indicated that the decision to lose weight was a personal one that was perceived as being uninfluenced by family members or peers.

Weight control problems were perceived as being caused by voluntarily controlled factors such as overeating rather than by such involuntarily controlled factors as heredity. Most respondents believed they were responsible for their perceived weight problems.

Twenty percent of respondents reported having been given advice by family or friends to stop weight control efforts. A majority of these respondents, primarily in the overweight and underweight groups, reported that they did not follow the advice. A large majority of respondents expressed a lack of concern for ever becoming too thin.

It was recommended that adolescent females be educated regarding the hazards of weight control activities during the pubertal growth spurt. In addition, it was recommended that teenage girls be advised of reasonable weight ideals as indicated in the National Center for Health Statistics data. Finally, recommendations for future research were made including a replication of this study with a larger size in which socioeconomic, racial, and ethnic variables could be controlled and examination of side effects in weight-conscious males and in women in other age categories.

PROBLEM-SOLVING BEHAVIORS OF COMMUNITY HEALTH NURSES

Meryn E. Vellinga, R.N., M.Sc. (Appl) Lecturer, School of Nursing, University of Ottawa, Ontario, Canada

The purpose of the exploratory descriptive study was to describe and classify the problem-solving approaches of community health nurses working with clients in an innovative community nursing setting. The study depicts how these approaches varied by type of problem, by nurse, and by point in time of interaction.

The study was completed at McGill University School of Nursing, Montreal, Quebec in 1979. Inquiries may be sent to Meryn E. Vellinga, School of Nursing, University of Ottawa, 770 King Edward, Ottawa, Ontario, Canada.

Theoretical basis

The task of the nurses employed in this setting was to provide a nursing service for healthy living, providing the structure for families to learn to be healthy. An interpersonal problem-solving model, based on Margerison's management framework, provided the theoretical basis for the study. Margerison theorized that behavior can be broken down into mutually exclusive and exhaustive categories of behaviors: problem-centered, with consultative and reflective behavioral orientations, and solution-centered, with directive, prescriptive, and negotiative behavioral orientations. The researcher and three nurse coders created a classification instrument that was adapted to nursing by moving between our own nursing experience, the data, and Margerison's definitions. Thus his two problem-centered behavioral orientations became three—reflective, information-giving and consultative, and questioning—and his three solution-centered behavioral orientations became two—prescriptive and negotiative.

Methodology

The data consisted of 39 transcribed nurse-client interviews collected using participant observation as part of the research activities of the health center. Nineteen of the interviews were first contacts and twenty were subsequent contacts, ranging from the second contact to the twenty-second. The study used a content analysis of the nurse-client interviews. Each sentence spoken by the nurse in every third line of transcribed communication was coded into either problem-centered or solution-centered categories using the client responses as contextual clues. Frequencies in each category were calculated and summarized according to the three variables. To describe the pattern of sequences and clusters of problem-solving behaviors, the interviews were divided into three groups: high, medium, and low interaction by number of units of interaction analyzed per interview. Interviews were then randomly sampled from each group.

Results

Findings of the study included the following:

1. Problem-centered behaviors (71.4%) were considerably more prevalent than solution-centered behaviors (27.8%). However, nurses used more "nurse-directed" behaviors (information-giving and consultative and prescriptive) than "client-centered" behaviors such as reflective questioning and negotiative. This finding calls into question the use of the management categories.

2. Nurses used approximately the same amount of problem-centered behaviors in first as in subsequent contacts with the client and family.

3. The eight nurses varied considerably in their use of problem-solving approaches.

4. Strategies of problem-solving behavior are least varied and most nurse-directed (predominantly information-giving and consultative and prescriptive) in the mother-child and weight control type of problem.

5. Clustering (consecutive repeated use of behaviors) appears frequently for all behaviors except negotiative. Clusters of information-giving and consultative behavior predominate.

6. All of the problem-centered behaviors interrelate with respect to preceding and following each other.

7. Information-giving and consultative, a problem-centered behavior, and prescriptive, a solution-centered behavior, precede and follow each other frequently. To a lesser extent, problem-centered questioning and solution-centered prescriptive also interrelate.

AN APPLICATION OF THE KERR-SOLTIS MODEL TO THE CONCEPT OF CARING IN NURSING EDUCATION

Delores Ann Gaut, R.N., Ph.D., Assistant Professor, Department of Maternal-Child Nursing, University of Washington, Seattle, Washington

The study attempted to show that nonempirical questions and problems require consideration if nursing as an enterprise is to be understood and improved. Caring is an example of such a