RN Mental Health Final Exam Practice Questions with Answers (Rated A).

written by

proficient

EBP (evidence based practice) Using the best available research evidence, clinical expertise, & patient preferences to make clinical decisions

The 5 A's of integrating best evidence into clinical practices includes:

Asking
Acquiring
Appraising
Applying
Assessing

The mental health recovery model is one of helping people with psychiatric disabilities effectively manage their symptoms, reduce psychosocial disability, and find a meaningful life in a community of their choosing.

3 specific areas are inherent within the art of nursing: caring, attending & patient advocacy.

- **Basic Brain Anatomy- what do the different part of brain control?**
  - **Frontal Lobe:** Thought Processes & Voluntary Movement (decision making)
  - **Temporal Lobe:** Auditory Processes (language, speech, connects to Limbic system)
  - **Occipital Lobe:** Vision (interprets visual images)
  - **Parietal Lobe:** Sensory & Motor (L/R orientation, reading, math, proprioception)
  - **Hypothalamus:** maintains homeostasis, regulates BP, Temp, libido, hunger, thirst, and sleep/wake cycles.
  - **Cerebellum:** Balance, Skeletal Muscle Coordination
  - **Neurons:** Nerves that translate electrical impulses into chemical signals released at the synapse
    - **Synapse-** The space between neurons in which neurotransmitters are released and either inhibit/excite the adjacent neuron. The 4 NT's are dopamine, norepinephrine, serotonin and acetylcholine.

- **Milieu Therapy:** ***Creating a SAFE, structured inpatient/outpatient setting*** where the mentally ill can test new behaviors and coping mechanisms with others.
  - ***Climate is essential to healing: paint color, relaxed environments are conducive to the healing process***.
  - Florence Nightingale believed that the environment helps heal

- **Maslow's Hierarchy of needs**
  - **Basic Needs:** food, oxygen, water, sleep, sex, and a constant body temperature. If all the needs were deprived, this level would take priority.
  - **Safety Needs:** Security, protection, freedom from fear/anxiety/chaos, and the need for law, order, and limits.
  - **Belonging and Love Needs:** intimate relationship, love, affection, and belonging, having a family and a home and being part of identifiable groups.
  - **Esteem Needs:** If self-esteem needs are met, we feel confident, valued, and valuable. When self-esteem is compromised, we feel inferior, worthless, and helpless.
  - **Self-actualization:** Reaching our full potential to feel inner peace and fulfillment.

- **Peplau's Theory of Interpersonal Relations**
  - **Created the Nurse-Patient Partnership** increasing individual and family roles in recovery. (Based off of Sullivan's Interpersonal Theory). Relationships greatly influence recovery

- **Freud- contributed to psychiatric setting -Unconscious thoughts**
  - **Id** – unconscious mind, instincts (this is dominant)
  - **Ego** – sense of self, use of defense mechanisms
  - **Superego** – our conscious and is greatly influenced by our parents morals and ethical stances

- **Erickson's**
  - **Trust vs. Mistrust (infant 0- 1 ½)** trust developed if caregivers give affection, love, care, attention, and reliability. (Feeding)
  - **Autonomy vs. Shame (toddlers 1 ½ - 3)** kids need to develop a sense of personal control. (Toilet Training)
  - **Initiative vs. Guilt (children 3-6)** children need to have power to explore their environment and not receive disapproval from parents. (Exploration)
  - **Industry vs. Inferiority: (school aged kids 6-12)** Kids dealing with new social and academic demands. Success leads to a sense of competence. (School)
  - **Identity vs. Role Confusion (teens 12-20)** Teens need to develop self-identity and personal identity to stay true to themselves. (Social Relationships)
  - **Intimacy & Solidarity vs. Isolation (young adults 20-30**) Young Adults need to form intimate, loving relationships. (Relationships)
  - **Generativity vs. Self-Absorption: (adults 30-65)** Need to create/nurture things by having children. (Work & Parenthood)
  - **Integrity vs. Despair (elderly 65+)** Need to look back and feel fulfilled by accomplishments; have wisdom and no regrets (Reflection on Life)

- **Sullivan** ***Personalities are influenced during childhood and mostly by the MOTHER***.

- **Therapeutic Communication:** goal directed, professional, scientifically based. The goal is to get information so that you can plan care for the patient.

  - **Active Listening**
    - **Clarifying:** promotes understanding of the patient's statement
    - **Restating:** repeating the same key words the patient has just spoken to echo their feelings. (Ex: If a patient remarks, "My life is empty…it has no meaning," additional information may be gained by restating, "Your life has no meaning?")
    - **Reflecting:** helps people understand their own thoughts better; summarizes (Ex: For example, to reflect a patient's feelings about his or her life, a good beginning might be, "You sound as if you have had many disappointments.")
    - **Exploring:** use of open-ended questions or statements to allow the patient to express thoughts/feelings. (Ex: "Tell me more…", "Give me an example of…")

- **Communication Technique Examples in Different Scenarios**
  - **For Suicidal Patients:** "These thoughts are very serious Mr. Adams. I do not want any harm to come to you. Can you tell me what you were feeling and if there were any circumstances that led you to this decision?"
  - **For Patients who start Crying**: Stay with your patient and reinforce that it is all right to cry & offer tissues. "You seem upset, what are you thinking right now?"
  - **For Patients who say they "don't want to talk"**: "Its alright. I would like to spend time with you. We don't have to talk." Or reapproach at a later time, "Our 5 minutes is up. I will be back at 10am and spend another 5 minutes with you."
  - **For Patients who ask the nurse to keep a secret:** Nurses cannot make such promises, as it may be important to share that information with other staff for safety reasons. "I cannot make that promise Mr. Adams as it might be important for me to share it with the other staff".
  - **Non-Verbal:**
    - Tone of voice (tone, pitch, intensity, stuttering, silence, pausing)
    - Facial expressions (frown, smile, grimaces, raises eyebrows, licks lips)
    - Posture (slumps over, puts face in hands, taps feet, fidgets with fingers)
    - Amount of eye contact (angry, suspicious or accusatory looks, wandering)
    - Sighs/Hand gestures (fidgeting, snapping fingers)
    - Yawning

