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Mission

The *Journal of Nursing Doctoral Students Scholarship* is a scholarly publication dedicated to the development of doctoral student scholarship and the advancement of nursing science. This journal is peer reviewed by doctoral students, edited by doctoral students, and targeted towards health practitioners, educators, scientists, and students. This journal has both a professional and an educational mission. To serve the profession, each issue features articles that represent diverse ideas, spark intellectual curiosity, and challenge existing paradigms. Doctoral students will have an opportunity to explore and analyze issues and ideas that shape health care, the nursing profession, and research around the world. To fulfill its educational mission, doctoral students will be trained in the editorial and administrative tasks associated with the journal's publication and assisted in preparing original manuscripts for professional publication. This journal will be evidence of the scholarly development of nurse scientists.

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Contents

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Darina Petrovsky, MN, RN first received her Bachelors of Musical Arts from the University of Michigan, and then pursued her Masters in Nursing (MN) from the Frances Payne Bolton School of Nursing (FPB) at Case Western Reserve University (CWRU). At graduation Darina was awarded the Dean's Legacy Award for her academic excellence, service to the larger community and the capacity for leadership and innovation in health care. Darina combined her passions for music and care for older adults to continue her doctoral studies at the University of Pennsylvania working with Pamela Cacchione, PhD, CRNP, BC, FAAN and Roy Hamilton, MD, MS, where she was the first nursing student to enroll and complete a Certificate for Social, Cognitive and Affective Neuroscience. Darina is exploring the cognitive processes of music in older adults with mild cognitive impairment (MCI) with the ultimate goal of developing a music-based intervention for older adults with cognitive impairment. She serves as a board member of the Doctoral Student Organization at the University of Pennsylvania School of Nursing and is a nursing representative to the Graduate and Professional Student Assembly at the university. Darina is a member of the Gerontological Society of America (GSA); the American Academy of Neurology and the Eastern Nursing Research Society and has recently been selected as a 2014-2016 National Hartford Centers of Gerontological Nursing Excellence Patricia G. Archbold Scholar and 2014-2016 Jonas Nurse Leader Scholar.

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Editorial

Spotlight on mentorship

In this issue of the *Journal of Nursing Doctoral Students Scholarship* (JNDSS) we highlight the topic of mentorship. In her editorial, Dean of the University of Pennsylvania School of Nursing, Antonia Villarruel, discusses "The Magic of Mentoring." In "Faculty Mentoring—Is it Needed?" doctoral candidate Michael Evans discusses the importance of mentorship for junior faculty in nursing. In this editorial, doctoral candidates and co-editors of JNDSS, Megan Streur and Darina Petrovsky, joined with their mentors, Dr. Barbara Riegel and Dr. Pamela Cacchione, to discuss essential strategies to facilitate a successful doctoral student mentorship. As a journal dedicated to nursing doctoral student scholarship, we focus on what doctoral students can do to enhance the relationship with their mentor. We posed two questions to the doctoral candidates and three questions to the mentors. In the following pages, we provide our responses to the questions, along with a brief discussion of the strategies we collectively believe have contributed to our positive mentorship relationships.

What do you do to facilitate a mutually beneficial relationship with your mentor?
Looking back to when I started working with my mentor I see how our relationship has changed and matured. In the beginning, as we got to know each other, I thought a lot about the required coursework and areas of research inquiry. As my relationship with my mentor developed I began to think about the areas of research inquiry that intersected with my mentor's and what role I can play in facilitating my mentor's area of research. If there was some way I could work with my mentor on our common areas of research inquiry and publish and disseminate the work, it would benefit not only my own career as a nurse scientist but also contribute to my mentor's growth as a research scientist. On a more practical level, I learned to set up short- and long-term goals with my mentor, as well as firm deadlines to meet those goals. Working and being a student in a very busy environment, it was important for me to acknowledge the work of my mentor and the many responsibilities that my mentor has in relation to not only teaching but also clinical practice, research, and mentoring other students. I became aware of my mentor's family responsibilities and life outside of the school. By acknowledging these various responsibilities of my mentor I worked on my own time management skills to meet our mutually set deadlines and give my mentor enough time to critique my work. Meeting these deadlines gave me and my mentor time to engage in a more iterative process of discussing my future work and issues pertaining to older adults living with dementia. ***~Darina***

I am upfront about my personal and professional priorities, and how I see them fitting together. While some people might prefer to keep their personal life private, I think it is helpful for my mentor to know about any major commitments or challenges in both my personal and professional life. My mentor reciprocates by keeping me informed in the same manner regarding her life. I have found this keeps us both on the same page regarding workload and timeframe expectations, and as a result we have realistic expectations regarding when the other can meet, review manuscripts, etc. ***~Megan***

Have you had conflicts with your mentor and how did you resolve them?
Almost all of the conflicts with my mentor occurred in the beginning of our relationship as we were not successful at setting short- and long-term goals. In addition, coming into the doctoral program I had my own idea of what I wanted to study, but did not realize that science occurs in teams and that my ideas would eventually evolve. These growing pains involved my mentor as we learned how to work with each other. By listening and by openly discussing my research interests with my mentor we worked through some of the difficulties and were able to successfully submit several grant and fellowship applications. Once we figured out how we work together, it became easier for us to understand each other's work habits and personalities. I learned to rely on my mentor's constructive feedback and know that my mentor has my best interest in mind. Just like a parent, my mentor is able to view me as a whole person and guide me in the ways that I am not able to see myself. This is the most valuable lesson that I learned in resolving conflicts working with my mentor. ***~Darina***

The PhD program can be overwhelming at times. If my mentor says, does, or asks for something that frustrates, upsets, or overwhelms me, I might take a day, or several days, before responding or talking with her about it. Sometimes my first reaction is wrong, or is actually related to ancillary stressors in my life, so if I take time to consider her point of view or intention, my frustration may dissipate on its' own. If I feel overwhelmed by a request or a stated expectation, sometimes taking a few days to consider the request allows me to formulate a plan that works for both of us. When it is necessary to discuss conflicts with my mentor, I do my best to remain professional and respectful but am very candid about my feelings, and she does the same. We have a very close relationship and I want to maintain that, which I think requires trust and a willingness to be vulnerable from both parties. ***~Megan***

How can a doctoral student facilitate your ability to mentor successfully?
I believe there is a joint responsibility of the faculty member and the doctoral student to be open and honest about their work patterns, communication styles, and their abilities to meet deadlines. This way they can develop a strong collaborative working arrangement with clear expectations on both sides. I have done this just through conversation and through our Geroscholars program, where we offered Myers-Briggs testing which was revealing for the students and faculty. It is very important for me that the doctoral student is a motivated and self-directed learner who needs guidance that matches my area of expertise. It is important to have a strong research match, but if this is not a clear a match it will be important for the student and the faculty member to have a clear understanding of what the faculty will be able to offer. ***~Dr. Pamela Cacchione***

Trust me. The thing that seems to get in the way sometimes is a lack of trust. I understand it intellectually, but I struggle to get past it because trust is built over time. But if one waits to feel trust then much of the time together is lost. I wish that I could sprinkle 'fairy trust dust' that would stay in place until the relationship matures. Talk to me. It's common to see a student who feels that they are so unimportant (they're not) that they don't talk to their mentor about what's happening and how they feel about what's happening. But, talking about events and feelings facilitates the bond between the mentor and mentee. ***~Dr. Barbara Riegel***

What is the most important thing a mentee can do to ensure a mutually beneficial mentorship relationship?

Mentees must keep the lines of communication open and accept feedback gracefully. Mentees must be respectful of their mentor's expertise and time. It is also important for a mentee to be respected as well, so: keeping the lines of communication open and providing feedback to the mentor when something is working well and when it is not working well. I think it is also very important to be able to celebrate successes together as well as mourn the projects that haven't gone as well and move on to be productive. Always say thank-you! It goes a long way! ***~Dr. Pamela Cacchione***

Communication is essential. I need to trust that my student mentee will tell me what's going on, engage me in decisions, and ask for advice. I have seen problems occur when a student goes off alone and then comes back with a final decision. I find myself thinking 'How did you get there?' 'Why?' I may say OK to the decision, but I feel left out, not trusted, and unimportant in the relationship. Making your mentor feel unimportant is a sure way to get little mentoring from that person. ***~Dr. Barbara Riegel***

How do you expect the mentorship relationship to change over time?

Our goal is to facilitate our mentees' progress toward being independent researchers and to have the skill set to begin developing their own program of research. As a mentor I expect that my mentees will begin reaching out beyond what I have to offer and explore opportunities for their future. We encourage our mentees to do postdoctoral work outside of the University of Pennsylvania School of Nursing to expand their worldview prior to settling into their next role, whether that be a tenure-track faculty position, clinical researcher position, or industry. ***~Dr. Pamela Cacchione***

This question makes me think of my own experiences with my primary mentor; we started working together 33 years ago! Obviously, the relationship has changed a lot over the years. Based on this experience and my own relationships with a wide variety of students and colleagues, I expect the relationship between a mentor and a mentee to change immensely over time. The major change I expect is for the relationship to mature from a purely mentored (one-way) relationship to a collegial (bidirectional) relationship and hopefully to a friendship built on shared experiences. If I am mentoring well, these shared experiences will be shared successes and clear evidence of professional growth. I hope that over time my mentee will become my research collaborator, my co-author, and my partner on professional committees. But, as with all successful relationships, this kind of success requires open communication and work on the part of both people. ***~Dr. Barbara Riegel***

The key aspects of a successful mentorship relationship that were threaded throughout these responses are trust and communication. As wonderful as it would be to trust your mentor/mentee instantly, trust is something that typically develops over time. Open, frequent, and clear communication regarding professional development and responsibilities may facilitate early formation of the bonds of trust between a doctoral student and a faculty mentor (Erdem & Aytemur, 2008). Both the doctoral student and faculty member can also facilitate trust by demonstrating empathy, addressing the psychosocial aspect of mentorship that may be neglected in the academic setting (Erdem & Aytemur, 2008; Stewart & Krueger, 1996).

Another recurring theme in the responses was reciprocity. Mentorship is not a unidirectional relationship, but a two-way give-and-take (Stewart & Krueger, 1996). In the beginning, the doctoral student will take the most away from the relationship, but over time the doctoral student can do more and more to ensure the relationship is mutually beneficial. Even in the earliest stages of mentorship, a doctoral student can implement several strategies to benefit the mentor. Keeping your research aligned with your mentor's expertise, remembering that science occurs in teams, and being clear regarding priorities and deadlines are all strategies doctoral students can use to ensure a reciprocal relationship with mentors. Over time and with sustained effort, the mentorship can continue to evolve into a mutually beneficial relationship as the two parties become collaborators and co-authors.

Finally, although only briefly mentioned in the responses above, the importance of graciousness should not be understated. Mentorship is a gift. A positive mentorship experience may be the difference between a positive or negative perception of a career in academia (Erdem & Aytemur, 2008). Mentorship requires substantial commitments of time and effort. As doctoral students we should make it a priority to say thank-you and ensure our mentors know just how much we appreciate everything they do for us.

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Editorial

The magic of mentoring

Mentoring is a critical component of graduate education. Mentoring provides students with a guide into the profession, introduction to ways of learning, valuable research, publication, and other learning opportunities, and introduction into a professional network. It's easy to think of mentoring as magic. Two people come together with mutual interests and create magic – great collaborations, good science, and fulfilling educational experiences. I think back on my experiences as a mentee during graduate and post-graduate work, and also experiences as a mentor for graduate students. There is no magic in mentoring – it is hard work! That being said, there is a way to make magic.

It starts with you! What do you need from a mentor? What are the types of skills you are trying to develop? What type of support do you need? Do you want someone to affirm your choices or are you looking for someone who will challenge them? What types of opportunities are you looking for from a mentor (e.g. publication, grant writing, conference presentations, connections to a network)? What types of learning environments are best for you (e.g. structured vs. unstructured; team vs. individual)? The clearer you are about what you need, the easier it will be to find the right mentor for you. Of course, as you grow and develop, a mentor who served you well at one point in your career might not be the best for you at a later point in your career.

Next is the mentor. What are the expectations from the mentor? How involved can you be in his or her work? How available is the mentor to work with you? Some mentors work as advisors and counselors by helping you find your own path and connecting you to resources. Other mentors are much more prescriptive. I recall a colleague of mine talking about his approach to mentoring. World-renowned in his field, he is often approached by people who want to be mentored by him. He lets potential mentees talk about their interests and aspirations, but at the end he always says, "Great . . . but this is what I do." The message is clear. If you want to work with him, you need to work on his research and have similar interests. His rationale is that he has limited time, and the best way to learn from him is to be imbedded in his research.

How do you find a mentor? First, familiarize yourself with a person's work. Who do you aspire to be, or what type of work do you aspire to do? This will lead you in a good direction. Of course, you will and should get recommendations from your colleagues and peers as you consider with whom you might work. Information is good – but don't let that be the limiting factor. You need to appreciate that someone might have had a good or bad experience with a particular mentor, but there is no guarantee you will have the same experience.

It is tempting to be drawn to mentors who have specific characteristics. I ask students how they choose mentors, and many say they choose mentors because they are "nice" or because they are "senior" scholars. As a note of caution, "nice" may not translate into challenging or it might not be the best substantive fit. I do redirect many potential mentees who want to work with me if there is no substantive base for the relationship. Of course, I avail myself for advice or future contact, but finding a good mentor should lead you to a person who shares your passion for the science. In other cases, students have indicated they want to work with senior faculty because of their established expertise and networks. While this makes logical sense, there are eager and willing junior faculty who are anxious to have mentees and colleagues with whom they can work. It is important that you not limit your options at the onset and that you are open to all possibilities.

It's important to note that it is usually impossible to find one person who has all the qualifications, abilities, and time that you may need. It is more the norm that you will have multiple mentors. I have research mentors, leadership mentors, career mentors, and a cadre of people I consider mentors who I know care about me professionally and personally – whom I can call on, who will listen, provide honest feedback, and help me figure out a particular issue.

Once you have your mentor in place, now comes the work that creates magic: the relationship. It is important to understand that mentoring is a two-way street. The most successful relationships are ones that can balance the "give" and the "take." You need to be clear as to what you bring into the relationship – and what you are willing to do to build, maintain, and grow the relationship. At a minimum it starts with being respectful of your mentor's time. Developing an agenda ahead of any meeting, providing your mentor with time (that they determine they need) to review your work, and understanding how best to communicate with each other and the frequency of communication are important groundwork that at minimum should occur. When mentees provide me with information in advance of our meeting such as an agenda or a draft of a paper, it is not only a message that they value my time, but it makes our meeting time more productive. This mutual understanding can take the form of an informal understanding or it could be a more formal written contract. Regardless of the format, revisiting how things are working for you both is important for the work and the relationship.

