Victoria Carroll, RN, MSN
CLINICAL INSTRUCTOR
AND SAFETY ADVOCATE

Nurses on Violence
Preventing, intervening and healing
You're an expert practitioner.

The new CCNS credential will recognize your expertise.

Are you an educator, manager, advanced practitioner, consultant, researcher or maybe all of the above?

Are you an expert in clinical judgment, clinical inquiry, systems thinking and caring practices?

Do you facilitate learning, respond to diversity and collaborate and advocate for staff, patients and families?

If these characteristics describe your practice as a clinical nurse specialist in acute and critical care, then the AACN Certification Corporation has the credential that reflects your expert knowledge and experience.

These characteristics formulate the Synergy Model, the basis of the new CCNS certification. They reflect your unique contributions as a clinical nurse specialist to your profession and your patients.

As you already know, to be a successful advanced practitioner in today's healthcare environment, certification has moved from being desired to being essential. Add the CCNS credential to your list of accomplishments and further your career today!

Call 800-899-2226 and become one of the first to have the CCNS credential. Or visit www.certcorp.org.

If I can't have you no one can

The murder of pregnant women before delivery or immediately after has caused a leading researcher to discover what nurses can do to help. Prenatal care may be the only opportunity to assess for danger. Now you'll find nursing tools to screen for abuse and homicide.

Sex offenders with guts to change

A therapist and researcher uses emotionally grueling treatment tasks to restore humanity to many of society's most heinous and hated violators.

Our elderly—harmed, exploited, abandoned

Nurses at a large New York City hospital stay vigilant over elder abuse. All elderly patients greet a friendly nurse who gracefully searches for life-threatening as well as life-enhancing circumstances.

Wounding the healers

Civil strife in South Africa explodes into hospital emergency rooms. Health specialists explore the traumas and demands for change. Yes, it is South Africa, but these experiences are unfailingly universal.

Violence, and stress in nursing

Armed with a major study, the Irish Nurses Organization rallies its government for safer workplaces for nurses. Forty percent of Ireland's nurses will leave the profession if other jobs are available.

Day shift is most violent time—Taiwan

Emergency room nurses look at violence—U.S.A

Cover Story

One-third of nurses are abused in the workplace

Colorado's Victoria Carroll shares the troubling results of a multistate study on violence in health care. Nurses, the most vulnerable of workers, come face to face with the facts.

Poetry

A nurse's views on courage and anger.

News

Posters meet clinical news needs

Now scientific posters find popularity in universities and hospitals.

Supporting global health

Sigma Theta Tau International's strategic planning increases its global relationships. A Slovenian nurse prepares former Soviet bloc nations for health innovations.

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Nurses, take issue with workplace violence
Notes from the executive officer
An inoculation called apathy cures no one

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NURSES, TAKE ISSUE WITH WORKPLACE VIOLENCE

Nurses care for victims of violence, perpetrators and witnesses to violent acts. The experiences of nurses who care for those affected by violence in many parts of the world point out the pervasive nature of violence. In addition, nurses themselves are at risk for violence in their personal lives, in their communities and, unfortunately, in their place of work. Violence in nursing is seldom discussed and if it is, it is in hushed tones and with a "thank goodness it's not me" sentiment.

Along with the stories of nurses who treat victims of violence, the courageous nurses who speak out on violence in nursing is seldom discussed. An "everything's fine" attitude is promulgated by health care administrators, physicians and often nurses who dismiss bullying, verbal abuse and even shoving as little more than a necessary job condition that cannot be changed. But it can be changed. Otherwise, abusive behavior will continue. No longer should any nurse accept abuse by word or action from any person. Abuse—verbal or physical—is an attempt to control others. It is insidious and, if left uncontested, it escalates. Intimidation becomes humiliation, degradation, and harassment and leads to accusing and blaming. Fear of physical harm or isolation allows the abuse to continue. And when one is abused, others are controlled as well.

Nurses can and must stand up to verbal abuse and, more importantly, must insist on being safe from physical harm in the workplace. Although absolute security can never be assured, working conditions in health care must provide adequate protection for nurses and other employees as well as patients and their families. Basic to recruiting and retaining the next generation of nurses is a safe work environment.

Nurses care for and about others. It’s why you are a nurse; it’s why I am a nurse. We are courageous, but we don’t have to suffer indignities or harm to do our jobs. All we need is respect for our professional work and to be safe. It’s little enough to ask. ☺
PRESIDENT'S MESSAGE

Eleanor J. Sullivan, R.N, PhD, FAAN

NURSES, TAKE ISSUE WITH WORKPLACE VIOLENCE

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This is the only way we can go on serving, helping, healing.

The school shootings in the past year point up, again, the need to recognize the threat of violence and intervene before it erupts. The parallels with nursing are striking. An "everything's fine" attitude is promulgated by health care administrators, physicians and often nurses who dismiss bullying, verbal abuse and even shoving as little more than a necessary job condition that cannot be changed. But it can be changed. Otherwise, abusive behavior will continue. Now longer should any nurse accept abuse by word or action from any person. Abuse—verbal or physical—is an attempt to control others. It is insidious and, if left uncontested, it escalates. Intimidation becomes humiliation, degradation, and harassment and leads to accusing and blaming. Fear of physical harm or isolation allows the abuse to continue. And when one is abused, others are controlled as well.

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AN INOCULATION CALLED APATHY CURES NO ONE

Killings in Kosovo, shootings in schools, bombings in Belgrade—all extreme acts that have become the expression of our differences. Violence has invaded our homes, workplaces, communities and countries as we continue to document increases in homicide, suicide and in sexual, physical and domestic abuse. Is it not time for our society to look into its soul and ask what has gone so terribly wrong?

It seems to me there is this common theme that runs through all these acts of violence: an all-too-frequent willingness on the part of people to resort to violence when they disagree with someone or find another person's lifestyle or skin color objectionable. But what I find most distressing is the high degree of apathy and acceptance that "this is just the way it is in the '90s"—a response I hear much too often.

We all express our sorrow over the horrific headlines about the chaos and loss wrought by violence. We shake our heads in dismay over the alarming statistics. But there is a tendency to ignore these symptoms revealing a major public health problem. For these acts have not touched us personally, and we hope their prevalency will go away. However, if one believes in individual dignity and the health of populations as nurses do, we cannot turn a blind eye to this issue and survive.

This issue of Reflections shows us that many nurses are not turning away from this problem. They are avidly seeking to establish a balance and to shift the paradigm from acceptance to action. While they recognize no one solution will provide answers or be perfect, they are taking positive, effective action. In this way they are preserving human dignity, tending to the health of populations and protecting basic societal principles while respecting differences.

Nancy Dickenson-Hazard, RN, MSN, CPNP, FAAN

COALESCE

Ministering to your needs, I forget my own.
With the folding of your bed corners, I tuck myself neatly into your world.

BEYOND THE FLOW SHEET

Charts, chronicles of illness.
No space on the flow sheet to grade your courage, record your valor.

TRAPPED RAGE

She has Rheumatoid Arthritis
and as I touch the swollen distorted joints and feel the loculated anger captured there
I am reminded of my mother who from beyond her painless grave urgently urges me to let mine out.


Nancy Dickenson-Hazard, RN, MSN, CPNP, FAAN

WHO Employment OPPORTUNITIES

Gain professional experiences around the world!

If your journey to the future includes adventures in international employment, the World Health Organization (WHO) offers opportunities for Sigma Theta Tau International members.

Since short-term and long-term staff positions are available, you are able to apply for the position that best suits your personal and professional goals.

Benefit from once-in-a-lifetime opportunities to share your expertise as you gain valuable insights into the delivery of culturally competent care.

Check all of the WHO position announcements. Cast a wide net! Your qualifications may match a posting for scientist, technical, administrative services, managerial and information services, as well as nursing.

To learn more about the positions:
www.nursingsociety.org/career

(see opportunities at the World Health Organization)
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to let mine out.

If I Can't Have You
No One Can

Murder linked to battery during pregnancy

BALTIMORE, May 1999—Battering of female partners in general and battering or abuse during pregnancy in particular are recognized as widespread problems with serious health consequences (Campbell, 1998; King et al., 1993).

Nursing research, advocacy, and practice have been on the forefront of the health care response to this issue since its first recognition as an important health problem (Campbell & Humphreys, 1993; Campbell & Parker, 1999). Battering can be defined as “repeated physical and/or sexual assault within a context of coercive control” (Campbell & Humphreys, 1993). Abuse can be considered to be a broader term, including emotional degradation, threats, and intimidation.

Most studies show that between 4 and 14 percent of adult pregnant women are experiencing physical violence from an intimate partner, with 10 to 24 percent of women reporting physical abuse in the year before pregnancy and up to 30 percent sometime during their lives (Gazmararian et al., 1996). Even higher proportions of adolescents, 20 percent, say they are abused during pregnancy (Parker et al., 1993).

Nursing studies have often found the highest prevalence of battering during pregnancy, perhaps related to using prenatal care nurses to assess for abuse at each prenatal care visit. Abuse during pregnancy has been linked with maternal health problems such as smoking, decreased weight gain, and substance use (McFarlane, Parker et al., 1996). The infants whose mothers were abused

By Jacquelyn C. Campbell
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By Jacquelyn C. Campbell
are endangered by problems like low birthweight, miscarriage, fetal distress and child abuse.

One aspect of domestic violence as a threat to women's safety and health that has not always been recognized is the link between abuse during pregnancy and homicide of women, or femicide. Femicide is now the leading cause of maternal mortality—death immediately before or after delivery—in at least two United States cities, rather than the traditional causes like toxemia that we have been trained to consider (Dannenberg et al., 1995). It is also the leading cause of death for young African-American women in this country. Although homicide of men by intimate partners is decreasing, femicide has not declined. The primary risk factor for homicide, either male or female being killed, in intimate partner relationships is battering of the female partner (Campbell, 1992).

Abuse during pregnancy has been identified as a risk factor for battered women being killed in several studies of intimate partner homicide (Campbell, 1986). Battering during pregnancy also has been associated with increased severity of abuse, further suggesting that the man who beats his pregnant partner is extremely dangerous (Campbell, 1998; Fagan, Stewart, & Hansen, 1983). Men who abuse their wives or girlfriends during pregnancy are more likely to own guns and/or knives—part of the mechanism that puts these women at increased risk (McFarlane et al., 1998). Women are at increased risk for serious abuse or femicide when the father of the baby is not a current husband or partner, or even when a partner thinks the baby isn’t his (Daly, Wiseman & Wilson, 1997; Campbell, Pugh et al., 1997). This kind of extreme jealousy is another part of the context that places women who are battered during pregnancy at risk for being killed. In an ongoing study of domestic femicide, we find that prenatal care is one of the few places where women—before they are killed or become victims of attempted homicide—are seen by helping professionals (Sharps et al., 1997). Prenatal care could be an important place to identify women who are abused and therefore at risk for homicide. It is extremely important that nurses conduct a lethality assessment with battered women when they are seen in any health care setting, so that they can be aware of their own level of risk and take safety measures accordingly (Campbell, 1986).

A lethality assessment increases women's realistic appraisal of the danger Assessment

Jacquelyn C. Campbell, RN, PhD, FAAN
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Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen to your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. Beating up; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

If any of the descriptions for the higher number apply, use the higher number.

Mark Yes or No for each of the following:

(*Note: refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically harming you.)

1. Has the physical violence increased in frequency over the past year?
2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?
3. Does he ever try to choke you?
4. Is there a gun in the house?
5. Has he ever forced you to have sex when you did not wish to do so?
6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack," street drugs or mixtures.
7. Does he threaten to kill you and/or do you believe he is capable of killing you?
8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
9. Does he control most or all of your daily activities? For instance, does he tell you when you can leave the house, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here:____)
10. Have you ever been beaten by him while you were pregnant?
11. Is he violently and constantly jealous of you?
12. Have you ever threatened or tried to commit suicide?
13. Has he ever threatened or tried to commit suicide?
14. Is he violent toward your children?
15. Is he violent outside of the home?

TOTAL "YES" ANSWERS

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Women are at increased risk for serious or even when a partner is likely to own guns and/or knives—part of the mechanism that puts these women at risk for being killed.

In an ongoing study of domestic femicide, we find that prenatal care is one of the few places where women—before they are killed or become victims of attempted homicide—are seen by helping professionals (Sharps et al., 1997). Prenatal care could be an important place to identify women who are abused and therefore at risk for homicide. It is extremely important that nurses conduct a lethality assessment with battered women when they are seen in any health care setting, so that they can be aware of their own level of risk and take safety measures accordingly (Campbell, 1986).