- **Non-Therapeutic Communication:** not goal-directed, ***false reassurances***, double messages, giving personal opinions, making assumptions of feelings, asking "Why" questions, showing disapproval, excessive questioning, non-attending behaviors, poor non-verbal communication (eye rolling, staring off into distance, ignoring patient).
    - Double Bind Messages: intent of the message is to cause confusion
    - Double Messages: conflicting/mixed messages
    - ***Giving premature advice***
    - ***Presenting reality and focusing***

- **Phases of the Nurse-Patient Relationships**
    - **Orientation Phase:** first time the nurse & patient meet, interact according to their own backgrounds/standards/values/beliefs, ***roles of the patient and nurse are clarified***, confidentiality is discussed and assumed, ***nurse becomes aware of transferences & countertransference issues***, goals are established, termination terms are introduced.
    - **Working Phase:** exploration of feelings or situations that are causing the problems, re-experiencing of old conflicts can awaken high levels of anxiety, intense emotional states may surface, defense mechanisms, denying, manipulation, evaluation of problems and goals, promote alternative reactions/behaviors to situations, etc. *The* ***nurse's awareness of his or her own personal feelings and reactions to the patient are VITAL for effective interaction with the patient.***
    - **Termination Phase:** ***summarization of goals***, review of what was achieved during communication, discussing new ways to implement new coping strategies, evokes strong feelings in both client & nurse.

- **Legal, Ethical, and Cultural**
    - **Negligence** –or **malpractice** is an act or an omission to act that breaches the duty of due care and results in or is responsible for a person's injuries. The five elements required to prove negligence are: (1) duty, (2) breach of duty, (3) cause in fact, (4) proximate cause, and (5) damages.
        - Example – A nurse know that a patient's IV is malfunctioning and the wires are frayed, but decides not to act in a timely manner and leaves the IV on the patient and doesn't tag it for repair, this results in the patient dying.
    - **Beneficence** - This relates to the quality of doing good and can be described as charity.
        - Example - A nurse helps a newly admitted client who has psychosis feel safe in the environment of the mental health facility.
    - **Autonomy** - This refers to the client's right to make her own decisions. But the client must accept the consequences of those decisions. The client must also respect the decisions of others.
        - Example - Rather than giving advice to a client who has difficulty making decisions, a nurse helps the client explore all alternatives and arrive at a choice.
    - **Justice** - This is defined as fair and equal treatment for all.
        - Example - During a treatment team meeting, a nurse leads a discussion regarding whether or not two clients who broke the same facility rule were treated equally.
    - **Fidelity** - This relates to loyalty and faithfulness to the client and to one's duty.
        - Example - A client asks a nurse to be present when he talks to his mother for the first time in a year. The nurse remains with the client during this interaction.
    - **Veracity** - This refers to being honest when dealing with a client.
        - Example - A client states, "You and that other staff member were talking about me, weren't you?" The nurse truthfully replies, "We were discussing ways to help you relate to the other clients in a more positive way."

- **Rights for Voluntary and Involuntary Admission**
    - **Voluntary Commitment** – The client or client's guardian chooses commitment to a mental health facility in order to obtain treatment. A voluntarily committed client has the right to apply for release at any time. This client is considered competent, and so **has the right to refuse medication and treatment.**
    - ***Involuntary (civil) Commitment*** **–** The client enters the mental health facility against her will for an indefinite period of time. The commitment is based on the client's need for psychiatric treatment***, the risk of harm to self or others, or the inability to provide self-care.*** The need for commitment could be

determined by a judge of the court or by another agency. The number of physicians, which is usually two, required to certify that the client's condition requires commitment varies from state to state. Clients admitted under involuntary commitment are still considered competent and have the right to refuse treatment, unless they have gone through a legal competency hearing and have been judged incompetent.

- **Informed Consent**
  - The principle of informed consent is based on a person's right to self- determination, as enunciated in the landmark case of Canterbury v. Spence (1972): True consent to what happens to one's self is the informed exercise of choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant on each. Proper orders for specific therapies and treatments are required and must be documented in the patient's chart. Consent for surgery, electroconvulsive treatment, or the use of experimental drugs or procedures must be obtained
- **Confidentiality/HIPAA**
  - Therefore, you may not, without the patient's consent, disclose information obtained from the patient or information in the medical record to anyone except those individuals for whom it is necessary for implementation of the patient's treatment plan.

- **Psychiatric Nursing Assessment – priority interventions, nursing dx, etc**

  - Establish rapport.
  - Obtain an understanding of the current problem or chief complaint.
  - Review physical status and obtain baseline vital signs.
  - Assess for risk factors affecting the safety of the patient or others.
  - Perform a mental status examination (MSE).
  - Assess psychosocial status.
  - Identify mutual goals for treatment.
  - Formulate a plan of care.

- **Mood Disorders**
- **Primary vs. Secondary Depression**
  - **Primary Depression**: due to family history, female gender, 40yrs +, post-partum, chronic illness, ETOH abuse, stressful life events.
  - **Secondary Depression:** Resultant from another mental health disorder or debilitating chronic illness. Person is depressed BECAUSE of their decline in physical or mental functioning.

- ***Borderline personality disorder* - *produces emotional lability and inconsistency in behavior.***
  **** Nurse should be consistent with clients with a personality disorder***

- **Nursing Diagnosis for Depression**: ***Risk for Suicide***, Risk for Self-Mutilation, Ineffective Coping, Hopelessness, Powerlessness, Social Isolation, Risk for Loneliness, Situational Low Self-Esteem.

