Nursing History for Contemporary Role Development
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Nursing History for Contemporary Role Development

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Editors
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Foreword

Joan Lynaugh, my mentor and dear friend, said, “everything has a past.” As this book, Nursing History for Contemporary Role Development, edited by Sandra B. Lewenson, Annemarie McAllister, and Kylie M. Smith, wisely shows, the nursing profession indeed has an important past. Nurses have been a part of every social movement, conflict zone, institutional change, and aspect of care from the moment of individuals’ illnesses to their attempts and successes protecting their health, to their deaths. That past is a critical part of our ability to understand how our current roles as nursing professionals changed over time, and how we might think about them in the future. Our past shapes everything we do, whether we explicitly acknowledge it or not.

It is important to remember our past. We sometimes think our modern roles are extraordinary and new, that what we do as clinicians, educators, and policy decision makers has no bearing on or does not draw from the past. We would be misguided to think this way and to forget that although the context has changed, our clinical and policy decisions are fundamentally steeped in the past. For example, as we focus our practices, educational programs, and policy on the culture of health, we would be remiss to forget that nurses throughout their history have tried to mediate the effects of poverty on health, as well as educate patients about the health benefits of clean air and good nutrition. School nurses, mental health nurses, and public health and rural nurses in particular understood the importance of the environment and the family to the health of an individual (although there are also examples of nurses who were biased, racist, and classist). Today, the context and the language are different. We have sometimes forgotten and minimized our focus on the social determinants of health—for example, our educational programs and practice since the 1950s rested
on acute care—but these factors, in the context of our fragmented and expensive health system, are becoming more prominent in our health policies today. We have a renewed recognition of how social determinants of health do inform how we treat and engage patients over a continuum of care, as several of the chapters in this book illustrate.

Technology is another example of how our past practices inform our present and future. I recently attended a symposium on innovation in nursing. All were excited to see what they could develop from a kit of circuit boards, bands, and other pieces of equipment, but few knew the history of nurses’ innovations. By understanding our history, we know that nurses inventing new devices and models of care, or repurposing typical materials and devices to better care for their patients, is not new, but a constant factor in the way nurses protected their patients and improved their patients’ care. Nurses, as we see in this volume, created new models of care, developed “work arounds” to make equipment work better, and reorganized care to protect their most vulnerable patients. Perhaps because nursing has traditionally been characterized as a woman’s profession under medical control, new ideas and making things work have not typically been recognized as “nursing innovation.” Our practice and our educational programs covertly and overtly teach students about the opportunities of creativity and idea generation, but without the historical context, each device or model seems new and untethered to larger social and cultural structures and meanings.

As we think about how our professional and disciplinary roles will change over the next decades, it would be wise to remember that how we practice, educate, and influence policy today will inform the future. Today’s work is tomorrow’s history. Our profession and our patients are critically dependent upon future nurses, how they are educated, and how and where they practice. Our history must be a key part of any curriculum we offer, and provide the foundation for new ideas and instill meaning for our practice and policy making. Indeed, “everything has a past,” but we need to know our history, embrace it, and build on it. This is exactly the purpose and the mission of this book. It provides students with a foundation to know about the past, understand the present, and think about the future. This book also provides a rich resource and opportunity for faculty who might not be well versed in their profession’s history to integrate history into their courses across all content areas and program levels. It provides a “lifeline” from the
past to the future, nicely illustrating why an understanding of the past situates us to better shape our future.

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Preface

“We older nurses look to you to do better than we have done,” said Lillian Wald, the noted leader of public health nursing, in an address she gave to the 1918 graduating class of the Johns Hopkins School of Nursing (Wald, 1918a, p. 12). She turned to these new nurses in hopes of a better future. Women in America still did not yet have the vote, and World War I was slowly abating, leaving a trail of social disruption. Access to better health care for those in urban and rural settings, along with political equality, Wald believed, needed to be something for nurses to work toward. That same year, Wald (1918b) wrote, “women should support with their political influence the taxation and legislation which are needed for the establishment and the maintenance of visiting and public health nurses since the health of the community rests largely with such nurses” (p. 1). She, like other nursing pioneers, linked nursing and politics with better health care outcomes. Her political beliefs, along with her nursing knowledge and her ability to inform the public, provide lessons for nurses today who seek similar goals of health care for all. Wald looked to the new graduates to lead the way toward a better future where there would be public and private support for new nursing initiatives. These students took courses in nursing history where they learned of the early nurse leaders, such as Wald herself, and the obstacles these pioneers overcame. The link between nursing and political advocacy was made explicit to students, as it was considered central to improving the health of the public and achieving the future that Wald envisioned.

The question, then, for students of today is how do we make that link between nursing and political advocacy for the patients, families, communities, and populations in our care? How do we find our place among the many roles that nurses undertake today in the practice,
education, and research arenas? One response to these questions can be to look at our history. History informs us of who we are, where we came from, what we are doing now, and even where we are going. But there is more to nursing history than this. Nursing history matters because of nursing’s history, because it is that history that has so sharply defined and shaped and even constrained the profession we know today. We need to know the mistakes that have been made so we can try not to make them again. We need to know the victories, to remind ourselves of what this profession is capable. Yet if we were to ask most nurses today what they know about nursing history, they are hard pressed to name anyone of note beyond Florence Nightingale. Nightingale’s impact on nursing cannot be denied, but her “heroic” legacy threatens to overshadow the reality of the profession she helped to create, and the multitude of women (for they were mostly women) who made the ancient work of caring for the sick into the complex set of practices that it is today. In their article “History Counts,” Julie Fairman and Patricia D’Antonio set out explicitly the ways in which today’s health care systems, policies, and practices, which are often regarded as timeless and inevitable, are in fact shaped by both deliberate choices and exigent circumstances over which nurses sometimes had no control, and over which they sometimes did (Fairman & D’Antonio, 2013). Understanding the historical forces that have shaped contemporary nursing facilitates a critical analysis of the assumptions, often taken for granted, that underpin contemporary health systems. Within these systems, nurses have been self-consciously active in the making of their own profession, the work they do, and the circumstances under which they do it; and we are not at the end of that process.

WHY WRITE THIS BOOK?

Nursing history scholarship is a rapidly growing field with new and exciting work emerging about nursing’s past and its impact on the present. For students and faculty dealing with already laden curricula, often focused on techno-rational clinical competencies, engaging with historical scholarship can be seen as overwhelming and difficult. A number of nursing scholars from around the world have previously demonstrated that finding ways to bring historical elements into nursing curricula is needed, and that the benefits to students are manifold (D’Antonio, Connolly, Wall, Whelan, & Fairman, 2010; Lewenson, 2004;
McAllister, John, & Gray, 2009; McAllister, Madsen, Godden, Greenhill, & Reed, 2010; Smith, Brown, & Crookes, 2015; Toman & Thifault, 2012).

This book aims to address this need in an accessible and innovative way, summarizing existing histories and showcasing the work of emerging nursing history scholars that may not be available elsewhere. In this way, we hope to stimulate the interest and intellect of students in nursing to help them understand the relevance of historical context for all aspects of nursing and health care. The book helps faculty and students access and apply historical research to current issues in nursing education, research, and practice, as well as reflect on the enduring themes currently found in nursing and health care. And as students develop an understanding of what history can offer them, they, too, may become interested in becoming historians of the future.

**WHAT IS UNIQUE ABOUT THIS BOOK?**

*Nursing History for Contemporary Role Development* identifies a number of significant issues relevant to the complexities of contemporary nursing, and examines the background of those issues within the context of time and place. It then relates these historical findings to contemporary practice, drawing on the scholarship of expert historians to unravel the ways in which that practice has developed. In this way, the book provides a unique depth and breadth to our understanding of approaches to human health that are relevant for nurses and other health professionals as they work toward a healthier society.

The chapters in the book address key themes in contemporary nursing practice, providing evidence of how nursing fits within the broader context of culture and society, from the late 19th century to the present. The book uses historical case studies that relate to specific issues in the development of the profession. The contributing authors introduce their chapters with a contemporary issue, and then provide the contextual background for the reader to understand. The case studies provide a springboard for each chapter's further discussion and conclusion. The chapters address issues, such as how certain specializations in the profession evolved, how nurses have been educated, how differentiation of practice affects health outcomes, how nurses have engaged in health care policy and political advocacy addressing vulnerable populations, how legal and ethical issues affected practice, and how nurses provided care during wartime. The rights of
vulnerable populations, whether in the community or in schools, in the newly formed neonatal intensive care units (NICUs), in mental institutions, in academia, or in war zones, resonate throughout this work and raise questions about nursing roles during contemporary times.

This book provides students with the historical context that otherwise may not be readily available to them, making explicit this connection between the past and the present. By drawing on the expert scholarship of historians, and using primary source case studies, it also provides a rich tool with which to facilitate self-reflection, socialization, and decision-making skills essential for students and all nurses. The chapters in this book include questions at the end requiring reflective and critical thinking, making history readily accessible to students in their education and, therefore, their subsequent practice.

The editors conceived of this book to be used by all students of nursing and all nurses. Nursing History for Contemporary Role Development supports students in undergraduate and accelerated programs and enriches students in master’s and doctoral programs. In academia, educators designing curricula for undergraduate, graduate, and doctoral programs will find this book a useful resource. Undergraduate students need an understanding of nursing and health care history so they can appreciate how nursing fits into society, how the profession evolved within the context of societal norms and issues, and what it means for their own development as leaders within the profession. The chapters in this book help graduate and prelicensure students explore the development of the advanced practice role, licensure and registration issues, and how nursing relates to social and health care legislation over time (e.g., Medicaid, Medicare, the Affordable Care Act, and other historical and contemporary social reform acts). Students engaged in doctoral research can use this book to facilitate analysis of the ethical, political, and leadership issues that shape their future practice; for example, considering the long-term ramifications of nurses participating in government-sanctioned ethnic cleansing, or understanding why there are three educational pathways into nursing practice and what this means for the future. These issues and more are addressed in this text and allow students at all levels to read about an issue, consider what has been published in the literature, explore a related historical exemplar, and then consider the implications of this history for the future.

And finally, we see the audience as those nurses in clinical settings where a historical framework can provide depth and breadth to past
practice, current issues, and futuristic thinking. Critical thinking and clinical reasoning “at the bedside” can be informed by a historical sensibility that seeks to question routines and procedures that are sometimes taken for granted, negotiate ethical and interpersonal issues in health care systems, and understand patients in the context of their whole lives, as a product of their society.

**ORGANIZATION OF THE BOOK**

*Nursing History for Contemporary Role Development* invited expert historians of nursing from around the world to contribute a chapter. These authors write about a key theme in contemporary practice and include historical case studies to be used for knowledge translation. The 11 chapters are organized into four sections, according to the time of the historical story. Earlier historical context is given in the various sections, creating a rich tapestry that spans time and space.

In Section I, the authors explore issues concerning diversity, vulnerable populations, and the rise of nursing specialties. Themes addressed in this section include being part of a minority population and what that means to health care or lack of health care. Another theme explores the origins of public health nursing, specifically examining rural public health nursing and the American Red Cross. The third theme in this section expands on the role of school nurses in rural America. Overlapping historical background adds richness to these first three chapters in the book and provides a foundation of what happens in later years.

