

Therapeutic Interpersonal Interactions: The Sacrificial Lamb?

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TOPIC. *Emotional upheaval is rampant in society, affecting mental and physical health. Yet the focus, in the "Era of the Brain," lacks direction on how to address these issues. However, psychiatric-mental health nursing possesses the know-how to provide solutions.*

PURPOSE. *To explore the history of psychiatric nursing and its impact on the nursing profession and society and how its legacy can support and facilitate change.*

SOURCES. *Primary and secondary*

CONCLUSIONS. *Therapeutic interpersonal interactions are quintessential competencies for advanced practice psychiatric-mental health nurses and should be upheld, promoted, and implemented to improve outcomes.*

Search terms: *Nursing history, therapeutic, interpersonal, advanced nursing practice, psychiatric-mental health nursing, nurse-patient relations, nursing theory*

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At a critical time in American history, Franklin D. Roosevelt expounded, "The only thing we have to fear is fear itself." Yet fear of disease, disaster, injury, poverty, and death mold our day-to-day existence as human beings (Dozier, 1998). Americans fear terrorist attacks, anthrax, smallpox, and SARS; and even though, over the past century, the risk of annihilation from disease has been drastically reduced through the interventions of antibiotics, vaccinations, and sanitary standards, fear in American society seems to be spiraling out of control. Bloom (2005) reported that by 2020 global rates of infections, such as tuberculosis, pneumonia, and diarrhea, will decline relative to a chronic disorder, like depression, which will increase, as it wins second place on the list of contributors to the world's disease burden.

Besides the emotional upheaval and anxiety that fear perpetuates, its deleterious impact on the health of mind, body, and spirit serves to wreak havoc on the lives of people. Siegel (2005), professor of medicine at the New York University Medical School, spoke about the irony of fear and stated that worrying about health jeopardizes well-being, increasing the risk for physical conditions and mental problems, such as heart disease, stroke, and depression.

One in five Americans lives with mental illness, and an estimated one half of all visits to primary care physicians are related to conditions that have a mental or emotional component (Poster, 2004). Mental illnesses in the United States, such as major depression, obsessive-compulsive disorder, and schizophrenia, are leading causes of disability and contributors to mortality, with suicide being the most preventable cause of death.

In addition to the generalized fear that permeates society, the nursing profession is confronted with fear-provoking challenges of its own that are increasingly

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worrisome to such an extent that they jeopardize the health of nurses and professional nursing in the 21st century. Gordon (2005), in her book *Nursing Against the Odds*, wrote about the dire circumstances and low morale of nurses, who stand on picket lines, and of burnt-out nurses, who protest, as the silent majority, against low wages and poor working conditions. The emotional labor related directly to the stressors of nurses' work can lead to professional exhaustion called "compassion fatigue" (Cox, 2005), a term used to describe a form of posttraumatic stress disorder (PTSD) that results from exposure to those experiencing emotional or physical trauma. The burnout that ensues not only leads to emotional exhaustion for nurses, but to increased depersonalization at work and reduced personal achievement.

Adding to the challenges in nursing, there is a growing shortage of nurses, reports of poor communication between nursing factions, and conflicts arising from time-worn battles over the level of education appropriate for nurses to enter the profession (Gordon, 2005). The aging population of nurses creates new challenges and fears about the demise of the profession and about the urgency to replace the workforce with a new generation of practitioners and educators. Fragmentation is the primary challenge facing professional nursing in the 21st century, according to Roy, a nurse educator and theorist (Silverstein, 2002). Nurses are scattered in focus, fleeing from the bedside (Atkinson, 2005), which some contend will be the downfall of traditional roles of nursing that require a hands-on approach. In addition, advanced technology and the economics of managed health care are threatening the integrity of the unique, therapeutic nurse-patient relationship, resulting in further conflicts for professional nursing.

