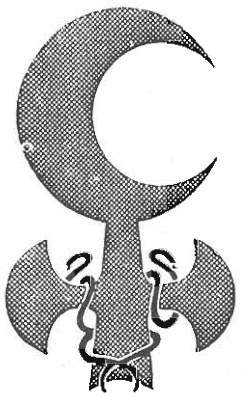

CASSANDRA

radical feminist nurses newsjournal

P.O. Box 341, Williamsville, NY 14231-0341

VOLUME 7:4 DECEMBER 1989

Dear Faith,

I am happy to be able to respond to you in this forum. Hopefully, other Cassandra readers can benefit from our dialogue, and I have the opportunity to say some things in public that editors generally do not allow. I really appreciate your letter (I notice that AJN has not published it - at least not yet!). As a feminist nurse in academe, I have both the desires to be recognized as a scholar and to have my work make a difference in the health care of women experiencing violence. I therefore make both conscious and unconscious compromises on my feminist values. Having been first made aware of the androcentric nature and oppressive potential of language by Peggy Chinn and JoAnn Ashley 10 years ago, I find to my chagrin that I only struggle toward cleaning up my own language. Feminist awareness is a process, and deeper understanding comes only with time, self-analysis and being open to others' critiques. Some days I feel I haven't gotten anywhere yet. Jan Humphreys and I wished we could change the word victims in our 1984 book, Nursing Care of Victims of Family Violence, to survivors, almost as soon as it was written. We felt as you do that the word victims didn't adequately convey the strengths we saw in women who were experiencing violence. Since that time, others have recognized and used the term survivors for women who have experienced various forms of violence, and some have differentiated survivors from victims in terms of the recovering process. I have started to use survivors almost exclusively in speaking but have had individual women who have experienced violence point out to me that the word victim better conveys for them their absolute helplessness in their abusive situation. This may be even more true for women abused as children.

Therefore, I basically agree with your comments about using the word survivor rather than victim as an empowering strategy. As I reread the AJN article I see that some of the time we used the word victim purposefully (as in "rapist and his victim") and at other times (like in the sentence you quoted), it would have been far preferable to use survivor. For the most part we used the words woman or "respondent" (rather than research subject to try to get away from that representation of hierarchy). But this shows me that I will need to start scanning everything I write for the word victim to be sure it doesn't slip into my writing inadvertently. When I saw your letter I was quite sure the word victim could not have appeared in that article more than twice -- to my chagrin so far I have counted five times, and I probably am still missing some!

I also wouldn't put it past the editors to have changed survivor to victim somewhere along the line, but I am not

going to take the time to search the original manuscript and compare it to the galleys versus the final product. One thing I an VERY sure about -- the title was changed from our "The Health Consequences of Marital Rape" to "The Dark Consequences of Marital Rape" with an illustration I felt was equally sensationalizing as the title change, done without our permission or knowledge prior to publication. Many things happen on the route to publication, including editing to remove feminist values. This has happened to me many times. Although one usually has the chance to withdraw the manuscript if the final galleys still don't reflect your intent (this was not true in the AJN case), that takes more guts than I have had so far. One can negotiate with the editor(s), but that takes a great deal of energy, is demoralizing, and almost necessarily ends up in compromise. The only real way to protect feminist intent is to publish in expressly feminist journals. One has to weigh that choice, which can be seen as "preaching to the converted," with reaching (and hopefully enlightening!) a wider audience.

In terms of your specific point in the next to last paragraph, I do include women who are sexually abused as their "only" form of physical violence in my categorization "battered women" (See my article in ***Nursing Research***, 1989). I meant the word battered in the quote you used to represent physically abused, and the latter no doubt would have been clearer!

In a great deal of my writing I have used the term "battered woman" (rather than abused woman) since I generally restrict my exploration to responses to physical and sexual violence (rather than emotional). However, I am starting to be persuaded that there is some labeling that goes on with that terminology also. Many of the women I have talked to, both research participants and shelter residents, don't think of themselves as abused or battered. They say it is because their experience is not bad enough, often making a comparison between themselves and the Farah Fawcett character in the TV movie, "The Burning Bed." Other women have told me that it was only when they started to think of themselves as battered or abused that they were ready to take some decisive action in the situation. I have tried in my writing and speaking to show the problems with making general assumptions about all women experiencing violence and I am afraid that my use of "battered woman" has perhaps added to the problem. As Bell Hooks (1989) states:

A category like "battered woman" risks reinforcing this notion that the hurt women ... becomes a social pariah, set apart, marked forever by this experience. A distinction must be made between having a terminology that enables women, and all victims of violent acts, to name the problem and categories of labeling that inhibit that naming. ... This is an empowering process that should not be diminished by labels that imply this wounding experience is the most significant aspect of identity. (In Talking Back: Thinking Feminist, Thinking Black published by South End Press, Boston, p. 89)

My friend and fellow woman's advocate, Jan Findlater, likes to use the terminology "women who have experienced violence," and I like it. Again, it is a bit awkward, but it conveys more of the sense that it is but one facet of their lives and that this could easily be any one of us. I'm also trying out the phrases "women being battered" and "women who have experienced abuse from a partner," because violence is perhaps too generic. Good grief, this language stuff is hard!!

