

ORTHODOX
JEWISH
NURSES
ASSOCIATION

THE OJNA JOURNAL

Issue 7 | Winter 2020



Mental Health & Psychiatric Nursing

**Nurse
Burnout**

**Mental Health in
the Orthodox
Jewish Community**

**Social Media and
Mental Health**

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The Orthodox Jewish Nurses Association was founded in 2008 by Rivka Pomerantz, BSN, RN, IBCLC. It seeks to provide a forum to discuss professional issues related to Orthodox Jewish nurses and arrange social and educational events. We strive to meet the needs of our members, promote professionalism and career advancement, and be a voice for Orthodox Jewish nurses across the world.

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Editor's Note

Dear Members,

Psychiatric/Mental Health nursing may be a niche field, but patients with psychiatric diagnoses are cared for across practice settings. Yes, we care for patients with psychiatric diagnoses in the psych ward, but we also treat them on the postpartum unit, in critical care, on a general medical surgical unit and in the emergency department, in schools and in outpatient clinics. We come across mental health diagnoses as they touch our family, friends, and community and oftentimes we experience issues of mental health in our own lives.

This year I was touched by mental illness in a new, beautiful and terrifying way. A woman I know, an intelligent and educated person, called me shortly into the COVID-19 pandemic. She seemed breathless with nervous energy, excited and fearful at the same time. She was ready to share with me secrets and knowledge that she had become privy to. She divulged that she had spoken with Hashem. She now knew of His ways and of His plans. She felt His love, and wanted to share that with me. She described the Light and how much He loved us. She knew of terrible and frightening days ahead but of a goodness that would come of it all. She knew her role in it, and that sacrifices would have to be made. She hinted to horrors she would have to endure, and yet she was willing, now that she knew Him and His ultimate plan.

I wanted so badly to be drawn into her world. It was so real to her, and I almost wanted it to become real for me too. I was an outsider to her beautiful reality, one where she could find peace knowing, in full details, Hashem's ultimate plan. The rational part of me knew it was her psychosis speaking, a psychosis induced by medications she had been recently placed on. But the dreaming, spiritual part of me wished, and wondered. Why is my reality right and hers wrong? How can I ever trust my sense of equilibrium in this world knowing how easily one can slip into an alternate universe? What would it take to put me there, and how could I differentiate between reality and a psychosis-derived world if I ever tumbled into one? On a continuum between reality and psychosis, where are spirituality and the numinous experience? As religious and spiritual people who believe that there is a reality called *nevuah* (prophecy), how can we distinguish between true prophecy and delusions that sound remarkably similar?

This woman has since recovered from her bout with psychosis, and we have not since spoken about that episode. For me, it was a stark reminder of the hazy and tenuous character of the line between mental illness and mental health. It's a continuum, and a blurred one at that. Moreover, mental health and mental illness aren't binary. You can have poor mental health without having a diagnosed mental illness. And conversely, there are those with diagnosed mental illnesses who experience good mental health.

Working in an ICU setting, I've had my share of patients struggling through polysubstance abuse withdrawal, fighting for their lives after an attempted suicide, and I've managed many patients with delirium and ICU psychosis. I've also personally worked through postpartum depression and guided a family member dealing with postpartum anxiety. But truly focusing on mental health is not something I've done since nursing school. Our decision to focus on this ever-present, important topic in this issue of the OJNA Journal has been a remarkable experience for me as an editor. I hope you all feel the same way after you close the final page.

Be well,

Chaya Milikowsky

THIS ISSUE AT A GLANCE:

Disturbed sleep is indeed a modifiable risk factor in the development of PPD...

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NURSES WHO ENTER THE FIELD WITH THE GOAL OF HELPING OTHERS MAY BE MORE **SUSCEPTIBLE TO BURNOUT**, AS THEY ARE MORE LIKELY TO TAKE THEIR PERCEIVED **JOB-RELATED SUCCESSES OR FAILURES PERSONALLY.**

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...found that **positive religious coping** and **trust in God** were associated with decreased depressive symptoms

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How does it feel to have a mood disorder? ***And how does it think to have a mood disorder?***

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These meaningful moments of patient connection are my **nursing tea essence.**

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Among oncology patients, the prevalence of psychological comorbidities and suicide is **more than double** when compared to the general population...

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Standard treatment for depression consists of either psychotherapy, pharmacotherapy, or a combination of the two.

is this really the way that the system cared for an **extremely vulnerable woman?**

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Stigma toward mentally ill patients has been found to lead specifically to lack of attention to the medical needs of patients, mismanagement of their care, and it also contributes to social marginalization.

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...one must determine the parameters of the question from both **mental health and halachic perspectives.**

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THE INTERNET AND SOCIAL NETWORKING FORUMS HAVE **INFLUENCED SIGNIFICANT CHANGES** IN THE WAY **PEOPLE COMMUNICATE AND INTERACT.**

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The Orthodox Jewish Community and Mental Health

By Tobi Ash, MBA, BSN, RN,

Introduction

Mrs. C.S. Goldstein, a 54-year-old Chasidic woman, is a daughter and daughter-in-law of Hungarian Holocaust survivors. She had trouble getting pregnant and felt a deep sense of shame and depression about her infertility. She finally gave birth at 32 years old to an only child, a daughter, who is now 22 years old and has been diagnosed with bipolar disorder. Mrs. Goldstein worries that her daughter will never get married if anyone finds out about her "mental problems." She feels that she ought not complain about her problems compared to the tragedies and stress her parents and in-laws faced. She also feels that if she just had stronger emunah and bitachon, she wouldn't feel so depressed.

The National Institute of Mental Health states that in 2017, about 1 in 5 adults, 18.9% of the population, or 46.6 million individuals in the US experienced some form of mental illness. One in 25 adults, 11.2 million individuals, or 4.5% of the population experienced severe mental illness [1]. About 7.7 million children from ages 6-17 (16.5%) experienced some form of mental health disorder [2]. Shockingly, the average delay between the onset of mental illness and treatment is 11 years [3].

Depression is the leading cause of disability found worldwide [4]. Those suffering from depression have a 40% greater risk of developing metabolic and cardiovascular disease than the general population [5]. One of the most common reasons for hospitalizations for people aged 45 and under in the US is mood disorders [6].

An estimate in 2008 showed serious mental illness costs the US economy almost \$200 billion in lost earnings annually [7].

Prevalence of Mental Illness in the Jewish Community

The number of Jewish comedians and public figures who talk about their neuroticism, anxiety, and depression may give the impression that Jews are more anxious and neurotic than the general population.

In the 1990s, the 5-HTT gene was identified in both its long and short forms. This gene makes a protein that modifies the way nerve cells use serotonin (a chemical messenger that regulates mood). The shorter version of 5-HTT was linked to a neurotic personality. The media immediately dubbed this "the Woody Allen" gene after the famous Jewish comedian who has parlayed his neuroticism as his life's work [8]. Whatever one's feelings are about Woody Allen, this nickname reflects the Jewish tendency to verbalize anxiety and neuroticism.

Research from the 1950s and onward showed Jews do suffer from certain mental illnesses at higher rates as compared to Catholics and Protestants. These include major depression, dysthymia (persistent depressive disorder), schizophrenia, and simple phobia [9,10]. However, recent studies show that the rates of mood (bipolar disorder) and anxiety disorders, such as panic disorder and agoraphobia, in the Jewish population are within the range of other religious groups in Western countries [11]. Jews are

more likely than Catholics or Protestants to seek help [12]. Jews do not necessarily have higher rates of obsessive-compulsive disorder (OCD) [13]. Overall, rates for mental illnesses except for depression were not higher for Jews. However, there is evidence that Orthodox Jewish females do have a higher rate of eating disorders as compared to the general population [25,26].

Previous research in a 1979 study posited that Orthodox Jews were woefully underserved and remained a community with particular challenges. This was especially true with the ultra-Orthodox Jewish community who are most in need of services [14]. In 2014, a follow-up study found that there was a positive movement towards obtaining mental health services although barriers, including continuing stigma relating to mental illness and the concept that psychotherapy may conflict or even violate Jewish laws and values, persisted [15].

Jews have been a major force in the establishment of psychology, and many of the famous names in psychology theory are Jewish: Alfred Adler, Erik Erikson, Viktor Frankl, Sigmund Freud, Erich Fromm, and Abraham Maslow, to name a few [16]. Despite a list of more than 100 famous influential Jews in psychology, sociology, and psychiatry, the Jewish community has not always been comfortable dealing with mental illness or even talking about it.

Mental Illness in the Torah

The first mention of mental distress happens in Deuteronomy while recounting the curses and is considered a form of divine punishment. יִכְּהָה, בְּשֵׁעוֹן וּבְעֵוֹן; וּבְתַמְהוֹן, לִבְבִּי "Hashem will afflict you with madness, blindness, and confusion of mind." (Deuteronomy 28:28).

The word used to describe the punishment of the madness that will fall upon those who do not heed the word of Hashem is *shigaon*, the origin of the Yiddish word "*meshuga*" or crazy.

In the Talmud (*Chagigah* 3b), there are four categories of mental capacity:

1. *Pikeach* - a competent person
2. *Cheresh* - a deaf-mute
3. *Katan* - a minor
4. *Shoteh* - "insane"

Although the *shoteh* is not as clearly defined as the other three, the Talmud lists several actions that demonstrate a detachment from reality. These include going out at night, being heedless to danger, sleeping in a cemetery, ripping one's clothes, and losing everything they have (*Chagigah* 3b). Rambam (Maimonides) brilliantly added that a *shoteh* is someone who cannot discriminate between contradictory ideas, is disoriented, or impulsive (*Hilchot Eduh*). Even today,

(continued on following page)



we use these terms to describe mental illness.

There are many Jewish prayers for healing the sick, and there are even specific versions for weekday and shabbat/holidays. The weekday version of a *mi shebeirach* for illness asks for a complete recovery including “*Refuat hanefesh u’refuat haguf*” for both the soul (emotional and mental) and physical healing. Judaism recognizes the whole individual where both a healthy body and mind are crucial.

Even though Jews are more likely to seek mental health help than other populations, there is still a significant stigma about psychiatric illnesses. Mental illness is seen as shameful and an embarrassment to families [12]. This leads to concealment and continued suffering.

Can We Blame the Holocaust?

The effects of the Holocaust have been studied on both Holocaust survivors and their descendants. The biology of epigenetic changes due to post-traumatic stress disorder (PTSD) in the Holocaust survivor affecting their second and third-generation descendants continues to be debated [17]. However, there is consensus that a survivor's experiences do have a significant impact on the intergenerational mental health of their families. Some of these issues relate to the survivor's own mental health issues suffered prior to, during, and post-Holocaust, attachment and parenting issues, overall lifetime stressors, and physical/genetic predisposition to depression and other mental illnesses [17].

A review of the literature does not indicate a single factor in determining the mental health outcome in Holocaust survivor descendants. If a survivor parent had a psychiatric problem, there was a definite association with their child's mental health issue including substance abuse and mood and anxiety disorders. If a parent has PTSD, there is an association with their child's depression and PTSD [18]. If both parents were Holocaust survivors, there is a higher risk of their child having mental health problems. The results also show that Holocaust survivor mothers have more influence on mental health than survivor fathers. Some of these factors relate to parenting styles, attachment, over-involvement, physical neglect, and emotional abuse as a result of parental PTSD [19]. Other groups with PTSD include Jews who emigrated from the former Soviet Union (FSU) and their children. In addition to the parents' religious repression and persecution while in the FSU, they experienced significant cultural, language, and vocational challenges once in the US [17].

History of Mental Health Organizations for Orthodox Jews

Many Jewish Family Services programs to assist mental health issues originate from charitable organizations set up by Jews in the USA from the 19th century onward. For Orthodox Jews, one of the first programs to address mental illness was Ohel Children's Home and Family Services which opened up a group residence for

boys with emotional and developmental disorders in 1969. Over the past fifty years, other Orthodox Jewish organizations began offering family counseling, crisis intervention, suicide prevention, counseling for addiction, domestic violence, and other mental health issues.

Many Orthodox Jews became mental health professionals to provide psychological and psychiatric care from a shared cultural perspective. In 1992, rabbis and Orthodox Jewish mental health professionals founded Nefesh to address specific mental health issues affecting the Jewish community. Their mission is to develop appropriate and effective Torah-based treatment approaches for their communities [20].

Resistance

In 1999, the US Surgeon General prepared the first-ever report on the mental health of Americans. The report stated that “stigma must be overcome”. In an attempt to dispel the stigma of mental health, the Surgeon General further stated that mental disorders are legitimate illnesses with treatments similar to physical illnesses [21].

In the Orthodox Jewish community, there are unique factors that may impact the recognition of mental illness and willingness to treat the disorders.

Certain rabbis may dissuade their congregants from seeking help from outside sources. Some of the reasons include a long-standing wariness of outside influences on Jewish life and fear of these influences affecting their congregants. Other problematic issues are the secular education psychologists and therapists receive, and fears may include the concern that the mental health professional might report certain issues to governmental agencies [22].

Other rabbis may exhort their congregants to have “trust in *Hashem*” rather than seek professional help. There may be negative stereotyping of mental illnesses including “just get over it/yourself” as if mental illness was a result of low willpower or lack of faith in *Hashem* and a moral failing [22].

Most Orthodox Jews have a tradition of using a *shadchan* (matchmaker) to find their *shidduch* (match) for marriage. The vetting process may include an investigation of the family's mental health history. Some members in certain communities may shun much needed treatments, including therapy and medications, to not “*shtet* the *shidduch*” or ruin the marital match [22].

There are very few reliable studies of Orthodox Jews with alcohol and substance abuse problems [23]. As an example, a 1962 report stated that alcoholism and drug addiction were entirely absent in American Jewry [24]. While these statistics may show some denial related to Orthodox Jewish alcohol and substance abuse, there has been an acknowledgment of its presence in the overall Jewish and Orthodox communities since the 1980s. Orthodox Jews in need of treatment

may not be aware that there are Jewish and Orthodox-affiliated programs to provide confidential assistance. These include Alcoholics Anonymous, Narcotics Anonymous, Amudim, as well as the umbrella organization Jewish Addiction Awareness Network (JAAN) and others.

The pressure for Orthodox Jewish women to be thin, especially when they are in the *shidduch* age range, may reflect the higher rates of eating disorders in this demographic. A statistic by Dr. Ira Sacker is often repeated in studies focusing on eating disorders. In a 1996 study that he performed, he found that one out of 19 girls had disordered eating in the ultra-Orthodox and Syrian Jewish community in Brooklyn, New York. This rate is 50% higher than the general female population [25]. A Canadian study in 2008 showed that 25% of Jewish females had disordered eating compared to 18% of non-Jewish females [26]. Researchers have proposed that much of Jewish culture may create disordered eating because so much revolves around food, whether it's holiday feasts, fast days, or kosher food laws. The separation of kosher eating with food placed into specific categories of permitted/non-permitted and milk/meat is similar to the division of accepted and unaccepted food categories in disordered eating pathology. Proscribed fast days can similarly be another challenge. Although ultra-Orthodox Jewish women do not consume social media on the same levels as other women do, they may still be affected by societal expectations reflected in marketing efforts targeted to women [27,28,29].

Orthodox Jews that struggle with infertility may not recognize that these challenges can also affect mental health. Orthodox Judaism is considered a pronatalist culture where having children is of utmost importance. Individuals struggling with infertility may feel that they do not belong in the religious community based on the first commandment of the Torah to “be fruitful and multiply” (Genesis 1:28). There are multiple stressors involved in the management of infertility including frequent physical examinations, hormonal treatments, financial considerations, and specific restrictions in sexual intercourse. Most ultra-Orthodox Jewish couples experiencing infertility usually have the woman undergo initial extensive testing rather than have the husband provide an ejaculate sample due to the prohibition of spilling seed (*Niddah* 13a). These stressors greatly affect mental wellbeing and can contribute to high rates of anxiety and depression [30].

SCAN THIS CODE



For videos & more resources on mental health in the Jewish Community

The 2016 Pew Report stated that Jews are the “most highly educated of the world’s major religious groups”. More than 99% of Jews have primary education and 61% have post-secondary degrees [31]. There is significant stress for Orthodox Jews to “fit in” as well as be smart, and high academic achievement is the standard. Many believe that the way to get close to *Hashem* is to study the Torah intensely. Those with learning disabilities, ADHD, or other impediments to doing well in scholarly environments may lose status, not be able to attend a school of their or their parent’s choosing and become marginalized in the community [32].

Should Orthodox Jews go to a non-Jewish or irreligious mental health professional, they may fear being misunderstood or misjudged due to their religious observance. This fear is not unfounded. In 1993, a review of the religious content of the DSM-III-R stated that almost 25% of all cases of mental illness were described using religious illustrations [33].

Therapists who do not understand Orthodox Jewish prohibitions on certain behaviors such as a female therapist with a male client having the door closed or handshaking with the opposite sex, may make judgments about their client’s behaviors without understanding the context of religious belief. Research from the 1990s shows that many mental health professionals did view religious clients as “more disturbed” [34]. Some may fear that their particular Orthodox Jewish traditions may be diagnosed as abnormal

or pathological. Orthodox Jewish professionals may be best qualified to ascertain these decisions in conjunction with rabbinic advisors [35].

Some Orthodox Jews may have reservations about going to a counselor or psychotherapist from their own community because of fears of confidentiality and a perceived lack of professionalism [36].

Some Orthodox Jewish clients may feel bound by the prohibition of speaking *lashon hora* (evil speech/gossip) about another person. They will hesitate to disclose current or past sexual, physical, or emotional abuse because of the rules of respecting a parent, elder family member, or teacher. They may be unaware that there is rabbinic support for such disclosure [22].

Currently, most Orthodox Jewish mental health organizations receive rabbinical approval, or *haskama*, on their work to alleviate those concerns.

There has been a dramatic shift in the understanding of how loneliness, addiction, and mental anguish can affect the lives of Orthodox Jews. In April 2020, in response to the COVID-19 pandemic, Rav Dovid Cohen, a well-regarded rabbi who provides *haskama* to many Orthodox Jewish organizations and institutions dealing with mental health concerns, issued a ruling to allow individuals struggling with their mental health (not merely physical symptoms) to use technology such as Zoom, phones, or other connective technology on *Pesach* and *Shabbos*. The Rav stated in a short video that *pikuach nefesh*

(saving a life) for mental health issues takes precedence even over holy days.

Support

A study on the method Orthodox Jews use for mental health issues found this order: prayer, speaking to a Rabbi, an anonymous service (helpline), culturally sensitive mental health professionals (from a different religious or cultural background), and finally, mental health professionals from a similar religious background (but not from their own community) [36].

Orthodox Jewish life emphasizes the importance of *emuna* (religious faith) that all that happens in life is for an individual’s growth. One must trust in *Hashem* and serve Him with joy; doing so provides a sense of positive well-being. Another important aspect of Orthodox Jewish life is the tradition of doing mitzvot (good deeds) for other people as part of a community. Many of these activities such as visiting the sick, providing for orphans and widows, and consoling the bereaved along with other charitable and other forms of social support, are all performed voluntarily. Volunteering is a well-known predictor of improved health. Studies from the 1980’s onward have shown the benefits of volunteering in improved physical and mental health (depression) in all age groups and especially seniors [37]. A study in 2019 highlighted the physical and mental benefits of volunteering even for individuals with serious mental illnesses [38].