In Chapter 1, J. Margo Brooks Carthon addresses the health care needs of the African American community in Philadelphia, a community that faced lack of adequate housing, racism, and poor access to care. Similar to today, minority communities continued to experience the untoward effect of insufficient access to health care laced with pervasive racial bias and a lack of a diverse workforce, all of which adversely affected the quality and safety of the health care offered and the health care outcomes obtained. Carthon uses the historical exemplar of Mary Elizabeth Tyler, a minority public health nurse, at the turn of the 20th century in Philadelphia to describe how diversity in nursing positively affected the health care outcomes of a community. The Whittier Centre, a philanthropic association in Philadelphia, addressed the Black community’s efforts to combat a tuberculosis outbreak in the
city. This organization hired a Black nurse to work and live within the community to serve as a liaison between the community and the Whittier Centre. The success of her work during that period provides, first, an historical account of public health nursing, specifically, the contributions of minority nurses in this area. Second, it offers contemporary nurses an opportunity to be reflective about the need for a diverse workforce that will care for an increasingly diverse population. It forces us to consider the possibilities of what has happened in the past and the ways in which a diverse workforce can improve the health care for all today.

When we see reports concerning public health issues in current media sources, they are often presented as if they are new and in need of new public health strategies. In Chapter 2, Sandra B. Lewenson examines the long-held role of the public health nurse through the lens of the larger framework of primary health care. Using Healthy People 2020 (2016) that laid out goals for a healthier nation, Lewenson argues that public health nurses should work together with community activists in order to provide the resources needed to meet the health needs of the community.

Lewenson presents an early 20th-century effort to address the health needs of a small rural community in upstate New York. The leadership in the town of Red Hook joined forces with the American Red Cross in the early 20th century and determined the needs of the community using data collected in a door-to-door survey of the town. Using these data, the town partnered with the American Red Cross’s rural public health service called Town and Country Nursing Service and created strategies to provide for the health and well-being of this rural population. This case study demonstrates how community leaders worked together with public health nurses using evidence-based data as a basis for planning for the needs of the community. As contemporary public health nurses work within a broad primary health care framework to achieve the goals outlined in Healthy People 2020, their roles include collaboration with many participants both locally and nationally. The efforts of the leaders of a small, rural town in upstate New York in the early 20th century to provide for the health needs of its citizenry still resonate today and serve as an exemplar for the continued value of the role of the public health nurse.

Historians often find it amazing that what has been written more than 100 years ago reflects the ideas of today. In Chapter 3, we see the need for school nurses reflected time and time again in urban and,
even more so, in rural settings. The future of the country relies on the health of its young! So why not more school nurses? And, what is the role of the school nurse? As Mary Eckenrode Gibson notes, school nurses provide families the access to health care that they might not typically have. All children, especially those from particularly vulnerable populations, need the resources that a school nurse can provide. Gibson clearly lays out the statistics supporting this need, as well as the historical background of school nursing that reflects the challenges nurses faced in rural settings as they brought health care into the classroom. The role of the school nurse over the past 100 years provides a broad view of public health nursing that needs to be amplified. The author’s rationale reflects upon how nurses work with others in an interprofessional and collaborative role that results in political advocacy for more school nurses.

In Section II, we see social and political issues raised with a world embroiled in war. Wartime raises questions about ethical behaviors as well as how nursing care continues amid destruction and despair. How do nurses carry on with the work of providing adequate nutrition, when doing so might mean sending the troops back to the war zone? Why did some nurses consent to government-sanctioned euthanasia and others did not? What lessons can we learn from these legal and ethical issues in our contemporary role development today? We often take for granted the nutrition needed to live, and we rarely see nourishment as part of a conversation about nursing during war or crisis. Yet, without proper nourishment, people will not heal, and any semblance of normalcy is lost.

In Chapter 4, Jane Brooks asks the reader to consider nursing under the duress caused by war—whether on the battlefield or in internment camps. Brooks considers nursing’s role of ensuring an environment in which someone can heal, even at times when it means sending them back to a war zone when healed.

Brooks’s discussion of the ethical dilemma, as well as the pragmatic role of providing nutrition, resonates with us today as nurses face the challenge to provide food to those in need—whether in our current war environments around the world, or in our urban and rural settings where hunger for many underserved populations exists as a daily reality. The chapter considers how wartime behaviors that include killing and maiming poise challenges to nursing’s professional values that are dedicated to healing. As nurses today from across the world care for civilians and combatants in a variety of war zones, Brooks asks us
to consider questions about nursing’s political involvement in these conflicts. Brooks also asks that we look at the expertise that military nurses needed to ensure that the injured, diseased, and malnourished patients received adequate nutrition when that may not have been easily available. Nursing can be informed by this particular historical exemplar, and this chapter presents an opportunity to dialogue about this nursing role in the ever-present war zones of today.

In Chapter 5, historians Linda Shields and Susan Benedict address an often-hidden historical exemplar to demonstrate the ways in which nursing ethics and the state can sometimes conflict. In Nazi Germany, the edicts of the state and the ethics of the profession collided, profoundly affecting how some nurses treated those entrusted to their care.

Since the start of the American Nurses Association in 1896, nurses have discussed the moral and ethical ways to conduct oneself in practice and private life. A code of ethics was finally adopted in 1950 and continues to evolve today. Similarly, the International Council of Nurses that began in 1899 adopted an international code in 1953. These codes were developed as a direct response to the atrocities committed in World War II, but even before then semblances of codes existed in the United States and internationally, including laws that governed the way the state could influence health care professionals and their work. Nurses in Nazi Germany and other situations acted against these laws, and this continues to be an important issue for nurses today.

Nurses must reflect on their individual behavior and that of the profession (historically and currently) in which they took an oath to uphold the welfare of their patients, regardless of country or state. In this chapter, Shields and Benedict provide us with an exemplar from history where the professional ethics of nurses conflicted with governmental edicts. Some nurses succumbed to the alternative values espoused by the Nazi regime, whereas others stood fast to the ethical principles to which nursing subscribed. Shields and Benedict ask the reader to consider how they would have responded then and how they would respond now to some of the ethical dilemmas nurses face today—whether related to pro-life or pro-choice, euthanasia, determining organ donors, or prolonging life. History can inform these discussions and ultimately our decisions.

Section III highlights the years immediately following World War II, in which nurses were needed at home, new educational programs were established, and questions about the differentiation of the
roles of the nurse were raised. As we see, these questions about whether nurses need to be educated at the university level, and whether that makes a difference in the practice of the nursing role, continue to be widely debated.

In Chapter 6, coeditor Kylie M. Smith writes with Geertje Boschma to address the development of mental health nursing as a clinical specialty, demonstrating the way in which this central component of human health has been subject to political and social forces often beyond its control. Yet nurses themselves were active in this time period, advocating for a distinct and independent role of the nurse as a therapeutic agent. This required the generation of advanced knowledge and educational programs, made possible by post–World War II concerns with social stability and the subsequent shift of attention and funding toward the mental health sciences. Increasing concerns with human and patient rights fed into the move toward deinstitutionalization, and the move to community-based mental health services required that nurses themselves develop new approaches to practice that relied on relationships with patients. The authors demonstrate that mental health nurses were capable of high-level theorizing and innovation, but that mental health continues to be a problematic area of practice linked to historical, political, and cultural attitudes toward mental illness itself.

April D. Matthias offers another view of nursing education as she explores the differentiation of practice and how the three educational pathways prepared nurses for practice. In Chapter 7, Matthias takes a close look at the failure of the nursing profession to define the practice role of each of the three pathways: diploma, associate degree, and baccalaureate degree. The different pathways all culminate in the same licensing exam and as a result nurses share the same practice role based on licensure and not on level of education. The nursing profession has grappled with this entry-into-practice issue almost since the inception of the Nightingale training schools. Contemporary efforts to advance the education of the nurse and to define the baccalaureate degree as the minimum educational preparation have been bolstered by evidence-based research citing a better patient outcome in hospitals with a higher percentage of baccalaureate-degree nurses (Aiken, Clark, & Chung, 2003; Aiken, Clark, & Sloane, 2002; Institute of Medicine [IOM], 2010). Matthias broadens the understanding of each entry level by including an examination of early programs: the Bellevue School of Nursing (1873) as the diploma case study, the University of Cincinnati
School for Nursing and Health (1916) as the bachelor of science in nursing (BSN) case study, and the Cooperative Research Project (CRP) in Junior and Community College Education for Nursing (1952), which resulted in the associate degree nurse (ADN) model for the education of nurses. Each pathway was developed with the intent of advancing the education of nurses and differentiating the practice role of each type of education. Although the pathway developments did succeed in advancing the education of some nurses, role differentiation did not occur. Matthias argues that the current “BSN in 10” efforts still do not address the lack of defined practice roles of the nursing workforce, and the lack of a phased plan to terminate diploma and associate-degree programs allows for the continued production of nurses from multiple program types. Her chapter informs the reader of the barriers to a single pathway into the profession, as well as past flawed strategies as we continue to advocate the baccalaureate degree as the minimal requirement for all nurses.

Following Matthias’s chapter, a closer look at the history of the ADN is explored through the lens of preparing the educator. The educator role lies squarely within the purview of the professional nurse. Whether educating new nurses, new graduates, or patients and their families, teaching is inherent in this position. Yet rarely is this role examined from the perspective of how we educate nurses to fulfill this important function. In Chapter 8, coeditor of this book Annemarie McAllister uncovers a long-forgotten history of how nurse leaders at Teachers College, Columbia University in New York, the mecca for educating early nurse educators and administrators, developed a curriculum in the late 1950s specifically for the faculty role in the newly developed associate degree programs. McAllister provides us with an understanding of what the world was like following World War II, and why this country embraced the need for more education of all Americans, including nurses. With the rise of the community college–based associate degree programs in the early 1950s, the need for faculty in this college-based setting soared. Nurse leaders adapted to this challenge by developing systematic programs to educate the educators in associate degree programs. This author provides us a look at this important story in nursing that shows innovative ways that support nurses in their role as educators. Much can be learned from this past experience to meet the challenges of our nursing programs today.

In Section IV, we examine the volatile years of the Civil Rights and Women’s Liberation movements, where we see the professional role of
the neonatal nurse develop, where nurses undertook extensive advocacy efforts to provide the best care for those with sickle cell anemia in Canada, and nursing advocacy specifically for women’s health care as a civil right comes to our attention. Nurses continually address the tension that surrounds the perception of nursing as a profession. Today, given the goals set out by a national agenda, such as found in the Affordable Care Act and the IOM’s report *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010), nurses, the public, and legislators in particular need greater clarity about this role. Nurses must be able to practice to the fullest extent that their education prepares them to perform. That means the professional role must be fully actualized by those in nursing, as well as others. In Chapter 9, Briana Ralston Smith addresses the ideas about nursing and the developing professional role through the lens of caring for the very vulnerable population of critically ill neonates. Through the work of these early pioneering nurses, she establishes the ideas about what a profession is, and addresses the conflicting views about such a profession. Using the newly developing NICUs of the 1960s and 1970s, Ralston Smith shows how nurses honed their knowledge and skills to provide the quality care that was so needed. Nurses became central to the story about this emerging field of practice, along with other relevant players, such as physicians who typically receive the accolades. This raises the question of gender, and broadens the discussion on how it affects the notion of professionalism. Ralston Smith establishes nursing as a profession in this chapter and this in turn allows us to think about how we actualize this role in all health care settings today.

