Psychiatric and Mental Health Nursing

DeMYSTiFieD®

Hard stuff made easy™

Detailed OVERVIEW of common psychiatric conditions

Clear LEARNING OBJECTIVES and KEY TERMS keep you on the right track

Coverage of PATHOPHYSIOLOGY, symptoms, DIAGNOSES, treatment, and NURSING INTERVENTION

NCLEX-style practice QUESTIONS at the end of every chapter

McGraw Hill Education

Jim Keogh

Psychiatric and Mental Health Nursing

DeMYSTiFieD

Jim Keogh, RN

McGraw Hill Education | Medical

New York Chicago San Francisco Athens London Madrid
Mexico City Milan New Delhi Singapore Sydney Toronto

ISBN: 978-0-07-182051-6

MHID: 0-07-182051-5

The material in this eBook also appears in the print version of this title: ISBN: 978-0-07-182052-3,
MHID: 0-07-182052-3.

eBook conversion by codeMantra
Version 1.0

Notice

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required. The authors and the publisher of this work have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standard accepted at the time of publication. However, in view of the possibility of human error or changes in medical sciences, neither the editors nor the publisher nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they disclaim all responsibility for any errors or omissions or for the results obtained from use of the information contained in this work. Readers are encouraged to confirm the information contained herein with other sources. For example and in particular, readers are advised to check the product information sheet included in the package of each drug they plan to administer to be certain that the information contained in this work is accurate and that changes have not been made in the recommended dose or in the contraindications for administration. This recommendation is of particular importance in connection with new or infrequently used drugs.

This book is dedicated to Anne, Sandy, Joanne, Amber-Leigh Christine, Shawn, Eric, and Amy. Without their help and support, this book couldn't have been written.

—Jim Keogh, RN-BC, MSN

About the Author

Jim Keogh, RN-BC, MSN, is Board Certified in Psychiatric-Mental Health and has written McGraw-Hill's Nursing DeMystified series. These include *Pharmacology DeMystified*, *Microbiology DeMystified*, *Medical-Surgical Nursing DeMystified*, *Medical Billing and Coding DeMystified*, *Nursing Laboratory and Diagnostic Tests DeMystified*, *Dosage Calculations DeMystified*, *Medical Charting DeMystified*, *Pediatric Nursing DeMystified*, *Nurse Management DeMystified*, *Schaum's Outline of ECG Interpretations*, *Schaum's Outline of Medical Terminology*, and *Schaum's Outline of Emergency Nursing*. His books can be found in leading university libraries including Yale School of Medicine, Yale University, University of Pennsylvania Biomedical Library, Columbia University, Brown University, University of Medicine and Dentistry of New Jersey, Cambridge University, and Oxford University. He is a former member of the faculty at Columbia University and is a member of the faculty of New York University and Saint Peter's University in New Jersey.

Contents

This page intentionally left blank

Introduction

A person seeks medical help for mental health issues when the person becomes unable to cope with activities of daily living and life becomes too much to bear, but how does the healthcare provider determine what is wrong and what to do to restore the patient to good mental health? The answer depends on the patient's signs and symptoms. In this book you will learn to identify these signs and symptoms, conduct psychiatric and mental health assessments, and perform the nursing interventions that will assist in solving or alleviating the patient's psychiatric and mental health problem.

Psychiatric and Mental Health Nursing DeMystified contains 14 chapters, each providing a description of major mental disorders that can affect patient. The discussion of each disorder is divided into the following sections:

- What Went Wrong?
- Prognosis
- Hallmark Signs and Symptoms
- Common/Interpreting Test Results
- Treatment
- Nursing Diagnoses
- Nursing Interventions

The "What Went Wrong?" section presents a brief description of how the body is affected when a particular disease or disorder occurs. The "Prognosis" section discusses the possibilities of curing the disease and permanent damage that can occur. The remaining sections present the information as lists of

symptoms, diagnoses, etc., that make it easy for you to learn and that also serve as useful tools for later reference.

A Look Inside

Since psychiatric and mental health nursing can be challenging for the beginner, this book has been written to provide an organized, outline approach to learning about major diseases and the part the nurse can play in the treatment process. The following sections provide a thumbnail description of each chapter.

Chapter 1 Foundation of Psychiatric and Mental Health Nursing

Mental illness is a psychological or behavioral disorder that alters thinking, mood, and the ability to perform activities of daily living and to relate to others. There is no medical test used to diagnose a mental disorder. Instead, practitioners use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) published by the American Psychiatric Association to determine if a person is experiencing a mental disorder. The DSM-5 lists categories of mental disorders and clinically significant behaviors that are associated with a diagnosis. The practitioner uses objective and subjective information to assess the person's behavior to determine if the person has a mental disorder and, if so, which disorder. The practitioner differentiates between expected behavioral change such as depression following a death and behavior that is not expected such as depression in the absence of death or other depressive situations. In this chapter, you will learn to understand the basis of mental illness and psychiatric and mental health nursing.

Chapter 2 Childhood and Adolescent Psychiatric Disorders

The US Surgeon General reports that about 5 million children and adolescents in the United States have a serious mental illness. A serious mental illness is a diagnosable mental disorder that impairs a child's daily life. The challenge that a practitioner faces is to differentiate between normal growth and development in a child who at times exhibits symptoms of a mental illness and symptoms of a mental disorder. For example, is defying authority a sign of autonomy or a symptom of oppositional defiant disorder? Until recently, researchers focused on adult mental illness primarily because of the difficulty in differentiating between normal and abnormal growth and development. A child's behavior might appear bizarre at age 2 yet the child demonstrates normal behavior at age 3. The bizarre behavior is considered normal growth and development.

Today researchers are investigating factors that may lead to childhood and adolescent mental illness such as neglect, severe emotional trauma, physical abuse, and extreme stress. In this chapter, you will learn about childhood and adolescent psychiatric disorders and how to care for this population.

Chapter 3 Anxiety and Anxiety Disorders

Anxiety is common to all ages and is characterized by fear and worry. Anxiety is normal. For example, children between 6 and 18 months old experience separation anxiety, and everyone experiences the fight or flight response to stressful situations. Anxiety becomes a disorder when a person is unable to cope with stressors and they interfere with the person's activities of daily living. Central to anxiety disorder is the person's misinterpretation of stressors and exaggeration of a response to the stressor. A stressor is a situation that triggers a stress response. In this chapter, you will learn about anxiety disorders and what actions a nurse can perform to assist in the patient's recovery.

Chapter 4 Somatoform and Dissociative Disorders

Somatoform disorders are psychiatric disorders where a patient reports symptoms of health problems that have no medical basis or the patient complains about their body image when nothing is wrong with the patient's body. Both symptoms and poor body image are perceived as real problems for the patient, leading the patient to seek medical help to address those problems. The patient becomes frustrated when medical tests are negative and the practitioner does not offer medical treatment. In response, the patient may seek out other practitioners for help and self-refer to specialists. The patient is unlikely to provide practitioners with a history of visits to other practitioners or acknowledge previous medical tests, resulting in duplicated tests. Dissociative disorders are psychiatric disorders where the patient feels detached from themself and reality. Feeling detached from one's self is called depersonalization. Detachment from the external world is called derealization. Historically somatoform disorders and dissociative disorders were classified as hysterical neuroses, which is why both are discussed in the same chapter. Neurotic disorders, according to psychoanalytic theory, stem from unconscious conflicts that increase anxiety, leading to symptoms of somatoform disorders and dissociative disorders as a defense mechanism to address the conflicts. This chapter explores somatoform and dissociative disorders and how to care for patients who experience them.

Chapter 5 Schizophrenia

Schizophrenia is a mental illness characterized by a patient's abnormal misinterpretation of reality, referred to as psychosis. The patient's behavior seems bizarre to others because the behavior is inappropriate to reality. However, the behavior is appropriate to the patient based on their misperception of reality. For example, all of us become paranoid when walking down an unfamiliar dark street as part of our survival mechanism. However, a paranoid schizophrenic may become paranoid over normal activities around the house such as the familiar mail carrier dropping mail in the mail box. The paranoid schizophrenic may see the familiar mail carrier as a threat and react appropriately to the patient's reality but inappropriately according to everyone else. In addition, some schizophrenic patients may be unable to distinguish between fantasy and reality. For example, a schizophrenic may be obsessed with watching old western movies and then put on a full western costume complete with two toy guns and a badge and walk the streets thinking he is the sheriff protecting everyone in town from the "bad guys." It is important that the nurse understands that the schizophrenic behavior is usually appropriate according to the patient's perceived reality. The inappropriateness of the patient's behavior is a result of the misperception of reality by the patient. In this chapter, you will learn about schizophrenia and the interventions that mitigate symptoms for the patient.

Chapter 6 Personality Disorders

Personality is a pattern of feelings, behaviors, and thinking that defines the way a person is perceived. Personality develops during childhood and remains stable during adulthood. All of us have these traits. For example, you may cut in line at the checkout counter or pretend to be sick to avoid going to a family gathering. At times you might have a violent outburst when someone tells you that you are wrong. Many of us pretend we are challenged by a task that we do not want to do in order to have someone come to our rescue. A person with a personality disorder displays these same traits but in the extreme and is unable to modify their behavior. For example, a person who does not have a personality disorder exhibits avoidant behavior by avoiding situations that are perceived to be dangerous. However, the person returns to a more normal behavior once the perceived danger dissipates. A person diagnosed with an avoidant personality disorder exhibits the same behavior but is unable to return to a more normal behavior when the perceived danger passes. Context is a key factor that differentiates between normal behavior and abnormal behavior as exhibited in a personality disorder. For example, a person who moved into a quiet block in the

suburbs may be apprehensive about their neighbors for the first few months until they get to know them. Apprehension is reasonable. There should be less apprehension afterward unless something threatening occurred. A person with an avoidant personality disorder may never let down their guard. In this chapter, you will learn about personality disorders and ways to mitigate symptoms of personality disorders.

Chapter 7 Mood Disorders

A mood is a temporary feeling generally described as positive or negative, commonly referred to as a good or bad mood. The origin of a mood is vague. A person cannot explain why they are in a good or bad mood. Good moods are associated with less stress, such as when a task is completed and there is a pause before the next task begins. The origin of a bad mood is usually unclear, although sometimes a person associates a bad mood with an adverse event. However, there are times when a person is in a good mood after the same adverse event. During mood swings, a person alternates between good and bad moods. Sometimes mood swings occur without any cogitative trigger. They just happen. Other times a person can do something to change moods. For example, a person in a bad mood can change to a good mood by listening to music or watching an uplifting movie. A mood disorder is disruption of a normal mood or mood swing. A person diagnosed with a mood disorder is in a positive or negative mood for long periods of time. Moods change slowly or rapidly depending on the mood disorder. A person diagnosed with a mood disorder exhibits extreme affect and behavior called manic, hypomanic, and depressive moods. Manic occurs when the patient is highly frustrated, possibly leading to violent behavior. The patient has difficulty controlling themself. Hypomanic occurs when the patient is hyperactive but can control themself. Depressive mood is when the patient has lost interest in life and has difficulty performing activities of daily living. You will learn about mood disorders and what to do about them in this chapter.

Chapter 8 Substance Abuse

Substance abuse occurs when a person continues to use a substance knowing that the substance will have an adverse effect on their health and activities of daily living. For example, a person may use the substance to "relax" on Friday and Saturday and then abstains on Sunday with the hope of returning to normal and being fully functional for work on Monday. Substance dependency occurs when a person uses a substance to feel normal.

Initially, the person uses the substance to "relax." However, the person goes through withdrawal symptoms as the level of the substance in the bloodstream decreases and the body attempts to compensate for the missing substance. Withdrawal symptoms are uncomfortable and may cause serious health problems, such as seizures, depending on the substance. The person reuses the substance to alleviate the withdrawal symptoms. In addition, the person builds a tolerance for the substance, requiring a higher dose to achieve "relaxation" and to prevent withdrawal symptoms. There are two types of substance dependency. These are physical dependency and psychological dependency. Physical dependency occurs when the person experiences withdrawal symptoms when abstaining from the substance. Psychological dependency occurs when the person exhibits drug-seeking behaviors after the physical dependency has dissipated. Addiction is a psychiatric disorder that occurs when a person is psychologically dependent on a substance. A person who is addicted to a substance will spend most of their waking hours focused on obtaining and using the substance with total disregard to activities of daily living including family and employment responsibilities. Substance abuse, substance dependency, and addiction and what to do about them are presented in this chapter.

Chapter 9 Eating Disorders

An eating disorder is a psychiatric disorder that can lead to medical complications, which can result in death. The underlying cause of an eating disorder is the misperception by a patient of their body image; that is, the patient perceives themself to be too fat based on their understanding of normal weight for their age and height.

Food becomes an obsession with the patient. Some patients diagnosed with an eating disorder also have a co-psychiatric diagnosis, which may include depression, anxiety, or obsessive-compulsive disorder. The patient strives to look perfect based on peer pressure or society's definition of the perfect body and ignores the reality of body image. Although eating disorders affect both men and women, there is a higher prevalence of eating disorders in adolescent girls who fall prey to peer pressure. Young boys and girls also develop eating disorders when trying to improve performance in sports. For example, high school and college wrestlers and gymnasts try to decrease weight to excel in sports. Adult women can also develop eating disorders when they focus on regaining a youthful appearance. In this chapter, you will learn about these disorders and the treatments that can correct them.

Chapter 10 Sleeping Disorders

Sleep is an absence of consciousness, inactivity of voluntary muscles, and absence of sensory activities that occurs for approximately 8 hours each day. The ability of a person to react to stimuli is diminished but not totally absent, enabling the person to be aroused. Brain activity, breathing, and other physiologic functions change but remain active. The amount of physiologic activity depends on the stage of sleep.

The reason for sleep is unknown, although researchers have put forth several theories of why a person sleeps. Restorative theory states that sleep provides an opportunity for the body to repair. This is supported by studies that show that major restorative functions occur during sleep such as tissue repair, muscle growth, release of growth hormone, and protein synthesis. A sleeping disorder disrupts sleep, resulting in symptoms that impede the patient's activities of daily living. In this chapter, you will learn about sleep and sleeping disorders and how to intervene to minimize the effects of a sleeping disorder.

Chapter 11 Sexual Disorders

A sexual disorder means that a person is having an ongoing abnormal sexual experience. The abnormal sexual experience becomes a sexual disorder if the experience is causing distress in the person's life, resulting in disruption of relationships with family and friends or employment or legal issues. There are three areas of sexual disorders. These are sexual activity, gender identity, and paraphilia. A person can be diagnosed with a sexual disorder any time in their life. Some sexual disorders, such as gender identity disorders, tend to occur early rather than later in life. Other sexual disorders, such as paraphilia, can progress through life as a person loses impulse control and begins to act out sexual fantasies. The cause for many sexual disorders is unknown. Some researchers believe psychological trauma or a problematic early development period may be the root cause of the sexual disorder. Other researchers feel there is a biological or physiologic basis for a sexual disorder. In this chapter, you will learn about these disorders and discover ways to mitigate them.

Chapter 12 Therapeutic Communications

For a moment, imagine being a patient brought from the emergency department in a wheelchair to a locked-down unit. You are wearing a hospital gown. Your street clothes and other belongings are in a clear plastic bag on your lap. This may or may not be your first time being admitted to a psychiatric unit. As

you are wheeled into the unit, you notice patients walking around dressed in street clothes. You are greeted by a nurse who looks down toward you from over the nurse's station. Your relationship with your nurse begins. The nurse is a key member of the patient's treatment team along with the psychiatrist, social workers, nursing assistants, recreational therapist, and others whose goal is to stabilize the patient and enable them to return to activities of daily living. The therapeutic goal is achieved through medication, one-on-one counseling, therapy groups, therapeutic activities, and informal interaction between the patient and the staff and among patients. Collectively these activities enable the patient to return to the life prior to the most recent episode of their illness. A relationship is the way two people connect with each other. There are various types of relationships, such as casual, friendly, professional, collegial, business, and intimate relationships. All of us engage in relationships. Some relationships are stable and do not change over time, such as a business relationship with the owner of a local store. Other relationships change over time, such as a collegial relationship that develops into friendship. A therapeutic relationship is a connection between a member of the patient's treatment team and the patient whose goal is to follow a prescribed course of treatment to help them return to activities of daily living. A therapeutic relationship is a stable relationship and must not develop into another kind of relationship. That is, the nurse must never become the patient's colleague or friend even after the patient is discharged from the nurse's care. Therapeutic communication is a major element in a therapeutic relationship; it enables the nurse to help the patient deal with a mental disorder. In this chapter, you will learn about how to develop a therapeutic relationship using therapeutic communication with the patient.

Chapter 13 Patient Psychiatric Assessment and Patient Psychiatric Care Plans

There is no universal consensus on the definition of mental health primarily because there is no way to objectively measure mental health. The inability to definitively diagnose a mental disorder is unique in medicine because the science of medicine is founded on an objective assessment followed by laboratory and imaging tests that collectively enable the practitioner to arrive at a medical diagnosis. Once diagnosed, the practitioner prescribes treatment that will likely correct or mitigate a patient's disorder. Mental health is different because there are no laboratory or imaging tests that confirm the practitioner's assessment that the patient is experiencing a specific mental health disorder. That is, there is no blood test or CT scan that will confirm a patient is bipolar or has major depression or one of the many psychiatric diagnoses. The challenge is for the practitioner

to know what is normal and abnormal. This is true for any disorder. For example, the practitioner can review the results of a liver function test to know if the liver is functioning normally. Likewise, a pulmonary function test provides insight into the functioning of the lungs. Normal is defined by researchers who tested both healthy and unhealthy individuals and then compared the results. Certain test results were found in healthy individuals, whereas different test results were found in individuals who were ill. Their findings provided a basis for using the test to diagnose patients. There is also a physiologic understanding for test results. For example, the level of liver enzymes in the blood correlates to the number of liver cells that are dying because liver enzymes are inside liver cells. Knowing what is normal and abnormal in mental health is even more challenging than in other fields of medicine because normal and abnormal mental health is subjective. Behavior is a key indicator of a patient's mental health; however, behavior that seems normal to you may be abnormal to me. We make judgments based on our experiences and beliefs, many of which are influenced by our family, community, education, and culture. You will learn about how to perform a psychiatric assessment and care for psychiatric patients in this chapter.

Chapter 14 Physiologic Basis of Mental Illness

Mental health is a continuum that begins with structure and function of the brain at the physical level. Next is the personal level where each of us cares about ourselves; this leads to the interpersonal level where we interact with others. The continuum ends at the societal level where we embrace social and cultural beliefs. Mental illness has been defined as the inability to see oneself as others see you and the lack of the ability to conform to what culture and society consider normal. General medical conditions are considered when assessing mental health because an underlying medical disorder can mimic symptoms of mental illness. For example, hypothyroidism may result in fatigue and lack of energy, which is a sign of clinical depression. In contrast, hyperthyroidism may present with signs of anxiety, nervousness, increased irritability, and difficulty in sleeping, which may mistakenly lead the clinician to focus on mood disorder or anxiety disorder. Psychosocial and environmental problems with family and support groups, educational challenges, lack of a job and job skills, housing issues, and financial and legal problems have to be addressed. There is a blurred line between mental illness and neurologic disorders since researchers are discovering that mental illness is the result of changes in chemistry of the brain. Such changes could be considered a neurologic disorder since these chemical changes occur in the brain and affect the neurologic system. In this chapter, you will learn about the physiologic foundations for mental illness.

This page intentionally left blank

chapter 1

Foundation of Psychiatric and Mental Health Nursing

LEARNING OBJECTIVES

1. Models of human behavior
2. Therapeutic relationship
3. Therapeutic communication
4. Barriers to communication
5. Defense mechanisms
6. Legal environment
7. Psychiatric therapies
8. Psychiatric assessment tests
9. American nurses association (ANA) Standard of care
10. Nursing assessment
11. Mental status examination
12. Summarize the nursing assessment
13. Developing a nursing diagnosis

KEY TERMS

Active listening
Axis
Chemical restraint
Defense mechanisms
Global assessment of functioning
Legal commitment
Locked seclusion
Mental Health Systems Act of 1980
Mental illness
Mental status examination
Milieu therapy
Models of human behavior
Nonverbal communication
Process recording
Psychiatric assessment
Restraint
Seclusion
Therapeutic communication
Therapeutic relationship

Mental Illness

Mental illness is a psychological or behavioral disorder that alters thinking, mood, the capability of performing activities of daily living and the capability of relating to others. There is no medical test used to diagnose a mental disorder. Instead, practitioners use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) published by the American Psychiatric Association to determine if a person is experiencing a mental disorder. The DSM-5 lists categories of mental disorders and clinically significant behaviors that are associated with a diagnosis. The practitioner uses objective and subjective information to assess the person's behavior to determine if the person has a mental disorder and, if so, specifically the disorder. The practitioner differentiates between expected behavioral change such as depression following a death and behavior that is not expected such as depression in the absence of death or other depressive situations.

1. Models of Human Behavior

The foundation of psychiatric and mental health nursing is based on theoretical **models of human behavior**. These models provide a basis for understanding a patient and diagnosis and treatment of psychiatric conditions. Models of human behavior are used collectively in caring for a patient rather than basing care on

a particular model. The psychiatric nurse can apply the appropriate model to help meet the patient's needs.

- Medical Model: Abnormal behavior is caused by an underlying disease that affects neurochemicals in addition to socio-environmental factors. Treatment of the abnormal behavior focuses on addressing the underlying disease.
- Nursing Model: A holistic approach is used to care for the person. The nurse develops a therapeutic relationship with the person that focuses on the person's biopsychosocial needs. Nursing interventions are determined by the person's reaction to the therapeutic relationship with the nurse.
- Interpersonal Model: A person's behavior is governed by the desire to be satisfied and to avoid anxiety. The nurse's therapeutic relationship with the patient develops trust that is used to satisfy the patient's needs.
- Social Model: Abnormal behavior is defined by the patient's sociocultural environment. A behavior may be acceptable in one society and considered abnormal in another society.
- Behavioral Model: Behavior is learned through rewards for positive behavior and punishment to prevent negative behaviors. Mental illness is considered a behavior.
- Existential Model: A person should be in contact with their emotions and needs based on current experience. A person focused on past experiences may become self-alienated and is likely to display abnormal behavior.
- Communication Model: The meaning of behavior is dependent on successful communication. Abnormal behavior occurs when communication is clouded. Normal behavior occurs when communication is clear. Degrees in clarity in communication explain degrees of abnormal behavior.
- Psychoanalytic Model: Freud proposed five stages of psychosexual childhood development (oral, anal, phallic, latency, and genital). Disruption in psychosexual childhood development results in deviated behavior as an adult.
- Humanistic Model: Maslow's Hierarchy identifies six levels of need. A person needs to meet lower level needs before striving for higher level needs.
  - Self-actualization: Acceptance of facts, problem solving, morality, creativity
  - Esteem: Confidence, self-esteem, respects for others and respected by others, achievement
  - Love/Belonging: Sexual intimacy, friendship, family

- Safety: Health, security, morality
- Physiologic: Food, sleep, sex, water, excretion

2. Therapeutic Relationship

A **therapeutic relationship** is a relationship between a patient and nurse that provides the framework to help the patient resolve clinical problems using interpersonal communication techniques. The psychiatric nurse must establish the therapeutic relationship as a clinical relationship and not friendship. At times there can be a blur in the relationship, especially in an inpatient unit where the patient and the psychiatric nurse may develop a friendlier-than-clinical rapport. There is a fine but definite line between a clinical rapport and friendship. It is the psychiatric nurse who must clearly define the difference and maintain the clinical rapport.

A therapeutic relationship also provides the foundation for the psychiatric nurse to help the patients cope with situations that confront the patients. Processing is thinking logically through a situation to reach an appropriate response to the situation. The psychiatric nurse should not tell the patient what to do. Instead, the psychiatric nurse should ask questions that lead the patient through the process of logical thinking, enabling the patient to reach their own decision.

The therapeutic relationship framework consists of four phases:

- Preinteraction Phase: The nurse assesses unresolved problems presented by the patient with or without the patient's active participation.
- Orientations Phase: The nurse is introduced to the patient and defines the nurse's role and the patient's role in the therapeutic relationship. The nurse is working with the patient—not for the patient. The objective is to develop trust and set mutually agreed upon goals for addressing the patient's unresolved problems based on the results of the preinteraction phase. It is important to tell the patient the rules of confidentiality; what information will be shared and with whom; and what information will not be shared.
- Working Phase: The nurse helps the patient examine unresolved problems and helps the patient achieve goals defined during the orientations phase. A goal is to develop the patient's problem-solving ability to change resistance behaviors and embrace adaptive behaviors.
- Termination Phase: The nurse ends the therapeutic relationship by summarizing accomplishments and unachieved goals of the working phase and

exploring why any goal was not met. Particular care must be given to recognize that the patient may not want to terminate the therapeutic relationship. The nurse focuses on accomplishments made during the therapeutic relationship and encourages the patient to go forward with follow-up care.

3. Therapeutic Communication

Therapeutic communication is the primary tool used in a therapeutic relationship and involves both verbal and nonverbal communication. The transactional theory model is a model for therapeutic communication. The transactional model is a communication process where a message is sent using face-to-face communication enabling the transmission of verbal and nonverbal messages simultaneously by the psychiatric nurse and the patient. Successful communication occurs when the sender's message is received as intended by the sender.

Communication is influenced by the following factors:

- Preexisting Condition: Preexisting conditions are beliefs, knowledge, developmental level, culture, social status, and religion.
- Environmental Conditions: Environmental conditions are distance (the space between the nurse and the patient during the communication process); territoriality (who "owns" the space where the communication takes place. For example, the patient "owns" the space in the patient's room. The nurse "owns" the space at the nurse's station. A conference room is a neutral territory where no one "owns" the space.); and density (the number of participants in the communication).
- **Nonverbal Communication**: Nonverbal communication factors are: facial expressions, maintaining eye contact, posture, appearance, and paralanguage that conveys emotion (volume, intonation of speech, and pitch that modifies meaning of the verbal message).

Therapeutic Communication Process

Therapeutic communication is effective if the psychiatric nurse follows a communication process that fosters a therapeutic relationship between the psychiatric nurse and the patient. Here are steps to follow:

- Introduce yourself by name and title to the patient.
- Ask the patient how they would like to be addressed.

- Recognize that your nonverbal communication greatly influences your therapeutic relationship with the patient. The patient sees you before they listen to you.
- Maintain eye contact with the patient.
- Sit facing the patient using an open relaxed posture.
- Avoid distractions.
- Provide the patient opportunity to express themself.
- Focus on the patient when the patient is speaking.
- Answer the patient's questions directly and avoid giving immediate advice.
- Assess the patient's nonverbal and verbal messages separately. For example, a patient's verbal message may indicate that the patient is calm and in control, whereas the patient's nonverbal message may indicate anxiety and agitation. Remember that a psychiatric patient's nonverbal communication (i.e., behavior) is likely to be considered abnormal and therefore can lead to miscommunication with the nurse.
- Assess the patient's preexisting conditions.
- Respect the patient's preexisting conditions (i.e., values, beliefs).
- Modify your verbal and nonverbal communication to meet the patient's communication needs.
- Be honest with the patient. Explain the patient's rights and limitations to confidentiality regarding the patient's treatment team, family, and friends.
- Express empathy for the patient and develop a care plan that leads the patient to self-care within the patient's capabilities.

Therapeutic Communication Techniques

Therapeutic communication techniques are methods the psychiatric nurse can use to communicate with the patient so that the communication focuses on addressing the patient's clinical problems. A goal of therapeutic communication is for the patient to have the opportunity to express themself freely with the psychiatric nurse. The psychiatric nurse must engage in therapeutic communication using techniques that encourages the patient to speak.

Here are commonly used techniques to encourage the patient to openly engage in communication.

- Give Broad Opening: Invite the patient to select the topic for discussion.
  - "I see that you would like to talk about something."

- Recognition: Acknowledge the patient and compliment the patient on noted changes in the patient's progress toward reaching a goal.
  - "You are dressed smartly today."
- Offering: Encourage the patient to continue expressing themself.
  - "Can I sit with you for a few moments?"
- Accepting: Express the feeling that the patient is understood by the nurse.
  - "I understand what you are saying."
- Restating: Express the general meaning of what the patient says to be sure that the nurse correctly understands the patient.
  - "I understand that you said you are having difficulty staying awake."
- Exploring: Ask more about a statement made by the patient.
  - "Tell me more about what you saw."
- Seek Clarification: Restate the patient's statement and ask the patient if your understanding is correct.
  - "I'm a little unsure of what you said, can you tell me more about the situation?"
- Reflecting: Ask the patient for advice on a problem that the patient faces.
  - "What do you think is the appropriate thing to do?"
- Silence: The patient is given time to think before responding.
- Sequence Event: Explore when events occurred
  - "What happens next?"
- Making an Observation: Verbalize an observable behavior of the patient.
  - "I see that you are picking at your skin. Is something bothering you?"
- Describe Perceptions: Ask the patient to say what the patient is hearing or seeing. This is useful when a patient experiences hallucinations.
  - "What do you see on the table?"
- Focusing: Return the patient to the topic that is being explored.
  - "Can we go back and talk about your childhood?"
- Reality Setting: Clearly state the reality of a situation.
  - "I know you are seeing bugs on the table, but there aren't any bugs there."
- Translate: Desymbolize a patient's statement into true feelings.
  - "Are you saying that you feel alone?"

- Doubt: Express doubt about what the patient states.
  - "I find that is difficult to believe."
- Offering Self: Tell the patient that the nurse is available to assist the patient.
  - "I will stay and talk with you for a while."
- Suggest Collaboration: Encourage the patient to work with the nurse to achieve a goal.
  - "Let's come up with a goal together."
- Planning: Help the patient explore options when a problem specified by the patient presents in the future.
  - "The next time that you don't understand what the doctor is saying, ask the doctor or nurse to clarify what was said."
- Summarizing: State your understanding of what the patient stated, then permit the patient to clarify any misstatements.
  - "You and I decided to develop a goal for you the next time we meet."

4. Barriers to Communication

A barrier to communication is something that impairs transmitting the message or receiving the message for either the psychiatric nurse or the patient. A goal of therapeutic communication is to avoid barriers to communication. Avoiding barriers to communication is challenging since many of them are natural responses most people use in a conversation. Therefore, the psychiatric nurse must make a conscious effort to modify a natural response to a therapeutic communication response.

Here are common barriers to communication:

- Approval/Disapproval: The nurse passes judgment on the patient's statement or action. The nurse should be nonjudgmental about a patient.
  - "You made a good choice."
- Giving Advice: The nurse makes a decision for the patient. The nurse should discuss options and let the patient make their own decision.
  - "Just say no."
- Defending: The nurse protects a person from verbal attack by a patient. The patient has the right to criticize a person or situation.
  - "Your doctor doesn't make mistakes."

- Denial: The nurse denies that a problem exists with a patient after the patient identifies a problem. This makes it difficult for the nurse to help the patient explore the problem.
  - "Your problems can be solved."
- Trite Expressions: The nurse should avoid using meaningless expressions with the patient.
  - "This happens to everyone."
- Minimizing: The nurse's expression leaves the patient feeling that their problem is not important. The nurse should empathize with the patient.
  - "That won't hurt you."
- Interpreting: The nurse restates the patient's statement to give the statement meaning. The nurse should encourage the patient to restate their remarks to clarify their statement.
  - "You really mean to tell me that you don't like taking your medicine."
- Nonverbal Negative Expression: The nurse disengages from the patient, leading to the patient feeling that the nurse is not interested in their statement.
- Value Judgment: The nurse expresses negative feelings based on the patient's unacceptable behavior. The nurse should focus on acknowledging the behavior and develop a therapeutic rapport enabling the nurse to help the patient correct the behavior.
  - "How come you are eating junk food even though you are overweight?"
- Changing the Subject: The nurse changes the subject during a conversation with the patient.
  - "Let's talk about your childhood and we'll talk about your medicine another time."
- Reassurance: The nurse should not give the patient any false hopes. The nurse must communicate realistic outcomes.
  - "All your problems will go away in time."
- Probing: The nurse should persistently question a patient about a topic that the patient does not wish to discuss.
  - "Tell me all the times that you were arrested by the police."