I also struggled with terminology for what it is I study. I started with recognizing the obfuscation of gender in the terms "spouse abuse" or "marital violence." However, I also felt that "wife abuse", although gender specific, did not recognize violence toward unmarried women by an intimate partner. Abuse of female partners is what I settled on, using "abuse" rather than battering when I was

including emotional and sexual abuse as well as physical abuse. It is a bit awkward, but I haven't figured out anything better. I like the Canadian terminology, "wife assault" to be clear about the violation of law as well as body involved, but abuse seems to reflect the ongoing nature of the beast, while assault can be a single occurrence. And wife again has the married assumption problem. We also have to recognize that abuse can happen between same gender partners, although the extent of the problem among lesbians (by all indications from the very few research investigations conducted) is minuscule in comparison to the prevalence against women in heterosexual couples. So, I guess Faith, the best label for the shelters would be shelters for women who are experiencing abuse from a partner -- but precision can be cumbersome!

About the women being forced into "homosexual sex," this exact phrasing was used by one of the women in describing her experience. I have also been told of this experience by another battered woman and several shelter advocates. Although I did not actually talk to the respondent in the study, the written description and the incidents described by other women referred to the man forcing (by threat of beating or with a weapon) her to engage in sexual acts with another woman. Although the terminology "homosexual sex" is not accurate to describe this experience as you point out, it was the woman's phrase not ours (and therefore should have been put in quotation marks) and her placement of that experience in the general category of other coerced sexual acts. Of course, her violation was in being forced into the act, not the act itself.

To respond to your points about nurses, grassroots advocates, and battered women, I can only say that I spend a great deal of my time and energy trying to decrease the distances between the three groups, and I hate it if the article came across as trying to set nurses "above and apart." I have worked with shelter advocates and women in shelters for ten years, providing nursing services, leading support groups, belonging to boards of directors, scrubbing windows and bathrooms, and moving furniture! The study described in the article was designed and implemented in conjunction with grassroots advocates from both the battered women's movement and the rape crisis volunteer network. The Director of the Michigan Coalition Against Domestic Violence arranged with shelter directors the questionnaire distribution and procedures for administration. The discomfort on the part of advocates I described has been revealed over time in my work in shelters, and discussed with me by many shelter directors in three states, as well as told to me and to other advocates as part of our training efforts in conjunction with the study. I do regret that the written report did not adequately convey the collective nature of the research and the legal efforts. And although I agree that nursing education and experience does not necessarily translate into sensitivity, there is that background in nursing that may be advantageous. I am trying to get nurses more involved, more caring about women being abused and to see that they have a role in that arena. I hope we as nurses can work WITH advocates, and I am as concerned about advocates feeling that nurses have no credible role with battered women as the opposite.

There are also underlying issues around the notion that only those who have been there can really study it well, or represent it accurately, or be truly empowering. These issues are of concern in the battered women's movement generally. They can also be raised in terms of white women (or nurses) doing research with, writing about, or providing care to women of color or other oppressed groups. I have not been battered and I am white and hopelessly middle class, and I have worked with primarily poor and minority persons all of my professional life. I struggle with ethnocentrism and elitism all the time and I am probably only partly successful. But I believe it is extremely important for me to keep trying to understand and to use my concern and my

research skills to persuade others about the importance of the health care needs of women being battered, especially minority battered women. They have not been well represented in the battered women's movement until recently, but I really admire how that movement is trying to address the issue by use of task forces of women of color, formerly battered women, and lesbians who have identified and formalized (as well as informal) input into decisions and training. I try to use my volunteer work in an urban shelter to stay in close touch with the realities of battered women and women of color, and I try to stay open to critiques like yours. Your letter along with a class on feminist critique and research methods I taught this summer has helped me get back in touch on a very conscious level with some of these issues and how easy it is for me to slip into assuming my feminist values come across without my working at it! I hope I haven't sounded hopelessly defensive and self-serving in all of this, and I hope that we as fellow Cassandrans can meet some time and talk some more!

Sincerely,
Jackie Campbell

***

Dear Cassandrans,

I took the lead from Faith Hansen in the last ***NewsJournal*** by sending along a copy of a letter I recently sent to ***Ms.*** in response to an article in the September issue. Thanks, Faith.

I believe men **and** women share in the causes of violence in our society, and that each of us as an individual is responsible for countering the forces that allow and encourage it. We need to open our eyes to the subtle ways we encourage little boys to be aggressive and little girls to be passive, and to the implicit acceptance of the denigration of women in our private lives when we do not speak out against it.

As nurses, we need to re-think the development theories that taught us that "normal" is to separate from others, and that (by default) to seek out relationships is somehow "not normal." In our practices, we need to provide " safe" environments for little boys to be "little persons" and not "little men" in terms of socially accepted norms of what a man should do or be. We need to help parents to learn that insisting on gender-based, stereotypical roles for their children denies them the opportunity to explore their full potentials. As educators, we need to help students (men **and** women) to develop self-concepts that provide positive self-esteem and assertiveness, not aggressiveness, and to model this behavior. As administrators, we need to recognize the implicit nature of power in human hands and the role the exclusive seeking thereof has in the destruction of relationships with those we should be leading. As researchers, we need to explore hypotheses concerning the etiology of violent behavior in our society, and to support the construction of developmental theories that apply to **both** genders.

These are my thoughts; would love to read about yours in the ***NewsJournal.***

Peace to you,
Jini Miller
Graduate Student
Austin, Texas

Letters to the Editors
Ms. Magazine
One Times Sq.
NY, NY 10036

October 4, 1989

Dear Editor,

Hurray for Ms. Pogrebin's article, "Boys Will Be Boys" in the September issue of *Ms.* Having become a feminist in the early '80's, my conscious awareness of gender-based imbalances and inequities in our society has grown by leaps and bounds over the years. Her comments formalized ideas that had been circulating in my mind, but had not "made sense" until now.