The Orthodox Jewish lifestyle and its emphasis

Orthodox, Ultra-Orthodox, and Orthodox Friendly Mental Health Organizations

Referrals / Resources / Education / Helplines

Amudim

<https://amudim.org/>
646-517-0222

Jewish Addiction Awareness Network
<https://www.jaanetwork.org/>

Madraigos

<https://madraigos.org/>

Nesivos Pathways

<https://asap.care/organization/nesivos/>

Ohel Children’s Home and Family Services

<http://www.ohelfamily.org/>
800-603-0HEL

Project Ometz

(Troubled Youth with Mental Illness)

<https://www.projectometz.org>
201-357-0495

Project Tikva at Aleph Institute

(Troubled Youth with Mental Illness)

<https://aleph-institute.org/wp/project-tikvah-general-info/>
310-598-2142

Relief Resources

<https://reliefhelp.org/>
718-431-9501

Shalom Task Force

<https://shalomtaskforce.org/>

Yad Rachel (Postpartum Disorders)

<http://yadrachelnj.org/>
732-364-4462

Treatment Centers

Center for Anxiety

www.centerforanxiety.org
888-837-7473

Center for Applied Psychology (CAPs) at Bikur Cholim

<http://www.bikurcholim.org/caps.html>
845.425.7877

Counterforce (Children & Families via Torah U’Mesorah)

<http://www.counterforce.services/>
718-787-4412

JBFCs

<https://jewishboard.org/>
212.582.9100

MASK

<http://maskparents.org/>
718-758-0400

Monsey Family Medical Center

(also known as Project Ohr)

<http://cmadc.weebly.com/behavioral-health.html>
845-352-6800

Ohel Children’s Home and Family Services

<http://www.ohelfamily.org/>
800-603-0HEL

Refuah

<http://www.refuah.net/>
646-395-9613

Refuah Community Health Collaborative

<http://www.refuahchc.org/>
845-694-6300

The Living Room / Our Place

<http://www.ourplaceny.org/>
718-692-4058

Torah and the Twelve Steps

<http://torahwelvesteps.org/>
305-776-3794

Peer-Led Groups

Chazkeinu

www.chazkeinu.org
314-346-7414

Refaenu

<http://refaenu.org/>

In Israel

Enosh – The Israeli Mental Health Association

www.enosh.org.il/he/service/enosh-the-israeli-mental-health-association/
972-74-7556100

Family Institute at Neve Yerushalayim

<https://nevefamilyinstitute.org/072-2/2075-2/>
02-654-4600

Hakshiva Beit Shemesh

<https://hakshiva.org/>
02-992-5152

Machon Shiluv

<http://shiluv.org.il/en/>
02-625-1390

Nitza (Post-partum Depression)

<http://www.nitza.org/>

In addition, virtually every local Jewish federation in North America has a Jewish Family Services agency that provides counseling and assistance for families and individuals suffering from mental health issues among other services.

on trust in Hashem may also have a protective effect. A study examined trust and religious coping and its relationship to depressive symptoms, and it found that positive religious coping and trust in G-d were associated with decreased depressive symptoms [39]. A recent study on thirty ultra-Orthodox Jewish patients with psychotic symptoms and receiving either in-patient or daycare treatment showed similar results. Those patients with positive religious coping and trust in G-d had more favorable outcomes. They demonstrated better engagement and motivation for their mental health treatment, reduced psychiatric symptoms, and a greater quality of life [40]. Another study examining the effects of COVID-19 on Orthodox Jews also showed that those with intrinsic religious belief, trust in G-d, and associated positive religious coping demonstrated less stress. Orthodox Jews with negative religious coping and mistrust in G-d showed higher levels of stress during the initial lockdown of the pandemic [41].

The National Alliance for Mental Illness created the “CureStigma” campaign to reduce the stigma of mental illness for the general population [42]. In Orthodox Jewish communities, there may be even greater misconceptions about mental illness resulting in disapproval and critical judgment towards those suffering from these disorders as well as their families. This can cause even deeper shame. Several organizations meant to serve Orthodox Jews with mental health issues are making in-roads into all levels of Orthodoxy. Some provide referrals to mental health practitioners (both Orthodox and non Orthodox). Others have websites with written personal stories or videos featuring Orthodox-looking individuals.

There are several mental health professionals conducting research on evidence-based treatments and the special needs of the Orthodox Jewish community to better serve this population. For example, concerted efforts of an inclusive team in the UK made significant improvements for Orthodox Jews to access mental health. This culturally sensitive collaboration enlisted trusted community leaders in addition to NHS mental health professionals [43]. Lastly, Orthodox Jews themselves have been reaching out to tell their stories on Jewish themed websites such as Times of Israel, Forward, and the Jewish Week. This relatively new development bodes well for the future of this community.

Supreme Court Justice Louis Brandeis has been quoted as saying “Sunshine is the best disinfectant” [44]. Increased acknowledgment of mental health issues and the acceptance of evidence-based and medically sound mental health treatments for Orthodox and ultra-Orthodox Jews brings light to a hidden and dark topic.

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Patient Involvement In Defining Psychiatric Disorders

Unlike many somatic disorders that can be defined by empirical data, psychiatric disorders are often characterized by external descriptions of behaviors and features as discerned by clinicians. The diagnoses are then described using clinical terminology in classification systems such as the ICD and DSM. The definitions rarely take into account the internal and lived experiences of those who suffer from the diseases. Additionally, the use of medical jargon and technical terms in major classifying systems means that patients may feel confused and powerless in discussions with their health-care providers [1].

In anticipation of the upcoming release of the ICD-11 slated to replace the ICD-10 in January 2022, researchers in collaboration with the World Health Organization have sought to incorporate feedback and perspectives from patients who are diagnosed with depression, anxiety, schizophrenia, bipolar I, or personality disorder [1]. The study was carried out through the use of diagnosis-specific focus groups, and included participants from the US, UK, and India. Participants were given two versions of the diagnostic guidelines to assess: the draft of the clinical descriptions and diagnostic guidelines [CDDG], and then a user friendly summary of the guidelines using appropriate health literacy language. Clinicians in India and the UK were also asked for feedback on the CDDG and layperson summaries.

Several themes emerged from the study. First, there exist some experienced features of each disease that the participants felt were not included within the draft. For example, those with schizophrenia felt that their challenges with interpersonal communication were not adequately addressed. Second, there were some features that were included within the draft that the participants felt did not match the experiences of living with the diseases.

For instance, in the bipolar focus group, participants did not agree with the descriptor of “decreased need for sleep” but instead reported that although they needed more sleep, they often were unable to do so. A third theme was the inclusion of some terminology that the participants felt was objectionable and could be interpreted in negative ways such as the use of the term “retardation” to describe depressive episodes. Lastly, most of the participants appreciated the summaries as more easily understood as well as more in line with their lived experiences.

In an ideal situation, a mental health diagnosis allows for understanding between patients, clinicians, and the patient families, and a shared language is what allows these partners to communicate and work towards recovery. This can best be achieved when a patient’s lived experiences and a clinician’s reasoning align. Taking patient perspectives into account is an important first step towards this goal. The researchers involved in this study noted that it was the “first time that service users have participated in systematic research and recommendations on proposed diagnostic guidelines for a major system” and shared that a future goal was where patients in close collaboration with clinicians could produce the diagnosis summaries. Such summaries would not only incorporate the lived experiences of the patients, but could also induce a better patient-clinician relationship and could be used to educate the general public.

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Using Biomarkers to Predict Transition to Psychotic Disorders in At-Risk Patients

The development of a psychiatric disorder is known to be multifactorial and is affected by genetic, biological, and environmental factors. In recent years, the complement and coagulation cascades have been implicated in the development of psychiatric disorders specifically in schizophrenia [1]. The complement cascade is a system of proteins that are part of the immune system that become activated through a number of channels and result in pathogen lysis and the initiation of other inflammatory responses. [2]. The coagulation, or clotting, cascade occurs through two different pathways, resulting in hemostasis with the deposition of fibrin [3]. Although these systems appear to have very different functions, there is known overlap between the two with each system able to modulate the other’s activity. Though there is still much that is not known about the interplay between the systems, dysregulation in these protein systems is consistent with the increased inflammatory tone that often precedes the development of schizophrenia and other psychiatric disorders [1].

Because the complement and coagulation cascades appear to be involved in the development of neuropsychiatric disorders, researchers have looked at levels of specific proteins within these systems to determine whether they can be used as predictive biomarkers of those at significant risk of developing psychiatric disease [1]. Being able to identify individuals at high risk for the development of psychosis allows patients to be closely monitored and offered early treatment which has the potential to significantly improve their outcomes. Predictive models using clinical data, neuroimaging, and bloodwork of high risk individuals who are likely to transition to psychosis have been inadequate to date [4]. Even in a group of patients at “ultra high risk” for psychosis, only 16-35% will ultimately develop psychosis [5]. The development of a model based on protein biomarkers can further assist in predicting which high risk patients will develop psychosis.

In a study published in August 2020 by Mongan, et al [5], researchers developed a model using both clinical and protein biomarker data to predict

the likelihood of transition to psychiatric disease in high risk individuals. The study drew its participants from the ALSPAC and EU-GUI cohorts; subjects were all determined to be of “clinical high risk” for psychiatric disorders based on the Comprehensive Assessment of At Risk Mental States exam. These individuals had bloodwork drawn and assessments performed prior to, during, and after the study to determine development of psychosis. Of the 344 participants, 18.9% went on to develop psychosis within the two year period. Researchers then compared plasma proteins between the two groups: high risk individuals who developed psychosis and those who did not. Researchers identified the most predictive proteins to utilize in a model based on those specific proteins in conjunction with clinical markers. Notably, many of the proteins identified are associated with the coagulation and complement cascades. The model showed good predictive value for the development of psychosis in clinically high risk individuals.

Further studies will be needed to identify these biomarkers in other cohorts of high risk individuals, to learn about the underlying mechanisms, and to determine the extent to which these protein biomarkers contribute to individualized prognoses. This will allow for individuals at risk of developing psychosis to be identified and potentially treated earlier.

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Comparing Medications for Idiopathic Neuropathic Pain

Chronic pain affects a large percentage of Americans, and a significant proportion of that is due to neuropathic pain. The prevalence of neuropathic pain is estimated to be 7-10% of the population [1]. Neuropathic pain is pain that occurs in response to a signal from the brain and is typically not in direct response to an acute injury. Neuropathic pain often occurs as a result of prior nerve damage, infection or disease such as in the cases of diabetic neuropathy, phantom limb pain, cancer or chemotherapy. While in most cases it is possible to diagnose the cause of the neuropathic pain, in at least 25% of cases, the cause of the neuropathic pain remains idiopathic or cryptogenic wherein a cause cannot be identified [2]. A number of medications with different mechanisms of action are utilized to treat cryptogenic sensory polyneuropathy (CSPN) but there has been little research comparing the efficacy of these medications. Because there has been no prospective research into medications for the treatment of CSPN, insurance companies will sometimes reject payment for the use of these medications for the treatment of CSPN [3].

The PAIN-CONTRoLS (Patient Assisted Intervention for Neuropathy: Comparison of Treatment in Real Life Situations) trial looked at four commonly utilized prescription medications in the treatment of CSPN from different drug classes: nortriptyline (a tricyclic antidepressant), duloxetine (a selective serotonin and norepinephrine reuptake inhibitor), pregabalin (a GABA analogue used to prevent seizures), and mexiletine (an antiarrhythmic drug). In addition to looking at the effectiveness of these drugs in reducing painful symptoms, the trial also assessed the likelihood of adverse effects and the ability of patients to remain on the medication. Efficacy in pain reduction was determined as a 50% improvement in reported pain [2].

The study enrolled 402 participants who were randomly assigned to take

one of the four drugs over a 12 week period. Participants were evaluated at the 4, 8, and 12 week marks. None of the drugs had a notably superior effect in pain reduction. Nortriptyline had the highest rate of pain reduction at 25%, followed by duloxetine at 23%, mexiletine at 20% and pregabalin at 15%. However, when side effects and quit rate are taken into account, the overall benefit of the drugs shifts somewhat. Of those taking nortriptyline, 56% had side effects and 38% stopped taking it. For those on duloxetine, 47% had side effects and 37% stopped taking it. Of those taking pregabalin, 40% had side effects and 43% stopped taking it, and finally for those on mexiletine, 39% had side effects and 58% stopped taking it. In patients who were able to complete the course of treatment, mexiletine did show the most significant improvement in fatigue and pain interference with life. One limitation of the study is that the reasons for stopping the medications were not delineated. For example, many patients stopped taking pregabalin due to the cost and not related to side effects. Taking these reasons into account could be an important factor when determining the actual tolerance level and adherence to each prescribed medication.

Practically, based on both efficacy rate and tolerance level, nortriptyline and duloxetine appeared to outperform pregabalin and mexiletine. The study therefore recommends that these medications be considered before the other two drugs assessed in this study.

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Mental Health During Times of COVID-19

By Ariella Kaufman, RN

Social distancing, lockdowns, and quarantines have affected the social fabric of our lives influencing our ability to be together and cope with the grief and worry we feel about the virus. Employment, education, finances, housing, healthcare, transportation, recreation, and social and religious gatherings have all been affected by the COVID-19 pandemic [1].

Negative changes in the above realms, such as unemployment, social isolation, travel restrictions, changes in the stock market, and the absence of school structure, are leading to an increase in feelings of anxiety [2] with concerns about becoming infected with the virus of course a primary stressor. Those with pre-pandemic psychiatric illness, those with prior life stressors, and those at greater risk of becoming sick with COVID-19 due to pre-existing medical conditions have been found to have higher levels of stress and anxiety [3].

What is at Risk?

When reviewing data from past infectious disease pandemics such as Ebola, SARS, and MERS, increased stress on healthcare workers led to somatization, depression, anxiety, OCD, fear of contagion and infecting family members, emotional disturbance, social disruption of daily life, and vulnerable feelings [4]. Macro events such as terror attacks, natural disasters, and economic recessions tend to cause an increase in the rates of post traumatic stress disorder (PTSD) as well as an increase in alcohol use. The same is seen during the current COVID-19 pandemic [5]. Increased feelings of anxiety, depression, grief, suicidal ideation, worsening mental health conditions, and the use of substances to deal with the stress have been on the rise since the beginning of this pandemic [2]. The CDC reports an increase of depression, anxiety, and suicidal ideation during June 2020 for those with and without pre-existing mental health conditions. Short term inability to cope with the current situation may lead to prolonged grief syndrome and major depressive disorders causing an inability of an overwhelmed healthcare system to deal with the aftermath of mental health disorders [1].

Adults with high stress levels reported an increase in alcohol consumption since the pandemic began which is similar to studies performed during the SARS outbreak. Alcohol use went up as early as two weeks after the pandemic was announced by the World Health Organization in March 2020 and has led to long term increased alcohol use [5].

Others are experiencing somatic problems such as dizziness, back pain, and chest pain. The theory of the behavioral immune system describes a system where negative emotions and distress lead to physical symptoms. Sports events have been canceled, work settings have been altered, and businesses have closed. These changes along with social distancing practices have altered the way the public engages in everyday activities. Decreased physical activity, smoking, alcohol consumption, and change in sleep patterns are just a few of the physical effects experienced by individuals during this pandemic. [5]

Identifying Populations at Risk

Communities who have been affected with higher rates of COVID-19 infection such as Latinos, African Americans, the elderly, healthcare workers, and those in lower socioeconomic groups are at increased risk for exhibiting mental health symptoms [1]. Young adults, racial minorities, those with pre-existing mental health disorders, and unpaid adult caregivers are experiencing increased levels of distress [2]. The elderly, who may already be lonely and socially isolated in their homes or nursing facilities, are now further limited with visitor restrictions and bans on social gatherings. Caregivers and those with chronic medical conditions have increased fear of getting sick from the virus. Additionally, high school and college students are unable to continue their education or internships causing increased levels of stress, anxiety, and depression [6]. Those who felt stress before the pandemic reported that the stress and depressive symptoms became more acute and severe.

Healthcare workers (HCW) employed in high risk areas, those exposed to COVID-19, and those without enough PPE are at higher risk for mental health symptoms, with females more at risk than males [4]. Studies conducted in China showed an increased level of alcohol use in HCW as well as in the general adult population during COVID-19 [5]. HCW who work in areas with less resources, less support, and disorganized healthcare systems reported increased levels of stress [7]. COVID-19 has led to increased demand and decreased resources available for HCW leading to psychological stress, depression, anxiety, insomnia, denial, anger, and fear [8].

Those with pre-existing mental health conditions were most at risk for worsening symptoms, increased depression, and suicidal ideation [3].

Contributing Factors

Changes in Health Behaviors

A strong correlation exists between high levels of physical activity and lower psychological stress. Changes in social activity and decreases in physical activity can cause an increase in psychological stress and can subsequently lead some to change their smoking, alcohol, and sleep habits. All of these behaviors lower the immune system and may make one more susceptible to getting sick and preventing full recuperation from COVID-19 [9]. There are many aspects of psychological distress that are associated with changes in health behavior. An online survey performed in April 2020 assessed 1,491 adults in Australia. Survey results analyzed the increase in severe depression in those who experienced depression prior to COVID-19. Numerous stressors mentioned in the survey include uncertainty about the future, job loss, and financial stress. Half of the respondents reported a negative change in sleep habits. About half of chronic smokers reported increased smoking. Though only about a quarter of respondents reported drinking more alcohol during COVID-19, those who did endorsed drinking more than usual to cope with psychological distress [9].

Mental Health Services

Many individuals live in areas where mental health services are already lacking adequate resources. Lack of access to mental health care can be due to lack of finances, lack of technology, and under-enforcement of laws. Quarantine also limits physical access to care. Mental health professionals are a less diverse population than the people whom they serve meaning there may be less access in certain areas with inadequate culturally and linguistically appropriate mental healthcare services. There is even less access for those without insurance or those with fewer benefits including immigrants and those in lower socioeconomic groups.

Healthcare Workers

HCW experience psychological stress at work due to multiple factors. A first category of stress involves the ambiguous aspect of COVID-19 with no identified treatment. Other stressful experiences for HCW include hav-



ing to wear protective gear at all times, working overtime, the repetitiveness of shiftwork, isolation, fear of infection and bringing the disease home to family members, and dealing with the death of patients and colleagues.

Organizational and social stressors were other categories that HCW identified as stress-inducing. HCW may feel mistrust towards management for lack of transparency, staffing shortages, lack of protective and technical equipment, and having to work under duress and pressure. In terms of social demands, HCW may sense distrust from others and may also feel concern about the lack of concern in others [8]. Additional stress is caused by the moral dilemma of having to decide between the loss of pay, if one needs to quarantine, versus the risk to the health of others if one shows up ill to work [6].

Media Coverage

During a natural disaster or pandemic, the public looks to the media for information and guidance. However, previous research during infectious disease outbreaks, natural disasters or incidents of mass violence indicates that exposure to the media increases the collective trauma to the public. While the public is being informed, they are also increasing their stress, worry, anxiety, and perceived risk of getting sick which all make coping more difficult [3]. Frequent exposure to pandemic related news, increase in consistent social media use, and exposure to conflicting information causes the most stressful symptoms [3].

