At the Seventh Annual Convention of the American Psychiatric Nurses’ Association (APNA) in October 1993 in Chicago, Grayce Sills, new President of the APNA, introduced Rhetaugh Dumas (excerpted):

Rhetaugh Dumas is the first woman and the first nurse to have served as Director of the National Institute for Mental Health. She is a charter fellow of the American Academy of Nursing. She has received numerous awards and honorary degrees, including one from her alma mater, Dillard University. This remarkable leader has a powerful vision of nursing. The Yale University Alumni Citation stated: "No catalog of her personal and professional accomplishments does justice to the power of her person, the scope of her service, and the depth of the way in which she has touched the lives of others."

Since I left the National Institute for Mental Health (NIMH) 12 years ago in 1981, I have felt less in touch with the mainstream of psychiatric nursing; however, my identity as a psychiatric nurse has remained solid. I have never wavered from my commitment to promote advances in this field, wherever I have been. Soon I will step down from my deanship at Michigan. I have "paid my dues" to the APNA and I look forward to joining you in your efforts to place psychiatric nursing at the forefront of the nation’s health care revolution.

I want to illustrate how changes in mental health policy and politics of public funding have influenced the development of psychiatric nursing. I want to highlight some of the pitfalls of the past, which I hope we will avoid in the future, and I want to share some current concerns. I also will share some ideas related to leadership, boundary management, and the significance of communication in our negotiations. These ideas will be important to our success in gaining the kind of unity that is going to be necessary as we move into the next era.

Background

Great Beginnings. Landmark legislation established the NIMH in 1946. Until recently, the NIMH administered federal funding not only for research, but also for training mental health professionals, aiding state services for the mentally ill, and originating pilot projects. These funds played a significant role in increasing the supply of psychiatric/mental health nurses with advanced preparation.

By the 1950s, psychiatric nursing had begun to flourish—in the 1960s, the field was in its prime. It was considered one of the most progressive, specialized fields of nursing. Master’s programs were outstanding in quality and they usually had larger enrollments than other specialties. Most of the undergraduate programs in nursing had NIMH grants to integrate behavioral science concepts throughout the curriculum.

Among the first doctorates in nursing, if my memory serves me correctly, was a Doctor of Nursing Science degree in psychiatric nursing offered by the Boston University School of Nursing. June Mellow provided the leadership in that program.

Psychiatric nurses provided outstanding professional and intellectual leadership in advancing the development of nursing knowledge through scholarly activities and pioneering research. For some time, psychiatric nurses were producing the majority of publications in our field. Psychiatric faculty were sought out to take key positions in progressive nursing schools and government, and to head major organizations.

So only two decades ago this field was considered avant-garde and on the cutting edge of change for the entire nursing profession. The pioneering clinical experiments in nursing practice, conducted by me and my collaborators, stimulated a wave of clinical nursing studies that paved the way for more rigorous investigation.

These developments occurred amidst a revolution in mental health care that we know as the community mental health movement. Unfortunately, the movement and the progress of that era were difficult to sustain.

Major Obstacles. To say that the
Advancing Psychiatric Nursing

Nixon administration was unsupportive of mental health would be a serious understatement. Beginning in 1970, we were faced with repeated efforts to phase out NIMH support for training. In 1978, in the publication Mental Health in America, a commission that was appointed by President Carter and chaired by Roslyn Carter called attention to the shortcomings and inequities existing in mental health systems. The need for more comprehensive and responsive service systems and strategies for achieving these objectives provided the basis for the National Mental Health Systems' Act, which was passed by the Congress in 1980.

The hope that came from these developments was short-lived. President Reagan set about to undo much of the progress in mental health; what he left undone was completed by his successor, President Bush. The NIMH is no longer an independent agency: its research is under the National Institutes of Health and its service components under the new Substance Abuse and Mental Health Services Administration. Consequently, we have witnessed the end of a significant era in the mental health field.

The Future of Psychiatric Nursing

But a new day is dawning, with unparalleled opportunities. The critically important question we must ask ourselves is: Are we equipped to handle the challenges and fully exploit the new opportunities that are ahead?

We must manage change more effectively. The lack of overall planning to direct the course of progress results in confusion and fragmentation in our ranks.

As new dimensions and levels of practice and scholarship emerged, we expanded roles and proliferated into more narrowly defined subspecialties. As our numbers increased, definitions of the nature and scope of nursing practice became progressively vague. We were psychotherapists, family therapists, child therapists, sex therapists, and marriage counselors. We extended our boundaries broadly. This expansion has been a mixed blessing. It has been exciting and rewarding to go into positions never before occupied by nurses. However, in so doing, we have become more closely identified with the new subculture and we often have neglected that culture that identifies us as nurses.