Another important aspect of the relationship is being willing to listen to each other. I have a running joke with a colleague who tells everyone I am her mentor. I counter with, "But she never does anything I tell her!" The point here is that while a mentee may seek advice and counsel, the advice is but one factor in decision making. If you are asking a mentor for advice, you are obliged to listen. Your mentor will respect and support whatever decision you make – even if they don't agree with your choice. In addition to what you need from the relationship, you might be asked to help your mentor with some of his or her scholarly work. Sometimes the work you are asked to do may or may not be related to your area of interest. For example, I will often ask my mentees to read an article I am preparing for publication or even a grant application – even if they are not authors or involved in the research. I do this because my work is strengthened by careful critique by others; as for my mentees, I believe there is always something you can learn from reading and critiquing the work of others. Importantly, when you assist your mentor with his or her work, you are helping your mentor help you – by giving him or her some extra time and helping to reduce his or her stress. Of course, there is always the need to maintain a balance in terms of what you put in and get out of a mentoring relationship, but a willingness to help your mentor goes a long way.

In summary, mentoring is a critical component of graduate education and professional development. Mentoring is a relationship that requires a good initial match and a commitment to growing, maintaining, and, in some cases, ending the relationship in a professional manner. While this critical relationship takes effort, if done well the results for both mentor and mentee can certainly create magic!

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Faculty mentoring — Is it needed?

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Abstract

Faculty mentoring is a needed component in nursing education as nursing schools struggle to recruit and retain qualified nursing faculty. This paper will discuss faculty mentoring in nursing education and its importance in retaining nursing faculty.

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I would like to thank Judith Hupcey, EdD, RN, FAAN, Associate Dean for Graduate Education and Professor of Nursing in The College of Nursing at The Pennsylvania State University and Suzanne Morgan, Administrative Support Assistant at Penn State Worthington Scranton, for their help proofreading and editing this manuscript.

Faculty Mentoring — Is it Needed?

In today's world, nursing is faced with the challenge of not only addressing the nursing shortage but also the nursing faculty shortage. Without immediate attention to the latter, the nursing shortage will continue to intensify. The shortage of nursing faculty is an ever-increasing problem in the United States. According to a survey conducted by Fang and Li (2012-2013) for the American Association of Colleges of Nursing (AACN), there were over 1000 faculty vacancies in over 600 schools with baccalaureate and/or graduate programs in the United States. Beside these vacancies, the schools cited the need to create approximately 100 faculty positions to accommodate student demand (American Association of Colleges of Nursing, 2014). Approximately 75,000 qualified applicants from baccalaureate and graduate programs were turned away due to the lack of nursing faculty, among other reasons, causing the overall nursing shortage to intensify (AACN, 2014).

There are several factors contributing to the nursing faculty shortage. Many of these factors influence the recruitment of new faculty; such as insufficient funds to hire new faculty, workload demands, and job competition with higher paying marketplaces (Fang & Li, 2012-2013). The faculty shortage also puts an increased demand on current nursing faculty, which may lead to burnout and job dissatisfaction and eventually resignations (Garbee & Killacky, 2008). Therefore, with the nursing faculty shortage reaching critical levels, it is vital that nursing education enhance not only its recruiting efforts but also its retention efforts through activities such as faculty mentoring.

Why Do We Need Faculty Mentoring?

Faculty mentoring is a much-needed resource for new nursing faculty. Nursing faculty often enter academe after many years of "bedside" nursing and this is often a stressful transition. Nursing faculty members are expected to prepare graduates to enter an increasingly complex profession while also providing service, conducting research, maintaining clinical skills, and enhancing their teaching (National League for Nursing [NLN], 2006). A qualitative study by Schriner (2007) looked at the transition of clinical nurses into the faculty role and identified the following themes: stressors and facilitators of transition, deficient role preparation, changing student culture, realities of clinical teaching and practice, hierarchy and reward, and cultural expectations versus cultural reality. For example, faculty were stressed about teaching new students in unfamiliar clinical settings and being responsible for 8 to 10 students rather than just themselves. In addition, faculty often felt that their graduate preparation did not adequately prepare them for a career in academe. The results of this study further demonstrate the need for a structured faculty-mentoring program, where new faculty have the opportunity to observe effective teaching (Schriner, 2007).

Faculty mentoring is critical because very few nursing faculty have any formal preparation for the nurse educator role (NLN, 2006). Unlike other professions, nursing faculty are expected to perform at a high level from day one (Hostetler, Prichard, & Sawyer, 2004). Nursing students expect and deserve faculty who are prepared and capable of delivering high quality content from their very first class. As stated by Hostetler et al. (2004, p. 142), "Professors, too (like physicians and lawyers), must be able to practice immediately and in all legitimate areas of the domain. Few excuses are acceptable." Unfortunately, the mentoring of new faculty is not as commonplace as the mentoring of new nurses in clinical practice (NLN, 2006). A structured faculty-mentoring program could help new nurse faculty adjust to the formal role of nursing educator. Mentors could allow new educators to shadow them in the classroom, provide them with resources to develop their lesson plans, and answer questions as they arise. Furthermore, a faculty-mentoring program would enable new nursing faculty to adjust to balancing the multifaceted demands of academia, including teaching, service, scholarship and quite often, clinical practice. Often new faculty feel overwhelmed during their first few months on the job and wonder if they made the right decision in becoming a faculty member as they juggle personal and professional concerns (Hostetler et al., 2004). If involved in a structured faculty-mentoring program, new nursing faculty members would be able to receive guidance regarding many of these struggles and make informed decisions on how to best manage the demands of academia. According to Billings and Kowalski (2008), new nursing faculty involved in mentoring programs experience less isolation, easier role transition, faster promotion, higher salaries, and higher satisfaction levels. This could help alleviate the current nurse faculty shortage by increasing faculty retention.

Finally, a structured nurse faculty-mentoring program could prove to be beneficial not only to the mentee but to the school of nursing. A mentoring program could benefit the school of nursing by allowing for more productive faculty members who will integrate into the school of nursing more easily, increasing effectiveness, retention, and productivity (Billings & Kowalski, 2008). With the current nurse faculty shortage reaching critical levels, it is vital that schools of nursing develop and utilize structured mentoring programs to enhance the recruitment and retention of qualified nurse faculty.

Conclusion

In conclusion, nursing leaders must develop and implement strategies to recruit and retain qualified nursing faculty. One way to retain faculty is through a structured faculty-mentoring program. This would allow new faculty "to get their feet wet" in the often unfamiliar world of academia while having a "shoulder" to lean on. New nursing faculty would become better acquainted with their responsibilities of teaching, service, and scholarship, while adjusting faster to the culture of the department and school through the guidance and coaching of a mentor. Faculty mentoring is a necessary resource for new nursing faculty. It is a vital component in ensuring a successful transition from "bedside nursing" to academia and should be a part of every school's orientation process. Mentoring will not end the nursing faculty shortage. However, it certainly can help remedy the problem of large numbers of nursing faculty leaving academia for other careers, by improving retention and helping to decrease the overall nursing and nursing faculty shortages.

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Relationship power and partner condom use among HIV-positive Haitian women

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Abstract

HIV continues to be a life-altering illness affecting the physical, emotional and psychosocial well-being of millions of people around the world. Haiti has one of the highest incidence rates of HIV/AIDS in the world. Haitian women, especially, are infected in proportionally high numbers. Condoms can be a safe and effective way to prevent HIV transmission through vaginal intercourse; however, in Haiti women have been seen as having less power in an intimate heterosexual relationship which can prevent them from negotiating safe sex practices with their partners. To further examine this phenomenon, it is imperative to understand Haiti's social and political history which has affected the nationwide response to the HIV virus. A theoretical framework, the Theory of Gender and Power, has helped explain power imbalances in an intimate relationship. By understanding the external risks that increase the likelihood of partners participating in unsafe sex, nurses can be prepared with the knowledge necessary to help increase condom use among HIV-positive partners.

Introduction

Aside from sub-Saharan Africa, the Caribbean is the region most affected by the HIV epidemic (UNAIDS, 2012a). The human immunodeficiency virus (HIV) weakens the body's immune system and as it progresses, transforms into autoimmune deficiency syndrome (AIDS), which can lead to many negative health outcomes including death (U.S. Department of Health and Human Services [HHS], 2012). Those infected with HIV/AIDS are more likely to suffer from opportunistic infections, including tuberculosis, due to their lowered immune system. HIV can be transmitted through the blood, semen, genital fluids, or breast milk of an infected person. Two of the most common ways HIV is transmitted are through unprotected sex and intravenous drug use. Although there are treatments such as antiretroviral therapy, there is no cure or reversal of HIV/AIDS (HHS, 2012). Besides abstinence, one of the most effective ways to reduce the transmission of HIV through sexual intercourse is by the consistent use of condoms (UNAIDS, 2012b). The Centers for Disease Control (CDC) emphasizes that HIV infections are more likely to occur when condoms are used incorrectly and inconsistently, rather than through product failure (CDC, 2012).

Within the Caribbean nations Haiti had approximately 120,000 people living with HIV/AIDS in 2011 (UNAIDS, 2012a). Over half of the infected population in Haiti are women ages 15 years and older (UNAIDS, 2012a). Since 1985, the number of new cases in Haiti has been increasing due to transmission by heterosexual intercourse (Koenig et al., 2008). With this increase, the ratio of infected Haitian women to men has been increasing as well. Women are often seen as very vulnerable to HIV and other sexually transmitted infections (STI) due to gender and power inequality in Haiti (Koenig, et al., 2008). The number of women infected has also lead to the spread of HIV from mother to child (Koenig et al., 2008).

Statement of the Problem

The high proportion of HIV- positive Haitian women challenges us to examine possible factors responsible for this incidence rate. Condoms, if used correctly, are one method by which HIV transmission can be reduced. If a woman is involved with a sexual partner who chooses not to wear a condom, her chances of contracting and spreading the virus greatly increase (CDC, 2012). Nurses, as the main communication link between the other health care providers and patient, play a vital role in addressing the high incidence of HIV transmission. HIV prevention is a nursing issue as nursing encompasses all aspects of care, including prevention. Nurses can and should provide education to HIV- positive men and women about ways of preventing the spread of the virus. Understanding the external risks that increase the likelihood of partners participating in unsafe sex can prepare nurses with the knowledge necessary to help increase condom use among HIV-positive partners.

Haiti's History and the Rise of HIV

Haiti has a long history of social conflict, governmental instability, and poor economic development which has caused problems in creating a self-sustaining country (Katel, 2005). Social structures and HIV prevention efforts are closely linked in Haiti. Since gaining its independence from France in 1805, Haiti has struggled to develop a proper and effective government for its people (Katel, 2005). The Duvalier family, which ruled from 1957 to 1986, supported the interests of the upper class as well as foreign interests, which strengthened inequalities among rich and poor (Griffen, 1992). During this regime, HIV was first discovered and Haitians were officially described by the United States government as a main cause of the spread of the virus to the United States (Walton et al., 2004). This caused almost all tourism to Haiti to cease and the economy was never able to recover (Walton et al., 2004).

In terms of HIV, the Ministry of Health in Haiti (MoH) has often looked to private organizations to set up prevention programs (Walton et al., 2004). National programs were uncommon, especially during Duvalier's dictatorial rule. In 1987 the AIDS Coordination Bureau was developed, but this bureau was not very effective due to Haiti's unstable government at that time. Non-governmental organizations (NGOs) such as Partners in Health instead took the lead in addressing the HIV epidemic and became advocates for better HIV/AIDS care in Haiti (Walton et al., 2004).

After the Duvalier family was deposed, the next few governmental elections quickly succumbed to military regimes and Haiti did not conduct its first democratic election until 1990 when Jean-Bertrand Aristide was elected. He was ousted from leadership in 1991. Subsequently, in 2000, Aristide was elected again and he aimed at decreasing the gap between lower and upper class as well as advocating for better HIV/AIDS programs (Robinson, 2008). In 2001, Aristide developed the HIV/AIDS Strategic Plan and, with the help of international funding, Haiti saw an increase in condom sales (Walton et al., 2004). Within ten years of the implementation of the HIV/AIDS Strategic Plan the number of HIV infections decreased by almost half (Walton et al., 2004). Although Haiti began to make strides, Aristide's effort to equalize the class system met with much resistance from the upper class as well as countries like the United States, which cut off all aid to Haiti in the early 2000's (2000-2004) (Robinson, 2008). This resistance eventually led to Aristide's overthrow in February 2004 (Robinson, 2008). Considering the governmental instability, the HIV prevention and treatment strategies during that time have been seen as remarkable (Walton et al., 2004).

Haiti still has one of the highest rates of HIV infection (UNAIDS, 2011). After an earthquake measuring 7.0 on the Richter magnitude scale hit Port-au-Prince, the capital of Haiti, on January 12, 2010, many national health buildings were destroyed (UNAIDS, 2011). In order to continue the vigorous fight against HIV/AIDS, it is imperative that this infrastructure be rebuilt, for without this human resource entity, decreasing HIV-positive incidence may prove difficult to achieve (UNAIDS, 2011). Since that time, while infrastructural needs still remain, Haiti has begun to lose the presence of some of the NGOs that were first stationed after the quake and has also lost international funding (WHO, 2008). With over one million people displaced due to the earthquake, many people have been forced to relocate into rural areas that have inadequate infrastructure to tend to the needs of those who are HIV- positive (UNAIDS, 2011). This has caused a push for better prevention programs focused towards those living in refugee camps or hard-to-reach areas (UNAIDS, 2011). As previously mentioned, over half of the people infected with HIV/AIDS in Haiti are women (HHS, 2012). Currently, HIV is the leading cause of death among Haitian women of reproductive age with an estimated 1.2 million females newly infected in 2011 (HHS, 2012). Given that inconsistent condom use increases the likelihood of infection, the inability to negotiate safe sex with a partner may play a part in the high rate of women infected (Pulerwitz, Gortmaker, & DeJong, 2000). Feeling powerless or unable to communicate with a partner may also contribute to the gender imbalance in terms of negotiating safer sex.

Conceptual Framework

The conceptual framework chosen for this paper was the Theory of Gender and Power (TGP). This theory was chosen in order to help understand relationship dynamics among men and women. The TGP is a theoretical framework that examines the external sources in society and institutions that cause an imbalance of power in heterosexual relationships (Connell, 1987). R.W. Connell developed the TGP to understand how relationship power affects sexual behaviors and sexual risks (Connell, 1987). This structural framework focuses on three interdependent concepts: sexual division of labor (economic inequality), sexual division of power (male partner control in relationships), and the structure of cathexis (social norms related to gender roles) (Connell, 1987). The theory states that gender-based inequalities are social characteristics that lead to males having a disproportional amount of power and control over decision making, including sexual relationships (Pulerwitz et al., 2000). The structures exist at two levels: societal and institutional (Connell, 1987). On the societal level, these concepts are spread throughout historical and sociopolitical forces that continue to separate power between men and women as well as determine social norms based on societal gender roles (Connell, 1987). As society changes, these structures remain intact (Connell, 1987). At the institutional level these structures can be found in, but are not limited to, schools, work, healthcare systems, media, families, and relationships (Wingood & DiClemente, 2000). These structures remain intact in institutions through actions such as unequal pay, discrimination at the workplace, and stereotyping (Wingood & DiClemente, 2000).