From clients' perspectives, the effects of depersonalization have been harshly felt (Carey, 2005b). Patients complain about the degrading shift from person to patient as they enter the hospital for care, often feeling dehumanized, helpless, and resentful. Other patients report feeling "sick and scared" as they await attendance

by scarce healthcare providers (Kolata, 2005). And many are overwhelmed with information and face loneliness and uncertainty on how to proceed with their treatments (Hoffman, 2005).

Amidst the fear, anxiety, and contention, there exists an antipsychiatry movement. The unlikely person who recently stirred up adversarial dialogue about psychiatry was the celebrity and actor, Tom Cruise. In an interview by Matt Lauer (2005) on the NBC show "Today," Cruise, a star of the movie *War of the Worlds*, stated that there is no such thing as chemical imbalance, and he decried the use of drugs, especially those given to unsuspecting children. He explained, as a Scientologist, that there were alternative ways, besides drugs, to deal with postpartum depression. In her rebuttal, another celebrity, Brooke Shields (2005), directed her anger at Cruise, by claiming that drugs and cognitive therapy helped her to overcome postpartum depression and suicidal tendencies.

Not only is controversy brewing against psychiatry, but there is a schism within its ranks, as psychiatrists focus on the biomedical model and the "diseases of the brain" in an effort to revise the *DSM-IV*. Carey (2005a) reported that psychiatrists do not have answers regarding the boundaries between mental illness and "normal" mental struggles. This dichotomy has created a battle line that has divided psychiatry into "two viscerally opposed camps."

Mohr (2003) suggested discarding ideology that has questionable utility for mental health nursing, such as Freud's concepts. She asserted that the contentious mind-body split perpetuated within nursing is outdated and requires replacement in the 21st century with concepts based on extant research in modern neuroscience and molecular biology. This assertion of Mohr strongly claimed that "mental" illness, widely acknowledged as psychologically induced, at least in part, is merely a disease of the brain. The mindset promoted by the biopsychiatry movement in mental health nursing has fueled yet another heated debate within the specialty. Psychiatric nurses, who grapple to maintain core values based on psychodynamic

principles and interpersonal relations, oppose abandonment of ideology (Raingruber, 2003).

Fear of the Unknown

Arising out of the dark abyss of turmoil, important questions surface towards the light: At a time in American history when depersonalization and fragmentation are driving people to despair, why has the advancement of psychological interventions and therapeutic interpersonal interactions taken a back seat to the antipsychiatry and biopsychiatry movements? What can advanced practice psychiatric-mental health nurses do to prevent mental illness and promote health? Peplau (1983) saw prevention as an "urgent task." Although prevention seemed to be an impossible venture at first glance, Peplau believed that "there ought surely to be some good reasons for exploring what is possible."

Do You Know the History?

Accusing TV host Lauer (2005) of being ignorant about psychiatry's past, Cruise argued: "You don't know the history of psychiatry." Peplau (1989), referred to as the "psychiatric nurse of the 20th century" and credited with the development of the Theory of Interpersonal Relations, made a similar accusation. She argued that students found the future too difficult to understand, so they relieved their anxieties by living in the present, which resulted in little, if any, appreciation of relationships on a timeline. If Peplau were alive today, would she take the same stance? Do psychiatric nurses know the history of their past? What influential decisions did psychiatric nurse leaders make? What events took place that influenced the current climate and conditions of psychiatric-mental health nursing in the United States today? To answer these questions, it is necessary to take a journey back in time, by looking through the window of opportunity that opened up for psychiatric nurses long ago.

The "Living" History

The development of modern psychiatric-mental health nursing dates back to 1882, when the first training school for mental nursing opened at the McLean Asylum in Massachusetts, under the tutelage of Dr. Edward Cowles (Schubert, 1972). From the beginning, nursing students admitted to the program at McLean were expected to learn concepts about how to deal with the mentally ill, beyond the "bodily" care traditionally given by general nurses of the day. In an attempt to develop "all-around" nurses, Cowles thought that whether a nurse dealt with physical or mental needs, the basic tenets for training would be the same, thus allowing the nurse to be more versatile. Cowles included in the instruction the observation of mental symptoms, such as hallucinations and delusions, as well as care for the physically sick.

