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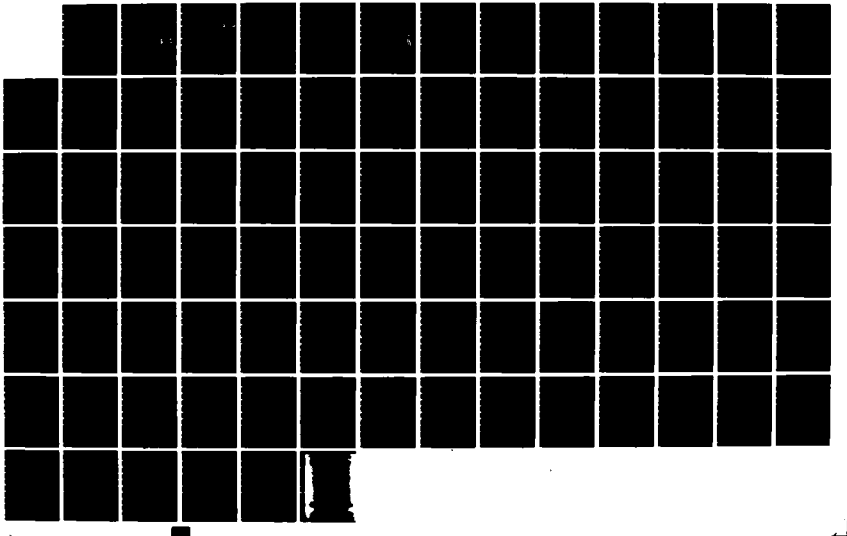

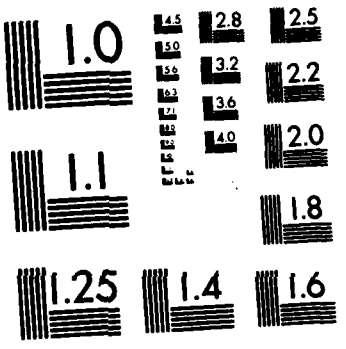

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Thesis Abstract

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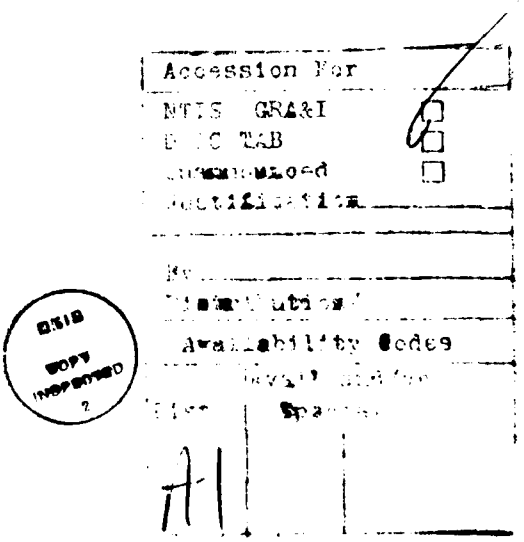
Results of the study revealed that nurses identified an average 34.4% of the breast cancer risk factors, while 76.7% of the nurses identified the correct technique for performing BSE. Assessment of breast cancer risk factors and BSE instructional needs with followup teaching was never completed by 54.4% of the sample, while 33.4-39.4% reported they seldom perform these behaviors. BSE instruction was not provided the spouse or significant other by 90.9% of the nurses in the sample. The most frequent reasons reported for performance of client assessment and teaching were: client request, 30.3% and the nurses' feeling that clients should take responsibility for their own health, 18.2%.

Leading reasons for non-performance of client assessment and teaching were: lack of time, 42.4%, and failure to consider the possibility, 57.6%. These were also the most frequently reported reasons for not including the spouse or significant other in BSE knowledge assessment and teaching.

A conclusion which can be made as a result of the findings from this study is that BSE knowledge assessment and teaching is not a high priority for nurses in this sample when providing nursing care.



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NURSES' ASSESSMENT AND TEACHING BEHAVIORS REGARDING BREAST SELF-EXAMINATION WITH REASONS FOR ACTIONS

by

PATRICIA E. HARRIS

Presented to the Faculty of the Graduate School of
The University of Texas at Arlington in Partial Fulfillment
of the Requirements
for the Degree of

MASTER OF SCIENCE IN NURSING

THE UNIVERSITY OF TEXAS AT ARLINGTON
May 1984

NURSES' ASSESSMENT AND TEACHING BEHAVIORS REGARDING BREAST SELF-EXAMINATION WITH REASONS FOR ACTIONS

APPROVED:

Mary Ellen Hyers
(Supervising Professor)

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Susan K. Jones

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I would like to express my appreciation to the many special people who provided assistance and support while I was conducting this study. My family was always there to provide love and express confidence in me. Dottie, Jean, Dennis and Joy supplied the encouragement, motivation and light-hearted moments so necessary during a major educational endeavor. Good luck to them in their future careers. My committee members, Mary Ellen Wyers, Ed.D., Elois Field, Ph.D., and Susan Grove, Ph.D., provided the expert professional guidance so vital to successful completion of this research project. I would also like to express my appreciation to the U.S. Air Force for providing the opportunity for me to achieve a personal and professional goal, a graduate degree in nursing.

April 9, 1984

ABSTRACT

NURSES' ASSESSMENT AND TEACHING BEHAVIORS REGARDING BREAST SELF-EXAMINATION WITH REASONS FOR ACTIONS

Patricia E. Harris, M.S.N.

The University of Texas at Arlington, 1984

Supervising Professor: Mary Ellen Wyers

This descriptive study explored registered nurses' knowledge about breast self-examination (BSE) and breast cancer risk factors, frequency of determining clients' risk factors and knowledge and followup instruction with reasons for actions. The convenience sample consisted of 33 registered nurses caring for adult female clients in two secondary healthcare settings. Each nurse completed a questionnaire designed to gather data answering the research questions. The research questions were:

1. Do registered nurses in secondary healthcare settings know the risk factors for cancer of the breast as identified by the American Cancer Society?

2. Do registered nurses in secondary healthcare settings know the correct technique for performing BSE as delineated by the American Cancer Society?
3. How frequently do registered nurses in secondary healthcare settings assess the breast cancer risk factors and BSE instructional needs of their female clients?
4. How frequently do registered nurses in secondary healthcare settings teach BSE to their adult female clients and significant others?
5. What reasons do registered nurses in secondary healthcare settings report for or for not assessing client risk factors and knowledge of BSE and then providing needed BSE instruction to clients and significant others?

Results of the study revealed that nurses identified an average 34.4% of the breast cancer risk factors, while 76.7% of the nurses identified the correct technique for performing BSE. Assessment of breast cancer risk factors and BSE instructional needs with followup teaching was never completed by 54.4% of the sample, while 33.4-39.4% reported they seldom perform these behaviors. BSE instruction was not provided the spouse or significant other by 90.9% of

the nurses in the sample. The most frequent reasons reported for performance of client assessment and teaching were: client request, 30.3%, and the nurses' feeling that clients should take responsibility for their own health, 18.2%.

Leading reasons for non-performance of client assessment and teaching were: lack of time, 42.4%, and failure to consider the possibility, 57.6%. These were also the most frequently reported reasons for not including the spouse or significant other in BSE knowledge assessment and teaching. A conclusion which can be made as a result of the findings from this study is that BSE knowledge assessment and teaching is not a high priority for nurses in this sample when providing nursing care.

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CHAPTER I

INTRODUCTION

Introduction

Cancer of the breast is the most prevalent form of cancer affecting women in the United States (Bennet, Lawrence, Fleischmann, Gifford & Slack, 1983). It is estimated that it will affect one out of every eleven women. Despite these odds the prognosis for breast cancer, if found early before lymph node metastasis, is good.

Breast self-examination (BSE) has been shown to be an effective means for the adult female population to detect breast abnormalities in early stages. Greenwald (1978) estimated that cancer mortality may be reduced about 20% using monthly BSE and routine physical examination. Although BSE has been shown to be an effective mass screening technique, several studies have shown that less than one-fourth of the female population practice monthly BSE (Gallup Poll, 1974; ACS, 1980). Many reasons have been given for failure to utilize this fast, effective, cost-free measure for prevention of illness. One of the major reasons cited for not performing BSE is lack of knowledge about the

proper technique. This can lead to a lack of confidence regarding one's ability to detect an abnormality, thus contributing to non-practice.