Condom Use

In the general population, gender-based differences evolve from exposures and risks that may affect women's health (Wingood & DiClemente, 2000). These exposures and risks, whether physical or social, can greatly increase women's vulnerability to HIV (Wingood & DiClemente, 2000). This is crucial for understanding the impact of power in a sexual relationship on condom use. In relationships with unequal power, women tend to depend on their partner for their financial needs (Wingood & DiClemente, 2000). Some physical exposures that affect these women: a partner who disapproves of practicing safer sex or one who does not use condoms consistently (Wingood & DiClemente, 2000). A man's physical power and social power over a woman can greatly affect safer sex negotiations (Wingood & DiClemente, 2000). In a cross-sectional study, Wingood and DiClemente (1998) reported that young African American women were less likely to use condoms if they had a partner who resisted condoms, if they were not sexually assertive or if they believed that condom negotiating would imply accusations of infidelity. The social power that a man had in making sexual decisions greatly impacted condom use (Wingood & DiClemente, 1998).

Although there is literature regarding these variables with other vulnerable populations in the United States and abroad, there is a lack of research in Haitian populations. Due to this gap, this discussion will focus on Haiti as well as similar vulnerable populations. Young African American women are one of the most susceptible populations in the United States to become infected with HIV (Bralock & Koniak-Griffin, 2007; Raiford, Wingood, & DiClemente, 2007). Young women are much more likely to contract HIV compared to males. With 70% of the poor in the world being women, they have less economic choice and are more likely to become dependent on their male partner (Bralock &Koniak-Griffin, 2007). In stereotypical situations, women often report they would have difficulty implementing condom use when in a low-power situation (Woolf & Maisto, 2008).

In samples of young African American women where consistent condom use was low, a reported one-fourth of sexual episodes in the previous three months were protected with a condom (Bralock & Koniak-Griffin, 2006). Many young African American women are in relationships with older males which are seen to decrease the chance of using condoms (Bralock & Koniak-Griffin, 2006).

In some African American populations where the young women express higher relationship power, they tend to have higher self-efficacy in influencing condom use with their partner (Bralock & Koniak-Griffin, 2006). A woman with high self-efficacy may also refuse sexual intercourse if her partner will not wear a condom (Raiford et al., 2007). Consistent condom use among older African American women can vary with HIV-status. It becomes extremely important to identify factors affecting condom use among women already HIV-positive in hopes of reducing the spread. Among HIV-positive African American women, consistent condom use decreases when a male partner is also HIV-positive (Raiford et al., 2007). However, women who perceive themselves as having high partner communication and self-efficacy are more likely to use condoms regardless of HIV-status (Raiford et al., 2007).

Multiple aspects of the TGP, such as communication and partner violence, influence condom use (DePadilla, Windle, Wingood, Cooper, & DiClemente, 2011). Partner communication, understood through Sexual Division of Power, is a strong predictor of condom use (DePadilla et al., 2011). Physical violence in a relationship can lead to negative personal affect which is an indirect predictor of condom use as well (DePadilla et al., 2011). Partner abuse can be expressed as three different forms: physical, verbal, and threatening abuse (Teitelman, Tennille, Bohinski, Jemmott, & Jemmott, 2011). Fear is often a reason for not negotiating condom use in physically/sexually abusive relationships. Males may also use emotional manipulation to forgo condom use. By promising relationship commitment, males can get their female partners to not demand the use of a condom. Accusing the female partner of being unfaithful when she demands condom use is another form of verbal and emotional abuse used by males to impede condom use (Teitelman et al., 2011). These actions by males can lead the young female to be silenced in her negotiation and leave the female feeling powerless over her sexual health (Teitelman et al., 2011).

Asian Americans, another cultural minority group in the United States, also have associations with gender power and HIV risk (Hahm, Lee, Rough, & Strathdee, 2012). In a culture that emphasizes distinct gender roles such as women being the home caretakers without compensation, the Theory of Gender and Power can be easily applied (Hahm et al., 2012). Forced sex, but not consensual vaginal sex practices, has been associated with Asian American women who have less power in a relationship. This may be explained by an Asian American woman's desire to forgo a condom to increase intimacy with partner (Hahm et al., 2012). Similar to Asian Americans, Vietnamese women follow traditional gender roles within a relationship (Bui et al., 2010). Vietnamese women are often economically dependent on their partner as well as expected to uphold a submissive societal role (Bui et al., 2010). This lessens the woman's power to negotiate with her partner. Although few quantitative studies have focused on relationship power and safe sex negotiations among this population, research has found that the more a Vietnamese woman follows traditional gender roles, the less confident she feels in communicating about sex (Bui et al., 2010). Non-communication about sexual practices can greatly increase a woman's sexual health risks.

External impacts on condom use have been studied in other regions of the world, including Sub-Saharan Africa and South Africa. Because Sub-Saharan Africa is the area most affected by HIV, research on HIV reduction and prevention is crucial, however empirical knowledge is limited (Sa & Larsen, 2007). As explained through the TGP, gender inequality is an important determinant of a woman's vulnerability to HIV (Connell, 1987). In Tanzanian society, gender inequality is seen as commonplace (Sa & Larsen, 2007). Male sexual aggression and a woman's passiveness are considered normal in the society (Sa & Larsen, 2007). From inequality comes economic deprivation, which, along with sexual violence, can increase women's vulnerability to HIV (Sa & Larsen, 2007). Among those living with HIV, disclosing one's status to a sexual partner can be an important aspect of preventing transmission of HIV to one's partner. Research has been limited to studies focusing solely on female heterosexual relationships and HIV disclosure. However, Przybyla et al. (2012) found that heterosexual women were 85% more likely to disclose their HIV status than men who have sex with men. This study also found that disclosing HIV status was more likely among those who had primary sexual partners rather than casual sexual partners (Przybyla et al, 2012). Similarly, Vu et al. (2012), in a sample of HIV-infected men and women in South Africa, found that HIV-positive persons with a steady sexual partner and a partner with a known HIV status were more likely to disclose status to a partner than if they had a casual sexual partner. Disclosing status to one's sexual partner has been found to be associated with condom use (Dave, Stephenson, Mercey, Panahmand, & Jungmann, 2006). That same study also found that those who know their partner's status are more likely to use condoms (Dave et al., 2006). These findings emphasize the role of healthy communication in relationships into reducing risks of HIV transmission.

Haitian women, especially HIV-positive Haitians, have been under-researched. Relationship power, gender inequality, and condom use are slowly starting to advance as a main area of study; however, few studies specifically test those variables. Kershaw et al. (2006) was the first to examine the association between relationship power and condom use among women in Haiti, specifically looking at pregnant women with negative or unknown HIV-status. With Haiti having one of the fastest growing HIV infection rates in the world, it is imperative to understand ways to slow this rate. With already low levels of reported condom use (20%), Kershaw et al. (2006) found risk factors from Sexual Division of Power to be the most related to condom use with 18% variance. Haitian women who had more decision-making power in their relationship, measured by the Sexual Relationship Power Scale (SRPS), reported more intentions to use condoms with their partner (Kershaw et al., 2006). When women feel that they do not have power they may not feel that they can talk to their partner about their sexual health, and thus it decreases the chance of introducing condoms in the relationship (Kershaw et al., 2006).

Relationship Power

The TGP has also provided the structure to develop scales to measure relationship power such as the Sexual Relationship Power Scale (Pulerwitz et al., 2000). Previously, few validated scales focused on relationship power (Pulerwitz et al., 2000). The TGP and the Social Exchange Theory helped aim the development of this scale, which is divided into two subscales of relationship power: Relationship Control and Decision-Making Dominance (Pulerwitz et al, 2000). The Sexual Relationship Power Scale (SRPS) was designed to examine power in intimate relationships and incorporates events common among dating and married couples with help from the theoretical framework (Pulerwitz et al., 2000). This scale was first tested among Latin American and African American women and the final scale consisted of 23 items with an internal reliability and consistency of 0.84 for both English and Spanish versions (Pulerwitz et al., 2000). This scale has now become a common, useful measure in gender power relationships and HIV transmission and condom use.

Poverty differences stemming from gender inequality are seen throughout South Africa (Shisana, Rice, Zungu, & Zuma, 2010). Poverty that affects women disproportionally can account for HIV risks (Shisana et al., 2010). In situations where females are heads of households, women are significantly more likely to become infected with HIV when compared to their male counterparts (Shisana et al., 2010). Although there is an awareness of HIV, condom use in South Africa is suboptimal (Shai, Jewkes, Levin, Devin, & Nduna, 2010). South African women who report condom use are three times more likely to know their HIV status than those who do not report condom use (Shai et al., 2010). Self-efficacy is an important factor in general condom use, and South African women who report less association with trust are more likely to report condom use (Shai et al., 2010). One longitudinal study in South Africa reported that women who admitted to intimate partner violence (IPV) as well as higher gender inequity had higher incidence of HIV infection (Jewkes, Dunkle, Nduna, & Shai, 2010). This longitudinal study provides strong temporal evidence in support of a causal association between gender inequity or IPV and HIV infection (Jewkes et al., 2010).

Conclusion

Although limited, the research discussed above found similar results with respect to gender, power, HIV risks, and condom use. The impact of gender inequality on HIV risk and condom use can be seen across the world. However, there is an extreme lack of research regarding Haitian women and this topic. The Theory of Gender and Power (Connell, 1987) has been a framework for examining relationship power and condom use among a global population and further research should continue to adapt this framework to Haitian women. This framework can be used to continue to identify factors in Haiti such as poverty and gender norms which can increase the level of gender inequality between men and women. As previously discussed, gender inequity can impact HIV risks, and thus research on the associations between gender inequality and condom use among women in Haiti would provide necessary information to reduce incidence rates of HIV. Considering the incidence of HIV in Haiti, much more on HIV and external factors on the growing rate in this country should be undertaken. By continuing to analyze the role of relationship power, condom use, and HIV, nurses can better serve these populations. Nursing education surrounding HIV prevention in vulnerable populations should be included in nursing curriculum. The implementation of screening tools to help identify at-risk groups, specifically those with low power in an intimate relationship, should be widespread throughout primary care and hospital settings. Nurses are at the front line of patient care and should be able to identify and care for these vulnerable populations in order to prevent further negative health outcomes.

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We can do better: An argument for improved care of the opioid addicted mother-infant dyad

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Abstract

As the number of addicted maternal-infant dyads increases, so does the need for nursing to expand its understanding of the addiction process and the evidence-based interventions that best serve mothers and infants. Nursing attitudes toward the opioid-addicted mother and infant dyad are influenced by knowledge deficits and communication difficulties. Care required encompasses medical, legal, social, and economic perspectives. Professionals and society at large have disagreements regarding whether to approach the phenomenon from a punitive or supportive strategy. Facilities to care for the mother-infant dyad with addiction are limited. Increasing knowledge has great potential for active understanding and ability to impact these vulnerable patients. Policies must be carefully considered and nuanced. Opportunities for research are myriad. Nurses are well positioned to intervene and create positive outcomes for mother-infant dyads experiencing opioid addiction.

Introduction

Drug use in the United States (US), including among pregnant women, is rising: 4.4% of pregnant women use illicit drugs, with a much higher rate in women aged 15 to 25 years. Approximately 180,000 infants annually are born with neonatal abstinence syndrome (NAS) (Caitlin, 2012), which can directly affect infant development. Many of these infants require prolonged hospitalizations, and multifaceted inter-professional skills are required to guide them and their mothers through the period of withdrawal.

The American Congress of Obstetricians and Gynecologists (ACOG) states that there are multifactorial reasons for drug use, which is a biologic and behavioral problem with genetic components (ACOG, 2014). Substance abuse affects more people who are living in poverty, who have experienced abuse or trauma, and who are unemployed or have mental illness. This means that a large percentage of women who deliver opiate-exposed infants are uninsured or on Medicaid. By one estimate Medicaid will pay one trillion dollars for substance abuse over the next twenty years (Coleman & Miller, 2006). This translates into problems for families, healthcare systems, legal systems, and society.

Caring for patients with NAS requires empathy, knowledge, and curiosity. It demands experience and stamina, which can be corrupted and exhausted. Research indicates that nurses feel unprepared to care for these families (Fraser, Barnes, Biggs, & Kain, 2007; Maguire, Webb, Passmore, & Cline, 2012). Due to increased numbers of opiate-exposed mother-infant dyads, the stress and challenge of caring for vulnerable families is only increasing. The nurse, mother, and infant are in a continual feedback loop with the actions of each affecting the reactions of the other (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014). Nursing needs to expand its knowledge and understanding of the addiction process and the evidence-based interventions that best serve mothers and infants.

Background

Hill (2013) defines addiction as a "chronic, relapsing disease that is characterized by compulsive drug seeking and use, despite harmful consequences" (p. 183). Addiction is a disease of both brain and behavior, and science has yet to understand the various reasons why people use drugs or how drugs affect the brain to compel addiction (Hill, 2013). This lack of understanding creates a chasm into which fall many well-intentioned ideas that have no basis in fact.

Nurses may be conflicted by the need to advocate for these vulnerable, sick infants whose issues stem directly from maternal actions. They are frequently not trained in addiction behaviors and the experiences of those with addiction (Fraser et al., 2007; Maguire et al., 2012). This may impede the nurse-mother relationship and in turn accentuate negative feelings held by the mother. Hill (2013) notes that lack of a trusting relationship can mean a mother is four times less likely to receive adequate preventive and ongoing health care. This may include how to bond with her infant. If a nurse can impart "competence and confidence" in the mother by focusing on what she can do for her infant, she may give the mother the needed boost to care for herself and seek or stay in treatment (Hill, 2013).

Without the ability to understand and empathize with the opioid-addicted mother, nurses may find themselves frustrated and unintentionally contributing to the failure of successful maternal-infant bonding (Fraser et al., 2007). The nurse who lacks an understanding of what the mother experiences may reinforce negative behavior such as non-visitation on the part of the mother (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014). Attitudes of the nurse toward the mother, and the ability or inability of the nurse to communicate with the mother, impact care of the mother and infant (Cleveland & Bonugli, 2014). Additionally, a paucity of maternal education by the nurse on the topic of infant cues and signs of withdrawal exhibited by the infant may perpetuate maternal actions that exacerbate infant distress (Velez & Jansson, 2008).

Current Trends

There is a growing movement nationally to enact punitive approaches to the opioid-addicted mother. This may be driven not by evidence but by a perceived need to intervene in the abuse cycle. Nurses are increasingly raising their voices against the mother, advocating for foster care (Bauer & Diedrik, 2014) or legal ramifications for the mother (B. Hall-Long, personal communication, July 21, 2014). These ideas seem born of frustration rather than evidence. Evidence suggests that mothers and infants kept together have improved outcomes (Isemann, Meinzen-Derr, & Akinbi, 2011; Saiki, Lee, Hannam, & Greenough, 2010). Studies have also pointed out that mandatory reporting systems create fear of incarceration and fear of removal of the infant from parental care, or require entry into the social service system. Nurses who advocate for foster care or legal ramifications may not be aware of the lack of evidence to support this position and that they are in conflict with many nursing organizations (ANA, 2011; AWHONN, 2015).