We have lagged behind in developing appropriate concepts and theories, and have not monitored how basic psychiatric concepts are handled in nursing curricula. We have allowed the so-called integrated curriculum to eliminate courses called psychiatric nursing. In some undergraduate programs, psychiatric nursing has been totally removed. We are lagging in the development of an adequate database for assessing the needs in our field.

Psychiatric nursing courses have been downsized and diminished; and have suffered as strategic plans were developed by nurse faculties. There is no eagerness to establish new programs; but, there are shortages in the psychiatric nursing work force, and people are being deprived of services and care that they need for the promotion of health. Mind and body cannot be treated as separate and distinct entities. Psychiatric nurses are needed to care for people with a variety of illnesses and situations. Our place is in primary care settings; we are participants in managed care arrangements (and we will continue to be) in the reformed health care system.

We also know that the challenges and demands that we might expect to confront are dictated not so much by logic as by social, economic, and political expediency, which mold public attitudes and chart the course of outcomes.

Health Care Reform. The President's new health security plan should be read and studied by all psychiatric nurses. We should understand that states will have much to say about what happens. Each nurse should consider how the developing plan—it is not finished—will affect his or her work.

There is a shift in language in the newest draft: The term nurse practitioner has been replaced with the term advanced practice nurse. This has important implications for psychiatric nurses. Clinical nurse specialists, defined by statute, are not nurse practitioners. The use of the term advanced practice nurse incorporates both. It is refreshing to see definitions that are more inclusive rather than exclusive. The boundaries are being expanded. To incorporate a broader mix of health care providers.

The success of whatever form the national health care plan takes will depend on where nurses are placed in the scheme of things. Expanded boundaries have increased the visibility of nurses during the various stages in the development of the plan. Nurses are gaining the respect they deserve, from the highest levels of government in Washington. We have been included in several special events, and are included in planning. We are being heard and understood.

It is refreshing, encouraging, and inspiring when the President and the First Lady talk about access to health care—and include nurses in their statements. They know the difference between health care and medical care, and it shows. And the unrelenting advocacy of Mrs. Gore provides a frequent reminder that ensuring universal access to health care means making sure that mental health and psychiatric care are included in the basic benefit package.

A major revolution within our own ranks will be demanded by whatever form the final plan takes. We, as nurses, must take full advantage of this moment and move swiftly to chart the course for a new revolution in American nursing.

Complete Restructure. We need to restructure our whole system of education and rid ourselves of this fragmented approach. The time has come to settle
the issue of entry into practice and to establish one statutorily defined nurse that everybody will know as the American nurse, without any need to qualify the definitions.

Now this restructuring is an awesome undertaking, but we have little choice. The currents of change are already buffeting long-held traditions and those who are unable to manage change and those who cannot manage to change will find themselves “lost in familiar places.” We will lack the connections for relating to and advancing in the real world—a world that will change at an even more rapid pace in the future.

Managing Boundaries. Managing change and managing to change are major tasks in any progressive endeavors in the new era. This is managing boundaries—the major task of leadership. When we talk about restructuring, reforming, redefining, organizing and reorganizing, we are talking about managing boundaries. Boundaries enable us to set limits and to distinguish what to divide and separate. They denote the relative position of each entity within the organizational structure. Boundaries define roles, responsibilities, and prerogatives. They come into play in configuring what is in and outside organizations. We also know that boundaries conceal, guard, and protect. They are involved with identity, autonomy, and privacy. They function to focus on details. Boundaries provide shelter in the midst of a storm, and they allow us to maintain our composure, or a modicum of sanity, when the world around us threatens to drive us crazy.

Boundaries that are too narrowly defined may block important communications and prohibit possibilities for negotiations. However, boundaries that are too vaguely defined and lack integrity can increase vulnerability.

The manner in which boundaries are managed can make the difference between confusion and clarity, order and chaos, rationality and frivolity, competence and incompetence, and unity and disunity. When boundaries are ignored, or poorly managed, we can expect the kind of constraints and barriers that we have referred to so often in our history as the gap between nursing education and nursing service . . . or the tensions between psychiatric nursing and other clinical specialties, or between physicians and nurses.

To bring distinct and even opposing groups together for the cooperative and collaborative endeavors necessary to accomplish our goals, we must be able to manage boundaries. Our leaders must help maintain and monitor boundaries so that collaboration occurs and so that we are not isolated from another domain or organization.

