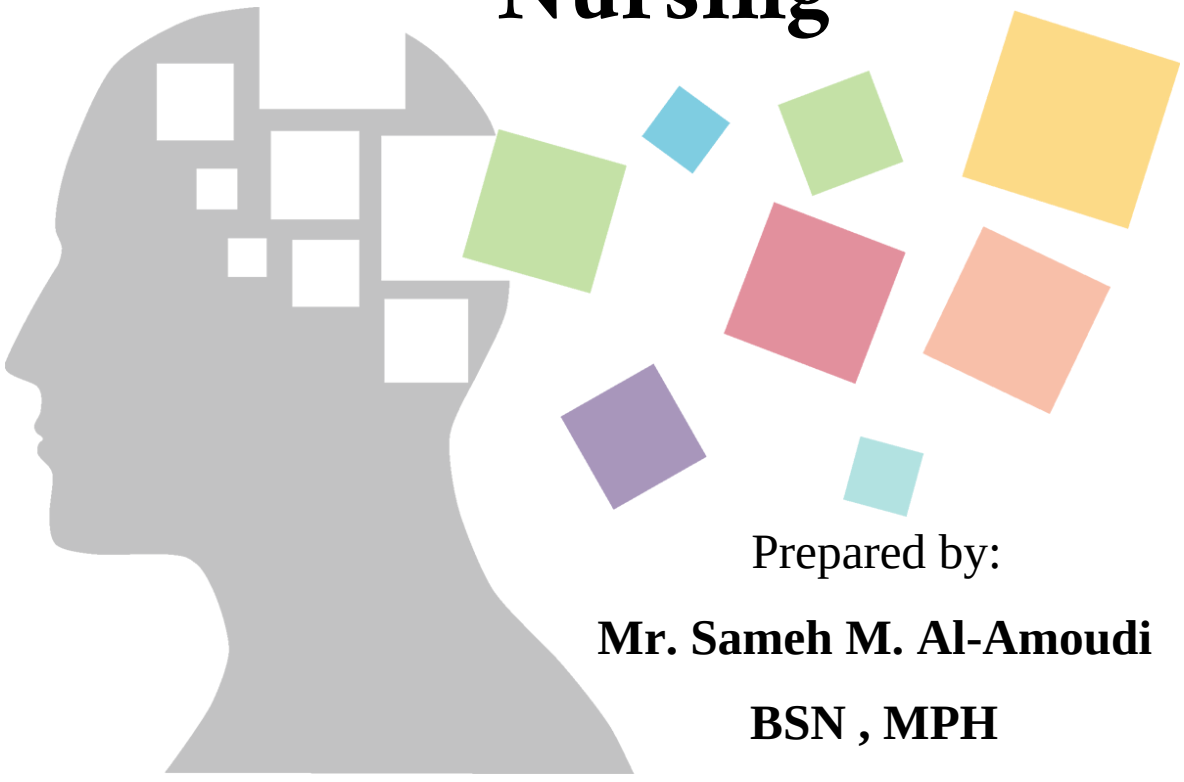
Israa University

Faculty of Health Professions

Nursing Department

Psychiatric Mental Health Nursing



Prepared by:

Mr. Sameh M. Al-Amoudi

BSN , MPH

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Contents

Chapter 1

Foundation of Psychiatric Mental Health Nursing

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Define mental health and mental illness.

2) Discuss the Maslow's hierarchy of needs .

3) Identify to Ego Defense Mechanisms

Mental health and Mental illness

Mental health and Mental illness are difficult to define precisely. People who can carry out their roles in society and whose behavior is appropriate and adaptive are viewed as healthy. Conversely, those who fail to fulfill roles and carry out responsibilities or whose behavior is inappropriate are viewed as ill. The culture of any society strongly influences its values and beliefs, and this in turn affects how that society defines health and illness.

What one society may view as acceptable and appropriate, another society may see as maladaptive and inappropriate.

Mental health

The world health organization "WHO" defines health as a state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

This definition emphasizes health as a positive state of wellbeing.

Mental health means the successful performance of mental function, resulting in productive activities, fulfilling relationship, and ability to adapt, to change and cope with adversity. Mental health provides the capacity for rational thinking, communication, learning, emotional growth, resilience, and self-esteem. (National Institute of Mental Health [NIMH], 2006).

Maslow's hierarchy of needs: Maslow (1970) emphasized an individual's motivation in the continuous quest for self-actualization. He identified a "hierarchy of needs," with the most basic needs requiring fulfillment before those at higher levels can be achieved and with self-actualization defined as fulfillment of one's highest potential.

self-actualized individuals possess the following characteristics:

- An appropriate perception of reality .
- The ability to accept oneself, others, and human nature .
- The ability to manifest spontaneity .
- The capacity for focusing concentration on problem solving .
- A need for detachment and desire for privacy .
- Independence, autonomy, and a resistance to enculturation .
- An intensity of emotional reaction .
- The ability to achieve satisfactory interpersonal relationships .
- A democratic character structure and strong sense of ethics .
- Creativeness .

Criteria of Mental health

The following have been defined as criteria of Mental health:

1. Positive attitudes toward the self.
2. Growth, development, and self-actualization including utilization of abilities, future orientation, concern with work, and so on.
3. Integration, as in a balance of psychotic forces, the unifying of one's outlook, and resistance to stress and frustration.
4. Autonomy, as in self-determination, independent behavior and when appropriate.
5. A true perception of reality.
6. Environmental mastery, meaning adequacy in love, work, and play, adaptation and adjustment, and the capacity to solve problems.

Mental illness

the American Psychiatric Association (APA, 2000) defines a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with present distress (e.g., a painful symptom) or disability (e.g., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom".

General criteria to diagnose mental disorders include:

1. Dissatisfaction with one's characteristics, abilities, and accomplishments.
2. Ineffective or unsatisfying relationships.
3. Dissatisfaction with one's place in the world.
4. Ineffective coping with life events.
5. Lack of personal growth.

Ego Defense Mechanisms

Definition :

The term defense mechanism refers to a predominantly unconscious self-protective process that seeks to shield the ego from intense feelings or affect and impulses.

Successful mechanism

- **Compensation**

Covering up a real or perceived weakness by emphasizing a trait one considers more desirable .

EX A physically handicapped boy is unable to participate in football, so he compensates by becoming a great scholar.

- **Identification**

An attempt to increase self-worth by acquiring certain attributes and characteristics of an individual one admires .

EX A teenager who required lengthy rehabilitation after an accident decides to become a physical therapist as a result of his experiences.

- **Intellectualization**

An attempt to avoid expressing actual emotions associated with a stressful situation by using the intellectual processes of logic, reasoning, and analysis.

EX Sarah's husband is being transferred with his job to a city far away from her parents. She hides anxiety by explaining to her parents the advantages associated with the move.

- **Rationalization**

Attempting to make excuses or formulate logical reasons to justify unacceptable feelings or behaviors .

EX John tells the rehab nurse, "I drink because it's the only way I can deal with my bad marriage and my worse job."

- **Repression**

Involuntarily blocking unpleasant feelings and experiences from one's awareness .

EX An accident victim can remember nothing about his accident.

- **Sublimation**

Rechanneling of drives or impulses that are personally or socially unacceptable into activities that are constructive .

EX A mother whose son was killed by a drunk driver channels her anger and energy into being the president of the local chapter of Mothers Against Drunk Driving.

- **Undoing**

Symbolically negating or canceling out an experience that one finds intolerable .

EX Joe is nervous about his new job and yells at his wife. On his way home he stops and buys her some flowers.

Unsuccessful mechanism

- **Denial**

Refusing to acknowledge the existence of a real situation or the feelings associated with it .

EX A woman drinks alcohol every day and cannot stop, failing to acknowledge that she has a problem.

- **Displacement**

The transfer of feelings from one target to another that is considered less threatening or that is neutral .

EX A client is angry with his physician, does not express it, but becomes verbally abusive with the nurse.

- **Introjection**

Integrating the beliefs and values of another individual into one's own ego structure .

EX Children integrate their parents' value system into the process of conscience formation. A child says to a friend, "Don't cheat. It's wrong."

- **Isolation**

Separating a thought or memory from the feeling, tone, or emotion associated with it .

EX A young woman describes being attacked and raped without showing any emotion.

- **Suppression**

The voluntary blocking of unpleasant feelings and experiences from one's awareness .

EX Scarlett says, "I don't want to think about that now. I'll think about that tomorrow."

Chapter 2

Principles of the Nurse – Client Relationship

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Identify goals of the nurse-client relationship.

2) Describe the Roles of the psychiatric nurse .

3) Describe the phases of relationship development and the tasks associated with each phase.

4) Identify and discuss essential conditions for a therapeutic relationship to occur.

5) Describe therapeutic and nontherapeutic communication techniques.

6) Identify for Roles of mental health team.

The art of caring is embodied in the therapeutic nurse-client relationship, which is the basis for psychiatric mental health nursing.

The relationship is used as a therapeutic vehicle to affect change, promote growth, and heal mental and emotional wounds.

The therapeutic interpersonal relationship that develops between nurse and client is a vehicle for affecting client change and growth.

The nurse–client relationship is an interaction aimed to enhance the well-being of a "client," which may be an individual, a family, a group, or a community.

❖ Roles of the psychiatric nurse

1. The Stranger

A nurse is at first a stranger to the client. The client is also a stranger to the nurse. This principle implies: (1) accepting the patient as he is; (2) treating the patient as an emotionally able stranger.

2. The Resource Person

A nurse provides specific answers to questions usually formulated with relation to "a larger problem" , also the nurse explains, in language that the client can understand, information related to the client's health care.

3. The Teacher

In this subrole, the nurse identifies learning needs and provides information required by the client or family to improve the health situation.

4. The Leader

According to the patient mental state, the nurse may allow patient to be active participant in designing nursing plans for him, or may show a lack of personal interest in the client.

5. The Surrogate

Clients may view the nurse as a mother figure, a sibling, a former teacher, or another nurse who has provided care in the past.

6. Care Manager

Nurses in this role assess patients and develop treatment plans, coordinate resources and care provided by others. The Care Manager also manages patient needs and resources episodically and is skilled in managing psychiatric rehabilitation as well as relapse prevention.

7. The Counselor

The nurse uses “interpersonal techniques” to assist clients to learn to adapt to difficulties or changes in life experiences.

Phases of a Therapeutic Nurse-Client Relationship

The therapeutic interpersonal relationship is the means by which the nursing process is implemented.

Through the relationship, problems are identified and resolution is sought.

1. Pre-orientation Phase

The pre-interaction phase involves preparation for the first encounter with the client. Tasks include

■ Obtaining available information about the client from his or her chart, significant others, or other health-care team members. From this information, the initial assessment begins.

■ Examining one's feelings, fears, and anxieties about working with a particular client. For example, the nurse may have been reared in an alcoholic family and have ambivalent feelings about caring for a client who is dependent on alcohol.

The nurse needs to be aware of how these preconceptions may affect his or her ability to care for individual clients

2. Orientation Phase

During the orientation phase, the nurse and client become acquainted.

Tasks include :

- Creating an environment for the establishment of trust and rapport.
- Establishing a contract for intervention that details the expectations and responsibilities of both nurse and client
- Gathering assessment information to build a strong client database.
- Identifying the client's strengths and limitations.
- Formulating nursing diagnoses.
- Setting goals that are mutually agreeable to the nurse and client.
- Developing a plan of action that is realistic for meeting the established goals.

- Exploring feelings of both the client and nurse in terms of the introductory phase.

Introductions are often uncomfortable, and the participants may experience some anxiety until a degree of rapport has been established. Interactions may remain on a superficial level until anxiety subsides. Several interactions may be required to fulfill the tasks associated with this phase.

Contract between the client and nurse

A contract emphasizes the client's participation and responsibility because it shows that the nurse does something with the client rather than for the client. The contract, either stated or written, contains the place, time, date, and duration of the meetings. During the orientation phase, the client may begin to express thoughts and feelings, identify problems, and discuss realistic goals.

Therefore, the mutual agreement on goals is also part of the contract.

Contract example

Student: Mrs. James, we will meet at 10 AM each Thursday in the consultation room at the clinic for 45 minutes, from September 15th to October27th. We can use that time for further discussion .and use Psychosocial Nursing Tools of your feelings of loneliness and anger you mentioned and explore some things you could do to make the situation better for yourself.

3. Working Phase

The therapeutic work of the relationship is accomplished during this phase.

Tasks include :

- Maintaining the trust and rapport established during the orientation phase.
- Promoting the client's insight and perception of reality.
- Problem-solving using the model .
- Overcoming resistance behaviors on the part of the client as the level of anxiety rises in response to discussion of painful issues.
- Continuously evaluating progress toward goal attainment..

As the relationship evolves through an ongoing series of reactions, each participant may elicit in the other a wide range of positive and negative emotional reactions. Remember that the projection of feelings in the client to the nurse is referred to as ***transference***, and the projection of feelings in the nurse or clinician to the client is referred to as ***countertransference***. As discussed earlier, the nurse is responsible for identifying these two phenomena and maintaining appropriate boundaries.

4. Termination Phase

Termination of the relationship may occur for a variety of reasons:

- The mutually agreed-on goals may have been reached,
- The client may be discharged from the hospital
- In the case of a student nurse, the clinical rotation ends.

Termination can be difficult for both the client and nurse. The main task involves bringing a therapeutic conclusion to the relationship.

This occurs when :

- Progress has been made toward attainment of mutually set goals.
- A plan for continuing care or for assistance during stressful life experiences is mutually established by the nurse and client.
- Feelings about termination of the relationship are recognized and explored. Both the nurse and client may experience feelings of sadness and loss.

The nurse should share his or her feelings with the client. Through these interactions, the client learns that it is acceptable to have these kinds of feelings at a time of separation. With this knowledge, the client experiences growth during the process of termination.

Essential Conditions to Development of Therapeutic Relationship

Several characteristics that enhance the achievement of a therapeutic relationship have been identified. These concepts are highly significant to the use of self as the therapeutic tool in interpersonal relationship development.

1. Rapport

Rapport implies special feelings on the part of both the client and the nurse based on acceptance, warmth, friendliness, common interest, a sense of trust, and a nonjudgmental attitude.

2. Trust

To trust another, one must feel confidence in that person's presence, reliability, integrity, veracity, and sincere desire to provide assistance when requested. Examples of nursing interventions that would promote trust include keeping promises, being honest, ensuring confidentiality, attending activities with client in which he/she fear to be alone .

3. Respect

To show respect is to believe in the dignity and worth of an individual regardless of his or her unacceptable behavior. It called unconditional positive regard. The nurse can convey respect by calling the client by name, or spending time with the client.

4. Genuineness

Genuineness refers to the nurse's ability to be open, honest, and "real" in interactions with the client. To be "real" is to be aware of what one is experiencing internally and to express this awareness in the therapeutic relationship.

5. Empathy

Empathy is the ability to see beyond outward behavior and to understand the situation from the client's point of view. With empathy, the nurse can accurately perceive and comprehend the meaning and relevance of the client's thoughts and feelings. The nurse must also be able to communicate this perception to the client by attempting to translate words and behaviors into feelings.

It is not uncommon for the concept of empathy to be confused with that of sympathy. With sympathy, the nurse actually "shares" what the client is feeling, and experiences a need to alleviate distress.

Therapeutic Communication Techniques

Therapeutic Communication

Caregiver verbal and nonverbal techniques that focus on the care receiver's needs and advance the promotion of healing and change. Therapeutic communication encourages exploration of feelings and fosters understanding of behavioral motivation .It is nonjudgmental, discourages defensiveness, and promotes trust.

Therapeutic Communication Techniques

identified a number of techniques to assist the nurse in interacting more therapeutically with clients. These are important "technical procedures" carried out by the nurse working in psychiatry, and they should serve to enhance development of a therapeutic nurse-client relationship.

Therapeutic Communication Techniques		
TECHNIQUE	**EXPLANATION/RATIONALE**	**EXAMPLES**
Using silence	Silence gives the client the opportunity to collect and organize thoughts, to think through a point, or to consider introducing a topic of greater concern than the one being discussed.	The client pauses midsentence in answering a question. The nurse remains quiet, does not "rescue" the client with prompts or by moving on to another question, and ensures that his or her body language and facial expression project interest in and willingness to wait for the client to answer.
Accepting	Conveys an attitude of reception and regard.	"Yes, I understand what you said." Eye contact; nodding.
Giving recognition	Acknowledging and indicating awareness is better than complimenting, which reflects the nurse's judgment.	"Hello, Mr. J. I notice that you made a ceramic ash tray in OT." "I see you made your bed."
Offering self	Making oneself available on an unconditional basis helps to increase the client's feelings of self-worth.	"I'll stay with you awhile." "We can eat our lunch together." "I'm interested in talking with you."
Giving broad openings	Allowing the client to take the initiative in introducing the topic emphasizes the importance of the client's role in the interaction.	"What would you like to talk about today?" "Tell me what you are thinking."
Offering general leads	General leads, or prompts, offer the client encouragement to continue.	"Yes, I see." "Go on." "And after that?"
Placing the event in time or sequence	Clarifying the relationship of events in time enables the nurse and client to view them in perspective.	"What seemed to lead up to . . . ?" "Was this before or after . . . ?" "When did this happen?"
Making observations	Verbalizing what is observed or perceived encourages the client to recognize specific behaviors and compare perceptions with the nurse.	"You seem tense." "I notice you are pacing a lot." "You seem uncomfortable when you. . .

Therapeutic Communication Techniques—cont'd		
TECHNIQUE	**EXPLANATION/RATIONALE**	**EXAMPLES**
Encouraging description of perceptions	Asking the client to verbalize what is being perceived is often used with clients experiencing hallucinations.	"Tell me what is happening now." "Are you hearing the voices again?" "What do the voices seem to be saying?"
Encouraging comparison	Asking the client to compare similarities and differences in ideas, experiences, or interpersonal relationships helps the client recognize life experiences that tend to recur as well as those aspects of life that are changeable.	"Was this something like ? "How does this compare with the time when . . . ?" "What was your response the last time this situation occurred?"
Restating	Repeating the main idea of what the client has said lets the client know whether an expressed statement has been understood and gives him or her the chance to continue or to clarify if necessary.	Cl: "I can't study. My mind keeps wandering." Ns: "You have trouble concentrating." Cl: "I can't take that new job. What if I can't do it?" Ns: "You're afraid you will fail in this new position."
Reflecting	Questions and feelings are referred back to the client so that they may be recognized and accepted and so that the client may recognize that his or her point of view has value—a good technique to use when the client asks the nurse for advice.	Cl: "What do you think I should do about my wife's drinking problem?" Ns: "What do *you* think you should do?" Cl: "My sister won't help a bit with my mother's care. I have to do it all!" Ns: "You feel angry when she doesn't help."
Focusing	Taking notice of a single idea or even a single word works especially well with a client who is moving rapidly from one thought to another. This technique is *not* therapeutic,however, with the client who is very anxious. Focusing should not be pursued until the anxiety level has subsided.	"This point seems worth looking at more closely. Perhaps you and I can discuss it together."
Exploring	Delving further into a subject, idea, experience, or relationship is especially helpful with clients who tend to remain on a superficial level of communication. However, if the client chooses not to disclose further information, the nurse should refrain from pushing or probing in an area that obviously creates discomfort.	"Please explain that situation in more detail." "Tell me more about that particular situation."

Therapeutic Communication Techniques—cont'd		
TECHNIQUE	**EXPLANATION/RATIONALE**	**EXAMPLES**
Seeking clarification and validation	Striving to explain that which is vague or incomprehensible and searching for mutual understanding of what has been said facilitates and increases understanding for both client and nurse.	"I'm not sure that I understand. Would you please explain?" "Tell me if my understanding agrees with yours." "Do I understand correctly that you said . . . ?"
Presenting reality	When the client has a misperception of the environment, the nurse defines reality or indicates his or her perception of the situation for the client.	"I understand that the voices seem real to you, but I do not hear any voices." "There is no one else in the room but you and me."
Voicing doubt	Expressing uncertainty as to the reality of the client's perceptions is a technique often used with clients experiencing delusional thinking.	"I understand that you believe that to be true, but I see the situation differently." "I find that hard to believe (or accept)." "That seems rather doubtful to me."
Verbalizing the implied	Putting into words what the client has only implied or said indirectly is a helpful technique to use with clients who are reticent to speak as well as with clients who are mute or are otherwise experiencing impaired verbal communication. This clarifies that which is *implicit* rather than *explicit.*	Cl: "It's a waste of time to be here. I can't talk to you or anyone." Ns: "Are you feeling that no one understands?" Cl: (Mute) Ns: "It must have been very difficult for you when your husband died in the fire."
Attempting to translate words into feelings	When feelings are expressed indirectly, the nurse tries to "desymbolize" what has been said and to find clues to the underlying true feelings.	Cl: "I'm way out in the ocean." Ns: "You must be feeling very lonely right now."
Formulating a plan of action	When a client has a plan in mind for dealing with what is considered to be a stressful situation, it may serve to prevent anger or anxiety from escalating to an unmanageable level.	"What could you do to let your anger out harmlessly?" "Next time this comes up, what might you do to handle it more appropriately?"

open communication between the nurse and client. Nurses should recognize and eliminate the use of these patterns in their relationships with clients. Avoiding these communication barriers will maximize the effectiveness of communication and enhance the nurse-client relationship.

