Psychiatric Nursing 14

The icon ✦ denotes content of special importance for NCLEX®.

RECOVERY

A. People with mental health (MH) disorders get better with treatment.
B. Substance Abuse and Mental Health Services Administration (SAMHSA).
   1. Defines *recovery* as process of change through which individuals
      a. Improve their health and wellness.
      b. Live a self-directed life.
      c. Strive to reach full potential.
   2. Identifies four dimensions that support recovery:
      a. Overcoming/managing disease (living in a healthy way).
      b. A stable/safe place to live.
      c. Meaningful daily activities.
      d. Supportive relationships and networks.
   3. Psychiatric nursing practice supports recovery.
   4. Psychiatric nursing care should be client- and family-centered.

KEY ORGANIZATIONS/CONCEPTS

A. Organizations:
   1. SAMHSA.
   2. National Alliance for the Mentally Ill (NAMI).
   3. American Psychiatric Nurses Association (APNA).
   4. The Joint Commission.
      a. Hospital-based inpatient psychiatric services (HBIPS) core measure.
         (1) Admission screening for violence, trauma, client strengths.
         (2) Hours of seclusion and restraints.
         (3) Clients discharged on multiple antipsychotic medications (and with justification).
         (4) Continuing care plan at time of discharge.
         (5) Continuing care plan transmitted to next level of care.
      b. Behavioral health care national client safety goals.
         (1) Identify individuals served correctly—two client identifiers.
         (2) Use medicines safely—medication reconciliation.
         (3) Prevent infection—Centers for Disease Control and Prevention (CDC) or World Health Organization (WHO) hand hygiene guidelines.
         (4) Identify safety risks—identify individuals at risk to try or commit suicide.

B. Ruling out medical conditions as etiology for psychiatric conditions is always the first step in evaluation. Thorough nursing assessment and interview is integral to the process.

MENTAL STATUS ASSESSMENT

The mental assessment is completed throughout the physical assessment and history-taking time frame. It is not generally considered a separate entity. Mood, memory, orientation, and thought processes can be evaluated while obtaining the health history.

The purpose of a mental status assessment is to evaluate the present state of psychological functioning and to determine if there is an immediate risk of harm to self or others, or deficit in ability to care for self as a result of mental health issues. It is not designed to make a diagnosis; rather, it should yield objective data that will contribute to the total picture of the client as he or she is functioning at the time the assessment is made. (See **Table 14-1**.)

The initial factors that the nurse must consider in completing a mental status assessment are to correctly identify the client, the reason for admission, record of previous mental illness, present complaint, any personal history that is relevant (living arrangements, role in family, interactional experience), family history if appropriate, significant others and available support systems, assets, and interests.

A spiritual assessment can be obtained as a part of the health history, although specific sociocultural beliefs may need to be ascertained separately. The purpose of a spiritual assessment is to facilitate the client adapting to the hospital environment and help the staff understand stressors the client may be experiencing as a result of belief systems.

The actual assessment process begins with an initial evaluation of the appropriateness of the client's behavior and orientation to reality. The assessment continues by noting any abnormal behavior and ascertaining the client's chief verbalized complaint. Finally, the evaluation determines if the client is oriented to reality enough to answer particular questions that will further assess the client's condition.

RATIONALE FOR COMPLETING A MENTAL STATUS ASSESSMENT

- To collect baseline data to aid in establishing the etiology, diagnosis, and prognosis.
- To evaluate the present state of psychological functioning.
- To evaluate changes in the individual's emotional, intellectual, motor, and perceptual responses.
- To determine the guidelines of the treatment plan.
- To ascertain if some seemingly psychopathological response is, in fact, a disorder of a sensory organ (e.g., a deaf person appearing hostile, depressed, or suspicious).
- To document altered mental status for legal records.

✦ Table 14-1 MENTAL STATUS ASSESSMENT

Assessment	Normal	Abnormal
General Appearance, Manner, and Attitude		
Assess **physical appearance, sleep patterns.**	General body characteristics, energy level, sleep patterns	Inappropriate physical appearance, high or low extremes of energy, poor sleep patterns (hypersomnia, insomnia)
Note **grooming,** mode of dress, and **personal hygiene.**	Grooming and dress appropriate to situation, client's age, and social circumstance Clean	Poor grooming Inappropriate or bizarre dress or combination of clothes Unclean
Evaluate **eye contact**.	Focused, not staring	Staring, darting, averted, glaring
Note **posture.**	Upright, straight, and appropriate	Slumped, tipped, or stooped, stiff posturing Tremors
Note speed, pressure, pace, quantity, volume, and diction of **speech.**	Moderated speed, volume, and quantity Appropriate diction	Accelerated or retarded speech, pressured, paucity, hyperverbal Poor or inappropriate diction
Note relevance, content, and organization of **responses.**	Questions answered directly, accurately, and with relevance	Inappropriate responses, unorganized pattern of speech Tangential, circumstantial, or out-of- context replies
Expressive Aspects of Behavior		
Note **general motor activity.**	Calm, ordered movement appropriate to situation	Overactive (e.g., restless, agitated, impulsive); repetitive, tremors Underactive (e.g., slow to initiate or execute actions), sluggish, immobile
Assess **purposeful movements** and **gestures.**	Reasonably responsive with purposeful movements, appropriate gestures	Repetitious activities (e.g., rituals or compulsions) Command automation Parkinsonian movements, involuntary
Assess style of **gait**		Ataxic, shuffling, off-balance gait, unsteady
Mutism	Verbal response to questions	No verbal response
Consciousness		
Assess **level of consciousness.**	Alert, attentive, and responsive Knowledgeable about time, place, person, and/or purpose	Disordered attention; distracted, cloudy consciousness Delirious Stuporous, sedated Disoriented in time, place, person, and/or purpose
Thought Processes and Perception		
Assess **coherency, logic,** and **relevance** of thought processes by asking questions about personal history (e.g., "Where were you born?" "What kind of work do you do?").	Clear, understandable responses to questions Attentiveness Interactive Questions are coherent/relevant	Disordered thought processes Autistic (detachment from reality when self-preoccupation and involvement are predominant); abstract (absent-mindedness); concrete thinking (being definitive and specific rather than abstract), distractable
Assess **reality orientation:** time, place, and person awareness.	Orderly progression of thoughts based in reality Awareness of time, place, and person	Disorders of progression of thought: looseness of association, circumstantial, incoherent, irrelevant conversation, blocking (a gap or interruption in speech that is related to distracted or absent thoughts) Delusions of grandeur or persecution: neologisms (use of words whose meaning is known only to the client) Echolalia (automatic repeating of words or questions) Echopraxia (mimicking of behavior or actions) No awareness of day, time, place, or person

✦ Table 14-1 MENTAL STATUS ASSESSMENT

Assessment	Normal	Abnormal
Assess **perceptions** and reactions to personal experiences by asking questions such as "How do you see yourself now that you are in the hospital?" "What do you think about when you're in a situation like this?"	Thoughtful, clear responses expressed with understanding of self	Altered, narrowed, or expanded perception, exaggeration, minimization, disorienting Illusions (distorted perceptual experience where the individual misinterprets actual data from the environment) Depersonalization (feeling or subjective experience of separateness or alienation from oneself; the state in which the client cannot distinguish self from others)
Positive and negative symptoms. Refer to Schizophrenic Disorders.		
Thought Content and Mental Trend		
Ask questions to determine general themes that identify **degree of anxiety** (e.g.,"How are you feeling right now?" "What kinds of things make you afraid?").	Mild or 1+ level of anxiety in which individual is alert, motivated, and attentive	Moderate to severe levels of anxiety
"On a scale of 1–10, how anxious are you?" (0 = no anxiety)		Refer to anxiety
Assess **ideation** and **concentration.**	Ideas based in reality Able to concentrate	Ideas of reference (a distortion of reality in which a person believes that activities of others have a personal reference to him or her) Paranoia: unrealistic fear or suspicion that others are plotting against the individual Hypochondria (abnormal concerns about health) Obsessional Phobias (irrational fears) Poor or shortened concentration Easily distracted
Mood or Affect		
Assess prevailing or **variability in mood** by observing behavior and asking questions such as "How are you feeling right now?"	Appropriate, even mood without wide variations high to low	Cyclothymic mood swings (alterations in mood from euphoria, elation, and ecstasy to depressed and withdrawn); dysthymic, euphoric, expressing hopelessness, powerlessness, suicidal ideation
Check for presence of abnormal **euphoria** (flight of ideas).	Euthymic	
If you suspect **depression,** continue questioning to determine depth and significance of mood (e.g., "How badly do you feel?" "Have you ever thought of suicide?" "How long have you been sad?" "What caused this sadness?").	May be sad or grieving but mood does not persist indefinitely	Flat or dampened responses, blunted Inappropriate responses Ambivalence (the simultaneous existence of contradictory or contrasting emotions toward a person or object—that is, love and hate feelings existing together) Tearful, morose
Memory		
Assess **past and present memory** and **retention** (ability to listen and respond with understanding or knowledge); ask client to repeat a phrase, such as an address.	Alert, accurate responses Able to complete digit span Past and present memory appropriate	Hyperamnesia (excessive loss of memory); amnesia (loss of memory caused by physical or emotional trauma); paramnesia (belief in events that never occurred) Preoccupied Unable to follow directions
Assess **recall** (recent and remote) by asking questions such as "When is your birthday?" "What year were you born?" "How old are you?"	Good recall of immediate and past events	Poor recall of immediate or past events Gaps in memory

(*Continues*)

✦ Table 14-1 MENTAL STATUS ASSESSMENT (*Continued*)

Assessment	Normal	Abnormal
Judgment		
Assess **judgment, decision-making ability,** and interpretations by asking questions such as "What should you do if you hear a siren while you're driving?" "If you lost a library book, what would you do?"	Ability to make accurate decisions Realistic interpretation of events	Poor judgment, poor decision-making ability, poor choices Inappropriate interpretation of events or situations
Awareness		
Assess **insight** (the ability to understand the inner nature of events or problems) by asking questions such as "If you saw someone dressed in a fur coat on a hot day, what would you think?"	Thoughtful responses indicating an understanding of the inner nature of an event or problem	Lack of insight or understanding of the problems or situations Distorted view of situation
Intelligence		
Assess **intelligence** by asking client to define or use words in sentences (e.g., recede, join, plural).	Correct responses to majority of questions	Incorrect responses to majority of questions indicates possible severe disorders
Assess **fund of information** by asking questions such as "Who is President of the United States?" "Who was the president before him?" "When is Memorial Day?" "What is a thermometer?" (Consider client's cultural and educational background.)	Correct responses to majority of questions	Deteriorated or impaired cognitive processes
Sensory Ability		
Assess the **five senses**—vision, hearing, tasting, feeling, and smelling abilities.	Able to perceive, hear, feel, touch appropriate to stimulus	Lack of response Suspicious, hostile, depressed Kinesthetic imbalance
Developmental Level		
Assess client's **developmental level** as compared to normal.	Behavior and thought processes appropriate to age level and intellectual capability	Wide span between chronological and developmental age Developmental disability
Lifestyle Patterns		
Identify **addictive patterns** and effect on individual's overall health.	Normal amount of alcohol ingested Smoking habits Prescriptive medications Adequate food intake for physical characteristics	High quantity of alcohol taken frequently Heavy smoker Addicted to illegal drugs Habituative medication; user of over-the-counter or legal medications Anorexic eating patterns Obese or overindulgence of food
Coping Devices		
Identify **defense-coping mechanisms** and their effect on individual.	Conscious coping mechanisms used appropriately such as compensation, fantasy, rationalization, suppression, sublimation, or displacement Mechanisms effective, appropriate, and useful	Unconscious mechanisms used frequently such as repression, regression (reverting to types of behavior characteristic of an earlier level of development), projection (defense mechanism by which one transfers to another person impulses, thoughts, or wishes that actually belong to oneself), reaction-formation, insulation, or denial Mechanisms inappropriate, ineffective, and not useful

Whenever findings are abnormal, either initially or during treatment, etiology should be explored (e.g., laboratory test results, vital signs, physical assessment findings).

Nursing plan of care should reflect mental status findings and changes as identified, if significant.

THE NURSE–CLIENT RELATIONSHIP

✦ *Definition*: The nurse–client relationship is a dynamic, therapeutic, professional relationship in which interaction occurs between two persons—the nurse, who possesses the skills, abilities, and resources to relieve another's discomfort, and the client, who is seeking assistance for alleviation of some existing problem or need.

Principles Underlying Relationship Therapy

A. The client's value as a unique individual with physical and psychosocial needs must be acknowledged.
B. The nurse's level of self-awareness, understanding of human interaction and relevant theories, and needs enhances the development of the therapeutic relationship.
C. Some degree of emotional involvement is required, but objectivity and adherence to professional communication and boundaries on the part of the nurse must be maintained.
D. Appropriate limits must be set, and consistency must be maintained.
E. Empathic understanding is therapeutic; sympathy is nontherapeutic.
F. Honest, open, genuine, and respectful communication is basic to the therapeutic process.
G. Expression of feelings, within safe limits, should be encouraged.

✦ Phases in Nurse–Client Relationship Therapy

A. Preinterview phase.
   1. Prepare for first encounter by reviewing available information.
   2. Evaluation one's feelings, fears, beliefs.
B. Initiation or orientation phase.
   1. Establish boundaries of relationship.
   2. Assess anxiety levels of self and client.
   3. Identify expectations/needs of client.
   4. Identify problems; set goals of the relationship.
   5. Responsibilities of client and nurse are defined.
   6. Confidentiality is stressed.
C. Continuation or active working phase.
   1. Promote attitude of acceptance and trust of each other to maintain therapeutic relationship.
   2. Use specific therapeutic and problem-solving techniques to develop working relationship.
   3. Continually assess and evaluate problems.
   4. Focus on increasing client's independence and promoting the client's problem-solving skills.
   5. Maintain the goal of client's confronting and working through identified problems to facilitate change.
D. Termination phase.
   1. Plan for the conclusion of therapeutic relationship early in the development of relationship.
   2. Maintain initially defined boundaries.
   3. Anticipate problems of termination.
      a. Client may become too dependent on the nurse. Encourage client to become independent.
      b. Termination may cause client to recall previous separation experiences, feelings of abandonment, rejection, anger, and depression.
      c. Discuss client's previous experiences and help work through any negative ones.
   4. Discuss client's feelings about termination.
   5. Summarize the goals and objectives achieved.

Assessment

A. Determine purpose of establishing a nurse–client relationship.
✦ B. Assess the overall condition of the client to determine what benefits will be derived from a nurse–client relationship.
C. Observe what is happening with the client here and now.
✦ D. Identify developmental level of client so relationship goals will be realistic.
✦ E. Determine whether client exhibits verbal or nonverbal communication patterns so the nurse can respond therapeutically.
F. Assess anxiety level of client.
G. Identify client expectations of a therapeutic relationship and describe parameters of the relationship.
H. Examine your own feelings and expectations that may potentially impact the development of a therapeutic relationship.

Implementation

✦ A. Assume the role of facilitator in the relationship.
✦ B. Accept client as having value and worth as a unique individual.
✦ C. Maintain relationship on a professional, therapeutic level.
D. Ensure appropriate, safe environment for interactions.

E. Establish or identify time frame for interaction if required.
F. Provide an environment conducive to client's receiving healing, supportive emotional experiences.
✦ G. Keep interaction reality oriented—that is, in the here and now.
H. Listen actively, reflect feelings.
I. Use nonverbal communication to support and encourage client.
1. Recognize meaning and purpose of nonverbal communication.
2. Keep verbal and nonverbal communication congruent by identifying and exploring incongruent messages.
J. Focus content and direction of conversation on client.
K. Interact on client's intellectual, developmental, and emotional level.
✦ L. Focus on "how, what, when, where, and who" rather than on "why."
✦ M. Teach client problem-solving skills to correct maladaptive patterns.
N. Help client to identify, express, and cope with feelings; assist client to express thoughts and feelings that result in an emotional release (catharsis) and progression towards achievement of personal, recovery, and treatment goals.
O. Help client develop alternative, adaptive coping mechanisms.
P. Recognize a high level of anxiety and assist client to cope.
✦ Q. Use therapeutic communication techniques.
1. Use techniques to increase effective communication. (See Therapeutic Communication Techniques, **Table 14-2**.)

✦ Table 14-2 THERAPEUTIC COMMUNICATION TECHNIQUES

Listening	The process of consciously receiving another person's message. Includes listening eagerly, actively, responsively, and seriously.
Acknowledgment	Recognizing the other person without inserting your own values or judgments. Acknowledgment may be simple and with or without understanding. For example, in the response "I hear what you're saying," the person acknowledges a statement without agreeing with it. Acknowledgment may be verbal or nonverbal.
Feedback	The process the receiver uses to relay to the sender the effect the message has had, which either helps keep the sender on course or alters his or her course. It involves acknowledging, validating, clarifying, extending, and altering. *Nurse to client:* "You did that well." Involves giving constructive information to clients about how the nurse perceives and hears them.
Mutual fit or congruence	Harmony of verbal and nonverbal messages. For example, a client is crying and says, "I feel okay." The nurse says, "You say you feel okay, but you are crying. Let's talk about what's going on."
Clarification	The process of checking out or making clear either the intent or hidden meaning of the message, or of determining if the message sent was the message received. *Nurse:* "You said you feel funny. Can you describe what 'funny' means?"
Focusing or refocusing	Picking up on central topics or "cues" given by the individual; concentrates attention on a single point. *Nurse:* "You were telling me how hard it was to talk to your mother."
Validation	The process of verifying the accuracy of the sender's message. *Nurse:* "Yes, it is confusing with so many people around."
Reflection	Identifying and sending back a message acknowledging the feeling expressed or reflecting back last few words of the message; directs questions, feelings, and ideas back to the client (conveys acceptance and great understanding). *Nurse:* "You feel depressed?" or "Depressed?"
Open-ended questions	Asking questions that cannot be answered "Yes" or "No" or "Maybe," generally requiring an answer of several words to broaden conversational opportunities and to help the client communicate. Do not ask, "Did you have a good time on your pass?" Rather, ask, "How did your pass go?"
Nonverbal encouragement	Using body language to communicate interest, attention, understanding, support, caring, and/or listening so as to promote data gathering. *Nurse:* Nods appropriately as someone talks.
Restatement	Restating what the client says; repeats the main idea expressed. *Nurse:* "You said that you hear voices."
Paraphrase	Summarizing or rewording what has been said. *Nurse:* "What I hear you saying is that you can't live comfortably at home."
Neutral response	Showing interest and involvement without saying anything else. *Nurse:* "Yes …" "Uh hmm …"
Incomplete sentences	Encouraging client to continue. *Nurse:* "Then your life is …"
Minimum verbal activity	Keeping your own verbalization minimal and letting the client lead the conversation. *Nurse:* "You feel …?"
Broad opening statements	Opening the communication by allowing the client freedom to talk and to focus on himself or herself. *Nurse:* "How have you been feeling?" "What would you like to talk about today?"
Confrontation	Pointing out a discrepancy in behavior, negative result of behavior or incongruence in behavior. If done in a positive, caring way, may lead to positive change. An example may be, "You say you have no self-confidence, yet you take over every meeting and won't let others talk."

✦ Table 14-3 BLOCKS TO COMMUNICATION

Internal validation	Making an assumption about the meaning of someone else's behavior that is not validated by the other person (jumping to conclusions). The nurse finds the suicidal client smiling and tells the staff he's in a cheerful mood.
Giving advice	Telling the client what to do. Giving your opinion, or making decisions for the client, implies client cannot handle his or her own life decisions and that you are accepting responsibility for the client. *Nurse:* "If I were you, …"
Changing the subject	Introducing new topics inappropriately, a pattern that may indicate anxiety. The client is crying and discussing her fear of surgery, when the nurse asks, "How many children do you have?"
Social response	Responding in a way that focuses attention on the nurse instead of the client. *Nurse:* "This sunshine is good for my roses. I have a beautiful rose garden."
Invalidation	Ignoring or denying another's presence, thoughts, or feelings. *Client:* "Hi, how are you?" *Nurse:* "I can't talk now. I'm on my way to lunch."
False reassurance/ agreement	Using clichés, pat answers, "cheery" words, advice, and "comforting" statements as an attempt to reassure client. Most of what is called "reassurance" is really false reassurance. *Nurse:* "It's going to be all right."
Overloading	Talking rapidly, changing subjects, or asking for more information than can be absorbed at one time. *Nurse:* "What's your name? I see you're 48 years old and that you like sports. Where do you come from?"
Underloading	Remaining silent and unresponsive, not picking up cues, and failing to give feedback. *Client:* "What's your name?" *Nurse:* Smiles and walks away.
Incongruence	Sending verbal and nonverbal messages that contradict one another; two or more messages, sent via different levels, seriously contradicting one another. The contradiction may be between the content, verbal message or nonverbal message. This contradiction is labeled a double message. Nurse says,"I'd like to spend time with you," then turns and walks away.
Value judgments	Giving one's own opinion, evaluating, moralizing, or implying one's own values by using words such as "nice," "good," "bad," "right," "wrong," "should," and "ought." *Nurse:* "You shouldn't do that—it's not right." "That's good."
Interpretation	Analyzing and explaining the client's feelings, behavior, and motivation to the client.

2. Recognize blocks or barriers to effective communication and work to remove them. (See Blocks to Communication, **Table 14-3**.)

THERAPEUTIC COMMUNICATION PROCESS

✦ *Definition*: Communication is a continuous, dynamic process of sending and receiving messages by means of symbols, words, signs, gestures, or other action. It is a multilevel process consisting of the content or information of the message and the part that defines the meaning of the message. Messages sent and received define the relationship between people. *Therapeutic communication utilizes the principles of communication in a goal-directed professional framework.*

Characteristics

A. A person cannot not communicate.
B. Communication is a basic human need.
C. Communication includes verbal and nonverbal expression (includes tone and quality of speech, manner of dress, use of space).
D. Successful communication includes
   1. Appropriateness.
   2. Efficiency.
   3. Flexibility.
   4. Feedback.

✦ E. Communication skills are learned as the individual grows and develops.
F. The foundation of the person's perception of him- or herself and the world is the result of communicated messages received from significant others.
✦ G. High anxiety in both nurse and client impedes communication.
H. Self-awareness during the interview facilitates honest communication.
I. Factors that affect communication:
   1. Intrapersonal framework of the person.
   2. Relationship between the participants.
   3. Purpose of the sender.
   4. Content of the message.
   5. Context of the message.
   6. Manner in which the message is sent.
   7. Effect on the receiver.
   8. Environment in which the interaction takes place.
J. Purpose of communication.
   1. To transfer ideas from one person to another.
   2. To create meaning through the communication process.
   3. To reduce uncertainty, to act effectively, and to defend or strengthen one's ego.
   4. To affect or influence others, one's physical environment, and oneself.

The Interview Process

Assessment

A. Determine purpose of the interview.
B. As the first step in therapeutic interviewing, do an initial assessment of the client's total condition—physical, emotional, cognitive, spiritual, and social.
C. Observe accurately what is happening with client in the here and now.
D. Be aware of your own feelings, reactions, and level of anxiety.
E. Assess client's communication patterns, behavior, and general demeanor.
F. Determine and assess life situation of client.
G. Assess environmental conditions that may affect nurse–client interaction.

Implementation

✦ Components of Interview Process

A. Provide a safe, private, comfortable setting if possible. If utilizing an electronic workstation, refocus on client as much as possible.
B. Encourage client to describe perceptions and feelings.
   1. Focus on communication; offer leads.
   2. Speak briefly.
   3. Encourage spontaneity, expression of feelings.
   4. If the client is hyperverbal, ask closed-ended questions.
C. Assist client to clarify feelings and events and place them in time sequence.
   1. Focus on emotionally charged area(s).
   2. Maintain accepting, nonjudgmental attitude.
D. Give broad openings and ask open-ended questions to enable client to describe what is happening with him or her.
E. Use body language to convey empathy, interest, and encouragement to facilitate communication.
F. Use silence as a therapeutic tool; it enables client to pace and direct his or her own communications. Long periods of silence, however, may increase client's anxiety level and should be avoided.
G. Define the limits of the interview: Determine the purpose and structure the time and interaction patterns accordingly.
H. Never employ interviewing techniques as stereotyped responses during an interview.
   1. Use of such responses negates open and honest communication.
   2. Use of structured responses is counterproductive, as it presents nurse as a nonempathic communicator.
   3. Interaction must be alive and responsive, not dependent on a technique for continuance.
   4. Use "I" messages rather than "you" messages. (For example, "I feel uncomfortable," not "You make me feel uncomfortable.")
I. Watch for transference reaction from client (unconscious process of attributing feelings toward the nurse that originally belonged to a significant person in client's previous experience).
J. Assist client to build more effective coping mechanisms.
   1. Gather pertinent data.
   2. Define the problem.
   3. Mutually agree on working toward a solution.
   4. Mutually set goals.
   5. Select alternatives.
   6. Activate problem-solving behavior for identified problems.