One need only watch the evening news or read a daily paper to witness the continual parade of carnage in our society. We seem numb to it. We seem to barely notice that the perpetrators of the violence in our society are predominantly male, and if we do notice, we tend to pass it off as "boys will be boys."

It **is** time "to examine why so many sweet little boys grow up to feel the need to hurt women." Social attitudes expressed by **both** men and women subtly (and not so subtly) encourage aggressive behavior in little boys and passive behavior in little girls, support the denigration of women, and unwittingly maintain the belief that violence by males against females is "all-American as apple pie." Each of us in our own lives must become aware of how we play roles in sustaining these beliefs, and must change our ways if we are to find answers to Ms. Pogrebin's question.

Sincerely,
Virginia G. Miller
4704-B Sagebrush Cir.
Austin, TX 78745

***

To The Women of Cassandra:

I am a feminist and I work as a nurse. A friend has told me about your group, and I am very interested in learning more about: the work you do; relevant literature; other feminist nurses/health care professionals/practitioners (within or outside of the "US professional health care system") here in WI; perhaps a branch of Cassandra out here? (and if not, do you have suggestions on how to begin one?)

My decision to study and practice nursing was a deliberate, thoughtful decision. However, it is only upon entering a hospital as a G.N. that I am realizing how horribly anti-woman the health care system in this country truly is. Any support would be greatly appreciated!

In Sisterhood,
Debbie Beilfuss
203H Eagle Heights Apts.
Madison, WI 53705

***

Contribution Information

WEBSTER - women in nursing who participate in CASSANDRA's decision making and receive all publications: $35-$50. (Nursing students, retired, unemployed, or differently-abled nurses: $15.)
FRIEND - women who are not nurses and men who support CASSANDRA and receive the Newsjournal: $25.
INSTITUTION SUBSCRIPTION - groups who receive the newsjournal: $35.

IF YOUR MAILING LABEL HAS THE RENEWAL DATE CIRCLED IN RED, THEN YOUR RENEWAL IS DUE BEFORE THE MAILING OF THE NEXT NEWSJOURNAL

***

FEMINIST NURSING *OR* NURSING AND FEMINISM?
or Feminism and Nursing or Feminism in Nursing...

by Linda Bernhard

I read with great interest "A List of Feminist Nursing References" by Sheila Bunting and Jacquelyn C. Campbell in the May ***Cassandra***, and was quite excited about what they had done. Their directed study is something I would love to have done when I was a student, and would love to do now as a faculty member.

I own in my library or files and/or have read almost everything on their list. With regard to this list, the questions that continue to bother me are: how much of what they list is ***feminist nursing***, how much is what feminist nurses might use, and how much is simply references from other feminist literature. Some of the authors listed are not nurses. I don't pretend to have the answers to these questions, but they are questions that need to be discussed. How far back do we want to go? Maybe doing a complete review is a project for a nurse historian. Should we consider feminist research only?

In any case, I dashed into my own files and pulled a few citations to add to their list:

Hagell, E.I. (1989). Nursing knowledge: Women's knowledge. A sociological perspective. ***Journal of Advanced Nursing***, 14(3), 226-233.

Mason, D.J., & Talbott, S.W. (Eds) (1985). ***Political action handbook for nurses.*** Menlo Park, CA: Addison-Wesley.

Mulligan, J.E. (1980). Together we go, separate we stay. In B.C. Flynn & M.H. Miller (Eds), ***Current perspectives in nursing: Social issues and trends*** (Vol 2), pp. 210-220. St. Louis: Mosby.

Speedy, S. (1986/1987). Feminism and the professionalization of nursing. ***The Australian Journal of Advanced Nursing***, 4(2), 20-28.

Webb, C. (1985). Barriers to sympathy. ***Nursing Mirror***, 160(1), vi-viii.

Webb, C. (1984). Feminist methodology in nursing research. ***Journal of Advanced Nursing***, 9, 249-256.

Webb, C. (ed). (1986). ***Feminist practice in women's health care.*** New York: Wiley.

Webb, C. (1983) Words fail me. ***Nursing Times***, 79 (27), 65-66.

I would, further, refer the Cassandra readership to the following, more general references:

Leppa, C.J. & Miller, C. (Eds) (1988). ***Women's health perspectives: An annual review*** (Vol 1). Phoenix: Oryx. [Vol. 2 should be out Fall 1989; future editions will be published annually]

Women's Health Nursing Scan. Published bimonthly by J.B. Lippincott Company. To subscribe call 1/800/638-3030. For more information contact the Editorial Liaison, Beverly J. McElmurry, at the University of Illinois at Chicago, College of Nursing, 845 S. Damen, Chicago, IL 60612

Nursing: A Women's Studies Bibliography. Compiled by E.S. Adler, 1984. Available from University of Wisconsin, Women's Studies Librarian-at-Large, 112A Memorial Library, 728 State Street, Madison, WI 53706

CARING

by Evangeline Lane

I believe that caring is sharing energy. I believe this because of the information that has come down through the generations to me and is in my genes and through my having experienced and reflected upon the events in my life. The following statements are made in an attempt to share my thoughts with you. These statements "feel right" to me at the moment. I cannot say whether or not they will "feel right" tomorrow. I would like to know how these ideas feel to you. If they "feel right", will you share this information with me? If you feel a "dissonance" with these ideas can/will you share with me where/how/why you believe these ideas do not "feel right" to you? Your sharing your ideas with me will help me in my search for an understanding of what "caring" means to me. I honor your need/right to your understanding of what caring means to you. I will appreciate your sharing your ideas and feelings with me whether our sharing of ideas is over a brief or extended period of time and whether or not we reach a mutual agreement on the meaning of the term caring.