Since teaching is one of the primary roles of professional nurses and they are in frequent, daily contact with clients, nurses are in an excellent position to instruct these individuals on BSE, but do nurses take advantage of this opportunity? In a 1977 study by Stillman, it was found that only four women out of 142 had learned BSE from a nurse. This seems to indicate many missed opportunities for teaching by nurses in hospitals, community health settings and physician's offices. Before this problem can be overcome, the reasons nurses report for or for not assessing their clients' breast cancer risk factors and knowledge of BSE have to be identified. Identification of these reasons will assist nursing administrators and educators in supporting those that promote the desired behaviors and researching interventions which would remove the barriers nurses perceive as reasons for not performing these activities.

The purpose of this descriptive study was to explore selected registered nurses' knowledge about BSE and breast cancer risk factors, frequency of determining client's risk factors and knowledge, and followup instruction with reasons for actions.

Statement of the Problem

Do registered nurses in secondary healthcare settings teach BSE to clients and significant others and what are their reasons for doing or not doing so?

Background and Significance

Historically, cancer of the breast has been the most commonly occurring cancer in women, however statistics indicate that when it is found and treated early, the five-year survival rate is 87% compared to 47% when metastasis is present (American Cancer Society, 1982).

Breast self-examination (BSE) is one of the most effective mass screening techniques for early detection of breast cancer. BSE was developed and first promoted in the late 1940's at which time it was adopted and continues to be used by the American Cancer Society (ACS). Despite the relative ease with which this technique can be learned and used, many studies have shown that only about one-fourth to one-third of adult women practice BSE on a regular basis (Turnbull, 1978; Huguley & Brown, 1981). Reported reasons for this lack of practice include but are not limited to; ignorance of the technique and its benefits, forgetfulness, fear, embarrassment and lack of confidence in one's ability to perform BSE effectively (Keller, George, & Podell, 1980).

Lack of confidence in one's ability to perform BSE is usually associated with inadequate knowledge of the proper technique (Huguley & Brown, 1980).

One of the primary roles which professional nurses claim is that of educator, but research indicates other healthcare professionals and the general public do not see nurses as primary sources of healthcare information (Rose, 1978; Petravage, Reynolds, Gardner, & Reading, 1979). This perception is emphasized by nurses' lack of enthusiasm for this increasingly important aspect of healthcare. Syred (1981) asserts that many nurses abdicate this role by finding excuses not to interact with clients and/or to avoid contact with them altogether. This is extremely unfortunate as nurses are in a unique position to provide one-on-one and group instruction but there is some controversy regarding nurses' preparation and ability to assume this role. Grosser (1981) asserts that professional nurses have many of the qualities needed to be good instructors but another health educator indicates that nurses are ill-prepared and ill-equipped to fulfill this role (Graham & Glier, 1980).

Health education which leads the client to greater self-responsibility regarding health is the direction healthcare is taking (Flynn, 1980). Nurses are in a

position to be leaders in health promotion if they take the initiative to provide BSE instruction during the many opportunities that present themselves daily.

To reverse role abdication by nurses and thus increase public awareness of nurses as healthcare educators, two questions must be answered, "What motivates nurses who do routine healthcare teaching for clients?" and "What do nurses perceive as barriers to providing this information?" Armed with answers to these questions, nursing administrators and educators could support the motivators of health teaching by nurses and work to overcome the problems which nurses perceive as barriers to providing essential healthcare information to clients.

This study utilized nurses in staff positions to determine nurses' knowledge of BSE, frequency of client teaching and reasons for the actions taken.

Conceptual Framework

This study was based on the concept of holistic health which includes the individual and everything in his environment. Health is defined as a dynamic state in which the individual strives for an optimal level of functioning. The emphasis in holistic health is on the promotion of health and prevention of illness as well as care and treatment during illness. High-level wellness, a focus on the

individual rather than the disease and responsibility for one's own health and that of others, when appropriate, are major characteristics of holistic healthcare. It is the responsibility of the healthcare professional to help clients help themselves by education about the choices available. The nurse as a professional healthcare educator, must take the initiative in aiding clients to identify their needs, as society has not prepared the consumer for this role.

Clients also have the right to expect healthcare practitioners to practice what they preach and maintain themselves as examples of health and wellness. Nurses who practice health promotion behaviors will be more effective healthcare educators as their beliefs are reflected in their actions (Flynn, 1980).

Nurses must make a more diligent effort to integrate the elements of holistic healthcare, specifically health promotion, into their practices. To accomplish this, nurses must avail themselves of every opportunity to increase their knowledge base regarding behaviors that promote and maintain health as well as prevent illness. This knowledge must then be combined with effective educational methods to provide instruction in health maintenance behaviors such as BSE.

Until a thorough assessment of the client and family is completed, it is impossible to ascertain who requires education and the specific content they need. Making a conscious effort to see and care for the whole person rather than just their admitting diagnoses will lead nurses to a more complete health assessment and accurate identification of client needs. Subsequent healthcare education may be unrelated to the admitting diagnoses but very related to the client's needs.

Family and friends are seen as extremely vital to the whole person, providing guidance and advice in interactions within the environment. They also provide support for the individual in all phases of health from illness to rehabilitation to promotion of specific health behaviors.

Adoption of holism as a philosophy of healthcare will aid nurses in discontinuing abdication of their role as assistants to the client through the provision of healthcare education and will help the client to stop abdicating primary responsibility for his own health. Utilization of this healthcare framework will also serve as a constant reminder of the responsibility nurses have to themselves and their clients, which involves caring for the "whole" person. If nurses focus on the individual rather than the disease, opportunities for education in healthcare

maintenance and promotion will not be overlooked or relegated to a place of lower priority.

Statement of Purpose

The purpose of this descriptive study was to explore selected registered nurses' knowledge about BSE and breast cancer risk factors, frequency of determining clients' risk factors and knowledge, and followup instruction with reasons for actions.

Statement of Research Questions

Five research questions were formulated for this research study. The research questions were:

1. Do registered nurses in secondary healthcare settings know the risk factors for cancer of the breast as identified by the American Cancer Society?
2. Do registered nurses in secondary healthcare settings know the correct technique for performing BSE as delineated by the American Cancer Society?
3. How frequently do registered nurses in secondary healthcare settings assess the breast cancer risk factors and BSE instructional needs of their female clients?

4. How frequently do registered nurses in secondary healthcare settings teach BSE to their adult female clients and significant others?
5. What reasons do registered nurses in secondary healthcare settings report for or for not assessing client risk factors and knowledge of BSE and then providing needed BSE instruction to clients and significant others?

Assumptions

The following assumptions were made in this study.

1. That all the registered nurses participating in this study have had previous instruction on BSE and breast cancer risk factors.
2. That all registered nurses recognize the effectiveness of BSE in early diagnosis of cancer of the breast.
3. That self-report of RN's is congruent with reality of actions.

Definition of Terms

For the purposes of this study the following definitions will be used.

1. Registered nurse -- any nurse licensed to practice professional nursing in the state of Texas and employed in a secondary healthcare setting.

2. Breast self-examination -- the self-examination of both breasts (or one if one has been removed) in a systematic manner for the purpose of detecting an abnormality (Stillman, 1977).
3. Secondary care setting -- an environment in which the primary concern is early diagnosis and prompt treatment of illness and disability limitations through prevention of illness sequelae (Brill & Kilts, 1980, p. 52).
4. Risk factors -- those pre-existing elements, conditions or characteristics which, according to the ACS, have been shown to be related to an increased possibility of developing breast cancer.

Limitations of the Study

The limitations of this study are as follows:

1. Since this was a self-report study, the reported frequency of assessment of breast cancer risk factors, knowledge of BSE and need for teaching and actual teaching could have been artificially inflated related to the Hawthorne effect.
2. This is a descriptive study using a convenience sample which limits the generalizability of the results.

3. Reliability and content validity for the instrument have not been established.

Summary

In summary, the purpose of this descriptive study was to explore selected registered nurses' knowledge about BSE and breast cancer risk factors, frequency of determining clients' risk factors and knowledge, and followup instruction with reasons for actions. The need for nursing research concerning this problem was documented. Flynn's model of holistic nursing provided the conceptual framework for this study. The research questions for this study focused on nurses' knowledge of BSE, client assessment practices and reasons reported for or for not teaching BSE to their clients.

