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Yale Nurse

Yale School of Nursing

Yale Nurse

Ruth Knollmueller

GRADUATION - ALUMNAE/I WEEKEND

SEPTEMBER 1984

Yale University School of Nursing

ALUMNAE/I ASSSOCIATION

Newsletter

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Editor

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September 1984

Picture credits

Ruth Knollmueller

Mary Colwell

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...from the dean...

This is the last of these little letters, at least from this dean. And I have a confession to make.

When I came into the deanship twelve years ago, one of the things I was most frightened about, and looked least forward to, was dealing with the alumnae and alumni. I was unknown, untried, awfully young and a graduate of YSN's graduate program that was still new and still suspicious to those who remembered vividly the the closing of the basic program. See, I was in the first class of a brand new school of nursing for my basic preparation (University of Denver) so there were no alumnae and I had no idea what to expect. Except the worst.

The confession really is that I have found working with the alumnae and alumni, with the Board of the Association, one of the most interesting and fulfilling parts of the deanship. And while I will continue to be a faithful alumna, I will miss very much the opportunity for contact, for meeting and speaking with you and writing to all of you out there.

YSN's graduates are a very special group. As our splendid Weekend in June demonstrated over and over, you are brilliant and creative women and men, and above all concerned, and serious about issues even when you may not practice professionally any more.

And more even than that, you are generous. That generosity is what was to me the theme of the Alumnae Weekend and what made it so moving to be in your company. There was no feline scratching, and there was a great deal of sharing the triumphs of nurses of the past, glorying in our history and our present, basking in the ideas presented in the papers, and just humming to feel so inspired and fortified.

I am proud of what the school has accomplished in these last few years. Please know that we could not have done it without the moral support, the compliments, and the occasional complaints of the alumnae/i body. You are our trust and endowment -- the "loyal opposition" -- and it has been an extraordinary privilege to serve YSN.

Thank you all....

Love,

Donna

* * * * * * *

60th Anniversary

Engagement Calendars

for 1984

on sale 1/2 price

$2.50

plus postage .75

$3.25

Write to YSN Alumnae Office

COMMENCEMENT DAY - MAY 28, 1984

and it rained!

Karen Johnson ('84) was chosen as Banner Bearer for her class at Commencement this year. The Banner Bearer is privileged to wear the academic costume given to the School by P.E.T. Gower of the Class of 1974. In addition, the person selected received a modest cash prize.

This year, Karen requested that the prize be used to establish a student emergency fund. With great generosity, she matched the contribution and the Student Government Organization has also matched the gift. An anonymous contributor brought the total up to $200.

The student emergency fund will be used as an emergency loan fund when students run into unanticipated financial exigency, particularly personal. It is set up so that students who have an emergency may have access to the funds in a hurry if necessary.

Karen's generosity is well-known within the School for she has given of herself to activities of her class and the larger institution throughout her two years here. Karen is a Major in the United States Air Force, now stationed at Wright-Patterson Field in Dayton, Ohio.

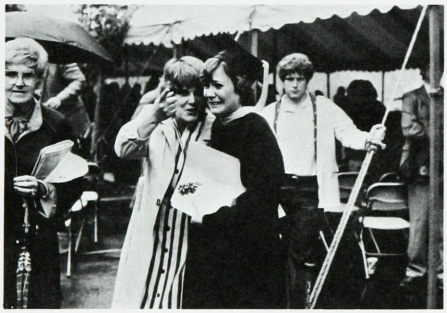
Karen Johnson,
Banner Bearer

Veckerelli Prize

The generosity of June Veckerelli, of the Class of 1955, has provided a prize named in honor of her father, and in fulfillment of a family tradition. The prize is given annually to a graduating student chosen by a faculty committee whose clinical and scholarly work has achieved a level of excellence through which it has inspired others. This year, the Veckerelli Prize goes to Adele Waring Pike.

For one who is only recently a nurse, her reputation for clinical excellence has already made her sought by peers, colleagues, and community organizations. Her faculty have characterized her as an energetic, superior student, self-directed, poised, articulate and mature. Her previous background in social work has been melded with her new identity as a nurse to create an unusually gifted clinician and scholar. She has written for the lay public, and published and presented for professional audiences. Her ability to synthesize complex information and find the implications for practice is outstandingly developed. Her personal qualities led her colleagues to say she has the unique ability to bring harmony to a group of dissidents without being a Pollyanna. She is a lovely human being.

It does honor to the School of Nursing to present the Veckerelli Prize to Del Pike.



Veckerelli Prize winner Adele Pike, with faculty member Linda Norton, '80.

Annie Goodrich Award

Bestowal of the Annie Goodrich Award is based upon nominations received from members of the student body. The nominations received for this year's award recipient paint a vivid portrait of her excellence as a nursing educator. I would like to share some of these nominations with you:

"She is a catalyst in the classroom. Her enthusiasm and charismatic flavor inspire many ... she is the best and strives to continuously cultivate that in her own work and in that of others with whom she works...her genuine friendliness and kind goodwill are exhibited in all she does."

"She is a superb teacher who has the knack to make even the driest material palatable and the ability to imbue one with a zest for learning."

"...a tireless encourager of nurse researchers, an inspiring and stimulating research lecturer and an exceptional role model for scholarship by nurses."

"...her wisdom and scholarship; her outstanding teaching expertise; her support of students; her research acumen; and her ability to be a mentor and role model for many of us. All of the above are transcended by her spirit, her sense of humor and her humaneness...she is a brilliant scholar who applied her knowledge and activates it in such a way that students want it."

"She presents an exciting, intelligent, and articulate image of nursing. May I vote more than once?"

This year's recipient received her B.S. in Nursing and Psychology from the University of Maryland. She received her M.S. in Nursing from the Pediatric Nursing Program here in 1974 and was also the recipient of the Yale School of Nursing Andrew Veckerelli Student Award for excellence. In 1982, she received her Ph.D. in Clinical and Developmental Psychology and Experimental Psychopathology from the University of Pennsylvania.

Her teaching career at the Yale School of Nursing began in 1974, and after a brief interlude as a Research Associate at the University of Utah and as a doctoral student and faculty member at the University of Pennsylvania, she, fortunately for us, returned to the Yale School of Nursing in 1982 as a member of the Research faculty. She has been involved in multiple research studies and has numerous publications in nursing, medical, and other scientific journals. In July, she will begin her appointment as Chairperson of the Pediatric Nursing Program here at Yale. I am honored to present this year's Annie Goodrich Award to a faculty member who is respected and enjoyed, both personally and professionally, by a good many of us -- Dr. Madelon Visintainer.

* * * * * * *

Request

I am searching for women who were in the armed forces during World War II. I am conducting a survey of women's use of the education benefits in the G.I. Bill. Veterans who are interested in participating please send your name and address. I will mail the questionnaire to you.

Beth Verdicchio
5 Storybook Lane
St. James, New York 11780

Remarks by the Dean

The tradition of these brief Commencement remarks is that the Dean takes one last shot at the graduates. This year that tradition is bittersweet, for not only are the graduates leaving, but so is the Dean. And so I have this awful urgency to lay on you, the Class of 1984, everything I ever wanted to say, in the coincidence of the year of the brave new world.

I want to tell you that you, the Class, individually and collectively, have done us honor by electing to come to Yale for your graduate work. And I want to make you understand how important your initial decision was -- apart from our collection of tuition. For when you came here you made a choice and we did too, and it worked. And neither you nor we will ever be the same.

And I want to tell you, one last time, that "impact" is not a verb.

And I want to tell you how impossibly beautiful nursing is. I want desperately to stuff in your heads the joy of discovering that nursing is grand.

And I want to tell you to give to the Alumnae Fund.

And I want to tell you that the tortured questions you have asked of yourselves and your faculty are real questions, and right ones, and the the answers you may have been unsatisfied with are also real and right, for the dialogue, the discourse, the inquiry, the debate and the search for meaning are the protein of our personal and professional lives.

And I want to tell you to believe in nursing, in the widest possible expanse of role and function, and believe so strongly that your beliefs can sustain you through the battles with the unknowing, unthinking, deluded, and the barefoot pragmatists who would wish to restrain the ideas and talents of nurses, women and men.

And I want to tell you that you are very, very smart (otherwise we would not have graduated you) and you should know that so securely that the knowledge will carry you over the hurdles put up by the dimly dumb.

And I want to tell you to be generous with your ideas, ideals and talents, to make them available to the widest range of audiences.

And I want to tell you to work always from precise assessment of issues, whether they are diagnostic or political, to get all the facts you can get, to candle all the possibilities for action, and when you have to act, to take the consequences with the grace that only comes from sure reason.

And I want to tell you how to survive, how to prosper, how to move forward the cause of humane health service (which is, of course, nursing). And that lesson is so simple and so complicated -- it is just to know what the work is and derive all other things, clinical decisions, administrative confrontations, legislation, public policy from as clear and deep and understanding of what it is to do patient care as possible.

And I want to tell you to observe, to watch, and if necessary, wait, until you define the moment or the issue or the combination thereof to exercise your wisdom.

And I want to tell you to read, to enjoy words, for they will both guide and inspire you. And I want to tell you to write, for if there is something nursing needs more than anything else, it is the expression of language that describes and explains and predicts the nature of the work.

And I want to tell you to use your powers of analysis which we have, if not taught, at least reinforced, to tell the difference between the trivial and the important, between the biased and the balanced, between the real and the ideal, and between the data and the decision.

And I want to tell you to be strong and powerful in your gifts, but not arrogant, and value quality without thoughtless elitism, and know always through searching self contemplation, the depth of yourself and the limits of both your tolerance and your talent. Nobody, especially in nursing, can possibly be good at all things, all the time.

And I want to tell you to have a dream of responsibility that does not require abnegation, justice that is not cold, right that respects the range of human choice, in the colorfully complicated context.

And I want to tell you that you are nurses and that is an appelation to be seized, not denied, actualized, not buried, but most of all apprehended. You will be tried and tested and it may seem easier to drift from an identity of nurse, so confused is that identity. I want to tell you that the confusion is somebody else's issue, not ours, not nurses who know the privilege of doing the work we do, the access to intimacy with human beings, the presses to fix the unfixable, and explain why not, the challenges to define the undefinable. I want to tell you to ignore those challenges, for they are naive and stupid and devisive and you know what you can give and you have done it.

And I want to tell you to remain connected with each other and with those of us who stay here after you go, for out of these connections will grow the reform of health services we might all wish for.

And I want to tell you that the energy you expend on doing the work is called "love".

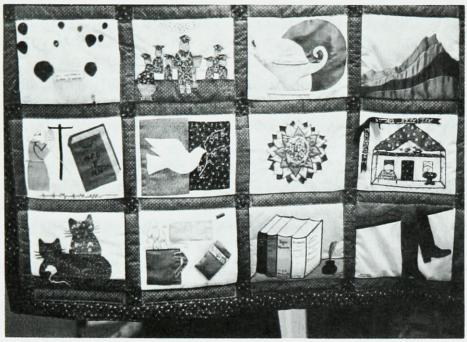
And I want to tell you...

Actually, I think I have.

You leave us then on the wings of a benediction given first by the Reverend William Sloane Coffin, on the occasion of the Fiftieth Anniversary of the Yale School of Nursing, and peculiarly appropriate this year:

Oh God, who has created a day beautiful beyond any singing of it, yet one which is full of rebuffs and heartaches and the mysteries of pain and death, we thank thee for all nurses who do not deny these mysteries, but deal with them; for all nurses who know the human touch, the professional touch; for all nurses who know that while the several parts may be ugly, the whole remains beautiful. Bless all who

work in this School of Nursing. May the complexities of problems only increase their zeal to solve them, and may they continue to keep everything together -- heart, mind and body, education and service, cure and prevention, doctor and patient. May this School live always declaring to others that caring is the greatest thing, that caring matters most.



The Class of '84 presented their gift to Dean Diers, a quilt designed and made by class members -- each square having special significance.

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ALUMNAE/I WEEKEND

The School of Nursing Alumnae/i Weekend on June 7-8-9 was a smashing success! The prime ingredients were there: a chance to reminisce with others about YSN -- a place which changed our lives, and in which we grew; the chance to share concerns about professional issues with knowledgeable and creative colleagues; and an opportunity to be "recharged" in this exciting atmosphere, all of which confirmed our loyalty and pride in YSN!

The early arrivals to New Haven greeted each other on the courtyard of Yale's historic Old Campus, near the dorm assigned to YSN alums.

Following a picnic supper, Sherry Shamansky '69, chairman of the Community Health Program at YSN gave a very informative talk about the growth and development of the Community Health Program at YSN. Some historical background leading up to the philosophy and curriculum of today's program with the Clinical Specialty and Family Nurse Practitioner tracks. A run-down of the positions held by graduates was impressive!

The "Dean's Choice" of speakers for the Alumnae/i College Colloquium on Nursing on Friday was strictly "blue ribbon". The record turnout attendance for the day was a glowing

tribute to Donna who will be relinquishing the deanship at the end of December this year. (full texts of the speeches begin on page).

At the banquet on Friday evening those three ladies attending their 50th reunion were introduced and each received a corsage.

Iva Torrens, Mary Huntington Shaw and Harriet Wilcoxson attend 50th reunion at YSN

Representatives from some other reuning classes are shown below.