Nontherapeutic Communication Techniques		
TECHNIQUE	**EXPLANATION/RATIONALE**	**EXAMPLES**
Giving reassurance	Indicating to the client that there is no cause for anxiety devalues the client's feelings and may discourage the client from further expression of feelings if he or she believes they will only be downplayed or ridiculed.	"I wouldn't worry about that if I were you." "Everything will be all right." Better to say: "We will work on that together."
Rejecting	Refusing to consider or showing contempt for the client's ideas or behavior may cause the client to discontinue interaction with the nurse for fear of further rejection.	"Let's not discuss. . . ." "I don't want to hear about. . . ." Better to say: "Let's look at that a little closer."
Approving or disapproving	Sanctioning or denouncing the client's ideas or behavior implies that the nurse has the right to pass judgment on whether the client's ideas or behaviors are "good" or "bad" and that the client is expected to please the nurse. The nurse's acceptance of the client is then seen as conditional depending on the client's behavior.	"That's good. I'm glad that you. . . ." "That's bad. I'd rather you wouldn't. . . ." Better to say: "Let's talk about how your behavior invoked anger in the other clients at dinner."
Agreeing or disagreeing	Indicating accord with or opposition to the client's ideas or opinions implies that the nurse has the right to pass judgment on whether the client's ideas or opinions are "right" or "wrong." Agreement prevents the client from later modifying his or her point of view without admitting error. Disagreement implies inaccuracy, provoking the need for defensiveness on the part of the client.	"That's right. I agree." "That's wrong. I disagree." "I don't believe that." Better to say: "Let's discuss what you feel is unfair about the new community rules."
Giving advice	Telling the client what to do or how to behave implies that the nurse knows what is best and that the client is incapable of any self-direction. It nurtures the client in the dependent role by discouraging indepen - dent thinking.	"I think you should. . . ." "Why don't you. . . ." Better to say: "What do you think you should do?" or "What do you think would be the best way to solve this problem?
Probing	Persistent questioning of the client and pushing for answers to issues the client does not wish to discuss causes the client to feel used and valued only for what is shared with the nurse and places the client on the defensive.	"Tell me how your mother abused you when you were a child." "Tell me how you feel toward your mother now that she is dead." "Now tell me about. . . ." Better technique: The nurse should be aware of the client's response and discontinue the interaction at the first sign of discomfort .

Nontherapeutic Communication Techniques—cont'd		
TECHNIQUE	**EXPLANATION/RATIONALE**	**EXAMPLES**
Defending	Attempting to protect someone or something from verbal attack, or defending what the client has criticized, implies that he or she has no right to express ideas, opinions, or feelings. Defending does not change the client's feelings and may cause the client to think the nurse is taking sides against the client.	"No one here would lie to you." "You have a very capable physician. I'm sure he has only your best interests in mind." Better to say: "I will try to answer your questions and clarify some issues regarding your treatment."
Requesting an explanation	Asking the client to provide the reasons for thoughts, feelings, behavior, and events asking "why" a client did something or feels a certain way—can be very intimidating and implies that the client must defend his or her behavior or feelings.	"Why do you think that?" "Why do you feel this way?" "Why did you do that?" Better to say: "Describe what you were feeling just before that happened."
Indicating the existence of an external source of power	Attributing the source of thoughts, feelings, and behavior to others or to outside influences encourages the client to project blame for his or her thoughts or behaviors on others rather than accepting the responsibility personally.	"What makes you say that?" "What made you do that?" "What made you so angry last night?" Better to say: "You became angry when your brother insulted your wife."
Belittling feelings expressed	When the nurse misjudges the degree of the client's discomfort, a lack of empathy and understanding may be conveyed. Telling the client to "perk up" or "snap out of it" causes the client to feel insignificant or unimportant. When one is experiencing discomfort, it is no relief to hear that others are or have been in similar situations.	Cl: "I have nothing to live for. I wish I were dead." Ns: "Everybody gets down in the dumps at times. I feel that way myself sometimes." Better to say: "You must be very upset. Tell me what you are feeling right now."

Roles of mental health team

1. Psychiatric Nurse

- Nurses have the most widely focused position description of any of the member roles.
- They interact with clients in individual and group settings.
- Manage client's care .
- Administer and monitor medications.
- Assist with numerous psychiatric or physical treatments.
- Participate in interdisciplinary team meetings
- Teach clients of families.
- Take responsibility for client advocate.
- Act as a client advocate.
- Interact with client's significant others.
- Assess and intervene with client's psychiatric, biological,
- psychosocial, cultural or spiritual problems.
- Master's and doctoral –prepared nurses act as clinical specialists in individual group at family therapy, with expanded roles within psychiatric setting, or they act autonomously in private practice.
- In some US states clinical nurse specialists prescribe medications and manage client case loads.

2. Psychiatric social worker :

- Can work with clients on an individual basis .
- Conduct group therapy sessions .
- Work with client's family .
- Act as a liaison with the community to place clients after discharge .
- They emphasize intervention with the client in the social environment in which he / she will live.

3. Psychiatrist:

- Licensed medical physician who specialized in psychiatry .
- Responsibilities include **:**
  - Admitting clients into acute care settings .
  - Prescribing &monitoring psychopharmacologic agents .
  - Administering electroshock therapy .
  - Conducting individual and family therapy .
  - Participating in interdisciplinary team meeting that focus on their clients.

4. Psychologist :

- Licensed individual with a doctoral degree in psychology .
- Not MD .
- Can specialize further: Clinical psychology , educational psychology, etc …
- Trained in using tools such as IQ test .
- Works along with psychiatrist(helps in diagnosing and treating people with mental or emotional illness).

5. Psychiatric technician :

- Has direct client contact in psychiatric setting and usually reports to the registered nurse .
- Trained to observe and record symptoms and intervene under supervision .
- In some states they can administer med. under supervision of registered nurse.

Chapter 3

Psychiatric Assessment

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Identify and discuss Psychosocial Assessment .

2) Identify and discuss Mental Status Examination :

- General appearance .
- Psychomotor behavior .
- Attitude .
- Mood and Affect .
- Speech .
- Thought .
- Perception .
- Sensorial and cognition .
- Insight .
- Judgment and Impulse control **.**

Psychiatric assessment is the means by which a diagnosis of mental illness is established and an appropriate plan of action is made.

Psychiatric assessment aims to answer this questions:

1. Is the patient suffering from mental illness, and if so what is the diagnosis?
2. What is the severity of the illness and are there any risk factors resulting from the illness?
3. What factors have contributed to the causation of the mental illness?

Difference Between Psychiatric & Medical Assessment:

1. Psychiatric assessment usually takes a longer time. A psychiatric interview takes 60 to 90 minutes or more.
2. Information from other people is necessary.
3. patients may feel ashamed.

Methods of Psychiatric Assessment:

Psychiatric assessment involves:

1. Psychiatric History.
2. Mental State Examination.
3. Physical Examination.

A. Psychiatric history

1. Identifying Data

These data include name, gender, age, race/culture, occupational and functional status, educational level, significant others, living arrangements, religion, and medical diagnosis.

Chief complaint is other important data which can identified by the following questions:

A. For what reason did you come for help today?

B. What seems to be the problem?

2. History of Present Illness

- Reason that the patient is presenting for evaluation.
- Psychiatric review of systems, including anxiety symptoms and panic attacks.
- Past or current sleep abnormalities, including sleep apnea.
- Impulsivity.

3. Psychiatric History

- Past and current psychiatric diagnoses.
- Prior psychotic or aggressive ideas or behavior, including physical or sexual aggression.
- Prior suicidal ideas, suicide plans, and suicide attempts or intents.
- History of psychiatric hospitalization and emergency department visits for psychiatric issues.

  Past psychiatric treatments.
- Use of tobacco, alcohol, and other substances (e.g., marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter medications.

4. Medical History

- All medications the patient is currently or recently taking and the side effects of these medications, also allergies or drug sensitivities.
- Past or current medical illnesses and related hospitalizations.
- Relevant past or current treatments, including surgeries, other procedures.
- Past or current neurological or neurocognitive disorders or symptoms.

  Physical trauma, including head injuries.
- Sexual and reproductive history.
- Cardiopulmonary status
- Past or current infectious disease.

5. Review of Systems

- Psychiatric (if not already included with history of present illness)
- Constitutional symptoms (e.g., fever, weight loss)
- Review include all the following: eyes, ears, nose, mouth, throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breast); neurological; endocrine; hematological/lymphatic; allergic/immunological systems.

6. Family History

Family history include the assessment for history of suicidal or violent behaviors in biological relatives (for patients with current suicidal ideas or with current aggressive ideas).

7. Personal and Social History

- Presence of psychosocial stressors (e.g., financial, housing, legal, school/occupational or interpersonal/ relationship problems; lack of social support; painful, disfiguring, or terminal medical illness).
- Review of the patient's trauma history.
- Exposure to violence or aggressive behavior.
- Personal/cultural beliefs and cultural explanations of psychiatric illness.

B. Mental Status Examination

PURPOSE: The of mental state examination is to reach a tentative diagnosis. It is the diagnosis of general cerebral functions. It is designed to detect abnormal functions. An experienced nurse can complete all the MSE. Important information can be taken from first sight (when entering the room, sitting or talking. Also, level of consciousness can be observed.

1. GENERAL APPEARANCE:

General appearance is a good indicator of the patients overall mental functioning. It includes weight, height and general body built.

Nutritional Status: Poor nutrition can result from medical or psychiatric disorders . In anorexia nervosa the patient is emaciated but still thinks she is fat. Overweight can point to overeating as in affective disorders with hyperphagia.

Hygiene and dress: Self care and cleanliness reflects patient's awareness and activity level . In depression: the patient loses interest in his appearance and hygiene . In mania, the patient dresses in colorful and flamboyant manner. She may use too much makeup and mismatched dress . In schizophrenia, the patient may use strange items for dress e.g. antennas, bags to protect them from the control of space people.

Eye contact : People usually maintain eye contact when they speak and track movement and gestures of interviewer . Abnormal eye movements can be diagnostic as:

-Wandering eyes show distractibility, visual hallucinations, mania or organic states.

-Avoidance of eye contact may be due to hostility, shyness, or anxiety .

-If the patient is suspicious, he tracks your movements and looks to every gesture.

2. PSYCHOMOTOR BEHAVIOR:

Psychomotor activity describes the patient's physical movement, such as type, level of activity and unusual movements.

Psychomotor activity reduced in depression and catatonic schizophrenia or increase in mania.

a. Posture : The way the patient sits, walks, and behaves .

b. Facial Expression : Sad face in depression, mask face or happy face in mania.

c. Activity level : Restlessness in anxiety, agitation in some depressed patients, and excitement in mania.

d. Abnormal movements : can be voluntary or involuntary. Voluntary abnormal movements such as the mannerisms of the schizophrenia or bizarre movements also seen in schizophrenia. Involuntary movements such as hand tremor in anxiety.

3. MOOD AND AFFECT:

A. Mood: is a descriptive term that refers to the pervasive and sustained emotions or feelings described by a person. Types of mood responses includes depressed mood, elated, fearful, euphoric, irritable, anxious, guilty and labile mood, These responses listed in the following (Table 2.2)

Table 2.2 Types of mood responses

Responses	Description
1. Fearful	Demonstrates or verbalizes feeling of apprehension associated with real or perceived danger.
2. Anxious	
3. Elated	a. Expresses feelings of joy and intense pleasure. b. Is intensely optimistic.
4. Euphoric	a. Demonstrates a heightened sense of elation. b. Expresses feelings of grandeur (“Everything is wonderful!”).
5. Guilty	a. Expresses a feeling of discomfort associated with real or perceived wrongdoing. b. May be associated with feelings of sadness and despair.
6. Labile	a. Exhibits mood swings that range from euphoria to depression or anxiety.

B. Affect: individual's present emotional responsiveness. It is external, observable manifestation of one's emotion. Types of affective responses include; congruence with mood, constricted or blunted affect, flat affect, appropriate and inappropriate affect. These responses listed in the following (table 2.3).

Table 2.3 Types of affective responses

Responses	Description
1. Congruence with mood	Outward emotional expression is consistent with mood (e.g., if depressed, emotional expression is sadness, eyes downcast, may be crying).
2. Constricted or blunted	Minimal outward emotional expression is observed.
3. Flat affect	Absence of any facial expression that would indicate emotions or mood.
4. Appropriate affect	The outward emotional expression is what would be expected in a certain situation (e.g., crying upon hearing of a death).
5. Inappropriate affect	a. The outward emotional expression is incompatible with the situation (e.g., laughing upon hearing of a death).

4. SPEECH :

a. Amount of speech: Increased in mania and anxiety states were the patient is talkative. Patient with mania may experience a pressure to speak continuously, while patient with depression speaks very little and brief.

b. Speed : Anxious patient speaks rapidly, depressed one speaks slowly.

c. Articulation : Speech can be slurred (dysarthria) as in organic brain disorders or intoxication with alcohol or hypnotic.

d. Rhythm : In depression speech is monotonous.

5. THOUGHT:

A. Thought Process:

Thought process is the "how" of the patient's self-expression. A client's thought process is observed through speech. Thought process descriptors include:

1. ***Flight of ideas*** refers to verbalizations that are continuous and rapid, and flow from one to another).
2. ***Associative looseness*** is a shift of verbalization from one unrelated topic to another.
3. ***Circumstantiality*** is characterized by verbalizations of lengthy and tedious, and because of numerous details, are delayed reaching the intended point).
4. ***Tangentiality*** is characterized by the verbalizations that are lengthy and tedious, and never reach an intended point.
5. ***Neologisms*** is a type of thinking in which the individual is making up nonsensical-sounding words, which only have meaning to him or her.
6. ***Concrete thinking*** describes the thinking as literal; elemental, with absence of ability to think abstractly and inability to translate simple proverbs.
7. ***Clang associations*** is a speaking in puns or rhymes; using words that sound alike but have different meanings.
8. ***Word salad*** refers to using a mixture of words that have no meaning together; sounding incoherent.
9. ***Perseveration*** describes persistently repeating the last word of a sentence spoken to the client (e.g., Ns: “George, it’s time to go to lunch.” George: “lunch, lunch, lunch, lunch”).
10. ***Echolalia*** is a persistently repeating what another person says.
11. ***Mutism*** refers to inability to speak (either cannot or will not).
12. ***Poverty of speech*** refers to very little speech; may respond in monosyllables.

B. Thought Content :

Thought content is the specific meaning expressed in the patient's communication. It refers to the "what" of the patient's thinking. These contents include:

1. Delusions

Delusions are false fixed beliefs that have no basis on reality; (does the person have unrealistic ideas or beliefs?). Their content may include:

a) Persecutory delusions: a belief that someone is out to get him or her is some way (i.e., belief that one is going to be harmed cheated, spied on, followed, or poisoned by an individual, organization, or other group).

b) Referential delusions: an idea that whatever is happening in the environment is about him or her (i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself).

c) Grandiose delusions: an idea that he or she has all-powerful or of great importance (i.e., has exceptional abilities, wealth, or fame, having some great talent or insight or having made some important discovery).

d) Jealous delusions: the individual believes that his or her spouse or lover is unfaithful.

e) Erotomania delusions: (i.e., when an individual believes falsely that another person is in love with him or her).

f) Somatic delusions: a belief that he or she has a dysfunctional body part also it focus on preoccupations regarding health and organ function.

g) Thought withdrawal: the belief that one's thoughts have been "removed" by some outside force.

h) Thought insertion: are thoughts have been put into one's mind.

i) Delusions of control or reference: refer to a belief that one's behavior, body or actions and thoughts are being controlled by external forces.

j) Nihilistic delusions: describe the belief that he or she, or a part of the body, or even the world does not exist or has been destroyed (e.g., “I am no longer alive.”).

2. Suicidal or homicidal ideas: includes the ideas of harming self or others.

3. Obsessions Irresistible recurrent thought or feeling that can not be eliminated by logical effort and associated with anxiety.

4. Paranoia/ suspiciousness: is the type of thinking in which the person continuously scans the environment or refuses to answer questions.

5. Magical thinking: is characterized by speaking in a way that indicates his or her words or actions have power.

6. Religiosity: is the demonstration of obsession with religious ideas and behavior.

7. Phobias: are irrational fears of a specific object, or a social situation.

8. Poverty of content: of thoughts refers to little information conveyed by the client because of vagueness or stereotypical statements.

C. Capacity for abstract thinking

Abstract thinking is the ability to deal with concepts. Concrete thinking or literal thinking refers to limited use of metaphor without understanding nuances.

Methods to test abstract thinking are proverb test, the proverb should be based on sociocultural and educational background. Another method, is to test similarities between different things. If literal translation for proverb by the patient, called as concrete thinking.

" Can the individual interpret proverbs correctly? "

“What does ‘no use crying over spilled milk’ mean?”

6. PERCEPTION :

The two major types of perceptual problems are hallucinations and illusions. Detailed description of hallucinations and illusions are below:

- **Hallucinations**

Hallucinations are false sensory perception that occur without an external stimulus. They are clear, and not under voluntary control.

Five types of hallucination include:

a. Auditory: (Is the individual hearing voices or other sounds that do not exist?)

b. Visual: (Is the individual seeing images that do not exist?)

c. Tactile: (Does the individual feel unrealistic sensations on the skin?)

d. Olfactory: (Does the individual smell odors that do not exist?)

e. Gustatory: (Does the individual have a false perception of an unpleasant taste?)

Clinical implications

* Auditory hallucinations suggest schizophrenia.

* Visual and tactile hallucinations suggest organic mental disorders.

● **Illusions**

Does the individual misperceive or misinterpret real stimuli within the environment? (Sees something and thinks it is something else?) .

● **Depersonalization** refers to altered perception of the self, the individual verbalizes feeling "outside the body;" visualizing himself or herself from afar.

● **Derealization** refers to altered perception of the environment. The individual verbalizes that the environment feels "strange or unreal." A feeling that the surroundings have changed.

7. SENSORIUM AND COGNITION :

● **Level of Consciousness**

Mental status examinations routinely assess a patient's orientation to the current situation. Deciding whether a patient is oriented involves evaluating some basic cognitive functions, by answer the following questions:

a. Is the individual clear-minded and attentive to the environment?

b. Or is there disturbance in perception and awareness of the surroundings?

● **Orientation**:

The patient should be questioned regarding orientation t to time, place, and person. Typically the nurse can determine this by evaluating the patient's answers to this simple question:

Is the person oriented to the time, place, person or circumstances?.

● **Memory**

Memory is the ability to recall past experiences, events, information, and people. Memory includes:

a. Immediate (Recall of data or information to which a person was just exposed)

b. Recent. (Is the individual able to remember occurrences of the past few days, or week?)

c. Remote. (Is the individual able to remember occurrences of the distant past?)

d. Confabulation. (Does the individual fill in memory gaps with experiences that have no basis in fact?)

● **Level of Concentration and Calculation**

Concentration is the patient's ability to pay attention during the course of the interview. While **Calculation** is the person's ability to do simple math. To assess concentration and calculation.

a. Does the person hold attention to the topic at hand?

b. Is the person easily distractible?

c. Is there selective attention (e.g., blocks out topics that create anxiety)?

d. Do simple calculation, such as 1+27.

● **Intelligence and information :** The patient's fund of information should be relevant to his educational and social background . Ask about important dates, persons, or …

8. INSIGHT AND JUDGMENT :

a. Insight : is the Degree of the patient's awareness that he is ill . The patient may deny completely that he has any problem (insight is totally lost). Some

patients realize that there is a problem but explain it to be the result of somatic or social cause (partial insight).

b. Judgment : is the ability to choose appropriate goals and appropriate means to reach them . Ask the patient what he would do if he smelled smoke in his house or found a closed addressed letter in the street.

9. IMPULSE CONTROL :

- Is the patient ability to control his sexual, aggressive and other impulses .
- Some patients cannot resist impulses to explore your office; they look in books and turn things e.g. mania .

-Impulse control can be assessed from the patient's history.

10. RELIABILITY :

- How reliable is the information gathered about the patient?
- Did he/she report his/her condition accurately or was there any difficulty due to mental retardation, dementia or impaired consciousness?
- Is there a need for further investigations?

11. SUMMARY :

- Major positive and negative data from the history and MSE are summarized .
- A provisional diagnosis is suggested and a differential diagnosis is given
- Investigations and tests needed are listed.