Bereavement

Public health measures to prevent the spread of COVID-19 have influenced and changed the rules regarding funeral practices and customs. There are restrictions on funeral attendees, limited to no interaction with the body during the ceremony, and a lack of opportunities for mourners to physically comfort one another, touch the coffin, hold a reception, socialize, or bid farewell the way in which they are culturally accustomed. Due to these changes and restrictions, many family members are unable to cope or process their grief leading to an increase in mental health symptoms [10].

Solutions

Community resilience is important to foster during a time of crisis. This can be done by providing support to individuals with preexisting mental health conditions, mitigating secondary stressors, and monitoring and minimizing exposure to the media [3]. Community mental health support should be part of COVID-19 response and preparedness plans. Those plans should include protection of vulnerable populations, extra support to HCW, provision of mental health services to the community and HCW, and the continuation of regular healthcare services for the general population with additional treatment and support provided to those who are affected by the virus [7].

An increase in mental health illness and symptoms is an important finding that forces us to find solutions and prevention methods to mitigate the effects of the pandemic. One of the most important interventions at this time is to identify populations who are at higher risk for poorer outcomes and focus efforts there. Efforts should focus on assessment, providing resources and support, and increasing access to healthcare and treatment [2].

Further research is required to determine the main stressors leading to an increase in anxiety. Resources should be provided that promote emotional wellbeing, stress reduction, coping strategies, increased health services, culturally and linguistically appropriate messaging, and health communication strategies [2].

The federal government has established the Families First Coronavirus Response Act to provide paid emergency sick leave, enhanced unemployment insurance, and increased funding for Medicaid. These resources can slightly mitigate the anxiety of financial losses due to the pandemic. The CDC provides a list of available mental health resources, and it is up to us, as nurses, to publicize these resources to the public.

Telehealth is an effective way to assess, diagnose, and treat patients, and populations at higher risk for COVID-19 should be encouraged to utilize this tool to maintain their health during this stressful time.

For healthcare workers at risk of experiencing severe stress and anxiety, prevention of these outcomes can be encouraged through implementations reducing the likelihood of infection and the provision of mental health support. Protecting HCW should be a priority. Providing adequate PPE and addressing fatigue can also positively impact HCW [4]. Education on how to properly perform hygiene procedures and don PPE can lower the related stress as well as the actual risk of acquiring COVID-19 [4]. Additional support should include having management serve as strong leaders, increasing social support opportunities, decreasing media coverage, providing adequate financial support to hospitals and employees, and strengthening coping techniques. Witnessing patient recovery, strong teamwork, external appreciation and personal faith are all factors that positively reduce stress [8].

For the protection of the public's mental health, the media should be held responsible for the information it disseminates. Often the media does not accurately portray actual risk, but instead represents greater risk thereby increasing the public's level of anxiety. This can also lead to the development of conspiracy theories which may cause the public to not take recommended health behaviors seriously. Since the public relies heavily on the media for its information, especially during times of crisis, the media has a responsibility to put out accurate and reliable information that is clear and non-contradictory [3].

To promote healthy grieving, funeral planning and preparation are shown to benefit the bereavement process by providing a sense of belonging and comfort and a chance to say goodbye. Death rituals provide meaning, reinforced bonds, eased grief, and help process a loss. High funeral attendance typically demonstrates social support to those grieving, and it may be harder to create a meaningful funeral service when done virtually due to COVID-19 restrictions. However, smaller, in-person funerals can be experienced as being more intimate and personal in nature. To mitigate psychological distress from limited social support, it's important for funeral officiates to create meaningful funeral and burial services that are based on what the family would find meaningful, while providing social support to the bereaved family members [10].

While initially fearing the loss of millions of lives, the government enacted strict guidelines and mandates during the early phases of the novel Coronavirus. Infection and death rates, media coverage, and the restrictive measures created a great fear in the public. The initial goal was to "flatten the curve" and not overwhelm the healthcare system. In just a few short months, we have seen the effects of the ongoing strict guidelines taking a toll on the public's mental and emotional health. It is crucial to focus our efforts on preventing and treating current mental health issues before a second pandemic arises. By focusing on vulnerable populations and those most at risk, we can offer interventions to support and mitigate future mental health pandemics.

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Confronting Adult Depression in the Community: An Overview for Nurses

By Estie Mermelstein, FNP-BC

In 2017, 17.3 million Americans over the age of 18 had a diagnosis of major depressive disorder [1]. That number has likely gone up since the COVID-19 pandemic upended daily routines and stable employment [2,3]. People experiencing constant stress may ask nurses in their community about whether their mood is a normal reaction to the uncertainties of the COVID-19 pandemic, or whether it warrants a depression screening by their health care provider. The following review of symptoms, screenings, and initial treatment for depression outlined in this article is a useful guide for nurses who are unsure of how to advise their communities.

Risk Factors

The first thing nurses can do when approached by community members or friends with questions about depression is to assess for existing risk factors. Risk factors for depression can be divided into three categories: internal factors, external factors, and adverse life events (see Table 1) [4].

Internal Factors	External Factors	Adverse Life Events
Female sex	Substance use	History of childhood sexual abuse
History of anxiety	Conduct disorder	Unstable home environment
Low self-esteem		History of divorce
Neuroticism		Lifetime trauma
		Inadequate social support
		Low educational status
		Parental loss
		Existence of two or more comorbid conditions [5]

Table 1. Risk Factors for Depression

Women are twice as likely as men to have depression. Certain temperaments can predispose a person to depression such as neuroticism, a temperament marked by elevated stress reactivity that results in frequent negative emotions [4]. Conduct disorder, characterized by ongoing behavior that breaks social rules, such as acting aggressively toward people or animals, destroying other people’s property on purpose, lying, or stealing, can also be a depression risk factor. Adults with conduct disorder generally have problems with social interactions and may downplay or deny their behaviors [6].

Symptoms

The nurse should ask pointed questions about symptoms of depression to separate the occasional blues from major depressive disorder. Knowing the symptoms that meet the criteria for depression allows nurses to offer accurate guidance.

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), symptoms of major depressive disorder include:

1. Depressed mood most of the day, nearly every day – feeling down, sad or hopeless
2. Anhedonia or a marked loss of interest or pleasure in all, or almost all, activities nearly every day
3. Significant unintentional weight loss or weight gain – more than 5% of one’s body weight in one month – or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation – feelings of restlessness or being slowed down, nearly every day
6. Fatigue or lethargy nearly every day
7. Excessive guilt or feelings of worthlessness nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day

9. Recurrent thoughts of death, recurrent suicidal ideation without a plan, or a specific plan or attempt to commit suicide

At least five of the above symptoms, including either depressed mood or anhedonia, warrants screening for depression by a medical provider. Based on the number of symptoms a person has, and how those symptoms affect their daily functioning, their depression can be classified as mild, moderate or severe [7].

Screening Tools

The United States Preventive Services Task Force (USPSTF) recommends regular depression screening for adults in the primary care setting including pregnant and postpartum women [8]. Though no specific screening interval is recommended, patients are typically screened at their annual physical exam unless risk factors or symptoms warrant more frequent screenings.

The depression screening tools commonly used in primary care settings are the two-item and nine-item Patient Health Questionnaires (PHQs). The PHQ-2 consists of two questions addressing how often the patient experiences depressed mood and anhedonia in the past two weeks. The PHQ-9 consists of nine questions addressing the frequency of all depression criteria in the DSM-5 over the past two weeks.

Though the PHQ-2 and PHQ-9 have comparable sensitivity, the PHQ-9 has greater specificity ranging from 91% to 94% compared with the PHQ-2 which ranges from 78% to 92%. Therefore, if a PHQ-2 is positive, it should be followed up with either a PHQ-9 or a clinical interview with the patient’s healthcare provider [4].

Since it is easy to access depression screening tools online, depression screening can be a simple at-home method for determining if someone should see their healthcare provider. However, this informal screening does not replace a doctor’s visit. The USPSTF recommends screening with “adequate systems in place,” [8] meaning if someone has a positive depression screen, they must be properly diagnosed and treated according to evidence-based practice and referred to a setting that can provide relevant care.

What to Expect at the Initial Doctor’s Visit

It is important for nurses to be familiar with what happens during an initial visit to a primary care provider for depression. This allows the nurse to educate patients about depression and its signs and symptoms and decrease the stigma associated with mental illness allowing those who truly need treatment to do so without unnecessary anxiety.

For an initial depression consult in a primary care setting, the patient can expect the following [7]:

- Filling out screening questionnaires such as the PHQ-2 and/or PHQ-9.
- Completing a full medical history and physical exam. Since certain chronic illnesses, like hypothyroidism or sleep apnea, may manifest similarly to depression, the primary care provider needs to rule those out as possible reasons for the patient’s symptoms.
- Obtaining blood work to rule out conditions that may manifest similarly to depression such as hypothyroidism, anemia, and vitamin deficiencies
- A comprehensive psychiatric interview. This provides the health care provider with details of the depressive symptoms and any social, situational, or cultural factors that may contribute to the development of depression.

Treatment

With a confirmed diagnosis of major depression, the next step is treatment. Standard treatment for depression consists of either psychotherapy, pharmacotherapy, or a combination of the two. The specific treatment modality

To have a mood disorder... In their own words

By Dena Croog Cohen, *reprinted with permission from the Jewish Standard*

As of late, we've made great strides in the Jewish community and in the world at large as we campaign against the stigma that surrounds mental illness and substance use disorders. We've been starting to acknowledge them as real and concrete health issues. We've been spreading awareness about their existence and how to spot them. Some personal war stories are being shared publicly. Support networks are spreading.

We have a long way to go in terms of medical insurance, but some effort has been made toward more easily, equally, and financially accessible health coverage (see the Mental Health Parity and Addiction Equity Act [MHPAEA] and the Mental Health Parity Compliance Act of 2019). Hey, it's a start. Let's not talk about life insurance yet, though. We've gone pretty much nowhere with that, and it's a topic in its own right.

But as a society, we're moving forward in recognizing that mental illness and substance use disorders are serious public health issues that affect both the people who have them as well as the family and friends who care about and for them.

Along this journey toward public awareness, I think that it's helpful, if not crucial, to understand for what and for whom exactly we are fighting. We talk about stomping out stigma and creating support groups and working toward better mental healthcare quality and coverage, among other efforts—about which I am thrilled. That's all on the outside, though. In a way, even spreading education about symptoms (which, again, is crucial), also, still, only cracks the surface.

I want to know what it's like on the inside. I can speak here only of mood disorders, which include depression and bipolar disorder. I have my own understanding as someone with a mood disorder, but each individual's experience is different. What I want to know and what I want you to know is the following:

How does it feel to have a mood disorder? And how does it think to have a mood disorder?

This second question may be oddly phrased, but what I mean by it is that mood disorders affect not only mood, but thought as well. Although depression and bipolar disorder are not by definition "thought disorders," they certainly affect a person's thinking — which, in turn, affects mood, which then affects thoughts, and there it continues in its merry-go-round of emotions until the ride is stopped or runs its course.

What does it feel like? What does it think like? What's the experience?

Rather than going on and on with my own response to these questions (and believe you me, I certainly have the capacity to do so), I'd like to share with you the views of other people with mood disorders. I believe that it's important for you to understand this, as much as you might,

in the words of those who experience and manage these disorders every single minute of every single day. And to those of you who experience a similar reality — know that you are not alone in your triumphs and struggles.

In their own words:

"Mental health issues are draining; that's the short of it. Sometimes you feel like there's a band of pressure around your chest, keeping you from taking in much-needed, calming, filling air. You can't calm yourself with deep breaths as your chest is locked and barred and closed for business. It's not even hyperventilating, more like a heavy anchor lying on you, dragging you down with shallow malfunctioning intakes.

"Then there's the various medications you keep track of which might not play nicely with other vital yet enervating drugs, and both may contain side effects you'd rather do away with altogether. I once took an antidepressant that caused an overindulgence of sleep, which made it hard to function during the day. The solution? Remove the drug from my rotation, and suffer interrupted sleep as well as tearfulness. This was a recent decision, so time will tell whether these side effects go away or are yet more issues I have to combat indefinitely.

"And let's not forget that depression or anxiety and the like can rear their heads and require professional intervention, such as with a counselor or therapist. I like to think that everyone, even those who aren't suffering from a mental disorder, is like a spool of thread that has been unraveled, and that time and dedication, either solitarily or with professionals, will help wind the spool of thread taut. However, this is quite time consuming, frustrating, and (again, there's that keyword) draining, as you go in circles and cycles of issues like childhood, fulfillment, satisfaction, relationships, and a host of other concerns, all in an effort to gather up your strings and threads and wind them whole again."

Regarding peer support, another person explains:

"I once tweeted, 'The best part about being in a fandom is that when trying to explain something totally random, all you have to say is, "It's like that time KIRK told VADER that GANDALF chose HARRY to operate the TARDIS and even SHERLOCK was surprised." And the other person knows exactly what you mean.'

"Having a mood disorder is like being in a fandom. The difference is most people join fandoms because they like the thing, not because their brains are chemically set up for it. Life with a mood disorder is like being a fan before finding your fandom; trying to explain something you are passionate about to people who have no idea what you are talking about. Everyone looks at you like you are strange and they start to avoid

you, so you become Eleanor Rigby; 'wearing a face that you keep in a jar by the door.' You hide, and put on a façade, a mask, and pretend like you don't spend hours watching your favorite episodes frame by frame. You bite your tongue to correct a misquote and you don't mention the obscure trivia you know. Because that's just not done in polite society. And you live alone and in silence.

"It's a hard life. One you did not choose and never wanted. One you cannot enjoy. But unlike a fandom, where you can quit at any time, you cannot quit your mood disorder. It will forever be a part of you. To never explain it, never talk about, creates a pain that makes life heavy. Too much to bear on your own.

"One thing that can help make it easier is finding someone who will listen to you go on about your fandom, even if they haven't experienced it. But they try to learn, even a little, so that when you need to tell them about the next big plot point, they have even a vague idea of the story.

"That is called Support. Support is a lifesaver, because it tells you, 'You are not alone in this. I am also here.' And when you've found your tribe, who understand, or try to understand what you are talking about, the burden you carry becomes a little lighter."

Another view on staying well is that it begins with a person accepting the mental illness in a compassionate, non-judging way. As one person reflects:

"Acceptance is key to staying well and staying focused on what works — medication, psychotherapy, and a healthy lifestyle. Living with mental illness (I have heard people speak that living with mental illness is less stigmatizing than struggling with mental illness or suffering from mental illness) doesn't mean that you can't have a 'normal' life — marriage, children, work."

Shares the same person about mania:

"Unfortunately, due to the media, people often have a romanticized view of mania. But mania doesn't always result in some great poem or painting; it can result in enormous trauma for you and your family. Mania isn't always about feeling superhuman, but it can drive you to believe that the world is a horrifying place. Mania can result in forced hospitalizations and treatment trauma."

One person vividly described the feelings and thoughts associated with being manic or depressed:

"I will start by saying that the part of having a mood disorder that involves actually calling it a mood disorder, exemplified in an opportunity such as this one when I can write about having a mood disorder, can be a huge relief. It puts words to internal experiences and sensations

that had endlessly perplexed and devastated you and others. The very label can be a pressure release valve.

“My particular mood disorder feels like the volume being turned up on life. My therapist described it that way and it immediately resonated. The highs are high and the lows are low. Everything is heightened. Frustrations are extra frustrating. Joy is overly joyful. Sadness is total doom. Nervousness over one particular morning or even one moment can lead to days of agitation and fear.

“Moods, when you have a mood disorder, feel like unyielding and disorienting external structures built around you by some unseen force that you have to live within, rather than a transient and rationalizable series of feelings that come from and are controllable by some sort of ‘me.’ A mood disorder feels like feeling some ‘thing’ in a situation with a person or people or a place and becoming 100 percent fixated on all of the possible reasons for that feeling and ways that feeling connects with all feelings and all situations and all communities and all universes and the implications of all of that. Having a mood disorder can feel like being very proud of all of the interconnections you make and feel, as well as the level of depth you experience, and then also hating yourself for thinking that highly of yourself and thinking for that long about all of that stuff. You just ride it all out!”

This self-criticism is a common theme among those with whom I’ve spoken. Says one person:

“I usually liken depression to being in a hole, trying to claw my way up and out. Medication takes away the persistent feeling of dread that accompanies it. Depression, for me, is a state of dysphoria. There’s hopelessness mixed with guilt that I’m like this.”

Yet one more description, to which I particularly relate:

“Sometimes depression can feel like your worst enemy has gained control of your brain. They now control your thought patterns, your nerve-endings, your pain-points — and they’re using them against you in the most sadistic ways possible.”

Personally, I view a mood disorder as an actual “It” — a thing, a being, an interloper that hijacks the brain and pretends to actually be that person. An “It” that in itself thinks and feels in a cognitively destructive manner — whether in a depressed or manic or agitated state — but makes a person think that It is the actual person. And It doesn’t only affect a person’s inner reality. The inner world affects how a person acts on the outside, in the physical world.

It’s difficult — and understandably so — for others in that outside world to see that it’s the “It” at work, causing chaos on the inside. So that the repercussions for the person’s behavior and the reactions of others take place in the physical world. What’s going on mentally is beside the point.

In a nutshell, a mood disorder manifests both internally as well as externally. It’s a challenge to live with and it can take a whole lot of work to stay stabilized. And it often makes a person feel lonely. But there are things that help, small gestures by others that can make the difference between isolation and feeling heard.

“How are you doing today?” We can all start with that.

As we follow the course of reducing stigma, working toward better services, creating networks to help, and all the important efforts that are currently underway, we need to remember that we’re talking about individuals. We’re talking about individuals with experiences that are challenging, each in their own unique way. Individuals who, just like any of us, want to be understood. Individuals whose lives can be enriched were you only to notice them.

Reading their words helps. Reaching out is even better.

Dena Croog Cohen, is a writer and editor as well as the founder of Refaenu, a nonprofit organization dedicated to mood disorder awareness and support in the Jewish community.

Mental Health and Burnout Among Nurses

Sarah Bracha Cohen, MSN, RN

Overview

Many nurses report suffering high levels of occupational stress and burnout from their work environments. When nurses’ work demands are unequal to their knowledge, skills, or abilities, this creates a series of reactions that eventually exceeds their ability to cope, resulting in burnout, turnover, and low-quality patient care [1]. Nurse burnout is a physical, psychological, and emotional state caused by chronic overwork and lack of job fulfillment and support [1]. It is often characterized by physical or emotional exhaustion, job-related cynicism, and a low sense of personal accomplishment [2].

Signs/Symptoms

Every nurse experiences burnout differently and may endure a combination of symptoms in varying intensities. It is important to know the varying manifestations of burnout so that one can recognize the signs in oneself or coworkers early and can get appropriate care in good timing [1]. Symptoms include irritability, frequently calling out sick, change intolerance, constant fatigue and exhaustion, a “checked out” mentality, feeling overworked or under-appreciated, lack of enthusiasm about work, and compassion fatigue [1,3].

