Development of a Measure Of Learned Helplessness

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The purpose of this study was to develop a measure of learned helplessness. Based on a review of the literature, 50 items were developed for inclusion in the proposed Learned Helplessness Scale (LHS). On the basis of independent reviews by three experts, 20 items were selected for inclusion in the LHS. An individual's response to each item was graded, using a Likert scale. A standardized alpha reliability coefficient of .85 was obtained for a sample of 241 healthy adults. There was a positive correlation between the LHS scores and Beck's Hopelessness Scale (HS) scores (r = .252) and a negative correlation between the LHS scores and Rosenberg's Self-Esteem Scale (SES) scores (r = −.622). These correlations were in the direction postulated by various theorists. A Varimax-rotated factor analysis of the LHS data yielded five factors. Three of these factors tapped content relevant to the attributional styles of learned helplessness. Clinical data were also obtained on samples of oncology, hemodialysis, and spinal cord patients. Because the alpha reliability coefficients of the LHS and the Pearson product moment correlation coefficients between the LHS and the HS and the LHS and the SES were in the same direction, the instrument is believed to have adequate internal consistency.

Although the theory of learned helplessness has been advanced by many researchers and correlated with many concepts, few reliable and valid means for objectively assessing the related behaviors are available. Only two scales have been discussed in the literature on this topic. A scale for measuring attributional style was developed by Peterson et al. (1982). This scale, however, is lengthy as a screening tool. Most research using this scale has focused on learned helplessness as a model of clinical depression (Peterson, Rosenbaum, & Cohen, 1985; Peterson, Schwartz, & Seligman, 1981; Peterson & Seligman, 1984). A second instrument, the H25, is a subjective helplessness measure developed by Donovan, O'Leary, and Walker (1979). Normative data were obtained on a sample of 76 male veterans participating in an inpatient alcoholism rehabilitation program.

The purpose of the present study was to determine the reliability and validity of an objective instrument designed to measure learned helplessness. The research described in this article represents pilot sample data obtained from a variety of normative and clinical populations over a 3-year period.

Theory of Learned Helplessness

The theory of learned helplessness was developed from the animal research of Seligman and Maier (1967). They proposed that " . . . subjects learned as a consequence of inescapable shock that responding was independent of shock termination, and therefore the probability of response initiation during shock decreased" (p. 8). Thus, the dogs which had learned they could not affect an outcome in a situation became helpless in their behavior.

According to Maier (1980), the learned helplessness effect refers to the fact that organisms (both human and infrahuman) exposed to aversive events in one situation " . . . often fail to escape that event in a different situation where escape is possible" (p. 171). He also stated that the learned helplessness hypothesis is grounded in cognitive learning theory, that is, subjects learn that situational outcomes are independent of voluntary responses.

Abramson, Seligman, and Teasdale (1978) proposed an attributional framework to address the major theoretical controversies arising from the original learned helplessness theory that individuals either implicitly or explicitly engage in a causal search for why they are helpless. Because the instigating stimulus to the development of learned helplessness behaviors is the expectation of noncontingency between response and outcome, Abramson et al. suggested attributions made for present noncontingency resulted in learned helplessness. The generalization and chronicity of these learned helplessness behaviors, however, are determined by the attributions individuals make for their helplessness.

The reformulated attributional learned helplessness theory delineates three dimensions of attributions (Abramson et al., 1978). The first dimension distinguishes between universal helplessness and personal helplessness. This dimension describes a continuum of attributional style referred to as internality versus externality. The frame of reference used to determine an individual's relative placement on this continuum is the self–other dichotomy. Simply stated, an individual may believe that noncontingency between response and outcome can be attributed solely to internal, personal factors. An individual at the opposite end of the continuum may attribute noncontingency to external, universal factors. For example, an individual who ascribed poor performance on a college examination to stupidity and basic lack of intellectual ability may eventually believe that failure is inevitable and thus give up trying. This individual is said to be operating in a personal helplessness mode. Another individual may ascribe similar poor examination performance to external factors such as having a cold, lack of sleep, inappropriateness of test items, or instructor bias. This person may also feel that failure in the course is certain. However, this person is said to be operating in a universal help-

lessness mode.