- Rejecting: The nurse rejects the patient's ideas. The nurse should use therapeutic communication techniques to enable the patient to discover for themself that the idea is unsound.
  - "Enough! Don't tell me that again!"
- Why: The nurse should not ask the patient to provide a reason for their statements or behaviors. This places the patient in a defensive position and breaks down communication with the nurse.
  - "Why do you act that way?"

Active Listening

Active listening requires the psychiatric nurse to be attentive to what the patient is saying and use nonverbal communication to demonstrate that the nurse is listening. Active listening conveys respect for the patient and helps the patient build a trusting relationship with the nurse. Implementing active listening is challenging especially in an inpatient unit when a psychiatric nurse is multitasking and patients are free to engage the psychiatric nurse at any time. When interacting with a patient, even for a brief moment, give the patient your full attention. If you are unable to do so, then schedule a time (i.e., "Let's talk in 5 minutes") when you can focus fully on the patient.

Here are techniques for active listening:

- Maintain eye contact with the patient.
- Avoid distraction during a conversation with the patient.
- Listen to the patient. Make sure that you understand what the patient is saying.
- Restate what the patient is saying. Ask the patient to validate your understanding of the message.
- Request the patient to clarify any points that are unclear to you.
- Observe the patient's nonverbal communication.
- Provide appropriate feedback to the patient.

Process Recording

A **process recording** is a document that contains a verbatim record of the conversation between the psychiatric nurse and the patient and is used by the psychiatric nurse to assess if the conversation was therapeutic or not. Information in the process recording is not part of the patient's chart. Process

recordings are primarily used by student nurses to improve their communications skills.

The psychiatric nurse creates a process recording following the conversation with the patient and not during the conversation with the patient. There is a risk of distortion in the process recording because the process recording is dependent on the psychiatric nurse's memory of the conversation.

Both verbal and nonverbal communications are documented in the process record in the order in which they occurred in the conversation as illustrated in Table 1-1.

Nonverbal Communication

Nonverbal communications such as facial expressions, eye contact, and tone in the patient's voice express the patient's feelings just as what the patient says expresses feelings. Nonverbal communication is referred to as a patient's affect. Listen to what the patient says and observe the patient's affect. The patient's verbal communication and nonverbal communication should be congruent. For example, a patient's nonverbal communication should be sad if the patient is talking about their current depression.

A patient who is diagnosed with a psychiatric disorder may express one thought while the patient's affect displays a contradictory message. The psychiatric nurse must use therapeutic communication to assess which is the true message that the patient is sending.

TABLE 1-1 Example of a Process Recording

Process Recording			
Nurse's Response	**Patient's Response**	**Therapeutic/ Nontherapeutic**	**Comments**
"Good evening Mr. Jones. Can we speak for a few minutes?"		Therapeutic	Giving recognition
Silent		Therapeutic	Encouraging the patient to respond
	"Yes"		Expected response
	Hesitancy and anxious		Increased anxiety noted
"Nothing to be nervous about."		Nontherapeutic	May devalue the patient's nonverbal response

For example, a patient may be speaking in a calm and controlled tone with a relaxed facial expression while moving quickly toward the psychiatric nurse in a threatening posture. The psychiatric nurse must decide if the patient's intent is to threaten the nurse or to simply engage the psychiatric nurse in conversation. The psychiatric nurse can intervene by engaging the patient in conversation before the patient enters the psychiatric nurse's personal space. The conversation will elicit more information to assess. If the patient continues toward the psychiatric nurse's personal space, the nurse can extend their hand signaling the patient to stop as a police officer stops traffic. This is a nonverbal gesture that the patient should recognize and cause the patient to change their behavior. The patient's reaction to the psychiatric nurse's nonverbal gesture implies the patient's intent.

A patient's affect can be bizarre, leading the psychiatric nurse to respond inappropriately to the patient and causing the patient to become aggressive. Therefore, the psychiatric nurse should observe and listen to the patient and then assess the patient before reacting to the patient's behavior.

For example, a psychiatric nurse was taking vital signs of all patients in the unit's day room where there were jigsaw puzzle pieces spread on a table. A patient who is noted for bizarre behavior was sitting in a chair and then suddenly moved quickly toward the psychiatric nurse. The psychiatric nurse's initial assessment was that the patient was about to attack them. However, the psychiatric nurse moved to the side and the patient quickly dove under the table to pick up a puzzle piece that had fallen on the floor. The patient was diagnosed with obsessive-compulsive disorder (OCD) among other psychiatric disorders. This patient aggressively takes action to place anything out of order back in order. The situation would have escalated unnecessarily if the psychiatric nurse had called for the intervention team. The intervention team, consisting of a psychiatrist, mental health aides, and supervisory staff, is able to take steps to prevent the patient from injuring themself or others.

Special Needs

Normal verbal and nonverbal communication is based on what is normal for the patient based on the patient's culture, native language, education, and medical condition. The psychiatric nurse must assess if miscommunication by the patient is caused by factors other than a psychiatric disorder. Therefore, psychiatric nurses should be trained in cultural sensitivity.

The psychiatric nurse and the healthcare facility are responsible to communicate with a patient and to implement processes that remove barriers to

communication. For example, a translation service should be used if the patient is unable to communicate because of a language barrier or hearing impairment.

Psychiatric Barriers to Communication

A patient's psychiatric disorder can cause barriers to effective communication with a patient. The psychiatric nurse must employ techniques that overcome those barriers to engage the patient in therapeutic communication.

Here are some tips to help communicate with patients with specific psychiatric disorders.

- Delusion: A patient who has delusions has irrational beliefs but believes their beliefs are rational and will aggressively defend their irrational beliefs. The psychiatric nurse should help the patient focus on reality without agreeing with or arguing about the patient's delusion.
- Thought Disorders: A patient who has a thought disorder is unable to correctly understand the message sent by the psychiatric nurse. The psychiatric nurse should ask simple concrete questions and permit the patient to express themself. The psychiatric nurse should then clarify the patient's answer by restating the patient's response.
- Dementia: Dementia is irreversible deterioration of the patient's mental capacity affecting memory, language, and logical thinking. The psychiatric nurse must reduce distractions from the environment and ask simple, concrete questions that leave no room for misunderstanding by the patient.
- Paranoid Thinking: Paranoid thinking occurs when a patient is mistrusting of the psychiatric nurse and others. The psychiatric nurse should appear nonthreatening and make no movement that could be misinterpreted as a threat.
- Delirium: A patient who is delirious is confused and disoriented and responds inappropriately because the patient misinterprets the psychiatric nurse's statements. The psychiatric nurse should ask simple, direct questions and reassure the patient that the nurse understands their answers.
- Hallucinations: A hallucination occurs when a patient hears or sees something that is not real such as hearing voices or seeing bugs. The psychiatric nurse should acknowledge that the patient is hearing or seeing something but that what they are hearing or seeing is not real. The psychiatric nurse should also give concise commands to redirect the patient.

- Inappropriate Response: An inappropriate response occurs when the patient changes the topic to avoid answering the nurse's questions. The psychiatric nurse should listen to what the patient is saying without judging the patient. The psychiatric nurse should return to the original topic after the patient completes their thought.

Nursing Barriers to Communication

A psychiatric patient may display bizarre behavior during a psychiatric episode. Bizarre behavior can invoke a nontherapeutic response from the psychiatric nurse when the psychiatric nurse reacts intuitively to the patient's bizarre behavior and sends an inappropriate nonverbal message to the patient. It is important that the psychiatric nurse avoid responses that are barriers to effective therapeutic communication.

Here are some traps to avoid.

- Judging or criticizing the patient
- Stereotyping the patient
- Providing false reassurance
- Not focusing on what the patient is saying
- Criticizing other patients and staff in front of the patient
- Becoming angry or argumentative with the patient
- Asking too many questions or not giving the patient time to answer your questions
- Not letting the patient finish talking before you respond

5. Defense Mechanisms

A patient who experiences increased anxiety will use a defense mechanism as a way to cope with the anxiety. A **defense mechanism** is an unconscious effort to manipulate reality to maintain self-esteem and social acceptance. The psychiatric nurse must be able to identify behavior as a defense mechanism to focus on the underlying issue that caused the patient to invoke the defense mechanism.

For example, a patient who denies that they have a chronic illness is expressing a defense mechanism as a way of coping with the distressful situation. A patient's denial is likely to interfere with treatment of the illness in that the

patient will not take prescribed medication or be compliant with follow-up care. The psychiatric nurse must recognize the defense mechanism and then intervene to address the patient's anxiety related to the diagnosis of a chronic illness. The patient should be able to avoid using the denial defense mechanism once they accept that they have a chronic illness. There are many defense mechanisms. Defense mechanisms can be classified as pathological, immature, neurotic, and mature.

Here are common defense mechanisms.

Pathological

- Conversion: A patient presents with physiologic symptoms with no explanation such as a patient who suddenly limps for no known medical reason. Conversion is also known as hysteria.
- Delusional Projection: A patient has delusions of being persecuted such as a patient who states the staff is picking on them.
- Denial: A patient refuses to accept reality such as a patient who denies that they have a chronic illness.
- Distortion: A patient redefines reality to justify the patient's perception of reality such as the patient did not abuse the prescribed medication. They only took a few extra pills to make them feel better.
- Splitting: A patient views a person or situation as either good or bad such as the patient telling the nurse that the physician is not a capable medical practitioner.

Immature

- Acting Out: A patient expresses destructive behavior to themself or others in an effort to gain attention because of the patient's inability to cope with reality such as a patient who self-inflicts superficial cuts on their wrist to gain the attention of the staff.
- Fantasy: A patient enters into unrealistic beliefs when the patient is unable to cope with reality such as a patient who believes they do not have a mental illness.
- Idealization: A patient perceives that another individual has more positive attributes than the individual has such as a patient who perceives that a nurse is better than a patient.

- Passive Aggression: A patient is an obstructionist demonstrated by procrastination, learned helplessness, stubbornness, and a deliberate attempt to fail such as a patient who refuses to speak with the physician because the patient dislikes the medication that the physician prescribed to the patient.
- Protection: A patient shifts the patient's unacceptable feelings, such as prejudice and jealousy, to someone else such as a patient saying that a politician was elected because of their race.
- Somatization: Negative feelings toward others are transformed in a patient's pain, anxiety, or illness such as a patient who becomes anxious when seeing a staff member they dislike.

Neurotic

- Dissociation: A patient temporarily postpones feelings to avoid emotional distress such as a patient who shows no emotions following a motor vehicle accident.
- Intellectualization: A patient distances themself from emotional distress by focusing on the intellectual components of a situation through rituals, magical thinking, and rationalization such as a patient who procedurally describes a traumatic event.
- Rationalization: A patient makes excuses through faulty reasoning that a wrongful act was either not done or the patient was justified for performing the wrongful act such as a patient who states that they had to take their sister's car without permission because they had a job interview.
- Isolation: A patient separates feelings from an emotional event while describing the event such as a patient who describes the death of their parent in concrete terms.
- Displacement: A patient redirects an emotional response to a less threatening person such as a wife yelling at her husband when she received a traffic ticket rather than at the police officer who issued the ticket.
- Reaction Formation: A patient displays a behavior opposite to the behavior the patient wants to display such as being calm when the patient faces a dangerous situation.
- Repression: A patient moves thoughts of a disturbing event to the unconscious preventing the thoughts from entering the consciousness, such as

through lack of awareness or memory lapse, such as a patient who says they do not recall if their father abused medication when their father died of a drug overdose.

- Regression: A patient temporarily reverts to an earlier stage of development rather than coping with a situation in an age-appropriate way such as a patient who throws a tantrum when they do not get a room change.
- Undoing: A patient attempts to reverse an unacceptable behavior by doing an acceptable behavior such as a patient who acts out and then behaves like an ideal patient.
- Withdrawal: A patient removes themself from an interaction fearing that the interaction will cause the patient to recall painful thoughts such as an aunt who lost her only son refraining from attending family gatherings.
- Hypochondriasis: A patient is excessively focused on having an illness such as a patient who frequents a physician asking the physician to authorize unnecessary medical tests.

Mature

- Sublimation: A patient transforms a negative emotion into a positive emotion such as a patient who learns new job skills after losing employment.
- Identification: A patient unconsciously adopts the characteristics and behaviors of another person such as a patient adopting the perceived characteristics of a celebrity.
- Altruism: A patient experiences personal satisfaction by helping others such as serving food to residents of a homeless shelter.
- Thought Suppression: A patient consciously avoids coping with an unpleasant event by pushing thoughts of the event into the preconscious such as a patient faced with credit card bills.
- Introjection: A patient identifies with an object to the extent that the object becomes part of the person such as car that brings perceived social status to the patient.
- Anticipation: A patient plans on how to handle a discomfort that will occur in the future such as planning for the death of a pet.
- Humor: A patient uses witticism or self-deprecation to express feelings that are too unpleasant to address seriously such as making light of death.

6. Legal Environment

Psychiatric patients have the same rights as other patients even if the patient's illness leaves them with limited function. The patient has the right to humane treatment and the right to self-determination within the patient's ability to function.

The **Mental Health Systems Act of 1980** created a bill of rights for psychiatric patients. The bill of rights states that:

- Treatment must be provided by a quality staff in the least restrictive setting based on the patient's treatment plan. The patient has an expectation of privacy and must be provided comfortable accommodation, recreation, and an appropriate diet.
- The psychiatric nurse must be sure that the patient is told their diagnosis and that the patient understands and participates in the patient's treatment plan within the patient's ability. It must be clearly documented why the patient is unable to understand or participate in the treatment plan based on objective evidence.
- The patient must be told how to prepare for discharge.
- The patient has the right to consent to treatment, the right to refuse treatment, and the right to be discharged from the hospital.
- The patient has the right to marry, have children, choose their own lifestyle, and use contraception.

Legal Commitment

Legal commitment is a process by which a judge requires a patient to undergo treatment. Commitment laws are set by state statue and are therefore unique to each state. Generally, the commitment process is as follows:

- The patient demonstrates bizarre behavior that risks injury to themself, others, or property.
- Someone calls the police. Depending on state law, the police may have the authority to bring the patient to the hospital emergency department without the patient's consent. Some states require a crisis psychiatric evaluation to be performed on site by a trained evaluator to assess if the patient should be brought to the hospital without consent. The crisis psychiatric evaluator makes an independent, objective determination if the patient is a danger to themself, others, or property. If so, then the patient is taken to the emergency department.

- Once in the emergency department, two psychiatrists must independently determine if the patient is a danger to themself, others, or property. If so, then the patient is committed to the hospital. The patient becomes an involuntary patient and cannot leave the hospital.
- Within 72 hours of the commitment, the patient has a hearing before a judge. The patient is provided legal counsel whose job is to guard the patient's rights. The patient's healthcare team led by the psychiatrist presents evidence why the patient is to remain committed. The judge determines the disposition of the patient.

The judge can also order that the patient receive medication against the patient's wishes. The order may describe a three-step process for administering medication.

1. The patient is offered medication as a pill or liquid.
2. If the patient refuses, the patient is offered the medication as an injection.
3. If the patient refuses, then the order states that the medication is administered as an injection.

The psychiatrist can at any time discharge the patient or make the patient a voluntary patient if the psychiatrist determines the patient is no longer a danger to themself, others, or property. For example, a patient diagnosed with schizophrenia may become noncompliant with medication, resulting in bizarre behavior. Once the patient becomes medication compliant, then the patient is no longer a danger to themself, others, or property and therefore must be made voluntary.

A voluntary patient may not have the right to immediate discharge from the hospital. Depending on the state law, the patient who wishes to leave the hospital can ask the psychiatrist to discharge them. The psychiatrist can refuse to discharge the patient. The patient then signs a document that officially notifies the psychiatrist that the patient wants to be discharged from the hospital. The psychiatrist has 48 hours to respond to the patient's request. During the 48 hours the psychiatrist assesses the patient to determine if the patient is a danger to themself, others, or property. If so, then the psychiatrist must commit the patient. If not, the psychiatrist must discharge the patient.

Competency to Give Informed Consent

A patient must be competent to give informed consent for treatment and be of age to give consent based on state law, which is commonly 18 years of age. If the patient is not of age to give consent, then the patient's parents or legal guardian will make the decision for the patient.

For an adult patient, the psychiatric nurse must make sure that the patient is competent to give consent based on assessment of the patient's mental status. The patient must

- Be alert and oriented to time, place, person, and situation.
- Be able to be attentive and to concentrate.
- Be able to understand.
- Be able to reason using abstract concepts.
- Be able to reason logically.
- Be able to communicate.

If the patient is not competent to give consent, then the psychiatrist may commit the patient. If the patient remains incompetent after treatment, then a judge will likely appoint a guardian for the patient until the patient is deemed competent by a psychiatrist.

It is important to understand that a patient can be competent even if the patient has been committed to the hospital by a judge. Commitment means that the patient is a danger to themself, others, or property and does not mean that the patient is incompetent.

Patient Rights

The American Hospital Association's Patient's Bill of Rights, the American Nurses Association's Code of Ethics, and Health Insurance Portability and Accountability Act (HIPAA) regulations specify patient's rights. Within these regulations, a hospital has the right to create and enforce policies that limit a patient's right compared to a person who is not hospitalized. For example, smoking might be prohibited and the patient's diet may be restricted to food provided by the hospital.

The patient has a right to

- All communications between the patient and healthcare team, which are confidential.
- Their records, which are confidential.
- Refuse to have their photo taken.
- Decide who, if anyone, has access to their record. Written consent must be acquired before any information, including if the patient is a patient at the hospital, can be released.
- Rescind consent to share information.

There are three exceptions to the patient privacy rules that allow release of patient information, these are:

1. A patient states they will harm another person upon discharge and the patient is being discharged. The healthcare team has a duty to warn the prospective victim.
2. A court order.
3. Education. Patient information contained in the patient's record can be used for educational purpose as long as the patient's identity is expunged from the record.

Seclusion and Restraints

Seclusion is placing the patient in a room that isolates the patient from other patients when the patient becomes agitated and is at risk of injuring themself or others. The seclusion room typically has a bed. There is nothing in the room that can be used by the patient to injure themself.

Open seclusion can be used to give the patient a time-out to compose themself away from the distraction and stimulus of the unit. In this scenario, the seclusion door is open and the patient is free to leave the seclusion room at any time.

Locked seclusion is placing the patient in the seclusion room and locking the door, preventing the patient from leaving the room if the patient becomes violent. The key to the door must always be inserted in the lock so that the door can be opened in an emergency.

Restraint is physically preventing the patient from injuring themself or others through the use of force such as holding a patient or strapping the patient to a bed. Placing a patient in a bed and raising four rails is also considered a restraint because the rails prevent the patient from leaving the bed.

Hospital policy will dictate who can place a patient in seclusion, locked seclusion, and restraints. For example, a registered nurse can direct the staff to place the patient in seclusion without a follow-up assessment by a practitioner. Likewise in some hospitals, a registered nurse can place the patient in locked seclusion or restraints; however, a practitioner must be notified and assess the patient within an hour and determine if the patient should remain in locked seclusion or restraints.

Special procedures must be followed if the patient is in restraints. Depending on hospital policy, the patient must:

- Be placed on consent observation.
- Be asked if they need to use the toilet or want water or food frequently.

- Have their vital signs taken at a prescribed frequency.
- Have the patient's circulation assessed every 15 minutes.
- Have the practitioner assess the patient and renew the order at a set frequency depending on the age of the patient.
- Be assessed and the restraint must be documented every 15 minutes.
- Have the practitioner release the patient from restraints once the patient is no longer a risk of injuring themself or others.

Chemical restraint is restraining the patient through the use of medication, which is illegal. Practitioners commonly prescribe Ativan 2 mg, Haldol 5 mg, and Cogentin 1 mg to the patient for extreme agitation, which is part of the patient's treatment plan. This combination of medication has a calming effect and reduces the need for locked seclusion and restraints. The patient is offered the medication by mouth or by injection. Medication that is part of the patient's treatment plan is not considered a chemical restraint.

7. Psychiatric Therapies

Psychiatric therapies are treatments that focus on improving a patient's psychiatric diagnosis to the point where the patient can be functional in society within the patient's limitations. Psychiatric therapies fall into five categories; these are:

- Milieu Therapy: **Milieu therapy** is a therapeutic approach that uses shared responsibilities and rules within a therapeutic community to influence changes in the patient's behavior and attitudes.
- Counseling Therapy: Counseling therapy is a therapeutic approach where the therapist helps the patient think through problems by presenting a logical approach to problem solving and encouraging the patient to consider consequences of potential decisions before making the decision.
- Psychotherapy: Psychotherapy is a therapeutic approach that explores the underlying cause of the psychiatric disorder with the goal of changing behavior and attitudes. Common psychotherapies are:
  - Crisis Intervention: A crisis is a situation where the patient becomes overwhelmed and lacks the coping skills to address the crisis. Crisis intervention is a therapeutic approach that helps the patient deal with the crisis.
  - Cognitive Therapy: Cognitive therapy is a therapeutic approach that identifies and alters the patient's negative feelings about themself.

- Individual Therapy: Individual therapy is a therapeutic approach where a therapist works one-on-one with the patient to identify and resolve the patient's psychiatric problems.
- Group Therapy: Group therapy is a therapeutic approach where a therapist works with a small group of patients who experience the same or similar psychiatric problems to resolve those problems with assistance from other members of the group.
- Family Therapy: Family therapy is a therapeutic approach that focuses on behavior that interferes with a working family relationship. One or more members of the family may have psychiatric problems, which are resolved during family therapy sessions.

- Drug Therapy: Drug therapy is a therapeutic approach that uses medications to modify the chemical balance in the brain that results in change in behavior and attitudes.
- Behavior Therapy: Behavior therapy is a therapeutic approach that focuses on unlearning unacceptable behaviors and replaces them with acceptable behaviors through training. Here are common behavior therapies:
  - Desensitization: Desensitization is used to treat a patient who experiences phobias by gradually exposing the patient to the situation that causes the patient's anxiety while coaching the patient to relax.
  - Flooding: Flooding is used to treat phobias by exposing the patient to the situation that causes the patient's anxiety and allowing the patient to experience anxiety. The patient remains in the situation without coaching and is expected to confront the problem. The patient's anxiety will reduce over time and the patient will be able to cope with the situation.
  - Positive Conditioning: Positive conditioning exposes a patient to positive reinforcement while gradually exposing the patient to a situation that causes the patient's anxiety.
  - Aversion Therapy: Aversion therapy introduces a painful stimulus whenever the patient has an undesirable behavior with the expectation that the patient will avoid the undesirable behavior to avoid the painful stimulus.
  - Response Prevention: Response prevention is used to treat patients who experience compulsive behavior by redirecting or distracting the patient when the patient is about to express the compulsive behavior.
  - Token Economy: A token economy is a behavior therapy technique that rewards a patient with a token each time the patient performs an

acceptable behavior. At some point during the day, the patient is able to exchange tokens for a privilege or something that the patient values.

- Thought Stopping: Thought stopping requires the patient to realize they are having unacceptable thoughts and to say "stop," and then refocus on positive thoughts.
- Thought Switching: Thought switching requires the patient to substitute positive thoughts for unacceptable thoughts.
- Assertiveness Training: Assertiveness training shows the patient how to express feelings and actions without developing guilt over their feelings or actions.

8. Psychiatric Assessment Tests

Psychiatric assessment tests may provide insight into a patient's problem at the moment the patient is administered the test. A psychiatric test is different than medical tests in that a medical test may be used to definitively diagnose a patient. There is no psychiatric test that definitively diagnoses a psychiatric disorder.

These tests can also be used to estimate the effectiveness of treatment. First, the patient is administered the test and the score is noted in the patient's chart. This is the patient's baseline score. The test is readministered for several weeks after treatment begins. The score is compared to the baseline score to determine if there was any improvement in the patient's condition.

A psychiatric assessment test is no substitution for a thorough psychiatric evaluation. Some practitioners do not administer psychiatric assessment tests to patients who reside in an inpatient facility because a hospitalized patient is constantly being observed by psychiatric nurses and seen by a practitioner daily.

It is important to consider the patient's physical and cognitive abilities before administering a psychiatric assessment test. Any impairment or barriers such as language in the patient's ability to comprehend instructions on the test and to take the test may invalidate the results.

Here are commonly administered psychiatric assessment tests:

- Beck Depression Inventory: The Beck Depression Inventory is a self-administered and self-scored test that asks the patient to identify symptoms of depression that the patient may be experiencing.

- Minnesota Multiphasic Personality Inventory (MMPI): The MMPI is a written test that assesses the patient's personality traits to help identify if the patient has a potential for being violent and is at a risk of suicide.
- Thematic Apperception Test: The Thematic Apperception Test is used to assess the patient's interpersonal relationships and conflicts as well as personality traits. During the test the patient is presented with pictures of ambiguous situations and asked to tell the examiner what the patient believes is happening in the picture.
- Rorschach Test: The Rorschach Test is similar to the Thematic Apperception Test except that the patient is shown 10 inkblots and is asked to describe what they see.
- Sentence Completion Test: The Sentence Completion Test is used to assess the patient's anxieties, aspirations, and other elements of the patient's personality. During the test, the test administrator asks the patient to complete a series of sentences such as, "When I am angry, I …."
- Functional Dementia Scale: The Functional Dementia Scale measures the patient's ability to perform activities of daily living. During the test, the patient is asked to do things such as putting on clothes and pouring juice to assess how well the patient can care for themself.
- Global Deterioration Scale: The Global Deterioration Scale assesses primary degenerative dementia. The patient is tested for neurologic function such as memory and orientation.
- Cognitive Capacity Screening Examination: The Cognitive Capacity Screening Examination assesses the patient's cognitive ability by testing the patient's memory, language, and calculation skills.
- Cognitive Assessment Scale: The Cognitive Assessment Scale measures the patient's cognitive ability by testing the patient's psychomotor functions, general knowledge, and mental capability.

9. American Nurses Association Standards of Care

The American Nurses Association (ANA) developed a standard of care that nurses are expected to follow in the care of patients diagnosed with mental illness. The standard provides a framework within which the psychiatric nurse provides clinical actions to care for the patient. The psychiatric nurse is expected

to assess the patient, determine one or more nursing diagnoses, and then identify desired outcomes for patient care. Next, the psychiatric nurse develops a care plan and nursing interventions to achieve those outcomes.

Assessment

The psychiatric nurse is expected to collect healthcare information about the patient during the assessment interview to create a database of patient information based on subjective statements made by the patient and objective observation of the patient's behavior. The psychiatric nurse must be aware that the patient's physical speaking capability, culture, and knowledge of the language spoken by the nurse can limit the patient's responses. Those limitations are not caused by mental illness.

Diagnosis

The psychiatric nurse analyzes the database of patient information to determine if there is a pattern of information that may lead to a psychiatric nursing diagnosis. The psychiatric nurse must be aware that signs and symptoms of a physical illness mimic a mental illness. For example, a patient who has hypothyroidism may experience signs of depression. A patient who has hyperthyroidism may experience signs of anxiety or a hypomanic episode.

Outcome

An outcome is a goal to improve or relieve one or more signs and symptoms of mental illness based on the patient's diagnosis. For example, an outcome for a patient who has anxiety may be to identify two coping skills that reduce the anxiety.

Planning

The psychiatric nurse develops a care plan for the patient to achieve the patient's outcome. The care plan defines long-term goals. Each long-term goal is divided into one or more short-term goals. Each short-term goal contains evidence-based interventions that lead to completion of the short-term goal. These are interventions that are known to lead to the desired outcome.

Implementation

The psychiatric nurse implements interventions daily and documents the outcome of the intervention. There are eight categories of interventions in psychiatric nursing; these are:

1. **Counseling**

   The psychiatric nurse provides one-on-one counseling and group counseling that focuses on developing coping skills and behavioral changes that encourages good mental health and reduce the likelihood of relapse.

2. **Milieu Therapy**

   A milieu is a therapeutic community structure within which patients reside and interact with staff and other patients. There are community rules, community meetings, and patient assignments to help the community function. The psychiatric nurse is expected to maintain the milieu.

3. **Promote Self-Care Activities**

   The psychiatric nurse develops a care plan with the goal that the patient will perform activities of daily living with minimal support from staff.

4. **Psychobiological Interventions**

   The psychiatric nurse will administer medications as prescribed and evaluate the effectiveness of the medication.

5. **Health Teaching**

   The psychiatric nurse will teach patients about nutrition and other self-care tasks that result in healthy living.

6. **Case Management**

   The psychiatric nurse will coordinate patient care with others on the healthcare team to ensure that the patient receives timely, appropriate treatment.

7. **Health Promotion and Health Maintenance**

   The psychiatric nurse implements interventions that encourage the patient to maintain mental health and prevent the patient from experiencing psychiatric illness.

8. **Evaluation**

   The psychiatric nurse is expected to provide ongoing evaluation of the patient's goals and intervention to determine if the care plan is achieving the desired outcome. The care plan is modified if outcomes are not achieved.

Axis

A psychiatric diagnosis is divided into five sections called an **axis**. Each section provides specific information about a patient's condition. A psychiatric diagnosis is a medical diagnosis made by a practitioner based on a psychiatric evaluation and physical assessment. The psychiatric diagnosis is used to assist the psychiatric nurse to develop the patient's care plan.

Axis I: Clinical disorder such as depression, bipolar, anxiety disorders
Axis II: Personality disorders and mental retardation
Axis III: General medical condition
Axis IV: Psychosocial and environmental problems, such as lack of a support system
Axis V: Global assessment of functioning (GAF) describes the person's social, psychological, and employment capabilities as a value between 0 and 100

Global Assessment of Functioning

The **global assessment of functioning** is a subjective scale (see Table 1-2) assigned to a patient based on the patient's social, occupational, and psychological functionality. The value assigned to the patient by a practitioner is associated with the person's ability to perform activities of daily living and capability to address problems associated with living. The practitioner's assessment is based on subjective data provided by the patient, family, and friends, and objective data gathered during the practitioner's psychiatric evaluation of the patient. The GAF value is used to evaluate the patient's level of care and treatment outcome. For example, a patient with a GAF value greater than 50 might be treated at an outpatient facility, whereas a patient with a GAF value of 50 or lower might be better treated in an inpatient facility. Success of a patient's treatment is measured by an appreciable increase in the patient's GAF value.

10. Nursing Assessment

The psychiatric nursing assessment follows a process that identifies the patient's psychosocial deficits and strengths, which form the foundation for a diagnosis, desired outcome, and care plan that address the patient's deficits. The psychiatric interview is the primary tool used to assess a psychiatric patient. The

TABLE 1-2 Global Assessment of Functioning Scale

91-100	Asymptomatic. The person is able to handle life's problems
81-90	Minimal symptoms. The person may experience mild anxiety and have occasional arguments but otherwise can handle life's problems
71-80	Transient symptoms. Symptoms are expected reactions to stressors. The person experiences slight impairment such as difficulty concentrating after an argument or temporarily falling behind schedule
61-70	Mild symptoms. The person generally functions well. The person may experience mild insomnia, depressed mood, occasional absence from work without cause, or theft within the family
51-60	Moderate symptoms. The person has difficulty at work or in social environments. The person presents with occasional panic attacks, flat affect, and circumstantial speech and has few friends or has conflict with associates
41-50	Serious symptoms. The person is unable to maintain employment, has no friends, expresses suicidal ideation and antisocial behavior such as stealing, and performs severe obsessional rituals
31-40	Impaired reality testing. The patient is unable to work, is depressed, neglects family, or avoids friends. The person is defiant, assaultive, moody, and demonstrates poor judgment and illogical thinking
21-30	Behavior influenced by delusions or hallucinations. The person acts grossly inappropriate or is unable to function. The patient is incoherent, remains in bed, has no friends, is unemployed, and is preoccupied with suicide
11-20	Danger of hurting self or others. The patient has attempted suicide with no expectation of death, is manic, violent, incoherent, or has poor personal hygiene
1-10	Persistent danger of hurting self or others. The person displays recurrent violence, has attempted suicide with expectation of death, or is unable to maintain personal hygiene.
0	Unable to assess due to lack of information

interview provides the opportunity for the psychiatric nurse to assess the patient's psychological functioning and identify the underlying cause that leads the patient to seek psychiatric help. The goal of a psychiatric interview is to gather a database of information about the patient that is used to help the psychiatric nurse understand the patient's problems.