CHAPTER II

REVIEW OF LITERATURE

Introduction

This review of the literature will include a brief history of BSE, statistics on how many women practice it regularly, reports on the effectiveness of BSE and how women learn about BSE, risk factors for breast cancer, the role of nursing in healthcare education and reasons why nurses do or don't do health teaching.

Historical Background

Until the very recent past the emphasis in medicine and nursing has primarily been on treatment of disease. The mindset of the lay public has been to seek assistance from healthcare professionals only when something is perceived to be wrong. Passive prevention was the next phase, wherein the individual received immunizations or antibiotics to preclude infections to which the physicians felt the client may be susceptible. The advent of the science of epidemiology provided a large part of the foundation for the healthcare education which is just starting to be accomplished with vigor and enthusiasm.

Populations and individuals at risk for particular problems can now be identified and measures can be taken to not only prevent morbidity and mortality but to promote health.

One of the simplest, most cost-effective health promotion behaviors which can be taught is BSE. BSE has been practiced for over thirty years but little is known of its origin or development. National distribution of a film on BSE was promoted by Dr. A. M. Popma in 1947. Two years later the National Cancer Institute and the American Cancer Society collaborated in making a teaching film (Eggertsen & Bergman, 1983). The American Cancer Society has since added only one step, palpation of each breast while showering. Even in the early fifties some members of the American Cancer Society felt it was probably of more use to teach BSE to women rather than physicians because most women find breast tumors themselves (Eggertsen & Bergman, 1983). In 1952, Dr. C. D. Haagensen urged physicians to start teaching BSE to their clients as a means of detecting breast abnormalities at an earlier stage of development. When physicians expressed skepticism at teaching women this technique, they were reminded that it would be impossible for them to examine women often enough to detect tumors at the earliest time they were palpable (Haagensen, 1952). The usefulness of the film on BSE for public

health education by nurses was emphasized by Peterson and Saller and Knapp (1951). They also provided an outline of the information nurses should use to supplement the content contained in the film. Most of this information would continue to be appropriate for use while doing healthcare education in the 1980's. Letton (1952) extols the benefits of monthly BSE through emphasis on the high five-year survival rate for treatment of tumors found when very small. A quote from The Cancer Bulletin (1951, p. 16) reiterates the extreme importance of teaching BSE to all adult women and is appropriate for inclusion in this literature review.

> Throughout the history of warfare, the simplest, most obvious weapons have often turned the tide of some great battle. So it is, potentially, in today's war on cancer of the breast - womankinds' greatest enemy among tumors. The x-ray machines and skilled medical minds are secondary forces, held ready to combat the foe, cancer, when his attack is discovered. But it must first be discovered. The enemy must be recognized before he may be fought. Thus, the victim becomes the front line of defense. Upon her vigilance depends the success of science in controlling disease.

Relevant Literature

Cancer of the breast is the leading site of cancer in women. It is estimated that there will be 114,000 new cases of breast cancer in the United States during 1983 and an estimated 37,000 deaths (ACS, 1982). The five year survival rate for breast cancer, which has spread, is 47% but the same figure for breast cancer found and treated in its earliest stages is 87% (ACS, 1982). Since no absolute cure for cancer has been found, effective screening techniques coupled with a knowledge of breast cancer risk factors must be utilized to detect breast cancer at its earliest stages and thus decrease mortality and morbidity resulting from this disease.

Despite the fact that women find over 90% of breast cancers themselves, many are not found until they have invaded axillary lymph nodes and other tissues (Turnbull, 1978). Most of the literature seems to reveal that regular, monthly BSE is practiced by only a small percentage of the population. A 1974 Gallup Poll found that only 18% of the women practiced BSE monthly. In a study of graduate nursing students and graduate students in other fields, Turnbull (1978) found 25-30% of the nursing students practiced monthly BSE, while only 17-29% of the non-health-related students did so. Foster (1978) and associates

found a similar rate of practice in a study of women who were newly diagnosed with breast cancer. Before their diagnosis of breast cancer, only 25% practiced monthly BSE. Similarly low percentages for monthly practice were reported in studies conducted by Keller, George and Podell (1980) who reported 19% and Huguley and Brown (1981) who reported an overall rate of 34%.

The effectiveness of correctly performed, monthly BSE in early detection of breast abnormalities has been widely accepted. The findings of a 1978 study by Foster et al. showed that half the women who practiced monthly BSE had either Stage 0 or I cancer compared with only one-third who practiced BSE less frequently and one-fifth of those who never practiced BSE. This study also noted that in those patients with lymph node involvement who practice more frequent BSE, there tended to be fewer positive lymph nodes. Bayley, Cochram, Fatin, and Wilson (1980) emphasized the potential effectiveness of BSE from the viewpoint that it costs nothing and can be more frequently accomplished for a larger group of people than any other mass screening program. Huguley and Brown (1981) conducted a study with results similar to Foster's, where they found 30% of the women who practiced monthly BSE had tumors in Stage 0 or I, whereas only 19% of the women who did not practice BSE had tumors confided to these stages.

They also found that women who did not practice BSE were more likely to have four or more positive lymph nodes than those who practiced BSE. Breast self-examination is also encouraged as an effective means of early detection by the Surgeon General (1979) and the ACS (1982). Despite all of the studies that seem to point to the effectiveness of BSE in early detection, there are several studies which do not support this relationship. Smith, Francis and Polissar (1980) found no difference in the stage of cancer in women who did practice BSE versus those who did not. In a study of 1216 cancer patients, Sonie, Rosen and Lesser (1981) arrived at the same results. One possible reason given for these conflicting results is that the populations may have differed in their use of other screening techniques (Cole & Austin, 1981). In other words, if multiple cancer screening methods are utilized the additional effectiveness of BSE is smaller than if they are less frequently used and/or BSE is the only technique utilized.

As previously noted, many studies have found that BSE is practiced regularly by about one-fourth of the women surveyed. These studies list many different reasons women report for or for not practicing regular BSE. The 1974 Gallup Poll listed three major reasons for failure to perform BSE by women who were aware of the procedure.

These factors included, "Ignorance of the importance of frequent breast examination . . . , Fear and anxiety . . . , and lack of knowledge about self breast examination and confidence in how to do it . . ." (p. 21). This article also suggested that the phrase aware of BSE means that the women had heard of the procedure but may have little specific knowledge of it. This is important for healthcare professionals to keep in mind when assessing the patient's knowledge and practice. Stillman (1977) corroborates these findings in her study of 122 women, as these women reported lack of instruction, too busy, or they would rather not think about it as reasons for non-practice. In her study involving health-oriented and non-health-oriented graduate students, Turnbull (1978) found that the major factors in non-practice of BSE were; lack of motivation and forgetfulness among the health-oriented group and lack of understanding of how to perform BSE and forgetfulness among the non-health-oriented group. This same study indicated that the most significant factors influencing practice of BSE in the health-oriented group were knowledge from graduate and undergraduate education and fears related to cancer and various professional experiences. The non-health-oriented group reported the most significant factors were fear of cancer, mass media and the guidance of the physician. The two main reasons given for practicing

regular BSE in a study of 158 women with a breast concern were an awareness of the importance of early detection and a belief that they could get breast cancer, while 42.6% of the non-practicers felt they were not at risk (Kelly, 1979). Other reasons reported for non-practice coincide with many of those previously discussed. In an Australian study of 47 female registered nurses, "the wish to know you are healthy" (Bayley et al., 1980, p. 43) was the most frequently reported reason for practicing BSE. Additional reasons for practice included fear of cancer and the effect of the mass media. The reasons for non-practice given by the nurses in this study were similar to those of the lay female population and are comprised of fear, the desire not to think about it and a feeling they are too busy. Edwards (1980) studied the effects of four types of instruction on the practice of BSE and found that peer support plays an important part in encouraging the regular practice of BSE. This concept was reiterated by Howe (1981) who found an increase in the effectiveness of a new media message promoting monthly BSE, particularly in women with good social support networks. In another study by Howe (1981) a positive association was found between knowledge about BSE, education, social influence and the frequency of practice of BSE. Unlike several

other studies, Howe's study found no association between perceived risk for breast cancer and frequency of BSE. Schlueter (1982) conducted a survey of 263 women from sorority alumnae and YWCA groups finding no significant relationship between beliefs or knowledge and frequency of practice of BSE. This study partially conflicts with Howe's study. Conflicts of this nature appear to be as common in the literature as are the consistencies of some of the findings. Bennett et al. (1983) emphasize the positive association between level of confidence in one's ability to detect an abnormality and frequency of BSE, a finding that was consistent throughout the literature reviewed.