Chris Cannon 1979

W. Annette Massey 1959

Dottie Needham, Phil Gower, Penny Hatcher, Doris Banchik, Marianne Scanlon, Mary Sennott, Sharon Bidwell Cerone, Mary Erlandson Maloney, --- Class of 1974 celebrate at 10th reunion

The awarding of the Distinguished Alumna Awards was the climax of the evening --

Priscilla Olson Anderson

Her life and work -- whether formal and professional or volunteer -- are all of a piece. The generosity of spirit that makes her available to help -- whether the help is required from friends, colleagues, classmates, or patients -- reflects deeply held values. She combines nursing acumen with apparently boundless energy for loving service especially to those at the ending of life. Her devotion to her ideals and her family, her commitments to the hospice model of care and to her alma mater, are an inspiration to all who are fortunate enough to know her.

Priscilla Olson Anderson '47 (left) with Classmates Mary Ellis and Gigi Hartdegen Booth

Grace Kathryn Eckelberry

This woman is among the very few for whom the word "teacher" has a capital "T". She has been called a spiritual guide, a person so clear in her thinking and so gifted in her practice that she drew out not only the principles of community health, but the originality, and the independence -- however outrageous -- of her beloved students and junior faculty. Through her work and her presence, she has made nursing sing, merging her passions for music and human service.

Grace Eckelberry 1938

Alice Eleanor Johnson Gifford

The health of the public has been her consuming interest and she has chosen to exercise her wisdom in unusual combinations of choices. Always a nurse, she has contributed that perspective to studies of congenital syphilis, to teaching human ecology, to developing the first doctoral program in occupational health nursing, and to the hardest issue of all -- nursing governance in institutional settings. A Fellow of the American Academy of Nursing, she upholds the very highest standards of nursing practice and education in a field of specialization that needs her clear-headed confidence and constance.

Alice Gifford Johnson 1938

We recognize her outstanding career as clinician, researcher, and educator.

Judith Belliveau Krauss

Hers is the distinction hardest to win: recognition as a clinical scholar for the visionary thought that has defined anew the complicated context of chronic mental illness. Her writing, research, teaching and clinical work have brought her deserved professional and public attention as she has worked to return psychiatric nursing to its roots in human service, unfettered by pallid euphemism or territorial imperative. In addition, she has created and filled the often thankless role of student champion, without privilege and with only the power of persuasion. And she has represented women and nursing to the wider University community with subtlety and decisiveness. Her service to the School and to the students who become alumnae/i shares the same qualities of brilliance, compassion, and intellectual excellence that define her scholarship.

Judith Belliveau Krauss 1970

Dorothy Jean MacLennan

She is a quiet and gentle woman, a woman whose convictions, commitments and loyalty define her. Her career has taken her from nursing service administration to graduate nursing education in pediatric practice to national nursing service at the National League for Nursing. Her gifts to others have always been to set and maintain high standards of ideals and performance. She has the uncanny ability to always grow, always change, but never simply to adjust to new times, personalities or political agendas. It has been said of her that in her position as Director of Council Affairs, Council of Baccalaureate and Higher Degree Programs of the National League for Nursing, she brought to every issue and every school to whom she consulted, "a bit of Yale".

Dorothy Jean MacLennan 1952

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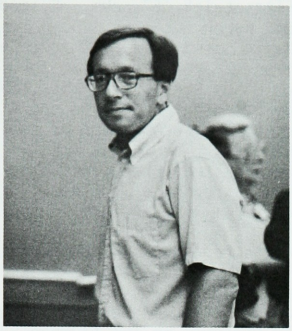
Saturday was another long and busy day -- which started with greetings to all alumnae/i of the School of Medicine, Epidemiology & Public Health and Nursing by Yale President A. Bartlett Giamatti. Then all alumni attended seminars sponsored by the Medical School.

Following an informal lunch President Jean Butler '50 conducted the annual meeting of Y.U.S.N.A.A.

Minutes of this meeting are on page 10.

A session concerned with Health Care Marketing was presented by Steven Permut, Associate Professor of Marketing at the School of Organization and Management. This very revelant topic

set in motion many ideas in minds of his listeners!



Professor Steven Permut

Dr. Howard Hamilton YSM '44 presented a most unusual performance of Japanese Noh Theater, which is sacred, true ritual drama and is the oldest continually extant theater in the world today. Dr. Hamilton has studied and performed Japanese Noh since 1956.

Because this Alumnae/i Weekend was the last one Donna would attend as Dean, she was honored at a reception attended by all alumni attending events at the Medical Center that weekend. Tributes and toasts were given by Robert Berliner, Dean of Medical School; John Thompson, Professor of Public Health, Nursing Administration; Florence Wald '41, former Dean YSN; Judy Krauss '70, Associate Dean YSN; and Jean Butler, President of YSN Alumnae/i Association. They presented her with an autographed copy of a book by Donna's favorite mystery writer Dick Francis -- a gift from the Alumnae/i Association Board.

Donna listens attentively to toasts

Dean Robert Berliner

John Thompson

Florence Schorske Wald

Judy Krauss

Donna receives book from Jean Butler

* * * * * * *

YALE UNIVERSITY SCHOOL OF NURSING
ALUMNAE/I ASSOCIATION
ANNUAL MEETING, June 9, 1984

The annual meeting of the Association was called to order at 12:30 p.m. on Saturday, June 9, 1984.

Toni Tyndall, chairperson of the Nominating Committee, introduced the newly elected officers and board members. There was some expression of dissatisfaction over the new balloting system, but in general, there was understanding and agreement with the system.

Each year, one half of the Board members are elected; this year the newly elected members are: President-elect: Sheila Conneen '79, Treasurer: Beatrice Burns '79, Board Members: Beverly Calza-Gerdes '77, Andree deLisser '79, Shirley Parkhill '47. Nominating Committee: Elizabeth Fitzpatrick '67, chm., Elizabeth Ercolano '81, Karen Suchanek '79.

Jane Rambo Stewart '47 has accepted appointment as AYA representative for '84-'87. She replaces Sandy Bialos '71 whose YSN term is over. Sandy has been elected to the AYA Board of Governors by vote of members of the Assembly in April 1984.

Vicki Wirth, treasurer, gave a brief report of the 11 months of business - the final detailed report will be included in a future Yale Nurse.

Mary Ellis reported on the Bequest and Endowment Fund, and hoped that this kind of financial planning will be included in many YSN alumnae' future. She and Mary Jane Kennedy work very closely together on the Alumnae Fund Affairs.

Mary Jane Kennedy reported for the Fund this year. The goal is higher this year, we are close, and must keep working on it. She told of the Phonathon this Spring and how very successful it was - and it will be done again. She was praised for her superb efforts in behalf of YSN and was named a "Champion Fund Raiser".

Dean Donna Diers gave her, as always, eloquent report on the State of the School. She announced the funding of a new grant in Pediatrics, which will include developing an acute care track.

There have been three new tenure appointments on the faculty since last year - Judith Krauss, Ann Slavinsky, and Dorothy Sexton. This will make several changes in the governance of the School because there will be a promotions and tenure review within the School for the first time.

Next year's enrollment is up a little - total 198 (which includes 25 part-time students).

Helen Burst, chairperson of the Search Committee for the new dean, reported in detail the elaborate and careful process by which 150 suggestions were winnowed down to six recommendations which were passed on to the President of Yale. This number is now at the point of three candidates. The committee meets again with President Giamatti later in June. She predicts we will know the next dean by the end of the summer.

Florence Wald requested permission from the floor to offer her praise of the work of the Search Committee.

Mary Colwell introduced and thanked the members of the Board for the implementation of the Alumnae/i Weekend.

Jean Butler issued a general thank you to Mary Colwell for her boundless energy and superb work throughout the year.

The meeting was not formally adjourned because we had all melted into puddles.

Toni Tyndall
recorder pro tem

* * * * * * *

Papers presented at Alumnae/i College, June 8, 1984 (space permits us to giver you 2 of 4 outstanding papers. More to come in a later Yale Nurse).

NURSING, MADNESS, AND MENTAL HEALTH

-- Judith B. Krauss, R.N., M.S.N.

It is often the case that one is asked to title a paper long before it is actually presented or, for that matter, created. The wise presentor chooses a title that is so expansive as to allow them to say anything, on the general topic provided (in my case, psychiatric nursing), in the time allotted, to the audience intended. Such was my philosophy when Mary Colwell squeezed a title out of me a few months ago. And, much was my surprise when I couldn't move beyond that title to put thoughts to paper as I finally began preparing for today's presentation. I thought there were three possible interpretations for my dilemma and, being a well trained psychiatric nurse, I proceeded to explore each one.

The first explanation that lept lightly to mind was that having so brilliantly titled my paper I had nothing left to say on the subject! I quickly dismissed this explanation as irrational and unfounded in reality -- largely, because if I dwelt on it very much longer I knew that I would never produce the necessary manuscript pages to allow me to stand in front of you for the next hour.

The explanation is a close cousin of the first. It has a good deal of basis in reality but I have no intention of admitting that to you. It seemed entirely plausible to me that the reason I couldn't get beyond my title was that I was awestruck -- made mute by the realization that I would be keeping company at the podium with the likes of Rhetaugh Dumas, Inga Mauksch and Madelon Visintainer; summoned, no less, by the nursing scholar's scholar herself Donna Diers; and asked to perform in front of you, my most respected and esteemed nursing colleagues. Having said that, and if you must know, having spent countless hours working it through, I'll tell you the real reason the title gave me pause. The title had hidden meaning beyond the broad utility of covering whatever sins I will commit here today.

The title, "Psychiatric Nursing, Madness, and Mental Health", captures the complex contexts in which the practice of psychiatric nursing unfolds. I have had a privileged exposure to the multifaceted prism of practice in the past year. In any given week, on a Monday I might spend the day at Merritt Hall, the rehabilitation building at Connecticut Valley Hospital, where our graduate nursing students concentrating in the care of the chronically mentally ill complete their second year advanced practicum. The building is located in an idyllic setting high on a hill overlooking Middletown, Connecticut, surrounded by farmland, with a view of the Connecticut River. Inside, past the well appointed outpatient lobby, one is confronted with a cacophony of smells and sounds: urine; psychotic screams; music; cafeteria cooking; shuffling feet; proud declarations like, "Today, I start my job!"; requests for cigarettes, for money, for caring attention -- "My name is Jane. Do you like me? Do you like me? Do you like me?"...I watch the nurses, many of them seasoned experts, some of them frightened neophytes, all of them at risk for burn out. Their practice involves establishing small, miniscule, achievable goals for the severely disabled; encouraging resumption or assumption of self-care; reducing the stimuli for the acutely psychotic; increasing the stimuli for the severely withdrawn, monitoring medication effects; managing the mileau; negotiating, yes, battling, with physicians to ensure quality health care practices; organizing and making do with scarce resources. At the end of such a day I am deeply troubled by the mayhem of madness.

On Wednesday, I work with my psychiatric nursing faculty colleagues as we struggle to evaluate and alter our curricula so that they will remain relevant to the changing face of mental health services and consumer populations. There is represented among us a rich expertise in the psychiatric nursing care of selected populations spanning the developmental stages (child to adult) and extending from and beyond traditional psychiatric service delivery settings to the general hospital, the primary care center, and the community. One colleague is an expert in the care of the chronically mentally ill in the community; another, is a student of culture and ethnicity as it influences the delivery of community based psychiatric services in a catchmented neighborhood; another, is an expert in sexuality and sexual dysfunction; one specializes in alternative interventions, for example relaxation techniques for the management of pain; another in care of the terminally ill and their families; one received special training as a Robert Wood Johnson Fellow and cares for patients in a primary care center whose complex medical disorders are further exacerbated by psychiatric dysfunction; and yet another is an expert in the special needs of foster children; while some among us specialize in diagnosis and care of the system, small groups, large groups, and intergroups, that effect the delivery of services.

Towards the end of the week I meet with my students in the Clinical Research Seminar. Among them are psychiatric mental health nursing students in their first year who are struggling with the formulation of clinical problems that will guide their research proposals for the master's thesis. It is this forum, more than any other, that inevitably reminds me that the practice of psychiatric mental health nursing extends from the management of madness to the promotion of mental health. This year the clinical research problems range from studies of the mad (factors associated with violence on an inpatient psychiatric unit; coping resources and natural networks of the chronically mentally ill in the community; assessment of dementia and depression in the elderly) to studies of the care providers (the efficacy of various shift report methods as they relate to the use of restriction on an inpatient unit; death anxiety and attitudes toward the suicidal patient; personal therapy and its relationship to the provision of empathic psychotherapy) to studies of the mentally well (music as a metaphor for life in an adolescent population; music as a mediator of chronic arthritic pain; stressors associated with dual career marriages). The framework of psychiatric mental health

nursing becomes the conceptual kaleidoscope through which one views the interwoven textures, colors, and hues, of the mad and the sane as they grant us the privileged intimacy to share the ordinary and the extraordinary excerpts of their lives.

And, so, this paper is about madness and mental health as viewed from a psychiatric nursing perspective. It is about shaping and reshaping psychiatric mental health nursing in a changing mental health care system--changing because the consumer base is altering in need and demand and changing because there is a discernable shift from a medical model dominated system to a psychosocial rehabilitation system. It is about the challenge of delivering humane care from a contextually based professional practice framework.