Causes

There are many work-related factors that lead to nurse burnout. The most common reasons are work environment and job responsibilities such as long shifts, intense workload, high-stress, traumatic or grief-stricken environments, inadequate management, and poor work environments [1,4]. Due to their high stress and emotionally draining environments, nurses who work in emergency departments (ED), critical and intensive care units (ICUs), and pediatric and oncology departments are most susceptible to work burnout [1,4-6]. Sex, marital status, work shift, illness, and working unit/site are significant factors related to work stress [1]. The physical workplace itself, including temperature, lighting, and sound levels, has a major impact on the level of stress among healthcare workers [4]. Other elements affecting nurse burnout are related to individual personality, the quality of relationships among hospital workers, a lack of independent decisionmaking, and the constant pressure to meet social expectations [1,4]. Nurses who enter the field with the goal of helping others may be more susceptible to burnout, as they are more likely to take their perceived job-related successes or failures personally [1]. One study found that 44.4% of nurses reported the main sources of workplace stress was “workload,” 40.6% reported emotional issues related to patient death and dying, and 37.2% reported conflict with a supervisor and other nurses [1].

Effects

Occupational stress has a significant impact on nurses’ work behavior, productivity, satisfaction, turnover rate, absences, and early retirement. In addition, it can affect a nurse’s health and well-being as well as their quality of personal and family life [1,4]. Work-related stress can lead to anxiety, depression, insomnia, physical illness, violence, yelling, and verbal abuse [1,2,7]. Chronic stress can weaken the immune system and increase the risk of serious medical conditions such as heart disease [1]. Burnout not only affects nurses, but their patients as well, affecting patient satisfaction, outcomes, safety, and even mortality [5].

Prevalence

The 2012 U.K. Health and Safety Executive estimated that work-related stress affects one in three employees and costs countries \$5.4 billion per year [4], and some data suggests the United States loses upwards of \$300 billion yearly in lost productivity due to workplace stress [7]. A 2019 U.S. study found that nurse burnout was among the leading patient safety and quality issues in healthcare [5].

According to the 2001 General Health Questionnaire in the south of England, 27% of all hospital staff were classified as suffering from stress and mental health issues as compared to 14-18% of the general population [4]. A 2012 Ethiopian study found that 37.8% of nurses reported experiencing occupational stress [1].

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MENTAL HEALTH & BURNOUT AMONG NURSES

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A 2012 Iranian study showed that 49.2% of their surveyed nurses suffered from occupational stress and 42.4% experienced high levels of anxiety [4]. A 2019 U.S. National Nursing Engagement Report found that 15.6% of nurses reported feelings of burnout [6]. In strong contrast, 41% of unengaged nurses reported feeling burned out as compared to less than 8% of fully engaged nurses [6]. What is most surprising is that this study found that 50% of burned out nurses have no plans to leave their organization, and 97% of these nurses reported experiencing feelings of emotional exhaustion, “clocking in” but feeling emotionally “clocked out” [6]. These international studies show just how widespread of an issue mental health and burnout are in nursing.

According to one study, female nurses were twice as likely as their male counterparts, divorced and widowed nurses were 10 times more likely than married nurses, nurses working rotating shifts were four times more likely than those working fixed shifts, and those who reported illness were 2.7 times more likely than those who were healthy to experience occupational stress [1]. Another study found the prevalence of somatic symptoms, anxiety, depression, and mental disorders among night shift nurses was 1.15 to 4.16 times greater than rotating shift nurses [4].

One study found that 13% of critical care nurses shifted positions due to nurse burnout, while 5% left the nursing field altogether [5]. Another study found that 25% of nurses in high-intensity work environments such as the ED and ICU left due to nurse burnout [5]. A third study showed that compared with nurses working in psychiatry units, nurses working in medical wards and emergency units were more likely (three and eight times, respectively) to report occupational stress, while nurses working in surgical wards were less likely (0.18 times) to report stress than nurses working in psychiatry units [1].

Prevention & Treatment

Despite nurse burnout clearly being such a large concern, few nurses find their organizations to be addressing it. As few as 5% of nurses indicate their healthcare organizations are highly effective, 39% slightly effective, and 56% either slightly or highly ineffective at helping address staff burnout [5].

The best way to deal with burnout is to prevent it from happening in

the first place. Perhaps the best way to avoid and reduce work stress is by adapting positive behaviors outside of work by keeping professional and personal life separate and avoiding dwelling on work-related issues at home [2]. Take time for self-care by eating well, exercising, meditating, getting adequate sleep, and enjoying hobbies and relaxing activities [2,3].

One must take proper precautions to protect one's mental health and reduce work-related stress. Instead of leaving the nursing field entirely, one can consider switching departments or specializations [3]. Many hospitals offer employee assistance programs that include free phone counseling sessions, professional and pastoral counseling, support groups, and therapy [2].

Hospitals are encouraged to include communication training programs to improve basic and intuitive communication strategies that will promote safety and health in the workplace [2]. The Joint Commission outlined ways to reduce nurse burnout and its consequences by supporting nurses through administrator interventions including resilience training [5]. Fully engaged nurses lead to better work environments and patients outcomes [6]. Nurses are more likely to be fully engaged when they have supportive leadership who promote participation in work-related decisions, value employee opinions, encourage teamwork and respect, express confidence in employees' performance, facilitate goal attainment, provide autonomy, and who are accessible, responsive to the needs of their staff, and trustworthy [6,8].

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The Relationship between Subjective Sleep and Postpartum Depression

By Sammi Sternbach, MSN, CNM

Postpartum depression (PPD) is a prevalent complication during the peripartum period [1]. PPD affects one in seven women during their pregnancy or within the first 12 months after delivery [1]. PPD is increasingly recognized as a health issue that has comprehensive consequences for mothers and their infants [2].

The effects of PPD are far-reaching. If left untreated, PPD can have devastating effects not only on mothers, but also on infants and families [1]. Studies have shown that women suffering from PPD exhibit poor parenting practices and have little confidence regarding infant care [3,4]. Severe PPD can even lead to infanticide ideation and suicidal behaviors among mothers. Infants of mothers with PPD are at greater risk for long-term negative outcomes, such as affective, behavioral, and cognitive problems [3].

A history of mood disorders, current depression, or anxiety increase the risk that a woman may develop PPD [1,3]. Krawczak et al. (2016) conducted research that involved both healthy women as well as women with histories of mood disorders. Although all women in the study were euthymic at the beginning of the study, they each showed worsening depressive symptoms over the duration of the study. Interestingly, the participants with a history of mood disorders exhibited more biological rhythm changes and sleep dis-

turbances than did women with no history of mood disorders [3].

According to ACOG, less than 20% of women report depressive symptoms to their health care provider. Also, providers may overlook the development of PPD because its initial manifestations such as changes in libido, appetite, and sleep can resemble the changes that normally occur during pregnancy and the postpartum period. Women underreport the severity of these changes, which also leads to delay in diagnosis or under-diagnoses of PPD [1].

Multiple methods exist for measuring PPD. The Edinburgh Postnatal Depression Scale (EPDS) is the most widely used survey tool [1,2,4]. The EPDS is a 10-question survey that helps providers identify women at risk for PPD.

Major depressive disorders are often accompanied by disturbed sleep and other sleep abnormalities [3,4]. Throughout the perinatal period, women experience physical, hormonal, and emotional changes that affect both the quality and quantity of sleep [3]. Postpartum sleep is more fragmented, shorter in duration, and less efficient than sleep during pregnancy. This is due to the mother's need to attend to the newborn, hormonal changes, and fluctuations in melatonin levels [4].

Disturbed maternal sleep has negative cognitive and emotional effects on maternal functioning, and it increases maternal emotional vulnerability. Studies on sleep deprivation have shown that adults who suffer sleep loss have decreased alertness, attention, and memory [4]. This research also has shown that sleep loss can cause increased negativity, irritability, and difficulty processing emotions. Park et al. suggest that disrupted sleep and lack of restful sleep contribute to the development of PPD [2].

Measurements of maternal sleep can be taken by both subjective and objective methods. A common way to measure objective sleep is through wrist actigraphy which provides an objective measurement of wake and sleep periods by recording arm movements [2,4]. Methods of measuring subjective sleep vary from sleep logs and diaries to questionnaires and surveys. Common sleep questionnaires include the Pittsburgh Sleep Quality Index, the General Sleep Disturbance Scale, and the Insomnia Severity Index [2,3,4].

The connection between the development of PPD and various aspects of maternal sleep such as quality, maintenance, and duration has only recently become a subject of scientific interest [2]. When examining subjective versus objective sleep, research shows that subjective sleep was a more accurate predictor of depressive symptoms as compared to objective sleep. Women's actual, objective sleep quantity did not predict depressive symptoms, however, women's perceptions of the sleep they received did correlate with higher scores on the depression scale. The quantity of sleep was not such an important factor during the early postpartum period, rather it was sleep fragmentation and sleep inefficiency identified as major factors leading to a diagnosis of PPD [2].

Other studies have similarly found that EPDS scores were elevated in individuals with poor, subjective maternal sleep. There is a greater perception of a negative mother-infant relationship among women who reported higher levels of subjective insomnia. It is known that decreased confidence in caring for an infant can cause depression. Therefore, the positivity or negativity of the perceived mother-infant relationship is an important factor here [3,4].

Most studies that evaluated sleep using subjective methods found that poor subjective sleep is associated with an increase in depressive symptoms [2,4]. In the absence of an objective evaluation method, the combination of the EPDS and a subjective scale known as Pittsburgh Sleep Quality Index are used to measure development of depressive symptoms [3]. When results of these two scales are combined, findings reveal a stronger correlation between PPD and biological rhythm changes than between PPD and subjective sleep. It is not the biological rhythm of sleep, but rather the biological rhythms in social patterns, activity, and eating patterns that are predictive of PPD [3].

The importance of managing sleep and its subjective perception is integral to perinatal and postpartum care and the prevention of PPD [2,3,4]. Preemptive sleep interventions such as sleep education and prescribed naps may help improve sleep quality and reduce the severity of PPD [2]. In addition, an attempt to stabilize the circadian system during the last trimester of pregnancy may also protect against the development of PPD [3]. Disturbed sleep is indeed a modifiable risk factor in the development of PPD, and this idea has been proven by many studies containing multiple variants [2]. Although there are multiple causative agents of PPD, research has indicated that negative views of subjective sleep contribute greatly to the development of the disorder [2,3,4].

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Bias and Trust: Caregivers and the Mentally Ill Patient

By Malka Kruger, MSN, RN

A familiar scene: two nurses, standing outside a patient's room, giving report at the change of shift. As they discuss the clinical status of the case, necessary tasks, and treatment goals, the outgoing nurse finishes off by saying to the incoming, "Good luck with that one, anyway. That patient's bipolar. You'll never get anywhere with that." A new situational understanding and expectation has just been set forth, and the patient's treatment will be different because of it.

Brilliantly directed by the famed Alfred Hitchcock, *Psycho* (1960) is one of the most renowned films of all time. It is also an enduring source that perpetuates the idea that mentally ill individuals are fundamentally dangerous. Many other sources, some well known and some lesser known, both in fact and fiction, also present and support this idea. Other well-known media portrayals of mental illness include the novel and film titled *One Flew Over the Cuckoo's Nest*, *A Beautiful Mind*, *The Bell Jar*, *Halloween* and *The Exorcist* [1]. Although none of these are recent productions, their classic status speaks strongly to their lasting impact on subsequent generations of viewers and consequent development of negative ideas regarding the mentally ill. Stigma is defined by Merriam-Webster as "a mark of shame or discredit" [2]. Bias is defined as "an inclination of temperament or outlook; especially a personal and sometimes unreasoned judgement: prejudice" [2]. The stigma of mental illness leads to the development of bias towards the mentally ill; bias leads to discrimination, and discrimination to poor outcomes and health inequities [3]. Stigma toward mentally ill patients has been found to lead specifically to lack of attention to the medical needs of patients, mismanagement of their care, and it also contributes to social marginalization [3].

According to a 2014 article published in *The Lan-*

cet, stigma operates on three levels that are inter-related: structural stigma, which encompasses discriminatory policies, social structures, and can lead to health disparities; interpersonal stigma, which encompasses deficits of knowledge, such as ignorance and misinformation, prejudiced attitudes, and discriminatory behaviors, including violence, hostility, and human rights abuses; and intrapersonal stigma, which encompasses negative feelings about the self, including a sense of shame, alienation from others, and depressed mood [4].

Studies have shown that people with mental illness are perceived in many negative ways including being strange, weird, scary, unpredictable, physically aggressive, having little control of self, and being violent and dangerous [5]. With regard to healthcare, these perceptions extend to believing that patients with comorbid diagnoses of mental illness are likely to be unstable, non-compliant, unintelligent, have poor literacy, and lack logical reasoning skills. The presentation of severely mentally ill people, including characteristics such as disorganized thought and speech, bizarre and inappropriate behavior, and inconsistency between affect and mood, can be intimidating to nurses in non-psychiatric areas and contribute to inaccurate perceptions and therefore lead to stereotyping [6]. These perceptions are also often influenced by exposure to fiction, such as the films and novels mentioned above, or media reports which, as they are formulated in such a way as to draw in viewers, may be sensationalizing or overemphasizing the role of mental illness in the story being reported [1]. Inaccurate portrayals of mental illness is another cause of stigma. Accurate representations of the mentally ill have been found to decrease stigma [7].

Several assessment tools are used by researchers

to assess attitudes and perceptions toward the mentally ill. Determining the existence and degree of stigma in the caregiver population is necessary to determine the appropriate response to stigma. The Whatley Social Distance Scale measures distancing that prevents interaction with persons diagnosed with mental illness, such as living near, riding in a taxi driven by, hiring an employee, and allowing a daughter to marry a person with a diagnosis of mental illness. Various versions of the Attitudes toward Mental Illness scales are also used to evaluate caregiver and community member beliefs; these ask whether persons with mental illness appear different from "normal" people, if they can be recognized, whether they are intelligent, whether most are not dangerous, and whether they are capable of making decisions about everyday concerns [8].

Use of these tools allows researchers to evaluate in detail how caregivers approach persons with mental illness, and how that approach might change after interventions intended to improve the attitudes toward and treatment of persons with mental illness.

These beliefs, biases, and stigmas contribute a significant barrier to appropriate treatment options for mentally ill persons, in both mental health care and physical health care. They are also a source of lower quality of care, less attention to patients' medical needs, and mismanagement of patients' care [3]. One of the key elements to the patient-caregiver relationship, trust, is difficult to build when such biases and stigma are present [8]. One study, published in the *Journal of Clinical Psychiatry*, found that clinicians who were treating patients with schizophrenia for medical conditions expected those patients to be less compliant with treatment regimes. They also were less likely to refer them to a weight reduction program, as they believed that patients with schizophrenia were incapable of understanding the education involved or have the capacity to manage the treatment [9].

Changing perceptions to improve accuracy and eliminate bias and discrimination is not a simple matter. Exposure outside the clinical setting to people with mental illness has been shown to be beneficial. Providers who had non-clinical exposure to someone with mental illness, such as a friend or family member, generally were found to have less biased attitudes. Education is, as always, a key element. Many national and international organizations have created programs designed to increase awareness of mental illness, ensure that the mentally ill have access to appropriate and affordable care, to decrease the stigma of mental illness, and to decrease the discriminatory treatment of the mentally ill. These include the "Open the Doors" program created in 1996 by the World Psychiatric Association, the



Australian campaign "Beyond Blue," to specifically address depression, and "Time to Change," in England [3]. Changes in policy at the highest levels of legislation and government are part of the goals of these organizations, and there is a significant role that caregivers can have in effecting these essential and important changes.

Treating patients with mental illness is certainly challenging, and many providers would recognize the scenario with which this article opened, and recollect the difficulty of the ensuing shift. However, it is possible, and even probable, that without the presentation of the comorbid diagnosis of Bipolar disorder as a significant negative that is likely to be problematic, the situation might have been different. Certainly, as providers, it is incumbent upon every nurse, doctor, and other caregiver to work always to build trust, to treat every patient – every person – with genuine respect, and to provide accurate and honest information and assessments of the patient's needs and care. Improving awareness of personal biases and increasing education about appropriate and realistic ways to care for the mentally ill can be a powerful force for change.

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Getting Through Hard Days at Work: Perspective From a Psych Nurse

By Mollie Lorberbaum, RN

I keep a small piece of art taped to the front of my locker at work. I work in a psychiatric hospital with over 200 inpatient beds and primarily work with patients with severe eating disorders. One week we had a patient experiencing an intense psychotic episode. She was unable to sit still for more than a few minutes and didn't meaningfully communicate with staff or peers. She was frequently agitated. Every night I tried a new approach to connect with her. The first night I invited her to sit with me and do an activity, but she was too restless and stressed to sit and interact. The next night I put out a coloring book and a bin of colored pencils and invited her to sit with me. Again, she had trouble and only sat with me briefly before resuming to pace around the unit. The third night I simplified my request by choosing one coloring page and a few colored pencils, again inviting her to sit with me. She only sat for a minute or so at a time and didn't engage directly with me. I started the coloring page for her and left a few pencils with it on the table hoping she would find a way to settle herself and engage in an activity other than pacing. The next night, she was transferred to another unit before my shift began. I went to our unit and found the coloring page and pencils in the same spot I'd left them the night before but with one addition - the patient had colored in part of the page next to where I'd colored. We connected! While it may seem like a small milestone, this felt like a giant win. The patient seemingly did decide to sit and color hopefully feeling calmer even if only for a short time.

Patients with psychosis can be a challenging population to care for. Our ability to communicate, meaningfully engage, and alleviate their distress can be limited. I taped a piece of this coloring page to my locker to remind me that connection with patients is more than verbal, it can take days to establish, and that small wins are progress. It reminds me to keep trying even when the odds don't seem in my favor.

All nurses have good and bad days. Eight months into a global pandemic, we're all working in conditions of chronic stress. Caregiver fatigue is our new normal. How do we pull ourselves through the low points? From where do we draw strength on difficult shifts?

There's a *chassidic* story that teaches that our joy all year long stems from *Simchas Torah*. The story explains that people used to brew very concentrated tea called "tea essence" before *Shabbos*. On *Shabbos* one would take a little tea essence and mix it with hot water to make a cup of tea. Like tea essence, the story goes, we get a large portion of joy on *Simchas Torah* and draw from this concentrated happiness all year round for our daily portion of joy.

Consider your nursing tea essence, made up of concentrated moments of success, as tools to reach for on hard days. This toolkit can be built not only with memories but with thank you notes, drawings, and letters. For me, my nursing tea essence is a collection of patient connections that supersede the difficult times. They remind me why I'm a nurse and the impact of each connection. Perhaps your tea essence is filled with medical wins, like that time you performed

CPR for fifteen minutes and brought the patient back. Whatever your wins are - collect them, celebrate them, and draw upon them on days when successful moments are harder to find.

Allegra (name changed) was a woman in her 60s well known to the seasoned staff on our unit. Like many of our older patients, her disordered eating was secondary to major depression. She wanted to die and had withdrawn from most aspects of life including nutrition. The first time I met Allegra, she was wheeled to my unit on a stretcher in 4-point restraints as she was hitting herself while admitted to the hospital. Someone had lined the rails of the transfer bed with blankets because even in 4-point restraints, she tried to hit her head against the sides of the bed. Allegra had no interest in participating in the admission assessment, for she seemed focused on trying to hurt herself.