- ***First-line* treatment for Depression:**
  - ***TCA's are #1 (Amitriptyline, Imipramine, Doxepin).***
  - ***2nd is SSRI/SNRI's (citalopram, fluoxetine, sertraline, bupropion, Buspirone)***
  - ***Last option is MAOI (phenelzine, isocarboxazid)***

BOX 15-2 DRUGS TO BE USED WITH CAUTION IN PATIENTS TAKING A TRICYCLIC ANTIDEPRESSANT

- Phenothiazines
- Barbiturates
- Monoamine oxidase inhibitors
- Disulfiram (Antabuse)
- Oral contraceptives (or other estrogen preparations)
- Anticoagulants
- Some antihypertensives (clonidine, guanethidine, reserpine)
- Benzodiazepines
- Alcohol
- Nicotine

- **Suicidal Ideation – Assessment, Risk Factors & Interventions**
  - **Suicide Risk Factors:** presence of a plan, previous suicide attempt, recent loss/life event, TBI/Brain Injury, recent visit to PCP, ***WHITE MALES***.
  - **Patient will say/do: "**Everything will be okay now", "Things will never work out", giving away prized possessions, making a living will, suddenly increase in happy mood/euphoria.
  - **Assessment:**
    - ***Are you thinking of harming yourself?***
    - Do you have a plan?
    - Precipitating Event?
    - History of attempts? Why did they fail?
    - Any MH dx that puts them at higher risk?
  - **Diagnosis:**
    - ***RISK FOR SUICIDE (outcome would be "Self Restraint from Suicide") this is a priority diagnosis!***
  - **Interventions:**
    - ***#1 is suicide precautions*** (1:1 monitoring, keep an arm's length from pt, no suicide contract)
    - ***Make environment safe*** (remove sharp objects, metal silverware, mirrors, glass, cords, belts)
  - **After Crisis Period:**
    - Have friend stay the night or have pt stay with family
    - Remove weapons and pills from the house
    - Encourage the patient to talk openly about their feelings.
    - Don't give person more than 1-3 days supply of a medication due to overdose ***(SSRI's are least lethal)***

- **Lithium Levels & Toxicity –**
  - **Therapeutic Range:** 0.8-1.4 (fine hand tremors & mild N/V are normal)
  - **Maintenance Range:** 0.4 – 1.3
  - **Toxic Range**: 1.5 and over
  - **Toxicity:** slurred speech, blurry vision, seizures, coarse tremors, severe N/V, thirst
  - **Patient Teaching:** regular salt diet, doesn't get dehydrated, stay out of hot climates, avoid excessive exercise, take with food.
  - ***Lithium toxicity*** ***-possible when one becomes dehydrated, nausea or diarrhea.***

- **Anxiety Disorders**

Anxiety Levels & Stages

  - **Mild:** Everyday anxiety, better focusing, more alert and in-tune with surroundings (nail biting, fidgeting, foot tapping are common)
  - **Moderate:** Narrowed perceptual field, hears/sees/grasps less info. (Pacing, pounding heart, banging hands on table)

- **Severe:** Cannot learn or problem solve. Confusion, hyperventilation, making threats and feeling of "impending doom". (Stomach aches & physical symptoms are common: dizziness, H/A, insomnia, nausea)
- **Panic:** Extreme Anxiety. Cannot problem solve/learn, Dilated Pupils, shouting, screaming, and hallucinations. Lost touch with reality.

Nursing Interventions for Anxiety

- **Mild/Moderate:** ***Be calm and listen!*** Find out what worked before. Clarify, use open-ended questions, have the patient NAME the anxiety/trigger, "what were you thinking *right* before the attack?".
- **Severe/Panic:** ***Firm, Short Answers, Set Limits (you cannot hit me or anyone else), move patient to quiet room, low pitch voice & speak slow,*** reinforce reality, remain with the patient (don't leave them alone), Prevent dehydration & exhaustion (high calorie fluids). Gross motor activities to drain some of the tension (ping pong, dancing, etc)

Anxiety/Depression Meds:

- **Antidepressants** - ***prevents/relieves depression***.
  - ***SSRI's***– (Ex: fluoxetine, citalopram, sertraline). ***Black Box Warning: increased suicidal thoughts*** are possible. ***Takes 2-4 weeks to work***. Helps treat Depression, ETOH withdrawal, OCD,
  - **Side Effects:** Anxiety, tremors, sexual dysfunction, H/A, agitation, sleeplessness. Dry mouth.
  - **S/Sx of Overdose**: Serotonin Syndrome (fever, Hyper-Reflexia, sweating, high BP, delirium, hostility). Wait 2 weeks before starting an MAOI or vice-versa.
  - **Contraindications:** Those who have attempted suicide don't use! Pregnancy, Renal/Liver issues, Elderly (due to increase of osteoporosis/fractures)
  - **Patient Teaching:** OTC drug interactions, slow standing, don't take w/in 2 weeks of MAOI, monitor for suicidal ideations

  - ***Serotonin Syndrome Treatment:***
    - ***STOP medication***. •Serotonin receptor blockade: cyproheptadine, methysergide, propranolol •Cooling blankets, chlorpromazine for hyperthermia •Dantrolene, diazepam for muscle rigidity or rigors •Anticonvulsants •Artificial ventilation •Paralysis

- **TCA's** – ***Used for Depression, anorexia, insomnia***, ODC, Panic disorder, and neurogenic pain. ***Takes 10-14 days to become effective.*** Provider will chose this drug if (1) it worked on family member in past and (2) severity of adverse effects. "Start low and go slow"
  - **Side Effects:** Anticholinergic effects ***(urinary retention, dry mouth***, blurred vision, ***dizziness, tachycardia***, constipation, reflux), Postural Hypotension.
  - **S/Sx of Overdose:** tachycardia, MI, heart block, dysrhythmias
  - **Contraindications:** Elderly and those with Cardiac Disease
  - **Patient Teaching:** takes 6-8 for full effect, get up slowly from sitting position, ***take at BEDTIME*** to reduce side effects, good mouth care/lozenges for dry mouth, don't stop cold turkey