Madness and Mental Health

Professional and lay interest in madness and mental health intensified in the post World War II era. Rochefort (1984), in a health policy analysis traces the origins of the Community Mental Health Centers Act of 1963 to post-war influence of significant proportions. He notes, "A number of major social, scientific, and intellectual developments stimulated a reshaping of the mental health system in the post-World War II era" (p 2). These phenomena altered our perceptions of madness and contributed to the development of national policy which reflects our view of mental health services.

The Second World War itself had three observable effects on our view of madness. First, the war provided evidence that mental illness existed in America in large proportions. From 1942 to 1945 approximately 12% of all men screened for induction into the armed services were rejected on neurological or psychiatric grounds -- accounting for almost 40% of all rejections (Rochefort, 1984). About 37% of all men judged fit to enter the service were eventually discharged for neuropsychiatric problems. Rochefort (1984) points out that this represents the loss of well over two million men which exceeds the total number of servicemen who were stationed in the Pacific during World War II. Since these young men were considered to be America's finest these statistics were troubling and disquieting -- how many other citizens could be counted among the psychiatrically disabled?

Second, the psychiatric casualties that resulted from the War led to the development of new psychiatric interventions -- intensive diagnosis, the use of groups, acute treatment and rapid discharge, and the use of sedation and hypnosis as well as a view toward social and environmental determinates of illness (Rochefort, 1984; Ewalt and Ewalt, 1969; Mechanic 1969).

And third, the return of psychiatrically disabled veterans to this country had a profound influence on the stigma associated with mental illness. Apparently anyone could become mad irrespective of social class, race, or other life circumstances. Those to whom we owed the protection of the honor of our country had returned mad and deserved our respectful, caring intervention.

Rochefort (1984) goes on to document the now well known post-war developments that, while not a direct result of the war, likely resulted because of the changing view of madness and its treatment: 1) the advent of drug therapy with the discovery of reserpine and chlorpromazine in India and France respectively; 2) the introduction of the concept of the therapeutic community -- inextricably interwoven with the calming effects of the psychotropics so that we cannot, even today, separate the influence; 3) greater attention to the epidemiology of psychiatric illness reflected in Hollingshead and Redlich's (1958), Social Class and Mental Illness and the conflicting findings of Srole, et al (1962) in the Midtown Manhattan Study; and, 4) an enhanced, almost romantic, notion of community and its role as both participant in and recipient of treatment.

There is evidence in the popular literature that the attention of the American public has been captured by the nature of madness since the 1950's. Popular novels and personal accounts both of patients and therapists abound. In the mid-forties Life published "Bedlam USA", and "The Shame of Our Mental Hospitals" appeared in Reader's Digest. Several newspapers -- The Cleveland Daily Press, Chicago Daily News, San Francisco News, and St. Paul Dispatch -- assigned reporters to regular coverage of local state mental hospitals (Ridenour, 1961). Deutch (1948) wrote one of the early book-length exposes of the mental health care system -- The Shame of the States. Ward (1946) wrote her now classic memoirs, The Snake Pit. Ken Kesey's (1962), One Flew Over the Cuckoo's Nest, and Hannah Green's (1964), I Never Promised You a Rose Garden, are still popular novels some twenty years after they were written. More recently, Schreiber's, Sybil (1973), and The Shoemaker: The Anatomy of a Psychotic (1983), and Keye's (1981), The Minds of Billy Milligan, provide contemporary evidence that madness still attracts our interest and troubles our souls. Rossner's (1983), August, is the profound, intense, and, at times, irreverent book that captures the essence of the psychotherapeutic relationship from both the perspective of the patient and the therapist. It reminds us of the frailty of humans, both mad and sane, and demystifies the process of psychotherapy.

Social-scientific critique has also proliferated since the fifties. The now famous studies and exposés by psychiatrists, sociologists, and anthropologists served to uncover the massive problems with institutionalization and, perhaps more significantly, offered an explanation for the social disability associated with the illness that was the result of the treatment not the disease. These studies include: The Mental Hospital (Stanton and Schwartz, 1954); The Psychiatric Hospital as a Small Society (Caudill, 1958); Asylums (Goffman, 1961); and more current works by Backrach (1976); Talbott (1981); and Klerman

(1977) that point to the problems with the social policy of deinstitutionalization that resulted from the Joint Commission on Mental Health and Illness (1961) and the Community Mental Health Center Act of 1963.

And, what was nursing's involvement with the mentally ill during the post-World War II era? To answer that question I will borrow heavily from Krauss and Slavinsky (1982), The Chronically Ill Psychiatric Patient and the Community (pp 313-338) -- with major credit to my co-author, Ann Slavinsky, who developed the chapter on the history of psychiatric nursing.

Psychiatric Nursing Theory

As late as the 1950's, although it was estimated that as many as 50% of all patients were classified as mentally ill, it was not generally recognized that psychiatric nursing content was helpful in all aspects of nursing practice. The nursing profession had not yet acknowledged the importance of the involvement of the nurse in the direct care of the psychiatrically ill. The passage of the National Mental Health Act, in July 1946, provided the impetus and the funds for training nurses in psychiatric nursing practice in more sizeable numbers.

Although the impetus was provided the results were less than immediate. The National Mental Health Act brought down the curtain on the prespecialization era that could hardly conceal the growing problem of overcrowding in existing hospitals, rapidly growing demands for services, and the growing unavailability of nurses prepared to care for patients in these institutions. The lack of success in both recruiting and training nurses to work in mental hospitals was particularly marked in the decades of the fifties and early sixties. Despite growing numbers of educational programs preparing nurses in this area and the recognition of the care of the mentally ill as a specialty within general nursing, few nurses were attracted to such work. Goodnow (1950), a nursing historian, explains this lack of response as a reaction to the belief that the mentally ill were chronically disabled and hopeless:

> So long as mental diseases were looked upon as incurable, a nurse who went into this work was merely a caretaker for a chronic invalid who was not only uninteresting but often rebellious, and her work seemed hardly worthwhile (p 142).

There are several events that mark the period between 1946 and 1961 that could be characterized as the Era of the Mental Hospital and the Development of Nursing Theory. The first of these events was the publication in 1948 by the Russell Sage Foundation of a landmark study, Esther Lucile Brown's, Nursing for the Future. Although not the first major statement on future directions for nursing, it was the first to specifically address psychiatric nursing. In this report, based on a national survey of 50 schools of nursing, Brown, a sociologist, outlines the existing lack of practitioners trained in the principles of mental health or in psychotherapeutic techniques. The report claims that:

> The average physician would seem to be in much the same position as the nurse in needing instruction in simple methods of psychotherapy (p 89).

The conclusions of Brown's study, sponsored by the National Nursing Council, were that professional education was essential for all nurses, including preparation for both practice in general medical settings and more specialized training for work with individuals with a diagnosed mental disorder. She emphasezed the importance of developing advanced clinical roles for nurses that focused on patient care rather than administration and teaching. This report stimulated movement toward advanced preparation in nursing practice as a way of building toward the future and meeting the health care needs of the present. Works such as Brown's mark the distinctly educational orientation of this period within nursing. If the years preceding 1946 could be characterized by their lack of educational focus, those between 1946 and 1961 illustrate the tremendous interest and preoccupation of nursing with "catching up" educationally with other specialties. Brown (1948), speaking both to and on behalf of the National Council addressed this notion, stating:

> The writer's part in this study has afforded her an exceptionally rich opportunity to see and share in the ongoing life of the profession of nursing, which is at once so old but in its professional aspect so new. She hopes that nursing education will soon be established on a sounder and more substantial base; that nurse educators will be able to look back on these years of struggle and uncertainty with wonder that the road could have seemed so hard, and able to look ahead with some gaiety of spirit, secure in the knowledge that theirs is a socially vital and a socially recognized profession (p 24).

Much of the leadership in this era was provided not by individuals identified as clinicians but by those with strong ties to the university. The university became the focus of nursing preparation in psychiatric nursing, much as the mental hospital became the major focus of nursing practice in this field. Both the hospital and the university represented the belief in formal institutions as a panacea to major social problems.

The next events continued to reflect the trend toward theory development growing out of the university focus. In 1952, two major works were published. One, a book by Hildegard Peplau, revolutionized thinking about the nursing care of the individual with a psychiatric disorder. The second, Tudor's article in Psychiatry, established the authority and role of the nurse beyond the boundaries of nursing. Both Peplau's book and Tudor's article had a tremendous impact on the theory and practice of psychiatric nursing and deserve careful attention.

Peplau's book, Interpersonal Relationships in Nursing, elaborated principles of nursing practice that fit well in Brown's vision of the potential role of the nurse with advanced preparation. The book was intended to serve as a conceptual framework, guiding the therapeutic relationship of the nurse with the hospitalized patient, although the principles outlined had clear implications for nursing in a wide range of settings. It was also intended as a resource for both graduate and student nurses. Peplau introduced her work as follows:

> Being able to understand one's own behavior, to help others to identify felt difficulties, and to apply principles of human relations to the problems that arise at all levels of experience -- these are functions of psychodynamic nursing. Helping nurses to understand the relationship of nurse personalities to these functions is an aim of this work (p xiii).

Her theory was derived from and rooted in the works of Sullivan and Fromm, in addition to her own ideas, observations, and clinical practice. The theory that she outlined pertained to the process and objectives of nurse-patient interaction. She identified four overlapping phases of the nurse-patient relationship. These phases are orientation, identification, exploitation, and resolution, and can be found to span the course of a mentally ill individual's hospitalization from admission, through the intensive treatment period, into convalescence and rehabilitation, until the time of discharge.

Peplau also articulated the varying roles that the nurse might play during this process, roles such as "stranger", "resource person", and "teacher". The nurse-patient relationship was seen as a specific means through which patients could be helped to complete unfinished developmental tasks. Peplau envisioned that nurses might do this by helping patients with specific psychological tasks, such as "learning to count on others", "learning to delay satisfaction", "identifying oneself", and "developing skills in participation".

This theory continues to have direct and immediate application to a wide range of current situations, even in a much changed system of mental health services. The theory applied equally well to nursing interactions with both the acutely and chronically ill as well as to patients both within and without the hospital setting. Dr. Peplau herself still stands as a role model without parallel in psychiatric nursing practice and education.

The second work, Tudor's article, was published in a psychiatric journal, Psychiatry. This 1952 article was not published in a nursing journal for the simple reason that there were no journals then in psychiatric nursing. It was not until 18 years later that the article was finally reprinted in a nursing publication, Perspectives in Psychiatric Care. At the time of reprint, it was noted that publication of Tudor's article in a medical journal has been "the motivating force behind the creation of Perspectives in Psychiatric Care" (p 10).

The article, "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mural Withdrawal on a Mental Hospital Ward,' is a classic in psychiatric nursing care for several reasons. It documents the impact of the behavior of a nurse on severely disturbed, withdrawn patients. One of the two patients described as illustrative of the theory is a chronically ill schizophrenic woman who is only 28 years old and has already been hospitalized for 10 years at the time of Tudor's study. Tudor introduces her article by saying that:

> Psychiatric nurses in a mental hospital are increasingly expected to manifest their competence in nursing by an awareness of and an ability to handle their interpersonal relations with patients in a therapeutically useful manner (p 174).

Tudor demonstrates this point by documenting that not only can the nurse help the patient but she can also have a profoundly negative effect on the course of an illness.

In addition, to the way in which Tudor demonstrates the effect of the nurse's behavior, she also clearly outlines other nursing theory. She elaborates the importance of paying attention to and maximizing the potential of the general social context within which the nurse-patient interactions occur. She demonstrates the importance of taking a social science perspective on behavior. She defines mental illness largely as a defect in communication. If the defect is in communication or, more specifically, in interpersonal behavior, the solution and the objective of nursing intervention then should be to manipulate the patient's interpersonal environment in order to facilitate social interaction.

The social disability dimension of chronic illness has made this theory particularly relevant to many aspects of the care of the chronically ill. These "mental health" principles, as well as the accompanying nursing theory, apply equally well almost 30 years after they were first formulated. They also seem to apply equally well to patient care in medical settings, in the community, and in the psychiatric hospital.

In 1961 another publication by a university-based nurse introduced a different focus to theories of care. Orlando's, The Dynamic Nurse Patient Relationship, exemplified a shift in nursing attention from the needs of the seriously ill, such as the chronic patient, to a more general interest in "mental health". Orlando's book represents the result of work begun at the Yale University School of Nursing in 1954 with funding from the National Institute of Mental Health. The intent of the project had been to identify key elements in the integration of mental health concepts in general nursing education. Orlando began with a statement that:

> Since a person who is ill is likely to have his sense of adequacy or well-being disrupted, it logically followed that all nursing must have a mental health orientation regardless of the patient's illness (p vii).

The book explicates a process of communication

YSN ALUMNAE/I FUND REPORT

Message from Mary Jane Kennedy - YSN Alumni Fund Chairman:

Last year, we raised our goal from $75,000 to $80,000 on the strength of a landslide total for the 60th anniversary - with, I admit - some trepidation on my part.

I am thrilled to report, however, that we indeed reached - and exceeded our goal for a grand total of $85,501. And 55% of us contributed, making YSN the leading graduate school at Yale in percentage of participation.

Once again the credit goes to our dedicated agents, and to their contributing classmates whose names appear below - and to our phonathon volunteers. A special thank you belongs to Flora Lavery '64 who organized the Donna Diers Fund which put us over the top!

