Combating Nurse Stereotypes Through Communication About Our Work

In her 2009 memoir, *Weekends at Bellevue*, psychiatrist Julie Holland (2009) described 9 riveting years of work in the psychiatric emergency department at New York’s celebrated Bellevue Hospital, the largest and oldest public hospital in New York City and a name virtually synonymous around the world, with psychiatric treatment. Holland (2009) presented a cut-throat, self-absorbed, attention-grabbing diva, a kind of Doctor Mean Girl, cartoonishly hungry for sexual attention from supervisors, gleefully humiliating professional rivals, and habitually, disturbingly talking about patients as if they were animals—even at one point referring to herself, metaphorically, as a “zookeeper.” Smart, sassy, and eminently readable, not least because of Holland’s lurid and titillating reports about her sexual conquests on the job, the book was highly successful, landing for a time on the U.S. national bestseller list. But many readers panned it—and for not surprising reasons. Critics, particularly in the mental health field, noted that it is difficult to like a person who mocks her patients and then imagines her writings might sit alongside the New Testament in the nursing station bookshelf.

Along comes the antidote in Elizabeth Ford’s (2017) *Sometimes Amazing Things Happen*, another Bellevue-based tell-all. A psychiatrist, like Holland, Ford started out self-involved and ambitious, and she grew into the job. Unlike Holland, however, Ford appears to be interested in her patients rather than in their antics. She notices their humanity and not just their misbehavior, she wonders how their lives might have blossomed under different circumstances, and she asks about their families and the people they have loved. Ford (2017) does a yeoman’s service describing the sordid organizational politics, interagency conflicts, and broader policy failures embedded in the giving and receiving of mental health treatment in this complicated setting. For those of us who work in this field and struggle with its often-stunning dysfunctions, her stories ring true: this is a great read.

What these books have in common, however, is their view of nursing. Nurses are mostly invisible in these pages—maybe a notch above the level of furniture. And when we do make appearances, they are generally not flattering. We fill syringes, we attend the office parties, we are helpful (most of the time) with seclusion and restraint. We’re friendly enough. But we’re also frequently impatient, harried, emotionally hair triggered, absorbed by task deadlines, and lacking in intellectual curiosity. We perseverate about personal gripes and rarely contribute in sensitive or sophisticated ways to clinical decisions and conversations. At times, we keep our mouths shut when moral courage would call for speaking out.

Is this us? It is remarkable how these representations differ from our own conception of our work.

Many of us know psychiatric nurses like the ones depicted in these books, for sure. But why don’t these writers seem to notice the energy and creativity that the rest of us invest virtually continually in complex relational work on our units? Why don’t they see that an atmosphere of trust and stability, built largely by floor duty nurses in a multitude of day-to-day encounters, is what enables patients to make the most of the treatments these physicians prescribe? A great deal of nursing labor is deeply embedded in all the care scenarios described in these books. So why, even in a place like Bellevue, should it be so invisible?

Stereotypes about nurses are part of our problem, as Shattell (2017) pointed out recently. A few important new books go a long way toward correcting the bad image, at least in non-psychiatric settings (Alexandra Robbins’ [2016] best-selling *The Nurses*, Lee Gutkind’s [2013] *I Wasn’t Strong Like This When I Started Out*, and Theresa Brown’s [2015] *The Shift* come to mind). But the problem cannot and should not be boiled down to someone else’s stereotypes. A good bit of responsibility rests with us—with our own tendency to talk mostly to ourselves about key elements of our work.

In how many psychiatric nursing courses do students learn about communicating across the disciplines, and with individuals who speak a different clinical language? In how many courses do students learn about coordinating optimally with others involved in treatment? About ways nurses might figure in case formulation, or about the specific ways we might bolster efforts by other clinicians working with our patients? What do we know about their caseloads, schedules, and clinical challenges? And what do they know, really, about ours?
Psychiatric settings can be particularly fraught and charged, as everybody absorbs the violent emotions and psychological undercurrents endemic to the work. But how often do we take time to identify those undercurrents in our clinical conversations at work? Or explain our techniques for managing them in ourselves and on our units? The answer is: almost never, which is a major source of the problem of our invisibility.

If we want to break stereotypes, if we want our work on psychiatric units to be noticed and acknowledged, we need to give names and words to what we are doing so that our coworkers can see it. That means talking to non-nurses not only about medication administration or patient behavior, but also about unit-management functions, including the steps we take, on any given day, to set tone and structure in the clinical environment. Our morning team conferences often exclude these, as we usually skip that kind of milieu management information when reporting on specific patients. Much of the time, even nursing administrators are not particularly interested in hearing about it.

There is no psychiatrist in any hospital—Bellevue or elsewhere—who works without the buttress of intensive nursing labor of this type. Our talking about it will be key to helping others see us as thoughtful collaborators and professional colleagues.

REFERENCES

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