- **MAOI**–. (ex: Phenelzine/Nardil, Isocarboxazid, Parnate)
  - **Side Effects:** insomnia, palpitations, H/A, loss of libido, Orthostatic Hypotension
  - **Contraindications:** Foods with ***Tyramine*** (causes Hypertensive Crisis. Food Ex: avocados, figs, bananas, smoked meats, organs, lunch meat, yeast, aged cheese, beer/wine, smoked fish, soy sauce), Pregnancy!!!
  - **Patient Teaching:** Hypotension is HUGE – get up slowly from sitting, avoid Tyramine foods, avoid cold medications, go to ER if pounding H/A, avoid eating at Chinese restaurants.

- **Benzodiazepines – commonly given & teaching needed for patients**
  - (Ex: Alprazolam, Diazepam, Lorazepam)("Pam and Lam sisters")
  - ***Very sedating, quick onset***

- ***Dependence on meds is HUGE. Don't use a Benzo with a patient who has a history of drug abuse.***
  Adverse Reactions: sedation, dry mouth, decreased cognitive function.
  Patient Teaching: increase fluids for dry mouth, don't take if breastfeeding or if you have a drug abuse problem (ETOH too). Taper off the med. Take with or shortly after meals. Don't take with Antacids, alcohol or caffeine.

- **Defense Mechanisms**
  - **Altruism** – emotional conflict are addressed by meeting the needs of others.
  - **Sublimation** – substituting something constructive for something they feel they lack or are inadequate at
  - **Suppression** – denial of something disturbing
  - **Repression** – forgetting/excluding unpleasant things from memory (forgetting a death of a parent, etc)
  - **Displacement** – transferring feelings from a particular person/event to something non-threatening (Boss yells at man → man yells at wife → wife yells at child → child kicks the dog).
  - **Undoing** – compensation for a negative action, common in OCD (Ex: giving a gift to undo an argument. Washing hands frequently to reduce anxiety about dirty thoughts).
  - **Somatization** – turning anxiety into physical symptoms
  - **Dissociation** – the pain/anxiety is too much to deal with, so the patient dissociates to get away from it (an "out of body" experience).
  - **Projection** – ***blaming another PERSON*** for your own issues
  - **Reaction Formation** – unacceptable feelings are kept out of awareness by doing the opposite behavior (Ex: person who doesn't like children becomes a boy scout leader)
  - **Passive Aggressive** – aggression towards others is expressed by procrastination, failure, and illness that affect others more than themselves.
  - **Splitting** – qualities of a person are either all good, or all bad – not a healthy mix. (either good, loving, nurturing or bad, mean, hateful).
  - **Idealization** – emotional issues are dealt with by exaggerated qualities to others (putting someone on a pedestal, AKA "the perfect man"). When other person doesn't hold up to their idealization, they are disappointed.
  - **Denial** – ignoring the existence of realities (Ex: denying the diagnosis of cancer, even when presented with the lab work and diagnostics)

- **Benefits of Buspirone**
  - ***Less sedating than Benzodiazepines.*** Takes 3+ weeks to become effective (slow onset).
  - ***No physical dependence*** (patients who have drug abuse problems can safely take this medication).
    Patient Teaching: ***Taper off the med***. Take with or shortly after meals. Don't take with Antacids, alcohol or caffeine.
  - ***Side effects - Tardive dyskinesia. (Facial tics, involuntary repetitive body movements, not reversible, lip smacking, eye blinks, etc)***
  - ***may be prescribed over diazepam as it does not result in physical dependence***

- **Thought Disorders**
- **Positive and Negative Symptoms of Schizophrenia**
  - **Positive:** delusions, paranoia, hallucinations, unreal perceptions
  - **Negative:** flat affect, loss of joy (anhedonia), no motivation, laziness
  - **Cognitive:** cant concentrate, poor judgment, focus & memory impaired
  - **Affective:** hopeless, suicide ideations, inadequacy, poor social skills

- **EPS/Tardive Dyskinesia**
  - ***Tardive Dyskinesia: spasms of the mouth, tongue, lip-smacking, facial grimacing (not reversible, no antidote/cure)***
  - **Acute Dystonia:** muscle stiffness (especially neck and head)
  - **Akathisia:** restlessness, pill rolling, pacing (rocking back in forth in a chair, shifting weight from side to side)

- **Neuroleptic Malignancy Syndrome**
  - ***Results from use of Typical Antipsychotics (Ex: Haldol)***
  - **Symptoms:** Severe muscle rigidity, confusion, agitation, increased temperature (103+), pulse and BP
  - **Interventions**:
    1. Stop the medication
    2. Dantrolene (fever reducing agents)
    3. Cool body to reduce fever
    4. Maintain hydration with IV fluids
    5. Treat cardiac dysrhythmias

- **Summary of Delusions**
  - **Thought broadcasting**—belief that one's thoughts can be heard by others (e.g., "My brain is connected to the world mind. I can control all heads of state through my thoughts.")
  - **Thought insertion**—belief that thoughts of others are being inserted into one's mind (e.g., "They make me think bad thoughts.")
  - **Thought withdrawal**—belief that thoughts have been removed from one's mind by an outside agency (e.g., "The devil takes my thoughts away and leaves me empty.")
  - **Delusion of being controlled**—belief that one's body or mind is controlled by an outside agency (e.g., "There is a man from darkness who controls my thoughts with electrical waves") and made to feel emotions or sensations (e.g., sexual) that are not one's own.
  - **Nursing Interventions**: Don't try to correct the patient. DON'T TOUCH the patient because they already are untrusting of people. Offer fluids and foods in containers so that people can see that you haven't tampered with it (or "poisoned it"). Good options are soda in the can, food in wrappers, fruit, yogurts, and hard-boiled eggs. Use 1:1, PRN meds and seclusion instead of restraints.