To deliver specialized care to those in mental institutions, mental nurses were required to possess specific qualities and demonstrate unique abilities, such as sympathy, intelligence, and trustworthiness (Church, 1982). Other essential attributes included knowing how to calm the nerves of an anxious or suicidal patient by using empathy and tact. Mental nurses' abilities set them apart from other nurses, but were difficult to define and understand, for they were ethereal in nature and not easily describable. For example, in his book on nursing the insane, Dr. Charles Mills (1887) described the ambiguous meaning of tact:

It means, literally, touch . . . it includes the mental touch, something more complete than the other; not a touch merely, but a grasp,—a grasp of the situation, the comprehension of a difficulty, the grasping of it on all sides so that it disappears in your hands (p. 13).

Since mental nurses lived and worked in remote and isolated mental institutions, and were educated in separate facilities, general nursing did not accept them

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(Schubert, 1972). In fact, these nurses were feared and ostracized, along with their patients, and carried a “stigma-by-association” (Church, 1982, p. 17). Although the unique talents of early psychiatric nurses lacked recognition for their therapeutic value, mental nurses strove to meet their goals. As early as the late 19th century, nurse interactionists, such as May, Anstead, and Taylor, who believed that the mind and body were inseparable, spearheaded campaigns to integrate mind-body concepts into nursing curricula, and they were successful in incorporating them into the 1917, 1927, and 1937 guidelines. Peplau reported that in the 1930s she and her classmates were disconcerted and felt hopeless and helpless because the physicians who taught them did not know what caused mental illness and did not understand how to cure it (D’Antonio, 1985).

During the Mental Hygiene Movement, begun by Clifford Beers in 1908, the need for psychiatric nursing was evident in World War I, as military nurses battled shell shock, along with the soldiers. But major changes in psychiatric nursing practice and education did not come about until World War II (Pittman, 1974), with the passage of the *Bolton Act* (1943) and the *National Mental Health Act* (1946). At this time the attitudes and beliefs about mental illness in American society were favorably swayed with the winds of time, when many soldiers returned from war with combat fatigue (now called PTSD).

An advanced graduate program for psychiatric nursing, initiated by Peplau, began at Teachers College, Columbia University, in 1948. Peplau’s class on interpersonal relations became a popular course for nurses, as they were introduced to psychodynamic concepts (Callaway, 2002). However, there was much controversy over the novel approach to experiential teaching and learning and to the focus on education, rather than on service.

1952: A Banner Year

By 1952, a banner year for psychiatric nursing, influential events occurred that furthered the cause for the specialty. They were:

- Peplau’s book, *Interpersonal Relations in Nursing*, was published, which proposed a unique, systematic, and therapeutic approach to interpersonal interactions in the nurse–patient relationship.
- The drug Thorazine was introduced for the first time in clinical trials, which promised to free mental patients of anxiety and overwhelming fear and served to liberate the staff in mental hospitals to approach mental illness therapeutically.
- The first *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was published by the American Psychiatric Association, supplying a basis for clinical diagnoses and treatments.
- Peplau requested specialty status at the 56th National Convention of the National League, and psychiatric nurses won the battle, gaining in prestige (Pittman, 1974).
- The Interdivisional Council on Psychiatric Nursing was formed.
- The National League initiated the “Integration Project.”
- Tudor (1952/1982), a psychiatric nurse, published the results of her classic study on mutual withdrawal.
- MacLean introduced the concept of the limbic system, where the emotional brain is housed (LeDoux, 1996), thus supporting the connection between emotion and disease—the mind and body.