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Elinor M. Schulte
Evelyn M. Soriano
Mildred K. Taylor
Pamelia P. Tisza
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Carolyn B. Wheeler
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Elizabeth D. Wortham
Vera V. Yordon
Cicely L. Zeppa

1952
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Joan W. Cresap
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Jane W. Donovan
Ila W. Gocke
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Judith E. Lissner
Dorothy J. MacLennan
Marjorie M. Naso
Mary S. Page
Patricia K. Pagliarini
Ellen P. Powell
Lenore F. Seldeen
Helen M. Sullivan
Helen A. Turner
Mary N. Van Ronzelen
Ardis D. Wagner

1953
Jeanne S. Benninghoff - Agent
Naomi B. Ament
Jeanne S. Benninghoff
Mary H. Bliss
Lois S. Brunton
Bernice H. Clayton
Helen B. Crowell
Nancy S. Doolittle
Shirley F. Edwards
Sally C. Foster
Elaine Childs Gowell
Louise Z. Greenlaw
Shirley J. Greenwald
Eileen F. Hemond
Marion E. Highriter
Constance C. Hornickel
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Rauha K. Koski
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Peggy B. Masterson
Martha C. Newton

1953 (continued)
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Marie c. Pepe
Phoebe J. Samelson
Corinne M. Schultz
Alphonse Charles Sootkoos
Helen Lowe Stover
Evelyn A. Sturmer
Helen T. Watson

1954
Jacqueline P. Cannon - Agent
Carolyn W. Aguiar
Phyllis C. Beard
Doris Bloch
Maria R. Bosnak
Beverly B. Bretthauer
Jacqueline P. Cannon
Annabelle S. Carone
Eleanor M. Crispell
Dorothea L. Dunn
Mary B. Edward
Laverne F. Elliott
Frances M. MacDougall
Rhoda K. Martel
Teresa Molinari
Louisa M. Murray
Julia P. Pace
Joan K. Parsons
Jean E. Robinson
Merlyn I. Robinson
Jean B. Roddy
Margretta M. Styles
June S. Wentz
Jean W. Youngen

1955
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Irene Bennett
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Larice R. Burtt
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Janet H. Crovatto
Angela C. Daukas
Helen H. Downing
Beverly N. Dunston
Elaine R. Gariepy
Reeva M. Liverman
Lorraine M. McManus
Fotine D. O'Connor
Frances D. Park
Marguerite G. Quinn
Gordon Sawatzky
Margaret A. Scherer
Esther T. Sherrod
Margaret D. Todesco
Patricia A. Vergara
Caroline R. Weiss
Elmo G. Winger

1956
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Sally C. Elliott
Betty Ann Ford
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Priscilla D. Kissick
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Jane N. Manning
Gretchen P. Minners
Joan E. Mulligan
Anne G. Packer
BarbaraS. Pratt
Vesta K. Rich
Marion M. Russell
Ellen J. Seligson
Cameron T. Wroblewski

1957
Mary R. Dalbey - Agent
Joceline K. Alexander
Madalon O. Amenta
JoAnn Tietje Briggs
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Mavis Chittick
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Elizabeth S. Crouse

1957 (continued)
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Martha Ray Harris
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Eleanore L. Hayden
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Barbara N. Klaus
Hui-Chen Ku
Phyllis O. Lawrence
R. Jeannine Lyerly
Anna W. McKown
Helen S. Miller
Cynthia D. Pugh
Tanya K. Ratney
Janice R. Salter
Barbara H. Schneider
Lois G. Swander
Priscilla R. Ulin
Marjorie L. Wallace
Elizabeth N. Winkel
Jane M. Wylie
Louise M. Young
Sylvia M. Zigun

1958
Lorraine J. Hall - Agent
Sally Ann Yeomans - Agent
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Janet Glover Bell
R. Pendleton Camp
Katherine N. Campbell
Katharine R. Dreyfuss
Anna Baziak Dugan
Didine S. Ebersole
Shirley M. Ellefsen
Lorraine J. Hall
Carmelia S. Lattizori
Jean W. Loh
Eleanor P. Montanari
Jean S. Ney
Shirley H. Tenney
Virginia S. Vidaver

1959
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Winifred T. Garrity
Armentia T. Jarrett
W. Annette Massey
Elizabeth O. Richard
Elizabeth S. Sharp

1960
Ruth G. Elder - Agent
Ruth G. Elder

1961
Martha E. Barden - Agent
Martha E. Barden
Claudette B. Barry
Hilda Mertz
Jeanne S. Neideck
Maryann B. Tarasuk

1962
Audrey Ralph - Agent
Barbara A. Johnson
Sheila T. Myers
Audrey C. Ralph

1963
Patricia Murphy - Agent
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Evelyn M. La Flesh
Elizabeth Z. Mayberry
Edith M. McHugh
Patricia M. Murphy
Elizabeth A. O'Connell

1964
Flora V. Lavery - Agent
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Bernice S. Hibbard
Flora V. Lavery
Angela Barron McBride
Ann H. Watkins
Carolyn K. Zackin

1965
Jeanette T. Brown - Agent
Jeanette T. Brown
Jean R. Fisher
Jean Dunham Goss
Ann P. Hempy
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Helen M. McDonald
Roberta K. Spurgeon
Marjorie R. Wright

1966
Kathleen D. Stokes - Agent
Marjory W. Heyd
Joyce W. Light
Ruth Schmidt
Kathleen D. Stokes

1967
Carol K. Scales - Agent
Elizabeth W. Fitzpatrick
Virginia G. Kinnick
Carla F. Robb
Carol K. Scales
Ann T. Slavinsky
Marie-France C. Thibaudeau

1968
Mary Jane Kennedy - Agent
Judith A. Blocker
Carrie Conser
Eileen C. Hodgman
Mary Jane Kennedy
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Elizabeth A. Strutzel
Nancy S. Winship

1969
Sandra R. Haldeman - Agent
Jane C. Covey
Elizabeth B. Deutsch
Sandra R. Haldeman
Agathokleia R. Luckner
Mary Lee Mantz
Donna Shields-Poe
Nancy Koehne Spring

1970
Judith G. D'Afflitti
Donna O. Berger
Judith G. D'Afflitti
Veronica P. Dembeck
Judith B. Krauss
Marilyn Yunek Steffan

1971
Saundra Bialos - Agent
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Mary H. Cannarella
Mary Agatha Cebula
Gretchen D. Cohen
Maureen O. Doran
Anita W. Finkelman
Catherine Kiene Forrest
Carolyn T. Glenn
Eileen M. Gloor
Paula W. Goering
Patricia D. Ho
Gretchen F. Kuempel
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Carol B. Rinzler
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1972
Dianne S. Davis - Agent
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Dianne S. Davis
Barbara I. Dobay
Judith F. Flanagan
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Carolyn Mazur
Virginia Nehring
Beckett M. Rodgers
Anita L. Silberberg
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Carol D. Tessman
Linda P. Vieira
Carolyn Webster-Stratton

1973
Eileen Korman - Agent
Carol A. Baer
Suzan D. Boyd
Janet S. Cellar
Sally Isenberg Cohn
Sarah Dillian Cohn
Linda C. Corinne
Anne L. Donabedian
Therese Doucet
Constance P. Fisher
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Beverly S. Greenwood
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Barbara B. Hedstrom
Judith S. Kane
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Carole Ann McKenzie
Paulette B. Mundy
Christine Niemyski Nuger
Marilyn Perkins
Anne Mulkeen Romond
Donna Teachey
Mary T. Wigodsky
Susan K. Wilensky

1974
Patricia Doyle - Agent
Marianne K. Scanlon Agent
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Sharon Bidwell Cerone
Denise E. Fitzpatrick
Mary Geary
Philip Edwin Thomas Gower
Patricia J. Harris
Penny Hatcher
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Jean McCormick
Barbara E. Meyers
Dottie S. Needham
Helene M. O'Keefe
Catherine Scala
Marianne K. Scanlon
Marcia Schlotman
Mary Sennott
Ruth B. Timothy
Susan Willis

1975
Christina W. Stephenson Agent
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Mary C. Collins
Alice F. Farquhar-Mayes
Jane S. Ferriss
Priscilla O. Greene
Vincenta M. Leigh
Jo Ann Love
Helena McDonough
Ruth M. Ouimette
Eileen F. Skowronski
Nancy Strafford-Hesko
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Sara E. Woolbert
Susan B. Zekauskas

1976
Carol M. Batton - Agent
Carol M. Battin
Barbara M. Caporael-Katz
Margaret J. Cushman
Janice G. Davey
Linda J. Goodhart
Margaret J. Grey
Karen M. Hafsted
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Cecilia W. Mukai
Ann Kyoko Nakamoto
Kay R. Plymat
Marilyn McHugh Rochester
Barbara-Jean Sullivan
Victoria H. Wirth

1977
Judith S. Burkholder Agent
Jill C. Strawn - Agent
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1977 (continued)
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Glenn S. Ekblad
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Eva-Lynn Janson
Susan J. Kennedy
Gretchen Mosman
Sarah G. Potter
Christina M. Schenk
Kathleen K. Stone
Dianne Taylor
Michele S. Wane
Nancy M. Wineman

1978
Karen W. Pettigrew Agent
Mary Ellen Ungate - Agent
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Susan K. Davis
Harriet A. Fellows
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Bernadette M. Forget
Beth Elissa Goldberg
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Debra J. Harrison-Atlas
Vickie Greene Healey
Michael Sherer Hellenbrand
Marsha E. Kaye
Nancy Kraus
Barbara J. Mieras
Lynne Morishita
Katherine W. Parker
Dolores Perteet
Karen White Pettigrew
Clyde P. Sanchez
Janet S. Taft
Winifred Thomas
Patricia Trotta
Mary Ellen Ungate
Elizabeth Vitale

1979
Elizabeth D. Selvaggio Agent
Andree L. deLisser
Patricia D. Barry
Mary Wilson Bassis
Gail J. Briceland
Beatrice R. Burns
Sheila Conneen
Janet S. D'Agostino
Patricia W. Emmons
Judith A. Fardig
Dawn Lee Ferguson
Thomas E. Fickett
Denise Gaunya
Yvonne Theresa Green
Ann Elizabeth Greig
Richard F. Jennings
Linda J. Lisk
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Sheila H. Pavlis
Sylvia M. Rasie
Nancy Ellen Rosenblum
Lois S. Sadler
Barbara Lee Sellars
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Debra Faith Sweeney
Judith C. Tierney
Antoinette V.B. Tyndall
Debi Welch-McCaffrey

1980
Nancy C. Allen - Agent
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Nancy C. Allen
Susan S. Baxa
Michele V. Coral

1980 (continued)
Elizabeth Manning D'Amour
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Roberta Danza
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Raymond F. Fellows
Shannon Fitzgerald
Marilyn F. Germano
Jody Gross
Mary Pennington Harmon
Barbara B. Janeway
Bonny Libbey Johnson
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Marianne H. Lewis
Elizabeth S. May
Joan M. Monchak
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Maria A. Rawlings
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Karen Schefiliti
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Helen E. Sirica
Sally Beth Solomon
Susan Sumner Stengrevics
Dawn Tiedemann
Tracy Carol Wittreich

1981
Kathleen Comeau Agent
Elizabeth Ercolano Agent
Cheryl W. Fida - Agent
Danuta I. Bujak
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Christina G. Conforti
Lauren S. Corbett
George Daneri
Candis C. Danielson
Louise Dodd
Pamela L. Driscoll
George T. Eckenrode
Elizabeth A. Ercolano
Jane M. Fall
Mary Jane Galvin
Dana K. Higgins
Donna M. Hird
Jane M. Hirsch
Nina J. Kleinberg
Heidi K. Kylberg
Patricia C. Murphy
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Margaret L. Plunkett
Phelps F. Pond
Claudia Reid
Carol A. Sheridan
Dian E. Sparling
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M. Eileen Walsh-Escarce
Susan P. Wood

1982
Joan De Maio Agent
Luc Pelletier - Agent
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Ann Ritchie Atherton
Suzanne Ballard
Nancyellen Brennan
Bruce Carmichael
Annabel G. Ching
Deborah Ann Chyun
Susan Lee Cooley
Lisa M. De Dominicis
Ruth De Loatch
Joan A. De Maio
Linda Degutis
Marilyn Derksen
Joan King Dreyfus
Laura F. Foerst

1982 (continued)
Deborah D. Frank
Rachel M. Frazin
JoAnn L. Graziano
Judy Kier
Mary Kathryn Knobf
Kristen M. Kreamer
Barbara M. Maddox
Maureen U. Matthews
Beverly Milofsky
Faith Minard
Judy Kay Morris
Janet Mullen
Mary A. Quindlen
Catherine R. Schwob
Jessica M. Shank
Jude W. Sim
Thomas J. Sincic
Carole J. Singer
Rebecca Stockdale-Woolley
Patricia Tauber
Polly Wallian

1983
Audrey G. Knight - Agent
Eileen Sherburne Agent
Patricia M. Antos
Susan E. Bogar
Catherine Anne Buck
Margaret E. Colby
Bernice Coleman
Frances S. Combe
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Jeanne M. Erickson
Anna Fisher
Stephen William Foster
Donna J. Haggarty
Nancy B. Hall
Cornelia Anne Handy
Deborah Holdeman
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Linda M. Lenoce
Heidi W. McCloskey
Linda Knight Morse
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Gina Novick
Rebecca K. Olin
Deborah Pentland
Susanna Peyton
Cassy D. Pollack
Rebecca V. Reed
H. Gilmore Rinard
Eileen Sherburne
Lisa Summers
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that any nurse might use in her interaction with a patient. The process is defined as the interaction of three components -- the behavior of the patient, the reaction of the nurse, and any resultant nursing actions designed for the patient's benefit. She elaborates ways in which nursing observations may be made and validated to improve the quality of communication between nurse and patient through the use of this process.