A lethality assessment increases women’s realistic appraisal of the context that places women who are battered during pregnancy at risk for being killed.

Abuse during pregnancy has been identified as a risk factor for battered women who are killed in intimate partner relationships is decreasing, femicide has not declined. The primary risk factor for homicide, either male or female being killed, in intimate partner relationships is battering of the female partner (Campbell, 1998; Fagan, Stewart, & et al., 1997). This kind of abuse is another part of the threat to women’s safety and health that is now the leading cause of maternal mortality—death immediately before or after delivery—in at least two United States cities, rather than the traditional causes like toxemia that we have been trained to consider (Dannenberg et al., 1995). It is also the leading cause of death for young African-American women in this country.

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Danger Assessment
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5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark Yes or No for each of the following: "Yes" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.

1. Has the physical violence increased in frequency over the past year?
2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?
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8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
9. Does he control most or all of your daily activities? For instance, does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tells you, check here: __)
10. Have you ever been beaten by him while you were pregnant?
   (If you have never been pregnant by him, check here: __)
11. Is he violently and constantly jealous of you?
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TOTAL "YES" ANSWERS

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.


BALTIMORE, Md., May 1999—Renewal comes slowly in the innocent safety of private moments for a mother and daughter at the House of Ruth. Because pregnancy often elevates abusive situations, nurses are conducting interventions to improve women’s health and the health of the future born.
Abuse Assessment Screen

Adapted from Family Violence Prevention Fund, Domestic Violence Guide by the Women's Place University of Virginia Health System, by Barbara Parker, RN, PhD, FAAN, professor and director, doctoral program and Center for Nursing Research

Domestic violence is a pattern of assault and coercion, including physical, sexual, and psychological attacks between adult or adolescent intimate partners.

ASK
Screen the patient alone in a safe, private environment. Ask direct questions.

"Have you ever been emotionally or physically abused by your partner or someone important to you?"

"Within the last year, have you been hit, slapped, kicked, pushed or shoved, or otherwise physically hurt by your partner or ex-partner?"

If YES, by whom?
Number of times?
Does your partner ever force you into sex?
Number of times?
I believe you.

Does your partner ever force you into sex?
Number of times?
Are you afraid of your partner or ex-partner?

ACKNOWLEDGE
I believe you.
You are not alone.
This is not your fault.
You don't deserve to be treated this way.
There is help available.

ASSESS PATIENT SAFETY
Is it safe to go home today?
Are there weapons in your home?
Has your abuser threatened to kill you, him/herself, or others?
Do you have a safety plan?
Do you want police intervention?

DOCUMENT FINDINGS
Use the patient’s own words regarding injury and abuse.
Legibly document all injuries, use a body map.
Take photographs of all injuries.
Include the name of the assailant and relationship to the patient.


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Jacqueline C. Campbell, RN, PhD, FAAN, is Anna D. Wolf Endowed Professor and associate dean for doctoral education programs and research at Johns Hopkins University School of Nursing.
Abuse Assessment Screen

**Adapted from Family Violence Prevention Guide by the Women's Place University of Barbara Parker, R.N, Ph.D, FAAN, project program and Center for Nursing Research.**

Domestic violence is a pattern of assault physical, sexual, and psychological attacks on adolescent intimate partners.

**ASK**

Screen the patient alone in a safe, private setting.

"Have you ever been emotionally or physically abused by a partner or someone important to you?"

"Within the last year, have you been hit, slapped, or physically hurt by a partner or someone important to you?"

If YES, by whom?

Number of times?

Is it safe to go home today?

Do you have a safety plan?

Are there weapons in your home?

Does your partner ever force you into sex?

Number of times?

Do you want police intervention?

There is help available.

This is not your fault.

You don't deserve to be treated this way.

There is help available.

**ACKNOWLEDGE**

I believe you.

You are not alone.

This is not your fault.

You don't deserve to be treated this way.

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Is it safe to go home today?

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Do you have a safety plan?

Do you want police intervention?

**DOCUMENT FINDINGS**

Use the patient's own words regarding

Legibly document all injuries; use a

Take photographs of all injuries.

Include the name of the assailant and the patient.

For further information on the Abuse Assessment...  

"Empowering Survivors of Abuse: Health care, battered women and their children,"  

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**SEX OFFENDERS WITH GUTS TO CHANGE**

By Rochelle Scheela

BEMIDJI, Minn., June 1999—Sex offenders are often feared and despised (Marshall, 1996). They are considered by many to be remorseless, untreatable monsters. Rather than treatment, an enraged public demands vengeance—life imprisonment, torture, mutilation, death (Blanchard, 1995).

I understand this reaction. Sexual abuse is a terrible crime that causes profound pain and suffering. Sex offenders are responsible and must be held accountable.

However, I have worked with and researched sex offenders since 1987 and have discovered many offenders who are remorseful, work very hard in treatment, and make remarkable changes to become safe, productive members of society. I have also discovered that sex offenders are more like the rest of us than they are different. Other therapists and researchers agree (Blanchard, 1995; Marshall, 1996).

There is no sex offender profile. Sex offenders represent every social, economic, educational and occupational level. They are parents, grandparents, step-parents, siblings, relatives, friends and neighbors. A small percentage are strangers. Sex offenders represent both genders. In fact, although most reported offenders are male and prior research has documented low percentages of female offenders (1 to 20%), several recent studies found female offenders actually accounted for higher percentages (Hunter & Mathews, 1997).

Etiological theories of sexual abuse range from prior victimization, attachment disorders, learned behavior, addictions, psychopathology and distorted cognitions to endocrine or neurological impairment. Some of the most current thinking is that sexual abuse is a symptom of our dysfunctional society and thus must be addressed as a national public health problem (Blanchard, 1995; Freeman-Longo & Blanchard, 1998).

To understand what was involved with the major changes I saw, I conducted a series of grounded theory studies exploring sex offenders' perceptions of the process they experience as they progress through sex offender treatment. The men described the process as remodeling. Metaphorically, the offenders see the treatment program as the blueprint, the treatment tasks as remodeling tools, and themselves as remodelers who must do custom remodeling on themselves to prevent further abuse...
Scheela falls apart when he meets with his wife and sexually abuses his daughter. He takes on responsibility for the abuse, painful—or as he describes for working hard in treatment and also falls apart many times throughout emotionally and physically as the abuse out, rebuilding, doing the upkeep and daughter to apologize for (Scheela, 1992, 1996; IONIA, 1994).

Carl, not his real name, is an example of such remodeling. Carl describes himself as a “mean drunk.” He bares his wife and sexually abuses his daughter. Carl finds himself falling apart emotionally and physically as the abuse is reported and he is incarcerated. He also falls apart many times throughout treatment as he faces his abuse and its impact on his daughter and family. Carl falls apart when he meets with his daughter to apologize for all the terrible things he has done. He experiences the “taking on” aspect of remodeling when he takes on responsibility for the abuse, for working hard in treatment and quitting drinking. In an emotionally painful—or as he describes “bloody”—soul-searching process, he tears out unhealthy feelings, thoughts and behaviors as he comes to grips with his own childhood victimization and his abuse of others.

He does the “rebuilding” by changing himself and the way he relates to his wife and children, so that he will not reoffend. He is doing the upkeep by maintaining the changes he makes and by employing his safe plan whenever he slips into old thoughts, feelings or behaviors. Two years after entering treatment he graduates from the sex offender program and moves on to a productive life with his family. His sense of self-worth is increased. Treatment is the best thing that ever happened to him, he says, because it has forced him to examine his entire life. He is now the kind of person he wants to be. His family reports his remodeling is genuine, and they are happy to have him home. Fortunately, Carl’s story is not uncommon. Although media often highlight the unrepentant sex offenders who torture and murder, serial murderers, such as Ted Bundy and Jeffrey Dahmer, are the rare exception, not the rule (Blanchard, 1995). Most offenders I have worked with are remorseful men who work hard in treatment to learn why they abuse and how they can prevent abuse in the future. Recidivism research supports this experience.

Many studies report that incest offenders recidivate less than other sex offenders (Finkelhor, 1986; Lang, Pugh, & Langevin, 1988; Simkins, Ward, Bowman, Rinck, & DeSouza, 1990). In addition, research shows that treated offenders recidivate less than untreated offenders (Meyer & Romero, 1980; Owen & Steele, 1991; Simkins, Ward, Bowman, & Rinck, 1990); and first-time offenders recidivate less than repeat-offenders (Marshall, Jones, Ward, Johnston, & Barbaree, 1991).

In a 1999 follow-up study of sex offenders who were released from Minnesota prisons in 1992, the rearrest rate for a sexual offense was 18 percent for the entire sample, 14 percent for those who successfully completed treatment, and 3 percent for first-time offenders who completed treatment (Minnesota Department of Corrections, 1999). This means that 82-97 percent of the sex offenders in this study had not reoffended in the six years following release. Studies in other states are documenting similar results. Obviously, treatment can and does work for many sex offenders. There is also research documenting that it is cost-effective for society to provide sex offender treatment (Pendery & Burgess, 1990).

The reaction of Carl’s family is also not uncommon. Many incest victims and families want the abuse to stop but desire reunification. They hate the abuse but love the abuser. They report that sex offender treatment is helpful to them as well as the offender. They are able to focus on their own issues, knowing that their loved ones are receiving help in a respectful, therapeutic environment.

It is a sex offender like Carl who makes this work rewarding. Despite the terrible things one must hear about, the feelings of increased vulnerability, and the disillusionment with treatment failures, the positives of the work far outweigh the negatives. Offenders and families do heal.

Most nurses will never be involved in sex offender treatment. However, nurses may work with victims or families who have experienced sexual abuse. They may have sex offenders as patients. Therefore, I think it is important for nurses to realize that most sex offenders are remorseful and treatable.

Treatment is not a slap on the wrist, but a very difficult emotional process of soul-searching and healing that reduces recidivism. It is also important to know that there are victims and families who wish to reuni te and are able to do so in a safe way. Such knowledge may help nurses deal with patients, families and offenders in a nonjudgmental, supportive and hopeful manner.

Public health nurses will become increasingly involved as sexual abuse is more widely accepted as a public health issue. In addition, therapists working with sex offenders report feeling satisfied with their work, because they are contributing not only to the welfare of offenders but to the safety of victims and community (Scheela, manuscript submitted for publication; Edmunds, 1997; Ellerby, 1997; Farraknopf, 1992; Freeman-Longo, 1997; Jackson, Holzman, Barnard, & Paradis, 1997, Rich, 1997).

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Rachelle Scheela, RN, MA, MS, PhD, CS, is a professor at Benedict State University Department of Nursing in Remedia, Minn., and a therapist at Upper Mississippi Mental Health Center. She has worked with adult male sex offenders since 1987. On a recent sabbatical in Vietnam, she taught sexual abuse courses to psychology students at Hanoi University and worked with Vietnamese professionals and organizations.

Sex Offenders’ Treatment Tasks

DISCLOSURE

The offenders orally and in writing disclose all the details of their abuse.

EMPATHY DOCUMENT

To face the damage caused and develop empathy for their victim(s), offenders write about specific episodes of abuse as if they were the victims. They address the thoughts and feelings of the victims before, during and after the offenses and list the lifelong effects victims might experience.

APOLOGY LETTER

The offenders write letters of apology to victims and families. Whether or not the letters are sent or shared face to face is dependent upon the victim's and families' wishes.

AUTOBIOGRAPHY

The offenders write a detailed account of their family of origin; childhood; educational, occupational, military, marital, health/medical, and criminal history; and social and sexual development. This enormous task encourages the offenders to examine the past in relationship to the present and recognize factors and patterns that contributed to the abuse.

ABUSE CYCLE

The men pinpoint how their thoughts, feelings and behaviors led to the abuse and enabled it to continue. They identify distorted thinking, isolation, control, and abuse behaviors; fantasies; and dysfunctional coping patterns.

SAFE PLAN

The offenders synthesize everything they have learned from all other tasks and develop in-depth personalized plans to prevent future abuse. Note: The offenders read these documents in the group therapy and receive feedback from the other men. It usually takes many attempts before the documents are accepted as being heartfelt and thorough. It is so emotionally painful to do these tasks that some offenders choose to go to prison to avoid it.
Scheela falls apart when he meets with his impact on his daughter and family. Carl involves falling apart, taking on, tearing painful—or as he describes for working hard in treatment and of such remodeling. Carl describes quitting drinking.

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NEW YORK CITY, May 1999—Geriatric mistreatment assessments are routinely conducted on elderly patients hospitalized at Mt. Sinai-New York University Health. Geriatric nursing consultant Dr. Terry Fulmer, RN, gets acquainted with patients before beginning assessments.