- **Summary of Hallucinations**
  - **Auditory:** hearing voices or sounds that aren't there but are projections of inner thoughts or feelings
  - **Visual –** seeing a person or object that isn't there
  - **Olfactory** - smelling things that aren't there
  - **Gustatory –** tasting sensations are altered (Ex: Sam wont eat his food because he "tastes" the poison the FBI is putting in his food)
  - **Tactile –** feeling strange sensations from an object that wouldn't feel that way
  - **Nursing Interventions: (1) What are the voices saying to do? (2) Do you recognize the voices? (3) Do you plan to follow the command?** *Speak in louder voice, remind the patient that the voices are not real (Ex: "your voices…."*, take safety measures ASAP if patient is harm to self/others*

- **Antipsychotic Medications**
  - **Atypical Antipsychotics/ 2nd Gen.**
    - (Ex: Clozapine, Risperidone, Quetiapine (Seroquel), Olanzapine, Abilify) ***Targets both POSITIVE and NEGATIVE symptoms.***
    - ***Clozapine: drug is for bipolar disorder***
      Adverse Effects: weight gain, hypertension, increased glucose levels, Heart Disease
  - **Typical Antipsychotics/1st Gen.**
    - (Ex: Haldol, Chlorpromazine) ***Targets POSTITIVE symptoms only***.
      Adverse Effects: Highly sedating, EPS, TD, Neuroleptic Malignant Syndrome (give Cogentin & lower drug dose), Check blood sugars regularly, falls risk.
  - ***Tardive dyskinesia***. ***(Facial tics, involuntary repetitive body movements, not reversible, lip smacking, eye blinks, etc)***

- **Personality, Somatoform, and Eating Disorders**: Traits of a person exaggerated to the point in which they interfere or cause destruction in one's life. Your "Difficult Patient". Have issues working and with relationships/loving. Use Primitive (Immature) Defenses. ***Don't treat with Benzos! Use 2nd Gen Antipsychotics and Antidepressants***.
  - ***Histrionic:*** (think Marilyn Monroe – sex icon) flamboyant, wears a ton of make-up, tight clothes, and seductive behavior, seeking attention/love/admiration. Throws tantrums if attention needs not met.
  - **Schizotypal** – eccentric, magical thinking, odd/strange behavior, illogical speech.
  - ***Obsessive-Compulsive*****:** concerned with order, neatness, rules, perfection, and lack sense of humor, superficial intimacy in relationships.
  - ***Narcissistic:*** (assholes) attention seeking, grandiosity (sense of entitlement), shallow relationships focused on what others can do for them, arrogant.
  - ***Borderline: (self-mutilation & suicide prone behaviors)*** emotional instability sees relationships to not feel abandoned/alone. – ***Nurse should be consistent***
  - ***Antisocial: (manipulators & con-artists), no remorse, no moral values, lie, steal, feel no responsibility. Don't let them be in a position of power (judge, public speaker, etc.).***
  - ***Dependent:*** afraid of being alone, cannot survive if left alone, stays in abusive relationships or may "relationship-jump", have high anxiety.

- **Manipulation Interventions**
  - ***Set clear rules on behaviors and enforce them CONSISTENTLY***
  - ***DON'T make promises***, keep secrets, do special favors or accept gifts

- **Highest nursing priority with these dx**
  - ***SAFETY is #1***
  - Diagnosis depends on the type of PD the person has
  - ***Think Maslow….Basic Needs/Safety/Love & Belonging***
  - ***Anorexia and appropriate nursing diagnosis. Inability to gain weight.***

- **What comorbidities exist with Anorexia and Bulimia?**
  - Depression, OCD, Social Phobia, Anxiety (feelings of emptiness and helplessness).
  - ***Always assess for suicide/self-harm in these patients.***

- **Eating Disorder S/Sx:**
  - **Anorexia S/Sx:** Terrified of gaining weight, moving food around plate, cutting food into tiny pieces, wearing baggy clothes to hide body, sunken eyes, protruding bones, views self as fat, exercising to exhaustion, lanugo, amenorrhea, osteoporosis.
  - ***(Test Question for Select All that Apply (was on Exam 3): Milieu Therapy for Anorexia: (1) Scheduled meal times, (2) Scheduled weights (3) Selects from a specific menu (4) Observe before/after meals & in bathroom***
  - **Bulimia S/Sx:** Erosion of teeth***, GERD***, stomach pain***, frequent trips to bathroom to purge (especially after meals), Russell's sign (calluses on knuckles)***, cardiac dysrhythmias

- **Conversion Disorder**
  - Patient has motor/sensory deficits with no medical reason (blindness, loss of function of limbs, seizures, abnormal gait, deafness).
  - **"La Belle Indifference"** – patient wants MD care, but not concerned with their symptoms.
  - Patient Example: " I woke up this morning and I couldn't move my arm"

- **Conduct Disorder**
  - Aggressive behavior towards others (cruelty to animals, using weapons), destructive behaviors, lying, manipulating, running away from home, truancy, sexually active at very young age
  - **Nursing Intervention**: ***#1 is protection from harm***, provide positive feedback for acceptable behavior, provide immediate non-threatening feedback for negative behavior, and Help child use tools to control impulses and toleration of frustration, use ROLE PLAY to help them learn how to respond to feelings.

- **Addiction, Abuse and Violence**

Signs of Alcohol Withdrawal

- ***Peak: 24-48 hours***
- **Symptoms:** ***hyper-alert, jerky movements, irritability***, startles easy, "shaking inside", tachycardia, sweating, increased: BP, HR***, hallucinations***, disorientated, agitation, small pupils
- Seizures: 7hrs – 48 hours after stopping drinking
- ***Complications associated with alcohol dependence: pancreatitis, cirrhosis, and Korsakoff's psychosis***

Alcohol Dependence – know associated dx

- Risk for Suicide, Risk for other-directed Violence, Hopelessness, Denial, Low-Self-Esteem, Anxiety
- Depression & Alcohol go hand in hand.