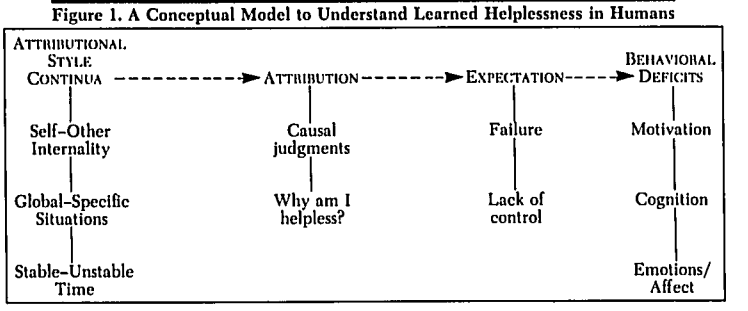
The second dimension distinguishes between global helplessness and specific helplessness. Global helplessness infers that learned helplessness deficits occur across a wide range of situations. Specific helplessness infers that the deficits occur across a narrow range of situations. Again, this is another attributional style occurring on a continuum of global versus specific. Attributing noncontingency to global factors results in helplessness generalized to other situations; when attributed to specific factors, however, helplessness deficits occur only in the original situation.

The third dimension involves the influence of learned helplessness deficits occurring consistently over time. This dimension consists of a continuum of stable and unstable attributions. Stable attributions are generally recurrent factors; unstable attributions are short-lived or intermittent factors. "The attribution merely predicts the recurrence of the expectations, but the expectation determines the occurrence of the helplessness deficits" (Abramson et al., 1978, p. 59). The descriptions of attributional style are interrelated. Thus, an individual's relative placement on each of the three continua in any particular situation both determine the helplessness deficits exhibited and assist in predicting the occurrence of future deficits.

According to Abramson, Garber, and Seligman (1980), learning that outcomes are uncontrollable results in three deficits: motivational, cognitive, and emotional. These deficits occur when an individual develops the expectation that outcomes are uncontrollable. Originally, research on these deficits was conducted with animal subjects (Overmier & Seligman, 1967; Seligman & Maier, 1967; Seligman, Maier, & Geer, 1968).

More current research involving human subjects has examined the theory of learned helplessness for its use in understanding behavior in a variety of situations. Relationships between learned helplessness and depression (Hollon & Garber, 1980; Klein, Fencil-Morse, & Seligman, 1976; Weiner & Litman-Adizes, 1980), control (Avorn & Langer, 1982; Mercer & Kane, 1979; Taylor, 1979), self-esteem (Morse & Gergen, 1970), coronary artery disease-prone personality (Glass, 1977), and stress (Garber, Miller, & Abramson, 1980) have been investigated. Figure 1 depicts a conceptual model which may be used to explain learned helplessness in humans.

Figure 1. A Conceptual Model to Understand Learned Helplessness in Humans



Original Learned Helplessness Scale

Item Development: The initial step in instrument development was the choice of items appropriate to the theoretical implications of learned helplessness. The investigators developed a pool of 50 test items from the literature that reflected the attributional styles theorized to operate within the construct of learned helplessness and distributed to three experts. The expert panel included Martin E. P. Seligman, PhD, Lyn Abramson, PhD, and Christopher Peterson, PhD. The experts were asked the following questions relative to each item: (a) Do you believe the item measures learned helplessness? and (b) How strongly do you feel that the item measures learned helplessness?

Based on the independent reviews of the test items, a total of 20 items were chosen for inclusion in the Learned Helplessness Scale (LHS). These particular items were rated as being either strongly indicative of learned helplessness or orthogonal to learned helplessness. In addition, several items were modified in accordance with suggestions from the experts. In the original version of the LHS, 10 items were positively stated and 10 items were negatively stated in order to minimize response set bias.

The participant's response to each item was rated on a 4-point Likert scale ranging from strongly agree (1) to strongly disagree (4). Participants were asked to read the statements carefully and then indicate how closely they agreed or disagreed with each item's description of themselves or their feelings about themselves. The range of possible scores is from 20 to 80. Thus, the higher the score on the LHS, the higher the participant's degree of learned helplessness.

Normative Sample and Findings: The original LHS was administered in 1984 to a sample of university undergraduate students enrolled in summer courses. The nature and purpose of the study were explained to potental participants by one of the investigators. Apart from the requirement that potential participants be able to read and write English, there were no restrictions to inclusion in the study. Individuals who agreed to participate in the study were given a packet of the following materials: (a) letter of explanation, (b) informed consent form, (c) personal information sheet; (d) original LHS, (e) Hopelessness Scale (HS), and (f) Self-Esteem Scale (SES).

Because self-esteem and hopelessness have been theoretically linked to learned helplessness, participants' scores on the HS (Beck, Weissman, Lester, & Trexter, 1974) and Rosenberg's (1965) SES were compared to scores on the LHS to determine concurrent, criterion-related validity.