Orlando, then, as we neared the end of institutionalization turned our attention from an exclusive focus on the mad to an emphasis on prevention and mental health -- an appropriate perspective as we approached the era of deinstitutionalization and community-based nursing.

Psychiatric Nursing Roles

In the last 23 years, under the social policy of deinstitutionalization psychiatric mental health nursing has matured and developed. In the first decade of the Sixties several events took place that solidified psychiatric mental health nursing as one of the four core disciplines in the mental health care system. In 1963 the first edition of Perspectives in Psychiatric Care was published. Dorothy Mereness published the lead article, "The potential significant role of the nurse in community mental health services", which raised questions about the educational preparation of such nurses and who should care for the mental patient in the community. Mereness advocated minimum preparation at the baccalaureate level and advanced preparation in psychiatric nursing. She singled out the use of public health nurses in the care of the mentally ill as an error, stating:

> Many public health nurses lack special preparation for understanding an emotionally ill patient or for working psychotherapeutically with a family group in the home. Therefore, this aspect of community mental health services will be more profitably carried out by prepared psychiatric nurses (p 38).

In a rebuttal article, Wolff (1964), a nursing administrator with background in psychiatric and public health nursing, took exception to Mereness claim that care of the mentally ill should be the sole domain of psychiatric nursing. She pointed out that psychiatric nursing, confronted, with a manpower shortage could not begin to meet the demands of hospital patients let alone expand services to the "hundreds of thousands waiting in the community". She documented that public health nurses did not suffer from shortages and were adequately educationally prepared to manage families in the home setting. She explicated the public health nurses knowledge of the community, its resources, and special abilities to manage difficult clients in a non-institutional setting. Finally, she suggested the possible collaborative roles of the public health and psychiatric nurse through the development of a consultative role for the psychiatric nurse with the provision of direct care reserved for the more abundant and already trained public health nurses. This debate, aired in the new psychiatric nursing journal, has had far reaching significance in the slowly developing network between psychiatric and public health nurses.

Meanwhile, in 1966 the American Nurses' Association established the Division of Psychiatric Mental Health Nursing which further ligitimized the authority of the psychiatric nurse to define her own practice. Indeed, the Division produced a practice statement in 1967 indicating that psychiatric nursing included a wide range of functional roles of which both prevention and treatment of mental illness were a part. The statement also indicated that the psychiatric nurse would be expected to function in a wide range of settings and use a variety of approaches to patient care.

The Seventies brought a proliferation of publications far too numerous to review that marked the intensified focus on specific aspects of psychiatric nursing practice or patient care issues. The end of this decade saw the development of standards, credentialing, and certification as a means of acknowledging expertise and distinguishing generalist from specialist roles and responsibilities as well as safeguarding the public.

The first half of the Eighties has witnessed the development of the ANA Social Policy Statement (1980) and the resultant revision of the Standards of Psychiatric and Mental Health Nursing Practice (1982).

Jean Steel, in the opening address at the ANA conference, "New Knowledge for Nursing Practice" held in Denver, Colorado November 3-6, 1983 suggested that the Social Policy Statement reflects major trends in health care and provides "enabling definitions and descriptions, seeking to clarify the direction in which nursing has evolved and to provide a means for future development." In less than four decades psychiatric nursing has grown from the reluctant custodian of the back ward mad, to the university based researcher and theoretician, and finally, to the alliance with the consumer of mental health services in the society at large. The American Nurse (1984) quotes Steel's address:

> The relationship between nurses and consumers can be deepened when both groups realize that the professions belong to and are the property of the society which grants the professions rights, responsibilities, and privileges in practice. This helps keep us honest, focusing our attention on meeting patient needs -- not institutional or personal needs -- and elevates us to a partnership with the people we serve rather than a partnership solely with other health care providers (p 4).

It is societies that determine, in accord with their different technological and economic levels of development and their socio-economic, political, and cultural conditions and values, what professional skills and knowledge they most need and desire. A profession is owned by society.

A profession, by definition, has a base in technical, specialized knowledge and applies that knowledge from a service as opposed to a profit or orientation. Because the professions are based on highly specialized knowledge and technology, society must rely on the members of a given profession to regulate themselves through research, systematic training, and collegial review.

Society vests the professions with the authority to use knowledge and technology in their practice. Paul Starr, a noted sociologist and author of the best seller, The Social Transformation of American Medicine, suggests that professional authority is based on 3 claims:

1. That the knowledge and competence of the professional has been validated by a community of peers;
2. That this consensually validated knowledge and competence rests on rational scientific grounds; and
3. That the professional's judgments and advice are oriented toward a set of substantive values, such as health.

He suggests that health care professionals are not only vested with the authority to advise action based on knowledge and technology but are granted the authority to "make meaning" of health and illness phenomena.

Just as Annie Goodrich suggested back in 1929 that the nurse must speak both the tongue of science and that of people so Paul Starr suggests in 1982 that the practitioner, in this case the professional nurse, uses science to develop a technology that allows them to intervene in the process of illness or enhance the process of health. One's technology, to a large extent, determines one's perspective on illness and health phenomena.

Lew Thomas (1974), a physician, research pathologist, and eloquent essayist, has written about the technology of Medicine. He says that there are three distinct technologies of Medicine: high technology, halfway technology, and non-technology. The real technology of Medicine is high technology. High technology comes as result of a genuine understanding of disease mechanisms through basic biological research. High technology is relatively simple and inexpensive to deliver when it becomes available. Such technology has virtually eliminated typhoid, pulmonary tuberculosis, end state syphilis, and poliomyelitis. Compare, for example, the relative costs of polio vaccines and their ease of administration to the days of Sister Kenny and her elaborate clinics and expensive rehabilitation techniques.

Halfway technology are the things done after the fact to compensate for disease. Halfway technology makes up for disease or postpones death. Thomas describes it as simultaneously complex and primitive. Heart transplants, kidney transplants and liver transplants all fall into the category of halfway technology; so do certain types of cancer treatments and treatment for mental disease. Whole medical complexes have grown out of halfway technology – intensive care units and dialysis units with their expensive and complicated machinery, chemotherapy and radiation clinics, sleep disorder and affective disorder clinics, to name a few. Halfway technology is expensive and imprecise, especially if compared to high technology. In fact, in a later publication Thomas (1984) indicts the phenothiazines as a halfway technologic advance in medicine that has resulted in more untoward social damage than any other halfway technology. He refers, of course, not to the medications themselves (for they still represent our most advanced technology in the treatment of mental illness), nor to their side effects (although there is cause for concern about those) but to the two social policies that resulted from the early positive effects of the medications: Deinstitutionalization and The Community Mental Health Centers Act. We know now that these policies may have been ill conceived or only half-baked, much like the medical technology that prompted them.

Non-technology, according to Thomas, is impossible to measure in terms of its capacity to alter disease or its eventual outcome. It's what we do with victims of diseases, like certain of the cancers, arthritis, multiple sclerosis and mental disorders, that we know little about. Non-technology includes just "standing by", supportive therapy, or providing reassurance. Thomas says non-technology is little understood, very complex, and very expensive to deliver (especially when delivered by physicians).

Thomas (1974) ends this essay on the levels of medical technology with a statement that reflects the medical model view about the relative value of each:

> It is when physicians are bogged down by their incomplete technologies, by the innumerable things they are obliged to do in medicine when they lack a clear understanding of disease mechanisms, that the deficiences of the health care system are most conspicuous. If I were a policy maker interested in saving money for health care over the long haul, I would regard it as an act of high prudence to give high priority to a lot more basic research in biologic science. This is the only way to get the full mileage that biology owes to the science of medicine, even though it seems, as used to be said in the days when the phrase still had some meaning, like asking for moon (p 36).

If we were to formulate health policy on the basis of the high technology of medical science alone we would be judged an inhumane society, indeed! -- at least over the short haul -- for it can be a considerably long time between basic scientific discoveries! It seems to me that the non-technology of medicine is the high technology of nursing. While both medical and nursing science serve humanity, it is the technology of nursing science that makes care humane.

Before examining the technology of psychiatric nursing care more closely it is important to look at the contexts in which the care is delivered. There are some clear shifts in both the location of care and the consumers of care

that will influence the role of the psychiatric mental health nurse in the next decades. Merwin and Ochberg (1983), two health policy analysts, one a psychologist and the other a psychiatrist, suggest that there are generally three categories of users of mental health services. There is the 25% of the population of consumers of mental health services who are not considered "mentally ill" but instead suffer from mild to moderate reactive depression or anxiety or psychophysiologic problems. Their distress is attributable to life stressors, marital and family problems, financial problems, developmental changes, low self-esteem, or altered role performance. This quarter of the consumer population does not generally seek care in either the public or private sector of the mental health services delivery system. Instead, they seek care from primary care providers (usually, although not exclusively, private physicians); from natural support systems, for example, Mechanic (1980) reports that of people seeking advice for a mental health problem 33% seek help from a friend and 28% from a relative; and from alternative treatment systems such as women's centers, hot-lines, shelters, family service centers, crisis clinics and the like. The 1978 President's Commission Report noted that in a 1975 survey 54% of those persons seeking "treatment" for a mental disorder received their services from the primary care sector.

Talley (1984) tells us that Depression is the most commonly encountered emotional problem in the primary care setting. She suggests that Depression may present in the form of normal depressive reactions to situational crises or as severe disorders with neurovegetative changes and suicidal behaviors. Her analysis of a case study illustrates that collaboration between generalist and specialist can enhance the treatment for patients with complex physical and emotional problems who are being cared for in non-psychiatric settings. Davis (1983) and Robinson (1984), in their reports of the role of the psychiatric liaison nurse in the general hospital setting document another growing population of mental health care consumers outside of the mental health care system. Patients admitted to general hospital settings with complicating psychiatric disorders will become an increasingly important consumer target population for psychiatric nurses. With HCFA prospective reimbursement regulations in effect since October it becomes economically essential to prevent long complicated hospital stays. Psychiatric liaison nursing consultation may reduce days in hospital for those patients admitted for medical conditions whose emotional problems might complicate stay. And finally, women, as a group, constitute yet another special population of consumers who make up the 25% who seek mental health services outside the system. A recent UPI release in the New Haven Register reported the latest Labor Department statistics on women and employment. Working women outnumbered those without paying jobs for the first time in May as more women than ever moved into the labor-force. The Department's monthly report on jobs and unemployment showed 50.5% of all women 20 or older held jobs. This is the first time that the percentage has moved above 50%. A decade ago 42.8% of all women were employed. A quote from Philip Rones, Labor Department analyst, provides a clue about the stressors these women may face: "Proportionately there are fewer women now who fall into that nice neat category of married with husband working." There are more single women, divorced women, and women whose husbands are unemployed now in the labor market than ever before. Add to that the increasing numbers of women who count themselves as half of a dual career marriage and you have a picture of the changing work role of women without the concomitant change in societal views, values, and norms about working women and their families. A total of 43,099,000 women were employed in May. What percentage of those will suffer transitional stress, or be labeled as mentally ill when their coping repertoires break down in the face of role strain? Gilligan (1982), in her book, In A Different Voice, points out that women think differently about relationships, intimacy, and caring and that these themes have a different influence on adult female development. Women who are faced with the dual task of managing work relationships and family relationships (with partners and children) may not find models for these complex affiliative roles and, further, may not find mental health professionals who understand the source of strain inherent in them. Psychiatric mental health nurses, with a professional emphasis on human responses, privileged intimacy, and caring may well be the only single discipline already prepared to address such issues. Since these consumers, the primary care users, the general hospital patients, and those at risk for role strain or stress (such as women) do not seek care in traditional mental health settings psychiatric mental health nurses will have to locate themselves strategically in the community. Some percentage of these consumers will be served by psychiatric nurses in private practice, still others will be served through a variety of private or publicly sanctioned consultation relationships, and some non-mental health settings will employ psychiatric nurses to meet the growing emotional needs of the clients they serve.

The second group of mental health services consumers are those consumers "at risk" for developing emotional problems requiring professional interventions. It is harder to set a finite percentage on this group. They are people who suffer from trauma, rape, abuse or battering, unusually high stress jobs, massive unemployment, chronic physical illness, terminal illness, or who fall into certain developmental risk categories, such as teenage parents or the disaffiliated elderly. We know, for example, that America is graying at a phenomenal rate. The Select Committee on Aging released a report in May 1983 which indicated that 26 million people in the United States are now over the

age of 65. Two point three million of this group are over the age of 80. This figure is expected to double by the year 2000 and double again by the year 2050. Some 15-20% of the elderly experience some memory loss or other impairments but none substantial enough to prevent their caring for themselves, alone or with minimal assistance. Only 5% of the elderly suffer from serious irreversible dementia. At least 80% retain normal intellectual functioning as long as they live. However, the National Council on the Aging recently released the results of a survey which discovered that nearly half of all Americans (45%) believe that senility is as much a part of aging as gray hair.