We nurses are faced with the strategic opportunity to take control of our own practice in ways that before were not possible. We will succeed in doing so only to the extent that we are able to pull together the various sectors of the profession in productive efforts to forge needed reforms within our own ranks.

We must guard against conditions that might cause splintering of the mass. Effective leadership is therefore essential to establish and embrace the fundamental unity between this field and other sectors in the nursing body politic. It is important that we understand that unity within our field, and between our field and other fields, will largely determine the level of unity that can be achieved within the profession as a whole. We are influential.

Facing Opposition. There will be challenges to nursing that demand a unified response. For instance, a group of Michigan physicians produced a brochure that warns the public against the dangers of nonphysician providers being empowered under health care reform. The brochure warns against allowing nonphysicians to broaden their scope of practice. Nonphysicians are referred to as “quacks”; little ducks with stethoscopes in their ears illustrate the brochure. A caption says: “Michigan physicians! Don’t duck the bill. Join or upgrade in this organization today!”

This is an example of the kind of protest we will encounter when boundaries are reformed. These protests must be handled appropriately and productively. We cannot simply “circle our wagons”; conflicts must be managed well.

Developing linkages will allow the management of boundaries in ways that will foster the reconciling of disagreements and conflicts, and a sense of commitment and loyalty to shared goals. Parties do not have to like each other (or even get along) so long as there is commitment to move in concert toward goals. The kinds of linkages that allow people to join together for mutual benefits are necessary in order for us to communicate to Congress what we want in that health care reform package. We all know that this is easier said than done.

Leaders are necessary to manage the far-reaching ramifications of these changing boundaries. Boundary issues and problems associated with them are not unlike an encounter with fire ants: You get stung, destroy the ant, and think the problem is solved, only to be stung again. Then you discover that what you are standing on is a hidden anthill. Boundary issues are the unseen anthills within groups and organizations.

Boundaries are not unnecessary evils. The points at which sectors and groups sometimes clash are also the points at which connections can be made. Settling disputes and making deals can occur there. In common parlance, boundaries are “where the action is.” When they are ignored and poorly managed, we can expect constraints, barriers, and problems.

Communication/Negotiation. A second critically important area to consider is communication. It means ensuring that there are adequate opportunities, structures, and processes to facilitate the interchange of thoughts, opinions,
advancing psychiatric nursing

key points


1. A critically important question we must ask ourselves is: Are we equipped to handle the challenges and fully exploit the new opportunities that are ahead? To do this, we must manage change more effectively.

2. We need to restructure our whole system of education. The time has come to settle the issue of entry into practice and to establish one statutorily defined nurse that everybody will know as the American nurse, without any need to qualify the definitions.

3. Managing change and managing to change require effective leadership; that is, the capability to monitor, facilitate, and enhance communication and negotiation across boundaries. Boundaries include those of role, race, age, social status, sexual orientation, and other characteristics that differentiate. These characteristics, however, enrich and liven the discourse among us.

ideas, and information across boundaries. It means ensuring that important issues, problems, and disputes that arise will be handled by communicating. Specifically, the type of communication needed is negotiation.

One fundamental lesson in negotiation is about the starting point for negotiating. It is a mistake to assume that because another party’s position is different from ours, we are in conflict. For example, in the book, On Getting to “Yes”: Negotiating Agreement Without Giving In there is the proverbial case of two sisters quarreling about an orange. Each wants the whole orange. They settle the dispute by cutting the orange in half. One sister eats the fruit and throws the peel away; the other sister eats the fruit and uses the peel to bake a cake. If they had communicated and negotiated, they each could have had the whole of what they wanted—the fruit or the peel. Think about that. Interests must be made known for good negotiations to occur.

Managing change and managing to change require effective leadership; that is, the capability to monitor, facilitate, and enhance communication and negotiation across boundaries. Boundaries include those of role, race, age, social status, sexual orientation, and other characteristics that differentiate. These characteristics, however, enrich and liven the discourse among us. They expand possibilities for creative endeavors and cutting edge discoveries in ways not likely to occur in homogeneous groupings. Indeed, there is no doubt in my mind that diversity will be an essential element for fostering the kind of advances that will be needed to define the place of psychiatric nursing at the forefront of health care delivery in this era of revolutionary change.

references

Bibliography

the national aids information clearinghouse

now—one toll-free number for reference assistance and to order publications:

New toll-free number
1-800-458-5231
FAX: 1-301-738-6616

Call us. We’re your centralized resource for information on HIV/AIDS programs, services, and materials.

A service of the U.S. Department of Health and Human Services
Public Health Service ■ Centers for Disease Control

14