Chapter Four

Schizophrenia and Other Psychotic Disorder

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Discuss the concepts of schizophrenia and other psychotic disorders.

2) Identify predisposing factors in the development of these disorders.

3) Describe various types of schizophrenia and other psychotic disorders.

4) Identify symptomatology associated with these disorders and use this information in client assessment .

5) Assigning Nursing Diagnoses to Behaviors Commonly Associated With Psychotic Disorders .

Background

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

Etiology

The cause of schizophrenia is still uncertain. Most likely, no single factor can be implicated in the etiology; rather, the disease probably results from a combination of influences that include biological, psychological, and environmental factors.

1. Biological Influences

Genetics:

The body of evidence for genetic vulnerability to schizophrenia is growing. Studies show that relatives of individuals with schizophrenia have a much higher probability of developing the disease than does the general population. Whereas the lifetime risk for developing schizophrenia is about 1 percent in most population studies, the siblings of an identified client have a 10 percent risk of developing schizophrenia, and individuals with one parent who has schizophrenia have a 5 to 6 percent chance of developing the disorder .

Twin Studies

The rate of schizophrenia among monozygotic (identical) twins is four to five times that of dizygotic (fraternal) twins and approximately 50 times that of the general population.

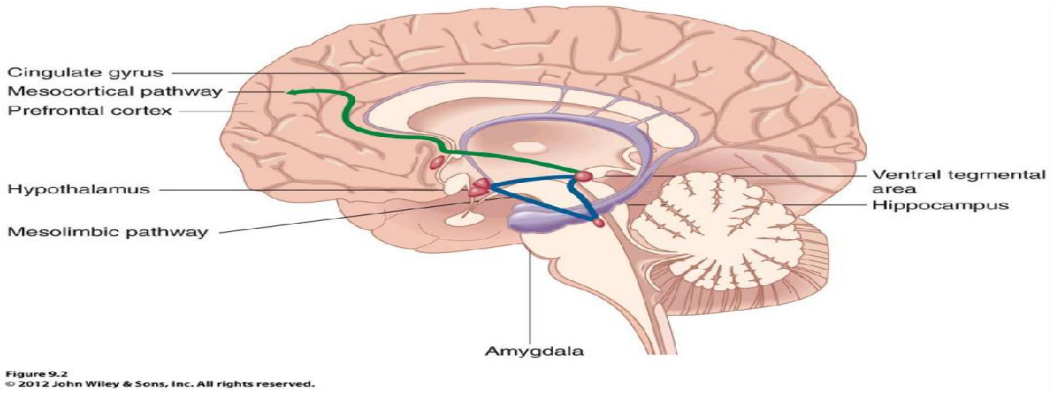
Biochemical Influences

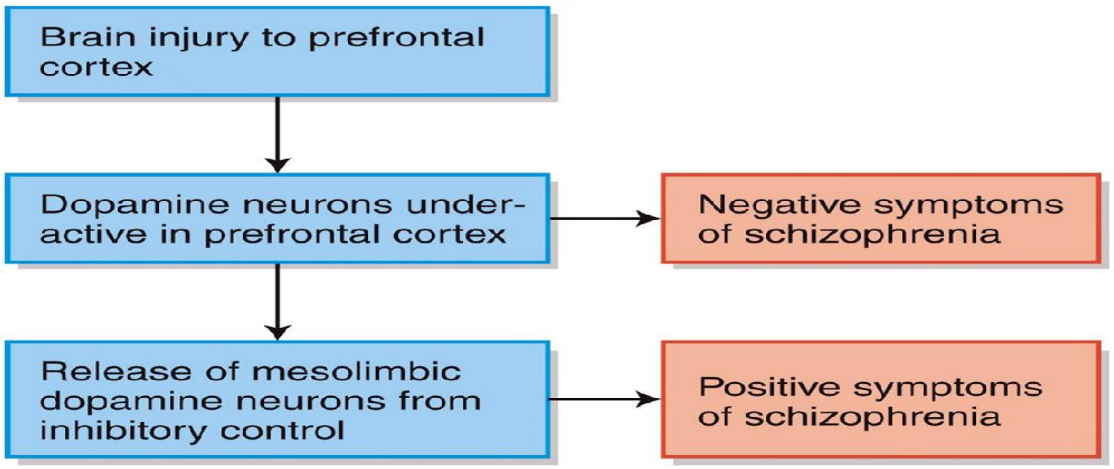
The oldest and most thoroughly explored biological theory in the explanation of schizophrenia attributes a pathogenic role to abnormal brain biochemistry. Notions of a ―chemical disturbance‖ as an explanation for insanity were suggested by some theorists as early as the mid-19th century.

A) The Dopamine Hypothesis

This theory suggests that schizophrenia may be caused by an excess of dopamine-dependent neuronal activity in the brain. This excess activity may be related to increased production or release of the substance at nerve terminals, increased receptor sensitivity, too many dopamine receptors, or a combination of these mechanisms.

Dopamine Theory of Schizophrenia





B) Other Biochemical Hypotheses

Various other biochemical have been implicated in the predisposition to schizophrenia. Abnormalities in the neuronal activity of the neurotransmitters norepinephrine, serotonin, acetylcholine, and gamma-aminobutyric acid and in the neuroregulators, such as prostaglandins and endorphins, have been suggested.

- **Physiological Influences**

A number of physical factors of possible etiological significance have been identified in the medical literature. However, their specific mechanisms in the implication of schizophrenia are unclear.

A) Viral Infection

Researchers **report** that epidemiological data indicate a high incidence of schizophrenia after prenatal exposure to influenza. Another study found an association between viral infections of the central nervous system during childhood and adult onset schizophrenia.

B) Anatomical Abnormalities

Structural brain abnormalities have been observed in individuals with schizophrenia. Ventricular enlargement is the most consistent finding; however, sulci enlargement and cerebellar atrophy are also reported.

C) Histological Changes

Cerebral changes in schizophrenia have also been studied at the microscopic level. A ―disordering‖ or disarray of the pyramidal cells in the area of the hippocampus has been suggested.

D) Physical Conditions

Several medical conditions are known to cause acute psychotic episodes, including but not limited to Huntington's disease, hypo- or hyperthyroidism, hypoglycemia, calcium imbalances, temporal lobe
epilepsy, Wilson's disease, central nervous system (CNS) neoplasms, encephalitis, meningitis, neurosyphilis, and stroke .

2. Psychological Influences

The early theories implicated poor parent–child relationships and dysfunctional family systems as the cause of schizophrenia, but they no longer hold any credibility. Researchers now focus their studies in terms of schizophrenia as a brain disorder.

3. Environmental Influences

- **Sociocultural Factors**

Statistics have shown that greater numbers of individuals from the lower socioeconomic classes experience symptoms associated with schizophrenia than do those from the higher socioeconomic groups.

- **Stressful Life Events**

It is known that extreme stress can precipitate psychotic episodes. Stress may indeed precipitate symptoms in an individual who possesses a genetic vulnerability to schizophrenia. Stressful life events may be associated with exacerbation of schizophrenic symptoms and increased rates of relapse.

Key features that define the psychotic disorders

Positive Symptoms:

1. Delusions

Delusions are false personal beliefs inconsistent with the person's intelligence or cultural background.

The individual continues to have the belief despite obvious proof that it is false or irrational.

Delusions are subdivided according to their content , such as grandiose, jealous, erotomania, or somatic delusions, thought withdrawal/ or insertion, or delusions of control. Persecutory delusions are most common, referential delusions are also common.

2. Hallucinations

Auditory hallucinations are false perceptions of sound. Most commonly, these are voices, but the individual may report clicks, rushing noises, music, and other noises. Command hallucinations are "voices" that issue commands to the individual. They are potentially dangerous when the commands are for violence to self or others. Auditory hallucinations are the most common type in schizophrenia.. The second most common type is visual hallucinations, while other hallucinations may be rare.

3. Disorganized Thinking and Speech

In disorganized thinking, the individual may demonstrate **loose associations** or tangentiality. Rarely, speech may be so severely disorganized that it is nearly incomprehensible (incoherence or "word salad").

4. Grossly Disorganized or Abnormal motor Behavior (including Catatonia)

It may manifest in a variety of ways, ranging from childlike "silliness" to unpredictable agitation that leading to difficulties in performing activities of daily living.

Catatonic behavior is a marked decrease in reactivity to the environment. This ranges from resistance to instructions (**negativism**); to maintaining a rigid, inappropriate or bizarre posture; to a complete lack of verbal responses (**mutism**) and motor responses (**stupor**). It can also include purposeless and excessive motor activity without obvious cause **(catatonic excitement).** Other features are repeated stereotyped movements, staring, grimacing, mutism, and the echoing of speech.

Negative Symptoms

Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and avolition. Other negative symptoms include alogia, anhedonia, and asociality.

1. **Diminished emotional expression**, it may include variety of symptoms as feelings of indifference toward people, activities, and events (Apathy), blunted or flat affect.

2. Avolition is a decrease in motivated self-initiated purposeful activities.

3. Alogia is manifested by diminished speech output .

4. Anhedonia is the decreased ability to experience pleasure from positive stimuli or a degradation in the recollection of pleasure previously experienced.

5. Asociality refers to the apparent lack of interest in social interactions.

Table 9.1 Summary of the Major Symptom Domains in Schizophrenia

Positive Symptoms	Negative Symptoms	Disorganized Symptoms
Delusions, hallucinations	Avolition, alogia, anhedonia, blunted affect, asociality	Disorganized behavior, disorganized speech

Schizophrenia

Schizophrenia lasts for at least 6 months and includes at least 1 month of active-phase symptoms. During the prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more positive symptoms in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Prevalence

The lifetime prevalence of schizophrenia appears to be approximately 0.3%-0.7%, although there is reported variation by race/ethnicity, and across countries .

Diagnostic Criteria (DSM 5):

A. Two (or more) of the following, at least one of these must be (1), (2), or (3):

1. **Delusions.** **2. Hallucinations.** **3. Disorganized speech**
4. **Grossly disorganized or catatonic behavior.** **5. Negative symptoms**

B. Decreased level of interpersonal relations , self-care, academic, or occupational functioning .

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Suicide Risic

Approximately 5%-6% of individuals with schizophrenia die by suicide, about 20% attempt suicide on one or more occasions, and many more have significant suicidal ideation. Suicidal behavior is sometimes in response to command hallucinations to harm oneself or others.

Prognosis: About 20-30 % of patients may recover a normal life, 40- 60 % remain significantly impaired.

Delusional Disorder

Delusional disorder is characterized by at least 1 month of delusions but no other psychotic symptoms.

Diagnostic Criteria

A. The presence of one (or more) delusions with a duration of 1 month or longer.

B. Functioning is not markedly impaired, and behavior is not obviously bizarre or odd.

C. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder.

Specify whether: erotomaniac type, grandiose type, jealous type, persecutory type, somatic type, or mixed type (when no one delusional theme predominates). Unspecified type applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

Specify if: ***With bizarre content***

Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual's belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars).

Prognoses:

- Usually starts at middle age (25-40).
- May become chronic especially persecutory type.
- Rarely that prevents the daily performance of the patient.
- The patient and his working ability is not affected even when disorder becomes chronic.
- Social and marital relationships are usually affected, but in general the patients are normal in appearance, behavior if no relation with their delusions.

Brief Psychotic Disorder

Brief psychotic disorder is a disturbance that involves the sudden onset of at least **one of the positive symptoms** of psychosis such as hallucinations, delusions, disorganized speech, or grossly disorganized or catatonic behavior. The disturbane occurs for **at least 1 day but for less than 1month**, as the individual eventually exhibits a full recovery or return to the former level of functioning.

Diagnostic Criteria

A. Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3):

1. **Delusions.**
2. **Hallucinations.**
3. **Disorganized speech (e.g., frequent derailment or incoherence).**
4. **Grossly disorganized or catatonic behavior.**

B. Duration of an episode is at least 1 day but less than 1 month.

C. The disturbance is Not due to other psychological condition, or to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Prognosis

- Disorder occurs in adolescence or early adulthood with acute onset of psychotic symptoms after few hours of stressful events.
- Psychotic symptoms disappear in less than 1 month.
- Psychotic symptoms may be followed by symptoms of depression or lack of self-confidence.

Treatment

- Admission may be needed if symptoms are severe or for confirmed diagnoses.
- Drug therapy and psychotherapy to help the patient to get rid of immature defense mechanisms and to increase his self-esteem and self-concept.

Schizophreniform Disorder

Schizophreniform disorder is characterized by a symptomatic presentation equivalent to that of schizophrenia except for its duration **(last at least 1month but less than 6 months)** and the absence of a requirement for a decline in functioning.

Prognosis

- Mostly, onset is acute and these psychotic symptoms cause disturbance in vocational and social performance, because prognosis is improvement always.
- During onset, there is danger on the patient from suicide during acute symptoms or depression following psychotic symptom.

Treatment

- Admission maybe needed especially for completion of diagnostic process or performing some treatment, or to protect the patient from himself.
- ECT may be needed especially in catatonic symptoms.
- Psychotherapy is very important in helping them in social and psychological adjustment after experience of psychoses.

Schizoaffective Disorder

Schizoaffective disorder is characterized by an uninterrupted period of illness during which, at some time, the client experiences a major depressive, manic, or mixed episode along with the negative symptoms of schizophrenia.

During the same period of illness, in the absence of prominent mood symptoms, the individual exhibits delusions or hallucinations for at least 2weeks .

In schizoaffective disorder, a mood episode and the active-phase symptoms of schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms (major depressive or manic).

Prognosis

- Disorder starts in early adulthood and tends to become chronic.

Treatment

- Admission of the patient to hospital is needed with giving drugs (anti-depression, anti-mania) in addition to psychotherapy and social therapy.

Catatonic Disorder

Catatonia can occur in the context of several disorders, including neurodevelopmental ,psychotic, bipolar, depressive disorders, and other medical conditions (e.g., cerebral folate deficiency, rare autoimmune and paraneoplastic disorders) .

A. catatonia associated with another mental disorder (catatonia specifier) .

B. catatonic disorder due to another medical condition .

C. unspecified catatonia .

The diagnostic criteria for all three conditions as the followings:

A. The clinical picture is dominated by three (or more) of the following symptoms:

1. Stupor (i.e., no psychomotor activity; not actively relating to environment).
2. Catalepsy (i.e., passive induction of a posture held against gravity).
3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).
4. Mutism (i.e., no, or very little, verbal response).
5. Negativism (i.e., opposition or no response to instructions or external stimuli).
6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity).
7. Mannerism (i.e., odd, circumstantial caricature of normal actions).
8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements).
9. Agitation, not influenced by external stimuli.
10. Grimacing.
11. Echolalia (i.e., imitating another's speech).
12. Echopraxia (i.e., imitating another's movements).

Prognosis:

- Varies, depending on the age of onset, which is often in the early 20s to 30s .
- It tends to begin with an acute episode.
- If the client has developed a good support system, before illness he will probably recover from acute phase and have partial or complete remission.

Management of schizophrenia :

1. **Hospitalization:**

- Is indicated in acute stage of disorder.
- The patient may be aggressive or self-destructive.
- The patient may have to be restrained.

2. **Psychopharmacological Treatment :**

- Neuroleptics:
- Also called anti-psychotic or major tranquilizers.
- Used to treat psychotic symptoms.
- Dose is determined by the patient's response and presence of side effects.
- They do not treat schizophrenia, but symptoms.

A. Typical Antipsychotics

1. **Chlorpromazine (Thorazine) (Largactil):**

- Is the drug of choice in acute stage.
- It has a sedative effect in addition to anti-psychotic effect.
- It is present in oral form, IM and IV preparation.
- It acts by blocking dopamine receptors.
- Its side effects are **extrapyramidal symptoms (EPS)**, hypotension and anti-cholinergic effects.
- Dose: 40–400 mg daily.

2. **Haloperidol (Haldol):**

- Potent blocker of dopamine receptors.
- Produces more **extrapyramidal symptoms (EPS)** and less sedation.
- Can be used in acute stage, but mainly for maintenance in chronic stage.
- Dose: 2-100 mg. daily.

Side effects of neuroleptics:

The effects of these medications are related to blockage of receptors for which they exhibit various degrees of affinity. Blockage of the dopamine receptors is thought to be responsible for controlling positive symptoms of schizophrenia .

a. Acute dystonia: Involuntary muscle contraction particularly of jaw and neck or external ocular muscles.
-Treated by IV Anticholinergic drug e.g. benztropine.

b. Parkinsonian syndrome*:* due to continued treatment with neuroleptics it includes: tremor, rigidity and bradykinesia.

c. Akathesia*:* A subjective sense of restlessness and the patient keeps moving here and there.

- Treated by benzodiazepines.

d. **Tardive dyskinesia**: A disorder that involves involuntary movements, especially of lower face.

- Symptoms may include: Facial grimacing, finger movement, jaw swinging, repetitive chewing, and tongue thrusting.
- The worst side effects of neuroleptics.
- Occurs after prolonged use of neuroleptics.
- It is resistant to treatment.

* Anticholinergic side effects: confusion, dry mouth, blurred vision, tachycardia, urine retention, etc…
* Antiadrenergic side effects: drowsiness, postural hypotension, impaired sexual function.

B. Atypical Antipsychotics

Atypical antipsychotics are weaker dopamine receptor antagonists than conventional antipsychotics but more potent antagonists of the serotonin (5-hydroxytryptamine) type 2A (5HT2A) receptors.

They also exhibit antagonism for cholinergic, histaminic, and adrenergic receptors.

Selected Antipsychotic Drugs

Generic Name	Trade Name	Dosage Range for Adults (mg/d)
Selected Conventional Antipsychotic Drugs Used to Treat Psychosis in the United States		
First-Generation		
Chlorpromazine	Thorazine	30–800
Fluphenazine	Prolixin; Permitil	0.5–20
Haloperidol	Haldol	1–15
Loxapine	Loxitane	20–250
Mesoridazine	Serentil	100–300
Molindone	Moban	15–225
Perphenazine	Trilafon	4–32
Pimozide	Orap*	1–10
Prochlorperazine	Compazine†	15–25
Thiothixene	Navane	5–25
Trifluoperazine	Stelazine	5–25
Triflupromazine	Vesprin	60–150
Second-Generation		
Aripiprazole	Abilify	10–15
Clozapine	Clozaril	200–600
Risperidone	Risperdal	4–16
Olanzapine	Zyprexa	10–20
Ouetiapine	Seroquel	300–400
Ziprasidone	Geodon	40–160

3. Psychosocial Treatment

Other forms of treatment like behavioral, occupational and group therapy may be used according to needs and functional status of the patient. Supportive psychotherapy is employed and depends on establishing a relationship with the patient to make a treatment alliance.

-This is very difficult in regressed, aggressive or suspicious patients.

-Therapist must be flexible and take into account the patient's fear of intimacy and close relationships.

4. Electroconvulsive therapy (ECT):

-It is less effective than neuroleptics and is indicated in catatonic patients or patients who cannot take medications

Assigning Nursing Diagnoses to Behaviors Commonly Associated With Psychotic Disorders

Behaviors	Nursing diagnoses
Impaired communication (inappropriate responses), disordered thought sequencing, rapid mood swings, poor concentration, disorientation, stops talking in midsentence, tilts head to side as if to be listening	**Disturbed sensory perception**
Delusional thinking; inability to concentrate; impaired volition; inability to problem-solve, abstract, or conceptualize; extreme suspiciousness of others; inaccurate interpretation of the environment	**Disturbed thought processes**
Withdrawal; sad, dull affect; need-fear dilemma; preoccupation with own thoughts; expression of feelings of rejection or of aloneness imposed by others; uncommunicative; seeks to be alone	**Social isolation**
Risk factors: Aggressive body language (e.g., clenching fists and jaw, pacing, threatening stance); verbal aggression; catatonic excitement; command hallucinations; rage reactions; history of violence; overt and aggressive acts; goal-directed destruction of objects in the environment; self-destructive behavior; active, aggressive suicidal acts	**Risk for violence: Self-directed or other-directed**
Loose association of ideas, neologisms, word salad, clang associations, echolalia, verbalizations that reflect concrete thinking, poor eye contact, difficulty expressing thoughts verbally, inappropriate verbalization .	**Impaired verbal communication**
Difficulty carrying out tasks associated with hygiene, dressing, grooming, eating, and toileting	**Self-care deficit**
Neglectful care of client in regard to basic human needs or illness treatment, extreme denial or prolonged over concern regarding client's illness, depression, hostility and aggression	**Disabled family coping**
Inability to take responsibility for meeting basic health practices, history of lack of health seeking behavior, lack of expressed interest in improving health behaviors, demonstrated lack of knowledge regarding basic health practices, anosognosia (lack of insight about illness)	**Ineffective health maintenance**

Chapter Five

Mood Disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Recount historical perspectives of bipolar disorder.

