

Psychiatric Nursing Concepts and Care



SELF-CONCEPT

- A. *Self-concept*: all beliefs, convictions and ideas that constitute an individual's knowledge of himself or herself and influence his or her relationships with others.
- B. *Self-esteem*: an individual's personal judgment of his or her own worth obtained by analyzing how well his or her behavior conforms to his or her self-ideal.

✓ **NURSING PRIORITY:** *A healthy self-concept, (i.e., positive self-esteem) is essential to psychological well-being; it is universal, (i.e., something everyone wants and needs).*

Data Collection

- A. Factors affecting self-esteem.
 - 1. Parental rejection in early childhood experiences.
 - 2. Lack of recognition and appreciation by parents as child grows older.
 - 3. Overpossessiveness, overpermissiveness, and control by one or both parents.
 - 4. Unrealistic self-ideals or goals.

✓ **OLDER ADULT PRIORITY:** *The use of wheelchairs, canes, walkers, hearing aids, or any combination of these will have an impact on the self-esteem of the older client.*

- B. Behaviors associated with low self-esteem.
 - 1. Self-derision and criticism: describes self as stupid, no good, or a born loser.
 - 2. Self-diminution: minimizes one's ability.
 - 3. Guilt and worrying.
 - 4. Postponing decisions and denying pleasure.
 - 5. Disturbed interpersonal relationships.
 - 6. Self-destructiveness and boredom.
 - 7. Polarizing view of life.


💡 **TEST ALERT:** *Promoting a positive self-concept is basic to all psychotherapeutic interventions. Look for options that focus on this concept; acknowledging the client as a person is an example.*

Nursing Intervention


- A. Promote an open, trusting relationship.
- B. Work and expand on whatever ego strength the client possesses.
- C. Maximize the client's participation in the therapeutic relationship.
- D. Encourage the client to accept his or her own feelings and thoughts.
- E. Assist the client to clarify his or her concept of self and relationship with others through appropriate self-disclosure.
- F. Explore with client maladaptive thinking patterns such as:
 - 1. Catastrophizing: thinking that the worst will happen.
 - 2. Minimizing and maximizing: tendency to minimize the positive and maximize the negative.
 - 3. Black-and-white thinking: tendency to look at situations in extremes; no middle ground.
 - 4. Overgeneralization: If something happens once, it will happen again.
 - 5. Self-reference: tendency to believe that people are particularly aware of their mistakes.
 - 6. Filtering: selectively taking certain details out of context while neglecting to look at more positive facts.
- G. Communicate empathically, not sympathetically, and remind client that he or she has the power to change himself or herself.
- H. Encourage client to define and identify problem.
- I. Identify irrational beliefs such as:
 - a. "I must be loved by everyone."
 - b. "I must be competent and not make mistakes."
 - c. "My whole life is a disaster if it doesn't turn out exactly as planned."
- J. Identify areas of strength by exploring areas such as hobbies, skills, work, school, character traits, personal abilities, etc.

✓ **PEDIATRIC PRIORITY:** *If parents assist children to accomplish goals that are important to them, children begin to develop a sense of personal competence and independence.*

- K. Explore client's adaptive and maladaptive coping responses.
- Determine "pay-offs" for maintaining self-defeating behaviors such as:
 - Procrastination.
 - Avoiding risks and commitments.
 - Retreating from the present situation.
 - Not accepting responsibility for one's actions.
 - Identify the disadvantages of the maladaptive coping responses.

 **NURSING PRIORITY:** *An individual's functional level of overall self-esteem may change markedly from day to day and moment to moment.*

- L. Realistic planning.
- Assist client to identify alternative solutions.
 - Encourage creative visualization to enhance self-esteem through goal setting.
 - Assist client to set realistic goals by encouraging him or her to participate in new experiences.
- M. Commitment to action.
- Providing an opportunity for client to experience success is essential.
 - Reinforce strengths, abilities, and skills.

 **TEST ALERT:** *Assist and reinforce nursing care given by caregivers/family on ways to manage client with behavioral disorders. Promote positive self-esteem and identify strengths of client and family members.*

CULTURAL COMPETENCE

- A. Definitions.
- Culture: the beliefs, values, and norms of the individual, group, or community that are used in everyday life.
 - Cultural competence: process whereby the nurse develops cultural awareness, knowledge, and skills to promote effective health care.
 - Cultural diversity: unique differences in areas such as age, gender, socioeconomic status, religion, race, and ethnicity.
- B. Barriers to culturally competent care.
- Miscommunication.
 - Failure to assess for cultural perspective.
 - Differences in understanding the way in which people function, interact, and behave every day.
 - Clients use culturally specific language to describe medical symptoms or problems.
Example: Native Americans may express depression symptoms as "having heart pain or heartbroken." Hispanics may say that their soul is lost because of another's ability to put an "evil eye" on them.

BODY IMAGE

Evaluation of Body Image Alteration

- A. Types of body image disturbances.
- Changes in body size, shape, and appearance (rapid weight gain or loss, plastic surgery, pregnancy).
 - Pathological processes causing changes in structure or function of one's body (e.g., Parkinson's disease, cancer, heart disease).
 - Failure of a body part to function properly (paraplegia or stroke).
 - Physical changes associated with normal growth and development (puberty, aging process).
 - Threatening medical or nursing procedures (catheterization, radiation therapy, organ transplantation).
- B. Principles.
- Body characteristics that have been present from birth or acquired early in life seem to have less emotional significance than those arising later.
 - Body image changes, handicaps, or changes in body function that occur abruptly are far more traumatic than ones that develop gradually.
 - The location of a disease or injury greatly affects the emotional response to it; internal diseases are generally less threatening than external diseases (trauma, disfigurement).
 - Changes in genitals or breasts are perceived as a great threat and reawaken fears about sexuality and virility.

SPECIFIC SITUATIONS OF ALTERED BODY IMAGE AND NURSING INTERVENTION



Obesity

Data Collection

- Body weight exceeds 20% above the normal range for age, sex, and height.
- Feeding behavior is gauged according to external environmental cues (i.e., availability of food, odors, stress) rather than hunger (increased gastrointestinal motility).
- Increased incidence of diabetes, cardiovascular disease, and poor healing; skinfold thickness greater than 0.2 inches measured with skinfold calipers.
- Often has symptoms of depression, fatigue, dyspnea, tachycardia, and hypertension.

Nursing Intervention

- Encourage behavior modification programs.
- Promote activities and interests not related to food or eating.
- Identify client's need to eat and relate the need to preceding events or situations.
- Decrease guilt and anxiety related to being obese.

- E. Provide long-range nutritional counseling.
- F. Encourage an exercise program.
- G. Assess for complications (hypertension, cardiovascular disease).



Stroke

Data Collection

- A. Change of body function due to loss of bowel and bladder control, speech, and cognitive skills, as well as loss of motor skills.
- B. Disordered orientations in relationship to body and position sense in space; body image boundaries disrupted.

Nursing Intervention

- A. Decrease frustration related to speech problems by encouraging speech effort, speaking slowly, and clarifying statements.
- B. Do not try to hurry or rush client.
- C. Promote reintegration of altered body image caused by paralyzed body part by means of tactile stimulation and verbal reminders of the existing body part.



Amputation

Data Collection

- A. Feelings of loss; lowered self-esteem; guilt; helplessness.
- B. Depression, passivity, and increased emotional vulnerability.
- C. Phantom limb pain in most clients: increased experience if amputation occurs after 4 years of age; almost universal experience after age 8.
- D. Phantom limb pain stronger in upper limbs and lasts longer than that in lower limbs.

Nursing Intervention

- A. Discussion of phantom limb phenomenon and exploration of client's fears regarding amputation.
- B. Acknowledge phantom limb pain; reassure client that this is a normal process.
- C. Provide pain medication as needed.



Pregnancy

Data Collection

- A. Produces marked changes in a woman's body, resulting in major alterations in body configuration within a short period of time.
- B. Second trimester: Woman becomes aware that her body is widening and requires more body space.
- C. Third trimester: very much aware of increased size; may feel ambivalent about the changes in her body.

- D. Perceives her body as vulnerable, yet as a protective container for the unborn.
- E. Mate experiences changed body image and sympathetic symptoms during woman's pregnancy.

Nursing Intervention

- A. Explanation and reassurance of the normal physiological changes that are occurring.
- B. Provide discussions of alterations in body image for both mates.
- C. Encourage verbalization of feelings relating to changed body image.



Cancer

Data Collection

- A. Clients with cancer may experience many changes in body image.
- B. Removal of sex organs (breasts, uterus) has a significant impact on client's preception of sexuality.
- C. Disfiguring head-and-neck surgery has devastating impact on body image, because the face is one of the primary means by which people communicate.
- D. Symptoms of depersonalization, loss of self-esteem, and depression may occur.

Nursing Intervention

- A. Provide anticipatory guidance to help client cope with crisis of changed body image.
- B. Set long-term goals to help client with cancer adjust to physiological and psychological changes.



Enterostomal Surgery

Data Collection

- A. Client often shocked at initial sight of ostomy.
- B. May experience lowered self-esteem, fear of fecal spillage, alteration in sexual functioning, feelings of disfigurement and rejection.

Nursing Intervention

- A. Preoperative explanation by use of drawings, models, or pictures of how stoma will appear.
- B. Reassurance that reddish appearance of stoma and large size will diminish in time.
- C. Encourage discussion and recognize importance of client talking with a "successful ostomate."

HUMAN SEXUALITY

- A. Effect of illness and injury on sexuality.
 1. Depressive episodes often precipitate a decrease in libido.
 2. Sexual preoccupations and overtones may be experienced by the client with psychosis.

3. Certain medications contribute to sexual dysfunction, failure to reach orgasm in women, and impotence or failure to ejaculate in men (e.g., reserpine, phenothiazine, and estrogen use in men decrease libido; while androgen use in women increases libido).
 4. Clients with spinal cord injuries may lose sexual functioning.
 5. Trauma and disfigurement may precipitate an alteration in sexuality.
- B. Effect of the aging process on sexuality.
1. Physiological changes in the woman are frequently caused by decreasing estrogen supply, which results in decreased vaginal lubrication, shrinkage and loss of elasticity in vaginal canal, and decrease in breast size.
 2. Physiological changes in the man include a decrease in testosterone, decrease in spermatogenesis, and a longer length of time to achieve erection along with a decrease in the firmness of erection.

CONCEPT OF LOSS



TEST ALERT: Provide care or support for client and family at end of life. Assist with coping related to grief or loss.

Definition

1. Includes both biological and physiological aspects; loss of function (see Chapter 3).
2. Components of loss include death, dying, grief, and mourning.
 - a. Death: represents finality, the end of one's biological being.
 - b. Dying: the social process of organizing activities that prepare for death; provides others, as well as the client, a way to prepare for the future.
 - c. Grief: the sequence of subjective states that follow loss and accompany mourning.
 - d. Mourning: the psychological processes that are aroused by the loss of a loved object or person.

Data Collection

- A. Characteristic stages.
1. Death and dying (Kübler-Ross, 1969).
 - a. Denial and isolation.
 - b. Anger.
 - c. Bargaining.
 - d. Depression.
 - e. Acceptance.
 2. Grief.
 - a. Shock and disbelief.
 - b. Developing awareness.
 - c. Restitution or resolution of the loss.

Nursing Interventions

- ❖ **Goal:** To acknowledge the pain of the loss.
 - A. Assist the griever to recognize that he/she must yield to the painful process of grief.
 - B. Explain how grief affects all areas of one's life.
 - C. Try and view the loss from the griever's perspective.
- ❖ **Goal:** To assist the grieving and/or dying client to accept the reality of loss and/or death.
 - A. Encourage expression and verbalization of feelings with out interruption (i.e., crying, talking).
 - B. Listen nonjudgmentally with acceptance.
 - C. Reach out and make contact with client and family; let genuine concern and caring show.
- ❖ **Goal:** To provide for spiritual needs of the grieving and/or dying client.
 - A. Ask clergy to visit.
 - B. Pray with client and family (if requested to do so), read inspirational literature, play music.
 - C. Encourage the griever to allow self-respite times from the grieving process.
- ❖ **Goal:** To promote adjustment to life and living after the experience of loss.
 - A. Encourage reinvesting energies into new undertakings and relationships.
 - B. Promote letting go and moving on.

PSYCHOSOCIAL ASSESSMENT

* Complete data collection assessment includes descriptions of the intellectual functions, behavioral reactions, emotional reactions, dynamic issues of the client relative to adaptive functioning and response to present situations.



OLDER ADULT PRIORITY: Allow ample time to gather psychosocial data from older clients, because they are often starved for someone to listen to them (Box 6-1).

- A. Psychosocial assessment purpose: To obtain data from multiple sources (e.g., client, family, friends, police, mental health personnel) in order to identify patterns of functioning that are healthy, as well as patterns that create problems in the client's everyday life.
- B. Psychosocial data to obtain.
1. Chief complaint (CC): main reason client is seeking psychiatric help.
 2. History of the presenting illness (HPI): onset and development of symptoms or problems.
 3. Past medical history (PMH): previous previous mental health hospitalizations or treatment; information concerning client's birth, growth and development, illnesses, occupation, marital history, religious practices, use of tobacco, alcohol, or drugs, for example.
 4. Family history: Have any immediate family members sought psychiatric treatment or counseling?

BOX 6-1

OLDER ADULT CARE FOCUS

Aging and Mental Health

- Sensory losses (hearing and vision) can have behavioral changes that can be mistaken for disorientation.
- Financial and physical changes of aging can lead to social isolation.
- Exaggerated personal characteristics occur as a person ages.
- Anxiety, fear, and depression can occur from experiencing multiple losses (death, job changes, relocation from home, loss of independence) and grief, especially if they occur quickly.
- Alcoholism is often found in the older adult.
- Behaviors commonly seen are hopelessness and helplessness, which can lead to suicide.
- To assist coping with life circumstances, encourage reminiscence and life review.

5. Personality profile: client's interests, feelings, mood, and usual leisure or hobby activities.

C. Common client behaviors seen with illness.

1. Denial: refusal to believe he or she is ill; may result in maladaptive behavior if continues.
2. Anxiety: may see flight-fight fear response.
3. Shock: overwhelming feelings and emotion that paralyze client's ability to process information.
4. Anger: response related to feeling mistreated, injured, or insulted; may escalate to aggression.
5. Withdrawal: may be a sign of depression; ill person may isolate self from family.

MENTAL STATUS EXAMINATION

* The mental status examination differs from the psychiatric history in that it is used to identify an individual's *present* mental status.



TEST ALERT: Identify changes in client's mental status.

Aspects of the Examination



NURSING PRIORITY: Assess level of consciousness, vision, and hearing first (e.g., alert, lethargic, stuporous, or comatose) and ability of the client to comprehend the interview.

- A. Mini Mental State Examination (Folstein, Folstein, and McHugh, 1975).
 1. Widely used common mental status assessment for cognitive function.
 2. Quickly administered – questions related to orientation (person, place and time), registration

(repeating items, give client 3 common words and ask them to repeat the words), naming (point to a chair or object and ask client to name it), and reading (ask client to read and follow directions from a simple sentence).

3. Excludes assessment of mood, abnormal psychological experiences (hallucinations, delusions, illusions), and content and process of thinking.

COPING/DEFENSE/EGO/MENTAL MECHANISMS

* Specific defense processes used by individuals to relieve or decrease anxieties caused by uncomfortable situations that threaten self-esteem.

- A. Related principles.
 1. The primary functions are to decrease emotional conflicts, provide relief from stress, protect from feelings of inadequacy and worthlessness, prevent awareness of anxiety, and maintain an individual's self-esteem.
 2. Everyone uses defense mechanisms to a certain extent. If used to an extreme degree, defense mechanisms distort reality, interfere with interpersonal relationships, limit one's ability to work productively, and may lead to pathological symptoms.
- B. Common defense mechanisms (see Box 6-2).
- C. Nursing management.
 1. Accept coping mechanisms.
 2. Discuss alternative coping mechanisms and problem-solving situations.
 3. Assist the client in learning new or alternative coping patterns for a healthier adaptation.
 4. Use techniques to decrease anxiety.