Nursing Interventions & Assessment tools

- Keep them SAFE while they are withdrawing from drugs
- BAL (blood alcohol levels)
- Seizure precautions

Medications for Alcohol Withdrawal

- ***Chlordiazepoxide (Librium)*** – **provides SAFE withdrawal** and has anticonvulsant effects. ***Used for ACUTE withdrawal***. ***#1st Choice Med***
- **Disulfiram (Antabuse)** – Used for ***MAINTENANCE***. Makes you severely ill/sick if you drink alcohol. (Negative feedback) Metallic aftertaste.
- **Naltrexone (Revia)**- Used to reduce cravings. Used in the first 12 weeks of ACUTE recovery.

- **Interventions for Pre-Assaultive Patient**
  - Respond early and consistently to angry/aggressive behavior
  - Leave door open, stay between the door and the patient (never let patient get between you and the exit!), low tone voice, talk slowly and calmly, appear calm & collected, ask "What will help now?", sit at 45 degree angle to patient
  - Reintegration: gradual increase in the ability of the patient to handle stimulus.

- **Cognitive and Degenerative Disorders**

Alzheimer's - Understand Pathology

- ***Slow deterioration. NOT REVERSABLE***. Results in impaired memory (from death of neurons), judgment, agnosia, forgetfulness, inattention, ***Short Term Memory Goes First***, "Sundowning", Preservation (repetition of phrases or behaviors)
- ***HEAD TRAUMA***– Big influence in Dementia/Alzheimer's!!!
- Use ***Confabulation*** to fill in gaps of memory (putting truth and made up stores into the same sentence and they don't know the difference)
- ***4 A's of Dementia/AD:***
  - *Amnesia, Aphasia, Apraxia, Agnosia*

- **Alzheimer's – Meds used**
  - **Aricept (Donepezil)** – slows down the deterioration/cognitive decline, but only for a short while.
  - **Rivastigmine** (Exelon)– slows down the deterioration/cognitive decline, but only for a short while.
  - **Memantine** (Namenda) – targets symptoms of Alzheimer's disease in the moderate to severe stages.

- **Stages of Dementia:**
  1. Stage 1: mild/forgetfulness
  2. Stage 2: moderate/confusion
  3. Stage 3: severe/unable to identify objects/people
  4. Stage 4: late/end-stage

- **Defense mechanism**: ***Confabulation*** (***making up stories*** or answers to maintain self-esteem when they do not remember), ***Perseveration*** (repetition of phrases or behavior)

- **Nursing Interventions:** Always introduce yourself, call patient by name with every contact, expectations should be clear and explained in simple, step-by-step instructions, simple appropriate choices. Example "Do you want to wash your face before or after you brush your teeth."

- **Family teaching/education:** Nurses need to teach the families about dementia, where to get help, community resources, etc. Gradually take the car away, NO throw rugs, tape cords to the floors, mattress on the floor/bed alarms, keep it simple & Familiar as possible.

- **Nursing Diagnosis for Alzheimer's** ***Risk for Injury, Fear, Acute Confusion, Disturbed Sleep Patterns, Impaired Memory***, Powerlessness, Impaired Verbal Communication

- **Impulsive Behaviors:**
  - Short Periods between thoughts and actions. (Person doesn't stop and think, they just act to relieve anxiety/stress).
  - Stealing, fire setting, gambling, and sexting are examples. Person feels relief of anxiety once they complete the behavior.

- **Nursing Interventions for Impulsive Behavior:**
  (**Impulsive Behavior**: short periods between thoughts and actions)
  - What precedes the event? (Find the trigger)
  - How do they feel AFTER they do the act? Any repercussions?
  - Teach patient coping skills
  - Discuss alternative behavior

- **Patients in Crisis, Grief, Complementary Therapy Discuss factors that influence the grieving process**
  - Lack of support/empathy from others
  - Trying to hurry through the process to get back to their responsibilities
  - Failure to accept reality of loss or denying themselves the right to grieve/mourn.

- **Describe alarm, exhaustion, fight or flight**
  - **Alarm** – trigger of the fight or flight mechanism
  - **Exhaustion** – extreme fatigue (mentally, emotionally, physically)
  - **Fight or Flight** – (Sympathetic Nervous System triggered by hypothalamus). Is a survival mechanism that alerts our bodies to be ready to meet a threat or stress. Increased pulse, BP, respirations, HR, alertness.

- **Identify forms of complementary therapies**
  - Herbals, aromatherapy, acupuncture, pressure point therapy

- **Stress Reduction Techniques**
  - Meditation, Yoga, Massage, Deep Breathing, exercise, nature, sunlight therapy, Reframing, Decrease Caffeine intake, SLEEP!, Meaningful work/satisfying work, live with who you want, love who you want, set your own life goals
  - **Complementary therapies**. ***Does NOT include drug therapies. Consider massage, guided imagery, and animal therapy.***

- **5 Stages of Grief**
  1. **Denial** – person cannot accept his/her painful loss (feels numb or may be emotionally dry). Lasts a few hours or days.
  2. **Anger** – person places feelings on medical/nursing staff, or towards the deceased. Usually peaks during the 1st month after death.
  3. **Bargaining** – hope that one can avoid grief by making a bargain (I will change the way I live, if mom can live just one more year).
  4. **Depression** – extreme sadness and despair. Ex: "I miss my loved one, so why go on with life"
  5. **Acceptance** – Moving forward with one's life ("It's going to be okay".)