Psychodynamic Concepts of Interpersonal Theory

In her book on interpersonal relations, Peplau (1952/1991) created the first nursing theory and proposed the use of “concepts that may be learned and become incorporated into the functioning personality of every nurse who is willing to struggle toward greater maturity in her relations with others” (p. ix). Embedded within the theory, nurses were expected to “know themselves” by observing, examining, and monitoring their own emotional reactions and behavioral responses to others and by using this self-knowledge to enhance the therapeutic relationship. This was

accomplished by harnessing the energy of anxiety and by transforming it into a growth opportunity for themselves and their patients. In addition, the theory extended beyond patient relations to include nurse–student, nurse–nurse, and nurse–doctor relationships, as well as interactions with other disciplines. Students were taught to look for a constellation of symptoms that represented various layers of meaning, which required delving deeper beneath the surface of symptoms to understand the underlying elements (Peplau, 1953). Two guiding assumptions of this theoretical and scientific framework, which have major implications for nursing education today, are (Peplau, 1952/1991):

1. The type of person a nurse becomes makes a substantial difference to what a patient learns while nursed through the experience of illness.
2. Fostering the personality development towards maturity is the function of nursing education and nursing, which requires the use of concepts and methods that allow and guide the process of wrestling with everyday interpersonal challenges.

Conflictive Circumstances

Beginning in the latter part of the 1950s, a mass exodus took place from mental hospitals, as patients were discharged during the “Era of Deinstitutionalization.” At the time of the transition, public health nurses were thought to be best equipped to handle the influx of patients into the community, for they had established roots outside the hospital, while psychiatric nurses, who were primarily associated with mental institutions, were often left feeling displaced (Draper, 1988; Schmahl, 1957).

The national fight for freedom in war and integration in America was waged during the 1950s to the 1970s. Concurrently, “integration grants” were funded by the government to virtually all schools of nursing, to support the integration of sociopsychiatric and

mental health concepts into all clinical nursing courses (Peplau, 1983). Much controversy arose and battles raged within nursing as psychiatric nurses attempted to teach nurse educators and others how to develop therapeutic relationships, based on psychodynamic principles (Church, 1982). Psychiatric nurses were fearful that, if they divulged the entire content of their body of knowledge to others, their uniqueness and purpose to assist the chronically mentally ill would be diminished, which would facilitate their demise as a specialty. However, they were dedicated to complete the work on integration during difficult times, although psychiatric nurses who lived through the era still believe today that integration was not a good idea (Silverstein, 2002).

Another conflict existed because nurses and others contended that psychiatric nurses should not be allowed to do psychotherapy, because it was beyond the scope of tradition, but Peplau and other pioneers were steadfast in promoting one-to-one therapy and counseling, eventually called psychotherapy. Peplau predicted that nurses in the future would become independent practitioners and hang out shingles in private practice (Lego, 1980). In 1962, Peplau reiterated the importance of developing therapeutic nurse–patient relationships, declaring that nurses were not merely technicians, custodians, clerks, housekeepers, mother-surrogates, or sociotherapists, but were therapeutic agents.

A Special Breed

As a result of the surge of postwar interest in mental health and educational opportunities, psychiatric nurses emerged as visionaries, leaders, prolific writers, and educators. They were a special breed of creative thinkers, who were “able to stimulate new ideas among themselves and set many others to thinking” (Schutt, 1962, p. 49). A small cadre of clinical nurse specialists created new pathways, leading to innovation in nursing in areas of Research, Education, Administration, and Practice

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(REAP) (Silverstein, 2003), as evident in nursing literature dating back to the 1940s to the 1960s. However, the most valuable assets developed by psychiatric nurses during the mid-20th century are the uniqueness of the Theory of Interpersonal Relations and subsequent theories that supported the patient as a “whole” person, the nurse as a therapeutic agent in relationships with others, and the nursing profession as a social force in the deliverance of health care.