THERAPEUTIC NURSING PROCESS

* Therapeutic interpersonal relationship is the interaction between two persons: the *nurse* promotes goal-directed activities that help to alleviate the discomfort of the *client* by promoting growth and satisfying interpersonal relationships.


Characteristics

- A. Goal-directed.
- B. Empathetic understanding.
- C. Honest, open communication.
- D. Concreteness; avoids vagueness and ambiguity.
- E. Acceptance; nonjudgmental attitude.
- F. Involves nurse's understanding of self and personal motives and needs.

Phases

- A. Initial phase: goal is to *build* trust.
 1. Explore the client's perceptions, thoughts, feelings and actions.
 2. Identify problem.

3. Assess levels of anxiety of self and client.
 4. Mutually define specific goals to pursue.
- B. Working phase: goal is *to establish objectives* or a working agreement (contract).
1. Encourage client participation.
 2. Focus on problem-solving techniques; choose between alternate courses of action and practice skills.
 3. Explore thoughts, feelings, and emotions.
 4. Develop constructive coping mechanisms.
 5. Increase independence and self-responsibility.
- C. Termination phase: goal is *to evaluate goals* set forth and terminate relationship.
1. Plan for termination early in formation of relationship (in initial phase).
 2. Discuss client's feelings about termination.
 3. Evaluate client's progress and goal attainment.

 **NURSING PRIORITY:** *To effectively interview a client, be sure to start with a broad, empathetic statement; explore normal behaviors before discussing maladaptive behaviors; phrase inquiries or questions sensitively to decrease client's anxiety; ask client to clarify vague statements; focus on pressing problems when client begins to ramble; interrupt nonstop talkers as tactfully as possible; express empathy toward client while he or she is expressing feelings.*

THERAPEUTIC NURSE-CLIENT COMMUNICATION TECHNIQUES

- A. Planning and goals.
1. Demonstrate active listening; face-to-face contact.
 2. Demonstrate unconditional positive regard, interest, congruence, respect.
 3. Develop trusting relationship; accept client's behavior and display nonjudgmental, objective attitude.
 4. Be supportive, honest, authentic, and genuine.
 5. Focus on emotional needs and emotionally charged area.
 6. Focus on here-and-now behavior and expression of feelings.
 7. Attempt to understand another point of view.
 8. Develop an awareness of the client's likes and dislikes.
 9. Encourage expression of both positive and negative feelings.
 10. Use broad openings and ask open-ended questions; avoid questions that can be answered by yes or no.
 11. Use reflections of feelings, attitudes, and words.
 12. Explore alternatives rather than answers or solutions.
 13. Focus feedback on *what* is said rather than *why* it is said.
 14. Paraphrase to assist in clarifying client's statements.
 15. Promote sharing of feelings, information, and ideas instead of giving advice.

BOX 6-2

UNDERSTANDING DEFENSE MECHANISMS

Name of Defense Mechanism	Definition
Compensation	Attempting to make up for or offset deficiencies, either real or imagined by, concentrating on or developing other abilities
Conversion	Symbolic expression of intrapsychic conflict expressed in physical symptoms
Denial	Blocking out or disowning painful thoughts or feelings
Displacement	Feelings are transferred, redirected, or discharged from the appropriate person or object to a less threatening person or object
Dissociation	Separating and detaching an idea, situation, or relationship from its emotional significance; helps the individual put aside painful feelings and often leads to a temporary alteration of consciousness or identity
Identification	Attempting to pattern or resemble the personality of an admired, idealized person
Introjection	Acceptance of another's values and opinions as one's own
Projection	Attributing one's own unacceptable feelings and thoughts to others
Rationalization	Attempting to justify or modify unacceptable needs and feelings to the ego, in an effort to maintain self-respect and prevent guilt feelings
Reaction Formation	Assuming attitudes and behaviors that one consciously rejects
Regression	Retreating to an earlier, more comfortable level of adjustment
Repression	An involuntary, automatic submerging of painful, unpleasant thoughts and feelings into the <i>unconscious</i>
Sublimation	Diversion of unacceptable instinctual drives into personally and socially acceptable areas to help channel forbidden impulses into constructive activities
Suppression	Intentional exclusion of forbidden ideas and anxiety-producing situations from the conscious level; a voluntary forgetting and postponing mechanism
Undoing	Actually or symbolically attempting to erase a previous consciously intolerable experience or action; an attempt to repair feelings and actions that have created guilt and anxiety



TEST ALERT: *Recognize client's use of defense mechanisms.*

- B. Examples of therapeutic and nontherapeutic communication responses (Table 6-1 and Box 6-3).



TEST ALERT: Listen to client's concerns and use therapeutic interventions to increase client's understanding of his or her behavior; acknowledge differences between client's views/feelings and the health care provider's views/feelings; establish rapport with client or family.

INTERVENTION MODALITIES

Crisis Intervention

* A crisis is a self-limiting situation in which usual problem-solving or decision-making methods are not adequate.

- A crisis offers opportunities for growth and renewal.
- Crisis intervention strategy views people as capable of personal growth and able to control their own lives.
- Types of crisis intervention strategies.
 - Individual crisis counseling.
 - Crisis groups.
 - Telephone counseling.
- Crisis intervention requires support, protection, and enhancement of the client's self-image.

Group Therapy

* A structured or semi-structured process in which individuals (7 to 12 members is ideal size) are interrelated and interdependent and may share common purposes and norms.

- Emphasis on clear communication to promote effective interaction.
- Disturbed perceptions can be corrected through consensual validation.
- Socially ineffective behaviors can be modified through peer pressure.

Family Therapy

* A treatment modality designed to bring about a change in communication and interactive patterns between and among family members.



TEST ALERT: Provide emotional support to family, assess dynamics of family interactions, assess family's understanding of illness and emotional reaction, and help family adjust to role changes.

- A family can be viewed as a system that is dynamic. A change or movement in any part of the family system affects all other parts of the system.
- Family seeks to maintain a balance or "homeostasis" among various forces that operate within and on it.

BOX 6-3

INEFFECTIVE RESPONSES AND BEHAVIORS

- Not listening; talking too much
- Looking too busy
- Seeming uncomfortable with silence
- Avoiding sensitive topics
- Changing the subject
- Laughing nervously; smiling inappropriately
- Showing a closed body posture
- Focusing on personal issues of the nurse
- Making flippant comments
- Being defensive or making excuses

- Emotional symptoms or problems of an individual may be expression of the emotional symptoms or problems in the family.
- Therapeutic approaches involve helping the family members look at themselves in the here and now and recognize the influence of past models on their behavior and expectations.

Milieu

* A scientifically, planned, purposeful manipulation in the environment aimed at causing changes in the behavior and personality of the client.



TEST ALERT: Contribute to maintaining a safe and supportive environment for the client (e.g., therapeutic milieu, structured environment).

- Nurse is viewed as a facilitator and a helper to clients rather than a therapist.
- The *therapeutic community* is a very special kind of milieu therapy in which the total social structure of the treatment unit is involved as part of the helping process.
- Emphasis is placed on open communication, both within and between staff and client groups.

Mind-Body-Spirit Therapies

* Alternative therapies different from traditional Western medicine; often influenced by traditional Chinese medicine, which focuses on maintaining unity with nature and balancing our energy systems.

- Acupuncture: movement of energy through meridians of the body to restore energy balance.
- Imagery: change reality by creating a different mental picture.
- Therapeutic touch: manipulate and direct client's energy through the use of the practitioner's hands and direct energy from the practitioner to the client to enhance healing.

TABLE 6-1

THERAPEUTIC COMMUNICATION

Response	Example
Exploring	“What seems to be the problem?” “Tell me more about...”
Reflecting	Client: “I am really mad at my mother for grounding me.” Nurse: “You sound angry.”
Focusing	“Give an example of what you mean.” “Let’s look at this more closely.”
Clarifying	“I’m not sure that I understand what you’re saying.” “Do you mean...?”
Using general leads	“Go on...”
Broad opening leads	“Talk more about...” “Where would you like to begin?” “Talk more about...”
Validating	“Did I understand you to say...?”
Informing	“The time is...” “My name is...”
Accepting	“Yes.” “Okay.” Nodding, “Uh hmm.”
Sharing observations	“You appear anxious. I noticed that you haven’t been coming to lunch with the group.”
Presenting reality	“I do not hear a noise or see the lights blinking.” “I am not Cleopatra; I am your nurse.”
Summarizing	“During the past hour we talked about...”
Using silence	Nurse remains silent and waits patiently for the client to begin speaking.

NONTHERAPEUTIC COMMUNICATION

Response	Example
False reassurance	“Don’t worry; you will be better in a few weeks.” “Don’t worry. I had an operation just like it; it was a snap.”
Giving advice	“What you should do is...” “If I were you, I would do...”
Rejecting	“I don’t like it when you...” “Please, don’t ever talk about...”
Belittling	“Everybody feels that way.” “Why, you shouldn’t feel that way.”
Probing	“Tell me more about your relationships with other men.”
Overloading	“Hi, I am JoAnn, your student nurse. How old are you? What brought you to the hospital?” “How many children do you have? Do you want to fill out your menu right now?”
Underloading	Not giving enough information so that the meaning is clear; withholding information.
Clichés	“Gee, the weather is beautiful outside.” “Did you watch that new TV show last night? Everybody’s talking about it.”

- D. Massage: through touch unblocks energy flow and connects client with practitioner.
- E. Relaxation: imagery and progressive tensing and relaxing of muscle groups throughout the body.
- F. Music therapy and herbal therapy.
- G. Transcendental meditation: quiet meditation, focusing on getting beyond the self and becoming one with the universal energy source.
- H. Others: exercise, nutrition, prayer, religious practices.



TEST ALERT: Assess client’s use of alternative/complementary practices; evaluate client’s response to alternative therapy.

Somatic Therapies

- A. Restraints (Box 6-4).
 1. Mechanical restraints include camisoles, wrist and ankle restraints, and sheet restraints.
 2. Chemical restraints include the use of medications – antianxiety or antipsychotic.



NURSING PRIORITY: It is important to have a physician’s order for applying restraints and to provide for client’s biological needs (e.g., hygiene, elimination, nutrition, and method of communication).

- B. Seclusion.
1. Confinement to a room that may be locked. Often, the room is without a mattress or linens, and the client is wearing a hospital gown.
 2. There is limited opportunity for communication.

Psychosurgery

* **Surgical interruption of selected neural pathways that govern transmission of emotion between the frontal lobes of the cerebral cortex and the thalamus.**

- A. Recent resurgence of interest in psychosurgery as knowledge of neuroanatomy and “mapping” the cerebral cortex has become more sophisticated.
- B. Area of moral and ethical debate, especially because nerve tissue once damaged cannot regenerate.

Electroconvulsive Therapy

* **ECT is an electric shock delivered to the brain through electrodes that are placed on the head. The shock artificially induces a seizure.**

- A. Indications.
1. Severe depression; when other treatment modalities are ineffective.
 2. Acute schizophrenia (catatonic type).
 3. Number of treatments: usually given in a series that varies according to the client’s presenting problem and response to therapy; 2 to 3 treatments per week for a total of 6 to 12 treatments. May also use maintenance or continuation of ECT (once per month for 6 to 12 months).
- B. Nursing interventions.
1. Assess client’s record for routine preoperative-type checklist for information (informed consent).
 2. NPO for 6 to 8 hours before treatment.
 3. Remove dentures, hairpins, contact lenses, and hearing aids.
 4. Administer pre-procedure medication after electrodes are applied and before convulsion occurs.
 5. Provide for safety and observe progress of seizure (see Appendix 15-5).
 6. Care immediately following treatment.
 - a. Provide orientation to time.
 - b. Temporary memory loss is usually confusing; explain that this is a common occurrence.
 - c. Assess vital signs for 30 minutes to 1 hour after treatment.
 - d. Deemphasize preoccupation with ECT; promote involvement in regularly scheduled activities.

Other Therapies

- A. Psychodrama: the use of structured and directed dramatization of client’s emotional problems and experiences.
- B. Activities therapy: a number of vital programs come under this heading, such as music therapy, occupational therapy, art therapy, recreational therapy, ROPES, dance or movement therapy, etc.

BOX 6-4

USE OF RESTRAINTS

- Obtain an order or a consent to apply restraints.
- Selecting a restraint: it should restrict movement as little as possible, be obscure to others, not interfere with the client’s treatment, be readily changeable, and be safe for the age of the client (to keep an active child in bed, use a jacket restraint, as opposed to a wrist restraint).
- Secure restraint: check for adequate blood circulation to extremities.
- Pad bony prominences (wrists and ankles) before applying restraint.
- Always tie limb restraint with a knot (e.g., clove hitch) that will not tighten when pulled.
- Never tie ends of restraint to a side rail or to part of fixed bed frame if the bed position is going to be changed.
- Assess restraint every 30 minutes and document.
- Release all restraints every 2 hours and provide ROM and skin care; stay with client when restraint is removed and document.
- Keep in mind the principle of least restriction: restrain the client to the extent necessary to accomplish the restraint’s purpose.



TEST ALERT: Apply restraints or other safety devices per protocol (e.g., vests).

ANXIETY

- A. Definition.
1. An emotion, a subjective experience.
 2. A feeling state that is experienced as vague uneasiness, tension, or apprehension.
 3. Occurs when the ego is threatened.
 4. Provoked by the unknown; precedes all new experiences.
- B. Data collection (Table 6-2).
- C. Nursing management (Table 6-3).
- D. Specific disorders of anxiety (Table 6-4).



NURSING PRIORITY: Identify a client’s potential for a physical or emotional reaction to a crisis event and use client behavior modification techniques and therapeutic interventions to increase client’s understanding of his or her behavior.

Problems Associated with Anxiety

* **This group of problems has anxiety as the primary disturbance. In the past, these were grouped together as neuroses. Anxiety can be a predominant disturbance (panic and generalized anxiety), or anxiety is experienced as a person attempts to confront a dreaded situation (phobic disorder) or resist the obsessions and compulsions of an obsessive-compulsive disorder. In general, these are**

TABLE 6-2

ASSESSMENT OF ANXIETY

Physiological**Sympathetic Responses**

Tachycardia
Elevated blood pressure
Increased perspiration
Dilated pupils
Hyperventilation with difficulty breathing
Cold, clammy skin
Dry mouth
Constipation

Parasympathetic Responses

Urinary frequency
Diarrhea

Related Responses

Headaches
Nausea or vomiting
Sleep disturbances
Muscular tension

Psychological**Behavioral Responses**

Restlessness
Agitation
Tremors (fine to gross shaking of the body)
Startle reaction
Rapid speech
Lack of coordination
Withdrawal

Cognitive Responses

Impaired attention
Poor concentration
Forgetfulness
Blocking of thought
Decreased perceptual field
Decreased productivity
Confusion

Affective Responses

Tension
Jittery feeling
Worried
Apprehension, nervousness
Irritability
Dread
Fear
Panic
Fear of impending doom

common responses to emotional problems that are very seldom treated in a psychiatric setting, as the person has no great defect in reality testing nor demonstrates severe antisocial behavior. (Table 6-4)

Interpersonal Withdrawal

* *Interpersonal withdrawal* is characterized by avoidance of interpersonal contact and a sense of unreality.

- A. Physical withdrawal: Client sits or stands apart from others; may hide, assume a catatonic posture, or (in extreme form) attempt suicide.
- B. Verbal withdrawal: avoidance through silence or (in extreme form) mutism; silence may indicate resistance, a pensive moment, or the indication that nothing more is to be said.

Nursing Intervention

- A. Avoid punishment of client.
- B. Decrease isolation.
- C. Invite the client to speak.
- D. State the amount of time you are willing to stay with the client whether he or she chooses to speak or not.

- E. Change the context of the contact (for example, go for a walk together).
- F. Encourage the client to share responsibility for the continuance of the relationship.

Regression

* *Regression* is retreating to earlier, childish, or less complex patterns of behavior that once brought the client attention or pleasure.

