PSYCHIATRIC NURSING

FOUNDATIONS OF PSYCHIATRIC MENTAL NURSING

Mental Health

- It is a state of emotional, psychological, and social wellness evidenced by satisfying personal relationships, effective behavior and coping, apositiveself-conceptand emotional stability

Mental Disorder

- A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with present distress or disability or with significantly increased risk of suffering, death, pain, disability or an important loss of freedom (APA, 2000)

Components of Mental Health

- Autonomy and Independence
- Maximizing one's potential
- Tolerating Life's Uncertainties
- Self-esteem
- Mastering Orientation
- Reality Orientation
- Stress Management

HISTORICAL PERSPECTIVES OF THE TREATMENT OF MENTAL ILLNESS

Ancient Times

- A belief that any sickness indicates displeasure of the gods and punishment for sins and wrongdoing
- Peoplewithmentaldisordersareeither viewed as divine or demonic
- Divine = worshipped and adored
- Demonic = punished and burned
- Aristotledeveloped atheoryaboutthe amounts of blood, water and yellow and black bile in the body
- Thesefoursubstancescorrespondwith happiness, calmness, anger, and sadness.
- Any imbalance from the four substances will cause mental disorders
- Treatment: bloodletting, starving and purging

Early Christian Times

- Primitive and superstitious beliefs
- All diseases were blamed to demons.
- Mentally ill personswere viewed as possessed
- Treatment: performance of exorcisms to rid evil spirits
- If thatfails = incarceration in dungeons, flogging and starving

Renaissance

- People with mental illness were distinguished from criminals
- Ifharmless = allowed to wanderthe countryside
- Harmful (dangerouslunatics) = thrownin prison, chained and starved
- Hospital of St.Mary of Bethlehem = first hospital for insane
- Inmates were viewed as animals
- Also during this period, mentally ill people were viewed as evil and possessed.
- Treatment = witchhunts were conducted; offenders were burned

Period of Enlightenment

- **Philippe Pinel and William Tuke**
  - Formulated the concept of asylum (safe refuge)
- **Dorothea Dix** advocated adequate shelter, nutritious food and warm clothing to those who are mentally ill.

EmilKraepelin =classifiesmentaldisorders according to their symptoms.

Eugene Bleuler = coined the term schizophrenia.

THERAPEUTIC USE OF SELF

- Main tool used by the nurse in Psychiatric Nursing.
- Nurses use themselves as a therapeutic tool to establish therapeutic relationship with the client
- Introduced by Hildegard Peplau (1952)
- According to him, nurses must have a clear understanding of themselves to promote client's growth.
- Therapeutic use of self requires self-awareness

SELF-AWARENESS

- It is the processby which the nurse gains recognition of his or her own feelings, beliefs, and attitudes.

Goal: To know oneself so that one's values,attitudes, and beliefs are not projected to the client, interfering with nursing care.

- Onetoolthat is useful in learning about oneself is Johari's Window

Four Quadrants of Johari's Window

Quadrant I	✓ **Arena/Open/ Public Self** ✓ Qualities known to oneself and others
Quadrant II	✓ **Blind/Unaware Self** ✓ Qualities known only to others, not to self
Quadrant III	✓ **Façade/ Hidden/ Private Self** ✓ Qualities known only to oneself
Quadrant IV	✓ **Unknown** ✓ An empty quadrant to symboliz equalities as yet undiscoveredby oneself or others

METHODS USED TO INCREASE SELF — AWARENESS

- Role Play
- Introspection
- Discussion
- Enlarging one's experience

THERAPEUTIC COMMUNICATION

- It is an interpersonal interaction between the nurse and client during which the nurse focuses on the client's specific needs to promote effective exchange of information

Goals

- Establish a therapeutic nurse—client relationship.
- Identify the most important client concern at that moment (the client-centered goal).
- Assess the client's perception of the problem as it unfolded.
- Facilitate the client's expression of emotions.
- Teach the client and family necessary self-care skills.
- Recognize the client's needs.
- Implement interventions designed to address the client's needs.
- Guide the client toward identifying a plan of action to a satisfying and socially acceptable resolution.

THERAPEUTIC COMMUNICATION TECHNIQUES

Accepting

- Indicating reception

Examples: "Yes";"I follow what you said"; Nodding

Rationale: An accepting response indicates the nurse has heard and followed the train of thought. It does not indicate agreement but is non-judgmental.

Broad Openings

- Allowing client to take the initiative in introducing the topic

Examples: "Is there something you'dlike to talk about?";'Where would you like me to begin?"

Rationale: Broad opening makes explicit that the client has the leadin the interaction;may stimulate him or her to take the initiative

Consensual Validation
-Searching for mutual understanding, for accord in the meaning of the words.
Examples: "Tell me whether my understanding of it agrees with yours."; "Are you using this word to convey that?"
Rationale: For verbal communication to be meaningful, it is essential that the words being used should have the same meaning for all participants.

Encouraging Comparison
-Helping the client to understand by looking at similarities and differences.
Examples:'Was it something like?"; "Have you had similar experiences?"
Rationale:Comparing ideas,experiences, or relationships brings out many recurring themes;
He or she might recall past coping strategies that were effective or remember the he or she has survived a similar situation

Encouraging Description of Perceptions
-Asking client to verbalize what he or she perceives.
Examples:"Tell me when you feel anxious"; "What is happening?"; "What does the voice seem to be saying?"
Rationale: To understand the client. the nurse must see things from his or her perspective; may relieve the tension the client is feeling and he or she might be less likely to take action on ideas that are harmful or frightening

Encouraging Expression
- Asking client to appraise the quality of his or her experience.
Examples:'Whatare your feelings in regard to?"
Rationale:Encourages the client to make his or her own appraisal rather than accepting the opinion of others.

Exploring
- Delving further into a subject or idea.
Examples; "Tell me more about that."; 'Would you describe it more fully'?"; 'What kind of work?"
Rationale: This can help them examine the issue more fully; If the client expresses an unwillingness to explore a subject, however, the nurse must respect his or her wishes.

Focusing
- Concentrating on a single point.
Examples: "This point seems looking at more closely.";"Of all the concerns you have mentioned, Which is most troublesome?"
Rationale: This encourages the client to concentrate his or her energies on a single point, which may prevent a multitude of factors or problems from overwhelming the client; useful technique when a client jumps from one topic to another.

Formulating a Plan of Action
- Asking the client to consider kinds of behavior likely to be appropriate in future situations.
Examples: 'What could you do to let your anger out harmlessly?"; "Next time this comes up, what might you do to handle it?"
Rationale:It may be helpful for the client to plan in advance what he or she might do in future similar situations; making definite plans increases the likelihood that the client will cope more effectively in a similar situation

General Leads
- Giving encouragement to continue.
Examples:"Goon.";"And then?";"Tell me about it."
Rationale:Thisindicates that the nurse is listening and following what the client is saying without taking away the initiative for the interaction; encourage the client to continue if he or she is hesitant or uncomfortable about the topic.

Giving Information
-Making available the facts that the client needs..
Examples:"My name is...";"Visiting hours are. . ."; "My purpose in being here is..."
Rationale: Informing the client of facts increases his or her knowledge about a topic or lets the client know what to expect; builds trust with the client.

Giving Recognition
- Acknowledging, indicating awareness.
Examples:"Good morning,Mr.S...";"You've finished your list of things to do."' "I noticed that you've combed your hair."
Rationale: Greeting the client by name, indicating awareness of change, or noting efforts the client has made all show that the nurse recognizes the client as a person, as an individual.

Making Observations
- Verbalizing what the nurse perceives.
Examples: "You appear tense."; "Areyou uncomfortable when . . ?"; "I notice that you are biting your
Rationale: Sometimes clients cannot verbalize or make themselves understood.

Offering Self
- Making oneself available.
Examples: "I will sit with you a while."; "I will stay here with you."; "I am interested in what you think."
Rationale: The nurse can offer his or her presence, interest, and desire to understand; It is important that this offer is unconditional, that is, the client does not have to respond verbally to get the nurse's attention.

Placing event in Time Sequence
- Clarifying the relationship of events in time.
Examples: 'What seemed to lead up to?"; Was this before or after?"; 'When did this happen?"
Rationale: This helps both the nurse and client 'to see them in perspective;The client may gain insight into cause-and-effect behavior and consequences, or perhaps some things are not related. The nurse may gain information about recurrent patterns or themes in the client behavior relationship.

Presenting Reality
-Offering for consideration that which is real.
Examples: "I see no one else in the room."; "That sound was a car back firing."; "Your mother is not here.I am a nurse."
Rationale: When it is obvious that a client is misinterpreting reality, the nurse can indicate what is real.

Reflecting
- Directing client actions, thoughts, and feelings back to the client.
Examples
Client: "Do you think I should tell the doctor?"
Nurse: "Do you think you should?"
Client: "My brother spends all my money and then has the nerve to ask for more."
Nurse: "This causes you to feel angry'?"
Rationale: This encourages the client to recognize and accept his or her own feelings.

Restating
- Repeating the main idea expressed.
Examples
Client: "I can't sleep. I stay awake all night." Nurse: "You have difficulty sleeping."
Client: "I am really mad. I am really upset." Nurse: "You're really mad and upset."
Rationale: Restatement lets the client know that heor she communicated the idea effectively; encourages the client to continue

Seeking Information
-Seeking to make clear that which is not meaningful or that which is vague.
Examples: "I am not sure that I follow."; "Have I heard you correctly?'
'Rationale: This can help the nurse to avoid making assumptions that understanding has occurred when it has not;helps the client to articulate thoughts,feelings,and ideas more clearly.

Silence
-Absence of verbal communication,which provides time for the client to put thoughts or feelings in towords,regain composure, or continue talking.
Examples: Nurse says nothing but continues to maintain eye contact and conveys interest

Rationale: This often encourages the client to verbalize provided that it is interested and expectant; gives the client time to organize thoughts, direct the topic of interaction, or focus on issues that are most important.

Suggesting Collaboration
- Offering to share, to strive, to work with the client for his or her benefit.
Examples:"Perhaps you and I can discuss and discover the triggers for your anxiety."; "Let's go to your room and I will help you find what you are looking for."
Rationale: The nurseseeks to offer a relationship in which the client can identify problems in living with others, grow emotionally, and improve the ability to form satisfactory relationships.

Summarizing
-Organizing and summing up that which has gone before.
Examples:"Have I got this straight?"; "You've said that. ."; "During the past hour, you and I have discussed.."
Rationale: This brings out the important points of the discussion and to increase the awareness and understanding of both participants;omits the irrelevantand organizes the pertinent aspects of the interaction.

Translating Into Feelings
-Seeking to verbalize client's feelings that he or she expresses only indirectly.
Examples
Client: "I am dead."
Nurse: "Are you suggesting that you feel lifeless?"
Client: "I am way out in the ocean."
Nurse:"You seem to feel lonely or deserted."
Rationale: The nurse must concentrateon what the client might be feeling to express himself or herself this way.

Verbalizing the Implied
-Voicing what the client has hintedator suggested.
Examples
Client:"I can't talk to you or anyone.It is a waste of time."
Nurse: "Do you feel that no one understands?"
Rationale: This tends to make the discussion less obscure.

Voicing Doubt
-Expressing uncertainty about the reality of the client's perceptions.
Examples: "Isn't that unusual?"; "Really?"; "That is hard to believe."
Rationale: This permits the client to become aware that others do not necessarily perceive events in the same way or draw the same conclusions.

