes	Best Percent	Medium-Good Percent	Poorest Percent	No Experience Percent	No Response Percent
Expectant mothers or parents	20.2	14.6	.9	38.0	26.3
Red Cross home nursing	17.4	13.6	1.4	30.1	37.5
Other (Girl Scouts, baby-sitters, etc.)	14.1	11.3	2.8	27.2	44.6

Organized classes, sometimes regarded as the "backbone" of group work in public health nursing, were another focal point about which the nurses' opinions were sought in terms of rating their own contributions. These data, shown in Table 37, show a slightly higher proportion of "Best" responses for Expectant Mothers' or Parents' Classes. Approximately one-third of the

respondents felt that their contributions to these classes or to teaching Red Cross Home Nursing were "Best" or "Medium-Good" (34.8 percent and 31.0 percent respectively). Also approximately one-third of the nurses had not had experience with either of these types of classes.

Table 38 summarizes what the nurses considered to be their "Best" contributions to the group work roles listed in question 18.

Table 38. Proportion of "Best" Contributions in Various Group Work Roles

Total Sample n = 185

Type of Activity	Participant	Discussion Leader	Resource Person	Speaker	Teacher
	Percent	Percent	Percent	Percent	Percent
Public health nursing staff or committee meeting	44.6	8.9			
General agency staff meeting	31.5	3.3			
Regional or state public health meetings	23.9	.5			
Joint meetings with teachers	19.7	2.0	49.3		
Joint meetings with social workers	22.2	3.3	22.5		
PTA meetings	11.7	5.6	36.2	9.9	
Other community health meetings	17.4	4.7	17.8	4.7	
Parents' or mothers' class					20.2
Red Cross Home Nursing class					17.4
Other classes					14.1

Is There Desirable Sequence in Group Work?

As is apparent in the foregoing discussion, in the construction of the questionnaire, considerable thought was given to ways in which the nurses could respond or react to separate aspects of group work, i.e., being a health

resource person or a discussion leader in a specific group. Also in relation to this, nurses were asked if in their opinion, there was a desirable sequence for group work experience. (Q. 10). Respondents were asked to rank six experiences in the order which they considered most desirable. The results are shown in Table 39. Highest percentages in each column are underlined.

Table 39. Ideal Sequence for Group Work Experience Selected by Nurses in Study Group

Types of experience	Percentage Making This Choice n = 185					
	First	Second	Third	Fourth	Fifth	Sixth
	Percent	Percent	Percent	Percent	Percent	Percent
Participating in group discussion in agency	64.3	5.6	8.4	3.7	4.7	1.9
Serving as discussion leader in agency	1.9	46.0	8.0	11.3	11.3	9.9
Participating in group discussion in community	5.2	18.3	27.2	20.7	12.2	7.0
Serving as health resource person in community	13.6	11.3	23.5	17.8	13.1	11.3
Serving as discussion leader in community	2.4	6.1	10.3	19.7	23.5	26.3
Teaching a community class	5.6	4.2	13.2	13.6	21.1	28.2
No response	7.0	8.5	9.4	14.2	14.1	15.4

While Table 39 does not show complete agreement among the respondents in terms of a desirable sequence of experience for group work, it provides certain clues which tie in quite well with other evidence. The first two choices point to the agency as the most popular site for public health nurses to begin working in and with groups and a majority (64.3 percent) feel that participation precedes group leadership. These responses seem to agree with the data presented in Tables 34 to 36 showing the agency to be the place where the nurses felt that they made their "Best" contribution in these two roles.

Choices three and four present a rather blurred picture of any sequence. While the highest proportion (27.2 percent) regard participation in

group discussion in the community as a third step, this number is almost equalled by a group who would place serving as a health resource person next (23.5 percent). Again, these two, plus being a discussion leader in the community vie for the fourth position. The fifth and sixth choices seem clearer with the importance of serving as a discussion leader in the community more clearly established in the fifth place and retaining considerable importance as a sixth choice also. The experience of teaching an organized community class could perhaps be interpreted as a culminating experience in group work to which a number of other group work experiences had contributed. The writer is inclined to believe that the close relationship in the responses between leading a community group discussion and teaching a class is realistic and may show a healthy respect for the importance of experience and skills involved in each.

One of the questions which Table 39 does not answer is the placement of the health resource person role in a learning sequence. The responses to ranking this experience seem to show the greatest spread and least agreement in terms of a most desirable spot where one learns to function in this capacity. The fact that 13.6 percent of the respondents would place this first would seem to show that these nurses regarded it as a not too difficult "natural" sort of role with which they were apt to have easily accessible experience. The rather diffuse spread of these responses throughout Table 39 might also be related to the nurses' ratings of their contributions as a health resource person as shown in Tables 35 and 36. Here it was clearly a role that the nurses felt good about and, particularly in school-centered groups, far outdistanced their other "Best" replies. Perhaps the very lack of agreement in placement of this experience in a learning sequence tells something of the way in which it is regarded. Certainly these responses could be said to differ from those relating to leading community discussion

groups or teaching a community class for in the latter, sequence can be quite easily traced and one might assume that the respondents therefore regarded these as the most difficult.

As a whole, it should be remembered that Table 39 represents one method of attempting to pull together some relationships between the order of group work experience in which public health nurses might engage and to see to what extent these findings were related to what the nurses regarded as their "Best" contributions. This analysis will be considered further later in relation to the preparation and experience of the nurses.

Summary

Evidence from several questions pointed to the fact that the nurses rated their contributions as participant or discussion leader in agency groups more highly than their performance in these roles in community groups. They also strongly supported participation and leading discussion in the agency as desirable first experiences in group work.

The role of health resource person seemed quite popular particularly in school related groups. There was some evidence that nurses preferred this role rather than that of participant in community groups. Nurses in the sample rated themselves quite poorly as discussion leaders in group meetings outside the agency although the proportion rating their contributions as "Medium-Good" improved the total picture.

Although a large majority of respondents had had experience as a speaker at PTA or other community meetings, only a small proportion identified this as their "Best" group work role. Approximately one-third of the respondents rated their contributions as a teacher of an organized health class as "Best" or "Medium-Good". Approximately another one-third reported that they had not had any experience in this role.

In terms of a desirable sequence for group work experience, there was considerable evidence that leading a community group discussion or teaching a class were regarded as "senior" or culminating experiences.

Difficulties Encountered by Nurses in Working with Groups

A fifth and final objective of this chapter sought to learn what barriers or problems in working with groups the nurses would identify. The respondents were asked to review a list and select three items that represented the greatest problems to them. Opportunity also was given to indicate if respondents no longer had problems. (Q. 25)

Table 40. Difficulties Encountered by Nurses in Working With Groups: Proportion with No Difficulties.

Types of Problems	Percentage Making This Choice n = 185		
	First	Second	Third
	Percent	Percent	Percent
Role of leadership difficult	33.3	27.7	12.2
Insufficient knowledge to organize group	17.9	9.9	11.3
Insufficient knowledge to teach class	4.2	9.9	9.4
Not comfortable as health resource person	1.4	2.8	4.2
Other problems	3.3	.4	1.4
No difficulties in group work now	13.6	-	-
No response	26.3	49.3	61.5

Chi-square = 9.40, df = 6, P = .174. Differences in Outstate and Detroit responses (1st choice) not significant at 5 percent level.

It seems important that the role of group discussion leader was a problem to the largest proportion of nurses, appearing prominently, as Table 40 indicates, in each instance when they were asked to "pick out three things which bother you the most, (about group work) numbering them 1-2-3 in order of difficulty". Even discounting the second and third choices because

of the high proportion of no responses, the findings still seem to indicate a real problem area. The high proportions in the "no response" categories, particularly in second and third choices is difficult to explain since the question was no more complicated in form than many others. Was there perhaps a psychological factor involved; were some of the nurses reluctant to indicate weak spots?

Table 41. Differentiation Between Reasons Why Group Leadership was Difficult[1]

Source of Problem	Percentage Making This Choice n = 71		
	First	Second	Third
	Percent	Percent	Percent
Not prepared for group leadership	57.8	62.7	65.4
Not the "leader" type	42.2	37.3	34.6
Total	100.0	100.0	100.0

[1]n represents the number of nurses whose responses were classified as "role of leadership difficult" in preceding table (37).

While lack of preparation for the role of discussion leader is the most common reason, the proportion who responded that they were not the "leader-type" is also interesting. Does this response indicate that the nurses in question have tried leading groups and failed or not found the experience a satisfactory one? If this should be true or partially so, is it related to their concepts of what a leader does which, according to Table 31, could be said to have a rather authoritarian flavor? Or, have some of the nurses who responded that they were not the "leader type" avoided assuming this responsibility since Tables 34 to 36 show that a range of from 14.6 percent to 39.4 percent reported that they had not had experience as discussion leaders? A question could be raised also as to whether these responses in some ways reflect the traditional role of the nurse. Does she perhaps carry over an image of herself from basic nursing education and from hospital experience

which makes it difficult for her to assume leadership responsibilities? The effect of preparation on the nurses' feelings about their difficulties with group work will be analyzed in a later chapter.

Less than one-sixth (13.6 percent) of the total sample responded that they did not have any of the difficulties in working with groups cited in the question. The wording of the question and directions to respondents had implied "No difficulties now" with the thought that, while certain nurses might recall that such and such had once been her problem, she felt more competent to handle it at the present time. Sixteen percent of the Outstate sample gave this response as compared to 7.1 percent of the Detroit sample.

Other comments on Table 40 are the ranking given the problem of group organization and being a health resource person. In the former instance these data, showing group organization to be a problem second only to leadership, seem to support the findings of the group organization section of this chapter. Likewise, the very slight proportion who indicated that they had difficulty with the health resource role would agree with previous findings for this category. The writer was puzzled by what seemed to be an inconsistency in the responses in Table 40 relating to teaching a class. Previous evidence had suggested that nurses did not consider this one of their stronger roles and looked upon it as a "senior" experience which would follow less complicated group work settings. Perhaps the answer is to be found, however, in the relationship, brought out in Table 39, between group leadership and teaching a class. Had the nurses already responded to this phase of the question when they indicated that group leadership was their greatest and most consistent problem?

Summary

The nurses' responses showed that their greatest problem in group

work was difficulty with the leadership role. Specifically, about two-thirds felt that they lacked preparation and one-third of the sample indicated doubt as to whether they were the "leader-type". Other findings relating to this objective were not as significant and were quite closely associated with data in previous summaries.

Summary - Chapter V.

Evidence collected around the five objectives in Part I leads one to believe that group work was important to the public health nurses in the total sample. The majority expressed the feeling that group meetings or classes offered more opportunity for health education than did the individual conference.

Approximately one-half of the respondents had no preference with regard to working with community health groups which were already organized or organizing new groups affiliated with the health department. However, a large majority showed that they had problems in organizing new groups and considered the health education specialist as the best source of help. In-service education on group organization was rated slightly ahead of a university class dealing with this subject, although there was wide difference in Outstate and Detroit responses.

Problems in assuming the discussion leader role were apparent in many aspects of the responses. There was ample evidence that the public health nurses in the sample were active in a number of group work roles within both agency and community. Of the latter, serving as a health resource person in school centered meetings received the most votes as the spot where nurses made their "Best" group work contribution.

The teaching of organized health classes seemed to be regarded as a culminating or perhaps most difficult group work experience. An association

of this feeling with difficulties in the group leadership role seemed apparent.

Chi-square was used to test the significance of the difference in responses between the Outstate and Detroit nurses in a total of fifteen tables. In nine of these the chi-square values showed that any differences which existed between the two groups could be attributed to chance alone. In four instances (Tables 28, 29, 31, 33) the chi-square values barely reached the 5 percent level which indicates that the relationship is probably more than chance. Therefore, while these differences were termed "significant", in a more conservative sense they also might be considered in the area of doubt since the chi-square values were only slightly less than the tabulated values. In only two instances (Tables 22 and 32) were differences noted which would indicate that factors other than chance influenced the responses. As has been pointed out previously in relation to individual tables, the chi-square values alone can be accepted as evidence of difference only in a very limited sense. Even in Tables 22 and 32, where a relationship between response and belonging to either the Detroit or Outstate groups can be shown, the degree of relationship may be slight and the complexity of factors which are responsible are not indicated by statistical computations.

CHAPTER VI

HOW THE NURSES IN THE SAMPLE FELT PREPARATION FOR GROUP WORK COULD BEST BE OBTAINED

The previous chapter presented data to show how health department nurses felt about the importance of group work in public health nursing. In this chapter data related to Part II of the study problem are presented. They show more specifically how the nurses in the sample felt that preparation for group work could best be obtained. Some hints as to desirable sequence[1] and method of preparation[2] appear in topic summaries in Chapter V but it was hoped that further specific questions would elicit information which would be helpful in considering curriculum change.

The first objective[3] sought information concerning four specific group work roles (participant, leader, etc.) and what the respondents felt had helped them most in preparing for each. They were asked to respond only in terms of their own experience and this admonition was repeated in each question. Tables 42 through 45a show the results. In this series of questions (Q 20 - 23a) the respondents were asked to react twice to each situation. First they were asked to rank their feelings about the value of items on a common list of alternatives in preparing them for each of the four group work roles. (Q 20 - 23) In addition, the nurses were asked to rank a list of "other on-the-job factors" which had helped them in preparing for each of the roles.

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[1] Supra, p. 118.

[2] Supra, p. 105.

[3] Supra, p. 16.

The latter lists were varied from question to question (Q 20a - 23a) and in some ways overlapped with the common list. They were included as an attempt to localize or pinpoint responses and seem to have succeeded, to the extent that they resulted in fewer "no response" answers than the previous series of questions which utilized a common list. How much this element of variety in possible responses influenced the proportion who responded is not known. It should be said also that this whole series of questions (Q 20 - 23a) presented a rather detailed and perhaps repetitious appearance on the questionnaire, and this factor, as well as placement toward the end, might have influenced the responses. It should be remembered also that the nurses were asked to respond only if the item applied to them and in this sense some of the "no responses" could be interpreted as "no experience". The rise in the proportion of no responses from first to third choice in all but a few of these questions would seem to represent confusion or frustration with an over-complicated format.

What Helped Most in Preparing for Four Group Work Roles

In the following pages, a table presenting factors thought to be most helpful in preparing for each role will be accompanied by a table showing "additional on-the-job factors" which were helpful to the respondent in preparing for this role. The latter group of tables will be designated by adding a to the original table number.

Table 42. Factors Thought to be Most Helpful in Preparation for Participation in Group Discussion - Ranked in 1-2-3 Order

Alternative Responses	Percentage Making This Choice n = 185 First	Second	Third
	Percent	Percent	Percent
University courses on theory of group work	8.4	5.6	6.1
University courses providing theory and practice in group work	23.5	9.9	5.2
Agency inservice education on improving group work methods	23.5	15.0	8.5
Reading materials about discussion methods	9.4	25.4	16.4
Speech class	10.3	8.4	11.7
No response	24.9	35.7	52.1
Total	100.0	100.0	100.0

Table 42a. Additional On-the-Job Factors Which were Helpful in Preparation for Participation in Group Discussion

Alternative Responses	Percentage Making This Choice n = 185 First	Second	Third
	Percent	Percent	Percent
Group leader who made group comfortable	17.4	18.3	24.4
Previous experience in making home visits	15.5	18.8	15.0
Democratic attitude of group workers	3.8	12.7	15.5
Identification with many groups and attendance at meetings	9.8	13.6	14.6
Familiarity with subject matter being discussed	43.2	23.5	13.2
Other	.4	-	-
No response	9.9	13.1	17.3
Total	100.0	100.0	100.0

It is apparent in Table 42 that a university course which included both theory and practice in group work and inservice education on group work methods tied for the highest ratings. The proportion who rated reading materials

highly as a second or third choice seemed surprising but, if the respondents interpreted the question correctly, this must mean that reading materials pertaining to discussion methods actually were in quite wide use. Also, it should be remembered that literature relating to group discussion may have represented an available source of help to these nurses and may have been a resource they used when other forms of assistance were not at hand. A question could be raised also as to whether this response might reflect depth of interest in group discussion and desire to improve ones own skills. In this sense, reading materials might have been used by those who also had participated in in-service education on group work and/or attended a university course and thus represent a legitimate second or third choice for such respondents. These and later findings on the use of reading materials as a method of preparation will be related to preparation[1] and to experience[2] in Chapters which follow. Comments on Table 42a will be combined with those concerning other questions in this series.

Tables 43, 44 and 45 all show the university group work course which included practice to be the first choice as preparation for the group work role in question. Reading related literature was listed as second and third choices as preparation for the health resource person and discussion leader roles and was slightly outdistanced by inservice education as a second choice of help in preparing to teach a class.

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[1] Infra, p. 172

[2] Infra, p. 196

Table 43. Factors Thought to be Most Helpful in Preparation for the Health Resource Person Role at Community Meetings

Alternative Responses	Percentage Making This Choice n = 185 First	Second	Third
	Percent	Percent	Percent
University courses on theory of group work	7.5	2.8	4.7
University courses providing theory and practice in group work	25.8	9.9	3.8
Agency inservice education on improving group work methods	19.7	17.4	8.5
Reading materials about discussion methods	8.5	23.0	13.6
Speech class	7.0	4.7	13.1
No response	31.5	42.2	56.3
Total	100.0	100.0	100.0

Table 43a. Additional On-the-Job Factors Which were Helpful in Preparation for the Health Resource Person Role at Community Meetings

Alternative Responses	Percentage Making This Choice n = 185 First	Second	Third
	Percent	Percent	Percent
Observation of another nurse in similar setting	9.4	9.4	16.0
Familiarity with subject matter being discussed	49.8	23.0	5.6
Previous experience in making home visits	8.5	23.9	21.6
Pride in agency and its place in community	8.9	8.5	14.1
Help from supervisor and/or consultant	7.9	18.8	21.1
Other	.5	-	1.4
No response	15.0	16.4	20.2
Total	100.0	100.0	100.0

Table 44. Factors Thought to be the Most Helpful in Preparation for the Role of Discussion Leader.

Alternative Responses	Percentage Making This Choice First	Second	n = 185 Third
	Percent	Percent	Percent
University courses on theory of group work	6.1	1.9	4.7
University courses providing theory and practice in group work	24.4	6.6	5.2
Agency inservice education on improving group work methods	16.4	18.7	7.9
Reading materials about discussion methods	12.2	23.5	15.5
Speech class	8.5	6.6	13.2
No response	32.4	42.7	53.5
Total	100.0	100.0	100.0

Table 44a. Additional On-the-Job Factors Which were Helpful in Preparation for the Role of Discussion Leader.

Alternative Responses	Percentage Making This Choice First	Second	n = 185 Third
	Percent	Percent	Percent
Observations of others in similar situations	18.2	23.1	13.7
Previous experience in making home visits	3.8	8.9	10.8
Familiarity with Subject Matter being discussed	42.7	17.4	9.9
Help from supervisor and/or consultant	8.0	16.9	16.4
Encouraging atmosphere of agency situation	1.9	4.2	12.2
Identification with many groups and attendance at meetings	1.4	7.0	14.0
Other	.5	-	-
No response	23.5	22.5	23.0
Total	100.0	100.0	100.0

Table 45. Factors Which Helped Most in Preparation for Teaching a Class.

Alternative Responses	Percentage Making This Choice n = 185 First	Second	Third
	Percent	Percent	Percent
University courses on theory of group work	7.0	3.3	2.8
University courses providing theory and practice in group work	23.0	6.6	1.4
Agency inservice education on improving group work methods	9.9	17.8	6.6
Reading material about discussion methods	8.0	12.7	16.4
Speech class	6.1	7.0	8.9
No response	46.0	52.6	63.9
Total	100.0	100.0	100.0

Table 45a. Addition On-the-Job Factors Which were Helpful in Preparation for Teaching a Class.

Alternative Responses	Percentage Making This Choice n = 185 First	Second	Third
	Percent	Percent	Percent
Knowledge of subject matter involved	43.7	12.2	3.3
Observation of another nurse teaching a class	3.8	13.6	13.1
Previous experience in making home visits	1.9	8.0	10.8
Outline prepared by local, state or national agency	6.1	16.0	12.2
Help from supervisor and/or consultant	2.3	8.0	13.6
Experience as group leader in staff or community groups	4.7	4.2	7.1
Other	.9	.4	-
No response	36.6	37.6	39.9
Total	100.0	100.0	100.0

A summary of the first choice responses from Tables 42, 43, 44 and 45 is presented in Table 46. Here it is evident that a university course which

provided theory and practice in group work was regarded as the most helpful factor in preparing for three of the four group work roles and was challenged by inservice education for top rating in the fourth. Inservice education was regarded as a first choice by the next highest proportion of respondents. This is consistent with findings in the preceding tables where inservice education for group work made a strong showing as a second choice although outdistanced there by the reading of literature on group work in three out of four instances.

Table 46. Factors Which Helped Most in Preparation of Public Health Nurses for Several Group Work Roles

Alternative Responses	Percentage Making This Choice n = 185			
	Group Discussion	Health Resource Person	Discussion Leader	Teacher of Class
	Percent	Percent	Percent	Percent
University courses on theory of group work	8.5	7.5	6.1	7.0
University courses providing theory and practice	23.5	25.8	24.4	23.0
Agency inservice education on improving group work skills	23.5	19.7	16.4	9.9
Reading materials about discussion methods	9.4	8.5	12.2	8.0
Speech class	10.3	7.0	8.5	6.1
No response	24.8	31.5	32.4	46.0
Total	100.0	100.0	100.0	100.0

The value of a speech class as preparation for group work seemed doubtful when the data in Table 46 and those immediately preceding are considered. Ten percent or less of the respondents regarded this as the most important factor. When second or third choices were reviewed, the proportion rose slightly reaching 13.2 percent as a third choice as preparation for discussion leadership in Table 44.

These data are interesting to compare with those in the preceding chapter where it was reported that a large majority of the respondents had

had experience as speakers but only 10 percent considered this as their "Best" contribution in the group work area. Again, it should be remembered that the questions which contributed the data for Tables 42 to 46 directed the respondents to reply only in terms of their own experience. A question which cannot be answered here is whether these nurses lacked opportunity to get preparation for public speaking, even though, according to evidence in Chapter V, they seemed to feel a need. This question can be explored further in a later chapter when preparation is scrutinized in relation to the above responses.

Other On-the-Job Factors Which Helped

A review of the additional on-the-job factors which respondents reported had been helpful to them in preparing for group work roles provides some interesting data on the effect of the agency situation on the nurse's development. In all four tables (42a through 45a) it was apparent that the nurses' familiarity with or knowledge of the subject matter being discussed at the meetings had been of most support and help to them. While the writer believes that this particular item could be regarded as ambiguous and its inclusion in this series of questions (Q 20a - 23a) criticized as too general, the replies seem to point to the fact that nurses must have sufficient background in the subject under discussion if they are to feel comfortable in assuming certain group work roles. A question could be raised here also as to whether these responses indicate that public health nurses in the sample looked on group work primarily as a method or means of concentration on subject matter, i.e., teaching or learning about something, rather than a method concerned with process.