Nursing Intervention

- A. Avoid fostering dependency and childlike attitudes.
- B. Be patient and understanding.
- C. Confront client directly about his or her plan.
- D. Compliment client when he or she does something unusually well or assumes more responsibility.
- E. Promote problem solving, reality orientation, and involvement in social activities.
- F. Avoid punishment after periods of regression; instead, explore the meaning of the regressive behavior.
- G. Regression is a normal occurrence in young children who are hospitalized.

TABLE 6-3

NURSING MANAGEMENT OF ANXIETY

<u>Level of Anxiety</u>	<u>Assessment</u>	<u>Goal</u>	<u>Nursing Management</u>
Mild	Increased alertness, motivation, and attentiveness.	To assist client to tolerate some anxiety.	<ol style="list-style-type: none"> 1. Help client identify and describe feelings. 2. Help client develop the capacity to tolerate mild anxiety and use it consciously and constructively.
Moderate	Perception narrowed, selective inattention, physical discomforts.	To reduce anxiety; directed toward helping client understand cause of anxiety and new ways of controlling it.	<ol style="list-style-type: none"> 1. Provide outlet for tension, such as walking; crying; working at simple, concrete tasks.
Severe	Behavior becomes automatic; connections between details are not seen; senses are drastically reduced.	To assist in channeling anxiety.	<ol style="list-style-type: none"> 1. Recognize own level of anxiety. 2. Link client's behavior with feelings. 3. Protect defenses and coping mechanisms. 4. Identify and modify anxiety-provoking situations.
Panic	Overwhelmed; inability to function or communicate; potential for bodily harm to self and others; loss of rational thought.	To be supportive and protective.	<ol style="list-style-type: none"> 1. Provide nonstimulating, structured environment. 2. Avoid touching. 3. Stay with client. 4. Medicate client with tranquilizers if necessary.

Anger

* **Anger is the unconscious process used in order to obtain relief from anxiety that is produced by a sense of danger; it involves a sense of powerlessness. Fear of expressing anger is related to fear of rejection.**

Nursing Intervention

- A. Have client acknowledge or name feelings.
- B. Explore source of personal fear or perceived threat (e.g., illness, disability, disfigurement, or emotional crisis).
- C. Encourage verbalization of anxiety.
- D. Explore appropriate external expression of feelings.
- E. Avoid arguing with client.
- F. Acting-out behavior is often an indirect expression of anger; it attracts attention and often represents the feelings the person is experiencing.

✓ **NURSING PRIORITY:** *Nontherapeutic responses to a client's anger are defensiveness, retaliation, condescension, and avoidance.*

Hostility/Aggressiveness

* **Hostility or Aggressiveness is an antagonistic feeling; the client wishes to hurt or humiliate others; the result may be a feeling of inadequacy or self-rejection due to a loss of self-esteem.**

Nursing Intervention

TEST ALERT: *Plan interventions to assist client to control aggressive behavior (e.g., contract, behavior modification, set limits).*

- A. Prevent aggressive contact by early recognition of increased anxiety.
- B. Maintain client contact rather than avoid it.
- C. Encourage verbalization of feelings associated with a threat of frustration (helplessness, inadequacy, anger).
- D. Reduce environmental stimuli.
- E. Avoid reinforcement behavior (e.g., joking, laughing, teasing, and competitive games).
- F. Use distraction, or remove the client from the immediate environment to re-establish self-control.
- G. Set limits on unacceptable behavior.
- H. Protect other clients.

✓ **NURSING PRIORITY:** *When two clients are arguing, engage the dominant client first by using distraction or removing the client from the setting to allow time for de-escalation and processing of the situation.*

Violence

* **Violence is behavior that is a physical assault and risks injury to the self, others, and environment.**

TABLE 6-4

SELECTED ANXIETY DISORDERS

Problem**Panic Disorder**

(with or without agoraphobia): an extreme level of anxiety.

Phobia:

an intense, irrational fear of a specific object, activity, or situation.

Obsessive-Compulsive Disorder:

unconscious control of anxiety by the use of rituals, thoughts, obsessions, or compulsions.

Post-Traumatic Stress Disorder:

involves the development of characteristic symptoms after a traumatic psychological event in which the individual is unable to adapt or adjust (e.g., rape, military combat, airplane crashes, torture, or abuse).

Generalized Anxiety Disorder:

unrealistic or excessive anxiety and worry about life's circumstances; differs from panic disorder in that it never remits and onset is at early age.

Description

Agoraphobia (fear of being in places or situations; crowds, traveling).
May experience shortness of breath, dizziness, diaphoresis, palpitations.

Fear of being alone or in public places.
Claustrophobia (fear of enclosed spaces).
Acrophobia (fear of heights).
Social phobia (fear of circumstances that may be humiliating, e.g., speaking in public, eating in restaurants).

Obsessions: recurrent, persistent ideas, thoughts, or impulses that are not voluntarily produced.

Most common obsessions include thoughts of violence, contamination, and doubt.

Compulsions: repetitive, ritualistic behaviors that are performed in a certain fashion to relieve an unbearable amount of tension.

Most common compulsions include hand washing, counting, checking.

Client re-experiences the traumatic event.
Client withdraws, becomes isolated, and restricts emotional response.
Experiences hyperalertness, insomnia, nightmares, depression, and anxiety.

Physical symptoms associated with disorder are restlessness, apprehension, tension, irritability, "free-floating anxiety."

Nursing Intervention

❖ **Goal: To reduce panic level anxiety feelings by reinterpreting the feelings correctly** (see Table 6-3).

1. Anticipate administration of a tricyclic antidepressant.
2. Reduce amount of caffeine in diet.

❖ **Goal: To reduce phobic behavior.**

1. Do not force client to come in contact with the feared object or source of anxiety.
2. Have client focus on awareness of self.
3. Distract client's attention from phobia.

❖ **Goal: To assist in coping with the compulsive behavior.**

1. Accept rituals and avoid punishment or criticism; do not interrupt ritual, because this will increase anxiety.
2. Plan for extra time because of slowness and client's need for perfection.
3. Prevent physical deterioration or harm, and set limits only to prevent harmful acts (such as hand washing excessively that removes the skin from the hand surface).

❖ **Goal: To encourage client to develop different ways of handling anxiety.**

1. Reduce demands on the individual.
2. Convey acceptance of client, regardless of behavior.
3. Encourage alternative activity.

❖ **Goal: To determine precipitating stress factor in client's reaction.**

1. Reduce and prevent chronic disability.
2. Encourage verbalization of the traumatic event.

❖ **Goal: To maintain personal integrity.**

1. Provide physical, social, or occupational rehabilitation.
2. Somatic therapies are used to decrease anxiety (e.g., anti-anxiety agents, etc.).

❖ **Goal: To reduce level of anxiety.**

1. Administer anti-anxiety agent.
2. Teach anxiety-reducing techniques.
3. Reduce pressure and anxiety-provoking situations around client.
4. Divert attention from symptoms.

Nursing Intervention

✓ **NURSING PRIORITY:** Immediate intervention should focus on control and safety, followed by discussion to alleviate guilt and identify alternative behaviors to help prevent future episodes of violence.

- A. Establish eye contact.
 1. Conveys attention and concern.
 2. Elicits more information.
 3. Asks the person to look at you.

✓ OLDER ADULT PRIORITY: *Expect some older adult clients to have vision problems; they may not know who you are. Hearing problems occur with the older adult; don't shout or talk rapidly.*

- B. Avoid asking, "Why?" Instead ask, "What's bothering you?"
 1. *Why* questions are threatening and decrease self-esteem.
 2. Open-ended questions identify the problem, convey concern, and elicit more information.
- C. Speak to client softly, slowly, and with assurance.
- D. Give directions clearly and concisely. Tell the patient what you want him or her to do.
- E. Encourage client to verbalize feelings.
 1. Give the client an outlet for the physical tension, "Walk with me. Tell me what happened."
 2. Keep the conversation slow. Pace yourself. "Wait, I can't follow that. Tell me what you said."
 3. Listen more than talk.
 4. Let the person walk, move, or pound something to release the tension before you talk.
- F. Position yourself near the door.
 1. Don't block the door.
 2. Don't box the client into a corner.
- G. Self-protection and protection of other clients are primary concerns.
 1. Never see a potentially violent client alone; call security or other personnel.
 2. Keep a comfortable distance from client; don't intrude on his or her personal space.
 - a. With a client experiencing mild or moderate anxiety: sit near, about 2 feet away.
 - b. With a client experiencing severe anxiety or panic: stay 4 to 6 feet back (or farther).
 3. Be prepared to move quickly; violent clients act quickly and unpredictably.
 4. Determine that the client has no weapons before approaching him or her.
 5. Be supportive and intervene to increase client's self-esteem.
 6. Be honest; tell the client you are concerned that he or she is out of control, but you are not going to let anyone get hurt.
 7. Stay with the client, but don't touch him or her until you've asked permission and it has been given to you.
- H. When client is in control, review and process the situation in order to alleviate client's guilt and to discuss alternatives should client become anxious or angry in the future.

Manipulation/Acting Out

* **Manipulation/Acting Out** is a type of controlling behavior in which an individual uses others to meet

his or her own needs or to achieve specific goals; often disguises underlying feelings of inadequacy, inferiority, and unworthiness; an attempt to protect against failure or frustration and to gain power over another.

Nursing Intervention

- A. Be consistent and firm in the expectations of behavior.
- B. Allow some freedom within set limits.
- C. Consistently enforce previously set limits.
- D. Be alert to client's attempt to intimidate; allow verbal anger.
- E. Avoid involvement and intellectualization.
- F. Watch carefully for client's use of manipulative patterns; be alert to the many guises in which it may be manifested.
- G. Keep staff united, firm, and consistent.
- H. Encourage open communication about real needs and feelings.
- I. Maintain a sense of authority.
- J. Do not accept gifts, favors, flattery, or other forms of manipulation.

Dependence

* **Dependence** is a behavior pattern characterized by adopting a helpless, powerless stance; a reliance on other people to meet a basic need.

Nursing Intervention

- A. Assess client's abilities and capacities.
- B. Set firm and consistent limits on behavior.
- C. Provide only help needed.
- D. Encourage problem-solving and decision-making skills; emphasize accountability.
- E. Avoid making decisions for client or assuming responsibility for client's ability to make decisions.
- F. Maintain an attitude of firmness and confidence in client's ability to make decisions.
- G. Discourage reliance beyond actual needs.
- H. Give positive reinforcements for development of independent, growth-facilitating behavior.
- I. Encourage successful participation in social relationships.

Shame

* **Shame** is the inner sense of being completely diminished or insufficient as a person (e.g., feeling "less than").

Nursing Intervention

- A. Assist client to begin to externalize rather than internalize feelings of shame.
- B. Encourage client to share feelings honestly with individuals he or she feels "safe" with.
- C. Involve client in "debriefing," which is writing and talking about past shame experiences.

- D. Encourage client to make positive self-affirmations and involve himself or herself in creative visualization activities to improve self-concept.

Detachment

* **Detachment is characterized by aloofness, superficiality, denial, and intellectualization in interpersonal contact.**

Nursing Intervention

- A. Establish awareness of the process of detachment.
- B. Explore fears and fantasies inhibiting emotional expression.
- C. Encourage verbalization from global generalities to specific personal comments.
- D. Provide clarification of client's unclear responses.
- E. Emphasize awareness and exploration of feelings.

ABUSE

* **Abuse is difficult to define, because the term has been politicized and is not clinical or scientific.**



TEST ALERT: Report client abuse to authorities and protect client from injury.

Types of Abuse

- A. **Physical abuse:** nonaccidental, intentional injury inflicted on another person.
- B. **Physical neglect:** willing deprivation of essential care needed to sustain basic human needs and to promote growth and development.
- C. **Emotional abuse:** use of threats, verbal insults, or other acts of degradation that are intended to be injurious or damaging to another's self-esteem.
- D. **Emotional neglect:** absence of a warm, interpersonal atmosphere that is necessary for psychosocial growth, development, and the promotion of positive feelings of self-worth and self-esteem.
- E. **Sexual abuse:** lack of comprehension and consent on the part of the individual involved in sexual activities that are either exploitative or physically intimate in nature (e.g., fondling, oral or genital contact, masturbation, unclothing, etc).
- F. **Incest:** sexual activity performed between members of a family group.

Intrafamily Abuse and Violence

* **Patterns of dysfunctional, violent families can frequently be traced back for several generations. Adult behavior and role models for parenting are influenced by the childhood experiences within the family system.**



TEST ALERT: Assess dynamics of family interactions; identify risk factors; plan interventions to assist client and family to cope.

- A. The incorporation of violence within the family teaches the children that the use of violence is appropriate. When the children grow up and form their own families, they tend to recreate the same parent-child, husband-wife relationships experienced in their original family.
- B. Frequently, the abuser has inappropriate expectations of family members; the abuser may expect perfection and may be obsessed with discipline and control.
- C. Family members are confused regarding their roles in the family; parents may be unable to assume adult roles in the family. Adult family members who feel inadequate in their roles may use violence in an attempt to prove themselves and to maintain superiority.
- D. Family is usually isolated, both physically and emotionally. The family tends to have few friends and is frequently isolated from the extended family. Family members are ashamed of what is occurring and tend to withdraw from social contacts in fear that the family activities might become known to others.

Characteristics of Abuse: The Perpetrator

- A. The person who abuses or the perpetrator.
 1. Perpetrator has an inability to control impulses; explosive temper; low tolerance for frustration.
 2. Possesses greater physical strength than the victim.
 3. Low self-esteem.
 4. Tends to project shortcomings and inadequacies onto others.
 5. Emotional immaturity; decreased capacity to delay satisfaction.
 6. Suspicious of everyone; fear of being exposed; tends to isolate self from family.
 7. High incidence of drug and alcohol abuse.
 8. Often has experienced abuse as a child; has a greater tendency to demonstrate violence in his or her adult relationships.
- B. Common similarities between person who abuses and victim.
 1. Poor self-concept and feelings of insecurity.
 2. Feelings of helplessness, powerlessness, and dependence.
 3. Difficulty in handling or inability to handle anger.

Child Abuse

- A. Physical child abuse.
 1. Symptoms.
 - a. Bruises and welts from being beaten with a belt, strap, stick, or coat hanger or from being slapped repeatedly in the face.
 - b. Rope burns from being tied up or beaten with a rope.
 - c. Human bite marks.
 - d. Burns.
 - (1) Burns on the buttocks from being immersed in hot water.

- (2) Pattern of burns: round, small burns from cigarettes; patterns that suggest an object was used.
- (3) Burns are frequently on the buttocks, in genital area, or on the soles of the feet.
- e. Evidence of various fractures in different stages of healing.
- f. Internal injuries from being hit repeatedly in the abdomen.
- g. Head injuries: skull, facial fractures.
2. Behavior symptoms.
 - a. Withdrawal from physical contact with adults.
 - b. Inappropriate response to pain or injury; failure to cry or seek comfort from parents.
 - c. Infant may stiffen when held; child may stiffen when approached by adult or parent.
 - d. Very little eye contact with adults.
 - e. Child may try to protect abusing parent for fear of punishment if abuse is discovered.
3. Parents or caretakers.
 - a. Conflicting stories regarding accident or injury.
 - b. Explanation of accident is inconsistent with injuries sustained (fractured skull and broken leg from falling out of bed).
 - c. Initial complaint is not associated with child's injury (child is brought to the emergency room with complaints of the "flu," and there is evidence of a skull fracture).
 - d. Exaggerated concern or lack of concern related to level of child's injury.
 - e. Refusal to allow further tests or additional medical care.
 - f. Lack of nurturing response to injured or ill child; no cuddling, touching, or comforting child in distress.
 - g. Repeated visits to various medical emergency facilities.
 - h. Do not have realistic expectations of the child; do not understand stages of growth and development (severely spanking or beating a 1-year-old for lack of response to toilet training).

Nursing Intervention

- ❖ **Goal:** To establish a safe environment.
- A. It is important for the nurse to be knowledgeable of the legal responsibilities in regard to state practice acts and child abuse laws.
- B. All 50 states have a designated agency that is available on a 24-hour basis for reporting child abuse.
- C. All states have mechanism for removing the child from the immediate abusive environment.

Older Adult Abuse

- A. Types of older adult abuse (Box 6-5).
- B. Typical victim.