ANXIETY

✦ *Definition*: Anxiety is an affective response subjectively experienced as a response to an internal or external threat, real or imagined, known or unknown. It is experienced as a painful, vague uneasiness or diffuse apprehension, or focused such as chest pain. It is a form of energy whose presence is inferred from its effect on attention, behavior, learning, and perception. Anxiety is considered pathological if it interferes significantly with functioning or is striking in its lack of proportion to a situation.

Characteristics

A. Anxiety is perceived subjectively by the conscious mind of the person experiencing it.
✦ B. Anxiety is a result of conflicts between the personality and the environment or between different forces within the personality or physiological imbalances.
C. Anxiety may be a reaction to threats of deprivation from something biologically or emotionally vital to the person.
D. The causative conflicts and/or threats may or may not be in the awareness or in the conscious mind of the person.
✦ E. The amount or level of anxiety is related to the following factors:
   1. Degree of threat to the self.
   2. Degree to which behavior reduces anxiety.
F. Varying degrees of anxiety are common to all human beings at one time or another.
G. Anxiety is often found in mental health disorders.
H. Anxiety is easily transmitted from one individual to another.
✦ I. Constructive use of low-to-moderate levels of anxiety is healthy; it is often an incentive for growth.
J. The more capacity to manage anxiety, the more control an individual has over his or her environment.

STAGES OF ANXIETY

- Mild anxiety: Client is able to focus realistically on most of what is happening within and to him or her.
- Moderate anxiety: Client is able to partially focus on what is happening; focus is limited.
- Severe anxiety: Client cannot focus on what is happening to him or her; focus is on scattered details.

K. Anxiety may be acute (precipitated by an event or threat) or chronic (caused by various sources) present for a long period of time.
L. Disturbances in neurotransmitters/neurochemistry, brain anatomy, and endocrine systems are some causes implicated in pathophysiology.
M. Medical conditions may cause or contribute to worsening of anxiety.

Assessment

✦ A. A major assessment criterion for measuring the degree of anxiety is the person's ability to focus on what is happening to him or her in a situation.
B. Assess physiological, familial, environmental, and situational contributions to anxiety.
✦ C. Physiological reaction(s) present in client.
1. Increased heart rate, palpitations, chest pain.
2. Increased or decreased appetite.
3. Hyperventilation, dyspnea.
4. Tendency to void and defecate.
5. Dry mouth.
6. Butterflies in stomach, nausea, vomiting, cramps, diarrhea.
7. "Fight or flight" response, restlessness.
8. Tremors.
9. Dizziness, lightheadedness.
10. Numbness of extremities.
11. Perspiration.
D. Psychological reactions present in client.
1. Lack of concentration on work.
2. Feelings of depression and guilt.
3. Harbored fear of sudden death, mental illness, or loss of control.
4. Dread of being alone.
5. Confusion.
6. Tension.
7. Agitation and restlessness.
✦ E. States of anxiety vary in degree and can be assessed as follows:
1. Ataraxia (absence of anxiety).
a. State is uncommon.
b. Can be seen in persons who take drugs.
c. Indicates low motivation.
(1) Mild.
(a) Senses are alert.
(b) Attentiveness is increased.
(c) Motivation is increased.
(2) Moderate.
(a) Peripheral field is narrowed, attention is selective, ability to concentrate is diminished.
(b) Degree of pathology depends on the individual.
(c) May be detected in complaining, arguing, teasing behaviors.
(d) Can be converted to physical symptoms such as headaches, low back pain, nausea, diarrhea.
(3) Severe.
(a) All senses are gravely affected.
(b) Perceptual field greatly reduced.
(c) Behavior becomes automatic toward immediate relief.
(d) Energy is drained.
(e) Defense mechanisms are used to control severe levels of anxiety.
(f) Cannot be used constructively by person.
(g) Psychologically extremely painful.
(h) Learning and problem solving not possible.
(i) Nursing action always indicated for this state.
✦ (4) Panic.
(a) Individual is overwhelmed and feels helpless.
(b) Personality may disintegrate producing hallucinations or delusions.
(c) Wild, desperate, ineffective behavior may be observed, including sense of awe, dread, terror, uncanniness, and impulsivity.
(d) Detail previously focused on is exaggerated.
(e) Client may do bodily harm to self and others, accidentally or intentionally.
(f) Panic state cannot be tolerated very long.
(g) Condition is pathological.
(h) Immediate intervention is needed.

Implementation

A. Identify anxious behavior and the level of anxiety that determines degree of intervention.
✦ B. Remain with an anxious client.
C. Recognize anxiety in self may escalate client's anxiety.

✦ D. Maintain appropriate attitudes toward client.
1. Acceptance.
2. Calm, matter-of-fact, nonthreatening, succinct approach.
3. Willingness to listen and help.
4. Provide simple, clear instructions and explanations.
5. Emotional support.

E. Recognize if additional help is required for intervention.

F. Provide activities that decrease anxiety and provide an outlet for energy.

G. Establish person-to-person relationship.
1. Allow client to express his or her feelings.
2. Proceed at client's pace.
3. Avoid forcing client to verbalize feelings.
4. Assist client in identifying anxiety.
5. Assist client in learning new ways of dealing with anxiety.

✦ H. Provide appropriate physical environment.
1. Nonstimulating.
2. Structured
3. Designed to prevent physical exhaustion or self-harm or harm to others.

I. Administer medication as directed and needed.

Defense Mechanisms

Definition: Defense mechanisms are automatic, psychological processes caused by internal or external perceived dangers or stressors that threaten self-esteem and disrupt ego function.

Characteristics

✦ A. The purpose of defense mechanisms is to attempt to reduce anxiety and to reestablish equilibrium.

B. Adjustment depends on one's ability to vary responses so that anxiety is decreased.

✦ C. Use of defense mechanisms may be a conscious process but usually takes place at the unconscious level.

D. Defense mechanisms are compromise solutions and include those listed in **Table 14-4**.

E. Defenses may be pathological as well as adaptive.

F. Physiological imbalances may play a role in defense mechanisms a client is utilizing.

Assessment

A. Assess whether client evidences healthy adjustment in the way he or she uses defense mechanisms.

✦ 1. Healthy adjustment is characterized by
a. Infrequent use of defense mechanisms.
b. Ability to form new responses.
c. Ability to change the external environment.
d. Ability to modify one's needs.
e. Use of defense mechanisms to lower anxiety to achieve goals in acceptable ways.

2. Healthy adjustment patterns may include mechanisms such as rationalization, sublimation, compensation, and suppression.

✦ B. Assess whether client evidences unhealthy adjustment in the way he or she uses defense mechanisms.
1. Unhealthy adjustment is characterized by
a. Undeveloped ability or loss of ability to vary responses.
b. Retreat from the problem or reality.
c. Frequent use of defense mechanisms, which may interfere with maintenance of self-image and interfere with individual growth and interpersonal satisfaction.

2. Unhealthy adjustment patterns may include mechanisms such as regression, repression, denial, projection, and dissociation.

Implementation

A. Facilitate more appropriate use of defense mechanisms.

✦ B. Remember that defense mechanisms serve a purpose and cannot be arbitrarily eliminated without being replaced by more adaptive coping mechanisms.

C. Avoid criticizing client's behavior and use of defense mechanisms.

D. Help client explore the underlying source of the anxiety that gives rise to an unhealthy response.

✦ E. Assist the client in learning new or alternative coping mechanisms for healthier adaptation.

F. Use techniques to alleviate client's anxiety.

✦ G. Use a firm supportive approach to explore any maladaptive use of defense mechanisms.

Resilience

A. SAMHSA definition of resilience: "ability to adapt well over time to life changing situations and stressful conditions. Caring and supportive relationships can help enhance resilience" (Search Institute, 2015).

B. Prevention of childhood trauma (psychological, violence, neglect) supports development of resilience.

C. Personal qualities associated with resilience
1. Ability to make and implement realistic plans.
2. Positive, confident outlook.
3. Ability to communicate and solve problems.

✦ Table 14-4 DEFENSE MECHANISMS

Compensation	Covering up a lack or weakness by emphasizing a desirable trait, or making up for a frustration in one area by overemphasis in another area. This is learned early in childhood and may be easily recognized in adult behavior; for example, the physically handicapped individual who is an outstanding scholar.
Denial	Refusal to face reality. The ego protects itself from unpleasant pain or conflict by rejecting reality. Denial of illness is a common example; people wait to see a doctor because they don't want to know the truth. A more subtle example is the individual who avoids reality by getting "sick."
Displacement	Discharging pent-up feelings from one object to a less dangerous object. A fairly common mechanism; for example, your supervisor yells at you, you yell at your husband.
Dissociation	Emotional conflict is handled by altering consciousness, identity, memory or perception of the environment. An example is amnesia for an event (such as a car accident) that was traumatic.
Fantasy	Gratification by imaginary achievements and wishful thinking; for example, children's play. Sometimes, to satisfy a need, one relieves the tension by anticipating the pleasure of gratification.
Fixation	The persistence in later life of interests and behavior patterns appropriate to an earlier developmental age.
Identification	The process of taking on the desirable attributes in personalities of people one admires. Identification plays an important role in the development of a child's personality; for example, the child who mimics mother or father. A kind of satisfaction can be derived from sharing the success or the experience of others, such as the nurse who feels sick watching a traumatic procedure on a client.
Insulation	Withdrawal into passivity, becoming inaccessible to avoid further threatening circumstances. Sometimes the individual appears cold and indifferent to his or her surroundings. Insulation may be used harmlessly at times but becomes very serious if used so much it interferes with interaction with others.
Isolation	Excluding certain ideas, attitudes, or feelings from awareness. Isolation is separating the feelings from the intellect by putting emotions concerning a specific traumatic event into a lock-tight compartment; for example, the individual talks about a significant situation such as an accident or death without a display of feelings. This pattern can be positive if used temporarily to protect the ego from being overwhelmed.
Introjection	A type of identification in which there is a symbolic incorporation of a loved or hated object, belief system, or value into the individual's own ego structure; there is no absolute assimilation as in identification.
Projection	Placing blame for difficulties on others or attributing one's own undesirable traits to someone else; for example, the child who says to a parent, "You hate me," after the parent has spanked the child. In an adult, this mechanism is a predominant indicator of paranoia. The paranoid client projects hate for others by saying that others are out to get the client.
Rationalization	The mechanism that is almost universally employed to prove or justify behavior. It is face saving to give a reason that is acceptable rather than the real reason, as in remarks such as "It wasn't worth it anyway," "It's all for the best." This mechanism relieves anxiety temporarily and helps the person avoid facing reality.
Reaction-formation	Prevention of dangerous feelings and desires from being expressed by exaggerating the opposite attitude—a kind of denial. The overly neat, polite, conscientious individual may have an unconscious desire to be untidy and carefree. The behavior becomes pathological when it interferes with tasks or produces anxiety and frustration.
Regression	Resorting to an earlier developmental level to deal with reality. Regression is an immature way of responding, and it is frequently seen during a physical illness. It is sometimes used to an extreme degree by the mentally ill, who may regress all the way back to infancy.
Repression	The unconscious process whereby one keeps undesirable and unacceptable thoughts from entering the conscious. This repressed material may be the motivation for some behavior. The superego is largely responsible for repression; the stronger, more punitive the superego, the more emotion will be repressed. The child who is frustrated and downtrodden by a parent may rebel against authority in later life.
Sublimation	The mechanism by which a primitive or unacceptable tendency is redirected into socially constructive channels. This adjustment is at least partly responsible for many artistic and cultural achievements, such as painting and poetry.
Substitution	The replacement of a highly valued unacceptable object with an object that is more acceptable to the ego.
Suppression	The act of keeping unpleasant feelings and experiences from awareness.
Symbolization	Use of an idea or object by the conscious mind to represent another actual event or object. Sometimes the meaning is not clear because the symbol may be representative of something unconscious. Children use symbolization in this way and have to learn to distinguish between the symbol and the object being symbolized. Examples include obsessive thoughts or behavior (hand washing, cleansing) and the incoherent speech of the schizophrenic (by the time the painful thoughts reach the surface, they are so jumbled that they lose their painfulness).
Undoing	Closely related to reaction-formation—performance of a specific action that is considered to be the opposite of a previous unacceptable action. This action is felt to neutralize or "undo" the original action; for example, when Lady Macbeth washed her hands over and over.

ANXIETY DISORDERS

✦ *Definition*: Anxiety disorders are those disorders in which the predominant disturbance is one of anxiety. Anxiety may be manifested as panic, generalized anxiety, phobias, obsessive–compulsive behavior, or posttraumatic stress. Although there is overlap of symptoms, there are also variances by disorder. Anxiety is usually evaluated in context of medical diagnosis when it interferes with social, occupational, or other important areas of functioning and/or is out of proportion to a situation.

Generalized Anxiety Disorder

Assessment

✦ A. Client has unrealistic, diffuse persistent anxiety about two or more life experiences.
B. Client cannot control anxiety.
C. The individual's worry is out of proportion to the true impact of the worried event or situation; anxiety has been present for several months and is not attributable to a specific physiological cause.
✦ D. Psychological symptoms.
1. Difficulty concentrating, "going blank."
2. Feelings of depression and guilt.
3. Harbored fear of sudden death or loss of control.
4. Dread of being alone.
5. Confusion.
6. Rumination.
7. Agitation and restlessness—motor tension.
8. Impatience or irritability.
9. Difficulty making decisions.
✦ E. Physiological symptoms.
1. Tremors.
2. Dyspnea.
3. Palpitations.
4. Tachycardia.
5. Numbness of extremities.
6. Sleep disturbance.

Implementation

A. Recognize behavior in client that denotes anxiety.
B. Maintain calm approach because nurse's anxiety reinforces client's anxiety. Provide for safety.
✦ C. Help client to develop conscious awareness of anxiety, reorient to situation as needed.
D. Help client identify and describe feelings and source of anxiety, if identifiable. Support realistic view of the situation and evaluation strategies.
✦ E. Provide physical outlet for anxiety.
F. Remain with client, provide reassurance.
G. Decrease environmental stimuli.
H. Avoid reinforcing secondary gains (attention, sympathy).
I. Utilize medication if available and indicated. Provide medication education.

Panic Disorder

A. Panic attacks are characterized by recurrent, expected, and unpredictable attacks of severe anxiety lasting minutes to a few hours.
1. Intense physical symptoms include palpitations, sweating, shaking, dyspnea, chest pain, dizziness, chills or hot flashes, nausea, or abdominal distress.
2. Fear of losing control, choking. Fear of losing his or her mind or dying are also present.
3. People with panic disorder have a significantly higher incidence of mitral valve disorder (57%, versus 5–7% in the general population). The exact relationship between the two is unclear.
B. Attacks appear suddenly with no warning. May become associated with specific situations.
C. Interventions: Implement actions as you would for generalized anxiety disorder.

Phobic Disorders

Assessment

✦ A. Fear is recognized by individual as excessive or unreasonable in proportion to reality.
B. A compelling desire exists to avoid object or situation; fight or flight response may be exhibited.
✦ C. Client has unrealistic, irrational fear of object or situation that presents no actual danger.
D. Client uses projection, displacement, repression, avoidance, and sublimation.
E. Client may transfer anxiety or fear from its source to a symbolic idea or situation.
✦ F. Phobic disorders are classified into many different types. Examples are
1. Agoraphobia—intense, excessive anxiety or fear about being in places or situations from which escape might be difficult or embarrassing.
2. Acrophobia—fear of high places.
3. Social phobia—desire to avoid social situations in which individuals fear they will behave in an embarrassing way.
4. Simple phobia—persistent or irrational fear of simple objects or situations.
5. Claustrophobia—fear of enclosed spaces (elevators).
6. Belonephobia—fear of needles.

Implementation

✦ A. Draw client's attention away from phobia.
B. Have client focus on awareness of self.
C. Do not force client into situation feared.
D. Slowly develop sound, therapeutic relationship with client.

✦ E. Assist client to go through desensitizing process.
1. New studies indicate that high-tech virtual reality programs enable the client to become desensitized to the phobia.
2. Fear of elevators and flying are programs currently available as examples of in vivo desensitization.

Obsessive–Compulsive Disorder

Assessment

✦ A. Client has anxiety associated with persistent, undesired ideas, thoughts, or images that are experienced as senseless, unreasonable, or undesirable.
✦ B. Client releases anxiety through repetitive, ritualistic, stereotyped acts.
C. Personality characteristics.
1. Insecure, guilt-ridden.
2. Sensitive, shy.
3. Straight-laced.
4. Fussy and meticulous.
D. Client uses repression, isolation, and undoing to reduce anxiety.
E. Client is unable to control feelings of hostility and aggression.
F. Behavior interferes with social or role functioning.
G. Symptoms are distressing to client.
H. Most common obsessions are thoughts of violence, contamination, and doubt.
✦ I. Most common compulsions involve hand washing, counting, checking, and touching. Ritualistic body movements such as tapping or shrugging are also common and sometimes classified as tics.

Implementation

A. Avoid punishment or criticism.
✦ B. Allow episodes of compulsive acts, setting limits only to prevent harmful acts.
✦ C. Engage in alternative activities with client.
D. Limit decision making for client.
E. Provide for client's physical needs, provide a safe environment, and prevent complications such as skin breakdown.
F. Convey acceptance of client (nonjudgmental) regardless of behavior.
G. Establish routine to avoid anxiety-producing changes.
✦ H. Gear assignments to those that are routine and can be done with perfection, such as straightening linen or cleaning.
I. Plan therapy, any change in routine, or one-to-one contact after completion of a compulsive episode.
J. Positive feedback for successful attempts to decrease compulsive activities.

POSTTRAUMATIC STRESS DISORDER

✦ *Definition*: Condition follows a traumatic event that is outside the range of common experience (military combat, rape, assault, etc.). Symptoms persist for longer than a month and there is significant social, occupational, and other distress as a result of the symptoms.

In the DSM-V, posttraumatic stress disorder (PTSD) is classified in a new category, Trauma and Stressor-Related Disorders.

Characteristics

✦ A. Intrusive recollections of the trauma.
✦ B. As event is reexperienced, client suffers behavioral and emotional symptoms (Abreaction occurs: vivid recall of painful experience with emotion consistent with the original situation.)
C. Individual is not able to adjust to the event.
D. Persistent avoidance of stimuli associated with trauma occurs including isolation and modification of daily activities.
E. Persistent symptoms of increased arousal, such as difficulty falling/staying asleep, irritability, and/or negative cognition and mood symptoms, such as anhedonia, anger, impulsivity, negative thoughts, and self-destructive activities.

Assessment

A. Assess for symptoms:
1. Anxiety and depression.
2. Comorbidities.
3. Frequency/quality of intrusive recollections.
4. Emotional instability.
5. Feelings of detachment or guilt.
6. Nightmares, difficulty sleeping.
7. Withdrawal, isolation, and anhedonia
8. Self-destructive behavior such as use of drugs and alcohol and risk for injury.
9. Level of functioning.
B. Aggressive or acting-out behavior.
1. Explosive or unpredictable behavior.
2. Impulsive behavior; change in lifestyle.

Implementation

A. Assist client to go through recovery process.
1. Deal with conscious awareness of traumatic experience.
2. Adjust to acceptance of experience.
B. Protect client from self-destructive behaviors or acting-out behaviors.
C. Administration of prescribed medication as needed.
D. Encourage participating in treatment and access of supportive resources.
✦ E. Recovery process follows four stages.
1. **Recovery**—reassure client that he or she is safe following experience of the traumatic event.

2. **Avoidance**—client will avoid thinking about traumatic event; support client.
3. **Reconsideration**—client deals with event by confronting it, talking about it, and working through feelings.
4. **Adjustments**—client rehabilitates and adjusts to environment following event; functions and is able to view future positively.

SOMATOFORM DISORDERS

✦ *Definition*: Somatoform behaviors are physical symptoms that may involve any organ system, and whose etiologies are in part precipitated by psychological factors. There are three main types: psychosomatic, conversion disorder, and hypochondriasis. In the DSM-V, is classified in a new category, Somatic Symptoms and Related Disorders.

Characteristics

A. An individual must adapt and adjust to stresses in life.
   1. The way a person adapts depends on the individual's characteristics.
   2. Emotional stress may exacerbate or precipitate an illness.
B. Psychosocial stress is an important factor in symptom formation.

Psychosomatic Disorders

Assessment

✦ A. Determine which body systems are involved that resulted in somatoform disorder. Some possible examples are gastrointestinal (GI) disorders, skin disorders, and sexual dysfunction.
B. Evaluate history for physical symptoms of several years' duration.
C. Observe closely and assess client's present condition.
   1. Collect data about physical illness—symptoms (multiple sources).
   2. Life situations and psychosocial adjustment.
   3. Coping mechanisms that work for client.
   4. Strengths of client.
   5. Problem-solving abilities.
D. Note if symptoms are intermittent.
E. Assess what kinds of things aggravate or relieve symptoms.

Implementation

A. Provide restful, supportive environment.
   1. Balance therapy and recreation.
   2. Decrease stimuli.
   3. Provide activities that deemphasize the client's physical symptoms.
B. Care for the "total" person—physical and emotional.
✦ C. Realize physical symptoms are real and that person is not "faking."
✦ D. Recognize that treatment of physical problems does not relieve emotional problems.
E. Reduce demands on client.
F. Develop nurse–client relationship.
   1. Respect the person and the person's problems.
   2. Help client to express his or her feelings.
   3. Help client to express anxiety and explore new coping mechanisms.
   4. Allow client to meet dependency needs.
   5. Allow client to feel in control.
✦ G. Help client to work through problems and learn new methods of responding to stress.

Conversion Disorder

Assessment

A. Establish psychosomatic origin by assessing physical condition and ruling out any organic basis for symptoms (e.g., neurological examinations, laboratory tests).
✦ B. Identify conversion behavior/symptoms. Conversion behavior is the development of a physical symptom (blindness, paralysis, deafness) with no physical etiology identified.
✦ C. Evaluate client's attitude toward condition: "la belle indifference" (French term describing client's lack of concern or indifference toward physical symptom—a definite clue that condition is a conversion disorder).
✦ D. Identify primary gain.
   1. Keeps internal conflict or need out of awareness (repression).
   2. Symptom has symbolic value to client.
✦ E. Identify secondary gain.
   1. Provides additional advantages that result from particular behaviors that are not connected to the primary gain, such as avoidance, attention, or sympathy.
   2. Reinforces maladjusted behavior.
F. Assess whether symptoms disappear under hypnosis.

Implementation

✦ A. Establish therapeutic nurse–client relationship.
B. Reduce pressure on client.
C. Control environment.
D. Provide recreational and social activities.
✦ E. Do not confront client with his or her illness.
F. Divert client's attention from symptom.
G. Do not feed into secondary gains through anticipating client needs.

Hypochondriasis

Assessment

✦ A. Preoccupation with an imagined illness for which no observable symptoms or organic changes exist.
B. Evaluate severe, morbid preoccupation with body functions or fear of serious disease.
C. Assess whether client shows lack of interest in environment.
D. Assess whether client shows severe regression.
E. Determine if client goes from doctor to doctor to find cure or enjoys recounting medical history.
✦ F. Differentiate from malingering—deliberately making up illness to prolong hospitalization.

Implementation

✦ A. Accept client; recognize and understand that physiological complaints are not in client's conscious awareness.
B. Provide diversionary activities in which client can succeed in building self-esteem.
✦ C. Use friendly, supportive approach but do not focus on physical condition (i.e., avoid asking, "How are you today?").
D. Help client to refocus interest on topics other than physical complaints.
E. Provide for client's physical needs; give accurate information and correct any misinformation.
F. Assist client to understand how he or she uses illness to avoid dealing with life's problems.
G. Be aware of staff's negativity, as it may lead to exacerbation of client's symptoms.

EATING DISORDERS

Classified as Feeding and Eating Disorders in DSM-V.

Anorexia Nervosa

✦ *Definition*: A potentially life-threatening (results in death 10% of the time) eating disorder characterized by an intense fear of gaining weight or becoming fat. In pursuit of thinness, adopts extreme restriction on intake. The psychological aversion to food results in emaciation, physical problems, and possible death.

Characteristics

✦ A. Almost exclusively female—6:1 to 10:1 female:male ratio.
B. Most common in adolescent girls and young adults (age 12 to mid-30s).
C. Often unnoticed in early stages; female "goes on diet to lose weight."
✦ D. Dynamics of disorder.
1. History of a "model child"—extreme perfectionism.
2. Overprotected by parents in rigid, enmeshed family structure.
3. Conflict erupts at adolescence between poor involvement and family loyalty.
4. Becomes negative due to power struggles with family over pressure to eat.
5. Intense fear of obesity leads anorectic to report feeling fat.
6. Not a disturbance in appetite but distorted body image perceptions; related to disturbance in sense of self, identity, and autonomy.
7. Hormones altered—whether cause or effect is yet to be determined.
8. Anorectics do not want treatment. Potentially lethal disease: mortality up to 20% often due to cardiac complications or suicide.
9. Many anorectics have a single episode, then recover. Factors associated with positive prognosis include onset of problem before age 15 and weight gain within 2 years.