Here are tips for conducting the psychiatric interview:

- Observe the patient's affect and the way the patient answers questions while developing a database of information about the patient. The patient may avoid answering questions that probe sensitive areas of the patient's background fearing that the answer may be embarrassing or may expose the patient to undesired consequences such as legal charges.
- Do not pressure the patient for information. If the patient is uncomfortable answering a question, note the patient's response and move on to the next question.
- Be mindful that the patient may not be a good historian especially if the patient is experiencing a psychiatric episode. The patient provides subjective data that must be verified by other sources after the interview is completed.

Here are guidelines for conducting the psychiatric interview.

Begin the Interview

- Introduce yourself and ask the patient how they would like to be addressed.
- Explain the purpose of the interview and tell the patient that you will be making notes during the interview to help you remember what the patient said.
- Tell the patient how the information will be used in treatment of the patient and who will and who will not have access to this information.
- Explain that information cannot be shared with anyone who is not a part of the patient's healthcare team unless the patient grants written consent to share the information with specific individuals such as the patient's spouse.
- Conduct the interview in a private neutral place such as a conference room.
- Position yourself closest to the door and the patient farthest from the door for safety. The patient should not be able to block your egress from the room should the patient become aggressive during the interview.
- Present a calm, nonthreatening, friendly attitude, which encourages the patient to be open and participate in the interview process.

Chief Complaint

- Begin the interview with an open-ended question such as, "What brings you here today?" The goal is to identify the patient's chief complaint.
- Ask the patient to describe the chief complaint as onset, severity, duration, and impact on their life. Some patients may report nothing wrong because the patient is unaware of their psychiatric problem.
- Write down exactly what the patient says and note the patient's affect.

Biographical and Family Data

- Ask the patient for biographical data such as age, birthplace, marital status, and ethnic origin. The psychiatric nurse must be aware that cultural beliefs can influence the patient's responses to questions.
- Move the interview toward socioeconomic data such as employment, education, financial status, and housing. How does the patient support themself?
- Explore the patient's family. Identify parents, step-parents, foster patients, siblings, and children. Determine if any family member has had a psychiatric or medical disorder. Assess the relationships between the patient and family members. How frequently does the patient interact with family members? Will family members be involved in the patient's care?

Personality and Psychosocial History

- Inquire about the patient's personality by asking how the patient copes with stress, controls impulses, and handles judgment. Assess for clues that indicate the patient's capabilities to adapt.
- Explore the patient's lifestyle such as hobbies, spirituality, support network, relationships, marriage, divorce, children, home life, use of drugs and tobacco, diet, and sleeping.

Psychiatric History

- Focus the interview on the patient's psychiatric history. Has the patient ever been seen by a practitioner as outpatient or inpatient for symptoms of psychiatric disorders such as depression or manic episodes? Ask if the

patient ever experienced suicidal ideations or attempted to commit suicide. Does the patient have a history of self-mutilation such as cutting their arms or legs? Assess if the patient has ever experienced any psychological disturbance.

- Explore any psychiatric episode that the patient mentions during the interview. Gather as much detail as possible related to the episode including the number of episodes; when they occurred; what preceded the episode; and a complete description of the episode. Focus questioning on treatment and follow-up care. Ask the patient to tell you about the treatment. Find out if the patient was compliant with medication and follow-up care.

Physical and Medical History

- Take a full medical history of the patient. A psychiatric patient's medical condition must also be diagnosed and treated.
- Ask if the patient has any acute or chronic illnesses or has any surgical history.
- Determine if the patient has been diagnosed with a thyroid disorder. Hypothyroidism mimics symptoms of depression. Hyperthyroidism can mimic systems of a hypomanic episode.
- Ask if the patient has been diagnosed with diabetes mellitus. Symptoms of low or high blood sugar may resemble signs of psychiatric conditions.
- Determine medications that the patient takes. Include psychiatric and nonpsychiatric medications, over-the-counter medications, and herbal medication. Ask the patient for the dose and frequency of each medication and see if the patient can show you all their medication bottles.
- Ask the patient why they are taking each medication and if the patient feels the medication is effective.
- Identify allergies.
- The psychiatric nurse or the practitioner should perform a complete physical that includes screening tests to assess body function such as kidneys, liver, and metabolic disorders.
- A pregnancy test must be performed on all female patients before any psychiatric medication is administered to the patient. Some psychiatric medications are not safe to take if the patient is pregnant.

Suicide Assessment

The psychiatric nurse must assess a patient for the risk of suicide during each encounter with the patient. A patient may express suicidal ideation with or without a plan. Suicidal ideation is the thought of suicide. Those thoughts may be expressed explicitly by suicidal statements to the psychiatric nurse, staff, other patients, and friends and family. Suicidal ideation may be implied by the patient's actions such as giving away possessions, saying goodbye to family and friends, or preparing to close out their life.

The suicide risk assessment evaluates factors that may lead a patient to suicidal ideation. When performing a suicide risk assessment, evaluate the patient for the following characteristics. The existence of one or more characteristics does not mean the patient will attempt suicide. A thorough psychiatric evaluation must be performed to determine if the patient is a suicide risk.

- Current suicide attempt
- Current suicidal ideation with/without plan
- History of suicide attempt especially within the last year
- Family history of suicide or suicide attempts
- Depression
- Anxiety
- Impulsivity
- Self-injury behaviors
- Loss of pleasure
- Insomnia
- Hopelessness
- Helplessness
- Poor concentration
- Medical condition
- Psychiatric condition (psychosis, substance abuse, schizophrenia)
- History of physical, emotional, sexual abuse
- Incarcerated

If a patient is a suicide risk based on the suicide risk assessment, ask the patient if they have any thoughts of hurting themself. Also ask the patient to contract for safety. A contract for safety is a verbal agreement between the patient and staff that states: should the patient have feelings to hurt

themself, the patient will tell the staff before taking any actions so the staff can help the patient. If a patient refuses to contract for safety, then the patient should remain on constant observation until a practitioner is able to perform a thorough psychiatric evaluation. Constant observation means that a staff member must be within 5 ft of the patient at all times including when in the toilet.

Patients who are a high risk for suicide must be placed in a safe environment that includes:

- No strings, shoelaces, belts, or electrical cords.
- No sharp objects such as scissors, knives, pens, pencils, and nail clippers.
- Controlled access to the outside such as locked doors to the unit and windows that have limited openings.
- All glass in the unit must be safety glass.
- Only safety razors and supervised shaving.
- Shortened telephone cords.
- All items on the unit that can be used as a weapon, including furniture, pipes, and fixtures that can be broken by the patient, must be removed.

A patient who contracts for safety may still have suicidal ideation and may attempt suicide on the unit. A patient may have a secret plan to commit suicide; therefore the staff must be on constant alert for activities that may indicate the patient's intentions. For example, the patient may be pretending to take medication but instead be saving medication to be taken all at one time in an attempt to overdose on medication.

Likewise, a patient may carefully monitor the unit's routine to discover a time when the staff is distracted and not watching the patient such as at meal time and shift change. This gives the patient time to attempt suicide. It takes less than 15 minutes to tie a sheet over the bathroom door and around the patient's neck, stand on the toilet, and jump, breaking the patient's neck.

Always assess for change in behavior when a patient is deemed a suicide risk. A patient who is hopeless, helpless, depressed, and remains in bed all day probably lacks the energy to attempt suicide. However, be on high alert when that same patient is happy, socializing, and engaging with staff because the patient has the energy to commit suicide. The practitioner must evaluate the patient to assess if the change in behavior is related to successful treatment or a façade presented by the patient to conceal the patient's suicidal ideation.

11. Mental Status Examination

A **mental status examination** is used to assess the patient's psychological function and dysfunction that might have led the patient to ask for help. The mental status examination focuses on the patient's cognitive functions such as judgment, reasoning, problem solving, thought pattern, and other factors that can provide insight into the patient's mental function.

Here are questions to ask when conducting the mental status examination. Figure 1-1 illustrates where the examination results are documented in an electronic medical record (EMAR).

Appearance

- Is the patient appropriately groomed and dressed?
  - Abnormal: Disheveled, inappropriately applied cosmetics
- Does the patient dress appropriately for their age?
  - Abnormal: Dresses older or younger for their age
- Does the patient maintain proper hygiene?
  - Abnormal: Odor, poorly maintained teeth, nails, and hair
- Does the patient hold an erect posture?
  - Abnormal: Slouch, stiff posture, head lowered
- Is the patient's weight appropriate to his height, and does the patient have good nutritional status?
  - Abnormal: Overweight, underweight
- Does the patient have a normal gait?
  - Abnormal: Slow, fast, unsteady gait
- Does the patient appear alert and have normal facial expressions?
  - Abnormal: Sleepy, flat expression
- Does the patient make and maintain proper eye contact?
  - Abnormal: Poor eye contact, blank stare, stares at you, breaks eye contact, looks at the floor or around the room
- Is the patient's affect congruent with what the patient is saying?
  - Abnormal: Sadness, overly happy

Behavior:

Volume
- [ ] Normal
- [ ] Loud
- [ ] Soft

Speech
- [ ] Normal
- [ ] Slow
- [ ] Rapid
- [ ] Pressured
- [ ] Other

Eye Contact
- [ ] Good
- [ ] Fair
- [ ] Poor

Attitude
- [ ] Cooperative
- [ ] Med Compliant
- [ ] Warm
- [ ] Friendly
- [ ] Brighter
- [ ] Hopeful
- [ ] Thankful
- [ ] Apathetic
- [ ] Hopeless
- [ ] Helpless
- [ ] Uncooperative
- [ ] Worried
- [ ] Other

Fluency of Speech
- [ ] No Disturbance Noted
- [ ] Mute
- [ ] Hesitancy
- [ ] Late
- [ ] Other

Mood/Affect
- [ ] Calm
- [ ] Appropriate
- [ ] Pleasant
- [ ] Bright
- [ ] Constricted
- [ ] Evasive
- [ ] Guarded
- [ ] Congruent with Mood
- [ ] Happy
- [ ] Sad
- [ ] Angry
- [ ] Labile
- [ ] Elated
- [ ] Euphoric
- [ ] Neutral
- [ ] Worried
- [ ] Guilty
- [ ] Mixed (anxious and depressed)
- [ ] Incongruent (sad and smiling)
- [ ] Inappropriate
- [ ] Depressed
- [ ] Anxious
- [ ] Fearful
- [ ] Irritable
- [ ] Flat
- [ ] Withdrawn
- [ ] Other

Behavior
- [ ] Controlled
- [ ] Aggressive/Combative Behavior
- [ ] Guarded
- [ ] Preoccupied
- [ ] Impulsive
- [ ] Disorganized
- [ ] Refused Meal(s)
- [ ] Refused ADL(s)
- [ ] Refused Medication(s)
- [ ] Evasive
- [ ] Hostile
- [ ] Sexual
- [ ] Hyperactive
- [ ] Psychomotor Retardation
- [ ] Facial Movements (jaw/lip smacking)
- [ ] Distant
- [ ] Aloof
- [ ] Verbally Abusive
- [ ] Suspicious
- [ ] Restless
- [ ] Fearful
- [ ] Intrusive
- [ ] Other

Thinking (Process)
- [ ] No Disturbance Noted
- [ ] Concrete Thinking
- [ ] Circumstantial
- [ ] Tangential
- [ ] Loose Association
- [ ] Flight of Ideas
- [ ] Perseveration
- [ ] Echolalia
- [ ] Clang Association
- [ ] Blocking
- [ ] Word Salad
- [ ] Derailment
- [ ] Logical
- [ ] Other

Judgment - Insight
- [ ] Intact
- [ ] Impaired
- [ ] Denies Problems
- [ ] Understand Reason for Admission
- [ ] Recognizes Illness
- [ ] Other

Thinking
- [ ] No Disturbance Noted
- [ ] Ashamed
- [ ] Delusional
- [ ] Grandiose
- [ ] Guilty
- [ ] Hallucination (Audio)
- [ ] Hallucination (Gustatory)
- [ ] Hallucination (Olfactory)
- [ ] Hallucination (Tactile)
- [ ] Hallucination (Visual)
- [ ] Homicidal Ideation
- [ ] Idea of Reference
- [ ] Magical Thinking
- [ ] Obsessions
- [ ] Paranoia
- [ ] Persecutory Delusion
- [ ] Phobias
- [ ] Poverty of Speech
- [ ] Suicide Ideation
- [ ] Other

FIGURE 1-1 • After examining the patient, results of the mental status examination are recorded by checking appropriate boxes in an electronic medical record.

- Is the patient's behavior appropriate during the examination?
  - Abnormal: Hostile, uncooperative, indifferent, distant, tense, overly responsive, nonresponsive
- Are mannerisms appropriate?
  - Abnormal: Restlessness, nail biting, appears to be listening to someone who is not there or seeing things that are not there
- Is the patient's speech appropriate?
  - Abnormal: Fast or slow pace, illogical responses, overproductive (uses too many words), underproductive (uses too few words), loud or soft, defects in speech, delays responding to questions, or flight of ideas

Affect and Mood

- Does the patient experience a full range of emotions?
  - Abnormal: Depressed, manic, no emotion, mood swings, or patient is unable to discuss their emotions
- Is the patient's affect congruent with their mood?
  - Abnormal: Neutral, flat, depressed, hypomanic, manic, labile (rapid change in range of emotions), or mood is inconsistent with body language
- Is the patient calm and in control?
  - Abnormal: Overly excited, depressed, trembling, angry, provoking, sweating, or crying

Orientation

- What is your name? Where are you? What is today's date?
  - Abnormal: Unable to respond with the correct answers

Memory

- Ask the patient to repeat the words apple, house, and umbrella immediately to test immediate recall.
  - Abnormal: Patient is unable to repeat all the words.

- Continue with the assessment. After 5 minutes, ask the patient to recall the three words to test delayed recall.
  - Abnormal: Patient is unable to repeat all the words.
- Ask the patient about something that happened to them in the past day to test the patient's recent memory.
  - Abnormal: Patient is unable to recall the event
- Ask the patient about the neighborhood where they grew up to test the patient's remote memory.
  - Abnormal: Patient is unable to recall the neighborhood.
- Ask the patient to count backward from 100 by subtracting 7 to test the patient's attention status. Stop after five or six iterations.
  - Abnormal: Patient is unable to perform the subtraction.
- Ask the patient to read and explain a news story to test the patient's comprehension ability.
  - Abnormal: Patient is unable to explain the news story.
- Ask the patient what is meant by the expression "no man is an island" to assess the patient's ability to think abstractly.
  - Abnormal: Patient is unable to explain the expression or explains the expression in concrete terms.

Judgment, Perception, and Insight

Explore the patient's ability to make rational judgments and have an appropriate sense of reality. Also assess the patient's insight into the patient's clinical problem.

- Ask the patient what they would do if they were unable to keep an outpatient appointment.
  - Abnormal: Any response that implies the patient would not reschedule the appointment
- Ask the patient to explain the role of the practitioner.
  - Abnormal: Any response that implies the patient does not perceive that the practitioner is there to help the patient
- Ask the patient to indicate what might be causing their symptoms.
  - Abnormal: The patient's response shows no insight into their disorder.

Thought, Delusions, and Sensory Perception

Thought processing explores how the patient thinks, what the patient says, and whether what the patient says is based on reality. The patient should be focused on answering the nurse's questions and not be easily distracted or seem to be responding to internal stimuli.

Abnormal thought processing occurs when the patient experiences one of the following:

- Circumstantial Thinking: The conversation drifts off the point of discussion and then eventually returns and addresses the point.
- Flight of Ideas: The conversation changes quickly to a series of unrelated topics.
- Loose Associations: The conversation moves to a different but related topic.
- Tangential Thinking: The patient's response is without reference to the question.
- Thought Blocking: The patient's speech is interrupted before the patient completes the thought.
- Preservation: The patient uses few words to respond to questions
- Word Salad: The patient responds using real words when sentences are incoherent.
- Thought Broadcasting: The patient believes their thoughts are being transmitted into the environment.
- Thought Insertion: The patient believes someone is inserting thoughts into their mind.
- Magical Thinking: The patient has an irrational belief that a supernatural occurrence such as placing a spell on a person will cause the person to experience an adverse event.
- Ideas of Reference: The patient believes that an event has occurred, although the patient has no involvement in the event such as the patient feels they are the cause of an airplane crash.
- Depersonalization: The patient loses all sense of identity and expresses feeling that are different from the patient's normal feelings. For example, the patient may feel as if they are outside their body.
- Delusion: The patient has false belief even when presented with evidence to the contrary.

- Phobias: The patient has an irrational fear of a situation such as fear that an elevator will fall when the patient rides an elevator.
- Obsession: The patient is unable to stop thinking about an idea such as becoming a billionaire.
- Sensory Perception: The patient experiences misperceptions referred to as an illusion or hallucination. An illusion is caused by the presence of an external stimulus such as reflection of the sun on the desert giving the illusion of water. A hallucination occurs in the absence of an external stimulus such as hearing voices when no one is speaking (auditory); seeing things that are not there (visual); touching things that are not there (tactile); tasting things that are not present (gustatory); and smelling things that are not there (olfactory).

Cognitive Ability

Cognitive ability is the patient's capacity to remember, understand, reason, and solve a problem. Be aware of factors that may influence the patient's response. For example, a patient who has been an inpatient for several days may not recall the month and date because the patient is disoriented related to disruption in their normal schedule. Likewise, the patient's culture and primary language may provide misleading results. A patient whose primary language is other than English may have difficulty responding to questions. The patient may not have completed formal education.

Level of Consciousness

- Ask the patient their name, where they are, and the date and month.
  - Abnormal: Confused, slow to respond, or sedated.

Memory

- Immediate memory is assessed by telling the patient a series of numbers. Wait 10 seconds and ask the patient to repeat those numbers forward and backward.
  - Abnormal: The patient is unable to repeat the series of numbers forward and backward.
- Recent memory is assessed by asking the patient about an event that the patient was involved in yesterday. Be sure that you can verify the event.
  - Abnormal: The patient is unable to recall any portion of the event.

- Remote memory is assessed by asking the patient where they were born or about schools they attended.
  - Abnormal: The patient is unable to recall those events.

Concentration

- Ask the patient to start with 100 and continue to subtract 7 from the remainder for five iterations.
- Ask the patient to say the months of the year backward.
  - Abnormal: The patient is unable to answer these questions within a reasonable time period.

Abstract Thinking

- Ask the patient to interpret the meaning of common proverbs such as:
  - A stitch in time saves nine.
  - A bird in the hand is worth two in the bush.
- Ask the patient to identify similarities between
  - A bicycle and bus.
  - An orange and apple.
- Abnormal: The patient is unable to interpret proverbs or compare similarities between pairs of objects.

Judgment

- Ask the patient questions whose answers give you insight into the ability to make rational judgment.
  - Abnormal: The patient describes situations that demonstrated poor judgment by the patient such as blaming others for their poor behavior

Psychosocial Assessment

The psychosocial assessment collects objective data about the patient's responsibilities, education, employment, family, spirituality, resources, and culture. Each element of the psychosocial assessment can introduce stressors into the patient's life that could be an underlying cause of the patient's mental status.

Summarize the data and ask the patient to verify that the information you recorded is accurate based on the patient's knowledge. Remember that the information is based on the patient's ability and willingness to share the information with you. The patient may not be a good historian. The information you collected may not be accurate. You must be aware of the patient's cultural and cultural healthcare practices because the patient's culture may influence the patient's responses.

Validate the information provided by the patient with a secondary source after the patient gives you written consent. Secondary sources are family, friends, social services agencies, and healthcare providers who were treating the patient prior to admission.

Ask the patient the following:

- What is your primary language?
- How do you support yourself (e.g., employed, disability benefits, unemployment insurance, state subsidy)?
- Where do you live (e.g., house, apartment, homeless)?
- Who do you live with (e.g., significant other, alone)?
- Tell me about your family
- Do you have children? If so, then ask for detailed information about each child
- What is a typical day like for you?
- Do you practice or belong to any religion or spiritual group?
- What role does religion or spirituality play in your life?
- Describe your cultural background
- What do you do when you are upset?
- What relieves your stress?

Also assess the patient for the following:

- Does the patient have a positive attitude?
- Is the patient able to meet basic needs?
- Can the patient live independently?
- Is the patient able to make rational decisions?
- Does the patient have insight into their illness?
- Does the patient want to participate in treatment?
- Does the patient have a support system of family and friends?

Medication and Medical Assessment

The medication assessment collects objective data about the patient's medication. The assessment must explore the patient's use of prescribed, over-the-counter, and herbal/supplement medications and street drugs. Keep in mind that the patient may not be a good historian, and therefore the psychiatric nurse should verify all reported medication with the patient's prescriber and pharmacy, if possible. Always ask the patient or the patient's family to bring the patient's medication to the facility to enable you to properly identify medication prescribed to the patient.

The medical assessment collects information about the patient's general health. These include allergies, diet, acute or chronic medical conditions, pregnancy, and recent laboratory and medical test results. Enter the results into the patient's EMAR (Figure 1-2).

Here are questions to answer:

- What is the name of the medication?
- What is the dosage?
- How do you take the medication (route)?
- How frequently do you take the medication?
- What are the prescriber's name and contact information?
- How long have you been taking the medication?
- Why was the medication prescribed?
- Has the patient experienced side effects?
- Has the patient experienced good results taking the medication?
- Is the patient compliant taking the medication? If not, why?

Home Meds	Dose	Route	Frequency
SEROQUEL	300 MG	BY MOUTH	BED TIME
NEURONTIN	300 MG	BY MOUTH	3 × DAY
BACLOFEN	10 MG	BY MOUTH	3 × DAY
LISINOPRIL	10 MG	BY MOUTH	DAILY
VENLAFAXINE	75 MG	BY MOUTH	3 × DAY
NALTREXONE	50 MG	BY MOUTH	DAILY
CARISOPRODOL	350 MG	BY MOUTH	2 × DAY

FIGURE 1-2 • It is important that all medications taken by the patient are documented in the EMAR.

If the patient uses street drugs, then ask:

- What street drugs do you use?
- How much do you use?
- How frequently do you use?
- What is your behavior when you are under the influence of street drugs?
- When was the drug last used? Be alert that the patient may experience withdrawal symptoms if the patient uses street drugs regularly but has not used in the past several hours. Withdrawal symptoms can be severe and lead to seizures and delirium, depending on the drug.
- Have you ever experienced an overdose? If so, was it intentional or accidental?
- Have you ever attended a drug rehabilitation program? If so, ask for details.

12. Summarize the Nursing Assessment

The psychiatric nursing assessment summary is a document that describes the psychiatric nurse's findings and becomes a database of information used by the healthcare team to treat the patient. The psychiatric nursing summary contains the following sections:

Identifying Data

This section identifies the patient to the reader.

- "The patient is a 45-year-old single Caucasian male."

Chief Complaint

This section is the patient's description of why the patient came to the hospital.

- "I want to get off street drugs."

History of Present Illness

The psychiatric nurse describes the background of the patient's chief complaint based on the psychiatric nursing assessment of the patient.

- "The patient presented with symptoms of alcohol and opioid withdrawal and is seeking detox. The patient has a history of dependence on alcohol,

opioid, and cocaine that has led to severe impairment in his functioning. The patient denies any suicidal or homicidal ideations."

Present Medications

This section contains a listing of all medications prescribed to the patient along with any herbal or over-the-counter medications and supplements.

- Trazodone 100 mg p.o. at bedtime for insomnia
- Metoprolol-XL 50 mg p.o. daily for hypertension
- Lisinopril 20 mg p.o. twice a day for hypertension
- Vistaril 50 mg p.o. every 6 hours as needed for anxiety
- Spironolactone 25 mg p.o. twice daily for fluid retention

Psychiatric History

In this section the psychiatric nurse describes the patient's psychiatric history based on interviews with the patient and review of the patient's medical records.

- "The patient has a history of polysubstance dependency for more than 20 years. The patient uses alcohol, opioid, cocaine, and benzodiazepine daily. The patient has had five inpatient admissions in the Mentally Ill Chemically Addicted (MICA) unit and six inpatient admissions in the detox unit. The patient is currently being seen in the outpatient clinic."

Medical History

This section describes the patient's medical problems.

- "Hypertension, edema"

Social and Family History

This section describes the patient's psychosocial assessment.

- "The patient is a single unemployed construction worker living alone in an apartment. The patient last worked 9 months ago. The patient's parents are deceased from natural causes. The patient has one sibling, a brother who has a history of polysubstance dependence (alcohol, opioid, cocaine) and has been in recovery for 5 years. The patient has no other living relative."

Mental Status Examination

This section describes the nurse's assessment of the patient's mental status.

- "Alert and oriented X3. Appearance appropriate. Speech normal. Thought processes coherent. Thought associations intact. Mood and affect anxious. Denies auditory and visual hallucinations. Denies suicidal and homicidal ideations. Memory, attention span, and concentration are intact. Insight, judgment, and impulse control adequate."

Assessment of Risk or Violence to Self or Others

This section describes if the patient's behavior could put them or others in danger.

- "The patient denies any suicidal or homicidal ideations. Imminent risk is minimal."

Strengths

This section describes positive features displayed by the patient.

- "The patient is seeking help and willing to participate in treatment."

Weaknesses

This section describes negative features displayed by the patient.

- "History of substance abuse."

Initial Formulation

This section summarizes the nurse's assessment of the patient.

- "This is a 45-year-old man who is seeking inpatient treatment for polysubstance dependence that leads to severe impairment of his functioning."

Problem List

This section itemizes problems that must be addressed during the patient's admission.

- Polysubstance dependence
- Withdrawal
- Anxiety
- Hypertension

13. Developing a Nursing Diagnosis

A nursing diagnosis provides the basis for nursing short- and long-term outcomes and nursing interventions that will achieve those outcomes. The North American Nursing Diagnosis Association (NANDA) has defined an acceptable nursing diagnosis.

There are three elements of a nursing diagnosis:

1. Problem: The problem describes the deficiencies that are presented by the patient during the nursing assessment.

   Example: Substance dependency

2. Etiology: The etiology is the probable cause that contributes to nursing diagnosis.

   Example: Substance dependency related to ineffective coping skills

3. Supporting Data: Supporting data is the objective evidence that supports the nursing diagnosis.

   Example: Substance dependency related to ineffective coping skills as evidenced by multiple relapses

Two categories of goals are established for each nursing diagnosis. There is one long-term goal that specifies the long-term treatment objective. There are one or more short-term goals each creating short-term treatment objectives. The long-term goal is achieved when all short-term goals are achieved.

1. Long-Term Goal

   Example: The patient will achieve and/or maintain sobriety.

2. Short-Term Goal

   Example: Identify two or three stressors in the patient's life and identify two to three coping skills or strategies to handle the stressors.

The final step in developing a nursing diagnosis is to identify nursing interventions for each short-term goal. A nursing intervention is an activity performed by a nurse whose outcome helps to achieve the related short-term goal. Goals and interventions should be entered in the patient's care plan (Figure 1–3).

Example: The nurse will speak with the patient for 15 minutes each shift to help the patient identify a stressor and help the patient identify coping skills to handle the stressor.

- (BHS) Depressive Symptoms
  - LONG TERM GOAL: Patient will state that symptoms of depression have reduced.
    - SHORT TERM GOAL: Patient will engage in self care activities in accordance with the patient's ability.
      - (RN/LPN) Active listening with patient at least 15 minutes every shift while awake.
      - (SW) Active listening 5 times per week to education about depression.
- (BHS) Substance Dependency
  - LONG TERM GOAL: Patient will achieve and/or maintain sobriety.
    - SHORT TERM GOAL: Verbalize the use of substances as a problem in their lives within 3–7 days.
      - (RN/LPN) Positive/effective coping skills.
      - (SW) 1:1 interaction with patient to education on addiction.
- (BHS) Disposition Issues
  - LONG TERM GOAL: Patient will cooperate with discharge planning.
    - SHORT TERM GOAL: Patient will participate in meeting with family and/or appropriate agency.
      - (SW) Discharge planning to coordinate continuity of care.

FIGURE 1-3 • Long- and short-term goals along with corresponding interventions are entered into the patient's care plan in the EMAR.

CASE STUDY

CASE 1

A 23-year-old female patient diagnosed with depressive disorder and personality disorder was hospitalized in an inpatient acute psychiatric unit for 3 days. Hospital policy states that patients are permitted to use the telephone at the nurse's desk for 10 minutes each shift. The patient made a 10-minute phone call at the beginning of the shift and asked the charge nurse for permission to make another telephone call. The charge nurse says no. The patient tells the charge nurse that the staff on the previous shift let her make three phone calls because they were important phone calls. A few minutes later after noticing that the charge nurse is in the chart office, the patient asks the Certified Nursing Assistant (CNA) to make another telephone call. The CNA says no and the patient responds with the same statement.

QUESTION 1. What is the patient doing?
ANSWER: The patient is splitting staff by asking each staff member for permission to use the phone knowing that the patient has exhausted her phone privileges for the shift.

QUESTION 2. How would you respond to this situation?
ANSWER: The best response is to set boundaries for the patient such as enforcing the policy on when a patient is permitted to use the telephone at the nurse's station. Each staff member must enforce the policy. The patient will realize that she will not be rewarded by receiving additional telephone privileges by splitting staff.

FINAL CHECK-UP

1. **The psychiatric nurse on an inpatient acute unit notices a patient pacing the floor looking side-to-side quickly. What should the psychiatric nurse do first?**
   A. Call the practitioners.
   B. Medicate the patient.
   C. Use therapeutic communication.
   D. Place the patient in the seclusion room.

2. **A 53-year-old female patient is nearing discharge from an inpatient acute unit. The patient was admitted 15 days ago for chronic depression following 2 months of noncompliance with medication. The patient lives alone in an apartment that is subsidized by social services. The social worker wants the patient to move to a group home where she can have assisted living and socialize with her peers. The patient approaches the psychiatric nurse and asks what she should do. How should the psychiatric nurse respond?**
   A. Tell the patient that she will enjoy living in the group home because others will be there to help her.
   B. Tell the patient that she should live independently but needs to take her medication as prescribed by the practitioner.
   C. Tell the patient to speak with the social worker.
   D. Help the patient process her options, letting the patient make the final decision.

3. **A 73-year-old male patient is wandering the hallway in the dementia unit during dinner time. The hallway is lined with many doors, some opening to patient rooms and others to closets. All doors are clearly marked. What should the psychiatric nurse do first?**
   A. Take the patient to the dining room.
   B. Ask the patient if he needs to use the bathroom.
   C. Ask if he is a little confused.
   D. Medicate the patient.

4. **A 34-year-old man is admitted to the acute inpatient unit with a diagnosis of schizophrenia paranoid type. He arrives in a wheelchair, and then stands at the nurse's station staring in all directions. The psychiatric nurse introduces herself and the patient stares silently in her direction. What should the psychiatric nurse do first?**
   A. Medicate the patient.
   B. Call the practitioner.
   C. Calmly walk the patient into the seclusion room.
   D. Maintain a friendly tone and calmly explain the admission process and explain any activity that the patient may be seeing around the nurse's station.

5. **A 63-year-old divorced woman and mother of four adult children is admitted voluntarily to an acute inpatient unit for detoxing from Xanax. The patient says, "I get a little anxious since all my kids moved out of the house 4 years ago. My doctor prescribed me Xanax to help me." According to the report from the emergency department, the patient was prescribed a 30-day supply of Xanax and she used the entire supply in 3 days. The patient has six practitioners each prescribing Xanax unbeknown to the others. The patient is careful to have prescriptions filled in different pharmacies throughout the county to prevent pharmacists from discovering her plan. The patient tells the psychiatric nurse, "I don't know why they put me here with all these drug addicts. I'm not one of them. My doctor prescribed me my medication." What is the best explanation for the patient's statement?**

   A. The patient is displaying the distorted defense mechanism.
   B. The high dose of Xanax has made the patient delusional.
   C. The patient is displaying dissociation defense mechanism.
   D. The patient is displaying the undoing defense mechanism.