Legal Perspective

Mandatory reporting of opiate-exposed infants can be used as a proxy for local prevalence of maternal opioid use. It may lead to interventions by law enforcement or social services. Legislative action toward maternal opiate use is variable between states, and is creating disparities in care and intervention (Guttmacher Institute, 2015; Young et al., 2009). Some state policies regarding testing and reporting of mothers and infants with opiate exposure are more punitive, focusing primarily on the safety of the child, whereas others are more preventative and consider the health and well-being of the pregnant woman and her newborn. Testing and reporting policies can vary even within states (National Abandoned Infants Assistance Resource Center, 2012). Mandatory reporting, therefore, exposes women and infants to very disparate outcomes, depending on where they live and how local and state laws are interpreted and enforced.

A recent report from the Guttmacher Institute (2015) gives a national perspective of state laws. Eighteen states consider substance use in pregnancy child abuse and three consider it grounds for civil commitment. Fifteen states require healthcare workers to report suspected abuse to the state, and four mandate testing of pregnant women (Guttmacher Institute, 2015). A myriad of other laws exist in counties and municipalities, and definitions of suspected substance abuse, as well as who is mandated to report and when, are not consistent or clear. The potential negative effects that may occur as a result of the legal actions taken against prenatal drug abusers are many. These negative effects may include, but are not limited to, avoidance of prenatal care, constitutional infringements, discrimination, poor prison conditions, and ineffectiveness of punitive measures (Coleman & Miller, 2006).

The punitive approach is aimed at cost reduction and social well-being. Nationally, costs of all infant drug exposure total between $71 million and $113 million per year, but in particular treatment for opiate exposure is extremely costly (National Abandoned Infants Assistance Resource Center, 2012). However, legal action has many negative unintended consequences. ACOG (2014) states, "policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus" and that "seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing." ACOG also points out that it cannot be assumed that a pregnant woman who does not receive treatment does not want it, as availability of substance abuse treatment for pregnant women is limited (ACOG, 2014; Guttmacher Institute, 2015).

Professional Response

Many health professional organizations instruct their members that their duty is to a woman and her baby rather than to law enforcement. This may place healthcare workers at odds with state and local ordinances. The American Nurses Association (ANA) states that the threat of prosecution undermines nurse efforts to assist women seeking care and that nurses should align themselves with social services rather than law enforcement to help women and infants (ANA, 2011). The National Perinatal Association opposes criminal prosecution of women who abuse substances while pregnant, as there is no evidence that this helps the mother or infant (Advocates for Pregnant Women, 2011; National Perinatal Association, 2013). The American Society of Addiction Medicine (ASAM) supports treatment rather than criminalization as incarceration may hurt the health of the mother and fetus, and may not address efforts toward long-term recovery (ASAM, 2011). Most recently in January of 2015 the Association of Womens' Health, Obstetric, and Neonatal Nurses (AWHONN) released a position statement that, while endorsing a nurses' responsibility to follow the law, opposes incarceration or punitive legal action against women due to substance abuse in pregnancy. Additionally they affirmed nurses' role in supporting mandatory screening in all pregnant women for the purpose of providing referrals and treatment to support healthy outcomes (AWHONN, 2015).

Working Together

Some have advocated for combined punitive and supportive approaches. The national extent of maternal opioid abuse and resulting NAS is not clear, and it is variable around the country. Programs aimed at quantifying NAS as a diagnosis, looking at trends in geographic areas and in differing populations, are needed. Young et al. (2009) concluded we may be missing an opportunity to increase the impact of policy on the issue of substance use in pregnancy, and that solutions require public and private entities to work together to address how we serve families. Additionally there is opportunity for partnerships to identify where differences exist in policy goals versus implementation of local laws (Young et al., 2009).

De-identified mandatory reporting of infants exposed to opiates can provide data to drive interventions and has the potential to reduce physical, emotional, and financial costs of the NAS epidemic to individuals and society. Programs such as this are underway in Tennessee and Florida, the results of which are eagerly awaited (ASTHO, 2014; CDC, 2015; Bondi, 2014; Tennessee, 2015). Screening and reporting should be viewed as part of a larger issue of policy and practice interventions for individuals and families. Which mechanism to use for screening, where to collect and house the data, and how the data is used are all questions that need to be addressed. This issue requires a clear definition of terms, consistent implementation, and availability of treatment interventions, which are currently sparse. According to the Guttmacher Institute (2015) only 19 states have drug treatment facilities targeted to pregnant women, and only 11 provide these women with priority access. Four states do prohibit publicly funded programs from discriminating against pregnant women (Guttmacher Institute, 2015).

Family Response

Hogan (2007) provides another distinct point of view in researching how opioid-addicted parents view themselves, and how to best intervene. This study looked at various factors affecting the parenting ability of opioid addicts. Parents perceived themselves to have difficulty being emotionally available and responsive. Additionally, they were often separated from their children by incarceration, hospitalization, or drug seeking behaviors. The implication of this study is that "support should be targeted at families as systems, rather than at drug users as individuals. It should focus on ensuring continuity, not only of instrumental caregiving, but also of emotional caregiving to children" (Hogan, 2007, p. 17). Clearly all interventions attempted will need a systematic population health focus. As stated earlier, nurses need to understand how their actions are perceived, and what nursing modalities improve infant outcomes. Nurses' attitudes and actions toward an opioid-exposed mother may interfere with the mother's self-worth and ability to care for and bond with her baby (Cleveland & Gill, 2013; Davis & Yonkers, 2012; Fraser et al., 2007). Society has much work to do, and nurses who encounter these situations daily are well positioned to intervene and create positive outcomes for mother-infant dyads experiencing opioid addiction.

Nursing Challenges

Nurses need education regarding substance abuse and different ways to nurse that can mitigate challenges and decrease stress. Problems addressed should include how nurses are trained regarding NAS, what leads mothers to abuse opiates, and the psychosocial effects of the disease on the infant and his caregivers. They also need evidence-based strategies that are shown to aid mother and infant through the crucial early withdrawal and bonding moments. Velez and Janssen (2008) give a succinct, clear message about the care of our vulnerable infants when they describe the interactions between the nurse, the mother, and the infant experiencing NAS. They describe how dysregulated infants require stable responsive caregivers and how the infants' behavior can alter caregiver behavior. These authors also note that signs displayed by the infant, and the modification of the signs with concomitant recovery, depend on the ability of the caregiver to interpret these signs and provide appropriate individualized care (Velez & Janssen, 2008). Many things affect the mother's ability to interpret these signs and provide this care to her infant; therefore it is incumbent upon the nurse to "assess and interpret the infant's behaviors, determine how the mother understands and responds, and tailor interventions" to help the mother have confidence in her ability to care for her infant (Velez & Janssen, 2008, p. 119) thereby creating successful mother-infant bonds.

Increased perception of support from nursing staff results in decreased likelihood of depressive symptoms among opioid-exposed mothers (Davis & Yonkers, 2012). Also, there is increasing information that keeping the opioid-exposed mother-infant dyad together in the same room and breastfeeding leads to shorter hospital stays and increased bonding (Isemann et al., 2011; Saiki et al., 2010). Non-pharmacologic intervention and complementary therapies are used in neonates, but they have not been widely studied and while they have anecdotal success, they do not have proven efficacy (Sublett, 2013). The literature around approaches to pharmacologic and non-pharmacologic maternal and infant therapies as well as optimal feeding and differences in gestational age response is inconsistent (Isemann et al., 2011). The research possibilities abound. Validating and implementing potential interventions may go a long way toward allowing for increased understanding on the part of nurses and increased success of the mother-infant dyad.

Conclusion

While the number of substance-abusing mothers is increasing, so is the understanding of the addiction and withdrawal process and how we as professionals might best intervene. While current trends may encourage punitive responses to these mothers, the evidence is mounting that treatment and support are better options for families affected by substance abuse. Professional organizations are unanimous in calling for this approach. De-identified mandatory reporting of infants exposed to opiates may provide data to drive interventions and therefore has the potential to reduce physical, emotional, and financial costs of the NAS epidemic to individuals and society. Screening and reporting can be viewed as part of a larger issue of policy and practice interventions for individuals, families, and communities. Inter-professional cooperation can aid with mutual goal setting for affected mothers and children. Non-punitive policy solutions may include drug diversion courts, priority for pregnant women in treatment centers, and treatments designed specifically for women. There is a need to educate nurses, legislators, and society in general about the addiction disease process, to address issues upstream such as reasons that lead to opiate abuse, and to clarify the role of legislation and health care providers in the fight against opiate abuse. Educated nurses are well positioned to research, advocate, intervene, and create positive outcomes for mother-infant dyads experiencing opioid addiction.

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A literature review of the effect of acculturation on mental health in Asian American adolescents

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Abstract

Purpose: The purpose of this article was to review current research studies that examined the effects of acculturation on the mental health of Asian American adolescents.

Methods: Combinations of terms related to acculturation and mental health were used to search for studies, published between 2003 and 2013, in the CINAHL, PsychInfo, and PubMed databases. Inclusion criteria for this review were (a) primary or secondary research; (b) research that primarily looked at Asian American adolescents; (c) research that examined acculturation and the associated mental health outcomes; and (d) research published in peer-reviewed English-language journals. Of the 228 studies initially retrieved, 11 studies met the criteria.

Findings: Although there were inconsistencies in study designs, samples, concepts, and measures used, studies found significant associations between acculturation and mental health in Asian American adolescents. Five studies found that a higher level of acculturation was associated with higher self-esteem, lower depression, lower somatic complaints, and lower mental health symptoms. On the other hand, in five other studies a higher level of acculturation was found to be associated with more alcohol and substance use and higher delinquent behavior.

Conclusions: The study findings suggest that acculturation was a significant factor influencing mental health outcomes for Asian American adolescents. Future studies that use more rigorous designs and methods are needed to examine acculturation and mental health issues in this population.

Key words: acculturation, adolescence, Asian Americans, mental disorders

Introduction

Research into the prevalence of and factors related to mental health problems among Asian American adolescents has increased in recent years (Lai, 2005; Lim, Stormshak, & Falkenstein, 2011; Takeuchi, Hong, Gile, & Alegría, 2007). Asian American adolescents were more likely than European American adolescents to report depression but less likely to report delinquent behavior problems (Lorenzo, Frost, & Reinherz, 2000; Willgerodt & Thompson, 2006). As for psychiatric disorders, Asian American adolescents were more likely to be diagnosed with anxiety or adjustment disorder but less likely to be diagnosed with depression or attention deficit/hyperactivity disorder

(ADHD) than non-Asian American adolescents (Nguyen et al., 2004; M. Yeh et al., 2002). This difference indicates that many Asian American adolescents experience internalizing mental health problems such as depression. In addition, they exhibit lower utilization of mental health services and less access to providers although early intervention for affected youths reduces the development of serious mental health conditions (Kataoka, Zhang, & Wells, 2002).

Acculturation is defined as a psychological change that takes place when adapting to a different culture and new languages (Berry, 1997, 2005). There are two different interpretations of acculturation: the unidimensional perspective views acculturation as exposure or adaptation to American culture, whereas the bidimensional perspective holds that acculturation occurs in both American culture and within one's own ethnic culture (Ryder, Alden, & Paulhus, 2000). Asian American adolescents must learn to adapt to American culture and are expected to become more acculturated than their immigrant parents. Thus, differences in acculturation exist within a family system (Quintana et al., 2006). Individuals may experience acculturative stress, which is a reaction to life events related to the experience of acculturation. It may result in anxiety, depression, and psychosomatic symptoms (Berry, 1997).

Asian Americans are Americans of Asian descent, which is defined as a person having racial origins from any of the countries in Far East Asia, Southeast Asia, or the Indian subcontinent (U.S. Census Bureau, 2011). Asian American youths make up 4.3% of the U.S. population. Roughly 80% of Asian American youths are at least second generation (Passel, 2011). Immigration histories and backgrounds vary considerably between subgroups of Asian Americans. For example, in the Indian, Chinese, Filipino/a, and Japanese community, the history of immigration is long-standing; in the Korean and Vietnamese community, immigration is a more recent trend. With regard to parental socioeconomic status (SES), Indian Americans, Chinese Americans, and Japanese Americans tend to have higher levels of education and more highly skilled occupations than other Asian Americans (Choi, 2008; C. J. Yeh, 2003). Currently, in the U.S., the largest Asian American subgroup is the Chinese, followed by the Filipino/a, Indian, Vietnamese, Korean, and Japanese (Rhee, Chang, & Rhee, 2003).

Although the Asian American population is rapidly growing, little attention has been paid to the relationship between acculturation and mental health problems of Asian American adolescents compared to African American and Mexican American adolescents. This is because Asian Americans have been considered the "model minority" – they tend to work hard, behave well, and succeed. Thus, they may not manifest overt behaviors that would be indicative of mental health problems (Choi, 2007, 2008; Choi & Lahey, 2006). Therefore, until now, there have been very few integrative literature reviews about the relationship between acculturation and mental health problems of Asian American adolescents (Anderson & Mayes, 2010; Tosh & Simmons, 2007).

The purpose of this review was to summarize the findings of recent studies that have examined the effect of acculturation on mental health problems in Asian American adolescents. At issue was this question: "What is the state of the science surrounding the effect of acculturation on mental health problems in Asian American adolescents?" Not only can this review's methodological findings be used to guide future studies, its outcome findings on acculturation and mental health could be used to address mental health problems in Asian American adolescents at risk.

Methods

Search Strategies

A comprehensive literature search of the CINAHL, PsychInfo, and PubMed databases was conducted from January to June, 2013. Combinations of terms searched were acculturation and mental disorders, acculturation and mental health, and acculturation and psychological adaptation among Asian American adolescents. From the initial search, 228 studies were retrieved. To be included in this review, studies had to be (a) primary or secondary research; (b) research that primarily looked at Asian American adolescents (12-18 years old); (c) research that examined acculturation and the associated mental health outcomes; and (d) research published in a peer-reviewed English-language journal between 2003 and 2013. To narrow the field, each title and abstract were reviewed against the inclusion criteria. After each study was reviewed by title, 169 studies were omitted because they were not primary or secondary research or did not meet one of the inclusion criteria. The remaining 59 studies were reviewed by abstract; of these, 44 studies were eliminated because they did not examine the relationship between acculturation and mental health. After full text reviews were conducted for the remaining 15 studies, four studies were eliminated because they did not involve a clear definition of either acculturation or mental health. Finally, the review process resulted in 11 studies.