In Chapter 10, Karen Flynn shows how nurses serve as advocates for their patients, families, and communities. Early nursing leaders knew they had the knowledge and skills to speak for others. Nurses have a responsibility to advocate for all, regardless of race, class, ethnicity, gender, or illness. Flynn brings this to light in her chapter that shows how one nurse, Lillie Johnson, advocated to help others, especially nurses, understand and care for those with sickle cell anemia—an illness that did not get the attention that was so needed. Johnson led a path advocating inclusion of this disorder in nursing school curricula, in legislative debates, and in the minds of community activists. By increasing awareness and engaging in dialogue, the outcomes for those faced with this life-threatening disease improved.

In Chapter 11, Linda Tina Maldonado and Barbra Mann Wall contribute to the contemporary discussion about women’s health. Women’s
Health care, while a private matter, needed the political advocacy of nurses in the public arena. Margaret Sanger, founder of Planned Parenthood, continually sought to challenge the laws that prohibited the distribution of birth control information during the first half of the 20th century. She started a clinic in Brooklyn, New York, where birth control information was distributed among women in the community who wanted to gain access. In this chapter, we see a history of nursing’s engagement in community action, specifically directed at supporting women’s health. The authors provide us with nursing’s work with community coalitions that connect the many stakeholders interested in the rights of others. Social justice, civil rights, and access to health care, linked together, are all part of the advocacy role that nurses have engaged in the past, and continue to do so today. Read this chapter and consider the role nurses can play today as we address health care disparities while building a culture of health.

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CONCLUSION

Nursing History for Contemporary Role Development offers an account of the historical development of some contemporary issues in nursing. These are not the only issues, and these chapters do not provide all the answers. Despite our efforts to explain it, history itself is not neat and concise and there are many ways to view historical phenomena. But a historical sensibility does show, as these authors illustrate, that contemporary nursing has evolved as a result of political, economic, and social forces particular to time and place. Using case studies from the past to highlight nurses’ active participation in the development of their own practice and profession, we see the many ways in which nurses learned the work that was required to care for various populations. At times, nurses succeeded in bringing health care to those in need by advocating political and social change. At other times, nurses looked to educational reforms, such as university-based education versus hospital-based diploma training, to actualize their role. Negotiating the emergence of complex legal and ethical issues, nurses at times succumbed to political views that contradicted nursing’s developing moral and ethical code. Yet nurses, through war and peacetime, continued to
challenge the profession to raise its standards and address society’s health care needs. Today’s concerns for the vulnerable, the underserved, and the disparities that plague health care reform efforts continue to motivate the ever-changing (and hopefully improving) nature of nursing practice. The editors encourage readers to engage with all of the chapters, whether in order or not, so that they may continue the conversations that nurses started decades ago.

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REFERENCES


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We owe a debt of gratitude to all the contributors who supported this project, and to our editors at Springer Publishing Company, Joseph Morita, who helped tame our original idea, and Rachel Landes, who helped whip the words into shape. We especially want to thank our families, friends, furkids, and colleagues who continually support the efforts of this writing team! Throughout the writing of this book, we endured transcontinental moves, weddings, births, deaths, and a lot of shopping. We continued in the face of life’s events and became stronger editors and writers as a result.

This was a team effort right from the beginning. We shared our ideas, considered the ideas of others, and critiqued each other’s work and those of our contributors. And without this great team, this book would not have come together. We started this journey because we believe that the nurses and students of today need to understand the paths their forebearers carved out. We want today’s nurses and students to be as inspired and challenged as we are by that history. Every
decision we made in the process of this book was made with them in mind, and they were as much a part of the team as we were.

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Chapter 3: School Nursing: A Challenging Strategy in Rural Health Care in the United States

MARY ECKENRODE GIBSON

The children of today must be viewed as the raw material of a new State; the schools as the nursery of the Nation.

(Hoag & Terman, 1914, p. 4)

Child Health is the corner-stone of the edifice of public health and community welfare. A stream can rise no higher than its source. Childhood is the source of the Nation.

(Keene, 1929, p. 1)

Health and education affect individuals, society and the economy and as such, must work together whenever possible. Schools are a perfect setting for this collaboration.

(ASCD, 2014, p. 3)

These statements, dating from 1914, 1929, and 2014, were written by education professionals. Today’s philosophy still reflects the protective and hopeful beliefs of leaders in education of 100 years ago concerning the influence of child health on our nation’s future. What happens in our schools has a huge impact on the future of our country; therefore, keeping children in school, healthy and ready to learn, is a universal goal throughout the United States. Yet today, with the student population reflecting more children with disabilities and huge health disparities, we still have no comprehensive national health program in place for our school children. With these past and present views on the
importance of child health, why is it that over the past 100 years we have not achieved a coherent and universal plan for healthy school children in our country?

This chapter aims to examine today’s demand for school nurses, and to articulate the early 20th-century history of school nursing, particularly in rural areas. By linking the efforts of the past to the goals of today, we hope to allow history to be our “wise teacher,” not just teaching us who we are but also outlining a way to understand current issues that can lead us to insights about our future (Lewenson & Herrmann, 2008, pp. 1–2). Public health nurses led school nursing efforts a century ago and their work illustrates some surprising similarities to challenges that we face today. These include inconsistent funding, inadequate numbers of nurses in this role, and the sovereignty of local and state politics.

The National Association of School Nurses (NASN) defines school nursing as “a specialized practice of professional nursing that advances the well-being, academic success and lifelong achievement and health of students” (NASN, 2012, p. 2). The nurse in the school setting facilitates normal development, promotes health and safety, intervenes with health problems, provides case management, collaborates to help students and families adapt and manage, and advocates for students and their learning (Council on School Health, 2008; NASN, 2012). The NASN, founded in 1979, is the professional organization that advances the practice of school nurses, envisioning that every student will thus be healthy, safe, and ready to learn. The NASN definition places the nurse at the center of health management at the school level, partnering with the school system, local physicians, and the public, and argues for the importance of having a school nurse in every school, yet full-time RNs currently staff only about half of U.S. schools (Robert Wood Johnson Foundation [RWJF], 2010).

A recent publication stresses that “schools are situated within the contexts of neighborhoods and communities. The relationship between the school and the community affects the entire community, not just the students attending the school” (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015, p. 736). School nurses have played a key role in forging healthy communities during the past century. In the early 20th century, just as today, an environment conducive to learning (both inside and outside of the classroom) was key to the health and success of school children, and indeed to communities and our nation. The physical environment of schools, as well as the physical condition of
learners, have played huge roles in the strategies to improve school health. Today, a collaborative approach called “Whole School, Whole Community, Whole Child” (ASCD, 2014) currently underpins federal efforts to coordinate learning and health. The aim of this program is to provide holistic school programs to enhance students’ ability to learn by promoting healthy students and providing a healthy environment and access to health and behavioral services when needed. In fact, the whole student has been a focus of school nursing since its inception. Schools can be a gateway for some students to needed health services today just as they were in the past.

“Parents have to send their children to schools; they do not have to take them to private physicians’ and dentists’ offices or to public clinics,” argued Meckel (2013, p. 1) in his book, Classrooms and Clinics: Urban Schools and the Protection and Promotion of Child Health. Children are required to attend school but not required to access routine medical services. Having a nurse in the school encourages a link between the school and the health care system and promotes preventive care and health education, as well as provides for therapeutic care for some students. Today’s school nurses regularly treat or manage asthma, allergies, and chronic diseases such as diabetes; advise and counsel students on behavioral, substance abuse, or sexuality issues and prevention strategies; provide vision and hearing screening and immunization monitoring; and treat minor injuries (RWJF, 2010). The ability of today’s school children to be present and ready to learn includes some newer challenges, which affect the scope of practice of the school nurse.

Policy and Political Advocacy

Several key legislative events influenced the scope of school nurses’ work. In 1973, the Rehabilitation Act required access to public education for students with disabilities and required individualized services to be in place to accommodate their learning. The Individuals with Disabilities Education Act (IDEA) of 1975 and 1997 mandated that schools admit and provide educational services for children with disabilities, ranging from psychological and developmental services to physical services, sometimes for debilitating and chronic diseases. These two Acts virtually redefined the school population for public education, and required adjustments for even the most disabled children to be accommodated in the classroom in the least restrictive way.
These Acts essentially mandated that nursing services be provided for students, but failed to provide funding for such services (Wolfe & Seleman, 2002).

To provide some perspective on the scope of the issue, a U.S. Census Bureau study indicates that 5% of the children in metropolitan areas and 6.3% in nonmetropolitan areas have a disability (Brault, 2011). This adds up to a total of 2.8 million children with disabilities who need individualized services ranging from blood glucose testing to tracheostomy care (Brault, 2011; Wang et al., 2014). Add to this total the 8% of children (nearly 6 million, or one in 13) with food allergies who can experience life-threatening reactions while in school and more than 9% of children with asthma (approximately 6.8 million), and the acute need for qualified RNs in every school becomes clear (Centers for Disease Control and Prevention [CDC], 2015a; Food Allergy Research and Education [FARE], 2015).

In addition, health disparities affect countless students. The term health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by a group of people relative to another group (Kaiser Family Foundation, 2012). For example, impoverished families and persons of color experience worse health outcomes than other populations in the United States—they have poorer access to care, have poorer quality care, and are less likely to be insured. Health disparities contribute substantially to excess health care costs in the United States (Kaiser Family Foundation, 2012). In 2013, more than one in five children lived below the poverty level in the United States (Annie E. Casey Foundation, 2014). Other factors such as environmental threats, individual and behavioral factors, and educational inequalities enhance the disparity issues for school-age children (CDC, 2015b) and further document the need for nurses in schools.

Healthy People 2020 (Educational and Community-Based Programs [ECBP]—Objective 5; 2016) aims to increase the proportion of elementary, middle, and senior high schools that have a full-time school nurse (defined as an RN or a licensed practical nurse [LPN]) to student ratio of at least 1:750. In fact, 45% of the U.S. public schools met this challenge in 2006, and now the goal is to increase the ratio by 10% by 2020 (Healthy People.gov, n.d.). Further recommendations by the Council on School Health (2008) and the American Academy of Pediatrics (AAP) propose that schools with larger numbers of children with special health needs require more intensive nurse-to-student...
ratios. State laws and guidelines vary tremendously on this issue (see National Association of State Boards of Education [NASBE], 2014). For example, Iowa requires schools and school districts to employ a school nurse (RN) with at least a bachelor’s degree, and allows care to be delegated within the school to an LPN (NASBE, 2014). Iowa further set the goal of a nurse-to-student ratio of 1:750. In contrast, Virginia school boards may employ nurses if they meet certain Board of Education criteria, and local health departments may also provide personnel for health services in the school system. The Virginia law stipulates that skilled nursing services paid for by Medicaid must be performed by an RN or LPN under the supervision of an RN. The law recommends one nurse per 1,000 students (NASBE, 2014), but these recommendations are an unfunded mandate.