Women, once again, emerge as a subpopulation in need. They still constitute the largest percentage of the elderly and live longer lives than their male counterparts. They are by far the largest percentage of rape, abuse, and battering.

Our task with these consumers is largely one of prevention, through community consultation, education, and advocacy. Community Mental Health Centers, special interest groups, places of employment, and consumer advocacy groups are the likely sponsors of psycho-education programs designed to increase our knowledge of certain phenomenon and change our stigmatizing attitudes, toward the elderly, for example. The psychiatric nurse is likely to serve this group either through a formal institutional role in a mental health center consultation service or through responsible professional advocacy roles. It is my bias that each of us has a professional responsibility to provide community service either in the form of direct voluntary care or indirect committee and board representational activities that further the cause of the victims of mental illness and raise the collective consciousness of the communities who provide services to those victims. Prevention and case finding is best carried out within the fabric of the community. In fact, case finding is one of the activities that separates the bulk of the consumers in this second category from those who really belong in the third, and final, category of mental health consumer. The third category are those known as chronically ill or severly mentally disabled. To quote Merwin and Ochberg (1983):

> This group consists of diverse persons with widely ranging needs; what most of these people have in common is a marginal lifestyle at or below poverty line, a paucity of social supports, dependence upon public mental health organizations, and minimal coping and independent living skills. These consumers usually carry a diagnosis of a major mental disorder such as schizophrenia, manic depressive illness, or, increasingly, borderline personality. Directly affected by the policy, practice, and partial failure of deinstitutionalization, their lives lend themselves to both sensational newspaper exposes and heartwarming accounts of personal struggle and success in escaping institutional degradation and dehumanization (p 98-99).

Those of you in the field and, many of you who are not, know the statistics as well as I. Using the criterion of diagnosis and functional disability, the Department of Health and Human Services Steering Committee on the Chronic Mentally Ill estimates people with a diagnosis of serious mental illness at 3 million, people with moderate or severe disability at 2.4 million, and the number with both a prolonged and severe disability at 1.7 million. It is this 1.7 million that they conservatively label the chronic mentally ill. Talbott (1980), for instance, documents estimates of 4 million for this population. At any rate somewhat over half of these individuals are institutionalized in nursing homes or psychiatric hospitals for a year or more and slightly under half are in the community, with some 110,000 of those spending more than three months of any given year in a psychiatric inpatient unit. Other statistics, and I won't boggle your minds with numbers, have suggested that while we have shifted the locus of care of this population we have not significantly altered the rate of hospitalization, we have only shortened the length of stay in Veterans Administration hospitals and State/County hospitals, we have significantly increased the utilization of general hospitals, and we don't know how to interpret or even gather meaningful readmission date -- since it would be expected that those with a chronic psychiatric disorder, like those with a chronic physical disorder, might need to be hospitalized for acute exacerbations and since, to accurately compute readmission rates one has to follow individuals over time not deal in aggregates.

Among the chronically mentally ill we have those individuals who are discharged under the policy of deinstitutionalization who were referred to nursing homes, or to aftercare programs in the community, or dumped on the streets. We have those individuals who were never institutionalized, among them the so-called "young chronics" who represent the first generation of the seriously ill who are not treated in inpatient settings and, indeed, may not be found in traditional mental health settings at all. This group may frequent shelters or soup kitchens or may periodically appear in hospital emergency rooms or primary care centers. They have a low hospitalization rate, a high incidence of drug and alcohol abuse, a high incidence of suicide attempts and successes, a high incidence of conception (producing our next generation of high risk consumers), and a record of inconsistent to non-existent use of mental health services. Among this "young chronic" group are three identifiable sub-groups. First, there is the group that is essentially like their previously institutionalized counterparts. They have adopted the sick-role, have discovered replacement institutions in the community and function at a low level of social competence. The second sub-group is highly motivated to acquire valid community roles and functions well when not plagued by symptoms and exacerba-

tions. They drop in and out of the treatment system, fighting the sick role and developing few lasting networks of supports. And, the third group is aggressive, hostile to care, highly symptomatic and taxing to communities and family systems -- they live in their cars, on the street, out of shopping carts and eschew any form of organized care. When taken as a group this third category of mental health consumers, the chronic mentally ill, is by far the largest, most severely disabled, and in need of the most comprehensive treatment system. Bachrach (1980) has identified 12 principles that seem to be shared by most successful model treatment programs for this group:

1. The top priority in these programs is placed on the most severely disturbed.
2. Treatment programs are individualized, the format is flexible, and varies over time in frequency and duration according to the motivation and condition of the client.
3. There is open access to the program with easy entry and re-entry and a bare minimum of bureaucratic red tape and paper work.
4. The programs provide for the full range of comprehensive services that the total institutions used to provide.
5. They have strong links with other human resources and utilize some form of client management system.
6. The programs provide strong immediate response capabilities to crises and have access to hospital beds and liaison systems.
7. They use assertive outreach to help keep people in the programs or to at least maintain client monitoring.
8. They engage in strong advocacy on behalf of clients.
9. The programs are culturally relevant to consumers, including being streetwise and integrated into the consumer subculture if such exists.
10. The office-based model is minimized and many services are provided on consumer turf.
11. The staff is specially trained, attuned to the unique survival strategies necessary for the chronically ill, dedicated to this population, and able to see progress in even the most miniscule change.
12. The programs have built in mechanisms to address staff feelings of frustration, anger, anxiety, and burn-out and strive to build a strong inter-staff culture.

There is yet another group of chronic mentally ill -- a group seldom spoken of anymore. They are the patients who were left behind when deinstitutionalization emptied the back wards and the patients who, once readmitted or admitted to the state hospitals have required lengths of stay of one, two, even five years because of a combination of severe disability and lack of community resources. This group requires revitalized therapeutic community programs that concentrate on improving their functional ability and modifying their social disability. Some of this number can be relocated in the community in structured and less restricted environments and others may require permanent restricted care -- in which case they are deserving of a higher quality life than they currently lead behind the idyllic walls of our public mental institutions.

There is, of course, a fourth category of mental health consumer. They are the fortunate few who suffer from certain of the affective disorders -- selected depressions, manic-depressive illness, or from sleep disorders whose diseases are being controlled, even eliminated by the best that biomedical technology has to offer. There are the not so fortunate among this group, the 5% of the elderly who suffer from Senile Dementia of the Alzheimers Type or from Multi-infarct Dementia whose only real hope for improvement lies in the as yet unknown biomedical discoveries (Select Committee on Aging, 1983).

By and large, though, the mental health consumers of the next decades have demands that extend well beyond the medical psychiatric model. Successful programs have differed widely as to who did what to whom. If they follow any model at all it is the broadly defined psychosocial rehabilitation model which in Turner's (1982) words provides: "certain basic opportunities and services -- socialization, living arrangements, educational and work opportunities, training in community living skills, advocacy in the context of a supportive, normalizing group in the community." This is a hybrid model -- not purely mental health or purely rehabilitation, not purely self-help or purely professional. It is a model which requires expert psychiatric nurses at its heart and its head. It is a model uniquely suited to the humane technology of nursing.

Taken as I am with the writings of Lew Thomas, I have been struggling for months to capture and describe the technology of nursing in as eloquent terms as he has described the technology of medicine. Fortunately for me, and for you, I can give up the struggle because I've happened upon a new book by Patricia Benner (1984) entitled, From Novice to Expert: Excellence and Power in Clinical Nursing Practice, which captures the nature of nursing practice in exquisite narrative relying on the cases of practicing nurses. Benner builds the case for contextually based practice and uses the cases provided by the nurses in her study to illustrate that clinical expertise is situation based not skill or talent based and that involvement, commitment, and intimacy are necessary to establish salience for expert performance, for noticing nuances and subtle changes, for transforming skill to practice, for remaining embedded in perceptions not precepts. She utilizes the Dreyfus Model to analyze developing levels of expertise in nursing practice. That model posits five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Attainment at each level reflects changes in three aspects of skill performance:

1. Movement from reliance on abstract principles to the use of past concrete experience or paradigms;
2. A change in the learners perception of the demand situation in which the situation is seen less and less as a compilation of equally relevant bits and more and more as a complete whole in which only certain parts are relevant;
3. Passage from detached observer to involved performer.

Benner suspected that in order to describe expert care -- with an emphasis on care -- that she was going to have to capture critical incidents from nurses identified by their colleagues and supervisors on a continuum from beginner to expert. She believed that conceptual clarity follows more often than precedes experience and that real experts often know more than they can tell. Thus, her research was descriptive and grounded in the actual nursing practice situations. Her sample included expert psychiatric nurses in an acute inpatient setting. She has this to say about their practice:

> The psychiatric nurse has unique functions in the acute hospital by virtue of the nature of psychiatric illness and the context of the psychiatric unit...What sets the competencies apart from the others are the particular kinds of therapeutic goals and intentions of the psychiatric nurse.
>
> The psychiatric nurse uses many ways to channel a patient into ways of being that hold more potential for growth. As a guide and mediator helping confused people carve a path into a more shared, less idiosyncratic world, the nurse is firm, direct, and approaches the patient with as much clarity as possible. In trying to help people change, the nurse (1) acts as a psychological and cultural mediator; (2) uses goals therapeutically; and (3) works to build and maintain a therapeutic community (p 66-67).

Each of the competencies identified grew out of multiple, rich, case examples provided by expert nurses. For example, the following critical incident contributed to an understanding of the competencies involved with building and maintaining a therapeutic community:

> Expert Psychiatric Nurse: An unusual day that stands out for me was a day in which a patient had suicided on the unit (during the night), and the psychiatrists did not come in. We notified the family. We gave the night staff an option of staying over for the community meeting of the patients--got the patients up for breakfast, then called this special meeting to inform them of the incident and allow them to talk about how they were feeling. We wanted to deal with and respond to feelings that this loss brought up, e.g., "Why didn't you protect him? -- Can you protect me? Because a suicide brings up panic and brings down impulse control on the unit, we worked with patients to devise a special three-day emergency plan, whereby we intensified one-to-one availability, stopped off-unit privileges, stopped passes unless plans were detailed with a resource nurse, and stopped admissions temporarily (p 74).

From this incident came the understanding that patients interpret the meaning of psychiatric events -- suicide, acting out -- personally, in terms of their own ability to get well, to remain in control, and in terms of the staff's ability to assist, protect, and help them. Nurses must attend to such meanings. They also structure the environment in such a way that the meanings can emerge and be explored, so that the meanings can be reinterpreted or reshaped in the interest of therapeutic goals and the community. These things don't happen by accident and expert nurses make them happen a lot more smoothly than novice nurses.

Benner's thesis suggests that the power of nursing practice lies in caring. She discovered that all of the expert nurses were intimately involved with their patients and the situations in which they practiced. None made regular use of professional distance although all understood boundaries. She learned that it was only by giving up the rules of practice that were learned in school or relied on at an earlier stage of proficiency did nurses become expert. It was abundantly clear that nurses were expert in certain situations -- those in which they had had repeated exposure and practice -- but those same nurses might be novice or only competent in other situations -- those in which they had not had concentrated practice.

Benner's work has enormous implications for the practice of psychiatric nursing and for the empirical "fleshing out" of our technology of care. First, it argues that we must continually locate and evaluate the contextual bases of our practice. This involves identifying and prioritizing the consumer populations in need and locating practice either inside or outside the formal mental health care system, at various points in the community, and at the logical interfaces of consumer need and health services access.

Second, we must provide the opportunity for our practitioners and students to become expert. We know that expertise comes from concentration in selected areas of nursing practice, from exposure to a sufficient number of cases that they become paradigms for care, from experience. These notions legitimize the advanced practice roles in psychiatric mental health nursing and argue for the necessity to concentrate of sub-specialize within those roles. They further argue for staffing patterns that do not assume that a nurse can fill any function in the institution and can be all things to all people -- but rather that patterns should support concentration and specialization in an area or with a population in order to insure the development of expert nursing care and the delivery of quality care to clients. In our training programs we will need to devise ways to teach core content and leave time and space for in-depth concentration in specified areas

of practice so that our graduates can enter the practice domain with developing expertise. It has been argued that specialization leads to narrowly conceived and limited practice. On the contrary, specialization leads to depth and richness and familiarity that breeds expertise.

And finally, Benner's work argues for an increased commitment on the part of psychiatric nurses to grounded, descriptive research that will continue to uncover the components of expert practice and caring in the context of psychiatric nursing. For example, we need to know a lot more about the recovery trajectories of the chronically mentally ill -- how nurses assess them and at what points they initiate more aggressive, or more protective interventions. We need to understand the nature of the early warning signals, the soft signs, that psychiatric nurses use in crisis situations to avert further excacerbations -- in violent episodes on inpatient units, among family members of a suicide victim in the Emergency Room, in a group with an actively psychotic member. How do psychiatric nurses identify the subtle gradations between and among trauma victims, the raped or abused -- that distinguish between those that are coping well and those that are at risk for serious psychiatric disturbance? What are the elements of the therapeutic community that contribute to improved functional status of patients? In the general hospital setting, what are the family characteristics that signal the liaison nurse to actively intervene or let the family "do their own thing" when a family member is dying. How do the nursing interventions differ?