HARMED, EXPLOITED, ABANDONED

By Terry Fulmer

NEW YORK CITY, May 1999—If a child is seen in an emergency room with a bruise or symptoms that are suspicious, most nurses know immediately to contact a social worker or appropriate hospital administrator to assure a full and comprehensive assessment to rule out child abuse. This is not the case for the elderly in this country.

When they visit an emergency unit with similar signs—bruises, urine burns, excoriations or other unusual presentations—those symptoms are immediately attributed to disease in old age, or worse, stereotypes about aging. For example, bruises on an older person are often dismissed as common due to anticoagulation therapy or beliefs about blood vessel changes. If we are to make a difference in the lives of the elderly who suffer from the effects of abuse and neglect, this must change. Elder mistreatment, the term used to describe the outcomes of abuse, neglect, exploitation and abandonment, is estimated to affect 4 percent of the elderly in the United States, or approximately 700,000 to 1.2 million cases.

Elder mistreatment is a serious syndrome, which requires the vigilance of every nurse in America. In 1998, a national incidence study conducted under the auspices of the National Center on Elder Abuse documented that there are more than 400,000 new cases of elder mistreatment every year. With the growing number of older individuals in America, this number will only increase. Every nurse has the opportunity to add an assessment question, which could make a difference in the life of older people: Is there any elder mistreatment evident in this patient?

Elder mistreatment has been in the nursing literature since the late 1970s. Nurses who were among the first to study this syndrome, such as Linda Phillips, RN, PhD, FAAN, at the University of Arizona, have done much to help each of us understand that elder mistreatment can and does occur. However, The New York Times reported on March 22, 1999, that complaints about abusive treatment of the elderly in nursing homes are often ignored for many months by state and federal officials. Further, abuse and neglect in community-dwelling elderly have also received press attention with egregious stories, such as elders being victimized by their caregiving children, assault and battery in the home by caregivers, and serious, if not lethal, neglect by formal and informal caregivers alike.

Bruises—You can distinguish a bruise caused by falling down from one caused by being hit by asking; looking at the size of the bruise to see if it could have come from a fall as described; looking at the color to see if it is the right color for the time frame mentioned; checking location to see if a person can logically fall on the bruised spot. When a person falls, the hands usually go out to shield the rest of the body; therefore, bilateral bruising of the upper torso is more difficult to get from a fall.

Every practicing nurse has the opportunity to detect and intervene when early warning signals are noted to help improve the quality of life for the elderly persons they care for. The American Medical Association guidelines on the assessment and detection of elder abuse and neglect, published in 1992 by an interdisciplinary group continued important recommendations on actions to take when assessing for elder mistreatment, as well as intervening in these cases. If the nursing work force can add a mistreatment assessment question into the clinical evaluation of their elderly patients, much can be done to stop the seri-
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Nursing actions for elders

1. Develop a process at your workplace for reporting suspected elder mistreatment. Decide who will be responsible for reviewing all cases, and where the information will go.
2. Interview the elder alone so he or she may speak openly.
3. Ask the elder if there is any family violence he or she wishes to discuss, and consider cultural sensitivities when asking. Many people in the United States are relieved to be asked a straight-forward question.
4. Clinically note any signs and symptoms inconsistent with the person's history—for example, bruises or scars that are unexplained by the history.
5. Take color photographs of unusual bruises and symptoms for the file.
6. Discuss a safety plan with the elder. What will he or she do if there is danger?
7. Provide phone numbers of local resources that can provide help—hospitals, police and social service agencies.
8. Be familiar with conservatorship and guardianship services if the elder has memory problems.
9. Develop plans that allow you to follow the elder's safety status.
10. Evaluate the entire family system. Elder mistreatment may mean others in the family are at risk.

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Terry Fulmer, RN, PhD, FAAN, is a professor and director of the Center of Nursing Research at the New York University Division of Nursing in the School of Education in New York City.
With careful assessment and intervention, people who may be abused, neglected, or exploited or abandoned is likely to rise. For all these reasons, protective Services annually. Individuals who have been neglected are more likely to die than those in any other category in elder mistreatment. For all these reasons, nursing vigilance across the health care continuum can have lifesaving effects for the elderly.

At the turn of the century, only 4 percent of older adults lived to be over 65. Today, 15 percent of individuals live to be over 65, and it is anticipated that by the year 2020, fully 20 percent (one in five) of our population will be over age 65. Individuals over age 85 will be the most rapidly growing cohort. This means that for practicing nurses, the number of older people who may be abused, neglected, exploited or abandoned is likely to rise. With careful assessment and intervention, nurses can enhance the quality of life of older individuals.

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NEW YORK CITY, May 1999—Nursing Case Manager Marilyn Lopez, RN, GNP, New York University Medical Center assists patient.

JOHANNESBURG, South Africa, Oct. 19, 1995—Members of the South African police, armed with automatic weapons, stand guard at the ground floor of the Glynville Hospital in Johannesburg where a suspected serial killer was brought as a result of injuries sustained when he was taken into custody.

JOHANNESBURG, South Africa, March 1999—Struggling to save the life of a 27-year-old woman shot during a car hijacking, staff at Johannesburg Hospital Casualty view this Saturday night like all others—tragic and brutal. Nurses find a drunken woman whose face is disfigured with stab wounds slammed at the hospital's front doors. She curses and combats nurses trying to help. Later, two frantic women run screaming into the emergency department to find safety from armed criminals who are hunting them. Health workers take cover. Hospital security does little to help. This evening the gunmen do not take fire inside.

Violence and South Africa are synonymous. Before democracy, political violence dominated perceptions. Since 1994, political strife has been overshadowed by epidemic levels of interpersonal violence, with approximately 24,000 South Africans murdered per year and increasingly with guns.

By Alexander Butchart, Stephanie Burrows, Samantha Griffin
This equals 65 homicides a day and an annual incidence rate of 60 homicides per 100,000 citizens, making South Africa among the most violent of all Interpol-monitored nations in the world (South African Police Services, 1994-98). For every homicide, some 60 other people are hurt in non-fatal attacks, mainly involving knives and guns, many of whom require medical attention (Butchart & Peden, 1997).

Not everyone is equally at risk. Among residents of middle- or upper-income suburbs, homicide rates are 10 times lower than the national average, while self-directed violence is even more frequent than interpersonal violence.

For the poor, and especially those in low-income townships and shanty settlements, homicide rates soar. Here, self-directed violence is even more frequent than interpersonal violence.

One nurse describes the verbal abuse, threats of revenge and accusations of racism that are typically encountered when patients have to wait, or be referred elsewhere. These particular accounts from Johannesburg Hospital could have come from nurses at any of the large city hospitals here, such as Baragwanath in Soweto, Groote Schuur in Cape Town or King George VIII in Durban, and probably with a somewhat different inflection, from staff at the many smaller hospitals and clinics in towns and rural areas.

Because information forms the scientific basis for prevention efforts, it is unfortunate that as of mid-1999 there are no national data on the incidence and determinants of nurse victimization, and no proper investigations into the dynamics of reporting such violence. Nelouise Geyer of the Democratic Nursing Association of South Africa says that, while by no means new, it is only recently that nurses are starting to register their concerns about victimization, and they are pressuring authorities to make hospitals safer for them.

Violence toward nurses is being acknowledged as a problem. A framework for designing effective solutions exists. Still missing is the political will for action, which nurses must summon through their professional associations, through lobbying administrative structures at national and local government levels, and through the involvement of nongovernmental organizations.

Geyer says the delay in action has to do with a combination of factors. First, nurses have been socialized by the profession to feel it is part of their jobs to take whatever patients throw at them. Indeed, the professional code of conduct prohibits any form of retaliation, and nurses who refuse to treat abusive patients risk losing their jobs. Second, the sheer number of cases seen by South African trauma nurses may blunt their feelings of violation and thus inhibit expression.

Third, because some nurses grew up in dysfunctional families where violence may have played a role and currently live in violent relationships, they have become desensitized to the experience of verbal abuse and physical violence. Understandably, this results in high levels of stress, and the continuous threat that nurses experience is transformed into anger toward patients, the work environment and colleagues.

Violence by patients toward nurses means they are not only healers but also the wounded, and legitimate recipients of the violence prevention strategies applied to other high-risk groups in society. Among these is the public health approach, the four steps of which provide a clear agenda for action (WHO, 1997):

1. **Define the problem** through the conduct of surveys and establishment of ongoing registration systems to record the who, what, how, when and where of nurse victimization.

2. **Identify the risk factors** for violence against nurses by finding out the environmental features (i.e., physical, social, cultural) and personal factors that underlie the patterns revealed through problem definition.

3. **Design and pilot test interventions** by removing or modifying the risk factors and systematically measuring their effectiveness in reducing the incidence of victimization and increasing nurses' sense of safety and control.

4. **Implement interventions** that have been proven, or are highly likely to prove effective, by enacting and enforcing legislation governing environmental, occupational and educational standards and practices for nurse protection and safety promotion.

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Alexander Butchart, D Litt et Phil, associate professor and Stephanie Burrows, M Phil (Wits) researcher, are with the University of South Africa Institute for Social and Health Sciences in Johannesburg. Dr. Butchart is a guest researcher at the Karolinska Institute Department of Health Sciences in Stockholm. Samantha Griffin, CPN, is a trauma casualty nurse at Johannesburg Hospital, Ward 163.
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For the poor, and especially those in low-income townships and shanty settlements, homicide rates soar. Here, interpersonal violence predominates, and people are as likely to be attacked by strangers as by their lovers, relatives and acquaintances. Incidents peak during weekend evenings when the frustrations of unemployment and poverty are dissolved in alcohol and drugs, along with the inhibitions that otherwise keep aggression in check. A macho subculture of survival dominates both men and women, and by age 14 or 15, boys and girls are locked into a code of honour that resists outside interference.

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VIOLENCE AND STRESS IN NURSING

By Lenore Mrkwicka

DUBLIN, Ireland, May 1999—The Irish Nurses Organization’s definition of violence is used in the context of “violent incidents or incidents where persons are abused, threatened or assaulted in circumstances relating to their work involving explicit or implicit challenge to their safety.” This definition can be considered also to cover the area of sexual harassment and bullying. Nurses, the largest group of health professionals, are most at risk of assault at work.

Research in various nations highlights the prevalence of abuse and violence against nursing personnel, which has often been minimized or ignored in the past. The working conditions specific to the health sectors tend to place nurses and other health personnel at greater risk of violence. Inadequate staffing levels and safety measures contribute to the risk of violence to nurses. The 1989 Health and Safety Authority of Ireland alerted, at the initiation of the Irish Nurses Organization, trade unions and the Department of Labour on the seriousness of the situation in relation to violence in the workplace.

In June of 1998, the Health and Safety Authority of Ireland alerted, at the initiation of the Irish Nurses Organization, all health boards, voluntary hospitals, trade unions and the Department of Labour on the seriousness of the situation in relation to violence in the workplace. The authority stated that the various reports received clearly showed areas of great potential for fatal consequences, and failure by employers to fulfill their responsibilities in this seriously high risk area would render them liable to prosecution, either summarily or on indictment under legislation. The increasing incidence of abuse and violence in health care settings in Ireland is interfering with the provision of quality care and jeopardizing the personal dignity and self-value of health personnel.

Stress study

All violence is a cause of stress. Occupational stress shows that related illnesses carry considerable human and economic costs. The human costs have been measured in terms of both mental and physical ill health. Economic costs have been measured in terms of turnover and absenteeism.

A startling figure of 39.3 percent of the sample reported experiencing assaults by patients some time in their career, with five percent of nurses reporting assault from visitors. Small percentages reported assault from intruders, fellow nurses or other hospital colleagues. These figures mean that more than 46.6 percent of the sample had been assaulted at some time during the course of their work, almost making it a normal feature of their workplace stress. A disturbing 40.2 percent of the sample in our stress survey reported that they would very likely give up nursing if other jobs were available. The study clearly demonstrated a lack of support from administration, indicating the absence of policies and procedures to deal with all types of abuse against nurses.

The Irish Nurses Organization is proactive in its combined efforts to ensure that nurses have a safe place to work. It has set up a strategic alliance with the Health Service Employers Agency in relation to health and safety in the workplace. As a board member of the Health and Safety Authority, the organization has been proactive in its efforts to enact norms against violence. The Human and Safety Authority of Ireland, 1993, the Irish Nurses Organization invited the Work Research Centre to undertake a study on the exposure to stress among Irish nurses.