Analysis and Critique Strategies

Analyzing and critiquing the studies involved evaluating their overall study design, concepts and measures of acculturation and mental health, and determining the relationship between acculturation and mental health. Because different definitions and measures were used to assess acculturation and mental health of Asian American adolescents across the studies, study findings were categorized into several sections according to the mental health problems: self-esteem, depression, somatic complaints, mental health symptoms, substance use, and delinquent behavior. To determine the effect of acculturation on the mental health of Asian American adolescents, significant findings along with non-significant findings were reported while critiquing study limitations that may affect these findings.

Results

Profile of Studies

The studies' years of publication and data collection, disciplines of authors, and study designs are reported in Table 1. Four were secondary studies that obtained their data from the National Longitudinal Study of Adolescent Health (Add Health). The Add Health data collection period took place between 1994 (Wave I) and 1996 (Wave II). Three studies used data that were collected in 2001, 2005, and 2007; the remaining four studies did not report year of data collection. The disciplines of primary authors were as follows: social work (three studies); psychology (two studies); and nursing, public health, criminal justice, and medicine (one study each). Two studies did not disclose the author's field of discipline. All studies were quantitative: eight studies used a cross-sectional design and the other three studies used a longitudinal design.

Overall Study Design

With the exception of two studies that included 60 and 55 Asian American adolescents (Kim, Gonzales, Stroh, & Wang, 2006; Rhee et al., 2003), the sample size of each study was adequate to large based on statistical power (Fang & Schinke, 2011; Hahm, Lahiff, & Guterman, 2003; Hussey et al., 2007; Le, Goebert, & Wallen, 2009; Lee, Yim, Curry, & Rodriguez, 2012; Rogers-Sirin & Gupta, 2012; Thai, Connell, & Tebes, 2010; Willgerodt & Thompson, 2006; C. J. Yeh, 2003). Four studies used a nationally representative sample from the Add Health data (Hahm et al., 2003; Hussey et al., 2007; Thai et al., 2010; Willgerodt & Thompson, 2006); the other seven studies used non-representative samples (Fang & Schinke, 2011; Kim et al., 2006; Le et al., 2009; Lee et al., 2012; Rhee et al., 2003; Rogers-Sirin & Gupta, 2012; C. J. Yeh, 2003). As to geographic locations of the study, four studies were conducted in California because of its large Asian American population (Kim et al., 2006; Le et al., 2009; Lee et al., 2012; Rhee et al., 2003), while one study was conducted in the East Coast (C. J. Yeh, 2003) and the remaining two did not disclose their study location. The convenience sample is a limitation because it may not be representative of the Asian American adolescent population in the U.S. and may not include a broad or representative distribution of mental health problems, limiting generalizability of the study findings.

With regards to race and ethnicity, six studies included only Asian American adolescents, mainly Chinese, Filipino/a, Vietnamese, Cambodian, Laotian, Korean, and Japanese (Fang & Schinke, 2011; Hahm et al., 2003; Kim et al., 2006; Le et al., 2009; Lee et al., 2012; C. J. Yeh, 2003), while the other five studies also included other racial and ethnic groups such as Mexican, African, or European American adolescents (Hussey et al., 2007; Rhee et al., 2003; Rogers-Sirin & Gupta, 2012; Thai et al., 2010; Willgerodt & Thompson, 2006). When acculturation and mental health are studied in Asian American groups, comparisons within Asian subgroups were found to be important. Factors such as the history of immigration, SES, and culture vary within Asian American populations, potentially affecting the levels of acculturation that might be related to their mental health. In this review, only four studies examined Asian subgroup differences in the relationship between acculturation and mental health (Le et al., 2009; Thai et al., 2010; Willgerodt & Thompson, 2006; C. J. Yeh, 2003).

Concepts and Measures of Acculturation and Mental Health

Concept of Acculturation. Eight studies defined acculturation as unidimensional (Fang & Schinke, 2011; Hahm et al., 2003; Hussey et al., 2007; Lee et al., 2012; Rhee et al., 2003; Thai et al., 2010; Willgerodt & Thompson, 2006; C. J. Yeh, 2003). However, three studies defined it as bidimensional (Kim et al., 2006; Le et al., 2009; Rogers-Sirin & Gupta, 2012). The bidimensional definition of acculturation can better capture complex phenomena of acculturation because it is broader and more inclusive than the unidimensional definition which is primarily interested in assimilation as the phenomenon of acculturation (Ryder et al., 2000).

Measures of Acculturation. This review identified two types of measures of acculturation: a proxy measure and a standardized measure. Five studies used a proxy measure of acculturation, for example, immigration generation status (first, second, or third generation), English use at home, or birthplace (Fang & Schinke, 2011; Hahm et al., 2003; Hussey et al., 2007; Thai et al., 2010; Willgerodt & Thompson, 2006). These studies used the data from Add Health, except for one study which used data from the Family-Based Substance Use Prevention Trial for Young Girls. Due to limitations in manipulating variables and measures when using secondary analysis, proxy measures were commonly used. While acculturation phenomena cannot be explored well using only two or three variables, the reliability of proxy measures used in studies with secondary analysis is also questionable.

Six studies used a self-report Likert-type standardized measure to assess acculturation. Three of these studies (Lee et al., 2012; Rhee et al., 2003; C. J. Yeh, 2003) used the Behavioral Acculturation Scale (BAS), the Acculturation Behavior Scale for Adolescents, and the Suinn-Lew Asian American Self-Identity Acculturation Scale (SL-ASIA) respectively. These three tools measured the unidimensional aspect of acculturation. In the studies by Lee et al. (2012) and C. J. Yeh (2003), reliability of measures was excellent (Cronbach's alpha = .88 - .90). Measures of reliability were not reported by Rhee et al. (2003). The other three studies (Kim et al., 2006; Le et al., 2009; Rogers-Sirin & Gupta, 2012) used a revised version of the Acculturation Rating Scale for Mexican Americans (ARSMA-II), the Individualism-Collectivism (IND-COL) Scale, and the Collective Self-Esteem Scale-Race (CSE-R) respectively. The reliability of these three bidimensional measures of acculturation was good to excellent in Asian American adolescents (Cronbach's alpha = .72 – .93).

Mental health. This review identified a large variety of measures used in assessing mental health problems across the studies. Some used standardized measures to study self-esteem, depression, somatic complaints, and mental health symptoms, while others used non-standardized measures to study somatic complaints, substance use, and delinquent behavior. Self-esteem was assessed using the Rosenberg Self

Esteem Scale by Rhee et al. (2003). Depression was assessed using the Center for Epidemiologic Studies of Depression Scale (CES-D) (Kim et al., 2006), the Withdrawn/Depressed subscale of the Youth Self-Report (YSR) (Rogers-Sirin & Gupta, 2012), and a modified version of the CES-D (Willgerodt & Thompson, 2006). Somatic complaints were assessed using the Somatic Complaints subscale of the YSR (Rogers-Sirin & Gupta, 2012) and a 14-item scale about the frequency of symptoms such as poor appetite, trouble falling asleep, trouble relaxing, stomachache, and frequent crying spells (Willgerodt & Thompson, 2006). Mental health symptoms were assessed using the Symptom CheckList-90-Revised (SCL-90-R) (C. J. Yeh, 2003). The reliability of these standardized measures has been well established in the Asian American population and other ethnic groups.

Three studies assessed alcohol use with one question, asking about ever having used alcohol in the past 12 months (never used vs. ever used) (Fang & Schinke, 2011); how many days of alcohol drinking during the past 12 months (none vs. one or more days of drinking) (Hahm et al., 2003); and ever use of alcohol (never used vs. ever used) (Thai et al., 2010). Substance use including alcohol use was assessed in four studies, but none of the common measures were used. In Le et al.'s (2009) study, substance use was measured by a 14-item scale about ever use of cigarettes, beer, hard liquor, marijuana, ecstasy, heroin, ice, cocaine, LSD, painkillers, steroids, inhalants, tranquilizers, or other drugs. In Lee et al.'s (2012) study, substance use was measured by a two-item scale about the use of alcoholic beverages (beer, wine, or hard liquor) and marijuana or hashish, with Cronbach's alpha of .71. In Willgerodt and Thompson's (2006) study, substance use was measured by a six-item scale about ever use of smoking, alcohol, marijuana, cocaine, inhalants, and illegal drugs. In Hussey et al.'s (2007) study, eight risk behavior clusters were used: substance experimenters, sex experimenters, drinkers, smokers and sex, alcohol and sex, binge drinkers, combination sex and drug use, and high risk sex and drug use. Delinquent behavior was assessed using a two-item scale about stealing or trying to steal items worth more than $50 and using forceful methods to get money or things from other students, with Cronbach's alpha of .58 (Lee et al., 2012) and a 15-item scale about painting graffiti, stealing something worth more than $50, or using the car without permission, with Cronbach's alpha from .81 to .83 (Willgerodt & Thompson, 2006).

The Effect of Acculturation on Mental Health

Acculturation and self-esteem. Rhee et al. (2003) explored the association between acculturation and self-esteem among 99 Asian and 90 European American adolescents. This was a cross-sectional study, conducted in a public school in Los Angeles. The measurement tool for acculturation was the Acculturation Behavior Scale for Adolescents. Among Asian American adolescents, a higher level of acculturation significantly predicted higher self-esteem ($\beta = .27$, $p < .05$). Without an explanation of the attrition rate, only 55 of the 99 Asian American adolescents were included in the final regression model. Thus, this study may have lacked power, which could lead to bias in its findings.

Acculturation and depression. Three studies examined the relationship between acculturation and depressive symptoms (Kim et al., 2006; Rogers-Sirin & Gupta, 2012; Willgerodt & Thompson, 2006). Using the ARSMA-II, Kim et al. (2006) examined the relationship between cultural marginalization and depressive symptoms in 60 Asian American adolescents along with their parents. This was a cross-sectional study conducted in various community organizations in California. They found that Asian American adolescents' lower level of adaption to the Asian American culture was significantly associated with increased depressive symptoms ($\beta = .44$, $p < .05$). However, because most participants were Korean (77%), the study may have lacked the representativeness of other Asian American populations. Rogers-Sirin and Gupta (2012) analyzed the relationship of cultural identity (ethnic and U.S. identity) and depression using a longitudinal design. The study sample comprised 76 Asian American and 97 Latino/a adolescents, and the measurement tool for cultural identity was the CSE-R. The results showed that adolescents with higher ethnic identity in both groups were less likely to develop depression three years later. This study showed an excellent retention rate (85%) at three years' follow-up. Unlike the two studies mentioned above, Willgerodt and Thompson (2006) found no significant relationship between immigration generation status and depression. The study sample comprised 1,003 Asian Americans adolescents including Chinese and Filipino/a, and European American adolescents from the Add Health data. Based on the findings from these three studies analyzing the relationship between acculturation and depression, having a higher acculturation level and a positive ethnic identity were found to be associated with better depression outcomes for Asian American adolescents.

Acculturation and somatic complaints. Two studies found a significant relationship between acculturation and somatic complaints (Rogers-Sirin & Gupta, 2012; Willgerodt & Thompson, 2006). As mentioned above, Rogers-Sirin and Gupta (2012) found that Asian American adolescents with positive ethnic identity showed lower levels of somatic complaints at three years' follow-up. In Willgerodt and Thompson's (2006) study, third-generation Chinese American adolescents ($n = 216$) were more likely to report somatic complaints than first-($\beta = -.19$, $p < .01$) and second-generation ($\beta = .19$, $p < .01$) Chinese American adolescents. Both of these studies showed that a higher immigration generation status was associated with higher somatic complaints, whereas having a positive ethnic identity was associated with lower somatic complaints.

Acculturation and mental health symptoms. Yeh (2003) examined the association between acculturation and mental health symptoms in Asian American adolescents. The sample comprised 141 Chinese, 124 Korean, and 54 Japanese American adolescents from schools in a large East Coast city. The measurement tool for acculturation was the SL-ASIA. The study found that lower levels of acculturation ($\beta = -.12$, $p < .05$) significantly predicted higher mental health symptoms. Despite adequate sample size and a reliable measure for acculturation, this study lacked representativeness of the Asian American population due to convenience sampling from one location and the inclusion of only three ethnic groups.

Acculturation and substance use. Seven studies examined acculturation and substance use in Asian American adolescents. Three of these examined the relationship between acculturation and alcohol use (Fang & Schinke, 2011; Hahm et al., 2003; Thai et al., 2010). Fang and Schinke (2011) examined the relationship between English use at home, immigration generation status, and alcohol use in 130 Asian American girls. Their study found that Asian American girls with higher immigration status were less likely to use alcohol ($\beta = -.21$, $p < .05$). Using the Add Health data, Hahm et al. (2003) examined the relationship between acculturation and alcohol use. Here, acculturation was measured by English use at home and birthplace. Acculturation was then further categorized into four different groups, from most acculturated to the least: English use at home and U.S. born; English use at home and foreign born; no English use at home and U.S. born; and no English use at home and foreign born. The study found that the most acculturated Asian American adolescents had a significantly increased risk of alcohol use compared to the least acculturated adolescents *(Adjusted Odds Ration, AOR* = 11.3, 95% CI: 3.7 - 34.4). Unlike the two studies above, Thai et al. (2010) found no significant relationship between acculturation and substance use even though Thai et al. also utilized the Add Health data.

The remaining four studies examined the relationship between acculturation and substance use including alcohol use (Hussey et al., 2007; Le et al., 2009; Lee et al., 2012; Willgerodt & Thompson, 2006). Hussey et al. (2007) examined risk behaviors by immigration generation status among Asian and Mexican American adolescents using the Add Health data. They found that compared to first-generation adolescents, second-generation adolescents showed an increased risk of experimenting with substance use (*Relative Risk Ratio, RR* = 1.8, 95% CI: 1.3 – 2.5), alcohol drinking (*RR* = 2.6, 95% CI: 1.3 – 5.0), and binge drinking (*RR* = 2.2, 95% CI: 1.2 – 4.2). However, third-generation adolescents, compared to first-generation adolescents, showed an increased risk of binge drinking only (*RR* = 2.9, 95% CI: 1.5 – 5.7). Lee et al. (2012) examined the relationship between acculturation and substance use in 274 Korean American adolescents from Sunday schools of Korean Catholic churches in Los Angeles. The measurement tool for acculturation was the BAS. This study showed that a higher acculturation level significantly predicted higher substance use ($\beta = 1.64$, $p < .05$). In Willgerodt and Thompson's (2006) study, third-generation Chinese American adolescents were more likely to report substance use than first-generation ($\beta = -.18$, $p < .05$) and second-generation ($\beta = .24$, $p < .001$) Chinese American adolescents. In addition, second-generation ($\beta = -.20$, $p < .001$) and third-generation ($\beta = -.25$, $p < .05$) Filipino/a American adolescents were more likely to report substance use than first-generation Filipino/a adolescents. On the other hand, Le et al. (2009) found no significant relationship between acculturation and substance use in a sample of 329 Asian American adolescents.