By my next shift with Allegra, while she still struggled with a strong desire for self harm, she was no longer in restraints. She still, however, refused to talk. I noticed her working on a puzzle book - a common activity in the psych ward. Her puzzle book was new to me - it was a code breaking book. I sat with her and, as usual, she refused to talk or engage with me. That is, until I asked her to teach me about code breaking. This was our breakthrough; it turns out Allegra was a teacher for many decades. Her pained face brightened and her avoidant eyes lifted until they met mine. She explained how much she used to enjoy teaching and taught me how to break codes with her puzzle book. This formed our connection.

During her admission, Allegra continued to struggle with depression, anorexia, and self harm. Once we connected over the code breaking book, we maintained a therapeutic rapport. I would see Allegra curve her fingers into a fist and slowly bring her hand towards her skull. I'd move to sit next to her and she would regulate and regain her composure. In a short time we got from four point restraints to a meaningful connection and she was able to be supported just with me sitting near her, no restraints required. On hard shifts, I think about Allegra, wonder if she's well, and am grateful that she opened up to me and taught me code breaking. Had I never asked about her book, we likely wouldn't have connected. You never know what tool will be needed to connect with a patient but if you're persistent, eventually something works, connections are made, and therapeutic alliances are developed.

This is what I draw from on hard days. We need to keep the big picture in mind. For me, the big picture is composed of pieces of unique connections with patients over the years. These meaningful moments of patient connection are my nursing tea essence. I encourage you to develop your own stash of tea essence to draw from on hard days. When the stress, anxiety, and sadness of nursing weighs me down, returning to my essence of patient connections centers and grounds me. It reminds me that I'm a good nurse, a compassionate nurse with a history of successful therapeutic patient care. I hope all of you create your own recipe for nursing tea essence and draw from it to bring yourself back when you get lost among the chaos that is nursing during a global pandemic.

Social Media and Mental Health

OJNA Journal Staff

Social media is a virtual place where people can share, exchange, and communicate their ideas and knowledge. Social media permits users to interact through sharing texts, photos, and audio and video messages. It can also facilitate communication among individuals who are geographically dispersed, allow for advocacy on topics of concern, sharing of common interests, and provides individuals with the freedom to express their opinions and disseminate ideas. In the past 10 years, the rapid development of the internet and social networking sites such as Facebook, Twitter, Instagram, Snapchat, Tik-Tok, and so on, has caused several profound changes in the way people communicate and interact. Facebook is the biggest social networking forum used today, and it has more than one billion active users. It is anticipated that this number will significantly increase in the coming years especially in developing countries. Facebook is used for both business and personal communication, and its application has brought numerous advantages in terms of increasing connectivity, sharing ideas, and online learning. Our own OJNA Facebook page has definitely been used for these reasons. In general, social media has become ubiquitous in communication and learning and can be an exciting tool when used wisely.

Recently, however, some researchers have associated online social networking with several psychiatric disorders including depressive symptoms, anxiety, and low self-esteem. Since social networks are a relatively new phenomenon, many questions regarding their potential impact on mental health remain unanswered. On the other hand, due to the popularity of these online services in the general population, there is a dearth of literature correlating the use of social networking sites and an increase in mental health issues, as this would pose serious public health concerns.

There is currently a lack of consensus in the literature as to whether social media has a positive or negative effect on the mental health of its users. A 1998 study claimed the internet as a negative force in people's lives stating that it was associated with reductions in a person's social circle and decreased general communication with family members [1]. This study also found that internet use is also associated with an increase in depression and loneliness.

A follow up study in 2002 [2], using the same sample, found that the negative effects reported by participants had mostly disappeared with the later study showing a reduction in depression rates. In a separate study, reported in the same paper, the authors found that using the internet for communication and general social involvement was associated with positive effects [2]. In general, using the internet predicted positive outcomes for extroverts and people with higher levels of social support while predicting negative outcomes for introverts and people with lower levels of social support. Although over a decade has passed since these seminal studies, there is still complexity and paradox present in the literature that describes both negative and positive attributes to social media in relationship to mental health.

Consistent use of the internet, more specifically social media networking sites,

may build on and add to existing face-to-face relationships, and may improve the giving and receiving of social support resulting in improved mental health for the user. However, the exclusive use of the internet, especially in connecting with people online, displacing the traditional face-to-face social relationships, may unfavorably influence the quality of social support given and received. This exclusive use of social media to create and sustain connectedness may reduce the number and quality of existing friendships and relationships and can result in negative effects for the exclusive social media user.

Inappropriate use of social media is having a negative effect on the mental health of youth [3]. Of particular concern are cyberbullying, online harassment, exposure to unsuitable violent and sexual material, and the decline of real social interaction. A report by the Council on Communications [4] and endorsed by the American Academy of Pediatrics makes a number of recommendations. These recommendations include discouraging children below the allowable age from opening social media accounts, incorporating topics such as cyberbullying and inappropriate use of social media into child protection guidelines, and placing more emphasis on educating parents, teachers, and children on how to safely use social media.

Over time, repeated cyberbullying can be a traumatic experience for an adolescent. Cyberbullying can produce and exacerbate several mental health issues including depression, stress, social anxiety, loneliness, low self-esteem, and suicidal thoughts. Trolling can be the most destructive method of cyberbullying. Offensive comments made by trolls on social media have serious consequences with young people such as depression, anxiety, and insecurity. It is alarming that this abusive behavior is escalating on social media.

Social media addiction in adolescents is an emerging area of study. Social media addiction can be associated with a young person's obsession to acquire and preserve relationships. Having this sense of desperation for online acceptance releases undesirable personality characteristics that directly influences their mental health. Psychologists continue to explore the rise of social media dependency, cyberbullying, and its relationship to the psychosocial crisis on the mental health of adolescents. Furthermore, there is a need to encourage young people and their adult counterparts to use social media in a positive manner that is beneficial for their wellbeing, promote awareness of any negative effects of social media usage, and work towards prevention and awareness of mental health issues that may arise.

In conclusion, it is clear that during the past 10 years, the internet and social networking forums have influenced significant changes in the way people communicate and interact. It is unclear how some of these changes affect normal aspects of human behavior or cause an increase or exacerbation of mental health concerns. In the future, additional research is needed to identify and describe the potential relationship between the use of social media networks and various mental health issues.

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Postpartum Psychosis

By: Talia Stern, RN-BSN

There are moments in nursing that change who we are both as nurses and as people in general. For me, this moment occurred when caring for my last admitted patient during my final shift in my previous position.

It was one of those unexpected (but sometimes necessary) reminders that just when you think you've seen it all, you most certainly have not. The information given over started off as rather innocent. This mother had a vaginal birth three hours prior, her perineum was intact, she delivered a baby girl of average gestational age, it was her second vaginal delivery...except that her first child was no longer living. Those words put an end to what had been a relatively routine report until that point.

The rest of her shocking history unfolded over the next few minutes. The patient had delivered her first child, a son, four years prior. When he was a few weeks old, in an episode that was later determined to be postpartum psychosis, she killed him by throwing him out the window of their house. She then served three years of jail time in a maximum-security prison before being released, and shortly afterwards became pregnant with her second child. Because her history involved an episode of acute psychosis, she would require one-to-one supervision with a healthcare professional by her side at all times documenting frequent safety assessments. Various cords, pens, extra linen, and any other objects that she could use to harm herself or others were to be removed from the room.

In the complicated way that nursing works, I tried to treat the family just like any other family that came through our doors while also being acutely aware of their unique situation. They were kind and polite, thanking me for every piece of information I gave them and every little thing I brought them. In the time that I worked with them, their dark past was never mentioned between us. Initially, I had very little time to settle them in and speak with them before liaisons from the Administration for Children's Services showed up for a lengthy meeting.

During the few rare quiet minutes toward the end of the morning, my thoughts were consumed by this young mother, even younger than myself. The fact that she ended up in prison upset me deeply. Is this really the way the system cared for an extremely vulnerable woman? In contrast to the very dark and complicated report I had received, this family looked...completely typical. Rationally, I knew that made sense; but in some way it was still distinctly surprising to me. It reminded me, impactfully and poignantly, that we can very rarely know a person's whole story at first glance.

In the morning right before I completed my shift, I asked the parents what they had named the baby. Their answer was a name in their native language that I didn't recognize. The father paused and then said quietly, 'It means sunrise.' He then continued, 'Thank you for everything you've done for our family. I cannot begin to tell you what it means to us.' In that moment, I looked at a family—two parents and their newborn daughter—full of hope and similar to so many others I had met before, and yet with a devastating past that will haunt them, I can imagine, for the rest of their lives.

The postpartum unit—the happiest place in the world, right? Wrong. Things are not always so 'happy'. The world of childbirth is not immune to more complicated issues that are much less talked about.

I left that shift a different nurse than I was before, and I've never gone back. The staggering truth is that during pregnancy or the postpartum period, up to one year after delivery, approximately 1 out of 7 women experiences significant or life-altering perinatal mood and anxiety disorders including depression, obsessive compulsive disorder, post- traumatic stress disorder, and psychosis among others [1]. Postpartum psychosis is a rare but severe illness occurring in approximately 1-2 out of 1000 births. Most often, the onset is sudden and within the first two weeks after birth. Symptoms include hallucinations, delusions, paranoia, hyperactivity, and extreme and rapid mood swings. A personal or family history of bipolar disorder, along with a prior psychotic episode, are the most significant risk factors for developing postpartum psychosis. Though rare, infanticide and suicide are associated with a small percentage of cases. Postpartum psychosis is considered a medical emergency that requires immediate intervention [2]. Treatments include pharmacotherapy for stabilization and maintenance as well as intense inpatient or outpatient psychotherapy [3].

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Mental Health Considerations in Oncology

By Yocheved Weinreb, RN OCN, OJNA Journal Staff & Alyssa Freeman, LMSW

It is no revelation that a diagnosis of cancer confers a heavy emotional and mental burden. An oncology patient may face any number of possible side-effects and changes affecting their day-to-day life, function, image of themselves, and more. These effects can last from weeks to years. Feelings of fear, anxiety, sadness, denial, anger, grief, loneliness, and loss of control are common, and contribute to disturbances in emotional and mental health for cancer patients [1]. Among oncology patients, the prevalence of psychological comorbidities and suicide is more than double when compared to the general population - approximately 15-25% versus 7%; the more severe the diagnosis of cancer, the higher the rate of suicide [2]. While there is still need for further study and development of mental health interventions for those with cancer, oncology care has grown to acknowledge the importance of this unfortunate side effect and screening tools have been developed to aid in identifying patients in need of intervention [3]. Research has proven that the implementation of psychological interventions early in cancer diagnoses leads to improved outcomes and prognoses [4,5].

Now, consider, for a moment, the effect a cancer diagnosis has on the vulnerable population of those with a pre-existing serious mental illness. Surprisingly, there is not much research on this topic, but it is clear that pre-existing psychiatric illness plays a significant role in cancer treatment and survivorship [6]. Several studies have correlated pre-cancer mental illness with higher cancer mortality rates [7]. The obvious question is, how might a history of mental illness impact their oncology care? Is it possible for health-care professionals to mitigate these statistics? What resources are needed?

The following case study portrays practical and ethical issues surrounding oncology care of a mentally ill individual. (details of the case have been altered to protect the anonymity of the patient)

Case

SM is a 72-year-old female with adjustment disorder, anxiety with panic attacks, major depressive disorder with potential psychotic features, post traumatic stress disorder with a severe trauma history including domestic violence and sexual abuse, polysubstance abuse and smoking. Her medical history includes COPD, asthma, incontinence, anorexia, and cervical spondylosis.

SM was introduced to the clinic for management of newly diagnosed small cell lung cancer and is being treated with immunotherapy.

SM lives alone. Her daughter lives separately and is somewhat involved in her care, but overall, there is minimal family support.

At her initial visit, it was clear that SM had complex psychosocial needs, and her oncologist referred her to supportive services: palliative care, social work, psychiatry, and spiritual care. She is a poor historian, often reflecting on past traumas in the middle of conversations, making it difficult to assess her sense of past and present, and her tangential thinking and lack of organization makes it difficult to assess comprehension of her illness. She is easily, and often, distracted by internal thoughts and familial/social challenges. She frequently has angry outbursts in the middle of visits and treatment. Her judgement, coping skills, and ability to care for herself are clearly compromised. She struggles with chronic pain, but is unable to provide a pain history or track her use of pain medication, making it unsafe to prescribe controlled substances.

The team relied heavily on the social worker to establish a relationship with

SM. Creating a therapeutic alliance was an important initial step to gain trust within the relationship. SM calls and texts the social worker multiple times a day, leaving voicemails that are difficult to interpret and she constantly challenges boundaries. To meet SM's needs, the team established home care for her, but she often complains about the aides and quality of care and will dismiss them.

This case highlights the complications and additional amount of resources necessary when caring for patients with psychiatric comorbidities. SM continues to receive treatment, but is also non-compliant and inconsistent in her follow-up. Despite multiple attempts at coordination from the team to rearrange her appointments to her convenience and provide transportation assistance, she often will not show up. The team has become frustrated by the seemingly wasteful investment of resources. In this case, it seems the biggest barrier to care is her inconsistent follow-up.

There are also ethical considerations. Does SM have a meaningful understanding of her disease and treatment options? Diagnoses, such as schizophrenia, alzheimers, or dementia can also make determining true capacity for consent difficult and may limit treatment options [8]. Additionally, as with SM, mental illness and substance use disorders hinder effective cancer pain management, especially in the setting of the current opioid crisis in this country [9]. Other concerns could pose a barrier to care. It's possible health-care providers may hesitate to treat when there is a psychiatric component. Oncology patients require a high level of care at different points in their treatment. When there is obvious lack of support and complicated psychosocial issues, at what point might the provider consider it is no longer safe to treat the patient?

Nurses have an important role to play in establishing a therapeutic relationship for all cancer patients. Directly caring for patients puts them in a position to assess for and recognize potential disturbances in mental health. It may be helpful to remind patients what they are feeling is expected and normal. When there is a pre-existing psychiatric comorbidity, nurses are essential in monitoring and advocating for this vulnerable population. It is imperative to be cognizant of the stress caring for these patients may place on the healthcare team and acknowledge feelings of frustration and futility. Understanding your role, working as a team, seeking help, and providing support to one another are essential. It is clear that much work is needed in research and development of clinical interventions to improve healthcare outcomes for these patients.

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Mental health and GDR

By Rhona Lowy

GDR. It's probably not an acronym most nurses are familiar with. I certainly wasn't until I started working in long term care after more than 25 years in the hospital setting. GDR stands for gradual dose reduction and is a euphemism for "lets see if this person can do as well on a lower dose of their medication".

The reason it is not seen in hospital settings is because it is typically used for medications that are given to address dementia or a psychiatric issue, usually in the long term care setting.

I know and have seen how medications like haldol and ativan are used to 'knock patients out' so they wouldn't 'bother' the staff. Patients who otherwise are capable of moving around and assisting with their own care were overmedicated, supposedly to prevent falls and other issues. I understand the pitfalls of overprescribing psychotropic medications.

Recently, I experienced a resident at my facility who was more than just demanding. If another resident was blocking her way, she would yell and threaten to hit them if they didn't move quickly enough for her. She would repeatedly go into other resident's rooms to "use their bathroom". If staff tried to redirect her she would say, "This is America, I can do what I want", and when staff insisted, such as when the room she chose had a resident who was in isolation, we really had to convince her strongly to use her own bathroom otherwise she would start trying to punch. For patients like this, psychotropic medications might be appropriate.



But sometimes it's not so simple. When staff reports a resident who is consistently not sleeping at night and melatonin has not worked, the next step is often a low dose of trazodone. We start the resident on trazodone, and the resident is now sleeping through the night. A month later, that resident is seen by the psychiatric NP or PA who may make a recommendation for a GDR. At first we hold the trazadone one day a week, and at that point you usually won't see a difference in behavior. But then the provider will change it to holding the medication 2-3 times per week. Depending on the medication's half life, we may or may not see a change in behavior. And of course, a lot depends on how well the behaviors are documented.

The idea is to have the resident take the least amount of medication. This may sound like a good policy. We get evaluations from the pharmacy saying xanax can cause dizziness in the elderly, and this is true. But if we have an anxious patient with dementia, who is constantly trying to get up without assistance, this can be the difference between a broken bone and independence.

There is definitely a push to take away the stigma of poor mental health, and it seems like there is a double standard when it comes to psychotropic medications. We say that mental health is no different from physical health, but at the same time, by wanting people to reduce medications that can stabilize their mental status, we are in essence implying that the medication is a crutch that should not be needed. If we proclaim that mental health and mental illness are equivalent to other physical illnesses such as diabetes or epilepsy, and a patient is stable on his current regimen, why do we not try to lower the doses of those medications to see if the person can function as well on a lower dose? This double standard should not exist.

Rhona Lowy graduated with an ADN thirty years ago and completed her BSN two years ago after attending six different colleges and over 200 credits. She has worked Med/Surg in various hospitals in Maryland, California, New Jersey and Israel and currently work as Charge Nurse/Supervisor in a nursing home. She has had humor vignettes printed in Nursing magazine.

A Nurse's Work With the Intellectually and Developmentally Disabled Population Living in the Group Home Setting

By Michal Silverstein, RN, BSN, EMT

When a family finds themselves unable to manage the needs of their intellectually and/or developmentally disabled (I/DD) family member, they often turn to a group home setting as a viable alternative. For many reasons, a family may no longer be able to provide quality of life, enrichment, and personal growth opportunities for their I/DD loved ones who may have been living at home for many years.

The I/DD cohort comprises a diverse set of individuals, abilities, and needs. As a result of this diversity, nurses working at a group home confront varied strengths, weaknesses, health issues, and functional abilities among their residential patients.

Nurses in a group home setting have a unique relationship with the residents, and they work closely with an interdisciplinary team to identify and meet resident needs. These residents are not typical med-surg patients but rather individuals with long term needs who may not be able to communicate with words or report when they are in pain. The I/DD patients can be downright mysterious. Nurses must interpret their smallest behavioral aberrations which often indicate something is amiss. The nurse's detective work in this setting can be frustrating yet gratifying.

The I/DD nurse has great appreciation for the fragility and the eccentricity of each patient, and this appreciation drives the profound compassion at the heart of his/her work. According to the nurses who compiled the Developmental Disabilities Nursing Guidebook, I/DD nurses "serve many but delight in the uniqueness of each individual as we endeavor to promote health and wellness [1]."

Since the I/DD population has diverse and chronic medical needs, nursing is an inherent part of and an ongoing visible presence in a group home setting. In addition, staff in a group home are present around the clock. These staff members are typically unlicensed, Approved Medication Administration Personnel (AMAP) who are trained by the agency and the RN in med pass, MAR documentation and vitals. This layer of personnel are unique to the group home setting. They are trained to report adverse health-care issues to the RN, and to call 911 in emergencies. They are paid far less than the RN. The residents are the main topic of staff conversation, and patient narratives are shared among the team members. Patients are observed, discussed, interacted with, fed, bathed,

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A NURSES WORK WITH THE DEVELOPMENTALLY DELAYED

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toileted, and assessed constantly. If something appears problematic, the nurse is relied upon for expert advice.