6. **A 20-year-old man brought to the acute inpatient unit was diagnosed with major depression disorder. Two days before admission to the unit, the patient told his mother that he did not want to live anymore since his girlfriend broke up with him over the weekend. The patient's mother called the police who convinced the patient to go to the emergency department for medication. The patient calmly told the ER psychiatrist that he had no suicide plan and really had no intention to kill himself. With some arm twisting, the patient agreed to be admitted for overnight observation. Early the next morning the patient tells the psychiatric nurse that he is ready to go home. What is the best response?**

   A. I'll get your paperwork ready now. You'll be discharge in a couple of hours.
   B. Talk to the psychiatrist.
   C. You cannot be discharged for 48 hours.
   D. Speak with the psychiatrist. The psychiatrist can discharge you or ask you to stay for further observation or treatment. If you disagree with the psychiatrist, you can sign a 48-hour notice that informs the psychiatrist that you want to be discharged within the next 48 hours. According to our state law, the psychiatrist must discharge you at the end of the 48 hours if the psychiatrist does not feel you are a danger to yourself or others.

7. A 43-year-old female patient was brought to the hospital for bizarre behavior. The patient had been noncompliant with medication for 2 months. The patient was committed to the acute involuntary unit of the hospital. Four weeks after being medicated the patient showed normal behavior but remained involuntary. The charge psychiatric nurse asked a new psychiatric nurse to have the patient sign consent forms. What is the best response?

A. The new psychiatric nurse should explain the consent form to the patient and ask the patient to sign the form.
B. The new psychiatric nurse should tell the charge psychiatric nurse that the patient is not competent to sign the form because she is an involuntary patient.
C. The new psychiatric nurse should assess the patient to determine if the patient is competent. If so, then the nurse should explain the consent form to the patient and ask the patient to sign the form.
D. The new psychiatric nurse should tell the charge psychiatric nurse that she is not comfortable asking the patient to sign the document.

8. A 33-year-old male patient admitted to an acute inpatient unit for anxiety disorder had a verbal altercation with another patient over selection of a television program for evening viewing. The psychiatric nurse separated the patients. The 33-year-old male patient walked the hallway shouting and flaring his arms. What is the psychiatric nurse's first response?

A. Medicate the patient.
B. Place the patient in the seclusion room in four-point restraints.
C. Place the patient in the seclusion room.
D. Use active listening and therapeutic communication to de-escalate the patient.

9. A new psychiatric nurse is conducting the admission assessment with a 24-year-old female patient diagnosed with bipolar I disorder and borderline personality. The patient is calm and cooperative. On report the new psychiatric nurse learns that the patient stopped taking medication 1 month ago and voluntarily took herself to the hospital to have her medication adjusted. The only interviewing area available was in a vacant social worker's office down the hallway from the nurse's station. The new psychiatric nurse sat at the desk located in the center of the room and the patient sat in a chair near the door. The door was open during the interview. All the other patients were in group therapy while the interview was being conducted. Upon learning of the assessment, the charge psychiatric nurse reprimanded the new psychiatric nurse. Why was it necessary to reprimand the new psychiatric nurse?

A. The new psychiatric nurse was using the social worker's office for the assessment.
B. The new psychiatric nurse placed herself at risk.
C. The new psychiatric nurse violated HiPAA law.
D. The charge psychiatric nurse had no cause to reprimand the new psychiatric nurse.

10. A 42-year-old single woman, living alone, was brought to the emergency department by her sister. Her sister received a call from the patient's employer saying that the patient had missed work for the past week and he was concerned about her safety. Her sister found the patient lying in bed, the apartment was in disarray, dishes were unwashed in the sink, and the patient had poor hygiene. The patient told her sister that she had lost interest in everything over the past several months. All she wanted to do was sleep. What should the psychiatric nurse in the emergency department do first?

A. Place the patient on constant observation knowing that a patient with depression may attempt suicide.

B. Ask the practitioner if she wants to order a thyroid test panel.

C. Ask the practitioner if she wants to order a CT scan of the brain.

D. Prepare the paperwork so the practitioner can commit the patient.

CORRECT ANSWERS AND RATIONALES

1. C. Use therapeutic communication. Rationale: The patient is displaying anxiety that can easily escalate to agitation. Therapeutic communication helps to explore and address the underlying cause of anxiety.
2. D. Help the patient process her options, letting the patient make the final decision. Rationale: Do not give advice or make a decision for the patient. Help the patient reach a decision.
3. B. Ask the patient if he needs to use the bathroom. Rationale: Ask simple, concrete questions that leave no room for misunderstanding by the patient.
4. D. Maintain a friendly tone and calmly explain the admission process and explain any activity that the patient may be seeing around the nurse's station. Rationale: The psychiatric nurse should appear nonthreatening and make no movement that could be misinterpreted as a threat. Explaining what the patient is seeing helps the patient to recognize that those activities are nonthreatening. The patient will become less paranoid and more functional in due course.
5. A. The patient is displaying the distorted defense mechanism. Rationale: The patient redefines reality to justify the patient's perception of reality.
6. D. Speak with the psychiatrist. The psychiatrist can discharge you or ask you to stay for further observation or treatment. If you disagree with the psychiatrist, you can sign a 48-hour notice that informs the psychiatrist that you want to be discharged within the next 48 hours. According to our state law, the psychiatrist must discharge you at the end of the 48 hours if the psychiatrist does not feel you are a danger to yourself or others. Rationale: The psychiatric nurse explained the discharge process to the patient.

7. C. The new psychiatric nurse should assess the patient to determine if the patient is competent. If so, then the nurse should explain the consent form to the patient and ask the patient to sign the form. Rationale: An involuntary status does not make a patient incompetent. The psychiatric nurse assesses if the patient is:
   - Alert and oriented to time, place, person, and situation
   - Able to be attentive and to concentrate
   - Able to understand
   - Able to reason using abstract concepts
   - Able to reason logically
   - Able to communicate
8. D. Use active listening and therapeutic communication to de-escalate the patient. Rationale: The psychiatric nurse must use the least restricted technique to control the situation such as therapeutic communication, medication by mouth, open seclusion (give the patient time-out away from distractions), intramuscular medication, or four-point restraints.
9. B. The new psychiatric nurse placed herself at risk. Rationale: Position yourself closest to the door and the patient farthest from the door for safety. The patient should not be able to block your egress from the room should the patient become aggressive during the interview.
10. B. Ask the practitioner if she wants to order a thyroid test panel. Rationale: Determine if the patient has a thyroid disorder. Hypothyroidism mimics symptoms of depression.

This page intentionally left blank

chapter 2

Childhood and Adolescent Psychiatric Disorders

LEARNING OBJECTIVES

1. Attention deficit hyperactivity disorder (ADHD)
2. Autistic disorder
3. Conduct disorder
4. Oppositional defiant disorder (ODD)
5. Major depression disorder (MDD)
6. Mental retardation
7. Tourette syndrome

KEY TERMS

Acetylcholine
Attention deficit hyperactivity disorder (ADHD)
Antisocial behaviors
Autism Screening Questionnaire
Beck Depression Inventory
Center for Epidemiologic Studies Depression Scale
Checklist for Autism in Toddlers
Childhood Autism Rating Scale
Children's Depression Inventory (CDI)
Defiant behavior
Dopamine
Gamma-aminobutyric acid (GABA)
Genetic predisposition
Hyperactivity
Impulsiveness
Inattentiveness
IQ
Major depression disorder (MDD)
Motor tics
Negative behavior
Neurotransmitters
Norepinephrine
Oppositional defiant disorder (ODD)
Repetitive behavior
Screening Test for Autism in 2-Year Olds
Serotonin
Vocal tics

Childhood and Adolescent Mental Illness

The US Surgeon General reports that about 5 million children and adolescents in the United States have a serious mental illness. A serious mental illness is a diagnosable mental disorder that impairs the child's daily life. A challenge the practitioner faces is to differentiate between normal growth and development and symptoms of a mental illness or mental disorder. For example, is defying authority a sign of autonomy or a symptom of oppositional defiant disorder?

Until recently, researchers focused attention on adult mental illness primarily because of the difficulty in differentiating between normal and abnormal growth and development. A child's behavior might appear bizarre at age 2, yet the child demonstrates normal behavior at age 3. The bizarre behavior is considered normal growth and development. Today researchers are investigating factors that may lead to childhood and adolescent mental illness such as neglect, severe emotional trauma, physical abuse, and extreme stress. Researchers are also assessing if chemical messengers in the brain, called **neurotransmitters,** are unbalanced.

Diagnosing

Diagnosing a mental illness in children and adolescents is an involved process. The practitioner initially must rule out other causes for the behavior. In addition to normal growth and development, medical conditions can produce symptoms similar to symptoms of a mental disorder. For example, a metabolic disorder may present with signs similar to depression. Therefore, the practitioner must rule out both developmental and medical causes for the behavior.

There is no definitive test for diagnosing a mental disorder. Practitioners diagnose a mental disorder by accessing information reported by the patient and by third parties such as the patient's family and friends. Practitioners also gather information by clinically observing the patient. Once the practitioner assembles a database of information about the patient, the practitioner lists signs and symptoms presented by the patient and compares them to signs and symptoms described in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) published by the American Psychiatric Association. The DSM-5 defines each mental disorder as a set of signs and symptoms.

Treatment

Childhood and adolescent mental disorders require ongoing treatment. There are two categories of treatment that are effective. These are medication and psychotherapy. Medication is available to treat some, but not all, childhood and adolescent mental disorders by restoring the chemical balance in the brain. Psychotherapy, which includes various types of counseling, focuses on strategies that help the patient understand and deal with symptoms and behaviors. Psychotherapy is offered individually for the patient, and family psychotherapy is used to address family problems. Patients also attend group therapy where their peers help to explore symptoms and behaviors.

NURSING ALERT

Consider underlying medical conditions that mimic symptoms of a mental disorder before focusing on the possibility of a mental disorder.

Working With a Difficult Child

The psychiatric nurse who works on a *children and adolescent unit* will be responsible for caring for children who have mental and personality disorders that lead to disruptive behavior. Behavior can be controlled by using the following strategies:

- Create a token environment: A token environment is one where acceptable behavior is rewarded with a token that can be exchanged for a privilege. The token can be an object such as a coin or points on a daily record. A privilege is something that is desired by the child, like watching a movie or additional free time.
- Set expectations: All children on the unit must understand what acceptable and unacceptable behavior is. Furthermore, they should know the rewards for acceptable behavior and the consequences for unacceptable behavior.
- Authoritative care: Each child is expected to accept responsibilities for self-care and chores. The child should also be encouraged to make some decisions on their own.
- Positive feedback: The nurse should consistently engage the child, offering emotional support and nurturing. Encourage the child to express feelings; and listen carefully to what the child says. Be sure to provide positive feedback to indicate when the child is performing acceptable behavior.
- Time-out: The child must be given a time-out when the child displays disruptive behavior such as tantrums, yelling, hitting, or destroying property. A time-out requires that the child be immediately removed to the time-out room. Time-outs should be immediate and last a relatively short period of time, usually until the child calms down. The time-out is then seen as a consequence for unacceptable behavior. Tell the child why the child is in time-out. Don't talk to the child while in time-out. After time-out is over, discuss with the child alternative ways the child can behave. If the child leaves before time-out is over, then revoke 5 minutes of privileges for every minute that the child leaves time-out early. Always return the child to the time-out room.
- Remove privilege: Revoking a privilege is done for a short time period. For example, the child will not be permitted to watch one movie. If the child acts up a second time, then revoke a different privilege. Never increase the time period of a revoked privilege. Avoid revoking a privilege that a child has already earned. The earned privilege is a reward for previously acceptable behavior.

- Refuses time-out: A child must be physically assisted to the time-out room if the child refuses to go voluntarily.
- Out of Control: A child who is emotionally and physically out of control must be placed in a therapeutic hold to prevent the child from self-injury and injuring others. A therapeutic hold is a technique of restraining the child in a way that the child has limited range of motion of arms and legs while not injuring or causing the child any pain. In extreme situations, the child is placed in seclusion or is physically restrained. Seclusion is when a child is placed in a relatively bare room until the child regains self-control or medication calms the child. Restraint is where the child's arms and legs are tied to a bed using leather straps.
- Mess caused by disruptive behavior: The child must clean the mess that the child caused during the child's disruptive behavior after the child leaves time-out.

NURSE ALERT

Disruptive behavior is one way a child seeks attention and may be the child's attempt to control the situation. The nurse must not take such behavior personally. Focus should be on using good child care strategies to influence the child's behavior. Ask the supervisor to give you temporary relief if you feel you are becoming emotionally involved in the situation. Never interact with a child if you become emotionally involved in the situation.

1. Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is developmentally inappropriate behavior in school-age children that results in the inability of the child to focus on the task at hand. More boys than girls are diagnosed with ADHD. Some researchers believe a child can develop ADHD as early as 4 years of age.

What Went Wrong?

The underlying cause of ADHD is not known; however, the neurotransmitters dopamine and norepinephrine have been associated with hyperactivity deficits and serotonin with impulsivity. Researchers have found a family link to ADHD where a close family relation of a child diagnosed with ADHD also had been diagnosed with ADHD. ADHD also correlates with a child being exposed to complications at birth and low birth weight, lead poisoning, child abuse, drug

use by the child's mother when pregnant with the child, and frequent stressful situations. Some children diagnosed with ADHD are also diagnosed with anxiety disorder or depression.

Prognosis

Treatment helps children manage the disorder. Some children outgrow symptoms of ADHD, whereas others continue to express symptoms as adults.

Hallmark Signs and Symptoms

- **Inattentiveness**:
  - Unable to focus on new things; can focus on things they like doing
  - Easily distracted
  - Do not complete tasks
  - Make frequent mistakes
  - Avoid complex tasks
- **Impulsiveness**:
  - Interrupt someone when talking
  - Express views before thinking of what they are saying
  - Not waiting their turn
  - Unable to express their feelings
  - Acting out
- **Hyperactivity**:
  - Unable to sit still
  - Always moving and talking
  - Fidgety
  - Doing multiple things at the same time

Common/Interpreting Test Results

There is no test that is used to diagnose children for ADHD. The initial physiologic and developmental disorders are ruled out by conducting a

- Neurologic examination
- Hearing examination
- Vision examination
- Developmental examination

Once physiologic and developmental disorders are ruled out, the child is assessed for six symptoms from the following inattention group or six symptoms from the following hyperactive–impulsivity group before being diagnosed with ADHD. Symptoms must persist for 6 months.

- Symptoms present before age 7.
- Symptoms are inconsistent with the child's developmental level
- Symptoms present in two or more settings.
- Inattention
  - Does not listen when spoken to
  - Does not complete tasks
  - Loses tools necessary to complete tasks
  - Disorganized
  - Careless
  - Forgetful
  - Unable to focus on details
  - Unable to follow instructions
  - Distracted easily
- Hyperactivity–impulsivity
  - Cannot wait their turn
  - Talks excessively
  - Fidgets
  - Unable to remain seated
  - Unable to play quietly
  - Excessively active
  - Interrupts others

Treatment

Administer: Ritalin (methylphenidate), Dexedrine (dextroamphetamine), Cylert (pemoline)

- Immediate-release dose lasts 2 to 4 hours.
- Extended-release dose lasts 8 to 12 hours.
- Side effects include anorexia, weight loss, nausea, headache, and insomnia.
- Caution: These medications have a potential for abuse by the child and family members.

Nursing Diagnoses

- Impaired social interaction related to intrusive behavior
- Noncompliance with expectation of task related to low frustration tolerance and short attention span
- Risk for injury related to impulsive behavior and the inability to perceive self-harm

Nursing Interventions

- Minimize impulsiveness by scheduling frequent breaks in the activity.
- Break tasks into small steps that the child can complete within their attention span.
- Assist the child in identifying unacceptable and acceptable behaviors.
- Create an environment with minimum distractions.
- Encourage the child to express themself when they become frustrated or hyperactive.
- Monitor the child for fatigue and hunger that can lead to hyperactivity.
- Encourage activities with other children.

NURSING ALERT

Be aware that a diagnosis of a mental disorder can stigmatize the child and the child's family. Take special care explaining the mental disorder to them and the prognosis for the child.

2. Autistic Disorder

Autistic disorder is a pervasive developmental disorder characterized by impairment in social interactions, communication, and **repetitive behavior**. The child diagnosed with autistic disorder exhibits inappropriate responses and impaired language when interacting with others and the environment. The child is unable to understand what is happening around them, leading to the child being aloof and isolated from peers and family. Researchers report that autistic disorder is more likely in boys than girls, and parents who have a child diagnosed with autistic disorder will have a 6% chance of having a second child with autistic disorder.

What Went Wrong?

The cause of autistic disorder is unknown, although researchers have noticed impaired neural development and impaired connections between nerve cells. Researchers have also noticed abnormal structure and function in the brain. Researchers believe there is a connection between complications in pregnancy, **genetic predisposition**, and environmental factors that may influence development of autistic disorder. Environmental factors include vaccines, exposure to chemicals, and viral infections.

Prognosis

Some researchers have found that 78% of children diagnosed with autistic disorder have a poor to fair prognosis of overcoming many characteristics of autistic disorder. Approximately 60% will be employed, usually in volunteer or part-time work. Many autistic children develop language skills by age 5.

Hallmark Signs and Symptoms

- Infancy:
  - Does not seem to hear
- By 12 months:
  - No cooing
  - No waving
  - No grasping
  - No pointing
- By 16 months:
  - Unable to say words
- Age 2:
  - Rapid regression
  - Unable to say phrases
  - Loss of social skills
  - Loss of language skills
- Age 3 and older:
  - Impaired language development
  - Inability to communicate effectively
  - Repetitive motions and requires sameness

- Poor eye contact
- Fearless and self-injury behaviors
- Unprovoked outbursts
- Inability to make friends
- Inability to be emotional
- Inappropriate make-believe play
- Preoccupied with objects

Common/Interpreting Test Results

There is no test that is used to diagnose a child with autistic disorder. The initial physiologic and developmental disorders are ruled out by conducting a:

- Neurologic examination
- Hearing examination
- Vision examination
- Developmental examination

Once physiologic and developmental disorders are ruled out, the child is assessed using the following screening tests:

- **Autism Screening Questionnaire**: This questionnaire consists of 40 questions and is used to assess the child's social and communications skills. The child must be at least 4 years old to be assessed using this questionnaire.
- **Checklist for Autism in Toddlers**: This is a two-part questionnaire, half completed by the child's parents and the other half by the child's practitioner, and is used to assess the child at age 18 months.
- **Childhood Autism Rating Scale**: An observer monitors how well the child interacts with people, speaks, listens, and can manage change.
- **Screening Test for Autism in 2-Year Olds**: An observer monitors a 2-year-old child's attention and motor and play skills.

The child must demonstrate six characteristics from three of the following categories and at least two from the social interaction category and one from the communication or patterns category.

- Before age 3, delays in
  - Imaginative play
  - Communication
  - Interacting with family

- Social interaction
  - Impairment in nonverbal behaviors such as expression and postures
  - Lack of reciprocal emotions
  - Unable to develop friendship with peers
- Communication
  - Spontaneous make-believe behavior
  - Delay in language development
  - Unable to initiate or sustain a conversation
- Patterns
  - Unable to deviate from routines
  - Repetitive motion
  - Preoccupation with objects

Treatment

- No medication is available to treat autistic disorder. Researchers are studying the use of medication to control mood swings and outbursts.
- Family counseling: Helps the family cope with the child's behaviors.
- Residential placement: If the child's behavior cannot be managed by the family, then the child can be placed in a group home or other facility where trained staff care for the child 24/7.
- Education: Special education programs are available to help the child modify their behavior. A preferred approach is to mainstream the child by placing the child in a regular classroom and providing the child assistance to cope with interacting with the classroom environment. Key to the mainstream approach is the child's capability to be in a classroom setting.

Nursing Diagnoses

- Impaired social interactions related to inability to develop relationships with peers
- Disturbed through process related to fixation on animated objects
- Impaired communication related to underdeveloped communications skills

Nursing Interventions

- Speak in concrete terms when talking with the child.
- Speak to the child face-to-face.
- Maintain a safe environment.
- Avoid punishing the child since punishment might lead the child to self-injure themself.
- Give rewards for good behavior.
- Recognize behaviors that precede outbursts and intervene immediately.
- Identify situations that triggers outbursts and avoid those situations.
- Maintain a regular schedule using a picture board to show the order of activities.
- Introduce change gradually by modifying the picture board and reviewing the picture board with the child to introduce the child to the change.
- Ask parents to join a parent's group to help them cope with autistic disorder.

3. Conduct Disorder

A child diagnosed with conduct disorder violates the rights of others and demonstrates **antisocial behaviors** that result in being disciplined in school, taken into custody by authorities, and possibly incarcerated. Conduct disorder occurs before age 18 and can occur before age 10, which is referred to as early-onset conduct disorder. More males than females are diagnosed with conduct disorder.

What Went Wrong?

There is no known cause for conduct disorder. Researchers report that a detachment from family is a risk for conduct disorder. Also approximately 50% of children diagnosed with conduct disorder also are diagnosed with ADHD (see Attention Deficit Hyperactivity Disorder).

Prognosis

A child diagnosed with early-onset conduct disorder has a high probability of developing an antisocial personality as an adult. Approximately 50% of children

diagnosed with conduct disorder are likely to be diagnosed as having an antisocial personality as an adult.

Hallmark Signs and Symptoms

- Destroying property
- Stealing
- Fighting
- Sexually abusing others
- Cruelty to animals
- Not attending school
- Drug abuse
- Verbally abusing others

Common/Interpreting Test Results

There is no test that is used to diagnose a child with conduct disorder. The initial physiologic and developmental disorders are ruled out by conducting a:

- Neurologic examination
- Hearing examination
- Vision examination
- Developmental examination

Three of the following criteria must be present within the past year and one criterion present in the past 6 months.

- Under the age of 18
- Clinically significant impairment
- Aggression
  - Cruelty to people or animals
  - Forcing a person into sexual activity
  - Starting altercations
  - Threatening behavior
  - Using a weapon in an altercation
  - Robbing a victim

- Deceitfulness
  - Burglary
  - Steals valuable items in the presence of a victim
  - Swindles a person after gaining the confidence of the person
- Destruction
  - Purposefully destroys a person's property
- Rule violation
  - Running away from home for a long period of time
  - Cuts classes at school (age 12 years or younger)
  - Stays out late against parents' direction (age 12 years or younger)

Treatment

- No medication is available to treat conduct disorder.
- Psychotherapy:
  - Focus on behavior modification and developing skills to solve problems.
  - Reward good behavior and provide consequences for bad behavior.
  - Develop ways for the child to bond with family and friends.
- Education:
  - Focus on developing successes in school so that the child remains in school.

Nursing Diagnoses

- Risk for violence related to poor impulse control
- Knowledge deficit related to inappropriate coping skills
- Impaired verbal communication related to verbal altercations

Nursing Interventions

- Help the child to identify abusive communication and show the child alternative communication techniques.
- Help the child accept responsibility for their actions.
- Teach the child how to appropriately express frustration.
- Set expectations for acceptable behavior.

- Teach the child what is unacceptable behavior.
- Establish consequences for unacceptable behavior.
- Reward acceptable behavior.
- Help the child develop problem-solving skills.

4. Oppositional Defiant Disorder

Oppositional defiant disorder (ODD) is depicted in a child who displays a pattern of defiant, hostile, and disobedient behavior to parents, family, teachers, or any authoritative figure. Defiance is part of normal development and occurs related to an event such as the child being overtired and hungry. ODD occurs without an event triggering an episode. The child purposely annoys and will not back down in face of authority. Onset of ODD is between ages 3 and 19 and is more common in boys than girls before puberty and equally after puberty.

What Went Wrong?

The cause of ODD is unknown, although researchers have noticed that the risk increases if the child experiences family discord or parental rejection or if parents demonstrate oppositional **defiant behavior**. Researchers also report increased ODD in children who experience inconsistent child rearing, such as being supervised by many different caregivers.

Prognosis

Approximately 10% of children diagnosed with ODD will continue to have symptoms of ODD for life. Researchers report that treatment can improve in approximately 50% of the children diagnosed with ODD.

Hallmark Signs and Symptoms

- Blames others for own mistakes
- Loses temper frequently
- Revengeful
- Refuses to cooperate
- Fighting frequently
- Few friends

- Resentful of others
- Angers frequently
- Argues with adults
- Does not follow instructions given by adults
- Easily annoyed

Common/Interpreting Test Results

There is no test that is used to diagnose a child with ODD. The initial physiologic and developmental disorders are ruled out by conducting a

- Neurologic examination
- Hearing examination
- Vision examination
- Developmental examination

Four of the following criteria must be presented within 6 months to be diagnosed with ODD. The frequency must be more than that for a child at the same age. Rule out an episode of psychotic disorder and mood disorder. The child must be under the age of 18.

- **Negative behavior**
  - Argues with adults
  - Deliberately annoys adults
  - Annoyed by others easily
  - Vindictive
  - Resentful
  - Loses temper
  - Blames others for own mistakes
  - Noncompliant with rules
  - Noncompliant with directions given by adults

Treatment

- No medication is available to treat ODD.
- Individual psychotherapy
- Family psychotherapy

Nursing Diagnoses

- Ineffective coping related to poor problem-solving skills
- Ineffective relationship related to verbal altercation with adults
- Impaired social interaction related to loss of peer friendship

Nursing Interventions

- Teach communication skills.
- Help the child identify triggers that cause negative feelings.
- Help the child evaluate how their behavior affects others.
- Set expectations for the child.
- Discuss strategies the child can use to address accountability for their behavior.
- Help the child develop problem-solving skills.
- Reward good behavior and provide consequences for bad behavior.
- Explore ways the child can handle negative situations.
- Help the child express negative feelings appropriately.

5. Major Depression Disorder

Major depression disorder (MDD) occurs when a child is persistently depressed, leading to loss of appetite and an inability to get sufficient sleep. The child is unable to experience joy. A child is considered to have MDD if the child has one or more depressive episodes lasting 2 weeks or more. The child might be irritable and display aggressive behaviors when unable to focus and reach rational decisions.

What Went Wrong?

Researchers have found an imbalance in **acetylcholine**, **dopamine**, **gamma-aminobutyric acid (GABA)**, **norepinephrine**, and **serotonin** neurotransmitters as well as abnormal metabolism of glucose in the prefrontal cortex and temporal lobes. In addition, there is a genetic predisposition involving chromosomes 4, 11, 18, and 21. Researchers also believe there are psychological and social risk factors such as emotional trauma, child neglect, and chronic illness.

Prognosis

Researchers report that half of children diagnosed with MDD recover following one episode. The other half experience recurrent episodes. A child with MDD is at risk for psychosocial developmental problems and for suicidal behavior and substance abuse. A child with multiple episodes of major depression is at risk for experiencing major depression as an adult.

Hallmark Signs and Symptoms

- Lack of concentration
- Chronic sadness
- Boredom
- Frequent somatic complaints
- Withdrawn
- Irritable
- Disruption in normal sleep habits

Common/Interpreting Test Results

There is no test that is used to diagnose a child with MDD. Screening tests are used to assess a child for signs of depression. If the screening test is positive, then a further assessment is performed. Screening tests include:

- **Beck Depression Inventory** (adolescents)
- **Children's Depression Inventory (CDI)** (ages 7-17)
- **Center for Epidemiologic Studies Depression Scale** (adolescents)

If a screening test is positive, then physiologic and developmental disorders are ruled out. Rule out bereavement. The following conditions can mimic symptoms of MDD:

- Endocrine disorders
- AIDS
- Nutritional imbalance
- Electrolyte imbalance
- Cardiovascular disorders

Five of the following criteria must be present during the same 2 weeks for a child to be diagnosed with MDD. The symptoms must change from the child's previous behavior and affect the child's ability to function normally. One symptom must be loss of interest in a joyful activity or a depressed mood. Symptoms are reported by the child or others.

- Agitation
- Fatigue
- Unexplained weight loss
- Unexplained weight gain
- Irritable
- Decreased interest in activities
- Unexplained decrease in appetite
- Unexplained increase in appetite
- Decreased sleep
- Increased sleep
- Guilt
- Suicidal ideation
- Unable to concentrate
- Feeling worthless

Treatment

- Administer: Prozac (fluoxetine), Zoloft (sertraline), or Paxil (paroxetine)
  - Caution: The child should be weighed weekly to determine if there is any weight gain or loss as a side effect of the medication. The child should also be monitored for suicidal ideations.
- Individual psychotherapy

Nursing Diagnoses

- Hopelessness related to loss of interest in daily activities
- Social isolation related to decreased socialization with peers
- Risk for suicide related to low self-esteem

Nursing Interventions

- Monitor the child for suicidal ideations.
- Maintain a safe environment for the child.
- Ask the child to contract for safety. If the child feels like injuring themself, the child will tell an adult.
- Encourage the child to express the reasons for feeling depressed.
- Help the child explore the underlying causes of their negative statements.
- Provide positive ways for the child to cope with stressors.

6. Mental Retardation

Mental retardation is a disorder where a child's general intellectual function is below an **IQ** of 70, resulting in the child developing slower than other children of their age.

The initial physiologic disorders are ruled out by conducting a

- Neurologic examination
- Hearing examination
- Vision examination

Mental retardation is classified as:

- Mild: IQ 50 to 70
- Moderate: IQ 35 to 49
- Severe: IQ 20 to 34
- Profound: IQ below 20

What Went Wrong?

Sixty percent of children diagnosed with mental retardation had factors that predisposed the child to mental illness. Factors leading to predisposition to mental retardation are genetic, traumatic pregnancy or delivery, metabolic disorder, early childhood trauma or disease, and effects of other mental disorders. Forty percent of children diagnosed with mental retardation do not have factors leading to predisposition to mental retardation.

Prognosis

With training and education, children diagnosed with mild to moderate mental retardation can become self-sufficient with limitations and with ongoing support from family and the community. Children diagnosed with severe or profound retardation are likely to have an increase in medical problems that shorten their life and require consistent assistance from professional staff.

Hallmark Signs and Symptoms

- Inability to meet developmental milestones
- Acting out
- Language deficient
- Impaired psychomotor skills
- Unable to follow instructions
- Inappropriate social interactions
- Unable to cope with frustrating situations
- Unable to care for themself
- Immature behavior

Common/Interpreting Test Results

An IQ test is used to determine the intellectual functioning ability of the child. Clinical judgment is used to assess the potential intellectual functioning ability for a child who is too young to participate in an IQ test. An IQ of below 70 is a criterion for being diagnosed as mentally retarded. In addition, the child must be under 18 years of age and show deficits in at least two of the following:

- Home living
- Self-direction
- Self-care
- Interpersonal skills
- Use of community resources
- Academic skills
- Communication skills

Classification of mental retardation is based on the following criteria:

- Mild retardation
  - IQ 50 to 70
  - Can be employed
  - Can manage finances
  - Can learn
  - Achieved fourth-grade reading level
  - Can acquire vocational skills
  - Can care for themself
  - Can live on their own
- Moderate retardation
  - IQ 35 to 49
  - Unable to be employed
  - Can manage small amounts of cash
  - Can learn at a second-grade level
  - Can acquire busy-work skills with low expectations for vocational work
  - Must be closely monitored when performing self-care tasks
  - Cannot live on their own
  - Limited ability to interact with others
- Severe retardation
  - IQ 20 to 34
  - Unable to be employed
  - Limited ability to manage small amounts of cash and help an adult with shopping
  - Unable to learn except for basic skills
  - Poor motor skills
  - Must be closely supervised when performing any task
  - Cannot live on their own
  - Limited ability to interact with others
  - Profound retardation

- IQ below 20
  - Unable to be employed
  - Unable to learn
  - Poor motor skills
  - Constant supervision
  - Cannot live on their own
  - Unable to interact with others

Treatment

- No medication is available to treat mental retardation.
- Educational training
- Speech and language training
- Behavioral management
- Family therapy

Nursing Diagnoses

- Inability to meet role expectations related to impaired intellectual function
- Impaired social participation related to impaired intellectual function
- Inability to meet basic needs related to impaired intellectual function

Nursing Interventions

- Provide a safe environment
- Speak in short concise sentences
- Encourage the child to perform tasks within their ability
- Teach the child self-care skills
- Develop a daily schedule for the child and the family
- Reward the child's accomplishments
- Encourage the child to socialize within the child's tolerance and the tolerance of peers and family
- Encourage parents to send the child to school

7. Tourette Syndrome

The child with Tourette syndrome displays involuntary muscle movements and vocal sounds that occur gradually between 2 and 15 years of age. Muscle movements are commonly referred to as **motor tics** and can affect any part of the body. Vocal sounds are called **vocal tics** and may involve inappropriate words.