Assessment

✦ A. Assess weight: refusal to maintain body weight at or above a normal weight for age and height (loss of 15% or greater average body weight; calculate body mass index [BMI]).
✦ B. No menstrual period for 3 months.
✦ C. Assess for physical symptoms.
1. Malnutrition.
2. Fractures—calcium leaked from bones.
3. Teeth enamel eroded and poor gums.
4. Hypotension, hypothermia.
5. Anemia and decreased white blood cells.
6. Hypoproteinemia.
7. Sleep disturbances.
8. Cold intolerance (cyanosis and numbness of extremities).
D. Monitor for potential complications.
1. Electrolyte imbalance (cardiac dysrythmia).
2. Kidney failure, multiorgan failure.
3. Heart failure and coma, possible death.

Implementation

✦ A. Actions to improve nutritional status (to stabilize medical condition).
1. Diet.
a. High protein, high carbohydrate, vitamins, and amino acids.
b. Identify foods client prefers.
c. Small, nutritious, attractive feedings.
2. Nasogastric feedings: if client refuses to eat, administer tube feedings as ordered.
3. Total parenteral nutrition (TPN)/peripheral parenteral nutrition (PPN).
4. Dietary/nutrition consult.

B. Psychological and physical care.
   1. Care plan.
   ✦ a. Formulate plan that all staff agree on. Do not allow manipulation. Do not engage in power struggle. Matter-of-fact approach.
   ✦ b. Do not focus on food, taste, recipes, etc.
   c. Remain with client when eating or monitor when client eats with others.
   d. Do not accept excuses to leave eating area (to vomit).
   e. Set limits on amount client must eat. Reward when client adheres to plan.
   f. Ensure that weight is taken same time every day with client dressed in only a hospital gown. Evaluate weight in context of diet ordered/caloric intake.
   g. Be supportive in approach to client.
   h. Symptom management.
   i. Facilitate family involvement.
   2. Treatment.
   ✦ a. Medications: antidepressants—selective serotonin reuptake inhibitor (SSRI).
   ✦ b. Focused on behavior therapy.
      (1) Develop and implement individualized behavioral therapy treatment plan with reinforcement. Set limits.
      (2) Establish contract that specifies weight gain or loss correlated with privileges/restrictions.
   c. Insight-oriented therapy: correcting client's body perceptions and misconceptions about feelings, needs, self-worth, autonomy.
   d. Family therapy: important focus as issues of control and autonomy are connected to eating.
   e. Dietary/nutrition consult.
   f. Recreational therapy consult to promote appropriate level of activity; monitor activity levels.

Bulimia Nervosa

✦ *Definition*: Eating disorder characterized by loss of control during binge eating, frequently followed by self-induced vomiting, use of laxatives, or other compensatory measures to avoid weight gain.

Characteristics

✦ A. Etiology is unknown but this disorder is often accompanied by an underlying psychopathology and comorbidities.
B. More common in women than men.
C. Begins in adolescence or early adulthood and often follows a chronic course over many years.
D. Generally aware that eating patterns are abnormal (in contrast to anorectics).
E. Typically evidences impaired impulse control, low self-esteem, and depression.

Assessment

A. Assess degree of disruption in life caused by eating disorder.
✦ B. Assess degree of depression: often due to guilt over eating binges. (Studies suggest link between bulimia and affective disorder.)
C. Assess weight fluctuation and potential danger of weight loss.
✦ D. Assess for physical symptoms and complications.
   1. Enlarged parotid glands.
   2. Dental erosion and caries, esophagitis.
   3. Electrolyte imbalance (hypokalemia), hypoglycemia, low protein.
   4. Fluid retention.
   5. Constipation.
   6. Bradycardia, orthostatic blood pressure changes.

Implementation

A. Client is hospitalized if weight loss is severe or there are serious abnormal findings such as electrolyte imbalance, hematemesis, inability to maintain body weight, kidney dysfunction, or vital sign changes.
B. Symptom management.
C. Behavior-modification and insight-oriented therapy used with limited success.
D. Care plan is similar to anorexia nervosa with focus on interrupting binge/purge cycle and altering attitudes toward food and self.
✦ E. Combination of cognitive-behavioral therapy and psychopharmacology (SSRI antidepressants) more effective.
F. Nutritional rehabilitation to promote controlled weight gain and adequate nutrition.

SLEEP DISORDERS

Definition: Sleep disorders or sleep pattern disturbance can be categorized into four different groups: primary sleep disorders (dyssomnias and parasomnias), sleep disorders related to mental conditions, a medical condition, or substance-induced disorder.

Assessment

A. Dyssomnias.
   1. Primary insomnia.

a. Assess difficulty falling asleep or continuing sleep.
b. Assess problems with nonrestorative sleep.

2. Primary hypersomnia.
   a. Assess for prolonged sleep and excessive sleepiness that interferes with daily functioning.
   b. Excessive sleepiness is not caused by insomnia and is not accounted for by inadequate sleep.
3. Breathing-related sleep disorders.
   a. Assess for sleep apnea, obstructive type (upper airway partially collapses and opening it involves at least partial arousal).
   b. Assess for predisposing factors: obese, middle-aged men with a history of snoring.
4. Narcolepsy.
   a. Assess for a pattern of brief episodes of deep sleep, occurring daily.
   b. May be accompanied by cataplexy (sudden collapse of muscle tone or recurrent episodes of rapid eye movement).
5. Circadian rhythm sleep disorders.
   a. Assess for a recurrent pattern of sleep disruption due to mismatched sleep–wake schedules.
      (1) Disturbance causes stress or impairment of functioning.
      (2) Disturbance is not connected to other sleep disorders or a substance abuse.
   b. Assess for specific types: delayed sleep phase, jet lag, shift work phase or unspecified.

B. Parasomnias.
1. Somnambulism—sleep walking, nightmares, sleep terrors.
2. Bruxism—teeth grinding.
3. Enuresis—bed-wetting.

Implementation

A. Intervention is based on thorough identification of the type of sleep disturbance.
1. Diagnostic sleep tests (polysomnography) assists in confirming the diagnosis.
2. Treatment is based on subjective analysis unless specific symptoms suggest other disorders.

B. Interventions may include principles of sleep hygiene, coping mechanisms, medication, reduction or removal of an obstruction (sleep apnea), continuous positive airway pressure (CPAP) by nasal mask; in general, treatment is specific to each individual's problem.

DISSOCIATIVE DISORDERS

✦ *Definition*: These disorders involve disruptions in the usually integrated functions of consciousness, identity, memory, or perception of the environment. Methods of disruption are involuntary and often create risk for safety.

Characteristics

✦ A. Client attempts to deal with anxiety through various disturbances or by blocking certain areas out of the mind from conscious awareness.
B. Client has a psychological retreat from reality.
C. Repression is used to block awareness of traumatic event.
✦ D. Manifestations.
✦ 1. **Amnesia**—circumscribed, selective or generalized, and continuous loss of memory.
✦ 2. **Fugue**—condition experienced as a transient disorientation—client is unaware he or she has traveled to another location. Client does not remember period of fugue.
✦ 3. **Dissociative identity disorder (DID)**—dominated by two or more personalities, each of which controls the behavior while in the consciousness.
✦ 4. **Depersonalization**—alteration in perception or experience of self; sense of detachment from self.

Assessment

✦ A. Determine that symptoms are not of organic origin.
B. Assess in which form the dissociative disorder is manifesting.
C. Evaluate degree of interference in lifestyle and interpersonal relationships.
D. Assess presence of accompanying symptoms such as depression, suicide ideation, use of alcohol and drugs, etc.
E. Note inconsistencies in elapsed time.
F. Note complaints of voices "inside" the head talking to one another, as opposed to hallucinations that are "outside" the head.

Implementation

A. Support therapeutic modality as established by treatment team.
B. Provide for safety.
C. Reduce anxiety-producing stimuli.
D. Redirect client's attention away from self.
E. Avoid sympathizing with client.
F. Increase socialization activities.
✦ G. Therapy.
1. Hypnosis.
2. Abreaction (assisting client to recall past, painful experiences).

3. Cognitive restructuring.
4. Behavioral therapy.
5. Psychopharmacology (antianxiety and antidepressants).

PERSONALITY DISORDERS

✦ *Definition*: Disorders in which individual exhibits inflexible and maladaptive responses to stress, which produce dysfunctional behavioral problems.

Characteristics

A. Three major categories referred to as clusters: odd–eccentric, dramatic–emotional, and fearful–anxious.
B. Several traits are common to all three clusters.
   1. Lacks understanding of how his or her behavior affects others; lacks insight.
   2. Cannot take responsibility for own behavior.
   3. When threatened, cannot change own behavior, but attempts to change environment.
C. Other general traits common to personality disorders:
   ✦ 1. Experiences inadequate interactions with society and individuals.
      a. Difficulty in forming loving and lasting interpersonal relationships.
      b. Difficulty with authority, laws, and rules.
   ✦ 2. Assets may be social skills—intelligence, charm, and manipulation.
   3. Experiences low tolerance for anxiety and inability to tolerate frustration—will go to great lengths to avoid increased intellectual and emotional demands that raise anxiety.
   ✦ 4. A common characteristic is manipulation—influencing others or events to meet own needs without regard for others' needs.
D. For specific personality types, see **Table 14-5**.

Implementation: Manipulative Behavior

✦ A. Recognize characteristics of manipulative behavior—pervasive in all personality disorders.
   1. Uses bargains, threats, demands, or intimidation to get own way.
   2. Shows ability to identify and use other people's weaknesses for own benefit.
   3. Makes continuous, unrealistic demands.
   4. Pits one individual against another (e.g., clients against staff) and primitive defense mechanism of splitting.
   5. Pretends to be helpless and sorry for behavior.
   6. Lies to gain sympathy of staff or other clients.
   7. Acts out even when given acceptable behavioral alternatives.
   8. Keeps all relationships on a superficial level.
   9. Uses flattery, charm, and excessive compliments to have needs met.
   10. Exploits the generosity of others.
   11. Identifies with staff or authority figure and acts as if he or she is not confined.
   12. Finds a way around the unit rules and expectations.
   13. Uses sexuality to gain control over others—may even approach the staff sexually.
✦ B. Interventions for manipulative behavior.
   ✦ 1. Set clear and realistic limits with appropriate consequences. Be consistent and firm in setting behavioral expectations and limits.
   ✦ 2. Confront client about the manipulative behavior. Do not try to outmanipulate—client is a master at it.
   3. Reinforce adaptive behavior through positive feedback and realistic praise.
   ✦ 4. Do not be influenced by client's charming ways—all directed toward manipulating you.
   5. Do not be intimidated by client's behavior.
   6. Clearly and consistently communicate care plans and client's behavior to other staff. Present a united front.
   7. Accept no flattery, gifts, or favors.
C. Impulsiveness and not taking responsibility for behavior are common with these disorders.
   1. Assist client to identify consequences of behavior.
   2. Begin a behavior modification plan in which all staff consistently implement consequences of behavior.
D. Poor social/interpersonal relationships.
   1. Form a therapeutic nurse–client relationship in which positive behavior is reinforced.
   2. Help to develop trust in relationship by being consistent and doing what you promise to do.
   3. Point out unrealistic expectations in relationships.
E. Low self-esteem, which may lead to self-destructive behavior.
   1. Work with client to see assets, strengths, and positive attributes—group feedback is useful for this intervention.

PERSONALITY DISORDERS—NOT SPECIFIED

Passive–aggressive disorder	Behavior that is hostile, covered up by passivity and submissiveness. Manifested by procrastination, forgetfulness, inefficiency, lateness, and deniability.
Repressive personality disorder	Unhappy, gloomy people who get no joy out of life. Pessimistic about the future. Low self-esteem.

Table 14-5 PERSONALITY DISORDERS

Personality Types	Profile Characteristics
Cluster A (Odd–Eccentric)	
Paranoid personality	Pervasive, unwarranted suspiciousness, and mistrust of people.
	Guarded, secretive, devious, and scheming.
	Puts blame on others for problems.
	Argumentative and exaggerates difficulties.
	Affectively restricted and cold.
	Lacks soft, sentimental, or tender feelings.
Schizoid personality	Loners, lack of social relationships, pervasive pattern of detachment.
	No warmth or tender feelings toward others—appears cold and aloof.
	Prefers to be alone and has few friends—seclusive.
	Appears reserved, withdrawn, and seclusive.
	Flat affect—humorless and dull, emotionally cold.
	Takes pleasure in few activities.
Schizotypal personality	Peculiar ways of thinking, behavior, and looking.
	Related to schizophrenia but not severe enough to be labeled as such.
	Inappropriate affect, speech, and ideation.
	Under periods of severe stress, symptoms of schizophrenia may develop.
Cluster B (Dramatic–Emotional)	
Histrionic personality	Overly reactive, dramatic, and intense.
	Disruptive relationships with others.
	Seeks attention and tends to exaggerate.
	May exhibit angry outbursts or tantrums.
	Immature, self-centered, and dependent.
	Seductive and flirty with others.
Narcissistic personality	Grandiose sense of self-importance and entitlement.
	Preoccupation with fantasies of power, beauty, etc.
	Exhibitionistic, with indifference or rage in response to criticism.
	Lack of empathy and exploits others.
	Arrogant and haughty.
Borderline personality	Efforts to avoid abandonment.
	Impulsiveness that is self-damaging (e.g., gambling, sex, spending).
	Pattern of unstable relationships and affect.
	Explosive temper, affective lability, suicide gestures, and acts of self-mutilation.
	Lack of self-identity.
	Chronic feeling of boredom and emptiness.
Antisocial personality	Intelligent, charming, self-centered, "con artist."
	Inability to feel guilt or learn from past experience.
	Repeated lying and cheating, steals—diagnosis common in prisons.
	Emotionally immature—lack of impulse control and low frustration tolerance.
	Manipulation of others to fulfill wants and needs.
	Resists authority, rules, and laws.
	Impulsive, lacks judgment.
	Excessive use of drugs, alcohol, and sex.
	Uses rationalization to justify behavior.
Cluster C (Fearful–Anxious)	
Dependent personality	Passive, little sense of self-responsibility.
	Low self-esteem.
	Sees self as stupid and helpless.
	Dependent on others to meet needs.
	Inability to make decisions.
Obsessive–compulsive personality	Restricted ability to express warmth toward others—cold, rigid.
	Perfectionistic preoccupation with rules, orders, etc.; inflexible and stubborn.
	Excessive devotion to work.
	Indecisiveness but often high achiever.
Avoidant personality	Fears of not being liked or being shamed or ridiculed.
	Procrastinates, dawdles, and forgets; avoids interpersonal contact.
	Reluctant to take personal risks.
	Pervasive pattern of social inhibition, feelings of inadequacy, fear of negative evaluation.

2. Use of cognitive behavior techniques (stopping negative thoughts) is useful.
3. Self-destructive behavior may necessitate a stable, safe, secure environment with clear expectations of behavior, firm limits, and strict consequences.

F. Aggressive behavior.
1. Safe environment with strict limits for any unacceptable behavior.
2. Anger management so client can differentiate feeling angry from behavioral expression of anger.

Implementation: Paranoia

A. Determine client's degree of suspiciousness and mistrust of others.
1. Assess client's hostility toward others.
✦ 2. Determine if delusions are present. Delusions include persecution, grandeur, and/or hypochondriasis.
a. **Delusions of grandeur**: false belief that one is in a position of power, wealth, and prominence.
b. **Delusions of persecution**: false belief that one is being pursued, followed, or intimidated by an opposing power.
3. Evaluate client's degree of insecurity, inadequate self-concept, and low self-esteem.
4. Assess anxiety level and its impact on disorder.

✦ B. Establish a trusting relationship.
1. Be consistent and friendly despite client's hostility.
2. Avoid talking and laughing when client can see you but not hear you.
3. If client is very suspicious, use a one-to-one relationship, not a group situation.
4. Involve client in the treatment plan.
5. Give support by being nonpunitive.

C. Reduce client's anxiety associated with interpersonal interactions.
✦ 1. Avoid power struggles—do not argue with the client; arguing increases anxiety and hostility.
2. Do not proceed too quickly with one-to-one nurse–client relationship. Remember that a paranoid client is suspicious and mistrustful of others.
3. Be consistent and honest in approaches to client.

✦ D. Help differentiate delusion from reality (refer to section on delusions).
1. Do not explain away false ideas. Ideas are real to the client.
2. Avoid any attempt to disagree with delusion, as this action may reinforce it.
3. Use reality testing when possible.
4. Focus on reality situations in the environment.
5. Attempt to engage in activities that require concentration.

MOOD (AFFECTIVE) DISORDERS

Bipolar Affective Disorders

Definition: A group of mood disorders that include manic, hypomanic, and mixed episodes as well as depressed and cyclothymic episodes.

Manic Episode of Bipolar Affective Disorder

✦ *Definition*: One manifestation of an affective disorder that involves mood swings of elation, euphoria, and grandiose behavior.

Characteristics

A. Specific etiology is unknown. May be related to a genetic predisposition to illness or to increased levels of dopamine and norepinephrine in the brain. Attempts are now being made to discover why Eskalith (lithium) is therapeutic in hopes of solving the mystery of manic illness.
B. Women experience this illness slightly more frequently than men. The lifetime risk of developing this illness is 1–2% of the population.
C. The first manic episode usually occurs before age 30 and, interestingly, is more common in the higher socioeconomic group.

Cyclothymic Disorder

A. Category of bipolar disorder but a milder form—no severe manic or major depressive episodes.
B. Diagnosis is after client has evidenced chronic mood swings from hypomanic to depressive episodes for 2 years.

Hypomanic Disorder—Bipolar II

One or more hypomanic episodes and a number of depressive episodes.

✦ A. Mild elation, euphoria, "high"—a less extreme form of mania.
B. Mood swings are not severe enough to require hospitalization.
C. Therapeutic intervention and medication usually not necessary—unless mood swings interfere with lifestyle.

Mixed Disorder (Manic–Depressive)—Bipolar I

One or more manic episodes and one or more depressive episodes.

A. Both manic and depressive episodes are experienced almost every day for a 3-week period.
B. Episodes are severe and require hospitalization.

Assessment: Manic Episode

✦ A. Assess which stage of mania client is experiencing.
   1. **Mild elation**: difficult to detect, as it may not progress. Persons are often referred to as "hypomanics."
      a. Affect: feelings of happiness, freedom from worry, confidence, and noninhibition.
      b. Thought: rapid association of ideas but with little evidence of introspection.
      c. Behavior: increased motor activity (person always "on the go") and increased sexual drive.
   ✦ 2. **Acute manic episode**: symptoms more intensified and observable. Client usually requires hospitalization.
      ✦ a. Mood disturbance and lability: Mood is one of excessive euphoria. Expansive toward others, enthusiastic, and intrusive. Mood may change to one of irritability, annoyance, and even rage and violence. Mood swings may last for hours or days.
      ✦ b. Hyperactivity: motor restlessness and overindulgence in recreational, sexual, and other activities. Engages in sexual indiscretions and poor money management. Client uses poor judgment in planning and starting projects and is overoptimistic and unrealistic. Evidences disturbed sleep patterns, often going without sleep for days.
      ✦ c. Flight of ideas and pressured speech: Manic clients jump from one idea to another, using puns, jokes, and nuances in a continuous flow of loose and accelerated speech. Often, speech is loud, rapid, and inappropriate.
      ✦ d. Distractibility: Manic clients overly respond to environmental stimuli, switching focus rapidly from one stimulus to another.
      e. Distortion of self-esteem: Grandiose perceptions of one's importance is common with an inflated self-esteem. Often this characteristic is manifested in delusions of grandeur (special relationship with God or the president).
   3. **Delirium**: state of extreme excitement. Person is disoriented, incoherent, agitated, and frenetic.
      a. May experience visual or olfactory hallucinations.
      b. Exhaustion, dehydration, injury, and death are real dangers and must be prevented by the nurse.
   B. Determine if client requires hospitalization (depends on range of symptoms).
   C. Assess physical health.
      1. Poor sleep habits and no apparent fatigue.
      2. Poor nutrition.
      3. Poor or even bizarre habits of grooming.

Implementation

✦ A. Maintain a safe environment.
   1. Reduce external stimuli: noise, people, and motion.
   2. Avoid competitive activities. (Mild exercise, group singing, and swimming are examples of therapeutic activities.)
   3. Redirect energy into short, useful activities.
✦ B. Establish a nurse–client relationship.
   1. Maintain accepting, nonjudgmental attitude and create conditions where trust can develop in the relationship.
   2. Avoid entering into client's playful, joking activity.
   3. Allow client to verbalize feelings, especially hostility.
✦ C. Set realistic limits on behavior.
   1. Provide scope and limitations to behavior for a sense of security.
   2. Anticipate destructive behavior and set limits.
   3. Be firm and consistent.
   4. Involve client in setting own limits.
      a. Gives client sense of control.
      b. Client fears inability to control own behavior.
   D. Give attention to physical needs.
      1. Provide a high-calorie diet with vitamin supplements.
      2. Ensure adequate rest and sleep.
   E. Limit decision making during acute phase.

Depressive Episode of Bipolar Disorder

See Depressive Disorders below.

Schizoaffective Disorder

See page 802.

Depressive Disorders

✦ *Definition*: Another manifestation of affective disorder; symptoms range from a dysphoric, sad, or gloomy mood that is mild and only slightly debilitating to a pathological condition of overwhelming intensity and long duration. This disorder may be chronic or episodic but it involves no episodes of elation.

Characteristics

✦ A. The most common of all psychiatric illnesses, and more common in women than men. Depression is

a condition affecting up to 7% of the population, with 30% of those cases classified as severe. Lifetime prevalence is up to 16%.

B. Most common age for adult onset is between ages 25 and 44. Average age of onset is 32.

C. One cause is now thought to involve a genetic link; other possible causes are personality traits such as low self-esteem, neurochemical imbalances, and other biological factors. Lack of social support, widowhood, and seasonality are other associated factors.

✦ D. Most acute depressive episodes are self-limiting and last from a few weeks to a few months.

E. More than half of those persons who experience a first episode go on to suffer a recurrence, although individuals seeking treatment often recover.

Major Depression/Unipolar Disorder

A. General characteristics.

1. May be a single episode or recurrent (two or more) episodes.
✦ 2. Symptoms of a major depressive episode usually develop over a period of days to weeks and represent a change in previous functioning.
3. Episode may begin at any age and is twice as common in women.
4. The clinical picture of depression varies considerably, with no single symptom present in all clinical profiles.

✦ B. Affective symptoms.

✦ 1. Distinguished from grief reactions: Normal, self-limited reaction to obvious loss is labeled grief. Grief reactions are usually brief and milder than pathological depression.
✦ 2. Majority of depressed people experience prolonged periods of sadness, feeling down, gloomy, or unhappy. This depressed mood tends to color the whole of a person's life; it is pervasive and dominant.
✦ 3. Loss of motivation: loss of interest in life and activities, feelings of hopelessness and helplessness, and suicidal thoughts.
a. Suicide is the most serious complication. Suicide is the tenth leading cause of death in the United States.
b. The highest risk is after some improvement.
✦ 4. Vegetative behavior: Related to physical problems that include loss of energy, loss of libido, psychomotor retardation, or agitation. Individual experiences sleep problems (insomnia is more common) and appetite disturbance, usually anorexia.
✦ 5. Cognitive problems: Persistent low self-esteem is present, difficulty in concentrating, poor memory, and apparent occupation with inner thoughts. A pervasive sense of guilt and worthlessness is also present.
6. Physical complaints: A series of bodily complaints often accompany this illness, ranging from headaches and backaches to constipation and chest pain.

Dysthymic Disorder

✦ A. Characterized by a chronic depressive syndrome (mild to moderate in degree) that is usually present for most of the day:
1. Symptoms are present for at least 2 years.
2. Depression may be episodic or constant.

B. Psychosis is not present.

C. Significant distress in social and occupational functioning.

D. Several of the following symptoms are usually present with this diagnosis.
1. Low energy level.
2. Loss of interest in pleasurable activities.
3. Pessimistic attitude toward the future; thoughts of suicide.
4. Tearful, crying demeanor.
5. Feelings of low self-esteem.
6. Decreased ability to concentrate.

Assessment: Depression Episode

✦ A. Assess mood level (affect is sad, gloomy, or unhappy).

✦ B. Evaluate behavior (slowed actions, diminished purposeful movement, decreased participation in usual activities—anhedonia), and neglect of personal appearance).