These findings would seem to be related to those in Table 32, where three-fourths of the respondents reported that group leadership roles required extra preparation time on the part of the nurse.[1] The reason cited

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[1] Supra, p. 108.

most frequently in support of this opinion was that time was involved in looking up materials or doing research on the subject matter involved.

Along the same line of thought, this series of questions had attempted to ascertain whether the nurses would associate previous experience in making home visits to patients with preparation for group work. It may be assumed that working with individual patients might be expected to enrich certain aspects of the subject matter, upon which the nurses might draw in preparing to work with groups. Table 43a shows this experience to be selected as a second and third choice as being helpful in preparing for the role of health resource person. Table 42a indicates that this experience is in second or third place in all three choices of experience which were helpful in preparing to participate in group discussion but any relationship to preparation for the other two roles seemed negligible. However, these findings are supported by evidence in the previous chapter which suggested that nurses considered participation in group discussion and being a health resource person as rather "natural" experiences apparently closely related to their day-to-day work.

Other intra-agency influences such as help from a supervisor or consultant and observation of other nurses seemed important as third choices of helpful factors as indicated in Tables 43a, 44a, and 45a. An attempt was made to rank the value of strong agency morale as a supporting factor in preparing the nurse to work with groups. Statements such as "Pride in agency and its place in community" (Table 43a) and "Encouraging atmosphere of agency situation" (Table 44a) attained ratings as third choices but it is not possible to draw conclusions from this.

The effect of the group experience itself as an encouraging factor in helping the nurses to participate in group discussions was probed through items shown in Table 42a. However, while the group leader who made the group

comfortable ranked most important as a third choice and a democratic attitude on the part of group members attained third place in the same column, these factors would have to be termed of minor importance among those listed.

One item in Tables 42a, 44a, and 45a failed to be rated as highly by the respondents as had been anticipated. In the first two tables mentioned above this read "Identification with many groups and attendance at meetings". The responses showed that the nurses in the sample did not regard this as an important factor even as a third choice. In Table 45a, in relation to preparing to teach an organized class, the statement read, "Experience as a group leader in staff or community groups". The fact that such experience was regarded as of negligible importance by the respondents seems in opposition to the desirable sequence for group work experience suggested by the replies of nurses in the sample in Table 39.[1] In that instance, serving as a discussion leader in a community group was in fifth place, immediately preceding the teaching of a class which was in the sixth and final spot. This seeming inconsistency in replies is difficult to explain from available data. Perhaps it could be argued also that the above did not represent an inconsistency in responses but rather lack of clarity as to what was meant by the inclusive term "Community groups". Since, in the nurse's experience, these might have ranged from the very informal to the highly organized, it is possible that more careful definition would have resulted in a different degree of relatedness. Analysis of these findings in relation to preparation[2] and experience[3] is available in later chapters.

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[1] Supra, p. 118.

[2] Infra, p. 171, 172.

[3] Infra, p. 199.

Summary - Preparation for Group Work Roles

A university course providing both theory and practice in group work was the first choice of the nurses in the sample as the most helpful factor in providing for various group work roles. Reading literature on discussion methods and agency inservice education on improving group work methods were reported to be the next most helpful.

Familiarity with the subject matter to be discussed at the meetings was given as the most helpful "on-the-job" factor in preparing for a group work role.

Other Specific Experiences

The second objective for Part II of the problem contained another approach to learning how preparation for group work could best be obtained. Three questions were asked which sought greater detail concerning separate aspects of preparation. A fourth and final question was meant to be a summary and a means of checking the consistency of certain previous responses.

The first question asked of the nurses who had had university preparation in public health nursing was to rank a list of courses in terms of value to the nurse. They were asked to limit their choices to courses in which they had been enrolled. Table 47 summarizes the responses.

The questions (Q 24 and 24a) which sought information on this topic apparently did not give respondents specific directions. As worded, only the nurses who had completed university preparation should have responded to 24a. However, as Table 18 indicated, the "unprepared" category really consisted of two groups, 14.1 percent of whom had no university preparation for public health nursing while another 16.9 percent had partial preparation but less than one school year. The responses in Table 47 seem to indicate that some nurses who had taken one of the type of courses listed, whether fully

Table 47. University Courses Relating to Group Work Which Nurses Said Had Been Most Helpful.

List of Courses	Percentage Making This Choice First	Second	n = 185 Third
	Percent	Percent	Percent
Community Organization	9.9	9.4	5.6
Group Dynamics	5.2	4.2	2.8
Social Psychology	15.0	15.9	8.0
Adult Education	4.2	3.8	2.8
Required course in group work for public health nurses	21.6	6.6	3.3
Other	4.7	1.4	2.4
No response or not applicable	39.4	58.7	75.1
Total	100.0	100.0	100.0

prepared or not, responded in terms of appraising the value of the course to them. Only 19.2 percent of the respondents checked that they had not had preparation in public health nursing in response to question 24, which could be interpreted to include the 14.1 percent referred to above and others who, while partially prepared, had not had one of the courses listed. The no response category in Table 47 includes those who did not respond because they had had no university preparation. It is realized, of course, that since some of the nurses who responded had not had preparation in public health nursing, both the validity and the reliability of the data presented in Table 47 are open to question. They are included, however, simply for interest rather than as evidence upon which conclusions can be based.

As can be seen from the results in Table 47, the choices made by the nurses are not very conclusive and the increase in the no response category, when asked to rank their selections, would seem to indicate either confusion, lack of interest, or perhaps, lack of preparation in public health nursing.

The writer was aware, in framing this question, that even approximate course titles were rather meaningless and to attempt to generalize when nurses might have attended one of many universities, was perhaps impossible. The required group work course for public health nurses was thought to be most helpful although not by a large majority.

A second question (Q 19) sought to learn more about the types of in-service education in which nurses in the sample might have participated and which of these they considered to be most helpful. Table 48 shows the results.

Table 48. Types of Inservice Education for Group Work in Which Nurses Participated; Types Considered Most Helpful.

Listing of Types of Inservice Education[a]	Percentage Giving This Response n = 185			
	Participated in this type	Type Considered most helpful	No response	Total[b]
	Percent	Percent	Percent	Percent
Read reference on group work and reported at staff meeting	8.4	1.9	89.7	100.0
Tried to practice and apply new knowledge at agency meeting	17.4	8.4	74.2	100.0
Staff had assistance from expert in group work	13.2	5.2	81.6	100.0
Staff representative took "group dynamics" course and reported back	3.8	2.8	93.4	100.0
Attended workshop or meetings where group methods discussed and practiced	31.9	16.4	51.7	100.0
Staff utilized family case study discussions to develop group work skills	27.7	5.2	67.1	100.0

a. More than one response could be checked.
b. Coding provided for a three-way breakdown in responses.

It is apparent from a glance at Table 48 that the nurses did not respond well, making interpretation of the data difficult. It is interesting to note, however, that nearly one-third (31.9 percent) had attended a workshop or meeting at which group methods were discussed and practiced. This experience also was reported to be most helpful. Efforts within the agency to develop interest and skill in group work also are apparent, with the family care study

type of discussion the most prominent. Twenty-one percent of the respondents indicated that they had not participated in any inservice education on group work.

Even with its limitations, it is interesting to review Table 48 with the findings shown in earlier tables in this chapter. (Tables 42 to 46). In these, inservice education was, in general, rated as the second most helpful factor in preparing nurses for group work responsibilities. Reading literature about discussion methods was, except in Table 45, the nurses' second choice as a means of preparation. However, when asked about the latter specifically as a method of inservice education in Table 48, the responses indicated a slight degree of participation (8.4 percent) and only 1.9 percent considered this method the most helpful.

The writer wonders if these findings do not support her interpretation of the response concerning the use of reading materials in Tables 42 to 46 in that literature may have been a last resort and an individual effort not associated with planned inservice education. The fact that responses to question 19 showed that 21.6 percent of the nurses had not participated in any planned inservice education on group work would seem to lend support to the idea that nurses turned to literature when no other help was readily available. It is realized, however, that this association may rest upon too slim support in the way of real evidence. As mentioned previously, interest in reading might have been stimulated by other experiences.

A third question sought to learn to what extent the respondents had been members or officers of a large number of non-nursing groups and whether they felt that such experiences had contributed anything to their ability to do group work in public health nursing. This question (Q 3) was considered a failure by the writer. In contrast to other rather complicated questions, the responses were scanty and did not seem to contain enough information to

tabulate in a meaningful fashion. Of interest, however, is the fact that two church-centered activities, "church circle or club" and "Sunday School" received a better response than any of the other groups listed. Nearly one-half (48.8 percent) of the respondents reported that membership in a church circle or club had made a valuable contribution to their backgrounds for group work in public health nursing and 23 percent of these had been officers. Also, 43.7 percent reported that either attending or teaching Sunday School had been a valuable experience in providing background for group work and 9.0 percent had been officers. In general, the Outstate nurses responded to these two items and to the entire question slightly better than the nurses in the Detroit sample.

A sort of "blanket" category (activity in school groups - high school, nursing school, or college) received the only other sizable response. Here 47.3 percent felt that the experience had been valuable as preparation for group work in public health nursing and of these 20.1 percent had been officers in the groups mentioned. A few other groups such as PTA, Girl Scouts, Red Cross, and Business and Professional Womens' Club were thought to provide valuable experiences by approximately 17.0 percent of the respondents while responses to the other types of group experience fell below this.

The lack of response to this question seems to be consistent with the nurses' responses to the item in Tables 42a through 45a where they gave a low rating to "identification with many groups and attendance at meetings". One could not conclude from these data, however, that the public health nurses in the sample were not active in community affairs or had little experience in participating in meetings of various community organizations. The low rate of response does suggest that these questions may have been considered irrelevant and not of primary importance to the respondents. Other questions of equal or greater complexity in form and length received a much better

response.

The response to the final question in this series (Q 26) which sought to learn more about which experiences the nurse felt were most important in preparing for group work are summarized in Table 49. Here a number of alternatives were presented all of which had been included in various forms in previous questions. There seems to be a considerable degree of consistency between most of these responses and those in previous tables. A little less than one-half (42.7 percent) ranked a university course which included practice in group work in first place.

Table 49. Summary of Factors Which Nurses Listed as Most Important in Preparing for Group Work in Public Health Nursing

Alternative Responses	Percentage Making This Choice n = 185				
	First Percent	Second Percent	Third Percent	Fourth Percent	Fifth Percent
Good supervision of the job	11.3	24.9	18.3	14.5	9.4
University course on group work including practice	42.7	12.7	13.1	7.0	8.4
Agency where staff work well together	23.0	17.8	19.3	18.8	5.2
Membership and participation in wide number of groups	3.3	10.8	17.4	14.1	32.9
Inservice education on various aspects of group work	12.2	26.3	23.0	17.4	7.0
No response	7.5	7.5	8.9	28.2	37.1
Total	100.0	100.0	100.0	100.0	100.0

Inservice education ranked the highest as a second and third choice and good agency morale came into prominence as a fourth choice. Supervision, while not attaining a clear cut rating, shows as an important factor in the second column, and could be related to the morale factor also.

The one exception is the ranking attained by "membership and participation in wide number of groups" as a fifth choice. As has been pointed out previously, this item has not seemed to be a meaningful one to the respondents

as shown in Tables 42a to 45a. Perhaps, however, its spot here in fifth place, is consistent with previous findings since in the foregoing tables only three choices were requested.

Summary - specific types of experience.

The exploration of three separate aspects of the nurses' experience, enrolling in classes related to group work, participation in varied inservice education and membership in non-nursing groups yielded some additional information as to the respondents' attitudes about preparation for group work. A required course in group work for public health nurses was the first choice of the largest proportion of respondents (21.6 percent). Attending workshops or meetings where group methods were discussed and practiced was the most frequent inservice education experience (31.9 percent) and this also was listed as the most helpful type of learning. Approximately one-half of the respondents felt that experience in church groups had been a valuable experience in relation to group work in public health nursing and the responses to membership in high school, nursing school, or college groups were approximately the same. In general, the response to the three questions relating to this objective was not as good as in most other instances and could not be said to add very conclusive support.

Summary - Chapter VI

The data presented in the preceding chapter presented findings concerning the attitudes of the respondents toward the practice of group work in public health nursing - how important nurses felt it was, what part they liked best or least, and what problems they had encountered in this phase of their work. This chapter has presented additional information as to how these nurses felt that preparation for group work in public health nursing could best be obtained. A university course providing both theory

and practice in group work was the first choice of approximately one-half of the respondents. Inservice education on group work methods ranked next but the responses indicated that reading literature on discussion methods had also been of considerable value. Since approximately one-fifth of the respondents indicated that they had not participated in any planned inservice education, this raises the question as to whether reading literature about group work was a substitute method for some of the respondents.

In the questions on which data for this chapter were based special emphasis was placed upon responding in terms of actual practice. While it is hoped that this contributed to the value of these data, the writer feels that this positive factor perhaps was outweighed by the influence of a fairly high proportion of no response answers especially relating to the second objective. Thus, the additional data supplied in Chapter VI could be said to contribute to the objectives set for Part II of the study but in the case of the second objective, do not supply very conclusive evidence.

Chapter VII

The Effect of Preparation on the Responses of Nurses in the Outstate Sample

As shown in Chapters IV and V an effort was made to determine to what extent differences in responses from Outstate and Detroit nurses might be due to sampling error or to factors not attributable to chance. The chi-square test was used on a group of fifteen unselected tables with the results, in the majority of instances, not significant at the 5 percent level.[1] Even though these results cannot be considered conclusive without determining chi-square values for all of the data concerned, it was decided not to pursue this course of action further. As stated in Chapter IV the main purpose of the study was not to test differences in attitudes toward group work among Outstate and Detroit nurses.[2] The above findings were thought to provide some additional information as to the composition of the total sample and its tendency to respond in certain ways on certain questions; further claim cannot be made for them.

In spite of the chi-square findings reported above, certain characteristics of the two samples which were pointed out in Chapter IV would lead one to assume that some differences did exist between the two groups. The effect of a higher proportion of prepared nurses in the Detroit sample, 89.3 percent as compared to 61.8 percent in the Outstate group, in itself would seem to affect responses. Other influences which would seem to have an effect on

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[1] Supra, p. 125.

[2] Supra, p. 77.

the responses in the Detroit group were a fairly homogeneous staff, common inservice education, and the likelihood that a high proportion of the sample had studied public health nursing in the same university.

The Outstate sample, in contrast, offered a much less homogeneous group, fewer common experiences as with inservice education, and, most important, greater variability in academic preparation. Table 18 showed that 61.8 percent of the Outstate group were prepared while 38.2 percent had either no academic preparation for public health nursing or less than one school year. For these reasons, the decision was made to analyze the significance of the differences in the responses of the "prepared" and "unprepared" nurses using only the Outstate group. Chi-square values were computed and their significance determined at the 5 percent level.

Approach to Analysis of Preparation

It was assumed that, if using preparation as a variable with the Outstate group, the differences were less frequently due to chance than in the Detroit-Outstate computations, the results would seem to carry more weight. The reasoning behind this assumption was simply that preparation was known to be one of the differences in the Outstate-Detroit samples but it is coupled with other differences as mentioned above; if when the same test was applied to the Outstate data, a relationship between preparation and responses could be established, it would seem to indicate more clearly that preparation played a role in influencing responses within this group. Of course, it is necessary to add the same warning as in considering the limitations of chi-square with the Outstate-Detroit data. Here too, it is important to remember that factors influencing responses are very complex and analysis based upon one variable may be misleading.

However, since the entire study is concerned with ascertaining how a representative sample of Michigan public health nurses felt toward the group

work aspects of their daily practice, it seemed justifiable to attempt to sift out any apparent differences in the responses of those who had had university preparation. Any differences, even in a negative sense, should be of interest to those who are concerned with curriculum planning in public health nursing education.

In an effort to avoid repeating the same basic tables which presented data in Chapters V and VI, a somewhat briefer form has been used to show relationships between the responses of prepared and unprepared nurses in the Outstate sample through chi-square computations. The number of the parent table in a preceding chapter is shown in parenthesis following the title of each subheading as in Table 50. The subheadings are the same as in the parent tables but only the responses of the Outstate nurses appear in the prepared and unprepared columns. The parent tables had presented responses from the total state sample using percentages.[1] Thus Table 50 draws upon previous tables (19 through 23) which had presented data relative to the first objective of Part I of the problem. Table 51 combines Outstate responses from six previous tables (24 through 29) which related to the second objective, and so on.

Chi-squares which are significant at the 5 percent level are starred and the degrees of freedom are indicated for each computation.

A review of the data in Table 50 shows that in all but one instance (item 19) the chi-square values indicate that the differences in responses of the prepared and unprepared groups were not due to chance alone. These findings are quite different from the chi-square results on these same data using Outstate and Detroit responses, where only Table 22 showed a significant difference at the 5 percent level.

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[1] Supra, p. 91.

Table 50. Relative Importance of Group Work as Part of Public Health Nurses' Job: Chi-Squares of the Differences in Responses According to Preparation in the Outstate Sample.

Previous Tables Relating to Part I, Objective 1	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Health education value of meetings or classes compared to home visits. (19)			4	9.48	7.60	.092
More	41	22				
Same	26	11				
Less	20	17				
Can't tell	10	7				
No response	-	3				
Total	97	60				
Does group experience offer "plus values" in terms of health education (20)			3	7.81	10.2*	.019
Yes	89	46				
No	1	-				
Uncertain	6	8				
No response	1	6				
Total	97	60				

Table 50 - continued

Previous Tables Relating to Part I, Objective 1	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Does group work within agency require different skills than home visiting (21)			3	7.81	12.78*	.005
Same	41	28				
Different	55	24				
Can't tell	1	3				
No response	-	5				
Total	97	60				
Is more skill required in working with community groups than agency groups. (22)			4	9.48	16.25*	.003
More	44	30				
Same	46	17				
Less	4	1				
Can't tell	3	8				
No response	-	4				
Total	97	60				

Table 50 - continued

Previous Tables Relating to Part I, Objective 1	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings	Prepared	Unprep.	d.f	X^2	X^2	P
Nurses' preferences concerning working with individuals or groups. (23)			4	9.48	28.07*	.001
Prefer working with individuals	22	22				
Prefer working with groups	8	12				
Either way	67	19				
Uncertain	-	3				
No response	-	4				
Total	97	60				

Table 51. Differentiation Between Working With Existing Groups or Organizing New Groups: Chi-Squares of the Differences in Responses According to Preparation in Outstate Sample.

Tables Relating to Objective 2	Number of Responses = 157		X^2 Calculations			
			Specified Value $\alpha = 0.05$		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	χ^2	X^2	P
Preference for working with organized groups or organizing new ones (24)			3	7.81	23.54*	.001
Prefer organized groups	20	31				
Prefer organizing new groups	17	6				
No preference	60	20				
No response	-	3				
Total	97	60				
How much initiative should nurse take in organizing group (25)			3	7.81	9.60*	.019
Wait for request	1	4				
Take beginning steps in agency	86	46				
Go ahead with group in community	10	7				
No response	-	3				
Total	97	60				

Table 51 - continued

Table's Relating to Objective 2	Number of Responses = 157		χ^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	χ^2	χ^2	P
Skill in group organization ranked first by respondents (26)			6	12.59	17.85*	.006
Interpreting readiness	43	16				
Presenting ideas clearly	12	16				
Getting people to work together	9	12				
Picking key people to help	13	9				
Group dynamics	9	3				
Helping group think through course of action	10	1				
No response	1	3				
Total	97	60				
Where nurses would turn for help with group organization (27)			5	11.07	8.26	.156
Key people in community	28	23				
Specialist in health education	27	18				
Supervisor or consultant	35	13				
Themselves - most familiar with situation	5	2				
Other	1					
No response	1	4				
Total	97	60				

Table 51 - continued

Tables Relating to Objective 2	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
What nurses said would best prepare them for organizing groups; number who felt prepared (28)			5	11.07	20.87*	.001
University course on group organization	16	10[a]				
Inservice education on group organization	25	27				
Assistance from supervisor or consultant	13	11				
Observing another nurse	16	8				
Feel adequately prepared	24					
No response	3	4				
Total	97	60				
Does group work save the nurses' time? (29)			3	7.81	13.33*	.005
Yes	66	40				
No	20	4				
Uncertain	11	12				
No response		4				
Total	97	60				

[a] Unprepared included those with some courses but less than one school year of preparation.

Table 51 - continued

It is apparent that the responses of the prepared and unprepared Outstate nurses are significantly different at the 5 percent level in all but one of the six items making up Table 51. The results shown in Table 51 might suggest that prepared nurses have more confidence in themselves in approaching groups and in working with community organizations. It is interesting to note also, that in the one item where the chi-square value was not significant (item 27) the largest number of prepared nurses sought supervisory assistance when confronted with a problem in group organization while the unprepared indicated that they would seek help from key people in the community. This variation in response, while not contributing much to a significant chi-square result nevertheless tells something of basic differences in resources and perhaps in attitudes among the two groups.

The chi-square computations on these same data using Outstate-Detroit responses showed only Tables 28 and 29 in the probably significant area at the 5 percent level.

Table 52. Identification of Certain Group Work Roles by the Nurses: Chi-Squares of the Differences in Responses According to Preparation in Outstate Sample.

Previous Tables Relating to Part I, Objective 3	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Skills thought to be most important in serving as health resource person (30)			3	7.81	7.68*	.046
Understanding when and how to contribute	91	49				
Finding ways to describe health department program	3	2				
Evaluating situation but not speaking unless called upon	3	8				
No response	-	1				
Total	97	60				
Opinion as to how group leadership role differs from membership (31)			3	7.81	8.45*	.046
Leader carries most of responsibility	52	36				
Two roles more alike than different	43	18				
Participant does not have much responsibility	2	3				
No response		3				
Total	97	60				

Table 52 - continued

Previous Tables Relating to Part I, Objective 3	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Do leadership roles require extra preparation time beyond working hours (32)			3	7.81	3.53	.261
Yes	78	51				
No	10	2				
Uncertain	7	4				
No response	2	3				
Total	97	60				
If extra preparation time is involved for leadership roles, what should be done? (33)			3	7.81	8.60*	.029
Nursing should consider this part of professional responsibility	6	7				
Agency should allow time	25	13				
Combination of above	66	36				
No response		4				
Total	97	60				

Of the four items included in Table 52, one (33) shows a difference in the responses of the prepared and unprepared which is significant at the 5 percent level, two (30 and 31) are in the "probably significant" area, and one (32) does not show a significant difference.

When compared with the parent tables in Chapter V from which the data for Table 52 were drawn, the chi-square values are rather similar. In other

words, the Detroit-Outstate responses relating to objective 3 (identification of certain group work roles) did not show sharp differences when tested with chi-square. In Chapter V, Table 30, the difference was not significant at the 5 percent level; Tables 31 and 33 showed differences which probably were significant, and only Table 32 showed a significant difference. As was pointed out in the analysis in Chapter V, a certain ambiguity in some of the questionnaire items which produced these data undoubtedly limited their value and prevents drawing conclusions concerning findings related to Table 52.