Intentions to quit

For those under severe workplace stress, the only option may be to leave the profession. Voluntary organizations such as the Irish Nurses Organization have evidence that the number of nurses leaving due to workplace stress is on the increase. A disturbing 40.2 percent of workers reported stress in the workplace.

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Combating violence in the workplace is a trade union issue here, but trade unions must be supported by positive actions from employers. Government must provide adequate resources to ensure that those charged with the delivery of a safe and acceptable health care service are ensured of their own safety.

Strategies to reduce violence and to support assaulted nurses are desperately required. Nurses must lobby hospital and community health and safety committees, unions and professional organizations to raise the issue of violence as an unacceptable condition of their work and lives. Documentation of violence must be consistent, and wording of incident forms must be sensitive to the victim by eliminating questions that imply blame.

Employee incident forms that ask “What could you have done to prevent this?” serve to make nurses reluctant to report abuse. Support for clearly articulated and well-defined policies is essential. Consequences for violence must also be clear. Consideration of prosecution may be argued as acceptable on the grounds that violent acts should be part of the public record regardless of where they occur, and that patients may be deterred from violence if prosecution was seen as routine rather than the exception.

Response to the issue of violence against nurses must be supported by hospital policies, which should state that employees who are victims of violence must be provided with the services appropriate to any victim of violence.

This includes medical care, legal advice, information on employee compensation, counseling and peer support programs. In addition, debriefing sessions within 48 hours of the assault should be instituted for all staff involved.

The Irish Nurses Organization receives reports of both acts of violence perpetuated against any category of health personnel, employed person or private citizen.

Lenore Mrkwicka, RN, MA, is deputy general secretary of the Irish Nurses Organization. She conducts research on sexual harassment, bullying and stress on Irish nurses. She serves as a member of the advisory committee to the European Commission on Health and Safety and as a worker representative at the International Labour Organization Conference in Geneva.
VIOLENCE AND STRESS IN NURSING

By Lenore Mrkwicka

DUBLIN, Ireland, May 1999—The Irish Nurses Organization's definition of violence is in the context of "violent incidents or incidents where persons are abused, threatened or assaulted in circumstances relating to their work involving explicit or implicit challenge to their safety." This definition can be considered also to cover the area of sexual harassment and bullying. Nurses, the largest group of health professionals, are most at risk of assault at work.

Research in various nations highlights the prevalence of abuse and violence against nursing personnel, which has often been minimized or ignored in the past. The working conditions specific to the health sectors tend to place nurses and other health personnel at greater risk of violence. Inadequate staffing levels and safety measures contribute to the risk of violence to nurses. The 1989 Health and Safety Legislation in Ireland is based on the principle of prevention, a principle which, if applied throughout the health sector, would not alone reduce personal suffering but would yield economic benefit through savings in costs, lost time and reduced insurance premiums.

Each week the Irish Nurses Organization encounters nurses who have been subjected to violence and stress at work—physical, verbal, sexual harassment and bullying. Some nurses have left nursing as a consequence; others are finding it increasingly difficult to cope following their experiences. Among the victims are:

- A student nurse was forced up against the wall with a knife held to her throat.
- A staff nurse in an acute hospital was punched, kicked and had her nose broken escorting a male patient to his bed.
- A staff nurse in a long stay unit was rammed by a patient in a wheelchair and badly bruised.
- A nurse working in isolation who had been sexually harassed on a continuous basis over a long period finally resigned her position.

In June of 1998, the Health and Safety Authority of Ireland alerted, at the initiative of the Irish Nurses Organization, all health boards, voluntary hospitals, trade unions and the Department of Labour on the seriousness of the situation in relation to violence in the workplace, reminding employers of their legal responsibilities under Section 6 of the 1989 Legislation (i.e., to provide a safe place of work).

The authority stated that the various reports received clearly showed areas of great potential for fatal consequences, and failure by employers to fulfill their responsibilities in this seriously high risk area will rend them liable to prosecution, either summarily or on indictment under legislation. The increasing incidence of abuse and violence in health care sets tings in Ireland is interfering with the provision of quality care and jeopardizing the personal dignity and self-value of health personnel.

Stress study

All violence is a cause of stress. Occupational stress shows that related illnesses carry considerable human and economic costs. The human costs have been measured in terms of both mental and physical ill health. Economic costs have been measured in terms of turnover and absenteeism.

In 1998, the Irish Nurses Organization invited the Work Research Centre to undertake a study on the exposure to stress among Irish nurses.

A startling figure of 39.3 percent of the sample reported experiencing assaults by patients some time in their career, with five percent of nurses reporting assault from visitors. Small percentages reported assault from intruders, fellow nurses or other hospital colleagues. These figures mean that more than 46.6 percent of the sample had been assaulted at some time during the course of their work, almost making it a normal feature of an occupation.

A total of 1,662 questionnaires were distributed and 771 completed questionnaires were returned, giving a response rate of 46.4 percent, a high response to a postal questionnaire survey.

In spite of the prevalence of assault and its severity, the amount of time taken off by nurses is negligible. Ninety-six percent of nurses reported taking no time off. This finding is indicative of nursing culture, where showing signs of distress is discouraged, and calls into question the current structures and policies in place to deal with the issues.

Intentions to quit

For those under severe workplace stress, the only option may be to leave the profession. The Irish Nurses Organization has evidence that the number of nurses leaving due to workplace stress is on the increase.

A disturbing 40.2 percent of the sample in our stress survey reported that they would very likely give up nursing if other jobs were available. The study clearly demonstrated a lack of support from administration, indicating the absence of policies and procedures to deal with all types of abuse against nurses.

The Irish Nurses Organization is proactive in its continued efforts to ensure that nurses have a safe place to work. It has set up a strategic alliance with the Health Service Employers Agency in relation to health and safety in the workplace. As a board member of the Health and Safety Authority of Ireland, I have pressed for the setting up of an advisory committee on health and safety specifically for the health sector. This was agreed at the April meeting of the Health and Safety Authority Board and is currently in the process of being established.

Combating violence in the workplace is a trade union issue here, but trade unions must be supported by positive actions from employers. Government must provide adequate resources to ensure that those charged with the delivery of a safe and acceptable healthcare service are protected in the workplace.

Strategies to reduce violence and to support assaulted nurses are desperately required. Nurses must lobby hospital and community health and safety committees, unions and professional organizations to raise the issue of violence as an unacceptable condition of their work lives. Documentation of violence must be consistent, and wording of incident forms must be sensitive to the victim by eliminating questions that imply blame. Employee incident forms that ask "Could you have done to prevent this?" serve to make nurses reluctant to report abuse. Support for clearly enunciated norms against violence is essential. Consequences for violence must also be clear. Consideration of prosecution may be argued as acceptable on the grounds that violent acts should be part of the public record regardless of where they occur, and that patients may be deterred from violence if prosecution was seen as routine rather than the exception.

Response to the issue of violence against nurses must be supported by hospital policies, which should state that employees who are victims of violence must be provided with the services appropriate to any victim of violence.

These services include medical care, legal advice, information on employee compensation, counseling and peer support programs. In addition, debriefing sessions within 48 hours of the assault should be instituted for all staff involved.

The Irish Nurses Organization strongly condemns all acts of violence perpetrated against any category of health personnel, employed person or private citizen.

Lenore Mrkwicka, RN, MA, is deputy general secretary of the Irish Nurses Organization. She conducts research on sexual harassment, bullying and stress on Irish nurses. She serves as a member of the advisory committee to the European Commission on Health and Safety as a worker representative at the International Labour Organization Conference in Geneva.

LONDONDERRY, Northern Ireland, Aug. 11, 1996—Police hide behind armored landrovers in the Catholic Strand road area of Londonderry as petrol bombs fall near them early Sunday. The violence followed a Saturday march by 10,000 Protestants.
ONE-THIRD OF NURSES ARE Abused IN THE WORKPLACE

Nurses representing most practice areas in 7 states take part in violence study. Will the facts curb a wave of health care assaults?

FORT COLLINS, Colo., May 1999—In the health care arena, where patients' well-being and trust are significant to the healing process, nurses rarely consider—or even admit to—personal safety needs. The patient's physical and emotional safety retain highest priorities. Yet the courage to manage health crises requires an intense professional focus, and health workers easily experience denial about threats or harm to themselves.

"As nurses we are very nurturing in terms of our services and skills, and sometimes it's at the sake of our personal safety," said Deborah V. DiBenedetto, RN, BSN, MBA, president of the American Association of Occupational Health Nurses. "We need to always find balance and be assertive in how we deliver services. We give, and we give, and we give, and we lay aside the need to recognize issues of self...."

But a patient's safe haven may not always be a safe haven for the nurse. While psychiatric nurses are educated to treat troubled patients, most other nurses are not, and enter the workplace limited in their abilities to halt or prevent abuse.

One of the biggest problems in addressing workplace violence is the phenomenon of denial—it won't happen here. No hospital or health care agency is immune. While there have been increasing news reports of crimes against health care workers throughout the world, particularly nurses, it is not known if there are actually rising numbers of assaults to nurses or rising reports of them. However, in the United States 38 percent of all workplace violence occurs in health care settings, according to 1994 U.S. Bureau of Labor Statistics.

The need for current data and more understanding led the Colorado Nurses Association to create a 1997 violence task force to examine nurse safety. The group undertook a multi-state survey to gain a broad perspective on nurses' beliefs and experiences. State nurses' associations in Alabama, Delaware, Colorado, Hawaii, Illinois, Kansas and Missouri mailed

By Victoria Carroll, Julie Goldsmith
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"workplace violence" as verbal abuse, such as threats and foul language; sexual assault; and physical violence, such as kicks, slaps, pushes, or use of a weapon. A lesser, yet still significant majority of nurses (78 percent), defined sexual harassment as "workplace violence." Additionally, 71 percent of the nurses indicated training was needed where they worked.

It is possible, when considering the extent of these results, that the proportion of nurse assaults is actually higher than the multi-state survey indicates. Emergency department nurses comprised only 5 percent of the participants in the survey, and previous studies have shown that they experience the greatest risks for violence (Mahoney, 1991; Stultz, 1993).

A recent rise in the use of the illicit drug methamphetamine has affected the safety of emergency departments in Hawaii. As a result, the Hawaii Nurses Association is urging proactive measures to support nurse safety. Hospitals are undertaking in-service programs to enhance employee recognition and management of aggressive and assaultive behaviors, said Stephani Monet, director of education at the association.

A resolution on violence was adopted by the Hawaii Nurses Association, concluding: "The increasing numbers of acute and chronically mentally ill patients now being released from hospitals without follow-up care; patients who cannot be involuntarily hospitalized until they pose an immediate danger to themselves or others; and patients who have the right to refuse medication, even while involuntarily confined, have all contributed to the increased risk of violence towards nurses."

Other leaders in the discussion of workplace protections include the Kansas State Nurses Association, which took a bold look at hospital violence with help from an American Nurses Association grant in 1995. Two large urban and two small rural hospitals helped assess risk areas. (Carroll & Sheverbush, 1996). Eighteen months after the project, all four hospitals indicated that awareness of workplace violence had increased. Three of the hospitals added security coverage.

Violence exists on a continuum from verbal abuse to physical assault to homicide. Whether with patients, visitors or coworkers, successful violence reduction plans strongly correlate with the degree of management commitment and staff participation.

The escalation from verbal abuse to physical assault can occur quickly. A visitor, angry about his father's death in extreme, which most likely had early signs. Workplace assaults have the strongest opportunities for being prevented when actions are taken at the earliest stages. (Carroll & Sheverbush, 1996). Eighteen months after the project, all four hospitals indicated that awareness of workplace violence had increased. Three of the hospitals added security coverage.

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REFLECTIONS

Project calmness. Move and speak quietly and confidently.

- Carry, do not wear, health instruments that can be used as weapons, such as a stethoscope around the neck or hemostat clipped on a pocket.

- Increase health-related danger assessment knowledge and behavioral techniques.

- Attend safety programs.

- Take threats seriously and report them.

- Report suspicious individuals immediately.

- Know what to do in the case of a violent incident such as a bomb threat, a hostage situation or infant abduction.

- Voice safety suggestions to appropriate staff.

- Ask all emergency department patients to wear hospital gowns.

- Participate in planning, implementing and evaluating violence reduction plans.

When faced with violence or potential violence:

- Do not belittle or dare a violent person.

- Do not reject all of the person’s demands from the start.

- Be reassuring and suggest positive choices. Do not express confrontational body language, such as placing hands on hips.

- Make yourself aware of exits. Do not allow yourself to be backed into a room corner.

- Give a violent individual personal space.