Source of information and knowledge also has important impact on the frequency of BSE and confidence in one's ability to perform it. There are many sources of information for BSE but the physician seems to dominate the list. The 1974 Gallup Poll found 32% of all women first became aware of BSE through their physicians. Other sources mentioned in this article were magazine articles, television, radio and newspapers. Nurses were conspicuously absent from this list. Findings from this poll also indicated that the largest percentage of practicers first obtained their BSE information from a physician. In a survey by the

New Zealand Cancer Society, magazines and newspapers were identified as the primary source of BSE information by 27% of those surveyed with the physician or nurse and television tying at 18% each (Rose, 1978). Instructional pamphlets were close behind at 16%. Turnbull (1978) reports that physicians provide the majority of breast examinations and most of the teaching regarding BSE. In a study of over 900 women in the Salt Lake City area Petravage, Reynolds, Gardner, and Reading (1979) found that 86.6% of the women checked physicians as a useful source for obtaining additional information about breast or pelvic examinations, 68% checked pamphlets while only 53.4% indicated they would seek additional information from nurses. The authors comment that this ". . . is somewhat ironical because nurses are frequently the people doing the education" (p. 1043). Huguley and Brown's research (1981) reiterates the results of the previous studies regarding the role of the physician as the primary source of information. This study emphasized the relationship between competence, source of knowledge and frequency of practice. Competence in performance of BSE was found to vary with source of knowledge from: 71% for doctors, 68% for ACS programs, 58% for nurses and about 45% for the media. Overall the literature indicates the

tremendous need for healthcare professionals to take a more active role in education regarding BSE. This seems to be especially true for nursing as the public and other health professionals seem to be unaware of nurses' ability to provide healthcare education (Graham & Glier, 1981). This perception is promoted by nursing's lack of initiative in what they claim is a major part of their professional role.

Studies have shown that the need for knowledge about BSE exists and that most women want to know more about health care promotion and the functioning of their bodies (Petravage et al., 1979). Several authors emphasize the importance of the health education role of nurses in assisting individuals to assume responsibility for their health (Flynn, 1981; Grosser, 1981). Nurses are in a unique position to provide this education and must use the many opportunities that exist in their everyday practice (Stromborg, 1981; Michalek, Walsh, Burns, & Mettlin, 1981). Grosser states that "Nurses possess many qualities inherent in good teachers," and "Patients frequently perceive nurses as caring people who are less threatening than other health professionals; thus, patients are receptive to nurses as teachers" (1981, p. 217). As important as this role appears to be to the nursing profession, nurses appear to avoid interaction and contact with the client which is especially

unfortunate as clients don't ask questions and many times nurses don't offer information and initiate teaching. Chappell ". . . contends that the health promotion dimension of nursing has been accorded Cinderella status, overlooked in favour of involvement in cure of disease and care of illness" (1981, p. 6). Graham and Glier (1980) cite a health educator's belief that nurses are ill-prepared and ill-equipped to fill the communication gap between patients and physicians because their training is more oriented toward illness and rehabilitation.

No matter who provides the education it must begin with an assessment of the client's knowledge and risk factors (Flynn, 1981; Grosser, 1981; Adom & Wright, 1982). All of these authors agree on the importance of including the family in the assessment which should be accomplished on admission to the hospital. Flynn (1981) asserts that a well done assessment will help individualize the educational approach to the particular client, family and situation. Assessment of risk factors for breast cancer is another essential facet of the admission history, for it is in this manner that clients at high risk are identified and thus monitored more closely (Anthony, 1978). Seven major risk factors which are identified and explained in the article by Anthony include: family history of breast

cancer, prior personal history of breast cancer/fibrocystic disease, present age and age at first parity, administration of exogenous estrogens, an adverse hormonal milieu, certain drugs (i.e., phenothiazines, rauwolfia alkaloid and methyldopa), and certain environmental factors including viruses and excessive ionizing radiation. Burger (1979) mentions that women in certain geographic areas or from certain ethnic groups tend to have a lower incidence of breast cancer. It is found less often in the Orient, Africa and South America while blacks and Puerto Ricans have less incidence than whites. The greatest incidence appears to be in Jewish women in the high income brackets. Stromborg (1981) reiterates many of the factors already listed and adds high dietary fat intake, chronic psychological stress and the threesome of obesity, diabetes and hypertension. In an educational pamphlet from the ACS (1980) the list of risk factors is limited to five which include: age, race, family history, personal history and age at first parity.

Upon completion of the assessment phase an educational program can be tailored to meet the client's and family's knowledge requirements. This type of instruction has been emphasized by some researchers as extremely important in the adoption of frequent practice of BSE.

Chappell (1982) affirms that the mass media is useful for disseminating information, but the personal touch is required for initiating and maintaining of new or changed habits. One-on-one instruction seems to be the method which produces the most sustained behavior and is recommended by researchers (Stillman, 1977). Stromborg (1981) suggests the use of audio-visual aids but only as an adjunct to individualized instruction not a replacement for it. Demonstration or modeling has been shown to be the most effective and efficient method of individualized instruction for building confidence in the client's ability to detect abnormalities, thereby maintaining frequent practice of BSE (Magary et al., 1977; Edwards, 1980; Bennett, 1983). Petravage et al. (1979), in a study on the attitude of women about gynecologic exams, found it very important that the physician bring up topics regarding specific gynecological problems and needs if the client doesn't. This concept has important implications for all healthcare professionals in their educational roles.

The literature documents a lack of utilization of opportunities for BSE education by all healthcare professionals but there is another group who is in need of this instruction and receives it even less often--men. Several studies have found that spouses are effective in

encouraging their wives to practice BSE and/or performing it on their wives (Edwards, 1980; Taylor, 1982). In a study of over 600 women practicing BSE, it was noted that living with one's sexual partner was associated with more frequent practice of BSE (Bennett et al., 1983).

Despite these weaknesses on the part of nursing, results of one study of retention of BSE knowledge and performance skills among women of low socio-economic status were gratifying. This study reported that of 78 women who had been taught BSE before the study, those that had been taught by a nurse scored significantly higher on the pretest than those who received their instruction from relatives, physicians or the media (McLendon, Fulk, & Starnes, 1982).

An important step in promoting the healthcare education role in nursing is identifying the reasons nurses do or don't do health teaching. Schlueter (1982) suggests that nurses may be avoiding opportunities to teach BSE and should examine their own knowledge of BSE along with their attitudes and confidence in performing and teaching BSE. One might ask, "what influences nurses to become involved in teaching BSE?" Stevens and Conkling (1977) suggest some nurses see it as a challenge and part of their professional role, while others like the feeling of gratification expressed by clients. Patterson (1983) adds that

health education is really a time-saver for the nurse as it may prevent non-compliance or increased severity of an illness. She reminds us that many state Nurse Practice Acts mandate patient teaching.

Overall, very little research has been done on why nurses do not do more client education when they appear to have unlimited opportunities to do so. Stevens and Conkling's (1977) article on development of a BSE education program lists several reasons nurses reported for not fulfilling the teaching role including; own non-practice, lack of time, and fear due to own vulnerability and of what would happen if the patient found a lump. In an article discussing the teaching role of the nurse practitioner, Gibbs states that, "Too often the nurse practitioner views the education role as being of low priority within the total practice role and nurses do not always perceive their teaching obligation as an essential part of the nursing role" (1980, p. 37). In a British study designed to assess the potential of 785 female nurses as health educators, findings indicated that the value nurses attach to BSE is not necessarily based on the intrinsic value of the measure itself, but on the nurse's personal health practices and the perceived difficulty in performing the measure (Elking, 1980). This study also named other

barriers to nurses teaching BSE such as, ". . . lack of understanding of, and skills in health education and an inadequate knowledge base" (p. 417). Finally, in another article describing an education program to prepare registered nurses to teach BSE, Kochanczyk (1982) suggests that even though nurses are taught to perform BSE, they are not taught how to teach BSE to others.

In summary a review of the literature from the 1974 Gallup Poll to the present appears to indicate that even though the opportunities for teaching BSE are almost limitless, the nurse does not seem to be adequately fulfilling this professional role. Stillman (1977), along with others, found that the need exists for this knowledge as it is a major reason women don't practice BSE. The crucial first phase of assessment of breast cancer risk factors and client and family knowledge of BSE was explained and emphasized by Flynn (1980), Grosser (1981), and Adom and Wright (1982). The importance of men in providing support for women to practice BSE or performing it on their wives is discussed by Edwards (1980) and Taylor (1982). The gap between what we say is an important professional role and the way we practice, as documented in the literature, is wide. Bullough (1981) points out that our potential as healthcare educators is not widely known or accepted by the public and other healthcare professionals.