NON-THERAPEUTIC COMMUNICATION	
Advising - telling the client what to do	**Examples**: "I think you advising should."; 'Why don't you?" **Rationale:** This implies that client what to do only the nurse knows what is best for the client.
Agreeing **-** indicates accord with the client	**Examples**: "That is right." "I agree." **Rationale:** This indicates the agreeing
Belittling feelings expressed **-** misjudging the degree of the client's discomfort	**Example:** Client: "I have to live for…I wish I was dead" Nurse: "Everybody gets down in the dumps" or "I have felt the way myself." **Rationale:** When the nurse tries to equate in the intense and overwhelming feelings the client has expressed to "everybody" or to the nurse's own feelings, the nurse implies that the discomfort is temporary, mild self-limiting, or not very important
Challenging **–** demanding proof from the client	**Example: "**But how can you be the president of the United State?" "if you are dead, why is your heart beating **Rationale:** Often the nurse believe that if he or she can challenge the client to prove unrealistic idea, the client will realize there is no "proof" and then will recognize reality. Actually challenging causes the client to defend the

	delusions or misconception
Defending **-** attempting to protect someone or something from the verbal attack	**Example:**" the hospital has a fine reputation"; " I am sure your doctors has your best interest in mind." **Rationale:** this implies that he or she no right to express impression, opinion or feeling
Disagreeing **-** opposing the client's idea	**Example:** "that is wrong"; "I definitely disagree with…";"do not believe on that…" **Rationale:** this implies the client is " wrong"; consequently the client feels defensive about his or her point of view or ideas
Giving approval/ Agreeing - Sanctioning the client's behavior or ideas	**Examples:** "That is good."; "I am glad that." **Rationale:**Saying what the client thinks or feels if "good" implies that the opposite is "bad"; tends to limit the client's freedom to think, speak, or act in a certain way; can lead to the client's acting in a particular way just to please the nurse.
Giving literal responses - Responding to a figurative comment as though it were a statement of fact.	**Example:** Client:"They are looking in my head with a television camera." Nurse: "Try not to watch television." or 'What channel?" **Rationale:**Often the client is at a loss to describe his or her feelings, so such comments are the best he or she can do; usually it is helpful for the nurse to focus on the client's feelings in response to such statements
Indicatingthe existence of an external source -Attributingthe source of thoughts, feelings, and behavior to others or to outside influences.	**Examples:**'What makes you say that?"; 'What made you do that?"; "Who told you that you were a prophet?" **Rationale:** The nurse can ask, "What happened?" Or "What events led you to draw such a conclusion?";But to question "What made you think that?" implies that the client was made or compelled to think in a certain way.
Interpreting - Asking to make conscious that which is unconscious	**Examples:** "Whatyoureally meanis...";"Unconsciously you are saying ..." **Rationale:** Client's thoughts and feelings are his or her own, not tobe interpretedby the nurse or for hidden meaning.
Introducing an unrelates topic –change the subject	**Example:** Client: "I would like to die" Nurse: " did you have visitors last night?" **Rationale:** the nurse takes the initiative for the interaction away from the client
Making stereotype comments **-** offering meaningless clichés or tripe comments	**Example: "**Now tell me about this problem. You know I have to find out";" tell your psychiatric history". **Rationale:** Tend to make the client feel used or invaded; clients have the right not to talk about issues or concerns if they choose.
Reassuring **-** indicates that there is no reason for anxiety or other feelings of discomfort	**Example: "**I would not worry about that";" everything would be alright"; you are coming along just fine." **Rationale:** This is completely devalues the client's feelings.
Rejecting **-** refusing to consider or showing contempt for the client's idea or behavior	**Example:** " Let us not discuss…:";"I do not want to hear about…" **Rationale:** Nurse closes it off exploring; in turn, the client will feel personally rejected along with his or her ideas
Requesting an explanation **-** asking the client to provide reasons for thoughts, feelings, behaviors, events	**Example:**"why do you think that?; " why do you feel that way?" **Rationale:** using " why" question is intimidating
Testing **–** appraising the client's degree of insight.	**Example: "** do you know what kind of hospital this is"; "do you still have the idea that…?" **Rationale:** This is forces the client to try to recognize his or her problems.
Using Denial -Refusing to admit that problem exists.	**Example:** Client: "I am nothing. Nurse:"Ofcourseyou are something.Everybodyis something." Client: "I am dead." Nurse: "Do not be silly." **Rationale**:denies the client's feelings or the seriousness of the situation by dismissing his or her comments without attempting to discover the feelings or meaning behind them

DISTURBANCES IN THOUGHT PROCESS AND CONTENT

Circumstantial Thinking -a client gives out excessive unnecessary details, but eventually gets to the point.	**Example:** Nurse: "How have you been A client sleeping lately?" Client: "Oh, I goto bed,so I can get plenty of rest. I like to listen to musicor read books before bed. Right now I am reading a good mystery. Maybe I will write a mystery someday. But is it isn't helping reading, reading I mean. I have been getting only 2 or 3 hours of sleep at night."
Tangential Thinking -a client gives out excessive unnecessary details and never gets to the point.	**Example:** Nurse: "How have you been A client sleeping lately?" Client: "Oh, I goto bed,so Ican get plenty of rest. I like to listen to musicor read books before bed. Right now I am reading a good mystery. Maybe I will write a mystery someday. But sometimes I also like drama or non-fiction."
Word salad **-** It is a combination of jumbled words and phrase that are disconnected or incoherent and make no sense to the listener	**Example: "** corn, potatoes, jump up, play games, grass, cupboard."
Verbigeration **-**stereotyped repetition of wordsor phase that may or not have meaning to the listener.	**Example: "**I want to go home, go home, go home."
Perseveration -Persistent adherence to a single idea or topicandverbal repetition of a sentence, phrase, or word, even when another person attempts to change the topic.	**Example:** Nurse: "How have you been sleeping lately?" Client:"Ithinkpeoplehave been following me." Nurse: 'Where do you live?" Client:"At my place people have been following Nurse: 'What do you like to do in your free time?" Client: "Nothing because people are following me."
Echolalia - Client's imitation or repetition of what the nurse says.	**Example:** Nurse: Can you tell me how you're feeling? Client: Can you tell me how you're feeling,
Flight of Ideas Excessive amount andrate of speech composedof fragmented or unrelated ideas	**Example:** 'The sun is shining.Where is my sun? I love Lucy. Let us play ball."
Loosenessof Association - Disorganized thinking that jumps from one idea to another with little or no evident relation between the thoughts	**Example:** Nurse: "Do you have enough money to buy that candy bar?" Client: "I have a real yen for chocolate. The Japanese have all the yen and have taken all of our money and mark edit. You know,you have to be careful of the Marxists because they are friends with the Swiss and they have all the cheese and all the watches and that means they have taken all the time.The worst thing about Swiss cheese is all the holes. People have to be careful about falling into holes."
Delusion -False belief which is inconsistent with one's knowledge and culture	The client may claimtobe engaged to a famous movie star or related to some public figure such as claiming to be the daughter of the President of the Philippines
Hallucination - False sensory perceptions, or perceptual experiences that do not really exist.	The client may claim to be speaking with an imaginary person commanding him to do something bad to another person.
Neologisms -Words invented by the client	**Example:** "I'm afraid of grittiz. If there are any grittiz here, I will have to leave. Are you a grittiz?"

DISTURBANCES IN AFFECT

Inappropriate Affect
- ❖ Disharmony between the stimulus and the emotional reaction.

Blunted Affect
- ❖ Severe reduction in emotional reaction.

Flat Affect
- ❖ Absence or near absence of emotional/facial reaction that would indicate emotions or mood

Apathy
- ❖ Feelings of indifference toward people, activities, and events

Ambivalence
- ❖ Holding seemingly contradictory beliefs or feelings about the same person, event or situation. Presence of two opposing feelings.

Depersonalization
- ❖ Clients feel detached from their behavior
- ❖ Feelings of strangeness towards oneself
- ❖ Although client can state his name correctly, he feels as if his body belongs to someone else, or that his spirit is detached from is body.

Derealization
- ❖ Feeling of strangeness towards the environment
- ❖ Environmental objects become smaller larger, or seem unfamiliar.
- ❖ Individual feels that the outside world has changed.
- ❖ Everything may seem gray and dull

DISTURBANCES IN MOTOR ACTIVITY

Echopraxia
- ❖ The pathological imitation of posture or action of others
- ❖ Imitation of the movements and gestures of another person whom the client is observing

Waxy Flexibility
- ❖ Maintaining the desires position for long periods of time without discomfort even when it is awkward or uncomfortable

DISTURBANCES IN MEMORY

Confabulation
- ❖ Filling a memory gap with detailed fantasy believed by the teller
- ❖ Purpose of confabulation: Maintainself-esteem

Example:
Nurse: "Do you know Gemma? (referring to one the residents at the patient's home)
Patient: "Yes, I know her. I used to play cards war her husband."Actually, Gemma's husband was dead for many years and the patient had never met him.

Amnesia
- ❖ Inability to recall past events

BASIC ELEMENTS OF THE NURSE-PATIENT RELATIONSHIP

T — rust
R — apport
U — nconditional positive regard
S — etting limits
T — herapeutic communication

CHARACTERISTICS OF THE NURSE-PATIENT RELATIONSHIP

- Goal — directed
- Focused on the needs of the patient Planned
- Time-limited
- Professional

PHASES OF THE NURSE-PATIENT RELATIONSHIP

Pre-orientation Phase

- Begins when the nurse is assigned to a nurse
- Major task: Develop self-awareness
- Tasks include data gathering, planning for the first interaction

Orientation Phase

- Begins when the nurse and client meet
- Ends when the client begins to identify problems to examine.
- Tasks: establishing rapport, developing trust, assessment, establishing roles, purpose of the meeting, parameters of subsequent
- Major Task: develop a mutually acceptable contract

Working Phase

- Longest and most productive phase of the nurse-patient relationship
- Limit-setting is employed
- Divided in two sub-phases
  - **Problem identification**
    - ✓ Client identifies the issues or concerns causing problems
  - **Exploitation**
    - ✓ Nurse guides the client to examine feelings and responses and to develop better coping skills and a more positive self-image
  - **Transference**
    - Client unconsciously transfers his feelings to the nurse.
  - **Countertransference**
    - Therapist displaces on to the client attitudes or feelings from his / her past
  - **Resistance**
    - Development of ambivalent feelings toward self-exploration
  - **Termination Phase**
    - Also termed Resolution phase
    - Begins when problems are resolved
    - Ends when the relationship is ended.
    - It involves feelings of anxiety, fear and loss.

PSYCHOTROPIC DRUG CATEGORIES

ANTI-PSYCHOTICS

- Also known as Neuroleptics
- Used to treat symptoms of psychosis.
- Primary treatment for schizophrenia
- Used in psychotic depression, acute mania and drug-induced psychosis

ANTIPSYCHOTIC DRUGS	
Typical	Haloperidol (Haldol) Chlorpromazine (Thorazine) Perphenazine (Trilafon) Fluphenazine (Prolixin) Thioridazine (Mellaril) Mesoridazine (Serentil) Trifluoperazine (Stelazine)

Atypical	Clozapine Risperidone Olanzapine Quetiapine Ziprasidone
New Generation Antipsychotic	Aripiprazole

Side Effects

1. **Extrapyramidal Symptoms (EPS)**
   - ❖ Major side effects of antipsychotic agents
   - ❖ Includes acutedystonia, PseudoParkinsonism, akathisia, tardive dyskinesia
   - ❖ EPS happen when there is blockade of dopamine (D2) receptors in the midbrainregion of the brain stem.

Treatment for EPS

GENERIC NAME (TRADE)	DRUG CLASS
Amantadine (Symmetrel)	Dopaminergic Agonist
Benztropine (Cogentin)	Anticholinergic
Biperiden (Akineton)	Anticholinergic
Diazepam (Valium)	Benzodiazepine
Diphenhydramine (Benadryl)	Antihistamine
Procyclidine (Kemadrin)	Anticholinergic
Propranolol (Inderal)	Beta-blocker
Trihexyphenidyl (Artane)	Anticholinergic

Acute Dystonia

- Torticollis
- Opisthotonus
- Oculogyric crisis
- Acute muscular rigidity and cramping
- Stiff or thick tongue
- Difficulty swallowing
- Laryngospasm
- Respiratory difficulties

Treatment

- Intramuscular Benztropine mesylate (Cogentin)
- IM or IV Diphenhydramine (Benadryl)

PseudoParkinsonism

- Stiff, stooped posture
- Mask-like facies
- Decreased arm swing
- Shuffling, festinating gait
- Cogwheel rigidity
- Drooling
- Coarse pill-rolling movements of the thumbs and fingers while at rest.

Treatment

- Changing antipsychotic medication that has lower incidence of EPS
- Adding an anti-cholinergic agent or Amantadine.

Akathisia

- Inability to sit still
- Restless/anxious
- Rigid posture or gait
- Lack of spontaneous gestures

Treatment

- Change of antipsychotic medication
- Addition of an oral agent (Beta-blocker, Anticholinergic, Benzodiazepine)

Tardive Dyskinesia

- Vermiform (Worm-like) tongue movements
- Sucking, smacking movements of the lips
- Involuntary movements of the body
- Permanent, irreversible
- Appears after at least 8 months of antipsychotic therapy

Treatment

- Valbenazine
- Deutetrabenazine
- Progression can be arrested by decreasing the antipsychotic medication

2. **Neuroleptic Malignant Syndrome**

- ❖ Potentially fatal, idiosyncratic reaction to an antipsychotic
- ❖ Rigidity
- ❖ High fever
- ❖ Autonomic instability (unstable blood pressure, diaphoresis, pallor, delirium)
- ❖ May fluctuate from agitation to stupor
- ❖ Increasedrisk for: dehydration and poor nutrition

Treatment

- Immediate discontinuance of all antipsychotic medications
- Treatment of dehydration and hyperthermia

3. Anticholinergic Side Effects

- ❖ Often occurs with the use of antipsychotics
- ❖ Side effects usually decrease within 3 to 4 weeks but do not entirely remit

MANIFESTATIONS

Orthostatic hypotension
Dry mouth
Constipation
Urinary hesitance or retention
Blurry vision
Dry eyes
Photophobia
Nasal congestion
Decreased memory

Nursing Interventions

- Stool softeners
- Calorie-free beverages
- Adequate fluid intake
- Inclusion of grains and fruits in the diet

NURSING ALERT

Droperidol, Thioridazine, Mesoridazine

These drugs may lengthen the QT interval to potentially life-threatening cardiac dysrhythmia or cardiac arrest

NURSING RESPONSIBILITIES: ANTI-PSYCHOTIC DRUGS

Dry mouth	• Drink sugar-free fluids • Sugar-free hard candy
Constipation	• Increase OFI • Eat bulk-forming food • Exercise

	• Stool softeners but laxatives
Photosensitivity	• Use sunscreen • Avoidlongperiods time in the sun •Wear protective covering
Orthostatic Hypotension	• Rising slowly from sitting or lying postings
Drowsiness	•Avoid driving a car or performing other dangerous activities
Dizziness	• Wait to walk until any dizziness has subsided
Medication Compliance	• If you forget a dose of antipsychoticmedication, take it if the dose is only 3 to 4 hours late. If the missed dose is more than 4 hours late or the next dose is due, omit the forgotten dose • If you have difficult remembering your medication, use a chart to record doses when taken, or use a pill box labelled with dosage times and/or days of the week to help you remember when to take medication.