✦ C. Assess thought processes (slowed down until there is a paucity of thinking; content includes hopelessness, decreased ability to concentrate).

✦ D. Evaluate attitudes (pessimistic and self-denigrating; focus is on the problems and uselessness of life).

E. Assess physical symptoms.
1. Usually a preoccupation with body and poor health.
2. Weight loss, decreased appetite.
3. Insomnia or excessive sleep.
4. General malaise.

F. Determine social interaction patterns, which are reduced and inappropriate.
1. Feelings of isolation.
2. No contribution to interpersonal relationships.

G. Evaluate potential for suicide and perform suicide lethality assessment. Suicidal ideation, plan, and means should be assessed.

SEASONAL AFFECTIVE DISORDER

- Influenced by lack of natural light at a particular time of the year.
  a. Relationship between sunlight, biological rhythm, and depressed mood.
  b. Condition occurs mostly in winter months when natural (sun) light is decreased—disappears in spring and summer.
- Application of full-spectrum light through special light bulbs or lamps appears to alleviate or lessen disorder.

Implementation

✦ A. Provide a safe milieu and protect the client from self-injury (prevent suicide).
✦ B. Provide a structured environment to mobilize the client.
1. Allow time for daily activities.
2. Stimulate recreational activity.
3. Reactivate interests outside of the client's concerns.
4. Motivate client for treatment.
5. Introduce group and occupational therapy.

✦ C. Build trust through a one-to-one relationship.
1. Employ a supportive, unchallenging approach.
2. Use accepting, nonjudgmental attitude and behavior.
3. Show interest; listen and give positive reinforcement.
4. Redirect the client's monologue away from painful depressing thoughts.
5. Focus on any underlying anger and encourage expression of it.

D. Build the client's ego assets to increase his or her self-esteem.
1. Lower standards to create successful experiences.
2. Limit decision making with the severely depressed.
3. Support use of defenses to alleviate suffering.

E. Be attentive to the client's physical needs: Provide adequate nutrition, sleep, and exercise.
F. Monitor ECT treatments if ordered. See page 804.

For alternative therapies (e.g., St. John's wort for depression), see Alternative Nursing: Herb–Drug Interactions (Table 5-1) in Chapter 5, Pharmacology.

Suicide

Definition: Suicide is an act or instance of intentionally killing oneself. Fifteen percent of clients with mood disorder commit suicide.

Characteristics

✦ A. Suicide is the tenth most common cause of death for all ages in the United States today and a leading cause of death among college and high school-aged youth and young adults.
✦ B. Suicide statistics are probably low because of unknown cases such as car accidents.
1. Suicide ranks fourth as the cause of death in the 15-to-40 age group.
2. For every successful suicide, it is believed that there are five to ten attempted suicides.
3. Women make more suicide attempts than men. Four times as many men as women actually commit suicide. Firearms, suffocation, and overdose are common methods.
4. Suicide is increasing in the adolescent and elderly age groups.

C. Factors that contribute to suicide attempts.
✦ 1. The single most common cause is depression; alcohol is a common contributing factor.
2. Another common cause is that individuals feel overwhelmed by problems in living.
3. A final cause may be the attempt to communicate a message of hopelessness, anger, or distress to others.

✦ D. Depressed clients, when severely ill, rarely commit suicide.
1. They do not have the drive and energy to make a plan and follow it through when severely depressed.
2. Danger period occurs when depression begins to lift.

✦ E. Many individuals give warnings or messages through direct or indirect means. Many had seen a primary care provider within weeks of the suicide.
F. Accompanying symptoms range from depression, disorientation, and defiance to intense dependence on another.

Assessment

✦ A. Recognize level of depression and potential for suicide (when depression begins to lift).
✦ B. Determine presence of suicide ideation, means, plan, ability to complete plan.
C. Observe behavior closely as clues to potential suicide.
D. Listen to verbalization to determine what is meaningful for client.
E. Observe physical status so you can intervene if necessary (if client is not eating, sleeping, etc.).
F. Recognize ambivalence when client is considering suicide.

Implementation

✦ A. Client safety is the first priority—provide a safe environment to protect client from self-destruction.
✦ B. Observe client closely at all times, especially when depression is lifting. If client is not hospitalized,

monitor routinely and arrange for hospitalization if acuity increases.

✦ C. Establish a supportive relationship, letting client know you are concerned for his or her welfare.

D. Encourage expression of feelings, especially anger.

✦ E. Ask relevant questions that relate to potential suicide ideation (ideas): "Do you wish you were dead?" "Do you think you might do something about it? What?" "Have you taken any steps to prepare? What are they?"

✦ F. Evaluate the lethality of a suicide plan (specificity of details, lethality of proposed method, and availability of means).

✦ G. Recognize a continued desire to commit suicide by the client.

H. Focus on client's strengths and successful experiences to increase client's self-esteem.

✦ I. Provide a structured schedule and involve client in activities with others.

J. Structure a plan for client to use as a means of coping when next confronted with suicidal ideation.

K. Help client plan for continued professional support after discharge.

SUBSTANCE-RELATED DISORDERS/ ADDICTIVE DISORDERS

Definition: Substance dependence includes any process by which an individual ingests any mind-altering, nonprescribed chemical that produces physiological and/or psychological dependence. Withdrawal symptoms are usually manifested when the substance is not taken.

Characteristics

✦ A. Psychological dependence: emotional dependence, desire, or compulsion to continue taking the substance or drug to experience "normal" functioning.

✦ B. Tolerance: the need for greatly increased amounts of the substance to achieve the desired effect.

✦ C. Physiological dependence: physical need for the substance manifested by appearance of withdrawal symptoms when the substance is withheld.

D. Withdrawal from substance causes substance-specific syndrome—leads to impairment in areas of functioning.

Alcohol Abuse

✦ *Definition:* The abuse of any alcoholic substance combined with physical and psychological addiction.

Characteristics

A. Alcohol consumption is permitted by law and supported by most people in our society as a recreational activity.

B. A fine line exists between the social drinker and the addicted or problem drinker.

✦ C. The greatest difference involves the degree of compulsion to drink and the inability to survive the trials of everyday living without the ingestion of alcohol.

✦ D. An estimated 17 million Americans have alcohol use disorders including alcoholism and harmful drinking that does not reach the level of dependence.

E. Alcoholism is involved in thousands of deaths and injuries (auto accidents) every year.

F. The legal definition of intoxication in most states is 0.10% or higher blood alcohol level (in California, it is 0.08%).

G. Alcoholism decreases life span 10 to 12 years.

H. Suicide accounts for a significant percentage of deaths among alcoholics.

I. Loss to industry caused by alcoholism is estimated at $15 billion a year (affecting primarily the 35-to-55 age group) and overall costs of alcohol-related problems is estimated to be over $70 billion per year.

J. Major U.S. social concern is the dramatic rise in teenage alcoholism (estimated to affect 3 million adolescents).

Dynamics of Alcoholism

✦ A. Alcoholic disease implies the consumption of alcohol to the point where it interferes with the individual's physical, emotional, and social functioning.
1. The syndrome consists of two phases: problem drinking and alcohol addiction.
2. Dependence on other drugs is very common.

B. A genetic or familial predisposition to dependence may exist. Genetically determined genes determine the type of dependence an individual may develop.
1. Genetic influences are the same for both men and women.
2. Children of alcoholics have a four times higher risk of becoming alcoholic.

✦ C. Alcohol blocks synaptic transmission, depresses the central nervous system (CNS), and releases inhibitions. It acts initially as a stimulant but is actually a depressant.
1. Chronic excessive use can lead to brain damage.
2. High blood levels may cause malfunctions in cardiovascular and respiratory systems.

D. Psychological effects of alcohol appear to be the gratification of oral impulses and the reduction of superego forces; abuse leads to shame and guilt and impaired ego formation.

E. Alcohol may be said to be a defense against overwhelming psychological needs and conflicts; therefore, the client needs to work on problems causing his or her distress.

F. Illnesses associated with chronic alcoholism.
   1. Wernicke-Korsakoff's syndrome (related to thiamine deficiency).
   2. Delirium tremens.
   3. Gastritis, esophagitis, and pancreatitis.
   4. Malnutrition resulting in beriberi, pellagra, cerebellar degeneration, and anemia.
   5. Laënnec's cirrhosis, hepatitis, and fatty liver.
   6. Peripheral neuropathy (related to vitamin B deficiency).
   7. Osteoporosis.
   8. Individual is prone to infection.
   9. Blood dyscrasias.
   10. Sexual dysfunction.

Personality Characteristics of an Alcoholic

✦ A. Dependent personality with resentment toward authority.
B. High self-expectations and low frustration tolerance.
C. Life usually characterized by patterns of failure.
D. False sense of success, power, and confidence from use of alcohol.
E. Apparent need to ease suffering, reduce anxiety, and cope with life stresses through use of alcohol.
F. Decreased ability to function intellectually, emotionally, and socially as need for alcohol increases.
G. Difficulty in interpersonal relationships.
H. Tendency to work, play, and engage in sex more than is normal.
I. Risk-taking propensity.

Assessment

✦ A. Assess inability to control alcohol consumption.
   1. Episodic drinking.
   2. Continuous excessive drinking.
   3. Sneaking drinks.
   4. Morning drinking.
   5. Blackouts.
   6. Arguments about drinking.
   7. Absence at work or school due to hangovers and drinking episodes.
   8. Difficulty with interpersonal relationships due to drinking habits.
   9. Alcohol-related police record.

B. Recognize physical condition due to improper nutrition.
   1. Cirrhosis.
   2. Anemia.
   3. Peripheral neuropathy.
   4. Brain damage.
   5. Delirium tremens.

C. Evaluate accidents or physical injuries caused by intoxication.
D. Determine level of acute intoxication.
   1. Drowsiness, ataxia, nystagmus.
   2. Respiratory depression, stupor, possible coma, and death.

Alcohol Withdrawal Symptoms

A. Hangover: mild alcohol withdrawal (usually the day after); symptoms include headache, nausea, vomiting, restlessness, irritability and the "shakes."
B. General withdrawal symptoms from heavy drinking.
   1. Nausea and vomiting.
   2. Insomnia.
   3. Anorexia.
   4. Anxiety.
   5. Hyperalertness and irritability.
   6. Restlessness.
   7. Chronic tremors of hands, tongue, and eyelids.
   8. Malaise and weakness.
   9. Sweating.
   10. Elevated temperature.
   11. Depressed mood.
   12. Headache.

C. Delirium tremens: an acute condition usually manifested within 24 to 72 hours after the last ingestion of alcohol. May appear 7 to 10 days later during drinking periods when no food is ingested. *LIFE THREATENING.*
   1. Marked tremors/seizures.
   2. Hallucinations/illusions.
   3. Paranoia.
   4. Disorientation and severe agitation.
   5. Tachycardia.
   6. Tachypnea.
   7. Diaphoresis.
   8. Diarrhea and vomiting.
   9. Convulsions (grand mal).
   10. Death (10% to 15% from cardiac failure).

Implementation

✦ A. Nursing attitudes.
   1. Maintain a nonjudgmental attitude toward the alcoholic.
   2. Be firm and consistent in approach.
   3. Be accepting toward the individual, not his or her deviant behavior.
   4. Be supportive of attempts to change life patterns.

✦ B. Acute treatment phase. Utilize Withdrawal Assessment Scoring Guidelines (CIWA-Ar) (see **Table 14-6**).
   1. Provide adequate diet and fluid intake.
   2. Provide vitamin therapy, especially vitamin B_6 and B complex.
   3. Promote rest, provide reassurance.
   4. Control environment to decrease stimuli and provide for safety.

Table 14-6 ALCOHOL WITHDRAWAL ASSESSMENT SCORING GUIDELINES (CIWA-AR)

Assess and rate each of the following:

Nausea/Vomiting:
Rate on scale of 0–7.
0 = no nausea
1 = mild nausea with no vomiting
4 = intermittent nausea
7 = frequent nausea and vomiting

Anxiety: Ask about anxiety, observation.
Rate on scale of 0–7.
0 = no anxiety
1 = mildly anxious
4 = moderately anxious, or guarded
7 = equivalent to acute panic attacks as seen in delirium or acute schizophrenic reactions

Paroxysmal Sweats:
Rate on scale of 0–7.
0 = no sweats
1 = barely perceptible sweating, palms moist
4 = beads of sweat obvious on forehead
7 = drenching sweats

Tactile Disturbances: Ask about pins and needles, itching, burning, crawling skin.
Rate on scale of 0–7.
0 = none
1 = very mild itching, pins and needles
2 = mild itching, pins and needles, burning
3 = moderate itching, pins, needles, burning
4 = moderate hallucinations
5 = severe hallucinations
6 = extremely severe hallucinations
7 = continuous hallucinations

Visual Disturbances: Ask "Does the light appear to be too bright?", "Does it hurt your eyes?", "Are you seeing anything that disturbs?"
Rate on scale of 0–7.
0 = none
1 = very mild sensitivity
2 = mild sensitivity
3 = moderate sensitivity
4 = moderate hallucinations
5 = severe hallucinations
6 = extremely severe hallucinations
7 = continuous hallucinations

Tremors: Have individual extend arms and spread fingers.
Rate on scale of 0–7.
0 = no tremor
1 = not visible but can be felt fingertip to fingertip
4 = moderate with arms extended
7 = severe even with arms not extended

Agitation:
Rate on scale of 0–7.
0 = normal activity
1 = somewhat normal activity
4 = moderately fidgety and restless
7 = paces or constantly thrashing about

Orientation and Clouding of Sensorium: "What day/date is this?", "Where are you?", Who am I?"
Rate on scale of 0–4.
0 = oriented
1 = uncertain about date
2 = disoriented to date by no more than 2 days
3 = disoriented to date by > 2 days
4 = disoriented to place and/or person

Auditory Disturbances: Ask "Are you hearing sounds or voices around you?", "Do you hear anything that disturbs you or isn't there?", "Are they harsh?", "Do they startle you?"
Rate on scale of 0–7.
0 = none
1 = very mild harshness or ability to startle
2 = mild harshness or ability to startle
3 = moderate harshness or ability to startle
4 = moderate hallucinations
5 = severe hallucinations
6 = extremely severe hallucinations
7 = continuous hallucinations

Headache:
Rate on scale of 0–7.
0 = not present
1 = very mild
2 = mild
3 = moderate
4 = moderately severe
5 = severe
6 = very severe
7 = extremely severe

Total score for the 10 categories combined. Scale for scoring (scale used in different agencies may vary by a point or two in each level): 0–9 absent or minimal withdrawal; 10–19 mild to moderate withdrawal; > 20 severe withdrawal. Protocol interventions, including medication dosage and frequency, are determined by score. Frequency of vital signs is determined by score and client stability.

Reproduced from Assessment of Alcohol Withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar), *Br J Addict.* 1989 Nov; 84(11):1353–7.

5. Institute measures to control nausea and insomnia.
6. Observe signs of infection or physiological problems, including seizures.
7. Orient as needed.
8. Assess mental status including presence of tactile and auditory hallucinations, altered sensorium, confusion, and anxiety.
9. Administer tranquilizer as ordered or per CIWA protocol, usually a benzodiazepine.
10. Observe vital signs.

C. Long-term treatment phase.
✦ 1. Set up a controlled and structured environment until client is able to manage his or her own circumstances.
   a. Set behavior limits and confront the client who is manipulative.
   b. Suggest group involvement for the client who experiences loneliness.
   c. Remember that client needs support, firmness, and a reality-oriented approach.
✦ 2. Treatment techniques.
   a. Client must first go through detoxification—acute nursing care to cope with toxic state and return to a nonalcoholic state.
   b. Help client accept the fact that alcoholism is an illness.
   c. Help client accept that life must be managed without the support of alcohol.
   d. Provide activities such as group and family therapy and introduction to concepts of recovery.
      (1) Focus on the underlying emotional problems.
      (2) Offer assistance in handling anxiety.
      (3) Focus on relieving feelings of inferiority and low self-esteem.
   e. Provide for rehabilitation or long-term supportive care.
      (1) Encourage client to continue psychotherapy on an outpatient basis.
      (2) Refer client to recovery program, such as Alcoholics Anonymous. Encourage identification of sponsor and daily meeting attendance during initial abstinence.
      (3) Encourage client to continue taking prescribed medication such as Antabuse (disulfiram)—alcohol-sensitizing drug that causes vomiting and cardiovascular symptoms if the person drinks alcohol.
      (4) Suggest social or vocational rehabilitation community programs that are available.

Substance Dependence

Definition: Substance dependence is a state of dependency on drugs other than alcohol or tobacco that involves alteration of perception or mood and is produced by repeated consumption of the drug, causing tolerance to the substance and withdrawal symptoms.

Withdrawal may range from discomfort to life threatening. Many individuals mix substances. It is important to identify if there is multiple drug use as well as consumption of alcohol, which increases risk for overdose and death.

Generalized Personality Characteristics

A. Difficulty forming intimate relationships.
B. Feelings of insecurity and inadequacy.
C. Rebellious toward authority.
D. Self-centered.
E. Copes through escapism.
F. Difficulty with sexuality and sexual identification.

Specific Drug Addictions

✦ A. Opioid addiction.
   1. The most common types of opioids are heroin, Avinza (morphine), Vicodin (hydrocodone), Dilaudid (hydromorphone), Actiq (fentanyl), and OxyContin (oxycodone).
   2. Emotional dependence on the drug (to alter mood) occurs first, followed by physical dependence on the drug.
   3. Opioids (narcotics) have a sedative or depressant effect on the CNS.
   4. Tolerance level increases, so greater amounts of the drug are necessary to produce desired effects.
   5. Addiction tends to be chronic, with a high rate of relapse.
   6. Withdrawal symptoms.
      a. Anxiety.
      b. Nausea and vomiting.
      c. Sneezing, yawning, watery eyes, and runny nose.
      d. Tremor and profuse perspiration.
      e. Stomach cramps, muscle aches, and dehydration.
✦ B. Sedative–hypnotics, anxiolytics–barbiturate addiction.
   1. Common drugs include Valium (diazepam), Ativan (lorazepam), Soma (carisoprodol), Xanax (alprazolam), Luminal (phenobarbital), and Fiorinal (aspirin, butalbital, and caffeine).
   2. CNS depressants—danger of death from overdose and withdrawal. They are often implicated in suicide attempts.
   3. Psychological dependence occurs, followed by tolerance and physical dependence.
   4. Drug may have been prescribed for relief of chronic pain, anxiety, or sleeplessness.
   5. Withdrawal may result in delirium, seizures, and death.
   6. Overdoses and acute withdrawal are medical emergencies and require hospitalization. Onset of withdrawal symptoms depends on a number of factors including half-life of the substance used.

✦ C. Amphetamines—Benzedrine and Dexedrine.
1. All produce a "high."
2. All are CNS stimulants, so overuse may result in brain damage, mental status changes, capillary bleeding, cardiac changes, and death.
3. Large doses produce a hyperactive and agitated state.
4. Amphetamines are emotionally addictive, especially for persons who harbor insecurities,
5. Amphetamines affect individual's physical condition as the drug reduces appetite and awareness of body needs.

D. Lysergic acid diethylamide (LSD)—"acid."
1. LSD is a hallucinogenic drug and mimics hallucinations seen in psychoses.
2. LSD produces changes in perception and logical thought processes.
3. Drug not considered addictive per se, but individuals may become emotionally dependent on it.
4. Experiences with LSD range from ecstasy to terror, and the results are unpredictable.

E. Cannabis (marijuana).
1. Marijuana was considered to have low abuse potential but now most professionals agree that this is not the case.
2. It produces a "dreamy" state and feelings of euphoria, hilarity, and well-being.
3. Moods vary according to environmental stimuli.
4. Marijuana changes perception of space and time, which seem distorted and extendible.
5. High dosage may produce hallucinations and delusions.

✦ F. Cocaine.
1. Cocaine is classified as a stimulant.
2. Usual method of ingestion is by sniffing, intravenous (IV), or smoking.
3. Use may cause strong psychological dependence.
4. Physical dependence may occur, especially if used repeatedly.
5. Chronic users often abuse or are dependent on a narcotic, alcohol, or antianxiety drug to lessen the withdrawal symptoms of cocaine.

G. "Crack."
1. The most addictive drug known; a form of hydrochloride cocaine.
2. It is smoked in cigarettes or glass water pipes.
3. Crack is cheap and quickly addictive because there is a rapid high, then a "downer" that makes the person desire more crack.
4. Symptoms include paranoia, depression, and physical symptoms.

H. Phencyclidine (PCP)—"elephant tranquilizer," "angel dust."
1. PCP may also be ingested, injected, taken intravenously, or sniffed.
2. Reactions vary from a sense of well-being to acute anxiety to total disorientation and hallucinations.
3. PCP is considered an extremely dangerous "street" drug.
4. Psychological dependence may occur.
5. Cardinal signs of PCP use are blank stare, ataxia, muscle rigidity, nystagmus, and tendency toward violence.
6. Cerebral cellular destruction and atrophy occur with even small amounts.
7. Overdoses or "bad trips" are characterized by erratic, unpredictable behavior; withdrawal symptoms; disorientation; self-mutilation; or self-destructive behavior.
8. Overdoses are treated with sedatives, decreased environmental stimuli, and protecting client from harming self and others. Cannot be "talked down."

Assessment

A. Establish name and action of drug used.
B. Assess when addiction or abuse began in client's life.
C. Determine amount of drug used.
D. Determine other drugs used.
E. Assess physical condition of client by physical exam and blood and urine lab work.
F. Assess psychological network in which client lives.
G. Evaluate rehabilitative potential and support systems.

Implementation

✦ A. Support client during withdrawal, which is the first step in treatment and may be accomplished abruptly ("cold turkey") or gradually over a period of days depending on substance used.

B. Use of the Clinical Opiate Withdrawal Scale (COWS) is commonly used for assessment of clients withdrawing from opiates. It elicits an aggregate score for heart rate, sweating, restlessness, pupil size, joint and muscle pain, nasal discharge and tearing, GI distress, tremor, yawning, anxiety, and piloerection. Treatment options are determined based on score.

✦ C. Administer medications—e.g., Dolophine (methadone), Buprenex (buprenorphine), and Catapres (clonidine)—if ordered, to reduce the physical reaction and complications to withdrawal.

D. Provide other medical and psychiatric treatment if physical and emotional deterioration or complication including alterations in nutrition, gastrointestinal disturbance, seizures, anxiety, and craving.

E. Encourage client to participate in recovery programs by professional or community resources.
F. Provide client with information concerning rehabilitation programs designed to help client reenter the mainstream of society.
   1. Various self-help groups such as Narcotics Anonymous offer aid in rehabilitation.
   2. Therapeutic communities and group therapy programs also provide support.
✦ G. Provide support to client during adverse reaction, hallucinations, acute anxiety, and panic reactions to drug experiences or withdrawal.
   1. Place client in a quiet, safe environment with close supervision to prevent complications associated with LSD for example.
   2. Reassure client that this reaction is the result of the drug and of short duration.
   3. Provide careful reality orientation by nurse.
   4. Use nonthreatening, supportive approach.
   5. Reassure client that he or she will not be allowed to harm himself or herself.
   6. Refer client to drug counseling when the acute experience is over.

COGNITIVE IMPAIRMENT DISORDERS

✦ *Definition*: Cognitive disorders are disorders with organic etiology that may be reversible (delirium) or irreversible (dementia), and include clinically significant deficits in cognition or memory that result in significant changes in a client's level of functioning and disturbed behavior. Delirium is considered a medical condition while dementia a psychiatric condition. (See **Table 14-7**.)

Table 14-7 DELIRIUM VERSUS DEMENTIA

	Delirium	Dementia
Onset	Acute, rapid onset of impairment	Insidious onset—slow deterioration
Etiology	Interference with cerebral function Could be caused by injury, infection, metabolic, chemical or toxic exposure	Unknown, but may result from a variety of sources (prenatal, infection, circulatory, trauma, growth, etc.)
Progression	Reversible—lasts hours or weeks, usually resolves in few days	Irreversible—slow, progressive deterioration
Primary characteristics	Cloudy state of consciousness	Multiple cognitive deficits

Delirium

Characteristics

✦ A. Characterized by a disturbance or fluctuation of consciousness and a change in cognition that develops over a short period.
B. Approximately 10% of all hospitalized elderly have delirium and many develop delirium while hospitalized.
C. Global intellectual impairment with rapid onset.
D. Thinking, memory, attention, and perception are disturbed and impaired, but may vary—are not stable.
✦ E. Condition may last hours or weeks; usually resolves in a few days with treatment.
✦ F. Etiology.
   1. Any acute disease or injury that interferes with cerebral function and often is temporary and reversible.
   2. Includes infections (urinary tract infections; UTIs), circulatory disturbances, metabolic and endocrine disorders, neoplasms, and tumors.
   3. Injuries include brain trauma, invasive trauma.
   4. Other causes are toxic exposure, drugs, or systemic intoxication.