- Make use of the Golden Rule, and do not express apathy, condescension, or be misleading—giving an individual the runaround.

REFERENCES, Page 60.

Victoria Carroll, RN, MSN, is a clinical instructor at the University of Northern Colorado School of Nursing in Greeley, Colo. As a hospital staff nurse for more than 30 years, her work has included positions in emergency, intensive care, addiction recovery and medical-surgical units. In 1993, she was director of the Kansas State Nurses Association's Violence Assessment in Hospitals project. Julie Goldsmith is Reflections magazine editor.
violence in 1996. Most nurses indicated where they worked. Instead, they violence went unreported at work. surveys to their members, and 586 responded. Nurses were not asked to specify where they worked. Instead, they described the types of clinical nursing they performed, reporting some 30 practice areas—medical-surgical, critical care, community health, dialysis, chemical dependency, psychiatric or advanced practice, for example. As many as one-third of the nurses disclosed they were victims of workplace violence in 1996. Most nurses indicated patients were the assailants. Guns, knives, flare guns and chairs were the most commonly used weapons cited. Yet, half of the nurses acknowledged that violence went unreported at work. Since all nurses might not define “violence” the same way and differences in the interpretation might affect the survey, a question was asked about its meaning. Nearly all nurses defined "workplace violence" as verbal abuse, such as threats and foul language; sexual assaults; and physical violence, such as kicks, slaps, pushes, or use of a weapon. A lesser, yet still significant majority of nurses (78 percent), defined sexual harassment as "workplace violence." Additionally, 71 percent of the nurses indicated training was needed where they worked. It is possible, when considering the extent of these results, that the proportion of nurse assaults is actually higher than the multi-state survey indicates. Emergency department nurses comprised only 5 percent of the participants in the survey, and previous studies have shown that they experience the greatest risks for violence (Mahoney, 1991; Stultz, 1993). A recent rise in the use of the illicit drug methamphetamine has affected the safety of emergency departments in Hawaii. As a result, the Hawaii Nurses Association is urging proactive measures to support nurse safety. Hospitals are undertaking in-service programs to enhance employee recognition and management of aggressive and assaultive behaviors, said Stephanie Monet, director of education at the association. A resolution on violence was adopted by the Hawaii Nurses Association, concluding: "The increasing numbers of acute and chronically mentally ill patients now being released from hospitals without follow-up care; patients who cannot be involuntarily hospitalized until they pose an immediate danger to themselves or others; and patients who have the right to refuse medication, even while involuntarily confined, have all contributed to the increased risk of injury towards nurses."

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**PREVENTION**

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- Give a violent individual personal space.
- Make use of the Golden Rule, and do not express apathy, condescension, or be misleading—giving an individual the runaround.
Most of the 453 patients in the study were 20 to 30 years old, and 366 were men. The results show 453 violent incidents in only six months. The highest frequencies of violent behavior came from the youngest males, people with bipolar disorders, and new admissions (less than one week). The day shift experienced the most violence.

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Pervasive violence

AUSTIN, Texas—A study of violence against emergency department workers in Austin hospitals finds that most of the nurses, clinical assistants and social workers surveyed were assaulted by patients. Sixty-three percent reported one or more incidents, according to investigator Diane Presley, RN, MSN, director of nursing, critical care and emergency services at Seton Medical Center in Austin. The study included 101 emergency department staff.

Illicit drug impact

BOISE, Idaho—Male nurses were more likely than females to have been physically assaulted by patients in emergency departments, according to a survey of 63 members of the Idaho Emergency Nurses Association. The 1995 study by Mary Hereford, RN, MS, CEN, assistant professor, Boise State University Department of Nursing, also showed significant associations between threats and intimidation and the use of illicit drugs, and between alcohol involvement and verbal abuse. Nurses were most likely to report feeling angry, anxious or irritable following a violent act. Body tension, difficulty falling asleep and body soreness where hit were the most common biophysical responses.

Nurse reactions

OGDEN and PROVO, Utah—Emergency department nurses in two Utah hospitals described a variety of violent acts by patients, in a qualitative study. Four major themes emerged from the data: the nurses' emotional and physical reactions to the incidents; looking back to see if they would have done anything differently; how the nurses have changed practices to guard against violent acts; and reflections about how the violence has affected work environments and themselves. Despite their experiences with patient violence, the six female and three male nurses interviewed remained committed to their emergency department careers. The study was conducted by D. Carl Christensen, RN, MS, a family nurse practitioner in Ogden, Utah, and Elaine S. Marshall, RN, PhD, associate dean of the Brigham Young University College of Nursing in Provo, Utah. *

* By Jane Palmer

Noted researcher and former dean is editor of Image

INDIANAPOLIS, May 24, 1999—Sue Thomas Hegvarya, RN, PhD, FAAN, has been named editor of Image: Journal of Nursing Scholarship, a research journal published by Sigma Theta Tau International's Center Nursing Press.

Hegvarya, who begins her position as editor on July 1, 1999, is dean emeritus of the University of Washington School of Nursing in Seattle, where she is currently a professor in its Department of Biobehavioral Nursing and Health Systems, and an adjunct professor in its Department of Health Services and the School of Public Health and Community Medicine. She succeeds Beverly Henry, RN, PhD, FAAN, who was editor for the past six years. Dr. Henry will become editor of the Americas for the Journal of Advanced Nursing and will serve as assistant to the president at the Weinr Institute in California.

Dr. Hegvarya plans to continue the strong emphasis on scholarship and excellence in professional nursing, including the journal's global focus.

"This position is a good blending of my love of writing and my strong commitment to international health," Dr. Hegvarya says.

Dr. Hegvarya says the journal may go through some initial changes under her editorship, including reorganizing some sections, further emphasizing clinical scholarship and increasing participation from nurses in other countries.

For the past 10 years, Dr. Hegvarya directed the Nursing Systems Research Training Grant, funded by the National Institute for Nursing Research. Previously she served on the editorial advisory board of Nursing Policy Forum as well as editorial consultant for Nursing Care Guide, Pfizer Corporation; and as assistant editor of the Journal of Professional Nursing.

"The journal has been successful in promoting the work of Sigma Theta Tau to provide opportunities for nurses around the world to excel in their profession and in scholarship," said president Eleanor J. Sullivan, RN, PhD, FAAN. "Under Dr. Henry's leadership, Image has achieved extraordinary acclaim and I look forward to the future of the publication with Dr. Hegvarya."

The timing was perfect, according to Dr. Hegvarya, to become the new editor. She learned of the opportunity shortly after leaving the deanship, a position she held for twelve years. Her past experience through manuscript review boards and numerous editorial positions made her a good fit for the position.

Dr. Henry's accomplishments as editor include: expanding interdisciplinary thinking; expanding the journal's international scope including clinical guidelines; developing a health policy feature; publishing articles using historical analysis; balancing the scientific with the aesthetic; and exploring the spiritual dimension of people in illness and death through editorials and articles.*

Visit Sigma Theta Tau Online

Nursing group on violence

MODESTO, Calif., May 1999—The Nursing Network on Violence Against Women International welcomes new members from throughout the world. The organization encourages nursing practices that focus on health issues related to the effects of violence on women's lives. It views the abuse and exploitation of women as a social problem of epidemic proportions. Nurses may also participate in a research consortium and an annual conference.

Diane K. Bohn, RN, DNSc, CMN, assistant professor at the University of Minnesota School of Nursing, is president. For more information, contact Nursing Network on Violence Against Women International, 1801 H Street, Suite B5-165, Modesto, CA 95354-1215, or phone 209.523.6717. *
Blood Pressure

INDIANAPOLIS, April 12, 1999—Nurses gathered at the Midwest Nursing Research Society conference to present new nursing studies at the Indiana Convention Center. The presentations included research on blood pressures of black caregivers and noncaregivers in the ongoing program of Sandra Picot, RN, PhD, FAAN, of the University of Maryland. Age is a major risk factor for higher systolic blood pressure for all groups except hypertensive caregivers, the researchers reported. Caregiving is not associated with higher stress, she said, but is associated with having fewer resources, such as low income. Her presentation on the effects of stressors and resources on ambulatory blood pressures showed that marital status is not a competing stressor for caregivers but a resource.

Random Sampling

In a related presentation of black female caregivers given by June A. Tierney, RN, MSN, CA, of Case Western Reserve University at the Midwest Nursing Research Society conference, probability sampling was examined. Instead of making 60,774 phone calls to obtain a random sampling, Ms. Tierney coordinated a project that used reversed referral, asking patients for names to increase access to rare populations. The results led to making only 5,000 phone calls to obtain a sample of 200 people for a study, making it cost effective to obtain an unbiased sample.

Posters meet clinical news needs

By M. Diane Godkin

EDMONTON, Canada, April 1999—For many years posters have been a useful way of communicating research findings at scientific conferences. Today, the utility of posters is being extended into clinical and acute settings.

A poster can provide a wealth of information in an easy and quick-to-read format. With increasing workloads, many nurses find it difficult to incorporate time to attend in-service programs into their daily schedules. If a poster is mounted in a hallway in a clinical setting, nursing staff (as well as patients and visitors) can attend to the information at their own leisure and revisit the poster as needed. Using posters as a course assignment provides students with an opportunity to utilize their analytic skills and creativity. The end-product can be displayed and shared with others. Along the way, students develop skills in being succinct and clear.

Topics

In the clinical setting, you may wish to focus on a new and innovative treatment applicable to the patients on your ward. Alternatively, you can present information about new policies or legislation that may affect your practice. Or perhaps your nursing staff are struggling with a particular ethical issue that needs to be explored. In the classroom, posters can focus on course content, such as health issues in developing countries or pet therapy in long-term care. Select a topic that stirs your curiosity and piques your interest. This will help you see the poster through to its completion. Once you have settled on a topic, current and legitimate literature should be collected and summarized.

Content

Once you have gathered sufficient information, you need to subdivide the content into small sections. These sections will depend on the purpose of your poster and your potential audience, but may include a statement of the problem or concern (e.g., care of decubitus ulcers), a step-by-step guide of how to do a new procedure, information about when to use the new procedure and so forth. The information should be presented succinctly; point form or bulleted lists are visually easier to read and remember than lengthy text. Pictures, diagrams and flow charts highlighting or summarizing the topic can be very effective. Add a list of references for those seeking additional information.

Design

There are many guides and references that discuss the elements of good poster design (Sigma Theta Tau International Communication How To’s, 1999). A few key tips to remember include the liberal use of white space. In many posters too much information is squeezed in, resulting in a cluttered, unattractive, and difficult-to-read poster. The type size should be large enough to read from a four- to five-foot distance. Be sure to break up text with visual images. A judicious use of color will also add interest. A number of computer programs may be used, including Microsoft PowerPoint, Adobe PageMaker and WordPerfect. With scanners and color printers, the possibilities are limited only by time and creativity.

Evaluate Poster

Perhaps the easiest way to evaluate your poster’s impact is to spend a few minutes watching from a distance. When people walk by the poster, do they look? Do they stop? Do they read? Does the poster stimulate questions and discussion on the topic among staff and patients? Did a change in practice occur? And finally, did you learn something new during the process? If the answer is yes to any of these questions, you will have contributed to meeting the goals of disseminating information and raising awareness of important nursing issues.
KANSAS CITY to develop national teaching models

KANSAS CITY, Mo., March 31, 1999—Nursing schools faced with preparing graduates for rapidly changing roles will have some help from a new program that will develop national teaching models. Four projects are being launched in Kansas City. The projects will be led by the University of Kansas Medical Center School of Nursing, Avila College, and Central Missouri State School of Nursing. The educational bodies will join with health care groups to focus on innovative ways to teach nursing students. During the 18-month projects, Sigma Theta Tau International will serve as the overall coordinator.

The educational work we’re doing through this program will result in better nursing care for patients in this community and eventually throughout the nation," said Dr. Eleanor J. Sullivan, Sigma Theta Tau International president. The projects, totaling $85,000, are funded by local companies: Health Midwest, Hoehst Marion Roussel and Blue Cross Blue Shield.

The new projects are:

Clinical Outcomes, led by co-chairs Anne Kuckelman Cobb, RN, PhD, professor at the University of Kansas Medical Center School of Nursing, and Kristine Williams, RN, NP-C, CS, adjunct faculty member, will focus on measurement skills. Med 1, led by Kim Tankel, RN, ARNP, assistant professor at Central Missouri State University School of Nursing, will explore nursing students’ use of computerized medication software for patient education and symptom management.

Collaborative Orientation, led by Susan H. Fetsch, RN, PhD, chair and associate professor at Avila College, will develop an orientation curriculum model.