What Went Wrong?

There is no known cause of Tourette syndrome. Researchers report that children diagnosed with Tourette syndrome also have decreased levels of acetylcholine, dopamine, GABA, norepinephrine, and serotonin. There is also abnormal metabolism in areas of the brain. Some believe that emotional trauma during the first trimester of pregnancy may predispose the child to Tourette syndrome. Symptoms increase when the child is under stress.

Prognosis

Episodes of involuntary movements decrease with age, and the child may become symptom-free as an adult. Children diagnosed with Tourette syndrome experience a normal life expectancy without any developmental impairment.

Hallmark Signs and Symptoms

- Eye blinking
- Head jerking
- Grunting
- Obsessive actions
- Hitting head
- Guilt
- Obscene gestures (copropraxia)
- Cursing (coprolalia)

Common/Interpreting Test Results

There is no test that is used to diagnose a child with Tourette syndrome. The initial physiologic and developmental disorders are ruled out by conducting a

- Neurologic examination
- Hearing examination
- Vision examination
- Developmental examination

Tourette syndrome is diagnosed by clinical observation and family history. The child must

- Have onset before 18 years of age
- Exhibit motor tics and vocal tics that can occur together or separately
- Have tics occurring in clusters for more than 1 year
- Not be free from episodes for 3 consecutive months

Treatment

- Administer: Catapres (clonidine), Haldol (haloperidol), or Orap (pimozide)
  - Medication is not the first course of treatment. Some of these medications can cause parkinsonian symptoms (extrapyramidal reactions), tardive dyskinesia, dry mouth, weight loss, nausea, insomnia, agitation, and photosensitivity.
- Family psychotherapy
- Individual psychotherapy
  - Goal is to increase the child's coping skills for handling stressful situations and increase the child's self-esteem.

Nursing Diagnoses

- Body image disturbance related to tics
- Ineffective coping skills related to increased episodes when stressed
- Disturbance of self-esteem related to tics

Nursing Interventions

- Help the child cope with stressful situations.
- Assist the child to focus on the child's positive attributes.
- Explain Tourette syndrome to the child and situations that increase episodes of tics.

- Create a less stressful family environment for the child.
- Work with the family and school officials to create a less stressful educational environment for the child.

CASE STUDY

CASE 1

A 25-year-old mother of a 2-month-old infant is frantic because he seems to ignore her and her husband when they talk to him. She tells the psychiatric nurse that she is afraid that her son is mentally retarded and blames herself, saying that she must have done something wrong during her pregnancy. She tells the psychiatric nurse that she definitely knows her son is mentally retarded because her sister's daughter acted the same way and she was diagnosed with mental retardation. She is heartbroken and does not know what to do.

QUESTION 1. Why should the mother be concerned?
ANSWER: The infant should turn his head toward sounds by 2 months of age. The mother's concerns are justified because the infant does not respond to the voices of both parents.

QUESTION 2. What information should the psychiatric nurse gather from the parent?
ANSWER: Does the infant coo, pay attention to faces, and follow people and things with his eyes? Can the infant hold up his head and make smooth movements with his arms and legs? These are all important milestones of a healthy 2-month-old infant.

QUESTION 3. What might be the reason for the infant's lack of response to sound?
ANSWER: This could be an early sign of autistic disorder and mental retardation. However, the infant's presentation is also compatible with a hearing disorder, especially if the infant displays many of the 2-month-old milestones.

CASE 2

A 53-year-old grandfather is frustrated that his 11-year-old granddaughter was diagnosed with major depression disorder (MDD). He tells the psychiatric nurse that she is lazy and her parents play into her manipulation. The grandfather says he tells his granddaughter to get out of her moodiness and face reality. He reports always saying to her, "Pick yourself up, dust yourself off, and start over again if things get you down," which is a line from his favorite song. He thinks the doctor is too quick to put kids on medication.

QUESTION 1. What might be the rationale for the grandfather's opinion?
ANSWER: The grandfather, like many of us, has experienced periods of depression that last for a relatively short period of time after which his mood returns to normal. The grandfather assumes that clinical depression is the same as what he experienced. The grandfather also realizes that 11-year-olds sometimes manipulate parents to avoid activities that they dislike. The grandfather assumes his granddaughter is being manipulative.

QUESTION 2. What are the faults in the grandfather's rationale?
ANSWER: Researchers believe that clinical depression is caused by a chemical imbalance with neurotransmitters. A person diagnosed with clinical depression such as MDD cannot return to a normal range of emotions without administration of medication that returns balance to the neurotransmitter. Yes, 11-year-olds can be manipulative; however, a psychiatrist assessed the child and diagnosed the child as having MDD. In doing so, the psychiatrist has probably ruled out other causes of the child's behavior.

QUESTION 3. What should the psychiatric nurse suggest the grandfather do in this situation?
ANSWER: The psychiatric nurse should provide a brief explanation of MDD and how this differs from situational depressions that the grandfather occasionally experiences. The psychiatric nurse should also encourage the grandfather to ask his granddaughter's parents if he could attend the next family meeting with the psychiatrist so he can learn more about his granddaughter's condition.

FINAL CHECK-UP

1. **A parent tells the psychiatric nurse that her son has a conduct disorder because the school administrator called saying that he and a few of the other 8-year-old boys were fighting at recess. How should the psychiatric nurse respond?**
   A. Tell the parent that her son was just playing and there is nothing to be concerned about.
   B. Ask the parent how frequently her son fights with others.
   C. Tell the parent to bring the child for a psychiatric assessment.
   D. Tell the parent to bring the child for a medical assessment to rule out an underlying medical problem.

2. **A 35-year-old father is concerned that his daughter's IQ was recorded as 62. He read that an IQ under 70 means the child has mental retardation. What is the best response by the psychiatric nurse?**
   A. She will be better served by placement in a group home where a professional staff can care for her needs round the clock.
   B. An IQ of 62 means that she is moderately retarded and will have limited interaction with others.
   C. She should start home schooling as soon as possible.
   D. She will be able to acquire enough skills to be employed, live on her own, and care for herself.

3. **A crying 16- year-old boy tells the psychiatric nurse that he is embarrassed by unpredictable twitches and episodes of blurting out meaningless words. He does not know how he could function as an adult. What is the best response by the psychiatric nurse?**
   A. Ask your parents to take you to see a doctor who may be able to help you.
   B. You have Tourette syndrome.
   C. Ask your parents to take you to see a doctor. The doctor may be able to give you medication that will make your problem go away.
   D. Ask your parents to take you to see a doctor. The doctor may be able to give you advice that may make your problem go away.

4. **A neighbor tells her friend, who is a psychiatric nurse, that the neighbor's 15-year-old son is irritable, unable to concentrate at school, cannot get a good night's sleep, and stays in bed in his room with the door closed. What is the best response by the psychiatric nurse?**
   A. Suggest that the neighbor take her son to a medical practitioner for an assessment.
   B. Tell the neighbor to take her son to a child psychiatrist.
   C. Tell the neighbor to take her son to the school's child psychologist.
   D. Suggest that the neighbor take her son on a weekend vacation to give him a change in scenery.

5. **A 23-year-old mother asks the psychiatric nurse for the telephone number of a child psychiatrist because her 2-year-old daughter constantly refuses to do what she is told to do. She throws a tantrum in public when she does not get her way. The mother wants the psychiatrist to treat her daughter for oppositional defiant disorder (ODD). What is the best response by the psychiatric nurse?**
   A. Give the mother names and telephone numbers of a few local psychiatrists.
   B. Tell the mother that the child is demonstrating normal behavior and her actions are consistent with a child struggling with emerging independence.
   C. Tell the mother that treatment for ODD does not begin until age 3.
   D. Tell the mother to take the child to her pediatrician to rule out underlying medical conditions that might be causing the problem.

6. A psychiatric nurse is attending a PTA meeting in your son's school and a parent of an 8-year-old girl tells the nurse that her daughter is bipolar and she plans to take her to her pediatrician to get a medical test to confirm the diagnosis. What is the psychiatric nurse's best response?

A. There is no medical test to diagnose most mental disorders including bipolar disorder; however, the pediatrician can assess for any underlying medical condition that can mimic symptoms of bipolar disorder.

B. Tell me the symptoms that your child is experiencing.

C. Do not be concerned because bipolar disorder occurs only in adults and not in children.

D. Does bipolar disorder run in your family?

7. A mother of a 5-year-old boy reports that for the past 3 months he is always talking, cannot sit down for any length of time, and always pushes ahead of his 3-year-old brother when coming in to dine. The mother tells her friend, who is a psychiatric nurse, that she wants her son to be medicated for ADHD before kindergarten starts. What is the psychiatric nurse's best response?

A. Symptoms of ADHD are present before age 7.

B. The behavior could be normal for a 5-year-old. It is best to have your pediatrician assess his behavior.

C. He probably does not have ADHD because he would have to display symptoms for at least 6 months and it has only been 3 months.

D. Talk to your pediatrician about prescribing Ritalin.

8. The psychiatric nurse's friend's 2-year-old son seems to ignore the nurse the past several times when she has entered the house. Normally he would run to her saying a word or two and give her a hug. Now, he just stays in the corner filling a bag of blocks, and then emptying them and starting over. His mother says he is in one of his moods and has been like this for a few weeks. What should the psychiatric nurse do?

A. Ignore the child's behavior.

B. Ask her friend to describe other changes in the child's behavior.

C. Tell her friend to take the child to the emergency room immediately.

D. Ask her friend to share her child's recent behaviors with her pediatrician.

9. **A father is devastated that his 12-year-old daughter was diagnosed with MDD. He does not know what he is going to do. What is the psychiatric nurse's best response?**
   A. Tell the parent that MDD is caused by an imbalance of neurotransmitter in the brain.
   B. Tell the parent that he must protect his daughter from suicidal behavior and substance abuse.
   C. Tell the parent to ask the pediatrician about medication and therapy treatment that may lessen the frequency of depressive episodes.
   D. Tell the parent that his daughter might experience psychosocial developmental problems.
10. **The parent of a child who is newly diagnosed with autism disorder asks the psychiatric nurse how the parent should interact with the child. What is the psychiatric nurse's best response?**
   A. Ask your pediatrician.
   B. Speak with the child face-to-face, maintain a safe environment, give rewards for good behaviors, and do not punish for bad behaviors, which may lead to self-injury by the child.
   C. Treat the child as you would treat other children.
   D. Send the parent to an autism disorder website.

CORRECT ANSWERS AND RATIONALES

1. B. Ask the parent how frequently her son fights with others. Rationale: The child would have to demonstrate three symptoms within a year and one symptom in the past 6 months. An 8-year-old fighting with a group of boys one time is not considered conduct disorder.
2. D. She will be able to acquire enough skills to be employed, live on her own, and care for herself. Rationale: An IQ of 62 means that the child has mild retardation and with training can earn a modest living and live relatively independently.
3. A. Ask your parents to take you to see a doctor who may be able to help you. Rationale: The best response is to recommend that he ask his parents to take him to a practitioner who can properly assess the patient. Although he seems to have symptoms of Tourette syndrome, only a practitioner can make a medical diagnosis. Also, medication is not the first course of treatment, so telling him about the medication treatment is inappropriate.
4. A. Suggest that the neighbor take her son to a medical practitioner for an assessment. Rationale: Although the child presents with some symptoms of MDD, the initial step is to rule out any underlying medical condition that might also cause those symptoms. Therefore, assessment by a medical practitioner is more appropriate at this stage than being assessed by a psychiatrist or psychologist. A change of scenery will not address any medical or psychiatric causes for those symptoms.

5. B. Tell the mother that the child is demonstrating normal behavior and her actions are consistent with a child struggling with emerging independence. Rationale: The child is demonstrating normal behavior consistent with frustration of emerging independence. The early onset of ODD is at age 3. The mother is most likely taking her daughter to a pediatrician for regular checkups.
6. A. There is no medical test to diagnose most mental disorders including bipolar disorder; however, the pediatrician can assess for any underlying medical condition that can mimic symptoms of bipolar disorder. Rationale: The psychiatric nurse is correcting the parent's misperception of tests for mental disorders and supporting the parent's plan to have the pediatrician assess the child. The psychiatric nurse is also teaching the parent that symptoms can also be caused by an underlying medical condition and not a mental disorder. Asking the parent to describe symptoms is not appropriate because it implies that the psychiatric nurse is going to make a medical diagnosis, which is beyond the psychiatric nurse's scope of practice. Responses that explore bipolar disorder are inappropriate because the parent needs to have a practitioner diagnose the child as having bipolar disorder.
7. B. The behavior could be normal for a 5-year-old. It is best to have your pediatrician assess his behavior. Rationale: The psychiatric nurse is educating the parent that her son's behavior might be normal and also provides sound advice to have the child assessed by the pediatrician who will provide a full assessment of the child. Although the child has demonstrated this behavior consistently for 3 months, the child might continue the behavior for another 3 months, which could lead a practitioner to consider an ADHD diagnosis. While the other statements are true, the best response is to educate based on the diagnosis at hand, which is none, and refer the parent to the pediatrician to formally assess the child.
8. D. Ask her friend to share her child's recent behaviors with her pediatrician. Rationale: The child's behavior may indicate sudden regression from previously normal behavior. The child seemed to have loss of social skills and language skills, which are early signs of autistic disorder. The best response is to have the pediatrician to formally assess the child.
9. C. Tell the parent to ask the pediatrician about medication and therapy treatment that may lessen the frequency of depressive episodes. Rationale: The psychiatric nurse should advise the father to ask the pediatrician for treatment options. The other responses are correct but do not respond to the father's question as to what to do to help his daughter.
10. B. Speak with the child face-to-face, maintain a safe environment, give rewards for good behaviors, and do not punish for bad behaviors, which may lead to self-injury by the child. Rationale: Because the child was diagnosed with autism disorder, the psychiatric nurse can educate the parent on how to interact with the child. The other responses are inappropriate.

This page intentionally left blank

chapter 3

Anxiety and Anxiety Disorders

LEARNING OBJECTIVES

1. Acute stress disorder
2. Generalized anxiety disorder (GAD)
3. Obsessive-compulsive disorder (OCD)
4. Panic disorder
5. Phobia
6. Posttraumatic stress disorder (PTSD)
7. Substance abuse anxiety disorder

KEY TERMS

Activities of daily living
Acute stress disorder
Agoraphobia
Amygdala
Anxiety
Autonomic nervous system (ANS)
Basal ganglia
Cognitive therapy
Fight or flight response
Flashbacks
GABA
GABA neurotransmitter
Generalized anxiety disorder (GAD)
HPA axis
Hypothalamus
Norepinephrine
Norepinephrine neurotransmitter
Obsessive-compulsive disorder (OCD)
Panic disorder
Panic attack
Phobia
Posttraumatic stress disorder (PTSD)
Social phobia
Specific phobia
Stressor
Substance abuse
Traumatic event

Anxiety

Anxiety is common to all ages and is characterized by fear and worry. Anxiety is normal. For example, children between 6 and 18 months old experience separation anxiety, and everyone experiences the fight or flight response to stressful situations. Anxiety becomes a disorder when a person is unable to cope with stressors and anxiety interferes with the person's **activities of daily living.**

Central to anxiety disorder is the person's misinterpretation of stressors and exaggeration of a response to the stressor. A **stressor** is a situation that triggers a stress response.

Neurophysiology of Anxiety

The **amygdala**, located in the temporal lobe of the brain, is involved in detecting a threat and how a person responds to a threatening situation. A person constantly receives stimuli, which are processed by the amygdala. If the amygdala detects the stimuli as a threat (stressor), it signals the **hypothalamus** to initiate the stress response. Worrying involves the **basal ganglia**, which is located outside the thalamus. The basal ganglia is also involved in obsessive-compulsive disorder (OCD).

There are two different stress responses; these are as follows:

Autonomic Nervous System (ANS): The ANS response causes epinephrine to be released from the adrenal medulla into the bloodstream, causing the heart rate and blood pressure to increase. This is called the **fight or flight response** that is associated with anxiety. The fight or flight response is also referred to as the alarm reaction stage. According to the general adaptation syndrome, the body attempts to adapt to the stressor by either confronting the stressor (fight) or avoiding the stressor (flight). The body enters the resistance stage when the body's continued attempt to adapt fails. The body enters the exhaustion stage when it is unable to adapt to the stressor, leading to illness.

HPA Axis: The HPA axis involves interaction with the hypothalamus, pituitary gland, and adrenal gland. When a stimulus is seen as a threat (stressor), the hypothalamus releases corticotrophin-releasing hormone (CRH) into the bloodstream. CRH causes the pituitary gland to secrete adrenocorticotropic hormone (ACTH) into the bloodstream, signaling the adrenal gland to secrete cortisol into the bloodstream. Cortisol decreases inflammation and increases the use of glucose, leading to the body adapting to the stressor (adaptive response). If the stressor is not resolved, cortisol continues to be secreted, leading to hypertension, hyperglycemia, increased cholesterol, and arteriosclerosis. The patient may also experience memory problems.

The neurotransmitter **GABA** is related to anxiety. A decrease in GABA is related to increased symptoms of anxiety. Alcohol and benzodiazepine modify GABA, thereby lowering anxiety. Withdrawal from these drugs increases anxiety. Increased **norepinephrine** also increases symptoms of anxiety.

1. Acute Stress Disorder

Acute stress disorder occurs when a patient is unable to bring immediate closure to a **traumatic event**. Signs and symptoms of acute stress disorder begin within 4 weeks following the traumatic event and should resolve during the same period.

What Went Wrong?

A traumatic experience that usually is life threatening causes the patient either physical injury or psychological injury, leaving the patient in a state of acute

anxiety. The patient is unable to resolve the anxiety following the traumatic event, causing anxiety to recur during the period immediately following the trauma.

Prognosis

A patient diagnosed with acute stress disorder can be restored to the emotional functionality that existed before the trauma if psychological support is given during the period when the patient experiences acute stress disorder. The patient may experience major depressive disorder and posttraumatic stress disorder if acute stress disorder is untreated.

Hallmark Signs and Symptoms

- Sleep disturbance
- Anxiety
- Irritability
- Decreased concentration
- Flashback of the traumatic event
- Startle reflex
- Avoids things that recall the traumatic event
- Restlessness

Common/Interpreting Test Results

There is no test that is used to diagnose acute stress disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of acute stress disorder requires the following:

- The patient experienced or was confronted with an event that caused or threatened serious injury or death to the patient or to another person that left the patient in helplessness or intense fear.
- The patient avoids anything that may trigger reminders of the event.
- The patient reexperiences the event in **flashbacks** or becomes distressed when reminded of the event.
- The patient has signs and symptoms of anxiety (see "Hallmark Signs and Symptoms").

- The patient has impaired function caused by signs and symptoms of anxiety that are not related to a personality disorder or other mental disorder.
- The patient experienced three or more of the following symptoms during or after the event:
  - A loss of sense of identity (depersonalization)
  - A loss of reality (derealization)
  - Feeling dazed with reduced awareness of surroundings
  - A lack of emotional responsiveness
  - Unable to recall aspects of the traumatic event (dissociative amnesia)
- The patient experienced functional impairment for at least 2 days but not more than 4 weeks within 4 weeks of the event.

Treatment

- First line of treatment
  - **Cognitive therapy**: Teach the patient coping skills and slowly expose the patient to triggers that cause the patient to recall the event so the patient can use newly learned coping skills to control their response to the trigger.
- Second line of treatment
  - Administer: Catapres (clonidine), Inderal (propranolol)

Nursing Diagnoses

- Ineffective coping related to recurrent episodes of stress
- Risk for powerlessness related to inability to function normally
- Risk for ineffective activity planning related to inability to function normally

Nursing Interventions

- Develop a therapeutic relationship with the patient.
- Ask the patient to tell you about the traumatic event.
- Assist the patient to process factors that lead up to and occurred during and after the traumatic event.

- Help the patient look at various perspectives of the traumatic event.
- Help the patient identify triggers that cause stress related to the traumatic event.
- Teach the patient coping skills to use when the patient is confronted by triggers.

2. Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is a chronic disorder that develops over time. GAD occurs when a patient becomes overwhelmed by disproportionally anticipating future events, leading the patient to become dysfunctional. The patient is unable to cope with anxiety because the patient misinterprets events. The patient is at risk for self-medication with alcohol or other medication that is not prescribed to the patient.

What Went Wrong?

The cause of GAD is unknown. Researchers report that an imbalance in serotonin and GABA may influence whether a patient develops GAD. GABA limits impulses from nerve cells, and serotonin helps create a feeling of well-being. Researchers also believe that increased exposure to stress increases the patient's chances of developing GAD.

Prognosis

Episodes of GAD can be reduced through therapy and medication. The patient may develop panic disorder. The patient is at risk for becoming immunosuppressed, which can lead to infection and other medical conditions.

Hallmark Signs and Symptoms

- Trembling
- Sweating
- Fast heart rate (tachycardia)
- Irritability
- Fast breathing (tachypnea)
- Fatigue

- Insomnia
- Muscle pain
- Muscle tension
- Unable to relax

Common/Interpreting Test Results

There is no test that is used to diagnose GAD. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of GAD requires the following:

- At least three of the following signs and symptoms:
  - Disturbed sleep
  - Muscle tension
  - Restlessness
  - Irritability
  - Fatigue easily
  - Poor concentration
- Unable to control anxiety
- Worrying excessively about events for a majority of days for at least 6 months
- Signs and symptoms impair the patient's functioning

Treatment

- First line of treatment
  - Cognitive therapy: Teach the patient coping skills and slowly expose the patient to triggers that cause the patient to recall the event so the patient can use newly learned coping skills to control their response to the trigger.
- Second line of treatment
  - Administer:
    - Antidepressant: Paxil (paroxetine), Zoloft (sertraline), Effexor (venlafaxine), Tofranil (imipramine)

- Benzodiazepine: Ativan (lorazepam), Valium (diazepam), Librium (chlordiazepoxide), or Xanax (alprazolam). Note: limit to 6 weeks.
- Antianxiety: BuSpar (buspirone)

Drug Alert

Medication may cause fatigue, blurred vision, hypotension, drowsiness, tremors, slurred speech, and inability to control body movements (ataxia).

Nursing Diagnoses

- Disturbed sleep pattern related to anxiety
- Ineffective individual coping strategies related to inability to cope with anxiety
- Fatigue related to overwhelming feeling of exhaustion

Nursing Interventions

- Teach the patient signs of anxiety and develop coping skills such as distraction to reduce anxiety.
- Tell the patient not to stop taking medication without the practitioner's instructions. Discontinuing medication may produce adverse effects if not tapered.
- Tell the patient to avoid alcohol and caffeine.
- Decrease stimulation during an episode of anxiety.
- Remain with the patient during an episode of anxiety and encourage the patient to express the patient's concerns. Help the patient refocus on reality.

3. Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) occurs when a patient has obsessions, which are recurrent unwanted intrusive thoughts, and compulsions, which are repetitive behaviors used to address obsessions. There are two degrees of OCD; these are:

- Simple: The patient's repetitive behaviors are nonintrusive to the patient's activities of daily living.

- Complex: The patient's repetitive behaviors impede the patient's activities of daily living.

What Went Wrong?

The cause of OCD is unknown. Researchers found that some patients diagnosed with OCD have enlarged basal ganglia and increased glucose metabolism in the basal ganglia. Researchers report there is a genetic tendency for OCD. There is also a relationship between Tourette syndrome (see Chapter 2) and OCD. Other researchers believe that OCD is a conditional response to cope with events that cause anxiety. The repetitive behavior is the patient's attempt to cope with anxiety using the conditional response; however, the coping behavior eventually ceases to relieve the anxiety. There is also believed to be a relationship between beta-hemolytic streptococci infection and OCD.

Prognosis

The patient experiences periods of exacerbation and remission. Exacerbation is related to stressful events. Therapy can increase intervals between exacerbation and remission and reduce periods of exacerbation. The patient may develop decreased functionality without treatment.

Hallmark Signs and Symptoms

- Repetitive thoughts
- Repetitive behaviors
- Need to achieve perfection
- Preoccupation with thoughts and behaviors that impede activities of daily living

Common/Interpreting Test Results

There is no test that is used to diagnose OCD. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of OCD requires the following:

- Obsession-compulsion takes more than 1 hour a day or significantly impairs the patient's activities of daily living.

- Obsession:
  - Thoughts are not explained by excessive worrying about life's problems.
  - The patient understands that obsessions are created by the patient's mind.
  - Persistent recurrent thoughts are intrusive, leading to increased anxiety.
  - The patient tries to neutralize the thoughts.
- Compulsion:
  - Repetitive behaviors are performed in response to an obsession.
  - Repetitive behaviors are performed to reduce anxiety.
  - Repetitive behaviors are not connected to or are excessive for reducing anxiety.
  - The patient realizes that repetitive behaviors are unrealistic and excessive.

Treatment

- First line of treatment:
  - Cognitive behavioral therapy (CBT): CBT retrains the patient's thought pattern, making repetitive behaviors unnecessary. The patient is exposed to the obsession and then trained to properly cope with the anxiety caused by the obsession.
- Second line of treatment:
  - Administer: Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Anafranil (clomipramine), or Luvox (fluvoxamine)

Nursing Diagnoses

- Ineffective individual coping related to repetitive behaviors
- Ineffective role performance related to inability to perform activities of daily living
- Powerlessness related to the inability to stop performing repetitive behaviors

Nursing Interventions

- Accept the fact that the patient needs to perform repetitive behaviors. Do not be critical of the patient for this behavior.

- Acknowledge that the patient feels a need to perform repetitive behaviors.
- Do not prevent the patient from performing repetitive behaviors since this increases the patient's anxiety.
- Permit the patient time to perform repetitive behaviors.
- Gradually reduce the time available for the patient to perform repetitive behaviors and let the patient know that doing so will help the patient to reduce the compulsion.
- Help the patient identify triggers that lead to performing repetitive behaviors.
- Help the patient identify other ways to cope with anxiety such as diverting unwanted thoughts to positive thoughts when a trigger is identified by the patient.

4. Panic Disorder

Panic disorder occurs when a patient experiences unexpected periods of high anxiety and feelings of doom, resulting in the patient being unable to perform activities of daily living. The patient is preoccupied between panic attacks anticipating the next panic attack because panic attacks occur without a triggering event.

What Went Wrong?

Some patients experienced life-threatening illness such as asthma where they felt as if they were dying. The fear of an episode of the illness increases fear, which can lead to a **panic attack**. Researchers report there is a genetic tendency with first-degree relatives. Some researchers believe that the patient misinterprets and exaggerates triggers that cause mild anxiety, leading the patient to experience a panic attack. Other researchers state that malfunction of the catecholamine system causes high levels of norepinephrine, leading to heightened sensitivity to factors that cause anxiety.

Prognosis

A patient can develop agoraphobia (see "Agoraphobia"). Early onset of panic disorder may lead to other illnesses such as depressive disorder. Patients are also at risk for self-medicating, leading to alcoholism and substance abuse disorder.

Hallmark Signs and Symptoms

- Sense of dying
- Startle reactions
- Palpitations
- Pressure in the chest
- Nausea
- Diarrhea
- Pallor
- Trembling
- Shortness of breath
- Sweating
- Inability to think clearly
- Dizziness
- Chills

Common/Interpreting Test Results

There is no test that is used to diagnose panic disorder. The initial step is to rule out physiologic and other mental disorders as a cause of the symptoms before reaching a psychiatric diagnosis. Also, rule out adverse effects of medication that can produce symptoms of panic disorder. The psychiatric diagnosis of panic disorder requires the following:

- Panic attack occurred unexpectedly.
- Panic attack was not triggered by a situation where the patient was the focus of other people's attention.
- Panic attack was not caused by an underlying medical condition or reaction to medication.
- The patient experienced persistent fear of another panic attack for at least a month following the panic attack.
- The patient may or may not have agoraphobia.
- The patient experienced at least four of the following signs and symptoms during the panic attack. These started suddenly and peaked within 10 minutes.
  - Fear of dying
  - Sweating

- Trembling
- Chills
- Shortness of breath
- Feeling detached from one's self (depersonalization)
- Feeling of unreality (derealization)
- Dizziness
- Tingling sensation
- Palpitations
- Nausea
- Feeing of choking
- Fainting
- Feeling of going crazy

Treatment

- First line of treatment:
  - Cognitive behavioral therapy (CBT): CBT retrains the patient's thought pattern to lower the effects of anticipation of the next panic attack. The patient is exposed to possible triggers and then trained to properly cope with the anxiety caused by the trigger.
- Second line of treatment:
  - Administer: Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), or Effexor XR (hydrochloride). For emergency and short-term use, Xanax (alprazolam), Klonopin (clonazepam), or Ativan (lorazepam)

Drug Alert

A patient can become dependent on benzodiazepine medications such as Xanax, Klonopin, and Ativan. Practitioners may prescribe a benzodiazepine for a period limited to 6 weeks to reduce the likelihood of dependency.

Nursing Diagnoses

- Ineffective individual coping related to anticipation of a panic attack
- Risk for social isolation related to agoraphobia
- Risk for powerlessness related to unexpected panic attacks

Nursing Interventions

- During a panic attack
  - Reduce external stimuli such as lights, noise, and people.
  - Approach the patient calmly.
  - Do not touch the patient.
  - Give short, clear, single directions.
  - Keep the patient safe.
  - Stay with the patient.
  - Provide reassurance by your presence and not with words.
- After a panic attack
  - Help the patient identify events that might trigger an attack.
  - Help the patient develop coping skills to deal with anticipation of an attack.

5. Phobia

A **phobia** is persistent disproportional fear of a situation or object that causes the patient significant distress that disrupts the patient's activities of daily living. There are three categories of phobias; these are:

- **Social phobia**: Social phobia is the fear of being scrutinized by others such as during public speaking and engaging with people in a social setting.
- **Specific phobia**: Specific phobia is the fear of a specific object or situation such as flying, bugs, and heights.
- **Agoraphobia**: Agoraphobia is the fear of leaving home related to posttraumatic stress disorder, fear of germs, or feeling unsafe in unfamiliar surroundings. Some researchers believe that agoraphobia is the result of repeated panic attacks where the patient creates a safety zone at home.

What Went Wrong?

A phobia can develop when the patient experiences a frightening or stressful event that occurs before the age of 30. Fear of confronting that event leads the patient to experience a panic attack. Some researchers believe that a phobia can be learned from parents.

Prognosis

Seventy-five percent of patients diagnosed with social and specific phobias overcome the phobia with treatment. Also, 40% of patients diagnosed with agoraphobia become symptom free with treatment. However, 50% continue to experience a mild form of agoraphobia.

Hallmark Signs and Symptoms

- Desire to get away
- Palpitations
- Pressure in the chest
- Pallor
- Trembling
- Shortness of breath
- Sweating
- Inability to think clearly

Common/Interpreting Test Results

There is no test that is used to diagnose a phobia. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis.

- Social Phobia
  - Unreasonable persistent fear triggered by a social situation where the patient is exposed to possible scrutiny by others.
  - Exposure to the trigger results in a panic attack.
  - The patient realizes that the fear is unreasonable.
  - The patient avoids social situations or endures social situations with increased anxiety.
  - Responding to the trigger disrupts the patient's activities of daily living.
  - The phobia lasts at least 6 months, if the patient is under 18 years of age.
- Specific Phobia
  - Unreasonable persistent fear triggered by an object or situation.
  - The phobia lasts at least 6 months, if the patient is under 18 years of age.