The group home setting is highly social and can be therapeutic to its residents. On the other hand, group home residents may exhibit behaviors that challenge their caregiver's ability to tolerate and respond patiently and therapeutically. The I/DD nurse must search for ways to understand and respond to the behavior that his/her patients display in order to communicate their needs. The nurse is intrigued by the different ways his/her patients communicate, and finds satisfaction in connecting with them.

State mandates govern the responsibilities of nurses working in group homes. For example, in New York, the Office of People with Developmental Disabilities (OPWDD) codifies nurse duties and provides training in areas such as choking prevention, dietary guidelines, fall prevention and abuse prevention. Nurses are responsible for maintaining a schedule of mandated appointments such as annual and semi-annual physicals, dental care, and eye exams. The nurse also writes plans of care and trains staff about diagnoses specific to each patient. The nurse attends and reports on each resident's health status and priorities at bi-annual interdisciplinary life-plan meetings. Given that group home residents are not able to independently manage their own healthcare, the nurse is the liaison between the patients he/she supports, their families, as well as the diverse healthcare providers. The nurse cultivates and maintains trusting long term relationships with the patients and those involved in their care. As a healthcare provider and a change agent, the I/DD nurse is committed to their service.

Insufficient funding for the I/DD population indicates that their complex healthcare needs are not well understood, and perhaps not considered important enough to support. The I/DD community is clearly underserved and subject to misperceptions that marginalize its members. Funding and public support are needed and welcome to affect positive change for this special community.

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Michal (Elizabeth) Silverstein RN, BSN, EMT lives in Monsey, NY and became a nurse in 2012 - a second career after decades as a costume designer and wardrobe stylist. She has served the ID/DD community from the outset. Michal is currently responsible for managing comprehensive healthcare needs for 18 residents in 3 group homes, including compliance with NY State OPWDD mandates.

STUDENT CORNER

Learning Between Semesters

By Chava Segal

I had big plans for Summer 2020, the summer in between my two years of nursing school. I had hopes of being a student nurse on a labor and delivery unit. This would allow me to gain experience, make connections, and learn from nurses in the specific field into which I hope to work. As the summer neared, it became clear that my hopes were not going to become reality. Right before the summer started, I was offered the opportunity to work in a sleep-away camp. While camp nursing was not something I had in mind, I became excited to be in a new environment and to have the opportunity to have a good time and gain hands-on nursing experience especially after lacking in-person clinicals for a few months due to COVID-19.

Being in camp during COVID-19 was an absolute dream. Everyone was tested for COVID-19 prior to arriving and then again on the first day of camp; this environment was a "bubble" where nobody was allowed in or out. It was easy to forget about masks, social distancing, and keeping up with the news of numbers, lockdowns, and openings. My favorite part was seeing kids forget to say goodbye to their parents on the first day of camp after having a negative test. The kids experienced such excitement being in camp after months of not knowing if it would work out under new COVID-19 restrictions.

This summer made me realize the amount one can learn from every situation and how impactful it can be for nursing students to get involved with different opportunities even if they differ from one's desired field. Testing each camper and staff member for COVID-19 was a fun way to introduce myself to campers and get to know their faces. I also enjoyed implementing techniques that I learned in school to calm the campers' fears of being tested. I walked them through the process step by step allaying their fears.

I had the privilege of working with three RNs and three doctors. Their passion and desire to teach me showed me their love for what they do and their yearning to give over their knowledge. My appreciation for their patience, teaching moments, and patience in answering my questions has me thinking forward to the future. I too would like to assist nursing students and engage those interested in learning the profession.

I remember one shift when it felt as though thousands of campers came pouring through the door. I immediately felt overwhelmed. The nurse calmly told all of the campers to make a line outside and we would help them one at a time. He then reminded me that we were in no rush and would help each camper until they were all helped. I watched as we gave each camper individual attention, exactly what he/she needed, and then went on to the next. We helped each camper in the ideal way and successfully got through all of the campers efficiently. I learned a lot about concentrating on one task at a time and giving each patient proper care and support while being efficient in getting things done.

This summer also helped me appreciate the value of teamwork and the importance of everyone being on the same team. When coworkers look out for you it makes the environment feel less stressful. You feel supported and it leads to a happier work setting.

While I had the opportunity to give Covid tests, wrap ankles, administer growth hormone, and more, I learned so much from watching the way the nurses and doctors interacted with the campers and staff. The way a nurse or doctor speaks to you can truly make or break a camper's day. I loved noticing the techniques they used. A joke, laughter, or any kind of levity can make a camper feel much calmer and more comfortable. Validating feelings has an incredible impact on making a camper feel understood and more likely to share their concerns. I have seen that showing interest in people outside of their health issue can truly make them feel cared for and can be a great distraction! I enjoyed asking the campers about the highlight of the day, their favorite activities, and hearing about night activity the night before!

Being in camp taught me so much about taking care of my own mental health especially after many months in quarantine. Taking a break from regular daily life, whether it is going on vacation or taking a day off, can make the biggest difference. There were days in which I stayed in the infirmary for many hours at a time because I loved being there. After stepping out for some time and then coming back, I realized that, despite how much I love the work, even a small break can be rejuvenating. I have tried to implement that into studying, working, and every aspect of my life. Anne Lamott is quoted as saying, "Almost everything will work again if you unplug it for a few minutes, including you." I will remember this when I start my work as an RN where there is often not much time to sit down and relax. I have learned that even just a few minutes of free time, to refresh and clear one's mind, can make all the difference in one's ability to provide patient care.

Now that I am back to "real life" in a pandemic, I focus on the positives of being a nursing student in this situation. School is still online, and a few of my clinicals are as well. There are not many social

events taking place, and hanging out with friends requires taking into account many factors. This situation has its benefits. I enjoy not waking up early each morning to take an early train. I enjoy being able to take care of things in the house in between classes, and going to class with a blanket and slippers. As I sat on the couch reviewing information before an exam a few days ago, I remembered the stress of sitting in the classroom before a test and hearing the way in which each person studied, other classmate's anxieties about the exam and waiting for the professor to pass out each exam. I had a flashback of seeing when each student completed their exam and wondering if I moved too slowly or quickly. I now enjoy the peace and quiet of taking my exam at home with only my professor watching me and my not knowing which section of the exam each student is working on. Not having social events to attend means not feeling bad about missing them due to school obligations, or going to events knowing that I have a lot of studying to do. While it is important to see people, feel productive,

and do things we enjoy, it is nice to be able to plan them around my school schedule.

My recommendation for current nursing students or people interested in the field is to try to learn from any situation that arises. One can learn so much from just a few minutes of hearing a nurse talk about his or her job, or about the nurse's experience in nursing school. I learned an incredible amount about the many opportunities in nursing, specifically in women's health, from speaking to nurses that I know and ones whom I have met along my journey. Watching nurses while visiting a patient in the hospital or rehab, in a doctor's office, or at a community event can give insight into what nurses do, and there is always something to learn from observing. I have felt encouragement and support from nurses to whom I have spoken. While nurses may have one of the most difficult jobs, it is one that they feel is continuously rewarding.

HALACHA CORNER

Questions of Mental Health in Halacha

Prepared by Rabbi Elyakim Milikowsky

Mental health is a broad topic that can affect every facet of one's life. Consequently, questions of mental health manifest in almost every area of *halacha*. A person living with depression, anxiety, obsessive-compulsive disorder, anorexia or another mental illness as well as those struggling with addiction or substance abuse disorders will encounter many *halachic* questions regarding their obligations while suffering from their illness: what is permitted to aid in their recovery as well as what they may do to maintain their mental health when recovery is achieved. In addition to those who suffer from a diagnosed mental illness, all of us may at times encounter situations where we require *halachic* guidance when our mental health and stability are threatened.

These two categories of mental health *halachic* questions - for those with diagnosed mental health issues and for those in whom circumstances have wrought a mental health crisis - were brought into stark relief this past Spring as the Jewish community suffered a devastating COVID-19 outbreak over the *Pesach* season. In an example of the usually private questions of those suffering with mental health disorders being addressed publicly, the Amudim organization publicized a video of Rav Dovid Cohen stating that those suffering from addiction who feel that they need to access support through technological means can do so on *Shabbos* or *Yom Tov* if it may lead to *pikuach nefesh*, although it should be done with a *shinui* when possible [1].

In a similar vein, but addressing those who encountered a sudden crisis due to the unprecedented circumstances, Rav Hershel Schachter wrote, "If the government or a physician has decided that an individual must remain in isolation over the course of *yom tov* and this individual has a psychological condition where physicians who know this patient have determined that there is a possibility that this person being alone over the course of *yom tov* would be in a situation of *pikuach nefesh* (possible suicide) if the individual was not able to communicate or speak with family members, then the family members must reach out to this person over *yom tov* to speak on the phone or use the internet by leaving a connection open from before *yom tov*."

Each circumstance that offers a *halachic* question regarding mental health will differ in its particulars, and a competent rabbinic authority should be consulted for all practical *halachic* dilemmas. Just as a rabbi will consult with medical experts before deciding a *halachic* question regarding physical health, a competent rabbi will consult with the appropriate mental health professional before deciding a question that relates to mental health.

It is beyond the scope of this article to provide guidance for practical decision making. Instead, the aim is to illuminate some of the general *halachic* parameters that can be gleaned from the writings of the great *posek* Rav

Moshe Feinstein zt"l in *Igros Moshe*. It can be difficult to deduce the exact conditions Rav Moshe refers to in his responsa as he does not utilize standard medical terminology. In the following discussion, we will proceed with our best understanding of his intention. Regardless, no *halachic* determinations should be made based on this article as it is intended just to illuminate possible avenues for *halachic* exploration.

Pikuach Nefesh

Rav Moshe writes in multiple responsa addressing various underlying mental health concerns that they can be considered *pikuach nefesh* (saving an endangered life), and therefore, almost all actions that would otherwise be forbidden can be allowed with the exception of the three cardinal sins of idol worship, forbidden sexual relationships and bloodshed, as well as *chillul Hashem*, desecration of the name of G-d. In the varying questions that relate to mental health that he addresses throughout his responsa, he provides several different considerations that determine whether *pikuach nefesh* exists. In his responsa, Rav Moshe also describes various considerations that are not considered sufficient basis to validate a situation of *pikuach nefesh*.

Rav Moshe writes [2] that a woman with a history of postpartum depression can be allowed to use methods of birth control that would otherwise be forbidden as her situation is considered to be one of *pikuach nefesh* should she become pregnant and subsequently give birth. He predicates the determination of *pikuach nefesh* on two factors: the danger she poses to herself as a suicide risk as well as the danger she may pose to her young children if she is stricken with depression. In the same responsum Rav Moshe notes that another consideration, the possibility of a woman being driven to depression because she is not able to satisfy her sexual needs, is not sufficiently grounded to make a determination of *pikuach nefesh*. Regarding a similar question [3], Rav Moshe permits a woman suffering from depression to have her fallopian tubes tied because of *pikuach nefesh*.

Rav Moshe discusses whether a teenager suffering from an unspecified mental illness may temporarily be committed to an institution for treatment if it would be necessary for him to eat non-kosher food while remaining a patient there [4]. In his responsum, Rav Moshe writes that if the patient is eating the non-kosher food willfully then even *pikuach nefesh* would not allow the responsible parties to send him there as *pikuach nefesh* only permits one to transgress because he is forced to and does not apply to one who is sinning willfully.

However, Rav Moshe writes that if the patient is not willfully eating the non-kosher food it would be permitted to commit him to the institution if the doctors would stipulate to one of three circumstances which meet the criteria of *pikuach nefesh*. Two of these, namely being a suicide risk and

being in direct danger from the illness intensifying, are obvious circumstances of *pikuach nefesh*. The third criteria, however, introduces a new, more attenuated type of *pikuach nefesh* - the concern that if left untreated, the youth may likely become involved in criminal activities and subsequently be in danger as his illness could lead him to resist the police and put himself in danger.

This last consideration suggests that *pikuach nefesh* may be declared even when the danger is based on possible future events and is not directly present at the time. It is important to note that Rav Moshe only suggests this as a theoretical possibility and did not issue a practical ruling directly based on this consideration. Before one would extrapolate from this suggestion of Rav Moshe, it would be important to verify that an actual danger does exist even if only in potential form.



Possible Pikuach Nefesh

Rav Moshe discusses what the *halacha* would be if a woman who must travel to the hospital on *shabbos* in a taxi demands that her husband or mother accompany her as she is worried that without their presence she would be in an unsafe situation from a medical perspective. Would they be permitted to travel with her? [5]

In the first part of this responsum, Rav Moshe assumes that the travel would entail violating the *shabbos* and discusses whether their participation would be permitted because of *pikuach nefesh*. Rav Moshe writes that if there is a rational basis for the woman's fears then it clearly would be considered *pikuach nefesh* and travel on *shabbos* would be permitted to assist the woman and allay her worries.

However, Rav Moshe determined that in the specific circumstance the questioner presented, there was no actual medical concern that would require an attendant. As such, the question is whether the woman's worries themselves create a situation of *pikuach nefesh* even when unfounded. He concludes that even though there is no danger apparent to an outside observer, if the patient herself feels endangered even after having been reassured that there is no danger, one must consider her personal perspective and suspect that there is *pikuach nefesh* present; and the husband or mother is obligated to travel with her.

This category, "possible *pikuach nefesh*", differs from the earlier category of *pikuach nefesh* in that it is not intrinsically and automatically considered to be a situation of life endangerment which permits otherwise forbidden acts. It is a subjective *pikuach nefesh*. When the patient insists that she feels endangered, the worries themselves create a risk of life endangerment and permit that which is otherwise forbidden.

Mental Distress

The third category that we can glean from Rav Moshe's responsa is that of mental distress that does not rise to the level of even "possible *pikuach nefesh*". Although acts that are expressly forbidden by the *Torah* can only be permitted for *pikuach nefesh* or possible *pikuach nefesh*, there are other aspects of *halacha* where mental distress can permit things that would otherwise not be allowed even when there is no potential of danger at all.

In the aforementioned responsum discussing whether an attendant may travel in a taxi on *shabbos* with a worried patient, Rav Moshe notes that in many such cases there is no real transgression that occurs. If the trip is in one city, the traveler is not transgressing any specific *shabbos* prohibition and the only problem other than a general lack of *shabbos* comportment is the issue

of *mar'as ayin*, appearing to transgress *shabbos*.

Rav Moshe therefore concludes that even when the patient does not perceive herself to be in danger but nonetheless requests that her husband or mother accompany her, it is permitted. The mental distress alone is enough to override the consideration of *mar'as ayin* as no specific prohibition of the *Torah* is being transgressed.

Rav Moshe discusses whether one who is recovering in a hospital from a mental breakdown is obligated to leave the hospital to hear the *shofar* blown if the doctors believe that he is in danger of relapse should he leave at this time. Rav Moshe concludes that since we are discussing the fulfillment of a positive commandment rather than transgressing a negative one, it is permitted for him to remain in the hospital [6].

Rav Moshe bases this conclusion on the rule that if a person would need to spend more than one fifth of his assets to fulfill a positive commandment, he is considered an *ones* (unable to fulfill the commandment) and is not obligated to spend that money to fulfill that commandment. One's mental health and stability are clearly worth more to a person than a fifth of his assets, so we can deduce that he can be considered an *ones* and not obligated in *shofar* if it would come at the cost of his mental health. It is important to note that this ruling was granted in the case of a patient who was hospitalized for his mental illness. It would clearly be irresponsible and wrong to extrapolate a general 'mental distress heter' whenever the fulfillment of a positive commandment is difficult and causes any mental or emotional difficulties.

As we have seen throughout the responsa of Rav Moshe, before addressing questions that concern the interplay between mental health and *halacha*, one must determine the parameters of the question from both mental health and *halachic* perspectives.

One must first determine what kind of *halachic* prohibition the situation is dealing with. Perhaps the question deals with transgressing a specific prohibition of the *Torah* in which actual or potential *pikuach nefesh* would be required to allow the transgression. In other circumstances, the question may be dealing with a lesser obligation whether it is the fulfillment of a positive commandment, a generalized prohibition such as *mar'as ayin*, or perhaps even a question of custom. Or maybe the question deals with circumstances when even *pikuach nefesh* cannot allow permission such as when the prohibition falls into the category of the cardinal sins or *chilul Hashem*, or a situation where the patient would be sinning wilfully and the leniencies of *pikuach nefesh* only allows for those who are only transgressing because of duress.

If it is a matter that requires *pikuach nefesh* to allow it, one must consider whether the present circumstance is one in which danger to a life is present either to the patient herself or others in the patient's orbit. If there is no clear and present danger, one must consider whether there is a sufficiently strong potential for future danger that would allow one to permit the transgression. Even if there is no objective danger, one must ask whether there is a subjective feeling of danger that could allow for transgressing the prohibition.

If it is a lesser obligation that can be overridden by mental distress that does not entail *pikuach nefesh*, the *halachic* decision must weigh the strength of the obligation versus the severity of the distress as well as other secondary factors that may impact the calculus.

Although a layman cannot hope to decide questions of mental health and *halacha*, as to do so requires expertise in the both realms, a familiarity with the fundamental axioms upon which the questions will be decided can be helpful in knowing what questions must be asked.

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- [1] Harav Dovid Cohen, Shlita. (2020) Permissible technology on shabbos & pesach 2020: mental health crisis and those in recovery. Retrieved from <https://vimeo.com/404392700>
 - [2] Even HaEzer 1:65
 - [3] Even HaEzer 4:36
 - [4] Yoreh Deah 2:59
 - [5] Orach Chaim 1:132
 - [6] Orach Chaim 1:172
- Rabbi Milikowsky is a rebbe and administrator at the Yeshiva of Greater Washington. While not a nurse himself, he is married to one for many years and talks about creating an OJNSA for spouses.

OJNA BOARD LEADERSHIP UPDATES:

The board members of OJNA continue to work on organizational growth and development, strengthening OJNA committees, and growing our reach across the United States, Canada, and Israel. The organization continues to grow in membership, expand and improve member resources and services, and host various events.

Annual Conference

Due to continued COVID restrictions, the 2020 annual OJNA nursing conference did not take place. OJNA will continue to follow state and city guidelines and plan accordingly for an in-person conference in 2021. Thank you to the conference committee, Goldie Burstein, Shevi Rosner, and Linda Segel, for all your hard work and effort.

COVID-19

OJNA ran numerous projects to assist its members and the community during COVID-19. The organization fundraised and distributed N95 and surgical masks to more than 1,000 health care professionals in NY, NJ, MD, FL, and CT. Special thank you to the many volunteers and organizers of this project: Hadassah Gholian, Linda Segel, Malka Feibush, Rina Schachter, Tova Reiss, Miriam Halberstam, Sara Kimmel, Michael Samuel, Chavi Rosenstock, Elchonon Galbut, Mara McCrossin, Tzivie Max, Sender Galbut, Eli Stoll, Rochel Morgulis, Shevi Rosner, Bina Gottlieb Weiss, and Chaya Milikowsky.

OJNA held eight virtual support calls addressing medical, emotional, halachic, and psychological issues related to COVID-19. Up to 170 participants joined the calls each week and the feedback on this initiative was extremely positive. We are grateful to all our speakers for offering engaging and educational presentations to our group.