Case Manager/Care Coordinating, led by Kathy Fletcher, RN, PhD, assistant clinical professor at the University of Kansas Medical Center School of Nursing, will create an undergraduate case manager/care coordinator roles course which uses Web technology.

Blood Pressure

INDIANAPOLIS, April 12, 1999—Nurses gathered at the Midwest Nursing Research Society conference to present new nursing studies at the Indiana Convention Center. The presentations included research on blood pressures of black caregivers and noncaregivers in the ongoing program of Sandra Picot, RN, PhD, FAAN, of the University of Maryland. Age is a major risk factor for higher systolic blood pressure for all groups except hypertensive caregivers and conservative caregivers, she reported. Caregiving is not associated with higher stress, she said.

Resources, such as low income. Her presentation, "The utility of posters is being extended into clinical and community settings. A poster can provide a wealth of information in an easy and quick-to-read format. With increasing workloads, many nurses find it difficult to incorporate time to attend in-service programs into their daily schedules. If a poster is mounted in a hallway in a clinical setting, nursing staff (as well as patients and visitors) can attend to the information at their own leisure and revisit the poster as needed. Using posters as a course assignment provides students with an opportunity to utilize their analytic skills and creativity. The end-product can be displayed and shared with others. Along the way, students develop skills in being succinct and clear.

Clinical Outcomes, led by co-chairs Anne Kuckelman Cobb, RN, PhD, professor at the University of Kansas Medical Center School of Nursing, and Kristine Williams, RN, NP-C, CS, adjunct faculty member, will focus on measurement skills. Med 1, led by Kim Tankel, RN, ARNP, assistant professor at Central Missouri State University School of Nursing, will explore nursing students’ use of computerized medication software for patient education and symptom management.

Collaborative Orientation, led by Susan H. Fetsch, RN, PhD, chair and associate professor at Avila College, will develop an orientation curriculum model.

Case Manager/Care Coordinating, led by Kathy Fletcher, RN, PhD, assistant clinical professor at the University of Kansas Medical Center School of Nursing, will create an undergraduate case manager/care coordinator roles course which uses Web technology.

Random Sampling

In a related presentation of black female caregivers given by June A. Tierney, RN, MSN, CA, of Case Western Reserve University at the Midwest Nursing Research Society conference, probability sampling was examined. Instead of making 60,774 phone calls to obtain a random sampling, Ms. Tierney coordinated a project that used reverse referral, asking patients for names to increase access to rare populations. The results led to making only 5,000 phone calls to obtain a sample of 200 people for a study, making it cost effective to obtain an unbiased sample.

Ms. Tierney, left, talks with Dr. Picot on April 12, 1999, prior to presenting their studies on caregivers at the Midwest Nursing Research Society.

Content

Once you have gathered a sufficient amount of information, you need to sub-divide the content into small sections. These sections will depend on the purpose of your poster and your potential audience. A few key tips to remember include the liberal awareness of important nursing issues.

Evaluate Poster

Perhaps the easiest way to evaluate your poster's impact is to spend a few minutes walking from a distance. When people walk by the poster, do they look? Do they stop? Do they read? Does the poster stimulate questions and discussion? Does the audience appear engaged? All of these factors should be considered when evaluating the success of your poster presentation.

Posters meet clinical news needs

EDMONTON, Canada, April 1999—For many years posters have been a useful way of communicating research findings at scientific conferences. Today, the utility of posters is being extended into clinical and community settings. A poster can provide a wealth of information in an easy and quick-to-read format. With increasing workloads, many nurses find it difficult to incorporate time to attend in-service programs into their daily schedules. If a poster is mounted in a hallway in a clinical setting, nursing staff (as well as patients and visitors) can attend to the information at their own leisure and revisit the poster as needed. Using posters as a course assignment provides students with an opportunity to utilize their analytic skills and creativity. The end-product can be displayed and shared with others. Along the way, students develop skills in being succinct and clear.

Topics

In the clinical setting, you may wish to focus on a new and innovative treatment applicable to the patients on your ward. Alternatively, you can present information about new policies or legislation that may affect your practice. Or perhaps nursing staff in your area are struggling with a particular ethical issue that needs to be explored. In the classroom, posters can focus on course content, such as health issues in developing countries or pet therapy in long-term care. Select a topic that stirs your curiosity and piques your interest. This will help you see the poster through to its completion. Once you have settled on a topic, current and legitimate literature should be collected and summarized.

Content

Once you have gathered a sufficient amount of information, you need to sub-divide the content into small sections. These sections will depend on the purpose of your poster and your potential audience. A few key tips to remember include the liberal awareness of important nursing issues. If you have settled on a topic, current and legitimate literature should be collected and summarized.

M. Dianne Godkin, RN, MS, member of the Sigma Theta Tau International Public Relations Committee, is a doctoral student at the University of Alberta Faculty of Nursing in Edmonton, Canada.
**Supporting global health**

**By Jeanne Floyd**

INDIANAPOLIS—In Sigma Theta Tau's strategic planning survey, Dixie Koldjekpi of North Carolina wrote, "The society ought to enter into in-depth dialogue with the International Council of Nurses and review with the World Health Organization its initiatives...."

Fay L. Bower, past president of Sigma Theta Tau International, echoed this belief in her response: "Through partnerships with other organizations, the society can be a catalyst in bringing nurses together in one strong voice." Sigma Theta Tau International's Strategic Planning Task Force has endorsed this vision of members calling for new roles, involving their patients as partners in the society to promote international collaborative efforts and mutuality in global leadership.

Nancy Dickenson-Hazard, Sigma Theta Tau International executive officer, and I took the first steps in answering the call for building collaborative projects. We met with Nacema Al-Gasseer, World Health Organization nurse scientist, and Judith Oulton, International Council of Nurses chief executive officer, in Geneva.

During one-day sessions at each organization, Sigma Theta Tau received warm welcomes by nursing officers, project directors and consultants. The groundwork was established for fostering collaborative efforts and trust. We discussed organizational initiatives and identified areas for cooperative goal setting.

**WHO**

As a result of the meetings, web site linkages have been formed. This will provide the opportunity for the WHO staff to access the information and knowledge resources of Sigma Theta Tau International, including the Registry of New Nurse Educators and The Online Journal of Knowledge Synthesis for Nursing. Complimentary copies of Image: Journal of Nursing Scholarship and Reflections will be issued to the WHO library.

In society publications and on the web site, WHO research, resources and position opportunities will be announced. Members will be given the opportunity to apply for global employment positions at WHO. Dr. Al-Gasseer has been invited to provide quarterly news in publications. We are exploring the development of predoctoral and postdoctoral fellowships in health policy at WHO headquarters.

Interested individuals should contact the headquarters.

**Eastern Europe flags community nurses for better health care**

MARIBOR, Slovenia, May 1999—Since the downfall of the former Soviet Union, clinical nursing leaders from the transitional republics have been searching for new methods to deliver effective health care. At the World Health Organization's Collaborating Center, Majda Slajmer-Japelj, a nurse and sociologist, has been organizing studies and field work in primary health care nursing for her colleagues from 11 nations.

Through studies and field work in Maribor and rural areas, nurses are taking on new roles, involving their patients as partners in the nursing team.

Slovenia shares many of the concerns of its Eastern European and Asian neighbors.

"Slovenia's socioeconomic situation demands that we look for the most professional, efficient and cost-effective means of caregiving," says Ms. Slajmer-Japelj, the center's senior advisor for public health nursing. "Our nation has a good learning base of experiences and had to take similar paths as the others have."

The collaborating center has been conducting workshops to introduce community and family nursing into the various health systems, she says. Nurses then adapt the new roles to their national needs.

In Slovenia, community nurses, working with mental health nurses, take active roles in dealing with family violence. "The community nurse is usually the first person to talk with the violent person. If she cannot influence the person, the mental health services are included into the discussions," Ms. Slajmer-Japelj says.

"Dealing with family violence is particularly difficult due to its hidden aspects. Mental health nurses and other professionals staff help lines. But community nurses, on site for a variety of health issues, are accessible to victims who already trust them."

A multidisciplinary education, more available than many nursing specialties in Slovenia, is an asset for these life-saving, invasive nurses. Ms. Slajmer-Japelj says. "We have to understand as a beginning of new international nursing achievements as relationships and projects mature to support global health."

**ICN**

Similarly strong collaborations were initiated in the discussions held with ICN. Resources, including the ICN Research Network, will be available to the members of ICN's federation of national nurses associations. Nurse researchers, affiliated with ICN, have been invited to register their work with the World Health Organization Nursing Library. The library staff are prepared to provide support to the researchers.

Communications will be maintained regularly as programs in the society's International Leadership Institute are developed. Program areas include exploring the development of postdoctoral and postdoctoral fellowships in health policy at WHO headquarters.

Interested individuals should contact the headquarters.

**Sigma Theta Tau International executive officer by E-mail: nancy@ott.iupui.edu**

**GENEVA, April 27, 1999—**Nancy Dickenson-Hazard, left, executive officer of Sigma Theta Tau International meets with Sally Shaw, middle, and Judith Oulton at International Council of Nurses headquarters.

The Geneva meetings will be understood as a beginning of new international nursing achievements as relationships and projects mature to support global health.
Supporting global health

By Jeanne Floyd

INDIANAPOLIS—In Sigma Theta Tau’s strategic planning survey, Dixie Koldejek of North Carolina wrote, “The society ought to enter into in-depth dialogue with the International Council of Nurses and review with the World Health Organization its initiatives...” Fay L. Bower, past president of Sigma Theta Tau International, echoed this belief in her response: “Through partnerships with other organizations, the society can be a catalyst in bringing nurses together in one strong voice.”

Sigma Theta Tau International’s Strategic Planning Task Force has endorsed this vision of members calling for the society to promote international collaborative efforts and mutuality in global leadership.

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During one-day sessions at each organization, Sigma Theta Tau received warm welcomes by nursing officers, project directors and consultants. The groundwork was established for fostering collaborative efforts and trust. We discussed organizational initiatives and identified areas for cooperative goal setting. We discussed partnerships and mutual projects. We met with Naeema Al-Gasseer, World Health Organization, and I took the first steps in answering the call for building collaborative partnerships. We met with Nacessa Al-Gasseer, World Health Organization nurse scientist, and Judith Oulton, International Council of Nurses chief executive officer, in Geneva.

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The Geneva meetings will be best understood as a beginning of new international nursing achievements as relationships and projects mature to support global health. Jeanne M. Floyd, RN, PhD, G. CAE, is director of research and evaluation at Sigma Theta Tau International.

Eastern Europe flags community nurses for better health care

MARIBOR, Slovenia, May 1999—Since the downfall of the former Soviet Union, clinical nursing leaders from the transitional republics have been seeking new methods to deliver effective health care. At the World Health Organization’s Collaborating Center, Majda Slajmer-Japelj, a nurse and sociologist, has been organizing studies and field work in primary health care nursing for her colleagues from 11 nations.

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Majda Slajmer-Japelj, RN, senior advisor at the World Health Organization Collaborating Center in Maribor, Slovenia, introduces clinical nursing reforms to promote community health care in former Soviet bloc nations.

Slovenian community nurse Debrajca Sancen, RN, left, is responsible for the health of mothers and newborns at home after they spend their first year in hospital. She continues care, providing family health nursing services as needed.
Evolution of a Leader

Meredith J. Addison, RN, MSN, CEN

Emergency Department Staff Nurse
Terre Haute Regional Hospital
Terre Haute, Indiana, United States of America

Merry Addison reminds us that "not all of us work at the big hospitals in the big cities." Now a clinician in a rural regional hospital, her leadership palette has many hues, each representing a facet of her professional and personal life-officer of professional organizations, creative fundraiser for community and health care projects, continuing education course coordinator, spouse of a nurse and mother of two.

Education
ASN Indiana State University
BSN Indiana State University
MSN Indiana State University

How have professional associations helped shape your career?

My career has soared from the excitement, assistance and encouragement of the Emergency Nurses Association. I joinedENA when I received my BSN and it became a bridge between my clinical and my academic worlds. Through its community programs and continuing education, I learned to transfer what I learned in school to my practice world. I became the ENA state president for Indiana in 1998. As my professional outlook becomes broader, I'm learning about Sigma Theta Tau's valuable associations to help me reach out and grow beyond my local area.

What will make nursing a successful profession in the future?

Marcia Brown's classic story, "Stone Soup," has a powerful lesson for us. It's the story of three starving soldiers returning from war. They help their fellow townspeople learn that, by looking beyond what each person is trying to grab and using their special, but limited, gifts to help one another, their pooled riches were far greater. I know it's a lesson we often overlook. It reminds us that nursing won't be successful unless we adopt a genuine global outlook.