NURSING ALERT

Clozapine

✓ May cause agranulocytosis
✓ Clients should have a baseline WBC count anddifferential before initiation of treatment
✓ WBC count everyweek throughout treatment and for 4 weeks after discontinuation of clozapine

ANTI-DEPRESSANT DRUGS

❖ **Primarily used in the treatment of:**

- Major depressive illness
- Anxiety disorders
- Depressedphaseofbipolar disorder
- and psychotic depression

TYPES OF ANTIDEPRESSANT DRUGS

1. Selective Serotonin Reuptake Inhibitors (SSRI)
2. Tricyclic Antidepressant (TCA)
3. Monoamine Oxidase Inhibitors (MAOI)

Tricyclic Antidepressant Drugs (TCA)

- First choice of drugs to treat depression
- Available since 1950's

Nursing Alert

- Potentially lethal if taken in an overdose.
- Depressed or impulsive clients who are taking these drugs need to have prescriptions and refills in limited amounts to decrease the risk.

TRICYCLIC DRUGS	
Imipramine (Tofranil) Desipramine (Norpramin) Amitriptyline (Elavil) Nortriptyline(Pamelor) Doxepin (Sinequan) Trimipramine (Surmontil) Protriptyline (Vivactil) Maprotiline (ludiomil) Mirtazapine (remeron) Amoxapine (ascendin) Clomipramine (anafranil)	**Side Effects** • Dry mouth • Constipation • Urinary retention • Dry nasal passages • Blurred vision • Orthostatic hypotension • Sedation • Weight gain • Tachycardia • Sexual dysfunction • Agitation • delirium

Selective Serotonin Reuptake Inhibitor (SSRI)

- Replacedthe tricyclic drugs as the first choice in treating depression because they equalin efficacy and produce fewer side effects
- Effective in the treatment of obsessive-compulsive disorder
- Safest drug to give during panic attack

SSRI DRUGS	Side Effects
Fluoxetine (Prozac)	• Agitation
Fluvoxamine (Luvox)	• Akathisia
Paroxetine (Paxil)	•Nausea
Sertraline (Zoloft)	•Insomnia
Citalopram (Celexa)	• Sexual dysfunction
Escitalopram (Lexapro)	• Weight gain (less)
	• Sedation
	•Sweating
	•Headaches

Monoamine Oxidase Inhibitors

- With low incidence of sedation
- Can cause hypertensive crisis
- This drugshould not be givenwith other MAOIs, tricyclic antidepressants, Meperidine (Demerol), CNS depressants

MAOI DRUGS	Side Effects
Phenelzine (Nardil)	• Daytime sedation
Tranylcypromine (Parnate)	• Insomnia
Isocarboxazid (Marplan)	• Weight gain
	• Dry mouth
	• Orthostatic hypotension
	• Sexual dysfunction

Nursing Interventions

- Avoid tyramine foods
- No mature or aged cheeses or dishes made with cheese, such as lasagna, pizza (exceptcottage cheese. cream cheese, ricotta cheese, and processed cheese slices)
- No aged meats such as pepperoni, salami, mortadella, summer sausage, beef logs, and similar products.
- No Italian broad beans (fava) pods or banana peel.Banana pulp and all other fruits and vegetables are permitted
- Avoid all tap beers and microbrewery beer.Drink no more than two cans or bottles of beer (including non-alcoholic beer) or 4 ounces of wine per day

Side Effect of the other Antidepressant

Sedation	Nefazodone Trazodone Mirtazapine
Headache	Nefazodone Trazodone
Dry mouth & nausea	Nefazodone
Loss of appetite Nausea Agitation Insomnia	Bupropion venlafaxine
Dizziness Sweating Sedation	Venlafaxine
priapism	Trazodone

Nursing Alert

❖ **Bupropion**
- Can cause seizures at rate 4 times that of other antidepressants

NURSING RESPONSIBILITIES

SIDE EFFECTS	INTERVENTION
Nausea	Take the medication with food
Insomnia	Take daily doses in the morning. Do not use alcohol to inducesleep because this will worsen insomnia
Motor restlessness / hand tremor	Ask the physician for a medication such as Propranolol or Benzodiazepine
Dry mouth	Usecalorie-free beverages or sugar-free candy
Excessive Weight Gain	Balanced Diet
Constipation	Increase OFI Stool Softeners

Mood-stabilizing Drugs

❖ Used to treat bipolar disorder
❖ Functions to:
- Stabilize client's mood
- Preventing or minimizing the highs and lows that characterize bipolar illness
- Treat acute episodes of mania

Lithium is the most established mood stabilizer; this normalizes the reuptake of serotonin, NE, acetylcholine & dopamine.
- Other drugs that are effective in stabilizing the mood:
- Carbamazepine (Tegretol)
- Valproic acid (Depakote, Depakene)
- Gabapentin (Neurontin)
- Lamotrigine (Lamictal)

Lithium
- Available in tablets, capsules, liquid sustained-released form.
- No parenteral forms
- Normal level: 0.5 — 1.5 mEq/L
- Therapeutic level: 0.6 – 1.2 mEq/L
- Common side effects:
- Mild nausea/diarrhea
- Anorexia
- Fine hand tremor
- Polydipsia
- Polyuria
- Metallic taste in the mouth
- Fatigue
- Lethargy

TOXIC EFFECTS
- Severe diarrhea
- Severe vomiting
- Muscle weakness
- Lack of coordination

If left untreated, symptoms mayworsen and can lead to renal failure, coma and death
Lithium levels exceed 3.0 mEq/L = Dialysis

NURSING ALERT
Valproic acid can cause hepatic failurein fatality

Carbamazepine can cause aplastic anemia and agranulocytosis
Lamotrigine can cause Steven-Johnsons Syndrome

MOOD STABILIZING DRUGS: NURSE RESPONSIBILITIES

- Have serum levels monitored periodically
- Take the medication with food to minimize nausea
- For the fine hand tremors ask the physician to prescribe a beta-blocker such as propranolol (Inderal)
- To helpminimize weight gain,get a balance diet and get regular exercise. Expect some weight gain.
- Normal sodium intake (2-3days)
- Minimize side effects of sedation and drowsiness from anticonvulsant medications by taking larger dosesat bedtimeand smaller doses during the day
- If you are takinglithium, keep water intake in a normal rangeand avoid heavy sweating, because this increases serum lithium levels rapidly

ANTI-ANXIETY DRUGS (ANXIOLYTICS)

- Used to treat:
  - Anxiety disorders
  - Insomnia
  - OCD
  - Depression
  - Post-traumatic stress disorder
  - Alcohol withdrawal

- **Benzodiazepines** have proved to be most effective in relieving anxiety

ANTI-ANXIETY DRUGS

Alprazolam (Xanax)
Chlordiazepoxide (Librium)
Clonazepam (Klonopin)
Diazepam (Valium)
Flurazepam (Dalmane)
Lorazepam (Ativan)
Oxazepam (Serax)
Temazepam (Restoril)
Triazolam (Halcion)
Buspirone (BuSpar)

ANTI-ANXIETY DRUGS: NURSING RESPONSIBILITIES

- It is important for clients to know that antianxiety agents are aimed at relieving symptoms, such as anxiety or insomnia; it does not treat the underlying problems that cause the anxiety.
- Benzodiazepines strongly potentiate the effects of alcohol
- One drink may have the effect of three drinks (alcohol)
- Avoid driving (drowsiness)
- Benzodiazepine withdrawal can be fatal: once a course of therapy has been started, benzodiazepines should never be discontinued abruptly without the supervision of the physician.
- Take anxiolytic drugs only as prescribed.

Stimulants

- First used to treat psychiatric disorders
- Before, they were used to treat depression
- At present,they are used for attention deficit/hyperactivity disorder in adolescents and children

DRUGS	SIDE EFFECTS	
Methylphenidate (Ritalin)	• Anorexia	• Dizziness
Dextroamphetamine (Dexedrine)	• Weight loss	• Dry mouth
Pemoline (Cylert)	• Nausea	• Blurred vision
	• Irritability	• Palpitations

NURSING ALERT
Pemoline
- Can cause life-threatening liver failure
- May require liver transplantation in 4 weeks from the onset of symptoms

STIMULANT: NURSING RESPONSIBILITIES
- ❖ Never leave the supply of medication in a place the child can reach
- ❖ Nausea & vomiting: Take medication at meal time.
- ❖ Growth suppression: Monitor thechild's weight and height
- ❖ Try a dosage schedule that provides a dose of medication before beginning routine tasks of concentration such as nightly homework.
- ❖ Dry mouth: Calorie-free beverages or sugar-free candy
- ❖ Caffeine-free beverages; avoid chocolate & excessive sugar.
- ❖ Medications should be given in a manner that is not intrusive,nor should it draw undue attention to the child.

Disulfiram (Antabuse)
- Sensitizingagent that causes anadverse reaction when mixed with alcohol in the body.
- Usefulfor persons who are motivated to abstain from drinking and who are not impulsive.
- Symptoms begin to appear after five to ten minutes and may last from 30 minutes to 2 hours
  - ✓ Facial and body flushing
  - ✓ Throbbing headache
  - ✓ Sweating
  - ✓ Dry mouth
  - ✓ Nausea
  - ✓ Vomiting
  - ✓ Dizziness
  - ✓ Weakness
- In severe cases, there may be chest pain,dyspnea, severe hypotension, confusion and even death

Other side effects:
- Fatigue
- Drowsiness
- Halitosis
- Tremor
- Impotence

Nursing Responsibilities
Common products that may contain alcohol:
- Shaving cream
- Aftershave lotion
- Cologne
- Deodorant
- OTC drugs (cough preparations)
- Client must read the products carefully and select items that are alcohol-free

ELECTROCONVULSIVE THERAPY
Functions:
- Treat depression in select groups such as clients who do not respond to antidepressants
- Indicated to clients who are actively suicidal while waiting weeks for full effects of antidepressant medication

Preparation:
- NPO after midnight
- Void prior to the procedure
- I.V should be started for the administration of the medication

Procedure

- Client receives short acting anesthetic so she is not awake during the procedure
- Receives muscle relaxant to reduce outward signs of seizure
- The brain is monitored with EEG while the electrical stimulation is delivered
- Following ECT the client may be mildly confused, disoriented and may have short term memory impairment.

Voltage of electrical current administered to the client	70-50 volts
Length of electrical shock applied to the patient	0.5 to 2.0 seconds
Usual number of treatments needed to produce a therapeutic effect	6 -12 treatments(up to 15)
Frequency of treatments	There should be an interval of 48 hours for each treatment
Indication of effectiveness of ECT	The occurrence of generalized tonic-clonic seizure
Indication for ECT	-Depression -Mania -Catatonic -Schizophrenia

Very High Risks

- Increased intracranial pressure
- Recent Fracture
- Cardiac Condition
- Retinal detachment
- Pregnancy

Need for consent prior to ECT

- Yes, consent is needed

Atropine sulfate	To decrease secretions
Succinylcholine (Anectine)	Topromote muscle relaxation
Methohexital Sodium(Brevital)	Serve as an anesthetic agent

Common complications of ECT

- Loss of memory
- Headache
- Apnea
- Fracture
- Respiratory depression

Nursing Responsibilities After ECT

- The nurse or anesthesiologist mechanically ventilates the patient with 100% oxygen until the patient can breathe unassisted.
- The nurse monitors for respiratory problems.
- ECTcausesconfusionand disorientation; thus, it is important to help with reorientation (time, place, person) as the patient emerges from this unconscious state.
- Nurse might need to administer a benzodiazepine, as needed.
- Observation is necessary until the patient is oriented and steady, particularly when the patient first attempts to stand.
- All aspects of the treatment should be carefully documented for the patient's record.

PERSONALITY STRUCTURE

❖ Freud conceptualized personality structure as having three components

ID

❖ Seeks instant gratification; causes impulsive, unthinking behavior; and has no regard for rules or social convention

SUPER EGO

❖ Values, and parental and social expectations, therefore, it is in direct opposition to the id.

EGO

- ❖ Balancing or mediating force between the id and the superego.The ego represents mature and adaptive behavior that allows a person to function successfully in the world

EGO DEFENSE MECHANISM

RATIONALIZATION

❖ Excusing own behaviorto avoid responsibility, conflict, anxiety, or loss of self-respect

Examples: Student blames failure on teacher being mean; Man says he beats his wife because she does not listen to him.

REACTION FORMATION

❖ Acting the opposite of what one thinks are feels.

