Immediate Past President, Patricia D. Cunningham, wrote about the resiliency and versatility of psychiatric mental health nurses. Any of us working in health care, particularly the inpatient setting, have become accustomed to change. We have all had to contend with changes to our work environment, practice areas, reimbursement or allocation of resources. How we respond to change will inform how we shape our future. Will we embrace change, adapt and flourish? President Susie Adams encourages us to embrace change too, using our “seat at the table” to promote mental health in our homes and communities and to combat the stigma of mental illness.

I would echo our leadership in saying we can adapt, using our many talents and our seat at the table to help create a better future for our patients and ourselves. Who can deny that without mental health there can be no health and well-being? As psychiatric mental health nurses we have an important and essential contribution to make to what constitutes the best health care for optimal population health.

For many, the fall season represents a time for renewed purpose and focus. Perhaps I feel it more strongly in the fall because of my childhood anticipation of the new school year and new notebooks full of blank pages waiting to document my newly acquired knowledge. For others, spring is the time of year that is full of promise and new life. As I reflect on new promises, I ask you to reflect on what we may accomplish in our chapter in the coming year. Perhaps you can invite a fellow nurse to join APNA? Maybe you can mentor a student to become a psychiatric nurse? Or you can share your wealth of knowledge and experience with your nurse colleagues, friends, family and neighbors in order to decrease the stigma associated with mental illness.

Does your workforce need inspiration about the value of professional membership? We need the participation of all members to make the New England Chapter and our national organization a continued success. Please consider taking a student or colleague along as you attend the chapter conference this spring in Portland, Maine. Please contact your state representative to the NEAPNA board to see how you can help.

As the trees bud new leaves and daffodils bloom, think about renewal, be open to possibilities, say yes to opportunities and make a difference with your unique talents. Enjoy the changing season and be well.

Joanne Matthew, President, NEAPNA
“I Believe, Too”
Carol Anne Marchetti

I have no doubt that anyone who attended our annual conference left thinking about Carole Shea’s powerful and poignant words. A central theme in Carole’s presentation, “This I Believe, About Psychiatric Nursing,” spoke to the notion that psychiatric nurses have expertise and skills that are relevant not only to a subset of individuals who suffer from mental illness, but for all humanity. We share the need for social connection, compassion, and understanding. We need to be able to understand and predict human behavior. In our personal toolboxes, we need to store evolving coping skills that are fine-tuned and familiar, yet responsive and dynamic. While we value and honor the work of all nurses, whether they are generalists or specialists, novices or experts, Carole’s message stimulated us to think about the broad and pervasive applicability of the work we do as psychiatric nurses.

This notion reminded me of an analogy that I often share with my psychiatric-mental health nursing students. While discussing the seminal work of Hildegard Peplau, I elaborate on the far reach of her influence, not just in nursing but also in psychiatry, sociology, and other disciplines as well; that not only did she contribute but she also laid the foundation for the roles, structure and function of psychiatric nursing, and in doing so, the roles flourished. When we speak of relationship as being the centerpiece of our work with clients, we are talking about Peplau. Likewise when we reflect on our varied roles, including that of an advanced practice nurse, we are obliged to give a nod to Peplau. To bring this point home for the students, I compare the influence of Peplau’s contribution to nursing to that of Sigmund Freud’s to psychiatry, and William Shakespeare’s to the modern English language. To liven up this analogy, I enjoy sharing the following wonderful piece that was written by Bernard Levi:

“On Quoting Shakespeare”

If you cannot understand my argument, and declare “It’s Greek to me”, you are quoting Shakespeare; if you claim to be more sinned against than sinning, you are quoting Shakespeare; if you recall your salad days, you are quoting Shakespeare; if you act more in sorrow than in anger; if your wish is farther to the thought; if your lost property has vanished into thin air, you are quoting Shakespeare; if you have ever refused to budge an inch or suffered from green-eyed jealousy, if you have played fast and loose, if you have been tongue-tied, a tower of strength, hoodwinked or in a pickle, if you have knitted your brows, made a virtue of necessity, insisted on fair play, slept not one wink, stood on ceremony, danced attendance (on your lord and master), laughed yourself into stitches, had short shrift, cold comfort or too much of a good thing, if you have seen better days or lived in a fool’s paradise--why, be that as it may, the more fool you, for it is a foregone conclusion that you are (as good luck would have it) quoting Shakespeare; if you think it is early days and clear out bag and baggage, if you think it is high time and that that is the long and short of it, if you believe that the game is up and that truth will out even if it involves your own flesh and blood, if you lie low till the crack of doom because you suspect foul play, if you have your teeth set on edge (at one fell swoop) without rhyme or reason, then--to give the devil his due--if the truth were known (for surely you have a tongue in your head) you are quoting Shakespeare; even if you bid me good riddance and send me packing, if you wish I was dead as a door-nail, if you think I am an eyesore, a laughing stock, the devil incarnate, a stony-hearted villain, bloody-minded or a blinking idiot, then--by Jove! O Lord! Tut tut! For goodness’ sake! What the dickens! But me no buts! --It is all one to me, for you are quoting Shakespeare.