The beauty of the contextual approach both to practice and the study of it is that the phenomena remain whole and dynamic and the activity -- practice or research -- is intertwined -- not surprising observation for a product of the Yale School of Nursing which so values the marriage of practice, teaching, and research.

Psychiatric nursing's early roots, traced to the works of Peplau, Tudor, and Orland, lie in the relationship aspects of care. Our specialty has developed in a way that Benner would say has fostered expert nursing care.

The basic premise of psychiatric nursing practice is that the way people talk about their lives is of significance, that the language they use and connections they make reveal the world that they see and in which they act. Such was also the central assumption of Gilligan's research that explicated female development. She states that "the elusive mystery of women's development lies in its recognition of the continuing importance of attachment in the human life cycle...women's identities are inextricably tied to intimate relationships and have been from the beginning...even tho' it takes men until midlife to discover and celebrate relationship, intimacy, and care". The concept of attachment and separation appear in adolescence as identity and intimacy and in adulthood as love and work. For women, and for nurses, the two are the same - to work is to love in the context of privileged intimacy. But, then, Diers (Diers & Evans, 1980) told us that a long time ago.

WOMEN AND POWER

-- Rhetaugh Dumas

It is always a distinct pleasure for me to return to the Yale School of Nursing. But, today it is a very special pleasure. We are honoring Donna Diers, and I am extremely appreciative of the opportunity to join in celebrating her achievements as Dean of our distinguished alma mater and in wishing her well in her designs for the next stage of an illustrious career.

Donna's choice of topic Women and Power - for my presentation reflects an area of mutual interest and concern that has been the focus of continuing dialog between us from the time that she became my colleague on the faculty here to this present day.

Over the years I have become keenly aware that inherent in the notions about women and power are some complex dilemmas, posed on the one hand by the traditional gender stereotypes and the desire to transcend them, and on the other hand by the fear of powerful women that lies hidden just beneath rationality not only among men but among women as well.

At the Yale School of Nursing we were, no doubt, on the horns of such dilemmas during the sixties. We were charting new directions for the school. We were pioneering clinical nursing research and therefore operating on the cutting edge in the scientific development of nursing. We were negotiating new relationships within the school and between the school and other units of the University. Before these were settled, we were being challenged by the Civil Rights Movement, the Black Power Movement, and the Contemporary Women's Rights Movement, to expand our perspective beyond traditional psychological, social, and cultural boundaries of mission and goals. We were being pressured by groups and organizations within the New Haven communities to pay greater attention to their respective prerogatives and needs. Some of our colleagues in nursing education were challenging our strong emphasis on research at the masters level, which they believed was more appropriate to doctoral preparation. Within the profession, nursing roles were being expanded and nurses were having to deal with the resistance of colleagues in other disciplines. The demand for "community control" signaled the rise of a stronger consumerism which raised critical issues concerning the balance of power between consumers and health care providers.

It was in the mid 1960's, during those times of turmoil and exciting advances, that Donna and I would retreat into her office or mine after a very hectic day to try to unravel the perplexing course of events. We worked to better understand the dynamics that were occurring within the faculty as a whole and among the various subgroups. All were women struggling to gain greater power within the School of Nursing and on a number of fronts outside. None were willing to admit to their fierce competitive strivings nor to their power tactics. They were lacking the awareness as well that most often we were probably as frightened by the prospects of success as by the fear

of failure. In any case, the Dean was held responsible for our predicament. I am sure that this struggle is even more familiar today. For the struggle continues and is more intense today in the groups and organizations in which and with which we live and work. Without that struggle there is no progress. Power is an important consideration in all social relationships, often unacknowledged among women. Whether acknowledged or not, people (and women are not exempt) are concerned about their ability to influence the course of events that have important implications for their lives, and this ability may not exist without some degree of power.

The myth of the weaker sex appears overtly to have been attenuated, but covertly it is lurking in the crevices of the minds of women as well as men. I propose that it functions to conceal the fear of powerful women and the fear of being powerful. There is implicit support for this proposition in the works of Freud, more explicit in Melanie Klein. Wolfgant Lederer (1968) has perhaps the most explicit treatment of this issue in his book entitled, The Fear of Women. He speaks only of man's fear of women. Of all the things that occupy the thoughts of men, he says, relationships with women are perhaps the most basic. These relationships have been variously described in other literature and in conversations as intricate, perplexing, elusive, and so on. Lederer presents cases in which strong men fret about their experiences in relation to women. Their fantasies certainly contradict the notion that women are shy, timid, or weak. Rather, women are experienced as powerful and inescapable beings who arouse in men feelings of inadequacy, anger, bewilderment, fear, horror, awe, and at the same time, love, devotion, and dependence (p VII). The myth of the weaker sex masks these feelings and stereotypes of masculine and feminine roles, and force society to consider the recognition and expression of such fears unmanly and hence unacceptable behavior. While overt expression can be suppressed, its impact is nonetheless powerful. The fear is manifested covertly and has far-reaching ramifications in the lives of men and women. Fantasies about the power of women and what will happen if this power is unleashed prompt men and women to hold potentially powerful women in check. For many women, even today, reference to their aggressive and competitive strivings or their power potential is very threatening. Their strivings and struggles for power find expression in subtle, passive-aggressive behavior.

When I began to speak publicly about women and power just ten years ago, many of my colleagues in nursing became quite anxious. They denied having any interest in power, and they were concerned that I would convey the "wrong impression" to our colleagues in other disciplines and to the public. In their thinking, the concept of power and the concept of nursing as a helping profession were incompatible. They stressed the importance of concepts such as leadership, teamwork, cooperation, and collaboration without realizing that success in achieving these relationships involves the exercise of power.

They stressed the role of nurse as change agent, apparently unaware that the concept of change and the concept of power are inextricably tied together. They were unwilling to examine how nurses use power because they were preoccupied with the negative connotations of the concept. The old saying that power corrupts and absolute power corrupts absolutely held special meaning for them. They held the belief that power exists in some fixed quantity and that the exercise of power by one person or group renders another or others powerless. They associated power only with conflict, ignoring the fact that power can also foster cooperation. The desire to avoid conflict reinforced their resistance to deal openly with power issues. While some resistance still remains, larger numbers of nurses are realizing the need to give greater attention to this concept. Furthermore, issues regarding women and power, although still somewhat elusive in the minds of many, are being viewed as relevant to the status and progress of the nursing profession. And that's progress.

There is still much work to be done if we are to overcome the pitfalls of the early socialization of males and females that perpetuate gender stereotypes and that are retarding progress towards ensuring equal rights for women in this society. This is not to discount our progress toward this goal. We have come a long way since the early days in the founding of New England when Anne Hutchinson challenged church and state on behalf of new ideas of tolerance and religious freedom and questioned for the first time the validity of the place assigned her because of her sex. Since the days in the colony of Maryland when Margret Brent challenged the House of Burgesses to permit her to vote. Since the time women abolitionists won the right to speak in public and began to evolve a philosophy of their basic rights and deserved place in society. Since the time when Lucretia Mott, Elizabeth Cady Stanton, and Susan B. Anthony championed the cause for women's suffrage, and since the time that Sojourner Truth, a former slave, turned the full force of her eloquent elocution against those who ridiculed women too weak and helpless to be entrusted with the vote. That was in 1851 at a women's rights convention in Akron, Ohio, when one of the women present seemed able to answer an outbreak of heckling, and it looked as if their cause would be worsened at their own gathering (Flexner, 1972, p 90). Miss Truth gained the podium over the objections of many of the women who feared that she might do greater harm to the cause. Nevertheless, the chairperson gave her permission to speak -- and she saved the day.

With a gesture that electrified the audience, Sojourner Truth raised her black arm (in defense of women's causes and in demand for the respect and rights they deserve). "Look at my arm, I have ploughed and planted and gathered into barns, and no man could head me -- and ain't I a woman? I could work as much and eat as

much as a man -- when I could get it -- and bear the lash as well -- and ain't I a woman? I have born thirteen children, and seen most of them sold into slavery, and when I cried out with my mother's grief, none but Jesus heard me -- and ain't I a woman?"

Lucretta Mott, Elizabeth Cady Stanton, Susan B. Anthony, and their followers paved the way for the work for equal rights for women under the constitution of the United States, that work continues to this very day.

Attitudes have been changing towards women. We have witnessed increasing efforts to eliminate sex role stereotypes and discrimination. Educational opportunities have continued to expand and women have now reached parity with males in the median number of years of schooling completed. Career opportunities are expanding, and there have been progressive increases in the number of women in the labor force. Small numbers of women now head business enterprises. The number of women in high governmental positions have increased considerably, and numerous other gains could be cited. None could have occurred without some degree of power (yet we still have far to go before true equality is achieved).

Women comprise about 53% of the voting population in this country but hold on 12% of all public offices. They hold only two seats in the United States Senate and 21 seats in the House of Representatives. In State Legislatures, women comprise 12% of the total around the country. There is currently only one woman serving as Governor of her state, and there are seven women serving as Lieutenant Governors. Two women are members of the President's Cabinet; one woman on the Supreme Court; one on the Federal Reserve Board; one woman was recently named General Counsel for the National Labor Relations Board; and just recently a woman was confirmed as Deputy Attorney General.

Our power is increasing, but this is still a man's world. Law, architecture, natural sciences, engineering, and medicine, for example, are still male professions. Men hold the high academic posts. With only a few exceptions, men are the presidents of the major institutions of higher learning. They head the major economic institutions. They dominate the political area, the military establishment. The proportion of women to men on boards of trustees of academic institutions is too low to be significant. The privately endowed institutions depend in large part upon the corporate sector for survival. Only a small number of women serve on the boards of directors of large banks and corporations. It is estimated that a considerable proportion of the nation's wealth is owned by women but controlled by trust officers and executives who are men.

These and other glaring inequities are not likely to change significantly unless women are able to develop and mobilize stronger power bases. Otherwise, we may never fully realize equal rights under the law for all Americans.

In his book, The Active Society, Amitai Etzioni proposes that, under most circumstances, societal goals and decisions will not be implemented without some kind of power, even in situations where commitment and knowledge among the various actors are considerable. This proposition is based on the assumption that the realization of societal goals requires change in societal relations, and, as a rule, attempts to introduce change are met with resistance. "Unless the resistance is reduced," he says, "the course of action set will not be a course of action followed." (The capacity to overcome part or all of the resistance, to introduce changes in the face of opposition, is what Etzioni means by "Power"). According to Etzioni, in societies where the law prescribes civil and human rights, we cannot rely solely upon education and identification with the underlying values for the [safeguard] of these rights. Thus, any group of citizens whose rights are denied must have at least a latent capacity to exert sufficient power to activate the societal mechanisms necessary to restore their rights.

It is important to note here that in my conceptual schema, power is defined as that force that enables persons or groups of persons to realize their will even against opposition. This definition refers to power in social and political relationships. Thus, a clearer understanding of power demands a clearer understanding of the nature of social and political relationships since this is the context in which power exists.

By definition, the social relationship refers to the behavior of a plurality of parties in which each party takes into account and is oriented to the behavior of the others (a party might be an individual or a group) according to the Weberian definition: "The social relationship consists entirely and exclusively in the existence of the probability that there will be in some meaningful understandable sense, a course of social action. For a social relationship to exist, there must be at least a minimum of mutual orientation of each party to the action of the others or others. In general, social relationships can be dynamic, flexible, variable, and they may provide unlimited possibilities for influencing the course of events. It is important to realize that the meaning attached to a social relationship need not be reciprocal. In fact, those in which there is total correspondence between attitudes are often limiting cases. The consistent desire among women for concensus is a signal of the tendency to define social relationships too narrowly.

A social relationship can be temporary or of varying degrees of permanence. The subjective meaning of the relationship may not always remain the same. However, when the subjective meaning remains relatively constant, it is possible to formulate that meaning in terms of maxims that the parties involved expect their partners to adhere to. The more rational the action is, in relation to values or to given ends, the more possible this becomes -- rational formulations of the subjective meaning of busi-

ness relationships are, of course, much easier than those of intimate relationships. This partially accounted for by the fact that business contracts are easier to formulate, negotiate, and keep than are contracts dealing with emotional relationships and personal loyalty.

The term "influence" is used to refer to generic phenomena by which the behavior of one person or group has an effect on the thoughts or actions of another or others. Influence is reciprocal, although not necessarily equally distributed. Influence is limited, in that no matter how unequal, the dominant party is always limited to some degree by the other. Power is one type of influence. Authority is another type of influence. Leadership is a mechanism for exerting this influence in groups and politics is which is important for our consideration here.

Authority is that type of influence that enables an individual or group to do certain work, to take certain actions, to command the actions of others, and to have particular definitions of reality and judgments of meaning and value prevail as valid and true (Starr, 1983, p 13). Authority is dependent upon sanctions that are provided by a prescribed set of substantive values and codes of conduct.

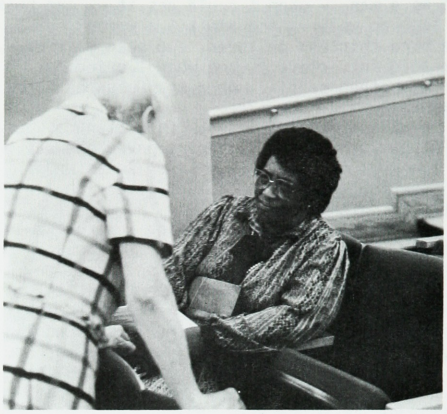
Bernard Barber uses the terms of legitimate and illegitimate to distinguish between authority and power, calling authority legitimate influence in that sanctions are provided by shared sentiments among the parties in the social relationship. He calls power illegitimate influence because it occurs in situations where parties do not share a set of common values or sentiments that sanction the decision or course of action. It is illegitimate only from the point of view of those who oppose the decisions or actions.