2) Discuss epidemiological statistics related to bipolar disorder.

3) Describe various types of bipolar disorders.

4) Assigning Nursing Diagnoses to Behaviors Commonly Exhibited by Individuals Experiencing a Manic Episode .

5) Discuss various modalities relevant to treatment of bipolar disorder.

Bipolar Disorder

People with this type of illness change back and forth between periods of depression and periods of mania (an extreme high, sometimes with agitation or irritability).

Bipolar disorder involves extreme mood swings from episodes of mania or hypomania to episodes of depression over time. (Bipolar disorder formerly was known as manic-depressive illness.)

Epidemiology:

- 19.3% of the general population develop a mood disorder.
- In terms of gender, the incidence of bipolar disorder is roughly equal, with a ratio of women to men of about 1.2 to 1.
- Average age of onset of bipolar disorder is mid to late twenties.
- Bipolar disorders occur more frequently in the higher socioeconomic groups.

Etiology:

The exact causes for mood disorders have not been established. They are thought to result from complex interactions among various factors.

Genetic factors: Genetic studies implicate that:

First-degree relatives of people with bipolar disorder have a 3% to 8% risk of developing bipolar disorder compared with a 1% risk in the general population.

For all mood disorders, monozygotic twins have a concordance rate (both twins having the disorder) 2 to 4 times higher than dizygotic twins.

Family Studies

Family studies have shown that if one parent has bipolar disorder, the risk that a child will have the disorder is around 28 percent. If both parents have the disorder, the risk is two to three times as great. This has also been shown to be the case in studies of children born to parents with bipolar disorder who were adopted at birth and reared by adoptive parents without evidence of the disorder. These results strongly indicate that genes play a role separate from that of the environment.

Altered Neurotransmission:. Serotonin has many roles in behavior: mood, activity, aggressiveness and irritability, Norepinephrine levels may be increased in mania and deficient in depression .

Neuroendocrine dysfunction:

- hyperthyroidism has been associated with mania

Medication Side Effects

Certain medications used to treat somatic illnesses have been known to trigger a manic response. The most common of these are the steroids frequently used to treat chronic illnesses such as multiple sclerosis and systemic lupus erythematosus. Some clients whose first episode of mania occurred during steroid therapy have reported spontaneous recurrence of manic symptoms years later. Amphetamines, antidepressants, and high doses of anticonvulsants and narcotics also have the potential for initiating a manic episode .

Life Events and stress theory: Significant life events (e.g., death, unexpected success) cause stress, which result in depression or mania.

Suicide Risk

The lifetime risk of suicide in individuals with bipolar disorder is estimated to be at least 15 times that of the general population. In fact, bipolar disorder may account for one-quarter of all completed suicides. A past history of suicide attempt and percent days spent depressed in the past year are associated with greater risk of suicide attempts or completions.

A. Bipolar I Disorder

Diagnostic Criteria

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode.

The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Mania An alteration in mood that may be expressed by feelings of elation, inflated self-esteem, grandiosity, hyperactivity, agitation, racing thoughts, and accelerated speech.

Mania can occur as part of the psychiatric disorder bipolar disorder, as part of some other medical conditions, or in response to some substances.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., puooseless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition. for the diagnosis of bipolar I disorder.

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

***** At this stage, the disturbance is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization

Assigning Nursing Diagnoses to Behaviors Commonly Exhibited by Individuals Experiencing a Manic Episode

Behaviors	Nursing diagnoses
Extreme hyperactivity; increased agitation and lack of control over purposeless and potentially injurious movements	Risk for injury
Manic excitement, delusional thinking, hallucinations, impulsivity	Risk for violence: Self-directed or other-directed
Loss of weight, amenorrhea, refusal or inability to sit still long enough to eat	Imbalanced nutrition: Less than body requirements
Delusions of grandeur and persecution; inaccurate interpretation of the environment	Disturbed thought processes
Auditory and visual hallucinations; disorientation	Disturbed sensory-perception
Inability to develop satisfying relationships, manipulation of others for own desires, use of unsuccessful social interaction behaviors	Impaired social interaction
Difficulty falling asleep, sleeping only short periods	Insomnia

B. Bipolar II Disorder

Must never have had full manic episode, at least one past major depressive and past hypomanic episode.

When the psychiatric nurse differentiates between Bipolar type I and Bipolar type II mood disorders he will recognize that:

* Type I at least had one manic episode, type II never had full manic episode.

Diagnostic Criteria

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

Bipolar II Disorder Diagnostic Criteria

A. Criteria have been met for at least one hypomanic episode and at least one major depressive

B. There has never been a manic episode.

C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Prognosis for bipolar disorder:

Prognosis is good, but it has high recurrence and relapse rate which depends on:

1- The number of previous episodes.

2- Family history of bipolar disorder.

3- Functional impairment during episodes.

4- Past psychotic episodes.

5- Past suicidal attempts.

Suicide risk

is high in bipolar II disorder. Approximately one-third of individuals with bipolar II disorder report a lifetime history of suicide attempt. The prevalence rates of lifetime attempted suicide in bipolar II and bipolar I disorder appear to be similar (32.4% and 36.3%, respectively).

Differential diagnosis:

The symptoms are the same of both manic and hypomanic episodes with difference in duration and severity (hypomanic episode is less sever).

- **Difference between manic episode and hypomanic episode:**

Area of Difference	Manic episode	Hypomanic episode
1- duration	At least one week	At least 4 days but lasts longer
2- Functioning	Severely disturbed	Mildly disturbed
3- Treatment	Require hospitalization	Usually treated in CMH centers
4- Activity	Aggressive or agitated	goal directed Hyperactivity
5- delusion	May have delusion of grandeur.	Absent.

C. Cyclothymic Disorder

The symptoms of cyclothymic disorder are identical to the symptoms of bipolar II disorder, except that they are generally less severe.

- In cyclothymic disorder, the changes in mood are irregular and abrupt, sometimes occurring within hours.
- The diagnosis of cyclothymic disorder is used when an individual displays numerous periods of hypomanic symptoms and depressive symptoms occur for at least 2 years, during which they do not subside for more than 2 months at a time.
- Cyclothymic disorder, like dysthymic disorder, frequently coexists with borderline personality disorder

Diagnostic Criteria

A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.

C. Criteria for a major depressive, manic or hypomanic episode have never been met.

D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or

other specified or unspecified schizophrenia spectrum and other psychotic disorder.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F .The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Management

A- Pharmacological treatment

1- Lithium: 900 to 1800 mg/day

Use: mood stabilizer for persons with mania and depression

Action: it alters brain neurotransmitters and inhibits the release of thyroid hormone. Lithium may take a week to begin to work, so sedatives are required during this period if the patient is agitate or aggressive.

Blood level for maintenance and safety in acute mania is 0.5 - 1.5 mEq/L therapeutic range is narrow.

Toxicity: it can occur quickly when lithium blood levels approaching 2 mEq/L and marked by nausea, vomiting, tremors, muscle weakness or twitching, ataxia, drowsiness, confusion, seizures, and coma.

Person must have enough salt and water in his diet, decrease salt and water intake increase lithium blood levels and toxicity.

Perspiration after exercise, sunbath or flu cause salt and fluid loss and increase lithium blood levels and toxicity.

Drug interaction: Clients taking lithium should use diuretics, ibuprofen and verapamil with extreme caution because they elevate lithium blood levels quickly.

Contraindication: Lithium can cause birth defects if it is taken in the first trimester of pregnancy.

Side effects : Neuromuscular effects (tremors and muscle weakness).

Central nervous system effects (forgetfulness and slowed cognition).

Gastrointestinal effects (nausea and diarrhea).

Weight gain, hypothyroidism and renal effects (polyuria).

Laboratory tests are done to ensure adequate functioning of the kidneys, heart, thyroid gland and electrolytes.

2- Anticonvulsants: used as mood stabilizers in the treatment of bipolar disorder if the client has side effects from taking lithium.

Carbamazpine (tegretol) 400 – 1600mg/day .

Valporic acid (Depakine)1000-3000mg/day.

Lamotrigine (Lamictal) 300 – 500mg/day.

3-Benzodiazpines:(diazepam) Assival and (Clonazepam) Clonex: used for irritability or agitation as sedative, and for sleep regulation .

4-Antipsychotics: (chloropromazine)Largactile, (Halipridol)Halidol, (clonazapine)Liponex): to relieve delusions, hallucination, agitative or aggressive behavior.

B- Psychotherapy :

Psychotherapy is not useful during acute manic stages because the person's attention span is brief and he or she can gain little insight during times of accelerated psychomotor activity. Psychotherapy combined with medication can reduce the risk of homicide, suicide and injury, provide support to the client and family, and help the client to accept the diagnosis and treatment plan.

C- Family Interventions

Although pharmacologic treatment is acknowledged as the primary method of stabilizing an acutely ill bipolar client, adjunctive psychotherapy has been recognized as playing an important role in preventing relapses and improving adjustment. Researchers suggest that involving the family in post-episode stabilization of bipolar disorder is important and helps family members:

- Integrate their experience of the mood disorder.
- Know the symptoms of bipolar disorder and what precipitates episodes.
- Understand the client's vulnerability to future episodes.

Family support is also important in helping the client accept the necessity of ongoing medication administration. Family dynamics and attitudes can play a crucial role in the outcome of a client's recovery. Interventions with family members must include education that promotes understanding that at least part of the client's negative behaviors are attributable to an illness that must be managed, as opposed to being willful and deliberate.

Chapter six

Depressive Disorder

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Discuss epidemiological statistics related to depression.

2) Describe various types of depressive disorders.

3) Identify predisposing factors in the development of depression.

4) Formulate nursing diagnoses and goals of care for clients with depression .

5) Discuss various modalities relevant to treatment of depression .

Depression

An alteration in mood expressed by feelings of sadness, despair, and pessimism. There is a loss of interest in usual activities, and somatic symptoms may be evident. Changes in appetite, sleep patterns, and cognition are common.

Every person experiences from time to time a change in his/her mood, which is related to everyday life events.

This is considered normal as long as it is appropriate to life event.

Mood is considered abnormal when it is excessively depressed or related out of proportion to the life experience.

-Normal grief: is the feeling that are precipitated by loss of a loved one and can occur in response to a variety of losses.

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, and other specified depressive disorder.

The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

Large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with depression-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced depressive disorder and depressive disorder due to another medical condition.

Epidemiology

Major depression is one of the leading causes of disability in the United States. Studies indicate that the incidence of depressive disorder is higher in women than

it is in men by about 2 to 1. The incidence of bipolar disorder is roughly equal, with a ratio of women to men of 1.2 to 1.

Several studies have shown that the incidence of depression is higher in young women and has a tendency to decrease with age. The opposite has been found in men, with the prevalence of depressive symptoms being lower in younger men and increasing with age. Results of studies have indicated an inverse relationship between social class and report of depressive symptoms.

The highest incidence of depressive symptoms has been indicated in individuals without close interpersonal relationships and in persons who are divorced or separated.

A number of studies have examined seasonal patterns associated with mood disorders. These studies have revealed two prevalent periods of seasonal involvement: one in the spring (March, April, and May) and one in the fall (September, October, and November). This pattern tends to parallel the seasonal pattern for suicide, which shows a large peak in the spring and a smaller one in October

- 2% of the general population develop a mood disorder.
- 21% of women and 13% of men develop major depression.
- Average age of onset for bipolar illness is mid-late 20's.
- Depression occurs more frequently in lower socioeconomic groups

Etiologic factors:

The etiology of depression is unclear. Evidence continues to mount in support of multiple causations, recognizing the combined effects of genetic, biochemical, and psychosocial influences on an individual's susceptibility to depression.

1. Neuro-biologic factors:

- Altered neurotransmission.
    - Neuroendocrine dysregulation.
    - Geriatric transmission.

2. Psychosocial factors:

a. Psychoanalytic theory:

-Depression is a result of loss.

b. Cognitive theory:

- Depression is a result of negative processing of thoughts.

c. Learned helplessness:

- Depression is a result of perceived lack of control over events

d. Life events and stress theory:

- Significant life events cause stress that results in depression or mania.

e. Personality theory:

- Personality characteristics predispose individual to Depressive disorder.

Clinical Picture Of Depression

The key symptoms are depressed mood and loss of interest or pleasure in all or most of the activities.

Diurnal Variation: Depressive symptoms change in severity during the day. They are worse in early morning hours, and improve as day passes.

Somatic Symptoms

-Decreased appetite and weight loss, but in some cases the patient may have increased appetite and his weight may increase.

-Sleep Disturbances (Insomnia): Early morning awakening, multiple awakening at night with difficulty to go back to sleep. Some patients may sleep most of the day (Hypersomnia).

Decreased sexual interest and activity

Low energy level: The patient cannot start any activity and when he starts he soon loses interest or energy to complete it.

A. Major depressive disorder

Major depressive disorder represents the classic condition in this group of disorders. It is characterized by discrete episodes of at least **2 weeks'** duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition, and neurogenerative functions and inter-episode remissions.

A diagnosis based on a single episode is possible, although the disorder is a recurrent one in the majority of cases. Careful consideration is given to the delineation of normal sadness and grief from a major depressive episode. Bereavement may induce great suffering, but it does not typically induce an episode of major depressive disorder. When they do occur together, the depressive symptoms and functional impairment tend to be more severe and the prognosis is worse compared with bereavement that is not accompanied by major depressive disorder.

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomania episode.

Prognosis

- Depression increases at late twenties but can start at any age.
- Could be sudden or gradual.
- Different period : one attack may continue for six months or more (if not treated).

- Prognoses is full improvement and the patient will be back to his previous social and vocational performance, but in some cases symptoms stay for 2 years without improvement (these attacks called chronic depression).
- The most serious complication is suicide.

Suicide Risk

The possibility of suicidal behavior exists at all times during major depressive episodes.

The most consistently described risk factor is a past history of suicide attempts or threats, but it should be remembered that most completed suicides are not preceded by unsuccessful attempts. Other features associated with an increased risk for completed suicide include male sex, being single or living alone, and having prominent feelings of hopelessness.

B. Persistent Depressive Disorder (Dysthymia)

People with this illness may be consistently and mildly depressed for years. They function fairly well on a daily basis, but their relationships and self-esteem suffer over time.

Diagnostic Criteria

This disorder represents a consolidation of defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating.

2. Insomnia or hypersomnia.

3. Low energy or fatigue.

4. Low self-esteem.

5. Poor concentration or difficulty making decisions.

6. Feelings of hopelessness.

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomania episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Prognosis

- Dysthymia often continues for years before individuals seek assistance for their symptoms.
- Over 50% of persons with dysthymia go on to develop major depression.

C. Other Specified Depressive Disorder

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The other specified depressive disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any

specific depressive disorder. This is done by recording ―other specified depressive disorder‖ followed by the specific reason (e.g., ―short-duration depressive episode‖).

Examples of presentations that can be specified using the ―other specified designation include the following:

1. Recurrent brief depression: Concurrent presence of depressed mood and at least four other symptoms of depression for 2-13 days at least once per month (not associated with the menstrual cycle) for at least 12 consecutive months in an individual whose presentation has never met criteria for any other depressive or bipolar disorder and does not currently meet active or residual criteria for any psychotic disorder.

2. Short-duration depressive episode (4-13 days): Depressed affect and at least four of the other eight symptoms of a major depressive episode associated with clinically significant distress or impairment that persists for more than 4 days, but less than 14 days, in an individual whose presentation has never met criteria for any other depressive or bipolar disorder, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for recurrent brief depression.

3. **Depressive episode with insufficient symptoms:** Depressed affect and at least one of the other eight symptoms of a major depressive episode associated with clinically significant distress or impairment the persist for at least 2 weeks in an individual whose presentation has never met criteria for any other depressive or bipolar disorder, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for mixed anxiety and depressive disorder symptoms.

❖ Management

1.Antidepressants: Block the reuptake of norepinephrine and serotonin **.**

A- Tricyclic antidepressants (TCA).

-The oldest antidepressants, They relieve symptoms of hopelessness, helplessness, anhedonia, guilt, suicidal ideation

-Inhibit re-uptake of nor-epinephrine and serotonin in synapses, increasing their concentration.

-There is a delay in action for up to 2 or 3 weeks and the patient should be encouraged to take the medication even if there is no rapid response.

-Treatment is started with a low dose and then gradually increased to get the maximum effect.

include:

Amitriptyline (elatrole) 50-300 mg/ day, has more sedative effects.

Clomipramine (Anfranile) 25-250 mg/ day treatment of obsessive compulsive disorder.

Imipramine (Tofranile) 75-300 mg/ day more sedative effects, used in treatment of nocturnal enuresis

Maprotiline (Ludiomil) 75- 225 mg/day intermediate acting effect.

Side effects of TCA: dryness of mouth, wt gain, constipation

Contraindications: impairment of liver function, myocardial infarction.

B- Serotonin reuptake inhibitors group (SSRIs):

The new category of antidepressant are effective for most clients. Their action is specific to serotonin reuptake inhibition; these drugs produce few sedating, anticholinergic, and cardiovascular side effects, which makes them safer for use in children and older adults, mostly used are:

Fluoxetine (Prozac) 20- mg/80day - **Paroxitine** (paxit) 10- 50 mg/day

Citalopram (citram) 20- 60 mg/day - **Setraline** (Soltex) 50- 150 mg/day

Escitalopram (Cipralex) 10- 20 mg/day.

Side effect: Dizziness, drowsiness, dry mouth.

c- Atypical (bicyclic) anti-depressants:

Atypical antidepressants are used when the client has an inadequate response or side effects from SSRIs. The most commonly used drug is:

- Venlafaxine (Effexor) 75- 375 mg/day.

S/E: ↑ blood pressure and pulse, dry mouth.

d- Monoamino oxidase Inhibitors (MAOIs):

- They act by inhibiting the enzyme Monamine Oxidase.
- This class of antidepressants is used infrequently because of potentially fatal side effects and interactions with numerous drugs.
- **Examples**: Phenelzene (Nadil), Tranacyle Sulphate (Parnate).

Course of response:

- Usually have a lag period of 1-6 weeks for initiation of therapeutic effects, during which time the Side effects are most pronounced.
- As antidepressants begins therapeutic effects, side effects diminish.
- first week: decrease anxiety and improve sleep.
- 1-3 weeks: increase activity, sexual derive, self care memory and concentration.
- 3-4weeks: relief depressed mood, less hopelessness, suicidal ideation subside.

2-Psychotherapy:

Cognitive therapy is the recommended psychotherapy for depression. This approach includes identifying and challenging the accuracy of the patient's negative automatic thoughts and encouraging behaviors designed to counteract depressive symptoms.

Psychodynamic therapy assists the patient to become aware of unconscious anger directed toward object loss and work through these feelings to alleviate depression.

Family therapy assists the patient and family members in developing a sense of self understanding. The patient is then encouraged to take responsibility for his own actions.

Prognosis of depression:

- Prognosis is good it will be controlled by medications and psychotherapy.
- Dysthymia often continues before individuals seeks for treatment.
- Over 50% of persons with dysthymia develop major depression.

Facts about suicide:

1- Some believe that People who talk about suicide never commit suicide. But Suicidal people often send out both subtle and direct messages of suicide should be taken seriously with appropriate interventions.

2- Suicidal people not only want to hurt themselves not others. While the self-violence of suicide demonstrates anger turned inward, the anger can be directed toward others in a planned or impulsive action to kill others who tries to thwart the suicide before killing the self.

3- Suicidal people have mixed feelings (ambivalence) often prompts the cries for help evident in overt or covert cues. Intervention can help as situational supports, learn new ways to cope, and move forward in life.

4- Asking about suicide does not cause a non-suicidal person to become suicidal, but it helps him to express his suicidal ideas .

3- Electroconvulsive Therapy

Psychiatrists may use electroconvulsive therapy (ECT) to treat depression in select groups, such as clients who do not respond to antidepressants or those who experience intolerable side effects at therapeutic doses (particularly true for older adults). In addition, pregnant women can safely have ECT with no harm to the fetus. Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication.

ECT involves application of electrodes to the head of the client to deliver an electrical impulse to the brain; this causes a seizure. It is believed that the shock stimulates brain chemistry to correct the chemical imbalance of depression.

Historically, clients did not receive any anesthetic or other medication before ECT, and they had fullblown grand mal seizures that often resulted in injuries ranging from biting the tongue to breaking bones. ECT fell into disfavor for a period and was seen as “barbaric.” Today, although ECT is administered in a safe and humane way with almost no injuries, there are still critics of the treatment.

Clients usually receive a series of 6 to 15 treatments scheduled thrice a week. Generally, a minimum of six treatments are needed to see sustained improvement in depressive symptoms. Maximum benefit is achieved in 12 to 15 treatments.

Preparation of a client for ECT is similar to preparation for any outpatient minor surgical procedure: The client receives nothing by mouth (or, is NPO) after

midnight, removes any fingernail polish, and voids just before the procedure. An intravenous line is started for the administration of medication.