Table 53. How Nurses Ranked Their Contributions to Various Group Work Roles: Chi-Squares of the Differences in Responses According to Preparation in Outstate Sample

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Professional public health meetings--how nurses ranked their contributions (34)						
Participant - public health nursing staff meetings (a)*			4	9.48	6.69	.148
Best contribution	48	21				
Medium--good	36	25				
Poorest	2	-				
No experience	1	2				
No response	10	12				
Total	97	60				

*Subheadings of items in Table 53 are designated by a, b, c, etc.

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Discussion leader--public health nursing staff meetings (b)			4	9.48	25.22*	.0001
Best contribution	13	--				
Medium - good	32	6				
Poorest	10	6				
No experience	10	9				
No response	32	39				
Total	97	60				
Participant - general agency staff meetings (c)			4	9.48	9.94*	.041
Best contribution	38	11				
Medium - good	39	28				
Poorest	4	2				
No experience	6	5				
No response	10	14				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of previous Tables	Prepared	Unprep	d.f.	X^2	X^2	P
Discussion leader - general agency staff meetings (d)			4	9.48	20.22*	.0005
Best contribution	5	-				
Medium - good	19	3				
Poorest	11	1				
No experience	24	14				
No response	38	42				
Total	97	60				
Participant - regional or statewide workshops (e)			4	9.48	15.01*	.005
Best contribution	30	11				
Medium - good	37	12				
Poorest	5	9				
No experience	12	13				
No response	13	15				
Total	97	60				
Discussion leader - regional or statewide workshops (f)			4	9.48	2.75	.603
Best contribution	1	-				
Medium - good	18	--				
Poorest	9	3				
No experience	34	18				
No response	35	39				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
School meetings--joint meetings teachers and nurses (35)						
Participant (a)			4	9.48	2.75	.603
Best contribution	22	12				
Medium - good	34	16				
Poorest	3	2				
No experience	5	2				
No response	33	28				
Total	97	60				
Resource person (b)			4	9.48	17.21*	.002
Best contribution	63	22				
Medium - good	18	13				
Poorest	1	1				
No experience	5	3				
No response	10	21				
Total	97	60				
Discussion leader (c)			4	9.48	14.16*	.007
Best contribution	10	1				
Medium - good	28	7				
Poorest	10	6				
No experience	14	9				
No response	35	37				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
School meetings - PTA (35)						
Participant (a)			4	9.48	6.13	.192
Best contribution	13	8				
Medium - good	27	18				
Poorest	5	-				
No experience	16	5				
No response	36	29				
Total	97	60				
Resource person (b)			4	9.48	32.57*	.0001
Best contribution	53	8				
Medium - good	18	20				
Poorest	1	-				
No experience	9	4				
No response	16	28				
Total	97	60				
Discussion leader (c)			4	9.48	23.08*	.0001
Best contribution	9	1				
Medium - good	20	2				
Poorest	9	1				
No experience	22	14				
No response	37	42				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations Specified Value P = 0.05		This Table	
Title and Stub Headings to Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Speaker (d)			4	9.48	15.59*	.005
Best contribution	14	3				
Medium - good	34	10				
Poorest	9	5				
No experience	12	7				
No response	28	35				
Total	97	60				
Other community meetings; joint meetings - nurses and social workers (36)						
Participant (a)			4	9.48	11.95*	.004
Best contribution	24	9				
Medium - good	32	15				
Poorest	3	3				
No experience	18	6				
No response	20	27				
Total	97	60				
Resource person (b)			4	9.48	13.24*	.010
Best contribution	27	7				
Medium - good	26	13				
Poorest	1	3				
No experience	18	8				
No response	25	29				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Discussion leader (c)			4	9.48	21.22*	.0001
Best contribution	5	-				
Medium - good	19	2				
Poorest	11	2				
No experience	28	16				
No response	34	40				
Total	97	60				
Other community groups; miscellaneous (36)						
Participant (d)			4	9.48	19.02*	.001
Best contribution	22	7				
Medium - good	26	5				
Poorest	4	2				
No experience	23	14				
No response	22	32				
Total	97	60				
Resource person (e)			4	9.48	10.81*	.0302
Best contribution	26	6				
Medium - good	27	12				
Poorest	2	1				
No experience	10	12				
No response	32	29				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Discussion leader (f)			4	9.48	19.38*	.001
Best contribution	7	1				
Medium - good	22	1				
Poorest	5	1				
No experience	21	16				
No response	42	41				
Total	97	60				
Speaker (g)			4	9.48	19.35*	.001
Best contribution	7	1				
Medium - good	20	3				
Poorest	11	1				
No experience	20	13				
No response	39	42				
Total	97	60				
Community classes (37)						
Expectant mothers or parents (a)			4	9.48	47.76*	.0001
Best contribution	24	1				
Medium - good	20	1				
Poorest	2					
No experience	37	22				
No response	14	36				
Total	97	60				

Table 53 - continued

Previous Tables Relating to Part I, Objective 4	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Red Cross Home Nursing (b)			4	9.48	11.50*	.022
Best contribution	20	9				
Medium - good	19	6				
Poorest	2	1				
No experience	30	12				
No response	26	32				
Total	97	60				
Other classes (c)			4	9.48	10.49*	.034
Best contribution	14	8				
Medium - good	8	10				
Poorest	4					
No experience	31	9				
No response	40	33				
Total	97	60				

Chi-square calculations were done on 23 separate items of data in Table 53, testing differences in the way prepared and unprepared Outstate nurses ranked their contributions to various group work roles. All but three of these differences were significant at the 5 percent level. The three instances in which the chi-squares were not significant all were related to the participant role. There was no significant difference in the way in which prepared and unprepared Outstate nurses ranked their responses to being a

participant at (1) agency public health nursing staff meetings, (2) joint meetings of nurses and teachers, and (3) PTA meetings.

Since, as was pointed out in Chapter V, the respondents seemed to do unusually well in answering a very complicated question (Q 18), any analysis of the resulting data seems to take on added value. Moreover, the writer considered that the type of data which this question supplied was essential to the purpose of the study in that it differentiated and clarified the respondents' feelings about various group work roles and separated out those who had not had certain group experiences. Hence, the quite sharp differences in the responses of the prepared and unprepared Outstate nurses tend to lend support to the weight of preparation or lack of it as a factor influencing the nurses' ranking of their contributions. This is brought out most clearly perhaps in item 37a in which prepared and unprepared nurses ranked their contributions to teaching expectant parents' or mothers' classes. It seems apparent that this was one group work activity in which nearly 50 percent of the prepared group considered that they did a good or fairly good job while the response from the unprepared nurses was negligible. The writer is aware also that the higher proportion of "no experience" and "no response" on the part of the unprepared group is responsible for at least part of the difference in replies on this item and other parts of the question.

It should be pointed out also that chi-square computations were not done on the Outstate-Detroit responses to this question, so it is not known if significant differences in these responses might exist between those groups.

Table 54. Difficulties or Barriers Encountered by Public Health Nurses in working with Groups: Chi-Squares of the Differences in Responses According to Preparation in Outstate Sample.

Previous Tables Relating to Part I, Objective 5	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Difficulties encountered by nurses working with groups (1st choice only) (40)			6	12.59	25.73*	.001
Role of leadership difficult	25	32				
Insufficient knowledge to organize group	18	6				
Insufficient knowledge to teach class	7	2				
Not comfortable as health resource person	3	-				
Other problems	3	-				
No difficulties now	23	2				
No response	18	18				

This is an interesting comparison between the prepared and unprepared nurses. In addition to the chi-square showing a significant difference in the responses of the prepared and unprepared, a review of responses on single items adds additional evidence. Approximately one-half (53.3 percent) of the unprepared nurses said that leadership was difficult as compared to one-fourth (25.8 percent) of the prepared nurses. Nearly one-fourth (23.8 percent) of the prepared group felt that they no longer had the problems listed in the question (Q 25) while only 3.3 percent of the unprepared gave this response.

Table 55. Factors Which Nurses Considered Most Important in Preparing for Group Work: Chi-Squares of Differences in Responses According to Preparation in Outstate Sample.

Previous Tables Relating to Part II, Objective 2	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Types of inservice education for group work in which nurses participated (48)			5	11.07	16.38*	.006
Read references on group work	5	5				
Tried to practice and apply new knowledge at agency meetings	24	7				
Assistance from expert in group work	23	3				
Staff representatives took "group dynamics" course	4	2				
Attended workshops where group methods discussed and practiced	30	18				
Utilized family case study discussions to develop group work skills	36	5				

Table 55 - continued

Previous Tables Relating to Part II, Objective 2	Number of Responses = 157		X^2 Calculations			
			Specified Value P = 0.05		This Table	
Title and Stub Headings of Previous Tables	Prepared	Unprep.	d.f.	X^2	X^2	P
Summary of factors which nurses listed as most important in preparing for group work in public health nursing (1st choice only) (49)			5	11.07	24.19*	.0001
Good supervision on job	9	9				
University course on group work including practice	43	14[1]				
Agency where staff works well together	28	15				
Membership and participation in wide number of groups	4	1				
Inservice education on various aspects of group work	12	8				
No response	1	13				

Chi-square computations were done on only two tables in Part II. Both of these are related to Objective 2 and deal with factors which the nurses considered most important in preparing for group work. The findings, presented in Table 55 show that in both instances (items 48 and 49) the difference in the responses of the prepared and unprepared nurses were significant at the 5 percent level. Since item 49 comprises a summary of much of the

[1] "Unprepared" included those with some courses but less than one school year of preparation.

data relating to Objective 1 which was presented in detail for the total respondents in Tables 42 through 46 in Chapter VI, it was not thought necessary to do chi-square computations on each segment. Rather, further analysis of the prepared and unprepared responses will be shown proportionately in later pages.

Summary - chi-square differences

In general, it can be said that in a large majority of instances where chi-square was used to test the significance of the differences in responses between the prepared and unprepared nurses in the Outstate sample, the difference was significant at the 5 percent level. In considering these findings, it must be repeated that an association such as has been shown to exist, while not due to chance alone, does not indicate a single causal relationship. As has been pointed out previously, while preparation undoubtedly is an important cause of difference in response, other factors also may have exerted an influence. Nevertheless, on the basis of findings presented in the preceding pages, preparation can be said to be significantly related to responses.

Further Analysis of the Preparation Factor

As was explained in a preceding paragraph, chi-square was not used to test any differences in responses of prepared and unprepared nurses in relation to the first objective of Part II. This objective sought to learn what experiences nurses in the study group had found most helpful in preparing for four specific group work roles, participant, resource person, discussion leader, and teacher.

Although data presented in a summary (Table 55, item 49) showed a significant difference in the responses of the prepared and unprepared, it was decided to analyze the specific responses of the Outstate nurses further

with respect to preparation comparing the findings with Outstate-Detroit data presented in Tables 42 - 45 in Chapter VI. It was hoped that this type of breakdown might throw additional light on the relationship of preparation to patterns of response. Tables 56 through 59 show the results.

Table 56. Factors Thought to be Most Helpful in Preparing to Participate in Group Discussion: First and Second Choices of Outstate Sample According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Percentage Making This Choice		Percentage Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
University courses on theory of group work	11.3	7.2	1.7	7.2
University courses on theory and practice of group work	27.8	15.5	1.7	7.2
Agency inservice education on group work	29.9	21.7	25.0	9.3
Reading materials about discussion methods	8.3	24.7	20.0	20.6
Speech class	11.4	11.3	1.6	18.6
No response	11.3	19.6	50.0	37.1
Totals	100.0	100.0	100.0	100.0

It will be noted that the respondents' choices in Table 56 do not differ essentially from the responses of the total group in Table 42. Both prepared and unprepared Outstate nurses rated agency inservice education as a first choice and reading materials on group discussion as second. However, in Tables 57, 58, and 59, while the prepared Outstate nurses responded in exactly the same pattern as the first and second choices of the total study group (Tables 43, 44, 45) the unprepared departed from this pattern. It seems apparent that the unprepared group relied much more heavily on reading

materials on group discussion, giving this as both first and second choice. Identifying this difference also perhaps helps explain what seemed like unusual emphasis on reading materials in the responses of the total group in Chapter VI. In this connection it is of interest to note that approximately twice as many (31.7 percent) of the unprepared nurses indicated that they had not participated in any inservice education on group work while only 15.5 percent of the prepared Outstate nurses gave that response.

Table 57. Factors Thought to be Most Helpful in Preparing to be a Health Resource Person at Community Meetings: First and Second Choices of Outstate Nurses According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Percentage Making This Choice		Percentage Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
University courses on theory of group work	10.3	4.1		
University courses on theory and practice of group work	33.0	15.5	5.0	
Agency inservice education on group work	25.8	20.6	18.4	8.4
Reading materials about discussion methods	4.1	22.7	23.3	18.3
Speech class	7.2	6.2		3.3
No response	19.6	30.9	53.3	70.0
Total	100.0	100.0	100.0	100.0

The set of tables (42athrough 45a) in Chapter VI which ranked other "on-the-job" factors which the nurses had found helpful in preparing for group work also were reproduced using the responses of prepared and unprepared Outstate nurses. A review of these data did not show any essential differences in responses from those presented for the total study group. The results are available in the Appendix.[1]

[1]See Appendix E for these tables.

Table 58. Factors Thought to be Most Helpful in Preparing to be a Discussion Leader: First and Second Choices of Outstate Nurses According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Percentage Making This Choice		Percentage Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
University courses on theory of group work	9.3	2.1		
University courses on theory and practice of group work	30.9	14.4	3.3	
Agency inservice education on group work	19.6	22.7	13.4	10.0
Reading materials about discussion methods	7.2	24.7	28.3	13.4
Speech class	11.3	8.3	1.7	3.3
No response	21.7	27.8	53.3	73.3
Total	100.0	100.0	100.0	100.0

Table 59. Factors Which Helped Most in Preparing to Teach a Class: First and Second Choices of Outstate Nurses According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Percentage Making This Choice		Percentage Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
University courses on theory of group work	11.3	5.2		
University courses on theory and practice of group work	27.9	10.3		
Agency inservice education on group work	14.4	17.5	8.3	11.7
Reading materials about discussion methods	4.1	14.4	21.7	8.3
Speech class	7.2	10.3		1.7
No response	35.1	42.3	70.0	78.3
Total	100.0	100.0	100.0	100.0

One other attempt was made to identify differences or similarities in the responses of the prepared and unprepared Outstate nurses. Data presented in Table 39, Chapter V, were reanalyzed to see if preparation made a difference in what the respondents considered to be an ideal sequence of group work experience. Tabulations for the prepared and unprepared groups followed very closely the pattern of Table 39, varying only to a slight degree. These data also can be found in the Appendix.[1]

The writer is of the opinion that the nearly similar responses of the prepared and unprepared Outstate nurses when ranking a desirable sequence for learning group work skills is desirable. Public health nursing educators are concerned with "what should come first" while supervisors in field agencies cope with the same problem when planning orientation for new staff nurses. The fact that the sequence checked by the respondents proceeds from the simple to the more complex types of group situations seems to lend support to the idea that nurses themselves feel that they need additional preparation for the latter, i.e., serving as a discussion leader in a community group or teaching a community health class.

The writer would raise a question also as to a possible relationship between these last two analyses which show no essential differences in the responses of the prepared and unprepared Outstate nurses. In both instances the questions (Q 10 and Qs 20 - 23) sought information about job-centered

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[1] See Appendix E for these tables.

situations. While the prepared nurses, as a whole, gave responses that could be considered better than the unprepared, apparently both groups identified with the questions sufficiently to produce comparable data. It should be remembered that the responses of the prepared and unprepared nurses in the Outstate sample showed quite marked differences when asked to rank how well they thought they performed various group work roles (Q 18). This is the more interesting since certainly the latter question also was concerned with a job-centered situation. The fact that the data do show such differences in responses on different issues could imply authenticity, i.e., careful consideration of the questions by the respondents.

Summary - Chapter VII

The intent of this chapter was to learn to what extent the responses of prepared and unprepared Outstate nurses were different as compared to (1) some differences between Outstate and Detroit responses noted in Chapter V and (2) responses of the total sample in terms of certain objectives.

The summary of chi-square differences reported on page 170 suggests that, in general, a much wider difference existed between the responses of the prepared and unprepared Outstate nurses than between Outstate and Detroit responses. The chi-square differences shown in Table 53 indicated especially that the prepared and unprepared nurses were significantly different when ranking what they felt were their best or poorest contributions to various group work roles.

Tables 57 - 59 show that the unprepared group relied almost exclusively on reading materials about group discussion as the "most helpful" factor in preparing for group work. Analysis of further data also relating to Part II, (How the nurses felt that preparation for group work could best be obtained) did not show much difference in the responses of the prepared and

unprepared when percentage results were examined. Both groups indicated the same desirable sequence of experience for learning about group work.

Nevertheless, it seems possible to claim that preparation had exerted an influence on the Outstate responses. Specifically, there was some evidence that prepared nurses took more initiative in group organization and had fewer problems; there was considerable evidence that preparation seemed to add confidence to the way the nurse looked upon her own contribution to group work; there was evidence that the prepared nurses had participated in a wider range of inservice education activities and that they ranked this experience as a helpful factor. In general, the writer believes that these data indicate that the prepared public health nurse showed more readiness, more confidence, and perhaps more interest in group work than the nurse who lacked academic preparation for her position.

CHAPTER VIII

THE EFFECT OF EXPERIENCE ON THE RESPONSES OF THE TOTAL SAMPLE.

A review of Table 14 in Chapter IV showed that nearly one-half of the total sample had had over ten years of experience in public health nursing and of these, 23 percent had been employed for twenty-one years or more. Only 8.4 percent had worked for less than one year in this field. While Table 14 provided six breakdowns in years of experience, it was decided that in most instances three would be sufficient for purposes of further analysis. Accordingly, Table 60 presents a condensation of the data in Table 14.

Table 60. Experience of Respondents Grouped Under Three Time Periods.

Number of Years of Experience	Outstate n = 157 Percent	Detroit n = 28 Percent	Total State n = 185 Percent
Five years or less	[illegible]	28.6	36.1
6 - 20 years	[illegible]	[illegible]	40.9
21 years and over	[illegible]	[illegible]	23.0
Total	100.0	[illegible]	100.0

It is evident that the Detroit sample differed from the Outstate group in that it contained fewer nurses in the first two categories and nearly one-half in the group with twenty-one years or more of experience. Nevertheless, a decision was made to use the total State sample in showing relationships between length of experience in public health nursing and responses. It was felt that in most instances such findings would present sufficient information as to any differences which would seem attributable

to the experience factor and avoid unnecessary detail. A few more specific breakdowns showing any effects of both extremes of the experience scale for Outstate and Detroit samples are presented later in this chapter around certain points of emphasis.

One other comparative table seemed important to the writer before proceeding with analysis of the experience variable, namely interrelationships between experience and preparation. Table 61 brings together data on preparation from Table 18 in Chapter IV and data on experience just presented in Table 60.

Table 61. Relationship of Three Experience Periods and Preparation Status of Respondents - Total Sample*

Status of Preparation	Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
No public health nursing course	27.3	8.0	4.1	14.1
Less than one school year of preparation	23.4	17.1	6.1	16.9
One or more years but not degree	15.9	38.1	65.3	36.6
Bachelor's degree including public health nursing	31.2	27.6	24.5	28.2
Master's degree including public health nursing	2.2	9.2		4.2
No response				
Total	100.0	100.0	100.0	100.0

*The groups above the dotted line are "unprepared"; those below are "prepared".

It can readily be seen that fifty percent of the group with the least experience lacked academic preparation for public health nursing while in the

total sample thirty-one percent were unprepared. Moreover, further breakdown of these data by experience (Table 62) shows that over three-fourths (83.3 percent) of the nurses who had been employed for one year or less were unprepared and of these, approximately one-half (55.6 percent) had had no public health nursing courses. While this fact is consistent with personnel policies in the Detroit Department of Health, whereby a nurse without preparation could be employed and would be expected to secure preparation within a three-year period, analysis of previous data (Table 18) indicated that only ten percent of the Detroit sample fell into this category. These findings raise an interesting question in relation to employment practices in the Outstate area. Was recruitment of "prepared" public health nurses such a problem that health departments had resorted to hiring graduate nurses without preparation to carry on the work? To the writer's knowledge, there had been no statewide policy or regulation stipulating that nurses so employed should seek academic preparation within a specified period of time. In light of certain differences in responses which have been related to preparation in Chapter VII, the outcomes of such employment practices might well be questioned as they relate to the productiveness and efficiency of the public health nurse's work in her community.

After careful review of total findings relating experience to responses, some but not all of the data are presented in the following pages. In considering data under each objective, findings were presented wherever experience seemed to be even a slight factor affecting responses. Since most of the tables in this chapter essentially repeat those in Chapters V and VI adding experience as a variable, it seemed unduly repetitious to present all of the replies in which experience of the respondent seemed to make no difference. Some data are presented under each objective, however, and, as in previous chapters, the tables follow objectives under Parts I, II and III of the study problem.

Table 62. Relationship of Five Experience Periods and Preparation Status of Respondents — Total Sample*

STATUS OF PREPARATION	YEARS OF EXPERIENCE					Total sample n = 185
	Under 1 year	1-5 years	6-10 years	11-20 years	21 and over	
	Percent	Percent	Percent	Percent	Percent	Percent
No public health nursing course	55.6	18.6	16.2	2.0	4.1	14.1
Less than one school year of preparation	27.8	22.0	16.2	14.0	6.1	16.9
One or more years but not degree		20.4	35.2	42.0	65.3	36.6
Bachelor's degree including public health nursing	16.6	18.	31.	38.	22.	32.2
Master's degree including public health nursing		3.1	1.4	4.0		1.2
No response	-	-	-	-	-	-
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

*The groups above the dotted line are "unprepared"; those below are "prepared".

EFFECT OF EXPERIENCE ON NURSES' CONCEPTS OF SKILLS: PREFERENCE FOR WORKING WITH INDIVIDUALS OR GROUPS.

Responses to three questions only are presented here in relation to the first objective in Part 1. Two of these (Q 4 and 5) are related to the idea that group work might require extra or additional skill on the part of the public health nurse. Tables 63 and 64 show the results in terms of experience.

Table 63. Does Group Work Within the Agency Require Different Skills Than Home Visiting - Effect of Experience on Responses.