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NEW! Distinguished Writers Program

Sigma Theta Tau International seeks individuals with expertise in writing, editing and publishing to apply for its Distinguished Writers Program. Accepted applicants will form a cadre of consultants who will assist nurse authors in the development of manuscripts for potential publication and/or lead workshops on writing for publication.

To receive an application, contact Melody Jones at Sigma Theta Tau International, 1.800.634.7575.1 (International), or fax: 317.634.8188.

DEADLINE FOR APPLICATIONS IS SEPTEMBER 15, 1999.

Help advance the dissemination of nursing knowledge by applying now for the Sigma Theta Tau International Distinguished Writers Program!
Evolution of a Leader

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Emergency Department Staff Nurse
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The power of leadership—broadening your view

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Charitable Gift Annuities: A Win/Win Situation for Donors

By Pamela Jones Davidson, JD

Many donors who want to provide ongoing and meaningful support for their favorite not-for-profit organizations such as Sigma Theta Tau International tell us that they need to preserve income from their assets. They are concerned about the flexibility because they fear they may require many sources of income for themselves and their spouses throughout what may be long lifetimes. The charitable gift annuity arrangement has proven to be very popular with many of these donors, because it can pay an often higher than market rate of return that is guaranteed, and it endows ongoing support for a cherished organization. 

Charitable gift annuities are simple contracts, governed by an extent by your state law. The contract, which is only a page or two in length and is easy to understand, provides that income will be paid to the donor and spouse (if that option is selected) for their lifetime(s), after which whatever is left is benefited to Sigma Theta Tau International. The donor is entitled to a charitable income tax deduction equal to the actualized calculated charitable remainder value. However, the donor is not able to deduct the value of the life income for self and spouse. The rates of return under these arrangements can be quite high, currently as much as 12% for a 90-year-old single lifetime beneficiary, 8% for an 80-year-old couple, and 7.3% for a couple both aged 75. The rates are reviewed each year by the American Council on Gift Annuities and consequently are subject to change. This rate of return to the donor is guaranteed, supported by Sigma Theta Tau International’s assets.

A great advantage of charitable gift annuities is that you can decide when your income begins (at retirement, for instance), yet you receive the income tax deduction in the year the arrangement is actually funded. This can be an excellent way to supplement retirement income by funding a gift annuity annually now and deferring the payment of income until age 65 or even 70. This deferral of income can greatly increase both the guaranteed rate of return and the resulting charitable deduction. We have even seen many gift annuities funded with annual mandatory distributions from retirement plans after age 70, when the donor wishes to have the income available at some later period.

Capitalize on your career investment—transform a career of care through giving.

As a nurse, you know that every contribution—no matter how small—can make a big difference to a patient’s health.

Our profession operates the same way. We need to work together to build respect for nursing, retain and enhance options for our own careers, and ensure success for individual nurses everywhere.

We all have choices when it comes to charitable giving. But your gift to Sigma Theta Tau clearly says, “I want to keep a good thing going.”

Even if you can’t afford a large gift, please consider some gift to Sigma Theta Tau today.

It’s a smart career move for you and for nurses everywhere.

FOR MORE INFORMATION, VISIT OUR SITE.

www.nursingsociety.org

Contact External Affairs, Sigma Theta Tau International, 888.634.7575 (toll-free U.S. and Canada), 317.634.8171, or E-mail lindge@stti.jupi.edu.

Unlimited gift annuities are clearly appreciated by those whose work and relationships in nursing have led them to choose a career of care through giving. For example, the Billye Brown Fellows will receive special pins, certificates, and many other benefits, and be recognized in publications and at society meetings.

Creation of this gift circle marks the inauguration of a Sigma Theta Tau initiative to assist chapter leaders with inviting planned gifts from their members. In addition to recognizing these special donors, the society makes available its director of external affairs and giving consultant to furnish ongoing counsel about planning arrangements best suiting their personal needs.

Fellows will be those members including a bequest beneficiary of their chapters and/or the international. Other nations may have different arrangements, or may require many tangible personal property that may be approved for acceptance in accordance with Sigma Tau’s philanthropic policies.

Fellows may be directed to Linda Brimmer, director of affairs, 1.888.634.7575 (U.S. and Canada toll free), or 1.757.1 (Global toll free).

For more information about these fellows, to receive a proposal, or to designate your chapter as a Billye Brown Fellow, please contact: Doris Edwards, RN, EdD; Emily Ibst, RN, MS; Sharon S. Farley, RN, PhD, FAAN; Diane N. MN; and Bonnie Kellogg, RN, DrPH, as its newest Sigma Theta Tau initiative to assist chapter leaders with inviting planned gifts from their members. In addition to recognizing these special donors, the society makes available its director of external affairs and giving consultant to furnish ongoing counsel about planning arrangements best suiting their personal needs.
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A painting of Dr. Edith Anderson by John A.

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but did not need it presently. An additional advantage of these contractual arrange­ments is that they may be funded with modest amounts, as little as $5,000. Many donors fund charitable gift annuities with certificates of deposit as they mature, doubling or even tripling their income and also their tax deduction. In this way, those donors personally benefit from the gift arrange­ment during their lifetimes, and have the joy of planning their gifts and being them­selves recognized, instead of leaving those details to an estate executor.

Depending upon the type of asset used to fund the charitable gift annuity arrangement, some of the income paid each year constitutes a tax-free return of principal that is not subject to income tax. This benefit is greatly enhanced from gift annuities funded with cash instruments such as certifi­cates of deposit, and diminishes when the gift annuity is funded with highly appreci­ated property, in which case most of the income would be ordinary and capital gain with relatively little tax-free return. Charitable gift annuities are frequently used to support your parents, siblings, or friends.

You can create gift annuities to assist your parents, provide them with what is usually a higher than market return and enable you to present charitable income tax deduction. And, you can use that charitable gift annuity to honor your parents, to enjoy the pleasure of your tribute and recognition now, during their debtors' lifetimes.

Gift annuity arrangements can also be used for memorial—named endowment—funds that provide interest income to you and eventually to Sigma Theta Tau. As part of your overall estate planning, you can provide charitable gift annuities for siblings and dear friends in your will or trust. The payments can commence upon your death and provide income for their lifetimes. We have software to prepare confidential calcula­tions for you. They will approximate the income and deduction effects of various gift scenarios. We welcome your inquiries about these flexible and affordable life income arrangements that can furnish so many benefits to you and others, as well as significant, much appreciated support for the important work of Sigma Theta Tau International.

Bil­lye Brown Fellows will receive special pins, certificates, and many other benefits, and be recognized in publications and at society meetings. Creation of this gift circle marks the inauguration of a Sigma Theta Tau initiative to assist chapter leaders with invited planned gifts from their members. In addition to recognizing those special donors, the society makes available its director of external affairs and planned giving consultant to furnish ongoing counsel about the estate planning arrangements best suit­ting their personal circumstances. Billye Brown Fellows will be those members including a bequest of any amount benefiting their chapters and/or the international organization in their wills; designating their chapters and/or Sigma Theta Tau as beneficiaries for a portion of life insurance policies or annuity proceeds; or, receiving tangible personal property that has been pre-approved for acceptance in accordance with Sigma Theta Tau’s philanthropic policies.

Questions may be directed to Linda Brimmer, director of external affairs, 1.888.634.7575 (U.S. and Canada toll free), 1.800.634.7575.1 (Global toll free).

Virginia Henderson Fellows Update

The society welcomes Doris Edwards, RN, EdD; Emily Holmquist, RN, MS; Sharon S. Farley, RN, PhD, FAAN; Diane Webby, RN, MSN; and Bonnie Kellogg, RN, DrPH, as its newest Virginia Henderson Fellows. Additionally, Dr. Edith H. Anderson was declared posthumously to be a Virginia Henderson Fellow. The biennial Heritage Society dinner for Virginia Henderson Fellows will be held on Sunday, November 7th, in San Diego.
Virginia Henderson International Nursing Library

By Judith Graves

New index to findings in the nursing research literature

A new service of the library is a "clinical knowledge index of the published nursing research literature." Research terms, variables and concepts are used to index the findings, statements and conclusions, taken from research abstracts. From the research statements one can do a free, real-time Pubmed search for the full abstract and citation. The index covers the nursing research literature from 1996 to the present and is updated monthly. The set of journals was selected using the following criteria: peer-reviewed nursing journals indexed by MEDLINE and/or the International Nursing Index, and containing approximately 50 percent research articles. For nursing journals that do not have as many as 50 percent research articles, the editors can arrange with us to provide specific electronic citation information and abstracts of completed research articles from each issue of their journal. We will process these without cost to the journal and will include them in our Index and add their names to the list of indexed journals. We also make this offer to the editors of proceedings of regional and national research conferences. For more information see the Directory of Nurse Researchers paper by J. Graves at http://www.nursingsociety.org/library and select > technical papers > clinical knowledge indexing.

HIV/AIDS arcs© knowledgebase comes to the WWW

In 1995, the Helene Fuld Foundation provided a grant to Sigma Theta Tau International to modify and transport the arcs© software to a Windows environment, use it to build selected knowledgebases, to test the output as a teaching paradigm, and to implement the software on the World Wide Web so that many knowledgebases could be made accessible across the web. The arcs© computer system allows users to store and retrieve any and all details about research studies and build causal/associational models of the knowledge that is entered. The first knowledgebase built in arcs© to appear on our web site is the HIV/AIDS clinical nursing knowledgebase built by Dr. Baisig and Goldrich with the assistance of graduate students at Georgetown University. The knowledgebase covers clinical knowledge from the time of the appearance of HIV/AIDS in the literature through 1997. This knowledgebase can be accessed on the library web by selecting > knowledgebases and is open to everyone. The arcs© application is read-only. No editing or entry of content is allowed; however, each record in the knowledgebase about each of the 249 studies can be "browsed." You can query the knowledgebase using preprogrammed queries that ask "what variables were studied," "how were variables operationally defined," "what conditions and controls (delimitations) were used in the domain," etc. If this doesn't satisfy your interest, you can build your own queries.

Graphical (causal/associational) maps are preprogrammed. As yet, users cannot develop their own maps but can see the map and related citation information and findings summaries as available for selected variables.

A more thorough bibliography used by the Georgetown group is accessible as a bibliographic database using software we provide. To search this database, go to the library site and select knowledgebases and click on the HIV/AIDS Nursing Care Bibliography. To extend the active life of the HIV/AIDS knowledgebase, the library is continuing to process the HIV/AIDS literature of MEDLINE/International Index to identify variables, concepts and findings and conclusions. This index is located under http://www.nursingsociety.org/library by selecting > clinical knowledge indexes > HIV/AIDS Literature 1998 to present. This index will serve as a filter for choosing relevant articles to incorporate into an ongoing arcs© knowledgebase. Also, we are expecting a national organization to adopt the knowledgebase and be responsible for its growth. We encourage other organizations interested in developing domain knowledgebases to contact the library.

We are awaiting the response to this form of knowledgebase publishing. If favorable, we will consider making this an ongoing library electronic publishing service and accept submissions that pass peer-review.

Judith R. Graves, RN, PhD, FAAN, is scholar in residence at Sigma Theta Tau International's Virginia Henderson International Nursing Library.
VI S I T  T H E  L I B R A R Y  A T  I T S  N E W  A D D R E S S
http://www.nursingsociety.org/library

Virginia Henderson International Nursing Library

By Judith Graves

New index to findings in the nursing research literature

A new service of the library is a "clinical knowledge index of the published nursing research literature." Research terms, variables and concepts are used to index the findings, statements and conclusions, taken from research abstracts. From the research statements one can do a free, real-time Pubmed search for the full abstract and citation. The index covers the nursing research literature from 1996 to the present and is updated monthly. The set of journals was selected using the following criteria: peer-reviewed journals indexed by MEDLINE and/or the International Nursing Index, and containing approximately 50 percent research articles. For nursing journals that do not have as many as 50 percent research articles, the editors can arrange with us to provide specific electronic citation information and abstracts of completed research articles from each issue of their journal. We will process these without cost to the journal and will include them in our Index and add their names to the list of indexed journals. We also make this offer to the editors of proceedings of regional and national research conferences. For more information see the Directory of Nurse Researchers paper by J. Graves at http://www.nursingsociety.org/library and select > technical papers > clinical knowledge indexing.