Acculturation and delinquent behavior. Two studies found that acculturation did affect delinquent behavior (Lee et al., 2012; Willgerodt & Thompson, 2006). In Lee et al.'s (2012) study, a higher acculturation level significantly predicted higher delinquency

($\beta = 2.13$, $p < .01$). Willgerodt & Thompson (2006) found that second immigration generation Filipino/a adolescents were more likely to report delinquent behavior than first immigration generation Filipino/a adolescents ($\beta = -.18$, $p < .001$). Based on the findings from these two studies, acculturation was found to be a significant predictor of delinquent behaviors of Asian American adolescents.

Discussion

This manuscript reviewed 11 studies that examined the effect of acculturation on mental health outcomes in Asian American adolescents. This review found inconsistencies in study designs, samples, concepts, and measures used in the studies. Eight of the studies in this review used cross-sectional designs. Because cross-sectional designs lack causality (Hulley, Cummings, Browner, Grady, & Newman, 2006), it is impossible to determine whether lower levels of acculturation increased mental health problems or mental health problems increased levels of acculturation in Asian American adolescents. Seven studies did not disaggregate their diverse Asian American samples into subgroups, prohibiting specific analysis of acculturation and mental health according to Asian American subgroups. In research studies, Asian American populations are often categorized into one large group because of their geographical and cultural similarity. By doing so, unique demographic and SES characteristics of different Asian American subgroups may be overlooked, leading to unclear relationships between acculturation and mental health outcomes (Choi, 2008; Lorenzo et al., 2000; Passel, 2011). Four of the studies were secondary analyses of the 1994-1996 Add Health data. Although the Add Health data included a large and nationally representative sample, the authors of the three studies (Hahm et al., 2003; Hussey et al., 2007; Thai et al., 2010) did not do subsequent analyses to control for variations across Asian American subgroups.

Furthermore, acculturation was not conceptualized and measured consistently across studies. Most studies that obtained their data from the Add Health used proxy measures of acculturation, thus limiting their ability to capture complex phenomena of acculturation, whereas other studies used standardized measures of acculturation. Proxy measures and some of the standardized measures defined acculturation as unidimensional. On the other hand, the other standardized measures defined acculturation as bidimensional. Consequently, relationships between acculturation and mental health may be ambiguous when studies do not clearly define and measure acculturation. A variety of measures were also used to assess mental health. Specifically, studies that examined the relationship between acculturation and alcohol use, substance use, and delinquent behavior, used non-standardized measures, limiting the reliability of these measures. This manuscript looked at studies that used self-reported measures of acculturation and mental health. While self-reports are useful, their accuracy relies on respondents' abilities to recall and perceive (Nunnally & Bernstein, 1994). For example, the question about alcohol use in the past 12 months may not be an accurate assessment of alcohol use due to the long time span to recall whether or not they drank alcohol. In addition, because mental health problems are a subjective experience, another suggestion is the utilization of the Kiddie Schedule for Affective Disorder and Schizophrenia-Present and Lifetime version (K-SADS-PL) (Kaufman et al., 1997) which is a structured interview assessed by psychologists or mental health professionals.

Despite the limitations of the existing literature, studies have found that acculturation appears to be a contributing factor of mental health outcomes for Asian American adolescents: a protective factor against depression, somatic complaints, mental health symptoms, and lower self-esteem. Interestingly enough, however, acculturation is a risk factor for increased alcohol use, substance use, and delinquent behavior, although there are some inconsistencies in the findings. Therefore, further studies are needed to significantly establish the relationship between acculturation and the mental health of Asian American adolescents; i.e., there is a need for more rigorous research methods employing a longitudinal design, using representative samples, comparing Asian American subgroups' differences, and using more reliable and valid measures. Furthermore, studying mediators and moderators on the relationship between acculturation and mental health is suggested. In addition, health care providers should assess issues of acculturation that Asian American adolescents experience, because levels of acculturation may put Asian American adolescents at risk for mental health problems. At the community level, diverse strategies to decrease mental health problems among Asian American adolescents should be expanded. Community centers, for example, can hold free classes for first-generation Asian American adolescents to learn about American culture to help reduce anxiety and fear towards the new society.

This review is not without its limitations. It included only published research studies between 2003 and 2013, limited its search of databases to CINAHL, PsychInfo, and PubMed, and used limited search terms. Hence, a more comprehensive search including "gray literature" and different databases is needed. Because this review included only quantitative studies, other qualitative and quantitative studies using bivariate analysis to examine the relationship between acculturation and mental health were excluded. Despite its limitations, this review is significant because it is the first integrative review to examine the effect of acculturation on the mental health of Asian American adolescents. The methodological findings revealed in this review could be used in future studies to improve upon the limitations of recent research on this subject.

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Table 1 **Summary of the Literature**

Author (year) & discipline	Sample, setting, & year of data	Design	Key variables (Measures)	Major findings	Limitations
Fang & Schinke (2011); Social work	Asian American girls (*N* = 130 along with mothers); 2007	Cross-sectional	- IV: English use at home, Generation status - DV: Alcohol use	- Generation status↑: Alcohol use↓ ($\beta = -.21$, $p < .05$)	Cross-sectional design, small sample size, limited generalizability, proxy measure of acculturation, clustered Asian subgroups
Hahm, Lahiff, & Guterman (2003); Social work	Asian American adolescents (*N* = 714); nationally represented sample (Add Health, 1994)	Longitudinal	- IV: English use at home, Birth place - DV: Alcohol use	- Acculturation↑: Alcohol use↑ (*AOR* = 11.3, 95% CI: 3.7 – 34.4)	Proxy measure of acculturation, clustered Asian subgroups
Hussey, Hallfors, Waller, Iritani, et al. (2007); Public health	Asian American adolescents (n = 1361) & Latino/a (*n* = 2551); nationally represented sample (Add Health, 1994)	Longitudinal	- IV: Generation status - DV: Substance use (8 risk behavior clusters)	- Generation status↑: Substance experiment↑ (*RR* = 1.8, 95% CI: 1.3 – 2.5), Alcohol drinking↑ (*RR* = 2.6, 95% CI: 1.3 – 5.0), & Binge drinking↑ (*RR* = 2.2, 95% CI: 1.2 – 4.2)	Proxy measure of acculturation, clustered Asian subgroups
Kim, Gonzales, Stroh, & Wang (2006)	Asian American adolescents (*N* = 60 along with parents; Korean, Chinese, Japanese); CA	Cross-sectional	- IV: Cultural marginalization (ARSMA-II) - DV: Depression (CES-D)	- Marginalization to Asian American culture↑: Depression↑ ($\beta = .44$, $p < .05$)	Cross-sectional design, small sample size, limited generalizability, clustered Asian subgroups
Le, Goebert, & Wallen (2009)	Asian American adolescents (*N* = 329; Cambodian, Chinese, Lao/Mien, Vietnamese); Oakland in CA; 2005	Cross-sectional	- IV: Individualism, Collectivism (IND-COL) - DV: Substance use (14-item scale)	- No significant relationship	Cross-sectional design, limited generalizability
Lee, Yim, Curry, & Rodriguez (2012); Criminal justice	Korean American adolescents (*N* = 274); Los Angeles in CA; 2001	Cross-sectional	- IV: Acculturation (BAS) - DV: Substance use (2-item scale), Delinquent behavior (2-item scale)	- Acculturation↑: Substance use↑ ($\beta = 1.64$, $p < .05$) & Delinquent behavior↑ ($\beta = 2.13$, $p < .01$)	Cross-sectional design, limited generalizability, clustered Asian subgroups
Rhee, Chang, & Rhee (2003); Social work	Asian American adolescents (*n* = 55; Taiwanese, Chinese, Korean, Japanese; Indian) & European American adolescents (*n* = 49); Los Angeles in CA	Cross-sectional	IV: Acculturation (the Acculturation Behavior Scale for Adolescents) - DV: Self-esteem (Rosenberg Self Esteem Scale)	- Acculturation↑: Self-esteem↑ ($\beta = .27$, $p < .05$)	Cross-sectional design, small sample size, information about missing data unreported, limited generalizability
Rogers-Sirin & Gupta (2012); Psychology	Asian American adolescents (*n* = 76; mainly Chinese) & Latino/a (*n* = 97)	Longitudinal	- IV: English proficiency, Ethnic & U. S. identification (CSE-R) - DV: Depression (Withdrawn/ Depressed subscale of the YSR), Somatic complaints (Somatic Complaints subscale of the YSR)	- Ethnic identification↑: Depression↓ & Somatic complaints ↓	Small sample size, proxy measure of acculturation, limited generalizability, clustered Asian subgroups
Thai, Connell, & Tebes (2010); Medicine	Asian American adolescents (*n* = 1,248) & other ethnic groups; nationally represented sample (Add Health, 1994)	Cross-sectional	- IV: English use at home, birth place, length of residence in U. S. - DV: Alcohol use	- No significant relationship	Cross-sectional design, Proxy measure of acculturation
Willgerodt & Thompson (2006); Nursing	Chinese American adolescents (*n* = 216), Filipino/a (*n* = 387) & European (*n* = 400); nationally represented sample (Add Health, 1994)	Cross-sectional	- IV: Generation status - DV: Depression (CES-D), Somatic complaints (14-item scale), Substance use (6-item scale), Delinquent behavior (15-item scale)	- Generation status↑: Somatic complaints↑ ($\beta = -.19$, $p < .01$), Substance use↑, & Delinquent behavior ↑ ($\beta = -.18$, $p < .001$) - No significant relationship between Generation status & Depression	Cross-sectional design; Proxy measure of acculturation
Yeh (2003); Psychology	Asian American adolescents (*N* = 319; Chinese, Korean Japanese); City on the East Coast	Cross-sectional	- IV: Acculturation (SL-ASIA) - DV: Mental health symptoms (SCL-90-R)	- Acculturation↓: Mental health symptoms↑ ($\beta = -.12$, $p < .05$)	Cross-sectional design, limited generalizability

Prescribing menopausal hormone therapy outside of treatment guidelines: Considerations for nursing

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Abstract

Although guidelines limit menopausal hormone therapy (HT) to five years, over 25% of prescriptions are written for women over age 60. "Ghostwritten" articles and CE courses attributed to specialists with ties to manufacturers are intended to cast doubt on guidelines. Some providers prescribe HT beyond recommendations with the understanding that the patient has decided to continue using hormones despite the risks. As nurses, we can help patients differentiate marketing messages from scientific findings that inform evidence-based practice.

Key words: Hormone therapy, menopause, guidelines, prescription, marketing

Introduction

The evidence-based recommendations of UpToDate® represent a synthesis of the best science and the most recent medical information on a given topic. The organization accepts no funding from pharmaceutical companies, medical device manufacturers, or any other commercial entity, and its clinical guidelines are used by 90% of academic medical centers in the United States alone (UpToDate, 2015). Because of risks to health associated with menopausal hormone therapy (HT), the guidelines in this online database suggest that prescription of systemic estrogen is not recommended (with rare exceptions, such as for osteoporosis that cannot be treated with bisphosphonates) beyond three to five years after the last menstrual period (Martin & Barbieri, 2015). Only the minority of women who are unable to discontinue estrogen because of persistent and severe symptoms that cannot be treated by other means should consider using HT beyond five years. The authors emphasize this point by specifically providing data to guide decision making for a period of up to five years in women ages 50 to 59 years. The recommendations of Martin and Barbieri (2015) regarding the use of HT are subtly but substantially different from those of the North American Menopause Society (NAMS), an organization with acknowledged ties to the pharmaceutical industry (NAMS, 2012). For example, in the guidelines authored by Martin & Barbieri (2015) there is no suggestion that the risks of HT beyond five years (even when estrogen is used alone) can be counterbalanced by "quality of life" benefits, as is suggested in NAMS publications.

Regardless of prescribing guidelines, at least 25% of prescriptions for menopausal hormone therapy were written for patients over the age of 60, women who are more than five years past menopause (Hersh, 2004). In 2009, the last year for which these data were available, the prevalence of use ranged from 12.7% in women aged 61 to 65 to 3.9% in women over age 75 (Steinkellner, Denison, Eldridge, Lenzi, Chen, & Bowlin, 2012). Although there is a trend toward prescription of lower doses, Corbelli & Hess (2012) observed that there is no evidence to support the intuitive hypothesis that lower doses are associated with lower risk. Only 25% of hormone therapy prescriptions were written for low-dose therapy through 2009 (Ettinger et al., 2012). Standard or high dose oral formulations remained the most common regimens observed through 2009, and the average length of use had steadily increased from 2002 to 2009.

The reasons why long-term users may resist discontinuing menopausal hormone therapy vary. Understandably, many women fear the resumption of unpleasant symptoms such as hot flashes that prompted their initiation of estrogen use. Beliefs about menopause, aging, and hormone therapy also play a role in the long-term use of estrogen. Prior to 2002, "hormone *replacement* therapy" was promoted aggressively for relief of hot flashes and vaginal dryness, prevention of chronic diseases such as cardiovascular disease and osteoporosis, stabilization of mood, and cosmetic benefits. Some women believe that estrogen helps them keep a youthful appearance and healthy sex drive, avoid mood swings, maintain a healthy weight, and slow the aging process overall. These beliefs originated with the marketing of estrogen.

Marketing Pharmaceutical Estrogen

As detailed in *The Estrogen Elixir: A History of Hormone Replacement Therapy in America* (Watkins, 2007), estrogen formulations have been used to alleviate hot flashes since the early part of the 20th century. Synthetic estrogen was first marketed in pill form in 1938, an event that coincided with the use of the term "menopause" as a diagnosis. The estrogen compound diethylstilberstrol (DES) was developed to treat hot flashes, but the side effect of pronounced nausea prevented its widespread use. Premarin®, a better-tolerated preparation derived from the urine of pregnant mares, was developed at about the same time by Ayerst Laboratories, one of the first companies to emerge in the new and profitable business of drug manufacturing. DES and Premarin® were approved by the Food and Drug Administration (FDA) in 1941 and 1942, respectively. By 1947, there were 53 different menopausal hormone formulations sold by 23 different companies.

Menopausal hormone therapy was marketed to treat hot flashes, menopausal irritability, sexual disinterest, and aging. Ayerst, a company that spent a million dollars annually on advertising by the late 1960s, secretly paid Robert Wilson, MD, to write "Feminine Forever." This best-selling book published in 1966 helped cement the connection between estrogen supplementation and healthy aging in the American consciousness (Watkins, 2007). According to Wilson's writings, menopause is an estrogen deficiency degenerative disease that requires treatment of all women who are otherwise "castrates." He claimed that estrogen prevented cancer, and he denied evidence to the contrary (Neel, 2002). The book helped create a discourse that: (a) promoted the idea and the product known as "hormone *replacement* therapy," (b) pathologized and medicalized menopause, (c) contributed to our culture's fear of aging and quest for eternal youth, and (d) conceptually related estrogen levels to the value (and self-esteem) of women.