In light of these statistics, it is astonishing to learn (even after 100 years of advocacy), that not all schools have an RN on site to serve the child and adolescent population as well as provide health promotion and health education in the schools. In fact, there are 73,600 RNs working in schools in the capacity of a school nurse, though not all are full time (Turner, 2016). In many areas of the country, depending on state laws, other paraprofessionals or lay persons may fill the role of a health clinician. These raw data numbers of nurses (73,600) as compared to the public and private school student numbers (50.1 million plus 4.9 million; National Center for Educational Statistics, 2015) might suggest an adequate force of school nurses (1:747); however, that figure disguises wide differences across the country. A recent survey documented that various regions of the country differ significantly in terms of nurse-to-student ratios—some more than double the recommended 1:750 ratio—and in terms of salary paid to nurses (NASN, 2012; Figure 3.1). A “patchwork of state and local policies on nurse practice and standards as well as inconsistent and sometimes fractured systems of financing” creates challenges for school nursing advocates (RWJF, 2010, p. 1).

Multiple professional groups endorse the need for the services of school nurses, such as the AAP, the National Education Association (NEA, 2015), the NASN, the American Nurses Association (ANA), and CDC, to name only a few. The Journal of the American Medical Association recently published a report documenting the cost-effectiveness of school nursing and noted that for every dollar invested in school nursing, society would gain $2.20 (Wang et al., 2014). The school nurse focuses
on education and prevention, but deals with more chronic medical conditions than acute ones. The nurse’s role not only saves health care costs, but provides that link to the health care system. A discussion of the past provides some perspective for the present.

BACKGROUND

Children born around the turn of the 20th century in the United States, depending on their location and race, had as high as a one-in-five chance of dying before their fifth birthday (Markel, 1998). Diseases such as measles, diphtheria, smallpox, systemic infections, and tuberculosis (TB), along with regional diseases such as pellagra or parasitic diseases such as malaria and hookworm, threatened children’s lives—that is, if they survived infancy. Impure milk and water led to gastroenteritis

FIGURE 3.1 Mrs. Edith McCarl Hickey.
Source: Sunset Magazine (1915, p. 552).
and diarrhea that along with respiratory infections claimed the lives of countless babies even before their first birthday (Golden, Meckel, & Prescott, 2004). Black children died twice as frequently as White children, and poorer children were subject to greater mortality as well (Brosco, 1999). In fact, the Children’s Bureau, founded in 1912, the first federal agency to address children’s health and needs, noted in one of its first studies that decreasing income was correlated with increasing infant mortality. The babies of the lowest wage earners and those of single mothers were more than twice as likely to die as those of the highest wage earners (Lathrop, 1919; Lindenmeyer, 1997). Some public health activists called cities children’s “abattoirs” (slaughterhouses), but rural children had different, yet equally challenging obstacles to surmount in order to achieve and maintain health, so critical to academic success.

In contrast to the perception of rural good health were challenges such as poverty, poor sanitation, child farm labor, parasitic infections, and skin infections along with infectious diseases and accidents. In addition, school terms lasted as little as 72 days in rural areas, and ramshackle school buildings were hardly optimal places for learning (Flannagan, 1914; Link, 1986). One public health nurse leader stated, “Unless one has actually visited the families living on small isolated farms, it is hard to realize the meaning of the poverty in many rural areas” (Randall, 1931, p. 193). In addition to isolated family or share-cropping farm work, there was mining, forges, wood cutting, saw mills, and other, often low-paying, rural labor pursuits that could bring this type of poverty into focus. A public health nurse in Washington state described her initial work in King County, “I spent one week among the mining camps, and the squalor of the homes, combined with the general neglect of the children, made my heart ache” (Hickey, 1913, p. 166). With poverty often comes poor health.

Public health professionals of the time sought innovative tactics to fight diseases and promote health in these rustic populations, yet school nursing was a consistent choice to address children’s health (Meckel, 1990) and was considered by many the most effective way of introducing public health nursing in a rural community (Brainard, 1922/1985). Discussing rural nursing, one author in the American Journal of Nursing stated, “In a great many cases the children are the only means of reaching the homes, sometimes situated in such out-of-the-way places that it is hard to find them” (Koeller, 1917, p. 317). Schools not only needed the services of the nurse, but also supplied the access to the children’s families in these often remote regions. It is hard for us
today to imagine the unpaved, rutted roads, or mere pathways over rough terrain that led to rural homes. These factors dictated the means of travel for those who visited. Although these issues may sound far different from our current experience, we have much to learn from the strategies that our nursing and public health counterparts used 100 years ago.

**Origin of School Nursing**

In 1892, Nurse Amy Hughes went into several London elementary schools located in poor neighborhoods. She examined up to 100 children a day—referred by teachers—and treated simple, contagious infections such as ringworm and pediculosis (lice) without excluding children from schools, thus keeping children in the classroom and ready to learn (Brainard, 1922/1985). The successes of Amy Hughes and a growing contingent of school nurses around London at the turn of the century suggested that the nurse, “for small ills, might be more useful than the doctor—identifying and treating head lice, eye disease, promoting cleanliness and referring the children to medical care if needed” (Report of the Commissioner of Education, 1906, p. 163). In 1897, London’s programs were recognized in New York City, where, using a different tactic, doctors began to inspect children in the city schools.

Physician medical inspectors excluded children who needed treatment from school, and sent them home with notices recommending parents seek treatment for the child. Parents often ignored or did not respond to the notice. Absences persisted and the goal of keeping children in the classroom to learn was not met, and children often remained an exposure risk in their families or neighborhoods.

**School Nursing in New York City**

Public health nursing leader Lillian Wald, fully aware of the work in London, offered the city schools the loan of a Henry Street Settlement nurse, Lina Rogers, to supplement the work of the inspecting doctors. Rogers visited four schools in a densely populated area of the city and followed up the inspections with in-school treatment when possible and paid home visits to the families of the children to ensure that appropriate management of the problem and health education occurred. Many of the exclusions involved skin diseases (such as ringworm,
scabies, impetigo), which, when “treated” on site at the school with soap, water, and ointments, or simple remedies, allowed the children to return to school. Rogers also documented and treated cases of pediculosis, eczema, eye infections, and minor wounds (Keeling, 2007). This month-long experiment in the fall of 1902 proved so successful that the city ultimately employed 12 nurses by the end of that year, and Lina Rogers became the superintendent of the work.

During the first year of school nurses in New York City schools, the monthly absentee rate dropped from 10,500 to 1,100 (Rogers, 1908). Rogers declared, “The care given to the children in the schools is the ameliorative, that given in the homes is the preventive part of the whole.” She considered home visits to be “by far the most important” (Rogers, 1906, p. 67). Another physician advocate later declared, “... it is impracticable to disassociate the school nurse from the home in successful school work” (Clark, 1922, p. 2193). These school nurses focused primarily on acute health issues. Urban schools began to adopt school nursing across the continent as programs launched in Chicago, Los Angeles, Boston, Pueblo, Colorado, and Toronto, Canada, within the first 10 years, and Rogers went on to become a leader in school nursing. But at the turn of the 20th century, only 40% of the population resided in urban environments (Iowa Data Center, n.d.; U.S. Census, n.d.).

**Rural School Nursing**

Rural schools, serving the other 60% of the population, faced many of the same health and social issues as urban ones. Many of these children were also poor, yet they had the additional burdens of isolation, dilapidated school houses, lack of public and private sanitation, and inadequate access to health care resources, along with unique social challenges. Throughout the country, such diseases as typhoid and TB, infected ears, trachoma, dysentery, malnutrition, and poor vision hampered rural children’s learning. In the South, malaria and hookworm were added to the list. Conditions in the schools promoted the spread of many of these infections. In the 1910s, multiple educational sources documented the lack of sanitary privies, clean water, and schoolhouse conditions that obstructed learning (Clark, 1914; Flannagan, 1914). Further environmental issues, now viewed as social determinants of health, also existed. As one social welfare worker put it, “Poverty and neglect, vice and crime, disease and death do not pertain exclusively to cities, nor do laziness and ignorance” (Curry, 1923, p. 200). Experts
noted irregular school attendance, poor nutrition, lack of good employment for parents, and inadequate housing in these rural areas.

One cannot consider the early 20th-century proposed reforms in public education, including healthy conditions for learning and the role of the school in society, without considering the ambiguity of progressive reform for the rural population. This ambiguity lies in the understanding of two conflicting ideologies—the concurrent drive to modernize and use science to reform societal problems, and the proud demand to preserve the independent, entrenched values of the provincial way of life. Modernization, or progressivism, therefore could conceivably unravel the traditional way of life, so dear to country people (Link, 1983). One school nursing proponent observed that “to awaken these good rural parents from their conservatism and to the necessity of safeguarding the physical welfare of their children” is one of the most important missions of the rural nurse (Cannon, 1921, p. 132).

Another noted (Stebbins, 1929):

> . . . we find our rural Missouri communities large in area, often handicapped by meager transportation . . . financially struggling . . . with an unawakened group consciousness, barely stirring . . . a surrounding open country peopled with . . . individualistically thinking and acting, self-reliant agriculturalists; a divergence of thinking between the town and open-country people; and in . . . sections of the state special racial and industrial problems. (p. 27)

School nursing in rural areas was a connecting link between the emerging bureaucratic systems of education and public health.

In the South, one public health nursing leader stated that although training was important, it was equally important “that we have southern women to do the work, as they understand conditions so much better than do nurses coming from the more prosperous North” (Virginia State Board of Health and State Health Commissioner, 1916, p. 138). This supports the notion that the rural nurse faced a double-edged role: as a reformer and improver of rural health and sanitation while treading a fine line to preserve rural identity; change was not easily accepted. Leaders recognized that having nurses come from the region where they would work had value and might not tip that balance that could derail the modernization efforts if rural values were not sustained.
School nurses, as representatives of their profession at the time, became the “entering wedge” to rural communities and schools, with the confidence that “the teaching of the nurse will be carried home through the child” (Ludwig, 1916, p. 76). Localities and schools first had to recognize that they needed this service, since funding was mostly local, and then they needed to locate a nurse who could meet the demanding criteria. Frequently hired by school boards but also funded through piecemeal sources, such as mothers’ clubs, local funds, parent teacher associations (PTAs), the Red Cross, and later by state health departments, school nurses tackled school children’s health and sanitation problems head on. They identified individual health problems in the schools, visited homes to seek consent for care, assessed whole families and their environments, and followed up with medical and nursing care (Figure 3.2). Whether or not the nurse had a medical inspector to assist in the work was a local decision. Physician inspectors were expensive, and had their own medical practices to tend. Authorities agreed that if the funds were available for only one health officer in a small town, the nurse was the most effective choice (Cabot, 1911).

FIGURE 3.2 Waiting for the nurse.
Certainly, there were challenges for the nurse—not only in funding but also rural transportation, physical isolation, sheer distance between schools, living quarters, and social and professional isolation. For example, one Missouri nurse opined:

Roads, their direction and condition, are a definite determining factor. It is sometimes necessary . . . to go many more miles . . . just because there is no road to the nearest . . . village, or its upkeep is so inferior . . . [for] it to be used. Sometimes, too, the “creeks are up.” (Stebbins, 1929, p. 25)

The nurse could face parental indifference and lack of understanding of the need for the nurse’s health message. In addition, there were often few available hospitals and clinics where parents could take their children for care. Nurses had to face pushback from the medical profession at times if they advocated for free or reduced cost care (Johnson, 1936; Kelly, 1921; Waterman, 1934; Williamson, 1927). In order to do their work, nurses were obliged to navigate and partner with local officials, school officials, teachers, physicians, the community, and the students and parents under their care, who often represented diverse interests and priorities.