Unfinished Business

Peplau (1983) spoke about the unfinished business of the second century of psychiatric nursing and considered the issues of prevention and health promotion as primary. She posited that psychiatric nurses should provide courses for the public by teaching theories and coping behaviors, which could have preventive effects. Among the concerns for psychiatric nurses, stated Peplau, are the threats of nuclear attack, the sped-up acceleration of the development of children, and the reactions of people to the upheavals in their lives that are caused by economic conditions and rapid social changes. Theories about anxiety, frustration, aggression, and conflict are as useful to clients as they are to staff, contended Peplau, so psychiatric nurses should refocus their efforts on “tools” that could provide self-help strategies that guide clients to help themselves.

Anxiety Management and Abatement

More than any other specialty, mental health nurses encounter increased exposure to distress and anxiety. Stressors, like unabated fear and anxiety, affect hormones that can sever connections in the brain and inhibit memory function (Cowley, 2003). A major challenge for nurses in all settings, stated Horsfall and Stuhlmiller (2001), is to manage anxiety that exists in human interactions. It is imperative for nurses to bear not only their anxiety, but also that of others, the

authors stressed. Peplau (1989a) explained that if nurses do not own and manage their anxiety, they run the risk of empathically transmitting it to their clients, thus impeding progress in recovery. Since facilitation of recovery is a major goal of nursing care, what are the implications for the nursing profession in a challenged environment of high anxiety, where psychological interventions and emotional components of disease have been de-emphasized?

Implications for Nursing

Six nurses from the California Nurses Association delegation visited Sri Lanka for the tsunami relief (Van Eyck, 2005). One nurse, Zyskowski, remarked:

The lazy breeze belies the inner frenzy of the walking wounded, those survivors still traumatized but not showing their internal wounds. They are scarred so deeply that they cannot function. I wish I remembered more about post-traumatic stress syndrome and active listening! (pp. 28–29).

Zyskowski’s words can have far-reaching effects if heard by the policy-making body of the National Council of State Boards of Nursing (NCSBN), since it revised the NCLEX-RN Test Plan and reduced the number of questions on psychosocial interventions from 12–22% to 6–12% (Poster, 2004). This ill-advised revision resulted after more than 4,000 newly licensed nurses listed in a survey the frequency and priority of over 130 nursing care activities deemed important in their practices as neophytes. Since the category of “psychosocial integrity” did not qualify as a priority area by these fledglings, the NCSBN placed the questions about psychosocial skills on the chopping block as the sacrificial lamb. Poster, alarmed by the revision, asked: “How can anyone . . . say that the emotional and mental well-being of patients is less important than the physical care?” She further queried: “Is it possible that psychosocial interventions are not frequently

implemented along with physical care because nurses need more education in this area?" (Poster, p. 43).

Since the reestablishment of somatic focus primarily on "bodily" care, which was prevalent in the 19th century prior to the introduction of psychosocial principles to generic curricula, what are the implications for the nursing profession that threaten its integrity?

- Educational trends can discourage students and graduate nurses from becoming self-reflective, which denies them potential professional and personal benefits.
- Without self-awareness, nurses are at risk from their own unrecognized anxieties, which they may transmit empathically and unwittingly to their clients, thus precluding therapeutic direction (Peplau, 1984) and increasing recovery time.
- Since nurses work under stressful circumstances, they may be more subject to physical and mental illnesses that have strong emotional components.
- Since stress hormones affect the brain and memory function, nurses may be more prone to experience memory deficits and errors on the job.
- If nurses lack expertise in coping strategies to assist themselves and their colleagues, they will be less adept at teaching the skills to patients and others.
- The nursing profession sets itself back 124 years in progress and discredits the work of early pioneer nurses, by "throwing the baby out with the bath water."
- The nursing profession dishonors the sanctity of the nurse-patient relationship, which is a prized possession, and the view of the patient as a "whole person."

Nurses Possess the Simple Tools

Peplau (1962) outlined how nurses could assist patients to abate overwhelming fear and anxiety with the use of a "simple interpersonal technique" (p. 53).