Assessment

A. Assess for clouding of consciousness—a cardinal symptom.
✦ B. Assess for intellectual deficits and changes.
   1. Recent memory loss.
   2. Poor abstract thinking.
   3. Poor problem-solving ability.
✦ C. Assess for presence of hallucinations (visual most common), delusions, and confusion.
✦ D. Assess for loss of contact with reality.
   1. Inattentive and distractible.
   2. Disorientation to time and place, but not usually to person.
E. Check for increased motor activity with no defined purpose (groping, sudden movements, restlessness, wandering).
F. Assess emotional stability.
   1. Reactions are blunted.
   2. Fearful or suspicious.
   3. Apathetic.
   4. Anxious.
   5. Euphoric.
G. Assess alterations in adjustment: tend to be worse at night, more fearful, moaning and calling out.

Implementation

A. Provide adequate nutritional and fluid intake as ordered by treatment plan.
✦ B. Keep client in a quiet, safe, structured environment.
C. Observe and monitor vital signs as necessary.

✦ D. Provide for safety, including falls.
E. Implement treatment plan for elimination of causative factors.
F. Provide reality orientation approach with client.
G. Set limits on inappropriate behavior.
✦ H. Express directions in a simple and concrete manner.
I. Observe client for signs of fever, shock, and increased intracranial pressure such as restlessness, acute anxiety, pain, and changes in vital signs.
J. Reassure and involve family as is appropriate.
K. Prevention and early detection are key.

Dementia

Characteristics

✦ A. Organic condition characterized by development of multiple cognitive deficits.
✦ B. Common cognitive disturbances include at least one of the following: aphasia, apraxia (impaired ability to carry out motor activities, despite intact motor function), agnosia (loss of sensory ability to recognize objects), or a disturbance in executive functioning.
1. Difficulty thinking abstractly, planning, initiating, and completing complex multistep tasks. Eventually, simple tasks become difficult.
2. Causes difficulties in social and occupational functioning.
✦ C. Insidious onset but slow, progressive deterioration occurs.
D. Etiology is specifically unknown: results from wide variety of sources.
1. **Prenatal causes**: congenital cranial anomaly, congenital spastic paraplegia.
2. **Infection**: central nervous system, syphilis, meningoencephalitis, human immunodeficiency virus (HIV).
3. **Intoxication**: drug or poison, alcohol.
4. **Trauma**: brain trauma by gross force, brain surgery.
5. **Circulatory disorder**: cerebral arteriosclerosis.
6. **Disturbance of innervation**: convulsions.
7. **Disturbances of metabolism, growth, or nutrition**.
a. Senile brain disease: dementia.
b. Glandular problems.
c. Pellagra.
8. **New growths**: brain neoplasm.

Types of Degenerative Conditions

Dementia, Alzheimer's Type

✦ A. Most common form of dementia: accounts for majority of known cases.
1. More than 5 million in the United States have Alzheimer's disease.
2. By 2050, over 14 million will develop this disease.
✦ B. Unknown etiology but diffuse atrophy of cerebral cortex occurs.
C. Usually begins after age 60 but can be observed at age 40. Dementia, Alzheimer's type (DAT) average course is 5 to 10 years but there is variance.
D. Symptoms gradually and progressively worsen, irreversible.
E. Clients may live for 10 years or longer but will eventually progress to requiring total care. The impact to families' emotional and economic well-being is dramatic.
F. Three clinical stages of DAT.
1. Early stage: Client is forgetful, confused, irritable; family begins to notice changes.
2. Middle stage: Increased memory loss, recall of recent events diminishes, activities of daily living (ADLs) become difficult to accomplish. Aggressiveness and social inappropriateness present. Wandering increases.
3. Late stage: severely disoriented, delusional, and paranoid. Client may not speak, forgets family members, and soon becomes helpless.

Pick's Disease

✦ A. Rare heredodegenerative process of frontal lobe not associated with normal aging.
B. Becomes well advanced in 2 to 3 years.
✦ C. Characterized by changes in personality early in course of illness.
D. Similar to Alzheimer's disease but involvement spares parietal lobes.
E. These clients act dull and lack initiative; otherwise, their disease resembles Alzheimer's disease.

Huntington's Chorea

✦ A. Genetically transmitted disorder caused by a single autosomal dominant gene.
B. Onset of symptoms—age 40 to 50 years.
C. Progressive mental and physical deterioration inevitable.
D. Characterized by personality changes with psychotic behavior, intellectual impairment, and, finally, total dementia.

Korsakoff's Syndrome

✦ A. A disorder that occurs in chronic alcoholism and is often associated with Wernicke's encephalopathy.
✦ 1. Wernicke's encephalopathy.
a. Acute, life-threatening neurologic condition that can occur as a result of chronic alcoholism (inadequate diet leading to thiamine deficiency).

b. Usual symptoms are cloudy consciousness, impaired mentation, ataxia, peripheral neuropathy.
c. Treatment is oral vitamin B complex and thiamine 100 mg intramuscularly (IM) STAT if client presents with the above symptoms and has a history of alcohol abuse.

2. Korsakoff's syndrome is a chronic condition that remains after Wernicke's encephalopathy is treated.

✦ B. Most important feature is recent memory impairment, especially in learning new information.
1. Confabulation (making up stories) accompanies memory impairment.
2. Memories for past events are not usually affected.

✦ C. Syndrome improves with adequate diet (especially including vitamin B complex and thiamine) but many do not recover fully.

Vascular Dementia

A. Type of dementia involving intermittent emboli or infarcts that destroy brain tissue. (Also called *ischemic vascular dementia*.) Hypertension is also implicated.
B. This form is the second most commonly occurring type of dementia.
C. Characteristics include abrupt onset with numerous remissions and exacerbations; client may also have a history of diseases affecting other organs.

Creutzfeldt–Jakob Disease

A. Suspected to be caused by an infection of a prion spread after transplant (cornea) or injection of human growth hormone.
B. A new variant of this disease known as mad cow disease (bovine spongiform encephalopathy [BSE]) was identified in 1996 and may be linked to eating contaminated beef.

Dementia with Lewy Bodies

A. This form of dementia is named for the development of Lewy bodies in the cerebral cortex.
1. The appearance of Parkinsonism symptoms is caused by effects on the extrapyramidal tract of the CNS.
2. Symptoms include intermittent confusion, lapses of consciousness, and psychiatric problems.

B. Clients may have this form of dementia alone (less common) or concurrent with DAT (20% to 30%).

Dementia Due to HIV Disease

A. Presence of a dementia that is a direct consequence of HIV disease.
B. Involves diffuse, multifocal destruction of white matter and subcortical structures.
C. Characterized by forgetfulness, slowness, poor concentration, difficulties with problem solving, and hallucinations.

Assessment

A. Assess onset, which is generally slow.
B. Evaluate if illness is stabilized or in remission.
C. Assess for increasing deterioration.
D. Look for the following symptoms:
✦ 1. Cognitive impairment.
a. Disorientation.
b. Severe loss of memory.
c. Judgment impairment.
d. Loss of capacity to learn.
e. Perceptual disturbances.
f. Decreased attention span.
g. Paranoid ideation.

✦ 2. Affective impairment.
a. Decreased motivation, interests, and self-concern.
b. Loss of normal inhibitions.
c. Loss of insight.
✦ d. Labile mood, irritableness, and explosiveness.
e. Depression.
f. Withdrawal.
g. Anxiety.

✦ 3. Behavioral impairment.
a. *Sundowning*—a syndrome of restlessness, confusion, and disorientation that typically begins in late afternoon and gradually worsens. Clients wander or exhibit other aberrant motor activities (such as pacing).
b. Ritualistic, stereotyped behavior to deal with environment.
c. Possible combativeness or verbal aggression.
d. Possible inappropriate and regressive behavior.
e. Alterations in sexual drives and activity.
f. Neurotic or psychotic behavior as client's defenses break down.

E. Assess psychological reactions to organic brain disorder.
1. Change in self-concept.
2. Anger and frustration as reactions to forced change in life role.
3. Denial used as defense.
4. Depression.

5. Acceptance of limitations.
6. Assumption of "sick" role by dependency and lack of motivation.

Implementation

✦ A. Meet client's physical needs and provide for safety.
   1. Avoid fostering dependence.
   2. Establish routine for activities of daily living.
   3. Assure the environment is safe. Prevent use of appliances, for example, to prevent injury.

✦ B. Help client maintain contact with reality.
   1. Give feedback.
   2. Avoid small chatter.
   3. Personalize interaction.
   4. Supply stimulation to motivate client.
   5. Keep client from becoming bored and distracted.

C. Assist client in accepting the diagnosis.
   1. Be supportive.
   2. Maintain therapeutic communication.
   3. During denial phase, listen and accept; do not argue.
   4. Assist development of awareness.
   5. Help client develop the ability to cope with his or her altered identity.

✦ D. Focus interactions with client and establish consistent contact.
   1. Have short, frequent contacts with client.
   2. Use concrete ideas in communicating with client.
   ✦ 3. Maintain reality orientation by allowing client to talk about his or her past and to *confabulate*—filling in memory gap with a made-up response (lie) to protect one's self-esteem.
   4. Acknowledge client as an individual.

✦ E. Provide activities that increase success of client.
   1. Social groups.
   2. Occupational therapy.
   3. Allow client, as interested, to do small chores around unit.

F. Monitor medications for dementia management.
   1. Acetylcholinesterase inhibitors.
      a. Inhibits the enzyme acetylcholinesterase, which slows the breakdown of acetylcholine, thereby allowing more information to be transmitted from one cell to another.
      b. Memory and general cognitive activity increases, thus slowing the progression of dementia, especially early in the process of the disease.
      c. Commonly used drugs in the category are Aricept (donepezil), which slows breakdown of brain chemical acetylcholine vital for transmission of nerve signals, Exelon (rivastigmine), and Razadyne (galantamine).
      d. These drugs have both positive and negative results and must be individualized for the client.
   2. Namenda (memantine) for treatment of moderate to severe Alzheimer's.
      a. Temporarily delays worsening of symptoms.
      b. Side effects: headache, constipation, confusion, dizziness.
   3. Depressive symptoms for dementia.
      a. SSRIs appear to be more efficacious—Celexa (citalopram), Prozac (fluoxetine), and Zoloft (sertraline).
      b. Evidence fewer side effects than other antidepressants.
   4. Psychosis and dementia.
      a. If psychotic thoughts are present, medication may be required. It is important to differentiate medication side effects (Namenda for example) from disease process.
      b. When psychosis is associated with violence or dangerous behavior, medication, often short-acting benzodiazepines starting with low doses, is often utilized but sparingly and for short periods of time.
      c. For chronic aggressive behavior, Risperdal (risperidone) may be effective. Dosing is individualized and always at lowest dose to achieve benefits. Goal should be to reduce or discontinue medication if possible.
      d. Seroquel (quetiapine) is also effective and does not worsen cognition.
   5. Anger and aggression.
      a. For an acute episode, redirection or other nonmedicinal strategies should be attempted before medication is utilized.
      b. For gradually evolving tendencies or if a comorbidity of a mood disorder is present, Depakote (valproic acid) (125 mg BID with gradual increases as needed) may be administered.

✦ G. Provide supportive environment.
   1. Ensure a consistent staff and environmental structure.
   2. Do not change schedule suddenly.
   3. Provide handrails, walkers, wheelchairs, etc., as necessary.

4. Ensure that the floor is not slippery and that the environment is well lighted.

H. Assess client's disabilities and develop a nursing plan to deal with them.
   1. Update conferences with treatment team.
   2. Involve client in treatment planning as able.
   3. Communicate client needs to rehabilitation team.

I. Involve family and community in treatment and rehabilitation program.
   1. Plan visits by client to social community events.
   2. Encourage family involvement.
   3. Establish communication with family by using a friendly, warm approach.
   4. Encourage and arrange community groups (church groups, volunteer societies, and school groups) to visit on units.
   5. Refer family to support services.

J. Assist client to function at the highest level possible.
   1. Increase self-esteem.
   2. Avoid dependency.
   3. Allow and encourage personalization of client's room and environment.
   4. Dress client in his or her own clothing.
   5. Maintain client's cleanliness: clothes, hair, and person.
   6. Do not isolate client from others on the unit.

SCHIZOPHRENIC DISORDERS

Definition: Schizophrenia is a psychiatric syndrome characterized by thought disturbance, delusions, hallucinations, disorganized speech and behavior, and severely impaired interpersonal relationships. DSM-V does not include subtypes.

✦ Characteristics

A. Schizophrenia may result from many possible factors: genetic constellation and abnormalities in levels of neurotransmitters, in vitro insult, a deficit in cognitive development, or other biological origin.

B. Major maladaptive disturbances include impaired interpersonal relationships, inappropriate mental and emotional processes, and disturbances in overt behavior patterns.

C. Manifestations of the illness include acute psychosis involving the total personality or a group of symptoms circumscribed to one area of the personality.

D. Schizophrenia symptoms are often classified as positive or negative.

SCHIZOPHRENIA—POSITIVE AND NEGATIVE SYMPTOMS (DSM-V)

- Positive symptoms.
  a. Hallucinations.
  b. Delusions.
  c. Disordered speech; loose associations—when one thought does not connect to another or does not make any logical sense.
  d. Bizarre, disordered, or hyperactive behavior.
  e. Inappropriate affect.
  f. Suspiciousness.
  g. Hostility.
- Negative symptoms.
  a. Poverty of speech or alogia.
  b. Affective blunting.
  c. Social withdrawal, isolation.
  d. Apathy.
  e. Lack of motivation (avolition).
  f. Anhedonia (inability to experience pleasure).
  g. Attention impairment.
  h. Memory deficit.

Positive Symptoms

Definition: Excessive symptoms not normally present in healthy adults.

A. **Delusions**—fixed misinterpretation of reality; false beliefs maintained despite evidence to the contrary (somatic delusions are false beliefs that something is wrong with the body).

B. **Hallucinations**—unwilled sensory perceptions with no basis in reality; auditory, visual, olfactory, tactile, gustatory.

C. **Disordered speech and behavior**.
   1. Disordered speech includes frequent derailment or incoherence.
   2. Behavior is disorganized—catatonic or random, purposeless.

D. Terms associated with disordered speech or behavior.
   1. **Withdrawal**—adoption of more satisfying regressive behavior; focus on internal world (autism).
   2. **Depersonalization**—feelings of estrangement or unconnectedness of body parts.
   3. **Echolalia**—a condition in which the individual consistently repeats what is heard.
   4. **Echopraxia**—a condition in which the individual mimics what is done.
   5. **Neologism**—term that refers to the coining of a new word.
   6. **Word salad**—communication characterized by jumbled words with no coherent message.

Negative Symptoms

Definition: Loss of normal function normally present in healthy adults.

A. Flat affect—feelings or emotions minimal (i.e., flat, blunted, or inappropriate).
B. Alogia or poverty of speech. Client answers questions with one word, which may signify lack of thoughts.
C. Avolition is when the client is unable to follow goal-directed behavior; this is not the same as laziness.
D. Anhedonia is the inability to experience joy or pleasure in any aspect of life.
E. The previous four symptoms can be remembered by the "four As": affect flattened, alogia, avolition, and anhedonia.

✦ Schizophrenic Subtypes

✦ A. **Paranoid type**.
1. Persecutory or grandiose delusions are prominent; often delusions are part of a system where several delusions fit together.
2. Extreme suspiciousness and withdrawal are common manifestations.

✦ B. **Catatonic type**.
1. Secondary symptoms of motor involvement are present.
   a. Underactivity results in bizarre posturing; labeled *waxy flexibility*.
   b. Overactivity leads to agitation.
2. Negativism: doing the opposite of what is asked.
   a. Rigidity is the simplest form of negativism.
   b. Mute behavior is another form of negativism.
3. Catatonic excitement—the opposite of mute, withdrawn behavior when client is agitated and out of control.

✦ C. **Disorganized type**.
1. Flat or inappropriate affect: giggling and silly laughter (formerly labeled *hebephrenia*).
2. Disorganization of speech.
3. Disorganized behavior.
4. Absence of systematized delusions.

✦ D. **Undifferentiated type**.
1. This type is characterized by a combination of symptoms, none of which discriminates a specific type of disorder.
2. Flat affect and/or autism is usually present.
3. Association disorders and thought disturbance, such as delusions or hallucinations, are usually present.
4. This condition includes other behavioral maladaptations that cannot be otherwise classified.

E. **Residual type**.
1. A subtype that refers to a client who has had one episode of schizophrenia but now has no positive symptoms.
2. Negative symptoms are present.

Assessment

✦ A. Assess any disturbance in thought processes.
1. Client's thoughts are confused and disorganized, and ability to communicate clearly is limited.
2. Client manifests tangential (off target or off the original point) or circumstantial speech and has problems with symbolic meaning of certain words.
   a. May be very concrete in thinking and demonstrate an inability to think in abstract terms.
   b. May live in a fantasy world, responding to reality in a bizarre or autistic manner, thereby having great difficulty in testing reality.

✦ B. Assess any disturbance in affect.
1. Client has difficulty expressing emotions appropriately, and subjective emotional experience may be blunted or flattened.
2. Client has difficulty expressing positive or warm emotions; when they are expressed, it is often in an inappropriate manner.
3. While client's feelings may seem inappropriate to the thoughts expressed, they are appropriate to the client's inner experience and are meaningful to him.
4. Client's inappropriate affect makes it difficult to establish close relationships with others.

✦ C. Assess any disordered behavior.
1. Client's behavior is often disorganized and inappropriate and apparently lacks a purposeful activity.
2. Client typically lacks motivation or drive to change his or her circumstances; general condition is one of apathy and listlessness.
3. Client's behavior may appear to be bizarre and extremely inappropriate to the circumstances.

✦ D. Assess any disturbance in interpersonal relationships.
1. Client typically has great difficulty in relating to others.
   a. Cannot build close relationships; probably has not experienced close, meaningful relationships in the past.
   b. Has difficulty trusting others and experiences fear, ambivalence, and dependency that influence client's relationships with others.

c. Often learns to protect self from further hurt by maintaining distance, thus experiences lack of warmth, trust, and intimacy.

2. Client's relationships are impaired by the inability to communicate clearly and to react in an appropriate and empathic manner.

Implementation

✦ A. General approaches.

1. Establish a nurse–client relationship.
   a. Gradually increase client's social contacts with others.
   b. Build a positive and trusting relationship with client.
   c. Provide client with a safe and secure environment.

✦ 2. Stress reality, help client to reality test, to leave his or her fantasy world.
   a. Involve client in reality-oriented activities.
   b. Help client find satisfaction in the external environment.

3. Accept client as he or she is.
   a. Do not invalidate disturbed thoughts or fantasies.
   b. Do not invalidate client by inappropriate responses.

✦ 4. Use therapeutic communication techniques.
   a. Encourage expression of emotions, negative or positive.
   b. Encourage expression of thoughts, fears, and problems.
   c. Attempt to have nonverbal behavior become congruent with verbal communications.
   d. Focus on clear communications with the client.

5. Avoid fostering dependency relationship.
6. Avoid stressful situations or increasing client's anxiety.
7. Use real objects or activities (singing, for example) to distract or redirect delusional client.
8. Decrease client's anxiety level.
9. Use direct, honest, authentic, matter-of-fact approach.
10. Recognize that the nurse and others influence client even if client appears unresponsive, remote, and detached at times.

B. Approaches to specific symptoms.

✦ 1. **Delusions**.
   a. Encourage client to recognize distorted views of reality.
   b. Focus on client's ego assets, strengths, etc.
   c. Provide a safe, nonthreatening milieu.
   ✦ d. Divert focus from delusional material to reality; involve in games, tasks, simple activities.
   e. Provide experiences in which client can feel success.
   ✦ f. Utilize specific nursing responses:
      (1) Avoid confirming or feeding into delusion.
      (2) Stress reality by denying you believe the client's delusion, but do not invalidate client by saying delusion is not true—for the client, it is true.
      (3) Respond to feelings underlying the content of the delusion. For example, validate the feelings of client by asking, "I sense you are afraid. Is this true?"

✦ 2. **Hallucinations**.
   ✦ a. Provide a safe, structured environment with routine activities.
   b. Protect client from self-injury or hurting others prompted by "voices."
   c. Initiate short, frequent interactions.
      ✦ (1) Respond verbally to anything real that client talks about.
      ✦ (2) Avoid denying or arguing with client about the hallucinations he or she is experiencing.
      ✦ (3) Involve the client in reality-based tasks or activities (i.e., a person cannot sing and hallucinate at the same time).
      (4) Increase client's social interaction gradually from interaction with one person to interaction with small groups as tolerated by client.

✦ 3. **Withdrawn behavior**.
   ✦ a. Assist client to develop satisfying relationships with others.
      ✦ (1) Initiate interaction; do not expect a withdrawn client to seek you out.
      (2) Build a trusting relationship by being consistent in keeping appointments, in attitudes, and in nursing practice.
      (3) Be honest and direct in what you say and do.
      (4) Deal with your own feelings in relation to client's hostility or rejection.
   b. Help client to modify perception of self.
      ✦ (1) Do not structure situation in which client will fail.
      (2) Increase client's self-esteem by focusing on genuine assets or strengths.
      (3) Relieve client from decision making until client is able to make decisions.

c. Teach client renewal of social skills.
✦ (1) Gradually increase social contacts with staff and other clients.
(2) Increase social contacts with significant others when appropriate.
d. Focus on reality situations.
(1) Use a nonthreatening approach.
(2) Provide safe, nonthreatening milieu.
e. Attend to physical needs (e.g., nutrition, sleep, exercise, occupational therapy).

C. Approaches to dealing with aggressive or combative behavior.
✦ 1. Observe client acutely for clues that client is becoming agitated. Utilize medication if client is willing.
a. Note rising anger—verbal and nonverbal behavior.
b. Note erratic or unpredictable response to staff or other clients.
2. Intervene immediately when loss of control is imminent.
3. Use a nonthreatening approach to client.
✦ 4. Set firm limits on unacceptable behavior.
5. Maintain calm manner and do not show fear.
6. Avoid engaging in an argument or provoking client.
✦ 7. Summon assistance only when indicated; sudden involvement of many people will increase client's agitation.
8. Remove client from the situation as soon as possible.
9. Use seclusion and/or restraints *only* if absolutely necessary to prevent injury to client or others.
10. Attempt to calm client so that he or she may regain control.
11. Be supportive and stay with client.
✦ 12. Use problem-solving focus following outburst of aggressive or combative behavior.
a. Encourage discussion of feelings surrounding incident.
b. Attempt to look at causal factors of the behavior.
c. Examine client's response to stimulus and alternative responses.
d. Point out consequences of aggressive behavior.
e. Discuss client's role of taking responsibility for his or her aggressive behavior.

✦ D. Approaches to dealing with verbally abusive behavior.
1. Do not respond in kind to abusive comments.
2. Do not take abuse personally.
3. Interact with client on a therapeutic basis.
a. Help client examine his or her feelings.
b. Do not reject client despite abuse.
c. Give client feedback concerning your reactions to abusive comments.
d. Teach alternative ways for client to express his or her feelings.
4. Maintain a calm, accepting approach to client.

E. Approaches to dealing with demanding behavior.
✦ 1. Do not ignore demands; they will only increase in intensity. Respond to realistic demands.
2. Attempt to determine causal factors of behavior (e.g., high anxiety level).
3. Set limits when client is demanding.
4. Control own feelings of anger and irritation.
5. Teach alternative means to getting needs met.
6. Plan nursing care to include frequent contacts initiated by the nurse.
7. Alert the staff to try to give client the reassurance he or she needs.

Schizoaffective Disorder

✦ *Definition*: Condition that does not directly fit either schizophrenia or a mood disorder and, thus, is a mixture of symptoms. Illness is characterized by episodes of depression, mania, or both, concurrent with symptoms of schizophrenia.

Characteristics

A. Client may experience depression, mania, or mixed symptoms.
B. Symptoms may include delusions, hallucination, disorganized speech and behavior.
C. Clients often have difficulty functioning in their lives.

Assessment

A. Assess thought processes as similar to schizophrenic disorder.
B. Observe for bizarre behavior and mood disorders ranging from depression to elation (bipolar disorder).

Implementation

✦ A. Clients will be treated according to symptoms manifested—schizophrenic and/or mood disorder.
B. Drug therapy may be either antipsychotic (usually prescribed) or antidepressant drugs.
C. Check implementation section for both schizophrenic and mood disorders.

CHILD PSYCHIATRIC CONDITIONS

Definition: Emotional disturbance in childhood encompassing markedly abnormal or impaired development

in social interaction and communication and a marked restricted repertoire of activity and interests.