Skills Required are	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Same	46.7	48.3	31.4	43.7
Different	48.0	48.3	60.8	51.2
Can't tell	5.3		3.9	2.8
No response		3.4	3.9	2.3
Total	100.0	100.0	100.0	100.0

Table 64. Is More Skill Required in Working with Community Groups than with Agency Groups - Effect of Experience on Responses

Skills Required are	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
More	45.4	35.6	36.7	39.4
Same	24.7	50.6	40.8	39.0
Less	7.8	2.3	6.1	5.2
Can't tell	18.2	10.3	12.3	13.6
No response	3.9	1.2	4.1	2.8
Total	100.0	100.0	100.0	100.0

Table 63 shows an almost even division in responses of nurses in the first two experience categories with some differences occurring in the responses of the group with over twenty-one years of experience. A review of responses to the "Why do you feel the way you do" part of this question did not reveal any additional information. Table 64 shows a slight decrease in the nurses' feelings that group work in the community required more skill as experience increased - from 45.4 percent for the least experienced group to

36.7 percent for the most experienced. Supporting this point of view also is the change in responses that the same skills were required in either agency or community groups. Approximately one-fourth of the least experienced category gave this response but it doubled in the group with 6 - 10 years of experience.

The third question considered under the first objective of Part I sought to establish a relationship between the experience of the nurse and any preference for working with individuals or groups. Table 65 shows the results.

Table 65. Effect of Experience on Nurses' Preferences for Working with Individuals or Groups.

Alternative Responses	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Prefer working with individuals	31.2	32.2	20.4	29.1
Prefer working with groups	11.7	16.1	18.4	15.0
Either way - doesn't matter	48.0	48.3	59.2	50.7
Not sure	9.1	-	-	3.3
No response	-	3.4	2.0	1.9
Total	100.0	100.0	100.0	100.0

Although this question (Q 2) specified that the answer should express feelings "at the present stage of your experience", and was concerned with the experience variable, the results are not helpful in this respect. The nurses' preference for working with groups rose slightly with experience but the same could be said for the "either way" response which was supported by approximately half of the respondents of all experience levels. In summarizing the foregoing findings relating to the first objective of Part I, it seems

clear that while comparison of the replies of the least and the most experienced show some differences, these could not be said to be very conclusive.

Effect of Experience on Attitudes about Group Organization.

Four tables are presented to show any effects of varying amounts of experience on the feelings which nurses in the sample expressed about their preferences in group organization.

Table 66. Preference for Working with Organized Groups or Organizing New Ones - Effect of Experience on Responses.

Preferences Expressed	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
To meet with organized groups, contributing to their programs	35.1	35.6	18.4	31.5
To organize or assist with organizing groups directly related to the health department program	14.3	13.8	24.5	16.4
No preference - work with both kinds	50.6	48.3	51.0	49.8
No response		2.3	6.1	2.3
Total	100.0	100.0	100.0	100.0

Except for a rise in interest in organizing new groups in the respondents with over twenty-one years of experience, Table 66 does not tell very much about the effect of experience. Also, with this one exception, the findings in each category are quite similar to those for the sample as a whole. Here as in the preceding tables there is a suggestion that there are differences between the least and the most experienced which might be analyzed in greater detail.

Table 67. Amount of Initiative The Public Health Nurse Should Take in Organizing New Groups - Effect of Experience on Responses.

Action Nurses Would Take	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Wait for request to come to health department	3.9	2.4	4.1	3.3
Take beginning steps such as discussing matter with supervisor	88.3	82.3	91.7	85.4
Go ahead and explore interest of group concerned	7.8	15.3	4.2	9.9
No response				1.4
Total	100.0	100.0	100.0	100.0

Table 68. Where Public Health Nurses Would Turn for Help in Group Organization* Effect of Experience on Respondents.

Sources of Help	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Key people in community with organization experience	26.0	33.3	22.5	30.5
Specialist in health education	33.7	27.6	44.9	33.3
Supervisor or consultant	33.7	28.7	28.6	28.2
Nurse herself - more familiar with situation	4.0	5.8	2.0	4.2
No response	2.6	3.4	2.0	3.3
Total	100.0	100.0	100.0	100.0

*1st choice only.

Neither Table 67 nor 68 gives much evidence that experience was a very important factor in the nurses' responses. Table 67 shows that the most experienced nurses were slightly ahead of the others in taking some initiative

in group organization. However the middle group (6 - 20 years of experience) expressed the most interest in proceeding "on their own" although this response constituted only 15 percent of their total category. The responses for all three experience categories in Table 68 were remarkably similar to those for the total sample irregardless of experience.

Table 69. What Nurses Said Would Best Prepare Them for Organizing Groups; Proportion Who Did Not Need Help - Effect of Experience on Responses.

Items Checked Most Important	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
University course on group organization	19.5	24.2	24.5	22.5
Inservice education relative to group organization	33.8	29.9	20.4	29.1
Assistance from supervisor or consultant	16.9	12.6	20.4	16.0
Observing how another nurse organized a group	22.1	9.2	14.3	15.0
Did not need help with group organization	2.6	19.5	14.3	12.2
No response	5.1	4.6	6.1	5.2
Total	100.0	100.0	100.0	100.0

Table 69 raises some interesting questions about the effect of experience on responses. The values placed upon a university course and agency inservice education as preparation for organizing groups seem to be reversed with increased experience. In other words, nurses who had been employed more than five years apparently placed a higher value on a university course than did those with less experience. Inservice education as an aid to organizing groups seemed less important to the more experienced nurses than to those with less than five years of experience. It should be remembered here that such

findings in relation to university preparation could be said to be consistent with those in Table 61 which showed that approximately one-half (49.3 percent) of the nurses in the least experienced group were prepared while three-fourths or more of the other two groups had completed preparation.

Observing how another nurse organized a group was rated as most important by approximately one-fifth of those who had been employed less than five years and received a lesser rating by the more experienced nurses. The proportion of respondents who felt that they no longer needed help with group organization rose sharply from 2.6 percent in the least experienced group to 19.5 percent in the group employed for six to twenty years.

In summarizing the effect of experience on the nurses' feelings about their role in group organization it seems clear that experience did not seem to have much effect on responses except as shown in certain instances in Table 69.

Effect of Experience on Nurses' Concepts of Leadership Roles.

Three tables will present findings in relation to the effect of experience on the nurses' feelings about leadership. Table 70 deals with the health resource role and shows the least experienced group to be most concerned with how and when to contribute.

Table 70. Skills Thought to be Most Important in Serving as Health Resource Person at Community Meetings - Effect of Experience on Responses

List of Items	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Understanding when and how to contribute	93.5	83.9	83.7	87.3
Finding ways of introducing description of health department program	6.5	3.5	12.2	4.2
Estimating situation but not talking unless called upon		11.5	4.1	8.0
No response		1.1		.5
Total	100.0	100.0	100.0	100.0

While, in general, the responses from the three groups in Table 70 do not differ widely from total responses it is of interest that the tendency to want to describe the health department program doubled from the least to the most experienced group of nurses. This might imply a sense of duty or a rather "set" concept of making use of all opportunities on the part of older more experienced nurses. However, it seems necessary to point out that this response was far outweighed by interest in the one which preceded it, namely, understanding when and how to contribute to discussion.

Table 71. Nurses' Opinions Concerning Group Leadership as Compared With Membership - Effect of Experience on Responses.

Responses on Leadership	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Leader carries most of the responsibility	59.7	59.8	69.4	62.0
The two roles are more alike than different	33.8	33.3	28.6	32.4
Group participant does not carry much responsibility	6.5	3.5	2.0	4.2
No response		3.4		1.4
Total	100.0	100.0	100.0	100.0

Here again the older more experienced group gave a somewhat more emphatic response than the other groups which might be interpreted as rigidity in their concept of the leader role. Nearly 70 percent of the group with over twenty-one years of experience felt that the leader carried most of the responsibility as compared to 59 percent for the other two groups. Also, a smaller proportion of the most experienced nurses felt that leader and participant roles were more alike than different. However, it should be pointed out that this response on the part of the most experienced group might be associated with saving time. Had they perhaps had experience in groups where shared leadership seemed inefficient in "getting things done"? In the writer's opinion, it would seem possible that some rather extreme experimental approaches to group leadership which might have come to the attention of these nurses might have influenced their responses on this point.

However, it seemed important to explore the possible effects of various amounts of experience on the nurses' responses on leadership. Tables 72 and 74 show a breakdown of responses according to the two extremes of the experience scale for both the Outstate and the Detroit samples.

Table 72. Comparison of Nurses' Responses on Group Leadership - Those With Least and Most Experience - Outstate and Detroit

Responses on Leadership	Responses by Years of Experience					
	Outstate n = 157			Detroit n = 28		
	Less than 1 year	1-5 years	21 or over	Less than 1 year	1-5 years	21 or over
	Percent	Percent	Percent	Percent	Percent	Percent
Leader carries most of the responsibility	56.3	55.6	52.2	100.0	71.4	84.6
The two roles are more alike than different	37.5	40.0	43.5	-	14.3	15.4
Group participant does not carry much responsibility	6.2	4.4	4.3	-	14.3	-
No response	-	-	-	-	-	-
Total	100.0	100.0	100.0	100.0	100.0	100.0

It is apparent from Table 72 that the differences in responses between the Outstate and Detroit samples are more noteworthy than those within the individual samples. The Outstate nurses seem to be moving in the direction of shared leadership (the second response) as their experience increases while the Detroit nurses identify much more strongly with the importance of the role of a single leader.

Table 73. Do Group Leadership Roles (Health Resource Person, Leader, or Teacher) Require Extra Preparation Beyond Working Hours - Effect of Experience on Responses.

Responses	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Yes	81.8	78.2	65.3	76.5
No	6.5	10.3	28.6	13.2
Can't tell	9.1	8.1	2.1	7.0
No response	2.6	3.4	4.0	3.3
Total	100.0	100.0	100.0	100.0

As might be anticipated, Table 73 shows that, as the nurses' experience increased, there were fewer responses indicating that group work took extra time in preparation - a range of from 81.8 percent to 65.3 percent. Likewise the "no" category increased with years of experience and the amount of uncertainty (can't tell) diminished sharply.

Table 74. Comparison of Nurses' Responses on Whether Group Leadership Roles Required Time Beyond Working Hours - Those with Least and Most Experience - Outstate and Detroit.

Responses	Responses by Years of Experience					
	Outstate n = 157			Detroit n = 28		
	Less than 1 year	1-5 years	21 or over	Less than 1 year	1-5 years	21 or over
	Percent	Percent	Percent	Percent	Percent	Percent
Yes	87.5	77.8	87.0	100.0	85.7	46.1
No	-	11.1	8.7	-	-	46.2
Can't tell	6.3	8.9	4.3	-	14.3	-
No response	6.2	2.2	-	-	-	7.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

It is apparent from Table 74 that the Detroit nurses in the most experienced category were about evenly divided in their "yes" and "no" replies to this question. In contrast, a very large majority (87.0 percent) of the Outstate respondents with the most experience were of the opinion that group leadership roles required preparation beyond working hours. These findings throw additional light on the data presented in Table 32[1] also, showing that it was the nurses with 21 years or more of experience within the Detroit sample who contributed most to the "no" category. As pointed out in discussion of Table 32, it is possible that types of group work differ between Detroit and the Outstate area, or that agency policy, written guides, or other variables might have influenced this response.

[1] Supra, p. 108.

In summary, amount of experience seemed to be responsible for some variations in nurses' concepts of leadership roles particularly when extremes in experience and responses from Outstate and Detroit samples were analyzed. There was some evidence suggestive that the most experienced group seemed somewhat more authoritarian in their opinions concerning leadership. It is only fair to say, however, that the evidence was not sufficient to allow for definite conclusions on this point.

Effect of Experience on Nurses' Feelings About a Desirable Sequence in Group Work.

Chapter V showed that nurses in the sample differentiated quite clearly between group work experiences which they considered most suitable for a beginner from those which were more complex (Q 10). Chapter VII presented evidence showing that both the prepared and unprepared groups ranked these experiences in essentially the same order. Since this matter seemed particularly significant to the writer in its implications for both nursing education and agency inservice education, it seemed important to learn if these findings varied with the nurses' experience backgrounds. Tables 75 through 77 show the results.

It seems apparent at a glance that the responses of the three groups did not change their general trend as experience increased nor did the breakdown in these three tables vary appreciably from Table 39. All three groups showed that they considered the agency to be the best place to begin one's group work experience, and all three apparently considered either teaching a community class or leading a community discussion group to be the most difficult.

Table 75. Ideal Sequence for Group Work Experience Selected by Nurses in The Study Group - Nurses Who Had Five Years or Less Experience.

Types of Experience	Percentage Making This Choice n = 185					
	First Percent	Second Percent	Third Percent	Fourth Percent	Fifth Percent	Sixth Percent
Participating in group discussion in agency	76.6	2.6	9.1	6.5	2.6	-
Serving as discussion leader in agency		54.5	6.5	9.1	9.1	7.8
Participating in group discussion in community	1.3	19.5	35.0	22.1	9.1	6.5
Serving as health resource person in community	11.7	9.1	26.0	28.6	13.0	11.7
Serving as discussion leader in community	2.6	1.3	6.5	14.3	23.4	32.5
Teaching a community class		3.9	7.8	10.4	31.2	29.9
No response	7.8	9.1	9.1	9.0	11.6	11.6

Table 76. Ideal Sequence for Group Work Experience Selected by Nurses in the Sample - Nurses Who Had Six to Twenty Years of Experience.

Types of Experience	Percentage Making This Choice n = 185					
	First Percent	Second Percent	Third Percent	Fourth Percent	Fifth Percent	Sixth Percent
Participating in group discussion in agency	64.4	5.8	6.9	6.9	5.8	3.6
Serving as discussion leader in agency	2.3	40.2	5.8	8.1	12.6	15.7
Participating in group discussion in community	5.8	24.1	24.1	24.1	16.1	7.2
Serving as health resource person in community	11.5	14.9	27.6	23.0	12.6	8.4
Serving as discussion leader in community	3.4	6.9	12.6	14.9	25.3	22.9
Teaching a community class	9.2	3.5	16.1	16.1	18.4	31.3
No response	3.4	4.6	6.9	6.9	9.2	10.9

Table 77. Ideal Sequence for Group Work Experience Selected by Nurses in The Sample - Nurses Who Had Twenty-one Years or More Experience.

Types of Experience	Percentage Making This Choice n = 185					
	First	Second	Third	Fourth	Fifth	Sixth
	Percent	Percent	Percent	Percent	Percent	Percent
Participating in group discussion in agency	44.9	10.2	10.2	2.0	6.1	2.0
Serving as discussion leader in agency	4.1	42.9	14.3	4.1	12.3	4.1
Participating in group discussion in community	10.2	6.1	20.4	36.7	10.2	8.2
Serving as health resource person in community	20.4	8.2	12.2	16.3	14.3	12.3
Serving as discussion leader in community	-	12.2	12.3	12.3	20.4	20.4
Teaching a community class	8.2	6.1	16.3	12.2	10.2	22.4
No response	12.2	14.3	14.3	18.4	26.5	30.6

In this sense, the findings in Tables 75-77 are consistent with Table 39 and also with similar tabulations according to preparation.[1]

However, the range between certain percentages shows some differences in attitudes concerning desirable sequence. Over three-fourths (76.6 percent) of nurses who had been employed five years or less felt that participating in group discussion in the agency was a preferred first step while only 44.9 percent of those who had been employed twenty-one years or more gave this response. In both instances it was ranked first among other alternative responses but the most experienced group showed more variation between this and other first choices. For instance, 20.4 percent of the latter group indicated that serving as a health resource person at a community meeting could be a beginning experience while approximately one-half that many (11.7 percent) of the least experienced group gave this response. The proportion of no responses to this question was considerably higher for the most experienced

[1]These tables may be found in Appendix E.

group suggesting that they questioned its importance or were more impatient with the detail involved.

Effect of Experience on Difficulties Encountered in Working with Groups.

Table 78 offers evidence that is consistent with previous data and shows more pronounced effects of experience than are found in previous pages of this chapter. The role of leadership is ranked first as a difficulty by all three groups although the high proportion of no responses in the most experienced group weakens the significance of the findings with respect to that group.

Table 78. Difficulties Encountered by Nurses in Working with Groups; Proportion With no Difficulties - Effect of Experience on Responses.*

Types of Problems	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
Role of leadership difficult	35.0	40.2	18.4	33.3
Insufficient knowledge to organize group	31.2	12.6	6.1	17.9
Insufficient knowledge to teach class	2.6	5.8	4.1	4.2
Not comfortable as health resource person	2.6	1.2	-	1.4
Other problems	1.3	4.6	4.1	3.3
No difficulties now	6.5	14.9	22.4	13.6
No response	20.8	20.7	44.9	26.3
Total	100.0	100.0	100.0	100.0

*1st choice only

The responses of the middle group (those employed 6 - 20 years) are rather baffling in that, they show the leadership role and preparation for

teaching a class to be slightly more of a problem than do those who were employed five years or less. Data relating to the health resource person role are consistent with those from earlier tables[1] indicating again that even the least experienced do not regard this type of activity as a problem area. As would be expected, the proportion reporting no difficulties in working with groups doubled and tripled in the more experienced categories.

A further breakdown of these data, presented in Table 79, shows somewhat similar tendencies. The Outstate nurses with 1 - 5 years of experience seem to respond in a manner which showed more awareness of problems than did the nurses who had been employed less than a year. The fact that nearly one-half of the nurses with over 21 years of experience failed to respond to this question lessens the value of the comparative findings in Tables 78 and 79.

Table 79. Comparison of the Difficulties Which Nurses With the Least and the Most Experience Encountered in Working with Groups - Outstate and Detroit.

Types of Problems	Responses by Years of Experience					
	Outstate n = 157			Detroit n = 28		
	Less than 1 year	1-5 years	21 or over	Less than 1 year	1-5 years	21 or over
	Percent	Percent	Percent	Percent	Percent	Percent
Role of leadership difficult	56.3	31.1	13.0	-	28.6	23.1
Insufficient knowledge to organize group	18.7	29.0	4.4	100.0	42.9	7.7
Insufficient knowledge to teach class	-	4.4	8.7	-	-	-
Not comfortable as resource person	-	4.4	-	-	-	-
Other problems	-	2.2	-	-	-	7.7
No difficulties now	12.5	6.7	30.4	-	-	15.4
No response	12.5	22.2	43.5	-	28.5	46.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

[1] Supra, pp. 113-114.

Effect of Experience on Nurses' Feelings About How Preparation for Group Work Could Best be Obtained.

Part II of the study problem sought information concerning what nurses felt were the best means of preparing for various group work roles. Since previous data have suggested that the nurses in the study group felt that two roles, serving as discussion leader in community health groups, and teaching community classes, were the most difficult, the writer decided to limit presentation of data concerning experience to these two areas. Tables 80 through 83 show the results.

Table 80. Factors Thought to be Most Helpful in Preparing to be a Discussion Leader* - Effect of Experience on Responses.

Alternative Responses	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
University courses on theory of group work	7.8	3.4	8.2	6.1
University courses providing theory and practice in group work	18.2	25.3	32.7	24.4
Agency inservice education on improving group work methods	11.7	18.4	20.4	16.4
Reading materials about discussion methods	18.2	11.5	4.1	12.2
Speech class	7.8	9.2	8.1	8.5
No response	36.3	32.2	26.5	32.4
Total	100.0	100.0	100.0	100.0

*1st choice only.

Here again, as in Table 69, the nurses with more experience placed a higher value on university preparation, in this instance, a course providing practice as well as theory in group work. These data, as those in

Table 69, would seem related to the fact, established in Table 61 that a higher proportion of the nurses in the sample with over five years of experience have had preparation for public health nursing and probably have been enrolled in such courses. Not consistent with Table 69 however, are the findings on inservice education for, in this instance, appreciation of the value of this increases somewhat with experience. Responses concerning the value of reading materials in preparing for group leadership might also be related to less preparation on the part of the least experienced group.

Table 81 shows considerable consistency when responses are analyzed further at the two extremes of the experience scale for both samples. One difference is the rank given to reading materials by nurses in the Outstate sample in the first five years of experience.

Table 81. Comparison of What Nurses With the Least and the Most Experience Thought Most Helpful in Preparing for Discussion Leadership - Outstate and Detroit.*

Alternative Responses	Responses by Years of Experience					
	Outstate n = 157			Detroit n = 28		
	Less than 1 year	1-5 years	21 or over	Less than 1 year	1-5 years	21 or over
	Percent	Percent	Percent	Percent	Percent	Percent
University courses on theory of group work	6.3	6.7	8.7	-	14.3	7.7
University courses providing theory and practice in group work	12.5	17.8	26.1	100.0	14.3	38.5
Agency inservice education on improving group work methods	6.3	13.3	26.1	-	14.3	15.4
Reading materials on discussion methods	12.5	22.2	8.7	-	14.3	-
Speech class	6.2	6.7	8.7	-	14.3	7.7
No response	56.2	33.3	21.7	-	28.5	30.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

*1st choice only

Table 82. Factors Which Helped Most in Preparing to Teach a Class - Effect of Experience on Responses.*

Alternative Responses	Responses by Years of Experience			Total Sample n = 185
	Five or less	6 - 20 years	21 and over	
	Percent	Percent	Percent	Percent
University courses on theory of group work	1.3	6.9	16.3	7.0
University courses providing theory and practice in group work	9.1	25.3	40.8	23.0
Agency inservice education on improving group work methods	10.4	9.2	10.2	9.9
Reading materials about discussion methods	9.1	10.4	2.1	8.0
Speech class	2.6	10.3	4.1	6.1
No response	67.5	37.9	26.5	46.0
Total	100.0	100.0	100.0	100.0

*1st choice only

With the exception of inservice education, the comments concerning Table 80 can also apply to Table 82. The high proportion of no responses in the least experienced group may indicate that this group, in addition to having less preparation for public health nursing, also may have had less actual experience with community classes. Table 37 in Chapter V showed that approximately one-third of all of the nurses in the sample had not had the experience of teaching such a class.

Table 83 presents rather consistent results and the very high proportion of those with five years or less experience who did not respond suggests that they may not have had experience in teaching a class. A question might also be raised in Tables 80-83 as to reasons why the nurses with 21 years or more of experience gave such a consistently high rating to a university course as a method of preparation for these two leadership roles.

Do their answers reflect clearer definition of need and interest in improving group work skills?

Table 83. Comparison of What Nurses With the Least and the Most Experience Thought Most Helpful in Preparing to Teach a Class - Outstate and Detroit.*

Alternative Responses	Responses by Years of Experience					
	Outstate n = 157			Detroit n = 28		
	Less than 1 year	1-5 years	21 or over	Less than 1 year	1-5 years	21 or over
	Percent	Percent	Percent	Percent	Percent	Percent
University courses on theory of group work	-	2.2	17.4	-	-	15.4
University courses providing theory and practice in group work	6.3	9.0	26.1	100.0	-	53.8
Agency inservice education on improving group work methods	6.3	11.1	21.7	-	14.3	-
Reading materials on discussion methods	6.2	13.3	4.4	-	-	-
Speech class	6.2	2.2	-	-	-	7.7
No response	75.0	62.2	30.4	-	85.7	23.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*1st choice only

The findings concerning the values the respondents gave to "additional on-the-job" factors which helped prepare them for these group work roles also were reviewed in relation to experience. Since the years of experience of the nurse did not seem to result in variation of these responses, in line with the plan for this chapter, findings are not presented here.