  - Exposure to the trigger results in a panic attack.
  - The patient realizes that the fear is unreasonable.
  - The patient avoids the object or situation or endures the object or situation with increased anxiety.
  - Responding to the trigger disrupts the patient's activities of daily living.
- Agoraphobia
  - Unreasonable persistent fear triggered by being in a public place.
  - Unreasonable persistent fear of being alone.
  - Unreasonable persistent fear of being in crowds.
  - Inability to leave the house for long periods of time.
  - Exposure to the trigger results in a panic attack.
  - The patient realizes that the fear is unreasonable.
  - The patient avoids the object or situation or endures the object or situation with increased anxiety.
  - Responding to the trigger disrupts the patient's activities of daily living.

Treatment

- First line of treatment:
  - Cognitive behavioral therapy (CBT): CBT retrains the patient's thought pattern to lower the effects of the trigger event. The patient is gradually exposed to triggers and then trained to properly cope with the anxiety caused by the trigger.
- Second line of treatment:
  - Administer: Prozac (fluoxetine), Celexa (citalopram), Lexapro (escitalopram), Zoloft (sertraline), or Paxil (paroxetine). For emergency and short-term use, Xanax (alprazolam), Klonopin (clonazepam), Librium (chlordiazepoxide), Valium (diazepam), or Ativan (lorazepam)

Nursing Diagnoses

- Ineffective individual coping related to fear of triggers
- Risk for social isolation related to inability to engage in social events and visit public areas
- Risk for powerlessness related to disruption in activities of daily living

Nursing Interventions

- During a panic attack
  - Reduce external stimuli such as lights, noise, and people.
  - Approach the patient calmly.
  - Do not touch the patient.
  - Give short, clear, single directions.
  - Keep the patient safe.
  - Stay with the patient.
  - Provide reassurance by your presence and not with words.
- After a panic attack
  - Help the patient identify events that might trigger an attack.
  - Help the patient develop assertiveness skills to effectively cope with triggers.

6. Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) occurs when a patient experiences severe anxiety, flashbacks, and nightmares about a previous traumatic event in the patient's life. The traumatic event may directly involve the patient, such as being involved in a severe automobile accident, or indirectly involve the patient, such as witnessing a severe automobile accident. There are two categories of PTSD; these are:

- Acute: Symptoms of PTSD are experienced within 6 months of the traumatic event.
- Chronic: Symptoms of PTSD occur 6 months or longer following the traumatic event.

What Went Wrong?

The cause of PTSD is unknown. Some researchers report that a person who has a first-degree relative with PTSD, depressive disorder, or GAD has a risk of developing PTSD. Other researchers report there is an overactive adrenaline response triggered by thoughts of the traumatic event, leading the patient to have a hyperresponse exhibited as symptoms of PTSD.

Prognosis

Posttraumatic stress disorder increases the patient's risk for self-medicating and abusing alcohol and nonprescribed medications, depression, suicidal ideations, suicide attempts, and autoimmune and cardiovascular diseases.

Hallmark Signs and Symptoms

- Emotional numbness
- Problems having close relationships
- Intrusive memories reliving the traumatic event
- Flashbacks of the traumatic event
- Exaggerated responses
- Insomnia
- Feeling guilty
- Avoids thinking about the traumatic event
- Memory lapses
- Unable to focus
- Self-destructive behavior

Common/Interpreting Test Results

There is no test that is used to diagnose PTSD. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis.

- The patient experienced or witnessed an event that caused or threatened to cause serious injury or death to the patient or another person, and the patient experienced helplessness, horror, or fear.
- Disruption of activities of daily living
- Experiences symptoms of PTSD for at least 1 month
- The patient reexperiences the traumatic event in one of the following ways:
  - Feeling that the traumatic event recurred
  - Feeling intense distress when exposed to triggers of the traumatic event

  - Distressing dreams of the traumatic event that recur
  - Intrusive persistent thoughts of the traumatic event
- The patient exhibits at least three of the following:
  - Avoids thoughts or feeling about the traumatic event
  - Avoids things that will recall the traumatic event
  - Detachment from others
  - Unable to recall part of or the entire traumatic event
  - Difficulty having close relationships with others
- The patient exhibits at least two of the following:
  - Exaggerated responses
  - Difficulty falling asleep
  - Irritability
  - Hypervigilance
  - Unable to focus
  - Outbursts
  - Insomnia

Treatment

- Cognitive behavioral therapy (CBT): CBT retrains the patient's thought pattern to lower the effects of the trigger event. The patient is gradually exposed to triggers and then trained to properly cope with the anxiety caused by the trigger.
- Administer: Minipress (prazosin), Prozac (fluoxetine), Zoloft (sertraline), Remeron (mirtazapine), Effexor (venlafaxine), Serzone (nefazodone), or Paxil (paroxetine). For emergency and short-term use, Xanax (alprazolam), Klonopin (clonazepam), Librium (chlordiazepoxide), Valium (diazepam), or Ativan (lorazepam)

Nursing Diagnoses

- Ineffective individual coping related to recurring thoughts about the traumatic event
- Risk for suicidal thoughts related to guilt
- Risk for powerlessness related to disruption in activities of daily living

Nursing Interventions

- Keep the patient safe during an episode of PTSD.
- Be alert for suicidal ideations and suicide attempts.
- Help the patient process thoughts about the traumatic event.
- Encourage the patient to talk about the traumatic event.
- Assist the patient to identify triggers that bring about thoughts of the traumatic event.
- Help the patient redirect outbursts and self-injurious behavior to safe coping mechanisms.

7. Substance Abuse Anxiety Disorder

Substance abuse anxiety disorder occurs when the patient experiences anxiety either while intoxicated or when withdrawing from drugs. Drugs include alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogens, inhalants, phencyclidine (PCP), and prescribed medications.

What Went Wrong?

The patient ingested drugs that either increased **norepinephrine neurotransmitter,** resulting in anxiety while the patient is intoxicated, or modified **GABA neurotransmitter** to decrease anxiety when intoxicated. If the drug decreased anxiety, then the patient experiences anxiety when the patient withdraws from the drug, leading to increased anxiety.

Prognosis

The patient will no longer experience anxiety symptoms after the patient has withdrawn from the drug that caused the substance abuse anxiety disorder. Researchers report that some patients will experience symptoms of OCD after withdrawal is completed.

Hallmark Signs and Symptoms

- Trembling
- Sweating

- Fast heart rate (tachycardia)
- Irritability
- Fast breathing (tachypnea)
- Fatigue
- Insomnia
- Muscle pain
- Muscle tension
- Unable to relax

Common/Interpreting Test Results

There is no test that is used to diagnose a substance abuse anxiety disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis.

- The patient experiences general anxiety, panic attacks, or other anxiety disorders as described in this chapter.
- Symptoms of anxiety developed within 1 month of when the patient was intoxicated or withdrawing from drugs.
- Symptoms of anxiety did not exist prior to the use of the medication.
- The drug is known to cause anxiety symptoms.
- Anxiety symptoms occur during and after the patient experiences delirium.

Treatment

- Detox the patient from drugs that cause symptoms of substance abuse anxiety disorder.
- During detox, administer Ativan (lorazepam) or Librium (chlordiazepoxide).
- The patient should go to an intense drug rehabilitation program to prevent further drug abuse.

Nursing Diagnoses

- Disturbed sleep pattern related to anxiety
- Ineffective individual coping strategies related to inability to cope with anxiety
- Fatigue related to overwhelming feeling of exhaustion

NURSING ALERT

A patient detoxing from alcohol may experience delirium tremens up to 3 days after the patient stops drinking alcohol.

Nursing Interventions

- Decrease stimulation during an episode of anxiety.
- Remain with the patient during an episode of anxiety and encourage the patient to express the patient's concerns. Help the patient refocus on reality.
- Encourage the patient to address the underlying cause of drug abuse.

CASE STUDY

CASE 1

A 43-year-old woman was watching television. Suddenly she rushes and locks all the doors and all the windows, and draws all the shades before turning off the television and all but one light off. She sits still in the chair and falls asleep. She tells her practitioner about the experience, concerned that she is "losing her mind" as she explains to the practitioner.

QUESTION 1. What should the practitioner suspect occurred?
ANSWER: The patient might be experiencing a panic disorder, generalized anxiety disorder (GAD), acute stress disorder, or posttraumatic stress disorder.

QUESTION 2. What should the practitioner do first?
ANSWER: Ask questions that will elicit the patient's history. The practitioner will focus on frequency of signs of an anxiety disorder and whether or not those symptoms impeded the patient's activities of daily living. Information about frequency, symptoms, and interference with activities of daily living helps the practitioner reach a formal diagnosis. In addition, the practitioner will develop a general history of the patient that may reveal if the patient experienced a traumatic event.

QUESTION 3. What might have caused the patient to react in such a way?
ANSWER: The patient may have experienced a trigger during the television show that caused the patient to panic. The patient's actions are those that are expected when a person is frightened and takes measures to protect herself by preventing anyone from entering her home. The practitioner will explore triggers that may cause flashbacks of a traumatic event that lead to the patient's overreaction.

CASE 2

A 32-year-old female grammar school teacher has experienced GAD for 3 years. Her practitioner is treating the patient with alprazolam. Gradually over the years, her dose of alprazolam has been increased as the medication has become less effective in reducing episodes of GAD. The patient is able to function and received the teacher of the year award last year.

QUESTION 1. What should be of concern to the patient's practitioner?
ANSWER: Increased doses of alprazolam needed to control episodes of GAD indicate that the patient is experiencing a tolerance to alprazolam. There is a risk that the patient is becoming dependent on alprazolam. The patient is conditioned to believe alprazolam prevents episodes of GAD.

QUESTION 2. What change in treatment should the practitioner consider for the patient?
ANSWER: The practitioner should introduce the patient to cognitive therapy, during which the patient will learn coping skills that can be used in place of alprazolam to control episodes of GAD. Cognitive therapy helps the patient identify triggers that cause the patient stress and develops methods the patient can use to react positively to triggers. Change in treatment will be challenging for the patient because she is likely dependent on alprazolam and will find it difficult to abandon medication treatment.

QUESTION 3. How should the practitioner discontinue alprazolam?
ANSWER: The patient must be detoxed from alprazolam, which is a benzodiazepine. The patient must be tapered from alprazolam to prevent withdrawal symptoms. The practitioner must not abruptly discontinue alprazolam because doing so exposes the patient to a risk of seizures during detox.

FINAL CHECK-UP

1. **A 35-year-old man witnessed a pedestrian being hit by a car 3 weeks ago. He tells you that he has difficulty sleeping because of flashbacks of the accident. His practitioner has sent him for therapy for 2 weeks and prescribed Inderal. He is afraid that he will never be able to sleep again. How would you respond?**
   A. Tell him to ask the practitioner about posttraumatic stress disorder.
   B. Tell him to report signs of depression to his practitioner immediately.
   C. Tell him that with the treatment he is receiving that he should be able to sleep normally at the end of the treatment period.
   D. Tell him that he has acute stress disorder and is being treated properly.

2. **A 65-year-old woman reports periods of palpitations, sweating, and slight shortness of breath. She feels like she's going to die. You speak with her daughter who reports that her father recently passed away and her mother lives alone. How would you respond?**
   A. Tell the daughter that her mother is likely experiencing panic attacks and will develop depressive disorder.
   B. Tell the daughter that her mother is likely experiencing depressive disorder.
   C. Tell the daughter that her mother is likely experiencing panic attacks.
   D. Tell the daughter that her mother is likely experiencing panic attacks and that she should tell her primary practitioner about it so she can be treated soon.

3. **A 36-year-old nurse who has worked in an inner city emergency department for 10 years feels burnt out. He seems to be taking more sick time than normal over the past 2 years. What might be the underlying cause of his situation?**
   A. The nurse is bored after 10 years of being in an emergency department and needs to change to a different specialty.
   B. The nurse is experiencing the effects of chronic anxiety.
   C. The nurse probably was exposed to a virus or bacteria and has not yet been diagnosed.
   D. The nurse is showing signs of PTSD.

4. **A 25-year-old man comes to you concerned that his 56-year-old mother no longer drives her car. Three weeks ago someone backed out of a driveway and hit his mother's driver-side door, while his mother who was driving passed the driveway. No one was injured. What is the best response?**
   A. Your mother is experiencing acute PTSD. Encourage your mother to drive short distances for routine trips such as food shopping.
   B. Your mother is experiencing acute PTSD. Your mother is at risk for self-medicating. Do not let her drive until she sees her primary care practitioner.
   C. Your mother is experiencing chronic PTSD. Your mother should see her primary care practitioner and be administered a low dose of Xanax.
   D. Your mother is experiencing chronic PTSD. Encourage your mother to drive short distances for routine trips such as food shopping.

5. **Each morning before going to work, a 43-year-old man spends 2 hours cleaning the outside and inside of his car even if the car is already clean. His wife is concerned and comes to you for help. What is your best response?**
   A. Your husband shows signs of complex obsessive-compulsive disorder (OCD). You should not be overly concerned since he will experience periods of exacerbation and remission. Consult with your primary care practitioner who might recommend cognitive behavioral therapy.
   B. Your husband shows signs of complex OCD. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might recommend cognitive behavioral therapy.

C. Your husband shows signs of simple OCD. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might recommend cognitive behavioral therapy.
D. Your husband shows signs of simple OCD. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might give prescription medication.

6. A 30-year-old woman who is diagnosed with acute stress disorder asks you why her primary care practitioner ordered Inderal. How would you respond?

A. It is best to ask your primary care practitioner.
B. When you have acute stress disorder, you have palpitations and your blood pressure is high, causing you to feel uncomfortable. Inderal is a drug called a beta blocker that slows your heart rate and lowers your blood pressure.
C. When you have acute stress disorder, you have palpitations and your blood pressure is high, causing you to feel uncomfortable. This is the same feeling performers have when they have stage fright. Inderal is used for stage fright.
D. Inderal is a heart medication that can reduce the symptoms of acute stress disorder.

7. You walked into a friend's home. She is frantic. She has been unable to leave the house during 4 days of heavy downpour. She does not know if the rain will ever stop. What is the first thing you would do?

A. Tell her that everything will be fine. The rain will stop.
B. Play CDs of her favorite songs.
C. Sit quietly and listen to her.
D. Take her to the hospital.

8. A 22-year-old woman noticed recently that her father is irritable, short tempered, and unable to sleep through the night. She said that her father was given a clean bill of health by his primary care practitioner. What would you ask the woman first?

A. Did your father stop smoking recently?
B. Is your father married?
C. How old is your father?
D. Tell me more about your father.

9. You are visiting a friend who is telling you about her job interview tomorrow. She becomes anxious and says, "I really need a drink." She tells you that she gets anxious anytime that she is going to meet people for the first time. She is unable to sleep, feels all her muscles tightening, and becomes restless. What is your friend experiencing?

A. Agoraphobia
B. Generalized anxiety disorder
C. Acute stress disorder
D. Drug abuse

10. **The patient's family reports that the patient has become irritable, is not sleeping, and tells them he cannot relax. This has been going on for 2 days. The family says he has not left the house in 2 weeks. A family member tells you there are empty beer cans all over the place. He assures you that he looked everywhere and there is no alcohol in the house, just the empty cans. What problem does the patient exhibit?**
    A. Alcohol abuse
    B. Agoraphobia
    C. Substance abuse anxiety disorder
    D. Panic attack

CORRECT ANSWERS AND RATIONALES

1. C. Tell him that with the treatment he is receiving that he should be able to sleep normally at the end of the treatment period. Rationale: Although his symptoms correlate to acute stress disorder and he is being treated for acute stress disorder, his question is about resuming normal sleep habits. His symptoms are not indicative of PTSD. He is unlikely to develop depression related to the traumatic event because he is being treated for acute stress disorder.
2. D. Tell the daughter that her mother is likely experiencing panic attacks and that she should tell her primary practitioner about it so she can be treated soon. Rationale: The patient may develop depressive disorder, but this is unlikely if the patient is treated for panic disorder. The nurse should educate the patient about the next course of action, which is to speak with the primary practitioner about the panic attacks.
3. B. The nurse is experiencing the effects of chronic anxiety. Rationale: Stressors stimulate the HPA axis. The stressor of the emergency department is not resolved over time, resulting in the body being unable to adapt to the stressor. Release of cortisol in response to stimulation of the HPA axis decreases the immune response and can lead to infection. Although the nurse was probably exposed to a virus or bacteria that caused the nurse to be sick at times, the underlying problem is chronic anxiety. The nurse does not show signs of PTSD.
4. A. Your mother is experiencing acute PTSD. Rationale: Encourage your mother to drive short distances for routine trips such as food shopping. Rationale: Gradually being exposed to the trigger—driving—helps her to cope with the stress of the accident. Although she is at risk for self-medicating, she should return to driving as soon as possible.
5. C. Your husband shows signs of simple OCD. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might recommend cognitive behavioral therapy. Rationale: Medication is usually prescribed as a second line of treatment. Complex OCD requires that the obsession interferes with the patient's activities of daily living.

6. B. When you have acute stress disorder, you have palpitations and your blood pressure is high, causing you to feel uncomfortable. Inderal is a drug called a beta blocker that slows your heart rate and lowers your blood pressure. Rationale: Since the primary care practitioner already diagnosed the patient and ordered treatment, the nurse should educate the patient about the treatment. The explanation of the medication should focus on how the medication will help the patient. Although Inderal is used for stage fright, the patient is not experiencing stage fright.
7. B. Play CDs of her favorite songs. Rationale: This has a distracting and calming effect. Her favorite songs are triggers to more calming moments. Telling her that everything will be fine does not provide a therapeutic response to the situation. Quietly listening is appropriate but does not proactively address the situation. Taking her to the hospital does not address the current situation.
8. A. Did your father stop smoking recently? Rationale: Her father is showing signs of substance abuse anxiety disorder, and nicotine is likely the drug if her father is a smoker. Other responses do not help rule out symptoms of substance abuse anxiety disorder.
9. B. Generalized anxiety disorder. Rationale: This patient likely as GAD because she has episodes whenever she is presented with the trigger of meeting new people. She is misinterpreting the events. Acute stress disorder occurs following a traumatic event. She is not afraid of leaving home or being in public places; therefore agoraphobia is not correct. Although she self-medicates with alcohol and may show signs of abuse, the patient is exhibiting signs of GAD.
10. C. Substance abuse anxiety disorder. Rationale: The patient may be abusing alcohol; however, the signs and symptoms of anxiety indicate alcohol withdrawal. The patient may have agoraphobia, but more evidence is required to support this diagnosis. The family may not know if the patient had left the house for short periods to buy alcohol. The patient's anxiety is not from a panic attack.

This page intentionally left blank

chapter 4

Somatoform and Dissociative Disorders

LEARNING OBJECTIVES

1. Body dysmorphic disorder (BDD)
2. Conversion disorder
3. Hypochondriasis
4. Pain disorder
5. Somatization disorder
6. Depersonalization disorder
7. Dissociative amnesia
8. Dissociative fugue
9. Dissociative identity disorder

KEY TERMS

Acute memory loss
Cognitive therapy
Cold/hot application
Deep breathing exercise
Distraction
Doctor shopping
Dream-like state
Dysfunctional sensory
Fixity of Beliefs Questionnaire
Flooding therapy
Global Assessment of Functioning Scale
Looking at self from afar
Misinterpreting signs and symptoms
Multiple personality disorder
Overly dependent on others
Psychiatric Status Rating Scale for Body Dysmorphic Disorder
Psychotherapy
Response prevention therapy
Self-awareness
Systematized
Worthlessness

What Are Somatoform Disorders and Dissociative Disorders?

Somatoform disorders are psychiatric disorders where the patient reports symptoms of health problems that have no medical basis or the patient complains about their body image when nothing is wrong with the patient's body. Both symptoms of health problems and poor body image are perceived as real problems for the patient, leading the patient to seek medical help to address those problems.

The patient becomes frustrated when medical tests are negative and the practitioner does not offer medical treatment. In response, the patient may seek out other practitioners for help and self-refer to specialists. The patient is unlikely to provide practitioners with a history of visits to other practitioners or acknowledge previous medical tests, resulting in duplicated tests being performed.

Dissociative disorders are psychiatric disorders where the patient feels detached from themself and reality. Feeling detached from one's self is called depersonalization. Detachment from the external world is called derealization.

Historically somatoform disorders and dissociative disorders were classified as hysterical neuroses, which is why both are discussed in the same chapter. Neurotic disorders, according to psychoanalytic theory, stem from unconscious conflicts that increase anxiety, leading to symptoms of somatoform disorders and dissociative disorders as a defense mechanism to address the conflicts.

Factitious Disorders and Malingering Disorders

It is important to realize the difference between somatoform disorders and factitious disorders and malingering disorders. A factitious disorder, also known as Munchausen syndrome, is when a patient fabricates symptoms to get attention. Symptoms cease once the patient receives attention. A malingering disorder occurs when the patient fabricates or exaggerates symptoms to receive care and avoid an undesirable activity such as work, court, or family responsibilities. Symptoms are no longer reported once the patient avoids the undesirable activity.

In factitious disorders and malingering disorders, the patient knows that the symptoms are fabricated and there is nothing wrong with the patient. However, in somatoform disorders, the patient believes symptoms are real and therefore seeks medical help.

1. Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) occurs when a patient dislikes their physical appearance, usually the face, head, or skin. Any slight defect causes distress to a point where the patient is unable to perform activities of daily living. Flaws can be scars or shape and size of body structure. Compliments by others are not reassuring.

What Went Wrong?

The cause of BDD is unknown. Some researchers report a genetic predisposition to psychiatric disorders that leads to developing BDD. Other researchers believe an imbalance of serotonin may be the underlying cause of BDD. Still other researchers believe that cultural influences that define an ideal physical appearance lead patients with low self-esteem to define their self-worth by the ideal physical appearance.

Prognosis

A patient diagnosed with BDD may become isolated and avoid intimate relationships. The patient focuses attention on fixing their appearance. A patient is at risk for suicidal ideation and suicide attempts if the patient is not treated.

Hallmark Signs and Symptoms

- Covers the perceived defect with clothing or makeup
- Obsessively compares their appearance with others who the patient believes have an ideal appearance
- Obsessively looks at body parts that the patient feels are defective
- Compulsively covers up body parts that the patient feels are defective
- Avoids socializing with peers and family
- Unable to have an intimate relationship
- Low self-esteem
- Obsessively tries to improve the perceived defective body part by grooming or using medical treatment
- Isolates self from others

Common/Interpreting Test Results

There is no test that is used to diagnose BDD. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of BDD requires the following:

- The patient is excessively concerned over the patient's perception of defects in the patient's appearance.
- The patient experiences clinically significant distress that impairs the patient's activities of daily living, including social interactions and working.
- The patient's behavior is not better explained by another psychiatric or behavioral disorder such as obsessive-compulsive disorder (OCD).

The degree of severity of BDD can be assessed using the following tests:

- **Fixity of Beliefs Questionnaire**
- **Global Assessment of Functioning Scale**
- **Psychiatric Status Rating Scale for Body Dysmorphic Disorder**

Treatment

- First line of treatment
  - **Cognitive therapy**: Teach the patient to identify triggers that cause the patient to engage in BDD behaviors. Help the patient to identify

alternative behaviors when the patient encounters a trigger. Encourage the patient to decrease the available time to perform BDD behaviors.

- **Flooding therapy**: Expose the patient to prolonged periods that focus on the patient's perceived defects in the patient's appearance. Prolonged exposure will desensitize the patient to the perceived defects in the patient's body.
- **Response prevention therapy**: The patient is distracted whenever the patient begins the BDD behavior.

- Second line of treatment
  - Administer Antidepressants: Celexa (citalopram), Lexapro (escitalopram), Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Anafranil (clomipramine)

Drug Alert

Antipsychotics, Desyrel (trazodone), lithium, and benzodiazepines may exacerbate BDD behavior.

Nursing Diagnoses

- Ineffective relationships related to isolation
- Risk for chronic low self-esteem related to perceived body defects
- Risk for disturbed personal identity related to distress of body image

Nursing Interventions

- Accept the fact that the patient needs to perform repetitive behaviors. Do not be critical of the patient for this behavior.
- Acknowledge that the patient feels a need to perform repetitive behaviors.
- Do not prevent the patient from performing repetitive behaviors since this increases the patient's anxiety.
- Permit the patient time to perform repetitive behaviors.

- Gradually reduce the time available for the patient to perform repetitive behaviors and let the patient know that doing so will help the patient to reduce the compulsion.
- Help the patient identify triggers that lead to performing repetitive behaviors.
- Help the patient identify other ways to cope with anxiety such as diverting unwanted thoughts to positive thoughts when a trigger is identified by the patient.
- Offer positive feedback to help build the patient's self-esteem.
- Engage in activities that let the patient experience self-esteem.

2. Conversion Disorder

Conversion disorder occurs when a patient experiences neurologic symptoms such as paralysis, numbness, and blindness that are not caused by an underlying medical disorder. There are periods of exacerbation brought on by stress and periods of remission during less stressful times during which there are no neurologic symptoms. Symptoms of conversion disorder are real and not caused by the patient faking symptoms. Some researchers believe there is no formal evidence that rules out a physiologic cause for symptoms of conversion disorder.

What Went Wrong?

Conversion disorder is a defense mechanism whereby anxiety is converted into neurologic symptoms, which enables the patient to avoid stressful situations.

Prognosis

Without treatment, the patient is at risk for complications related to unnecessary medical tests, procedures, and treatments ordered by the practitioner to diagnose and treat neurologic symptoms. The patient may not return to activities of daily living.

Prolonged periods of exacerbation can expose the patient to risk of atrophy, contractures, and ulcers. Furthermore, the patient may be exposed to unnecessary medical tests, procedures, and treatments that can place the patient at risk for complications.

Hallmark Signs and Symptoms

- Patient is not concerned about impairment (la belle indifference)
- Impaired coordination
- Difficulty swallowing (dysphagia)
- Impaired vision with normal pupillary reaction
- Urinary retention
- Inability to speak (aphonia)
- Psychological seizures (pseudo seizures)
- Impaired hearing
- Weakness
- Paralysis with normal tendon reflexes

Common/Interpreting Test Results

There is no test that is used to diagnose conversion disorder. The initial step is to rule out physiologic disorders or other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of conversion disorder requires the following:

- **Dysfunctional sensory** or voluntary motor function or seizures that are symptomatic of a medical disorder.
- Symptoms are not intentionally produced by the patient.
- Exacerbation of symptoms occurs following a stressor.
- The symptoms are not limited to sexual dysfunction.
- Symptoms impair the patient's activities of daily living.

Treatment

- **Psychotherapy**: Provide an environment where the patient is able to discuss and resolve internal conflicts.
- **Deep breathing exercise**: Encourage the patient to perform deep breathing exercise at the first sign of a stressful situation.
- Administer:
  - Benzodiazepine: Ativan (lorazepam), Xanax (alprazolam)

Nursing Diagnoses

- Impaired verbal communication
- Impaired physical mobility
- Risk for injury

Nursing Interventions

- Acknowledge that the patient's symptoms are real and that the patient is not faking symptoms.
- Focus conversations away from symptoms.
- Encourage the patient to express psychological conflicts and stressors that trigger anxiety.
- Avoid implying that symptoms are psychosomatic.
- Develop an accepting rapport.
- Prevent injury related to symptoms.
- Provide nursing interventions as if symptoms were caused by a medical disorder such as providing passive range of motion exercises on paralyzed limbs.
- Encourage the patient to perform activities of daily living within the patient's ability to avoid the patient becoming an invalid.

3. Hypochondriasis

Hypochondriasis is a disorder where the patient believes that they have a medical disorder despite no evidence to support the belief. The patient believes symptoms of the suspected medical disorder are real. Furthermore, the patient is not seeking attention.

What Went Wrong?

Some researchers believe the patient wishes to be cared for by others as a way to avoid responsibilities. Researchers noted that hypochondriasis can develop in patients who have experienced a serious medical disorder or who have someone close to them who has had a serious medical disorder. The patient suspects symptoms are related to a different serious medical disorder.

Prognosis

Untreated hypochondriasis can lead to disruption of the patient's activities of daily living. In addition, the patient is at risk for misdiagnosis of real medical disorders as a result of practitioners assuming that reported symptoms are related to hypochondriasis.

Hallmark Signs and Symptoms

- Multiple complaints about a system of the body
- Misinterpretation of normal body functions
- Frequent visits to practitioners regardless of negative test results
- Detailed description of symptoms
- Believes that the practitioner is not competent to diagnose the patient
- Symptoms do not follow a pattern leading to a medical diagnosis
- Symptoms intensify when patient is receiving attention from others

Common/Interpreting Test Results

There is no test that is used to diagnose hypochondriasis. The initial step is to rule out physiologic disorders or other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of hypochondriasis requires the following:

- **Misinterpreting signs and symptoms** as related to a serious disease
- Poor insight by patient into their behavior
- Preoccupation with having a serious disease
- Impaired activities of daily living related to preoccupation of having a serious disease
- Symptoms that last at least 6 months

Treatment

- The practitioner should tell the patient that they do not have a serious disease.
- Focus on ways the patient can cope with symptoms.
- Gradually focus attention away from symptoms to create a balanced lifestyle.

- Psychotherapy: Provide an environment where the patient is able to discuss and resolve internal conflicts.
- Cognitive therapy: Teach the patient to identify triggers that cause the patient to engage in hypochondriasis behaviors. Help the patient to identify alternative behaviors when the patient encounters a trigger.
- Administer:
  - Benzodiazepine: Ativan (lorazepam), Xanax (alprazolam)
  - Antidepressant: Elavil (amitriptyline), Tofranil (imipramine)

Nursing Diagnoses

- Deficient knowledge related to signs and symptoms reported by the patient
- Risk for chronic low self-esteem
- Risk for powerlessness

Nursing Interventions

- Acknowledge that the patient's symptoms are real to them.
- Explain why the practitioner does not believe that the patient has a serious medical disorder.
- Help the patient identify and cope with triggers that cause the hypochondriasis.

4. Pain Disorder

Pain disorder occurs when the patient reports persistent pain that results in disruption of the patient's activities of daily living. However there is either no medical basis for the pain or the medical cause of pain is not as debilitating as presented by the patient. Pain disorder is caused by underlying psychological factors. There may be exacerbations and remissions of symptoms of pain disorder.

What Went Wrong?

Some researchers believe the patient who is unable to express feelings uses expression of pain as a way to manipulate others to gain attention. Attention

given to the patient rewards the patient for this behavior, encouraging the patient to continue the behavior. Other researchers believe that depression and chronic anxiety decrease the patient's pain threshold, leading to increased complaints about pain.

Prognosis

The patient may develop substance dependency because practitioners may prescribe narcotics to treat the patient's symptoms. The patient is also at risk for interruption of activities of daily living including employment.

Hallmark Signs and Symptoms

- Head, back, abdominal, and chest pain without an underlying physiologic cause
- Medication-seeking behavior
- Anger toward the practitioner for not providing medication requested by the patient
- Anger toward the practitioner for not finding the medical cause of the pain
- Normal medical tests
- **Doctor shopping**, whereby the patient visits multiple practitioners seeking medication and help to relieve the pain

Common/Interpreting Test Results

There is no test that is used to diagnose pain disorder. The initial step is to rule out physiologic causes of the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of pain disorder requires the following:

- Pain cannot be attributed to other psychotic disorders.
- Pain causes impairment in activities of daily living.
- The patient's chief complaint is pain significant enough to require attention of a practitioner.
- Psychological factors influence pain.
- Severity and exacerbation of pain associated with a general medical condition are embellished by psychological factors.