In the 1950s and 1960s, full-page print ads in medical journals emphasized the value of Premarin® as a practice builder and a drug that could turn unattractive, irritable women into compliant, pleasant patients (Watkins, 2007). As a result of these advertising efforts, Premarin® maintained its position as the most popular brand of estrogen, placing it among the top five prescription medications by 1975. Premarin® was shown to cause endometrial cancer in the 1970s, a fact Ayerst denied for years in spite of evidence published in the New England Journal of Medicine (Smith et al.,1975; Ziel & Finkle, 1975; Watkins, 2007). The danger of unopposed estrogen to women with uteri was addressed clinically by the added prescription of a progestin, and in 1995, Prempro® (a combination pill) was added to the product line.

Starting in the 1980s, print and television advertisements used glamorous celebrities to market Premarin® and Prempro® directly to women. After Wyeth Laboratories, a division of American Home Products, acquired Ayerst in the late 1980s, it continued marketing aggressively to maintain the widely-held belief that estrogen could delay aging and promote health. In the late 1990s, Premarin® and Prempro® sales comprised almost 70% of the menopausal hormone therapy market in the US, and by 2001, the two products generated $2B in sales annually (Petersen, 2002). The prevalence of hormone therapy use among women 50-74 in the US was then over 30% (Ettinger et al., 2012), and despite increasing competition from other hormone manufacturers, Premarin® and Prempro® comprised 63% of total HT sales in the US (Hersh, 2004).

In 2012, Bloomberg.com reported that Wyeth had been sued by over 10,000 women for failing to warn them about the known risks of breast cancer associated with Premarin® and Prempro®, and the total amount estimated to be paid in settlements to plaintiffs exceeded $1.2B (Feely, 2012). Internal marketing materials in unsealed discovery documents associated with breast cancer litigation clearly show that Wyeth knew that Prempro® and Premarin® caused cancer (DIDA, 2014; Singer & Wilson, 2009). These documents describe how marketing efforts were directed toward dismissing conclusive evidence and distracting the public from the risk of breast cancer.

Promoting Hormone Therapy to Providers

The promotion of hormone therapy to providers (including nurses) includes direct contact by drug representatives, the provision of samples, orchestrating the authoring of continuing education materials and professional journal articles, and sponsoring conferences and continuing education courses. According to internal marketing documents, these efforts are tailored to specific provider categories based on their status and ability to influence patients and other professionals (DIDA, 2014; Krueger v. Wyeth, Inc., 2008). Nurses and nurse practitioners are positioned at the bottom of the hierarchical provider model, and their usefulness as agents in HT promotion is based on the assumption that, as managed care increasingly limits the time physicians can devote to direct patient care, nurses will continue to have time to counsel patients.

Situated above nurses and physicians in this marketing hierarchy are leading women's health specialists with whom Wyeth has established collaborative relationships (DIDA, 2014; Fugh-Berman, 2010; Krueger v. Wyeth, Inc., 2008). Wyeth recruited these "thought leaders" to present talks, author continuing-education courses, and publish articles in professional journals about the advantages of menopausal hormone therapy. During 2009, the year it acquired Wyeth, Pfizer spent $2M to fund continuing-education courses for nurses and physicians on the importance of estrogen to women's health (Rosenberg, 2010). In 2010, the majority of trustees and advisory board members of the North American Menopause Society had ties to hormone manufacturers, primarily to Wyeth and the company that acquired it, Pfizer (NAMS, 2010; Rosenberg, 2010).

One method drug manufacturers have used to promote HT is the strategic placement of "ghostwritten" journal articles and continuing education course materials, such as those authored by Mark Brincat, MD, and Leon Speroff, MD, (DIDA, 2014; Fugh-Berman, 2010; Fugh-Berman, McDonald, Bell, Bethards, & Scialli, 2011). The term "ghostwriting" refers to the development by marketing companies of manuscripts with authorship attributed to leading specialty physicians. By agreeing to allow themselves to be identified as authors of articles specifically tailored to sales objectives, such physicians participate in a marketing strategy designed to persuade other providers to prescribe hormones. Some of these physicians have been paid to publish, while others have benefitted by being prolific publishers, thereby securing academic credit. It has been demonstrated that ghostwritten manuscripts show bias in tone, and in some cases scientific content is intentionally misleading (Fugh-Berman, 2010; Fugh-Berman et al., 2011).

Ayerst/Wyeth spent millions of dollars asserting that estrogen clinically improves the skin, and publications attributed to Mark Brincat, MD, have been part of these efforts (Brincat, 1983, 1985, 1987, 2000; DIDA, 2014). In the Drug Industry Database Archives (DIDA) at the University of California San Francisco, a repository of unsealed discovery documents associated with breast cancer lawsuits against Wyeth, at least 41 documents link Brincat to Ayerst/Wyeth and ghostwriting. Research attributed to Brincat has been cited hundreds of times since 1983 as the basis for claims that estrogen preserves or clinically improves the skin, and most articles on the topic reference these publications. Brincat's findings have not been replicated, and other investigators have concluded that estrogen has no clinical cosmetic benefit (FDA, 2014; Haapasaari, 1997; Phillips, 2008).

More recent HT internal marketing literature is unavailable, as these materials ordinarily become public only after a judge orders the unsealing of discovery documents. Ascertaining whether the practice of ghostwriting orchestrated by marketing firms hired by hormone manufacturers is ongoing is less straightforward without such evidence. After sales of Prempro® and Premarin® fell precipitously in 2002, Wyeth's marketing shifted to efforts to cast doubt on the Women's Health Initiative findings (Fugh-Berman et al., 2011; WHI, 2002, 2004). Fugh-Berman et al. (2011) examined journal articles that comprised reviews, editorials, comments, or letters on the topic of hormone therapy prescribing published between 2002 and 2006. The goals of the study were: (a) to determine whether promotional tone could be identified by readers blinded to the authors' identities, and (b) whether the articles exhibiting a promotional tone were more likely to have been authored by those with ties to hormone manufacturers. Their findings indicate that articles with a promotional tone were more than twice as likely to be authored by physicians with ties to hormone manufacturers.

The Fugh-Berman et al. (2011) study also compared the content of articles authored by individuals with known ties to hormone manufacturers with articles by authors with no such ties. Some of the themes found in the articles written by those with ties to manufacturers were: (a) the risks of hormone therapy have been exaggerated, (b) randomized clinical trials are not better than observational studies for determining the risks of hormone therapy, (c) the study populations used in the Women's Health Initiative were inappropriate for determining risks, (d) ongoing studies are expected to demonstrate protective effects from hormone therapy, and (e) different formulations and doses have different risk/benefit profiles (that is, hormone therapy tailored to individual women based on their unique attributes may be beneficial and have minimal risk). Fugh-Berman et al. (2011) reported that articles from three authors with ties to the hormone industry contained sections of the same text repeated word-for-word in different articles, suggesting ghostwriting.

A continued belief (on the part of both providers and patients) that HT is protective is partially responsible for prescription of HT. This is not surprising in that claims that HT prevents cardiovascular disease and memory loss appear in popular media and professional literature (Goldman, 2014; Speroff, 2010). An example of this phenomenon is media attention given to the Kronos Early Estrogen Prevention Study (KEEPS) trial, which was designed to determine whether estrogen, when taken early in menopause, could prevent cardiovascular disease (CVD) and/or cognitive decline (Kronos Longevity Research Institute, 2012). The KEEPS study, which began in 2005 and ended in 2012, was largely conducted to test the "timing" hypotheses, which suggests that WHI data showing more CVD and dementia after use of HT were associated with starting HT after menopause (not early in menopause). At the 2012 annual meeting of NAMS, the authors of the KEEPS study announced preliminary findings supporting claims that HT was protective against CVD and dementia when started early in menopause. Press releases and related articles appeared widely in popular media such as USA Today and WebMD, giving the public the impression that there was evidence to support the claims. The 2012 assertions were not supported with study data, and it was not until 2014 that results on CVD outcomes showing no protection were published in a peer-reviewed journal (Harmon et al., 2014). (Results on cognition effects have yet to be published in a peer-reviewed journal.) A 2012 document claiming that KEEPS data showed that CVD and dementia had been prevented by HT remains on the NAMS website where it is prominently featured (NAMS, 2015).

Concluding Thoughts

Many providers are willing to continue prescribing hormone therapy beyond five years with the understanding that the patient has decided to continue using HT despite health risks. "It is a quality of life decision," are words used by providers and repeated by patients, phrasing that implies estrogen improves one's quality of life (Hunter, unpublished manuscript). Having warned patients of the risks, providers and hormone manufacturers are relieved of legal responsibility. Some women say that because the information they have received from the media and from their health care providers is inconsistent and conflicting, they do not find health warnings about hormone therapy persuasive (French, Smith, Holtrop, & Holmes-Rovner, 2006; Kolip, Hoefling-Engles, & Schmacke, 2009; Theroux, 2010). As nurses, we can help patients differentiate marketing messages from scientific findings that inform evidence-based practice. In that nurses have been targets for hormone marketing strategies, it is useful for us to examine our own knowledge and beliefs about menopause, aging, and the appropriate use of hormone therapy. Shared decision making that results in the prescription of menopausal HT outside of treatment guidelines demonstrates the effectiveness of seven decades of estrogen marketing. It also shows that the injunction to **do no harm** is often ignored by those who care for aging women.

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A critique of Peplau's theory: Interpersonal relations in nursing

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Abstract

Hildegard Peplau's Interpersonal Relations Theory was the first nursing theory of its kind to be published formally. Peplau's theory is a middle range theory that defines the nurse-patient relationship, the meaning of health, and the roles of the nurse. She sees the goal of nursing as helping individuals and communities improve their lives in healthy ways. Her theory begins simply, relates extensively to practice, and continues to be pervasive throughout nursing today. In this paper, the theory will be described and critiqued according to widely accepted criteria. Next, careful examination will occur from the perspectives of patterns of knowing and processes of reasoning. Finally, studies that tested Peplau's work and expanded upon her concepts will be mentioned. Her work stands up to critical analysis and demands attention for its long lasting effects.

Key words: nurse patient relationship, nursing theory

Introduction

After Florence Nightingale, nursing continued for many years without a champion in theory formation. Hildegard Peplau was a nurse who made many contributions to the profession and nursing's body of knowledge. She studied patients with psychiatric illness and their interactions with nurses, quickly realizing that nursing itself could not be practiced outside the context of a relationship (Peplau, 1987). The publishing of Peplau's (1952) book, *Interpersonal Relations in Nursing,* went against the cultural norms of the day which regarded only doctors capable of publishing scientific work in health-related disciplines. Her work was the first nursing theory to be formally printed and remains relevant today. Efforts in her writing to distinguish nursing as a separate profession from medicine were some of Peplau's greatest contributions. Additionally, she provided beginning leadership in nursing's first professional organizations. Peplau emphasized nursing's unique contributions to the health care team with its focus on the reactions of patients to health problems (McCrae, 2012). Finally, she deserves the distinction of being one of the first nursing theorists to ground her thoughts in philosophical foundations that are still germane today (Gastmans, 1998). Peplau collected empirical data with her students and then tested and refined the data in the context of social science theory. Her work provided structure to the education of nursing students regarding interpersonal skills, which had not been previously outlined (Peplau, 1987). Peplau brought unique definition to professional nursing and developed knowledge that influences current practice.

This paper aims to review the legacy of Hildegard Peplau through an overview of her theory's development and scope. First, the theory will be described in detail, and theory categorization will be discussed. Next, the theory will be examined via ways of knowing and unknowing in nursing. Furthermore, the processes of reasoning will be evaluated in light of Peplau's theory. Finally, key studies which have subsequently tested and evaluated the theory will be described. These many aspects will plumb the breadth and depth of nursing's first theory of interpersonal relations.

Theory Categorization

Peplau's Theory of Interpersonal Relations is a middle range theory that defines the nurse-patient relationship, the meaning of health, and the roles of the nurse. She sees the goal of nursing as helping individuals and communities improve their lives in healthy ways (Peplau, 1952). She defines health as "the forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive, personal and community living" (Peplau, 1952, p. 12). She also describes the phases of interaction in a successful, therapeutic relationship. Initially, Peplau (1952) developed four overlapping phases of the nurse-patient interaction: orientation, identification, exploitation, and resolution. These later became three phases: orientation, working and termination (Peplau, 1987).

The orientation phase presumes that patients are coming to a nurse with a problem or limitation requiring help in order to move toward better health. The nurse enters into a therapeutic, professional relationship where there exists an imbalance in expectations. The patient expects to receive more than the nurse. In this initial phase, nurses identify themselves and begin developing a relationship. The nurse then learns more about the patient and enters into the narrative. The identification phase follows, which allows patients to learn how to use the relationship to meet goals. Subsequently, the exploitation phase allows the patient to make full use of the benefits and strengths of the nurse-patient relationship. This is the stage where most of the work is accomplished both by partnering with patients and working on their behalf. As it comes to a close, the patient realizes the need for independence and recovery. Once the patient is ready, the relationship enters the termination phase where the individual achieves greater health and experiences freedom for more productive relationships. Peplau (1952) mentions that the end of medical treatment and the termination phase do not always line up exactly in real time.

It is important to note that Peplau changed some of the terminology as her work progressed, but the ideas remained similar. Peplau's phases were instrumental in delineating between a therapeutic and a nontherapeutic nurse-patient relationship.

A therapeutic relationship has the patient as the center with the nurse acting as the professional guide and healer. Her work proposed that all four phases are present in every nursing situation. These phases describe the reasons why patients seek help and what a therapeutic interaction looks like. The significance of Peplau's work is evident as her theory, for the first time, clearly defined the nurse's role as care for patients in their reaction to illness.

After the introduction of the four phases of interaction, Peplau addressed numerous situations and roadblocks through expanding concepts and applying them to practice. Additional concepts such as roles, patterns in relationships, the importance of addressing anxiety, and communication are discussed extensively throughout Peplau's writings.

Peplau emphasized that a nurse transitions through diverse roles throughout the four phases of the nurse-patient relationship. These include stranger, resource person, teacher, leader, surrogate, and counselor. She elaborated on these roles in her extensive writings, and researchers have examined them in a variety of clinical situations since (D'Antonio, Beeber, Sills, & Naegle, 2014). It is the emphasis on the patient which informs the nurse's reactions and interactions in each role.

Patterns of relationships should be studied in order for the nurse to have a working framework for understanding patients (Peplau, 1952). A pattern is a typical manner of behavior (Peplau, 1989). "Pattern is the genre, or category, or style of a group of separate acts having distinctive, similar features, including thoughts, feelings, and actions" (Peplau, 1989, p. 109). These patterns need to be understood and integrated into a cohesive whole.

Peplau also saw nurses as having a crucial part to play in reducing a patient's anxiety (Penckofer, Byrn, Mumby, & Ferrans, 2011). How do nurses reduce anxiety? Peplau (1952) would say through addressing felt needs and moving toward resolving their fears. Individual behaviors are not to be taken at face value, but as part of a process to move through.

All of the nurse-patient interactions involve communication. Communication is seen as the backbone of a working nurse-patient relationship and one of the key pieces missing in psychiatric practice during the first half of the twentieth century (Sills, 1978). Current practice in nursing emphasizes communication skills at the early prodding of Peplau.