I became a registered nurse many years ago and have considered myself a caring nurse throughout the years. I experienced an event several years ago in which I felt a turbulence in my caring relationship with a patient. I, in fact, felt a reluctance to enter a caring relationship with that patient. Needless to say, the situation was distressing to me and I subsequently spent many hours reflecting upon the situation and in seeking an explanation and understanding of what was going on in that situation. As I reflected upon that question I have articulated bits and pieces of information that answer my question about that event and about caring in general.

In that special event I was assigned to care for a patient who was very ill, one who was coping with the failure or near failure of several systems of the body. The illness had extended over a long period of time. The patient's devoted family members were tired although constantly in attendance with the patient.

As I used my caretaking skills to care for this patient, I was acutely aware of a "holding back" from this patient. Over time I cane to recognize this "holding back" as a reluctance to share my energy with the patient. I have decided the reason I felt this reluctance to share my energy was because the patient's needs for energy were so great that to share fully with that patient felt as though it would deplete my supply of energy.

In contrast, my reflections reminded me that in most situations I share energy with patients freely and without any recognized holding back. In other instances I share energy with the patient with some limitations. I may change from full sharing to sharing with reservations. These relationships are internally controlled by some "sensor" that works to

keep my energy level at the level necessary for me. They are not decisions that I make by saying to myself, "Today I will share so much energy with patient one and not so much with patient two." I share my energy on the basis of my supply at the moment and on the basis of the needs/demand by the patient. I perceive that perhaps the word demand is significant in this context. Perhaps the patient who has the need I experience as overwhelming may also present this need so as to feel like a "demand" to me rather than an energy sharing encounter. Regardless of how the need is presented it is an energy depleting experience. Having become aware of this situation I have become very sensitive to my energy sharing relationship with patients in general. I have come to recognize that there have been and are other instances in which I hold/held back from some patients. By that I mean I did/do not share my energy with the patient. What happens? Upon reflection, I realize that I did and do several things: I avoid looking into the patient's eyes. If I look into the patient's eyes I do so very briefly. I refrain from direct hands on contact. If I must touch the patient I do so as quickly and lightly as possible to accomplish the task at hand. I keep all areas of my body from contact with the patient as much as possible. I choose the words that I say to patients very carefully and keep them to the essential information sharing level. At the same time, I observe the patient regularly and as frequently as needed to monitor the patient's condition. I perform caretaking tasks with all the skill I have and use expertise in meeting the nursing care needs of the patient.

Happily for me, in most situations I use all my knowledge and caretaking skills in providing nursing care for the patient; and, I share my energy freely. I also receive any energy the patient has and is willing to share with me.

It is from the situations just described that I have developed my ideas about caring as sharing of energy in all situations. From my general perspective of caring as sharing energy, I believe that energy is shared between all living entities. There may be a sharing of energy between all or some entities we call inanimate objects and living entities; however, this paper focuses on the sharing of energy between living entities. This energy is shared by way of energy waves that resemble threads or tendrils with each wave having an end that makes connections with other energy waves of emits and receives the "charges" of energy. Energy waves are emitted from all surfaces of living entities. In animals/humans the most powerful energy waves are emitted through the eyes.

Individual animals/humans may vary in the amount of energy they have, ranging from high energy to low energy and in their willingness to share energy. This willingness to share energy may range from high to low also. These characteristics are true when the individual is living under the best of conditions for energy sharing.

I think of the energy level in the same way that I think of a fully charged battery or a tank full of gasoline. An individual's energy level may be full or fully charged or at any level between full and depleted. I perceive that each individual has an energy level range in which the individual functions and exchanges energy with other living entities without difficulty. If the individual's energy is depleted to a certain level an internal warning system is activated and the individual begins to conserve energy or seek energy replenishment. An individual may have the capability and may override her/his alarm system and continue to deplete her/his energy. This occurs when the individual, for whatever reason, feels that she/he cannot take the steps needed to conserve or replenish her/his energy.

In addition to the levels of energy the condition of the connectors at the end of the energy waves is a significant factor in energy sharing. These connectors may function at various levels from fully functional to minimally functional. They

may also become nonfunctional. Energy wave connectors are damaged when the individual receives messages of rejection or experiences an event the individual identifies as "traumatic." When the individual experiences a rejection or when she/he expresses a willingness to share energy and a rebuffing of her/his energy is received, and injury is sustained by her/his energy wave connectors. If the individual's energy supply is full or almost full the individual will be able to gain sufficient energy from incidental energy sharing encounters or from regular support systems to effect the healing of the injured connectors with little or no permanent change in the connector. The number, severity and frequency of these traumatic events are important in the overall energy sharing experiences of the individual. Also, the availability of energy for the healing process determines the outcome of the traumatic event. These injured connectors may heal quickly and remain fully functional or almost fully functional. These connectors may be traumatized and become scarred so that they are partially functional. Or these connectors may be so traumatized that the subsequent scarring causes the connectors to become nonfunctional. For most individuals, the majority of their energy connectors are fully or almost fully functioning all of their lives.