Experience and Inservice Education

While the data previously assembled (Table 48) concerning the respondents' experience with inservice education were somewhat questionable due to the high proportion of no responses to this item, the writer decided to see to what extent these responses were affected by experience. Table 84 shows the results.

Table 84. Effect of Experience on Participation in Inservice Education

Listing of Types of Inservice Education	Responses by Years of Experience		
	Five or less	6 - 20 years	21 or over
	Percent	Percent	Percent
Read references on group work and reported at staff meeting	8.7	4.9	9.2
Tried to practice and apply new knowledge at agency meeting	18.5	16.4	20.7
Staff had assistance from expert in group work	14.1	15.6	8.0
Staff representative took "group dynamics" course	3.3	5.8	4.6
Attended workshops or meetings where group methods practiced	33.7	31.1	39.1
Staff utilized family case study discussions	21.7	26.2	18.4
Total responses	100.0	100.0	100.0

It will be noted that the format of Table 84 presents only total responses, i.e., the proportion of nurses with five years of experience or less who had participated in the various activities listed. In this respect it differs from its parent, Table 48. On the whole, however, the three-way experience classification has not seemed to affect responses and each conforms quite closely to results for the sample as a whole.

The question from which these data were derived (Q 19) also asked nurses to indicate if they had not participated in any inservice education on group work. Here the least experienced group showed 17.8 percent to be in this category, as compared to 16.0 percent for the middle group and only 3.3 percent for the group with over twenty-one years of experience. These findings seem to indicate that the most experienced nurses had utilized inservice education opportunities approximately five times as much as the least experienced nurses. Whether or not equal facilities were available to all experience groups is not known and would seem unlikely. One point worth considering in relation to these findings, however, is that the nurses with five years of experience or less also are the least well prepared - only one-half have had academic preparation. (Table 61) Thus they might be said to have two counts against them as far as background and know-how about group work are concerned.

Summary - Chapter VIII

Part I. The effect of experience on the responses of nurses concerning the importance of group work can be summarized quite briefly. The effect of experience on the nurses' concepts of skills was very slight as was a relationship between experience and preference for working with groups. In the area of group organization, the two most experienced categories placed a higher value on a university course than did those with least experience. Need for help with group organization decreased as experience increased.

Experience seemed related to some rather small differences in the nurses' concepts of the leadership role, suggesting, however, that the most experienced nurses were more apt to associate leadership with authority. What nurses considered to be a desirable sequence for group work experience did not change appreciably with experience. The most marked differences which seem to be related to experience were found in the nurses' responses

to ranking of difficulties encountered in working with groups. In general, difficulties decreased with experience and those reporting no difficulties increased sharply as experience increased.

Part II. Experience cannot be shown to be a sharply delineating factor in reviewing how nurses felt that preparation for group work could best be obtained. Here again, as experience increased, appreciation of academic preparation did likewise. Table 80 showed that inservice education on group work was rated approximately twice as high by the most experienced group as by the least experienced. Reliance on reading materials concerning discussion methods decreased sharply as experience increased. Nurses with the least experience had much less participation in inservice education programs than did those with the greatest amount of experience.

In considering the data presented in this chapter and the rather small differences which seem to be related to the respondents' experience, the writer raises the following questions. Are the differences slight because the sample as a whole represented a rather mature, experienced group of nurses? Would the results have been different if a larger proportion of the sample had been employed for less than a year instead of only 8.4 per cent--or if more than 10.3 per cent had worked in the field of public health nursing from one to two years? It seems likely to the writer that a sample containing a more equitable spread of age and experience groups might have provided a better test of the experience variable.

CHAPTER IX

Summary, Conclusions, Implications, and Recommendations

Summary of Purposes and Method

Group work in public health nursing is not new but its relative importance as a way of giving service to people has been emphasized in recent years. This study has been concerned with an exploration of the attitudes of a sample of health department nurses toward group work, with study of relationships between attitudes and nursing background, and with implications for the education of public health nurses. It was hoped that a direct approach to a selected group of health department nurses in one state would yield information of benefit to those responsible for curriculum planning in nursing education, and, indirectly, to field agencies concerned with inservice education programs. While previous studies relating group work to nursing or public health nursing could not be found, the results of research in other fields such as adult education and group dynamics were consciously applied especially with reference to the philosophy and methodology of working with groups.

Therefore, this investigation was designed to elicit information on three aspects of the problem, designated as Parts I, II, and III. The objectives in Part I sought to learn how the nurses in the sample felt about the importance of group work in public health nursing. It was realized that attitudes about importance of group work could only be estimated from the nurses' replies to a number of specific inquiries related to work situations with which they were familiar. Such questions dealt with group

organization, differentiation of group work roles, desirable sequence for group work experience, and feelings of adequacy or inadequacy in various group situations.

Part II sought information about how the nurses in the sample felt that preparation for group work could best be obtained. Nurses were asked to respond from their own experiences in four specific group work roles and also in regard to some more generalized aspects of preparation.

Part III was concerned with the effect of two variables, university preparation and years of experience, on the responses of the nurses in the sample.

A mail questionnaire was constructed utilizing questions stemming from objectives under the three subheadings of the problem mentioned above. Pretesting of the instrument and follow-up interviews with pretest subjects resulted in improvement in clarity and sequence.

Subjects for the study were health department nurses in Michigan. Two sub-samples were drawn, one from a list of health department nurses employed in the Outstate area and the other from a list of Detroit Department of Health nurses. Sampling was systematic from lists by rank and last name according to place of employment. Fifty percent of the Outstate nurses were selected for the sample and twenty-five percent of the Detroit staff. A total of 185 individuals responded constituting 80.4 percent of nurses in the total sample. Responses from the Detroit sample were weighted in computing a total which would represent all respondents.

Data from the questionnaires were coded for IBM analysis, and the results tabulated and analyzed. In general, findings were presented in percentage tables with the chi-square test applied to frequencies in certain instances to determine whether or not observed differences were the result of sampling error. In the presentation of findings in Part I, approximately

three-fourths of the tables showed breakdowns between Outstate and Detroit responses. Since differences in the two groups, as tested by chi-square, were found significant in a relatively small number of instances, it was not thought essential to continue this practice in presenting findings throughout the study. Because it was shown that wider variation as to amount of preparation existed within the Outstate sample as contrasted to approximately 90 percent prepared in the Detroit group, the analysis of the effects of university preparation on the respondents' attitudes about group work was limited to the Outstate nurses. Analysis of the effect of the experience variable on the total responses was carried out with experience divided into three classes with a more detailed classification presented at certain points.

Because this was an initial study in an unexplored field, many details were not fully investigated. The fact that the sample was drawn from one state, Michigan, also has the effect of limiting the applicability of the findings and preventing broad generalizations. Therefore, while the summary of findings and conclusions which follow have been demonstrated by the data in preceding chapters, they present only part of what would be necessary to prove more generalized conclusions, and, in this sense, should be considered well-documented evidence rather than final proof.

Summary of Findings

The following findings are presented in what the writer believes to be a descending order of importance.

Nurses in the sample who had completed university preparation for public health nursing showed stronger identification with group work than did the nurses who lacked such preparation. While statistical support for differences between the prepared and unprepared groups is available only for

the Outstate sample, the findings there are definitive in many respects. Specifically the prepared nurses seemed to have more confidence in themselves in approaching groups and in working with community organizations. Even sharper differences seemed apparent in the higher ratings which the prepared nurses gave to what they felt their contributions were to various group work situations.

Another important finding was that the majority of nurses in the sample agreed upon a particular sequence which they considered would be most helpful in learning how to do effective group work. Those who disagreed with the majority sequence indicated only minor disagreements. These findings were consistent regardless of the preparation or experience status of the respondents. The sequence which the nurses considered desirable began with participation in group discussions within the agency, proceeded to having group leadership experience within the staff, then participation in group discussions in the community, and/or serving as a health resource person in school or community groups. The two experiences which all of the respondents ranked in either fifth or sixth place were serving as a discussion leader in a community health group and/or teaching an organized health class in the community. That nurses regarded these last two group work experiences as most difficult is reinforced by the findings on group leadership which follow.

Problems relating to the group leadership role were listed most frequently by respondents regardless of preparation or experience status. Slightly more than one-half of the respondents who listed this as their greatest group work problem indicated that they did not feel prepared for group leadership while the rest classified themselves as "not the leader type". These findings on group leadership were supported by the nurses' responses as to how they rated their group work contributions. A very small

proportion of nurses ranked experience as a discussion leader as a "best" contribution, regardless of the type of meeting involved. About two-thirds of the total respondents expressed what might be called authoritarian feelings about the role of the leader in a group.

Respondents divided about evenly as to preferences for working with already organized community groups or organizing new ones specifically related to the program of the health department. A large majority of the total respondents felt that they needed more preparation if they were to participate in organizing groups. Inservice education on group organization was rated as the preferred method of obtaining more preparation and the health education specialist was considered the best single source of help with group organization.

Nurses in the total sample, regardless of preparation or experience, rated a university group work course which included practice as the most important factor in preparing for group work in public health nursing. Inservice education on various aspects of group work was rated in second and third places. Further analysis showed that the above type of course tied with inservice education for first place as a means of preparing to participate in group discussion. However, the respondents ranked the university course as nearly twice as important as inservice education in considering preparation for group leadership and nearly three times as important when teaching a community class was involved. These data seem to support findings reported above suggesting concern or insecurity on the nurses' part with regard to the group leadership area.

The respondents as a whole considered that attending workshops or meetings where group methods were discussed and practiced was the most helpful type of inservice education. Utilization of family case study discussions within the agency was rated second as a method of developing group

work skills. While the responses of the unprepared Outstate nurses agreed in regard to the value of attending workshops, it seems significant that the prepared nurses rated agency family case study discussions slightly higher while the unprepared rated this method of learning about group work in fourth place.

Reading materials about discussion methods was reported as helpful preparation for group work by a rather surprising number of respondents, outdistancing inservice education for second place in some categories. There was rather sharp evidence showing that the unprepared nurses in the Outstate sample with the least experience relied most heavily on this method of preparation.

In reacting to additional "on-the-job" factors which were helpful in preparing for various group work roles, little evidence could be established to show that nurses regarded their experience in making home visits to individual patients as a strength in working with groups. Likewise, intra-agency influences such as supervisory assistance or the effect of strong agency morale did not attain prominence as a contributing factor.

All respondents, regardless of preparation or experience, apparently considered that serving as a health resource person at a school or community meeting was not especially difficult. Serving in this capacity at teacher and P.T.A. meetings was more popular than other types of community meetings and these were also the types in which respondents reported the greatest experience. A question might be raised as to whether this finding is contradictory to that reported concerning a desirable sequence for learning about group work where serving as a health resource person was in third or fourth place. It seems important to point out that in the finding just reported on page 206 data were derived from a question which asked respondents to rate their contributions to various group work situations. Thus, respondents

were comparing their own performances in one role or another in the above finding while in the sequence question they were projecting what they felt would be a logical order of experience. Considered in this light, the two findings seem to be supplementary rather than contradictory.

Amount of experience in public health nursing could not be said to produce very definitive differences in the respondents' attitudes about group work. In general, difficulties decreased as years of experience increased. There was some evidence that nurses with 21 years or more of experience showed a more authoritative attitude in regard to group leadership. Reliance on reading materials concerning discussion methods decreased sharply as experience increased. Nurses with the least experience reported much less participation in inservice education programs than did those with the most experience.

Conclusions

The following conclusions may be drawn from the findings of this investigation. Items 1-3 follow the three parts of the study problem.

1. The data show that the respondents considered group work to be an important aspect of public health nursing service. Their concern with identifying their reactions to group work in general as well as to various group work roles, with rating their own contributions, and specifying their problem areas all support this conclusion.
2. The nurses in the study group gave priority to a university group work course which included practice as the best method of preparing to work with groups in public health nursing. However, continuing inservice education on group work methods while on the job was also given strong support regardless of preparation or experience status of respondents.
3. Nurses who had completed academic preparation for public health nursing

showed more confidence in approaching group work and in coping with some specific problems than did the nurses who lacked such preparation. Amount of experience in public health nursing could not be said to produce very definitive differences in the respondents' attitudes about group work.

4. In general, the methodology used in this study seemed to be sound in relation to the established objectives. Internal consistency in responses could be demonstrated on several important issues. The writer realizes, however, that the personal interview method would have enhanced the values of the data at certain points.

Implications for Curriculum

The implications listed below stem from the study findings and conclusions just reported. However, at certain points the writer has raised questions or comments concerning the findings; some of these will be pursued further in the section "Suggestions for Further Research" which terminates this chapter.

While the points listed below are mainly concerned with curriculum, a few are more in the realm of inservice education. The writer believes that rather than separate the latter, they can properly be included under the above title as a legitimate part of "teaching public health nursing".

1. University courses on group work which include opportunity for student practice constitute a valuable method of preparing the public health nurse for community group work roles. Although this study has limited itself to nurses' reactions to university "group work" courses, a question may be raised as to the possibility of also utilizing certain nursing or public health nursing courses for the incorporation of principles of group work methodology. This could be done not for the purpose of complete integration or to produce such a degree of diffusion

that key group work concepts might escape identification by the students, but rather to provide additional opportunities for practice and to give students an increased sense of the values of the group process.

2. The respondents expressed rather strong feelings of inadequacy in discussion leader or "teacher" roles in community situations. This suggests that more effort in curriculum planning could be directed toward providing learning experiences which gradually would prepare the student to understand her potential contribution and increase her skill and confidence. How the student is taught, i.e., the ability of her instructors to cope with a variety of group situations should be a valuable contribution toward such learning.

3. The respondents did not recognize any very definite relationship which their work with individuals or families (home visiting) might have to working with groups. This raises a question as to how widely these two types of preparation may have been separated in the curriculum. It would be of interest to know whether bringing the two closer together in teaching nursing students might help carry over the listening, non-directive approach usually taught in interviewing to working with groups.

4. The high ranking given agency inservice education on group work methods, even by nurses who had completed university preparation, could mean (a) that academic preparation on group work methodology was insufficient or not practical (b) that the inexperienced public health nurse was unable to make the transfer from theory to field practice, or (c) that the challenges of working with ever-changing agency and community problems required constant study and reappraisal of group techniques. These implications could overlap one another but they suggest that the university has responsibility in either or all instances for "teaching

for transfer" and for helping students understand that learnings of this type are never static and must constantly be "polished" on the job.

5. The respondents' consistent reactions toward a preferred sequence for developing group work skills while on a job have implications for both curriculum and agency practice. A question could be raised as to whether curriculum group work emphasis (course titles, content, and references) has been focussed too exclusively on "teaching a class". Or perhaps the student has been forced to consider how to do this effectively before she has had sufficient experience in other less demanding group work roles. The findings suggest that those in charge of orientation experiences in public health nursing agencies as well as university faculty should give consideration to the sequence of group work experiences which this sample of nurses considered most desirable.

6. The respondents' feelings that a health education specialist was the most logical person to turn to for help in group organization also has implications for curriculum. A question could be raised as to where the nursing student, particularly in a basic collegiate school, becomes acquainted with the usual functions and responsibilities of this professional colleague.

7. Since the reading of reference materials relating to group discussion apparently was utilized as a main source of help by unprepared nurses and to some extent by all nurses early in their experience, thought should be given to means of sharpening this learning tool. The Michigan Department of Health or a local health department would seem to be a logical depository for such reference materials. A question could be raised also as to whether channels could be developed through which universities and field agencies might share responsibility for the selection of such references.

SUGGESTIONS FOR FURTHER RESEARCH

1. Because the responses of the nurses in this sample showed that they felt group work to be an important aspect of public health nursing service, the writer recommends that similar groups of public health nurses be approached about participating in further group work projects such as those reported by Auerbach in recent years. Specifically, there is need for further exploration of underlying problems which public health nurses have in the area of group leadership.
2. As suggested under the Implications heading, exploration of various ways of teaching group work concepts within the nursing or public health nursing curriculum is recommended. Such studies should analyze outcomes of different approaches to group work, i.e., ways of understanding peoples' needs in a group as a means toward helping them with health problems versus the "group teaching" approach.
3. The writer believes also that studies would be possible which would analyze public health nurses' understanding of common factors associated with ways of working with individual patients and working with groups.
4. A study of public health nurses' concepts of the scope of inservice education and its role in the development and maintenance of group work skills should prove productive. Such a study could explore more deeply than has this one such areas as preparation and experience and their effects upon appreciation of and participation in inservice education programs.
5. While this study showed that nurses who had completed preparation for public health nursing had a more positive attitude toward group work than nurses who lacked such preparation, because of problems which the writer encountered in defining preparation clearly, she recommends further research in this area. One suggestion is a comparison of group

work concepts possessed by basic collegiate graduates whose preparation had included public health nursing with those of specific graduate nurse groups, prepared and unprepared.

Thus while there has been almost no research in the group work aspects of public health nursing or ways of preparing nurses for this part of their service to people and communities, the writer believes that much more should come about in the future. This study will have made a worthwhile contribution if it stimulates such research.

APPENDICES

APPENDIX A

Suggested Objectives for Group Work in The Public Health Nursing Curriculum

I. Objectives relating group work in public health nursing to adult education (might be a part of preparation in educational psychology or a growth and development course which included the adult years).

1. Understanding how group work in public health nursing fits into a broad pattern of community adult education.

2. Understanding of what motivates adults to join educational groups.

3. Understanding of differences and similarities in the total learning situation faced by adults in a community class or study group, and high school or college students in regular school classes.

4. Understanding that methods may be adapted to the interests and needs of any group; that the group can participate in selection of method.

II. Objectives relating group work in public health nursing to work with families.

1. Understanding of how work with families prepares the public health nurse for working with groups.

2. Ability to listen and estimate the other person's interest as a basis for planning.

3. Understanding of how and why the teaching content should be patient or pupil rather than nurse centered.

4. Understanding of how to plan with rather than for individuals or groups.

5. Ability to leave decision-making to those who must carry out the decision, giving consultation and support as necessary.

III. Objectives relating to certain knowledge, understandings, and beginning competencies in group work.[1]

1. Knowledge of selected references interpreting basic concepts of group dynamics and understanding how to apply them to familiar group situations.

2. Understanding that nurses develop group work skills through practice; that practice in an agency and community setting under supervision is desirable.

3. Understanding that the attitudes which public health nurses have toward group work are the result of personal as well as professional experience.

4. Understanding of the importance of her role as a participating member of agency and community groups; beginning competence as a group member.

5. Understanding of the "resource", "consultant" or "expert" role in which the public health nurse is automatically placed by many non-public health groups in the community; beginning competence in this role.

6. Understanding of how the "resource role" differs from group leadership or "teaching".

7. Beginning competence in group leadership; understanding of ways in which the leader shares responsibility with the group.

8. Understanding of similarities and differences involved in planning to lead a single discussion on a health topic and planning for a series of classes.

9. Understanding of and beginning competence in a variety of group work methods.

10. Understanding of the principles that would guide a nurse in selection and use of visual aids in working with groups.

11. Understanding of the role of the public health nurse in the organization of groups for health education or service.

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[1] The term "beginning competence" has been used in public health nursing education to describe the earliest stage of a specific ability. See Proceedings of Work Conference, Collegiate Council on Public Health Nursing Education, Haven Hill Lodge, Milford, Michigan, Oct. 10-13, 1951. (New York: National League for Nursing), pp. 12-15.

12. Understanding of the skills involved in group organization, availability of possible assistance, etc.

13. Beginning competence in developing objectives, working out plans, and evaluating learning outcomes with group participation in all three steps.

14. Some understanding of ways in which the nurse's work with groups may be evaluated.

APPENDIX B

The Questionnaire

A Study of How Public Health Nurses Feel about Group Work

Each one of us belongs to quite a variety of groups. We belong to clubs, church groups, social groups, professional nursing organizations, etc. Most closely related to our work as public health nurses are our agency staff groups, school and community groups concerned with health and welfare, and perhaps organized class groups such as expectant parents' or home nursing classes.

This study is concerned with how public health nurses feel about group work. It is concerned with what you like or don't like about it, how you learned what you know about it and most important, how you think public health nurses ought to be prepared for group work in the future.

This type of information is not available at present. Your opinions, as a practitioner in public health nursing and the opinions of many other public health nurses will be considered in planning for public health nursing education.

	Circle One
1. Most public health nurses, early in their experience, accept that interviewing or health counseling as carried on in home or clinic visits, is an important means of health education. What about community group meetings or classes which you attend or conduct as part of your work? Would you say that such meetings or classes offered more, less, or the same opportunities for health education as the home or clinic interview?	More Same Less Can't tell

1a. Could you say why you feel the way you do? _____

_____

2. Thinking about group work as differentiated from individual visiting or conferences, how do you feel about working with groups of people - any groups that are related to your job - at the present stage of your experience. Check one:

- ☐ Prefer working with individuals
- ☐ Prefer working with people in groups
- ☐ Either way - it doesn't matter
- ☐ Haven't thought about it enough to be sure

2a. Could you say why you feel the way you do? _____

3. It is sometimes said that public health nurses learn to be good group workers and leaders through experiences they have had other than nursing.

Check if you have ever been a member of any of the following non-nursing groups and indicate how much you think each contributed to helping you do group work in public health nursing. (The following list is not meant to be all-inclusive. Please list other groups that have been important to you).

	Contribution which this made to helping you do group work in public health nursing			Check if you are or have been an officer
	Highly Valuable	Somewhat Valuable	Not Valuable	
1. Agricultural Extension Service				
2. American Legion Auxiliary				
3. Business and Professional Women's Club				
4. Campfire Girls-member or leader				
5. Church circle or club				
6. Community Chest-board or committee				
7. Eastern Star				
8. Girl Scouts - member or leader				
9. League of Women Voters				
10. Political party groups				
11. PTA (as a parent)				
12. Red Cross-chapter board or committee				
13. Sunday School-student or teacher				
14. Study club - for special purpose				
15. Woman's club (general)				
16. YWCA				
17. Zonta Club				
18. Others				
3a. Activity in school groups (high school, nursing school or college)				

Circle One

4. People sometimes seem to talk about group work as though special skills were involved. First of all, consider group work within your own agency - things like staff meetings, committee meetings, family study conferences, any activity which you share with a group. Do you feel that these things require skills from you that are different from what you do in home visiting?

Same

Different

Can't tell

4a. Why do you feel the way you do?_____

_____

5. How would you compare your participation in group activities in the agency and in the community in terms of what each seemed to require of you - did working with community groups seem to require more, less, or about the same background as working with agency groups?