The scope of the job itself remained a consistent barrier to adequate school nursing. Nurses might be hired to do school work, but as one teacher noted:

Her opportunity for service is limited only by her strength, her endurance and her vision. In many cases she is the leader in welfare activities of the community and takes the initiative not only in developing the school health program, but in organizing . . . the improvement of the health of school children. (Williamson, 1927, p. 392)

Rima Apple (2015), historian of public health nursing, contended that local funding and a supportive infrastructure influenced public health developments, including school nursing. “It was difficult for a single person, even a highly competent person, to sustain a job ‘so large,’ with ‘so much to accomplish,’ and at the same time ill-defined and so easily expanded” (Apple, 2015, p. 35). This infrastructure would eventually take the form of local health units that could support the work of the nurse, but was long in coming to many rural areas of the United States.
Historical Attributes of a Rural School Nurse

To be successful, the rural nurse needed to possess an almost impossible list of attributes. Of all qualities, tact and a cool head are most frequently cited in the literature (Koeller, 1917). But the nurse also required self-reliance, a 2-year nursing program; a postgraduate course in public health, registration in those states that required it, good health, courage, an even temperament, a sense of humor, a discreet and silent tongue, sympathy with country people, the broadest intelligence, and finally experience in managing a horse [cart] and automobile (Bigbee & Crowder, 1985; Lowe, 1916). One Kentucky nurse advised, “One needs to go into a small town with an open mind, open eyes and ears, but a closed mouth on local conditions regarding her work; but open and well prepared on the work she is going to do” (Lowe, 1916, p. 1187). A successful school nurse required courage, creativity, strong assessment skills, outstanding communication skills, discretion (what we might call emotional intelligence today), and a sense of caring and respect for the community.

CASE STUDY: The Case for School Nursing in the 1910s in Virginia

Virginia State Commissioner of Health, Ennion Williams, demonstrated his favor for school nursing in 1916:

It is our belief that the school is the first place for the nurse to begin her work . . . by operating in the schools, she can reach a considerable element of the population in a very short while. More than this, the school offers . . . the most effective point of contact between sanitation and the home. The nurse who comes to plead for the treatment of a child is accorded a welcome which a regular health inspector or health officer cannot hope to receive. (Virginia State Board of Health and State Health Commissioner, 1916, p. 69)

Progressive public health officials such as Williams, from primarily rural states, devised ways to intervene with the rural

(continued)
CASE STUDY: The Case for School Nursing in the 1910s in Virginia (continued)

population of the state and saw this challenge as no less than a crusade to improve health and sanitation. Jane Ranson, the first director of Bureau of Public Health Nursing for the state of Virginia, also favored school nursing as the best way to begin or extend work in rural areas, stating, “In country districts school nursing is advocated as having the greatest value, and bringing in the biggest return for the money expended” (Virginia State Board of Health and State Health Commissioner, 1917, p. 169). Schools were a likely place to start and school nursing was a broad yet spotty effort to address those same rural needs—broad in the sense that the nurse could serve multiple roles, and spotty in the sense that there were few nurses available and trained to take on this role that combined nursing, sanitary instruction, and social welfare. Virginia and other states prioritized child health.

Much like urban school nursing began in New York City at the turn of the century, rural school work included direct care, education (for students and teachers), and prevention at the school and during home visits. Inspection led to identification of “defects,” as they were called, in vision, hearing, teeth, weight, tonsils, or adenoids. The nurse would treat simple cases according to standing orders and follow up with parents on health issues requiring physician or dentist interventions, such as enlarged or infected tonsils or decayed teeth. Recall that in this preantibiotic era, frequent tonsillitis would have been treated by tonsillectomy; thus, a nurse would have to advocate for a visit to the physician who would schedule the surgery. In fact, in some cases, the nurse organized mass tonsillectomy or dental clinics. For example, Sarah Crosley, RN, organized and set up a makeshift operating room in an Accomack County high school in 1923, where 27 children had their tonsils and adenoids removed by a specialist. They were supported by local doctors, neighboring county nurses, and local volunteers in the care of the children (“With the nurses,” 1923, pp. 10–11). Due to
the scarcity of nurses and physicians in rural areas, along with travel challenges, the rural work demanded initiative, independent judgment, coordination efforts, and a great deal of what one nurse called “cheerful cooperation” (Figure 3.3; Gibbes, 1920, p. 927).

CASE STUDY: The Case for School Nursing in the 1910s in Virginia (continued)

School nurses were in the forefront of health promotion and education. In the schools, they taught students healthy patterns of living, such as tooth brushing and healthy eating. Nurses taught children how to drink more milk and to use a handkerchief to cover coughs, and used stories, songs, and poems to cement health messages that they intended for children to share at home. This brand of nursing led to maternal
and infant care in the homes visited; discovery of diseases such as TB in families; promotion of sanitation (clean water and sewage disposal); discovery and correction of hookworm, all the while advocating for the correction of vision, nutritional problems, tonsillitis, or the repair of decayed teeth in the school child. For example, a nurse might home visit to investigate a case of a school child’s poor vision, with the intent for the parents to take the child to get glasses, but come across a pregnant mother with other small children whose needs she would assess. Perhaps there would be feeding problems or lack of prenatal care. She would provide the information regarding the vision correction, but then begin to address other health issues she found. In one account, a neighbor alerted one nurse to visit a farm where five children lived, and the family’s cows appeared sickly. She visited, found, and observed the cows. They were thin and suspicious, so she called the state veterinarian, who visited and found the cows to be tuberculous, and they were euthanized. This nurse’s visit likely averted TB infection in the family (Carruthers, 1921). Another expert noted, “The rural school is the way to the improvement of the health of county children and of rural life” (Cannon, 1921). Disease prevention and health promotion led the list of nurse duties.

School nursing could be entirely centered on school children and their families, or it could be only a part of a county nurse’s work. In the latter, schools could only occupy part of the nurse’s time. Nevertheless, the number of nurses pursuing school nursing was never enough to meet all the needs. The dependence on local funding, the scarcity of qualified nurses for this work, and the thousands of square miles to be covered led many localities to ultimately hire generalist county public health nurses, who could include schools in their work.

The role was incredibly broad and challenging. An example of the work of a school nurse in 1927 provides some perspective:

I recall one day spent with a rural school nurse who visited seven schools by travelling sixty miles through beautiful mountainous country. As we drove from school to school . . . the nurse [assisted] the teacher in making an annual physical inspection which included the testing of vision and hearing, inspection of teeth and tonsils, and the weighing and measuring of the children. (Williamson, 1927, p. 392)
Another nurse gave an account of her work in rural Utah, “At Strawberry [School] I visited each of the two rooms, gave health talks and made class room inspections, also a thorough inspection of the building, grounds and out-houses, and made recommendations for beautifying and improving the premises” (Wiberg, 1921, p. 168). Following these school activities, home visits would ensue to inform parents of children needing treatment.

Depending on the distances, terrain, and the number of schools that the nurse covered, these inspections might occur only once a year, especially considering the follow-up needed for the children needing further care. One supervising nurse observed, “the nurse . . . each day, in bad weather and good, takes the trail and finds the people; for truly it is not easy to reach schools through the mountains, on roads impassable by automobile or buggy many months in the year and which can only be reached by horseback” (Webb, 1920, p. 840).

From West Virginia to Arkansas, to Mississippi, Utah, Oregon, Virginia, and New York—across the country—the stories of nurses’ work, courage, and resourcefulness are recorded in the journals of the era. To be successful, these nurses needed exceptional training and talent. Whether they were navigating muddy or steep roads, conducting toothbrush drills, treating lice with kerosene, locating a crippled child, transporting families to care, carrying specimens to the state lab for hookworm testing, or planning a clinic, these autonomous nurses adopted a broad definition of holistic health that included the environment, socioeconomic status, and sanitary schools and embraced scientific solutions to many rural problems. Organized public health services reached some areas sooner than others, but rural school children still faced health challenges.

Many of the same challenges that school nurses of 100 years ago faced remain today. Children face poverty, health disparities, and environmental challenges in the schools today just as they did 100 years ago. Funding remains a barrier to the provision of school nursing as do appropriate educational preparation, continuing education, and enough qualified nurses to do the work. Some are still not convinced that school nursing is essential, believing that the school secretary can handle most issues. School nurses need to partner with schools to conduct outcome research that will document their effectiveness. Clear associations between school nursing, student readiness for learning, and performance will strengthen the case for more standardized
placement of well-qualified RNs in all schools. Finally, all politics are local. Due to the relative autonomy of states in administering educational programs, nurses and schools need to convince local legislators (with data) that school nursing is a good investment.

ACTIVITIES FOR TEACHING AND LEARNING

1. In your community, explore the number of schools, the number of students in those schools, and the number of school nurses in those schools. Identify two main health issues that school nurses experience in those schools. Explore how the school nurse advocates for better health care in local and national legislative policy arenas.

2. Compare and contrast the role of the rural school nurse in the early 20th century with that of the rural school nurse today. Describe the challenges that the school nurse might face in both time periods, noting the similarities and differences.

REFERENCES


3. SCHOOL NURSING


3. SCHOOL NURSING


We were moving in the direction of psychotherapy. . . . We didn’t call it that, we called it 1:1, and we called it “talking with patients” and then we called it counseling and then we called it therapy. That took from 1948 until 1960.

(Peplau, 1985)

The World Health Organization (WHO) was founded in 1946 and when members wrote its constitution they defined health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). In this immediate postwar period, mental health was considered just as important for social stability as physical health. In the decades that followed, the powerful rise of a biomedical approach to health resulted in a focus on the physical and disease aspects of human health, often to the detriment of mental and social well-being. However, since the early 1990s, mental health has been recognized as a global human rights issue, reinforced by the United Nations General Assembly with the adoption of principles for the protection of persons with mental illness and the improvement of mental health care (United Nations General Assembly, 1991). The adoption of these principles endorsed the need for the improvement of mental health services globally, and required that responses needed to become more effective and equitable. In response, the WHO developed
several global strategies to enhance awareness of people’s mental health needs, disseminate knowledge, and support policy to decrease inequities in service access for individuals and families with mental illness. In 2002, the WHO launched a global program, “Nations for Mental Health,” with a particular focus on underserved populations. Major depression was identified as a leading cause of disability, among other illnesses such as epilepsy, schizophrenia, alcohol dependency, and the threat of suicide (Desjarlais, Eisenberg, Good, & Kleinman, 1995; WHO, 2002). Recognizing that for far too long mental health had been neglected, WHO argued in its final report on the topic that mental health was crucial to the overall well-being of individuals, societies, and countries. By the turn of the 21st century, mental health was recognized as a leading cause of disability and a priority health issue, globally. Nurses around the globe, united within the International Council of Nurses (ICN), advocated for national policies to ensure the breakdown of stigma and discrimination regarding mental health issues and to put in place more effective prevention and treatment programs (ICN, 2008; Saxena & Barrett, 2007).