Pervasive Development Disorders

For these disorders, including autism spectrum disorders and attention deficit–hyperactivity disorder, refer to **Chapter 13, Special Topics in Pediatric Nursing**.

Adolescent Adjustment Problems

Definition: Adolescent emotional disturbances occur in adolescents when their behavior becomes maladaptive and they cease to function effectively.

Characteristics

- A. Adolescence is a period of ambivalence—dependence versus independence.
- B. Influenced by peer group pressures, the adolescent may experience an identity crisis because his or her own identity has not yet been resolved.
- C. The adolescent evidences an inability to resolve conflicts and to master developmental tasks (identity versus role diffusion). For a full discussion of Erikson's stages of development, see Chapter 3.
- D. Tasks of this stage of growth.
  1. Emotional separation from the parents.
  2. Foundations for an adult sense of self. One of the most difficult situations parents must face is the arguing and the testing of limits in which their child engages to develop this sense of self.
  3. Sense of personal identity. Teenagers continue to need love, support, and consistency from the adults around them.
  4. Resolution of dependency and control issues.
- E. Normal adolescent behavior can be perplexing at times, so abnormal behavior may not be so obvious or blatant. Families may become desensitized to abnormal behavior. (See **Table 14-8**.)

Assessment

- A. Assess degree of maladaptation or adjustment problems.
- B. Assess presence of confusion that may result in anxiety, depression, acting out, or antisocial behavior.

Table 14-8 ADOLESCENT BEHAVIOR CHART

Normal Behavior	Dysfunctional Behavior
Tends to be secretive and demands privacy from rest of family. Uses friends to ventilate feelings and concerns.	Secretive about experiencing severe emotional distress. Has no friends with whom he or she can communicate.
Varying degrees of loneliness; may feel loved but not understood.	Profound loneliness; feels total lack of loving; has no meaningful relationships. Danger of suicide.
Experiences need for peer involvement; is very conscious of peer pressure.	May be friendless and does not socialize well; may act indifferent to making friendships.
Varying levels of depression.	Long-standing depression may show as excessive passivity or agitation (agitated depression is seen as restless, hyperactive, bored, reckless, acting-out behavior). Danger of suicide.
Usually has at least one person who provides loving, supportive parenting.	Absence of parent or parents from home because of work or divorce. Emotional abandonment by parents. Conflict with stepparents. Alcoholic or abusive parents.
Families have varying degrees of conflict, overt or covert.	Adolescent views family as having severe, long-term conflict.
Family may move several times while child is growing up; usually location is stable.	Very frequent moves with little internal stability; may be accompanied by breakup of family.
Usually has infrequent school changes; school achievement varies.	May have frequent school changes; poor school achievement.
Parental discipline varies.	Extremes of parental discipline: too harsh or too permissive; inconsistent discipline.
Usually has few, infrequent major losses while growing up.	Many losses (parental love, frequent moves, etc.).
Impulse control varies; usually has had consistent parental help to control behavior.	Poor impulse control, usually from lack of positive role model; can lead to drug abuse, violence, criminal behavior, suicide.
Usually feels safe and cared for at home.	May feel unsafe and unwanted at home (child abuse, conflict with stepparent, sexual abuse in home).
Self-esteem varies; struggles to find own identity; uses conflict with family as a vehicle to work out internal struggles.	Poor self-esteem; extreme difficulty in working out self-identity; cannot use conflict with family to work out internal struggles.
Develops personal goals.	Unable to develop personal goals.
May have vague physical ailments that come and go, especially when going through a high-growth period.	May present physical symptoms of chronic stress: frequent headaches, panic attacks, stomach ulcers, etc.

✦ C. Observe for specific behaviors in adolescent maladjustment.
   1. Defiance and hostility, especially toward authority figures.
   2. Sullenness and withdrawal.
   3. Sexual deviations.
   4. Addiction to drugs or alcohol.
   5. Depression and self-destructive impulses or risk.
   6. Acting out or testing.

D. Assess developmental level at which adolescent is functioning.

E. Assess skills in problem solving, motivation, and general attitude.

F. Assess if the client is in touch with his or her feelings; how does client see relationship with parents, other adults, own-age peers?

G. Determine if client is in treatment willingly or because of a court order, parental insistence, etc.

H. Evaluate client's general communication skills, level of self-esteem, and interaction with peer group and adults.

I. Assess how client uses the problem behavior to meet needs.

J. Evaluate family structure.
   1. Determine whether the parents will join in treatment program.
   2. Ask parents how they believe the client's problems can be resolved.
   3. Determine the communication skills of each parent.
   4. Observe how the client's behavior meets the parents' needs.
   5. Assess other problems in the family (marital problems, other children with behavioral problems, financial worries, etc.).

K. Family behaviors that foster adolescent dysfunction.
   1. Scapegoating.
   2. Child or sexual abuse.
   3. Marital disharmony.
   4. Parental indifference.
   5. Unhealthy communication patterns—use of double messages.

Implementation

✦ A. Provide the experience of a positive relationship.
   1. Encourage open interaction so that adolescent can share fears, problems, concerns.
   2. Reinforce authentic behavior from client.
   3. Encourage group interaction with peers.

✦ B. Use behavioral approach.
   1. Set firm limits and be consistent in approach.
   2. Confront maladaptive behavior and reinforce efforts to change it.
   3. Avoid being manipulated or supportive of acting-out behavior.
   4. Give verbal positive reinforcement for appropriate behaviors.
   5. Help client create alternate activities to use as substitutes for destructive behaviors.
   6. Assist client to notice when he or she returns to old patterns of destructive behavior.

C. Use clear, open communication.
   1. Role model effective communication skills.
   2. Assist client to practice new styles of communicating; make use of role-playing, etc.
   3. Encourage exploration of feelings; provide safe environment for expression of feelings.

D. Assist adolescent to develop personal goals.
   1. Encourage client to set up personal goals, and provide encouragement and feedback.
   2. Assist client to identify steps in obtaining goal.
   3. Encourage client to examine his or her family's rules and develop alternate rules for living.
   4. Support client in sharing alternate rules with family and explore areas of negotiation.

TREATMENT MODALITIES

Eye Movement Desensitization and Reprocessing

A. Recently developed therapy utilized in treatment of trauma and PTSD.

B. Reduces symptoms of depression, anxiety, and symptoms of PTSD.

C. Advantages of therapy.
   1. Significant efficacy across symptom profile.
   2. Often, positive results require only a few sessions; previously, it could take years to resolve these problems.

Electroconvulsive Therapy

✦ *Definition*: Use of electronically induced seizures for the safe and effective treatment of severe depression, depression with psychotic features, and mania. Also called *interventional psychiatry*.

A. Electroconvulsive therapy has been negatively perceived by general public; in fact, it is one of the most useful treatments for major depression, and does not cause tissue damage or brain damage. Studies have demonstrated its efficacy.

B. Involves induction of grand mal seizure via transdermal electric pulse—unilaterally or bilaterally (usually at the temple)—may reestablish biochemical balance.

C. Usually given several times a week for a total of 6 to 18 treatments.

✦ D. Advantages.
1. Works when antidepressants aren't effective or can't be used. Quicker acting than antidepressants; occasionally used when imminent risk of suicide requires quicker results.
2. Safer for elderly with history of cardiac illness than antidepressant medication therapy.
3. Highly effective in treatment of major depressive episode with vegetative aspects improvement rate.

✦ E. Administration.
1. Three types of medication administered: an *anticholinergic* (*Robinul* [*atropine*]) to block vagal stimulation so secretions are reduced; a short-acting *general anesthesia*, administered IV, to make the client more comfortable; and a *muscle relaxant* (such as Anectine [succinylcholine]), to reduce complications from the convulsion itself.
2. Preoxygenation of the brain reduces risk of anoxia.
3. EEG monitoring monitors the seizure to ensure a therapeutic effect.
4. New shock waveforms are being used that require one-third as much power—reduces amnesia, confusion, and EEG abnormalities.
5. Have emergency care available.
6. Preparation: informed consent, medical history, and physical exam; lab work-up and education of client and family.
7. Side effects: memory loss for recent events and difficulty learning new information—effects usually resolve in 6–9 months (side effect of memory loss; occurs less often or is less severe with unilateral electrode); headaches, muscle aches, weight gain, hypertension, and, occasionally, cardiac arrhythmias.

✦ F. Nursing considerations.
1. Prior to procedure. Confirm client identity using two client identifiers.
   a. Explain to client and family about the procedure and how client will react upon awakening: confusion, disorientation.
   b. Keep NPO after midnight or for at least 6 hours.
   c. Have client void and remove lenses, dentures, and jewelry prior to treatment. Make note of implants such as pacemakers.
   d. Confirm consent form is signed.
2. Following procedure.
   a. Place client in lateral, recumbent position for drainage.
   b. Remain with client until alert.
   c. Monitor vital signs after general anesthesia.
   d. Reorient to unit.
   e. Reassure regarding memory loss and confusion.
   f. Assist to eat.

Behavior Modification

✦ *Definition*: Behavior modification is a process for dealing with problematic, maladaptive human behavior through planned, systematic interventions. It is a three-stage process involving behavior assessment, intervention, and evaluation.

Characteristics

✦ A. Behavior modification assumes that maladaptive behaviors have been learned or acquired through life's experiences.

B. The process draws on learning theory as an approach to the modification of behavior.
1. It involves stimulus–response type learning.
2. Techniques are drawn from Pavlov, Skinner, or stimulus–response theory.
3. It has been labeled *behavior conditioning*; the older term was *operant conditioning*.
4. It assumes that learned behavior is specifically connected with environmental reinforcers (e.g., U.S. eating patterns).
5. The appropriate location for behavioral intervention and change is the individual's environment.

C. Behavior cannot be thoroughly understood independent of events that precede or follow it.

D. The concept of contingency relationships is basic.
1. Relationships occur between behavior and reinforcing events.

✦ 2. Positive reinforcer is a desirable reward produced by a specific behavior; for example, salary is contingent on work: no work, no salary.

✦ 3. Negative reinforcer is a negative consequence of behavior; for example, a mother spanks a child for playing with matches.

4. Removal of a positive reinforcer; for example, a student is not allowed to watch TV until his or her homework is finished.

5. Removal of a negative reinforcer; for example, a mother threatens a child until the child cleans up his room. Removal produces avoidance behaviors.

✦ 6. Principle of extinction.
   a. Reduces the frequency of a behavior by disrupting its contingency with the reinforcement.
   b. Arranges conditions so that the reinforcing event, which has been maintaining the behavior, no longer occurs.

E. Goal is to arrange and manage reinforcement contingencies so that desired behaviors are increased in frequency and undesirable behaviors are decreased in frequency or removed.
F. Specific terminology.
   1. **Behavior problem**: condemned, excessive, or deficient behavior.
   2. **Operant behavior**: voluntary activities that are strongly influenced by events that follow them.
   3. **Reinforcer**: a reward that positively or negatively influences and strengthens desired behavior.
      a. A primary reinforcer is inborn.
      b. An acquired reinforcer is not inborn.
   4. **Stimulus**: any event impinging on, or affecting, an individual.
   5. **Accelerating behavior**: increase in frequency of a desired behavior.
   6. **Decelerating behavior**: decrease in frequency of an undesirable behavior.
   7. **Target behavior**: particular activities that the nurse wants to accelerate.

Principles of Implementation

A. The nurse can be the major treatment agent because he or she has the most significant number of contacts with the client and his or her environment.
B. The nurse may be in charge of designing and implementing the program.
C. The nurse may be in charge of supervising a program that another staff member is putting into effect.
D. Proximity to the client enables the nurse to identify any specifically maladaptive behavior.

Domestic Violence

Definition: In a domestic or family setting, the abuser becomes destructive and abusive; threatens or attacks the victim.

Characteristics

A. The abuser (the majority are males) makes demands and threats against the victim who attempts to appease the abuser.
B. The abuser loses control and hurts the victim and then tries to make up for this behavior by becoming loving and apologetic (cycle of violence).
C. Most often other family members or outsiders do not know what is happening inside the family.
D. Often the victim hides the abuse and will not seek help from their family or the outside.
E. Abusers evidence certain characteristics similar to sociopathic personalities.
   1. Poor self-esteem.
   2. Suspicious and dependent.
   3. History of sexual abuse or violent abuse during childhood.
F. Victims also have low self-esteem, are dependent and often depressed; they feel helpless and without power to change the situation.

Assessment

A. Recognize and assess for abuse in the victim (bruises, cuts, broken bones, etc.).
B. Assess the family situation.
C. Report suspected cases of domestic abuse.

Implementation

A. Assure privacy for the victim during examination; remind victim that information is confidential to allay fears.
B. If indicated, report to appropriate agency as a mandatory reporter.
C. Establish a nurse–client relationship to provide climate for the victim to feel safe in discussing family situation.
D. Encourage therapy for both victim and abuser; suggest group therapy, family counseling, and support groups.
E. Suggest therapy for the victim that focuses on building self-esteem, self-protective abilities, and problem-solving ability.

Crisis Intervention

✦ *Definition*: Crisis intervention is a form of therapy aimed at immediate intervention in an acute episode or crisis in which the individual is unable to cope alone.

Crisis Situation

A. An individual is typically in a state of equilibrium or homeostatic balance.
B. This state is maintained by behavioral patterns involving interchange between the person and his or her environment.
C. When problems arise, the individual uses learned coping mechanisms to deal with them.
✦ D. When a problem becomes too great to be handled by previously learned coping techniques, a crisis situation develops.
   1. Result is major disorganization in functioning.
   2. In circumstances of inability to resolve crisis, the individual is more amenable to intervention, and the potential for growth increases.
E. Precipitant factors in a crisis.
   1. Threat to individual security, which may be loss or threat of loss.
      a. Situational crisis: actual or potential loss (job, friend, mate, etc.).

b. Developmental or maturational crisis: any change (e.g., marriage, new baby).
c. Adventitious crisis: crisis of disaster.
d. Two or more severe problems arising concurrently.

2. Precipitants typically occur within 2 weeks of onset of disorganization.

Stages of Crisis Development

A. Initial perception of problem occurs first.
B. Tension and anxiety rises; usual coping mechanisms are tried.
C. Usual situational supports are consulted.
D. Known methods prove unsuccessful and tension increases.
E. If new problem-solving methods are unsuccessful, the problem remains and cannot be avoided.
1. Person's functioning becomes disorganized.
2. Extreme anxiety is likely to be experienced.
3. Perception is narrowed.
4. Coping ability is further reduced.
F. Resolution usually occurs within 6 weeks with or without intervention.

Characteristics

✦ A. Crisis is self-limiting, acute, and lasts 1–6 weeks.
✦ B. Crisis is initiated by a triggering event (death, loss, etc.); usual coping mechanisms are inadequate for the situation.
C. Situation is dangerous to the person; he or she may harm self or others.
✦ D. Individual will return to a state that is better, worse, or the same as before the crisis; therefore, intervention by the therapist is important.
E. Person is totally involved—hurts all over.
✦ F. At this time the individual is most open for intervention; therefore, major changes can take place and the crisis can be the turning point for the person.

Assessment

A. Examine period of disorganization.
1. Assess degree of disorganization.
2. Assess length of time situation has existed.
3. Determine level of functioning.
✦ B. Determine precipitant event.
1. Determine problem that triggered crisis.
2. Evaluate significance of the event to the individual.
✦ C. Assess past coping mechanisms.
1. Check history of occurrence of similar situations in past.
2. Assess past history of coping with similar situations.
D. Evaluate situational supports.
1. Ask about significant others in individual's life.
2. Check available agencies and resources.
E. Determine alternative coping mechanisms.
1. Assess new coping alternatives.
2. Assess uses of situational supports.

✦ Implementation

A. Focus on immediate problem.
B. Use reality-oriented approach.
C. Stay with "here and now" focus.
D. Set limits.
E. Stay with client or have significant persons available if necessary.
F. Explore available coping mechanisms.
1. Develop strengths and capitalize on them.
2. Do not focus on weakness or pathology.
3. Help explore the available situational supports.
G. Clarify the problem and help the individual understand the problem and integrate the events in his life.
H. When the above steps are completed, some plans for future support should be established between nurse or crisis worker/therapist and the client.

Rape Trauma Syndrome

✦ *Definition*: Rape is a nonconsensual sexual assault on a person (vast majority of victims are female and most perpetrators are male) that is basically an act of violence; only secondarily considered a sex act.

Assessment

A. Before assessment, inform victim of his or her rights.
1. Use of a rape crisis advocate.
2. Notify victim's personal physician.
3. Privacy rights during assessment.
4. Confidentiality is maintained by staff.
5. Client gives consent for all tests and procedures.
B. Physical data gathered.
1. Assist with a complete physical examination.
2. Carefully assess and document all physical damage.
a. Injuries.
b. Signs of physical entry.
C. Emotional data.
1. Degree of emotional trauma.
2. Presence of symptoms.
✦ D. Crisis response phases.
1. **Impact or acute phase**: shock, crying, high anxiety, hysterical, incoherent, agitated, fearful, volatile, poor problem-solving ability.
2. **Reconstitution phase**: denial, appears calm and controlled, withdrawn, fearful, begins to talk about feelings, expresses anger, makes decisions.
3. **Resolution phase**: realistic attitudes, able to express feelings, controlled anger, acceptance of facts.

Implementation

✦ A. Treatment focus for rape trauma syndrome.
1. **Emotional**: crisis counseling and contact Women Against Rape; rape advocate.
2. **Medical**: immediate medical care; assess assault and degree of trauma.
3. **Legal**: do not bathe, douche, or change clothes; gather evidence, taking pictures may be part of protocol. Notify law enforcement.

B. Guidelines for care.
✦ 1. Recognize that the assault of rape is a humiliating and violent experience and that the victim is experiencing severe psychological trauma.
2. Accept the fact that the victim was indeed raped and that the victim is to be supported, not treated as the "accused."
3. Understand that the victim's behavior might vary from hysterical crying and/or laughing to very calm and controlled.
4. Victims may need encouragement and support to report rape to the authorities.

✦ C. Interventions.
✦ 1. Provide immediate privacy for examination.
2. Choose a staff member of the same sex to be with the victim.
3. Remain with the victim.
4. Administer physical care.
a. Do not allow client to wash genital area or void before examination; these actions will remove any existing evidence such as semen.
b. Keep client warm.
✦ c. Prepare client for complete physical examination to be completed by physician (same sex as client if possible).
d. Physical exam includes
(1) Head-to-toe exam.
(2) Pap smear.
(3) Saline suspension to test for presence of sperm.
(4) Acid-phosphatase to determine how recently the attack occurred.
e. Physical treatment may include
(1) Prophylactic antibiotics.
(2) Tranquilizers.
✦ 5. Provide emotional support.
a. Demonstrate a nonjudgmental and supportive attitude.
b. Express warmth, support, and empathy in relating to the victim.
c. Listen to what the victim says and document all information.
d. Encourage the victim to relate what happened, having client tell you in his or her own words if it appears that client would like to talk about the experience.
e. Do not insist if client chooses not to talk; allow the victim to cope in his or her own way.
f. During the interview, continue to be sensitive to the victim's feelings and degree of control. If in relating the attack client becomes hysterical, do not continue questioning at this time.
6. Provide beginning follow-up care.
a. Assess ability to cope when client leaves hospital (suicide potential).
b. Explore support system and resources.
c. Encourage victim to arrange follow-up visits with a counselor.
d. Involve in planning and support decisions.
✦ 7. Termination of crisis relationship.
a. Counsel client to receive repeat test for sexually transmitted diseases in 3 weeks and HIV in several months, or sooner if symptoms appear.
b. Help reestablish contact with significant people.
c. Refer to appropriate community resource for follow-up care.
(1) Sexual assault can have a long-term impact on the victim.
(2) Many communities have a "hotline" that offers crisis counseling to victims.
d. Keep accurate records, as they may be important in future legal proceedings.

Environmental Therapy

Definition: Environmental therapy is a broad term that encompasses several forms and mechanisms for treating the mentally ill.

Community Mental Health Act

✦ A. The Community Mental Health Act of 1964 provides for the establishment of mental health centers to serve communities across the country.
B. Each community must provide full service for its population.
C. Services include in- and outpatient treatment services, long-term hospitalization if necessary, emergency services, and consultation and educational services.

✦ Characteristics

A. Hospitalization may be provided by private or public psychiatric hospitals or in psychiatric units of general hospitals.

B. Day–night hospitals provide structured treatment programs for a specified part of each day, after which the client returns to his or her family.
C. Residential treatment facilities provide live-in accommodations with guidance and treatment available for clients who are not quite ready to return to the community and function independently.
D. Therapeutic communities provide milieu therapy, a therapy involving the total community (or unit). The staff formulates and, together with the clients, implements the treatment program. Emphasis is often on group therapies and group techniques.
E. Partial hospitalization offers organized, structured therapeutic activities to prevent hospitalization or as a transitional treatment option when discharged from a mental health day–night facility.
F. Intensive outpatient programs are similar to partial hospitalization programs, but typically have fewer hours/day.

Group Therapy

✦ *Definition*: Group therapy refers to the psychotherapeutic processes that occur in formally organized groups designed to improve symptoms or change behavior through group interactions.

Types of Groups

A. Structured group: Group has predetermined goals and leader retains control. Group has directed focus, factual material is presented, and format is clear and specific.
B. Unstructured group: Responsibility for goals is shared by group and leader; leader is nondirective. Topics are not preselected, and discussion flows according to concerns of group members. Often, emphasis is more on feelings than facts, and decision making is part of the group process.

Phases of Group Therapy

A. **Initial phase**: Group is formed; goals are clarified, and expectations expressed; members become acquainted; superficial interactions take place.
B. **Working phase**: Problems are identified; confrontation between members occurs; problem-solving process begins; group cohesiveness emerges.
C. **Termination phase**: Evaluation occurs; fulfillment of goals is explored; support for leave-taking is undertaken.

✦ Principles Underlying Group Work

A. **Support**: Members gain support from others in group via sharing and interaction.
B. **Verbalization**: Members express feelings, and group reinforces appropriate (versus inappropriate) communication.
C. **Activity**: Verbalization and expression of feelings and problems are stimulated by activity.
D. **Change**: Members have opportunity to try out new, more adaptive behaviors in group setting.

✦ Methods of Focusing Group Therapy

A. Focus on here and now versus there and then. Group members are helped to express inner experiences occurring in the present rather than in the past. The past cannot be altered; the person can only report on it.
B. Focus on feelings versus ideas. Abstract or cognitive focus directs group away from dealing with here-and-now feelings and experiences and allows no opportunity for exploring and coping with feelings.
C. Focus on telling versus questioning. Focus on the individual's reporting about self rather than on questioning of others, which is artificial and a defensive posture.
D. Focus on experience versus "ought" or "should." Avoid "should" systems, which focus on judgmental and critical content rather than on supportiveness.

Leader Functions and Roles

A. Determine structure and format of group sessions.
B. Determine goals and work toward helping group achieve these goals.
C. Establish the psychological climate of group (e.g., acceptance, sharing, and nonpunitive interactions).
D. Set limits for the group and interpret group rules.
E. Facilitate group process to promote flow of clear communication.
F. Encourage participation from silent members and limit participation of monopolizers.
G. Exert leadership when group flounders; always maintain a degree of control.
H. Act as resource person and role model.

Advantages of Group Therapy

A. Economy in use of staff is possible.
B. Increased socialization potential in group setting leads to increased interaction between clients.
✦ C. Feedback from group members occurs.
   1. Increases reality-testing mechanisms.
   2. Builds self-confidence and self-image.
   3. Can correct distortions of problem, situation, or feelings by group pressure.
   4. Gives information about how one's personality and actions appear to others.
D. Reduction in feelings of being alone with problem and being the only one experiencing despair—universality.
✦ E. Opportunity for practicing new alternative methods for coping with feelings such as anger and anxiety.

F. Increased feelings of closeness with others, thus reducing loneliness.
G. Potential development of insight into one's problems by expressing own experiences and listening to others in group.
H. Therapeutic effect from attention to reality, from focus on the here and now rather than on own inner world.

Family Therapy

✦ *Definition*: Family therapy is a form of group therapy based on the premise that it is the total family, rather than the identified client, that is dysfunctional.

Basic Assumptions

✦ A. An identified client is not ill; rather, the total family is in need of and will benefit from treatment.
B. An identified client reflects disequilibrium in the family structure.
C. Family therapy focuses on exploration of patterns of interaction within the family rather than on individual pathology.
D. Conjoint family therapy treats the family as a group. Method was originally developed by Virginia Satir for treatment for schizophrenics.

Therapist Behaviors

A. Models role of clear communicator.
1. Clarifies and validates communication.
2. Points out dysfunctional communication.
3. Sets limits for inappropriate behavior.
✦ B. Acts as resource person.
✦ C. Observes and reports on congruent and incongruent communications and behaviors.
D. Supports entire family as members attempt to change inappropriate patterns of relating and communicating with one another.
E. In general, follows the same therapeutic approaches as in nurse–client relationship therapy.