No definitive research was found on what motivates nurses to do or not do healthcare education. Schlueter (1982) suggested that nurses who were avoiding this role should examine their own knowledge and attitudes about performing and teaching BSE. Stevens and Conkling (1977) report some nurses see teaching as a challenge and part of their professional role, while others find the results of client satisfaction and appreciation very gratifying. For some it may be the mere fact that healthcare education is mandated by their respective states' Nurse Practice Act. Other studies suggested that reasons for not teaching BSE may be related to the nurse's own non-practice, lack of knowledge or time, fear of own vulnerability and a perception by the practitioner that the education role has low priority (Elkind, 1980; Gibbs, 1980).

The dilemma, the problem of non-utilization of opportunities for BSE knowledge assessment and education presents for nursing, is summarized by Graham and Glier (1980) and Bullough (1981) who assert that if nursing does not fulfill its role in healthcare education, others will step in and assume the role, thus nursing will lose another important role.

Summary

In summary, this review of literature has presented the history of BSE and an overview of the studies documenting the effectiveness of practice and BSE instruction by healthcare professionals, specifically nurses. The review focused on reasons why BSE is not practiced regularly by more women and why many nurses appear to neglect their health teaching role in their practices. Research related to breast self-examination was discussed in chronological order according to specific topics which included; frequency of practice, effectiveness of the behavior, reasons for practice or non-practice of BSE, nurses' role in BSE instruction, and reasons nurses do or do not provide this instruction.

Most of the studies cited indicate a low frequency of practice of BSE among all socioeconomic classes. Major reasons for this lack of practice included forgetfulness, inadequate knowledge of technique and lack of confidence in own ability to effectively perform BSE. One-on-one instruction has been shown to be the most effective in sustaining the desired behavior but research indicates that healthcare professionals, especially nurses, are remiss in providing this instruction. A few suggestions have been made regarding reasons why nurses tend to avoid

healthcare teaching but more research is needed in this area before the problem can be overcome. This review of the literature indicates more research is necessary to identify what promotes health teaching by nurses and what the barriers are to this important part of the professional practice of nursing.

CHAPTER III

METHODOLOGY

Introduction

The previous chapters explored the background and significance associated with the problems of low frequency of practice of BSE and nurses' lack of client assessment and teaching regarding breast self-examination. The review of literature contained studies pertinent to all aspects of these problems.

This chapter will discuss the research design, pilot study, population and sampling techniques and ethical considerations related to this study. It will also include an explanation of the instrument used for the study along with the procedures used for data collection and analysis. Methodological limitations are noted and a summary concludes the chapter.

Research Design

This study used a descriptive design which is a type of survey research often used to describe various characteristics, opinions or facts of a population (Polit & Hungler, 1978). It is also useful for comparing

subsamples of a population such as those of different age or education, which made it an appropriate design for this study. This study was designed to describe staff nurses' knowledge of breast cancer risk factors and BSE, client teaching behaviors and reasons for actions taken. The settings for this study were two secondary healthcare institutions. Since this was a descriptive study no attempt was made to manipulate the environment.

Pilot Study

A pilot study was conducted to establish face validity for the instrument. The questionnaire was administered to five registered nurse students in the undergraduate Individualized Program of Evaluation option at The University of Texas at Arlington (UTA) School of Nursing and five graduate nursing students who reviewed it for face validity. All registered nurse students participating in the pilot study were screened for employment in secondary healthcare settings, where they have the potential opportunity to assess client knowledge of BSE, breast cancer risk factors and correct technique for performing BSE; and where they can provide the required instruction to the client and significant other. Appropriate revisions were then made in the structure of the questionnaire.

Population and Sampling

The population for this study consisted of registered nurses who were employed in secondary healthcare settings and were providing care for adult female clients. The sample was divided between two secondary healthcare settings in a North Texas metropolitan area.

Subjects were a convenience sample from inpatient care areas where there is a potential opportunity for nurses to teach breast self-examination. Nurses working straight nights (11-7) and in critical care areas were excluded from the study. A convenience sample may be used when a random-sampling technique is not feasible. In this situation, the scope of the study should be restricted and the researcher should study as many subjects as possible to increase the possibility of making some legitimate conclusions (Waltz & Bausell, 1978). The sample included 33 registered nurses from various age groups, educational backgrounds and practice areas.

Ethical Considerations

In accordance with ethical guidelines, all participants in this study were given adequate information to make an informed decision. All participants received a letter which provided a brief explanation of the study and confirmation that permission to collect data had been obtained

from the hospital's nursing research committee (see Appendix A). Confidentiality and anonymity were guaranteed each participant by separating consent forms (sole source of individual names) from questionnaires at one institution and utilizing implied consent at the second institution (see Appendix B).

Anonymity and confidentiality were guaranteed the hospital in the institutional consent form which was signed by the researcher, a representative of the institution and the researcher's committee chairperson.

Instrument

The instrument used in this study was a self-administered questionnaire developed by this researcher. It consists of fourteen open and closed-ended questions and requires approximately 10-15 minutes to complete. Information requested by this instrument included demographic data, knowledge of breast cancer risk factors and correct technique for performing BSE, frequency of client assessment and BSE teaching, frequency of inclusion of significant other in BSE teaching, reasons reported for or for not completing client assessment and teaching and subject practice or non-practice of monthly BSE (see Appendix C).

Face validity was established for this instrument during a pilot study. No additional validity or reliability studies were accomplished.

Questionnaires are the most widely used technique in the behavioral sciences to collect data from physical counts to attitudes and opinions. This information can then be used to solve problems, assess needs, make comparisons or describe what exists (Isaac & Michael, 1981, p. 128). Since this study sought information for the purpose of solving a problem, a questionnaire was the appropriate instrument for data collection. The demographic data was collected for informational purposes only.

Data Collection

Data was collected from sample populations in two secondary healthcare settings. Institutional consent was obtained from the Nursing Research Committee of each hospital. The researcher then provided the chairperson of each nursing research committee with packets which included a letter of introduction, the questionnaire, consent form (one hospital only) and a return envelope. The letter of introduction explained the purpose of the study and the approximate length of time required to complete the instrument, guaranteed anonymity and confidentiality to each participant and gave instructions for

return of the questionnaire. It also explained that a copy of the thesis would be made available to the institution upon completion of the study.

The chairpersons of each committee then distributed the questionnaires to a convenience sample of the nurses meeting the established criteria for inclusion in the study. The participants returned the sealed questionnaires to a central collection point in the institution where they were recovered by the researcher. The consent forms were separated from the questionnaires as they were received by the researcher.

One hospital initially received sixty questionnaires and the second hospital received one hundred questionnaires due to a larger population of nurses meeting the criteria for inclusion in the study. An insufficient response was obtained during the first period of data collection and followup letters with additional research packets were distributed.

Data Analysis

This was a descriptive study yielding non-parametric data for which the most commonly used statistics are percentages and measures of central tendency (Polit & Hungler, 1978).

A mean percentage score for knowledge of breast cancer risk factors was calculated and displayed in table form. The range and mode were also reported for the scores related to this question. Data for the questions which addressed knowledge of correct BSE technique, frequency of client assessment and teaching of BSE to the client and/or significant other along with reasons for and for not doing so were reported in percentages. This information was presented in subsequent tables. Demographic data and frequency of self-practice of BSE by participants was reported in percentages of the total.

Methodological Limitation

The methodological limitation for this study is as follows:

1. The researcher had no way to motivate respondents because of institutional policies regarding data collection which resulted in a decreased sample size.

Summary

In summary, this chapter included a discussion of the research design employed, pilot study, sampling method and population characteristics. The ethical considerations

were discussed and the research instrument was explained. Data collection procedures pertinent to this study and methods for data analysis were described. Finally, the methodological limitations of this study were included.

CHAPTER IV

RESULTS

Introduction

This descriptive study was designed to explore selected registered nurses' knowledge about BSE and breast cancer risk factors, frequency of determining clients' risk factors and knowledge and followup instruction with reasons for actions. This chapter explains the characteristics of the sample which are then displayed in table form. Statistical findings for each research question are presented in tabular form.