The HS was designed by Beck et al. (1974) as an objective measure of an individual's negative expectancies. It is a 20-item true–false instrument which has a high degree of internal consistency, reliability, and validity. The HS was administered to a sample population of 294 hospitalized suicide attempt patients. The internal consistency of the HS was $r = .93$ using the Kuder–Richardson reliability formula. This same sample of patients showed significant item-total score correlation coefficients ranging from .39 to .76 (Beck et al.). When administered to a sample of 23 outpatients in general medical practice and to 62 hospitalized suicide attempt patients, the correlations with clinical ratings of hopelessness were .74 in the medical group and .62 in a suicide attempt group (Beck et al.).

The SES is based on intrinsic feelings of self-worth. It is a 10-item instrument reported along a 4-point continuum on a Likert scale from strongly agree to strongly disagree. This scale was administered to a sample of 5,024 high

school juniors and seniors randomly selected from 10 New York City public schools. Rosenberg (1965) found a significant correlation between SES scores and clinical ratings of depression in a sample of 150 volunteer adults. Correlations between the SES and similar measures and clinical ratings ranged from .65 to .83 (Silber & Tippett, 1965).

The final sample for the original LHS consisted of 229 participants. The majority of the sample (85%) were between 15 and 25 years of age; 124 participants (53%) were male, 105 (47%) were female. Because data on age were collected using intervals of 5 years, it was not possible to compute the standard deviation for age. Data obtained from this sample were analyzed using the SPSS–X (SPSS, Inc., 1983) computer program. Prior to data analysis, the 10 items on the original LHS which were orthogonal to learned helplessness were reverse scored so that a high score on the instrument could be interpreted as highly indicative of learned helplessness. In this sample of 229 participants, the mean LHS score was 39.12 with a standard deviation of 6.32. The standardized alpha reliability coefficient was .79.

The mean score on the HS was 22.26 (SD = 1.81, range 20 to 31). The mean score on the SES was 16.24 (SD = 4.33, range 10 to 31). Pearson product moment correlation coefficients were computed between the LHS scores and scores on both the HS and the SES. The Pearson correlation coefficient between the LHS scores the HS scores was r (229) = .352. A negative correlation was found between the LHS scores and the SES scores, r (229) = −.71.

Factor analysis was also used as a method of determining content, criterion, and construct validity (Kirk, 1982) (Table 1). As noted in Table 1, Factor 1 contained 16 items with loadings greater than .30. This factor accounted for 18.5% of the variance in the scores. This analysis indicated that the original LHS did not tap the three attributional styles of learned helplessness. In addition, many participants explained to the investigators that they were somewhat confused by the opposing nature of the items of the LHS. Thus, based on both the factor analysis results and the participants' queries, the investigators revised the original LHS and administered the revised scale to a variety of sample groups to obtain reliability and validity data.

Table 1. Factor Analysis of Original Learned Helplessness Scale

	Factors			
Item	1	2	3	4
17	.55710			
01	.55206			
07	.54033			
06	.53804			−.33217
03	.53292			
16	.48275			
19	.44891	−.32686		
11	.43843			
15	.43428	−.30700		
14	.42464			
04	.41077	.32874		
02	.38513			
20	.30375			
12				
13	.34856	−.50483		
05	.40729	.46199	−.56341	
09			−.49658	
10				
18	.51042		−.31900	.57305
08				

Table 2. Factor Analysis of the Revised Learned Helplessness Scale

	Factors				
Item	1	2	3	4	5
1	.032	−.227	−.685	−.017	−.251
2	.181	.021	−.234	.724	.137
3	.188	−.298	−.623	.300	.078
4	.144	−.219	−.022	−.157	−.708
5	.394	−.078	−.625	−.005	−.179
6	.040	−.241	−.640	.139	.060
7	.579	−.257	−.375	.257	−.115
8	.577	−.162	−.338	.362	−.009
9	.289	−.663	−.180	.094	.130
10	.781	−.230	−.180	.003	−.089
11	.728	−.180	−.058	.247	−.004
12	.580	−.176	.087	.157	−.486
13	.509	−.139	−.536	−.124	−.060
14	−.027	−.135	−.400	.220	−.650
15	.340	−.175	−.467	.196	−.337
16	.206	−.688	−.179	.075	−.103
17	.174	−.246	.044	.732	−.204
18	.197	−.743	−.198	.178	−.195
19	.039	−.687	−.195	.122	−.267
20	.132	−.662	−.154	−.056	−.175
Percentage of Variance Label	15% Internal–External	16% Global–Specific	14% Stable–Unstable	1%	1%

Revised Learned Helplessness Scale

Normative Sample, Clinical Samples, and Findings: The investigators reviewed each of the 20 items on the scale, reworded 2 items to improve clarity and face validity, and reworded the 10 orthogonal items so that agreement indicated learned helplessness.