- **Crisis - Environmental Disasters & Situational Crisis**
  - **Environmental:** floods, earthquakes, tornadoes, volcanoes, tsunamis, hurricanes, avalanches, mudslides, fires, snow emergencies
  - **Situational:** loss of a job, death of a loved one, unwanted pregnancy, financial changes, divorce, and severe physical/mental illness.

- **Crisis Nursing Interventions – *Highest Priority***
  - ***Physical Safety*** is **#1 Priority**. (This can be either keeping the patient safe from self-harm/suicide, or securing them to safety where food/shelter/clothing are available.
  - ***Crisis is an acute, time limited occurrence. Usually resolves in 4-6 weeks.***
  - Patient Safety & Anxiety Reduction are two basic goals
  - ***Teaching a coping class for families suffering from stressors***

- **Nursing Assessment Priority during Crisis**
  - **Can the patient identify: Precipitating event, situational supports and coping skills?**
  - AFTER ruling out suicide/self-harm, assess:
    1. **Patient's perception of the event** (Questions to ask: What leads you to seek help now? Describe how you are feeling now. Has anything upsetting happened to you within the past few days/weeks? How do you see this event affecting your future?)
    2. **Patient's support system** (Questions to ask: Whom do you live with? Who can you trust? Who is available to help you? Who do you talk to when you feel overwhelmed? Do you have other family?)
    3. **Patient's coping skills** (Questions to ask: Have you thought of killing yourself or someone else? If yes, do you have a plan? What do you do to feel better? What do you think might happen now?)

- **Interventions for Patients in Crisis**
  1. ***Assess for suicide/self-harm. SAFETY #1 ALWAYS!***
  2. Lower patient anxiety
  3. Listen & summarize what patient says at the end
  4. Contact social worker/shelter/babysitting, etc.
  5. Assess support systems
  6. ***Identify coping skills*** that patient has and ones they need to learn
  7. Plan f/u visits/phone calls/etc.

- **Nursing Diagnosis for Crisis:**
  - ***Risk for Self-Directed Violence***, Hopelessness, Social Isolation, Risk for Loneliness, Ineffective Coping, Powerlessness, Chronic Sorrow

- **Primary, Secondary and Tertiary Nursing Care**
  - **Primary:** promoting mental health (ex: teaching coping skills, stress reducing techniques, meditation, reducing life changes)
  - **Secondary:** interventions during an acute crisis to prevent prolonged anxiety (ex: working to assess problem, support systems, and coping styles). Happens in an ER, clinic, hospital, MH center, etc.
  - **Tertiary:** providing support for those in recovery from crisis/facilitating optimal levels of functioning & emotional wellbeing (ex: rehab centers, outpatient services, workshops, etc)

- **Disenfranchised Grief**
  - ***Grief experienced by a NURSE regarding a PATIENT who dies*** (or over an abortion, death from AIDS or execution, war heroes, divorced spouse, suicides). ***The nurse cannot openly grieve***, it may not be acknowledged by others, so it may be difficult to deal with.

- **Caring for a Dying Patient**
  - ***#1: Assess your own skill level and seek help from other nurses is necessary***
  - ***Good Listening Skills & Sensitivity towards patients and family***
  - ***Conservation of Dignity*** (access to wigs, clothing, cosmetics, discussing their legacy, allow patient as much control over their situation as possible, food/music/friends visiting, and spiritual comfort access)
  - ***Demonstrating care to grieving family***

- **Nursing Interventions for Acute Grief**
  - ***Be present. Listen to them***. Sharing painful feelings during periods of silence help with healing and convey concern.
  - Share information on the Grieving Process (let them know these feelings are normal). Provide handouts for reference and support information.
  - Encourage support of friends and family or even Bereavement Groups
  - Spiritual support
  - ***Empathetic Words are ALWAYS helpful!*** Examples are:
    - This must hurt terribly.
    - I hear anger in your voice. Most people go through periods of anger when their loved one dies. Are you feeling angry now?
    - Are you feeling guilty? This is a common reaction many people have. What are some of your thoughts about this?
    - This must be very difficult for you.
    - ***Active listening – includes paying attn.. to verbal and non-verbal communication***

Miscellaneous

Freud contributed the theory of personality structure and levels of awareness.

Maslow's Hierarchy of Needs. Safety should always come first.

complementary therapies. They would ***not*** include drug therapies. Consider massage, guided imagery, and animal therapy.

prioritizing a nursing diagnosis, consider safety first.

stages of the nurse-client relationship.
* **termination stage** -the nurse and client will look at the coping skills the client has learned and how to use them in everyday life
* **discharge plan** - reflect on the memories and perceptions related to changes made.

Medical professionals must not accept gifts from patients. Be kind to the patient, but do not accept the offering.

One may function better after a crisis due to learning **coping skills**.

Be able to note if one taking **yoga** classes has benefitted.

Violence, Abuse

primary prevention for domestic violence. For instance, teaching a coping class for families suffering from stressors.

It is important to develop **a safety plan for a woman/mother who is abused at home**. Understanding the cycle of violence allows the nurse to be aware of the potential for violence occurring again. Establishing a safety plan for the client will allow her to be prepared for the next incidence.

When a patient has been raped - the nurse should initially ensure the patient is safe and the extent of the injuries.

If one has been beaten progressively, talk to the patient about options so there is not the need to return to the environment.

Mania, Schizo, Bipolar

A client with mania and who has lost weight rapidly - the appropriate outcome to a nursing diagnosis of imbalanced nutrition related to insufficient caloric intake and hyperactivity.

When a schizophrenic patient speaks in words that are not understood - do not pretend to understand the client. Ask for clarification and speak directly to the individual. State you are having difficulty understanding what is being said.

If a client is challenging and manipulating the staff with erratic behaviors, consider holding a staff meeting to discuss limit-setting and consistency.