Severely traumatized individuals may have so few unbruised connectors or so many misshapen connectors that they are and will continue to be unable to share energy with other living entities, particularly human entities. I believe this situation was reflected by the TV program related to the Vietnam veterans who have chosen to live in the mountains rather than among other humans.

Energy replenishment and the healing of injured connectors requires energy from other living entities and some period of time away from energy depleting exchanges with humans. This means separating oneself from other human beings and going to a place where one may commune with nature or meditate. Damaged energy connectors may heal and energy be replenished in a quiet environment where the individual communes with nature or a source of spiritual strength. Whenever an individual is outside, at the seashore, beside a lake or in a garden, the individual shares energy with the living entities within the area; that is, the trees, flowers, grass, plants, bodies of water, birds, animals, insect, etc. Energy is shared with the atmosphere through sunlight, moonlight, and wind. In this situation the individual emits small amounts of energy and has access to all the free flowing energy in the environment. This free floating energy heals the wounded connectors and replenishes the individual's energy level over time. Healing energy may also be accessed through mediation in communion with a "higher being" or with one's own "higher self."

For individuals with bruised or slightly injured connectors and energy levels that are slightly depleted, energy connectors may heal and energy levels may be replenished with relatively brief opportunities to receive energy from an individual willing to share energy or to commune with nature or meditate. For individuals whose energy connectors have been severely traumatized or whose energy supply is depleted, as in the case of the Vietnam veterans, a long time will be required to heal the connectors and to replenish the individuals' energy.

For most of us, however, we share energy with other humans and it is through this sharing that energy connectors are maintained and energy levels replenished and sustained, I believe that every contact between humans is a positive energy sharing contact or a negative refusal to share energy contact. There are no neutral contacts. Because most of the energy shared between humans is shared through eye contact, energy is shared even though the eye contact may be very brief. Should one individual refuse to share energy with the other individual that refusal is rejection. This explains how one may feel "energized" or "rebuffed" after looking into the eyes of a stranger

or passerby in the street.

Individuals also share energy through touch and through the energy waves emitted from all surfaces of the body. This explains how the atmosphere in a room where individuals are meeting may feel "warm" and energizing or "cold," "hostile" and "tiring." In the "warm" room the individuals have energy, functioning energy connectors and a willingness to share energy with each other. In the environment that feels "cold," "hostile" and "tiring" the individuals present may have low or depleted levels of energy, may have energy connectors that are not fully functional or may be unwilling to share energy with each other.

When I was a very young nurse I read of a study in which infants were placed in an environment where their basic physical needs were met but they were not hugged or cuddled. The researchers called this environment a neutral environment. Even then I felt that the premise of a neutral environment was untrue. There was no such thing as a neutral relationship between living organisms and I continue to believe that the relationship between living organisms is always interactive. The relationship is positive, that is, sharing of energy takes place; or it is negative, that is, a refusal to share energy is present. Refusal to share even a tiny spark of energy is rejection. I believe that is why infants who are placed in a so-called neutral environment fail to thrive -- they are rejected.

The willingness to share energy by individuals who have the energy to share is necessary for the well-being of society. Each individual needs energy as she/he copes with events of the day and encounters other individuals. Individuals self-generate some of the energy they need. They do this through their relationship to a higher being, meditation, the joy they experience through various events in their life or through honoring themselves. And some energy is received from the environment; however, most of the energy an individual living and working among other individuals receives comes from other human beings. This sharing of energy means that each individual contributes energy to the sharing event. Even the individual who has a reduced supply of energy makes a small contribution to the individual from whom more energy is received.

I believe that selecting areas in which to work involves an intuitive recognition of this energy sharing demand. I believe that individuals who choose to work with tools and equipment rather than living organisms make this choice on the basis of a recognition, perhaps at an unaware level, that they do not have the energy to share or do not have the willingness to share their energy at the level that is needed from individuals in jobs of "service" to others. These types of jobs involve extended interpersonal relationships. Caring or sharing of energy is the essence of all interpersonal relationships, in fact, all relationships between living entities. Its absolute value or importance is related to the degree to which one individual in the sharing relationship is vulnerable. Vulnerability of the individual may be related to age (babies, children, elderly); physical or psychological illness or any level of dysfunction; or any state of energy depletion. From this perspective, I believe that caring is the essence of health care workers, teachers, ministers and lawyers because these workers provide services to individuals who are vulnerable. This list of workers provides examples of the type of workers I have in mind. There may be others of equal significance.

Because I am a nurse I shall focus on this "sharing of energy" from the perspective of the nurse. As stated earlier, all individuals need energy with which to cope with the events and the human encounters of the day. Any event or condition, physical or psychological, that threatens the integrity of the individual leads to a need for increased energy. This means that clients/patients will be seeking energy to assist them in coping

with their current situation or illness. The more serious or life-threatening the situation or illness, the more energy they need. Also the individual's response to the situation or illness such as anger or depression may create a need for more energy. The length of time the individual has been coping with the situation or illness will influence the amount and level of energy needed.

In our work world, we frequently think of the areas where many life-saving technical devices are in use as high-stress areas which means more high energy demand areas; however, we may fail to recognize that individuals who have long-term debilitating illnesses also make high energy demands. Or that the administrative nurse who is responsible and accountable for the work accomplished by others works in a high energy demand situation because they share energy with many individuals in crisis situations.