Examples: Woman who never wanted to have children becomes a super-mom;Person who despises the boss tells everyone what a great boss she is.

REGRESSION

❖ Moving back to previous developmental stage in order to feel safe or have needs met.

Examples: Five-year-old asks fora bottle when new baby brother is being fed; Man pouts like a four-year-old if he is not the center of his girlfriend's attention.

REPRESSION

❖ Excluding emotionally painful or anxiety-provoking thoughts and feelings
❖ Unconscious forgetting

Examples: Woman has no memoryof themugging she suffered yesterday; Woman has no memorybefore age 7 when she was removed from abusive parents.

SUPRESSION

❖ Excluding emotionally painful or anxiety-provoking thoughts and feelings
❖ Conscious forgetting

Examples: Woman has tried to forget her memoryof the financial problems she had in the past.

DISPLACEMENT

❖ Ventilation of intense feelings toward persons less threatening than the one who aroused those feelings.

Examples: A person who is mad at the boss yells at his or her spouse

COMPENSATION

❖ Over achievement in one area to offset real or perceived deficiencies in another area

Examples: Napoleon complex: Diminutive man becoming an emperor; Nurse with low self-esteem works double shifts so her supervisor will like her

CONVERSION

❖ Expression of an emotional conflict through the development of a physical symptom usually sensorimotor in nature.

Example: A teenager forbidden to see x-rated movies is tempted to do so by friends and develops blindness, and the teenager is unconcerned about the loss of sight

DENIAL

❖ Failure to acknowledge an unbearable condition; failure to admit the reality of a situation, or how one enables the problem to continue

Examples: Diabetic eating chocolate candy; spending money freely when broke; Waiting 3 days to seek help for severe abdominal pain

DIVISIONS OF THE MIND OR LEVELS OF AWARENESS

❖ Freud believed that the human personality functions at three levels of awareness: Conscious; Preconscious; Unconscious

Conscious

- ❖ Perceptions,thoughts,and emotions that existin the person's awareness such as being aware of happy feelings or thinking about a loved one

- Part of the mind focused on awareness

Preconscious

- Not currently in the person's awareness, but he or she can recall them with some effort.
- Part of the mind that contains information that can be recalled at will

Example: An adult remembering what he or she did, thought, or felt as a child.

Unconsciousness

- Realm of thoughts and feelings that motivate a person, even though he or she is totally unaware of them.
- This realm includes most defense mechanisms and some instinctual drives or motivations.
- It is the largest part of the mind; contains materials and information that can never be recalled

COMMON PSYCHOTHERAPEUTIC INTERVENTIONS

1**. Remotivation Therapy**

- Promotes expression of feelings through interactions facilitated by discussion of neutral topics
- Reality orientation for rehabilitative patients only and not for activetly psychotic patients

2. Music Therapy

- Use of music to facilitate relaxation, expression of feelings and outlet of tension

3. Play Therapy

- Enables the patient to experience intense emotion ina safe environment with the use of play

Example:For victims of child abuse, give dolls.

4. Group Therapy

- Therapeutic interactions of three or more patients with a therapist to relieve emotional difficulties, increase self-esteem, develop insight and improve behavior in relation with others
- Minimum number of members in a group is 3, while the ideal number is 8 —10

Types of Group

- **Therapeutic Group**
  - To gain insight into their problems (i.e. Alcoholic Anonymous)
- **Socialization Group**
  - To enhance interaction among patients
- **Life Review / Reminiscing Group**
  - To lessen isolation

5. Milieu Therapy

- Treatment by means ofcontrolled modification of the patients' environment to facilitate positive behavioral change
- Nurse identifies what each patient needs from the therapeutic milieu, while keeping in mind the needs of the larger patient group

6. Family Therapy

- Focuses on the total family as an interactional system
- Best suited for families where there is domestic violence

7. Psychoanalysis

- Focuses on the exploration of the unconscious, to facilitate identification of the patient's defenses
- Behavioral disorders are related to unresolved anxiety-provoking childhood experiences that are repressed into the unconscious
- Goal is to bring repressed experiences into conscious awareness and to learn healthier means of coping with anxiety.
- Utilizes dream analysis and free association (verbalization of thoughts without censorship)

8. Hypnotherapy

- Involves various methods and techniques to induce a transtate where the patient becomes submissive to instructions

9. Humor Therapy

- ❖ Use of humor to facilitate expression of feelings and to enhance interaction
- ❖ Therapeutic laughing lessens the high levels of tension that often as company discussions of serious matters.

10. Behavior Modification

- ❖ Application of learning principles in order to change maladaptive behavior
- ❖ It attempts to streng then a desired behavior or response by reinforcement, either positive or negative

Positive reinforcement

- If the desired behavior is assertiveness, whenever the client uses assertiveness skills in a communication group, the group leader provides positive reinforcement by giving the client attention and positive feedback.
- For example, a teacher praises her student for getting high grades, so that the student will be motivated to get high grades again the next time.

Negative reinforcement

- Involves removing a stimulus immediately after a behavior occurs so that the behavior is more likely to occur again.
- For example, if a client becomes anxious when waiting to talk in a group, he may volunteer to speak first to avoid the anxiety.

CRISIS AND CRISIS INTERVENTION

- ❖ Turning point in an individual's life that produces an overwhelming emotional response

Characteristics of a Crisis State

- Highly individualized
- Lasts for 4 — 6 weeks
- Person affected becomes passive and submissive
- Affects a person's support system

Types of Crisis

❖ **Maturational or Developmental Crisis**

- Expected, predictable and internally motivated events in the normal course of life such as:
  - ✓ Leaving home for the first time; Getting married
  - ✓ Having a baby; Beginning a career
  - ✓ Growth; Parenthood

❖ **Situational or Accidental Crisis**

- Unanticipated or sudden, unexpected, Unpredictable and externally motivated events that threaten the individual's integrity such as:
  - ✓ Death of a loved one
  - ✓ Loss of a job
  - ✓ Physical and emotional illness in the individual family or member; Car accident

❖ **Social or Adventitious Crisis**

- Includes natural disasters and acts 0 nature like:
- Floods Earthquakes Hurricanes
- War, Terrorist attacks; Riots
- Violent crimes such as rape or murder

Phases of a Crisis

1. **Denial** - Initial reaction
2. **Increased Tension**
   - Person recognizes the presence of a crisis and continues to do activities of daily living
3. **Disorganization**
   - Person is pre-occupied with the crisis and is unable to do activities of daily living
4. **Attempts to Reorganize**
   - Individual mobilizes previous coping mechanisms

CRISIS INTERVENTION

- A way of entering into the life situation of an individual, family, group, or community to help them mobilize their resources and to decrease the effect of a crisis inducing stress

Goal: To enable the patient to attain an optimum level of functioning

Types of Crisis Intervention

- **Authoritative Crisis Intervention**
  - Designed to assess the person's health status and promote problem- solving such as:
    - ✓ Offeringthe person new information, knowledge or meaning
    - ✓ Raising the person's self- awareness by providing feedback about behavior
    - ✓ Directing the person's behavior by offering suggestions or courses of action
- **Facilitative Crisis Intervention**
  - Aim at dealing with the person's needs for empathetic understanding such as:
  - ✓ Encouraging the person to identify and discuss feelings
  - ✓ Serving as a sounding board for the person
  - ✓ Affirming the person's self-worth

Primary Role of the Nurse in Crisis

- Active and directive, the nurse has to assist the patient

RAPE

- It is a crime of violence and humiliation of the victim expressed through sexual means
- It is the penetration of an act of sexual intercourse with a female against her will and without her consent, whether her will is overcome by force, fear of force, drugs, or intoxicants
- It is also considered rape if the woman is incapable of exercising irrational judgment because of mental deficiency or when she is below the age of consent.
- According to Republic Act 8353, it refers to the insertion of the penis into the mouth. vagina, anus of a victim
- It is generally considered as an act of hostility, anger or violence

POWER RAPE

- The intent of the rapist is not to injure the victim but to command and master another person sexually
- The rapist has an insecure self-image and feelings of incompetence and inadequacy,
- The rape is the vehicle for expressing power and potency.
- This is done to prove one's masculinity

SADISTIC RAPE

- Involves brutality
- The use of bondage and torture is not an expression of anger but necessary for the rapist's sexual excitement
- The assault is often eroticized and is sexually stimulating
- This is done to express erotic feelings

RAPE TRAUMA SYNDROME

- Group of signs and symptoms experienced by a victim in reaction to a rape

Phases of the Rape Trauma Syndrome

- Acute Phase - shock, numbness and disbelief
- Denial Phase - victim's refusal to talk about the event
- Heightened Anxiety- fear, tension, and nightmares
- Stage of Reorganization - victim's life normalizes

Nursing Care for Rape Victims

- In the emergency setting, provide immediate emotional support
- The nurse should allow the woman to proceed at her own pace and not rush her through any interview or examination
- Give as much control back to the victim as possible by allowing her to make decisions, when possible, about whom to call, what to do next, what she would like done, etc.

- It is the victim's decision about whether or not to file charges and testify against the perpetrator and the victim must sign consent forms before any photographs of hair and nail samples are taken for future evidence
- The priority in the care of a rape victim is the preservation of evidence
- Prophylactic treatment for STDs is offered
- Prophylaxis can be offered to prevent pregnancy
    - In some areas, HIV testing is strongly encourage
    - Referrals to rape crisis centers are encourage

AUTISM SPECTRUM DISORDER

- Disorder characterized by impairment in communication skills, or the presence of stereotyped behavior, interests and activities with associated impairment in social interactions
- More prevalent in boys than girls
- Identified no later than 3 years of age.
- It is treatable but not curable
- Does have a genetic link

Main Problem: Impaired Interpersonal Functioning

Manifestations

- Display little eye contact
- Few facial expressions towards others
- They do not use gestures to communicate
- Do not relate to peers and parents
- Lack spontaneous enjoyment
- No moods or emotional affect
- Little intelligible speech
- Stereotyped motor behaviors (hand-flapping body twisting, head-banging)
- Acts as deaf
- No fear of danger

Common Problems and Appropriate Management

- **Drug**
    - Low-dose Antipsychotic
- **Tantrums**
    - Involves head-banging
    - Provide safety
    - Helmet
    - Padded walls
    - Monitor behavior (1:1)
- **Communication**
    - All vowels
    - Use of short sentences when talking to the child
- **Nutrition: Less Than Body Requirements**
    - Provide well-balanced diet
    - Small frequent feedings
- **Routines**
    - Provide consistency
- **Love & Belongingness**
    - Family Therapy
- **Priority Nursing Diagnosis**
    - Risk for Injury

ATTENTION-DEFICIT HYPERACTIVITY DISORDER

- Characterized by inattentiveness, overactivity, and impulsiveness.
- Common in boys
- Identified and diagnosed when the child begins preschool or school (before the age of 7)

Common Etiological Factors

- UNKNOWN
- Neurologic impairment
- Early malnutrition
- Frontal lobe hypoperfusion
- Use of drugs and exposure to alcohol and tobacco during pregnancy

Risk Factors

- Family history of ADHD
- Male relatives with antisocial personality disorder
- Lower socioeconomic status
- Gender (Male)
- Marital or Family Discord

Clinical Manifestations

INATTENTIVE BEHAVIORS

Misses details
Makes careless mistakes
Has difficulty sustaining attention
Doesn't seem to listen
Dos not follow-through on chores
Has difficulty with organization
Avoids tasks requiring mental effort
Often loses necessary things

HYPERACTIVE BEHAVIOR

Fidgets
Often leaves seat (during a meal)
Runs or climbs excessively
Can't play quietly
Is always on the go; driven
Talks excessively
Blurts out answers
Interrupts
Can't wait for turn
Is intrusive with siblings/playmates

Treatment

DRUGS	NURSING CONSIDERATIONS
Methylphenidate (Ritalin)	• Monitor for appetite suppression and growth delays • Give regular tablet after meals • Alert client that full drug effect takes 2 days
Dextroamphetamine (Dexedrine)	• Monitor for insomnia • Give last dose early afternoon • Full drug effect takes 2 days
Pemoline (Cylert)	• Monitor for elevated liver function • Drug may take 2weeks for full effect

Nursing Interventions for ADHD

1. Ensuring the child's safety and that of others.
   - Stop unsafe behavior
   - Provide close supervision
   - Give clear direction about acceptable and unacceptable behavior
2. Improved role performance
   - Give positive feedback for meeting expectations
   - Provide a quiet place free of distractions for ask completion.