Treatment

- First line of treatment, nonpharmacologic therapy:
  - Cognitive therapy: Teach the patient to identify triggers that cause the patient to engage in behaviors. Help the patient to identify alternative behaviors when the patient encounters a trigger.
  - **Distraction**: The patient is asked to engage in an activity that will distract from pain at the first sign of a situation that triggers symptoms of pain disorder.
  - Deep breathing exercise: Encourage the patient to perform deep breathing exercise at the first sign of a situation that triggers symptoms of pain disorder.
  - **Cold/hot application**: Apply cold/heat therapy to reduce stress.
  - Back massage: A back massage will reduce stress.
- Second line of treatment
  - Administer:
    - Benzodiazepine: Ativan (lorazepam), Xanax (alprazolam)
    - Antidepressant: Elavil (amitriptyline), Tofranil (imipramine), Celexa (citalopram), Prozac (fluoxetine), Cymbalta (duloxetine), Effexor (venlafaxine)

Nursing Diagnoses

- Ineffective coping
- Risk for powerlessness
- Risk for ineffective activity planning

Nursing Interventions

- Acknowledge that the patient is feeling pain.
- Do not attempt to convince the patient that the pain is caused by a pain disorder.
- Help the patient identify situations that trigger symptoms of pain disorder.
- Engage the patient at times other than when the patient reports pain to break the patient's attention-seeking behavior.

- Teach coping skills that the patient can employ when the patient identifies triggers of symptoms.
- Encourage the patient to continue with activities of daily living.
- Explore with the patient possible underlying psychological stressors that may be causing symptoms of pain disorder.

5. Somatization Disorder

A somatization disorder occurs when a patient reports recurring physical complaints suggesting an underlying medical disorder but none exists. Onset is usually under the age of 30 and is more common in females. The patient goes from one practitioner to the next trying to find a diagnosis and treatment. Practitioners are unlikely to find a medical disorder causing the patient's physical complaints. The patient is needy, dependent on others, and demands and manipulates others to support them. The patient uses physical complaints to avoid responsibilities. Periods of exacerbation brought on by stress can last for years. Somatization disorder differs from hypochondriasis. Somatization disorder focuses on physical complaints. Hypochondriasis focuses on a specific disease that does not exist.

What Went Wrong?

An underlying feeling of **worthlessness** leads the patient to want to become **overly dependent on others**. Stress from triggers such as a loss causes exacerbation of the symptoms. Some researchers believe that the patient may have increased sensitivity to pain compared with others who do not have somatization disorder. Patients diagnosed with somatization disorder may also have major depression disorder and anxiety disorder.

Prognosis

The patient is at risk for substance abuse. Patients typically visit multiple practitioners, each of whom may prescribe medication that may duplicate the existing prescription provided by other practitioners, leading to overdosing. Furthermore, the patient may not tell a practitioner that they are also under the care of one or more other practitioners, leading to conflicts in prescribed medication. The patient is at risk for self-medication with alcohol and street drugs when they are unable to obtain prescribed medication from practitioners.

Hallmark Signs and Symptoms

- Constant symptoms
- Multiple medical visits to the same and different practitioners at various healthcare facilities
- Self-referrals to specialists
- Many diagnostic tests with negative results
- Mastery of medical terminology, medications, medical procedures, and diagnostic tests
- Extensive medical history without diagnosis
- The patient can explain their medical history in fine detail.
- Self-diagnosis
- The patient instructs the practitioner on tests and procedures that the practitioner should order.

Common/Interpreting Test Results

There is no test that is used to diagnose somatization disorder. The initial step is to rule out physiologic disorders or other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of somatization disorder requires the following:

- Onset before 30 years of age
- Symptoms are not intentionally produced.
- At least two of the following symptoms reported by the patient:
  - Abdominal pain
  - Nausea
  - Diarrhea
  - Vomiting
  - Unable to tolerate specific foods
  - Bloating
- At least four of the following symptoms reported by the patient:
  - Back pain
  - Urination pain
  - Menstrual pain

  - Pain in extremities
  - Pain during sex
- At least one of the following symptoms reported by the patient:
  - Loss of voice
  - Amnesia
  - Impaired vision
  - Seizures
  - Impaired hearing
  - Difficulty swallowing
  - Fainting
  - Impaired urination
  - Impaired voluntary muscle movement
- At least one of the following symptoms reported by the patient:
  - Impotence
  - Painful intercourse
  - Irregular menstrual periods
  - Excessive menstrual bleeding

Treatment

- There is no therapy to address somatization disorder since the patient believes the symptoms are real.
- Focus on ways the patient can cope with symptoms.
- The patient should have one practitioner.
- Gradually focus attention away from symptoms to create a balanced lifestyle.

Nursing Diagnoses

- Chronic low self-esteem related to needy behavior
- Ineffective individual coping related to inability to cope with anxiety
- Risk for self-mutilation related to suicidal behavior to gain attention

Nursing Interventions

- Tell the patient that you understand that their symptoms are real. Don't tell the patient that the symptoms are not real.
- Be honest when presenting results of diagnostic tests.
- Assist the patient in understanding the results of diagnostic tests.
- Help the patient cope with symptoms.
- The goal is not to eliminate the symptoms since eliminating the symptoms tends to impact the patient's relationships with the patient's support system.
- Teach the patient how stress relates to the symptoms described by the patient.
- Emphasize positive attributes of the patient.

6. Depersonalization Disorder

Depersonalization disorder occurs when the patient's **self-awareness** is temporarily altered, giving the patient the feeling of detachment from the patient's body or mental process. Depersonalization disorder can occur after a life-threatening event. Detachment can involve the entire body or a part of the body. The patient remains in touch with reality, although the patient may feel like they are viewing themself from the outside rather than from the inside.

NURSING ALERT

Symptoms of depersonalization disorder can occur when a person is intoxicated or when a person meditates. The person reports being in a dream-like state. This is not considered depersonalization disorder.

What Went Wrong?

The cause of depersonalization disorder is unknown. Researchers report that symptoms of depersonalization disorder can occur as a result of a severe stressful event, history of substance abuse, or physical or mental abuse. Researchers have also seen a relationship between brain injury and other neurologic disorders and depersonalization disorder.

Prognosis

Depersonalization disorder is a chronic disorder with short-lasting episodes and remissions with no longer term effects on the patient.

Hallmark Signs and Symptoms

- **Looking at self from afar**
- Feeling of detachment from body or body part
- Out of touch with reality
- In a **dream-like state**
- Anxiety
- Impaired activities of daily living
- Depression

Common/Interpreting Test Results

There is no test that is used to diagnose depersonalization disorder. The initial step is to rule out physiologic disorders, other mental disorders, or substance abuse causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of depersonalization disorder requires the following:

- Recurring depersonalization in a dream-like state or looking at self from afar.
- The patient is able to perceive their surroundings during an episode of depersonalization disorder.
- The patient experiences interruptions in activities of daily living as a result of an episode of depersonalization disorder.

Treatment

- No treatment may be necessary unless there are frequent episodes of depersonalization disorder.
- Cognitive therapy: Teach the patient to identify triggers that cause the symptoms of depersonalization disorder and identify alternative behaviors when the patient encounters a trigger.
- Psychotherapy: Provide an environment where the patient is able to discuss and resolve internal conflicts.
- Administer: Anafranil (clomipramine)

Nursing Diagnoses

- Risk for disturbed personal identity related to feeling detached from the patient's body
- Ineffective coping related to the inability to cope with underlying stress
- Disturbed personal identity related to the feeling of detachment from the patient's body

Nursing Interventions

- Remain nonjudgmental.
- Help the patient focus on the underlying stressors that trigger depersonalization disorder symptoms.
- Assist the patient in developing coping skills to better deal with the underlying stressors that trigger depersonalization disorder symptoms.

7. Dissociative Amnesia

Dissociative amnesia occurs when the patient has **acute memory loss** related to stress, leading to the patient being unable to recall personal information. Researchers have found that many patients realize they have experienced amnesia. Some patients are unaware that they experienced amnesia but realize a period of time has passed during which they are unable to recall what occurred during that period.

There are five types of dissociative amnesia; these are:

- Generalized: The patient experiences a prolonged memory loss.
- Localized: The patient is unable to recall the first few hours following a stressful event.
- **Systematized**: The patient is unable to recall a specific type of information.
- Selective: The patient is able to recall some but not all of a stressful event.
- Continuous: The patient is unable to recall all events starting from when the patient encounters the stressful event.

NURSING ALERT

Patients who experience an episode of dissociative amnesia may attempt to reconstruct missing memories.

What Went Wrong?

A patient diagnosed with dissociative amnesia copes with a stressful event by forgetting information associated with the event.

Prognosis

The patient is able to completely recover from an episode of dissociative amnesia. Complete memory of personal information is returned. Researchers believe, however, that stressful life events may never be recalled.

Hallmark Signs and Symptoms

- Loss of memory
- Confusion over being unable to recall periods of time during an episode of dissociative amnesia
- Unable to recall the stressful event that caused dissociative amnesia
- No medical explanation for loss of memory
- Memory loss not attributed to forgetfulness

Common/Interpreting Test Results

There is no test that is used to diagnose dissociative amnesia. The initial step is to rule out physiologic disorders or other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of dissociative amnesia requires the following:

- Inability to recall personal information is not related to forgetfulness.
- Impaired activities of daily living related to loss of memory.
- Amnesia is not related to any other medical or psychiatric disorder.

Treatment

- Psychotherapy: The therapist helps the patient try and fill in memory gaps, and the focus is switched to resolving the internal conflict. There is a risk that the therapist may cause an episode of dissociative amnesia when trying to fill in memory gaps.
- Administer:
  - Benzodiazepine: Ativan (lorazepam), Xanax (alprazolam)

Nursing Diagnoses

- Ineffective coping related to episodes of amnesia
- Risk for injury related to being unaware of surroundings during an episode of amnesia
- Risk for situational low self-esteem related to episodes of amnesia

Nursing Interventions

- Help the patient understand that amnesia is the way the patient is coping with a stressful situation.
- Encourage the patient to talk about the underlying stressful situation.
- Keep the patient safe during an episode of memory loss because the patient is likely to be unaware of the patient's surroundings.
- Help family members understand the basis for dissociative amnesia.

8. Dissociative Fugue

Dissociative fugue occurs when the patient leaves home to escape from a stressful event during which the patient temporarily assumes a new identity. During an episode of dissociative fugue, the patient is able to perform activities of daily living under the patient's new identity, which is more outgoing than the patient's normal behavior. The patient may experience amnesia of the episode. Episodes can last a few hours or months.

What Went Wrong?

The cause of dissociative fugue is unknown; however, researchers believe an episode of dissociative fugue is a way for the patient to cope with a stressful event. Other researchers feel that dissociative fugue is a way the patient can escape accountability for their action.

Prognosis

Episodes of dissociative fugue resolve, leading to a complete recovery, although the patient may experience recurring episodes.

Hallmark Signs and Symptoms

- No signs and symptoms are present during an episode of dissociative fugue since the patient performs activities of daily living under their new identity.
- The patient may be confused when discussing their past during an episode.
- After the episode, the patient may experience
  - Depression
  - Irritability at not being able to remember what occurred during the episode of dissociative fugue
  - Aggressive behavior when questioned about the episode
  - Low self-esteem

Common/Interpreting Test Results

There is no test that is used to diagnose dissociative fugue. The initial step is to rule out physiologic disorders or other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of dissociative fugue requires the following:

- Sudden unexpected travel from home
- Inability to recall the past
- The patient assumes an identity or is confused about their identity.
- Signs and symptoms interfere with the patient's normal activities of daily living.

Treatment

- Psychotherapy: The therapist helps the patient identify, explore, and resolve the underlying stress event that causes the patient to experience dissociative fugue.
- Cognitive therapy: Teach the patient to identify triggers that cause the patient to engage in dissociative fugue behaviors. Help the patient to identify alternative behaviors when the patient encounters a trigger.

Nursing Diagnoses

- Ineffective coping related to episodes of dissociative fugue
- Risk for injury related to irritability and aggressive behavior
- Risk for disturbed personal identity related to the patient assuming a new identity

Nursing Interventions

- Help the patient understand that the dissociative fugue is the way the patient is coping with a stressful situation.
- Encourage the patient to talk about the underlying stressful situation.
- Keep the patient safe during an episode of irritability and aggressive behavior.

9. Dissociative Identity Disorder

Dissociative identity disorder occurs when a patient has two or more personalities, each of which can control the patient's behavior, relationships, and memories. Dissociative identity disorder was formerly known as **multiple personality disorder**. Researchers have found that the primary personality has a strong moral sense and subsequent personalities have opposing personality traits such as overly sexual or aggressive. The primary personality may be unaware of subsequent personalities. A stressful or social event can trigger change in personality.

What Went Wrong?

There is no known cause of dissociative identity disorder. Some researchers believe an underlying traumatic event before age 15 may lead to dissociative identity disorder as a survival mechanism.

Prognosis

Treatment can take more than 6 years, during which time the therapist integrates personalities into one personality.

Hallmark Signs and Symptoms

- Pronounced changes in behavior
- Depression

- Somatic pain
- Sexual dysfunction
- Signs and symptoms of posttraumatic stress disorder
- Hallucination
- Amnesia
- Excessive risk taking
- Sleep disorder
- Guilt

Common/Interpreting Test Results

There is no test that is used to diagnose dissociative identity disorder. The initial step is to rule out physiologic disorders or other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of dissociative identity disorder requires the following:

- At least two personalities take control of the patient's behavior on more than one occasion.
- Each personality is distinct.
- The patient is unable to recall personal information after an episode.

Treatment

- Psychotherapy: The therapist focuses on each personality to stabilize the patient. The goal is for the therapist to integrate personalities.
- Administer:
  - Benzodiazepine: Ativan (lorazepam), Xanax (alprazolam)
  - Antidepressants: Elavil (amitriptyline), Tofranil (imipramine)

Nursing Diagnoses

- Risk for powerlessness related to multiple personalities
- Risk for ineffective coping related to multiple personalities
- Impaired memory related to inability to remember events when another personality takes over the patient's behavior

Nursing Interventions

- Develop a therapeutic rapport with each personality.
- Keep the patient safe during periods of aggressive personality.
- Assist the patient to identify each personality.
- Help the patient focus on the underlying traumatic event that caused the dissociative identity disorder.
- Encourage the patient to receive ongoing treatment.

CASE STUDY

CASE 1

A 53-year-old woman comes to a psychiatrist's office complaining about a headache, "strange pains" in her arms and legs, and always being tired. As the nurse, you gather additional history before the patient sees the psychiatrist. She reports on and off jaw pain and stomach pains, cold sweats, and light-headedness. You glance at the patient's history where you notice that she is being treated for hypochondriasis, that manifests as her being preoccupied with having a heart attack.

QUESTION 1. What should you do first?
ANSWER: Assess the patient for myocardial infarction. Patients with hypochondriasis do get ill and can have a myocardial infarction. Patients diagnosed with hypochondriasis or somatization disorder are at risk for not being diagnosed for a medical disorder because the practitioner assumes that reported symptoms are psychiatric based. The first step is to rule out a medical disorder.

QUESTION 2. What should be the focus of treatment?
ANSWER: The practitioner should focus on ways that the patient can cope with symptoms and develop a balanced lifestyle. Key to treatment is psychotherapy, during which the practitioner creates an environment where the patient is able to discuss and resolve internal conflicts.

QUESTION 3. What is the practitioner's concern when prescribing benzodiazepine to treat hypochondriasis?
ANSWER: The patient may be noncompliant with the prescription and take more medication than that prescribed by the practitioner. Furthermore, the patient may become dependent on the medication.

FINAL CHECK-UP

1. **A 23-year-old woman was admitted to the addiction unit from the emergency department reporting that the she feels like killing herself. During your admission interview, you notice superficial lacerations on her left forearm. Her toxicology study was positive for cocaine. At the end of the interview, the patient asks if the social worker can fax a letter to the court in the morning telling the court that she won't be able to attend her court hearing in the morning. What do you suspect occurred?**
   A. The patient is a high risk for suicide related to the pending court hearing.
   B. The patient is malingering to avoid the court hearing, during which the patient would test positive for an illegal substance.
   C. Lacerations are a sign of attention seeking.
   D. The patient is likely experiencing symptoms of a dissociative disorder.

2. **A 23-year-old woman keeps her neck covered both inside the house and when she leaves the house. Her mother asks you what will happen to her if she does not get treatment. Which is the best response?**
   A. Ignore her behavior and eventually she will be fine.
   B. She should seek treatment as soon as possible. There is a risk that she may isolate herself and avoid intimate relationships.
   C. She should eventually see a cosmetic surgeon who can improve the appearance of her neck.
   D. She is at high risk for suicide.

3. **A husband reports to you that his 53-year-old wife is constantly going to practitioners reporting all sorts of symptoms and no one has been able to diagnose her. He asks if she is losing her mind. What is your best response?**
   A. She might have hypochondriasis. She may believe that her symptoms are real. She should seek psychiatric care.
   B. She might have somatization disorder. She may believe that her symptoms are real. She should seek psychiatric care.
   C. She might have factitious disorder. Her symptoms may be a way of gaining attention. No psychiatric care is necessary.
   D. She might have somatization disorder. Her symptoms may be a way of gaining attention. No psychiatric care is necessary.

4. **A 45-year-old man, who was missing for 5 years and declared dead, called authorities to report that he is alive and well and living across the country. He is confused, telling authorities that he seems to have a different name and cannot remember much about the previous 5 years. What is the best explanation of this occurrence?**
   A. The patient probably experienced a dissociative fugue.
   B. The patient is malingering to avoid family responsibilities.

C. Authorities should perform a test to determine if the patient experienced a dissociative fugue or is malingering.
D. Authorities should investigate for insurance fraud.

5. Your neighbor tells you that her brother has persistent pain; however, physicians are unable to find the medical reason and suggest that he see a psychiatrist. Your neighbor asks you what the cause of his condition is. What is your best reply?

A. He is depressed.
B. He is seeking attention.
C. He is probably experiencing pain disorder. Some researchers believe patients diagnosed with pain disorder are unable to express feelings.
D. He is manipulative.

6. Your friend is concerned that she has depersonalization disorder because she felt like she was viewing herself from afar during a party last night. What's your best response?

A. You should see your practitioner immediately.
B. Were you drinking alcohol or using recreational drugs at the party?
C. You are probably under too much stress.
D. Ask your practitioner about taking Anafranil.

7. A relative asks you about the cause of dissociative identity disorder. Which of the following is your best response?

A. Some researchers believe dissociative identity disorder is a survival mechanism related to a traumatic event in early childhood.
B. Some researchers believe this is a multiple personality disorder.
C. Some researchers believe dissociative identity disorder is untreatable.
D. Some researchers believe treatment for 6 years is necessary to improve dissociative identity disorder.

8. What type of therapy is used to treat somatization disorder?

A. There is no therapy since the patient believes symptoms are real.
B. Talk therapy
C. Group therapy
D. Cognitive therapy

9. What is the first line of treatment for pain disorder?

A. Antidepressants
B. Benzodiazepine
C. Nonpharmacologic therapy
D. Celexa

10. Why shouldn't the nurse have a goal to eliminate symptoms of somatization disorder when treating a patient?

A. The patient believes symptoms are real.

B. Eliminating symptoms tends to impact the relationship between the patient, the nurse, and the patient's support system.

C. Symptoms cannot be eliminated.

D. The patient knows that symptoms are not real, and therefore, there is nothing to eliminate.

CORRECT ANSWERS AND RATIONALES

1. B. The patient is malingering to avoid the court hearing during which the patient would test positive for an illegal substance. Rationale: Lacerations are likely self-inflicted to give credence to the patient's suicidal ideation and not to gain attention. The patient is not a high risk for suicide related to the pending court hearing because the patient is asking that the social worker contact the court on her behalf. There are no symptoms of a dissociative disorder.
2. B. She should seek treatment as soon as possible. There is a risk that she may isolate herself and avoid intimate relationships. Rationale: Although there is a potential risk for suicide for a patient who has symptoms of body dysmorphic disorder, there isn't a high risk. Ignoring the behavior is not treating the disorder. Since the mother hasn't identified any deformity of the neck, there is no basis to suggest cosmetic surgery.
3. B. She might have somatization disorder. She may believe that her symptoms are real. She should seek psychiatric care. Rationale: Hypochondriasis requires the patient to focus on one disorder. No single disorder was identified in the question, which is a symptom of somatization disorder. She is unlikely faking the symptoms.
4. A. The person probably experienced a dissociative fugue. Rationale: There is no information in the question to support malingering. There is no test to diagnose a dissociative fugue. There is no information to support that the person was involved in insurance fraud.
5. C. He is probably experiencing pain disorder. Some researchers believe patients diagnosed with pain disorder are unable to express feelings. Rationale: The other answers are not complete responses.
6. B. Were you drinking alcohol or using recreational drugs at the party? Rationale: Symptoms of depersonalization disorder can be caused by alcohol or recreational drugs and therefore would not be considered depersonalization disorder. The other responses are not the best response.
7. A. Some researchers believe dissociative identity disorder is a survival mechanism related to a traumatic event in early childhood. Rationale: The other answers are not appropriate responses.

8. A. There is no therapy since the patient believes symptoms are real.
9. C. Nonpharmacologic therapy.
10. B. Eliminating symptoms tends to impact the relationship between the patient, the nurse, and the patient's support system.

chapter 5

Schizophrenia

LEARNING OBJECTIVES

1. Paranoid schizophrenia disorder
2. Disorganized schizophrenia disorder
3. Undifferentiated schizophrenia disorder
4. Residual schizophrenia disorder
5. Catatonic schizophrenia disorder

KEY TERMS

Active phase
Anhedonia
Apathy
Auditory hallucinations
Bizarre behavior
Blunted affect
Confusion
Degrees of schizophrenia
Delusion
Gustatory hallucinations
Hallucinations
Lack of motivation
Negative symptoms
Olfactory hallucinations
Persecutory delusions
Positive symptoms
Poverty of speech
Prodromal phase
Residual phase
Schizophrenia
Tactile hallucinations
Visual hallucinations

What Is Schizophrenia Disorder?

Schizophrenia is a mental illness characterized by a person's abnormal misinterpretation of reality referred to as psychosis. The person's behavior seems bizarre to others because the behavior is inappropriate to reality. However, the behavior is appropriate to the person based on the person's misperception of reality.

For example, all of us become paranoid when walking down an unfamiliar dark street as part of our survival mechanism. However, a paranoid schizophrenic may become paranoid over normal activities in the house such as the familiar mail carrier dropping mail in the mail box. The paranoid schizophrenic may see the familiar mail carrier as a threat and react in a way that seems appropriate to the schizophrenic but inappropriate to everyone else.

In addition, some schizophrenic patients may be unable to distinguish between fantasy and reality. For example, a schizophrenic might obsessively watch old western movies and then put on a full western costume complete with two toy guns and a badge and walk the streets thinking he is the sheriff protecting everyone in town from the "bad guys."

It is important that the nurse understand that the schizophrenic behavior is usually appropriate in the patient's perceived reality. The inappropriateness of the patient's behavior is a result of the misperception of reality by the patient.

Hallucinations

A person diagnosed with schizophrenia may have hallucinations. A **hallucination** is a perception of something real in the absence of reality. That is, the person experiences something that is real but is not real. There are several types of hallucinations. These are:

- **Visual**: Seeing something that is not there
- **Auditory**: Hearing voices but no one is saying anything. A voice may tell the patient to do something. This is referred to as a command voice or command hallucination.
- **Olfactory**: Smelling an odor that does not exist
- **Tactile**: Feeling something that does not exist
- **Gustatory**: Tasting something without anything being in the patient's mouth

Delusion

A **delusion** is the appropriate interpretation of a stimulus by the patient; however the patient gives a bizarre significance to the stimulus. For example, the patient may realize that the familiar mail carrier dropped mail in the mail box, but the patient believes that the mail carrier stopped briefly to read the patient's mind.

Positive and Negative Symptoms

A **positive symptom** of schizophrenia disorder is a symptom that appears when the patient has an episode of schizophrenia disorder. For example, hallucinations and delusions are positive symptoms of schizophrenia disorder because there is outward manifestation of the symptoms.

Two other positive symptoms are classified as disorganized symptoms. These are:

- **Bizarre behavior**: Bizarre behavior is where the patient displays strange and unusual behavior during an episode of schizophrenia disorder.
- **Confusion**: The patient experiences thought disorder that leads to disorganized speech and is unable to converse with others.

A negative symptom of schizophrenia disorder is a normal behavior that is absent. That is, a person who is not experiencing an episode of schizophrenia disorder should display specific behavior. However, a person having an episode of schizophrenia disorder does not display that behavior. Here are common **negative symptoms** of schizophrenia disorder:

- **Anhedonia**: Anhedonia is the inability to experience pleasure.
- **Apathy**: Apathy is the decreased interest in activities, people, and things.
- Asociality: Asociality is when the patient avoids relationships and withdraws from society.
- **Blunted affect**: Blunted affect is when the patient is unable to show emotions, although they continue to feel emotions.
- **Lack of motivation:** The patient is unable to begin activities.
- **Poverty of Speech**: The patient provides terse replies when someone tries to converse with them.

Phases of Schizophrenia Disorder

There are three phases of schizophrenia disorder that follow in a progression. Patients diagnosed with schizophrenia disorder rarely experience full remission. These are:

- **Prodromal**: The patient shows decreased functionality such as poor hygiene, lack of motivation, and beginning to withdraw from society. The patient is able to work, although there is a marked decrease in performance. This stage occurs about a year before the patient is hospitalized
- **Active**: The patient demonstrates positive or negative signs of schizophrenia disorder. This may occur continuously or episodically (i.e., with periods of exacerbation and remission). Two-thirds of patients diagnosed with schizophrenia disorder have multiple active phases in their lifetime.
- **Residual**: The patient demonstrates more negative signs of schizophrenia disorder than positive signs. Positive signs do not have a material effect on the patient's behavior. The patient's baseline functionality stabilizes.

Degrees of Schizophrenia Disorder

The **degree of schizophrenia** disorder is the variation of symptoms of schizophrenia during the patient's life. Symptoms are controlled by antipsychotic

medication. Patients who are compliant with treatment will typically experience fewer symptoms than patients who are noncompliant with medication. Symptoms can also increase if the prescribed antipsychotic medication is no longer effective. The degrees of schizophrenia disorder are:

- Mild: Less than two relapses by the age of 45. The patient is stable with few symptoms.
- Moderate: Multiple relapses by the age of 45. Stress increases symptoms that continue between relapses.
- Severe: Multiple relapses by the age of 45 with few stable periods. The patient is unable to perform activities of daily living.

Antipsychotic Medication Adverse Side Effects

Antipsychotic medication affects neurotransmitters to control symptoms of schizophrenia disorder. There are two categories of antipsychotic medication. These are typical and atypical. Typical antipsychotic medications are old medications that affect a broad number of neurotransmitters. Atypical antipsychotic medications are new medications that affect a narrow number of neurotransmitters. Typical antipsychotic medications affect neurotransmitters that cause symptoms of schizophrenia disorder and also affect neurotransmitters that have no relation to those symptoms. As a result, typical antipsychotic medications can have adverse side effects. The most common adverse side effects are:

- Akathisia: Akathisia is a sensation of restlessness and inability to remain still.
- Dystonia: Dystonia is uncontrolled sustained muscle contractions.
- Neuroleptic malignant syndrome: Neuroleptic malignant syndrome adversely affects temperature regulation, leading the patient to have a dangerously high temperature that cannot be treated by antipyretic medication.
- Sexual dysfunction: A patient may experience problems with arousal. This is a major reason why some patients diagnosed with schizophrenia disorder stop taking medication.
- Tardive dyskinesia: Tardive dyskinesia is involuntary repetitive body movements.

NURSING ALERT

Immediately withhold the next dose of antipsychotic medication and call the practitioner at the first sign of an adverse side effect from antipsychotic medication.

1. Paranoid Schizophrenia Disorder

Paranoid schizophrenia disorder occurs when the patient has delusions of grandiosity or persecution that are not based in reality. The patient may experience auditory hallucinations, such as hearing voices that are not present. Stress can increase symptoms of paranoid schizophrenia.

What Went Wrong?

There is no known cause of paranoid schizophrenia disorder. There is a genetic factor where a patient who has a close relative diagnosed with paranoid schizophrenia disorder is more likely to develop paranoid schizophrenia disorder.

Prognosis

Symptoms have minimum impact on the patient's activities of daily living. Typically patients respond well to treatment.

Hallmark Signs and Symptoms

- Anger
- Argumentative
- Auditory hallucinations
- Grandiose delusions
- High risk for violence
- **Persecutory delusions**
- Unnatural formality in interpersonal relationships

Common/Interpreting Test Results

There is no test that is used to diagnose paranoid schizophrenia disorder. The initial step is to rule out physiologic and other mental disorders causing the

symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of paranoid schizophrenia disorder requires the following:

- Frequent auditory hallucinations or preoccupation with delusions
- No signs of flat affect, inappropriate affect, disorganized behavior, or catatonic behavior

Treatment

- Psychotherapy: Provide an environment where the patient is able to discuss and resolve internal conflicts.
- Administer: Zyprexa (olanzapine), Risperdal (risperidone), Geodon (ziprasidone), Abilify (aripiprazole), Seroquel (quetiapine), Haldol (haloperidol), and Thorazine (chlorpromazine)

Nursing Diagnoses

- Ineffective individual coping related to fear of triggers
- Risk for social isolation related to inability to engage in social events and visit public areas
- Risk for powerlessness related to disruption in activities of daily living

Nursing Interventions

- Minimize contact with staff and other patients until the patient begins to develop trust.
- Approach the patient calmly.
- Build trust by making only promises that you can deliver.
- Give the patient options rather than giving firm direction to give the patient limited control over environment.
- Avoid situations that lead to arguments and mistrust. Remain neutral if the patient is demanding and condescending.
- Remain in control, but give the patient some control of the situation.
- Set limits. Provide factual explanation of situations.
- Acknowledge that the patient has auditory hallucinations, but also tell the patient that you do not hear those sounds.

NURSING ALERT

Be alert for suicidal and homicidal ideation and institute proper precautions immediately.

2. Disorganized Schizophrenia Disorder

Disorganized schizophrenia disorder occurs when a patient demonstrates disorganized behavior such as inappropriate responses to situations and decreased ability to perform activities of daily living. The patient may not make sense when speaking.

What Went Wrong?

There is no known cause of disorganized schizophrenia disorder. Disorganized schizophrenia disorder, like other forms of schizophrenia disorder, can run in families.

Prognosis

The patient may experience decreased social interactions related to behavior and inability to hold conversations with others. The patient may not experience remissions of symptoms. Symptoms begin gradually and have a cumulative effect. The patient is at risk for self-destructive behavior, homelessness, and drug abuse.

Hallmark Signs and Symptoms

- Social withdrawal
- Disorganized behavior that disrupts activities of daily living
- Unspecified hallucinations
- Blunted affect
- Incoherent speech
- Unspecified delusions

Common/Interpreting Test Results

There is no test that is used to diagnose disorganized schizophrenia disorder. The initial step is to rule out physiologic and other mental disorders causing the

symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of disorganized schizophrenia disorder requires the following:

- Inappropriate affect
- Disorganized behavior
- Disorganized speech

Treatment

- Psychotherapy: Provide an environment where the patient is able to discuss and resolve internal conflicts.
- Administer: Zyprexa (olanzapine), Risperdal (risperidone), Geodon (ziprasidone), Abilify (aripiprazole), Seroquel (quetiapine), Haldol (haloperidol), and Thorazine (chlorpromazine)

Nursing Diagnoses

- Impaired verbal communication related to incoherent communication
- Risk for social isolation related to disorganized behavior
- Risk for injury related to disorganized behavior

Nursing Interventions

- Create a safe environment for the patient.
- Prevent the patient from self-injuring behavior.
- Remain calm.
- Redirect the patient using clear short statements.
- Supplement activities of daily living that the patient is unable to do themself.
- Give the patient hope by encouraging them to perform as many activities of daily living as possible.

NURSING ALERT

Do not argue with the patient. Arguing with the patient escalates the situation. The goal is to de-escalate the situation.

3. Undifferentiated Schizophrenia Disorder

Undifferentiated schizophrenia disorder occurs when a patient displays general signs and symptoms of schizophrenia such as hallucinations, but collectively, the signs and symptoms do not meet the standards for a specific type of schizophrenia disorder.

What Went Wrong?