More

Same

Less

Can't tell

5a. Why do you feel the way you do?_____

_____

6. The term "health resource person" is vague but it describes the contribution which the nurse makes, or is prepared to make, at many school or community meetings which she attends as a representative of the health department (PTA's, service clubs, council of social agencies, etc.). You don't make a speech or lead discussion but you may have opportunities to interpret your agency's program or supply other health information. Which of the following skills would you consider most important in such a situation? Check one:

☐ Understanding how and when to contribute to the discussion.

☐ Finding ways of introducing a description of the health department program.

☐ Evaluating the situation but not saying anything unless called upon.

7. We hear a lot about group leadership today and we know that sooner or later most public health nurses are called upon to lead groups. While many public health nurses will participate in group work early in their job experiences - in the sense of attending meetings, being a member of committees, etc. there is often discussion as to when the nurse is "ready" for group leadership - in the sense of committee chairmanship or discussion leader. In your opinion, does the role of group leader involve anything different than being a participating member of a group? Check one:

☐ The two roles are more alike than different.

☐ A participant does not carry much responsibility.

☐ The leader carries most of the responsibility.

Circle One

8. At the present time do you feel that the knowledge and skills which are desirable in carrying out certain group work responsibilities associated with your job (serving as a health resource person, as a discussion leader, or conducting a class) would involve extra preparation in terms of time beyond working hours? Yes / No / Can't tell

8a. If yes, which one or ones and in what way?_____

_____

9. If extra time beyond working hours is involved (as in 8) what do you think should be done about it? Check one:

☐ The nurse should consider this part of her professional contribution to her job.

☐ The agency should allow time during working hours for such preparation.

☐ A combination of the two listed above.

10. While circumstances and need often determine sequence of experience in group work, if you could choose an ideal sequence how would you number the following? Number the one you would place first (1), the next (2) and so on:

a. ___ Participating in community group discussions on health topics.
b. ___ Serving as a health resource person in school or community groups.
c. ___ Teaching an expectant parents' class.
d. ___ Participating in group discussions within the agency.
e. ___ Serving as discussion leader within the agency.
f. ___ Serving as discussion leader on health topics in school or community groups.

11. Public health nurses become involved in many kinds of groups, some which already exist in the community and some which are organized in full or part by the nurse. Would you rather: Check one:

☐ Meet occasionally with organized groups (PTA's, child study clubs, teacher groups) fitting into their planning and contributing as you can.

☐ Organize or assist with organization of groups more closely allied to the health program (lay volunteer groups, expectant mothers, others).

☐ Work with both kinds - it wouldn't matter.

11a. Why do you feel the way you do?_____

_____

12. There is some difference of opinion as to whether the community or the public health agency should initiate group work. We are interested in how you feel about this, especially in regard to the amount of initiative the public health nurse should take. For instance, after you were

acquainted with your district if you felt there might be interest in forming an expectant parents' class would you: Check one.

☐ Wait for someone in the community to bring a request to the health department.

☐ Take some beginning steps like discussing the matter with your supervising nurse and/or the health officer.

☐ Go ahead and discuss the plan with expectant mothers or parents.

13. While health department policies regarding the organization of groups might vary, certain skills seem to be important in organizing any group. From your experience and observation of others in the field, which of the following skills do you think are the most important? Pick out three numbering them 1-2-3 in order of importance.

a. ___ Skill in presenting ideas clearly so that you are readily understood.
b. ___ Skill in group dynamics.
c. ___ Skill in getting people to want to work together.
d. ___ Skill in picking key people to help you.
e. ___ Skill in interpreting the total community situation, readiness for organization, etc.
f. ___ Skill in helping groups think through and adopt a course of action toward a common goal.
g. ___ Other (specify)_____

14. If, at the present time, you feel inadequately prepared to organize a new group such as expectant mothers or volunteers, what do you think would best prepare you for this responsibility - assuming that all methods are equally available. Check one: (Check last box if you feel adequately prepared).

☐ A university course relating to group organization.

☐ Inservice education relating to group organization.

☐ Assistance from a supervisor or consultant.

☐ Observing how another public health nurse organized a group.

☐

15. It is sometimes called to our attention that the organization of groups (a parents' class, a lay volunteer committee) takes considerable time. If you were considering plans for organizing such a group and wanted to conserve time, where would you look for help? Number the first place you would look (1) the next (2) and so on.

a. ___ Mainly to yourself as you are most familiar with the local situation.
b. ___ To key people in the community who have had organization experience.
c. ___ To a specialist in health education if available on your staff or in a consultant capacity.
d. ___ To a supervisor and/or public health nursing consultant.
e. ___ Other (specify)_____

Circle One

16. It is sometimes said that group work saves the nurse's time - for example, that a class of ten expectant mothers takes less time than making ten home visits. Do you think that this is true?

Yes
No
Don't know

16a. Why?_____

_____

17. Do you feel that the group experience itself as in a mother's class might be a "plus value" in terms of health education?

Yes
No
Don't know

17a. Why?_____

_____

18. We all like some parts of our jobs a little better than other parts. This is true of experience in working with groups also. In what types of group activity do you feel that you make your best professional contribution, a medium-good contribution, your poorest contribution.

	Best Contribution	Medium-good Contribution	Poorest Contribution	No Experience
I. Meetings which you share with other professional public health workers:				
A) Public health nursing staff meetings (inservice education and committees)				
1) Participant				
2) Discussion leader				
B) General agency staff meetings				
1) Participant				
2) Discussion leader				
C) Regional or statewide workshops or meetings				
1) Participant				
2) Discussion leader				
II. Meetings in the community which you attend as part of your job				
A) Joint meetings between teachers and nurses				
1) Participant				
2) Health resource person				
3) Discussion leader				
B) Joint meetings between social workers and nurses				
1) Participant				
2) Health resource person				
3) Discussion leader				

18. Continued

	Best Contribution	Medium-good Contribution	Poorest Contribution	No Experience
C) PTA meetings				
1) Participant				
2) Health resource person				
3) Discussion leader				
4) Speaker				
D) Other community groups (Tbc Ass'n., Polio Chapter, Child Study Clubs)				
1) Participant				
2) Health resource person				
3) Discussion leader				
4) Speaker				
III. Conducting classes such as:				
A) Expectant mothers or parents				
B) Red Cross Home Nursing				
C) Others (Girl Scounts, baby sitters, etc.)				

Can you give reasons for those marked "Best" or "Poorest"? Indicate situation to which your reason applies by the number, i.e. II, A, 1 - - -

19. In recent years there has been quite a bit of interest on the part of many public health workers, and perhaps public health nurses especially, in learning more about group work methods. Occasionally agencies have devoted some inservice education time to this theme. If you have participated in any planned effort to study group methods within your public health nursing or total agency staff, check what most closely

describes your experience. You may check more than one but place two checks before the one you thought most helpful.

a.___Read interesting references on group work and reported on them at nursing staff meetings.

b.___Tried to "practice" new methods or apply new knowledge in staff, committees, or other meetings.

c.___The staff had some assistance from an "expert" in group work.

d.___Representatives from the staff enrolled in a "group dynamics" course outside the agency and reported back on what they had learned.

e.___You or other members of the staff attended workshops or other meetings where group techniques were practiced and discussed - reporting on same to staff group at home.

f.___Supervisor and staff utilized family case study discussions as an opportunity to develop group work skills - (perhaps with students and other participating).

g.___Did not participate in any inservice education on group work.

19a. If you had other inservice education experiences which contributed to your preparation for group work indicate what they were_____

_____

_____

_____

20. Probably you have attended staff and community group meetings ever since working in the health department. What would you say helped you most in preparing to participate in group discussion? Simply from your own experience, review the following list and pick out the three which helped you most, numbering them 1-2-3 in order of importance. Do not number any items which do not apply to you.

Most helpful factors in learning to participate in discussion:

a.___University courses which provided theory about group work methods.
b.___University courses which provided theory and practice in group work methods.
c.___Inservice education directed toward improvement of discussion methods.
d.___Reading materials about discussion methods.
e.___A speech class.

20a. Many other things may have contributed to how you felt about participating in group discussion also. From your own experience, pick out three which helped you most, numbering them 1-2-3 in order of importance. Do not number any items which do not apply to you.

a. ___ A group leader who made you feel comfortable.
b. ___ Experience in making home visits in the community.
c. ___ The democratic attitude of the group members.
d. ___ Identifying yourself with many groups and attending meetings.
e. ___ Familiarity with subject being discussed and purpose of meeting.
f. ___ Other (specify)_____

21. One of the unique ways in which the public health nurse contributes to health education is in serving as a health resource person in many groups outside the public health agency. (PTA's, teachers' meetings, service clubs, etc.). When you first attended a meeting in this capacity can you recall which of the following experiences were most valuable? Review the following list and pick out the three things which helped you most, numbering them 1-2-3 in order of importance. Do not number any items which do not apply to you.

Most helpful factors in preparing to be a health resource person at a community meeting:

a. ___ University courses which provided theory about group work methods.
b. ___ University courses which provided theory and practice in group work methods.
c. ___ Inservice education directed toward improvement of discussion methods.
d. ___ Reading materials about discussion methods.
e. ___ A speech class.

21a. Many other things may have contributed to your feeling of being prepared or unprepared to be a resource person. Review the following list and pick out the three which helped you most, numbering them 1-2-3 in order of importance. Do not number any items which do not apply to you.

a. ___ Observation of another nurse in a similar situation.
b. ___ Familiarity with subject being discussed and purpose of meeting.
c. ___ Experience in making home visits in the community.
d. ___ Help from a supervising nurse and/or public health nursing consultant.
e. ___ Pride in your agency and its place in the community.
f. ___ Other (specify)_____

22. It is said that when we have to do something new we either fall back on previous learning or reach out for help. Do you recall how you felt about preparing to be chairman of a meeting or a discussion leader for the first time? Simply from your own experience, review the following list and pick out the three which helped you most, numbering them 1-2-3 in order of importance. Do not number any items which do not apply to you.

Most helpful factors in preparing to be a chairman or leader of discussion:

a. ___ University courses which provided theory about group work methods.
b. ___ University courses which provided theory and practice in group work methods.
c. ___ Inservice education directed toward improvement of discussion methods.
d. ___ Reading materials about discussion methods.
e. ___ A speech class.

22a. Probably some other things helped you too. Review the following and pick out those which helped you most in preparing to be a chairman or discussion leader numbering them 1-2-3 in order of importance. Do not number any items which do not apply to you.

a.___Observation of others in similar situations.
b.___Experience in making home visits in the community.
c.___Familiarity with the subject to be discussed and the purpose of the meeting.
d.___Help from a supervising nurse and/or public health nursing consultant.
e.___The encouraging atmosphere of the agency situation.
f.___Help from another staff nurse.
g.___Identifying yourself with many groups and attending meetings.
h.___Other (specify)_____

23. Public health nurses with widely different backgrounds have successfully taught organized classes (such as for expectant mothers or Red Cross home nursing). From your own experience, review the following list and pick out the three which helped you most, number them 1-2-3 in order of importance. Do not number the items which do not apply to you. If you have not conducted any classes, do not answer.

Items which helped you most in preparing to teach a class:

a.___University courses which provided theory but little work methods.
b.___University courses which provided theory and practice in group work methods.
c.___Inservice education directed toward improvement of discussion methods.
d.___Reading materials about discussion methods.
e.___A speech class.

23a. Perhaps some other things helped you also. Review the following and pick out those which helped you most in preparing to teach a class, numbering them 1-2-3 in order of importance. Do not number the items which do not apply to you.

a.___Knowledge of the subject matter involved.
b.___Observation of another nurse teaching a similar class.
c.___Experience in making home visits in the community.
d.___An outline prepared by a local, state or national agency.
e.___Help from another staff nurse.
f.___Help from a supervising nurse and/or public health nursing consultant.
g.___Experience as a group leader in staff or community groups.
h.___Other (specify)_____

24. Have you had university preparation in public health nursing? Circle One: Yes / No

24a. If yes, review the following list and if you have had courses of the type indicated, number them 1 through 5 in order of value to you as a public health nurse. Number only any courses you have had.

a.___Community Organization.
b.___Group Dynamics.

c. ___ Social Psychology.
d. ___ Adult Education
e. ___ A required course dealing with group work for public health nurses.
f. ___ Other (specify)_____

25. Are there things which you find difficult about doing group work at this time? Review the following list and pick out the three things which bother you the most, numbering them 1-2-3 in order of difficulty. (Check last space if you do not find any of these difficult now).

a. ___ Not knowing quite how to organize a health group - such as a lay committee or a mothers' class.
b. ___ Finding the role of group leader difficult because you don't feel prepared.
c. ___ Finding the role of group leader difficult because you think you aren't the leader "type".
d. ___ Not feeling comfortable in representing your agency as a health resource person in school or community groups.
e. ___ Not knowing how to plan teaching materials for an organized class such as expectant parents.
f. ___ Other (specify)_____
g. ___

26. Which of the following do you think most important in preparing public health nurses to do any kind of group work in public health nursing? Number in order of importance beginning with (1) as the most important.

a. ___ Good supervision on the job.
b. ___ University courses on group work which include opportunity for practice.
c. ___ The kind of agency staff where everyone works together well and where some common purposes are well understood.
d. ___ Membership and participation in a wide number of groups, social, civic and professional.
e. ___ Inservice education on various aspects of group work that are related to one's job.
f. ___ Other (specify)_____

Background Data

(Please do not sign your name)

27. Present place of occupation (Check one):
___ City health department
___ County health department
___ City-county health department
___ District health department
___ Combination agency (any type of health department combined with an organized visiting nurse service)

28. Present occupational status (Check the one that best describes your work):
___Administrator or supervisor
___Assistant supervisor
___Field teacher (for post or present students)
___Staff nurse

29. Total experience in public health nursing (regardless of type of work). (Check one).
___Less than 1 year
___1 - 2 years
___3 - 5 years
___6 - 10 years
___11 - 20 years
___21 or over

30. University preparation in public health nursing (Check one):
___No public health nursing courses.
___Less than one school year.
___One school year of public health nursing preparation but less than equivalent of certificate in public health nursing.
___Completion of the equivalent of certificate in public health nursing.
___Bachelor's degree and completion of public health nursing preparation.
___Bachelor's degree but not in public health nursing.
___Master's degree. What area of specialization?_____
_____

31. Age groups (Check one):
___21 - 25
___26 - 30
___31 - 40
___41 - 50
___51 - 60
___Over 60

32. Marital status (Check one):
___Never married
___Now married
___Widowed or other

33. Dependents
___Children living at home
___Other dependents living with you
___None

UNIVERSITY OF MICHIGAN
School of Public Health
Ann Arbor, Michigan

May 4, 1953

(Letter to supervising nurses)

You will see in the current Interdepartmental Circular from the Michigan Department of Health an announcement concerning a study on group work in public health nursing which I am undertaking.

I am eager to have the opinions of all health department nurses in Michigan about the group work part of their jobs and am asking your cooperation in getting this information. The ultimate purpose of the study is to see if there are ways in which public health nurses can be better prepared to work with groups and how universities can help.

At a meeting with the staff of the Public Health Nursing Section, Michigan Department of Health, the consultants suggested that where there was a supervising nurse or nursing director in a local agency, I mail the questionnaires to her and ask that she distribute them to her staff. Stamped envelopes will be enclosed so that the nurses may return the questionnaires individually.

The success of this study will depend upon completeness of response to the questionnaire. Traditionally, nurses are very helpful in this respect, and I am counting on the tradition continuing!

Sincerely yours,

Marion Murphy
Resident Lecturer
Public Health Nursing

UNIVERSITY OF MICHIGAN
School of Public Health
Ann Arbor, Michigan

May 7, 1953

To Health Department Nurses in Michigan

Attached is the questionnaire which was announced in the current issue of the Interdepartmental Circular of the Michigan Department of Health. As you know, I am trying to find out how you, as a public health nurse, feel about group work as part of your job. Are there ways in which public health nurses can be better prepared to work with groups and how can universities help with such preparation? We in the universities can only get an answer to this question through your response to the questionnaire!

I hope, before you let the length of the questionnaire bother you, you will leaf through it and get some notion of what it is all about. Once you do that, I'm sure you will see yourself and some of your every-day experiences reflected in the questions.

While your name does not appear on the questionnaire, a number system will be used for follow-up in order to secure completeness of response. I hope, however that you will fill in the questionnaire and return it so promptly that follow-up will not be necessary!

Sincerely yours,

Marion Murphy
Resident Lecturer
Public Health Nursing

UNIVERSITY OF MICHIGAN
School of Public Health
Ann Arbor, Michigan

May 7, 1953

To Detroit Department of Health Nurses

Attached is a questionnaire about group work in public health nursing which is being sent you with the approval of the Nursing Division. Your name was selected from an alphabetical list through use of a system of random numbers. Approximately every fourth nurse in your agency will receive a questionnaire.

I am trying to find out how you, as a public health nurse, feel about group work as part of your job. Are there ways in which public health nurses can be better prepared to work with groups and how can universities help with such preparation? We in the universities can only get an answer to this question through your response to the questionnaire!

I hope, before you let the length of the questionnaire bother you, you will leaf through it and get some notion of what it is all about. Once you do that, I'm sure you will see yourself and some of your everyday experiences reflected in the questions.

While your name does not appear on the questionnaire, a number system will be used for follow-up in order to secure completeness of response. I hope, however that you will fill in the questionnaire and return it so promptly that follow-up will not be necessary!

Sincerely yours,

Marion Murphy
Resident Lecturer
Public Health Nursing

1st follow-up notice

School of Public Health
Ann Arbor, Michigan
May 22, 1953

This is a follow-up on the questionnaire which I mailed to you on May 7. The response has been very good but I hope that I may hear from you too. If you have already mailed your questionnaire just disregard this notice. Thank you.

Marion Murphy

2nd follow-up notice

School of Public Health
Ann Arbor, Michigan
June 5, 1953

My questionnaires are coming in very well but I need yours too! The results of the study will be so much better if they are <u>really</u> representative of public health nursing opinion. May I hope to hear from you soon? If you have mislaid the questionnaire, please let me know and I will be happy to send you another.

If you have already sent it in, please disregard this notice. Thank you.

Marion Murphy

3rd follow-up notice

School of Public Health
Ann Arbor, Michigan
July 1, 1953

This is a third, and I'm sure we both hope, a last try to see if you have overlooked the questionnaire which I sent you in May. Approximately 72% of the public health nurses receiving the questionnaire have returned it, but the results would be better if you responded, too. I know you are busy, but I'll look forward to hearing from you.

Marion Murphy

Notice which appeared in the Interdepartmental Circular[1] for May 1953.

Marion Murphy of the Public Health Nursing faculty of the School of Public Health, University of Michigan, is undertaking a study of how health department nurses feel about group work as a part of their jobs.

Plans for the study have been cleared with the Public Health Nursing Section of the Michigan Department of Health and the Public Health Nursing Division of the Detroit Department of Health. In Detroit, approximately every fourth nurse on the Health Department staff will receive a mail questionnaire.

The ultimate purpose of the study is to see if there are ways in which public health nurses can be better prepared to work with groups and how universities can help. Opinions of field practitioners in public health nursing will be an important contribution toward this goal.

[1] Published monthly by the Michigan Department of Health, Lansing, Michigan.

APPENDIX C

Code Used in Tabulating Questionnaire Data (Columns 1 - 35 contain material tabulated on every card)

Question	Column	Code
	1 - 3	Questionnaire number
	4	Card number
	5	Group
		1. Outstate
		2. Detroit
27	6	Present place of occupation
		0. no answer
		1. city health department
		2. county health department
		3. city-county health department
		4. district health department
		5. combination agency
28	7	Present occupational status
		0. no answer
		1. administrator or supervisor
		2. assistant supervisor
		3. field teacher
		4. staff nurse
		5. other
29	8	Total experience in public health nursing
		0. no answer

Card 1

(material for every card)

Position	Column	Code
		1. less than 1 year
		2. 1 - 2 years
		3. 3 - 5 years
		4. 6 - 10 years
		5. 11 - 20 years
		6. 21 years or more
20	9	University preparation in public health nursing
		0. no answer
		1. no public health nursing courses
		2. less than one school year
		3. one school year of public health nursing preparation but less than equivalent of certificate
		4. completion of the equivalent of certificate
		5. bachelor's degree and completion of public health
		6. bachelor's degree but not in public health nursing
		7. master's degree
		8. MPH (area of specialization in 7)
		9. Other (area of specialization in 7)
31	10	Age group
		0. no answer
		1. 21 - 25
		2. 26 - 30
		3. 31 - 40
		4. 41 - 50

Card 1

(material for every card)

Question	Column	Code
		5. 51 - 60
		6. Over 60
32	11	Marital status
		0. no answer
		1. never married
		2. now married
		3. widowed or other
33	12	0. no answer
		1. children or other dependents living at home
		2. None
18	13-35	In what types of group activity do you feel that you make your best professional contribution, a medium-good contribution, your poorest contribution?
		0. no answer
		1. best contribution
		2. medium-good contribution
		3. poorest contribution
		4. no experience
I A1	13	participant - public health nursing agency staff meetings
I A2	14	discussion leader - public health nursing agency staff meetings
I F1	15	participant - general agency staff meetings
I F2	16	discussion leader - general agency staff meetings
I C1	17	participant - regional or state meetings or workshops
I C2	18	discussion leader - regional or state meetings or workshops

Card 1

(material for every card)

Question	Column	Code
II A1	19	participant - joint meetings between teachers and nurses
II A2	20	health resource person - joint meetings between teachers and nurses
II A3	21	discussion leader - joint meetings between teachers and nurses
II B1	22	participant - joint meetings between social workers and nurses
II B2	23	health resource person - joint meetings between social workers and nurses
II B3	24	discussion leader - joint meetings between social workers and nurses
II C1	25	participant - PTA meetings
II C2	26	health resource person - PTA meetings
II C3	27	discussion leader - PTA meetings
II C4	28	speaker - PTA meetings
II D1	29	participant - other community meetings
II D2	30	health resource person - other community meetings
II D3	31	discussion leader - other community meetings
II D4	32	speaker - other community meetings
III A	33	teaching expectant mothers' or parents' classes
III B	34	teaching Red Cross Home Nursing classes
III C	35	teaching other classes 1

[1] Material above dotted line (columns 1-35) tabulated on every card.