BOX 6-5

OLDER ADULT CARE FOCUS

Older Adult Abuse

Types of Older Adult Abuse

- Physical: willful infliction of injury.
- Neglect: withholding goods or services (such as food or attention) to the detriment of the elder's physical or mental health.
- Psychological: withholding affection or imposing social isolation.
- Exploitation: dishonest or inappropriate use of the older person's property, money, or other resources.

Neglect Indicators

- Poor hygiene, nutrition, and skin integrity.
- Contractures.
- Urine burns/excoriation.
- Pressure ulcers.
- Dehydration.

1. Woman of advanced age with few social contacts.
2. At least one physical or mental impairment, limiting the person's ability to perform activities of daily living.
- C. Assessment of older adult abuse.
 1. Symptoms: contusions, abrasions, sprains, burns, bruising, human bite marks, sexual molestation, untreated or previously treated conditions, erratic hair loss from hair pulling, fractures, dislocations, head and face injuries (especially orbital fractures, black eyes, and broken teeth).
 2. Behavior: clinging to the abuser, extreme guardedness in the presence of the abuser, wariness of strangers, expression of ambivalence toward family/caregivers, denial of abuse for fear of retaliation, depression, social or physical isolation.

Nursing Intervention

- ❖ **Goal:** To assess for older adult abuse.
- A. Use a private setting for interviewing victim and perpetrator.
- B. The interview must be unbiased, accurate, and appropriately documented.
- C. Avoid signs of disapproval that might evoke shame or anger in the older client; be nonjudgmental.
- ❖ **Goal:** To establish a safe environment.
- A. It is important for the nurse to be knowledgeable of the legal responsibilities in regard to state practice acts and reporting of abuse (see Box 6-6).
- B. Client and family teaching in the areas of nutrition, general physical care, etc.



Rape

- A. Legal definition of rape (varies from state to state): forced, violent, sexual attack on an individual without his or her consent. Includes sex acts other than forced intercourse as rape; some states do not recognize rape by the husband.
- B. Sexual assault is not a means of sexual gratification; it is a violent physical and emotional attack. Men attack women in an attempt to demonstrate their power and dominance; attempt to control, terrify, and degrade the woman.
- C. Victims: in all age ranges; highest risk age group is 12 to 20 years old.
- D. Majority of rapes are not sudden and impulsive, but they are well-planned.
- E. Most women know the rapist; most rape assaults occur between people of the same race.
- F. Rape-trauma syndrome – variant of posttraumatic stress disorder; has two phases, an acute phase and a long-term reorganization phase.

Data Collection

- A. Women may experience a wide range of emotional responses: rape trauma syndrome symptoms include sleep disturbances, nightmares, loss of appetite, fears, anxiety, phobias, suspicion, disruption in relationships with partner, family, and friends, along with low self-esteem, feelings of worthlessness, self-blame, guilt, and shame.
- B. Complete physical assessment: it is important for as much evidence as possible to be obtained.
- C. If possible, advise the woman to not “clean up”; the physical evidence may be destroyed. She should go immediately to the emergency department.

Nursing Intervention

- ❖ **Goal:** To assist the client through the acute phase after the rape experience.
 - A. Encourage the client to verbalize her feelings regarding the attack.
 - B. Assist her to set priorities and determine immediate needs.
 - C. Warm, respectful, accepting response from the nurse; protect the client from becoming overwhelmed and distressed from the initial physical examination and questioning.
 - D. Discuss need for follow-up care and physical examination regarding possible pregnancy and sexually transmitted disease.
 - E. Provide information regarding physical and emotional responses to rape.
 - F. Provide referral information and plan for follow-up contact within the next week.

BOX 6-6

DOCUMENTATION FOR SUSPECTED ABUSE

Procedure

1. Obtain the client’s or parent’s permission before photographing the victim.
2. Do not make assumptions about the identity of the perpetrator.
3. Chart the exact words used by the client/child to describe the abuser.
4. Record information very objectively; do not record your feelings, assumptions, or opinions of the incident or how it occurred.

History

1. Specify the time, date, and location as described by the client.
2. Report the sequence of events before the abuse/attack.
3. Identify and explain the period of time between the abuse/attack and initiation of medical attention.
4. List other people/children in the immediate vicinity of the abuse/attack.
5. Include quotations from the client.
6. Use objective, specific documentation when recording observations of the client and the person who brought the client to the emergency room.
7. Observe and record the interaction of the child and the parents.

Physical Examination

1. Be very specific in describing the location, size, and shape of bruises and lacerations. If possible, photograph the client to demonstrate the extent of the injuries.
2. If possible, describe the location and extent of injuries on an anatomical diagram.
3. Identify presence of other injuries.
4. Describe the victim’s reaction to pain, level of pain, and location of pain.

- ❖ **Goal:** To assist the client to work through the emotional phases that commonly occur after the initial trauma.

- A. Encourage mental health counseling during the first few days after the assault.
- B. Assist the client to understand and recognize the period of long-term reorganization that frequently follows a sexual attack.
 1. Victim may experience sexual problems.
 2. May experience a strong urge to discuss the incident and feelings related to the attack.
 3. During the reorganization phase, client should have professional counseling to assist her to positively cope with the situation.

CHILD-RELATED DISORDERS

Cognitive Impairment (Mental Retardation)

- * **Cognitive impairment, formerly referred to as mental retardation, is associated with developmental disabilities, intellectual deficits, and lack of adaptive behaviors.**

Assessment

- A. Characteristics.
 1. Irritability, temper tantrums, stereotyped movements.
 2. Multiple neurological abnormalities: dysfunction in vision or hearing or seizure activity.
- B. Down Syndrome - is a common chromosomal abnormality characterized by an extra chromosome 21 (trisomy 21); incidence increases with maternal age.
 1. Head: small in size; face has flat profile, sparse hair.
 2. Eyes: inner epicanthal folds; short and sparse eye lashes.
 3. Nose: small and depressed nasal bridge (saddle nose).
 4. Ears: small and sometimes low-set.
 5. Mouth: protruding tongue; high arched palate.
 6. Neck: short and broad; abdomen: protruding.
 7. Genitalia: small penis, cryptorchidism.
 8. Hands: short, stubby fingers; simian crease (transverse palmar crease).
 9. Muscles: hypotonic.
 10. IQ below 70, slow development.

Nursing Intervention

❖ **Goal:** To promote optimal development within a family and community setting.

- A. Involve child and parents in early stimulation program.
- B. Promote self-care skills.
- C. Help parents identify realistic goals for child.
- D. Encourage parents to enroll child in special day care programs and education classes.
- E. Emphasize to parents that child has same needs of play, discipline, and social interaction as all children.

❖ **Goal:** To promote independence by setting realistic goals.

- A. Teach basic skills in simple terms, with steps outlined.
- B. Use behavior modification as a method for behavior control.
- C. Use the principles of *repetition*, *reinforcement*, and *routine* when providing information for understanding and learning.

❖ **Goal:** To monitor for complications associated with Down syndrome.

- A. Prevent respiratory tract infections by teaching parents about postural drainage and percussion.
- B. Encourage use of cool mist vaporizer.
- C. Stress importance of changing infant's position frequently.
- D. Explain to parents about feeding difficulties; encourage small, frequent feedings; feed solid food by pushing food back inside of mouth; provide foods that will form bulk to prevent constipation.

❖ **Goal:** To prevent Down syndrome.

- A. Encourage pregnant women at risk (older than 35 years, family history of Down syndrome, or previous birth of a child with Down syndrome) to consider

amniocentesis before the sixteenth week to rule out Down syndrome.

- B. Encourage genetic counseling for couples with a family history of Down's syndrome.



Eating Disorders

* This group of disorders is characterized by gross disturbances in eating behavior; it includes anorexia nervosa and bulimia nervosa.

Assessment

- A. Anorexia nervosa.
 1. Intense fear of becoming obese.
 2. Need for control and perfectionism.
 3. Disturbance of body image.
 4. Occurs more often in females than males
 5. Weight loss of at least 15% of original body weight.
 6. No known physical illness.
- B. Bulimia nervosa.
 1. Recurrent episodes of binge eating.
 2. Awareness that eating pattern is abnormal.
 3. Secretive binge eating and purging behaviors (diuretics, laxatives, excessive exercise).
 - a. Russell's sign - bruises or calluses on the thumb or hand caused by trauma from self-induced vomiting.
 - b. Erosion of tooth enamel, pharyngitis from vomiting.
 4. Fear of not being able to stop eating voluntarily.
 5. Depressed mood and self-induced vomiting after the eating binges.

Nursing Intervention

❖ **Goal:** To exhibit no signs or symptoms of malnutrition.

- A. If client is unable or unwilling to maintain adequate oral intake, a liquid diet may be administered through a nasogastric tube.
- B. Explain to client details of behavior modification program.
- C. Sit with client during mealtimes for support and to observe amount ingested. A limit (usually 30 minutes) should be imposed on time allotted for meals.
- D. Accompany client to bathroom, if self-induced vomiting is suspected.
- E. Carefully document intake and output.
- F. Do not discuss food or eating with client, once protocol has been established. Do, however, offer support and positive reinforcement for obvious improvements in eating behaviors.
- G. Offer support and use nonjudgmental approach with the client.
- H. Administer antidepressants as ordered.

❖ **Goal:** To increase self-esteem.

- A. Assist client to reexamine negative perceptions of self and to recognize positive attributes.

- B. Offer positive reinforcement for independently made decisions influencing client's life.
- ❖ **Goal:** To identify an eating disorder and rule out a physiological cause.
 - ❖ **Goal:** To recognize complications.
- A. Anorexia nervosa – refeeding syndrome can result if system is replenished too quickly leading to cardiovascular collapse.
- B. Bulimia nervosa – if syrup of Ipecac is used to induce vomiting and vomiting does not occur, the absorption of the Ipecac can lead to cardiotoxicity and heart failure. Watch for edema and check breath sounds.



Psychiatric Considerations of Older Adults

- * **Delirium is a syndrome that usually develops over a short period of time. The constellation of symptoms typically fluctuates and is often reversible and temporary.**
- * **Dementia is a syndrome characterized by loss of intellectual abilities to such an extent that social and occupational functioning are negatively affected; involves memory, judgment, abstract thought, and changes in personality. Often, the disorders are progressive and follow an irreversible course in which the damage remains permanent (Box 6-7).**

Data Collection

- A. Causes of dementia.
1. Alzheimer's disease.
 2. Stroke.
 3. Parkinson's disease.
 4. Injury.
 5. Medication therapy.

BOX 6-7

KEY POINTS: ORGANIC MENTAL SYNDROMES

- Clients have varying degrees of awareness of the changes that are occurring, which is emotionally painful to them.
- Often, depression is mistaken for the early onset of dementia.
- Dementia disrupts the elderly couple's final stage of family development (generativity, retirement, etc.).
- Dementia interferes with family intergenerational development where adult offspring are unable to rectify past injustices, conflicts, and disappointments with parents.
- Caregiver coping is highly stressful and can be handled with a more positive approach when there is a focus on problem solving and education.
- Clients with Alzheimer's disease (AD) have loss of memory, intellectual functioning, orientation, affective regulation, motor coordination, and personality, with eventual loss of bowel and bladder control to the point of total incapacitation.

- B. Alzheimer's disease.
1. More commonly seen in older adult clients.
 2. Irreversible.
 3. Helpful mnemonic to remember symptoms: JAMCO
 - J:** Judgment
 - A:** Affect
 - M:** Memory
 - C:** Confusion
 - O:** Orientation
 4. Stages of Alzheimer's disease (Table 6-5).
 5. Special concerns.
 - a. Recent memory loss. Client can recall events and activities from 10 years ago, but not 10 minutes ago.
 - b. Sundown syndrome (sundowning): confused, disoriented behavior that becomes noticeable after the sun goes down and during the night.
 - c. Wandering behavior.
 - (1) Restlessness and activity-seeking behavior.
 - (2) The "stalking of old haunts."
 - (3) Disorientation and inability to sustain intentions; the person forgets what she or he set out to do.
 - d. Catastrophic reactions: heightened anxiety occurring during interviewing or questioning when a person cannot answer or perform.
 - e. Combative behavior.
 - f. Delusions and hallucinations.

Nursing Interventions

- ❖ **Goal:** To maintain adequate nutrition.
 - A. Reduce distractions while eating, such as television.
 - B. Encourage snacks.
 - C. Monitor weight monthly.
 - D. Encourage family to bring in client's favorite foods.
- ❖ **Goal:** To provide a quiet, structured environment in order to increase consistency and promote feelings of security.
 - A. Avoid dependency.
 - B. Establish routine for activities of daily living.
 - C. Meet client's physical needs.
 - D. Do not isolate client from others in the unit.
 - E. Provide handrails, walkers, and wheelchairs.
 - F. Do not change schedules suddenly: *routine*, *reinforcement*, and *repetition* are the key aspects of care.
 - G. Check for hazards in the environment (rugs on floor); make sure environment is well-lighted; do not move client suddenly into darkness.
 - H. Provide quiet, nonstimulating environment to decrease hallucinations; avoid furniture and bedding with bright colors and bold patterns.
- ❖ **Goal:** To promote contact with reality.
 - A. Make brief and frequent contact.
 - B. Give feedback and praise whenever possible.
 - C. Supply stimulation to motivate client to engage in activities.

- D. Use concrete ideas in communication.
- E. Maintain reality orientation by encouraging reminiscing.
- F. Frequently orient client to reality and surroundings. Allow client to have familiar objects around self. Use other items, such as clock, calendar, and daily schedules, to assist in maintaining reality orientation.
- G. Use simple explanations and face-to-face interaction when communicating with client. Do not shout message into client's ear.
- H. Allow sufficient time for client to complete projects.
- I. Reinforce reality-oriented comments and continually orient clients to person, time, place, and date.
- J. Use memory joggers: frequent notes, messages on calendars to decrease forgetful incidents.
 - ❖ **Goal:** To manage and minimize wandering behavior.
 - A. A protective environment is needed for the wanderers as well as room to move about.
 - B. Bed rails should be avoided (place mattress on floor if necessary).
 - C. Limit cash in wallet to a few dollars and coins to minimize danger of financial loss.
 - D. Have client wear a MedicAlert bracelet or necklace that cannot be removed (name, address, telephone number on bracelet or necklace).
 - E. Place name, address, and phone number on items of

TABLE 6-5

STAGES OF ALZHEIMER'S DISEASE

<u>Stage</u>	<u>Hallmarks</u>
Stage 1 (Mild) <i>Forgetfulness</i>	Shows short-term memory losses; loses things, forgets Memory aids compensate: lists, routine, organization Depression common – worsens symptoms Not diagnosable at this time
Stage 2 (Moderate) <i>Confusion</i>	Shows progressive memory loss; short-term memory is impaired; memory difficulties interfere with all abilities Withdrawn from social activities Shows declines in instrumental activities of daily living (IADLs), such as money management, legal affairs, transportation, cooking, housekeeping Denial common; fears “losing his or her mind” Depression increasing common; frightened because aware of deficits; covers up for memory loss through confabulation Problems intensified when stressed, fatigued, out of own environment, ill Commonly needs day care or in-home assistance
Stage 3 (Moderate to Severe) <i>Ambulatory dementia</i>	Shows ADL losses (in order) willingness and ability to bathe, grooming, choosing clothing, dressing, gait and mobility, toileting, communication, reading, and writing skills Shows loss of reasoning ability, safety planning, and verbal communication Frustration common; becomes more withdrawn and self-absorbed Depression resolves as awareness of losses diminishes Has difficulty communicating; shows increasing loss of language skills Shows evidence of reduced stress threshold; institutional care usually needed
Stage 4 (Late) <i>End stage</i>	Family recognition disappears; does not recognize self in mirror Nonambulatory; shows little purposeful activity; often mute; may scream spontaneously Forgets how to eat, swallow, chew; commonly loses weight; emaciation common Has problems associated with immobility (e.g., pneumonia, pressure ulcers, contractures) Incontinence common; seizures may develop Most certainly institutionalized at this point Return of primitive (infantile) reflexes

From Hall, G.R. (1994). Caring for people with Alzheimer's disease using the conceptual model of progressively lowered stress threshold in the clinical setting. *Nursing Clinics of North America*, 29(1), 129-141, as cited in Varcarolis EM, Carson VB, Shoemaker NC: *Foundations of psychiatric mental health nursing*, page 435.

clothing; attach this information to clothes so that client cannot remove it.