Characteristics of the Sample

The population in this study consisted of full-time registered nurses working days or evenings in a staff position within two secondary healthcare settings in a north Texas metropolitan area. Members of the population must have had the opportunity to provide healthcare for adult females in non-critical care, inpatient areas. A convenience sample of 33 registered nurses fulfilling the criteria participated in the study.

Data describing the nurse sample in relation to age, educational preparation and practice area are displayed in

Table 1. The age range was 18-45 years, with 57.6% of the sample between 26 and 35 years. In the sample, 57.6% of the nurses had a bachelor of science in nursing (BSN), while 18.2% had an associate degree in nursing (ADN) and 21.2% had a diploma in nursing. One nurse or 3.0% of the sample had a master of science in nursing (MSN). Slightly more than one-third or 36.4% of the participants worked on surgical units with the remainder divided between the obstetrical/ gynecological (OB/GYN) and medical/surgical units with 18.2% each and medical and "other" units with 12.1% each. One participant neglected to identify area of practice. There was one male in the sample of 33 nurses.

TABLE 1

DESCRIPTIVE DATA FOR PARTICIPANTS

Age	%	Education	%	Practice Area	%
18-25	18.2	ADN	18.2	Surgical	36.4
26-35	57.6	Diploma	21.2	OB/GYN	18.2
36-45	24.2	BSN	57.6	Med/Surg	18.2
		MSN	3.0	Medical	12.1
				Other	12.1
				Unknown	3.0

Findings

Percentages were used to report the results for each of the five research questions. The scores for research questions one and two concerning the nurses' knowledge of breast cancer risk factors and correct technique for performing BSE are depicted in Table 2. The range of scores for the question concerning identification of risk factors was 0-100%, with a mode of 50% and a mean of 34.4%. This equates to identification of less than two of the five risk factors listed by the American Cancer Society. Many of the nurses answering this question listed possible symptoms of breast cancer such as a lump in the breast, bloody discharge from the nipple, uneven contour of the breasts, and redness or swelling, instead of risk factors. A majority (76.7%) of the nurses in the sample correctly identified the proper technique for performing BSE.

TABLE 2

RESULTS OF NURSES' KNOWLEDGE OF BREAST CANCER RISK FACTORS AND CORRECT PROCEDURE FOR BSE

#[a]	Question	Score
4.	Risk Factors Identified	34.4%[b]
5.	Correct Procedure Identified	76.7%

[a]Number of question as it appears on the instrument.

[b]Mean of individual scores.

Table 3 displays data related to research questions three and four regarding frequency of assessment of clients' breast cancer risk factors and instructional needs, and the frequency with which nurses teach BSE to adult female clients and their spouses or significant other. Statistics for frequency of assessment of client breast cancer risk factors and instructional needs revealed that 9.1-12.1% of the nurses always make this assessment of their adult female clients. Of the sample, 33.4-36.4% disclosed they seldom complete the assessment, while 54.5% report never completing assessment of client risk factors, BSE knowledge and frequency of practice. The percentage of nurses always providing followup instruction on BSE is 6.1%, with 39.4% reporting they seldom provide this instruction and 54.5% reporting they never provide instruction on BSE. The results indicate that 6.1% of the sample always included the spouse or significant other in BSE knowledge assessment and instruction, while 3.0% reported seldom doing so and 90.9% revealed never including the spouse or significant other in BSE knowledge assessment and instruction.

Findings related to the fifth research question concerning reasons nurses do or do not assess their adult female clients' breast cancer risk factors and knowledge of BSE and then provide the required teaching are displayed

TABLE 3

FREQUENCY OF ASSESSMENT OF CLIENT RISK FACTORS AND BSE KNOWLEDGE WITH FOLLOWUP TEACHING

#	Question	Frequency		
		Always	Seldom	Never
6.	Frequency of assessment for:			
	a. Risk factors	9.1%	36.4%	54.5%
	b. BSE knowledge	12.1%	33.4%	54.5%
	c. Frequency of practice	12.1%	33.4%	54.5%
7.	Frequency of BSE teaching of female clients	6.1%	39.4%	54.5%
8.	Frequency of inclusion of spouse or significant other in:			
	a. Knowledge assessment	6.1%	3.0%	90.9%
	b. Instruction	6.1%	3.0%	90.9%

in Table 4. The most frequently reported reasons for assessing client risk factors and BSE knowledge and then providing the necessary instruction were client request (30.3%) and the strong feeling that clients must take responsibility for their own health (18.2%). Twelve percent disclosed that this assessment is part of the unit's nursing history and three percent conveyed the fact that a BSE educational program was available for clients. Two nurses reported that if the client has risk factors related to breast cancer they do instruct them on BSE. Of the two nurses who teach BSE to spouses and significant others, one identified all the choices listed in the questionnaire as reasons for providing the instruction. The second nurse cited client request as the reason for inclusion of the spouse or significant other.

Reasons nurses in the sample reported for not assessing client breast cancer risk factors and BSE knowledge and then providing necessary instruction included all of the choices listed in the questionnaire except, "It's not part of my job." The most frequently cited reasons were: lack of time (42.4%) or thought about completing the necessary assessment and subsequent instruction (57.6%), non-support from physicians, peers and nursing administration (18.2-24.2%) and lack of sufficient knowledge about BSE (18.2%). Fifteen percent of the nurses disclosed that they feel

TABLE 4

REASONS FOR PERFORMANCE OR NON-PERFORMANCE OF CLIENT ASSESSMENT AND TEACHING

#	Reason	Total
9.	For performance of client assessment and teaching:	
	a. Part of nursing history	12.1%
	b. Client request	30.3%
	c. Responsible for own health	18.2%
	d. Unit has BSE program	3.0%
	e. Other	6.1%
10.	For performance of spouse or significant other assessment and teaching:	
	a. Spouse/significant other request	3.0%
	b. Client request	6.1%
	c. Part of BSE program protocol	3.0%
	d. Recognize support spouse/s.o. can give	3.0%
11.	For non-performance of client assessment and teaching:	
	a. Lack time	42.4%
	b. Feel uncomfortable	15.2%
	c. Didn't consider this possibility	57.6%
	d. Not part of the job	0.0%
	e. Inappropriate in work setting	6.1%
	f. Lack sufficient knowledge of BSE	18.2%
	g. No support from:	
	(1) Peers	21.2%
	(2) Physicians	24.2%
	(3) Nursing Administration	18.2%
	h. Other	9.1%
12.	For non-performance of spouse or significant other assessment and teaching:	
	a. Lack time	27.3%
	b. Feel uncomfortable	18.2%
	c. Didn't consider this possibility	45.4%
	d. Not part of the job	3.0%
	e. Inappropriate in work setting	6.1%
	f. Unaware of support spouse/s.o. can give	9.1%
	g. Other	3.0%

uncomfortable providing this instruction, while 6.1% disclosed that it was inappropriate in their work settings. No explanations were provided for the latter choice. Other reasons reported included, BSE instruction is inappropriate if the client's level of anxiety about the primary diagnosis is too high, it is impractical to assess risk factors for problems unrelated to the primary diagnosis, most female clients on the unit are over sixty and clients never request this information. The reasons participants cited most frequently for not including the spouse or significant other in BSE knowledge assessment and instruction include, a lack of time (27.3%) or consideration of this possibility (45.4%) and a feeling of discomfort (18.2%). Two nurses indicated that inclusion of the spouse or significant other is inappropriate in the work setting but provided no explanation for this answer. Three nurses conveyed that they were unaware of the support spouses or significant others can give with regard to regular practice of BSE. One nurse disclosed the fact that this was not part of her job.

Summary

The descriptive characteristics of the convenience sample of this study and the statistical results of the questionnaire were discussed in this chapter. The findings

indicated 57.6% of the sample was in the 26-35 age group and had a BSN, while 36.4% worked on a surgical unit. The average score for the question concerning identification of the breast cancer risk factors specified by the American Cancer Society was 34.4%. Results showed most nurses do not assess adult female clients' breast cancer risk factors or knowledge of BSE and then do not provide the required instruction. Spouses and significant others were provided the instruction even less frequently. Client request and nurses' belief that the client should take the responsibility for his or her own health were most often cited by the nurses as reasons for completing the assessment and teaching. Reasons reported most frequently for not assessing breast cancer risk factors or BSE knowledge and then providing the necessary teaching were a lack of time or consideration of this possibility and non-support by physicians, peers and nursing administration. All results were reported in percentages of the total.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This descriptive study was designed to determine if registered nurses in secondary healthcare settings teach BSE to clients and significant others and what are their reasons for doing or not doing so. A questionnaire was distributed to a convenience sample of staff nurses in two north Texas metropolitan hospitals. Statistical findings indicated a large percentage of the nurses responding to the questionnaire do not assess clients' breast cancer risk factors and knowledge of BSE and then do not provide the necessary instruction to the client and significant other. Reported reasons for these actions included a lack of time or consideration of this possibility and a feeling of discomfort.