How to best provide care and services to people affected by mental illness continues to be a pressing issue. In fact, many questions we face today are not new. Throughout the 20th century, health professionals and patients alike have argued for better mental health care, although insights on how such improvement should take place have fluctuated as cultural and social perceptions of mental illness have changed (Tomes, 2006). This chapter addresses two major shifts in mental health policy during the 20th century that have affected mental health practice and transformed the way nurses provide mental health service today. Firstly, we examine how advancement in nursing education and psychiatric theory generated new therapeutic work and new roles for nurses as clinical nurse specialists (Case Study I). Secondly, we discuss how mental health care shifted from a dominant context of institutional and mainly custodial care in the first half of the 20th century to a community-based practice, bringing new roles for nurses following World War II (Case Study II). These shifts and changes are central to how we practice mental health care today and form key moments in understanding mental health nurses’ continued responses to challenging issues of stigma, lack of service, and human rights. Historical knowledge of these changes provides the context by which to understand the direction of contemporary mental health nursing,
especially as nurses seek to address new questions of scope of practice, consumer-driven care, and mental health promotion today.

**BACKGROUND**

This section sets out the background to developments in psychiatry that have shaped the nature of contemporary nursing practice, demonstrating how changes in science and medicine, and the shifting sands of politics and policies, have affected the development of nurse-specific theory and practice. By the end of World War I (1914–1918), hospitalization in large, state-funded mental hospitals was the dominant mode of psychiatric treatment. Such hospitals, mostly overcrowded and not providing much more than custodial care, became increasingly criticized for their inadequacy, especially when war veterans suffering from shell shock returned home to find there was little help available for them (D’Antonio, 2006; Grob, 1994). New scientific insights on prevention within an emerging mental hygiene movement gained momentum (Boschma, 2012). However, the impact of economic depression in the 1930s impeded efforts of change and reform.

Sweeping changes moved through psychiatry and psychology in the decades on either side of World War II, which came to profoundly affect nursing. American psychiatry lagged “behind” European practice in that there was no coherent, evidence-based approach to psychiatric theory, practice, or science in the early 20th century, which concerned practitioners in the politically tense era just prior to World War II (Deutsch, 1937; Grinker & Speigel, 1945; Menninger, 1948; Rees, 1945). In the absence of any real successful “medicine,” psychiatry as a profession in the United States in particular, was in desperate need of scientific and professional legitimacy (Dowbiggin, 1997; Grob, 1991; Pressman, 1998). With the persecution of the Jews in Europe and the consequent diaspora, Freudian psychoanalysis began to have an impact in the United States after it had already begun to wane in Europe. Psychoanalysis found traction largely because it appeared to offer a way forward from moral treatment and mental hygiene, for it relied on theory and technique that needed to be learned (and learned a specific way). It offered structure and theory that appeared to explain cause and effect, and it offered something for psychiatrists to do that set them apart from neurologists (Grob, 1994; Hale, 1995; Lieberman, 2015).
For many practitioners emerging from the experience of World War II in particular, psychoanalysis was seen as a useful tool because their wartime experience had led them to focus on mental illness that could be categorized as neurosis, which they believed was caused by environmental factors and could be treated. This concept of illness as behavioral rather than purely biological was the subject of much debate in Western psychiatry after World War II (Grob, 1991). In the United States, the Group for the Advancement of Psychiatry (GAP), led by William Menninger, engaged in a protracted struggle to wrestle mental health away from a strictly biomedical model to a more psychotherapeutic one, and this influence on public thinking and policy at this time was profound (Deutsch, 1959; Grob, 1991, 1994). These events occurred in the context of a rapidly changing policy and practice environment in the United States after World War II, where the passing of the National Mental Health Act in 1946 released vast amounts of funding for the establishment of the National Institute of Mental Health (NIMH) and the development of advanced educational programs for the mental health professions, including nursing. Historian Gerald Grob has suggested that nurses were not particularly vocal or active within psychiatry at this time due to the lack of numbers in the specialty, high turnover rates due to marriage, and the absence of any nursing scholarship (Grob, 1991, pp. 118–119). While these points are arguable, Grob is correct to the extent that nurses were largely perceived as under the control of the broader psychiatric hierarchy (Grob, 1991, p. 120). As had been the case for the medical profession before it, psychiatry needed nurses to help with its image problem. If psychiatry was to be taken seriously as an institution-based “medical” science, rather than head shrinking quackery with dubious ethics and practiced in Bedlam-type asylums, then respectable, educated, and well-trained nurses were central to this project.

Recently, scholars have attempted to address the role of the nurse within the changing field of psychiatry, documenting the type of work and care that they undertook and how these roles changed as the profession of nursing came to impact ideas about institutional care (Borsay & Dale, 2015; Boschma, 2003, 2012, 2013; D’Antonio, 2004, 2006; D’Antonio, Beeber, Sills, & Nagle, 2014; Olson, 1996). Within this work, Olson (1996) has argued that the mid-20th century was an important but difficult time for North American nurses as they struggled to identify what was unique to their practice and argued about the place of mental health nursing as a specialty in nurse education. Olson demonstrates the centrality of the idea of interpersonal theory, which
D’Antonio et al. (2014) have argued has been overshadowed by “the biologically and specialty based imperatives that have subsumed the significance of relationships in our practice” (p. 312). D’Antonio et al. argue that there is much to be learned from mid-century psychiatric nurse theorists, who championed the idea of the therapeutic relationship as the essence of mental health nursing practice. Boschma’s (2003) and Borsay and Dale’s (2015) collections demonstrate how these changing ideas about the nature of psychiatric illness and its related treatments affected the professional identity and the type of paid work that attendants and nurses undertook in institutions in Europe, the United Kingdom, and Australia throughout the 19th and 20th centuries. These scholars show that although there were differences in the evolution of psychiatric nursing that were specific to time and place, mental health nursing followed the same trends as general nursing toward increasing specialization and professionalization. These trends were shaped by local culture and politics, and the ability of nursing as an emerging profession to advocate for its role within broader mental health policy.

Psychiatric nurse education therefore became a hotly contested subject. Although the field had initially developed within mental hospital-based training schools, which were modeled after similar examples in general hospitals, by the end of the 1940s such educational models no longer fit the need or the scope of mental health nursing practice and new knowledge was urgently needed. It was in the United States that the first attempt at establishing mental health nursing as an advanced practice specialization was undertaken, and this took the form of new graduate courses, run wholly by nurses, in universities. The Case Study I addresses this change, offering two examples from the U.S. context about the way the influential U.S. nurse leaders, Laura Wood Fitzsimmons and Hildegard Peplau, took on a leading role in this transformation.

CASE STUDY I: Establishing Graduate Courses in the United States

The efforts of nurses to develop advanced practice courses were predicated on the availability of funding and the work of specific nurse leaders who attempted to redefine the role of psychiatric nursing. This process had begun during World War II when the American Psychiatric Association (APA) had

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acquired funding from the Rockefeller Foundation to establish a “nurse consultant” program. In 1941, the chair of the APA’s Committee on Psychiatric Nursing, Charles Fitzpatrick, wrote to the Rockefeller Foundation about the “emergency” in the current psychiatric nursing situation and requested funding for the employment of a “nurse consultant” who could act as a liaison between the APA, nursing bodies such as the National League of Nursing Education (NLNE), and schools of nursing (Fitzpatrick, 1941). The Rockefellers agreed and in July 1942 the APA appointed Laura Wood Fitzsimmons, RN, as its inaugural nurse consultant. Fitzsimmons was born in Virginia and trained at Walter Reed Veterans Administration Hospital. She had served as an Army nurse and was awarded a BSc degree from Columbia University in 1938. She was superintendent of nursing at St. Elizabeth’s Hospital, a psychiatric hospital in Washington, DC, when she came to work for the APA and the Rockefellers.

Fitzsimmons’s first task was to conduct a survey of the state of the field, and she did this through written questionnaires and personal visits. She traveled across the United States and Canada and documented the state of psychiatric nursing workforces as well as systems for nurse education, which culminated in a report delivered to the APA and the Rockefeller Foundation in June 1944. The report made eight major recommendations for the postwar period. These included the need for public awareness campaigns about mental illness; an increase of funds into mental health so as to facilitate better standards of hours, wages, and conditions for workers; a uniform system of training for attendants; the development of uniform standards of care for patients; more clinical placements in mental health for student nurses; the improvement of schools of nursing associated with mental hospitals; the revival and expansion of postgraduate courses in mental health; the specific professional recognition for mental health nurses; and the organization of mental health staff under a director of nursing (Fitzsimmons, 1944a).
CASE STUDY I: Establishing Graduate Courses in the United States (continued)

Although the APA was most interested in her work on attendants and aides training, Fitzsimmons herself was more concerned with the issue of education for nurses. Her work on attendants, culminating in a 371-page training manual, which the APA and Rockefellers printed and distributed to all North American psychiatric hospitals, had really sought to try and differentiate the nature of attendant or aide work from that of the RN (Figure 6.1).

Having dealt with that issue, Fitzsimmons moved her focus more intently to the development of university courses for psychiatric nursing. As Alan Gregg, the Rockefellers’ director of medical services, noted in his diary in June 1945:

![Image of a classroom scene](http://example.com/image1.png)

**FIGURE 6.1** Bernard Hall, MD, and Esther Lazaro, RN, associate director, School for Psychiatric Aides, Winter Veterans Administration Hospital, Topeka, Kansas, 1949.

*Source: Rockefeller Archive Center.*
CASE STUDY I: Establishing Graduate Courses in the United States (continued)

Mrs F-S says she wants next year’s emphasis to be spent principally on the development of postgraduate courses in psychiatric nursing... The desperately urgent need is for registered nurses with thorough postgraduate training in psychiatric nursing who can teach students and students of nursing on affiliation. (Gregg, 1945)

If there were to be any meaningful development of psychiatric nursing skills, then skilled nurses were needed to teach the next generation. Fitzsimmons wrote publically about these issues in journal articles. Writing in the *American Journal of Nursing* in December 1944, she set out a clear rationale for the development of university-based courses that would elevate the profession into the realm of academic scholarship and research, as well as provide leaders and administrators in the future:

For years we have talked about the need for a well rounded program of nurse education yet, while preaching this doctrine, year after year hundreds of nurses have been graduated from schools of nursing without having had any experience in the field of psychiatric nursing while psychiatry claims over 50 percent of the hospital beds of the nation. This has given concern to the leaders in nursing education. (Fitzsimmons, 1944b, p. 1166)

She summed up her 2-year survey of the existing situation for her readers by explaining that nothing could change until there were adequately trained instructors, and this was her justification for university-based courses:

... little can be done to advance psychiatric training at an undergraduate level... until more key
people are available to direct, instruct, and supervise these programs. The need for knowledge of psychiatric nursing has been so generally recognised that requests for student affiliations in all areas of the country are far in excess of the courses and nurse instructors available. (Fitzsimmons, 1944b, p. 1167)

Fitzsimmons worked with a number of nursing schools, the NLNE, and the U.S. Public Health Service during this period to help them work through the complex funding maze in order to obtain grants for postgraduate courses in psychiatric nursing (NLNE, 1945). At the same time, with the end of World War II, the passing of the GI Bill offered nurses returning from war the option of further study with tuition costs covered. The National Mental Health Act, passed in 1946, and the establishment of the NIMH in 1948 with its extensive grant program, meant that large amounts of funds became available to universities looking to develop graduate education courses. One nurse who availed herself of both of these opportunities was Hildegard Peplau.