Card 1

Question	Column	Code
1	36	Do group meetings or classes offer more, less or the same opportunities for health education as home or clinic interviews?
		0. no answer
		1. more
		2. same
		3. less
		4. can't tell
1a	37	Code reason for answer in appropriate category
		0. no answer
		1. more opportunity
		2. same opportunity
		3. less opportunity
		4. can't tell
1a	38	Do group meetings offer <u>more opportunity</u> for health <u>education than individual conference</u>? Code <u>which</u>
		0. no answer
		1. sharing of experience valuable
		2. reach more people
		3. when class or program "done effectively"
		4. people talk easier in a group situation
		5. more thorough coverage of topic
		<u>Same opportunity</u>
		0. no answer
		1. usually opportunities are present in either situation

Card 1

Question	Column	Code
1a (con't)	38	2. can see more people
		3. depends, to some extent, on subject.
		Less opportunity
		0. no answer
		1. some things come out of individual conferences which are not present in group
		2. people reveal more problems in home situation
		3. nurse has better contact in working with individual
		4. less chance for solution of individual problems in group
		5. do not always reach right people in group
		6. health education is best on individual basis
		Can't tell
		0. no answer
		1. not enough experience in groups to know
		2. depends on motivation of individuals or groups concerned
		3. they offer different types of opportunity in health education
		4. depends on subject matter
4	39	Does group work within the agency require different skills than those required in home visiting?
		0. no answer
		1. same
		2. different
		3. can't tell

Card 1

Question	Column	Code
4a	40	Code reason for answer in appropriate category 0. no answer 1. same 2. different 3. can't tell
4a	41	Does group work in agency require same skills as home visiting? Code which reason. 0. no answer 1. same skills as in a "good" home visit but different application 2. skills are mostly the same (more alike than different) 3. both situations are concerned with individuals and attitudes (people) 4. same skills but more highly developed in group work 5. same skills but more accomplished in home visit 6. same except for different terminology 7. same skills but shy nurse may do better in home visit
		Does group work in agency require different skills than in home visiting? 0. no answer 1. home visiting requires more skill: (a) nurse carries more responsibility in home visit — shares it in a group

Card 1

Question	Column	Code
4a (con't)	41 (con't)	(b) nurse must be prepared for wide variety of questions in home visit -- agency groups usually have planned topic
		(c) nurse is "on her own" in a home visit -- in agency group she has more security, feels support, etc.
		(d) lay people different than professionals in agency
		2. Group work in agency requires more skill:
		(a) expressing oneself in group is more difficult
		(b) interaction between individuals in group is more complicated than in home visit
		(c) more skill is required to get good participation in a group
		(d) more leadership, tact, and diplomacy are needed in group situation
		(e) helping a group with problem solving is more difficult than helping an individual
		(f) more poise is required in agency groups
		(g) more difficult to make meetings stimulating
		(h) material needs more formal organization
		Can't tell if group work in agency requires different skills than home visiting.
		0. no answer
		1. not enough experience to say

Card 1

Question	Column	
5	42	Objective 1 (c) Is group work the same, in terms of skills involved, whether in agency or community? 0. no answer 1. more skill required 2. same skill required 3. less skill required 4. can't tell
5a	43	Code reason for answer in appropriate category 0. no answer 1. more skill required 2. same skill required 3. less skill required 4. can't tell
5a	44	Does working with community groups require more skill than agency groups? Code which reason. 0. no answer 1. skill in knowing how to work with people with different backgrounds and interests 2. broader preparation in subject matter 3. more important to make "good showing" 4. less "we group" feeling than in agency 5. need to constantly interpret our job and agency to community groups 6. involves knowledge of community Same skill involved 0. no answer

Card 1

Question	Column	
5a (con't)	44	1. basic elements of group work same anywhere
		2. same in that nurse must understand motivation in each group
		3. will vary with situation but more alike than different
		4. same except for "vernacular" changes
		Can't tell
		0.
		1. not enough experience to say
		2. depends upon community
10		Objective 4 (c) Is there a desirable sequence for group work experiences? What is an ideal sequence for group work experience?
10	45	No. 1 Selection (from 0-6 below)
		0. no answer
		1. participating in community group discussions
		2. serving as a health resource person in school or community groups
		3. teaching an expectant parents' class
		4. participating in group discussions in agency
		5. serving as discussion leader within agency
		6. serving as discussion leader in community
10	46	No. 2 Selection
		0 - 6 as above

Card 1

Question	Column	
10	47	No. 3 Selection 0 - 6 as above
	48	No. 4 Selection 0 - 6 as above
	49	No. 5 Selection 0 - 6 as above
	50	No. 6 Selection 0 - 6 as above
11	51	Would you rather work with existing groups or organize new ones? 0. no answer 1. meet with existing groups 2. organize or assist with organization of new group 3. work with both kinds
11a	52	Code reason for answer in appropriate category 0. no answer 1. meet with existing groups 2. organize or assist with organization of new group 3. work with both kinds
	53	Reasons for preferring to meet with organized groups (Code reason) 0. no answer 1. feel inadequate to organize new group 2. shows that community is interested in health 3. shows that health department is interested in wide number of community groups

Card 1

Question	Column	
11a (con't)	53	4. lack of time for organizing new groups
		5. not desirable to have too many groups
		6. contribution of nurse should be unobtrusive
		7. lay people take more responsibility
		8. greater enjoyment on part of nurse
11a	53	Reasons for organizing or assisting with organizing new groups
		0. no answer
		1. better use of time - not a "hit or miss" experience
		2. possible to know such a group better and give better service
		3. promotes health department program to greater extent
		4. greater enjoyment on part of nurse
		5. these groups apt to be more interested
		6. feel that this area has been neglected
		No preference --work with both kinds of groups
		0. no answer
		1. if approached properly both experiences can be helpful in terms of community health education
		2. enjoy working with both kinds of groups
		3. the nurse needs to work with a wide variety of groups in order to give service
		4. nurse has to understand and fit into community situation
		5. each type of group is a learning experience for the nurse

Card 1

Question	Column	
11a (cont')	53	6. by meeting with organized group, nurse learns how to organize new groups
12	54	Amount of initiative nurse might take in organizing parents' class 0. no answer 1. wait for someone to make request 2. take some beginning steps in agency 3. go ahead and discuss plan with parents
		Objective 3 (a) Is the differentiation in terms of skills involved in group organization. Which of the following skills are most important? (numbered 1 - 2 - 3)
13	55	1st Choices (1) 0. no answer 1. skill in presenting ideas, etc. 2. skill in group dynamics 3. skill in getting people to want to work together 4. skill in picking key people to help 5. skill in interpretation, etc. 6. skill in helping groups think, etc. 7. other
13	56	2nd Choices 0 - 7 same as above
	57	3rd Choices 0 - 7 same as above
14	58	If inadequately prepared to organize a group, what would help most?

Card 1

Question	Column	
14 (con't)	58	0. no answer
		1. a university course relating to group organization
		2. inservice education relating to group organization
		3. assistance from a supervisor or consultant
		4. observing another nurse
		5. adequately prepared
15		Places to look for help in order to conserve time in group organization
	59	1st choice
		0. no answer
		1. mainly to yourself, etc.
		2. to key people, etc.
		3. to a specialist in health education
		4. to a supervisor or consultant
		5. other
	60	2nd choice
		0 - 5 same as above
	61	3rd choice
		0 - 5 same as above
	62	4th choice
		0 - 5 same as above
	63	5th choice
		0 - 5 same as above
	64	6th choice
		0 - 5 same as above

Card 1

Question	Column	
16	65	Does a class of ten expectant mothers take less time than home visiting same people? 0. no answer 1. yes 2. no 3. don't know
16a	66	Code reason for answer in appropriate category 0. no answer 1. yes 2. no 3. don't know
16a	67	Does group work save the nurse's time? Yes Code reason 0. no answer 1. saves the nurse considerable travel time 2. both involve preparation but the same amount of preparation would reach more people in a class 3. saves the nurse time in that people help answer each others questions 4. depends on what members get from group - they may want or need home visits anyhow 5. depends on whether it is nurse's first class - (1st class may involve more time than home visiting) 6. patients apt to digress less than in home visits 7. if class well organized

Card 1

Question	Column	
16a (con't)	67 (con't)	Does group work save nurse's time? No

0. no answer
1. only after class is well organized and nurse has some experience -- until then it will take considerable time
2. mothers' classes often result in "case-finding" in sense that home visiting seems indicated for individual problems
3. adequate class discussion takes a long time
4. preparation takes more of nurse's time
5. depends upon whether right people attend

Does group work save nurse's time? Don't know.

0. no answer
1. results in terms of learning are more important than method
2. time should not be an issue - learning is more important
3. the size of the class would be a factor -- with ten perhaps doubtful
4. not enough experience to say
5. depends upon the group

17	68	Is the group experience itself (as in a mothers' class) a "plus value" in terms of health education?

0. no answer
1. yes

Card 1

Question	Column	
17 (con't)	68 (con't)	2. no
		3. don't know
17a	69	Code reason for answer in appropriate category
		0. no answer
		1. yes
		2. no
		3. don't know
17a	70	Is the group experience itself helpful? Yes (regardless of content or time)
		0. no answer or answer not in terms of question
		1. may stimulate members to participate in other health activities
		2. group members learn much from each other
		3. it will depend to some extent on the members participation in the group
		4. members may feel more at ease in group than in home visit -- and ask more questions
		5. group experience as value to nurse
		Is group experience itself helpful? No
		0. no answer
		1. over-exaggerated
		Is group experience itself helpful? Don't know
		0. no answer
		1. non participants may not get help
		2. not enough experience to say

Card 2

Question	Column	Code
6	36	Which of the following skills are most important in serving as a health resource person? 0. no answer 1. understanding how and when to contribute 2. finding ways of introducing description of health department program 3. evaluating situation but saying nothing unless called upon
7	37	Does role of group leader involve anything different than being a participating member? 0. no answer 1. two roles are more alike than different 2. participant doesn't carry much responsibility 3. leader carries most of the responsibility
8	38	Would preparation for these responsibilities take time beyond working hours? resource person, discussion leader, teacher 0. no answer 1. yes 2. no 3. can't tell
8a	39	Knowledge and skill in group work involve extra preparation in terms of time beyond working hours Yes 0. no answer

Card 2

Question	Column	Code
8a (con't)	39 (con't)	1. for "brushing up" on topic, research on subject matter
		2. work load too heavy to allow for this during working hours
		3. for thinking through what methods to use, obtaining materials, etc.
		4. if you really want to do a good job
		5. especially important for the inexperienced nurse
		6. preparation in group techniques
9	40	If extra time involved what should be done?
		0. no answer
		1. nurse should consider it part of her professional responsibility
		2. agency should allow time during working hours
		3. combination of 1. and 2.
10		What is an ideal sequence for group work experience?
	41	No. 1 Selection (from 0-6 below)
		0. no answer
		1. participating in community group discussions
		2. serving as health resource person in school or community groups
		3. teaching an expectant parents' class
		4. participating in group discussions in agency
		5. serving as discussion leader within agency
		6. serving as discussion leader in community

Card 2

Question	Column	Code
10 (Con't)	42	No. 2 Selection 0 - 6 as above
	43	No. 3 Selection 0 - 6 as above
	44	No. 4 Selection 0 - 6 as above
	45	No. 5 Selection 0 - 6 as above
	46	No. 6 Selection 0 - 6 as above
21	47	Objective 1 (b) Experience most helpful in serving as health resource person 1st Choice 0. no answer 1. university courses providing theory about group work methods 2. university courses providing theory and practice in group work methods 3. inservice education 4. reading materials about discussion 5. a speech class
	48	2nd Choice 0 - 5 as above
	49	3rd Choice 0 - 5 as above
		Other factors that contributed

Card 2

Question	Column	Code
21a	50	1st Choice
		0. no answer
		1. observation of another nurse
		2. familiarity with subject, etc.
		3. experience in making home visits
		4. help from a supervisory nurse, etc.
		5. pride in agency
		6. other
	51	2nd Choice
		0 - 6 as above
	52	3rd Choice
		0 - 6 as above
22		Objective 1 (c) Preparation for being a discussion leader
	53	1st Choice
		0. no answer
		1. university courses providing theory about group work methods
		2. university courses providing theory and practice in group work methods
		3. inservice education
		4. reading materials about discussion
		5. a speech class
	54	2nd Choice
		0 - 5 as above

Card 2

Question	Column	Code
22a		Other factors that contributed
	56	1st Choice
		0. no answer
		1. observation of others
		2. experience in making home visits
		3. familiarity with subject and purpose
		4. help from supervising nurse or consultant
		5. encouraging atmosphere in agency
		6. help from another staff nurse
		7. identification with many groups
		8. other
	57	2nd Choice
		0 - 8 as above
	58	3rd Choice
		0 - 8 as above
23		Objective 1 (d) Preparation for being a "teacher" for series of classes
	59	1st Choice
		0. no answer
		1. university courses providing theory about group work methods
		2. university courses providing theory and practice
		3. inservice education
		4. reading materials about discussion
		5. a speech class

Card 2

Question	Column	Code
23 (con't)	60	2nd Choice
		0 - 5 as above
	61	3rd Choice
		0 - 5 as above
23a		Other factors that contributed
	62	1st Choice
		0. no answer
		1. knowledge of subject involved
		2. observation of another nurse
		3. experience in making home visits
		4. an outline prepared by local, state, or national agency
		5. help from another staff nurse
		6. help from supervising nurse or consultant
		7. experience as group leader in staff or community groups
		8. other
	63	2nd Choice
		0 - 8 as above
	64	3rd Choice
		0 - 8 as above
25		Objective 5: To learn if there are handicaps or barriers commonly encountered by nurses in working with groups
		What nurses find most difficult about group work (1 - 2 - 3 in order of difficulty)

Card 2

Question	Column	Code
25 (Con't)	65	1st Choice
		0. no answer
		1. not knowing how to organize a health group
		2. finding role of leader difficulty - lack of preparation
		3. finding role of leader difficult - not leader type
		4. not comfortable as health resource person
		5. not knowing how to plan teaching of class
		6. no problems now
		7. other (working with agency plan that moves too rapidly for group
	66	2nd Choice
		0 - 7 as above
	67	3rd Choice
		0 - 7 as above

Card 3

Question	Column	Code
2	36	Preference in working with individuals or groups
		0. no response
		1. prefer working with individuals
		2. prefer working with groups
		3. either way
		4. haven't thought about it enough to be sure
2a	37	Code reason for answer in appropriate category
		0. no answer
		1. prefer working with individuals
		2. prefer working with groups
		3. either way
		4. haven't thought about it enough to be sure
	38	Reasons for preferring to work with individuals (code which reason)
		0. no answer
		1. more at ease (nurse)
		2. not enough experience to feel secure with groups
		3. accomplish more - home visit is "backbone" of service
		4. can know individual better
		5. more satisfaction as a nurse
		6. response from individuals better
		Reasons for preferring to work with groups
		0. no answer
		1. group members contribute to problem solving and results of decision stick better

Card 3

Question	Column	Code
2a (Con't)	38 (Con't)	2. more stimulating
		3. have had much experience with groups
		4. saves time - reach more people
		5. more can be accomplished
		6. group members free of home distractions
		No preference - either way
		0. no answer
		1. guided by nature of situation, individual contact better in some, group in others
		2. both are important, individual discussion gets at some problems, group at others
		3. more variety valuable
		4. enjoy both types
		5. either all right, but if working with groups prefer that they be small
		6. easier to work with individuals but public health nurse needs to work both ways
		Haven't thought about it enough to be sure
		0. no response
		1. not experienced enough to express preference
3		Contribution made by experience with non-nursing groups to group work in public health nursing
	39	Agricultural extension service
		0. no response
		1. high valuable

Card 3

Question	Column	Code
3 (Cont'd)	39 (Cont'd)	2. somewhat valuable (Add "3" to 1, 2, or 3 to show if officer - code as 4, 5, 6) 3. not valuable
	40	American Legion Auxiliary 0 - 3 as above
	41	Business and Professional Women's Club 0 - 3 as above
	42	Campfire Girls 0 - 3 as above
	43	Church circle 0 - 3 as above
	44	Community Chest 0 - 3 as above
	45	Eastern Star 0 - 3 as above
	46	Girl Scouts 0 - 3 as above
	47	League of Women Voters 0 - 3 as above
	48	Political party group 0 - 3 as above
	49	P.T.A. 0 - 3 as above
	50	Red Cross 0 - 3 as above
	51	Sunday School 0 - 3 as above

Card 3

Question	Column	Code
3 (Cont'd)	52	Study Club
		0 - 3 as above
	53	Woman's Club
		0 - 3 as above
	54	YWCA
		0 - 3 as above
	55	Zonta Club or other service clubs -- Altrusa, Pilot, etc.
		0 - 3 as above
	56	Other
	57	Activity in school groups (high school, nursing school or college)
19		Types of inservice education in which nurse has participated:
	58	Reading interesting references, etc.
		0. no answer
		1. this answer checked once
		2. this answer checked twice
	59	Tried to practice new methods, etc.
		0. no answer
		1. this answer checked once
		2. this answer checked twice
	60	Staff had expert assistance
		0.
		1.
		2.

Card 3

Question	Column	Code
19 (cont'd)	61	Representatives enrolled in course
		0.
		1.
		2.
	62	Staff attended workshops
		0.
		1.
		2.
	63	Utilized family study conferences
		0.
		1.
		2.
	64	Did not participate in inservice
		0.
		1.
		2.
	65	Other
		0.
		1.
		2.
24	66	University preparation in public health nursing
		0. no answer
		1. yes
		2. no
		If prepared, what is value of certain courses?

Card 3

Question	Column	Code
24a	67	No. 1 Selection
		0. no answer
		1. community organization
		2. group dynamics
		3. social psychology
		4. adult education
		5. required course in group work for public health nurses
		6. other (group dynamics included in nursing classes)
		7. other
	68	No. 2 Selection
		0 - 7 as above
	69	No. 3 Selection
		0 - 7 as above
	70	No. 4 Selection
		0 - 7 as above
	71	No. 5 Selection
		0 - 7 as above
	72	No. 6 (other)
		0 - 7 as above
	73	No. 7 (other)
		0 - 7 as above

Card 4

Question	Column	Code
20		Objective 1: To learn what experiences the nurses in the study group have found most helpful in preparing for the following roles: (1 - 2 - 3)
		(a) Being a participant in group discussions in agency or community
	36	1st Choice
		0. no answer
		1. university courses providing theory about group work methods
		2. university courses providing theory and practice in group work methods
		3. inservice education
		4. reading materials about discussion
		5. a speech class
	37	2nd Choice
		0 - 5 as above
	38	3rd Choice
		0 - 5 as above
20a		Other factors that contributed:
	39	1st Choice
		0. no answer
		1. a group leader who made you feel comfortable
		2. experience in making home visits
		3. the democratic attitude of group members
		4. identification with many groups

Card 4

Question	Column	Code
20a (Cont'd)	39 (Cont'd)	5. familiarity with subject matter and purpose of meeting
		6. other
	40	2nd Choice
		0 - 6 as above
	41	3rd Choice
		0 - 6 as above
21		Objective 1 (b) Experiences most helpful in serving as health resource person
	42	1st Choice
		0. no answer
		1. university courses providing theory about group work methods
		2. university courses providing theory and practice in group work methods
		3. inservice education
		4. reading materials about discussion
		5. a speech class
	43	2nd Choice
		0 - 5 as above
	44	3rd Choice
		0 - 5 as above
21a	45	Other factors that contributed
		0. no answer
		1. observation of another nurse
		2. familiarity with subject, etc.

Card 4

Question	Column	Code
21a (cont'd)	45 (cont'd)	3. experience in making home visits
		4. help from a supervisory nurse, etc.
		5. pride in agency
		6. other
	46	2nd Choice
		0 - 6 as above
	47	3rd Choice
		0 - 6 as above
22		Objective 1 (c) Preparation for being a discussion leader
	48	1st Choice
		0. no answer
		1. university courses providing theory about group work methods
		2. university courses providing theory and practice in group work methods
		3. inservice education
		4. reading materials about discussion
		5. a speech class
	49	2nd Choice
		0 - 5 as above
	50	3rd Choice
		0 - 5 as above
22a		Other factors that contributed
	51	1st Choice
		0. no answer

Card 4

Question	Column	Code
22a (cont'd)	51 (cont'd)	1. observation of others
		2. experience in making home visits
		3. familiarity with subject and purpose
		4. help from supervising nurse or consultant
		5. encouraging atmosphere in agency
		6. help from another staff nurse
		7. identification with many groups
		8. other
	52	2nd Choice
		0 - 8 as above
	53	3rd Choice
		0 - 8 as above
23		Objective 1 (d) Preparation for being a "teacher" for series of classes
	54	1st Choice
		0. no answer
		1. university courses providing theory about group work methods
		2. university courses providing theory and practice
		3. inservice education
		4. reading materials about discussion
		5. a speech class
	55	2nd Choice
		0 - 5 as above
	56	3rd Choice
		0 - 5 as above

Card 4

Question	Column	Code
23a		Other factors that contributed
	57	1st Choice
		0. no answer
		1. knowledge of subject involved
		2. observation of another nurse
		3. experience in making home visits
		4. an outline prepared by local, state, or national agency
		5. help from another staff nurse
		6. help from supervising nurse or consultant
		7. experience as group leader in staff or community groups
		8. other
	58	2nd Choice
		0 - 8 as above
	59	3rd Choice
		0 - 8 as above
24	60	University preparation in public health nursing
		0. no answer
		1. yes
		2. no
24a		If prepared, what is value of certain courses?
	61	No. 1 Selection
		0. no answer
		1. community organization
		2. group dynamics

Card 4

Question	Column	Code
24a (cont'd)	61 (cont'd)	3. social psychology
		4. adult education
		5. required course in group work for public health nurses
		6. other (Group dynamics included in nursing classes)
		7. other
	62	No. 2 Selection
		0 - 7 as above
	63	No. 3 Selection
		0 - 7 as above
	64	No. 4 Selection
		0 - 7 as above
	65	No. 5 Selection
		0 - 7 as above
	66	No. 6 (other)
		0 - 7 as above
	67	No. 7 (other)
		0 - 7 as above
26		Objective 2: to learn what factors these nurses consider to be most important in preparing public health nurses to any type of group work in public health nursing
		Which of the following are most important?
	68	No. 1 Choice
		0. no answer
		1. good supervision on the job

Card 4

Question	Column	Code
26 (cont'd)	68 (cont'd)	2. university courses on group work including opportunity for practice
		3. the kind of agency where people work together well
		4. membership and participation in wide number of groups
		5. inservice education on group work methods and skills
		6. other
	69	No. 2 Choice
		0 - 6 as above
	70	No. 3 Choice
		0 - 6 as above
	71	No. 4 Choice
		0 - 6 as above
	72	No. 5 Choice
		0 - 6 as above
	73	No. 6 (other)
		0 - 6 as above

IBM Tabulating Sheets CARD 1

62	49	36	26	13	1
63	50	37	27	14	2
64	51	38	28	15	3
65	52	39	29	16	4
66	53	40	30	17	5
67	54	41	31	18	6
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CARD 2

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CARD 3

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73	61	49	37
74	62	50	38
75	63	51	39
76	64	52	40
	65	53	41
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CARD 4

72	60	48	36
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	71	59	47

APPENDIX D

A Ten-Year Review of Literature in Three Journals Classified According to the Group Learning and Community Learning Objectives of the Public Health Nursing Curriculum Guide.