3. Simplifying instructions/ directions
   - Get the child's full attention
   - Break complex tasks into small step
   - Allows break
4. Structured daily routine
   - Establish a daily schedule
   - Minimize changes
5. Nutrition
   - Provide finger foods
6. Client/Family education and support
   - Listen to parent's feelings and frustration

MENTAL RETARDATION

- ❖ Below-average intellectual functioning
- ❖ IQ less than 70
- ❖ Significant limitations in areas of adaptive functioning

Causes

- Hereditary (Tay-Sachs Disease; Trisomy 21)
- Pregnancy/Perinatal problems (fetal malnutrition)
- Medical conditions of infancy

Levels of Mental Retardation	IQ	What can be done
Mild	55 – 69	Educable
Moderate	40 – 54	Trainable
Severe	25 – 39	Need Close Supervision
profound	< 25	Custodial Care

- ❖ **Educable**
  - Patient can be thought how to read and write.
- ❖ **Trainable**
  - Vocational skills (cooking, sewing, etc.)
- ❖ **Close Supervision**
  - Activities of daily living (brushing, wearing clothes)
- ❖ **Custodial Care**
  - Client is totally dependent

Nursing Care

- Repetition
- Role modelling
- Restructuring the environment

Focus of Education for Mentally Retarded Patient

- Reading
- Writing
- Basic Arithmetic

ANXIETY

- ❖ Stage of uneasiness or discomfort experienced to varying degrees frequently coupled with doubts, fears, and obsessions.
- ❖ Feeling of terror or dread; the most uncomfortable feeling a person can experience

MILD ANXIETY	Positive states of heightened awareness and sharpened senses, allowing the person to learn new behaviors and solve problems, The person can take in all available stimuli (enlarged perceptual field)

MODERATE ANXIETY	Decreased perceptual field (focus on immediate task only) The person can learn new behavior or solve problems only with assistance
SEVERE ANXIETY	Feelings of dread or terror The person cannot be redirected into a task; he or she focuses only on scattered details and has physiological symptoms of tachycardia, diaphoresis, and chest pain. People with severe anxiety often go to emergency departments, believing they are having a heart attack.
PANIC ANXIETY	Loss of rational thoughts, delusion, hallucinations, and complete physical immobility and muteness The person may bolt and run aimlessly, often exposing himself or herself to injury

PRIORITY NURSING DIAGNOSES FOR ANXIETY

- ❖ Ineffective individual coping
- ❖ Anxiety

PRINCIPLES OF NURSING CARE IN ANXIETY

- ❖ Calm
- ❖ Administer medications
- ❖ Listen to the patient's concern
- ❖ Minimized environment stimuli

ANXIETY DISORDER

- ❖ Emotional illness characterized by fear, automatic nervous system symptoms and avoidance behavior
- ❖ Diagnosed when anxiety no longer functions as a signal of danger or a motivation for needed change but become chronicand permeates major portions of the person's life, resulting in maladaptive behaviors and emotional instability

Symptoms of Anxiety Disorder

- **Agoraphobia**
  - Anxiety about or avoidance of places or situation from which escape might be difficult or help might be unavailable

    Symptoms:
    - ✓ Avoids being outside alone or at home alone
    - ✓ Avoids travelling in vehicles; impaired ability to work
    - ✓ Difficulty meeting daily responsibilities (e.g., grocery shopping, going to appointments)
- **Panic Disorder**
  - It is characterized by recurrent, unexpected panic attacks that cause constant concern.
- **Panic attack**
  - It is the sudden onset of intense apprehension, fearfulness, or terror associated with feelings of impending doom

Symptoms: A discrete episode of panic lasting 15 to 30 minutes with four or more of the following:

- Palpitations
- Sweating
- Trembling or shaking
- Shortness of breath
- Choking
- Chest pain or discomfort
- Nausea
- Derealisation/depersonalization
- Dear of dying or going crazy
- Paresthesias
- Chills or hot flashes

- **Social Phobia**
  - It is characterized by anxiety provoked by certain types of social or performance situations, which of leads to avoidance behavior

Symptoms
- Fear of embarrassment or inability to perform
- Avoidance or dreaded endurance of behavior or situation
- Belief that others are judging him or her negatively
- Significant distress or impairment in relationship, work, or social life
- Anxiety can be severe or panic level.

Management
- Anti-anxiety medications
- Social skills training

GENERAL ANXITY DISORDER

- It is characterized by at least 6 month of persistent and excessive worry and anxiety

Symptoms
- Apprehensive expectation more days than not for 6 months or more about several events or activities
- Incontrollable worrying
- Significant distress or impaired social or occupational functioning
- Three of the following symptoms:
  - ✓ Restlessness
  - ✓ Easily fatigued
  - ✓ Difficulty concentrating of mind going blank
  - ✓ Irritability
  - ✓ Muscle tension
  - ✓ Sleep disturbance

Management
- Buspirone (Buspar) and SSRI antidepressants

ACUTE STRESS DISORDER

- It is the development of anxiety, dissociative, and other symptoms within 1 month of exposure to an extremely traumatic stressor; it last 2 days to 4 weeks

Symptoms
- Exposure to traumatic events causing intense fear, helplessness, or horror, marked anxiety symptoms or increased arousal;
- Significant distress or impaired functioning
- Persistent re-experiencing of the event
- Three of the following symptoms:
  - ✓ Sense of emotional numbing or detachment
  - ✓ Feeling dazed
  - ✓ Derealisation
  - ✓ Depersonalization
  - ✓ Dissociative amnesia (inability to recall important aspect of the event)

POST-TRAUMATIC STRESS DISORDER

- It is characterized by the re-experiencing of an extremely traumatic events, avoidance of stimuli associated with the event, numbing of responsiveness, and persistent increased arousal

Symptoms
- Flashbacks and nightmares
- Exposure to traumatic events involving intense fear, helplessness or horror;
- Avoidance of memory-provoking stimuli and numbing of general responsiveness
- Increased arousal (sleep disturbance, irritability or angry outbursts, difficulty concentrating, hypervigilance, exaggerated startle response)
- Significant distress or impairment

Management

- Anti-anxiety Medication Diazepam (Valium)
  - ✓ Oxazepam (Serax)
  - ✓ Chlordiazepoxide (Librium)
  - ✓ Clorazepate dipotassium
  - ✓ Alprazolam (Xanax)
- Anti-depressant Medications
- Group Therapy

When to Administer Anxiolytic Drug

- Best taken before meals, food in the stomach delays absorption

Side Effects of Anxiolytic Drugs

- Drowsiness; Sedation; Poor coordination; Impaired memory and clouded sensorium

Client Teaching on Anxiolytic Drugs

- Intake of alcohol and caffeine-containing foods alter the effect of the drugs.
- It potentiates the effect of the alcohol
- Administer separately, it is incompatible with any drugs.

Priority Nursing Diagnosis for Anxiety Disorder

- Ineffective Individual Coping

Treatment

Cognitive Behavioral Techniques

❖ **Positive Reframing**

- Turning negative message into positive messages
- Instead of thinking , "My heart is pounding. I think I am going to die" the client thinks, "I can stand this. This just an anxiety. It will go away".

❖ **Decatastrophizing**

- Involves the therapist's use of the questions to more realistic appraise the situation
- The therapist may ask: 'What is the worst thing that could happen? Is that likely? Could you survive that? Is that as bad as you imagine?"

❖ **Thought-stopping**

- The client uses thought stopping and distraction techniques to jolt himself from focusing on the negative thoughts
- Techniques that can break the cycle of negative thoughts includes:
  - ✓ Splashing the face with water
  - ✓ Snapping a rubber band worn on the wrist

❖ **Assertiveness Training**

- Helps the person take more control of the situation
- Techniques help the person negotiate interpersonal situation and foster self-assurance
- They involve using "I" statement to identify feelings and to communicate concerns or the needs of others

Example: "I feel angry when you turn your back while I'm talking", 'I want to have five minutes of your time for an uninterrupted conversation about something important

SPECIFIC PHOBIA

❖ Characterized by significant anxiety provoked by a specific feared object or situation which leads to avoidance behavior.

Symptoms

- Marked anxiety response to the object or situation
- Avoidance or suffered endurance of object or situation
- Significant distress or impairment of daily routing, occupation or social functioning
- Adolescent and adults recognize their fear as excessive or unreasonable

Management

- Anti-anxiety Medications
- Systematic Desensitization
  - ✓ The therapist progressive exposes the client to threatening object in a safe setting until the client's anxiety decreases

PERSONALITY

❖ Defined as an ingrained, enduring pattern of behaving and relating to self, other, and the environment; personality includes perception, attitudes, and emotions.

Categories of Personality Disorders

1. Cluster A
- Odd and eccentric behavior
- Includes paranoid, schizoid, and schizotypal personality

2. Cluster B
- Includes people appear dramatic, emotional, or erratic
- Includes antisocial, borderline , histrionic, and narcissistic personality disorder

3. Cluster C
- Includes people who appear anxious or fearful
- Includes avoidant, dependent, and obsessive –compulsive personality disorder

CLUSTER A

Paranoid Personality Disorder

Symptoms / Characteristics
- Mistrust and suspicion of others
- Uses the defense mechanism of projection, which is blaming other people, institutions or events for their own difficulties

Nursing Interventions
- Approach these clients in a formal, business –like manner and refrain from chi-chat and jokes (serious and straight forward approach)
- Involve the client in treatment planning
- Teach client to validate ideas before taking action.

Schizoid Personality Disorder

Symptoms / Characteristics
- Detached from social relationships
- Restricted affect and little, if any emotion; aloof and indifferent, appearing emotionally cold, uncaring, or unfeeling
- Report no leisure or pleasurable activities because they rarely experience enjoyment
- Involve themselves more with things than people

Nursing Interventions
- Focus in improved functioning of the client in the community
- Assist the client to find a case manager one who helps the client to obtain services and health care, manage finances, etc.

Schizotypal Personality Disorder

Symptoms / Characteristics
- Has social and interpersonal deficits marked by acute discomfort with andreduced capacity for close relationships
- Clothes are ill fitting, do not match, and may be strained or dirty
- Cognitive distortions include ideas of reference, magical thinking that he has special powers, unfounded beliefs

Nursing Interventions
- Development of self-care skills
- Nurse encourage clientto establish a daiy routine for hygiene and grooming
- Improve community functioning and provide social skills training

CLUSTER B

Antisocial Personality Disorder

Symptoms / Characteristics

- Violation of the right of others
- Lying
- Rationalization of own behavior
- Thrill-seeking behaviors
- Poor work history;
- Consistent irresponsibility

Nursing Interventions

- Promote responsible behavior
- Limit setting
- Consistent adherence to rules and treatment plan\the nurse should not become angry or respond to the client harshly or punitively
- Confrontation – technique designed to manage manipulative or deceptive behavior.

Example:

Nurse: "You've said you're interested in learning to manage angry outbursts, but you've missed the last three group meetings."

Client: "Well, I can tell no one in the group likes me. Why should I bather?"

Nurse: **"**The group meetings are designed to help you and the others, but you can't work on issues if you are not there."

Borderline Personality Disorder

Symptoms / Characteristics

- Fear of abandonment, real or perceived
- Unstable and intense relationship
- Recurrent self-mutilating behavior or suicidal threats or gestures
- Transient psychotic symptoms such as hallucinations, demanding self-harm

Nursing Interventions

- Promote client's safety
- Helping clients to cope and control emotions
- Cognitive restructuring techniques
- Structure the time
- Teach social skills

Histrionic Personal Disorder

Symptoms / Characteristics

- With a pervasive pattern of excessive emotionality and attention-seeking
- Clients are overly concerned with impressing others with their appearance
- Dress and flirtatious behavior are not limited to social situations or relationships but also occur in occupation and professional settings

Nursing Interventions

- It would be more acceptable to stand at least 2 feet away from them and to shake hands,
- Teaching social skills and role-playing those skills in a safe, non-threatening environment can help clients to gain confidence in their ability to interact socially
- Provide factual feedback about behavior.