Interpretations and Conclusions

The first research question asked if nurses in secondary healthcare settings know the risk factors for cancer of breast as indicated by the American Cancer Society. Since the mean score was 34.4% and many nurses

listed possible symptoms of breast cancer instead of risk factors, the researcher concluded that these nurses lack knowledge of breast cancer risk factors and may even lack an understanding of the concept of risk factor. The researcher also concluded that the low mean score for this question may be an indication of the lack of contemplation given to each question by the respondent.

The second research question asked whether registered nurses in secondary healthcare settings know the correct technique for performing BSE as delineated by the American Cancer Society. Results for this question show that 76.7% of the nurses know the correct procedure for performing BSE, which indicates this would not be a primary reason for not teaching BSE to adult female clients and significant others.

The third research question asked how frequently registered nurses in secondary healthcare settings assess the breast cancer risk factors and BSE instructional needs of their female clients. Eighty-eight to 91% of the nurses participating in this study seldom or never complete this assessment on their adult female clients. This finding leads one to conclude that these nurses do not practice from a holistic perspective and do not assess the "whole person" when completing the nursing history.

The fourth research question concerns the frequency with which registered nurses in secondary healthcare settings teach BSE to their adult female clients and significant others. Only 6.1% of the nurses always teach BSE to clients and spouses or significant others. Given this statistic, one can conclude that this sample of nurses does not consider BSE assessment and teaching a priority. It may also lead to the conclusion that teaching BSE to the spouse or significant other is not seen as important or necessary.

The fifth research question concerned reasons registered nurses in secondary healthcare settings reported for or for not assessing client risk factors and knowledge of BSE and then providing needed BSE instruction to clients and significant others. Client request was the most frequently cited reason for client assessment and teaching of BSE, which may indicate that health promotion teaching is provided only when clients take the initiative and ask for it. The second most commonly reported reason for completing client assessment and teaching was the nurses' feeling that the client should take responsibility for his own health, which represents a holistic framework of practice. From this, it may be concluded that nurses with this framework are more likely to do health-teaching unrelated to the admission diagnosis. Nurses appeared more likely to accomplish

client assessment and required teaching if it was part of the nursing history format. Two nurses from the sample included spouses or significant others in BSE instruction, one of which identified all four items listed in the questionnaire as reasons for doing so, thus leading to the conclusion that this nurse practices from a broader framework or perspective. The second individual only mentioned client request in response to this question.

Heading the list of reasons for not completing client assessment of risk factors and BSE knowledge and then providing the needed instruction to the client and significant other is non-consideration of this opportunity for education in health promotion. Lack of time is reported almost as frequently as a reason for not accomplishing the desired actions. Both of these reasons lend increased support to the previous conclusions that many of the participants in this study do not practice from a "whole person" framework and do not see client education as an important part of the professional role of nurses. This conclusion was supported in the review of literature. Several nurses reported that accomplishing these behaviors makes them feel uncomfortable, while one disclosed that including the spouse or significant other in BSE instruction is not part of the job. This may indicate a lack of support from peers, physicians or nursing

administration for the educative role of professional nurses. The low priority accorded BSE assessment and teaching may also be indicative of why society does not realize assessment and teaching should be primary roles of the professional nurse. From 18.2-24.2% of the sample cited lack of support from peers, physicians and nursing administrations as a reason for not assessing client risk factors and knowledge of BSE and then providing the required teaching. The conclusion which may be made in this instance is that without support, from these areas, practice in less traditional roles (like teaching BSE) will not be sustained.

Nursing Implications

Since this study used a convenience sampling technique and reliability and validity were not established for the instrument, the results cannot be generalized to the population of staff nurses in secondary healthcare settings. However, the data obtained suggests many important implications for nursing.

Implications for nursing education include placing more emphasis on health education and the teaching role in today's cost-conscious society. Additional emphasis is also needed on what it means to care for the "whole person" including other family members, health problems unrelated to the admitting diagnosis and assessment of risk factors

related to common illnesses such as breast cancer. Educators must encourage nurses to take the initiative in introducing health promotion behaviors to clients instead of waiting for a request from the less knowledgeable client. This may require spending more time educating nurses about how to do client teaching. When educators are able to assist nurses in adopting a more holistic framework for their practices, they may be able to decrease the need for extensive and expensive hospitalization and medical care. Another implication for nursing educators involves the need to more concisely define the concept of risk factor and its importance in health maintenance and prevention of illness.

Implications for nursing administration include the need for strong support of these roles possibly by adopting a holistic framework for nursing service or by weighting them more heavily in criterion-referenced performance evaluations. When individual nursing services are billed separately, as they possibly will be in the near future, it will be important for nursing administrators to have the functions of both professional and non-professional nursing personnel well delineated or face problems justifying the need for professional nurses. Two of the premier differences between professional and non-professional groups are the professional's ability to complete a thorough client assessment and provide client education based on

this assessment. Continuing education and inservice programs could be provided on BSE and how to complete more thorough nursing histories. The addition of phrases regarding risk factors and BSE practice as cues for nurses completing the nursing histories may improve the frequency with which this assessment is completed. Nurses also perceive lack of time as a big barrier in accomplishing the appropriate assessment with followup instruction, a factor which has major implications for nursing administration. Administrators could provide registered nurses more time for professional roles by decreasing clerical duties and providing non-professionals for some of the recurring technical tasks. This could also be accomplished through more innovative and efficient use of computers already present in many institutions. Another implication for nursing administrators is the need to develop or expand client education programs, which would alleviate part of the problem of lack of time. Potential clients who may require this education can be identified from the nursing history.

Recommendations

Nurses claim assessment and teaching as two of their professional roles, yet many times relegate them to a position of low priority. Recognition of this problem

should be followed by further investigation to determine what needs to be done to facilitate greater assumption of these roles by professional nurses. A replication study should be conducted to establish validity and reliability for the instrument used in this study and to clarify reasons nurses do not assess client BSE knowledge and risk factors and then provide needed instruction. Additional research in this area should include: a correlational study of nurses' BSE knowledge, practice, assessment and teaching actions and reasons for actions, an exploration of methods to eliminate barriers nurses perceive to greater assumption of the assessment and teaching roles, and investigation of the effectiveness of early nursing assessment and management of risk factors in relation to future wellness and cost containment. When nurses assume greater responsibility in the areas of assessment and teaching they will be recognized by other healthcare professionals and the public as leaders in health promotion and ultimately cost-containment.

APPENDIX A

LETTER OF INTRODUCTION

December 8, 1983

Dear Participant:

I am requesting your assistance with research in the area of health-promotion teaching. The study is being conducted in partial fulfillment of the requirements for a Master of Science Degree in Nursing. This study has been approved by the nursing research and publication committee of your hospital.

The attached questionnaire requests information concerning your knowledge assessment and subsequent teaching of breast self-examination for all your adult female clients. It will require approximately 10-15 minutes to complete. Please answer all the questions as accurately and thoroughly as possible and include any comments you may wish to make at the end of the questionnaire. NOTE: Questions 4 and 5 are to be answered without the use of reference material. After completing the questionnaire, insert it in the envelope marked "Questionnaire," seal it and return it to nursing service administration on the second floor by December 21, 1983.

Anonymity and confidentiality are guaranteed in the attached consent form. Please sign it and return it in the envelope marked "Consent Form."

Thank you for your participation in this study. Results of the study may be obtained from your hospital nursing research and publication committee after April 30, 1984.

Sincerely,

Patricia E. Harris, RN, BSN
Graduate Student, Nursing
University of Texas at Arlington

APPENDIX B

INDIVIDUAL CONSENT FORM

Individual Consent Form

I, _____, give permission to Patricia E. Harris, University of Texas at Arlington Graduate Student, to conduct the research concerning breast self-examination knowledge, practice and teaching experiences. I agree to be a member of the study group and understand that my name will not appear in the final report or abstract. All information is to be considered confidential. I understand that I may stop participation at any time and that I will receive no reimbursement for participation in this study. If I have any questions regarding the study, I may call UTA School of Nursing, 273-2292, leave a message, and the researcher will return the call.