OJNA distributed 450 pulse oximeters to community members in NY and NJ. The devices were given free of charge and detailed education and self-monitoring information was provided. Special thank you to the organizers of this project: Goldie Burstein, Shevi Rosner, and Linda Segel.

Community Education

Pulse oximeter education was provided to community members along with the devices they received.

Due to the increase in COVID cases in many communities in the Fall, OJNA hosted an event in September with a panel of school nurses to clarify and answer questions on COVID testing, isolation, and quarantine. This event was open to the public and was well attended. Thank you to our presenters, Adena Friedman, Hannah Kroll, and Chaya Milikowsky for an informative session.

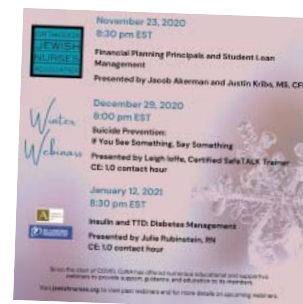
Continuing Education

In July, OJNA offered a webinar with continuing education credits on the topic of issues in camp and school nursing. Thank you to our presenters, Aviva Gluck and L'via Weinsinger, for an informative session.

In August, OJNA collaborated with Abbott Nutrition to offer an educational session on probiotics in the infant population. Thank you Abbott Nutrition for your support and educational presentation.

OJNA hosted a series of Winter Webinars on a range of

topics covering financial principals and nursing student loans, suicide prevention, and diabetes management. Two of the webinars offered continuing education credits. Thank you to our presenters, Jacob Akerman, Justin Kribs, Leigh Ioff, and Julie Rubinstein, for their very informative presentations. Special thank you to Akerman Financial and Gelt Charitable Foundation for their sponsorship.



A nine week medical halacha webinar series is scheduled to commence in mid-January and will provide extensive information on numerous issues regarding medical care of a patient in the hospital and at home as it relates to halacha, shabbos, yom tov, and more. We are fortunate to have an impressive line up of rabbonim to present this educational webinar series. The program is geared to health care professionals, and continuing education credits will be offered to participants. It is open to the public as well. Special thank you to our sponsors, speakers, and to Rabbi Shay Schachter and Shevi Rosner for organizing this program.

Membership

OJNA continues to increase in membership and some of the newest members hail from California, Florida, Massachusetts, New Jersey, New York, and Pennsylvania. Welcome!

Mentorship

OJNA's mentorship program has received much positive feedback. Over 60 new graduates have been paired with a mentor during the first six months of their nursing career. OJNA is conducting a research study to explore the role of mentoring among Orthodox Jewish nurses who are members of the Orthodox Jewish Nurses Association. This study will measure the mentor and mentee experiences and is aimed to determine the degree to which Orthodox Jewish nurses perceive the importance of characteristics of the mentor and mentoring relationship, as well as the level of satisfaction with the mentor and mentoring relationship. Special thank you to Toby Bressler and Mara McCrossin for your time and effort for this program.

Professional Development

OJNA has been an affiliate member organization of the American Nurses Association (ANA) during 2020 and will continue its affiliation in 2021. We are proud and honored to be an affiliate member of such a prestigious nursing organization.

OJNA is also honored that its Vice President, Toby Bressler, PhD, RN, OCN, has been inducted as a Fellow into the American Academy of Nursing (AAN). Inductees to AAN are recognized for their significant contributions to health and health care. This is one of the highest honors that can be bestowed upon a nurse leader.

Response to Emergency Medicine Statement

Chaya Milikowsky, MS, RN, AG/ACNP

On September 3, 2020 a number of emergency medicine professional organizations released the following statement, *"The undersigned representatives of Emergency Medicine physicians are united in their support of physician-led patient care and training. Although all who provide care in the emergency department setting must be appropriately trained, education of emergency medicine resident physicians and medical students must not be compromised or diluted. The terms "resident", "residency", "fellow" and "fellowship" in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs. Physicians must lead patient care teams and actively shape standards for education and scope of practice of non-physician providers. Hospitals or employers should not create or advertise post-graduate training of nurse practitioners or physicians assistants in the emergency department without the explicit involvement and approval of the emergency medicine departmental and residency leadership."* [1]

This statement was met with concern, and nursing and physicians assistant organizations to include the Emergency Nurses Association, the American Association for Critical Care Nurses, the National Association for Pediatric Nurse Practitioners, the American Association of Nurse Practitioners, the American Academy of Emergency Nurse Practitioners, the American Association of Physician Assistants, and the Society for Emergency Medicine Physician's Assistants swiftly published responses. Additionally, representatives from other non-advanced practice provider organizations expressed their concerns about this statement. The American College of Clinical Pharmacy noted that the terminology of "residency" has long been used and encouraged in the development of emergency medicine pharmacy resident programs. Establishing such programs was actually among the recommendations of an earlier position statement by the American College of Emergency Physicians in 2015 [2].

(continued on following page)

"I am married a few months and I am not feeling any pleasure in intimacy, are we doing it right?" "I have 2 toddler kids and a new baby and I have no libido, is this normal?"

"I am in my early 50s and my body is changing, is there anything I can do about the dryness and pain I am feeling?"

These are just some of the questions that many women ponder in their bedrooms. For the most part, the questions stay in the bedroom because until now there were few people to ask. The questions are often cloaked with, 'Is this normal?' ever echoing their shame. Who really has the knowledge and the ability to give them the comfort level to ask such personal questions? A doctor might offer medicine, a friend or relative might have the best intentions but has no idea how to help her with issues of intimacy.

Three friends, a Mikva board member, a social worker and a kallah teacher, all hotline advocates and with years of experience in relationship and marriage education, decided that the topic of intimacy must finally be addressed. Due to the sensitivity of the subject, the halachic ramifications, and the necessity to do damage control, the seeds were planted for the Ani Ledodi Helpline. A lot of planning, training and halachic guidance were blended with just the right dose of empathy, caring and common sense. Advocates were culled from different communities around the country and trained on Zoom by a professional sex therapist, nurse practitioner/ bodeket and a therapist who specializes in relationships and abuse. Overseeing the team is a veteran kalla teacher and wife of a renowned rosh yeshiva, and of course rabbinic endorsements from prominent rabbonim.

A caller to the Ani Ledodi Helpline will be answered by these advocates trained extensively in all areas of intimacy, physical health, relationship issues and abuse. All of the advocates are able to address issues with a kind, nonjudgmental attitude, acceptance, warmth and empathy. She will take the time to hear her problem, clarify,

and unpack what is truly bothering the caller. She will help her explore different courses of action. In many cases, a listening ear and some general information can help a woman identify the problem and come to a solution on her own. Sometimes, knowing that she is not alone in experiencing certain issues can relieve the stress and help her feel good about herself. If the necessity arises to refer, the advocate will access the extensive list of professional referrals

that are constantly being vetted and updated by the administration. In cases that warrant immediate, professional involvement, our advocates are trained to offer gentle guidance and safety planning to help her get the help she needs.

The helpline will operate Monday and Wednesday evenings and Tuesday and Thursday mornings. There is no caller-ID, thus ensuring the callers anonymity and privacy. Advocates will have regular in-service meetings, so that they stay up to date on current issues and learn from one another. Lectures, webinars, and informational articles will be posted on the website. We encourage you to explore our website, AniLedodihelpline.org for further information, and to leave feedback.

After much planning, training, administrative work and networking, the Ani Ledodi Helpline is almost ready to go live. Please help spread the word about this new initiative to enhance the intimate lives of Jewish women worldwide.



ANI LEDODI
JEWISH WOMEN'S INTIMACY HELPLINE

A discrete and anonymous referral helpline run by women for women, addressing questions and concerns regarding intimacy

Coming Soon!

All questions welcome. We are here for you!

646-746-4343
aniledodihelpline.org

RESPONSE TO EMERGENCY MEDICINE STATEMENT

(continued from previous page)

A first concern with the above position statement is that the emergency medicine community is attempting to take ownership of terminology that, while associated with postgraduate medical training, has also been long applied in a variety of fields to include dentistry, optometry, podiatry, pharmacy, veterinary medicine, physician assistant, and more recently nurse practitioner training. No single discipline owns the terminology, and attempting to restrict its use is both presumptuous and wrong. Furthermore, nurse practitioner and physician assistant residency training programs have always clearly identified themselves as such, and do not attempt to suggest that they are medical residency programs.

A second concern with the statement is the worrisome overstep by the signing medical organizations in their attempt to regulate and determine the educational path, scope, and standards of other disciplines. While it

is of course important to have physician involvement in the development of any emergency medicine program, physicians should take responsibility for physician training and education, and advanced practice nursing organizations should be ultimately responsible to provide standardized clinical training and education to their constituents.

It is unfortunate that one discipline would choose to place barriers to the best practice of another and attempt to restrict the ability of all providers to practice to the full extent of their education and licenses. The shared goal of the interdisciplinary team should be to improve patient safety and maximize patient outcomes. Divisive rhetoric stifles the ability of providers to provide the best care and ultimately harms no one more than those very patients we seek to help.

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NURSES TO KNOW

Shmuel Y. Bieler, RN

Nursing Role: Psychiatric Nurse

Where do you currently work, and can you describe your responsibilities?

I am the charge nurse for the night shift on the Psychotic Disorders Unit at Gracie Square Hospital of New York Presbyterian. I am responsible for managing up to 32 psychotic patients as well as the nurses and the nursing assistants that work with me. The unit can be intense, unpredictable, and at times violent. I am the designated educator and trainer for staff in the hospital on how to deal with crisis situations. For this reason, I am expected to go to all emergencies in the hospital. In a nutshell, I have seen it all and it is very hard to shock me.

Additionally, I started a recovery program called Shalva that is associated with a rehab called College Recovery. This program is designed for Orthodox Jews looking to get treatment without compromising any of their Orthodox Jewish practices or beliefs. I also am a recovery coach for individuals in Northern New Jersey and am working to obtain my recovery coaching certification.

How long have you been working in your field, and was this area of nursing your first position?

I have been a nurse for 9 years. For my first few years of nursing, I worked at Memorial Sloan Kettering Cancer Center on a Bone Marrow Transplant, Leukemia/Lymphoma unit. The last 6 years I have been at Gracie Square. I started on the Addiction Unit but have spent the last 4 years on the Psychotic Disorders Unit.

How has mental health as a specialty been affected by COVID-19? Your unit in particular?

My unit was designated as THE COVID-19 psychiatric unit for all of Manhattan. Psychiatric patients from other facilities who tested COVID-19 positive were transferred to us. That is on top of our own psychiatric COVID-19 positive patients. The impact of CO-

VID-19 was felt then and it is still felt now. Visitation and activities are limited. Mental health in general can be a very lonely place, and COVID-19 just makes it lonelier.

One instance involved a Jewish woman in her 80's. She presented with depression with psychotic features and was COVID-19 positive. It was early on in the pandemic that there wasn't much to offer patients in terms of making the days go by easier. There wasn't efficient PPE. This woman would be in the hospital over Pesach. The thought of being alone over a holiday due to COVID-19, on top of her mental illness, was causing her extreme distress. I offered to do bedikas chametz with her in her room. We turned off the lights, scattered some leftover bread and cereal around the room, used the light on my phone, and a feather and bag I brought from home, and did the bedika, bracha and all. I told the woman that the next day when I burnt my chametz I would burn hers as well. I took a picture of our chametz burning and sent it to my unit manager to show the woman. It was something so simple I could do for my fellow Jew and patient, and it made all the difference.

I have also seen the effects of COVID-19 on the mental health of our unit staff. Burnout, mental and physical exhaustion, as well as fear were palpable. Some staff, out of fear of contracting the virus, took a more "cautious" approach when caring for patients and the slack left over fell on the rest of the staff to ensure that every patient was cared for.

What advice would you give someone entering this field?

People need to understand that this field isn't just a recession-proof job with a steady paycheck. You have to do the little things, to go above and beyond. The patients in this field need special care, special attention, special empathy, and special compassion. If this is something you feel you want to do, then feel free to reach out to OJNA for my contact information, and I will be happy to talk to you.

If you would like to be profiled in future issues of The OJNA Journal, send a short paragraph detailing your background and role to OJNAjournal@gmail.com.

Reflections on the Evolution of a Psychiatric Nurse Coming Out of the Era of Community Mental Health

By Bonnie Berman R.N., M.A. C.S.

As the months of the pandemic pass while reflecting on my years in psychiatric nursing, those years seem overshadowed by current dilemmas. Widespread illness and loss of life are worldwide, and the consequent anxiety and depression are pervasive and a rapidly growing platform for a revitalized and intense program of mental health intervention. Current data points to 25% of the American population experiencing symptoms of depression with an increasing incidence of substance abuse. Government and healthcare leadership must respond with timely and well-funded programs to provide community based mental health services.

On a more personal note, these months have been quite sad. Separation, fear, and helplessness have challenged life in a way I certainly did not anticipate. I know I share these feelings with many and look to time for healing and restoration.

Reflecting upon my years in psychiatric nursing



and sharing that experience have been most difficult as we live day to day in this tragic time of disease and death. The daily events in New York City seem far more focal than the details of my career. I share with you those years and experiences but, please, consider as you read, the happenings of the time in which I write.

"I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use federal resources to stimulate state, local, and private action. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment, and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

With these words of advocacy for change in the

mental health system, John F. Kennedy stimulated the movement of change which culminated in the Community Mental Health Act of 1963. The mission, as defined by Kennedy, created the foundation for education in all the healthcare disciplines, but most significantly in nursing. In the documents which supported the passage of the act, the need to develop the force of change through a larger and better educated group of nurses was underscored. Graduate and undergraduate grants and fellowships for advanced study and education, richly endowed by the government, were key to changing the environment of care in mental health facilities both private and public. These fellowships and the grants to build new community based mental health facilities were funded with hope for establishing the path of change.

As an undergraduate nursing student at Boston University in the era of the integrated curriculum, I studied in a program where reflection and the interpersonal process were emphasized in groups led by graduate psychiatric nursing students in each year of study. It was the first of those graduate students whom I encountered, Dr. Judith LaRosa, whose warmth and unfailing acceptance led me and others in the group to consider psychiatric nursing as a career. The emphasis on the interpersonal was not only an introduction to the therapeutic relationship but to the world of Hildegard Peplau's use of "self."

Boston University encouraged psychiatry as a career path and promoted applications for undergraduate National Institute of Mental Health (NIMH) grants for those willing to commit to graduate study in psychiatric nursing. I was drawn by the clinical experiences led by a creative and committed faculty who encouraged applications for graduate fellowship. As a recipient of an NIMH fellowship at New York University, I had the privilege to complete my advanced degree in the program under the remarkable leadership of Dr. Claire Fagin. Known for her fearless leadership and caring heart, Dr. Fagin developed the program with an emphasis on Community Mental Health in the clinical placements. Supported by the fellowship, my years at New York University prepared me for the expanded role of the clinical specialist. It was encouraging and motivating to feel a part of caring for the patient who would be returning to community living often after years in a psychiatric hospital. My sub-specialty in education took me to a placement at Rutgers where I had the privilege of observing Hildegard

Peplau lead the faculty.

The second of the community mental health centers built to support the mission of the Kennedy act was established at Maimonides Medical Center in Brooklyn. With a high incidence of mental health problems in the area established in initial studies, Dr. Mark Tarail led the project. It was planned that the facility would care for patients within their area of residence as well as many who could return to the community from nearby Brooklyn State Hospital, a large heavily populated urban long-term care facility. The inpatient service of this newly established mental health center was where I first learned the value of involving patients and families in care and in recovery.

Changes in the traditional staff and patient roles encouraged interaction and expression. As a nurse, I was involved in care and learning from the interdisciplinary team that worked and struggled together. My novice years in the inpatient service, including time while in graduate school, were the learning years. The learning environment was energizing with staff open to teach and share. Nurses, physicians, and mental health workers were generous with time, knowledge, guidance, and support. After a few traditional initiation rites and tests, staff was protective but encouraging of exploration. Even the patients, keen at spotting novice staff, shared stories about their lives and struggles with mental illness. Education was both formal and informal, with clinical supervision a priority in developing staff. Social relationships made work engaging.

After two years in the inpatient service, I was most fortunate to have the opportunity to work in the adult outpatient department. There I was, part of a team of physicians, social workers, and psychologists with an assigned caseload that included individual & group therapy as well home visits. My most unique experience was working alongside an art therapist and psychiatrist with a group of patients who had limited verbal and expressive abilities. Patient artwork was the tool used to stimulate creative discussion and assess the patient's mental status. The psychiatrist prescribed in the setting of the group and the sharing was a rich source of social contact for the members sharing holiday and birthday celebrations. Trees were often the subject chosen to draw and the post group discussion would often explore the strength or weakness of the tree structure to assess the mental and social status of each patient. The long term nature of these relationships created special connections not only among the patients but among the treatment team.

While working in the outpatient service as one of two nurses on the outpatient team of eight, I was encouraged to apply for the position of director of nursing for the department of psychiatry. Recently vacated by the third nurse to hold the title, I was ambivalent about moving out of the clinical and into a managerial role. The core of the role was staffing the service, as well as educating and managing inpatient nursing staff. Applying from outside the service to compete with friends currently working on the service made it uncomfortable. Leaving direct care to join what some thought to be the “other side” was not an easy choice. I would be reporting within the department but would be the only non-union nurse in a strongly pro-union department. After some coaxing and seduction, I was the fourth director of nursing in the department’s history. Thus began almost 40 years of learning. Raised in the 1960s, I was part of an anti-management generation and it wasn’t comfortable to now find myself cavorting with the enemy. With no formal management training or administrative education, no experience in budget or finance, and no knowledge of human resource policy or law, every decision required study and consultation.

Fortunately, a few generous nurses in the hospital became personal mentors and links to resources in the medical center unknown to life in psychiatry (known as the department up the street). I worked at remodeling my relationships with nurses and mental health workers and at establishing authority with former outpatient peers. A year and a few months later, I left on maternity leave and my former competitor became my associate covering during my leave. Upon my return, a new unit of 30 beds opened and, with it, the line of reporting for the director position had changed. I returned to work reporting to the chief nurse of the medical center. I experienced the change as having been “sold out” since I had had no involvement in the decision to reorganize the table of organization. Complain though I did, the years of working in the nursing department helped me learn processes and leadership styles. Some issues were frustrating recognizing that I often thought differently. I cannot deny that my role, regardless of the many different titles, had been inspired and enriched by the chief nurses to whom I reported. In the transition from the social model which dominated psychiatric services in the community mental health era to the biological/medical model, nurses continue to be core to the provision of care for patients in the mental health system. The transition of nursing education to preparing nurse practitioners strengthens the biological focus in caring for patients. A program with balanced emphasis, including the environment of care, would support the well-established legacy of a generation of psychiatric nurses.

Bonnie Berman has been a lifelong psychiatric nurse and most recently held the position of Executive Director of Nursing for the Department of Psychiatry at Maimonides Medical Center.