- F. Install complex door locks opened by actions demanding thought rather than sheer strength.
 - G. Implement a buddy system in an institution.
 - H. Spend extra time with newly admitted clients; provide frequent reassurance, and attend to orientation carefully.
- ❖ **Goal:** To promote self-esteem.
- A. Client should wear own clothing; no night clothes during daytime hours.
 - B. Makeup should be available for women.
 - C. Client should carry purse or wallet; client should have a monthly allowance or a few coins to carry.
 - D. Use praise whenever possible.
 - E. Use affection.
 - F. Let client make choices whenever possible, but offer only two.
- ❖ **Goal:** To provide diversion activities that enhance self-esteem.
- A. Provide occupational therapy, physical therapy, and recreational therapy that client enjoys.
 - B. Maintain a flexible schedule and keep client from becoming bored and easily distracted.
 - C. Recognize specific accomplishments.
 - D. Encourage family involvement and provide emotional support.
 - E. Devise methods for assisting client with memory deficit. Examples:
 1. Sign and client picture on door identifying client's room.
 2. Identifying sign on outside of dining room door.
 3. Large clock, with oversized numbers and hands, appropriately placed.
 4. Large calendar, indicating one day at a time, with month, day, and year identified in bold print.
- ❖ **Goal:** To administer medication to slow the dementia disease process (Appendix 6-5).

✓ **OLDER ADULT NURSING PRIORITY:** *The 3 Ps for clients with dementia: protecting dignity, preserving functioning, and promoting quality of life.*

Psychophysiological Disorder

* A psychophysiological disorder is a physical illness that is strongly influenced by psychological factors. It was previously called psychosomatic disorder. It is thought that stress and anxiety arouse specific conflicts in an individual, which result in damaging effects on particular organs or organ systems that are under the control of the autonomic nervous system.

Data Collection

- A. Respiratory: hyperventilation syndrome, bronchial asthma.
- B. Cardiovascular: essential hypertension, angina, migraine headaches, tachycardia.
- C. Gastrointestinal: peptic ulcer disease, ulcerative colitis, colic.
- D. Integumentary: dermatitis, pruritus, excessive sweating, atopic dermatitis.
- E. Musculoskeletal: cramps, rheumatoid arthritis.
- F. Endocrine: diabetes mellitus, sexual dysfunctions, hyperemesis gravidarum, hyperthyroidism.
- G. Genital/urinary: amenorrhea, impotence, secondary outbreaks of herpes genitalis type II (HVH II).

Nursing Interventions

Pathophysiology and nursing interventions of the above disorders are discussed in the chapters under the appropriate body system affected.



Personality Disorders

* Personality disorders create disruptive lifestyles and are characterized by inflexible and maladapted behaviors. Those with personality disorders clash with society and with cultural norms and are often placed in correctional systems, mental hospitals, and child placement facilities.

Data Collection

- A. Problems are expressed through behavior rather than as physical symptoms of stress.
- B. Disruptive lifestyle is deeply ingrained and quite difficult to change; usually related to some form of abnormal behavior or the development of a particular pattern or trait.
- C. Often comes in conflict with others.
- D. Unable to develop meaningful relationships with others and communicate effectively.
- F. Rarely acknowledges that there is a problem.
- G. Types: paranoid, schizoid, schizotypic, antisocial, borderline, narcissistic, avoidance, dependent, and passive-aggressive.

Nursing Intervention

- ❖ **Goal:** To promote communication and socialization in the paranoid personality.
 - A. Decrease social isolation.
 - B. Verbal and nonverbal messages should be clear and consistent.
 - C. To decrease anxiety, plan several brief contacts, rather than one prolonged contact.
 - D. Promote trust by following through on commitments.
 - E. Be open and honest to avoid misinterpretation.
- ❖ **Goal:** To convey to the schizoid or schizotypal client the idea that you do not perceive reality the same way as he or she does but are willing to listen, learn, and offer feedback about his or her experiences.
- ❖ **Goal:** To promote a positive, therapeutic, interpersonal relationship.

- A. Set realistic expectations.
 - B. Provide a model of mature behavior.
 - C. Use problem-solving techniques to encourage a client to make changes.
 - D. Anticipate and deal with depression in a client who gradually acquires enough insight to realize and accept responsibility for his or her behavior.
 - E. Common sources of frustration for nurses.
 1. Client's immature behavior.
 2. Poor communication skills.
- ❖ **Goal:** To minimize manipulation and "acting out" behaviors and encourage verbal communication.
- A. Set firm, consistent limits without being punitive.
 - B. Be aware of how client may manipulate other staff members (e.g., playing one against the other or splitting).
 - C. Promote expression of feelings versus acting out.
 - D. Promote client's acceptance of responsibility for his or her own actions and a social responsibility to others.
- ❖ **Goal:** To assist client to manage anxiety.
- A. Anticipate client's needs before he or she demands attention.
 - B. Teach client to express his or her ideas and feelings assertively.
- ❖ **Goal:** To set realistic limits.
- A. Support the client who is gradually making more decisions on his or her own.
 - B. Offer assistance only when needed.



Alcohol Dependence (Alcoholism)

* **Alcoholism is a chronic pattern of pathological alcohol use is characterized by impairment in social or occupational functioning, along with tolerance or withdrawal symptoms.**

Data Collection

- A. Risk factors.
 1. History of alcoholism in family.
 2. History of total abstinence.
 3. Broken or disrupted home.
 4. Last or near-last child in a large family.
 5. Heavy smoking.
 6. Cultural groups: Irish, Eskimo, Scandinavian, Native American.
- B. General personality characteristics of alcoholics.
 1. Dependent behavior along with resentment of authority.
 2. Demanding and domineering with a low tolerance for frustration.
 3. Dissatisfied with life; tendency toward self-destructive acts, including suicide.
 4. Low self-esteem and poor self-concept.
- C. Signs and symptoms of possible alcohol abuse.
 1. Sprains, bruises, and injuries of questionable origin.
 2. Diarrhea and early morning vomiting.
 3. Chronic cough, palpitations, and infections.
 4. Frequent Monday morning illnesses; blackouts (inability to recall events or actions while intoxicated).
- D. Alcohol withdrawal syndrome. Consuming one fifth of whiskey daily for 1 month is generally considered sufficient to produce alcohol withdrawal. The withdrawal syndrome develops in heavy drinkers who have increased, decreased, or interrupted the intake of alcohol.
 1. Alcohol withdrawal.
 - a. Anorexia, irritability, nausea, and tremulousness.
 - b. Insomnia, nightmares, irritability, hyperalertness.
 - c. Tachycardia, increased blood pressure, and diaphoresis.
 - d. Onset within 8 hours after cessation of drinking (usually 48 to 72 hours); clears up within 5 to 7 days.
 2. Delirium tremens.
 - a. Autonomic hyperactivity: tachycardia, sweating, increased blood pressure.
 - b. Vivid hallucinations, delusions, confusion.
 - c. Coarse, irregular tremor is almost always seen; fever may occur.
 - d. Onset within 24 to 72 hours after the last ingestion of alcohol; delirium tremens usually lasts 2 to 3 days.
 - e. Convulsions/seizures may occur ("rum fits").
 - f. First episode occurs after 5 to 15 years of heavy drinking.
 3. Alcohol hallucinosis.
 - a. Auditory hallucinations.
 - b. Occurs within 48 hours after heavy drinking episode.
 - c. Often includes persecutory delusions.
 - d. Client may be suicidal or homicidal.
 - e. Spontaneous recovery within 1 week.
 - f. Wernicke's encephalopathy.
 - (1) an acute, *reversible* neurological disorder.
 - (2) triad of symptoms: global confusion, ataxia, and eye movement abnormality (nystagmus).
 - (3) occurs primarily in clients with chronic alcoholism; may develop in illnesses that interfere with thiamine (vitamin B1) absorption (e.g., gastric cancer, malabsorption syndrome, regional enteritis).
 - (4) treatment: high doses of thiamine; 100 mg, given intramuscularly, usually reverses eye signs within 2 to 3 hours of treatment.
- E. Korsakoff's syndrome (alcohol amnesiac disorder).
 1. A chronic, *irreversible* disorder, often following Wernicke's encephalopathy.
 2. Triad of symptoms: memory loss, learning deficit, confabulation (filling in of memory gaps with plausible stories).

- G. Other disorders associated with chronic alcoholism: pneumonitis, esophageal varices, cirrhosis, pancreatitis, diabetes (These are discussed in chapters 8, 10, 14 under the appropriate system).

Nursing Intervention

❖ **Goal:** To assess for alcoholism in a client through careful questioning.

- A. Identify the alcoholic client in the preoperative period.
1. Often, alcoholics are undiagnosed at the time of surgery and may go into withdrawal or delirium tremens after the NPO (nothing by mouth) period.
 2. Client usually takes longer to be fully responsive during postoperative period; client is susceptible to severe respiratory complications; client has more difficulty with healing because of poor nutritional state.

❖ **Goal:** To assist in the medical treatment of alcohol withdrawal.

- A. Benzodiazepines for agitation (see Appendix 6-1).
- B. Thiamine (vitamin B1) to prevent Wernicke's encephalopathy.
- C. Magnesium sulfate to increase effectiveness of vitamin B1. It helps reduce postwithdrawal seizures.
- D. Anticonvulsant (Phenobarbital) if necessary for seizure control.
- E. Encourage use of multivitamins, especially folic acid, B12, and vitamin C.
- F. Alpha-adrenergic blockers (clonidine) to decrease withdrawal symptoms.
- G. Beta-adrenergic blockers (atenolol, propranolol) to improve vital signs and decrease cravings.
- H. Encourage intake of fluids, but do not force.

❖ **Goal:** To provide for the basic needs of rest, comfort, safety, and nutrition.

- A. Safety measures, such as bed rest and use of bed rails, may be necessary.
- B. *If client is experiencing delirium tremens, stay with client and notify appropriate person.*
- C. Have room adequately lit to help reduce confusion and avoid shadows and unclear objects.
- D. Monitor vital signs every 1 to 4 hours.
- E. Encourage a high-carbohydrate, soft diet.

❖ **Goal:** To recognize complications of alcohol use.

- A. Obstetrical implications.
 1. Use of alcohol during pregnancy may lead to fetal alcohol syndrome.
 2. Alcohol withdrawal syndrome may occur in the intrapartum period as early as 12 to 48 hours after the last drink.
 3. Delirium tremens may occur in the postpartum period.
- B. Neonatal implications (fetal alcohol syndrome).
 1. Teratogenic effects may be seen along with growth and developmental retardation.
 2. Increased risk for anomalies of the heart, head, face, and extremities.

3. Withdrawal symptoms can occur shortly after birth and are characterized by tremors, agitation, sweating, and seizure activity.

4. *Maintain seizure precautions and report any seizure activity.*

- C. Medical complications of alcohol abuse.
1. Trauma-related to falls, burns, hematomas.
 2. Liver disease: cirrhosis, esophageal varices, hepatic coma.
 3. Gastrointestinal disease: gastritis, bleeding ulcers, pancreatitis.
 4. Nutritional disease: malnutrition, anemia caused by iron or vitamin B12 deficiency, thiamine deficiency.
 5. Infections, especially pneumonia.
 6. Neurological disease: polyneuropathy and dementia.

❖ **Goal:** To assist in the long-term rehabilitation of client.

- A. Avoid sympathy, because clients tend to rationalize and use dependent, manipulative behavior to seek privileges.
- B. Maintain a nonjudgmental attitude.
- C. Set behavior limits in a firm but kind manner.
- D. Place responsibility for sobriety on client; do not give advice or punish or reprimand client for failures.
- E. Provide opportunities to decrease social isolation by encouraging participation in social groups and activities.
- F. Encourage client to develop coping mechanisms other than alcohol to deal with stress.
- G. Refer clients and family to available community resources.
 1. Alcoholics Anonymous (AA): a self-help group focusing on education, guidance, and the sharing of problems and experiences unique to the individual.
 2. Al-Anon: a self-help support group for the spouses and significant others of the alcoholic.
 3. Alateen: the support group for teenagers with an alcoholic parent.
 4. Adult Children of Alcoholics (ACOA): support group for adult children of alcoholics and dysfunctional individuals.
 5. Families Anonymous: support group for the families whose lives have been affected by the addicted client's behavior.
 6. Codependents Anonymous: support group for codependents who may be alcoholics or drug addicts and for persons who are close to an addict.
- H. Promote adherence to prescribed therapeutic regimens.
 1. Disulfiram (**Antabuse**): a drug that produces intense side effects after ingestion of alcohol (severe nausea, vomiting, flushed face, hypotension, and blurred vision).
 2. Aversion therapy: a form of deterrent therapy attempting to induce alcohol rejection behavior by administering alcohol with an emetic.
 3. Naltrexone (**Revia**): opioid antagonist that decreases the craving for alcohol.
 4. Acamprosate (**Campral**): a drug that helps clients abstain from alcohol.

Polydrug Dependence

* Polydrug dependence is the regular use of three or more psychoactive substances over a period of at least 6 months.

General Concepts

- A. Effects of use.
 1. Relieves anxiety.
 2. Overdose can occur.
- B. General personality characteristics.
 1. Inability to cope with stress, frustration, or anxiety.
 2. Rebellious, immature, desire for immediate gratification.
 3. Passivity and low self-esteem.
 4. Difficulty forming warm, personal relationships.
 5. Uses defense mechanisms: denial, rationalization, intellectualization.

Data Collection

- A. General assessment.
 1. Determine the pattern of drug use.
 - a. Which drugs are being used by the client?
 - b. When was the last use?
 - c. How much does client use and how often?
 - d. How long has client been using drugs?
 - e. What combination of drugs is being used?
 2. Determine if there are any physical changes present (e.g., needle tracks, swollen nasal mucous membranes, reddened conjunctivae).
- B. Narcotic dependence.

Examples of narcotics: opium, heroin, morphine, meperidine (Demerol), codeine, fentanyl, methadone, OxyContin, oxycodone.

 1. Administration.
 - a. Heroin: sniffed, smoked, injected intravenously (mainlining), injected subcutaneously (skin popping).
 - b. Other narcotics are usually taken orally or injected.
 2. Symptoms of use.
 - a. Drowsiness and decreased blood pressure, pulse, and respiratory rate.
 - b. Pinpoint pupils, needle tracks, scarring.
 - c. Overdose effects: slow, shallow breathing, clammy skin, convulsions, coma, pulmonary edema, possible death.
 3. Withdrawal symptoms.
 - a. Onset of symptoms approximately 8 to 12 hours after the last dose.
 - b. Lacrimation, sweating, sneezing, yawning.
 - c. Gooseflesh (piloerection), tremor, irritability, anorexia.
 - d. Dilated pupils, abdominal cramps, vomiting, involuntary muscle spasms.
 - e. Symptoms generally subside within 7 to 10 days.
- C. Sedative-hypnotic dependence.


Examples of sedative-hypnotics: barbiturates (Nembutal, Seconal) and the benzodiazepines (Librium, Valium).

1. Administration: oral or injected.
2. Symptoms of use.
 - a. Alterations in mood, thought, behavior.
 - b. Impairment in coordination, judgment.
 - c. Signs of intoxication: slurred speech, unsteady gait, decreased attention span or memory.
 - d. Barbiturate use: often violent, disruptive, irresponsible behavior.
3. Withdrawal symptoms.
 - a. Insomnia, anxiety, profuse sweating, weakness.
 - b. Severe reactions of delirium, grand mal seizures, cardiovascular collapse.

D. Cocaine abuse.

Example: Cocaine.

1. Administration: intranasal (“snorting”) or by intravenous or subcutaneous injection; also smoked in pipe (free-basing).
2. Symptoms of use.
 - a. Euphoria, grandiosity, and a sense of well-being.
 - b. Amphetamine-like or stimulant-like effects such as increased blood pressure, racing of the heart, paranoia, anxiety.
 - c. Used regularly, cocaine may disrupt eating and sleeping habits, leading to irritability and decreased concentration.