HIV/AIDS arcs© knowledgebase comes to the WWW

In 1995, the Helene Fuld Foundation provided a grant to Sigma Theta Tau International to modify and transport the arcs© software to a Windows environment, use it to build selected knowledgebases, to test the output as a teaching paradigm, and to implement the software on the World Wide Web so that many knowledgebases could be made accessible across the web. The arcs© computer system allows users to store and retrieve any and all details about research studies and build causal/associational models of the knowledge that is entered.

The first knowledgebase built in arcs© to appear on our web site is the HIV/AIDS clinical nursing knowledgebase built by Dr. Baigis and Goldrich with the assistance of graduate students at Georgetown University. The knowledgebase covers clinical knowledge from the time of the appearance of HIV/AIDS in the literature through 1997. This knowledgebase can be accessed on the web by selecting > knowledgebases and is open to everyone. The arcs© application is read-only. No editing or entry of content is allowed; however, each record in the knowledgebase about each of the 249 studies can be "browsed." You can query the knowledgebase using preprogrammed queries that ask "what variables were studied," "how were variables operationally defined," "what conditions and controls (delimitations) were used in the domain," etc. If this doesn't satisfy your interest, you can build your own queries. Graphical (causal/associational) maps are preprogrammed. As yet, users cannot develop their own maps but can see the map and related citation information and findings summaries as available for selected variables.

A more thorough bibliography used by the Georgetown group is accessible as a bibliographic database using software we provide. To search this database, go to the library site and select knowledgebases and click on the HIV/AIDS Nursing Care Bibliography.

To extend the active life of the HIV/AIDS knowledgebase, the library is continuing to process the HIV/AIDS literature of MEDLINE/International Index to identify variables, concepts and findings and conclusions. This index is located under http://www.nursingsociety.org/library by selecting > clinical knowledge indexes > HIV/AIDS Literature 1998 to present. This index will serve as a filter for choosing relevant articles to incorporate into an ongoing arcs© knowledgebase. Also, we are expecting a national organization to adopt the knowledgebase and be responsible for its growth. We encourage other organizations interested in developing domain knowledgebases to contact the library.

We are awaiting the response to this form of knowledgebase publishing. If favorable, we will consider making this an ongoing library electronic publishing service and accept submissions that pass peer-review.

By Judith Graves, RN, PhD, FAAN, is scholar-in-residence at Sigma Theta Tau International's Virginia Henderson International Nursing Library.
Four nurses from the University of Tampere have been inducted into Gamma Kappa, State University of New York at Buffalo. Marita Paunonen, RN, PhD, is an assistant professor and head of the Department of Nursing; Pauli Aukst-Kurki, RN, PhD, is associate professor; Eila Paavilainen, RN, PhD, is assistant professor; and Marta-Terri Tarkka, RN, PhD, is assistant professor. Drs. Paunonen, Aukst-Kurki, and Paavilainen are studying family dynamics and child abuse and neglect in Finland with Marjorie A. White, RN, PhD, FAAN, former professor at State University of New York at Buffalo.

**MEXICO**

Sustana Segura Salas, BSN, RN, dean, and Laura Moran, BSc, professor at the University of Tampere, have been inducted into Alpha Sigma at the University of Alberta, Edmonton, Alberta, Canada. Ms. Salas is a founding member of the Mexican Association of Specialized Nursing in Critical Care and Intensive Therapy and has been honored by the Mexican Society of Cardiology for her work in cardiovascular nursing. Ms. Moran is the president of a Mexican nursing school association and a founding member of a distance education association.

**SLOVENIA**

Marita Rahine, RN, BSc, lecturer at the University of Ljubljana, has been inducted into Delta Beta at the University of South Florida in Tampa. Ms. Rahine has written two books and has been a co-translator for three books. She is investigating changes in nursing care delivery systems and is investigating the job satisfaction of Slovenian nurses.

**TAIWAN**

Min-Tao Hsiu, RN, PhD, associate professor of nursing at Kaohsiung Medical College in Kaohsiung, has received the 1999 Outstanding Research Award from Taiwan's National Science Council, the 1998 Mentor Award from Kaohsiung Medical College, and the Outstanding Dissertation Award from the University of Texas at Austin School of Nursing. Her current research focuses on ways to help Taiwanese widows cope with their husbands' deaths.

**THAILAND**

Noppawan C. Lueck, RN, C, PhD, associate professor of nursing at Florida Atlantic University in Boca Raton, Fla., is visiting professor of nursing at Phayao University in Chiang Mai, where she is developing a master in nursing science program.

**UNITED STATES**

**Arizona**

Janet Kenney, RN, PhD, professor at Arizona State University in Tempe, has received a Spirit of Women Foundation national award for mentoring women's health graduate students and for her research projects, including her current work on women and stress.

**California**

Janet Kaysor Jones, RN, PhD, FAAN, professor of nursing and medical anthropology at the University of California, San Francisco, has been awarded a five-year, $2.1 million grant from the National Institutes of Health to conduct the study "An Ethnography of Dying in Long-Term Care Facilities.

**Colorado**

Patricia Nesnen Palmcr, RN, MS, MM, CNE, has been appointed executive director of the Association of Operating Room Nurses. She previously was deputy executive director of the organization.

**Delaware**

Amanda Bulka-Penn, MSN, is an assistant director of nursing at University Hospital for Children in Wilmington.

**Florida**

Rose Rivers, RN, PhD, vice president of nursing at Shands Teaching Hospital at the University of Florida, Gainesville, is among 15 executive nurses chosen for the Robert Wood Johnson Foundation Executive Nurse Fellows Program.

**Georgia**

Linda L. McCullum, PhD, RN, CNNP, regional outreach coordinator for Emory University's Division of Neonatology in Atlanta, has received the 1999 Distinguished Nursing Achievement Award from Emory's Nurses Alumni Association.

**Indiana**

Judith R. Graves, RN, PhD, FAAN, scholar-in-residence at Sigma Theta Tau International's Virginia Henderson International Nursing Library, has been selected to receive the 1999 MacInnes Award by the New York University Division of Nursing, School of Education. The award will be presented to Dr. Graves in November in honor of her work with the Virginia Henderson International Nursing Library.

**Maryland**

Mary Arneson, BSN, RN, ASCN, associate professor at The Johns Hopkins School of Nursing and director of oncology research nursing at The Johns Hopkins Hospital in Baltimore, has been appointed American Cancer Society Professor in Oncology Nursing.

**Minnesota**

Marina Rantz, RN, PhD, associate professor at the University of Minnesota and professor of nursing at the University of Missouri Hospital and Clinics in Columbia, Mo., has received the Harriet H. Weyer New Investigator Award from the Midwest Nursing Research Society. Dr. Rantz is researching ways to improve care quality and outcomes for older adults, especially those in need of nursing home care.

**New York**

Carol Brews, RN, PhD, assistant professor at the University at Buffalo, State University of New York School of Nursing, has been awarded a SUNY/United University Professions Dr. Baldo McGavin Dreischer Affirmative Action Award for further research on the nursing labor supply.

**Rhode Island**

Jean E. Jezewski, RN, PhD, is an assistant professor at the University of Buffalo, State University of New York, Buffalo. She is the newly elected president of the Oncology Nursing Society.

**Rhode Island and Providence Plantations**

Joanne N. Hensley, RN, PhD, assistant professor and chairperson of the Salem State College nursing program, has been inducted as a fellow of the Stroke Council of the American Heart Association.

**Texas**

Marcia Antrobus, RN, PhD, associate professor at the University of Texas at Austin School of Nursing, has received the 1999 Major McInnes Award by the New York University Division of Nursing, School of Education. The award was presented to Dr. Graves in November in honor of her work with the Virginia Henderson International Nursing Library.
Women's Health Graduate Students and for Her

REFLECTIONS

TAIWAN

Susana Segura Salas, BScN, dean, and Laura Moran, BSc, master's in higher education, associate dean of graduate education, Universidad Nacional de Taiwan, has been appointed executive director of the Association of Operating Room Nurses. Ms. Moran is past president of the Association of Operating Room Nurses. She has been a perinatal nurse educator and consultant, is a clinical nurse educator at Valleylab Care and Intensive Therapy and has been honored by Emory's Nurses Alumni Association.

FINLAND

Bohinc has written two books and has been a co-translator for three books. She is researching women's health graduate students and for her current research focuses on ways to help Taiwanese widows cope with their husbands' deaths.

UNITED STATES

Janet Kenny, RN, PhD, professor at Arizona State University in Tempe, has received a Spirit of Woman Foundation national award for mentoring women's health graduate students and for her research projects, including her current work on women and stress.

California

Janet Kaysen-Jones, RN, PhD, FAAN, professor of nursing and medical anthropology at the University of California, San Francisco, has been awarded a five-year, $2.1 million grant from the Centers for Disease Control and Prevention for her work on the diversity of aging. After retiring, she taught English as a second language and Bible studies. Memorial contributions may be made to the American Cancer Society to support ovarian cancer research.

Colorado

Patricia Messmer Palmer, RN, MS, MWM, CAE, has been appointed executive director of the Association of Operating Room Nurses. She previously was deputy executive director of the organization.

Delaware

Alexis Bulka Peril, MSN, is assistant director of nursing at DuPont Hospital for Children in Wilmington.

Florida

Rose Rivers, RN, PhD, vice president for nursing at Shepard Teaching Hospital at the University of Florida in Gainesville, is among 15 executive nurses chosen for the Robert Wood Johnson Foundation Executive Nurse Fellows Program.

Georgia

Linda L. McCullum, PhD, RN, CNNP, regional outreach coordinator for Emory University's Division of Neonatology in Athens, has received the 1998 Distinguished Nursing Achievement Award from Emory's Nurses Alumni Association.

Indiana

Judith R. Graves, RN, PhD, FAAN, scholar-in-residence at Sigma Theta Tau International's Virginia Henderson International Nursing Library, has been selected to receive the 1999 Mac-Ivines Award by the New York University Division of Nursing, School of Education. The award will be presented to Dr. Graves in November in honor of her work with the Virginia Henderson International Nursing Library.

Maryland

Victoria Nick, DNSc, AOCN, associate professor at Johns Hopkins School of Nursing and director of oncology research nursing at the Johns Hopkins Hospital in Baltimore, has been appointed American Cancer Society Professor in Oncology Nursing.

Massachusetts

Joanne H. Evans, RN, EDD, CRNP, professor and chairperson of the Salem State College nursing program, has been inducted as a fellow of the American Heart Association.

Missouri

Marlom Rantz, RN, PhD, associate professor at the University of Missouri-Columbia and professor of nursing at the University of Missouri Hospital and Clinics in Columbia, Mo., has received the Harriet H. Wetry New Investigator Award from the Midwest Nursing Research Society. Dr. Rantz is researching ways to improve care quality and outcomes for older adults, especially those in need of nursing home care.

New York

Carol Brewer, RN, PhD, assistant professor at the University at Buffalo, State University of New York School of Nursing, has been awarded a SUNY/University Professors Dr. Huldah McGee Decker Affirmative Action Award for further research on the nursing labor supply.

New Jersey

Jane Kenney, RN, PhD, professor at Arizona State University of Phoenix Valley in Tempe, has received the 1998 Mentor Award from Kaohsiung Medical University. Her current research focuses on ways to help Taiwanese widows cope with their husbands' deaths.

Turkey

Sheila Dinorah Tau, RN, PhD, has been appointed to associate professor at the University of Botswana Department of Nursing Education.

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Indiana University School of Nursing celebrates 85 years

INDIANAPOLIS, Ind., April 16, 1999—Community health nurses at the Indiana University School of Nursing are concerned about stress faced by high school students who are parents. At an on-site clinical workshop at an Indianapolis school, Assistant Professor of Nursing Janie Canty-Mitchell, RN, PhD, and school coordinator LaTonya Turner, MS, are very much themselves, bringing levity to their work. Nursing student Xuefei Xu of China is discussing the impact of stress with a clinical poster. This year, the Indiana University School of Nursing celebrates in 85th anniversary. It is not only one of the oldest nursing schools in the world, but also one of the largest and most distinguished.
Indiana University School of Nursing celebrates 85 years

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This year, the Indiana University School of Nursing celebrates its 85th anniversary. It is not only one of the oldest nursing schools in the world, but also one of the largest and most distinguished.

Only five nurses graduated from the school in 1917, compared to 822 last year. Sigma Theta Tau International was founded there in 1922 by students from Indiana.

Now, the school has a broad international focus and is distinguished for its diverse programs, including an Institute for Action Research in Community Health, which is a World Health Organization Collaborating Center in Healthy Cities. Dean Angela Barron McBride, RN, PhD, FAAN, said the school of nursing can point with pride to excellence in three defined areas: interactive learning, health behavior research and community health. By Jane Palmer

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