When a patient is sexually inappropriate such as masturbating - set limits and place the patient in a private area. This accepts the client but rejects the behavior.

personality disorders paranoid, histrionic, narcissistic, and dependent. Be able to identify if an example is offered.

If one is having delusions of being harmed/poisoned - offer choices that do not appear to have been tampered with such as sealed containers.

Be consistent with individuals with a personality disorder. **Borderline personality** disorder produces emotional lability and inconsistency in behavior.

If a client is suffering a **manic phase** in a common area, remove the client from the area and offer redirection.

Working with patients with **histrionic personality disorder** a narcissistic personality disorder setting limits is necessary when determining priority nursing interventions.

Behaviors to anticipate with a **pediatric client** admitted with **conduct disorder asthma**, and tymanostomy. Note that conduct disorder is associated with aggressiveness, violence, intimidation, and bullying of others.

Be able to identify a **suicide plan** that is most lethal if provided examples. A client has access and is not likely to be rescued has a lethal plan. When others may be around, there is a chance of life-saving intervention.

Alcohol.

The appropriate drug for short-term management of alcohol withdrawal. benzodiazepines.

When working with family associated with an alcoholic or drug addict, family members must be able to tell the addict how the addiction has affected them.

one suffering alcohol withdrawal may be at risk for injury due to central nervous system stimulation such as delirium

complications associated with alcohol dependence. Consider pancreatitis, cirrhosis, and Korsakoff's psychosis.

hallucinations are common when experiencing alcohol withdrawal.

PTSD

Priority nursing diagnosis for one suffering from PTSD with a history of violence. Consider Risk for violence.

If a patient is experiencing a flashback, reassure the client. Ensure the client feels secure.

Anxiety, depression

Use a calm approach with one with **Generalized Anxiety Disorder** in the plan of care. Encourage the client to discuss feelings.

When caring for a patient with major depression, know that safety is a priority.

co-morbid conditions associated with anorexia. Depression is common.

anorexia and appropriate nursing diagnosis. inability to gain weight.

Bulimia nervosa, certain situations trigger the urge to binge/purge. This is a high priority for nursing care plan.

Identify statements that may trigger a primary nursing focus from a patient. For instance, a statement of hearing voices may trigger a primary focus.

Dying. **When working with family member of a dying patient**, encourage family members to express emotions, provide information, and answer questions related to the care of the person.

Meds.

The first line treatment for depression (SSRIs) Know what drugs may be classified as SSRIs.

If a patient starts suffering side effects w/an SSRI - such as agitation, confusion, fever, stop the medication and have the patient assessed.

Feeling dizzy and weak when getting out of a chair is indicative of **orthostatic hypotension**, which is a common side effect of anti-anxiety medications such as Xanax. The nurse should instruct the client to rise slowly from the sitting to standing position to avoid dizziness.

Consider using long-acting medications such as an injection for one that may be non-compliant with medication management.

lithium toxicity is a possible when one becomes dehydrated. One with nausea or diarrhea may be at risk.

side effects of risperidone. Tardive dyskinesia. (Facial tics, involuntary repetitive body movements, not reversible, lip smacking, eye blinks, etc)

patient teaching for SSRIs (sertraline) Know it takes a few weeks for the drug to be effective.

Buspirone may be prescribed over diazepam as it **does not result in physical dependence**.

Clozapine. Know this drug is for bipolar disorder.

Informed consent, Committed

A patient is involuntarily admitted to a psychiatric unit for expressing violent tendencies to another, he/she cannot leave without medical or court approval.

A patient who is admitted for suicide risk loses the right to privacy.

Rights a patient retains when involuntarily admitted to a behavioral unit. For instance the patients retain the rights to informed consent and right to refuse medications.

Understand informed consent. When providing Antabuse to a client, ensure the individual is cognitively able to understand the effects of ingesting alcohol while taking the drug.

Be able to note when an individual with mental illness may require **involuntary hospitalization**. Consider safety as a priority to self and/or others.

Communication.

Understand the concept of therapeutic and non-therapeutic communication. Do not limit the patient's ability to express feelings.

How to respond to someone that is critical of those with mental illness. Stop the dialogue if able

When offering therapeutic communication, explore along with reflective listening. This draws out the client and can help the client feel valued, understood, and supported. For instance, ask "What happened to make you feel that way?"

When offering therapeutic communication, ask questions and put into words what the client is referencing. If a client is feeling he/she is unable to talk to anyone or is not understood, ask the client if he/she feels misunderstood.

non-therapeutic techniques of giving premature advice, giving reassurance, presenting reality, and focusing.

Active listening includes paying attention to verbal and non-verbal communication.

Empathy Consider/understanding the individual's feelings and do not make personal statements. Make communication about the patient. Be willing to listen.

Active listening - let the other person know you are listening by maintaining eye contact and nodding. It takes practice.

Anger is not a helpful in caring for patients and may make being objective difficult. Show concern, empathy, and compassion.

Therapeutic communication strategy for one experiencing auditory hallucinations. Address the patient directly about the hallucination.

When one is suffering a crisis, consider the feelings of client and/or family first. One must be able to talk and express feelings/emotions.

When a client is delirious and yells out at the nurse, respond with empathy and offer support such as staying with the client.

Demonstrating care to a grieving family is important for a nurse to practice.

Delirium vs Alzheimers.

When one is experiencing delirium, orient the client to the day, place, and those around him. Do not attempt to explain or rationalize with the patient.

When working with a patient with Alzheimer's disease, provide routine and reminder signs.

Neurotransmitters implicated in the development of Alzheimer's disease. Acetylcholine and glutamate are factors.

Always assess the safety of the client with dementia. Medications may cause unsteadiness. Restraints are not necessary if a patient is not agitated.

Confabulation - used in a patient with Alzheimer's.

Agnosia – client does not recognize objects or understand what they're used for, so the nurse should give the client concrete directions. Do not do the task for the patient. Tell the client what to do with the object.