 **NURSING PRIORITY:** Crack (rock) has been labeled the most addictive drug. It is a potent form of cocaine hydrochloride mixed with baking soda and water, heated (cooked), allowed to harden, and then broken or “cracked” into little pieces and smoked in cigarettes or glass water pipes. Cardiac dysrhythmias, respiratory paralysis, and seizures are some of the dangers associated with crack use.

3. Withdrawal symptoms.
 - a. Severe craving.
 - b. Coming down from a “high” often leads to a severe “letdown,” depressed feeling.
 - c. Psychological dependence often leads to cocaine becoming a total obsession.
- E. Amphetamine dependence.

Example: dextroamphetamine (Dexedrine).

 1. Administration: oral or injected.
 2. Symptoms of use.
 - a. Elation, agitation, hyperactivity, irritability.
 - b. Increased pulse, respiration, and blood pressure.
 - c. Fine tremor, muscle twitching, and mydriasis (pupillary dilation).
 - d. Large doses: convulsions, cardiovascular collapse, respiratory depression, coma, death.
 3. Withdrawal symptoms.
 - a. Appear within 2 to 4 days after the last dose.

- b. Depression, overwhelming fatigue, suicide attempts.
- F. PCP (phencyclidine hydrochloride) abuse.
 1. Administration: snorted, smoked, or orally ingested; usually smoked along with marijuana.
 2. Symptoms of use.
 - a. Euphoria, feeling of numbness, mood changes.
 - b. Diaphoresis, eye movement changes (nystagmus), hypertension, catatonic-like stupor with eyes open.
 - c. Seizures, shivering, decerebrate posturing, possible death.
 - d. Synesthesia (seeing colors when a loud sound occurs).
 3. Overdose symptoms (“bad trip”): psychosis, possible death.
 - a. User may become violent, destructive, and confused.
 - b. Users have been known to go berserk; users may harm themselves and others.
 - c. Intoxicating symptoms lighten and worsen over a period of 48 hours.
- G. Hallucinogen abuse.

Example: LSD (lisergic acid diethylamide), psilocybin (“magic mushroom”), mescaline (peyote), DMT, MDA.

 1. Administration: usually oral, but LSD and mescaline can be injected.
 2. Symptoms of use.
 - a. Pupillary dilation, tachycardia, sweating.
 - b. Visual hallucinations, depersonalization, impaired judgment and mood.
 - c. “Flashbacks” and “bad trips.”
 - d. Usually no signs of withdrawal symptoms after use has been discontinued.
- H. Marijuana dependence.

Example: Marijuana, hashish, tetrahydrocannabinol (THC).

 1. Administration: oral, sniffed, and smoked.
 2. Symptoms of use.
 - a. Euphoria, relaxation, tachycardia, and conjunctival congestion.
 - b. Paranoid ideation; impaired judgment.
 - c. Rarely, panic reactions and psychoses.
 - d. Heavy use leads to apathy and general deterioration in all aspects of living.
 - e. Overdose effects: flashbacks, bronchitis, personality changes.
 3. Withdrawal symptoms.
 - a. Anxiety, sleeplessness, sweating.
 - b. Lack of appetite, nausea, general malaise.
- I. Designer drugs.

Example: Ecstasy, (MDMA [methylenedioxy-methamphetamine], Adam), MTPT (China White).

 1. Called *analog drugs* because they retain the properties of controlled drugs (e.g., MTPT is an analog of **Demerol**).

2. Symptoms of use and side effects are similar to those associated with the controlled substance from which they are derived.

Nursing Intervention

- ❖ **Goal:** To assess the drug use pattern.
- ❖ **Goal:** To assist in medical treatment during detoxification or withdrawal.
 - A. Narcotics.
 1. Narcotic antagonists, such as naloxone (**Narcan**), nalorphine (**Nalline**), or levallorphan (**Lorfan**), are administered intravenously for narcotic overdose.
 2. Withdrawal is managed with rest and nutritional therapy.
 - B. Depressants.
 1. Substitution therapy with a long-acting barbiturate, such as phenobarbital (**Luminal**), may be instituted to decrease withdrawal symptoms.
 2. Some physicians prescribe oxazepam (**Serax**) as needed for objective symptoms, gradually decreasing the dosage until the drug is discontinued.
 - C. Stimulants.
 1. Treatment of overdose is geared toward stabilization of vital signs.
 2. IV antihypertensives may be used, along with IV diazepam (**Valium**) to control seizures.
 3. Oral benzodiazepines (**Librium**) may be administered orally for the first few days while client is “crashing.”
 - D. Hallucinogens and cannabinoids.
 1. Medications are normally not prescribed for withdrawal from these substances.
 2. In the event of overdose, diazepam (**Valium**) or chlordiazepoxide (**Librium**) may be given as needed to decrease agitation.
 - E. Awareness that gradual withdrawal, detoxification, or dechemicalization is necessary for the client addicted to barbiturates, narcotics, and tranquilizers.
 - F. Abrupt withdrawal, or quitting “cold turkey,” is often dangerous and can be fatal.
 - G. Maintain a patent airway; have oxygen available.
 - H. Provide a safe, quiet environment (i.e., remove harmful objects, use side rails).
 - ❖ **Goal:** To decrease problem behaviors of manipulation and “acting out.”
 - A. Set firm, consistent limits.
 - B. Confront client with manipulative behaviors.
 - ❖ **Goal:** To promote alternative coping methods.
 - A. Encourage responsibility for own behavior.
 - B. Encourage the use of hobbies, exercise, or alternative therapies as a means to deal with frustration and anxiety.
 - ❖ **Goal:** To recognize complications of substance abuse.
 - A. Obstetrical implications.
 1. Narcotic addiction.

- a. Increased risk of pregnancy-induced hypertension, malpresentation, and third-trimester bleeding.
 - b. Provide methadone maintenance therapy for the duration of the pregnancy, because withdrawal is not advisable because of the risk to the fetus.
2. Other use of drugs causes increased risk to mother and fetus.
- B. Neonatal complications.
1. Withdrawal symptoms depend on type of drug mother used.
 2. Restlessness, jitteriness, hyperactive reflexes, high-pitched shrill cry, feeds poorly.
 3. Maintain seizure precautions.
 4. Administer antiepileptics to treat withdrawal and prevent seizures.
 5. Swaddle infant in snug-fitting blanket.
 6. Increased risk for congenital malformations and prematurity.
- C. Medical implications.
1. Increased risk of hepatitis, malnutrition, and infections in general.
- ❖ **Goal:** To assist in the long-term process of drug rehabilitation.
- A. Refer client to drug rehabilitation programs.
- B. Promote self-help residential programs that foster self-support systems and use ex-addicts as rehabilitation counselors.
- C. Methadone maintenance programs.
1. Must be 18 years old and addicted for more than 2 years, with a history of detoxification treatments.
 2. Methadone is a synthetic narcotic that appeases desire for opiates.
 - a. Controlled substance given only under urinary surveillance.
 - b. Administered orally; prevents opiate withdrawal symptoms.
- D. 12-Step self-help groups.
1. Narcotics Anonymous: support group for clients who are addicted to narcotics and other drugs.
 2. Nar-Anon: support group for relatives and friends of narcotic addicts.
 3. Families Anonymous.



Affective Disorders

* The major affective disorders are characterized by disturbances of mood.

Data Collection

- A. Bipolar disorder (Figure 6-1).
1. Manic.
 - a. Onset before the age of 30 years.
 - b. Mood: elevated, expansive, or irritable.
 - c. Speech: loud, rapid, difficult to interpret, punning, rhyming, and clanging (using words that
- B. Major depression.
1. May occur at any age.
 2. Differentiated as either a single episode or a recurring type.
 3. Symptoms the same as those listed under “Bipolar disorder, Depressive.”

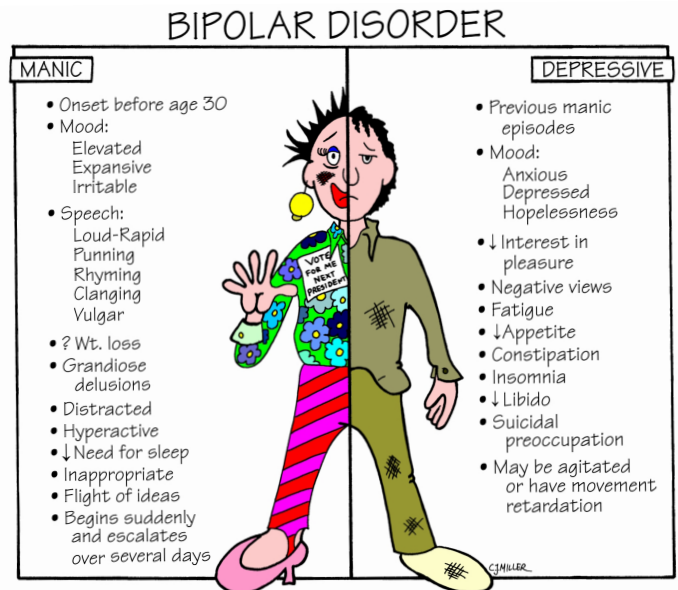


FIGURE 6-1 Bipolar Affective Disorder. (From Zerwekh J, Claborn J, Miller CJ: *Memory notebook of nursing*, vol 1, ed 3, Ingram, 2004, Nursing Education Consultants, Inc.)

- sound like the meaning rather than the actual word).
- d. Cognitive skills: flight of ideas, grandiose delusions, easily distracted.
 - e. Psychomotor activity: hyperactive, decreased need for sleep, exhibitionistic, vulgar, profane, may make inappropriate sexual advances and be obscene.
 - f. Course of manic episode: begins suddenly, rapidly escalates over a few days, and ends more abruptly than major depressive episodes.
2. Depressive.
 - a. Has had one or more manic episodes.
 - b. Mood: dysphoric, depressive, despairing, loss of interest or pleasure in most usual activities.
 - c. Cognitive process: negative view of self, world, and of the future; poverty of ideas; crying; and suicidal preoccupation.
 - d. Psychomotor: may have either agitation or retardation in movements, feelings of fatigue, lack of appetite, constipation, sleeping disturbances (insomnia or early morning wakefulness), and a decrease in libido.
 3. Mixed.
 - a. Involves both manic and depressive episodes, either intermixed or alternating rapidly every few days.
 - b. Depressive phase symptoms are prominent and last at least a full day.

4. Severity and type of depression vary with the ability to test reality.
 - a. Psychotic: feels worse in the morning and better as the day goes on.
 - b. Neurotic: wakes up feeling optimistic; mood worsens as the day passes.

Nursing Intervention (Manic Episode)

❖ **Goal:** To provide for basic human needs of safety and rest/activity.

- A. Reduce outside stimuli and provide a nonstimulating environment.
- B. Monitor food intake: provide a high-calorie, high-vitamin diet with finger foods, to be eaten as the client moves about.

✓ **NURSING PRIORITY:** *Physiological needs are the first priority in providing client care. During the manic phase, the client's physical safety is at risk because the hyperactivity may lead to exhaustion, and ultimately, cardiac failure.*

- C. Encourage noncompetitive solitary activities such as walking, swimming, or painting.
- D. Assist with personal hygiene.
- ❖ **Goal:** To establish a therapeutic nurse-client relationship.
 - A. Use firm, consistent, honest approach.
 - B. Assess client's abilities and involve client in his or her own care planning.
 - C. Promote problem-solving abilities; recognize that a false sense of independence is often demonstrated by loud, boisterous behavior.
 - D. Do not focus on or discuss grandiose ideas.
- ❖ **Goal:** To set limits on behavior.
 - A. Instructions should be clear and concise.
 - B. Initiate regularly scheduled contacts to demonstrate acceptance.
 - C. Maintain some distance between self and client to allow freedom of movement and to prevent feelings of being overpowered.
 - D. Maintain neutrality and objectivity: Realize that client can be easily provoked by harmless remarks and may demonstrate a furious reaction but calm down very quickly.
 - E. Use measures to prevent overt aggression (e.g., distraction, recognition of behaviors of increased excitement).
- ❖ **Goal:** To promote adaptive coping with constructive use of energy.
 - A. Do not hurry client, because this leads to anxiety and hostile behavior.

✓ **NURSING PRIORITY:** *In a hyperactive state, the client is extremely distractible, and responses to even the slightest stimuli are exaggerated.*

- B. Provide activities and constructive tasks that channel the agitated behavior (e.g., cleaning game room, going for a walk, gardening, playing catch).
 - ❖ **Goal:** To assist in the medical treatment.
 - A. Administer lithium (**Lithane** or **Eskalith**).
 - B. Teach client about lithium medication instructions (see Appendix 6-2).

Nursing Intervention (Depressive Episode)

✓ **NURSING PRIORITY:** *Depression and suicidal behaviors may be viewed as anger turned inward on the self. If this anger can be verbalized in a nonthreatening environment, the client may be able to resolve these feelings, regardless of the discomfort involved.*

- ❖ **Goal:** To assess for suicide potential.
 - A. Recognition of suicidal intent.
 1. Self-destructive behaviors are viewed as attempts to escape unbearable life situations.
 2. Anxiety and hostility are overwhelmingly present.
 3. There is the presence of ambivalence; living versus self-destructive impulses.
 4. Depression, low self-esteem, and a feeling of hopelessness are critical to evaluate, because suicide attempts are often made when the client feels like giving up.
 5. Assess for *indirect* self-destructive behavior: any activity that is detrimental to the physical well-being of the client in which the potential outcome is death.
 - a. Eating disorders: anorexia nervosa, bulimia, obesity, and overeating.
 - b. Noncompliance with medical treatment (e.g., diabetic who does not take insulin).
 - c. Cigarette smoking, gambling, criminal and socially deviant activities.
 - d. Alcohol and drug abuse.
 - e. Participation in high-risk sports (e.g., automobile racing and skydiving).
 - B. Suicide danger signs.
 1. The presence of a suicide plan: specifics relating to method, its lethality, and likelihood for rescue.
 2. Change in established patterns in routines (e.g., giving away of personal items, making a will, and saying good-bye).
 3. Anticipation of failure: loss of a job, preoccupation with physical disease, actual or anticipated loss of a significant other.
 4. Change in behavior, presence of panic, agitation, or calmness; usually, as depression lifts, client has enough energy to act on suicidal feelings.
 5. Hopelessness: feelings of impending doom, futility, and entrapment.
 6. Withdrawal and rejection of help.

- C. Clients at risk.
1. Adolescents and older adults; males usually complete the suicide act.
 2. Recent stress of a maturational or situational crisis.
 3. Clients with chronic or painful illnesses.
 4. Previous suicide attempts or suicidal behavior.
 5. Withdrawn, depressed, or hallucinating clients.
 6. Clients with sexual identity conflicts and those who abuse alcohol and drugs.

❖ **Goal:** To provide for basic human needs of safety and protection from self-destruction.

- A. Remove all potentially harmful objects (e.g., belts, sharp objects, matches, lighters, strings, etc.).
- B. Maintain a one-to-one relationship and close observation.

✓ **NURSING PRIORITY:** Be aware of special times when client might be suicidal (e.g., when suddenly cheerful, when there is less staff available, upon arising in the morning, or during a busy routine day).

- C. Have client make a written contract stating he or she will not harm himself or herself, and provide an alternative plan of coping.

❖ **Goal:** To provide for physical needs of nutrition and rest/activity.

- A. Assess for changes in weight (weight loss may indicate deepening depression) and report to nursing supervisor or primary care provider (PCP).
- B. Encourage increased bulk and roughage in diet along with sufficient fluids if client is constipated.

✓ **NURSING PRIORITY:** Depressed clients are particularly vulnerable to constipation as a result of psychomotor retardation.

- A. Encourage expression of angry, guilty, or depressed feelings.
- B. Convey a kind, pleasant, interested approach to promote a sense of dignity and self-worth in the client.
- C. Support the client in the expression of his or her feelings by allowing the client to respond in his or her own time.
- D. Seek out client; initiate frequent contact.
- E. Assist with decision making when depression is severe.