In the educational setting, students and faculty experience high energy demands. Students share energy with many classmates and a variety of faculty members. They are in high stress as they seek grades and performance skills that are acceptable. They, too, share energy with high energy demand patients. Faculty members share energy with students, with colleagues, and high energy demand patients. They are in high stress as they seek to attain and maintain a scholarly level of knowledge and understanding in several areas, conduct and report research, maintain clinical expertise, and contribute time and effort in community service.

Although each situation is different, the impact on "the nurse" is the same in the final analysis. "The nurse" is depleting her/his energy. In every situation, every individual who enters the area gives and receives energy according to their energy level, their needs, and their willingness to share energy. The level of energy they bring to the area and the level of their needs will be determined by the demands for energy they are coping with in their personal lives and the energy available to them from family members, friends, etc. An acute crisis of a personal nature makes demands for energy similar to the demands on the patient in an acute care setting. Individuals who must cope with troublesome, psychological, emotional or spiritual problems over time deplete their energy just as the patient with a long term illness depletes her/his energy.

Individuals who work outside each specific area just mentioned may note advantages or resources available to the individuals in the situation that may serve to diminish the demands for energy from the nurse. In fact, it is fairly easy for each of us to note the "advantages" of working in the other situations. A few examples are: (1) the nurse in the acute care setting is assigned to one or two patients only, and there are other medical care workers readily available for assistance and energy sharing; (2) the nurse in the long term care setting has a longer period of time in which to assist the patient and may call upon other health workers to assist; (3) the administrative nurse may withdraw from the crisis situation and call upon additional resources when needed; (4) the student and faculty member have shorter (less than eight) assigned work hours most days and freedom to seek assistance from many resources. True, each situation has advantages but each makes demands. Each individual arrives in the situation having left their personal world with its history, its resources and its demands for energy. The world of each individual consists of a combination of the personal and work a day giving and receiving of energy. Whenever the giving of energy exceeds the receiving of energy the individual's energy supply is depleted. All goes well as long as the individual is able to replenish her/his energy supply regularly. Depleting one's energy supply leads to energy exhaustion. Energy exhaustion is "burn out."

I believe the term "burn out" is very descriptive of the process that occurs when the energy level of the individual is exhausted. Again, I refer to the example

of the fully charged battery that "burns out" or the full tank of gasoline that is "used up." In each case, the level of energy is gone. "Burn out" is s very serious condition. Even as the individual's energy is depleted, the individual's performance reflects this loss of energy. If the energy depletion reaches the exhaustion phase, the individual becomes dysfunctional. If the energy wave connectors are so severely injured that they do not heal or when they heal they may become so badly scarred and distorted that they are dysfunctional, the individual becomes dysfunctional. Recovery requires the removal of demands for energy from the individual who is "burned out." Ideally, recovery will occur in a short period of time in a quiet environment where the individual can meditate or commune with nature and/or communicate with a limited number of selected individuals who have a full supply of energy and a willingness to share their energy. Under any circumstance, the individual who has exhausted her/his energy supply must have time and contact with the necessary energy source for recovery to occur. The recovery process for the severely "burned out" individual will be slow at first and should be paced by the individual involved.

Needless to say, the preferred plan for each individual is one of energy maintenance. I believe that it is important that each nurse's energy supply be "full." Each nurse attains and maintains a full supply of energy through her/his own balanced life style and by attending to her/his internal signals that her/his supply is getting low.

Yes, I believe that caring or sharing of energy is the essential element in high quality nursing care. I believe it is also essential in the high quality performance of some other, if not all, workers who provide interpersonal service in our society. The length of time the worker is in contact with the client/patient is one of the primary factors in the level of energy that must be shared. For this reason, nurses feel the impact of this sharing of energy very strongly. The length of patient/client contact may be one of the factors that influences nurses to select one field of nursing over another. This may be why the activities or tasks the nurse performs in assisting the client/patient are called caring activities. I believe these activities should be called caretaking or nursing care tasks. I believe these nursing care tasks are performed with more or less skill while energy sharing or caring is accomplished. I believe these nursing care tasks may be performed with technical expertise while very little energy is shared. Tasks that are performed with expertise while very little energy is shared may satisfy the requirements of safe effective nursing care; however, the sharing of energy is necessary for high quality nursing care. I also believe the rewards or benefits derived from sharing energy are intangible. This means that the salary and the fringe benefits the nurse receives will not be predicated upon caring or sharing of energy. Salaries and fringe benefits will be predicated upon the nurse's discriminative decision making, communication and technical skills. Nurses will be given tangible rewards to the extent that they are able to communicate to the members of society the significance of the nurses' discriminative judgment, communication and technical skills to the well being of each member of society.

Caring or sharing of energy is essential for high quality nursing care. The nurse who provides high quality nursing care must maintain a level of energy that allows her/him to share energy with the clients/patients and with other individuals in their environment. This means taking care of oneself. If each nurse takes care of herself/himself, the energy of all the nurses within the environment will support an energizing environment where caring or sharing of energy may be experienced by each individual in the environment and clients/patients may experience high quality nursing care through sharing energy with their nurses.

DARING TO CARE

by SueAnn Wooster Ames

This is a true story about women and caring - only the names have been changed to protect the privacy of the players in this amazing theatre of life.

My husband and I were at a social gathering in Rochester where we ran into some old friends from Buffalo who we had not seen in 20 years. Their careers had taken them South, and eventually to Rochester and RIT, where they both now work. We reminisced about a football game we had gone to in Boston some 22 years ago - a game between UB and Boston College. Several other couples, who were also good friends, were on that trip. As we reminisced, they asked us if we had heard about the tragedy in the lives of one of these couples. We had not. They told us this story.