**Hildegard Peplau and Interpersonal Relations in Nursing**

Hildegard Peplau was born in 1909 in rural Pennsylvania to German immigrant parents. Like many young women of her age and time, she undertook nurses training because it was the most easily accessible education and occupational opportunity and meant she could stay close to home. Peplau undertook her initial training at Pottstown Hospital in Reading, Pennsylvania, and there she was introduced to psychiatric nursing by Arthur Noyes, the Chief Psychiatrist at Norristown State Hospital. Noyes had written texts, such as *A Textbook on Psychiatry for Students and Graduates in Schools of Nursing* (1927) and *Modern Clinical Psychiatry* (1934), and was president of the APA from
1954 to 1955. It was not, however, until much later that Peplau formally pursued her interest in psychiatric nursing. In the early 1940s, after working in a variety of nursing positions in New York City, Peplau first undertook a bachelor’s degree in interpersonal psychology at Bennington College in Vermont, where she was also working as the college nurse. At Bennington, Peplau was exposed to the latest thinking in psychiatry, psychology, social psychiatry, and social work. By the 1940s, the college was home to some of the most influential names in psychology and psychiatry, with luminaries such as Erich Fromm, Frieda Fromm-Reichmann, and Harry Stack Sullivan all contributing to the program, with its strong focus on social psychiatry in the period leading up to World War II. In 1943, Peplau finished her degree and enrolled in the U.S. Army Nurse Corps. She was eventually posted to the U.S. Army’s 312th Neuropsychiatric Field Hospital in the south of England. She found Army nursing frustrating, and psychiatric practice ad hoc and often unethical, struggling with the reliance on experimental and drug-dependent treatments and the lack of theoretical rigor. Personally and professionally she chafed under the Army’s masculine hierarchy and the lack of respect accorded to her own expertise as a psychiatric specialist. Yet she was eventually given control of one whole ward, where she could bring her expertise into practice. She instituted a therapeutic program based on one-on-one interviews, group therapy, and occupational therapy (Callaway, 2002; Peplau, 1944).

In all of this work, Peplau saw the importance of the role of psychiatric and psychological theory, the need for practice based on research and evidence, and the unique opportunity for nurses to make a clear contribution to the therapeutic process. She knew, however, that the only reason she had been able to fight back against Army processes was because she had a thorough grounding in the knowledge, theory, and language of contemporary psychology and psychiatry. Her firm belief was that without

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graduate courses aimed at teaching emerging nurses and future
nurse educators these principles—indeed, without courses that
were devoted to the specific practice of psychiatric nursing as an
advanced specialty—the discipline itself would founder. To this
end, when she returned from World War II in 1945, she enrolled
in a graduate nurse education program at Teachers College (TC),
Columbia University, where she also completed a PhD. In 1948
she was then employed at TC to begin the process of remodel-
ing a graduate psychiatric nursing program, and solidified
her position in the field of psychiatric nursing with the publi-
cation in 1952 of Interpersonal Relations in Nursing: A Conceptual
Frame of Reference for Psychodynamic Nursing (Peplau, 1952).
This groundbreaking book appeared in the same year that the APA
published the first Diagnostic and Statistical Manual (DSM-I).

Yet her work was controversial and confronting, as it argued
that nurses themselves could and should be therapists, acting
autonomously from the psychiatrist. This would only be possi-
ble, however, if psychiatric nurses were fully versed in the lat-
est theories and methods. When Peplau was hired to set up the
brand new graduate psychiatric nursing program at Rutgers
University in New Jersey, she was given carte blanche to do it
her way in the absence of any existing standards. This was a
time for experimentation—the NIMH was interested in any and
all approaches to mental health, especially those that focused
on therapy, recovery, and prevention. Peplau’s colleague,
Dorothy Mereness, noted the varying effects this had on the
development of curricula: “Different places were developing
different ideas. . . . We all got similar amounts of money, and
all had to beat the bushes for their first class” (Mereness, 1985).

The essence of Peplau’s program at Rutgers was psycho-
therapy. Students themselves underwent analysis (as Peplau
herself had done) at the William Alanson White Institute in
New York City (where Peplau was also a certified psychothera-
pist). This self-development was combined with theory and

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CASE STUDY I: Establishing Graduate Courses in the United States (continued)

clinical case studies. She was able to arrange placements for students at Greystone Psychiatric Hospital and students spent intensive time with a patient talking and recording observations. This was a practice that Peplau had learned from Frieda Fromm-Reichmann, entrusting that listening to even the most delusional and schizophrenic of patients could reveal meaning and symbols in their “word salad.” She called this kind of training 1:1 relationship studies. But really, she explained, they “were moving in the direction of psychotherapy ... we didn’t call it that, we called it 1:1 and we called it talking with patients, and then we called it counseling and then we called it therapy. That took from 1948 until 1960” (Peplau, 1985).

“Talking with patients” was the essence of Peplau’s therapeutic approach. She set out in Interpersonal Relations in Nursing, her subsequent text Basic Principles of Patient Counseling (1964), and many other articles (Peplau, 1960, 1962, 1963, 1964), the techniques and strategies for nurse-directed therapy that were part of comprehensive patient care. This method “requires a marked shift in emphasis from telling a patient how to behave in line with preconceived goals of the nurse, toward helping the patient to inquire and to find out what is going on with him” (Peplau, 1956, p. 191). It also required the active presence of the nurse, for the nurse to know his or her own values and anxieties, to put aside judgments and the need to control, and to learn to listen. This way of working was in direct contrast to the paternalism inherent to existing theories of care, which saw the nurses’ role as “to do for” the patient what they were unable to do for themselves. Shifting the focus to the patient required the nurse to resist the urge to fix and control, and demanded instead that the nurse facilitate the patient’s own experience. This was a major refocusing of the goal of nursing practice, and was made possible through the framework of psychodynamic nursing.

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CASE STUDY I: Establishing Graduate Courses in the United States (continued)

Peplau’s theory of “interpersonal nursing” went on to have lasting and global impact, so that the concepts she developed—therapeutic use of self, thereness, talking with patients—have become so essential to disciplines beyond just psychiatric nursing that they are now taken for granted. Peplau herself was a hugely influential figure in professional nursing in the mid-20th century, not only running her own program, but also running seminars at other universities across the country, consulting to the NIH, publishing, lecturing, and serving on numerous professional organizational boards, including on the NLNE’s subcommittee on psychiatric nursing. From 1969 to 1974, she served as executive director, president, and second vice president of the American Nurses Association (Figure 6.2).


Photo used with permission from American Nurses Association and the Howard Gottlieb Archival Research Center, Boston University.
POLICY SHIFTS IN THE 1960s AND 1970s

Peplau’s biographer, Barbara Calloway (2002), has called Peplau “the psychiatric nurse of the century” and many may argue that her influence was wider even than this. However, the originality of Peplau’s ideas was overshadowed in the later decades of the century with the move to biomedical approaches to psychiatric illness. Developments in the 1960s and 1970s shifted mental health policy. Peplau’s model was predicated on the nurse having intense periods of time with patients, which was largely possible only in inpatient institutions. New professions such as social work and occupational therapy entered psychiatric care and teamwork emerged as a multidisciplinary approach to practice with stronger emphasis on rehabilitation and short-term treatment (Boschma, Yonge, & Mychajlunow, 2005). The advent of psychotropic medications in the 1950s as well as introduction of public health insurance programs during the 1960s further shifted policy. With the passing of the Community Mental Health Act of 1968, the disintegration of the institutional inpatient system began, resulting in new roles for nurses in community mental health. A similar shift occurred in Canadian mental health. In the next case study, we examine the emergence of such new roles for nurses, drawing from examples in the Canadian context (see Case Study II).

Public opinion about psychiatry after World War II had been shaped by popular movies, such as The Snake Pit (1948), which had had the effect of associating institutional care with stories of terrible conditions in archaic institutions, presided over by ill-minded psychiatrists, with little concern for patient welfare. In most Western countries, public controversy over poor conditions of mental hospitals grew stronger during the 1960s and 1970s, fueled by protest against authoritarian cultural and medical models, rising civic and patient rights movements, antipsychiatric critique, and a stronger voice of patients themselves (Goffman, 1961; Kesey, 1962). Canada was no exception (Moran & Wright, 2006). Large mental hospitals, for long the dominant, if not only, option for treatment, were now closed or downsized, although the timeline for such changes varied among states or provinces. The unmanageable size such institutions often had reached and a lack of patient rights stirred a public outcry among politicians and professionals as well as patients, a critique epitomized in the public mind through the film One Flew Over the Cuckoo’s Nest (1975), based on Kesey’s 1962 book by the same name.
Patient activism grew as well. In Canada, one of the first patient-led activist organizations, the Mental Patients’ Association (MPA), was founded in Vancouver, British Columbia, in 1971; and in the United States, Judy Chamberlain became an influential spokesperson for mental health patients’ rights (Chamberlain, 1978). As a result of these pressures, as well as the apparently mood-stabilizing effects of new psychotropic drugs and growing concerns over the cost of running large-scale institutions, mental health policy shifted toward deinstitutionalization of long-term hospitalized patients and new community-based services. For nurses, this shift had significant implications. As large numbers of discharged patients had to transition to living into the community, many nurses obtained new roles in community mental health, requiring new approaches to practice (Boschma, 2012; Church, 1987). An example of this process is explored in the next section.

CASE STUDY II: New Nursing Roles in Community Mental Health: A Canadian Example

In the construction of new community services, nurses had an essential but as yet ill-defined role and needed to carve out a new professional identity and approaches to practice that expanded their independence, therapeutic role, and capacity for leadership. New institutional structures, such as new psychiatric departments in general hospitals and new community-based mental health centers and outreach teams, formed the context of new nursing role development. Stories of community mental health nurses, shared in an oral history interview project conducted with mental health nurses in western Canada, provide insight into the way nurses transformed former institutional approaches into new rehabilitative practices and community outreach (Boschma, 2012, 2015; Boschma, Scaia, Bonifacio & Roberts, 2008). Drawing from these latter works, in this case study we specifically focus on the establishment of outpatient services in a new psychiatric department at the Foothills Provincial General Hospital in Calgary, Alberta, established around 1970.

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The story of Margaret Mandryk sheds light on the experience of these changes toward community mental health (Mandryk, 1999). Mandryk started her nursing career at Alberta (Mental) Hospital in Edmonton in 1962 at age 18. More than 30 years later, Mandryk remembered the many complex aspects of her work, which demonstrated that her career path was dramatically affected by the move toward community care. As she took on a new position in Calgary, her professional identity changed. She remembered how she became Calgary’s first community mental health nurse, a new identity she actively began to embrace in 1966. At that time, she was most likely called a psychiatric nurse. Only in retrospect did she use the phrase “community mental health nurse,” as it was in retrospect that she related to a transforming identity, a shifting context, for which the seeds were already planted in the third and last year of her training: “Even by my third year [in the mental hospital] things were a lot different in what we were studying, . . . looking at more things like the social factors of life, things like alcoholism” (Mandryk, 1999). Teaching moved away from the straight focus on anatomy and medications of the first year, she remembered.