Initially, the client receives a short-acting anesthetic so he or she is not awake during the procedure. Next, he or she receives a muscle relaxant/paralytic, usually succinylcholine, which relaxes all muscles to reduce greatly the outward signs of the seizure (e.g., clonic–tonic muscle contractions).

Electrodes are placed on the client's head: one on either side (bilateral) or both on one side (unilateral). The electrical stimulation is delivered, which causes seizure activity in the brain that is monitored by an electroencephalogram, or EEG. The client receives oxygen and is assisted to breathe with an Ambu bag. He or she generally begins to waken after a few minutes. Vital signs are monitored, and the client is assessed for the return of a gag reflex.

After ECT treatment, the client may be mildly confused or briefly disoriented. He or she is very tired and often has a headache. The symptoms are just like those of anyone who has had a grand mal seizure. In addition, the client will have some short-term memory impairment. After a treatment, the client may eat as soon as he or she is hungry and usually sleeps for a period. Headaches are treated symptomatically.

Unilateral ECT results in less memory loss for the client, but more treatments may be needed to see sustained improvement. Bilateral ECT results in more rapid improvement but with increased short-term memory loss.

The literature continues to be divided about the effectiveness of ECT. Some studies report that ECT is as effective as medication for depression, whereas other studies report only short-term improvement. Likewise, some studies report that memory loss side effects of ECT are short lived, whereas others report they are serious and long term.

ECT is also used for relapse prevention in depression. Clients may continue to receive treatments, such as one per month, to maintain their mood improvement.

Often, clients are given antidepressant therapy after ECT to prevent relapse. Studies have found maintenance ECT to be effective in relapse prevention.

Assigning Nursing Diagnoses to Behaviors Commonly Associated With Depression

Behaviors	Nursing diagnoses
Depressed mood; feelings of hopelessness and worthlessness; anger turned inward in the self; misinterpretations of reality; suicidal ideation, plan, and available means	Risk for suicide
Depression, preoccupation with thoughts of loss, self-blame, grief avoidance, inappropriate expression of anger, decreased functioning in life roles	Complicated grieving
Expressions of helplessness, uselessness, guilt, and shame; hypersensitivity to slight or criticism; negative, pessimistic outlook; lack of eye contact; self-negating verbalizations	Low self-esteem
Apathy, verbal expressions of having no control, dependence on others to fulfill needs	Powerlessness
Expresses anger toward God, expresses lack of meaning in life, sudden changes in spiritual practices, refuses interactions with significant others or with spiritual leaders	Spiritual distress
Withdrawn, uncommunicative, seeks to be alone, dysfunctional interaction with others, discomfort in social situations	Social isolation/Impaired social interaction
Inappropriate thinking, confusion, difficulty concentrating, impaired problemsolving ability, inaccurate interpretation of environment, memory deficit	Disturbed thought processes
Weight loss, poor muscle tone, pale conjunctiva and mucous membranes, poor skin turgor, weakness	Imbalanced nutrition: Less than body requirements
Difficulty falling asleep, difficulty staying asleep, lack of energy, difficulty concentrating, verbal reports of not feeling well rested	Insomnia
Uncombed hair, disheveled clothing, offensive body odor	Self-care deficit (hygiene, grooming)

Chapter seven

Anxiety and related disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Discuss historical aspects and epidemiological statistics related to anxiety, and related disorders.

2) Describe types of anxiety, and related disorders, and identify symptomatology associated with each. Use this information in client assessment.

3) Identify predisposing factors in the development of anxiety .

4) Formulate nursing diagnoses .

Anxiety disorders

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Panic attacks feature prominently within the anxiety disorders as a particular type of fear response. The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation.

Thus, while the anxiety disorders tend to be highly comorbid with each other, they can be differentiated by close examination of the types of situations that are feared or avoided and the content of the associated thoughts or beliefs. Anxiety disorders differ from normal fear or anxiety by being excessive and stress-induced, by being persistent .

Anxiety disorders are the most prevalent of chronic psychiatric disorders. Despite effective treatment of anxiety, outpatient settings are failing to adress anxiety and its associated symptoms appropriately, leading to increased use of emergency department (ED) visits and the incurrence of high health care costs.

Each anxiety disorder is diagnosed when the following criteria are met:

• The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

• The fear, anxiety, or avoidance is persistent, lasting for 6 months or more.

• It causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. .

• Anxiety, and fear is not attributable to the physiological effects of a substance, or another mental disorder or medical condition.

General considerations for anxiety disorders

- Often have an early onset- teens or early twenties.
- Show 2:1 female predominance.
- Have a waxing and waning course over lifetime.
- Similar to major depression and chronic diseases such as diabetes in functional impairment and decreased quality of life.
- Normal anxiety is adaptive. It is an inborn response to threat.
- Pathologic anxiety is anxiety that is excessive, impairs function.
- Anxiety may be due to one of the primary anxiety disorders
- OR secondary to substance abuse (Substance-Induced Anxiety Disorder),
- A medical condition (Anxiety Disorder Due to a General Medical Condition),
- Another psychiatric condition, or psychosocial stressors (Adjustment Disorder with Anxiety)
- **Anxiety disorders**

1- **Specific phobia**

2- **Social anxiety disorder (SAD)**

3- **Panic disorder (PD)**

4- **Agoraphobia**

5- **Generalized anxiety disorder (GAD)**

7. **Anxiety Disorder due to a General Medical Condition**

8. **Substance-Induced Anxiety Disorder**

9. **Anxiety Disorder NOS(Not Otherwise Specified)**

Genetic Epidemiology of Anxiety Disorders

- There is significant familial aggregation for PD, GAD, OCD and phobias

- Twin studies found heritability of 0.43 for panic disorder and 0.32 for GAD

Specific Phobia

Specific phobia is defined as marked, irrational and immediate fear or anxiety about or avoidant of a specific object or situation which may be not actually dangerous. According to DSM-V, there are various types of specific phobia such as animal, situational, natural environment, blood-injection-injury and other phobias.

The content of phobias and their prevalence vary with culture and ethnicity. A specific phobia must be diagnosed only if the fear is excessive in the context of the specific culture and the fear causes a significant impairment or distress.

Epidemiology

- Up to 15% of general population
- Onset early in life
- Female : Male 2:1

Etiology

- Learning, contextual conditioning

Diagnostic Criteria

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

B. The phobic object or situation almost always provokes immediate fear or anxiety.

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Table 4.1 Various Types of Specific Phobias

Types	Definiton
Animal	
(Zoophobia) (e.g., spiders, insects, dogs).	Fear of animals
Ophidiophobia	Fear of snakes
Entomophobia	Fear of insects
Natural environment (e.g., heights, storms, water).	
Aquaphobia/ Hydrophobia	Fear of water
Acrophobia	Fear of heights
Astrophobia	Fear of storms, lightning, or thunder
Situational (e.g., airplanes, elevators, enclosed places).	
Claustrophobia	Fear of enclosed places
Blood-injection-injury .	
Hematophobia	Fear of blood
Pathophobia	Fear of disease
Algophobia	Fear of pain
Larrophobia	Fear of doctors
Thanatophobia	Fear of death
Androphobia	Fear of men
Gamaphobia	Fear of marriage
Autophobia	Fear of being alone
Aviophobia	Fear of flying
Nyctophobia	Fear of night
Ochlophobia	Fear of crowds
Pyrophobia	Fear of fire

Treatment

- Systematic desensitization

Systematic desensitization, also known as **graduated exposure therapy** is a type of behavior therapy used in the field of psychology to help effectively overcome phobias and other anxiety disorders.

The process of systematic desensitization occurs in three steps.

1. The first step of systematic desensitization is the identification of an anxiety inducing stimulus hierarchy.
2. The second step is the learning of relaxation or coping techniques.
3. When the individual has been taught these skills, he or she must use them in the third step to react towards and overcome situations in the established hierarchy of fears. The goal of this process is for the individual to learn how to cope with, and overcome the fear in each step of the hierarchy.

Social Anxiety Disorder (SAD) (Social Phobia)

Social anxiety disorder is an excessive fear of situations in which a person might do something embarrassing or be evaluated negatively by others. The individual has extreme concerns about being exposed to possible scrutiny by others and fears social or performance situations in which embarrassment may occur .

In some instances, the fear may be quite defined, such as the fear of speaking or eating in a public place, fear of using a public restroom, or fear of writing in the presence of others. In other cases, the social phobia may involve general social situations, such as saying things or answering questions in a manner that would provoke laughter on the part of others. Exposure to the phobic situation usually results in feelings of panic anxiety, with sweating, tachycardia, and dyspnea.

Onset of symptoms of this disorder often begins in late childhood or early adolescence and runs a chronic, sometimes lifelong, course. It appears to be more common in women than in men .

Impairment interferes with social or occupational functioning and causes marked distress.

Social phobia, also referred to as social anxiety disorder, is compelling desire to avoid situations in which others may criticize a person. Social phobia begins in childhood or adolescence, interferes with development, predisposes one to depression and substance abuse, and prevents one from working, dating, or getting married. Early identification is important.

First-degree relatives of persons with social phobia are about three times more likely to be affected with social phobia than are first-degree relatives of those without mental illness. Because onset usually begins in childhood or

adolescence, it is important to differentiate social phobia from appropriate fear and normal shyness.

Diagnostic Criteria

A. Marked persistent fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others)

C. The social situations almost always provoke fear or anxiety

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Social Anxiety Disorder treatment

- Social skills training, behavior therapy, cognitive therapy
- Medication – SSRIs, SNRIs, MAOIs, benzodiazepines, gabapentin

Agoraphobia

The literal Greek translation of the word agoraphobias "fear of the marketplace." This term defines the fear that some clients have of being in open shops and markets, although it may be more related to fears of being vulnerable and in a less secure environment .

The individual experiences fear of being in places or situations from which escape might be difficult or in which help might not be available in the event that panic symptoms should occur. It is possible that the individual may have experienced the symptom(s) in the past and is preoccupied with fears of their recurrence.

Onset of symptoms most commonly occurs in the 20s and 30s and persists for many years. It is diagnosed more commonly in women than in men. Impairment can be severe. In extreme cases, the individual is unable to leave his or her home without being accompanied by a friend or relative. If this is not possible, the person may become totally confined to his or her home.

The individual fears these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. These situations almost always induce persistent fear or anxiety that last for 6 months at least and are often avoided and require the presence of a companion. Onset of symptoms may be sudden or gradual. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.

Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.

- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- The individual fears or avoids these situations because escape might be difficult or help might not be available
- The agoraphobic situations almost always provoke anxiety
- Anxiety is out of proportion to the actual threat posed by the situation
- The agoraphobic situations are avoided or endured with intense anxiety
- The avoidance, fear or anxiety significantly interferes with their routine or function

Panic Disorder

Panic disorder is characterized by recurrent panic attacks, the onset of which is unpredictable and manifested by intense apprehension, fear, or terror, often associated with feelings of impending doom (clients often fear they are dying) and accompanied by intense physical discomfort. The physical sensations can be so intense that the individual believes he or she is having a heart attack or other critical illness. The symptoms come on suddenly and unexpectedly;

That is, they do not occur immediately before or on exposure to a situation that usually causes anxiety (as in specific phobia). They are not triggered by situations in which the person is the focus of others' attention (as in social anxiety disorder).

The role of organic factors in the etiology has been ruled out.

at least four of the following symptoms must be present to identify the presence of a panic attack :

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Chills or heat sensations
- Paresthesias (numbness or tingling sensations)
- Derealization (feelings of unreality) or depersonalization (feelings of being detached from oneself)

■ Fear of losing control or going crazy

■ Fear of dying

* The attacks usually last minutes or, more rarely hours.
* The average age of onset of panic disorder is the late 20s.
* Genetic vulnerability, tendency toward negative emotions, history of childhood physical and sexual abuse, and smoking have also been identified as risk factors

Treatment

* See 70% or better treatment response .
* Education, reassurance, elimination of caffeine, Cognitive-behavioral therapy .
* Medications – SSRIs, venlafaxine, tricyclic's, MAOIs, benzodiazepines, valproate, gabapentin

Generalized anxiety disorder (GAD)

Generalized anxiety disorder (GAD) is characterized by persistent, unrealistic, and excessive anxiety and worry that have occurred more days than not for at least 6 months and cannot be attributed to specific organic factors, such as caffeine intoxication or hyperthyroidism.

The anxiety and worry are associated with muscle tension, restlessness, or feeling keyed up or on edge . These symptoms are like those often associated with anxiety in the general

population, but unlike the typical experience of anxiety,

the symptoms in generalized anxiety disorder are intense enough to cause clinically significant impairment in social, occupational, or other important areas of functioning. The individual often avoids activities or events that may result in negative outcomes or

spends considerable time and effort preparing for such activities. Anxiety and worry often result in procrastination in behavior or decisionmaking, and the individual repeatedly seeks reassurance from others.

The disorder may begin in childhood or adolescence, but onset is not uncommon after age 20. Depressive symptoms are common.

Diagnostic Criteria

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months);

1. Restlessness or feeling keyed up or on edge.

2. Being easily fatigued.

3. Difficulty concentrating or mind going blank.

4. Irritability.

5. Muscle tension.

6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

GAD Treatment

* Medications including buspirone, benzodiazepines, antidepressants (SSRIs, venlafaxine, imipramine)

* Cognitive-behavioral therapy

Chapter Eight

Obsessive-Compulsive and Related Disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Identify Diagnostic Criteria for Obsessive-Compulsive Disorder .

2) Discuss historical aspects and epidemiological statistics related to Obsessive Compulsive Disorders .

3) Describe Treatment to Obsessive-Compulsive Disorders .

4) Assigning Nursing Diagnoses to Behaviors Commonly Associated With Obsessive-Compulsive Disorders .

Obsession compulsion: repetitive acts or rituals to release tension or relieve anxiety.

-The patient carries out these acts even if he recognizes that they are inappropriate or foolish.

The manifestations of obsessive-compulsive disorder (OCD) include the presence of obsessions, compulsions, or both, the severity of which is significant enough to cause distress or impairment in social, occupational, or other important areas of functioning .

The individual recognizes that the behavior is excessive or unreasonable, but because of the feeling of relief from discomfort that it promotes, is compelled to continue the act. Common compulsions include hand washing, ordering, checking, praying, counting, and repeating words silently.

The disorder is equally common among men and women. It may begin in childhood but more often begins in adolescence or early adulthood. The course is usually chronic and may be complicated by depression or substance abuse. OCD is identified more frequently in single people than in married people .

Diagnostic Criteria

A. Obsessions or compulsions or both defined by:

Obsessions are defined by (1) and (2)

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming

(e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance

(e.g., a drug of abuse, a medication) or another medical condition.

***Specify* if:**

With good or fair insiglit: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/deiusionai beiiefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Tic-reiated: The individual has a current or past history of a tic disorder.

* Course and prognosis:

- Female: Male 1:1
- 25% of cases start by age 14 years. Onset after age 35 years is unusual but does occur .
- Chronic disorder and the patient may not present to psychiatrist for 5- 10 years.
- About 30% of patients: good improvement, 30-40%: mild improvement, and the rest: chronic or worse.
- Some patients may have depression, suicide or addiction.

* Treatment:

1- Drugs:

-Anfranil (Clomipramin): Drug of choice (6-12months).

2- Behavioral therapy:

-Effective in 60-70% of patients (may be treatment of choice).

-Techniques used: Desensitization, thought stopping, flooding and implosion therapy.

Aversive conditioning: means giving a painful shock or loud noise when thought occurs.

-Some use response preventing as: forcibly stopping the patient from responding to obsession.

3- Psychodynamic psychoanalytic therapy:

-Aims to help the patient get insight into his aggressive impulses and strengthens ego to deal with aggression in mature ways.

Assigning Nursing Diagnoses to Behaviors Commonly Associated With Anxiety, Obsessive-Compulsive, and Related Disorders

Behaviors	Nursing diagnoses
Palpitations, trembling, sweating, chest pain, shortness of breath, fear of going crazy, fear of dying (panic disorder); excessive worry, difficulty concentrating, sleep disturbance (generalized anxiety disorder)	Anxiety (severe/panic)
Verbal expressions of having no control over life situation; nonparticipation in decisionmaking related to own care or life situation; expressions of doubt regarding role performance (panic and generalized anxiety disorders)	Powerlessness
Behavior directed toward avoidance of a feared object or situation (phobic disorder)	Fear
Stays at home alone, afraid to venture out alone (agoraphobia)	Social isolation
Ritualistic behavior; obsessive thoughts, inability to meet basic needs; severe level of anxiety (OCD)	Ineffective coping
Inability to fulfill usual patterns of responsibility because of need to perform rituals (OCD)	Ineffective role performance
Preoccupation with imagined defect; verbalizations that are out of proportion to any actual physical abnormality that may exist; numerous visits to plastic surgeons or dermatologists seeking relief (body dysmorphic disorder)	Disturbed body image
Repetitive and impulsive pulling out of one's hair (trichotillomania	Ineffective impulse control)

Chapter Nine

Trauma- and Stressor-Related Disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Discuss historical aspects and epidemiological statistics related to trauma- and stress or related disorders.

2) Identify Diagnostic Criteria for Posttraumatic Stress Disorder .

3) Identify Treatment to Posttraumatic Stress Disorder .

Posttraumatic Stress Disorder (PTSD)

PTSD was described as “a reaction to an extreme trauma, which is likely to cause pervasive distress to almost anyone, such as natural or man-made disasters, combat, serious accidents, witnessing the violent death of others, being the victim of torture, terrorism, rape, or other crimes” .

These symptoms are not related to common experiences such as uncomplicated bereavement, marital conflict, or chronic illness but are associated with events that would be markedly distressing to almost anyone. The individual may experience the trauma alone or in the presence of others.

Characteristic symptoms include re-experiencing the traumatic event, a sustained high level of anxiety or arousal, or a general numbing of responsiveness. Intrusive recollections or nightmares of the event are common. Some individuals may be unable to remember certain aspects of the trauma. Symptoms of depression are common with this disorder and may be severe enough to warrant a diagnosis of a depressive disorder in addition to PTSD. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when others lost their lives.

They may also express trauma and guilt feelings about the things they had to do to survive. Substance abuse, anger and aggressive behavior, and relationship problems are common. The full symptom picture must be present for more than 1 month and cause significant interference with social, occupational, and other areas of functioning. The disorder can occur at any age. Symptoms may begin within the first 3 months after the trauma, or there may be a delay of several months or even years.

Diagnostic Criteria for Posttraumatic Stress Disorder

A. Exposure to actual or threatened death, serious injury, or sexual violence, in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) .

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s) Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behavior.

3. Hypervigilance.

4. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

5. Problems with concentration.

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupation, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Treatment

PTSD treatment can help the client to regain a sense of control over their life. The primary treatment is psychotherapy, but often included medication. Combining these treatments is necessary.

Psychotherapy (Talk therapy)

During the initial post trauma period, formal treatment is not required in the vast majority of cases. Instead, a provision of good social support and a temporary reduction in exposure to stressors is likely to aid recovery in most cases.

A minority of individuals will however suffer with most intense and impairing symptoms which are diagnostically referred to as acute stress disorder for the first month post-incident. These individuals may benefit from formal ‘early interventions’ and the strongest evidence for these is for Cognitive Behavioural Therapy (CBT) techniques being effective.

The most significant barrier to the effective provision of care for those who do not recover but instead develop PTSD is that the majority of people who suffer with mental health disorders, including but not limited to PTSD, do not seek any professional help at all.

For those who do come forward for help there is good evidence, that two forms of time-limited psychological therapies are effective treatments. The first is trauma focussed CBT, which include variants such as cognitive processing therapy (CPT). Traditionally this is delivered in 8–12 weekly sessions lasting between 60 and 90 minutes. Cognitive therapy helps the client to recognize the ways of thinking that are keeping him/her stuck, its often used along with exposure therapy.While exposure therapy helps the client to face frightening situation and cope with it effectively.

However, complex PTSD cases are likely to require more sessions, many of which will initially not be trauma focussed but instead aim to stabilize and improve the strength of the therapeutic alliance with the therapist.

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Chapter Ten

Personality disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Define personality.

2) Identify various types of personality disorders.

3) Identify Diagnostic Criteria for various types of personality disorders .

4) Discuss historical and epidemiological statistics related to various personality disorders.

5) Identify Treatment to various types of personality disorders .

Personality is :

Personality is a unique and long-term pattern of inner experience and outward behavior, Tends to be consistent and is often described in terms of traits", Also flexible, allowing us to learn and adapt to new environments

Personality traits may be defined as characteristics with which an individual is born or develops early in life. They influence the way he or she perceives and relates to the environment and remain stable over time.