PSYCHOTROPIC DRUGS

Definition: Psychotropic drugs are those used in psychiatry in conjunction with other forms of therapy that affect psychic functioning, mood, behavior, or experience; and are used to treat symptoms of psychiatric disorders.

Characteristics

A. Psychotropic drugs affect both the central and autonomic nervous systems.
✦ B. These drugs affect behavior indirectly by chemically interacting with other chemicals, enzymes, or enzyme substrates.
1. Changes in cellular, tissue and organ functions occur.
2. Drug effects vary from cellular activity to effect on psychosocial interaction.
C. Most psychotropic medications affect biological imbalances in the brain.

Antipsychotic Drugs

A. Drugs also known as neuroleptic; introduced about 1953.
B. Action: block the dopamine receptors in the CNS.
✦ C. Antipsychotic drugs relieve positive psychotic symptoms and assist in controlling behavior. Used in the treatment of schizophrenia and psychosis associated with other psychiatric and medical conditions.
✦ D. Earliest are phenothiazine derivatives called conventional or "typical": Thorazine (chlorpromazine), Stelazine (trifluoperazine), Trilafon (perphenazine), Prolixin (fluphenazine).
1. Extrapyramidal side effects (EPSEs) occur most commonly when phenothiazines are utilized, affecting voluntary movements and skeletal muscles.
a. Drug-induced parkinsonism (pseudoparkinsonism): symptoms occur in 1–4 weeks; signs are similar to classic parkinsonism—rigidity, shuffling gait, pill-rolling hand movement, tremors, dyskinesia, and mask-like face.
b. Akathisia: very common; occurs in 1–6 weeks. Signs: uncontrolled, uncomfortable motor restlessness, foot-tapping, agitation, pacing.
c. Dystonia: occurs as early as 1–2 days. Signs: limb and neck spasms (torticollis); muscle pain; difficulty in speaking and swallowing; and rigidity and spasms of muscles (oculogyric crisis is upward involuntary eye position).
d. Tardive dyskinesia: usually develops late in treatment, may be reversed if diagnosed early and treatment causing the condition is stopped. May be irreversible. Antiparkinson drugs are of no help in decreasing symptoms; characterized by facial grimacing, tongue thrusting, repetitive chewing, shuffling gait, drooling, and general dystonic symptoms.
2. Movement disorder scales can aid in assessment.
E. Another common antipsychotic drug (classification—butyrophenones) is Haldol (haloperidol).
1. Extreme caution in use with the elderly.
2. Also used in treatment of Tourette's syndrome.
3. Incidence of severe extrapyramidal reactions.

4. Other side effects include leukocytosis, blurred vision, dry mouth, urinary retention, and cardiac changes. When administered intravenously, continuous cardiac monitoring is often required. Other possible and serious side effects: neuroleptic malignant syndrome, hyperpyrexia, and heat stroke.
5. Causes sedation; avoid alcohol and other CNS depressants.

F. "Atypical antipsychotics," such as Risperdal, Seroquel (quetiapine), Zyprexa (olanzapine), Geodon (ziprasidone), and Abilify (aripiprazole). Invega Sustenna (paliperidone palmitate) is a newer atypical antipsychotic.
1. These drugs have fewer extrapyramidal symptoms
2. Can cause major weight gain and metabolic changes.
3. Cardiac side effects including hypotension can occur.
4. Increase in liver enzymes, blood dyscrasias, and neuroleptic malignant syndrome are potential effects; frequency with individual drugs varies or may not occur.

✦ G. Clozaril (clozapine): an atypical antipsychotic for management of psychotic symptoms in clients who do not respond to other antipsychotics.
1. Rare or low incidence of extrapyramidal effects and tardive dyskinesia.
2. Side effects similar to other antipsychotics; be aware of blood dyscrasias (leukopenia, neutropenia, agranulocytosis, eosinophilia).
✦ 3. Requires weekly white blood cell (WBC) count to determine potential for agranulocytosis. (Drug is discontinued if WBC < 2000 μL or granulocytes < 1000 μL.)
4. Monitor monthly bilirubin, liver function studies.

H. Thioxanthenes: Taractan (chlorprothixene) and Navane (thiothixene).

✦ I. Other antipsychotic side effects. Incidence and severity vary by drug.
✦ 1. Blood dyscrasias.
a. Agranulocytosis occurs in first 4–18 weeks of treatment. Symptoms: fever, sore throat, malaise, infection.
b. Leukopenia, preceded by altered WBC count.
✦ 2. Extrapyramidal symptoms and hormonal changes.
✦ 3. Hypotension: Orthostatic hypotension may occur. Monitor closely when client is elderly. Keep client supine for 1 hour and advise to change positions slowly. Fall risk, cardiac changes.
✦ 4. Anticholinergic effects: dry mouth, blurred vision, tachycardia, nasal congestion, and constipation. Treat symptomatically.
✦ 5. Neuroleptic malignant syndrome—a rare complication caused by an antipsychotic—is a medical emergency (20% mortality rate) and must be recognized and treated immediately.
✦ a. **Signs and symptoms**: muscle rigidity/motor abnormalities, hyperpyrexia, altered mental status, autonomic instability, irregular vital signs, elevated creatine phosphokinase, and possibly acute renal failure.
✦ b. **Treatment**: immediate discontinuation of drug, medical monitoring, administration of a dopamine-enhancing drug and/or Dantrium (dantrolene) and aggressive supportive medical treatment.

Antiparkinson Drugs

A. The term *extrapyramidal disease* refers to a motor disorder often associated with pathologic dysfunction in the basal ganglia. Antiparkinson drugs block the extrapyramidal symptoms.
1. Clinical symptoms of the disease include abnormal involuntary movement, change in tone of the skeletal muscles, and a reduction of automatic associated movements.
2. Reversible and irreversible extrapyramidal reactions may follow the use of certain drugs—the most common are the phenothiazine derivatives.

✦ B. Antiparkinson drugs act on the extrapyramidal system to reduce disturbing symptoms experienced from antipsychotic medications.
1. They are usually given in conjunction with antipsychotic drugs.
✦ 2. The most common drugs are anticholinergics: Artane (trihexyphenidyl), Cogentin (benztropine), Kemadrin (procyclidine), and Akineton (biperiden).
3. Side effects are dizziness, gastrointestinal disturbance, headaches, urinary hesitancy, restlessness, and memory impairment.

✦ C. Benadryl (diphenhydramine), an antihistamine, is often given in place of Artane or Cogentin.
1. Controls the extrapyramidal side effects of phenothiazines.
2. Preferred because it does not cause as many untoward side effects as the other antiparkinson drugs.

D. Other drugs occasionally ordered in this category are Symmetrel (amantadine), benzodiazepines, (Inderal) propranolol, Catapres, Procardia (nifedipine), Verelan (verapamil), and Dantrium used for treating *neuroleptic malignant syndrome*.

Anxiolytic (Antianxiety) Drugs

- A. Drugs induce sedation, relax muscles, and inhibit convulsions; major use to reduce anxiety.
- B. These drugs are the most frequently prescribed drugs in medicine; demand is great for relief from anxiety and they are safer than sedative–hypnotics.
- C. Potentiate drug abuse. Greatest harm occurs when combined with alcohol.
- D. Prescribed for psychological distress, psychosomatic disorders, or functional psychiatric disorders, but do not modify psychotic behavior.
- E. Classes of drugs
  1. **Benzodiazepines**: Librium (chlordiazepoxide), Valium (diazepam), Ativan (lorazepam), Klonopin (clonazepam), and Xanax (alprazolam) are used in depression, panic, and obsessive–compulsive disorders. Side effects: sedation, confusion, dizziness, paradoxical excitement.
  2. **Nonbenzodiazepine**: BuSpar (buspirone) does not depress CNS. Side effects: dizziness, headaches, nausea.
  3. Antihistamines are sometimes used to treat anxiety but are not as effective: Vistaril (hydroxyzine), Atarax (hydroxyzine), and Benadryl.
  4. Antidepressants: see Antidepressant Drugs for additional information.
- F. Frequency and severity of side effects vary by drug.
  1. Drowsiness (avoid driving or working around equipment).
  2. Blurred vision, mental confusion, dermatitis, paradoxical excitement.
  3. Habituation and increased tolerance may develop.
  4. Pancytopenia, thrombocytopenia, and granulocytopenia.
  5. Withdrawal symptoms occur with prolonged use (6+ months) and high doses.

Antidepressant Drugs

Definition: Drugs used for the treatment of major depressive disorders. Act by increasing concentration of neurotransmitters in the brain.

- A. Tricyclic antidepressants include Elavil (amitriptyline), Norpramin (desipramine), Tofranil (imipramine), Aventyl and Pamelor (nortriptyline).
  1. Block uptake of norepinephrine and serotonin.
  2. A lag period of 1 to 6 weeks between starting the medication and experiencing symptom relief exists.
  3. Effective but generally replaced by newer antidepressants that cause fewer side effects.
  4. Side effects.
     a. Anticholinergic effects: dry mouth, blurred vision, constipation, postural hypotension, urinary retention.
     b. CNS effects: tremor, sedation, seizures.
     c. Cardiovascular and cardiotoxic effects; changes in the electrical conduction. Assess any client with history of cardiovascular disease, especially heart block.
     d. Elderly clients should have electrocardiogram (ECG).
     e. Alterations in sexual functioning
     f. Induce mania.
     g. Weight gain.
     h. Most side effects appear in first 1 to 2 weeks and diminish or are better tolerated over a period of a few weeks or months.
  5. If client is switched from a tricyclic drug to a monoamine oxidase (MAO) inhibitor, a period of 1 to 3 weeks must elapse between drugs.
  6. Blood level assays provide therapeutic levels of tricyclic antidepressants.
- B. MAO inhibitors include Marplan (isocarboxazid), Nardil (phenelzine), and Parnate (tranylcypromine).
  1. MAO inhibitors are potent and have the potential to produce many serious side effects.
  2. Not the first antidepressant of choice because of side effect profile. Many dietary restrictions.
  3. Side effects.
     a. Most dangerous is hypertensive crisis.
     b. Drug interactions (sympathomimetic medications) can cause severe hypertension, hypotension, or CNS depression.
     c. Postural hypotension, headaches, constipation, anorexia, diarrhea, and chills.
     d. Tachycardia, edema, impotence, dizziness, insomnia, and restlessness.
     e. Manic episodes and anxiety.
  4. All clients must be warned not to eat foods with high tyramine content (aged cheese, pickled fish, meat extracts, red wine, beer, chicken liver, yeast); certain vegetables (pea pods, fava beans); bananas; combination foods such as pizza, lasagna, quiche, liver pate; soy sauce; sauerkraut; drink alcohol; or take other drugs, especially sympathomimetic drugs (amphetamines, L-dopa, epinephrine).
  5. MAO inhibitors must not be used in combination with tricyclics.

✦ C. Hypertensive crisis, due to elevated tyramine levels.
1. Severe symptoms: throbbing, occipital headache, confusion, drowsiness, vomiting, stiff neck, chills, chest pain.
2. Monitor for potential complications: encephalopathy, heart failure.
3. Treatment.
a. Discontinue MAO inhibitor (MAOI).
b. Administer short-acting antihypertensives.
c. Monitor vital signs, ECG, and neurological signs; blood pressure (BP) q 5 min, cooling measures.

✦ D. Selective serotonin reuptake inhibitors (SSRIs).
1. Drugs are highly selective for the serotonin pathway and exert little or no effect on the uptake of the other neurotransmitters or receptor sites.
✦ 2. SSRIs include: Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Celexa (citalopram), and Lexapro (escitalopram).
3. Exhibit fewer side effects than other antidepressant drugs.
a. Side effects: nausea (most common), anxiety/nervousness, insomnia, drowsiness, and headache.
b. Coadministration of alcohol and drugs is not recommended.
c. Discontinuation syndrome is often seen with SSRI, but can occur with other psychotropic medication when the medication is stopped suddenly. Irritability, dizziness, insomnia, nightmares, ataxia, lethargy, headaches, and GI disturbance can occur. Gradually tapering medication over a few weeks minimizes development of symptoms.
d. Serotonin syndrome is a potentially life threatening syndrome when the body's level of serotonin is elevated. Signs and symptoms include agitation, diarrhea, fever, mental status changes, muscle spasms, hyperreflexia, tremor, ataxia, erratic blood pressure, metabolic acidosis, and tachycardia. Must be taking serotonergic drug to be diagnosed with serotonin syndrome. Treatment includes Periactin (cyproheptadine) to block serotonin production, benzodiazepines, and other supportive measures. Life threatening if untreated.
4. Note danger of giving SSRIs to children.

E. Other antidepressants.
1. Desyrel (trazodone hydrochloride) is a member of a class of antidepressant drugs unrelated to the tricyclics.
a. Inhibits the reuptake of serotonin.
b. Well tolerated, with minimal side effects (sedation and orthostatic hypotension).
c. *Warning*: this drug has been associated with priapism—persistent, abnormal erection. If symptom occurs, immediately discontinue drug.
2. Wellbutrin (bupropion): unrelated to other antidepressants.
a. Used to treat depression and seasonal affective disorder as well as for smoking cessation.
b. Side effects: headache, weight loss, insomnia, GI disturbance, tachycardia, dry mouth.
3. Serotonin norepinephrine reuptake inhibitors (SNRIs)
a. Include Effexor (venlafaxine), Cymbalta (duloxetine).
b. Block uptake of both norepinephrine and serotonin.

Mood Stabilizers (Antimanic Drugs)

A. These drugs control mood disorders, especially the manic phase.
✦ B. Elevate mood when client is depressed; dampen mood when client is in manic episode.
C. Before lithium therapy is begun, baseline studies of renal, cardiac, and thyroid status obtained.
✦ D. The most common form of drug is lithium carbonate, a naturally occurring metallic salt; other forms include lithium citrate.
✦ E. Drug must reach a certain blood level before it is effective—0.6–1.2 mEq/L.
1. Stabilizing concentration occurs in 5 to 7 days; therapeutic effect 7 to 28 days or more.
2. Drug dose is maintained at 900–1200 mg/day to achieve serum level maintained in range of 0.6–1.2 mEq/L. Often drug is gradually increased to achieve therapeutic range and to minimize side effects.
✦ F. Lithium is metabolized by the kidney.
1. Deficiency of sodium results in more lithium being reabsorbed (lithium substitutes for sodium ion), thus increasing risk of toxicity.
2. Excessive sodium causes more lithium to be excreted and may lower level to a nontherapeutic range.
3. Normal dietary intake of sodium with adequate fluids to prevent dehydration is necessary.
4. Diuretics will increase absorption of lithium leading to toxic effects.
5. Serum levels measured two to three times weekly (12 hours after last dose) in beginning of therapy; for long-term maintenance therapy, every 2 to 3 months.

✦ G. Drug concentration and side effects.
   1. Therapeutic range of serum levels is 0.6–1.2 mEq/L.
   2. Side effects occur at upper ranges,
   3. Gastrointestinal disturbances, weight gain, hair loss, metallic taste in mouth, muscle weakness, fatigue, thirst, polyuria, and fine hand tremors are common side effects.
   4. Hypothyroidism is a long-term side effect of lithium therapy.

H. For acute manic episodes, Zyprexa has been approved.

I. Risperdal combined with lithium provides more rapid mood stabilization than lithium alone.

J. For clients who cannot take lithium, seizure medications may be prescribed, including Tegretol (carbamazepine), Depakote, and Lamictal (lamotrigine). Serum blood levels are utilized to monitor Tegretol and Depakote. Lamictal can cause serious and life-threatening rashes requiring hospitalization. Topamax (topiramate) and Trileptal (oxcarbazepine) are other seizure medications prescribed for mood stability.

✦ K. Lithium toxicity.
   1. Appears when blood level exceeds 1.5 to 2.0 mEq/L. May appear sooner depending on individual client.
   2. Central nervous system is the chief target.
   3. Signs and symptoms include nausea, vomiting, drowsiness, tremors, slurred speech, blurred vision, muscle twitching, oliguria, confusion, unsteady gait.
   4. If drug is continued, coma, convulsions, and death may result.
   5. Treatment for toxicity: gastric lavage, correction of fluid balance, administration of Osmitrol (mannitol) to increase urine excretion.

✦ General Nursing Responsibilities for Administering Psychoactive Drugs

A. Give correct *drug* and *dose* at correct *time* to correct *client*. Use two client identifiers.

B. Know specific actions and uses of drugs.

C. Be familiar with the side effects and precautions of major drug groups.

D. Observe client carefully for side effects.

E. Be aware that certain drug groups are not compatible—know half-lives and drug interactions.

F. Notify doctor of extrapyramidal side effects and lithium toxicity, and immediately implement nursing intervention.

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PSYCHIATRIC NURSING REVIEW QUESTIONS

NURSE–CLIENT RELATIONSHIP/ THERAPEUTIC COMMUNICATION

1. Trust may develop in the nurse–client relationship when the nurse

1. Avoids limit setting.
2. Encourages the client to use "testing" behaviors.
3. Tells the client how he or she should behave.
4. Uses consistency in approaching the client.

2. A client has just begun to discuss important feelings when the time of the interview is up. The next day, when the nurse meets with the client at the agreed-upon time, the initial intervention would be to say

1. "Good morning, how are you today?"
2. "Yesterday you were talking about some very important feelings. Let's continue."
3. "What would you like to talk about today?"
4. Nothing and wait for the client to introduce a topic.

3. A new staff nurse is on an orientation tour with the head nurse. A client approaches her and says, "I don't belong here. Please try to get me out." The staff nurse's best response would be

1. "What would you do if you were out of the hospital?"
2. "I am a new staff member, and I'm on a tour. I'll come back and talk with you later."
3. "I think you should talk with the head nurse about that."
4. "I can't do anything about that."

4. The nurse is in the day room with a group of clients when a client who has been quietly watching TV suddenly jumps up screaming and runs out of the room. The nurse's priority intervention would be to

1. Turn off the TV, and ask the group what they think about the client's behavior.
2. Follow after the client to see what has happened.
3. Ignore the incident because these outbreaks are frequent.
4. Send another client out of the room to check on the agitated client.

5. A nurse observes a client sitting alone in her room crying. As the nurse approaches her, the client states, "I'm feeling sad. I don't want to talk now." The nurse's best response would be

1. "It will help you feel better if you talk about it."
2. "I'll come back when you feel like talking."
3. "I'll stay with you a few minutes."
4. "Sometimes it helps to talk."

ANXIETY AND STRESS DISORDERS/ DEFENSE MECHANISMS

6. A student failed her psychology final exam and spent the entire evening berating the teacher and the course. This behavior would be an example of which defense mechanism?

1. Reaction-formation.
2. Compensation.
3. Projection.
4. Acting out.

7. The most effective nursing intervention for a severely anxious client who is pacing vigorously would be to

1. Instruct her to sit down and quit pacing.
2. Place her in bed to reduce stimuli and allow rest.
3. Allow her to walk until she becomes physically tired.
4. Give her PRN medication and walk with her at a gradually slowing pace.

8. A client is experiencing a high degree of anxiety. It is important to recognize if additional help is required because

1. If the client is out of control, another person will help to decrease his anxiety level.
2. Being alone with an anxious client can be dangerous.
3. It will take another person to direct the client into activities to relieve anxiety.
4. Hospital protocol for handling anxious clients requires at least two people.

9. A client with a diagnosis of obsessive–compulsive disorder constantly does repetitive cleaning. The nurse knows that this behavior is probably most basically an attempt to

1. Decrease the anxiety to a tolerable level.
2. Focus attention on nonthreatening tasks.
3. Control others.
4. Decrease the time available for interaction with people.

10. A client is suffering from posttraumatic stress disorder following a rape by an unknown assailant. One of the primary goals of nursing care for this client would be to

1. Establish a safe, supportive environment.
2. Control aggressive behavior.
3. Deal with the client's anxiety.
4. Discuss the client's nightmares and reactions.

11. A client's deafness has been diagnosed as conversion disorder. Nursing interventions should be guided by which one of the following?

1. The client will probably express much anxiety about her deafness and require much reassurance.
2. The client will have little or no awareness of the psychogenic cause of her deafness.
3. The client's need for the symptom should be respected; thus, secondary gains should be allowed.
4. The defense mechanisms of suppression and rationalization are involved in creating the symptom.

12. A female client has just received the diagnosis of hypochondriasis. This client continually focuses on gastrointestinal problems and constantly rings for a nurse to meet her every demand. The best nursing approach is to

1. Ignore the demands because the nurse knows it is not necessary to respond.
2. Assign various staff members to work with the client so no staff member will become negative.
3. Anticipate the client's demands and spend time with her even though she does not demand it.
4. Provide for the client's basic needs, but do not respond to her every demand, which reinforces secondary gains.

13. Persons with personality disorders tend to be manipulators. In planning the care of a person with this diagnosis, the nurse would

1. Allow manipulation so as to not raise the client's anxiety.
2. Appeal to the client's sense of loyalty in adhering to the rules of the community.
3. Know that when the client's manipulations are not successful, anxiety will increase.
4. Establish a nurse–client relationship to decrease the client's manipulations.

14. A male client on the psychiatric unit becomes upset and breaks a chair when a visitor does not show up. The first nursing intervention should be to

1. Stay with the client during the stressful time.
2. Ask direct questions about the client's behavior.
3. Set limits and restrict the client's behavior.
4. Plan with the client for how he can better handle frustration.

15. The nurse has been interviewing a client who has not been able to discuss any feelings. This day, 5 minutes before the time is over, the client begins to talk about important feelings. The intervention is to

1. Go over the agreed-upon time, as the client is finally able to discuss important feelings.
2. Tell the client that it is time to end the session now, but another nurse will discuss his feelings with him.
3. Set an extra meeting time a little later to discuss these feelings.
4. End just as agreed, but tell the client these are very important feelings and he can continue tomorrow.

MOOD (AFFECTIVE) DISORDERS/ SUICIDE

16. In working with a depressed client, the nurse should understand that depression is most directly related to a person's

1. Experiencing poor interpersonal relationships with others.
2. Remembering a traumatic childhood.
3. Having experienced a sense of loss.
4. Stage in life.

17. A 45-year-old female client has been in the hospital for 3 days with a diagnosis of depression. During this time, she has not put on a clean dress, washed her hair, or participated in any of the unit activities. On this day, the nurse observes that she is wearing a clean dress and has combed her hair. The appropriate statement to the client is

1. "Oh, I'm so pleased that you finally put on a clean dress."
2. "Something is different about you today. What is it?"
3. "That's good. You have on a clean dress and have combed your hair."
4. "I see that you have on a clean dress and have combed your hair."

18. A depressed client refuses to get out of bed, go to activities, or participate in any of the unit's programs. The most appropriate nursing action is to

1. Tell her that the rule of the unit is that no client can remain in bed.
2. Suggest she better get out of bed or she will go hungry later.

3. Offer to assist her out of bed and help her to dress.
4. Allow her to remain in bed until she feels ready to join the other clients.

19. When encouraged to join an activity, a depressed client on the psychiatric unit refuses and says, "What's the use?" The approach by the nurse that would be most effective is to

1. Sit down beside her and ask her how she is feeling.
2. Tell her it is time for the activity, help her out of the chair, and go with her to the activity.
3. Convince her how helpful it will be to engage in the activity.
4. Tell her that this is a self-defeating attitude and it will only make her feel worse.

20. A 60-year-old male client has been admitted to the psychiatric unit, with symptoms ranging from fatigue, an inability to concentrate, an inability to complete everyday tasks, to refusal to care for himself and preferring to sleep all day. One of the first interventions should be aimed at

1. Developing a good nursing care plan.
2. Talking to his wife for cues to help him.
3. Encouraging him to join activities on the unit.
4. Developing a structured routine for him to follow.

21. Three days after admission for depression, a 54-year-old female client approaches the nurse and says, "I know I have cancer of the uterus. Can't you let me stay in bed and have some peace before I die?" In responding, the nurse must keep in mind that

1. The client must be postmenopausal.
2. Thoughts of disease are common in depressed clients.
3. Clients suffering from depression can be demanding, making many requests of the nurse.
4. Antidepressant medications frequently cause vaginal spotting.

22. When a depressed client becomes more active and there is evidence that her mood has lifted, an appropriate goal to add to the nursing care plan is to

1. Encourage her to go home for the weekend.
2. Move her to a room with three other clients.
3. Monitor her whereabouts at all times.
4. Begin to explore the reasons she became depressed.

23. The nurse is assigned a client who is potentially suicidal. Of the following nursing objectives, which one is the most important?

1. Observe the client closely at all times.
2. Recognize a continued desire to commit suicide.
3. Involve the client in activities with others to mobilize him.
4. Provide a safe environment to protect the client.