The LHS was then administered to a sample of 241 healthy adults with a mean age of 39.8 years (SD = 12.98, range 18 to 80). The majority of the sample were female (175 participants; 72%). The majority of the participants were married high school graduates with either technical or professional jobs. The alpha reliability coefficient of the LHS in the sample was .85. Pearson product moment correlation coefficients were: between LHS and HS scores, r = .252; LHS and SES scores, r = −.622; LHS scores and age, r = .041; and HS and SES scores, r = −.430.

A Varimax-rotated factor analysis of the LHS data yielded five factors (Table 2). The criterion selected for factor loadings was .45. According to Tabachnick and Fidell (1983), a factor loading of .45 indicates at least a 20% overlap in variance between the variable and the factor. As noted in Table 2, Factor 1 contained six items with factor loadings greater than .45. Examination of the content of item 13 showed this item to be similar in concept to the items contained in Factor 3; thus, item 13 was included in Factor 3 rather than in Factor 1. Item 12 was included in Factor 1 rather than Factor 5 because of its content homogeneity or similarity to the items in this factor. Because Factor 1 tapped content relevant to the external–internal continuum, it was labeled Internality–Externality. Factor 2 contained five items with factor loadings greater than .45. These items theoretically tap the global–specific continuum of learned helplessness. The loadings of the items in Factor 2 express negative correlations between these items and the factor. Because the five items are worded to relate specific learned helplessness, it is theoretically significant that negative correlations exist between these items and the continuum of global–specific learned helplessness. Factor 2 was labeled Globality–Spe-

Table 3. Descriptive and Inferential Statistics for the Clinical Samples

Variables[a]	Oncology Sample	Hemodialysis Sample	Spinal Cord Injury Sample
Descriptive Data			
Sample size	24	30	20
Mean age	59.9	61.0	47.7
Age *SD*	7.11	10.14	12.53
% male	100%	100%	95%
% female	—	—	5%
LHS mean	44.5	41.9	36.9
HS mean	24.21	24.1	23.3
SES mean	28.88	31.77	31.4
LHS *SD*	6.02	9.71	5.10
HS *SD*	5.10	3.79	3.89
SES *SD*	5.24	4.51	4.99
Inferential Data			
Alpha coefficient	0.828	0.923	0.944
Pearson *r* LHS and HS	0.175	0.523	0.424
Pearson *r* LHS and SES	−0.683	−0.712	−0.764
Pearson *r* HS and SES	−0.431	−0.392	−0.536

[a]LHS = Learned Helplessness Scale; HS = Hopelessness Scale; SES = Self-Esteem Scale.

cificity. Factor 3 contained six items with factor loadings greater than .45. Because the items in this factor theoretically tapped the time dimension of learned helplessness, it was labeled Stability–Instability in conjunction with the stable–unstable continuum. Item 15 was included in this factor because of its content appropriateness to the stable–unstable continuum. The loadings in this factor are also negative. As the items are worded to express more unstable learned helplessness, these negative correlations between the items and the factor are appropriate.

Factors 4 and 5 each contain only two items. Factor 4 contains items related to individuals' beliefs concerning their inherent ability–inability to control or predict the outcomes of situations. These items are theoretically related to the concept of learned helplessness; therefore, it was decided to retain them in the revised scale. Factor 5 contains items concerning an individual's choice of situations in which the person intentionally participates. Because the idea tapped in these items is theoretically related to the concept of learned helplessness, it was again decided to retain these items in the scale.

To obtain normative data on clinical adult populations, the LHS was administered to samples of oncology patients, hemodialysis patients, and spinal cord injury patients. Because these clinical samples included relatively small groups of patients, only the coefficient alpha on the LHS and the Pearson coefficients between the HS and the LHS and between the SES and the LHS were computed on the data obtained. Table 3 includes the descriptive and inferential statistics for these samples.

Discussion

Because the alpha reliability coefficients for both the healthy adult sample and the clinical samples on the LHS were .82 or above, the investigators believe the internal consistency of the instrument is adequate. Content and face validity of the LHS have been assured by the review of independent experts. Concurrent, criterion-related validity has been assessed by examining the correlations between the LHS scores and the scores on instruments measuring theoretically related concepts. The correlations found between the concepts of learned helplessness, hopelessness, and self-esteem were in the direction postulated by various theorists.