Personality disorders occur when these traits deviate markedly from the expectations of the individual's culture, become rigid and inflexible, contribute to maladaptive patterns of behavior or impairment in functioning, and lead to distress.

The most common symptoms occurring in personality disorders are impairment in interpersonal relationship functions (41%), dysfunctions in cognition (30%), affect (18%), and impulse control (6%) .

In specific types of personality disorders, such as paranoid and schizotypal personality disorders, cognitive symptoms may appear more prominently. In other types, such as borderline personality and antisocial personality disorders, interpersonal dysfunctions may predominate .

Virtually all individuals exhibit some behaviors associated with the various personality disorders from time to time. As previously stated, it is only when significant functional impairment occurs in

response to these personality characteristics that the individual is thought to have a personality disorder. Personality development occurs

in response to a number of biological and psychological influences. These variables include (but are not limited to) heredity, temperament, experiential learning, and social interaction.

High comorbidity

Complicates a person's chances for a successful recovery from other psychological problems

Many sufferers are not even aware of their personality disorder.

Estimated that 9% to 13% of all adults may have a personality disorder

Classifying Personality Disorders:

The current diagnostic system classifies the personality disorders into three clusters according to description of personality traits. These include the following:

1. Cluster A: Behaviors described as odd or eccentric

a. Paranoid personality disorder

b. Schizoid personality disorder

c. Schizotypal personality disorder

2. Cluster B: Behaviors described as dramatic, emotional,or erratic

a. Antisocial personality disorder

b. Borderline personality disorder

c. Narcissistic personality disorder

d. Histrionic personality disorder

3. Cluster C: Behaviors described as anxious or fearful

a. Avoidant personality disorder

b. Dependent personality disorder

c. Obsessive-compulsive personality disorder

Cluster A : Behaviors described as odd or eccentric:

Extreme suspiciousness, social withdrawal, and peculiar ways of thinking and perceiving things.

1. **Paranoid Personality Disorder**

A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by
early adulthood and present in a variety of contexts, as indicated **by four (or more) of the following:**

1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4. Reads hidden demeaning or threatening meanings into benign remarks or events
5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights)
6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

Epidemiology

- Increased in families having one or more members diagnosed with paranoid personality disorder.
- Males more than females.
- Substance abuse is common.

Symptoms

- Distrust, suspicion
- Difficulty adjusting to change
- Sensitivity, argument
- Feeling of irreversible injury by others-often without evidence
- Anxiety, difficulty relaxing
- Short temper
- Lack of tender feelings toward others
- Unwillingness to forgive even minor events
- Jealousy of spouse or significant other-often without evidences

Prognosis

- Starts at adulthood and may continue for the end of his life.
- In some cases disorder severity decrease by age.
- Rarely that the patient is seeking for treatment and many problems appear in his relation with authority or people around him.

Treatment

- Psychotherapy is the treatment of choice and the therapist should recognize that areas of trust, love, tolerance are disturbed.
- Group psychotherapy is not appropriate.
- Drugs may be used especially in case of anxiety or agitation .

2. Schizoid Personality Disorder Include four or more of the following:

Schizoid personality disorder is characterized primarily by a profound defect in the ability to form personal relationships , an inability to form close, personal relationships. Symptoms include social isolation; absence of warm, tender feelings for others; indifference to praise, criticism, or the feelings of others; and flat, dull affect (appears cold and aloof).

Estimates within the general population vary between 3 and 5 percent.

Many people with the disorder are never observed in a clinical setting. although it is diagnosed more frequently in men.

Diagnostic Criteria for Schizoid Personality Disorder

pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Neither desires nor enjoys close relationships, including being part of a family
2. Almost always chooses solitary activities
3. Has little, if any, interest in having sexual experiences with another person
4. Takes pleasure in few, if any, activities
5. Lacks close friends or confidants other than first-degree relatives
6. Appears indifferent to the praise or criticism of others
7. Shows emotional coldness, detachment, or flattened affectivity

Epidemiology

- Males more than females.
- Increased prevalence in families with members who have schizophrenia or schizotypal personality disorder.

Symptoms

- Lack of desires to socialize; enjoys solitude
- Lacks strong emotions
- Detached, self-absorbed affect
- Lacks trust in others
- Brief psychotic episodes in response to stressful events
- Difficulty expressing anger
- Passive reactions to crisis

Prognosis

- Starts in childhood and stays long period; not necessarily for life.
- There is unknown percentage converted to schizophrenia.
- Limitation in social relationships and vocational performance.
- May be able to increase vocational performance in situations that need scientific achievement in socially separated conditions.

Treatment

- Similar to the treatment of paranoid personality disorder but the patient with paranoid personality disorder agrees with expectations of the therapist through seeing self from inside but exaggerates in fantasy.
- Group psychotherapy is useful which allows him to communicate others.

3. Schizotypal Personality Disorder

Individuals with schizotypal personality disorder were once described as "latent schizophrenics." Their behavior is odd and eccentric but does not decompensate to the level of schizophrenia. Schizotypal personality is marked by symptoms that are closer to those of schizophrenia than those in schizoid personality.

The former individuals show significant peculiarities in thinking, behavior, appearance and by deficits in interpersonal relatedness that are not severe enough to meet the criteria for schizophrenia . Studies indicate that schizotypal personality disorder has a prevalence of around 3 percent .

Diagnostic Criteria for Schizotypal Personality Disorder

A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by **five (or more)** of the following:

1. Ideas of reference (excluding delusions of reference) .
2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense;" in children and adolescents, bizarre fantasies or preoccupations) .
3. Unusual perceptual experiences, including bodily illusions .
4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped) .
5. Suspiciousness or paranoid ideation .
6. Inappropriate or constricted affect .
7. Behavior or appearance that is odd, eccentric, or peculiar .
8. Lack of close friends or confidants other than first-degree relatives .
9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self .

Epidemiology

- 30%-50% also have major depression.
- Individuals with schizotypal personality disorder seek treatment for anxiety and /or depression, not for personality disorder features.
- First-degree relatives of individuals with schizophrenia are at increased risk.
- Males more than females.
- The individual has deep and strange thinking style, appearance, behavior, limitation in relationships with others, but not enough to diagnose him as schizophrenia.

Symptoms

- Incorrect interpretation of external events/ belief that all events refer to self.
- Superstition, preoccupation with paranormal phenomena.
- Belief in possession of magical control over others.
- Constricted or inappropriate affect.
- Anxiety in social situation.

Prognosis

- 10% have suicide and some convert to schizophrenia.
- Many can marry and work despite of their strange nature.

Treatments for Schizotypal Personality Disorder

Therapy is as difficult in cases of schizotypal personality disorder, as in cases of paranoid and schizoid personality disorders.

Most therapists agree on the need to help clients ―reconnect‖ and recognize the limits of their thinking and powers

Cognitive-behavioral therapists further try to teach clients to objectively evaluate their thoughts and perceptions and provide speech lessons and social skills training

Antipsychotic drugs appear to be somewhat helpful in reducing certain thought problems .

Cluster B: Behaviors described as dramatic, emotional,or erratic

Almost impossible for them to have relationships that are truly giving and satisfying

- More commonly diagnosed than the others .
- Only antisocial and borderline personality disorders have received much study
- Causes of the disorders not well understood .
- Treatments range from ineffective to moderately effective

1. Antisocial Personality Disorder

Includes three or more of the following:

Antisocial personality disorder is a pattern of socially irresponsible, exploitative, and guiltless behavior that reflects a general disregard for the rights of others.

These individuals exploit and manipulate others for personal gain and are unconcerned with obeying the law. They have difficulty sustaining consistent employment and developing stable relationships. prevalence is estimated to be about 3 percent in the general population, but in prison populations, the prevalence is 50 percent or higher . It is more common in men than in women, among the lower socioeconomic classes, and especially among highly mobile inhabitants of impoverished urban areas.

Diagnostic Criteria(DSM5)

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Epidemiology

- Usually diagnosed by year 18.
- Have a history of conduct disorders before age 15.
- Males more than females.
- High percentage of diagnosed individuals are in substance abuse treatment settings, and prisons.
- More in lower socioeconomic classes.
- Substance abuse is common.
- Impulsive behavior is common.

Symptoms:

- Irresponsibility
- Failure to honor financial obligations, plan ahead, provide children with basic needs
- Involvement in illegal activities
- Lack of quilt
- Difficulty learning from mistakes
- Initial charm dissolves to coldness, manipulation, blaming others
- Lacks empathy
- Irritability
- Abuse of substances

Prognosis

- The beginning in childhood as a picture of disturbance in behavior; among boys in childhood, and among girls in adolescence.
- Bad behavior of patients may decrease after 30.
- Often failure in academic achievement, getting injury or die as a result of his/her disturbed behavior.
- If did not appear in childhood, he/she can succeed academically, politically or economically.
- Using work for his benefit and no consideration for values ethics and without blaming self or taking into consideration benefit of community.

Treatment

- Before starting treatment, the therapist should find method to stop self-destructive behavior of the patient and his fear of intimacy and friendship with others and convincing him to communicate with others without fear of pain result from this communication or reaction.

- The most useful method is group composed for their help and empathy with them and providing emotions they lost.
- Medications for anxiety or depression if found.

2. Borderline Personality Disorder:

A pervasive pattern of instability of interpersonal relationships, self- image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self- mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
6. Chronic feelings of emptiness.
7. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
8. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Epidemiology

- 75% are female.
- Have history of physical and sexual abuse, neglect, hostile, conflict and early parental losses or separation.

Symptoms

- Intense, stormy relationships
- Sees people as “all good” or “all bad”
- Impulsivity
- Self mutilation
- Difficulty identifying self
- Negative and angry affect
- Feelings of emptiness and boredom
- Difficulty being alone, feeling of abandonment
- Has impulsive acts (binging, spending money)
- Suicidal ideation

Prognosis

- The disorder starts early in adulthood and characterized by instability.
- Doesn't convert to schizophrenia but to major depression and sometimes to brief psychotic disorder.
- The most dangerous complication is suicide.

Treatment

- Psychotherapy is the treatment of choice in addition to drugs.
- Psychotherapy is considered difficult subject for therapist and patient since the patient tends to practice regression and fluctuating feelings toward the therapist.
- Drugs include anti-psychotic, anti-depression, anti-anxiety, and sometimes anti-convulsion.

3. Narcissistic personality disorder:

Diagnostic Criteria(DSM5)

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.

5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

Epidemiology

- Males more than females.

Symptoms

- Grandiose view of self.
- Lacks empathy toward others.
- Needs for admiration.
- Preoccupation with fantasies of success, brilliance, beauty, ideal love.

Prognosis

- Starts in early adulthood mainly chronic.
- Disturbance in their social relationships, difficulties with others, and unrealistic goals.

Treatment

- Difficult to be treated and need long-term psychoanalysis to establish change.

4. Histrionic Personality Disorder

Diagnostic Criteria(DSM5)

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood

and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.

Cluster C: Behaviors described as anxious or fearful

1. Avoidant Personality Disorder:

Diagnostic Criteria(DSM5)

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Epidemiology

-Males equals females.

Symptoms

- Fearful of criticism, disapproval, or rejection
- Avoid social interactions
- Withhold thoughts or feelings
- Negative sense of self, low self-esteem

Prognosis

- Starts in early adulthood and can work in socially comfortable situation.
- Some may have depression, anxiety, anger or social phobia.

Treatment

- Depends on acceptance of therapist to fears of the patient and stability of therapeutic relationships and encouraging him to communicate with outside world but carefully in order not to have any failure that may support original opinion of the patient.
- Group psychotherapy may help these patients.
- Training on self-confidence is behavioral method to teach the patient how to express feeling and needs and improve self-esteem.

2. Dependent Personality Disorder

Diagnostic Criteria(DSM5)

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.

7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Epidemiology

- Females more than males.
- Symptoms are demonstrated early in life.
- Children or adolescents with chronic physical illness or separation anxiety disorder may be predisposed.

Symptoms

- Submissive, clinging .
- Unable to make decisions by themselves .
- Can’t express negative feelings (emotions) .
- Difficulty following through on tasks .

Prognosis

- Appears in early adulthood and weakness in field of work achievement because of passivity.
- Some of the patients become addict or depressed or other psychiatric disorders.
- Little will live without psychiatric disorders.

Treatment

- Supportive psychotherapy is useful and taking into consideration internal passive aggression of the patient.
- Giving anti-depression if needed.

3. Obsessive-Compulsive Personality Disorder

Diagnostic Criteria(DSM5)

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met).
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
4. Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
8. Shows rigidity and stubbornness.

Epidemiology

- Males are twice more than females.

Symptoms

- Preoccupation with perfection, organization, structure, control
- Procrastination
- Abandonment of projects due to dissatisfaction

- Difficulty relaxing
- Rule-conscious behavior
- Self-criticism with inability to forgive own errors
- Reluctance to delegate
- Inability to discard anything
- Insistence on other's conforming to own methods
- Rejection to praise
- Reluctance to spend money
- Background of stiff and formal relationships
- Preoccupation with logic and intellect

Prognosis

- Starts in early adulthood.
- May have obsessive-compulsives disorder, schizophrenia or depression or hypochondriasis.
- May become adjusted with his condition.

Treatment

- Patient has insight and seeking for treatment to relief their suffering.
- Long-term psychoanalytic is useful.
- Behavior and group psychotherapy is less useful.
- Some drugs maybe added symptomatically.

Chapter Eleven

Somatic Symptom and Related Disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Describe various types of somatic symptom and dissociative disorders and identify symptomatology associated with each.

2) Identify Diagnostic Criteria for somatic symptom and dissociative disorders.

3) Comparison between organic and hysterical paralysis .

4) Identify Treatment to various types of somatic symptom .

Somatic symptom disorder and other disorders with prominent somatic symptoms constitute a new category in DSM-5 called somatic symptom and related disorders. This chapter includes the diagnoses of somatic symptom disorder, illness anxiety disorder, conversion disorder (functional neurological symptom disorder).

Somatic Symptom Disorder

Diagnostic Criteria(DSM5)

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
    1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
    2. Persistently high level of anxiety about health or symptoms.
    3. Excessive time and energy devoted to these symptoms or health concerns.
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Illness Anxiety Disorder

Diagnostic Criteria(DSM5)

A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.

F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive- compulsive disorder, or delusional disorder, somatic type.

Body Dysmorphic Disorder

- This disorder is characterized by a preoccupation with imagined defect in appearance.
- If the person has slight anomaly his or her concern is excessive.
- The preoccupation causes significant distress or impairment in social or occupational functioning.
- Finally, the preoccupation is not better accounted for by another mental disorder.

Course and prognosis:

- Starts in adolescence, 20's or 30's, stays constantly and may have result of social and vocational disability.
- One of the most important complication is having plastic surgeries without any need.

Treatment:

- Patients refuse psychotherapy despite their severe suffering and insist on having plastic surgeries so it is important for plastic surgeon to refer them to psychiatrist or psychologist.
- Medications may relief symptoms (anti-anxiety, anti-depression).
- Long-term psychotherapy is recommended.

Pain disorder

- The predominant focus of the clinical presentation of pain in 1 or more anatomical sites.
- The pain is severe to warrant clinical attention and causes major impairment in 1 or more areas of functioning.
- Psychological factorsplay important role in onset, severity exacerbation, or maintenance of pain.

- Acute: less than 6 months (duration).
- Chronic: more than 6 months (duration).

Course and prognosis:

- In female double than males.
- Increase at 4th and 5th decade and increase between poor persons.

Treatment:

Drugs: Giving analgesics or narcotics is not useful (addiction).

- Anti-depressant can be given: (Elatrol) or (Prozac).
- Anxiolotics or analgesics usually not effective.

Psychotherapy:

Important that the therapist helps the patient recognize psychogenic origin of pain.

- Explain to the patient how the person state of mind affects how much pain he can feel.
- Relaxation technique, sports exercice.
- Biofeedback.
- Sometimes, admission to hospital is needed to control feeling of pain (behavioral, cognitive and group psychotherapy may be used).

Somatization Disorder

- Frequently seeking and obtaining medical treatment for multiple clinically significant somatic complaints.
- Complaints must begin before 30 and cannot be explained by any medical disorder or direct effects of substance.
- Clients with multiple sclerosis patient would not be diagnosed by

somatization, because a general medical condition better explains their symptoms complex.

- Somatization could be differentiated from medical conditions if:
- There is an involvement of multiple organ systems (GI, neurological..).
- Symptoms exhibit early onset and chronic course, without development of physical signs or structural abnormalities.
- Absence of clinical (laboratory) abnormalities.

Course and prognosis:

- Females more than males.
- Less occurrence if high social class, more among poor and illiterate persons.
- Starts before 30.
- Increase among first-degree relatives.
- The disorder is chronic and the patient is rarely free of symptoms or for medical seeking.

Treatment:

- Long and empathic relationship with one therapist.
- Using medications is not recommended but anti-depressant or anxiolytics can be used symptomatically if anxiety or depression is present (addiction).

Conversion Disorder(Functional Neurological Symptom Disorder)

Diagnostic Criteria(DSM5)

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Conversion Disorder (Hysterical neurosis, Conversion Type):

- Loss or change in beady functioning that can't be explained by any medical disorder, and occurs in response to psychological stress.
- In females more than males.
- Usually starts in adolescence or young adulthood.
- Medical examinations do not reveal physical abnormality.
- The person is not conscious of producing symptoms.
- Histrionic personality patients are more exposed than others.
- Could happen if exposed to great stress.
- Loss or change can give sensory or motor symptoms or both.

Motor symptoms: Abnormal tremors, jerky movements or gait disturbance.

> **** Note***: In case of hysterical conversion tremors: it is irregular and disappears if attention moved to another subject, etc…
>
> -It differs from tremor in anxiety.
>
> -Hysterical aphonia: the patient can't speak, but can understand what is said.

*** *Note***: to differentiate, ask the patient to cough, if he does so, means vocal cords ok and is hysterical.

Paralysis: of a limb or hemiparesis, or weakness of a group of muscles.

Comparison between organic and hysterical paralysis

Organic	Hysterical
Change in deep reflexes	No change in deep reflexes
Weakness in extremities (difficulty to move fingers)	No weakness in extremities
Atrophy in muscles	Less atrophy in muscles
Can elevate his shoulder	Very difficult to elevate shoulder
Urine incontinence	Mainly no urine incontinence
Bed sores	Usually no bed sores

Tics: involuntary movement increases in embarrassing situations.
Hysterical comas: like normal sleep, doesn't respond to stimuli, needs care for urination and defecation, usually needs hospitalization, used to escape from reality.

Hysterical fits: differ from organic epilepsy as following:

Epilepsy	Hysterical fit
Doesn't hear around him	Hear around him
White foam will result in mouth	No white foam (secretion)
Voids on himself	Doesn't voids on himself
Bites his tongue	Doesn't bite his tongue
Sudden falling down	Doesn't have sudden falling down

Sensory symptoms:

- Anesthesia or loss of sensation in a part of body or one half of body.
- Hysterical deafness.
- Loss of olfactory or taste senses.
- Hysterical blindness.

Prognosis:

- Duration is brief.
- Starts and stops abruptly.
- Tends to recur.
- Prognosis is poor if secondary gain is high.

*Primary gain: Gain achieved by converting anxiety to somatic symptoms (symbolic of unconscious conflict).

*Secondary gain: Gain achieved by the symptoms, the patient's pain relieved from work or gets attention and sympathy from family by taking sick role.

Treatment:

- The first step is to exclude organic disease by physical examination
- Psychotherapy:
- Telling the patient that he has no physical problems and symptoms are psychological stress and will disappear if the patient expresses his feelings.
- Amytal: may be used to produce a state of relaxation and re- experience trauma which enable the patient to talk freely about her troubles.

Hypochondriasis

There are six major criteria associated with disorder:

1- The patient is preoccupied with fears of having, or the idea of having serious medical disorder based on his/her interpretation.

2- The misinterpretation of bodily symptoms persists despite appropriate medical evaluation and reassurance.

3- The patient's preoccupation with symptoms is not as intense or distorted as in body dysmorphic disorder.

4- The preoccupation causes clinically significant distress or impairment in social, occupational, or major areas of functioning.

5- The duration of disturbance at least 6 months.

6- The condition is not better accounted for by another anxiety disorder, somatization disorder, or major depressive episode (patient may show symptoms of anxiety or depression).

Course and prognosis:

- Mostly starts in 20's.
- 1/3 of patient don't improve, and social relations and vocation disturbed.
- Males and female are equal.

Treatment:

- Exclude any organic factor.
- Invasive procedure should be avoided.
- Psychotherapy is the preferred treatment even the patient resists this therapy (may accept it by a physician).
- Group psychotherapy: is the treatment of choice in patient's social support and interaction can improve their condition.
- Drugs not used unless depression/anxiety present.