24. A client makes a suicide attempt on the evening shift. The staff intervenes in time to prevent harm. In assessing the situation, the most important rationale for the staff to discuss the incident is that

1. They need to reenact the attempt so that they understand exactly what happened.
2. The staff needs to file an incident report so that the hospital administration is kept informed.
3. The staff needs to discuss the client's behavior to determine what cues in his behavior might have warned them that he was contemplating suicide.
4. Because the client made one suicide attempt, there is high probability he will make a second attempt in the immediate future.

25. When assessing a client for possible suicide, an important clue would be if the client

1. Is hostile and sarcastic to the staff.
2. Identifies with problems expressed by other clients.
3. Seems satisfied and detached.
4. Begins to talk about leaving the hospital.

26. A client with the diagnosis of manic episode is racing around the psychiatric unit trying to organize games with the clients. An appropriate nursing intervention is to

1. Have the client play ping pong.
2. Suggest video exercises with the other clients.
3. Take the client outside for a walk.
4. Do nothing, as organizing a game is considered therapeutic.

27. A client has the diagnosis of manic episode. Her disruptive behavior on the unit has been increasingly annoying to the other clients. One intervention by the nurse might be to

1. Tell the client she is annoying others and confine her to her room.
2. Ignore the client's behavior, realizing it is consistent with her illness.
3. Set limits on the client's behavior and be consistent in approach.
4. Make a rigid, structured plan that the client will have to follow.

SUBSTANCE ABUSE

28. While working with an alcoholic client, the most important approach by the nurse would be to

1. Maintain a nonjudgmental attitude toward the client.
2. Establish strict guidelines of behavior.
3. Explicitly outline expectations of the client.
4. Set up a working nurse–client relationship.

29. A client is admitted with the diagnosis of delirium tremens. He is exhibiting marked tremors, hallucinations, and tachycardia, and is perspiring profusely. The first nursing intervention is to

1. Establish an IV of D_5W with vitamin B complex supplement (standard orders).
2. Administer valium IM (standard orders).
3. Control the environment. Place the client in a soft lit, quiet, single room with side rails as needed for safety.
4. Establish baseline vital signs.

30. A client is admitted with Wernicke's encephalopathy. The nurse anticipates that the first physician's orders will include

1. Ordering a magnetic resonance image (MRI).
2. Administering a steroid medication, such as Decadron (dexamethasone).
3. Giving thiamine 100 mg IM STAT.
4. Ordering an EEG.

COGNITIVE DISORDERS

31. A client has the diagnosis of cognitive disorder—Alzheimer's disease. The client is constantly making up stories that are untrue. This characteristic of the disease is called

1. Senility.
2. Confabulation.
3. Lability.
4. Memory loss.

32. A client in a long-term care facility has the diagnosis of dementia—Alzheimer's disease. His care plan should include the goal of assisting him to participate in activities that provide him a chance to

1. Interact with other clients.
2. Compete with others.
3. Succeed at something.
4. Get a sense of continuity.

33. A 70-year-old client is admitted with the diagnosis of cognitive disorder, dementia type. In discharge planning with the family, the nurse would take into account that his prognosis is

1. Good, because the condition tends to be reversible.
2. Unpredictable, because the condition may reverse.
3. Poor, because symptoms are reduced intellectual capacity, emotional stability, memory, and judgment.
4. Poor, because the condition will rapidly progress.

34. A 56-year-old client is tentatively diagnosed as having Korsakoff's syndrome. In developing a strategy to care for this client, the nurse knows that this condition is a(n)

1. Neurological condition common with alcohol poisoning.
2. Neurological degeneration caused by vitamin deficiency.
3. Organic brain lesion brought on by repeated hepatitis attacks.
4. State resulting from severe, long-term psychosis.

SCHIZOPHRENIC DISORDERS

35. The most appropriate short-term nursing goal for clients with schizophrenia is to

1. Set limits on bizarre behavior.
2. Establish a trusting, nonthreatening relationship.
3. Quickly establish a warm, close relationship.
4. Protect client from inappropriate impulses.

36. When the nurse is talking with a client diagnosed with schizophrenia, the client suddenly says, "I'm frightened. Do you hear that? Terrible things." Which initial response by the nurse would be most appropriate?

1. "I don't hear anything."
2. "Who is saying terrible things to you."
3. "I don't hear anything, but you do seem frightened."
4. "What is someone saying to you?"

37. One day the nurse overhears a client with the diagnosis of schizophrenia talking to herself. She is saying, "The mazukas are coming. The mazukas are coming." Her use of the word *mazuka* is most likely

1. An example of associative looseness.
2. Flight of ideas.
3. A neologism.
4. A manifestation of dyslexia.

38. A young schizophrenic meets with the nurse regularly. On one occasion, with no apparent connection to the topic being discussed, he blurts out, "I am the devil! I am God! Open the gate for me!" The most *nontherapeutic* response would be to say

1. "Tell me your thoughts about religion and God."
2. "I don't understand. Can you tell me what that means?"
3. "Are you saying that you are both good and bad?"
4. "Most people have good thoughts and ones that they fear are bad."

39. The best explanation for the term "depersonalization," as seen in schizophrenics, is

1. The client cannot tolerate personal relationships.
2. The client personalizes all threats and uses projection.
3. A flight from reality related to oneself or the environment.
4. A mechanism seen in chronic schizophrenia.

40. A client with the diagnosis of schizophrenia has improved and is now able to attend group therapy meetings. One day, she jumps up and runs out after the group has been laughing at a story one of the clients told. She states, "You are all making fun of me." This client is displaying

1. Symbolic rejection.
2. Hallucinations.
3. Depersonalization.
4. Ideas of reference.

41. A 20-year-old male client is admitted to the psychiatric unit with a diagnosis of schizophrenia, acute episode. He is having auditory hallucinations and seems disoriented to time and place. The nurse knows that a hallucination can be explained as a(n)

1. Sensory experience without foundation in reality.
2. Distortion of real auditory or visual perception.
3. Voice that is heard by the client but is not really there.
4. Idea without foundation in reality.

42. A client with the diagnosis of paranoid personality disorder is admitted to the psychiatric unit. As the nurse approaches the client with medication, he refuses it, accusing the nurse of trying to kill him. The nurse's best strategy would be to tell him that

1. "It is not poison and you must take the medication."
2. "I will give you an injection if necessary."
3. "You may decide if you want to take the medication by mouth or injection, but you must take it."
4. "It's all right if you don't take the medication right now."

43. A 16-year-old client is hospitalized for adolescent adjustment problems. After assessing her, the nurse's first objective is to establish a nurse–client relationship. The next day, the nurse is late for the appointment. Knowing that the client has difficulty assuming responsibility for her own behavior, the nurse would like to use this situation as an opportunity for role modeling. The most appropriate statement the nurse could make is

1. "I'm late. I apologize."
2. "Thank goodness you are still here; I just had a flat tire."
3. "Oh, you are here. I thought we'd be arriving at the same time."
4. "What do you mean you are angry with me? I bet you keep people waiting."

44. The nurse is assigned to work on a unit that has a group of children with autism as inpatients. They have all been on the unit for at least 6 months and exhibit self-destructive and withdrawn behavior as well as bizarre responses. As a new member of the health team, the nurse knows that the first goal is to

1. Set limits on their behavior so the children will perceive the nurse as an authority figure.
2. Assess each child's individual developmental level so the nurse will have the data for realistic care plans.
3. Understand that the children must be protected from self-destructive behavior.
4. Establish some method of relating to the children, either verbal or nonverbal.

45. A newly admitted client to the psychiatric unit will receive electroconvulsive therapy (ECT). ECT is considered most effective in treating

1. Young clients with depressive reactions.
2. Elderly clients with depressive reactions.
3. Any age client with schizophrenia.
4. Young clients with paranoid reactions.

46. The treatment in crisis intervention centers is specifically intended to help clients

1. Return to prior levels of functioning.
2. Understand the dynamics underlying symptoms.
3. Make long-range plans for the future.
4. Accept their illness.

PSYCHOTROPIC DRUGS

47. A client comes to the emergency room with complaints of headache and vomiting. Upon questioning, the client says she is taking the drug Parnate (tranylcypromine). The nurse would continue the assessment by first asking

1. The dose of Parnate she is taking.
2. If she has recently had flu symptoms.
3. What foods she has been ingesting.
4. What other medication she is taking.

48. A client is to take Eskalith (lithium) regularly after he is discharged from the hospital. The nursing care plan includes discharge planning. The most important information to impart to the client and his family is that the client should

1. Have an adequate intake of sodium.
2. Limit his fluid intake.
3. Have a limited intake of sodium.
4. Not eat foods that have a high tyramine content (e.g., cheese, wine, liver, yeast) or drink alcohol.

49. A 50-year-old male client has a history of many hospitalizations for schizophrenia. He has been on long-term phenothiazines (Thorazine [chlorpromazine]), 400 mg/day. The nurse assessing this client observes that he demonstrates erratic choreiform movements, lip smacking, and neck and back tonic contractions. From these symptoms and his history, the nurse concludes that the client has developed

1. Tardive dyskinesia.
2. Parkinsonism.
3. Dystonia.
4. Akathisia.

50. A client with the diagnosis of schizophrenia has orders for Clozaril (clozapine). The nurse will evaluate the drug's effect as positive if the

1. Client develops leukopenia.
2. Monthly liver function studies change moderately.
3. Psychotic symptoms, such as hearing voices, are reduced.
4. Client's energy level and involvement in activities goes up.

PSYCHIATRIC NURSING ANSWERS WITH RATIONALE

NURSE–CLIENT RELATIONSHIP/ THERAPEUTIC COMMUNICATION

1. (4) One of the most important elements of trust is consistency. The client learns to trust that the nurse will follow through and do what is promised. Avoiding limit setting will not instill trust, nor will encouraging testing behaviors or telling the client how he should behave.

   NP:P; CN:PS; CL:C

2. (3) This is a broad opening statement and the nurse is giving the client the opportunity to bring up the same topic or not. The nurse should not make the assumption that what was most important to the client yesterday is still most important today. Answer (2) has the nurse directing the focus, not the client. The other two responses are not as therapeutic as (3).

   NP:I; CN:H; CL:AN

3. (2) As a new staff member, the nurse should clarify who she is and why she is there. She also should acknowledge the client's attempt to initiate interaction by offering to talk at a more appropriate time. Answer (1) might be used in a later interaction, but is not appropriate at this time.

   NP:I; CN:S; CL:A

4. (2) The immediate priority is to find the client and assess what further intervention may be needed. Whether the behavior has happened frequently in the past is irrelevant, because the behavior exhibited now is significant and should be followed up. Sending another client is inappropriate because an immediate intervention may be necessary.

   NP:I; CN:S; CL:A

5. (3) Simply offering comfort by staying with the client and being open for communication is the most therapeutic. The other responses place an additional burden on the client if she does not wish to talk.

   NP:I; CN:PS; CL:A

ANXIETY AND STRESS DISORDERS/ DEFENSE MECHANISMS

6. (3) The client is placing blame on others and not taking responsibility for her own behavior. The nurse needs to interpret the behavior in terms of the defense mechanism to understand the client. Reaction formation is preventing "dangerous" feelings from being expressed by exaggerating the opposite attitude. Compensation is covering up a weakness by emphasizing a desirable trait. Acting out is not a defense mechanism.

   NP:AN; CN:PS; CL:AN

7. (4) This client is in severe anxiety heading for a panic level. She requires immediate medication, constant attention, and a gradual lessening of activity according to her expressed level of energy. With moderate anxiety, directed activity helps to reduce the level.

   NP:I; CN:PS; CL:A

8. (1) If the client and/or the situation gets out of control, anxiety will only increase. Additional help may prevent this from occurring.

   NP:AN; CN:PS; CL:AN

9. (1) The primary reason for the compulsive activity is to decrease the anxiety caused by obsessive thoughts. The client is not trying to focus her attention on tasks, control others, or lessen interaction with others.

   NP:AN; CN:PS; CL:C

10. (1) A goal for this disorder should be broad-based and general, like establishing a safe, supportive environment.

Coding for Questions/Answers Abbreviations: Nursing Process: NP, Assessment: A, Analysis: AN, Planning: P, Implementation: I, Evaluation: E; Client Needs: CN, Safe, Effective Care Environment: S, Health Promotion and Maintenance: H, Psychosocial Integrity: PS, Physiological Integrity: PH; Clinical Area: CA, Medical Nursing: M, Surgical Nursing: S, Maternal/Newborn Nursing: MA, Pediatric Nursing: P, Psychiatric Nursing: PS; Cognitive Level: CL, Knowledge: K, Comprehension: C, Application: A, Analysis: AN.

Other answers would more directly refer to implementation of the goal strategies.

NP:P; CN:PS; CL:C

11. (2) This disorder has an unconscious mechanism in place; thus, there is a relative lack of distress or anxiety regarding the symptom. The client is likely to demonstrate "la belle indifference," an unconcerned, indifferent attitude toward the loss of function with no awareness of the psychogenic cause. Answer (3) is incorrect because secondary gains should be minimized. Answer (4) is incorrect because repression and displacement are the operating mechanisms.

    NP:AN; CN:PS; CL:A

12. (3) Anticipating demands (rather than ignoring them) from a hypochondriacal client will break the pattern of demanding behavior. These clients are usually fearful and anxious. Spending time with the client will be reassuring and therapeutic. Assigning various staff members (2) may be useful so no one will become overwhelmed, but it is not the primary approach.

    NP:I; CN:PS; CL:A

13. (3) Because a person with this disorder tends to manage his or her life through manipulation of others, when it doesn't work, the anxiety level goes up. The nurse should never allow the client to manipulate him or her. Answers (2) and (4) are not true.

    NP:P; CN:PS; CL:A

14. (3) The first intervention is to set firm, clear limits on his behavior. The nurse would also remain with the client until he calms down and then encourage him to discuss his feelings rather than act out.

    NP:I; CN:S; CL:A

15. (4) Because he may be trying to manipulate the nurse, it is important to end the interview at the agreed-upon time. Also, because the feelings are important, the nurse would need to encourage the client to bring them up again. Going over the agreed-upon time (1) is nontherapeutic because it allows manipulation. Answers (2) and (3) are also nontherapeutic.

    NP:I; CN:PS; CL:AN

MOOD (AFFECTIVE) DISORDERS/ SUICIDE

16. (3) Depressed people often suffer from a sense of loss—loss of status, relationships, significant other, etc. While depression is more common in the middle-age to older adult group, it is not necessarily related to stage of life (4). Neither poor interpersonal relationships (1) nor a traumatic childhood (2) is relevant as a cause of depression.

    NP:AN; CN:PS; CL:C

17. (4) The correct answer does not place a value judgment on the change by stating that it is good or that the nurse is pleased. It simply acknowledges that change, which is a positive reinforcement of the behavior. Answer (1) implies that the client needs to please the nurse. The opposing conclusion may be that if she does not continue this behavior, the nurse will be displeased. Answer (2) implies that the nurse does not care enough about the client to really notice what is different. This conclusion would contribute to the client's already lowered self-esteem. Answer (3) places a definite value judgment on the change in behavior. It may be interpreted as being "bad" if she does not continue to wear a clean dress.

    NP:I; CN:PS; CL:AN

18. (3) Be positive, definite, and specific about expectations. Do not give depressed clients a choice or try to convince them to get out of bed. Physically assist the client to get up and dressed to mobilize her. Do not allow her to remain in bed (4) or try to convince her by quoting the rules of the unit (1).

    NP:I; CN:PS; CL:A

19. (2) The nursing intervention is directed toward mobilizing the client without asking her to make a decision or trying to convince her to go. The nurse must be direct, specific, and not take no for an answer.

    NP:I; CN:S; CL:A

20. (4) While a good nursing care plan is important, the priority would be to get the client mobilized. Even without a specific diagnosis, the nurse will realize that part of what is happening with the client is a depressed mood. Providing a structured plan of activities for the client to follow will help his mood to lift and provide a focus so that he will not be centered on internal suffering.

    NP:I; CN:PS; CL:C

21. (2) Concern with having a life-threatening disease is a common issue with depressed clients. While demanding behavior (3) may be a symptom, it is not the issue here. Whether the client is postmenopausal (1) is not relevant.

    NP:AN; CN:PS; CL:C

22. (3) The goal is to implement suicide precautions because the danger of suicide is when the depression lifts and the client has the energy to formulate a plan. The nurse would not encourage her to go home (1) where she could not be observed constantly. She could be moved into a room with other clients (2), but this is not the priority concern.

    NP:P; CN:S; CL:A

23. (4) Because it is unrealistic to observe a client every minute (1), the environment must be kept safe for client protection. Answer (2) is important, but not the most critical objective. Involving the client in activities (3) does not address the problem of safety with a client who is potentially suicidal.

    NP:P; CN:S; CL:A

24. (3) Even though all of the reasons are important and should not be ignored, the most important task for the staff is to assess the client's behavior and to identify cues that might indicate another impending suicide attempt.

    NP:A; CN:PS; CL:AN

25. (3) Most suggestible of suicide is the sudden sense of satisfaction or relief (perhaps from finally making the decision to commit suicide) and detachment. Hostility (1), identifying with others (2), or thinking of the future (4) do not as clearly suggest suicidal thinking.

    NP:E; CN:S; CL:A

26. (3) Engaging the client in a large-muscle activity, such as walking with the nurse, will direct the client's energy but not be too stimulating, as would a competitive game such as ping pong (1) or group exercise (2). Answer (4) is nontherapeutic because it is too stimulating for a manic client.

    NP:I; CN:PS; CL:A

27. (3) Setting limits is important to avoid rejection of the other clients with subsequent lowering of self-esteem. Confronting the client (1) will not be productive and may just increase the annoying activity. Ignoring the behavior (2) will also be nontherapeutic, and the other clients on the unit will become even more hostile. This client will not be able to follow a rigid plan.

    NP:I; CN:PS; CL:A

SUBSTANCE ABUSE

28. (1) The most important nursing attitude, which underlies all interactions with this client, including a nurse–client relationship, would be to maintain a nonjudgmental approach. If a nurse carries any judgments about alcoholism, it will negate a working relationship with the client.

    NP:P; CN:PS; CL:A

29. (3) The first intervention is to place the client in a soft lit, single room so stimuli are decreased and the side rails are up for safety. This client could begin convulsing. Lights should be on, especially if the client is hallucinating, because seeing shadows might be very scary. The next interventions would be to establish an IV (1), take vital signs (4), and then administer a tranquilizer (2).

    NP:I; CN:PS; CL:AN

30. (3) With Wernicke's encephalopathy, the critical and often life-saving intervention is to give vitamin B (thiamine) STAT. This acute condition occurs in relation to chronic alcoholism (Korsakoff's syndrome) with an inadequate intake of basic nutrients. The syndrome improves with an adequate diet, but only 25% fully recover. Korsakoff's condition remains after Wernicke's encephalopathy is treated. The other answers would not be implemented.

    NP:P; CN:S; CL:C

COGNITIVE DISORDERS

31. (2) When clients make up stories or lies, it is called *confabulation*. This is an attempt to fill in memory gaps caused by the destruction of the neurons. This process protects their self-esteem and should not be discouraged or confronted.

    NP:AN; CN:PS; CL:K

32. (3) It is essential that the client participate in activities that provide him with immediate success and increase his self-esteem. Interaction with others is important but is secondary to improving his self-esteem. Competition may cause anxiety and would be nontherapeutic. Continuity in personnel is important, but not in activities.

    NP:P; CN:PS; CL:A

33. (3) Dementia has a poor prognosis and is usually progressive and irreversible; the symptoms are closely related to the client's basic personality. All of the characteristics in (3) fit the picture of cognitive disorder. The condition may or may not progress rapidly, but will generally deteriorate and is irreversible.

    NP:A; CN:PH; CL:C

34. (2) Korsakoff's syndrome (also called polyneuritic psychosis) is a form of cognitive disorder that is associated with long-term alcohol abuse and a deficiency of vitamin B complex, especially thiamine. Answer (2) is more specific than answer (1). This condition is not caused from a lesion, hepatitis (3), or psychosis (4).

NP:A; CN:PH; CL:C

SCHIZOPHRENIC DISORDERS

35. (2) The most important goal with a schizophrenic is to establish a trusting relationship, but not a warm, close one, which would be too threatening (3). It is not a short-term goal to set limits on behavior or protect the client from deviant impulses—inappropriate behavior will diminish as medication takes hold and the client becomes less disturbed (1).

NP:P; CN:PS; CL:K

36. (3) The best response when a client has the diagnosis of schizophrenia is to validate reality by saying the nurse doesn't hear anything and then to explore real feelings, like fear. Answer (1) is not enough to be therapeutic; answers (2) and (4) give validity to the voices if, in fact, the client is hallucinating.

NP:I; CN:PS; CL:A

37. (3) Mazuka is a made-up word, called a neologism. This characteristic is frequently present with the disorder and is a part of associative looseness. Answer (1) is not incorrect, but answer (3) is more specific. Flight of ideas is observed with a manic episode.

NP:AN; CN:PS; CL:C

38. (1) This response asks the client to discuss religion and God; this subject is very confusing for schizophrenics because they have difficulty knowing what is real. It is considered a nontherapeutic topic to discuss. The other three responses are acceptable. Answer (2) is the most therapeutic.

NP:I; CN:PS; CL:AN

39. (3) Depersonalization is the feeling or subjective experience of separating oneself or alienation; it is also the state in which the client cannot distinguish the self from others and involves disintegration of the ego—often observed in schizophrenics as a flight from reality.

NP:AN; CN:PS; CL:K

40. (4) Ideas of reference or misinterpretation occur when the client believes that an incident has a personal reference to oneself when, in fact, it is not at all related. Symbolic rejection does not apply to this situation and is not a term used in psychiatric theory (1). Hallucinations are false perceptions with no basis in reality (2). Depersonalization is alienation from oneself (3).

NP:AN; CN:PS; CL:A

41. (1) Hallucinations may involve any sense, and they have no basis in reality. The most common are auditory. Answer (3) is an example of an auditory hallucination. Answer (2) is an illusion; answer (4) is a delusion.

NP:AN; CN:PS; CL:K

42. (3) Giving the client a choice of how he would like to take his medication, while being firm that he must take it, gives the client a sense of control and helps to reduce the power struggle. Telling the client that the medication is not poison will do little to persuade him to comply. Answer (2) would represent a punishment. The client must take his medication; therefore, answer (4) is not appropriate.

NP:I; CN:PS; CL:A

43. (1) Assuming responsibility for one's behavior includes acknowledging the behavior and may include a statement of one's current status. It does not include making excuses, focusing outside of oneself, or blaming another.

NP:I; CN:PS; CL:AN

44. (4) Before the nurse can implement any care plan that might include setting limits or integrating the child into the group, the nurse would need to establish a relationship, either through verbal or nonverbal communication. After establishing a relationship, the nurse will assess each child.

NP:P; CN:S; CL:A

45. (2) Depression is more successfully treated by ECT than are the other conditions listed. It is a treatment of choice for elderly clients who experience depression with vegetative aspects. A dramatic lift of the depression may be seen after only a few treatments. None of the other disorders have been found to be successfully treated with ECT.

NP:P; CN:PS; CL:K

46. (1) The major goal in crisis treatment centers is to have the client return to a prior level of functioning. At this time in a crisis, it is not therapeutic to work on the dynamics underlying the symptom (2) or make long-range plans (3). Accepting the illness (4) may be a part of returning to a prior level of functioning.

    NP:P; CN:PS; CL:C

PSYCHOTROPIC DRUGS

47. (3) The nurse must first recognize that the drug Parnate is an MAO inhibitor. The assessment for the side effects of Parnate should include ascertaining whether the client has ingested foods containing tyramine (cheese, wine, etc.), which could lead to hypertensive crisis, which the presenting symptoms suggest.

    NP:A; CN:S; CL:AN

48. (1) The most important teaching is to maintain an adequate sodium intake to maintain fluid level. Low Na^+ or limited fluids can lead to Eskalith toxicity. (4) This instruction refers to an MAO-inhibiting drug that is given for depression.

    NP:P; CN:H; CL:A

49. (1) Tardive dyskinesia usually develops late in treatment and may occur in up to 50% of chronic schizophrenics with the long-term use of phenothiazine drugs. Anti-parkinson drugs such as Artane and Cogentin are of no help in decreasing the symptoms. Parkinsonism (2), dystonia (3), and akathisia (4) are also extrapyramidal side effects of phenothiazine use, but these conditions are reversible with drugs.

    NP:AN; CN:PH; CL:A

50. (3) This new drug (similar to a phenothiazine) manages psychotic symptoms such as hallucinations, and the incidence of these symptoms should be reduced. Leukopenia (agranulocytosis) (1) is a side effect, and altered liver function studies (2) would be negative. This medication should not affect the client's energy level (4).

    NP:E; CN:PS; CL:A