Narcissistic Personality Disorder

Symptoms / Characteristics

- Has a pervasive pattern of grandiosity, need for admiration, and lack of empathy for others

Nursing Intervention

- Provide matter-of-fact approach
- The nurse must not internalize such criticism or take it personally
- She sets limits to rude or verbally abusive behavior and explains his or her expectations from the clients.
- Teach client any needed self-care skills

CLUSTER C

Avoidant Personality Disorder

Symptoms / Characteristics

- Pervasive pattern of social discomfort and silence, low self- esteem and hypersensitivity to negative evaluation
- They fear rejection, criticism, shame or disapproval
- They remain aloof in their relationship and feel inferior to others

Nursing Interventions

- Require much support and reassurance from the nurse
- The nurse can help them to explore positive self-aspects, positive responses from other, and possible reasons for self-criticism

Dependent Personality Disorder

Symptoms / Characteristics

- Pervasive and excessive need to be taken care of which leads to submissive and clinging behavior and fears of separation

Nursing Interventions

- Foster client's self-reliance and autonomy
- Teach problem-solving and decision-making skills
- Cognitive-restructuring techniques

Obsessive – Compulsive Personality Disorder

❖ Involves obsessions (thoughts, impulses or image) that cause marked anxiety and/or compulsions (repetitive behaviors or mental acts) that attempt to neutralize anxiety

Symptoms / Characteristics

- Preoccupation with orderliness, perfectionism and control

OBSESSIONS	COMPULSION
Fear of Dirt and Games	Excessive Hand Washing
Fear of Burglary or Robbery	Repeated Checking of Door and window locks

Nursing Interventions

- Encourage negotiation with others
- Assist clients to make timely decisions and complete work
- Cognitive restructuring techniques

EATING DISORDERS

ANOREXIA NERVOSA

❖ Life-threatening eating disorder characterized by:
- Client's refuse or inability to maintain a minimally normal body weight
- Intense fear of gaining weight or becoming fat
- Significant disturbed perception of the shape or size of the body
- Refusal to acknowledge the seriousness of the problem
- Body weight that is 85% less than expected for their age and height

Clinical Manifestations

- Fear of gaining weight
- Body image disturbance
- Amenorrhea
- Depressed mood
- Social withdrawal
- Insomnia
- Feelings of ineffectiveness
- Limited spontaneity
- Complaints of constipation & abdominal pain
- Cold intolerance
- Lethargy
- Emaciation
- Dec BP, Dec Temperature, Dec PR
- Hypertrophy of salivary glands
- Elevated BUN
- Leukopenia & mild anemia
- Elevated liver function studies

Sub types:

- **Binge eating**
  - Consuming large amount of food in a discrete period of usually 2 hours or less
- **Purging**
  - Compensatory behavior designed to eliminate food by means of self-induced vomiting or misuse of laxatives, enemas and diuretics

Note: Some clients with anorexia do not binge but engage in purging behavior after ingesting small amounts of food

Treatment

- **Focus on:**
  - Weight restoration
  - Nutritional rehabilitation
  - Rehydration
  - Correction of electrolyte imbalance

- Drugs
  - Amitriptyline (Elavil) & Cyproheptadine (Periactin) for weight gain
  - Olanzapine (Zyprexa) = promotes weight gain and produces antipsychotic effect

- Individual therapy

BULIMIA NERVOSA

- Eating disorder characterized by recurrent episode (at least twice a week for 3 months) of binge eating followed by inappropriate compensatory behaviors to avoid weight gain such as purging, use of laxatives, diuretics, enemas, and fasting.
- Weight usually in normal range, although some clients are overweight or underweight.
- Low-self-esteem

Clinical Manifestations

- Recurrent episodes of binge eating and purging
- Selection of low-calorie foods
- Depressive and anxiety symptoms
- Substance use (alcohol and stimulants)
- Loss of dental enamel
- Chipped ragged or moth-eaten appearance to teeth
- Increased dental carries
- Menstrual irregularities
- Dependence in laxatives
- Esophageal tears
- Metabolic alkalosis (vomiting)
- Metabolic acidosis (diarrhea)
- Mildly elevated serum amylase levels

Common Nursing Diagnoses related to Eating Disorders

- Body Image Disturbance
- Self –esteem Disturbance
- Ineffective Individual Coping

Nursing Interventions

- Promote improved nutrition
- Assume a calm, matter-of-fact attitude and positive expectation of the client
- Behavior modification therapy
- Promote effective individual coping with anxiety
- Improved fluid volume
- Drugs: desipramine (Norpramin), Imipramine (Tofranil), Amitriptyline (Elavil), Nortriptyline (Pamelor), Phenelzine (Nardil)

SEXUAL DISORDERS

Paraphilias

- Group of psychosexual disorders characterized by unconventional sexual behaviors
- Abnormal expressions of sexuality

Non-Coercive Paraphilias

- **Fetishism**
  - Sexual arousal elicited by inanimate objects (shoes, leather and rubber) or specific body parts (feet, hair)
- **Autoerotic Asphyxia**
  - Constriction of the neck to enhance masturbation experience
  - Often leads to accidental death
- **Sexual Masochism**
  - Erotic interest in receiving psychological or physical pain, real or fantasized
- **Transvestitism**
  - Erotic interest is achieved by using the apparel of the opposite sex

Coercive Paraphilias

- **Exhibitionism**
  - International exposure of the genitals to a stranger
  - May be accompanied by arousal and masturbation either during or after the exposure
- **Voyeurism**
  - Secret observation of an unsuspecting person (usually a woman) engaged in a private act (e.g. undressing, having sex, etc.)
  - Voyeur often masturbates during or after the viewing
- **Frotteurism**
  - Intense sexual arousal elicited by rubbing the genitals a non-consenting person
- **Pedophilia**
  - Sexual interest in a child
- **Urophilia**
  - Urinating on the sexual partner
- **Coprophilia**
  - Smearing feces on the partner
- **Sadism**
  - Erotic interest in inflicting physical pain

Nursing Interventions

- Diversional activities
- Limit-setting
- Behavior modification

SCHIZOPHRENIA

- Coined by Bleuler to describe a lack of integration of the patient's functions
- Distorted and bizarre thoughts perceptions, emotions, movements and behavior
- Disturbance in thought process and perception for at least 6 months.
- Usually diagnosed in late adolescence and early adulthood
- Main Problem: Altered thought Process

Two major categories

- Positive/Hard symptoms
- Negative/soft Symptoms

POSITIVE/HARD SYMPTOMS	NEGATIVE/SOFT SYMPTOMS
Hallucination	Alogia
Delusions	Anhedonia
Ambivalence	Apathy
Associative Looseness	Blunted affect
Echopraxia	Catatonia

Flight of ideas Ideas of reference Perseveration	Flat affect Lack of volition (Avolition)

General Manifestations

1. Perceptual changes

- ❖ Perceptions may either be heightened or blunted
- ❖ May occur in all senses or in just one or two.
- ❖ Hallucinations (hallmark of Schizophrenia)
- ❖ May be visual, olfactory, gustatory, tactile or auditory

2. **Disturbances in Thought**

❖ **Clang associations**

- Ideas that are related to one another based on sound or rhyming rather than meaning.

Example: "I will take a pill if I go up to the hill but not if my name is Jill, I don't want to kill."

❖ **Delusions**

- Disturbances in the content rather than the form of thought.

Types

- **Persecutory/Paranoid Delusions**
  - ✓ Involve the client's belief that "other" are planning to harm the client or are spying, following, ridiculing or belittling the client in some way.

Example: The client may think that food has been poisoned or that rooms are bugged with listening devices.

- **Grandiose Delusions**
  - ✓ Characterized by the client's claim to association with famous people or celebrities, or the client's belief that he or she is famous or capable of great feats.

- **Religious Delusions**

✓ Often center around the **second coming of Christ** or another significant religious figure or prophet.

Example: client claims to be the Messiah or some prophet sent from God; believes that God communicates directly to him or her, or that he or she has a "special" religious mission in life or special religious powers.

- **Somatic Delusion**

✓ Generally vague and unrealistic beliefs about the client's health or bodily functions.

Examples: A male client may say that he is pregnant, or a client may report decaying intestines or worms in the brain.

- **Referential delusion / Ideas of Reference**

✓ Involve the client's belief that television broadcasts, music, or newspaper articles have special meaning for him or her.

Examples: The client may report that the president was speaking directly to him on a news broadcast or that special messages are sent through newspaper articles.

3. **Changes in Communication**

A. Circumstantial Communication
B. Tangential Communication
C. Thought Disorganization
   - ✓ Responses are inappropriate to the situation

D. Thought Blocking
   - ✓ Stopping abruptly in the middle of a sentence or train of thoughts
   - ✓ Sometimes unable to continue the idea

E. Alogia
   - ✓ Poverty of content describes the lack f any real meaning are substance in what the client says

Example:

Nurse: "How have you been sleeping lately?"
Client: "Well, I guess, I do not know... it's hard to tell."

❖ Thought Broadcasting

- A delusion belief that other can hear or know what the client is thinking

- ❖ Thought Insertion
  - A delusional belief that others are taking the client's thoughts away and the client is powerless to stop it.
- ❖ Neologisms
- ❖ Echolalia
- ❖ World salad

Treated for schizophrenia

- ❖ Antipsychotic (Atypical & typical)
  - Best taken after meals

Nursing Intervention

- Provide adequate communication
- Promote compliance with medical regime
- Assist with grooming and hygiene
- Promote organized behavior
- Promote social interaction and activity
- Social skills training
- Promote reality-based perceptions as hallucinations and illusions often frighten clients

MOOD / AFFECTIVE DISORDERS

- ❖ Pervasive alterations in emotions that are manifested by depression, mania or both.

Common Etiological Theories of Mood Disorders

- ❖ **Genetic Theory**
  - If one parent has a bipolar these is 25% chance of transmission to the child
- ❖ **Aggression Turned Inward Theory**
  - Overdeveloped superego leads to depression
- ❖ **Object Loss Theory**
  - Loss of parent before age 11 increases the risk of depression
- ❖ **Personality Organization Theory**
  - Obsessive-compulsive, oral-dependent, hysterical personalities have higher redisposition to moon disorders
- ❖ **Cognitive Theory**
  - mood disorder result from:
    - ✓ Negative views of the self and future
    - ✓ Negative interpretation of experiences
- ❖ **Learned Helplessness Theory**
  - Mood disorder is caused by a belief that one has no control over his environment.
- ❖ **Biologic factors**
  - Mania is related to increased levels of norepinephrine while depression is related to low norepinephrine levels.

Precipitating Factor

- Major life events
- Decrease coping resources
- drastic Physiological changes
- Loss of a loved one

Categories of Mood Disorder

1. Major depressive Disorder

- ❖ Last at least 2 weeks
- ❖ Person experience a depressed mood or loss of pleasure in nearly all activities
- ❖ Four of the following symptoms are present:
  - Changes in appetite or weight
  - Changes in sleep or psychomotor activities
  - Decreased energy
  - Feelings of worthlessness or guilt
  - Difficult thinking, concentrating or making decisions
  - Suicidal ideation, plans or attempts
- ❖ Symptoms must be present every day for 2 weeks

2. Bipolar Disorder

- ❖ It is diagnosed when a Person's mood cycles between extremes of mania and depression

3. Mania

- It is a distinct period during which mood is abnormally and persistently elevated expansive or irritable
- Period lasts for 1 week
- At least 3 of the following symptoms accompany the manic episode:
  - ✓ Inflated self-esteem 'grandiosity
  - ✓ Decreased need for sleep Pressured speech
  - ✓ Flight of ideas
  - ✓ Distractibility
  - ✓ Psychomotor agitation Hallucinations

Hypomania

- Period of abnormally and persistently elevated expansive or irritable mood tasting 4 days and including three or four of additional symptoms
- **Difference:** Hypomanic episodes do not impairthe person's ability to function and there are no psychotic features (hallucinations & delusions)
- Less severe than mania

Mixed episode

- Also termed as rapid-cycling
- Diagnosed when the person
- experiences both mania and depression nearly every day for at least 1 week.

Bipolar I Disorder	•With history of mania •One or more manic or mixed episodes usually accompanied by major depressive episode
Bipolar II Disorder	•No history of mania •One or more major depressive episode accompanied by at least one hypomanic episode

- ✓ Other disorders that are classified as mood disorders but lacks symptoms that required for a bipolar or depressive disorder:
  - ❖ **Dysthymic Disorder**
    - Less severethan major depression
    - Characterized by at least 2 years of depressed mood for more days than with some additional less severe symptoms that do not meet the criteria for a major depressive episode
  - ❖ **Cyclothymic Disorder**
    - ❖ Characterized by 2 years of numerous periods of both hypomanic symptoms that do not meet the criteria of bipolar disorder

3. Substance-Induced Mood Disorder

- ❖ Characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of ingested substances such as alcohol and other drugs, or toxins

Other Disorders that involve changes in mood include the following:

- ❖ Seasonal Affective Disorder (SAD)

Winter-Depression

- Fall-onset SAD
- People experience increased sleep
- Appetiteand carbohydratecravings
- Weight gain
- Interpersonal conflict beginning in the late autumn and a bating in spring and summer

Spring-onset

- Less common
- Insomnia, weight loss, and poor appétit
- Lasts from late spring or early summer until early fall.

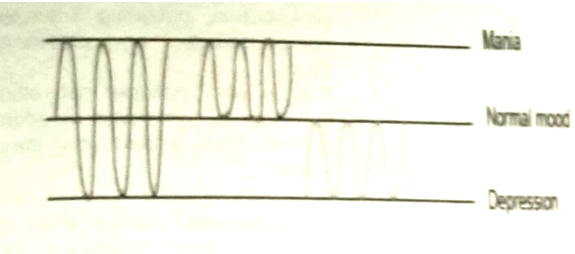
❖ **Postpartum Blues**
- Frequent normal experienceafter delivery of a baby
- Characterized by labile mood and affect, sadness. insomnia and anxiety.
- Peak in 3 to 7 days
- Disappear rapidlywithnomedical

Treatment

❖ Postpartum Depression
- Meets allthecriteria for a depressive episode with onset with. weeks of delivery

❖ Postpartum psychosis
- Psychotic episode developing within 3 weeks of delivery.
  - Begins with fatigue, sadness, emotional lability, poor memory, and confusion sod progressing to delusions & hallucinations.