Comparison between Somatization and Hypochondriasis

Somatization	Hypochondriasis
7 years duration needed for diagnoses	6 months duration needed for diagnoses
Look about symptoms and treatment	Look about the disorder behind symptoms
Complain of 13 or more symptoms	Complain of one or two symptoms
Doesn't like Dr. visit	Many Dr. visit

Chapter Twelve

Eating Disorders

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Discuss epidemiological statistics related to eating disorders.

2) Identify and differentiate among several eating disorders.

3) Identify Diagnostic Criteria associated with anorexia nervosa, bulimia nervosa and others eating disorders .

Etiology

1. **Biologic factors**
   - There is a connection between eating disorders and depression.
   - A biological tendency to be overweight may increase the likelihood of body dissatisfaction and dieting behavior, which along with other factors may trigger eating disorder to develop
2. **Socio-cultural factors:**
   - Diet and fitness industry
   - Fashion industry
   - Women's movement
   - Developmental peer pressure
3. **Psychological factors:**

Personality traits common among those with eating disorders include the following:

- Perfectionism
- Social insecurity
- Affective instability rapidly fluctuating moods
- Interceptive deficits inability to correctly identify a respond to bodily sensations
- Immaturity
- Compliance
- A sense of ineffectiveness in dealing with the world
- Low self-esteem .

4. **Familial factors**
   - Enmeshment
   - Poor conflict resolution
   - Separation / individuation issues
   - Some incidence of alcoholism or physical or sexual abuse

Epidemiology for Eating Disorder

- Average age(s) of onset is 14-18 years for anorexia nervosa, 18 years for bulimia nervosa.

- 95%-99% of clients are female
- Mortality rates for bulimia nervosa are from 0%-19%, for anorexia nervosa, from 6%-20 %
- Eating disorders are very rare in undeveloped countries .

Eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Pica

Diagnostic Criteria(DSM5)

A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
C. The eating behavior is not part of a culturally supported or socially normative practice.
D. If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Rumination Disorder Diagnostic Criteria(DSM5)

A. Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
B. The repeated regurgitation is not attributable to an associated gastrointestinal

or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.

D. If the symptoms occur in the context of another mental disorder (e.g., intellectual dis- ability [Intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify if: In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Anorexia Nervosa

Diagnostic Criteria(DSM5)

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self- evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Clinical symptoms

1. Behavioral Symptoms

- Self-starvation (reported intake restriction and refusal to eat).
- Ritual or compulsive behaviors regarding food, eating, and / or wt. loss.
- May engage in self-induced vomiting, laxatives, diuretics, or excessive exercise to lose weight.

2. Physical symptoms

- Weight loss 15 % below ideal weight.
- Amenorrhea–Absence of 3 or more menstrual cycles when expected to occur
- Slow pulse, decreased body temp
- cachexia, sunken eyes, protruding bones, dry skin
- Growth of lanugo hair on face
- Constipation

3. Psychological symptoms

- Denial of seriousness of current low weight.
- Body image disturbance, claiming to see self as fat when emaciated or to experience parts of body such as stomach, buttocks, hips and thighs as unrealistically large.
- Intense and irrational fear of weight. gain that does not diminish as weight is lost.
- Constant striving for "perfect" body.
- Self-concept unduly influenced by shape and weight.
- Preoccupation with food, cooking, nutritional in formation, feeding others.
- May exhibit delayed psychosexual development or lack age- appropriate interest in sex relations.

Treatment

- Complete physical examination especially in critical conditions.
- Treatment aims to correct nutritional condition as normal as possible because of danger of death.
- Admission in moderate-severe conditions which gives appropriate environment to gain weight.

1- Drugs:

- No drugs given unless there is a need to as the patient is depressed will be given anti-depression and if psychotic symptoms appear anti- psychotic will be given.

2- Psychotherapy:

- The patient is encouraged to express his anger and fear (It is noticed that the patient is using defense mechanism: denial so the therapist should move him to condition of insight to continue treatment).

3- Family psychotherapy:

- Patient's family should recognize that this disorder includes all family members and everyone should be aware of nature of communication among family members and their participation in helping other members.

4- ECT:

- Especially when there is depression ECT has quick effect to decrease it and to improve condition of the patient's condition.

* When performing treatment the following should be noticed:

- Usually the patient vomits after eating so it is important to make him away from bathroom for 2 hour after eating.
- Weigh the patient daily–weekly according to his condition and some measures should be taken into consideration when weighing the patient:
- Empty bladder.
- Do not give him food or drink much water.
- Be sure he has no heavy thing in his pockets or wearing heavy clothes.
- If the patient continues losing weight the therapist should discuss that clearly with him and tells him that if he doesn't gain weight about 1½Kg weekly therapist will feed him by nasogastric tube.
- About 75% of patients improve by treatment but the rest either having another episodes or die or suicide.

Bulimia Nervosa

Diagnostic Criteria(DSM5)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.

2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Clinical symptoms

1. Behavioral symptoms

- Recurrent episodes of binge eating rapid consumption of a large amount of food in a discrete period of time.
- Engages in purging behavior such as self-induced vomiting, use of laxatives, diuretics, diet pills, enemas, excessive exercise or periods of fasting to compensate for the binge.

2. Physical symptoms

- May experience fluid electrolyte imbalance as from purging.
- **Hypokalemia**, alkalosis, dehydration.
- **Cardiovascular**: Hypotension, dysrhythmia, cardiomyopathy.
- **Endocrine**: May experience menstrual dysfunction.
- **Gastrointestinal**: Constipation, diarrhea, gastroparesis (delayed gastric emptying), esophageal reflux, esophagitis.
- **Dental**: Enamel erosion.

3. Psychological symptoms

- Body image disturbance, seeing self as unrealistically fat when at or near ideal weight or experiencing parts of body as unrealistically fat or out of proportion.
- Persistent over concern with weight, shape, proportions.
- Constant striving “perfect” body.
- Self-concept unduly influenced by body weight shape.

Treatment:

- Long-term psychotherapy is used to get good results with modifying behavior by positive support for eating and extinction binge behavior.

Chapter Thirteen

Special Treatment Modalities

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

1) Describe indications, actions, contraindications, precautions, side effects, and nursing implications for the following classifications of drugs:

- Antianxiety agents .
- Antidepressants .
- Mood-stabilizing agents .
- Antipsychotics .
- Narcotic analgesics and antagonists .
- Antiparkinsonian agents .

Promethazine Hydrochloride

Trade name: Prothiazine.

Classification: is a prothiazine derivative processing several different types of pharmacological actions "antihistamine, antiemetic and sedative actions".

Uses:

-Symptomatic treatment of allergic conditions.

-Sedation, hypnosis and insomnia.

-Preoperatively and postoperatively.

-Antiemetic in postoperatively patients.

Contraindications: intra-arterial injection

Side effects:

Dry mouth "anticholinergic", dizziness, hypotension, skin rashes, tachycardia, irritation and thrombophlebitis.

Dose:

ampules 50mg/2ml

IM or IV: 20-40mg.

Nursing considerations:

1. Inject into large, undamaged vein "never S.C. or intra-arterial".
2. Avoid extravasation.
3. Monitor blood pressure frequently.
4. Provide safe environment.
5. Provide mouth care for postoperatively patients.

Antianxiety agents

Diazepam

Trade name: Valium or Assival

Classification: Antianxiety agent, benzodiazepine

Action:

The anxiolytic effect is believed to be mediated through the action of benzodiazepine to increase the inhibitory action of GABA "Gamma Aminobutyric Acid" so it inhibits CNS neurotransmitter.

Metabolized in the liver and excreted through the urine.

Indications:

Symptomatic relief of anxiety and tension.

Alcohol withdrawal

Muscle relaxant

Anticonvulsive agent

Preoperatively

Before gastroscopy or esophagoscopy

Treatment of status epilepticus

Relief of facial muscle spasm

Contraindications:

- Hypersensitivity
- Acute narrow angel glaucoma
- Pregnancy
- Shocks and coma
- Alcoholic intoxication and in depressed patients

Side effects:

Headache, fatigue, hypotension, visual disturbances, ataxia, drowsiness, and phlebitis at injection site.

Dose:

(ampules 10mg/2ml), (tab 2mg, 5mg, or 10mg)

IV or IM 2-20mg depending on the indication

Tablets 2-10mg, 2-4 times daily.

Nursing considerations:

1. Stress that drug may reduce patients' ability to handle dangerous equipment.
2. Avoid alcohol ingestion.
3. Don't stop taking medication suddenly, withdraw drug gradually.
4. Monitor blood pressure before and after administration.

Antipsychotic drugs

Chlorpromazine

Trade name: largactil

Action: act by blocking dopamine receptors, it has significant antiemetic effect, hypotensive, sedative and anticholinergic effect.

Uses:

- Acute and chronic psychosis (schizophrenia, mania and manic depression).
- Preanesthetic.
- Intractable hiccoughs
- Nausea and vomiting

Contraindications:

Severe depression, coma, and bone marrow depression.

Patient with history of seizures and on anticonvulsant therapy.

Hepatic and renal diseases, prostatic hypertrophy.

Dehydration, glaucoma or measles.

Side effects:

Depression, dizziness, seizures, gynecomastia, orthostatic hypotension, bronchospasm, laryngospasm, photosensitivity, leukocytopenea, aplastic anemia, dry mouth and tardive dyskinesia (tongue and face involuntary movements).

Dose:

(tablets: 10-25mg, 2-4 times daily)

IM: 25-50mg repeated 1 hour if needed.

Nursing considerations:

1. Should not be used to treat nausea and vomiting in children less than 6 months of age.
2. Avoid getting solution on hands or clothing (dermatitis).
3. Solutions with marked discoloration should be discarded.
4. Note any history of seizures.
5. Take kidney and liver function tests periodically.
6. Document and rotate injection sites.
7. Report side effects immediately.
8. Determine age of male patients and assess for prostatic hypertrophy.

Fluphenazine Deconate

Trade name: Modecate

Classification: antipsychotic phenothiazine.

Action: Is accompanied by a high incidence of extrapyramidal symptoms (tremors, dystonia, tardive dyskinesia and eye fixation) and a low incidence of sedation, anticholinergic, antiemetic and orthostatic hypotension.

Uses:

- Psychotic disorders.
- Chronic pain states as diabetic neuropath and patient trying to withdraw from narcotics.

Doses:

Tablets: 2.5-10mg/day in divided doses

IM 12.5-25mg can be repeated /1-3weeks

Thioridazine

Trade name: Mellaril

Classification: antipsychotic phenothiazine.

Action: probably related to drug's antidopaminergic effect.

Uses:

Schizophrenia
Depression
Anxiety
Alcohol withdrawal
Intractable pain and sleep disturbances

Dose:

P.O. 25mg (t.i.d.).

Side effects:

Headache, tardive dyskinesia, blurring of vision, orthostatic hypotension, nausea and vomiting, skin rashes and photosensitivity.

Contraindications:

Comatose patient
Parkinson's disease
Severe hypertension or hypotension

Nursing considerations:

1. Monitor vital signs before beginning therapy and at regular intervals.
2. Administer medication with meals to minimize GI upsets.

Haloperidol

Trade name: Haldol

Classification: antipsychotic

Action:

Block dopamine receptors: sedation.

Alpha adrenergic blockage: decrease the release of growth hormone and increase the release of prolactin.

Anticholinergic effect: sedation and orthostatic hypotension.

Uses:

Psychotic disorders (mania, drug induced psychosis or schizophrenia)

Aggressive and agitated patients (mental retardation)

Treating symptoms of dementia in elderly people.

Dose:

P.O. 3-5mg every (bid-tid).

IM 2-5mg every 4-8 hours.

IV 2-2.5mg every 30 minutes (in severe situations).

Side effects:

Headache, tardive dyskinesia, hypotension, dry mouth, photosensitivity, skin rashes, constipation, nausea and vomiting.

Contraindications:

Pregnancy or lactation.

Shock.

Bone marrow depression.

Hepatic or renal insufficiency.

Nursing considerations:

1. Monitor vital signs before and during therapy.
2. Administer oral medication with food.
3. Administer deep into large muscles.
4. Don't mix it with any drug.
5. If concentrate is spilled on skin, wash it immediately to prevent dermatitis.

Lithium carbonate

Trade name: Lithium

Classification: antipsychotic, antimanic

Action: unknown theories include: effectiveness to an alteration in Na metabolism within nerve and muscle cells "K and ATPase": decrease in catecholamines.

Uses:

Control of manic and hypomanic episodes.

Prophylaxis of Bipolar depression.

Dose:

P.O. 600mg (tid or qid)

Side effects:

Drowsiness, dizziness, hand tremors, hypothyroidism, ECG changes, lethargy, anorexia, dry mouth, polyuria, leukocytosis, slurred speech, nausea and vomiting.

Contraindications:

Cardiovascular, renal disease.

Brain damage.

Pregnancy and lactation.

Dehydration and patients receiving diuretics.

Sodium depletion.

Nursing considerations:

1. Monitor serum level of lithium every 1-2 weeks to prevent toxicity.
2. Monitor for pulse irregularity and changes in blood pressure.
3. Provide diet adequate in sodium.
4. Monitor for signs and symptoms of toxicity.

Antidepressants

Monoamine Oxidase (MAO) inhibitors

Note: they are highly toxic, prescribed only if tricyclic compounds are ineffective, and may also interfere with detoxification mechanisms, which occur in the liver.

Action: MAO is one of the enzymes that breaks down biogenic amines (Norepinephrine, Epinephrine and steroids), these drugs prevent this process: amines therefore accumulation in the presynaptic granules: increase the contraction of neurotransmitters, nerve stimulation, antidepressant effect.

Uses: individualized.

Contraindications:

Hypersensitivity, history of liver disease, pheochromocytoma, impaired renal function, hypertension, epilepsy, hyperthyroidism, glaucoma.

Side effects:

Headache, euphoria, agitation, urinary retention, jaundice, dizziness, ataxia, skin rashes and glaucoma.

Phenelazine sulfate

Trade name: Nardil

Classification: Monoamine Oxidase (MAO) inhibitors.

Uses:

Major depression with or without Melancholia.

Dose: P.O. 15mg tid

Tricyclic antidepressants

Clomipramine hydrochloride
Trade name: Anafranil
Classification: tricyclic antidepressant
Action: prevent the negative uptake of norepinephrine, serotonin or both into the storage granules of the presynaptic: increase concentration of these neurotransmitters in the synapses then alleviate depression.

Uses:
Treatment of obsessive compulsive neurosis.
Panic disorders.
Phobic disorders.

Dose:
P.O. 75-150mg /day in 1-3 divided doses.

Side effects:
Hyperthermia, orthostatic hypotension, seizures, muscle weakness, anemia, drowsiness, ataxia, blurring of vision, dry mouth and constipation.

Contraindications:
Pregnancy or lactation, shock or coma, bone marrow depression.

Nursing considerations:
Monitor vital signs before and during therapy.
Take with food to avoid GI upsets.

Imipramine hydrochloride

Trade name: Tofranil

Classification: tricyclic antidepressant.

Action: as Anafranil.

Uses:
Symptoms of depression.
Enuresis in children.
Bulimia nervosa.

Dose:

Depression: P.O. 50mg bid, tid

Child enuresis: more than 6 years of age 25mg /day, 1 hour before bedtime.

Antiparkinson agents

Parkinson's disease

Is a progressive neurological disorder affecting the brain centers that are responsible for control and regulation of movement affecting mostly people over the age of 50. Its characterized by bradykinesia (slowness of movement), tremors and muscle stiffness and rigidity.

Pathophysiology:

Dopamine, one of the major neurotransmitters located in the brain stem in substania nigra and found in high concentration in the basal ganglia, the function of dopamine are regulation of movements, involved in emotions. Depletion of dopamine levels in the basal ganglia is associated with bradycardia, rigidity and tremors.

Clinical manifestations:

Tremors, an early sign commonly affecting the hand, arm then the other and later in the head.

Bradykinesia (slowness of movement) and difficulty initiating movement.

Rigidity (decreased muscle tone and stiffness) with jerky movement.

Fatigue and muscle weakness.

Shuffling gait.

Impaired ability to turn in bed and rise from chair.

Masklike facial expression.

Dysphagia and sialorrhea (drooling).

Depression and withdrawal.

So administration of levodopa (precursor of dopamine) will relief symptoms.

Levodopa

Trade name: L-dopa

Classification: Antiparkinson agents.

Action:

It is a dopamine precursor, able to cross bllod brain barrier to enter the CNS. It is decarboxylated to dopamine in the basal ganglia, replenishing depleted dopamine stores and relief signs and symptoms of parkinsonism.

Uses:

Idiopathic, arteriosclerotic and postencephalitic parkinsonism.
Parkinsonism due to CO poisoning.

Side effects:

Choriform and dystonic movements, depression, paranoid ideation, hallucinations, insomnia, dementia, agitation, dizziness and nightmares.

Dose:

250mg bid, qid with food.

Contraindications:

Lactation, history of melanoma or undiagnosed skin lesion, hypersensitivity, hypertension, glaucoma, use of (MAO) inhibitors.

Nursing considerations:

1. Monitor vital signs before and during therapy.
2. Take with food to avoid GI upsets
3. Crushing tablets for patients with difficulty in swallowing.
4. Review medical history for drug contraindications.
5. Observe for signs of depression.
6. Offer emotional support during therapy.
7. Not to take vitamin B6 because it reverses the antiparkinson action of the drug.

Trihexyphenidyl hydrochloride

Trade name: Artane

Classification: antiparkinson, anticholinergic

Action:

Anticholinergic, relives rigidity, has little effect on tremors, antispasmodic on smooth muscles.

Uses:

For all types of parkinsonism.

Dose:

5-10mg daily bid.

Side effects:

CNS stimulation (insomnia, agitation, and restlessness), dry mouth, constipation, dizziness and urinary retention.

Anticonvulsant

Ethosuximide

Trade name: Zarontin

Classification: anticovulsant, succinimide type.

Action:

The succinimide derivatives suppress the abnormal brain wave pattern associated with lapses of consciousness in absence seizures.

Depress motor cortex and raise the threshold of the CNS to convulsive stimuli.

Uses:

Absence seizures (Petit mal)

Side effects:

Drowsiness, ataxia, dizziness, nausea, vomiting, anorexia and fatigue.

Contraindications:

Hypersensitivity.

Dose:

P.O. 500mg/day on divided doses.

Nursing considerations:

1. Report any increase in frequency of tonic-clonic (grand mal) seizures.
2. Monitor vital signs frequently.
3. Take drug with food to minimize GI upsets.
4. Frequent assessment of drug level.
5. Monitor presence of skin rashes, fever, joint pain, unusual bleeding and dark urine.

Acetazolamide

Trade name: Diamox

Classification: anticonvulsant, diuretic

Action:

It's a sulfonamide derivative, act as an anticonvulsant by inhibition of carbonic anhydrase in the CNS increasing the CO2 tension which will decrease the neuronal conduction.

As a diuretic it inhibits carbonic anhydrase in the kidneys that will decrease the formation of bicarbonate and H ion from CO2 that will decrease the availability of active transport.

Uses:

Absence of seizures.

Grand mal (tonic-clonic) seizures.

Glaucoma.

Side effects:

Drowsiness, polyuria, drowsiness, confusion and acidosis.

Contraindications:

Hypersensitivity to thiazide diuretics, low serum level of sodium and potassium, renal or hepatic dysfunction, adrenal insufficiency.

Dose:

Tablets 4-30mg /kg/day in divided doses.

Phenytoin

Trade name: Dilantin

Classification: anticonvulsant, antiarrhythmic.

Action:

Acts in the motor cortex of the brain to reduce the spread of electrical discharges from the rapidly firing epileptic foci in this area. Also it decreases the activity of centers in the brain stem responsible for the tonic phase of grand mal seizures.

Uses:

Chronic epilepsy

Premature ventricular contractions.

Tachycardia.

Side effects:

Drowsiness, ataxia, dizziness, measles like rash (common), gingival hyperplasia, hirsutism hypotension and hypoglycemia.

Contraindications:

Hypersensitivity.

Nursing considerations:

1. IV phenytoin may form a precipitate so flush tubing by saline (not dextrose) before and after administration.
2. Assess for hypersensitivity.
3. If a pregnant takes this drug, note her not to breastfed her baby.
4. Obtain liver and kidney functions tests.
5. Monitor serum drug levels on a routine basis.
6. Monitor B.P. during IV administration for signs of hypotension.
7. Take with food to minimize GI upsets.
8. If diabetic, monitor for hypoglycemia.
9. Oral hygiene to minimize bleeding from the gum.
10. Report any excessive growth of hair.

Carbamazepine

Trade name: Tegretol

Classification: anticonvulsant.

Action:

As anticonvulsant the action is unknown, it acts as cyclic antidepressant. It has also, antiemetic, antidiuretic, anticholinergic and antipsychotic effects.