Indeed, just as the influence of the work of Freud, Shakespeare, and Peplau is so pervasive as to easily go unnoticed, we, as both clinicians and human beings, require and utilize the skills that characterize the work of psychiatric nurses. This speaks not only to the ubiquity but also to the relevance of our work. I agree with Carole’s message that as psychiatric nurses we are well poised to utilize our collective knowledge and expertise to improve the lives of others and ourselves in profound and expansive way.
The NEAPNA spring conference was held in Newport, RI on Saturday, May 3rd, 2014 at the picturesque Salve Regina Campus. Approximately 100 of you came to learn, support each other and to network. We were happy to see the turnout for both the conference and the awards dinner the night before. At the awards dinner we honored the achievements of some our shining stars in the psychiatric nursing profession. We heard from excellent speakers, including our keynote speaker, Eric Arauz, who transfixed us as he helped us to understand the treatment experience from the eyes of a person being treated. He then provided attendees with signed copies of his book. Those who attended the conference received 6.5 CEU’s. It was a successful event! We look forward to seeing you again at the 2015 conference in Portland, Maine!

2014 Award Winners:

Nancy Valentine Award: Dr. Danny Willis
Grayce Sills Award: Carole Shea
Sue Scipione Award: Linda Sheppard-Reece
Tom Marland Scholarship: Eric Gallagher
Sue Scipione Award: Linda Sheppard-Reece

Nancy Valentine Award: Dr. Danny Willis
I’m probably not the most appropriate person to review this book since I am retired and have not worked in inpatient psychiatry for decades. This is a great book akin to that experienced, educated, practical and knowledgeable nurse mentor who manages to be Jack-of-all-trades, to say the right thing at the right time, to be available to hear your story without judgment, and to provide guidance without promoting dependency. Since this ideal psychiatric nurse mentor is not always available, this book fills the gap by presenting written strategies by expert nurses in understandable and useful ways. This book is not loaded with esoteric clinical terminology. Instead, it provides instruction in assessment and treatment that can be understood by all levels of psychiatric nursing. Active participation of the patient in treatment is encouraged.

In my day patients remained on the psychiatric unit for weeks and months. Today patients have limited stays with pressure for discharge as soon as possible. With knowledge of this book in the "back pocket," psychiatric nurses will be able to manage the angry, anxious, disorganized, manic, paranoid and withdrawn patient as well as the patient with non-suicidal self-injury, with suicidal ideation, with pain and substance abuse issues.

The book provides for mastery in assessment, intervention and discharge preparation. There are excellent sections on CBT, relaxation including Jacobson Relaxation Technique, as well as working with families and providing patient education material.

The chapter on non-suicidal self-injury reflects the experience, practice and generosity of an expert nurse. In my day working with the patient described as "borderline" was extremely stressful and treatment plans were often not practical or therapeutic. This chapter provides a road map for caring for patients with non-suicidal self-injury and promotes confidence in the nurse caring for the patient.

The steps to establishing trust relationships is woven throughout the book in a thoughtful and practical manner. This book is excellent for teaching novice, intermediate and expert nurses to provide best care in a consistent fashion.

Throughout the book, the authors stress the need for the psychiatric nurses to be aware of their own issues and how attitudes reflect on patient care. Individual and group supervision and is stressed to help psychiatric nurses iron out their wrinkles as they become instruments of good care. This book is an indispensable tool for successful caring of the inpatient psychiatric patient.
An Approach to Care from an Irreverent and Recalcitrant Psychiatric Nurse

Theresa M. Damien RN/NP, PMHNP-BC, CARN-AP

How does irreverence and recalcitrance fit into the work of a psychiatric nurse? The question has to be on some of your minds. What exactly is meant by such words? Let’s look at the meanings. Recalcitrant or per the Merriam-Webster’s dictionary means to be openly disobedient, rebellious, non-adherent is derived from the Latin verb ‘recalcitare’ meaning to kick back (http://www.merriam-webster.com/dictionary). In my opinion the best way to explain meaning of irreverence is exemplified by the from Mark Twain’s personal 1888 notebook: “Irreverence is the champion of liberty and its only sure defense.”