The reliability and validity of the LHS are adequate. Therefore, the LHS can be used in hypothesis-testing designs. Continued use of the LHS will necessitate reexamination of its reliability across different samples and over time. It is anticipated that the LHS will become a useful tool both as a screening device and eventually as a diagnostic instrument for use in a variety of health care situations to diagnose learned helplessness states. NR

Accepted for publication June 2, 1987.

This study was supported by a Support Grant from the Office of Research, College of Nursing, Rutgers, the State University of New Jersey.

The assistance of Janice Chandler, MS, RN, Kate Douglass, MS, RN, Catherine Lubliner, MS, RN, and Odarka Mechnycz, MS, RN, in the development of this instrument is acknowledged.

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CALENDAR OF RESEARCH EVENTS

February 6–7, 1988
"Relationships, Recovery and Relapse," the 6th Annual Drug and Alcohol Conference, will be held in Los Angeles, CA. For information contact: UCLA Extension, PO Box 24901, Los Angeles, CA 90024; 213/825-1901.

February 10, 1988
"The Ties That Bind: Interfamily Relationships," a continuing education midwinter series for nurses, will be held in Kansas City, KS. For information contact: David Baldwin, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, KS 66103; 913/588-4488.

February 25–26, 1988
"Diabetes Review and Update," a conference sponsored by the University of Pennsylvania School of Nursing and Eastern Virginia Medical School, will be held in Norfolk, VA. For information contact: Susan Mullen, MS, RN, CDE, Diabetes Program, Eastern Virginia Medical School, Norfolk, VA 23507; 804/446-5908.

March 1–2, 1988
The 3rd Association of Pediatric Oncology Nurses, sponsored by the Southern California Chapter of the Association of Pediatric Oncology Nurses, will be held in Long Beach, CA. For information contact: Sharon Bergeron, Childrens Hospital of Orange County, CA; 714/532-8525.

March 5–7, 1988
"Funding Nursing Research: The Critical Imperatives," a research forum sponsored by The Ohio State University College of Nursing and Center for Nursing Research, will be held in Columbus, OH. For information contact: Center for Nursing Research, Ohio State University, 1585 Neil Ave., Columbus, OH 43210-1216; 614/292-5371.

March 10–11, 1988
The 13th Annual March of Dimes Perinatal Nursing Conference, "Are Changing Lifestyles and Expectations Changing Delivery of Health Care?," will be held in Chicago, IL. For information contact: Pamela Ippoliti, Conference Coordinator, March of Dimes, 1 North Dearborn #1008, Chicago, IL 60602; 312/407-4007.

March 16, 1988
"Great 100 Nurses Night," sponsored by the New Orleans District Nurses Association, will be held in Metairie, LA. For information contact: P. K. Scheerle, RN, Chairperson, Ways and Means Committee, New Orleans District Nurses Association, 712 Transcontinental Dr., Metairie, LA 70001; 504/456-9122.

March 31–April 1, 1988
InfoFair '88, a conference on health sciences and nursing information, will be held in Salt Lake City, UT. For information contact: Barbara J. Kerr, MSN, RN, Coordinator for Community Services, College of Nursing, University of Utah, 25 S. Medical Dr., Salt Lake City, UT 84112; 801/581-8755.

April 9, 1988
"Nursing Research: The Link Between Theory and Practice," the 8th Annual Nursing Research Day, will be held in Tulsa, OK. For information contact: Joann P. Wessman, PhD, RN, Oral Roberts University Anna Vaughn School of Nursing, 7777 S. Lewis Ave., Tulsa, OK 74171; 918/495-6198.

April 14–15, 1988
"Stress, Coping Processes and Health Outcomes," a national conference sponsored by the University of Rochester School of Nursing and Epsilon Xi Chapter, Sigma Theta Tau, will be held in Rochester, NY. For information, contact: Ruth A. O'Brien, PhD, RN, Director, Research Office, School of Nursing, University of Rochester Medical Center, 601 Elmwood Ave., Rochester, NY 14642; 716/275-8880.

April 14–15, 1988
The 3rd Phyllis J. Verhonick Nursing Research Conference will be held in Charlottesville, VA. For information contact: Kathleen A. Koon, MSN, RN, Division of Continuing Education, Department of Conferences and Institutes, University of Virginia, PO Box 3697, Charlottesville, VA 22903; 804/924-7220.