During Easter vacation of 1989, Jan and Don Crane had taken their two children, Darren (age 14) and Katie (age 18) to Barbados for Easter break. Katie was going off to college in September and they thought this might be a great time to take a family vacation. On Good Friday they got up late and had breakfast in their hotel dining room. This hotel was the only one on the strip that served breakfast after 10 AM, so visitors from other hotels who were enjoying a lazy morning would often walk down the beach to breakfast there. On this particular morning, the dining room was quite empty except for the Cranes and, a few tables away, four nurses from New York City.

Jan and Don loved taking their children to new places and they all enjoyed traveling together as a family. Darren had severe asthma since childhood but he and his parents had learned to manage it well, and it was not a big problem on their trips. They always traveled with his inhalers and other needed supplies.

In the late afternoon Jan and Katie returned to their hotel room to get dressed for dinner. Don and Darren remained on the beach a little longer. Darren was riding a type of surf board on the sand. At one point he fell off and landed on his buttocks on the hard, wet sand. He was momentarily shaken. Don saw him fall and went to check on him, but Darren was already back up on his board trying again. Shortly thereafter Darren called to his Dad and asked him to bring over his inhaler because he was feeling short of breath. Don did so, but Darren got no relief. He used the inhaler again, and then asked for it a third time. Don became concerned as Darren rarely needed the inhaler more than twice, and he could see that Darren's breathing was becoming more labored by the second. He raced into the closest hotel lobby, called Jan in their room a few hotels down the strip, and asked her to bring Darren's other breathing equipment right away. Don raced back to Darren on the beach who was now barely breathing. He picked him up and ran with him in his arms into the hotel lobby, yelling for a doctor.

The four nurses from New York City had had a wonderful, relaxing day, and decided to walk down the strip and have cocktails in another hotel. They were in the bar when a man who knew they were nurses ran in to tell them that there was a boy in distress in the lobby. They raced into the lobby, assessed Darren, and two

began CPR while the other two tried to get some history on Darren from Don and Jan. For forty-five minutes they valiantly attempted to bring Darren back, unsuccessfully.

The next few minutes, hours, and days are a jumble in the minds of Jan and Don. In order to take Darren's body home, an autopsy was required. It was Good Friday, the beginning of Easter weekend, and they were having difficulty getting any assistance. When a pathologist was finally located, he said he only did autopsies on Thursday. Don finally bribed the man to do the autopsy so they could leave the island with Darren. However that was only one piece of red tape in an agonizing seven days that followed. Don called congressmen, influential friends, nothing got them any action. Mired in the bureaucracy, they were stuck in their hotel room without support systems, not knowing why Darren had died, and unable to get information or assistance from anyone.

Don and Jan called the physician in Buffalo who had cared for Darren since childhood, and who knew his asthmatic pattern well. They asked him to talk with the pathologist about the autopsy findings so that they might better understand the exact cause of Darren's death. The conclusion seemed to be that Darren's difficulty breathing was due to an injury to C-1 secondary to his fall on the sand and unrelated to his asthma. However for Don and Jan it remains unclear and may never be known because no tissue samples were sent with Darren's body and he had to be embalmed before leaving Barbados.

I learned of this tragedy three months after Darren's death and called Jan immediately. She was glad to hear from me, wanted and needed to talk about Darren, and we had a long and emotional renewal of our friendship and sharing of their horrible nightmare. She was at the point in her grieving process where she was really trying to sort things out, tie up loose ends that could be tied, and begin somehow to come to understand Darren's death. She had started a fabric business several years before and that responsibility, she said, is the only reason she gets up in the morning - her only reason for living. Don buried himself in his work and was traveling a great deal. Katie had a summer job, was busy with her friends and planning for college.

There were many unknowns for Jan and one that she had been thinking about a great deal was the four nurses who came to their aid. Who were they? Where had they come from? Were they experienced? Did they have any answers to her questions? Did she thank them for their willingness to get involved and their extraordinary efforts? She knew the last name of one of the nurses and the New York City hospital where she worked. She called the hospital and spoke to someone there about making contact with this nurse. The hospital lawyer returned her call. She and Don made other efforts to track down the nurses, but so far nothing had happened. Jan assured me that they had never thought about legal action against anyone, they just needed to gather their lives together and the nurses were crucial to this process. After all, she said, "they were the only ones who shared our experience. They were there, they lived through it too." Jan and Don wanted and needed to talk through what happened, and Jan thought that perhaps these nurses might want and need to, too. I told her I would try to help.

I called nurse friends to see if anyone knew a nurse at this New York hospital. I went through lists of names in nursing conference brochures and contributor lists in nursing books, looking for a contact at this hospital. I came up empty.

One of the nicest experiences I have had in Rochester has been making new female friends. At a community dinner one night, I was seated next to a Rochester physician who is a nice enough guy, but his wife, Nancy, is dynamite. We talked around him for so long that he finally got up and let us sit together. She had recently completed a book that is a study of patients who've had coronary by-pass surgery, and is currently working on a book about breast cancer. We became

instant friends and have met for lunch monthly since then. In July, Nancy had a chest x-ray, a lesion was found which was thought to be malignant but fortunately was not, went to Sloan Kettering and had surgery. She remembered several nurses from her experience there. One in particular, a Recovery Room nurse named Rhonda, stood out in her mind because she was so competent and caring. At one of our lunches I told Nancy the story of Darren and the search for the New York City nurses. She told me about Rhonda and suggested that I call her, even though Sloan Kettering was not where these nurses worked. I called the nursing office at Sloan Kettering, was told what shift Rhonda works and to call then, which I did. The gal who answered the phone said that she would get my message to Rhonda.