GRAPHIC REPRESENTATION OF CYCLES OF BIPOLAR DISORDER



TREATMENT

❖ Lithium carbonate
- Can stabilized bipolar disorder by reducing the degree and frequency of cycling or eliminating manic episode
- Mechanism of action is unknown
- Works in the synapses to hasten destruction of catecholamines, inhibit neurotransmitter releases & decrease the sensitive of postsynaptic receptors
- Crosses the blood-brain barrier and placenta
- Not used during pregnancy

LITHIUM THERAPHY: NURSING RESPONSIBLITY	
Medication Administration	Best taken after meals
Normal level	0.5- 1.5 mEq/L
Toxicity	**Report**: Severe nausea, vomiting diarrhea, muscle weakness & tremors **Management:** Administration of Mannitol
Therapeutic Effects	Take 10 -14 days before therapeutic effect becomes evident
Fluids	Adequate amount of fluid (2-3 L/day)
Sodium	Salt intake (2-3 L/day)
Weight	Monitor daily weights and the balance between intake and output and checking for dependent edema
Other Information	If there is too much water, lithium is diluted and the lithium level will be too low to be therapeutic
	Drinking too little amount of water or losing fluid through excessive sweating, vomiting or diarrhe will increase the lithium level, which may result in toxicity

Nursing Intervention
- provide for client's physical safety and safety of those around the client
- Assess client for suicidal Ideation. plans or thoughts of hurting others
- Clients in the manic phase have little insight into their anger and agitation and how their behaviors affect others
- Set limits on clients behavior when needed and remind client to respect distances between self and others
- Clarity the meaning of client's communication
- Frequently provide finger foods that are high in calories and protein
- Promoterestandsleepby decreasing environmental stimulation
- Establishing bedtime routine
- Nurse should handle behavior in a matter-ot tact approach and non-judgmental manner
- It is Important to treat clients with dignity ,us, s respect despite their Inappropriate behavior

Treatment Modalities for Depression

- Electroconvulsive Therapy
- psychopharmacology
  - ✓ Tricyclic Antidepressant
  - ✓ MAOI
  - ✓ SSRI

SOMATOFORM DISORDER

❖ **Description:** it can be characterized as the presence of physical symptoms that suggest a medical condition without a demonstrable organic basis to account fully for them:

❖ **Three Central Features:**

- Physical complaints suggest major medical illness but have no demonstrable organic basis
- Psychological factor and conflicts seems important in initiating, exacerbating, and maintaining the symptoms.
- Symptoms or magnified health concerns are not under the client's conscious control.

❖ **Somatoform disorder:**

➢ **Somatoform disorder-** Characterized by multiple physical symptoms. It begins by 30 years of age, extends over several years, and includes a combination of pain and gastrointestinal, sexual, and pseudo-neurologic symptoms.

SYMPTOMS OF SOMATIZATION DISORDER

Pain symptoms: complaints of headaches; pain in the abdomen, head, Joints, back, chest, rectum, pain during urination, menstruation, or sexual intercourse

Gastrointestinal symptoms: nausea, bloating, vomiting (other than during pregnancy), diarrhea, or Intolerance of several foods

Sexual symptoms: sexual Indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting through-out pregnancy

Pseudo-neurologic symptoms: conversion symptoms such as Impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting

- **Conversiondisorders**-sometimes called conversion reaction,involves unexplained, usually sudden deficits insensory or motor function (e.g., blindness, paralysis)
  - ✓ These deficits suggest a neurologic disorder but are associated with psychological factors.
  - ✓ La belle in difference, a seeming lack of concernor distress, is a key feature.

- **Pain disorder**- has the primary physical symptom of pain,which generally is unrelieved by analgesics and greatly affected by psychological factors interms of onset,severity, exacerbation and maintenance.

- **Hypochondriasis**
  - ✓ Disease conviction- is preoccupation with the fear that one has a serious disease
  - ✓ Disease phobia- one will get a serious disease
  - ✓ It is thought that clients with this disorder misinterpret bodily sensations or functions.

- **Body dysmorphic disorder**
  - ✓ It is preoccupation with an imagined or exaggerated defect in physical appearance such as thinking one's nose is too large or teeth are crooked and unattractive.

❖ **Other Related Disorders**

- **Malingering**
  - ✓ it is the intentional production of false or grossly exaggerated physical or psychological symptoms
  - ✓ it is motivatedby incentives suchasavoiding work, evading criminal prosecution, obtaining financial compensation, or obtaining drugs.
  - ✓ People who malinger can stop the physical symptoms as soon as they have gained what they wanted

- **Factitious disorder** occurs when a person intentionally produces or feigns physical or psychological symptoms solely to gain attentions.
  - ✓ **Munchausen's syndrome-** people with factitious disorder may even inflict injury to themselves to receive attention
  - ✓ **Munchausen's by proxy**- Occurs when a person inflicts illness or injury on someone else to gain the attention of emergency medical personnel or to be a "hero" for saving the victim.

❖ **Psychosocial Theories**

- **Internalization**- people with somatoform disorders keep stress, anxiety, frustration inside rather than expressing them outwardly.
- **Somatization**-clients express these internalized feelings and stress through physical symptoms
- Both internalization and somatization are unconscious defense mechanisms.
  - **Primary gains** are the direct external benefits that being sick provides such as relief of anxiety, conflict, or distress.
  - **Secondary gains** are the internal or personal benefits received from others because one is sick such as attention from family members

❖ **Biologic Theories**

- Clients cannot sort relevant from irrelevant stimuli and respond equally to both types.
- They may experience a normal body sensation such as peristalsis and attach a pathologic than a normal meaning to it
- Awareness of physical symptoms and exaggerates response to bodily sensations.
- This amplified sensory awareness causes the person toexperience somatic sensations as more intense, noxious, and disturbing

❖ **Management:**

- Treatment focuses on managing symptoms and improving quality of life.
- The health care provider must show empathy and sensitivity to the clients physical complaints
- A trusting relationship will help to ensure that clients stay with and receive care from one provider instead of "doctor shopping.'
- The nurse should never try to confront the client about the origin of these symptoms until the client has learned other coping strategies.
- Selective serotonin re-uptake inhibitors are used most commonly for the accompanying depression
  - ✓ Fluoxetine (Prozac)
  - ✓ Sertraline (Zoloft)
  - ✓ Paroxetine (Paxil)

Pain

- Pain management such as visual imaging and relaxation.
- Services such as physical therapy to maintain and build muscle tone help to improve functional abilities.
- Providers should avoid prescribing and administering narcotic analgesics to these clients because of the risk of dependence or abuse
- Clients can use non-steroidal anti-inflammatoryagents to help reduce pain. Involvement in therapy groups is beneficial for some people with somatoform disorders

Health teaching:

- Establish a daily routine.
- Promote adequate nutrition and sleep**.**
- Expression of emotional feelings
- Recognize relationship between stress/coping and physical symptoms.
- Keep journal
- Limit time spent on physical complaints
- Limit primary and secondary gains.
- Coping strategies
- Emotion-focused coping strategies such as relaxation techniques, deep breathing, guided imagery, and distraction
- Problem-focused coping strategies such as problem-solving strategies and role playing

- **Two categories of coping strategies:**
  - **Emotion-focused coping strategies,**which help clients relax and reduce feeling of stress
    - ✓ Progressive relaxation
    - ✓ Deep breathing
    - ✓ Guided imagery
    - ✓ Distractions
- **Problem-focused coping strategies:** which help to resolve or change a client's behavior and situation or manage life stressor
    - ✓ Problem-solving method
    - ✓ Applying the process to identified problems
    - ✓ Role-playing interactions with others.

Substance Abuse

- **Terminologies:**
  - **Intoxication**- use of a substance that results In maladaptive behavior
  - **Withdrawal syndrome**- refers to the negativepsychological and physical reactions that occur when use of a substance abuse ceases or dramatically decreases
  - **Detoxification**- the process of safely withdrawing from a substance
  - **Substance abuse**- defined as using a drug in a way that is inconsistent with medical or social norms and despite negative consequences. Itdenotes problems in social, vocational, or legal areas of the person's life.
  - **Substance dependence**- includes problems associated with addiction such as tolerance, withdrawal and unsuccessful attempts to stop using the substance.
  - **Black-out-** a episode during which the person continues to function but has no consciousawarenessof his or her behavior
  - **Tolerance**- the patient needs more of the substance (alcohol) to produce same effect.
  - **Tolerance break**- after continued heavy drinking, the person experiences intoxication in a very small amount of the substance (alcohol).
  - **Spontaneous remission**- also known as natural recovery. Some people with alcohol problems can modify or quit drinking on theirownwithouta treatment program

- **Biological factors**
  - **Generic/ hereditary-** children of alcoholic parents are at higher risk for developing alcoholism and drug dependence than are children of non-alcoholicparents.
  - Distribution of the substance throughout the brain alter the balance of neurotransmitter that modulate pleasure, pain, and reward responses

- **Psychologic factors**
  - Inconsistency in the parent's behavior, poor role modelling, and lack of nurturing pave the way for the child to adopt a similar style of maladaptive coping, stormy relationship, and substance abuse.

- **Social and environmental factors**
  - Cultural factors, social attitudes, peer behaviors, laws, cost, and availability all influence initial and continued use of substance.

ALCOHOLISM

- **Intoxication:**
  - **Clinical manifestations**
    - ✓ Slurred speech
    - ✓ Unsteady gait
    - ✓ Lack of coordination
    - ✓ impaired memory. and judgment
    - ✓ Aggressive or display inappropriate sexual behavior
    - ✓ Blackout
  - **Treatment:**
    - ✓ Gastric lavage
    - ✓ Dialysis

- ✓ Support of respiratory and cardiovascular functioning in an intensive care unit.
- ✓ The administration of central nervous system stimulants is contraindicated

❖ **Withdrawal and Detoxification**

- Symptoms of withdrawal usually begin 4 to 12 hours after cessation or marked reduction of alcohol intake
- Withdrawal may take 1 to 2 weeks.

Clinical manifestations:

- ✓ Coarse hand tremors
- ✓ Sweating
- ✓ Elevated pulse and blood pressure
- ✓ Insomnia
- ✓ Anxiety
- ✓ Nausea or vomiting
- ✓ Transient hallucinations, seizures, or delirium— **delirium tremens (DTs).**

Treatment:

- ✓ Administration of benzodiazepines such as:
  - ➢ Lorazepam (Ativan),
  - ➢ Chlordiazepoxide (Librium)
  - ➢ Diazepam (Valium).

- **Detoxification:**
  - ✓ **Disulfiram- Antabuse**

PHYSIOLOGIC EFFECTS OF LONG-TERM ALCOHOL USE

- Cardiac myopathy
- Wernicke's encephalopathy
- Korsakoff's psychosis
- Pancreatitis
- Esophagitis
- Hepatitis
- Cirrhosis
- Leukopenia
- Thrombocytopenia
- Ascites

Sedatives, Hypnotics And Anxiolytics

❖ This class of drugs includes all central nervous system depressants:

- Barbiturates
- Nonbarbiturate
- Hypnotics
- Anxiolytics

❖ **Intoxication:**

- **Clinical manifestations**:
  - ✓ Slurred speech
  - ✓ Lack of coordination
  - ✓ unsteady gait
  - ✓ Labile mood
  - ✓ Impaired attention or memory
  - ✓ Stupor and coma

❖ **Benzodiazepines**

- ✓ rarely fatal
- ✓ lethargic and confused

❖ **Barbiturates**
- ✓ Can be lethal
- ✓ Coma
- ✓ Respiratory arrest
- ✓ Cardiac failure
- ✓ Death

❖ **Treatment:**
- ✓ **Benzodiazepines:**
  - ➢ Gastric lavage
  - ➢ Ingestion of activated
  - ➢ charcoal
  - ➢ Saline cathartic
  - ➢ Dialysis.

- ✓ **Barbiturates:**
  - ➢ Intensive care unit
  - ➢ Lavage or dialysis
  - ➢ Support respiratory and cardiovascular function

❖ **Withdrawal and Detoxification**
- The onset of withdrawal symptoms depends on the half-life of the drug
- **Clinical manifestations:**
  - ✓ Autonomic hyperactivity (Increased pulse, blood pressure, respirations and temperature)
  - ✓ Hand tremors
  - ✓ Insomnia
  - ✓ Anxiety
  - ✓ Nausea
  - ✓ Psychomotor agitation
  - ✓ Seizures
  - ✓ Hallucinations

❖ **Detoxification:**
- Managed medically by tapering the amount of the drug the client receives over a period of days or weeks,
- Tapering, or administering decreasing doses of a medication, is essential with barbiturates to prevent coma and death that willoccur if the drug is stopped abruptly.

STIMULANTS (AMPHETAMINE, COCAINE AND OTHERS)

- **Stimulants** are drugs that stimulate or excite the central nervous system.
- **Amphetamines** ("uppers") were popular in the past;they were used by people who wanted to lose weight or to stay awake
- **Cocaine**anillegal drug with virtually no clinical use in medicine, is highly addictive and a popular recreational drug because of the intense and immediate feeling of euphoria it produces.
- **Methamphetamine** is particularly dangerous. It is highly addictive and causes psychotic behavior. Brain damage related to its use is frequent, primarily as a result of the substances used to make it.
- **Intoxication and overdosage**

  Clinical Manifestation
  - ✓ High or euphoric feeling
  - ✓ Hyperactivity
  - ✓ Hypervigilance
  - ✓ Talkativeness
  - ✓ Anxiety
  - ✓ Grandiosity
  - ✓ Hallucinations
  - ✓ Stereotypic or repetitive behavior
  - ✓ Anger
  - ✓ Fighting

- ✓ Impaired judgment
- ✓ Tachycardia
- ✓ Anorexia/ Loss of appetite
- ✓ Elevated blood pressure
- ✓ Dilated pupils, perspiration or chills, nausea, chest pain, confusion, and cardiac dysrhythmias.
- ✓ Overdoses of stimulants can result in seizures and coma ; deaths

❖ Treatment with Chlorpromazine (Thorazine), an antipsychotic,controlshallucinations, lowers blood pressure, and relieves nausea

❖ **Withdrawal and Detoxification**
- Withdrawal from stimulants occurs within a few hours to several days after cessation of the drug and is not life threatening.
- Marked dysphoria is the primary symptom andisaccompaniedby fatigue, vivid and unpleasant dreams, insomniaor hypersomnia, increased appetite, and psychomotor retardation or agitation
- Marked withdrawal symptoms are referred to as "crashing symptoms;"
- The person may experience depressive symptoms including suicidal ideation for several days.
- Stimulant withdrawal is not treated Pharmacologically.