Both types of influence -- power and authority -- may be formal or informal. Formal being that type of influence that occurs by virtues or defined roles and positions structured within groups and organizations. Informal by virtue of roles and positions that are not formally defined within a group or organization.

Let me summarize:

1. Power is a relational concept.
2. It is a type of influence in social relations.
3. It is that type of influence that occurs when parties subject to the influence do not share a set of common values or sentiments that sanction the action.
4. It is that type of influence that is necessary when the authority of a party or parties is inadequate to implement decisions or gain sanction for a certain course of action.

Both types of influence -- authority and power are vital to our concerns of women and of nurses. In considering sources of power, I have found the works of C. Wright Mills (1956), Abraham Zaleznik (1976), and Paul Starr (1983), particularly illuminating.



Rhetaugh G. Dumas '61

No one can be truly powerful unless he/she has access to the command of major institutions, says C. Wright Mills in his book, The Power Elite. It is true, he says, that not all power is anchored in and exercised by means of such institutions, but only within and through them can power be more or less continuous and important (p 9). This same author continues: "If we took the one hundred most powerful men in America, the one hundred wealthiest, and the one hundred most celebrated away from the institutional positions they now occupy, away from their resources of men and women and money, away from the media or mass communication that are now focused upon them, then they would be powerless and poor and uncelebrated. For power is not of a man, wealth does not center in the person of the wealthy, celebrity is not inherent in any personality. To be celebrated, to be wealthy, to have power requires access to major institutions, for the institutional positions men occupy determine in large part their chances to have and to hold these valued experiences (pp 10-11). Mills' comments refer to the power elite composed of men whose positions enable them to transcend the ordinary environments of ordinary men and women. They are in positions to make decisions having major consequences. They are in command of the major hierarchies and organizations of modern society. They rule the big corporations. They run the machinery of the state and claim its prerogatives. They direct the military establishment. They occupy the strategic command posts of the social structure, in which are centered the effective means of the power and the wealth and the celebrity which they enjoy (pp 3-4). Below the elite there are those at the middle levels of power -- for example, members of congress, pressure groups, members of the upper class. Although such individuals or groups may not hold top posts in any dominating hierarchy, they are able to gain the ear of those who do hold such positions and who can exercise direct power on their behalf, if they choose to do so.

This reference is especially helpful to develop a better understanding of sources of power at the highest reaches of the social structure in this country.

In a book entitled, Management for Nurses (1976), edited by Stone et al., Abraham Zaleznik focuses his discussion of power more narrowly, and describes the initial "capitalization" that makes up an individual's power base. His conceptualization includes three elements that provide the capital for an individual's power base: (1) the amount of formal authority vested in his/her position, (2) the amount of authority vested in his/her expertise and reputation for competence, and (3) the attractiveness of his/her personality to others -- how much he/she is respected or liked. He suggests that the capitalization of power requires one to internalize all the sources of power capital in a manner similar to that in which she/he develops a sense of self-esteem. The individual knows that he/she has power, assesses it realistically and is willing to risk personal esteem to influence others. To retain this power base, he says, the individual must perform and get results. Attrition in the power base may erode confidence, which often leads to self-doubt and undermines the psychologic work that enabled the individual to achieve power in the first place.

Mills cites society's major economic, social, and political institutions as the primary sources of power, and Zaleznik cites personal characteristics and more importantly, I believe, formal authority as power capital.

Paul Starr's book, The Social Transformation of American Medicine (1983), puts all of these sources in bold perspective. His book gives a brilliant historical account of how American doctors, who were bitterly divided and financially insecure in the 19th century, have united to form one of the most powerful and authoritative professions of the 20th century. How they have achieved an especially persuasive claim to authority in health affairs, and how they have converted their clinical authority into social and economic privilege, and power is indeed instructive for us.

Medicine was transformed into an authoritative and powerful profession by the interaction of factors related to its internal development and those related to the social, economic, and political context of the times. Social and scientific advances in the late 19th century promoted more internal cohesiveness as doctors became more dependent upon each other for referrals and use of facilities. Greater cohesiveness strengthened their authority. Better diagnostic technology strengthened their authority.

Before the profession consolidated its position, some doctors had great personal authority. They pronounced on all kinds of problems not limited to physical illness. But that authority was inherent in the person, not the role, nor the profession. Authority was not institutionalized in a system of standardized education and licensing. And so the authority was not transmitted across that generation nor was it reproduced from one generation to the next. And so a doctor might have great authority as a result of his personal character and relationship with his particular patients. But until the authority of the physician was institutionalized, it remained limited and dependent upon individual character and lay attitudes. Once institutionalized, standards for education and licensing conferred authority upon all who passed through them. The institutionalization of professional authority also regulates the relationships among doctors. People have become increasingly dependent upon medical authority for a variety of gatekeeping functions and doctors have become dependent upon each other's referrals and sanctions. Both of these developments have contributed to the ability of the profession to confirm and strengthen its authority. The conversion of that authority into power and privilege involved gaining control over the markets for health services and over the various social, economic, and political hierarchies in health-related arenas. That control was gained by shaping the structure of hospitals, insurance, and other private institutions that impinge upon medical practice. Organizational and political arrangements have been very important to the rise of the medical profession and to its defeating national health plans that incorporate physicians as employees. Their gatekeeping authority has given doctors a strategic position in relation to health-related organizations. Their authority to decide whether and where to admit patients, to prescribe drugs, to select expensive equipment, etc., gives them great leverage over hospital policy and wins them good will, financial and political support from drug companies and other businesses that profit from the practice of medicine.

I believe that there are lessons here that might be useful to women.

1. Authority is a significant source of generating power -- but its greatest value is derived when that authority transcends the mere command of actions -- or social authority. We must be able to influence thoughts, ideas, information, experience. We must have cultural authority. This would mean that we are able to have our definitions of reality, our judgments of meaning and value as women prevail and to have them sanctioned as valid.
2. Professionalism and social unity are sources of power.
3. Command or control of markets is a source of power.

Finally, the importance of sound organizational and political strategies can never be overemphasized in any consideration related to women and power. None of this will be effective until we have found ways to diminish the fear of powerful women, not only as objects but also subjects (i.e., ourselves).

Conclusion:

Throughout the history of this nation, women have struggled to transcend gender stereo-

types that have defined their "place" in society as subordinate to men. They have continued in the quest for the respect and status that they deserve and for more significant numbers in high positions of authority and power in this society's major institutions.

Women have continued to challenge and extend the boundaries of "woman's place" and a new woman has been ever emerging, insisting that neither providence nor anatomy blueprints her for all times; that the status and role of women are socially determined and thus subject to social amendment; that broad social policy that sanctions a wider scope of functions and prerogatives, higher positions of authority and power for women will be meliorative not only for women but for the societies in which we live and work (Reeves, p L6-L7).

The voices of women through our history heralding women's legal position, their education, their work, their involvement in politics, their rights and prerogatives, as human beings and as citizens of this nation -- are resounding the challenge for women in the twentieth and twenty-first centuries.

More power to you!! Thank you.

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ALUMNAE/I NEWS

Regional Meetings

Violent weather changes are no stranger to YSN gatherings, it seems. Hence, the Spring meeting arrived almost in the threes of the recent surprise winter storm. The few who dared to travel and attend the meeting are to be envied! The speaker, the mini-field trip in the hospital, and the discussions that followed were all of excellent quality affording much information and stimulation of thought. The mutual feelings of the group were to continue to offer meetings to the New York Chapter since the quality of the programs have always matched up to Yale standards.

On Saturday, March 31st, Kathleen Reilly Powderly '75, Director, Perinatal Major, Graduate Program at Columbia University School of Nursing, conducted the meeting dealing with Ethical Issues in Nursing within the Neonatal Intensive Care Unit. Not only did she arrange a visit to the Neonatal I.C.U. but then led the discussions which talked about pending and ensuing legislation relating to the right to life and right to die. The knowledge base of all who attended was most assuredly intellectually stimulated and expanded.

Eleanor Grunberg '46
Elizabeth Plummer '46W
Co-Chairmen, New York Regional YSNAA

On Tuesday evening April 10th the Connecticut Regional Group met at AYA House in New Haven.

Margaret Flinter, '80, talked about "Third Party Reimbursement for Nurses in Connecticut". Margaret is a Family Nurse Practitioner at the Community Health Center in Middletown, CT., and a member of the Board of Directors for Co-op America National Health Insurance.

Donna Vose discussed The Center for Nursing Innovations of which she is Executive Director. Ms. Vose is past Executive Director of the Connecticut Nurses Association.

Alumni Fund

From Alumnae/i Fund Chairman, Mary Jane Kennedy

On May 6-9, 1984 a pilot program of telephone solicitation for the Yale School of Nursing Alumni Fund was held at the Fund office, 155 Whitney Avenue.

Dedicated volunteers, lots of support from Claire Lauterback, at the Fund office, and great refreshments helped to make these four days a success and has convinced us that an annual phonathon is a definite plus. We are happy to report that our efforts resulted in firm pledges of almost $6,000. Moreover, all volunteers reported enjoying themselves and have said they'd do it again. And we will!

(left to right) Toni Daniels '30, Mary Jane Kennedy '68, Mary Dalbey '57, Shirley Greenwald '53, Margaret Allman '49, Ruth DeLoatch '82, Evelyn LaFlesh '63, "Boots" Day '52, Connie Fisher '73

Eleanor Herrmann has been named to the Academy of Distinction of the Adelphi University Alumni Association.

The Academy was established in 1972 to recognize the achievements of outstanding alumni. It is a University-wide body. She was presented with the Academy of Distinction Medallion on Founder's Day, May 20th.

Eleanor is Associate Professor of Nursing - teaching in both Med-Surg and 3 year Programs at YSN.

Dorothy Sexton presented a research abstract, "Impact of a Husband's Chronic Illness (COPD) on the Spouse's Life," and a Meet the Professor Session, "Thinking about Research Questions in Respiratory Nursing," at the American Thoracic Society Annual Convention in Miami, Florida, in May.

Linda Norton '80 also presented, "Advances in ICU Monitoring: Computerized Pulmonary Monitoring," at the ATS Convention.

Constance Donovan spoke on "Allocation of Nursing Resources in the Acute Care Setting in an Era of Cost Containment - Clinical Expertise and Cost" at the ANA Convention in New Orleans in June.

Anne Bavier presented a paper at the Oncology Nursing Society Annual Congress held in Toronto in May. The paper was entitled, "Interdisciplinary Collaboration: A Model for Self Learning."

Kathleen T. Flynn, Associate Professor in the Medical-Surgical Nursing Program, visited the People's Republic of China with an American Study Tour. Hospitals, schools of nursing and commune health clinics were toured in Shanghi, Nanjing and Beijing. Kay spoke on a Framework for Treatment of Primary Breast Cancer and discussed selected examples of treatment modes and the implications for nursing practice and research. The clinical study trip was funded in party by the Connecticut Division of the American Cancer Society.

Marjorie Funk, M.S.N. (YSN '84) has been appointed Instructor in Medical-Surgical Nursing and Clinical Nurse Specialist-Cardiovascular Nursing (40%) at Yale-New Haven Hospital.

Marjorie studied for her B.A. at Wheaton College and her B.S.N. at Cornell University.

She has had several years of critical care nursing experience and was an instructor in the Nursing Education Department at Yale-New Haven Hospital. She is a certified critical care nurse.

Marge was awarded a Louise Mellen Graduate Fellowship in Critical Care Nursing for her two years of study at YSN.

Marge's thesis was entitled, "The diagnostic reliability of right precordial EKG leads in right ventricular infarction." Her recent publication, "Preparing the patient for a MUGA study," appeared in Critical Care Nurse in 1983.

Marjorie plays tournament golf and is a former Connecticut Women's Golf Champion.

Student News

Student Scholarship Awards, 1984-85 Announced

American Cancer Society

Linda Lonski '85
Deborah Mayer '85
Regina Shannon '86
Marcia Caruso-Bergman '86

American Lung Association

Margaret Haggerty '85

American Lung Association - Connecticut

John Cosenza '85
Lauren Hinson '85
Jan Parkosewich '85

Mellon Foundation

Lois Strecker '85

Debbie Mayer '85 has been re-elected as Treasurer of the Oncology Nursing Society for 1984-86. The election results were announced at the organization's Ninth Annual Congress held in Toronto, Canada in May.

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In Memoriam

Yvonne Yonick Sherwood '36 died Summer of 1984.

Ellen Boyd Bigelow '40 died July 24, 1984.

Donna Dailey Bettes '45 died May 1984.

Jessie Alexander '45W died January 15, 1984.

Mathilde A. Haga '46W died May 1, 1984.

Florice Dunham Lyon ex'46W died April 20, 1984.

Janet Hart Simmons ex'48 died February 17, 1984.

Doris Cranch '55, deceased, notification April 2, 1984.

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NOTE

The Class Notes section will be included in our next issue of Yale Nurse.

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