Uses:

Epilepsy
Tonic-clonic seizures
Resistant schizophrenia
Trigeminal neuralgia
Alcohol withdrawal

Side effects:

Photosensitivity, drowsiness, ataxia, dizziness, unsteadiness, aplastic anemia, blurring of vision, nausea and vomiting.

Contraindications:

Hypersensitivity, lactation, bone marrow depression, patients taking MAO inhibitors.

Nursing considerations:

1. Assess for hypersensitivity.
2. Obtain liver and kidney functions tests.
3. Take with food to minimize GI upsets.
4. Protect tablets from moisture.
5. Obtain baseline eye examination.
6. Blood cells evaluation every week.
7. Monitor intake and output.
8. Advise client to avoid sunlight (photosensitivity).

Valporic acid

Trade name: Depakin

Classification: anticonvulsant.

Action: unknown

Uses:

Epilepsy

Dose:

Initial: 5-10mg /kg/day, increase at one week
Interval: 5-10mg /kg/day-60mg/kg/day

Side effects:

Nausea, vomiting, sedation, depression, bone marrow depression, skin rashes, transient alopecia and hepatotoxicity.

Narcotic analgesics and antagonists

Narcotic analgesics

- It includes opium, morphine, codeine and opium derivatives.
- These substances have similar pharmacological properties.
- Meperidine (Demerol) is the best known.
- The relative activity of all narcotic analgesics in measured against morphine.

Dependence and Tolerance:

- Remember that all drugs of this group are addictive.
- Psychological and physical dependence and tolerance develop even when using clinical doses.
- Tolerance usually develops because the patient requires shorter periods of time between doses or larger doses for relief of pain.

Effects of narcotic analgesics:

1. On CNS:
   Alteration of pain perception (analgesia).
   Euphoria, drowsiness, changes in mood, mental clouding and deep sleep.
2. Overdose will cause respiratory arrest and death.
3. Depress cough reflex: Codeine in small doses (antitussive).
4. Nauseate and emetic effect: stimulate the chemoreceptor trigger zone.
5. Morphine: vasodilation, hypotension.
6. Pupillary constriction (the most obvious sign of dependence).
7. Decrease the peristaltic motility: constipation.

Acute toxicity:

Characterized by respiratory depression, deep sleep, stupor, coma, pinpoint pupil, respiratory rate 2-4 breath/ minute, cyanosis, hypotension, decrease urinary output, hypothermia, clammy skin and then death because of respiratory failure.

Treatment of acute overdose:

1. Induce vomiting or gastric lavage.
2. Artificial respiration.
3. Give narcotic antagonist (Narcan 0.4mg IV)

Note: respiratory stimulants (caffeine) should not be used to treat depression from overdose of narcotics.

Chronic toxicity:

The problem of chronic dependence on narcotics is well known and is not only the problem of the street but it is also found often among those who have easy access to narcotics "physicians, nurses or pharmacists". Narcotic analgesics sometimes used for nontherapeutic purposes.

Signs and symptoms:

- Constricted pupils constipation, skin infections, needle scar abscesses, and itching on the anterior surface of the body.
- Withdrawal signs appear when drug is withheld for 4-12 hours and characterized by (intense craving for the drug, insomnia, yawning, sneezing, vomiting, diarrhea, tremors, sweating, mental depression, muscular aches, pain, chills, and anxiety).

Action of narcotic analgesics:

Narcotic analgesics attach to specific receptors in the CNS resulting in analgesic action that is unknown but may be by decrease cell membrane permeability to sodium that decreases transmission of pain impulses.

Uses of narcotic analgesics:

- Severe pain.
- Hepatic and renal colic.
- Preanasthetic medication.
- Postsurgical pain.
- Diarrhea and dysentery.
- Pain from MI, carcinoma or burns.
- Postpartum pain.
- Antitussive.

Contraindications:

Asthmatic conditions or emphysema, sever obesity, convulsions, diabetic ketoacidosis, myxedema, Addison's disease, hepatic cirrhosis, children less than 6 months.

Side effects:

Respiratory depression, apnea, dizziness, euphoria, headache, mental clouding, insomnia, nausea, vomiting, constipation, dry mouth, skin rashes, laryngospasm, urinary spasm and decrease libido.

Nursing considerations:

1. Use supportive nursing measures as relaxation techniques.
2. Explore the source of pain, use nonnarcotic analgesics if possible.
3. Administer the medication when needed, prolonging the medication administration.
4. Monitor vital signs:

- Respiratory rate to assess respiratory depression.
- Blood pressure to assess hypotension.
- If the pulse was less than 60 beats/min., withhold the drug.

5. Monitor mental status
6. Monitor bowel function to assess constipation.
7. Encourage client to empty bladder every 3-4 hours to avoid urinary retention.
8. If the client is bed ridden, use side rails.
9. Inform the client/family that the drug may become habit forming.
10. Document any history of asthma or other contraindications.
11. Have emergency equipment and narcotic antagonist available.

Codeine sulfate

Classification: narcotic analgesic, morphine type.

Action:

Resembles morphine pharmacologically but produce less respiratory depression, nausea and vomiting.

High doses more than 60mg will irritate the cough center but in lower doses it is a potent antitussive, it is ingredient in many cough syrup.

Uses:

Relief mild to moderate pain.

Antitussive.

Dose:

Analgesic: 15-60mg every 4-6 hours.

Antitussive: 10-20mg 4-6 hours.

Meperidine hydrochloride "Pethedine hydrochloride"

Trade name: Demerol

Classification: narcotic analgesics, synthetic.

Action:

Similar to opiates.

Has no antitussive effect.

The duration of action is less than opiates.

Uses:

- Severe pain.
- Renal and hepatic colic.
- Obstetric preanasthetic medication.
- In minor surgeries.
- Spasm of GI tract or uterus.
- Prior some diagnostic procedures e.g. Cystoscopy.

Contraindications: hypersensitivity, diabetic ketoacidosis, convulsive states, head injury, children less than 6 months.

Another side effects: transient hallucinations, hypotension.

Dose: tab., syrup, IM or S.C (50-100mg every 3-4 hours).

Methadone hydrochloride

Classification: narcotic analgesic, morphine type.

Action:

- Produce only mild euphoria, which is the reason it is used as a heroin withdrawal substitute and for maintenance programs.
- It produces physical dependence but the abstinence syndrome develops more slowly upon termination of the therapy.
- Withdrawal symptoms are less intense but more prolonged than those associated with morphine.
- It is not effective for preoperative or obstetric anesthesia.
- It doesn't produce sedation or narcosis.

Uses:

Severe pain.

Drug withdrawal and maintenance of narcotic dependence.

Contraindications:

Pregnancy, IV use, liver disease.

Another side effects:

Constipation and pulmonary edema.

Dose:

Oral, IM or S.C (2.5-10mg every 3-4 hours).

Morphine sulfate

Classification: narcotic analgesics, morphine type.

Action: see narcotic analgesics

Uses:

- Intrathecally, epidurally, orally or IV infusion for acute or chronic pain.
- Preoperative medication.
- To facilitate induction of anesthesia or to decrease the dose of anesthesia.
- It is given in lower doses for continuous pain and in higher doses in sharp intermittent and all kinds of pain.

Another considerations:

Epidural or intrathecal, if infection is present at injection site.
for patients on anticoagulant therapy. Bleeding diathesis.
If the patient has received parenteral corticosteroids within the past 2 weeks.

Dose:

Oral: 10-30mg every 4 hours.
IM: 5-20mg/70kg every 4 hours as needed.
IV:2.5-15mg/70kg in 4-5ml of water for injection over 4-5 minutes (slowly).
Continuous infusion: 0.1-1mg/ml in 5%dextrose in water by a controlled infusion pump.

Percodan

Classification and content: narcotic analgesics (aspirin 325mg, oxycodone HCL 4.5mg and oxycodone terephthalate 0.38mg).

Uses:

Treatment of moderate to severe pain
Dose: 1tab every 6 hours.

Narcotic antagonists

Narcotic antagonists are able to prevent or reverse many of the pharmacological actions of morphine-type analgesics and meperidine as respiratory depression induced by these drugs within minutes.

Naloxone hydrochloride

Trade name: narcan

Classification: narcotic antagonist
Action:

- Block the action of narcotics by displacing previously given narcotics from their receptor sites or preventing them from attaching to opiates receptors.
- The duration of action of naloxone is shorter than that of the narcotics so the respiratory depression may return when the naloxone worn off.

Uses:

- Respiratory depression induced by narcotics but it is not effective when respiratory depression is induced by hypnotic, sedative or nonnarcotic drugs.
- Drug of choice when the depressant drug is unknown.
- Diagnosis of acute opiate overdose.

Contraindications:

Hypersensitivity, narcotic addicts: severe withdrawal symptoms, neonates.

Side effects:

Nausea, vomiting, sweating, tremors and hypertension, but if it used postoperatively it causes pulmonary edema, hyper or hypotension.

Dose: IV, IM or S.C (0.4-2mg).

Nursing considerations:

1. Determine the etiology of respiratory depression.
2. Assess and obtain baseline vital signs.
3. Monitor respiration closely after the duration of action.
4. Have emergency drugs and equipment available.
5. If the patient is comatose, turn him to his side to avoid aspiration.
6. Maintain safe environment (side rails and soft support).

Special Treatment Modalities

Electroconvulsive therapy

- ECT is the induction of a grand mal (generalized) seizure through the application of electrical current to the brain.
- Stimulus is applied through electrodes placed bilaterally in the fronto-temporal region or unilaterally on the same side as the dominant hand.
- Dose of stimulation is based on the client's seizure threshold, which is highly variable among individuals.
- The duration of the seizure should be at least 25 seconds.

➢ **Indications**

ECT has been shown to be effective in the treatment of severe depression. It is usually not considered the treatment of choice for depression but may be administered after a trial of therapy with antidepressant medication.
ECT is also indicated in the treatment of acute manic

episodes of bipolar affective disorder. It has been shown to be effective in treating manic clients who are refractory to antimanic drug therapy.

ECT can induce a remission in some clients who are diagnosed with acute schizophrenia, but it seems to be of little value in the treatment of chronic schizophrenia.

➢ **Contraindications:**

- The only absolute contraindication for ECT is increased intracranial pressure (from brain tumor, recent CVA, or other cerebrovascular lesion).
- Individuals at high risk with ECT include those with myocardial infarction or cerebrovascular accident within the preceding 3 months, aortic or cerebral aneurysm, severe underlying hypertension, and congestive heart failure.

➢ **Side effects**

- The most common side effects are temporary memory loss and confusion a headache, muscle aches, or nausea after the treatment.

Chapter Fourteen

Common Nursing Diagnoses

LEARNING OBJECTIVE

After reading this chapter, the student will be able to:

- Identify Common Nursing Diagnoses and Interventions for Individuals disorders and Possible Etiologies .

HOMEWORK ASSIGNMENT

- Nursing Diagnoses .
- Short-Term Goals And Long – Term Goals .
- Interventions With Selected Rationales .
- Outcome Criteria .

Common Nursing Diagnoses and Interventions for Individuals with Schizophrenia and Other Psychotic Disorders

(Interventions are applicable to various health-care settings, such as inpatient and partial hospitalization, community outpatient clinic, home health, and private practice.)

RISK FOR SELF-DIRECTED OR OTHER-DIRECTED

VIOLENCE

Definition: At risk for behaviors in which an individual demonstrates that he or she can be physically, emotionally, and/or sexually harmful [either to self or to others.]

Related/Risk Factors ("related to")

Lack of trust (suspiciousness of others) Panic level of anxiety
Catatonic excitement
Negative role modeling Rage
reactions Command
hallucinations Delusional
thinking
Body language-rigid posture, clenching of fists and jaw, hyperactivity, pacing, breathlessness, and threatening stances.
History or threats of violence toward self or others or of destruction to the property of others
Impulsivity, Suicidal ideation, plan, available means
Perception of the environment as threatening
Receiving auditory or visual commands of a threatening nature

SOCIAL ISOLATION

Definition: Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.

Possible Etiologies ("related to")

- Lack of trust
- Panic level of anxiety
- Regression to earlier level of development Delusional thinking
- Past experiences of difficulty in interactions with others Repressed fears
- Unaccepted social behavior

INEFFECTIVE COPING

Definition: Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources.

Possible Etiologies ("related to")

Inability to trust Panic
level of anxiety Personal
vulnerability Low self-
esteem
Inadequate support systems
Negative role model Repressed
fears
Possible hereditary factor Dysfunctional
family system

DISTURBED SENSORY PERCEPTION: AUDITORY/VISUAL

Definition: Change in the amount or patterning of incoming stimuli [either internally or externally initiated] accompanied by a diminished, exaggerated, distorted, or impaired response to such stimuli.

Possible Etiologies ("related to")

Panic level of anxiety
Withdrawal into the self
Stress sufficiently severe to threaten an already weak ego

DISTURBED THOUGHT PROCESSES

Definition: Disruption in cognitive operations and activities.

Possible Etiologies ("related to") Inability
to trust] [Panic level of anxiety Repressed fears
Stress sufficiently severe to threaten an already weak ego Possible
hereditary factor

IMPAIRED VERBAL COMMUNICATION

Definition: Decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols to communicate.

Possible Etiologies ("related to")

Altered perceptions
Inability to trust Panic
level of anxiety
Regression to earlier level of development
Withdrawal into the self
Disordered, unrealistic thinking

SELF-CARE DEFICIT (Identify Specific Area)

Definition: Impaired ability to perform or complete [activities of daily living (ADLs)].

Possible Etiologies ("related to")

Withdrawal into the self
Regression to an earlier level of development Panic
level of anxiety
Perceptual or cognitive impairment
Inability to trust

INSOMNIA

Definition: A disruption in amount and quality of sleep that impairs functioning.

Possible Etiologies ("related to")

Panic level of anxiety
Repressed fears
Hallucinations Delusional
thinking

Common Nursing Diagnoses and Interventions for Depression

RISK FOR SUICIDE

Definition: At risk for self-inflicted, life-threatening injury.

Related/Risk Factors ("related to")

Depressed mood
Grief; hopelessness; social isolation
History of prior suicide attempt
Has a suicide plan and means to carry it out
Widowed or divorced
Chronic or terminal illness Psychiatric
illness or substance abuse States desire to
die
Threats of killing self

COMPLICATED GRIEVING

Definition: A disorder that occurs after the death of a significant other [or any other loss of significance to the individual], in which the experience of distress accompanying bereavement fails to follow normative expectations and manifests in functional impairment.

Possible Etiologies ("related to")

Real or perceived loss of any concept of value to the individual Bereavement overload (cumulative grief from multiple unresolved losses Thwarted grieving response to a loss

Absence of anticipatory grieving

Feelings of guilt generated by ambivalent relationship with lost entity

LOW SELF-ESTEEM

Definition: Negative self-evaluation/feelings about self or self capabilities.

Possible Etiologies ("related to")

Lack of positive feedback
Feelings of abandonment by significant other Numerous failures (learned helplessness Underdeveloped ego and punitive superego Impaired cognition fostering negative view of self .

SOCIAL ISOLATION/IMPAIRED SOCIAL INTERACTION

Definition: Social isolation is the condition of aloneness experienced by the individual and perceived as imposed by others and as a negative or threatened state; impaired social interaction is an insufficient or excessive quantity or ineffective quality of social exchange.

Possible Etiologies ("related to")

Developmental regression
Egocentric behaviors (which offend others and discourage relationships) Disturbed thought processes [delusional thinking]
Fear of rejection or failure of the interaction Impaired cognition fostering negative view of self Unresolved grief
Absence of significant others

POWERLESSNESS

Definition: Perception that one's own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening.

Possible Etiologies ("related to")

Lifestyle of helplessness Healthcare environment Complicated grieving process Lack of positive feedback Consistent negative feedback]

DISTURBED THOUGHT PROCESSES

Definition: Disruption in cognitive operations and activities.

Possible Etiologies ("related to")

Withdrawal into the self Underdeveloped ego; punitive superego
Impaired cognition fostering negative perception of self and the environment

IMBALANCED NUTRITION, LESS THAN BODY REQUIREMENTS

Definition: Intake of nutrients insufficient to meet metabolic needs.

Possible Etiologies ("related to")

Inability to ingest food because of:
Depressed mood
Loss of appetite
Energy level too low to meet own nutritional needs
Regression to lower level of development
Ideas of self-destruction

DISTURBED SLEEP PATTERN

Definition: Time-limited interruptions of sleep amount and quality due to internal or external factors.

Possible Etiologies ("related to")

Depression Repressed
fears
Feelings of hopelessness
Anxiety
Hallucinations Delusional thinking

COMMON NURSING DIAGNOSES AND INTERVENTIONS FOR MANIA

RISK FOR INJURY

Definition: At risk of injury as a result of environmental conditions interacting with the individual's adaptive and defensive resources

Related/Risk Factors ("related to")

Biochemical dysfunction Psychological
(affective orientation) Extreme
hyperactivity
Destructive behaviors
Anger directed at the environment
Hitting head (hand, arm, foot, etc.) against wall when angry Temper
tantrums—becomes destructive of inanimate objects
Increased agitation and lack of control over purposeless, and potentially injurious, movements .

RISK FOR SELF-DIRECTED OR OTHER-DIRECTED VIOLENCE

Definition: At risk for behaviors in which an individual demonstrates that he or she can be physically, emotionally, and/or sexually harmful [either to self or to others]

Related/Risk Factors ("related to")

Manic excitement
Biochemical alterations
Threat to self-concept
Suspicion of others Paranoid
ideation Delusions
Hallucinations
Rage reactions
Body language (e.g., rigid posture, clenching of fists and jaw, hyperactivity, pacing, breathlessness, threatening stances)
History or threats of violence toward self or others or of destruction to the property of others
Impulsivity

Suicidal ideation, plan, available means
Repetition of verbalizations (continuous complaints, requests, and demands)

IMBALANCED NUTRITION, LESS THAN BODY REQUIREMENTS

Definition: Intake of nutrients insufficient to meet metabolic needs

Possible Etiologies ("related to")

Refusal or inability to sit still long enough to eat meals Lack of appetite
Excessive physical agitation
Physical exertion in excess of energy produced through caloric intake Lack of interest in food

DISTURBED THOUGHT PROCESSES

Definition: Disruption in cognitive operations and activities

Possible Etiologies ("related to")

Biochemical alterations Electrolyte imbalance
Psychotic process Sleep deprivation

DISTURBED SENSORY PERCEPTION

Definition: Change in the amount or patterning of incoming stimuli [either internally or externally initiated] accompanied by a diminished, exaggerated, distorted, or impaired response to such stimuli

Possible Etiologies ("related to")

Biochemical imbalance Electrolyte imbalance
Sleep deprivation Psychotic process

IMPAIRED SOCIAL INTERACTION

Definition: Insufficient or excessive quantity or ineffective quality of social exchange

Possible Etiologies ("related to")

Disturbed thought processes Delusions of grandeur
Delusions of persecution Self-concept disturbance

INSOMNIA

Definition: A disruption in amount and quality of sleep that impairs functioning

Possible Etiologies ("related to")

Excessive hyperactivity
Agitation
Biochemical alterations

Common Nursing Diagnoses and Interventions for anxiety disorders

ANXIETY (PANIC)

Definition: Vague uneasy feeling of discomfort or dread accompanied by an autonomic response (the source often nonspecific or unknown to the individual); a feeling of apprehension caused by anticipation of danger. It is an alerting signal that warns of impending danger and enables the individual to take measures to deal with threat.

Possible Etiologies ("related to")

Unconscious conflict about essential values and goals of life
Situational and maturational crises
Real or perceived threat to self-concept Real or perceived threat of death Unmet needs
Being exposed to a phobic stimulus

Attempts at interference with ritualistic behaviors Traumatic experience

FEAR

Definition: Response to perceived threat that is consciously recognized as a danger.

Possible Etiologies ("related to")

Phobic stimulus
Being in place or situation from which escape might be difficult Causing embarrassment to self in front of others

INEFFECTIVE COPING

Definition: Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources.

Possible Etiologies ("related to")

Underdeveloped ego; punitive superego Fear of failure
Situational crises Maturational crises Personal vulnerability
Inadequate support systems
Unmet dependency needs

POWERLESSNESS

Definition: The perception that one's own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening.

Possible Etiologies ("related to")

Lifestyle of helplessness
Fear of disapproval from others Unmet dependency needs
Lack of positive feedback Consistent negative feedback

SOCIAL ISOLATION

Definition: Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.

Possible Etiologies ("related to")

Panic level of anxiety
Past experiences of difficulty in interactions with others
Need to engage in ritualistic behavior in order to keep anxiety under control
Repressed fears

SELF-CARE DEFICIT (IDENTIFY SPECIFIC AREA)

Definition: Impaired ability to perform or complete [activities of daily living (ADL) independently].

Possible Etiologies ("related to")

Withdrawal; isolation from others
Unmet dependency needs Excessive
ritualistic behavior Disabling anxiety
Irrational fears

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