Cannabis (Marijuana)

❖ **Cannabis sativa** is the hemp plant that is widely cultivated for its fiber used to make rope and cloth and for oil from its seeds.

❖ Marijuanarefers tothe upper leaves, floweringtops,and stems of the plant; hashish is the dried resinous exudate from the leaves of the female plant.

❖ Cannabis is most often smoked in cigarettes ("joints"), but it can be eaten.

❖ **Effects:**
- Cannabis begins to act less than 1 minute after inhalation.
- Peak effects usually occur 20 to 30 minutes and last at least 2 to 3 hours

Clinical Manifestations:
- ✓ Impaired motor coordination
- ✓ Inappropriate laughter
- ✓ Impaired judgement and short-term memory
- ✓ Distortion of time and perception.
- ✓ Anxiety
- ✓ Dysphoria
- ✓ Social withdrawal
- ✓ Increased appetite
- ✓ Conjunctive injection (bloodshot eyes)
- ✓ Dry mouth
- ✓ Hypotension
- ✓ Delirium
- ✓ Cannabis-induced psychotic disorder

❖ **Withdrawal and Detoxification**
- No clinically significant withdrawal syndrome is identified
- Cannabis does not cause intoxication.

Opioids

❖ Populardrugsofabusebecausethey desensitize the user to both physiologic and psychological pain and induce a sense of euphoria and well being

❖ Opioids:
- Morphine
- Meperidine (Demerol)
- Codeine
- Hydromorphone

- Oxycodone
- Methadone
- Oxymorphone
- Hydrocodone
- Propoxyphene
- Heroin
- Normethadone

❖ **Intoxication**
- **Clinical manifestation**
  - ✓ Euphoric feeling
  - ✓ Apathy
  - ✓ Lethargy
  - ✓ Listlessness
  - ✓ Impaired judgement
  - ✓ Psychomotor retardation or agitation
  - ✓ Constricted pupils
  - ✓ Drowsiness
  - ✓ Slurred speech
  - ✓ Impaired attention and memory
  - ✓ Coma
  - ✓ Respiratory depression
  - ✓ Papillary constriction
  - ✓ Unconsciousness
  - ✓ Death
- **Treatment**
  - ✓ Administration of Naloxone (Narcan)
    - ➢ An opioid antagonist
    - ➢ Is the treatment of choice because it reverses all signs of opioid intoxication.
    - ➢ Naloxone is given every few hours until the opioid level drops to nontoxic

❖ **Withdrawal and Intoxication**
- **Clinical Manifestations:**
  - ✓ Anxiety
  - ✓ Restlessness
  - ✓ Aching back and leg
  - ✓ Cravings for more opioids
  - ✓ Nausea
  - ✓ Vomiting
  - ✓ Dysphoria
  - ✓ Lacrimation
  - ✓ Rhinorrhea
  - ✓ Sweating
  - ✓ Diarrhea
  - ✓ Yawning
  - ✓ Fever
  - ✓ Insomnia.

- **Treatment:**
  - ✓ Do not require pharmacologic intervention to support life or bodily functions.
  - ✓ Methadonecanbeusedasa replacement for the opioid

Hallucinogens

❖ Substances that distort the user's perception of reality and produce symptoms similar to psychosis including hallucinations (usually visual) and depersonalization.

❖ **Examples of hallucinogens:**
- Mescaline
- Psilocybin
- Lysergic acid
- Lysergic acid Diethylamide (LSD)
  - "Designer drugs" such as Ecstasy.
- Phencyclidine (PCP)

❖ **Intoxication and Overdose**
- **Clinical Manifestations**
  - ✓ Anxiety
  - ✓ Depression
  - ✓ Paranoid ideation
  - ✓ Ideas of reference
  - ✓ Fear of losing one's mind
  - ✓ Potentially dangerous behavior such as jumping out a window in the belief that one can fly.
  - ✓ Sweating
  - ✓ Tachycardia
  - ✓ Palpitations
  - ✓ Blurred vision
  - ✓ Tremors
  - ✓ Lack of coordination
  - ✓ Belligerence
  - ✓ Aggression
  - ✓ Impulsivity
  - ✓ Unpredictable behavior

- **Treatment:**
  - ✓ These drugs are not a direct cause of death although fatalities have occurred from related accidents, aggression and suicide
  - ✓ Treatment is supportive.
  - ✓ Psychotic reactions are managed best byisolationfrom external stimuli
  - ✓ Physical restraints
  - ✓ Cooling devices such as a hyperthermia blanket are used and mechanical ventilation is used to support respirations

❖ **Withdrawal and Detoxification**
- ✓ No withdrawal syndrome has been identified for hallucinogens,although some people have reported a craving for the drug.
- ✓ Hallucinogens can produce flashbacks, which are transientrecurrencesof perceptual disturbances

Inhalants

❖ Diverse group of drugs including anesthetics, nitrates, and organic solvents that are inhaled for their effects.
❖ Inhalants can cause significant brain damage, peripheral nervous system damage, and liver disease.

❖ **Inhalants**:
- Gasoline
- Glue
- Paint thinner
- Spray paint
- Cleaners
- Correction fluid
- Spray can propellants
- Esters
- Ketones
- Glycols

❖ **Intoxication**
- **Clinical manifestations:**
  - ✓ Dizziness
  - ✓ Nystagmus,
  - ✓ Lack of coordination
  - ✓ Slurred speech
  - ✓ Unsteady gait,
  - ✓ Tremors
  - ✓ Muscle weakness
  - ✓ Blurred vision
  - ✓ Stupor and coma can occur
  - ✓ Belligerence
  - ✓ Aggression
  - ✓ Apathy
  - ✓ Impaired judgment
  - ✓ Inability to function.

- **Acute toxicity:**
  - ✓ Anoxia
  - ✓ Respiratory depression
  - ✓ Vagal stimulation
  - ✓ Dysrhythmias
  - ✓ Death- bronchospasm,cardiac arrest, suffocation, aspiration of the compound or vomitus

- **Treatment**
  - ✓ Supporting respiratory and cardiac functioning until the substance is removed from the body
  - ✓ There are no antidotes or specific medications to treat inhalants toxicity.

❖ **Withdrawal and detoxification**
- There are no withdrawal symptoms or detoxification procedures foe inhalants
- Persistent dementia
- Inhalant-including disorders- psychosis, anxiety, or mood disorder

MANAGEMENT

❖ Alcoholics Anonymous (AA)
- Founded in the 1930's by alcoholics
- Self-help group developed the 12 step program model for recovery which is based on the philosophy that total abstinence is essential and that alcoholics need help and support of others to maintain sobriety.

❖ AA meetings
- "Closed" - only those who are pursuing recovery can attend
- "Open"- anyone can attend
  - ✓ Narcotics Anonymous
  - ✓ Al-Anon-Asupport group for spouses, partners, and friends of alcoholics
  - ✓ AlaTeen- A group for children of parents with substance problems.

❖ **Nursing Alert:**
- **Alcohol**
  - ✓ VitaminB1 (thiamine) often is prescribed to prevent or to treat Wernicke's syndrome and Korsakoff's syndrome,which are neurologic conditions thatcan result from heavy alcohol use.
  - ✓ Cyanocobalamin (Vitamin B12) and folic acid often are prescribed for client with nutritional deficiencies.
  - ✓ Disulfiram (Antabuse) may be prescribed to help to deter clients from drinking.
    - ➢ If aclient taking disulfiram drinks alcohol, a severe adverse reaction occurs:
      - Flushing
      - Throbbing headache
      - Sweating
      - Nausea and vomiting
      - Severe hypotension

- Confusion
- Coma
- Death

- **Opiates**
  - ✓ **Methadone**
  - ➢ A potent syntheticopiate is used as a substitute for heroin in some maintenance programs
  - ➢ Meets the physical need for opiates but does not produce cravings for more

  - ✓ **Levomethadyl**
  - ➢ Is a narcotic analgesic whose only purpose is the treatment of opiate dependence

  - ✓ **Naltrexone (ReVia)**
  - ➢ It is an opioid antagonist often used to treat overdose.
  - ➢ It blocks the effects of any opioids that might be ingested
  - ➢ Negating the effects of using more opioids used in the same manner as methadone.

  - ✓ **Clonidine (Catapres)**
  - ➢ Is analpha-2-adrenergic agonist used to treat hypertension.
  - ➢ It is given to clients with opiate dependence to suppress some effects of withdrawal or abstinence
  - ➢ It is most effective against nausea, vomiting, and diarrhea but produces modest relief from muscle aches, anxiety, and restlessness

  - ✓ **Ondansetron (Zofran)**
  - ➢ A 5-HT3 antagonist that blocks the vagal stimulation effects of serotonin inthe small intestine
  - ➢ It is used as an antiemetic.

NURSING INTERVENTIONS FOR CLIENTS WITH SUBSTANCE ABUSE

- Health teaching for the client and family
- Dispel myths surrounding substance abuse
- Decrease codependent behaviors among family members
- Make appropriate referrals for family members
- Promote coping skills
- Role-play potentially difficult situations
- Focus on the here-and-now with clients
- Set realistic goals such as staying sober today

DISSOCIATIVE DISORDERS

- ➢ **Dissociation**-is a subconscious defense mechanism that helps a person protect is or her emotional self from recognizing the full effects of some horrific or traumatic event by allowing the mind to forget or remove itself from the painful situation or memory.
- ➢ **Dissociative disorders**-essential feature of a disruptionintheusually integrated functions of consciousness, memory,identity or environmental perception

TYPES OF DISSOCIATIVE DISORDER

❖ **Dissociative amnesia**
- The client cannot remember important personal information usually of a traumatic or stressful nature.

❖ **Dissociative fugue**
- The client has episodes of suddenly leaving the home or place of work without any explanation, traveling to another city,and being unable to remember his or her past or identity. He or she may assume a new identity

❖ **Dissociative identity disorder**
- Formerly multiple personality disorder

- The client displays two or more distinct identities or personality states that recurrently take control of his or her behavior.
- This is accompanied by the inability to recall important personal information.

❖ **Depersonalization disorder**
- The client has a persistent or recurrent feeling of being detached from his or her mental processes or body.
- Thisis accompanied by intact reality testing
- The clientis not psychotic or out of touch with reality.

ASSESSMENT FINDINGS

❖ **General Appearance and Motor Behavior**
- Appears hyperalert and reacts to even small environmental noises with a startle response.
- He or she may be very uncomfortable if the nurse is too close physically
- The client may appearanxious or agitated and may have difficulty sitting still
- Pace or move around the room.
- Curl up with arms around knees

❖ **Mood and Affect**
- Look frightened or scared, or agitated
- May cry, scream, or attempt to hide

❖ **Thought process**
- Self-destructive thoughts and impulses
- Intermittent suicidal ideation

❖ **Sensorium and Intellectual Process**
- Memory gaps-periodsfor which they have no clear memories

❖ **Self-concept**
- Clients will have low self-esteem. They may believe they are bad people who somehow deserve or provoke the abuse.

❖ **Roles and Relationships**
- Close relationships are difficult or impossible
- Ability to trust others is severely compromised.

❖ **Physiologic signs**
- Difficulty sleeping because of nightmares or anxiety over anticipating nightmares
- Overeating or lack of appetite
- Clients use alcohol or other drugs to attempt to sleep or to blot out intrusive thoughts or memories

MANAGEMENT

❖ **Pharmacologic management:**
- Paroxetine (Paxil)
- Sertraline (Zoloft)

❖ **Psychotherapy:**
- Group or individual therapy
- Cognitive behavioral therapy
- Focuses on re-association or putting the consciousness back together

❖ **Nursing Management**:
- Assess the client's potential for self harm or suicide
- Help the client learn to go to a safe place during destructive thoughts and impulses so that he or she can calm down and wait until they pass
- Grounding techniques remind the client that he or she is in the present, as an adult and is safe.
- Getting the client to standand walk around helps to dispel the dissociative or flashback experience.

- The nurse encourages the client to write down feelings throughout the day at specified intervals
- Deep breathing and relaxation
- Focus on sensory information or stimuli in the environment
- Engage in positive distractions
  - ✓ Physical exercise
  - ✓ Listening to music
  - ✓ Talking to others,
  - ✓ Engaging in a hobby or activity
- Often it is useful to view the client as a survivor of trauma or abuse rather than a victim.