❖ **Goal:** To provide for meaningful socialization activities.

✓ **NURSING PRIORITY:** The depressed client often has impaired decision-making/problem-solving ability and needs structure in his or her life. The nurse must devise a plan of therapeutic activities and provide client with a written time schedule. **Remember:** The client who is moderately depressed feels best early in the day, while later in the day is a better time for the severely depressed individual to participate in activities.

- A. Encourage participation in activities (e.g., plan a work assignment with client to do simple tasks: straightening game room, picking up magazines, etc.).
- B. Assess hobbies, sports, or activities client enjoys, and encourage participation.
- C. Encourage client to participate in small-group conversation or activity; practice social skills through role playing and psychodrama.
- D. Encourage activities that promote a sense of accomplishment and enhance self-esteem.

❖ **Goal:** To assist in medical treatment.

- A. Administer antidepressant medication (see Appendix 6-3).
- B. Assist in electroconvulsive therapy (ECT) (Box 6-8).

SCHIZOPHRENIC DISORDERS



Schizophrenia

* Schizophrenia is a maladaptive disturbance characterized by a number of common behaviors involving disorders of thought content, mood, feeling, perception, communication, and interpersonal relationships.

Prepsychotic Personality Characteristics

- A. Aloof and indifferent.
- B. Social withdrawal; peculiar behavior.
- C. Relatives and friends note a change in personality.
- D. Unusual perceptual experiences and disturbed communication patterns.
- E. Lack of personal grooming.

Psychodynamics of Maladaptive Disturbances

- A. Disturbed thought processes.
 1. Confused, chaotic, and disorganized thinking.
 2. Communicates in symbolic language in which all symbols have special meaning.
 3. Belief that thoughts or wishes can control other people (i.e., magical thinking).
 4. Retreats to a fantasy world, rejecting the real world of painful experience while responding to reality in a bizarre or autistic manner.
- B. Disturbed affect.
 1. Difficulty expressing emotions.
 2. Absent, flat, blunted, or inappropriate affect.

BOX 6-8

ELECTROCONVULSIVE
THERAPY (ECT)

ECT is an electric shock delivered to the brain through electrodes that are applied to both temples. The shock artificially induces a grand mal seizure.

Indications

1. Severely depressed clients who do not respond to medication.
2. High risk for suicide/starvation.
3. Overwhelming depression with delusions or hallucinations.
4. Number of treatments: usually given in a series that varies according to the client's presenting problem and response to therapy; 2 to 3 treatments per week for a period of 2 to 6 weeks.

Nursing Intervention

- *To prepare client for ECT.*
 1. Assess client's record for routine pretreatment checklist for information.
 2. Teach client about procedure: what to expect before, during, and after.
 3. NPO status for 6 hours before treatment.
 4. Remove dentures.
 5. Administer pretreatment medication.
- *To provide support and care immediately after treatment.*
 1. Provide orientation to time.
 2. Temporary memory loss is usually confusing; explain that this is a common occurrence.
 3. Assess vital signs for 30 minutes to 1 hour after treatment.
 4. Deemphasize preoccupation with ECT; promote involvement in regularly scheduled activities.
- *Long-term goal: To promote and develop a positive self-concept and realistic perception of self.*
 1. Encourage problem solving in social relationships; identify problem areas in relationships with others.
 2. Acknowledge and encourage statements that reflect positive attributes and/or skills.
 3. Reinforce new, alternative coping methods, especially if client uses a new method to handle sad situations and painful feelings.

3. Inappropriate affect makes it difficult to form close relationships.
- C. Disturbance in psychomotor behavior.
1. Display of disorganized, purposeless activity.
 2. Behavior may be uninhibited and bizarre; abnormal posturing (agitated or retardation catatonia); waxy flexibility.
 3. Often appears aloof, disinterested, apathetic, and lacking motivation.
- D. Disturbance in perception (Box 6-9).
1. Hallucinations and delusions; auditory forms are most common.

2. Abnormal bodily sensations and hypersensitivity to sound, sight, and smell.
- E. Disturbance in interpersonal relationships.
1. Establishment of interpersonal relationships is difficult because of inability to communicate clearly and react appropriately.
 2. Difficulty relating to others.
 - a. Unable to form close relationships.
 - b. Has difficulty trusting others and experiences ambivalence, fear, and dependency.
 - c. "Need-fear dilemma": withdraws to protect self from further hurt and consequently experiences lack of warmth, trust, and intimacy.
 - d. "As if" phenomenon: feels rejected by others, which leads to increased isolation, perpetuating further feelings of rejection.

Data Collection

- A. Four "A's": Eugene Bleuler's classic symptoms.
1. *Associative looseness*: lack of logical thought progression, resulting in disorganized and chaotic thinking.
 2. *Affect*: Emotion or feeling tone is one of indifference or is flat, blunted, exaggerated, or socially inappropriate.
 3. *Ambivalence*: conflicting, strong feelings (e.g., love and hate) that neutralize each other, leading to psychic immobilization and difficulty in expressing other emotions.
 4. *Autism*: extreme retreat from reality characterized by fantasies, preoccupation with daydreams, and psychotic thought processes of delusion and hallucination.
- B. Other characteristics.
1. Regression: extreme withdrawal and social isolation.
 2. Negativism: doing the opposite of what is asked; typical behavior is to speak to no one and answer no one; used to cover feelings of unworthiness and inadequacy.
 3. Religiosity: excessive religious preoccupation.
 4. Lack of social awareness: crudeness and social insensitivity; neglectful of personal grooming and hygiene.

Nursing Intervention

- ❖ **Goal:** To build trust.



TEST ALERT: Building trust is the primary goal for the client with schizophrenia. Maintain a therapeutic milieu; stay with client to promote safety; reducing fear and assisting client to communicate effectively are important nursing care measures.

BOX 6-9

DISTURBANCES IN PERCEPTION

- Hallucinations: false sensory perception with no basis in reality; can be auditory, olfactory, tactile, visual, and gustatory; auditory most common.
- Delusions: fixed, false beliefs, not corrected by logic; develop as a defense mechanism against intolerable feelings or ideas that cause anxiety.
- Delusions of grandeur: related to feelings of power, fame, splendor, magnificence.
- Delusions of persecution: people are out to harm, injure, or destroy.
- Illusions: misinterpretation of reality (e.g., seeing a mirror image turn into a monster).



TEST ALERT: Identify behavioral changes associated with mental illness (e.g., hallucinations, delusions).

- A. Encourage free expression of feelings (either negative or positive) without fear of rejection, ridicule, or retaliation.
- B. Use nonverbal level of communication to demonstrate warmth, concern, and empathy because client often distrusts words.
- C. Consistency, reliability, acceptance, and persistence build trust.
- D. Allow client to set pace; proceed slowly in planning social contacts.
- ❖ **Goal:** To provide a safe and secure environment.
- A. Maintain familiar routines. Make sure persons who come in contact with the client are recognizable to the client.
- B. Avoid stressful situations or increasing anxiety.
- ❖ **Goal:** To clarify and reinforce reality.
- A. Involve client in reality-oriented activities.
- B. Help client find satisfaction in the external environment and ways of relating to others.
- C. Focus on clear communication and the immediate situation.
- ❖ **Goal:** To promote and build self-esteem.
- A. Encourage simple activities with limited concentration and *no* competition.
- B. Provide successful experiences with short-range goals realistic for client's level of functioning.
- C. Relieve client of decision-making until he or she is ready.
- D. Avoid making demands.
- ❖ **Goal:** To encourage independent behavior.
- A. Anticipate and accept negativism.
- B. Avoid fostering dependency.
- C. Encourage client to make his or her own decisions, using positive reinforcement.

- ❖ **Goal:** To provide care to meet basic human needs.
- A. Determine client's ability to meet responsibilities of daily living.
- B. Attend to nutrition, elimination, exercise, hygiene, and signs of physical illness.
- ❖ **Goal:** To assist in medical treatment.
- A. Administer antipsychotic medications (see Appendix 6-4).
 1. Assist with ECT; may be useful in some instances to modify behavior.
- ❖ **Goal:** To deal effectively with withdrawn behavior.
- A. Establish a therapeutic one-to-one relationship.
 1. Initiate interaction by seeking out client at every opportunity.
 2. Maintain a nonjudgmental, accepting manner in what is said and done.
 3. Attempt to draw client into a conversation without demanding a response.
- B. Promote social skills by helping client feel more secure with other people.
 1. Accept one-sided conversations.
 2. Accept client's negativism without comments.
- C. Attend to physical needs of client as necessary.
- D. Have client focus on reality.
- E. Protect and restrain client from potential destructiveness to self and others.
- ❖ **Goal:** To deal effectively with hallucinations.
- A. Clarify and reinforce reality.
 1. Help client recognize hallucination as a manifestation of anxiety.
 2. Provide a safe, secure environment.
 3. Avoid denying or arguing with client when he or she is experiencing hallucinations.
 4. Acknowledge client's experience but point out that you do not share the same experience.
 5. Do not give attention to content of hallucinations.
 6. Direct client's attention to real situations, such as singing along with music.
 7. Protect client from injury to self or others when he or she is prompted by "voices" or "visions."



Paranoid Disorders

* Paranoid disorders are maladaptive disorders characterized by delusions, usually persecutory, and extreme suspiciousness.

Data Collection

- A. Extreme suspiciousness and withdrawal from emotional contact with others.
- B. Aloof, distant, hypercritical of others.
- C. Frequent complaining by letter writing or instigating legal action.
- D. Resentment, anger, possible violence.
- E. Delusions of grandeur and persecution and hypochondriasis.

- F. Misinterpretation or distortion of reality; may refuse food and medications, insisting that he or she is being poisoned despite evidence to the contrary.

Nursing Intervention

- ❖ **Goal:** To establish a trusting relationship.



TEST ALERT: Use therapeutic interventions to increase client's understanding of behavior. The lack of trust in the paranoid client is often a focus of test questions surrounding the serving of meals or the administration of medications.

- A. Maintain calm, matter-of-fact attitude.
B. Keep promises made; be honest.
C. Avoid whispering or acting secretive.
D. Allow a choice of activities and foods; involve client in treatment plan.
- ❖ **Goal:** To increase self-esteem by providing successful experiences.
A. Allow client to set pace in closeness with others.
B. Avoid involvement in competitive, aggressive activities requiring physical contact (e.g., football, basketball).
C. Involve client in solitary activities (e.g., drawing, photography, typing) and progress to intellectual activities with others using games (e.g., chess, bridge, Scrabble).
D. Reward completion of meaningful tasks.
- ❖ **Goal:** To deal effectively with delusions.
A. Clarify and focus on reality; use reality testing.
B. Avoid confirming or approving false beliefs.
C. Point out that client's beliefs are not shared.
D. Divert attention from delusions to reality; focus on here and now.

Study Questions: Psychiatric Nursing Concepts and Care

1. The nurse is admitting an older adult client to an extended care facility. The client is confused, very poorly nourished, and has contusions with bruises and welts over the trunk. What would be the most important nursing intervention at this time?
 - 1 Perform a physical assessment.
 - 2 Notify the nursing supervisor or PCP regarding client's condition.
 - 3 Establish communication and rapport with the client.
 - 4 Notify authorities regarding suspected elderly abuse.
2. The nurse is caring for a client who is confused. What would be a-priority of care for this client?
 - 1 Frequent orientation to person, place, and time.
 - 2 Offering client frequent meals that are easy to eat.
 - 3 Assisting the client to select comfortable clothing.
 - 4 Arranging for a pastor from client's church to visit.
3. A client who does not speak any English is admitted to the unit. What would be the best approach for the nurse to determine the client's immediate needs and collect assessment data?
 - 1 Contact the nursing office and determine if there is a translator available.
 - 2 Ask a family member to translate the necessary questions and answers.
 - 3 Use pictures and pantomime to try to communicate and determine client needs.
 - 4 Perform the physical assessment and respect the client's privacy.
4. A nurse whose family has a history of drug abuse makes derogatory comments while caring for a substance abuse client. What might be an explanation for the nurse's behavior? The nurse:
 - 1 Has an issue with denial and repression.
 - 2 Is unaware of her feelings when working with this type of client.
 - 3 Is experiencing a need to act out her feelings.
 - 4 Feels this type of client is insensitive and should be dealt with honestly.
5. A client is suspicious about her surroundings and is paranoid toward the nursing staff. What therapeutic approach should be avoided?
 - 1 Maintain silence and do not attempt to explain circumstances.
 - 2 Make sure you have the client's attention and maintain direct eye contact.
 - 3 Accept the need for the client to be suspicious, and be direct and honest in responses.
 - 4 Sit with the client and console through touch and being very open and friendly.
6. A client is observed by the nurse opening and closing his fist, and mumbling angrily while walking back and forth in his room. The nurse should:
 - 1 Attempt to determine source of anxiety.
 - 2 Give PRN **Ativan** for anxiety.
 - 3 Call for help to restrain the client.
 - 4 Leave the client alone.
7. The nurse notes that a client is quite suspicious during an assessment interview and believes that her family is under investigation by the CIA. What would be appropriate nursing intervention with this client? (Select all that apply.)
 - 1 Use active listening skills to seek information from the client.
 - 2 Encourage the client to describe the problem as how they see it.
 - 3 Ask the client to tell you what exactly they think is happening.
 - 4 Tell the client that they are delusional and you can help them.
 - 5 Explain to the client that most people are not investigated by the CIA or FBI.
 - 6 Reassure the client that you are not with the CIA.
8. The nurse is concerned a client is becoming depressed. What nursing observations would support the development of depression?
 - 1 Insomnia, loss of libido, restlessness.
 - 2 Anorexia, psychomotor retardation, poor grooming.
 - 3 Hypervigilance, overeating, poor grooming.
 - 4 Flight of ideas, weight loss, lack of interest.
9. The nurse on a long-term care unit is planning assignments for the day. What will be important for the nurse to consider in assigning staff to care for a client who is dying?
 - 1 Change the staff assigned to care for the client daily.
 - 2 Assign the temporary and part-time staff to this client.
 - 3 Whenever possible, assign the same staff to care for the client.
 - 4 To prevent staff depression, rotate staff every other day.
10. What would be important for the nurse to assess for in caring for a client who is schizophrenic?
 - 1 Delusions and hallucinations.
 - 2 Depression and delusions.
 - 3 Self-care deficits and memory loss.
 - 4 Bradycardia and flat affect.
11. A client is on antipsychotic drug therapy. The client has developed Parkinson-like symptoms. What is the nursing interpretation of this observation?
 - 1 This is an allergic response to the drug.
 - 2 The client is demonstrating the therapeutic response to the drug.

- 3 Observations are classified as extrapyramidal side effects.
- 4 Symptoms are cholinergic side effects.
12. A male client is experiencing auditory hallucinations. What would the nurse be most concerned about?
 - 1 Feelings of depression when the voices stop.
 - 2 How the voices are telling him to hurt someone.
 - 3 Feelings of happiness to hear the voices.
 - 4 How the voices sound like a woman's voice.
13. The family is present as their mother is dying. The family needs assistance as the mother's death becomes imminent. How can the nurse best assist the family to begin preparatory grieving?
 - 1 Assuring them that their mother will suffer no intense pain.
 - 2 Advising the family about ways they can manage after their mother dies.
 - 3 Supporting them while they share feelings about their mother's impending death.
 - 4 Sympathizing with them as they talk about the meaning of their mother's imminent death.
14. The family of a client with Alzheimer's disease asks the nurse about caring for the client. What advice would the nurse give to the family?
 - 1 Identify ways they can limit the client's behavior.
 - 2 Identify stimuli that may cause recurring episodes.
 - 3 Prioritize client care and family and client needs.
 - 4 Place locks on all rooms to maintain client safety.
15. Familiar environment and routine for an older adult client fulfills which of Maslow's hierarchy of needs?
 - 1 Self-actualization.
 - 2 Biological integrity.
 - 3 Spirituality.
 - 4 Safety and security.
16. A child is brought into the emergency department with bruises and raised welts on the child's back. The nurse suspects child abuse. What would be the appropriate action?
 - 1 Demand an explanation from the parents.
 - 2 Observe the child's response to family members.
 - 3 Call the police.
 - 4 Call the emergency room (ER) nursing supervisor for follow-up reporting.