Another formative influence during her training was a taste of community work she had been able to get. By the mid-1960s, the Alberta Hospitals both in Edmonton and Ponoka had begun to downsize and discharge their chronic mentally ill population:

I did some community, a little bit of work with a social worker there at Alberta Hospital in Edmonton as part of my, um, I think it was an elective, . . . really enjoyed community work and often thought “Gee, that would be what I [would like to] do when I graduate,” but again, you just, you just sort of dream about those sort of things, and when I came to Calgary I
6. TOWARD COMMUNITY-BASED PRACTICE

CASE STUDY II: New Nursing Roles in Community Mental Health: A Canadian Example (continued)

started to look for work, there wasn’t a whole lot open for psychiatric nurses. (Mandryk, 1999)

Inspired by those experiences, however, Mandryk preferred to stay in psychiatry. What she dreamed of was indeed not readily available because Calgary did not have a large mental hospital, so jobs for psychiatric nurses were scarce. At the same time, Alberta Hospital Ponoka (AH-Ponoka), a large mental institution in the middle of the Canadian province of Alberta, was discharging patients to the city of Calgary. This required the development of the so-called “after-care services” for patients discharged from AH-Ponoka. “After-care” refers to the care patients need to make the transition after discharge from the mental hospital. Such care, however, did not exist at this time and had to be invented and made to work. These new services needed nurses such as Mandryk, who actually understood these clients and the medications they were on, which now needed monitoring, if not administering, in the community. Mandryk’s experience was valued: “And so I went to AH-Ponoka, I think the next Tuesday, . . . we traveled to AH-Ponoka every Tuesday [to coordinate discharges] and we went to AH-Ponoka the next Tuesday and they hired me and that’s how I had my job” (Mandryk, 1999). A new era of community mental health nursing began for Mandryk. She would take on a key role in constructing and shaping it, as nurses trod new ground in the grassroots development of skills and services in the community. She developed new group work for discharged patients in the community and helped develop community outreach when a new department of psychiatry was formed in the Foothills Provincial General Hospital in the late 1960s. In her story, we can trace the larger social changes of which she was part.

Joyce Taylor (pseudonym) was another nurse active at this time of change (Taylor, 2004). Her strongest memories were of patients: the people who had to make the transition from

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CASE STUDY II: New Nursing Roles in Community Mental Health: A Canadian Example (continued)

institution to community, often at an older age, after having spent years, if not decades, in the institution. In her story, she reconstructed leaving the institution as a challenge. Despite the optimism with which community care was developed, many of the former patients ended up quite isolated once again, and not all received the support they needed, Taylor explained. Her stories about her clients illustrated how the formerly hospitalized patients were still not well when they moved into the community, and they were not always able to get the support they needed. Her account also gives unique insight into the meaning of self-help in community care. In the more unpredictable context of the community, support was a complex process, not only to create or provide, but also to get. Patients were visible only when they connected to a clinic or agency on a regular basis, but there was no guarantee this would actually happen. Taylor followed patients who came to the Foothills Provincial General Hospital’s psychiatric clinic in Calgary on a monthly or biweekly basis. The psychiatrist leading the follow-up program ran a group for schizophrenic patients. During their visit, the patients attended the group, saw the psychiatrist individually if necessary, and also saw the nurse.

Taylor worked primarily with elderly individuals who were in their 70s at the time of their discharge from AH-Ponoka: “They were becoming elderly because, you know, they’d been in AH-Ponoka for so many years” (Taylor, 2004). Sometimes, reinstitutionalization (in nursing homes or lodges) occurred as these elderly clients became too frail. One frail elderly lady Taylor (2004) visited in the community on a regular basis “was somebody, you know, that survived, just barely survived, so when she became extremely frail we were actually able to get in the geriatric mental health team and they moved her to a nursing home to spend her last days.” Taylor (2004) continued to point out that getting people with a psychiatric diagnosis into a nursing home was very difficult at the time, but also...
CASE STUDY II: New Nursing Roles in Community Mental Health: A Canadian Example (continued)

essential: “I was having to move a lot of these people into nursing homes because they just were not surviving on their own and there wasn’t family support.” Taylor observed how people were functioning during home visits, and she tried to revitalize connections with siblings, or sometimes with children of the discharged person. Occasionally, she was able to find families, but “they didn’t understand, they weren’t given the, the teaching about schizophrenia . . . and so this particular [elderly] lady had a sister and a brother I was able to contact regarding her care, but you had to do a fair amount of pushing to get, to get the family involved” (Taylor, 2004).

For people living with mental illness in the community, a “self-help” philosophy sometimes emerged out of necessity, and peer help was a crucial survival strategy (Shimrat, 1997). Emerging patterns of self-help have been looked upon both in positive and negative terms, and are at the heart of the consumer movement that grew in the context of deinstitutionalization (Tomes, 2006). For some, these developments underscored how psychiatry did not work, and that, as a result, consumers or survivors had to rely on each other, in a context where actual resources were lacking. Others saw self-help as the beginning of a more independent life in the community, prompting healthy coping mechanisms that helped people with mental illness recover and survive (Tomes, 2006).

The stories of home visiting and community mental health care demonstrate how the strategy to actively help people socialize, as well as the pressure former patients experienced to survive in a new context of “community,” pushed a new agenda of rehabilitation, in which people with mental illness took on an active role in the management of their lives and care. Taylor’s and Mandryk’s stories also illuminated how rehabilitation provided nurses the opportunity to construct a more independent, therapeutically based professional identity. Finally, the stories illustrate how the ideal of independence in the community was

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CASE STUDY II: New Nursing Roles in Community Mental Health: A Canadian Example (continued)

fragile, difficult to achieve, and fraught with many new problems as the demand for community care increased and resources fell short. Many of the dilemmas and challenges of long-term institutional care were reproduced rather than resolved in the new community-based mental health services.

Establishing rehabilitation and community care in the 1960s and 1970s was a complex process constrained by pressures of funding and fragmentation (Fingard & Rutherford, 2011). From the stories, we learn that deinstitutionalization, increased reliance on psychiatric departments in general hospitals, and more community services have not resolved the complex problems people living with mental illness continue to face, including stigma, homelessness, disparities in access, and lack of specialized services (Kirby, 2005). The shift to community settings produced new, more fluid, and even more complex institutional contexts, raising the question whether we really can speak of a process of deinstitutionalization. As a result, persistent dilemmas of mental health care continue to be high on the health policy agenda—and nurses are called upon to make rehabilitative services work in an increasingly complex political and social context.

DISCUSSION AND CONCLUSION

Mental health sits at the intersection of a number of often-competing political and cultural philosophies about the nature and meaning of mental illness. Although there may be increased awareness and acceptance of the idea of mental illness, many in the community are unsure what this means, or how best to deal with the often complex and uncomfortable issues it can cause. Nurses need to be mediators of this process, negotiating the medical and scientific aspects of illness and treatments with the social and community expectations of care. Stigma about mental health is still strong, and can have devastating consequences for patients who are often severely marginalized.
by under-resourced services and the judgments of practitioners. People with mental illness from underserved communities are more likely to be incarcerated than treated medically, and are more vulnerable to violence and homelessness. Although the concept of social determinants of health is gaining increasing attention in general health care, more work needs to be done on understanding the link between environment and mental health, and more and better services continue to be needed as the rates of mental illness around the world continue to climb.

Nurses are at the frontline of mental health services in all aspects of health care, as deinstitutionalization has meant that there is no longer any real separation between mental and general health care. People with mental illness can and do present in all areas of nursing, and nurses must be able to recognize people’s health challenges and act accordingly, with compassion and care, keeping patients’ individual needs and rights balanced with potential risks to others. This raises many ethical dilemmas for nurses, who must act within the law but also seek to uphold human rights, increasingly difficult in a biomedical and risk-averse health care system. Somatic treatments and psychotropic drugs, while bringing benefits, can impinge on individuals’ sense of autonomy and sovereignty over their own body, and nurses must recognize the position of power they hold over people in extremely vulnerable emotional states (Holmes & Gastaldo, 2002; Perron, Fluet, & Holmes, 2005).

Nurses in the past knew that this was a difficult and complex area of clinical practice, with wide-reaching social and cultural implications. Before psychiatric nursing emerged as an advanced practice or clinical specialty, nurses such as Laura Fitzsimmons and Hildegard Peplau identified the need for high-level, theoretically based, and clinically prepared psychiatric nurses, and set about creating the educational programs and professional associations that would ensure this level of practice. These nurses believed in the primacy of the nurse as a therapeutic agent and carved out a role for psychiatric nursing that encouraged independent practice, developing the core principles that continue to underpin not just psychiatric but also general nursing. By focusing on the patient and the concept of recovery, nursing itself became empowered as an interpersonal process, equipping nurses with the skills and knowledge they needed to imagine and create healthy, respectful, and compassionate relationships with patients (D’Antonio et al., 2014).
Nurses who experienced the subsequent shift from institutions to community-based services needed to invent practices and methods of care that had no precedent, and that could support people with a broad range of health, family, and social needs. They adapted the theory and practice of institutions to new circumstances, shifting the locus of care to communities, families, and peers. These nurses worked ever closer with patients themselves, learning and modeling valuable lessons about the importance of patients’ rights and the imperative of person-centered care.

Despite continued advances in neuroscience and brain biology, mental health nursing is still essentially an interpersonal process. This is a unique and significant contribution of nurses to provide holistic care that seeks to combine mind, body, and spirit, thus facilitating a patient-driven approach to recovery. This is an increasingly difficult task as funds continue to be cut at the same time as rates of illness continue to rise. Nurses working in mental health today need ever more complex theoretical and interpersonal skills with which to negotiate the nexus between body and mind, between patients and families, and between families and communities. Nurses work across the spectrum in mental health, from homelessness to maternity, to youth and child health, to suicide prevention, and to public health. This is an exciting and challenging field, which psychiatric nurses in the past faced with critique, courage, and innovation, taking the reins of leadership to ensure that nurses themselves imagined and created their own knowledge, practice, and identity. In an increasingly biomedical model of health service provision, the imperative for nursing to stay cognizant of and critical about its unique role is more necessary than ever.

**ACTIVITIES FOR TEACHING AND LEARNING**

1. Watch the movie *The Snake Pit* from 1948.
   Reflect on the role of the nurses: Which different therapeutic techniques, effective or less effective, do you recognize? Reflect on the role of gender and power: How do these social forces shape the nurse–client relationship?

2. Watch the documentary on the Mental Patients’ Association (MPA): “The inmates are running the asylum: Stories from the MPA” is a documentary about the group that transformed Canada’s psychiatric landscape (DVD, 36-minutes; created by the MPA founders’
6. TOWARD COMMUNITY-BASED PRACTICE


3. Do patient and professional points of view about supportive communities for people with living with mental illness differ? How effective was the model of peer help that the MPA developed? Would it provide a model for service today?

4. Locate a copy of Peplau’s book *Interpersonal Relations in Nursing* from 1952. What concepts, theories, and ideas do you recognize as fundamental to your own practice today?

REFERENCES


III. MID-20TH CENTURY


Fitzpatrick, C. (1941). Letter to Allan Gregg (Rockefeller Foundation RG 1: Series 200, Box 70, Folder 850, American Psychiatric Association—Nursing 1941–1942), Rockefeller Archive Center, Sleepy Hollow, NY.


National League of Nursing Education (NLNE). (1945). Courses in clinical nursing for graduate nurses: An advanced course in psychiatric nursing. Prepared by
III. MID-20TH CENTURY

Subcommittee on Psychiatric Nursing of the Special Committee on Postgraduate Clinical Nursing Courses. New York, NY: National League of Nursing Education.


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