_____ Signature of Participant

_____
Patricia E. Harris, RN, BSN
Graduate Student
University of Texas at Arlington

APPENDIX C

QUESTIONNAIRE

Questionnaire

1. Age group: ____ 18-25 ____ 36-45 ____ over 55
   ____ 26-35 ____ 46-55

2. Education: (highest level) ____ Diploma ____ BSN
   ____ ADN ____ MSN
   ____ Other (specify) _____

3. Practice area: ____ Medical ____ Med/Surg
   ____ Surgical ____ Other (specify)
   ____ OB-BYN _____

4. List (at least) four of the risk factors for cancer of the breast as identified by the American Cancer Society.

   a.

   b.

   c.

   d.

5. Which group of statements most accurately describes the correct technique for performing breast self-examination (BSE)?

   _____ a. While standing, palpate each breast with fingers of opposite hand for any hard knot, lump or thickening.
   b. Next, while lying down, repeat the procedure and include the axillary area.
   c. Squeeze the nipple and report any milky discharge.
   d. Lastly, stand in front of a mirror with hands overhead and note presence of any swelling, dimpling or changes in the nipple.

   _____ a. While in the shower, examine each breast with the fingers of the opposite hand and note any lump, thickening or hard knot.

b. While standing in front of a mirror, inspect both breasts with arms at your side, then raised high overhead and finally with palms on hips pressing firmly downward. Note any swelling, dimpling, changes in color or changes in the nipples.
c. Next, while lying on your back, palpate the entire breast with fingerpads, starting with the upper-outer quadrant and progress in a circular motion to the nipple also including the axillary area.
d. Squeeze the nipple gently and report any clear or bloody discharge.

_____ a. Palpate each breast with fingerpads of opposite hand while standing.
b. While lying down, palpate each breast with fingers of opposite hand using a circular motion and progressing outward from the nipple.
c. Stand in front of a mirror and inspect both breasts for redness, swelling, dimpling or any other changes.
d. Squeeze each nipple gently and report any discharge.

6. How frequently do you assess your female clients':

a. Breast cancer risk factors:

____ always ____ seldom ____ never

b. Knowledge of BSE:

____ always ____ seldom ____ never

c. Frequency of practice of BSE:

____ always ____ seldom ____ never

7. How frequently do you teach BSE to your female clients?

____ always ____ seldom ____ never

8. How frequently do you include the spouse or significant other in your BSE?

a. Knowledge assessment:

____ always ____ seldom ____ never

b. Instruction:

____ always ____ seldom ____ never

9. If you do assess your clients' breast cancer risk factors and knowledge of BSE and provide needed instruction, please indicate your reasons. (Mark all appropriate answers.)

____ Standard part of nursing history in your institution.

____ Clients request this information.

____ Feel strongly that individuals should take responsibility for their health.

____ Unit on which work has BSE education program.

____ Other (Please specify) _____

_____

10. If you do include spouses and significant others in your BSE knowledge assessment and instruction, please indicate your reasons. (Mark all appropriate answers.)

____ Spouse or significant other requested the instruction.

____ Client requested spouse or significant other be included.

____ Part of the BSE education protocol on the unit.

____ Recognize the significance of the spouse or a significant other in providing support for client to practice monthly BSE.

____ Other (Please specify) _____

_____

11. If you do not assess your clients' breast cancer risk factors and knowledge of BSE or provide instruction on BSE, please indicate your reasons. (Mark all appropriate answers.)

____ Lack the time.

____ Feel uncomfortable.

____ Don't think about making this assessment or providing this instruction.

____ Not part of my job. (Explain)_____

_____

____ Think it's not appropriate in my work setting.

(Explain)_____

____ Do not think I possess knowledge necessary to teach BSE.

No support from:

____ Peers ____ Physicians ____ Nursing Administration

____ Other (Please specify)_____

_____

12. If you do not include the spouse or significant other in your BSE knowledge assessment and instruction, please indicate your reasons. (Mark all appropriate answers.)

____ Lack the time.

____ Feel uncomfortable.

____ Didn't think about this possibility.

____ Not part of my job. (Explain) _____

_____

____ Inappropriate in my present work setting.

(Explain)_____

____ Unaware of the support spouse or significant other can give client in this area.

____ Other (Please specify)_____

_____

13. Do you perform BSE at least monthly? (on yourself)

____ Yes ____ No

14. Comments:

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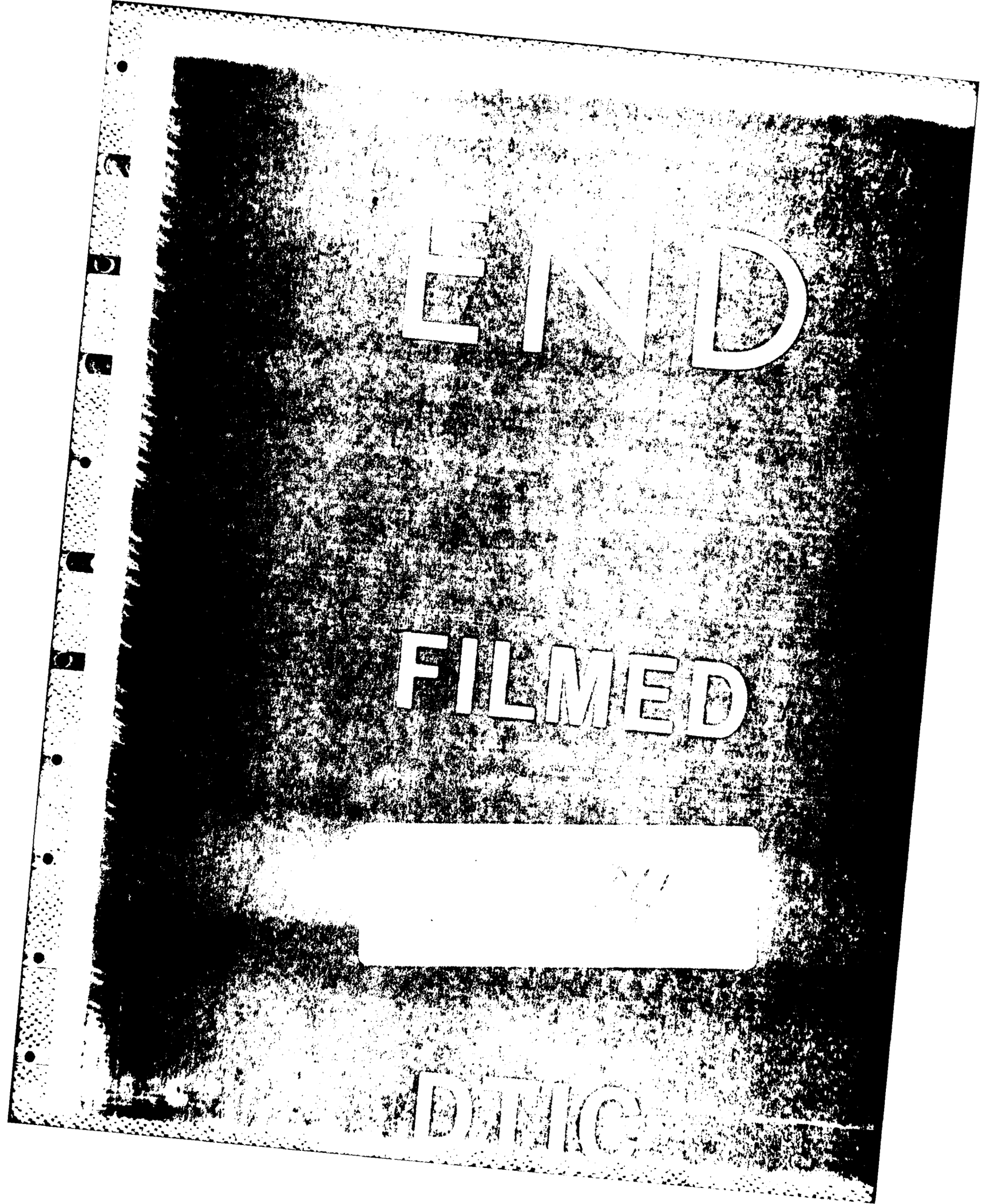
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