As a result of these various concepts, critics have argued about the complexity of Peplau's theory. When viewing the breadth of her scholarship, it seems complex due to the sheer volume that a lifetime of working in nursing can produce. Yet, her theory begins simply, relates extensively to practice, and continues to be pervasive throughout nursing today. Next, Peplau's philosophical thoughts and motivations will be examined.

Philosophical Underpinnings

Peplau did not declare her theory's philosophical underpinnings explicitly, yet many theorists and scholars have speculated about her thoughts by reading between the lines of her work. Currently, Peplau is widely understood to be influenced by humanistic psychology and phenomenology (Gastmans, 1998).

Peplau's (1952) interest in humanistic psychology came from Henry Stack Sullivan's lectures and work with patients experiencing psychiatric illness. Peplau (1952) did give credit to Sullivan's theory of interpersonal relations, yet, she stated that much of her work came from her extensive observation of patients experiencing mental illness and observation by her students.

Her concern with the context of each patient illustrates her phenomenological perspective. She saw nurses as primarily responsible for the growth and change of a patient's context for the purpose of improved health (Peplau, 1952). It is evident that she knew nurses could not perform their daily tasks in a value-free manner (Gastmans, 1998).

A variety of other concepts such as Peplau's emphasis on developmental stages, participant observation, communication, and growth came from theorists such as George Hubert Mead, Carl Rogers, and Maslow (Forchuk, 1991). Reed (1996) stated it well when she wrote, "Peplau's interpersonal process is a strategy for knowledge development that incorporates a modernist emphasis on theory as a source of truth with a postmodern emphasis on the significance of everyday contexts" (p. 30). Peplau's influences are wide and varied, creating a firm foundation for a worldview that she applied to the nursing clinical arena. Her theory's strength is evaluated using clarity, consistency, simplicity or complexity, usefulness, congruence, and contagiousness as widely accepted criteria.

Theory Critique

Clarity

Scholars argue about the clarity of Peplau's entire body of work, yet it is not difficult for many critics to identify the central theme of her theory. It is clear that the dominant focus of Peplau's theory remains the relationship between nurse and patient. She states her assumptions and describes her four phases plainly in her initial book (Peplau, 1952). Some peripheral concepts and the accumulation of a life's work may have detracted from the theory's clarity. For example, it is unclear whether the nursing roles described by Peplau are active in each phase. Some critics see a simple progression of the roles, almost in a stepwise fashion. Other authors, including Peplau herself, seem to allow more overlapping and fluid appearances of the described nursing roles. It is possible that this concept and others mentioned in depth, such as anxiety or communication, could potentially detract from the theory's clarity. Overall, however, the central theme and focus of her main theory is apparent.

Consistency

Peplau changed her categories of the nurse-patient relationship from four phases (orientation, identification, exploitation, and resolution) to three phases (orientation, working, and termination) in her later work (Peplau, 1987). Often scholars will alternate between the two sets of categories without much mention of the change. This alternation could be thought of as inconsistent and difficult to follow, yet the concepts do remain the same in both descriptions. Peplau did not offer any explanation as to the two alternate terminologies. Her central theme remains, but her message could have been more consistent with unchanged vocabulary.

Simplicity and Complexity

It has been argued that Peplau's work is both simple and complex. She is seen as simple by many in her reliance on a few concepts such as interpersonal relations, communication, and anxiety (Reed, 2005). Yet others have seen Peplau's work as complex, citing the many roles, patterns, preconceptions, and learning elements cited in her work (Forchuk, 1991). It has also been postulated that in the inherent complexity of working with multiple patients and multiple problems, inevitably various terms will be introduced (Chinn & Kramer, 1995; Reed, 2005). It can be argued that both simplicity and complexity are seen within Peplau's work, with integrity still present.

Usefulness

Peplau wrote her book in order to bring scholarship to nursing practice and to promote professionalism in nursing. Her audience for the 1952 book was clearly the practicing nurse and those interested in graduate study. Peplau desired for nursing practice to be a scholarly endeavor (Reed, 1996). Hircshmann (1989) found in a late twentieth-century survey of American and Canadian nurses that Peplau's theory is the most cited guide for practicing psychiatric nurses. Yet many cite the ineffectiveness of the theory for patients who cannot communicate, are unresponsive, or do not present a clear problem (Howk, 2002). Despite these limitations, Peplau purposed her theory for the practicing nurse, and it continues to see benefit in its intended setting.

Congruence with Values of Self and Profession

Peplau's theory remains congruent with the values of the author as critic and the nursing profession as a whole. Peplau influenced the creation of professional codes of ethics and responsibility within prominent nursing organizations. Her theory has interacted with nursing over the last sixty years, remaining strong in its congruency with the profession's values.

Circle of Contagiousness

It is evident from the sheer volume of work, citations in other works, and continuing presence of her name in the literature that Hildegard Peplau is an influential nursing theorist and educator. At the time of her writing in the 1970s, Sills (1978) pointed out that there existed continued reliance and reference to the work of Peplau in the literature. It continues today, with articles still referencing and testing her theory.

Peplau's theory gave impetus for another theory on interpersonal relations, Orlando's interaction theory (Forchuk, 1991). Most recently, Hrabe (2005) tested Peplau's theory regarding computer-mediated relations and found it to be useful and explanatory. It can be said that her work is not merely cumulative but expansive in breadth and depth. As a result of its expansiveness, Peplau's theory incorporates many patterns of knowing in nursing. It is important to study Peplau's theory in light of accepted patterns of knowing in order to assess her reach further.

Patterns of Knowing

In this section Peplau's theory will be examined according to Carper's patterns of knowing and the pattern of unknowing put forth by Munhall. Carper (1978) proposed four patterns of knowing within nursing: empirical, ethical, personal, and aesthetic. As an addition to these traditional patterns, Munhall established that nurses need to often appreciate what they do not know in order to be empathetic and open (Lakeman, 2014). Peplau's theory can serve as a guide in nursing practice and research substantively in all five areas.

Empirical

Empirical knowing finds its foundation in the senses. Observation uses the senses, driving the development and discovery of new knowledge in the view of many scientists. This data collection method creates new knowledge, often through traditional methods of hypothesis testing. Chinn and Kramer (1995) argue that "ideas about what is legitimate for the science of nursing have broadened to include activities that are not strictly within the realm of hypothesis testing, such as phenomenological descriptions or inductive (grounded) means of generating theory" (p. 7). Peplau's work is empirically based, as evidenced by her emphasis on observation from the beginning of the nurse-patient interaction. Peplau "provides a theory based on reality" (Howk, 2002, p. 388). However, Peplau's data describes qualitative attributes of the nurse-patient interaction. Her interviewing style in research and practice approaches patients from a phenomenological perspective. While patients describe their health concerns, the nurse should be studying and observing the nonverbal and verbal communication occurring (Peplau, 1987). These facts should allow the nurse to understand the patient's health problem and seek resolution. Peplau's work clearly seeks to create empirical knowledge throughout with examples such as process recordings, models of interviews, and diagrams displaying the relationship process. Yet, her focus is not solely on empirical knowledge creation.

Ethical

Peplau sees value in an individual's interaction and growth in community with others. Placing relations at the core of nursing reflects an ethical decision made by Peplau (Gastmans, 1998). Ethical knowing requires tacit knowledge of a moral framework and explicit knowledge of principles and theories (Chinn & Kramer, 1995). It is important when evaluating Peplau's ethical knowledge to put her work in the context of early twentieth-century psychiatric care. Her efforts to value patient interactions were against the norm of the day which frequently advocated restraints, lobotomies, and drug-induced comas among other treatments done *to* patients (Sills, 1978). Peplau emphasized partnering *with* patients for a common goal of improved health through guided, professional, therapeutic work. Peplau advocated and valued for patients experiencing mental illness and worked towards realizing their potential. Peplau encouraged and modeled spending time with patients in an effort to understand their problems and alleviate their anxieties. What was seen as previously incomprehensible communication, such as hallucinations, could be cast in a different light as a window into unresolved conflict and fear (Peplau, 1952). Her ethical compass was sure as she valued patients and placed their needs above those of the nurse.

Personal

Looking at all the patterns of knowing, Peplau perhaps championed personal knowing in nursing most ardently. According to Peplau (1952), knowing oneself in a nurse-patient relationship allows nurses to put aside their own ambitions or feelings in order to care for their patients. She emphasized the professional nature of the relationship and the imbalanced expectations resulting from the nurse-patient interaction. The patient should be the one receiving the greater amount of energy in a professional nurse-patient relationship. Nurses should seek the improvement of the patient's life, not their own. In order for that to occur, nurses must know themselves enough to be therapeutic. She frequently writes about not allowing oneself to find completion or value in the nursing role. According to Chinn and Kramer (1995), personal knowing requires "full awareness of the self, the moment and the context of interaction" (p. 9). Personal knowledge does not involve expressing these reflections through language. Peplau (1991) encourages nurses to be reflective and processing inwardly from the beginning of the phases of interaction. Understanding life context and personal awareness are crucial for moving forward in nurse-patient interactions.

Aesthetic

Although Peplau possibly spoke most of personal knowing, she also encouraged aesthetic knowing to become pervasive. It is almost unattributed to her because she perhaps did not use the phrase "art of nursing" until her later years in writing. Nevertheless, she described the careful meaning of artistry in nursing from the beginning of her scholarship (Peplau, 1988). Context, environment, and the unfolding drama of the interaction are the aesthetic components important to Peplau. Each interaction progressing through the four phases expressed a creation of art. She incorporated the social context and physical space within which a patient receives care as crucial elements that can add or detract from healing. "The hospital ward as a social context in which the patient can be aided to grow in the direction of health requires investigation into its conditions" (Peplau, 1952, p. 13). Although not explicitly stated in Peplau's (1952) initial book, art is formed through shared participation in the nurse-patient relationship. Peplau hopes to educate and mature a patient in order to allow progress and healthy views of the self.

Unknowing

Although empirical knowledge formation followed Carper's patterns of knowing for decades, a challenge to those patterns has emerged as a complete account of all possible areas of nursing knowledge. In the late twentieth century, Munhall (1992) presented the need to practice unknowing in a nurse-patient relationship. Early conclusions or early closure can both result in unhelpful outcomes for the patient. The unique role and focus of psychiatric nurses in patient interactions necessitates an understanding of the narrative that patients bring to the relationship. Peplau acknowledged the value of hearing a patient's story, and she allowed for subjectivity to remain without immediate intervention. Accepting what we cannot know as nurses creates a more open and humble tone in a therapeutic relationship (Lakeman, 2014). All these ways of knowing and unknowing seen throughout Peplau's work lend their strength to its foundation. Finally, processes of reasoning and the subsequent results of testing will be evaluated within Peplau's theory.

Processes of Reasoning

Peplau clearly used both inductive and deductive reasoning in her scholarship and practice. Empirical data partially drove the creation of Peplau's theory, denoting a process of induction. Inductive arguments are based on repeated observations or experiences. However, induction is limited in that the observations sensed today will not necessarily produce the same results in the future, and yet Peplau does take ideas or inferences from observations and apply them generally. Subsequently, Peplau draws on theories from other disciplines to guide her practice using deduction. Peplau's theory is then tested and influences nursing practice today in an inductive and deductive manner (Gastmans, 1998).

The third form of reasoning, abduction, relies on that which has not been observed. It is often an educated guess which gives the researcher an initial thought in their quest. Abduction's leap from informed guess to hypothesis requires a personal context or framework from which to form the initial thought. Polanyi would argue that all such beginnings of hypotheses and abductive thoughts are completely rational and also perfectly personal. Peplau is often adamant about her reliance on observation, and thinks that all things can be derived from it. Yet it can be conjectured that Peplau used abductive reasoning to intuit questions to ask in her interviewing of patients. Although Peplau would say some knowledge is empirically derived, she also thought all information gathered was being obtained through a lens or context. In abduction, our observations are never simply what we see; we always see in a context (Råholm, 2010). Peplau's contextual and phenomenological perspective when interacting and researching with patients necessitates abductive reasoning. Therefore, Peplau used all three types of reasoning as she developed her theory and processes of knowledge development. These three types of reasoning result in the testing of hypotheses. Results and methods of testing Peplau's theory are discussed in the following final section.

Testing

Often ubiquitous theories, such as Peplau's interpersonal relations theory, are not empirically tested. Frequently the literature reveals a majority of studies using the theory as a conceptual framework or a guide, not testing it as a theory. Peplau herself noted the difficulty of integrating scholarly practice into the life of a nurse. "One of the main problems in the observation and study of human behavior and interaction in relations between nurses and patients is the multiplicity of factors to be studied" (Peplau, 1952, p. 276). Peplau (1952) initially encouraged process recording as a research methodology using her nurse process form. These forms were useful in clinical practice for nurses and students enabling teaching, learning, and qualitative research.

After reviewing the literature, countless studies reflect Peplau's ideas and cite her works. Fewer studies model their interventions on her principles and test her theory through qualitative and quantitative measurements. Some studies examined Peplau's theory as it relates to client outcomes, such as decreased hospital admissions, decreased depression scores, and lower treatment costs (Forchuk et al., 2000). For example, a community mental health program using interventions based on Peplau's theory looked at client outcomes over two years. The outcomes were decreased social isolation, decreased hospital admissions, and increased independence in activities of daily living (Forchuk, 1991). Additionally, a qualitative, descriptive study used an intervention based on Peplau's theory to help women recover from depression successfully (Peden, 1998). Finally, Forchuk (1994) tested the orientation phase of the nurse-patient relationship for the presence of the concepts of anxiety, interpersonal relationships, and preconceptions. She found in this study that not all these concepts were present significantly in the orientation phase, yet the preconceptions of the nurse influenced the nurse-patient relationship (Forchuk, 1994). These studies mainly tested her theory within the context of psychiatric nursing interventions. Peplau recognized the need for further testing of her theory and development of the concepts within it before her death.

Recently, Peplau's theory was used to explore retention strategies and the researcher-participant relationship (Penckofer et al., 2011). Howk (2002) stated that Peplau "suggested that the constructs of focal attention, dissociation, forbidding gestures, and personification deserve additional study" (p. 387). The attempts at empirical testing have not yet been comprehensive, but salient outcomes are noted. Peplau's theory can be tested, remains pervasive in current literature, and will continue to have far-reaching influence.

Conclusion

Peplau's interpersonal relations theory remains useful in daily practice as a reference manual, guide, and inspiration. As Sills (1978) emphasized, Peplau's work is responsible for a transformation within the system of nursing itself. She championed change in the profession through leadership in organizations such as the American Nursing Association and the International Council of Nurses. She has been cited by many as the mother of psychiatric nursing (Forchuk, 1991; Gastmans, 1998; Penckofer et al., 2011). One scholar noted that her work demonstrates "an approach to knowledge development through the scholarship of practice" (Reed, 1996, p. 29). Ethically and morally, Peplau sought the betterment of her profession and her patients. Empirically, her theory has been tested and continues to yield qualitative and quantitative outcomes. Her work stands up to critical analysis and demands attention for its long-lasting effects.

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