Answers and rationales to these questions are in the section at the end of the book titled Chapter Study Questions: Answers and Rationales.

Appendix 6-1 ALZHEIMER'S MEDICATIONS



GENERAL NURSING IMPLICATIONS

Two types: (1) *cholinesterase inhibitors*, which prevent the breakdown of acetylcholine, thus making it available at the cholinergic synapses and resulting in enhanced transmission of nerve impulses and (2) a new drug—an *NMDA receptor antagonist*—which blocks calcium influx and modulates the effects of glutamate (major excitatory transmitter in CNS).

Drugs do not cure and do not stop disease progression, but they may slow down the progression by a few months.

MEDICATIONS

SIDE EFFECTS

NURSING IMPLICATIONS

Cholinesterase Inhibitors
 Donepezil (**Aricept**): PO
 Galantamine (**Razadyne**): PO
 Rivastigmine (**Exelon**): PO
 Tacrine (**Cognex**): PO

GI symptoms: nausea, vomiting, dyspepsia, diarrhea
 Dizziness and headache
 Tacrine: high risk for liver damage

1. Abrupt withdrawal of medication can lead to a rapid progression of symptoms.
2. Monitor for side effects since drug is typically given in high doses to produce the greatest benefit.

NMDA Receptor Antagonist
 Memantine (**Namenda**): PO

Dizziness, headache, confusion, constipation

1. Used for moderate to severe cases.
2. Better tolerated than cholinesterase inhibitors.

Appendix 6-2 ANTIANXIETY AGENTS

**GENERAL NURSING IMPLICATIONS**

- Withhold or omit one or more doses if excessive drowsiness occurs.
- Assess for symptoms associated with a withdrawal syndrome in hospitalized clients: anxiety, insomnia, vomiting, tremors, palpitations, confusion, and hallucinations.
- When discontinuing, the drug dosage should be gradually decreased over a period of days, depending on the dose and length of time the client has been taking the medication.
- Schedule IV drug requires documentation.
- Promote safety with the use of side rails and assistance with ambulation as necessary.
- Teach client and family not to drink alcohol while taking an anti-anxiety agent and not to stop taking the medication abruptly.

MEDICATIONS**SIDE EFFECTS****NURSING IMPLICATIONS**

BENZODIAZEPINES: Reduce anxiety by enhancing the action of the inhibitory neurotransmitter GABA on its receptor; also promote anticonvulsant activity and skeletal muscle relaxation.

Chlordiazepoxide (**Librium**): PO, IM, IV
 Diazepam (**Valium**): PO, IM, IV
 Clonazepam (**Klonopin**): PO
 Chlorazepate dipotassium (**Tranxene**): PO
 Midazolam (**Versed**): IM, IV

CNS depression, drowsiness (decreases with use), ataxia, dizziness, headaches, dry mouth.
Adverse effects: tolerance commonly develops, physical dependency.

1. May cause paradoxical effects and should not be taken by mothers who are breastfeeding.
2. Assess for symptoms of leukopenia, such as sore throat, fever, and weakness.
3. Encourage client to rise slowly from a supine position and to dangle feet before standing.
4. Versed is commonly used for induction of anesthesia and sedation before diagnostic tests and endoscopic exams.
5. Flumazenil (**Romazicon**) is approved for the treatment of benzodiazepine overdose; has an adverse effect of precipitating convulsions, especially in clients with a history of epilepsy.
6. *Uses:* anxiety and tension, muscle spasm, preoperative medication, acute alcohol withdrawal, and to induce sleep.

NONBENZODIAZEPINE AGENTS: Interact with serotonin and dopamine receptors in the brain to decrease anxiety; lack muscle-relaxant and anticonvulsant effects; do not cause sedation or physical or psychologic dependence; do not increase CNS depression caused by alcohol or other drugs.

Buspirone (**BuSpar**): PO

Dizziness, drowsiness, headache, nausea, fatigue, insomnia.

1. Not a controlled substance.
2. Some improvement can be noted in 7-10 days; however, usually takes 3-4 weeks to achieve effectiveness.
3. *Uses:* short-term relief of anxiety and anxiety disorders.

CNS, Central nervous system; *GABA*, gamma-aminobutyric acid; *IM*, intramuscularly; *IV*, intravenously; *PO*, by mouth (orally).

Appendix 6-3

ANTIMANIC MEDICATIONS



MEDICATIONS

SIDE EFFECTS

NURSING IMPLICATIONS

LITHIUM CARBONATE: Acts to lower concentrations of norepinephrine and serotonin by inhibiting their release; believed to alter sodium transport in both nerve and muscle cells. **Uses:** bipolar affective disorder (manic episode).

Lithium (**Eskalith, Lithane**): PO

High incidence: increased thirst, increased urination (polyuria).
Frequent: 1.5 mEq/L levels or less: Dry mouth, lethargy, fatigue, muscle weakness, headache, GI disturbances, fine hand tremors.
Adverse effects: 1.5-2.0 mEq/L may produce vomiting, diarrhea, drowsiness, incoordination, coarse hand tremors, muscle twitching.
 2.0-2.5 mEq/L may result in ataxia, slurred speech, confusion, clonic movements, high output of dilute urine, blurred vision, hypotension.
Acute toxicity: seizures, oliguria, coma, peripheral vascular collapse, death.

1. Monitor lithium blood levels: blood samples are obtained 12 hours after dose was given.
2. Teach client the following:
 - a. Symptoms of lithium toxicity.
 - b. Importance of frequent blood tests (every 2-3 days) to check lithium levels at the beginning of treatment (maintenance blood levels done every 1-3 months).
 - c. Importance of dietary intake and taking dose at same time each day, preferably with meals or milk.
3. Encourage a diet containing normal amounts of salt and a fluid intake of 3 L per day; avoid caffeine because of its diuretic effect.
4. Report polyuria, prolonged vomiting, diarrhea, or fever to physician (may need to temporarily reduce dosage or discontinue use).
5. Do not crush, chew, or break the extended-release or film-coated tablets.
6. Assess clients at high risk for developing toxicity: postoperative, dehydrated, hyperthyroid, those with renal disease, or those taking diuretics.
7. Blood levels:
 - a. Extremely narrow therapeutic range: 0.5-1.5 mEq/L.
 - b. Toxic serum lithium level is greater than 2 mEq/L.
8. Management of lithium toxicity: possible hemodialysis.
9. Long-term use may cause goiter; may be associated with hypothyroidism.

OTHER AGENTS: Both medications listed below were originally developed and used for seizure disorders. Both have mood-stabilizing abilities.

Carbamazepine (**Tegretol**): PO

Drowsiness, dizziness, visual problems (spots before eyes, difficulty focusing, blurred vision), dry mouth.
Toxic reactions: blood dyscrasias.

1. Used primarily for clients who have not responded to lithium or who cannot tolerate the side effects.
2. Avoid tasks that require alertness and motor skills until response to drug is established.
3. **Tegretol:** monitor CBC frequently during initiation of therapy and at monthly intervals thereafter.

Valproic acid (**Depakene; Depakote**): PO

Nausea, GI upsets, drowsiness, may cause hepatotoxicity.

1. **Depakene; Depakote:** monitor liver function studies.

CBC, Complete blood count; GI, gastrointestinal; PO, by mouth (orally).

Appendix 6-4 ANTIDEPRESSANT MEDICATIONS



GENERAL NURSING IMPLICATIONS

- SSRIs are the drugs of choice for depression.
- Because of the potential interactions with other drugs and certain foods, MAOIs are used as second-line drugs for the treatment of depression.
- Therapeutic effect has a delayed onset of 7-21 days; however, SSRIs may take as long as 6 weeks to become effective.
- Can potentially produce cardiotoxicity, sedation, seizures, and anticholinergic effects and may induce mania in clients with bipolar disorder (SSRIs are less likely to cause these problems).
- Drugs are usually discontinued before surgery (10 days for MAOIs; 2-3 days for TCAs) because of adverse interactions with anesthetic agents.

MEDICATIONS

SIDE EFFECTS

NURSING IMPLICATIONS

TRICYCLIC ANTIDEPRESSANTS: Prevent the reuptake of norepinephrine or serotonin, which results in increased concentrations of these neurotransmitters.

Imipramine hydrochloride
(**Tofranil**): PO, IM
Nortriptyline hydrochloride
(**Aventyl**): PO
Doxepin hydrochloride
(**Sinequan**): PO
Amitriptyline hydrochloride
(**Elavil**): PO, IM

Drowsiness, dry mouth, blurred vision, constipation, weight gain, and orthostatic hypotension.
Adverse reactions: cardiac dysrhythmias, nystagmus, tremor, hypotension, restlessness.

1. Should not be given at the same time as an MAOI; a time lag of 14 days is necessary when changing from one drug group to the other.
2. Because of marked sedation, client should avoid activities requiring mental alertness (driving or operating machinery).
3. Instruct client to move gradually from lying to sitting and standing positions to prevent postural hypotension.
4. **Sinequan** is tolerated better by older adults; has less effect on cardiac status; dilute the concentrate with orange juice.
5. Contraindicated in clients with epilepsy, glaucoma, and cardiovascular disease.
6. Usually given once daily at bedtime.
7. *Uses:* depression; **Tofranil** is also used to treat enuresis in children.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI): Cause selective inhibition of serotonin uptake and produce CNS excitation rather than sedation; have no effect on dopamine or norepinephrine.

Fluoxetine (**Prozac**): PO
Sertraline (**Zoloft**): PO
Paroxetine (**Paxil**): PO

Nausea, headache, anxiety, nervousness, insomnia, weight gain, skin rash, sexual dysfunction.

1. Give medication in the morning.
2. *Uses:* depression, obsessive-compulsive disorder, bulimia, appetite suppression in obese clients.

MONOAMINE OXIDASE INHIBITORS (MAOI): Inhibit the enzyme monoamine oxidase, which breaks down norepinephrine and serotonin, increasing the concentration of these neurotransmitters.

Isocarboxazid (**Marplan**): PO
Phenelzine sulfate (**Nardil**): PO
Tranylcypromine (**Parnate**): PO

Drowsiness, insomnia, dry mouth, urinary retention, hypotension.
Adverse reactions: tachycardia, tachypnea, agitation, tremors, seizures, heart block, hypotension.

1. Potentiate many drug actions: narcotics, barbiturates, sedatives, and atropine-like medications.
2. Have a long duration of action; therefore 2-3 weeks must go by before another drug is administered while a client is an taking MAOI.
3. Interact with specific foods and drugs (ones containing tyramine or sympathomimetic drugs). May cause a severe hypertensive crisis characterized by marked elevation of blood pressure, increased temperature, tremors, and tachycardia. Foods and

Appendix 6-4

ANTIDEPRESSANT MEDICATIONS — cont'd



drugs to avoid: coffee, tea, cola beverages, aged cheeses, beer and wine, pickled foods, avocados, and figs and many over-the-counter cold preparations, hay fever medications, and nasal decongestants.

4. Monitor for bladder distention by checking urinary output.
5. **Parnate:** most likely to cause hypertensive crisis; onset of action is more rapid.
6. **Uses:** primarily psychotic depression and depressive episode of bipolar affective disorder.

MISCELLANEOUS ANTIDEPRESSANTS

Trazodone (Desyrel): PO	Sedation, orthostatic hypotension, nausea, vomiting, can cause priapism (prolonged, painful erection of the penis).	See General Nursing Implications.
Bupropion (Wellbutrin): PO	Weight loss, dry mouth, dizziness.	See General Nursing Implications.

CNS, Central nervous system; *IM*, intramuscularly; *MAOIs*, monoamine oxidase inhibitors; *PO*, by mouth (orally); *SSRIs*, selective serotonin reuptake inhibitors; *TCAs*, tricyclic antidepressants.

Appendix 6-5 ANTIPSYCHOTIC (NEUROLEPTIC) MEDICATIONS



GENERAL NURSING IMPLICATIONS

- Use cautiously in older adults.
- Should make the client feel better and experience fewer psychotic episodes.
- Maintain a regular schedule; usually take daily dose 1-2 hours before bedtime.
- Explain to client and family the importance of compliance with medication regimen.
- Medications are not addictive.
- Discuss side effects and importance of notifying PCP if client experiences undesired or side effects.
- When mixing for parenteral use, do not mix with other drugs.
- Inject deep IM; client should stay in reclined position 30 - 60 minutes after dose administration.

MEDICATIONS

SIDE EFFECTS

NURSING IMPLICATIONS

PHENOTHIAZINES: Block dopamine receptors and also thought to depress various portions of the reticular activating system; have peripherally exerting anticholinergic properties (atropine-like symptoms: dryness of mouth, stuffy nose, constipation, blurring of vision).

Aliphatic types:

Chlorpromazine hydrochloride (**Thorazine**):

PO, IM, IV suppository

Promazine hydrochloride (**Sparine**):

PO, IM, IV

Piperazine types:

Prochlorperazine (**Compazine**):

PO, IM, IV, suppository

Fluphenazine hydrochloride (**Prolixin**):

PO, IM

Trifluoperazine (**Stelazine**): PO, IM

Piperidine types:

Thioridazine (**Mellaril**): PO

Mesoridazine besylate (**Serentil**): PO, IM

Extrapyramidal effects (movement

disorder): occur early in therapy and are usually managed with other drugs

Acute dystonia—spasm of muscles of tongue, face, neck, or back; oculogyric crisis (upward deviation of the eyes); opisthotonus.

Parkinsonism—muscle tremors, rigidity, spasms, shuffling gait, stooped posture, cogwheel rigidity.

Akathisia—motor restlessness, pacing.

Tardive dyskinesia: occurs late in therapy; symptoms are often irreversible—earliest symptom is slow, wormlike movements of the tongue; later symptoms include fine twisting, writhing movements of the tongue and face, grimacing; lip smacking; involuntary movements of the limbs, toes, fingers, and trunk.

Neuroleptic malignant syndrome: rare problem, fever (greater than 41° C, 105° F), “leadpipe” muscle rigidity, agitation, confusion, delirium, respiratory and acute renal failure.

Endocrine—amenorrhea, increased libido in women, decreased libido in men, delayed ejaculation, increased appetite, weight gain, hypoglycemia, and edema.

Dermatologic—photosensitivity.

Hypersensitivity reaction—jaundice, agranulocytosis.

1. Check blood pressure before administration; to avoid postural hypotension, encourage client to rise slowly from sitting or lying position.
2. Be aware of the antiemetic effect of the phenothiazines; may mask other pathology such as drug overdose, brain lesions, or intestinal obstruction.
3. Client teaching: protect skin from sunlight—wear long-sleeved shirts, hats, and sunscreen lotion when out in the sunlight.
4. Explain importance of reporting any signs of sore throat, fever, or symptoms of infection.
5. Encourage periodic liver function studies to be done.
6. Teach that drug may turn urine pink or reddish brown.
7. Extrapyramidal symptoms treated with anticholinergics, (e.g., **Cogentin**).
8. Long-term use of phenothiazines requires assessment of involuntary movement (AIMS testing).
9. **Uses:** severe psychoses, schizophrenia, manic phase of bipolar affective disorder, personality disorders, and severe agitation and anxiety.

OTHER ANTIPSYCHOTIC DRUGS

Haloperidol (**Haldol**): PO, IM

Significant extrapyramidal effects; low incidence of sedation, orthostatic hypotension; does not elicit photosensitivity reaction.

1. May reduce prothrombin time.
2. Often used as the initial drug for treatment of psychotic disorders.

Risperidone (**Risperdal**): PO

Anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, GI upset, rhinitis.

1. **Uses:** tics, vocal disturbances, and psychotic schizophrenia.
2. **Risperdal** is the most frequently prescribed antipsychotic because of less serious side effects.

Clozapine (**Clozaril**): PO

Blood dyscrasias (agranulocytosis), sedation, weight gain, orthostatic hypotension, seizures, diabetes.

1. Used with caution in clients with diabetes and those with history of seizures.
2. Treatment is started slowly and gradually increased; it is important that the client not stop taking medication.