The next day I received a call from Rhonda, and felt good about her immediately. She is warm and caring, and listened patiently as I relayed the Crane's story, on her dime! (I offered to call her on mine, but she refused!) Before she agreed to help, she wanted to be sure that there was no possibility that Jan and Don were thinking about a law suit, and I assured her they were not. She took me at my word, said that she had some contacts at the hospital in question, and would get back to me in a week or two and let me know whether or not she had had any success. I knew that she had been touched as a woman, a nurse, and a mother by what happened to Darren and his family, and I marveled at what a small and good world women can fashion.

Rhonda called me several hours later - she had found one of the nurses whose name was Paula. Paula had two calls this same week telling her that Jan and Don wanted to meet with her and urging her to call them. These calls were a result of earlier feelers Jan and Don had put out. But the call from Rhonda, another nurse, seemed to make a difference. Rhonda told me that she thought Paula would call me. Paula called the next day and told me this story.

Paula, her sister, and two friends, all nurses, enjoyed vacationing in Barbados. They had been there several times, and now knew a number of people on the island. Two are ICU nurses and two work in Recovery Room. On Good Friday, during a late morning breakfast in a hotel down the beach, they noticed a family a few tables away. They commented on how loving they were towards each other and how much they obviously enjoyed being together. They were particularly struck by the son, - he was so bright, so happy, a beautiful young man. Later, while having a cocktail in the bar of another hotel on the strip, a man they knew and who knew they were nurses, ran into the bar to tell them about the boy in the lobby who couldn't breathe. They responded without hesitation.

Looking at the stricken boy, they recognized him as the happy youth they had seen that morning. They tried valiantly for 45 minutes to revive him, and would have continued had Jan and Don not asked them to stop. They felt terrible for the family, they wondered what had happened after the unsuccessful CPR. They walked by the hotel each day and talked about the family and the experience, assuming that the family was back in the States, burying their son. They didn't know anything more and they wondered.

I brought Paula up to date, as best I could, on some of what Jan and Don had been through since they parted on that Good Friday. She said that she had never feared a lawsuit, but the hospital had involved its lawyer because it was the prudent action to take. She gave me her phone number, told me when Jan could best catch her at home, and asked me to tell Jan that she would be happy to talk with her. Jan called Paula several days later, they cried, they shared, and they arranged to meet in New York City for dinner in a few weeks.

In August Jan and Don met with the four women who had come to their aid. It was an emotional meeting, a cleansing meeting; a time to question, to share, to fill in the missing pieces, to get to know those with whom you have been linked forever through

tragedy. One of the nurses said she had had a dream several days before Darren's death that she was resuscitating someone in a hotel. Paula discovered that she and Darren shared the same birthdate.

It is now October 1st, a little over 6 months since Darren died. I spoke with Jan last night. She still wonders why she is alive and often wishes she wasn't. Katie is away at school and having some difficulties. Don buries himself in his work. Jan and Don have gone to Compassionate Friends, a support group, and Jan continues to find some solace there. They no longer go to church.

Darren would have been a freshman in high school this Fall. Jan's heart flips over everytime a school bus goes by her shop; everytime a group of young people going to and from school pass by. She dreads the coming holidays.

These four nurses had been cautioned by their colleagues and friends not to go to the meeting with Jan and Don. Too risky!! These four nurses didn't have to interrupt their hard earned and much needed vacations to get involved in the lives of an unknown family. Too risky!! And Rhonda, who was singled out because of her excellence as a care giver, didn't have to became a go-between in this real life event on the word of a sister nurse who she has never met. Too risky!! These women exemplify the highest and the best of our profession. I am proud to have made my own connection with them and am uplifted and energized by their willingness to risk and to care. They have made a difference in the lives of the Cranes and in our lives, too, because they cared enough to do what was right. No greater role models hath any woman.

***

Dear Websters.

Thanks to all who contributed material for this ***NewsJournal***, and for those of you who shared comments of guidance about the ***NewsJournal***. Last issue I proposed that we take a less structured approach to publishing within specific time frames. The feedback received on that idea was all positive, so I shall proceed with the plan to publish as material becomes available.

For those of you who produce your material on computer, consider sending your material for the ***NewsJournal*** on disk rather than a print out. I use Professional Write as the word processing package here and am able to import ASCII files from any PC and can directly import files from Multimate, Microsoft (ver 3,4), OfficeWriter (ver 6), PFS: First Choice (ver 1-3), Wang PC, WordPerfect (ver 3-5), and WordStar (ver 3,4). When the articles are lengthy, it would facilitate entry as well as contribute to error free entry and reduce proof reading time.

There are some changes underway here at P.O. Box 341. Several Websters around the country are discussing ways that we can expand involvement of other people who want to contribute energy to the survival of Cassandra. For a number of reasons, and after due consideration, we will probably be closing P.O. Box 341 and having mail forwarded to another P.O. Box. That might contribute to some confusion (for the US Postal Service). In the next issue of the ***NewsJournal***, I will bring you up to date on things and let you know the new address. At this point, it will probably be February 1990 before the next publication. More on all of that later.

Sincerely,
Your NewsJournal Staff Nurse
Charlene Eldridge Wheeler