CAREERS TO CONSIDER

Psychiatric Mental Health Nurse

Tziporah Newman, BSN, RN

Job Description / Basic Responsibilities [1-3, 8]

- ▶ Provide treatments to improve the quality of life and mental health of individuals across the life spectrum
- ▶ Build a trusting rapport with each patient
- ▶ Assist patient during times of distress, emotionally and physically
- ▶ Educate patient and family on the various mental health conditions and treatment options
- ▶ Crisis and violence preparedness and deescalation
- ▶ Medication administration

Educational Requirements [1, 4-5]

- ▶ RN license
- ▶ Certification:
 - Psychiatric-Mental Health Nursing Certification (RN-BC)
 - Psychiatric Mental Health Nurse Practitioner (PMHNP-BC)
 - » MSN required
 - » Requires a minimum of 500 faculty-supervised clinical hours through the nurse practitioner program
 - Both are issued through ANCC and require 2,000 fieldwork hours in the mental health field and 30 continuing education credits within a 3-year period

Recommended Experience [2-3]

There is no necessary experience to become a psychiatric mental health nurse. Nurses interested in this specialty can apply immediately after receiving their nursing licensure. However, two years of med-surg experience is encouraged.

Salary [6]

\$50,000-\$92,000 with an average pay of \$66,727

Work Environment [1,7]

Home care, hospitals, psychiatric inpatient and outpatient clinics, addiction facilities, substance abuse treatment facilities, schools, prisons, Veteran Affairs, private practice

Typical Work Schedule [5,7]

Typically 10-hour shifts with rotating weekends and holidays, on-call evenings

Job Outlook [2]

While there are no statistics specific to the psychiatric field, psychiatric mental health nurses are expected to be in high demand due to the increase in mental health awareness and the nursing shortage

Suggested Skills

- ▶ Compassion
- ▶ Sympathy
- ▶ Sensitivity
- ▶ Emotional Support
- ▶ Good Communication skills

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When Caring Counts Most

By: Henya Storch, MSN, RN

When Caring Counts Most - A Guide for Jewish Caregivers was recently published by the *Chevrah Lomdei Mishna* and was written to help Jewish caregivers manage the many legal, medical, and practical issues of caring for an ill or elderly person. The book comprises articles written by a wide range of medical professionals, rabbis, lawyers, and laypeople each offering different perspectives and advice on related topics. One of the chapters was written by OJNA member Henya Storch, MSN, RN titled How Family Caregivers Should Speak so Professionals Should Listen. Below is a short excerpt from her chapter.

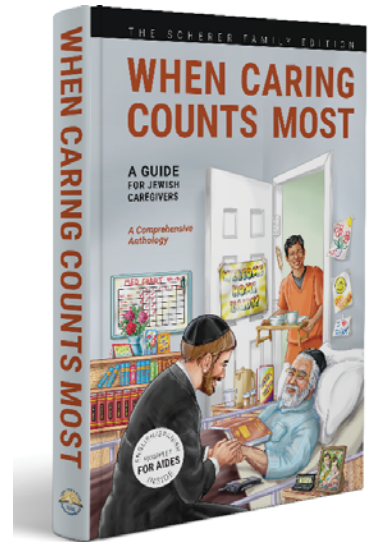
“Today’s family caretaker must interact with a wide range of health professionals. In the olden days, the family doctor was available 24/7, made housecalls, often cared for multiple family members, and was witness to and aware of the family dynamics. As medicine has become highly specialized, care today is likely to be more fractured and less personal.

“Today, there are hundreds of medical services and sub-specialties offered in multiple venues – doctors’ offices, clinics, treatment centers, hospitals, nursing and rehab facilities, and group homes. The most basic office visit to a primary-care physician looks very different than it did even twenty years ago. It is common today to be examined by a physician’s assistant or nurse practitioner often without ever seeing the primary doctor. There are dozens of specialized healthcare technicians – sonographers, phlebotomists, and EKG and x-ray technicians – and many allied professionals, including therapists, social workers, dieticians, and pharmacists. In the religious commu-

nity, there is a dazzling array of volunteer organizations functioning in critical roles: medical and mental health referral agencies, case-management and funding agencies (e.g., Ohel and Chai Lifeline), Hatzolah, *bikur cholims*, medical-equipment lending *gemachs*, and many others.

“Before interacting with any medical professional, the family caregiver needs to ask him or herself the following questions: What is my role? What is the goal of my communication with the professional? What is the setting in which we are meeting? With whom am I speaking? What am I not seeing? Why should they listen? What is the best way to communicate? What is the best time for this communication? How should I communicate so that my message will be heard? What if I feel the patient is not being treated properly? Let’s explore each question...”

Henya Storch, MSN, RN, is the CEO of Storch Agency International, which specializes in healthcare, business, and talent coaching, publicity/PR, and communal outreach. Henya lives in Woodmere, NY.



Member Milestones

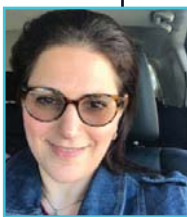
YEHUDIS APPEL, BSN, RN, was recently published in the American Journal of Nursing’s “Off the Charts” blog. Her piece is titled Those Special Moments Nurses Sometimes Talk About and is available at <https://ajnonoffthecharts.com/those-special-moments-nurses-sometimes-talk-about/>.

GEILA (GILI) BEN NAIM, BSN, RN, recently accepted a new position in a Level 3 NICU in Central Florida. This has been a dream job and is her first position after moving from Israel.



TOBY BRESSLER PHD, RN, OCN, has been inducted as a Fellow into the American Academy of Nursing. This is one of the highest honors that can be bestowed upon a nurse leader.

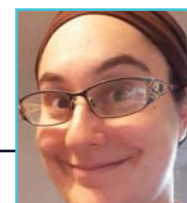
MICOLE GALAPO-GOLDSTEIN, FNP-BC, IBCLC, LCCE, presented a poster at the New York Nurse Practitioner Association Conference on October 17, 2020. The poster is titled The Role of the Nurse Practitioner in Promoting Wellness of Mother/Infant/Family in a Home Visiting Setting.



AVIVA GLUCK, BSN, RN, graduated in December 2020 with her BSN from Drexel University. Aviva started working toward her BSN back in 2011 but had to take a leave of absence due to the passing of her father. After an eight-year hiatus she picked back up and completed what she started. Lesson: never give up.

LEVANA NOROWITZ, BSN, RN, graduated from SUNY Downstate’s accelerated BSN program in August 2020 and subsequently passed her NCLEX.

TOVAH JULIE RUBINSTEIN, RN, BSCN, recently accepted a new position as Diabetes Nurse Educator in Toronto, Ontario.



SCOTT TOPIOL, MSN, RN, PHN, CEN, MICN, EMT, graduated with his MSN in Education on November 1, 2020 from Western Governors University.

HENYA STORCH, MSN, RN, contributed a chapter titled How Family Caregivers Should Speak so Professionals Should Listen to the book When Caring Counts the Most by the Chevrah Lomdei Mishnah. The book was written to assist Jewish caregivers of the ill or elderly.

TO HAVE YOUR MILESTONE FEATURED IN OUR NEXT JOURNAL EMAIL OJNAJOURNAL@GMAIL.COM

Representing the Tribe/Us Versus Them

By: Laura Silverstein

I grew up out of town, so I am very used to the idea of being The Only Jew: the only Jew on the block, the only Jew in ballet class and the only one wearing a skirt on the ski slope. Just to be clear, I was not the only “*frum*” Jew. I was the only Jew.

We had no kosher restaurants and no Jewish youth groups. Outside of school and shul, there were no opportunities to interact as a group with other Jewish children that were like me.

I will never forget the first time I saw a school bus with Hebrew writing on it. I was 11 years old and I was near Monticello, N.Y. for the summer. I couldn't believe such a thing existed. It definitely made me wonder about how other *frum* Jews lived in their communities and how those communities were different than mine.

When I was in nursing school I was one of two *frum* women in the program. I was very easily identifiable as the Jew. I viewed this as an advantage. I could have blended in more both in my dress and my actions, but I deliberately chose not to. I purposely wore a headscarf instead of a wig and I did not seek permission from my rabbi to wear scrub pants but wore a skirt instead. I made a choice to be The Jew.

People asked me all sorts of questions about *halacha*, *yom tov*, observance choices, birth control, divorce, the hole in the sheet, about other Jews who had been caught breaking laws and much more. I quickly learned that I could be the one to set the record straight for these people. I often spoke about how we all make choices. Even priests and rabbis, nurses and doctors, everyone makes choices. There is no lightning bolt that will strike us down when we choose wrongly, but I believe that there are consequences and I believe G-d is in charge. Surprisingly, no one disagreed with me.

One of my first jobs as a nurse was in home care. I worked for a large, national company and I was based in New Jersey. There, I was lucky to work with a great group of people none of whom had ever closely interacted with a Jew. Any Jew. Ever. I went to the interview in a *sheitel*, but I arrived on my first day of work in a headscarf. The director asked me about it, and I explained that it was a religious covering, and she seemed fine with that. I had explained that I could not work the full day on Fridays but guaranteed them all of my visits would be completed as required. They seemed hesitant but didn't give me any problems. Of course, my visits *were* always completed, and then some. I hoped that by completing my work and keeping my word, I had successfully started to create trust between myself and my employer.

I quickly realized that I was going to represent all Jews to my co-workers. I took this responsibility very seriously. I didn't talk about my religion unless it came up in conversation because I didn't want to make a big deal out of it. Really, how relevant is my religion during my work hours? But if the topic did come up, and it often did, I laid it all out on the line. I encouraged ques-

tions and promised that they could ask me anything they wanted. Kosher was a favorite topic and why the rabbi had to “bless the food” was frequently asked about. I shared information when I was asked and worked there happily for many years.

I know that some people purposely avoid being easily identifiable as a *frum* Jew so others don't treat them differently. I think this is a missed opportunity. I want to be easily identified, I want people to expect more from me. I want to have the chance to make a good impression so the next time my coworker has a conversation with someone else about *frum* Jews, they think of me, and not the person being represented in the media or on a TV show.

The responsibility of doing the right thing and being The Jew didn't change when I found myself working in a predominantly Jewish environment. People are still watching and judging, Jews and non-Jews alike.

I frequently invite co-workers, Jew and non-Jew alike, to my home for *shabbos* and *yom Tov*. Let them see me and my crazy family. Let them taste my mother's famous matza balls and let them see what really goes on at a *Pesach* seder. The unexpected result of these meals is that my children get to experience my co-workers as well. My children have few opportunities to interact with non-Jews. They are not having the experience that I had growing up. We live in a Jewish neighborhood, they go to a large Jewish school and interact, almost completely, in our own circles. These meals are the chance for them to see that non-Jewish people aren't so different and deserve kindness and respect like any other person. This should be a given, but of course it's not. The unknown can be scary and there are definitely misconceptions. I am grateful that I have had the opportunity not just to make a good impression on my co-workers, but also to my children. Someone asked me recently why I bothered inviting our non-Jewish co-worker Jessica for the *Pesach* seder. “They will always hate us, it says it right in the *chumash*, *Eisav soneh et Yaakov* (Eisav hated Yaakov)”. I said, “That may be, but Jessica is not Eisav”.

I recognize that I have never encountered blatant anti-semitism at work. This definitely colors my view as determined, optimistic, and hopeful. I am deeply sorry for those that have worked in situations that are hopeless because no matter what they do they will always be The (cheap, stingy, difficulty to work with, litigious, conniving) Jew. I believe in those situations there is just nothing that can be done to change things. Sadly, most people's minds cannot be changed. It will always be “us versus them”. But that doesn't mean we can't have hope. I am proud to represent The Tribe and I hope to continue to have opportunities to be the example.

Laura Silverstein has worked as a nurse in a wide variety of home care settings over the past 12+ years. She has a Master's Degree in Nursing Management and Leadership and is also wound care certified. Laura is currently a Director of Patient Services at a licensed home care service agency in NYC.

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Please email info@jewishnurses.org if you are interested in joining any of our initiatives and become more involved in OJNA.

Here's Why I'm Taking Part in a Coronavirus Vaccine Trial

By: Janice Silbermann

There is a part of me that feels a sort of scientific obligation. Anything that I can do to help further the current research to curb this pandemic, I will do. After all, I am a nurse. It is in my very nature to want to help others and decrease suffering. And naturally, as a healthcare worker, I want a vaccine to be available for the sake of my own health as well, as we are in especially vulnerable positions as frontline workers. But there is far more to it than merely that, more to it than the obvious and practical reasons, more to it than the simple fact that someone has to stand up and volunteer for these trials.

I work in psychiatry, and you cannot imagine the effect the pandemic has had on people's mental health. We see plenty of news coverage about the physical ramifications, but just as much damage has been done to people's emotional well-being throughout this crisis. We have all been forced into unwilling isolation, our social ties severed by quarantines and tense days of waiting for those telltale symptoms to manifest in ourselves and in our loved ones. We must sit and watch people's entire worlds fall apart in the wake of deaths and medical bills and unemployment. We must watch patients die alone in quarantined hospital rooms, almost entirely cut off from their loved ones during what surely must be the most terrifying days of their lives, and we must do this knowing that somewhere outside the hospital is a family coming to terms with the fact that the loved one they sent into the hospital is likely to never come out again. As civilians, we have to carry the weight of our own grief; as nurses, we have to carry the weight of our patients' grief and our coworkers' grief as well.

No one wants to believe that they will never see a loved one again. Every day, I think about my 85-year-old mother and the fact that the Atlantic Ocean stands between us. I was going to go visit her, but my trip was abruptly canceled as the virus spread. Even if she never catches COVID-19 herself, the pandemic and the extreme danger that comes with traveling during it may very well still end up being to blame for me never getting to see my mother again. By the time I can safely go visit her again, it may be

too late. It's impossible for me to not be motivated to take part in a vaccine trial that could potentially lead to me seeing my mother again.

Never mind the economic effects this crisis has had. In a world dominated by conglomerates and massive corporations, it was already a struggle for locally owned small businesses to compete. Now they are in positions where they often cannot afford to stay open under the various restrictions or due to lack of staff or supplies. But they certainly cannot afford to close either. I've seen so many businesses suffer, and I cannot help but be acutely aware of the fact that behind every strained or destroyed small business is a family that has now lost their primary — and sometimes only — source of income. This is happening every day even in places that have strong community support. The business owners and their usual patrons have been financially demolished.

Like everyone else, I simply want my life back. I want to go outside without a mask, to see my friends' faces again. I want to go back to movie theaters and restaurants without having to gamble with my health, and by extension, the health of my family. I want to go to the grocery store, without having to wipe down everything and wear gloves to avoid touching anything that might still carry the virus on its surface. I want to go on a real vacation again. And I want to be able to wake up in the morning without living in fear that at any moment I could get the call telling me that one of my friends or relatives has taken ill or dropped dead.

People are calling this the new normal, but there is nothing normal about this degree of suffering. I have to do whatever I can to change that. So when people ask me again how I could volunteer for this trial despite the fear and uncertainty, I feel the right answer is so obvious:

How could I not?

Janice Silbermann is a psychiatric nurse from Memphis, TN. This article was originally published in the Baltimore Jewish Times.



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MEET THE TEAM:



Chaya Milikowsky, MS, AG/ACNP, AG/ACCNS, RN, received her Master of Science in Clinical Nurse Leadership from the University of Maryland School of Nursing in 2010, after which she went directly into critical care nursing. In 2015 she received a post-masters certificate as an Adult/Gerontology Acute Care Nurse Practitioner and Clinical Nurse Specialist from the University of Maryland School of Nursing. She continues to work in critical care and is a nocturnist in the intensive care unit at MedStar Montgomery Medical Center. In addition to her role on the OJNA Board, she is also on the Advanced Practice Council of the MedStar Hospital system. She lives in Silver Spring, Maryland, with her husband and five children.



Tobi Ash, MBA, BSN, RN, received her Bachelor of Science in Nursing from Barry University in 1998, her Masters in Business Administration from Nova Southeastern University in 2001, and is currently completing her Ph.D. at Walden University. Tobi is the Director of Women's Health Care at Nano Health Associates in Miami Beach. Tobi has more than 20 years of experience working with families, with an emphasis on women's health. She is a member of Sigma Theta Tau International Honor Society of Nursing and served the Nurse position on the Health Care Advisory Committee for the City of Miami Beach for two consecutive terms. She sits on the board of the Greater Miami Jewish Federation, LimmudMiami, EMES Initiative, NCSY Southern Region, Miami Beach Garden Club, Helping Hands, and is the former chair of Ohel South Florida Advisory Board. She lives in Miami, Florida.



Toby Bressler, PhD, RN, OCN, FAAN is the Director of Nursing for Oncology and Clinical Quality in the Mount Sinai Health System. She received her BSN Magna Cum Laude from SUNY Downstate, Master's degree from NYU and her PhD from Molloy College of Nursing. Dr. Bressler's research interests focus on the Orthodox Jewish community, care of the cancer patient, the promotion of palliative care and quality of life of patients and families. She has authored more than 50 articles, chapters, and posters and has presented widely. Dr. Bressler is an elected officer with the American Nurses Association NY, Vice Chair of the Nursing Section of the New York Academy of Medicine, Chair of the Eastern Nurses Research Society Palliative Care Research Interest Group and also served as a Jonas Policy Scholar with the American Academy of Nursing. She lives in New York.



Sarah Bracha Cohen, MS, RN, received her Bachelor of Arts in Health Sciences from Hebrew Theological College in 2013 and her Master of Science in Nursing and Clinical Nurse Leader from the University of Maryland School of Nursing in December 2017. She is a member of Sigma Theta Tau International Honor Society of Nursing, the Honor Society of Phi Kappa Phi, and the American Nurses Association. She is a fertility nurse at Reproductive Medicine Associates (RMA) of New York. In addition to her work for the OJNA Journal, she volunteers for the Vaccine Task Force of the EMES Initiative, is a birth doula and is on the board of In Shifra's Arms, helping Jewish women with unplanned pregnancies. She lives in New York City.



Tziporah Newman, BSN, RN, received her Associate Degree in Nursing from Middlesex County College in 2012. She received her Bachelor of Science in Nursing from Thomas Edison State College in 2014. She currently works as a field nurse with medically fragile children. She recently took on the additional role of nurse supervisor. She previously worked as a director of nursing for a home health care agency, supervising and teaching nurses and home health aides. She is a member of the American Nurses Association, the New Jersey State Nurses Association, and the Society of Pediatric Nurses. She actively volunteers for Chai Lifeline and her local Bikur Cholim. She lives in Highland Park, New Jersey.



Shevi Rosner, MSN, RN-C received her Bachelor of Arts from Hunter College, Bachelor of Science from Columbia University, and Masters in Nursing Education from Ramapo College. She has been working as a bedside and charge nurse in Morgan Stanley Children's Hospital of New York Presbyterian since 2007, with more than eight years in their neonatal ICU. Aside from her work for OJNA, she volunteers for the Academy of Neonatal Nursing, and is an active member of her hospital's committees. She is a member of the American Nurses Association, New York State Nurses Association, and Sigma Theta Tau International Honor Society. She lives in New Jersey with her husband and four children.



Yocheved Weinreb, RN, OCN, received her Bachelor of Science in Nursing from New York University in 2011. She started her nursing career as a bone marrow transplant nurse and found her passion in oncology nursing. She recently transitioned to working in supportive oncology and palliative care at Mount Sinai Downtown. She is a member of the Oncology Nursing Society and was chosen for the Mount Sinai Emerging Leaders program. She is currently pursuing her Masters in Nursing Education from Chamberlain University and hopes to be an oncology nurse educator or nurse administrator in the future. She lives in Brooklyn, New York.