Using the Patient–Family–Nurse Triad to Improve Advocacy and Patient Care

I am a psychiatric nurse practitioner who lives with bipolar I disorder. I am a wife and mother to three amazing boys, ages 10, 8, and 8, one of whom has autism. Over the past 5 years, my husband and I have seen various specialists trying to obtain an accurate diagnosis for the youngest of our 8-year-old sons, as we believed there was an issue in addition to his autism. Did my son have disruptive mood disorder (DMDD) or pediatric bipolar disorder? His inpatient and outpatient psychiatrists could not agree on a diagnosis. We have spent this past summer trying to figure it out, as my husband and I knew that an accurate diagnosis meant a better chance that our son would receive appropriate treatment.

The purpose of this guest editorial is to show the importance of advocacy for patients and their families by using my personal story to demonstrate how the relationship between psychiatric nurse, patient, and family is essential.

MY STORY

My son saw a therapist weekly. A mood stabilizer was suggested by one psychiatrist and then he was placed on it by another psychiatrist. Despite this treatment, my son had what appeared to be a manic, or at the very least a hypomanic, episode toward the end of the school year into early summer. We plugged through it with adjustments in medication by his psychiatrist; his medication was carefully up-titrated to an appropriate dose. My son was kicked out of camp on the first day due to behavioral issues, which likely may have been related to the mania/hypomania my husband and I were seeing at home. Ultimately, once the drama died down and he was reinstated at camp, one evening my son stated he wanted to hurt himself, and not with simple self-harm behaviors. He wanted to take a knife and stick it through his heart and die. We took him to the emergency department (ED).

What happened next was surreal. No one listened. Our social worker in the ED effectively pitted my husband and me against each other to meet her agenda of discharging our son to an intensive outpatient program (IOP) despite our stating that an IOP was physically impossible for our family to manage with our work schedules. My husband, who talked to our son’s outpatient psychiatrist that day, was told that she was fully on board with admission for safety and medication management. However, we learned that she was concurrently telling the ED staff a different story—she did not support admission. Our son was excessively irritable, possibly hypomanic, and suicidal. He was admitted only after I spoke to a prominent child psychiatrist not involved in the case who called in favors, which had the unit chief override the ED social worker and on-duty psychiatrist.

My son’s inpatient hospitalization, although helpful, was not without conflict. Once my son was admitted, the attending psychiatrist stopped his mood stabilizer to determine mood and watched him for 8 days. We watched him become more irritable and uncomfortable, begging us to take him home. During this time, my son was given the diagnosis of DMDD and started guanfacine hydrochloride (Tenex®). During this push for discharge to a partial hospitalization program (PHP), someone on the inpatient staff referred us to the Department of Children and Family Services (DCFS). We were not referred due to neglect, abuse, or concerns of harm. We were referred because of medication information I had disclosed during the time we did not have insurance, which psychiatry philosophically disagreed with. The DCFS turned out to be a blessing in disguise. They made it clear they saw a family that loved its son and tried to do right for him and supported the choice not to discharge him to PHP due to the burden it would place on the family. The DCFS gave us access to tools and resources not available to the general public or hospital team, which would allow us to properly care for him postdischarge and set him up for success, teaching us how to be the parents we need to be for our son now and in the future.

WHAT’S NEXT?

I recently remarked on Twitter: “I know how to be a psych provider. I know how to be a psych patient. Learning how to be a parent to a child who is inpatient psych is the hardest thing I will ever do.” There are three roles here—patient, family, and psychiatric nurse. It is the most critical, powerful, important triad a psychiatric patient and his/her family will learn about and depend on in the journey to remission and wellness. The nurse is the cornerstone of this triad. Nurses advocate for their patients as well as give voice to both patients and family, helping them...
communicate not only with each other, but with inpatient and outpatient health care team members.

As I prepare for the American Psychiatric Nurses Association Conference this fall, I will present about psychiatric nursing advocacy and how we can be better advocates, using my experience as a psychiatric provider, patient, and mother of a son with what is presently being called DMDD. My portion of the interdisciplinary panel (which includes a former Congressman) will highlight numerous issues; however, the crux of my talk will focus on the patient–family–nurse triad and making the triad a more positive, effective one. As nurses, we do not know or understand the fear and emotions coursing through the veins of these families while summoning up the courage to seek our help in asking the simplest of questions. When families seek nurses’ opinions, expertise, or guidance on how to be there for their loved one, how to talk to physicians and other health care providers more effectively, and how to be heard when imparting critical information, nurses need to step up and stand up for patients and their families. It is a key moment when the family opens the triad to the nurse and allows him/her to be a change agent and advocate. That moment must be seized. Unless another patient on the unit is in danger, there is nothing more pressing to attend to than that family in that moment.

CALL TO ACTION

As nurses, it is easy to feel pressed for time during a busy shift. That very stress for time creates a barrier in allowing for a functional patient–family–nurse triad. Lack of time does not allow the nurse to be open to possibilities. Other barriers can include being quick to judge either the patient or family, which I believe we have all been guilty of at one time or another during our career. Letting go of judgements and opening communication increases nurses’ chances to be the successful glue in the triad while working on critical communication skills such as trust, empathy, kindness, listening, and respect.

It was a nurse on an adult unit where I was hospitalized several years ago who gave me words of hope to cling to when I thought remission would never be possible.

It was the nurses on the weeknights when I visited my son who showed compassion and never failed to make me feel welcome. It was the nurse manager of his unit—when I sat on a bench sobbing during a horrible day, knowing the DCFS was coming, feeling I wasn’t listened to by the physicians, and aware that my son was in the “quiet room”—who listened to me and arranged a meeting so I could be heard. Advocacy will forever remain a tenet of nursing in general and psychiatric nursing specifically. I challenge you to remember you are the glue of the triad, holding it together on the best and worst days for families and patients. Be the advocate individuals with mental illness so desperately need. Be the voice for the voiceless.

Ann Roselle, MSN, ACNP-BC
GAP Clinical Care and Research Center
Hamden, Connecticut

The author has disclosed no potential conflicts of interest, financial or otherwise.

doi:10.3928/02793695-20180817-02