Unit B. Group Learning[1]

	Articles from Public Health Nursing	Classification
1943	Birk, Allene, et al, "At Fourteen--Questions Galore", XXXV, (September, 1943), 517.	School group
	Blee, Margaret, "The Nurse's Part in Health Education", XXXV, (August, 1943), 465.	Group work in general
	Jung, Estelle H., "Rural Schools Stress Parent Participation", XXXV, (January, 1943), 52.	School group
1944	Kilpatrick, William H., "Applied Democracy in Intergroup Relationships", [illegible], (June, 1944), 265.	Group methods
	Sheddan, Louise and Sulo, Helen M., "Mothers' Classes for Service Men's Wives", XXXVI, (February, 1944), 97.	Mothers' class
	"Six Lesson Course in Red Cross Home Nursing", XXXVI, (July, 1944), 391.	Red Cross Home Nursing
1945	Putzerin, Pola, "Home Nursing Instruction", XXXVII, (September, 1945), 456.	Red Cross Home Nursing
	Gardner, Bernice C., "Staff Workshop Gets Results", XXXVII, (November, 1945), 573.	Inservice Education
	McCoy, Elizabeth C., "Group Instruction Comes Alive", XXXVII, (May, 1945) 261.	Red Cross Home Nursing
	McCullough, Ruth W., "Teaching High School Home Nursing", XXXVII, (September, 1945) 459.	Red Cross Home Nursing
	Walters, Robina, "A Report on the 'Six Lessons' Class", XXXVII, (September, 1945), 458.	Red Cross Home Nursing

[1] Curriculum Guide, op. cit., p. 163.

1946	Abramson, Judith and Freedman, Donald, "Health Education in a Housing Project", XXXVIII, (April, 1946), 178.	"Other" class
	McNeil, Ella, "Lets Have a Workshop", XXXVIII (March, 1946), 116.	Discussion methods
1947	Hampton, Patricia, "Participation of the Nurse in Health Education", XXXIX, (September, 1947), 447.	School group
1948	Strang, Ruth, "Motivations in Health Education", XL, (January, 1948), 11.	School group
1949	Ford, Malcolm J., "Diabetic Patient Education", XLI, (October, 1949), 527.	"Other" class
	Thompson, L. J., Barbarer, Marion, Woestendick, Josephine, "Mothers Classes for Physical and Emotional Growth", XLI, (August 1949), 427.	Mothers' class
	Wilhelm, Margaret A., "Teaching the Baby Sitter", XLI, (November, 1949), 601.	"Other" class
	Wilson, Dorothy, "Staff Education: Principles and Purposes", XLI, (March, 1949), 126.	Inservice Education
1950	Coffey, Hubert, "Role Playing in Exploring Relationships", XLII, (May, 1950, 267.	Discussion Methods
	Herrold, Kenneth F., "Conference Planning and Action Through Use of the Group Process", XLII, (April, 1950), 199.	Discussion Methods
	Hiller, Geraldine and Gring, Anna, "Why Are We Waiting", XLII, (April, 1950), 184.	Inservice education
	Rue, Clara B., "Public Health Nursing Studies and Inservice Education", XLII, (September, 1950), 510.	Inservice education
1951	Brown, Bettie and Cahill, Imogene, "Preparation of Students for Teaching Mothers' Classes", XLIII, (November, 1951), 606.	Mothers' class
	Cole, Miriam L., "Classes that Mothers Like", XLIII, (August, 1951), 442.	Mothers' class
	Fulcher, Elizabeth, "We Held a Tuberculosis Work Conference", XLIII, (April, 1951), 222.	Inservice education
	Hollister, W. G. and Husbands, C. ..., "Sociodrama: A Way of Teaching Mental Health Skills", XLIII, (September, 1951), 490.	Discussion methods

1951	Jump, Dorothy, "Mothers' Classes and Preparation for Labor", XLIII, (March, 1951), 153.	Mothers' class
	Peck, Elizabeth, "Mothers' Classes Answer a Community Need", XLIII, (November, 1951), 616.	Mothers' class
	Peterson, Olivia, "Non-nurse Instructors Teach Home Nursing", XLIII, (April, 1951), 224.	Red Cross Home Nursing
	Thompson, L. J. and Lowe, Marie, "Mental Health and Mothers' Classes", XLIII, (March, 1951), 151.	Mothers' class
1952	Chisholm, Rita, "Parents' Classes--A Fertile Field for Mental Health Concepts", XLIV, (May, 1952), 273.	Mothers' class
	Genne, William, "Training for Childbirth", XLIV, (July, 1952), 392.	Mothers' class
	Guntert, Muriel and Henry, Elizabeth, "The Diabetic Goes to School", XLIV, (June, 1952), 335.	"Other" class
	Hassels, Anna, "A Work Conference That Clicked", XLIV, (November, 1952), 631.	Inservice
	Hawley, Eleanor, "Preparation for Family Living", XLIV, (February, 1952), 76.	School group
	"How One School Health Council Succeeded", XLIV, (May, 1952), 268.	School group
	Kitchen, Mrs. Max, "An Approach to Congenital Syphilis Through the Case Study Method", XLIV, (April, 1952), 201.	Inservice education
	Magnuson, Ann, "The Teaching Procedures Used in Red Cross Home Nursing", XLIV, (January, 1952), 21.	Red Cross Home Nursing
	Mandell, Sibyl, "Role Taking and Discussion in an Inservice Education Program in Mental Hygiene", XLIV, (April, 1952), 203.	Discussion methods
	Rives, Ruth, "Inservice Education", XLIV, (July, 1952), 394.	Inservice education
	Rives, Ruth, "Inservice Education", XLIV, (October, 1952), 553.	Inservice education
	Scholl, L. Evelyn, "Recording Talks for Group Work", XLIV, (January, 1952), 9.	Discussion methods

	Shetland, Margaret, "Work Conferences Promote Growth", XLIV, (September, 1952), 484.	Discussion methods
	Walsh, Jane, "Twelfth Grade Girls Study Problems of Marriage and Family Living", XLIV, (April, 1952), 181.	School group

Articles from American Journal of Nursing		Classification
1944	Butzerin, Eula and McCoy, Elizabeth, "Six-Lesson Course in Red Cross Home Nursing", XLIV, (July, 1944), 671.	Red Cross Home Nursing
	Schermann, Lena, "Home Care of the Sick", XLIV, (March, 1944), 203.	Red Cross Home Nursing
	Viglione, Amy, "Parents Classes--Experience in Health Teaching", XLIV, (September, 1944), 874.	Parents' class
1947	Hamilton, Pearl, "Patients' Families are Important", XLVII, (December, 1947), 793.	Inservice education
	Morris, Ernestine, "I Learn to Teach Home Nursing", XLVII, (February, 1947), 69.	Red Cross Home Nursing
	Wenrich, Marian and Justus, Katherine, "The Family Care Study", XLVII, (March, 1947), 179.	Inservice education
1949	Dickerman, Watson, "Madam Chairman, This is for You", XLIX, (September, 1949), 557.	Discussion methods
	Freeman, Ruth, "Extending Instruction in Home Nursing", XLIX, (March, 1949), 171.	Red Cross Home Nursing
	Goodman, Lois, "Preparing Public Health Nurses to Teach Home Nursing", XLIX, (August, 1949), 498.	Red Cross Home Nursing
	"Group Dynamics for Nurses", Ed., XLIX, (September, 1949), 543.	Discussion methods
	Hilbert, Margaret, "Home Nursing in the High School", XLIX, (November, 1949), 698.	Red Cross Home Nursing
1950	Holstein, Clara Belle, "The Group Process in Faculty Meetings", L, (July, 1950), 430.	Discussion methods
	Muse, Maude B., "Group Dynamics in Education", L, (April, 1950), 238.	Discussion methods
1951	Carter, Launar, "Social Psychology and the Nursing Profession", LI, (August, 1951), 488.	Group work in general

1951	Croom, Louise, "Classes in Human Relations", LI, (February, 1951), 85.	"Other" class
	Nelson, Ruth, "Never Too Old to Learn", LI, (September, 1951), 572.	Red Cross Home Nursing
	"The Group Process in Problem Solving", report prepared by Catherine Molinari and Louise Schlicting, (T.C. Workshop), LI, (April, 1951), 269.	Discussion methods
	White, Verna and Chages, Agnes, "A Workshop Experiment in Latin America", LI, (June, 1951), 374.	Discussion methods
	Zderad, Loretta, et al, "Dynamics in Group Discussion", (class project at Catholic University), LI, (December, 1951), 716.	Discussion methods
1952	"Checklist for Program Planners", from Adult Leadership "Progress Planning Tool Kit", May 1952; LII, (September, 1952), 1090.	Discussion methods
	Davidson, E. Rita, "Mothers' Classes", LII, (August, 1952), 983.	Mothers' classes
	Eckelberry, Grace, "Group Work Skills in Nursing Practice", LII, (December, 1952), 1512.	Discussion methods
	Ketcham, Katherine, "Role Playing", LII, (March, 1952), 334.	Discussion methods

Articles from American Journal of Public Health

1944	Chope, Harold, "The Case Method in Teaching Public Health Administration", XXXIV, (June, 1944), 605.	Discussion methods
1946	Faville, Katherine, "The Public Health Nurse in the Department of Health", XXXVI, (April, 1946), 377.	Group work in general
1950	Frost, David and Anderson, Genevieve, "A Health Department Stimulates Community Thinking for Mental Health", XL, (August, 1950), 978.	Inservice education
	Murphy, Marion, "Implications for Public Health Nursing in Changing Practices in Maternity Care", XL, (July, 1950), 798.	Mothers' class
1951	Janeway, Carol, "What and How Shall We Teach Expectant Parents", XLI, (November, 1951), Part II, 110.	Parents' class

1952	Burney, LeRoy, "Teaching Home Nursing in Indiana", XLII, (October, 1952), 1299.	Red Cross Home Nursing
	Freeman, Ruth, "The Nurse as Family Health Counselor", XLII, (November, 1952), 1379.	Group work in general
	Kutzer, Almira, "Nursing Aspects of Good Maternity Care", XLII, (May, 1952), 521.	Inservice education

Unit C. Community Learning[1]

Articles from Public Health Nursing		Classification
1943	Clark, Dean A., "Broadening the Base of Community Participation in Public Health", XXXV, (November, 1943), 606.	Community planning
	Gebhard, Bruno, "Teaching Nutrition with Pictures", XXV, (February, 1943), 93.	Exhibits
	McKinney, Marion, "Exhibits for Health Education", XXXV, (November, 1943), 637.	Exhibits
1944	O'Connor, Lillian M., "Speech and the Nursing Profession", XXXVI, (December, 1944), 624.	Talks
	Smith, Charlotte P., "Community Action Against Venereal Disease", XXXVI, (July, 1944), 368.	Community planning
	. . ."The Visiting Nurse Is on The Air", XXXVI, (March, 1944), 144.	Radio
1945	Gebhard, Bruno, "Visual Communication in Health Education", XXXVII, (October, 1945), 506.	Exhibits
	Kleinschmidt, H. E., "How to Use [illegible]", XXXVII, (August, 1945), 392.	Films
	McCarthy, Irene E., "Picture Language", [illegible], (December, 1945), 612.	[illegible] visual
	O'Connor, Lillian M., "Unaccustomed [illegible]", XXXVII, (August, 1945), 409.	[illegible]
	Reid, Margaret, "Something New in Visual Education", XXXVII, (September, 1945), 461.	Films
	Voge, Nathalie, "Tale of [illegible]", (August, 1945), 398.	Publicity
	Wensley, Edith, "Biography [illegible]", (May, 1945), 226.	[illegible]

[1] Curriculum Guide, op. cit., p. 164.

1946	Anderson, Elin L., "Community Nursing-- The Challenge of Nursing Education", XXXVIII, (December, 1946), 637.	Community organization
	Allen, Dorothy M., "A Day with a Rural Public Health Nurse", XXXVIII, (September, 1946), 483.	Publicity
	Cook, Beatrice, "Publicity Pays - And How", XXXVIII, (May, 1946), 243.	Publicity
	Lifson, S. S., and Wilson, Alberta, "Health Education in the Health Department", XXXVIII, (August, 1946), 421.	Role of Health educator
	Rath, Elizabeth H., "We Put on an Exhibit", XXXVIII, (July, 1946), 339.	Exhibits
	Wensley, Edith, "Public Health Nursing's First 'Week'", XXXVIII, (September, 1946), 445.	Exhibits
1948	Ferree, John W., "Health Councils and Their Potentialities", XL, (September, 1948), 461.	Community organization
	Horkavi, Helen, "Dramatics in Health Education", XL, (December, 1948), 597.	Other audio-visual
	Mayo, Leonard, "Organizing the Community for Nursing Service", XL, (October, 1948), 493.	Community organization
	Weniger, Charles E., "Speech - A Nurse's Qualifications", XL, (March, 1948), 136.	Talks
1949	Moore, Winifred L., "Adventuring with Visual Education", XLI, (March, 1949), 134.	Other audio-visual
	Randle, Bosse B., "Initiating New Community Health Programs", XLI, (December, 1949), 664.	Community organization
1950	Blackwell, Gordon W., "The Social Scientist Looks at the Health Council Movement", XLII, (June, 1950), 316.	Community organization
	Coy, Harold, "Nursing is News", XLII, (November, 1950), 602.	Publicity
	Koos, Earl L., "Community Organization for Health", XLII, (April, 1950), 196.	Community organization
	Martin, Mary, "Everybody Quiet, Please", XLII, (March, 1950), 139.	Television
	"We Nail the NO PHN to the Wall", XLII, (March, 1950), 143.	Exhibits

1951	Cervinski, Bernadine, "The Plus Value in Annual Reports", XLIII, (August, 1951), 449.	Publicity
	Hamm, Elsie, "The Community Health Survey", XLIII, (February, 1951), 94.	Community planning
	Mayo, Leonard, "Common Ground for Common Objectives in Public Health", XLII, (January, 1951), 5.	Community planning
	Wilson, Marie, "Puppet Nurse", XLIII, (September, 1951), 481.	Other visual aids
1952	Geiger, James, "Tips on Using Educational Films", XLIV, (August, 1952), 435.	Films
	Moore, Winifred, "The Second Black Bag", XLIV, (June, 1952), 315.	Other visual aids
	Peskin, Samuel, "A Challenge to Health Councils", XLIV, (January, 1952), 29.	Community organization

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1945	Winslow, C.E.A., "Postwar Trends in Public Health and Nursing", XLV, (December, 1945), 989.	Community planning
1946	"A Family Life Program", XLVI, (January, 1946), 6.	Community planning
	Bernays, Edward, "Nursing and Community Groups", XLVI, (May, 1946), 297.	Community planning
	Petry, Lucile, "Community Nursing--the Challenge to Nursing Education", XLVI, (November, 1946), 757.	Community organization
1949	"Do Public Health Nurses Take More Interest in Political Activities than Institutional Nurses", XLIX, (March, 1949), 133.	Nursing participation
	Gebhard, Bruno, "The Industrial Nurse in Health Education", XLIX, (June, 1949), 365.	Exhibits
1950	Reed, Elizabeth, "Exhibits for Meetings", L, (August, 1950), 468.	Exhibits
1951	Harris, Elizabeth, "A Study of Nurses' Participation in Community Activities", LI, (August, 1951), 518.	Nursing participation

1952	Miale, Julie, "How to Make That Speech", LII, (December, 1952), 1497.	Talks

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1943	Brown, Earle, "Health Education in a Medium Urban Community", XXXIII, (August, 1943), 985.	Community planning
	Gately, G. L., "Organizing a Large Community for Health Education", XXXIII, (June, 1943), 691.	Community organization
	Gonzales-Rivera, Manuel, "Ways to Community Health Education", XXXIII, (February, 1943), 146.	Community planning
	Murray, Margaret and Turner, C. E., "Radio Listening Habits of Mothers Who Attend Well Baby Clinics", XXXIII, (August, 1943), 952.	Radio
	Oppenheim, A., "Health Education in Action", XXXIII, (November, 1943), 1339.	Community organization
1944	Massey, Arthur, "Popular Health Education", XXXIV, (November, 1944), 1179.	Films, radio, etc.
	McClusky, Howard, "Block Organization for Health Education", XXXIV, (June, 1944), 648.	Community organization
1945	Kleinschmidt, H. E., "Health Education Methods of the Red Cross", XXXV, (November, 1945), 1181.	Community organization
	Nichtenhauser, Adolf, "A Program on Health Films", XXXV, (April, 1945), 343.	Films
	Zimand, Savel, "Tips and Tricks for the Practice", XXXV, (June, 1945), 631.	Films, radio, etc.
1946	Frank, Lawrence, "Health Education", XXXVI, (April, 1946), 357.	Community planning
	"Three Health Education Projects--A Critical Analysis", XXXVI, (July, 1946), 782.	Community planning
1947	Marquette, Bleecker, "Health Councils in Local Communities", XXXVII, (August, 1947), 959.	Community organization
	Calver, Homer, and Wingo, Otis, "Public Opinion Measurement as an Instrument in Public Health Practice", XXXVII, (April, 1947), 426.	Community planning

	"What is Health Education" - A Symposium, XXXVII, (June, 1947), 641.	Process of health education
1948	James, George, "Community Resources for Health Education-How Well Are They Being Utilized in School Program", XXXVIII, (September, 1948), 1258.	Community planning
1949	Ferree, John and Lifson, S.S., "Some Effects of Health Council Programs on Basic Health Education", XXXIX, (September, 1949), 1167.	Community organization
	Galston, Iago, "Motivation in Health Education", XXXIX, (October, 1949), 1276.	Community planning
	Getting, Vlado, "Public Relations in Public Health", XXXIX, (December, 1949), 1561.	Community planning
	Steinhaus, Arthur and Fant, Karl, "Sources of Supplementary Materials for Health Education", XXXIX, (November, 1949), 1407.	Other audio visual
1950	"Health Education and Public Relations" - a symposium, XL, (March, 1950), 251.	Process of health education
1952	"Health Education as a Two-Way Process", Ed. XLII, (January, 1952), 74.	Process of health education
	Leach, Charlotte and Rosen, George, "The Idea Review", XLII, (September, 1952), 1041.	Community planning
	Riley, Philip, "The Health Officer and Health Education", XLII, (June, 1952), 679.	Role of health educator
	Rosen, George, "Health Education and Preventive Medicine-'New' Horizons in Medical Care", XLII, (June, 1952), 687.	Community organization

APPENDIX E

Additional Tables Relating to Chapter VII.

Table 85. Additional On-the-Job Factors Which were Helpful in Preparing to Participate in Group Discussion: First and Second Choices of Outstate Sample According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Proportion Making This Choice		Proportion Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
Group leader who made group comfortable	14.4	16.5	18.3	18.3
Previous experience in making home visits	13.4	13.4	20.0	18.3
Democratic attitude of group members	7.2	18.6	1.7	8.3
Identification with many group and attendance at meetings	16.5	16.5	1.7	8.4
Familiarity with subject matter being discussed	42.3	29.9	35.0	18.4
Other	1.0			
No response	5.2	5.1	23.3	28.3
Totals	100.0	100.0	100.0	100.0

Table 86. Additional On-The-Job Factors Which were Helpful in Preparing to be a Health Resource Person at Community Meetings: First and Second Choices of Outstate Sample According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Proportion Making This Choice		Proportion Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
Observation of another nurse	7.2	8.3	11.7	10.0
Familiarity with subject matter being discussed	60.8	26.8	38.3	18.4
Experience in making home visits	11.4	21.6	8.3	20.0
Pride in agency and its place in community	10.3	13.4	5.0	8.3
Help from supervisor and/or consultant	5.2	23.7	10.0	15.0
Other	1.0			
No response	4.1	6.2	26.7	28.3
Totals	100.0	100.0	100.0	100.0

Table 87. Additional On-The-Job Factors Which were Helpful in Preparing to be a Discussion Leader: First and Second Choices of Outstate Sample According to Preparation

Alternative Responses	Prepared n = 97		Unprepared n = 60	
	Proportion Making This Choice		Proportion Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
Observations of others in similar situations	19.6	27.9	13.3	23.3
Experience in making home visits	4.1	10.3	6.7	5.0
Familiarity with subject matter being discussed	50.5	15.5	33.4	16.7
Help from supervisor and/or consultant	8.3	15.5	8.3	11.7
Encouraging atmosphere of agency situation	4.1	7.2		
Identification with many groups and attending meetings	3.1	12.3		5.0
Other	1.0			
No response	9.3	11.3	38.3	38.3
Totals	100.0	100.0	100.0	100.0

Table 88. Additional On-The-Job Factors Which were Helpful in Preparing to Teach a Class: First and Second Choices of Outstate Nurses According to Preparation

Alternative Responses	Prepared n = 97 Proportion Making This Choice		Unprepared n = 60 Proportion Making This Choice	
	1	2	1	2
	Percent	Percent	Percent	Percent
Knowledge of subject matter involved	53.6	12.4	28.3	10.0
Observation of another nurse	3.1	17.5	1.7	6.7
Experience in making home visits	1.0	8.3	1.7	1.7
Outline prepared by local, state, or national agency	10.3	16.5	5.0	13.3
Help from supervisor and/or consultant	2.1	11.3	1.7	3.3
Experience as group leader in staff or community meetings	5.2	7.2	1.6	3.3
Other		1.0		
No response	24.7	25.8	60.0	61.7
Totals	100.0	100.0	100.0	100.0

Table 89. Ideal Sequence for Group Work Experience Selected by Prepared Nurses in Outstate Sample

Types of Experience	Proportion Making This Choice n = 97					
	1	2	3	4	5	6
	Percent	Percent	Percent	Percent	Percent	Percent
Participating in group discussion in agency	73.2	5.2	6.2	3.1	5.2	2.1
Serving as discussion leader in agency	1.0	52.6	9.3	11.3	11.3	9.3
Participating in group discussion in community	5.2	22.7	26.8	26.8	8.3	6.2
Serving as health resource person in community	14.4	11.3	27.8	19.6	15.5	8.2
Serving as discussion leader in community	2.1	3.1	11.3	18.6	25.8	34.0
Teaching a community class	3.1	3.1	16.5	14.4	25.7	30.9
No response	1.0	2.0	2.1	6.2	8.2	9.3
Totals	100.0	100.0	100.0	100.0	100.0	100.0

Table 90. Ideal Sequence for Group Work Experience Selected by Unprepared Nurses in Outstate Sample

Types of Experience	Proportion Making This Choice n = 60					
	1	2	3	4	5	6
	Percent	Percent	Percent	Percent	Percent	Percent
Participating in group discussion in agency	60.0	1.7	10.0	8.3	1.7	-
Serving as discussion leader in agency	1.6	35.0	3.3	15.0	11.7	13.3
Participating in group discussion in community	6.7	21.7	30.0	10.0	13.4	1.7
Serving as health resource person in community	15.0	18.3	21.7	15.0	8.3	3.3
Serving as discussion leader in community	1.7	6.7	8.3	16.7	28.3	15.0
Teaching a community class	1.7		6.7	11.7	13.3	43.4
No response	13.3	16.6	20.0	23.3	23.3	23.3
Totals	100.0	100.0	100.0	100.0	100.0	100.0

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