To quell anxiety, Peplau suggested that patients be encouraged to recognize and name the anxiety, connect with the relief-giving patterns of the experience, and view the triggers that set off the anxiety attack, so a plan of action could be devised.

Conti-O'Hare (2002) stated that the roots of trauma may not be visible, but since nurses may experience unrecognized "wounding in their personal and professional lives, they need to develop some awareness for the purpose of their own health as well as that of their patients" (p. 67). Otherwise, unresolved trauma could result in PTSD. But Cox (2005) offers new hope for the future of nurses, by presenting the concepts of an accelerated recovery program for compassion fatigue that includes identifying the triggers, acknowledging the symptoms, using self-help techniques, setting boundaries, and developing coping strategies. Programs of this type can be adapted to the general public to quell the prevalent fears and anxieties in the communities in which nurses live.

Summary

Americans in the 21st century are writhing with fear that is spiraling out of control. This fear produces anxiety that adversely affects physical and mental health. Adding to the challenges facing nurses are internal conflicts within the profession, causing depersonalization, fragmentation, and contention. Clients reveal their dissatisfaction and uncertainty in the face of advanced technology and managed care. Antipsychiatry and biopsychiatry movements further aggravate the existent opposing forces.

By taking a glimpse back at the development of psychiatric nursing, nurses can better relate to their history and to the hard-won wars waged against early psychiatric nurses as they worked to integrate concepts into general nursing. It was through sheer determination and courage, by overcoming stigma (Halter, 2002) and fear, that these nurses developed psychodynamic theory and practice, giving all nurses

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systematic methods and techniques to improve therapeutic nurse–patient relationships.

Psychiatric nursing had a profound impact on the nursing profession since the 19th century. Its principles were developed and steadfastly defended with confidence by its leaders, establishing it as a specialty. As independent practitioners, psychiatric nurses of today are free to hang out shingles in private practice. The core competencies of advanced psychiatric nurse practitioners (National Panel for Psychiatric–Mental NP Competencies, 2003), through prevention of illness, therapeutic interactions, and health promotion, are practiced autonomously.

Advanced practice psychiatric nurses possess the tools to assist colleagues and others to abate fear and anxiety. The implementation of interpersonal skills for all nurses, who are willing to reach personal and professional maturity, will facilitate client recovery and progress in nursing's future, but the absence of these skills will hinder them.

Conclusion

Knowledge from the past can be used to build a better future. This truism applies to the integration of psychosocial and mental health concepts into generic nursing curricula. Years ago, during Nightingale's reign, no systematic method or theory on interpersonal interactions existed to direct nurses on how to improve communications and alleviate fears and anxieties, nor was knowledge extant about how to cure the bubonic plague. However, since the 1950s, psychodynamic concepts were not only acquired and instituted, but were subsumed and hard-coded into the subconscious and conscious mind of nursing theory and practice, significantly benefiting the nursing profession. No other healthcare profession can boast about such an extraordinary accomplishment.

Therapeutic interpersonal interactions are the quintessential competencies for advanced psychiatric-mental health nursing and should be upheld,

promoted, and implemented to improve outcomes. They provide a springboard for abating today's challenges. In addition, these interactions lay the foundation for a strong structural edifice. This superstructure supports therapeutic, psychosocial interchange between nurses, clients, and others, through mental health promotion and protection, prevention, and treatment, as well as through the professional roles of consulting, counseling, teaching, coaching, advocating, coordinating, and collaborating.

Practice- and research-based interventions that have biological origins can be respected within a relational paradigm that values the core identity, uniqueness, and holistic commitment of the specialty without sacrificing the complexity, ethic, and art that has sustained it in the past (Raingruber, 2003). Advanced practitioners of psychiatric-mental health nursing today have the advantages of a proud legacy as leaders and educators, and as a result, have a responsibility to themselves, their colleagues in nursing, and the public. By believing in the dictum "The only thing we have to fear is *ourselves*," these specialists will continue to make an impact on the nursing profession and society—today and tomorrow . . .

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