As a child, I was described as both irreverent and recalcitrant, but then likened to a “heart of gold”. Childlike logic found these to non-congruent and were dismissed swiftly.

How do the description, definition, and quotation relate to this psychiatric nurse’s approach to care? A page to the ER where a consult and liaison was needed for a seven month pregnant woman whose “chief complaints” were insomnia and severe panic is the origin of the story. The approach to the room of Ms. X’s room was the same as usual. I perused the chart and had the inner locution of “high risk”. High risk for a multitude of reasons: pregnancy, primiparous, insomnia, anxiety, and a past history of psychosis within Bipolar Disorder. Initially I thought, “why me and why did I not call in sick to work?” I entered the room to find Ms. X sobbing profusely, sitting with her mother, her husband, and her grandmother in the consult room.

Ms. X did not look at me. My initial impression was that I was an intrusion to the profound sadness and comfort provided by her family. My own traumatic C-section, the tears that followed, probably richened by empathetic response to her plight and response. “Pain without purpose is useless”, my mother’s favorite incantation ran through my brain. My pain, my purpose, at least at this very moment, was my only tool to help Ms. X. Quietly, I sat in the corner allowing Ms. X and her family to have their space. Her grandmother piteously offered me a smile and said, “I hope you can help her.” I smiled back; again the negative chatter of my mind, “if only I could help myself.” I decided to be both irreverent and recalcitrant to my own fears, my personal terrors, and my human inadequacies and attend to Ms. X. She explained that she could not sleep, she could not have the baby, her feelings of terror and impending doom were with her for the past month, her days were filled with flashbacks of her own abuse as a teen, and that she needed a caesarian section. Intuitively I felt her hesitance to expound on her statement was due to privacy, so I handed her my pen and pad. The words ‘please ask them to leave, I don’t want them to be mad at me’, were scribbled. I waited a minute and carried out her request. Clarification of her statements was made during a routine mental status examination. She did not have any overt evidence of psychosis and denied urges to hurt herself or others. The flashbacks and inability to deliver the child vaginally were derived by multiple sexual assaults experienced by her as a teen.
“Tokophobia” or the intense fear of childbirth blurted from my mouth. Confidently I repeated this word and assured Ms. X that she was suffering from a “real (non DSM5) diagnosis of tokophobia.” She appeared to be relieved that she was not alone. She explained to me that she asked her OBGYN for a C-section, but was informed that the standard of care was a vaginal delivery. Ms. X did not want her OBGYN to know of her trauma history. She told me it was bad enough that the OBGYN knew about her mental illness. She did not want the baby taken away from her. Losing this child was her greatest fear. It even was greater than vaginal delivery.

Recalcitrance and irreverence again propelled me to challenge the OBGYN’s sacred directives of a vaginal birth as the preferred and evidenced based mode of delivery. The result was my consultation note for Ms. X that recommended the method of delivery in relation to her current psychiatric symptoms. The recommendation was made to OBGYN to reconsider the request of Ms. X. The coup de grâce of the consult, utilization of the deadly bullets: perinatal and postpartum psychosis supported by literature and wrapped in the bows of trauma informed care coupled with the person centered care approach (Marce International Society, 2013) (Massachusetts General Hospital Center for Women’s Mental Health, 2014) (Foulkes, 2011).

Ms. X. did not want her sexual assaults disclosed to anyone including the OBGYN, so I cloaked the damage they did to her with the word tokophobia A.K.A post-traumatic stress disorder. Ms. X’s initial symptoms were addressed. Dysphoria replaced with trust. She and her family left the hospital together appearing placid. She had an appointment with her outside psychiatric treators, who were made aware of her ER visit.

The dilemma of how does a provider utilize a person centered approach which is mindful of trauma, protect privacy, and adhere to evidence based guidelines? This challenge will be a more frequent scenario in my opinion as we progress to a changing healthcare system. I fear that one day I will not be able to keep her psychiatric history to a minimum level of disclosure as well integrate care. Then my mind wandered, did I just utilize “virtue ethics” by being both rebellious and irreverent? I shook off my shock and attended to my next consult.

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