There is no known cause of undifferentiated schizophrenia disorder. Undifferentiated schizophrenia disorder, like other forms of schizophrenia disorder, can run in families. Some researches believe there is a neurobiologic connection related to excessive levels of dopamine.

Prognosis

Patients with early-onset undifferentiated schizophrenia disorder have a poor prognosis related to increased rate of brain abnormalities. Patients with late-onset undifferentiated schizophrenia disorder have the most positive prognosis if the patient complies with treatment. Increased stress and intense emotional family environments tend to increase relapses.

Hallmark Signs and Symptoms

- Hallucinations
- Thought withdrawal
- Delusions
- Thought insertion

Common/Interpreting Test Results

There is no test that is used to diagnose undifferentiated schizophrenia disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of undifferentiated schizophrenia disorder requires:

- Two or more of the following symptoms during a period of 1 month:
  - Delusion
  - Hallucinations
  - Disorganized behavior

- Disorganized speech
- Catatonic behavior
- Negative symptoms

- In the last 6 months, the patient must display disturbed behavior.
- Decrease in:
  - Social functioning
  - Interpersonal functioning
  - Occupational functioning

Treatment

- Psychotherapy: Provide an environment where the patient is able to discuss and resolve internal conflicts.
- Family therapy: Provide an outlet for family members to express their feelings and help the family members interact with and care for the patient.
- Administer: Zyprexa (olanzapine), Risperdal (risperidone), Geodon (ziprasidone), Abilify (aripiprazole), Seroquel (quetiapine), Haldol (haloperidol), and Thorazine (chlorpromazine)

Nursing Diagnoses

- Risk for social isolation related to disorganized behavior
- Risk for injury related to disorganized behavior
- Impaired verbal communication related to incoherent communication

Nursing Interventions

- Create a safe environment for the patient.
- Prevent the patient from self-injuring behavior.
- Remain calm.
- Do not argue with the patient.
- Redirect the patient using clear short statements.
- Supplement daily activities that the patient is unable to do by themself.
- Give the patient hope by encouraging them to perform as many activities of daily living as possible.

4. Residual Schizophrenia Disorder

Residual schizophrenia disorder occurs when the patient, after experiencing an episode of schizophrenia, continues to exhibit less pronounced symptoms such as delusions and hallucinations.

What Went Wrong?

There is no known cause of residual schizophrenia disorder. Residual schizophrenia disorder, like other forms of schizophrenia disorder, can run in families.

Prognosis

The patient is at risk for not being able to maintain activities of daily living. Although the patient is typically able to stay independent, the patient will require financial support and social support from friends and family.

Hallmark Signs and Symptoms

- Bizarre behavior
- Inappropriate affect
- Loose association
- Isolation

Common/Interpreting Test Results

There is no test that is used to diagnose residual schizophrenia disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of residual schizophrenia disorder requires:

- Negative symptoms or two or more of the following:
  - Mild hallucinations
  - Mild disorganized behavior
  - Mild delusions
- No gross symptoms

Treatment

- Psychotherapy: Provide an environment where the patient is able to discuss and resolve internal conflicts.

- Family therapy: Provide an outlet for family members to express their feelings and help the family members interact with and care for the patient.
- Administer: Zyprexa (olanzapine), Risperdal (risperidone), Geodon (ziprasidone), Abilify (aripiprazole), Seroquel (quetiapine), Haldol (haloperidol), and Thorazine (chlorpromazine)

Nursing Diagnoses

- Risk for injury related to disorganized behavior
- Risk for social isolation related to disorganized behavior
- Risk for powerlessness related to symptoms of schizophrenia

Nursing Interventions

- Create a safe environment for the patient.
- Prevent the patient from self-injuring behavior.
- Supplement activities of daily living that the patient is unable to do themself.
- Encourage the patient to perform as many activities of daily living as possible.

5. Catatonic Schizophrenia Disorder

Catatonic schizophrenia disorder occurs when a patient experiences periods of a daze and is unable to move or speak. The patient also experiences periods of hyperactivity such as bizarre behavior and spurts of talkativeness. A patient diagnosed with catatonic schizophrenia disorder has a propensity for destructive behavior.

What Went Wrong?

There is no known cause of catatonic schizophrenia disorder. Catatonic schizophrenia disorder, like other forms of schizophrenia disorder, can run in families.

Prognosis

Prognosis for a patient diagnosed with catatonic schizophrenia is excellent since treatment can extend periods of remission and reduce periods of exacerbation.

Hallmark Signs and Symptoms

- Mute
- Physical immobility
- Resistance
- Mimicking speech
- Mimicking movement
- Movement that has no purpose
- Bizarre mannerisms

Common/Interpreting Test Results

There is no test that is used to diagnose catatonic schizophrenia disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of catatonic schizophrenia disorder requires at least two of the following:

- Peculiar voluntary movements
- Excessive motor activity
- Lack of motor movement
- Extreme negative symptoms such as mutism or rigid posture with resistance to movement
- Imitating movement and speech

NURSING ALERT

Catatonic schizophrenic disorder is uncommon. Signs and symptoms of catatonic schizophrenic disorder may be caused by medication or medical disorders.

Treatment

- Electroconvulsive therapy (ECT): Electroconvulsive therapy has improved the symptoms of catatonic schizophrenic disorder.
- Administer: Valium (diazepam), Ativan (lorazepam)
- Provide passive range of motion treatment to ensure adequate circulation.

Drug Alert

Antipsychotic medication may increase catatonic symptoms.

Nursing Diagnoses

- Risk for injury related to destructive violent behavior
- Impaired verbal communication related to muted communication
- Risk for altered nutrition related to long periods of catatonic behavior

Nursing Interventions

- Keep a safe distance from the patient since the patient is at risk for unpredictable violent behavior.
- Reassure the patient by staying with them during a catatonic episode.
- Talk to the patient. Although the patient shows lack of movement and speech, the patient is aware of the surroundings and can hear.
- Do not talk about the patient in front of them. Acknowledge to the patient that you know the patient can hear you.
- Focus on bringing the patient back in touch with reality.
- Give the patient clear, direct instructions. Do not give the patient options.
- Prevent the patient from injuring themself during periods of excessive movement.
- Keep the patient in a safe environment.

CASE STUDY

CASE 1

A 39-year-old man is in the day room on the unit. He stares out the window at the sun, placing each thumb to the side of his head and separating other fingers. Periodically he squints both eyes and purses his lips. He becomes irritable when other patients try to enter the day room. He stands nearly toe-to-toe with them with a threatening expression. He remains in that position until they leave. A few patients react with aggression toward him, but he continues with his threatening in-your-face stare not saying a word.

QUESTION 1. What should you do first?
ANSWER: Safety is the primary goal. Request that all other patients except the 39-year-old male patient to leave the day room to prevent opportunity for confrontation. Do not enter the day room. Open the door and direct patients to leave. Always stay away from the door as patients are leaving to prevent yourself from being injured should the confrontation turn violent. Never enter a violent situation. Always call for assistance.

QUESTION 2. What should you do next?
ANSWER: Calmly engage the 39-year-old male patient in a therapeutic conversation. First, ask the patient if he feels safe. Although he is safe on the unit, the patient needs to perceive that he is safe; otherwise the patient will react as if he is being threatened, which can lead to violent behavior as the patient defends himself. Next, focus the conversation on the patient's behavior. Say, "I noticed you looking out the window. Do you want to talk about something?" This open-ended question gives the patient the opportunity to express his concerns and explain his behavior. Keep in mind that the behavior of a patient diagnosed with schizophrenia disorder may seem inappropriate to others but is appropriate to the misinterpretation of a situation.

QUESTION 3. The patient tells you that the sun is giving him instructions on what to do today while on the unit. His hands are like an antenna. When he stares at the sun, he is receiving instructions. When he squints his eyes, he is sending a reply to the sun. How do you respond?
ANSWER: The objective is to acknowledge the delusion and to bring the patient back to reality. Tell the patient that you understand that the patient believes he is communicating with the sun. Also help return the patient to reality by telling the patient that you don't believe the sun is giving him instructions because the sun cannot give instructions. Help the patient remember recent times when the patient made his own decisions on the unit and that those decisions were positive ones without the aid of the sun.

FINAL CHECK-UP

1. **A family member of a patient who is diagnosed with catatonic schizophrenia disorder asks you if the practitioner should prescribe antipsychotic medication for the patient. What is your best response?**
   A. Yes, that is a good suggestion. I'll mention this to the practitioner.
   B. Antipsychotic medication is not prescribed because the medication may increase the catatonic symptoms, which is why the practitioner has not ordered the medication for the patient.
   C. Yes, that is a good suggestion. Please mention this to the practitioner.
   D. The practitioner knows what is best for the patient.

2. A new patient presents in the emergency department as mute, immobile, and resistant to movement. What should the nurse suspect?

A. The patient may have a medical condition or adverse drug reaction.
B. The patient has catatonic schizophrenia disorder.
C. The patient has some form of schizophrenia.
D. The patient is faking an illness so the patient will be admitted to the hospital. The patient is homeless.

3. A family member mentioned that his sister barricades herself in her house and calls the police every time the mail carrier drops off mail. She has been diagnosed with schizophrenia; however, the family member doesn't understand her behavior. What is the best response?

A. The mail carrier scares her.
B. She is experiencing hallucinations.
C. She is experiencing delusions.
D. She is misinterpreting reality and behaving as if her perception of reality is real.

4. Your neighbor has a son who was diagnosed with schizophrenia several years ago. You ask your neighbor how his son is doing. Your neighbor says that he is doing fine. He exhibits no more violent behavior. He gets up, eats, and watches television quietly all day. How should you respond?

A. The medication seems to be working well.
B. You should tell your son's practitioner about his behavior.
C. Television is a good way to occupy his time.
D. Medication takes several months to have an effect on behavior.

5. The brother of a patient reports that the patient's medication stopped working and he has returned to walking the streets late at night chasing trucks out of his neighborhood. The patient lives alone in subsidized housing. You are asked what other medications can be prescribed to the patient. What is the best response?

A. Maybe it is time for your brother to live with you.
B. Is your brother taking his medication?
C. Ask the practitioner for alternative medications.
D. You should take your brother to the emergency room and have his medications adjusted.

6. New parents raise concerns that their son will develop schizophrenia disorder because the husband's mother had been diagnosed with paranoid schizophrenia disorder for most of her adult life. What is the best response?

A. There is no known cause of paranoid schizophrenia disorder; however, there is a genetic predisposition to developing the disorder if a close relative has been diagnosed with paranoid schizophrenia disorder.
B. There is a genetic predisposition; however, a predisposition does not mean that your son will develop paranoid schizophrenia disorder.

C. There is little chance that he will develop paranoid schizophrenia disorder.
D. Watch for symptoms of paranoid schizophrenia disorder when he reaches 16 years of age.

7. A new patient diagnosed with paranoid schizophrenia disorder arrives on your unit. How should you react?

A. Perform the admission assessment immediately and show the patient to her room.
B. Welcome the patient while standing behind the nurse's station and engage in an informal conversation with the patient.
C. Welcome the patient while standing behind the nurse's station and avoid any conversation with the patient.
D. Take the patient by the hand and lead her into the examination room.

8. A patient walks in and out of other patients' rooms looking for his dog Mike. You notice a stain on the front of his pants. He is not wearing shoes or sockets. He tries to open all the closed doors on the unit. What is your first intervention?

A. Call security to report an attempted elopement.
B. Prevent the patient from self-injuring behavior.
C. Sternly direct the patient back into his room.
D. Sternly direct the patient back into his room and help the patient wash his body and put on clean clothes.

9. A father of a 42-year-old man who has been diagnosed with undifferentiated schizophrenia disorder for many years tries to control his son's bizarre behavior by yelling at him and limiting his movements within the house. Which recommendation is best to give the father?

A. Create a calm supportive environment at home. Stress and emotional family environments tend to increase signs and symptoms of undifferentiated schizophrenia disorder.
B. Send your son to a group home where he will experience a less stressful home environment.
C. Avoid limiting your son's movement because this is a violation of the Americans with Disabilities Act.
D. Ask your son's practitioner to increase his medication.

10. A mother of a 21-year-old man tells you her son has undiagnosed schizophrenia. She reports that he appears normal and then suddenly takes on the characteristics of an 8-year-old boy called Billy Bob. At other times, he appears to be a British rock star called Reggie. And then suddenly he is back to being himself. What is the best response?

A. He has undifferentiated schizophrenia disorder. You should have your son assessed by a psychiatrist as soon as possible.
B. He has undifferentiated schizophrenia disorder. Take your son to the emergency room immediately.

C. You should have your son assessed by a psychiatrist as soon as possible to determine if he has dissociative identity disorder.
D. Your son is probably pretending to be those personalities.

CORRECT ANSWERS AND RATIONALES

1. B. Antipsychotic medication is not prescribed because the medication may increase the catatonic symptoms, which is why the practitioner has not ordered the medication for the patient. Rationale: The nurse has the responsibility to educate the family about medication.
2. A. The patient may have a medical condition or adverse drug reaction. Rationale: The patient is showing signs of catatonic schizophrenia; however, catatonic schizophrenia is rare. The same signs can be caused by a medical disorder or adverse reaction to medication.
3. D. She is misinterpreting reality and behaving as if her perception of reality is real.
4. B. You should tell your son's practitioner about his behavior. Rationale: The neighbor is describing negative symptoms of schizophrenia. The neighbor's son should be reevaluated by the practitioner. The patient may be in the residual phase of schizophrenia.
5. B. Is your brother taking his medication? Rationale: A common problem is that patients diagnosed with schizophrenia disorder are noncompliant with medication treatment especially if they are not monitored daily. Signs and symptoms of schizophrenia can return.
6. B. There is a genetic predisposition; however, a predisposition does not mean that your son will develop paranoid schizophrenia disorder. Rationale: The first signs and symptoms of schizophrenia disorder occur as early as 16 years of age; however, this is not the best response to tell new parents.
7. B. Welcome the patient while standing behind the nurse's station and engage in an informal conversation with the patient. Rationale: The goal is to develop trust. Standing behind the nurse's station acknowledges the patient's personal space. An informal conversation facilitates developing trust.
8. B. Prevent the patient from self-injuring behavior. Rationale: Safety is the first goal.
9. A. Create a calm supportive environment at home. Stress and emotional family environments tend to increase signs and symptoms of undifferentiated schizophrenia disorder. Rationale: Sending his son to a group home will likely increase stress because his son will be in unfamiliar surroundings.
10. C. You should have your son assessed by a psychiatrist as soon as possible to determine if he has dissociative identity disorder. A common myth is that schizophrenia disorder is exhibited as multiple personalities.

This page intentionally left blank

chapter 6

Personality Disorders

LEARNING OBJECTIVES

1. Antisocial personality disorder
2. Avoidant personality disorder
3. Borderline personality disorder
4. Dependent personality disorder
5. Histrionic personality disorder
6. Narcissistic personality disorder
7. Obsessive-compulsive personality disorder
8. Paranoid personality disorder
9. Schizoid personality disorder
10. Schizotypal personality disorder

KEY TERMS

Assertiveness training
Cheeking medication
Clinging behavior
Defense mechanism
Dialectical behavior therapy (DBT)
Eccentric behavior
Fear of abandonment
Grandiose behavior
Impulsive behavior
Limbic system
Partial hospital program
Personality
Self-centered behavior
Self-destructive behavior
Splitting
Stereotypical thinking
Suicidal gestures
Suicidal ideations
Temperament
Vague speech

Personality and Personality Disorders

Personality is a pattern of feelings, behaviors, and thinking that defines the way a person is perceived. Personality develops during childhood and remains stable during adulthood. Personalities can be classified as:

- Antisocial: No respect for the rights of others
- Avoidant: Exaggerating the negative to avoid a new situation
- Borderline: Frequent mood swings and periods of impulsiveness that can lead to violent behavior in reaction to criticism
- Dependent: Needy behavior that transfers a person's responsibility to others
- Histrionic: Exaggeration to get attention
- Narcissistic: Preoccupied with self-importance
- Obsessive-Compulsive: A sense of perfection and righteousness and becomes angry when challenged
- Paranoid: Mistrust of others
- Schizoid: Prefers to be alone than with others
- Schizotypal: **Eccentric behavior**

All of us have these traits. For example, you may cut in line at the checkout counter or pretend to be sick to avoid going to a family gathering. At times you might have a violent outburst when someone tells you that you are wrong.

Many of us pretend we are challenged by a task that we do not want to do in order to have someone come to our rescue.

A person with a personality disorder displays these same traits but in the extreme and is unable to modify their behavior. For example, a person who does not have a personality disorder exhibits avoidant behavior by avoiding situations that are perceived to be dangerous. However, the person returns to a more normal behavior once the perceived danger dissipates. A person diagnosed with an avoidant personality disorder exhibits the same behavior but is unable to return to a more normal behavior when the perceived danger passes.

Context is a key factor that differentiates between normal behavior and abnormal behavior as exhibited in a personality disorder. For example, a person who moved into a quiet block in the suburbs may be apprehensive about their neighbors for the first few months until they get to know them. Apprehension is reasonable. There should be less apprehension afterward unless something threatening occurred. A person with an avoidant personality disorder may never let down their guard.

Clusters

Personality disorders are organized in three clusters based on signs and symptoms that may be common among disorders within the cluster.

- Cluster A (Odd Behavior): Paranoid, schizoid, and schizotypal
- Cluster B (Erratic Behavior): Antisocial, borderline, histrionic, and narcissistic
- Cluster C (Fearful Behavior): Avoidant, dependent, and obsessive-compulsive

NURSING ALERT

A change in personality may indicate an underlying medical illness. Treating the underlying medical illness will likely restore the patient's personality.

1. Antisocial Personality Disorder

Antisocial personality disorder occurs when the patient is impulsive, aggressive toward others, and lacks remorse. The patient violates rules and has no respect for other people's rights, leading to poor performance in school, work, or family life.

What Went Wrong?

There is no known cause of antisocial personality disorder; however, some researchers believe reduced inhibition may be caused by problems with the regulation of serotonin. Other researchers suggest that abnormalities in the prefrontal brain can lead to antisocial personality disorder. Still other researchers found there is correlation between antisocial personality disorder and exposure to criminal behavior, low socioeconomic status, unstable family life, isolation, and substance dependency.

Prognosis

The patient's behavior is likely to result in unemployment, divorce, and criminal charges that lead to periods of incarceration.

Hallmark Signs and Symptoms

- Recklessness
- Cold and callous
- Power-seeking
- Poor planning
- Manipulative
- No remorse
- Lack of feelings
- Deceitfulness
- Irresponsibility
- Arrogant
- Unlawful behavior
- Grandiose
- Destructive behavior
- Intimidating
- Poor interpersonal relationships

Common/Interpreting Test Results

There is no test that is used to diagnose antisocial personality disorder. The initial step is to rule out physiologic and other mental disorders causing the

symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of antisocial personality disorder requires the following:

- The patient is at least 18 years old.
- Since age 15, the patient has demonstrated three or more of the following:
  - Failure to sustain consistent employment
  - Impulsivity
  - Irritability
  - Deceitfulness
  - Lack of remorse
  - Aggressiveness
  - Unlawful acts
  - Serious rule violations
  - Property destruction

Treatment

- Psychotherapy: Individual psychotherapy with focus on exploring antisocial behavior and why the patient lacks feelings. Reasons for the patient to want to work on improving antisocial behaviors should be ascertained.
- Group therapy: Group therapy should be conducted such that everyone in the group is diagnosed with antisocial behavior.

Nursing Diagnoses

- Risk for ineffective relationships related to antisocial behavior
- Ineffective coping related to failure to express feelings
- Impaired social interaction related to manipulative behavior

Nursing Interventions

- Set limits as needed when the patient interferes with the rights of others.
- Do not set limits when you are stressed.
- Focus on behavior modification.
- Be consistent, especially with the actions of other staff members.
- Be alert to attempts by the patient to split staff in an effort to circumvent rules.

- Establish trust with the patient using a matter-of-fact technique.
- Avoid being manipulated by the patient.
- Avoid a power struggle.
- Do not argue.
- Acknowledge what information you are required to share with the legal system.
- Have the patient sign a behavioral contract that clearly states acceptable behavior and the consequences for inappropriate behavior.
- Set explicit expectations.
- Set explicit consequences for not meeting expectations.
- Make the patient accountable for their behavior.
- Reinforce appropriate behaviors.
- Do not threaten the patient. Patients diagnosed with antisocial behavior disorder do not respond to threats.
- Help the patient relate antisocial behavior to their feelings.
- Help the patient acknowledge the consequence of their behavior and how changing the behavior lessens the consequence.
- Help the patient manage inappropriate behavior by asking them to express their feelings.

2. Avoidant Personality Disorder

Avoidant personality disorder occurs when the patient exaggerates the negative as a reason for avoiding new situations. The patient has low self-esteem and an underlying feeling of inadequacy that leads to social withdrawal. The patient is very sensitive to being judged by others, which results in extreme social anxiety and a fear of being rejected by others.

What Went Wrong?

There is no known cause of avoidant personality disorder; however, some researchers believe that temperament is associated with avoidant personality disorder. **Temperament** consists of the emotional characteristics of a person such as thoughts, behaviors, and reactions. In particular, some researchers believe a timid temperament in early childhood predisposes the person to avoidant personality disorder. Other researchers see avoidant personality disorder as a **defense**

mechanism when the patient is unable to cope with overstimulation. The basis for this opinion is a low arousal threshold due to the structure of the **limbic system** in the brain. Still other researchers believe avoidant personality disorder stems from constant rejection of the patient by family and friends as a child.

Prognosis

Prognosis is good once the patient undergoes treatment; however, many patients diagnosed with avoidant personality behavior do not seek treatment, and therefore the prognosis is poor. Without treatment, the patient may be economically and socially limited. The patient is at risk for depressive disorder and mood disorder.

Hallmark Signs and Symptoms

- Low self-esteem
- Mistrust of others
- Socially withdrawn
- Avoids new activities
- Anxiety
- Self-conscious
- Shyness
- Perfectionism
- Unsuccessful relationships
- Excessive social avoidance activities

Common/Interpreting Test Results

There is no test that is used to diagnose avoidant personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of avoidant personality disorder requires at least four of the following behaviors:

- Feeling inferior and personally unappealing
- Restraint in intimate relationships
- Reluctance to take personal risk for fear of embarrassment
- Avoidance of work activities that involve interpersonal interaction for fear of rejection

- Focusing on being criticized in social situations
- Becoming involved with others only if the patient knows they will be accepted by others.

Treatment

- Psychotherapy: Psychotherapy with focus on solving specific problems for a short time period
- Administer: Nardil (phenelzine) to increase assertiveness and confidence in patients with moderate-to-severe avoidant personality disorder

Nursing Diagnoses

- Risk for chronic low self-esteem related to avoidant behavior
- Risk for loneliness related to avoiding social situations
- Ineffective relationship related to mistrust of others

Nursing Interventions

- Focus on gaining the patient's trust.
- Avoid activities that encourage the patient to become dependent on staff.
- Set expectations on when staff will be available to assist the patient.
- Avoid surprising the patient.
- Monitor signs of dependency.
- Monitor signs of depressive disorder and mood disorder.
- Help the patient cope with social situations.
- Encourage the patient to make simple decisions, and then work on more complex decisions.
- Be supportive.
- Encourage the patient to express feelings.

3. Borderline Personality Disorder

Borderline personality disorder occurs when a patient has significant emotional instability expressed by frequent mood swings and periods of impulsiveness that can lead to violent behavior in reaction to criticism. The patient has a

distorted sense of self and feels mistreated, misunderstood, and empty, which can lead to **self-destructive behaviors**. The patient uses splitting as a defense mechanism whenever they perceive dangerous anxiety. **Splitting** is where the patient sees another person as either all good or all bad, and this view alternates swiftly. A patient diagnosed with a borderline personality disorder presents with **impulsive behavior** with disregard to consequences of the behavior. **Fear of abandonment** can lead to substance abuse and suicide attempts.

What Went Wrong?

The cause of borderline personality disorder is unknown. Some researchers believe that the patient's cognitive functioning becomes overwhelmed by emotions, preventing them from implementing appropriate coping behavior. Other researchers believe the limbic system or frontal lobe of the brain is not working properly or there is a decreased serotonin level. Still other researchers believe a major loss early in life factors into developing a borderline personality disorder.

Prognosis

Symptoms of borderline personality disorder manifest between early childhood and the early 20s. Although this period is challenging for the patient, family, and friends, the patient is likely to stabilize in their 30s when many of the symptoms dissipate and they are able to hold down a job and have personal relationships. The patient is at risk for developing substance abuse disorder, depressive disorder, and anxiety disorder.

Hallmark Signs and Symptoms

- Feeling of emptiness
- Paranoid ideation
- Fear of abandonment
- Unstable interpersonal relationships
- Self-destructive behavior
- Violent behavior with others
- Avoids being alone
- Swift mood swings
- Outbursts of anger

- Seeing others as either all good or all bad
- **Clinging behavior**
- Low self-esteem
- Impulsivity without regard to consequences

Common/Interpreting Test Results

There is no test that is used to diagnose borderline personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of borderline personality disorder requires the following criteria.

From early childhood, the patient has experienced five or more of the following:

- Impulsivity in two areas that leads to self-damage
- Attempts to avoid perceived or real abandonment
- Self-mutilating behavior such as **suicidal gestures** or ideations
- Unable to control intense anger, leading to physical fights
- Paranoid ideation or symptoms of dissociative disorder
- Feeling empty or bored
- Short periods of intense irritability

Treatment

- Psychotherapy: Individual psychotherapy with focus on providing a structured therapeutic setting within which limits are set and enforced
- **Dialectical behavior therapy (DBT)**: Dialectical behavior therapy includes individual therapy and group therapy during which participants work on skills training. Skills training focuses on coping techniques. The patient is able to consult with the therapist in person or by phone.
- **Partial hospital programs**: Partial hospital programs are day programs during which the patient is assigned to one group during the course of treatment. The group has five sessions daily. Each session focuses on coping skills or psychotherapy. Each patient receives one-on-one counseling.
- Administer: Depakote (valproate), Eskalith (lithium), Zyprexa (olanzapine), Risperdal (risperidone), BuSpar (buspirone), ReVia (naltrexone)

Nursing Diagnoses

- Risk for self-mutilation related to self-destructive behavior
- Defensive coping related to fear of abandonment
- Hopelessness related to low self-esteem

Nursing Interventions

- Ask the patient to sign a behavioral contract that contains expectations and consequences.
- Reward positive behaviors.
- Ensure that the patient experiences the consequences for the patient's actions.
- Help the patient think through problems, but let them solve their own problems.
- Avoid nurturing.
- The patient must take responsibility for their actions.
- Limit interaction with the patient to reduce the opportunity for them to split and manipulate staff.
- Be alert for self-destructive behaviors, such as **cheeking medication** in an attempt to gather enough medication to overdose.
- Keep the patient safe. Watch for signs of suicidal ideation or suicide attempt.

4. Dependent Personality Disorder

Dependent personality disorder occurs when a patient displays consistent needy behavior where the patient transfers their responsibility to others and seeks protection from others. The patient rushes from one relationship to another when a relationship fails. The patient requires validation from others because of their self-doubt about their capabilities and is sensitive to criticism.

What Went Wrong?

The cause of dependent personality disorder is unknown. Some researchers believe dependent personality disorder is influenced by overbearing parents

who were either overly protective or overly strict, leading the patient to believe that they are unable to survive without constantly depending on others. Other researchers believe childhood abuse or trauma may influence the development of dependent personality disorder.

Prognosis

Prognosis for a patient diagnosed with dependent personality disorder is good if the patient undergoes treatment. Patients usually are compliant with treatment because treatment is a form of dependency.

Hallmark Signs and Symptoms

- Overly pessimistic
- No self-confidence
- Low self-esteem
- Clinging behavior
- Difficulty making decisions
- Fear of losing approval
- Submissive
- Insecure
- Need for constant approval
- Self-effacing
- Overly dependent on others
- Fear of being alone
- Overly sensitive to criticism

Common/Interpreting Test Results

There is no test that is used to diagnose dependent personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of dependent personality disorder requires the patient to display at least four of the following:

- Reluctance to take personal risk
- Avoids a person until the patient is sure that the person likes them
- Avoids interpersonal contact with people for fear of being criticized

- Shame of being in an intimate relationship
- Perception of being inferior
- Fear of being inadequate

Treatment

- Psychotherapy: Individual psychotherapy should focus on the patient making decisions by helping them process facts about the situation. Therapy must terminate so the patient does not become dependent on the therapist. The patient's behavior pattern follows a continuum from being overly dependent on the therapist to being less dependent on the therapist at the end of therapy.
- Group therapy: Group therapy should be conducted such that everyone in the group is diagnosed with dependent personality disorder. The focus of the group is to share experiences and get suggestions from group members on how to deal with problems.
- Partial hospital programs: Partial hospital programs are day programs during which the patient is assigned to one group during the course of treatment. The group has five sessions daily. Each session focuses on coping skills or psychotherapy. Each patient receives one-on-one counseling.
- **Assertiveness training**: Assertiveness training focuses on changing the patient's submissive, dependent behavior to assertive behavior so that the patient can take control of their life.

Nursing Diagnoses

- Disturbed personal identity related to lack of self-confidence
- Risk for powerlessness related to inability to make autonomous decisions
- Anxiety related to losing dependency on another person

Nursing Interventions

- Create activities that require the patient to make independent decisions, and then help the patient through the decision-making process. However, the patient must make the decision.
- Limit interactions with staff to encourage the patient to be less dependent.

- Offer the patient options about treatment, but let them make the decision.
- Be persistent.
- Use a matter-of-fact approach when the patient presents a problem. Do not ignore the problem, but also do not overly be concerned about the problem.
- Build a therapeutic rapport.
- Avoid interactions that may result in dependent behavior by the patient.
- Promote patient autonomy.

5. Histrionic Personality Disorder

Histrionic personality disorder occurs when a patient is excessively emotional and exaggerates gestures and language to gain attention and dominate the conversation. Emotions are shallow and can change quickly to extremes. The patient is focused on outward appearance and dresses to become the center of attention.

What Went Wrong?

There is no known cause of histrionic personality disorder. Researchers believe that events during childhood might result in an emotional loss that influences the development of a histrionic personality disorder.

Prognosis

Patients with histrionic personality disorder are functioning at a high level and can sustain employment, although histrionic behavior can interfere with relationships. However, the patient is unlikely to seek treatment.

Hallmark Signs and Symptoms

- Impulsive
- Shallow
- Outbursts of anger
- Manipulative behavior
- Denial of weakness
- Suicidal gestures

- Dramatization
- Always wants to be center of attention
- Interrupts conversations
- Preoccupied with medical symptoms
- Alcohol and drug abuse
- Demanding
- Impatient
- Impressionable
- Focused on appearance

Common/Interpreting Test Results

There is no test that is used to diagnose histrionic personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of histrionic personality disorder requires the patient to exhibit at least five of the following:

- Self-dramatization
- Provocative behavior
- Easily influenced by others
- Uncomfortable when not the center of attention
- Feeling that a relationship is intimate when the relationship is not intimate
- Shallow emotions
- Impressionistic speech
- Changes appearance to gain attention

Treatment

- Psychotherapy: Individual psychotherapy with focus on helping the patient solve specific problems in the patient's life. It is important to bring a sense of reality to the patient's self-perception without appearing threatening to the patient. The goal is not to help the patient to explore the underlying emotional problems that may be leading to histrionic behavior because the patient is unable to explore their thoughts.

Nursing Diagnoses

- Ineffective impulse control related to impulsivity
- Fear related to fear of being alone
- Risk for suicide related to **suicidal ideations**

Nursing Interventions

- Contract the patient for safety since the patient is at a high risk for suicidal gestures.
- Establish a trusting rapport.
- Avoid dependent situations.
- Do not try to rescue the patient.
- Help the patient develop appropriate social skills.
- Help the patient think through problems.
- Encourage the patient to express feelings.
- Become a role model.

6. Narcissistic Personality Disorder

Narcissistic personality disorder occurs when a patient creates a perception of superiority and is self absorbed. The patient wants only to associate with others who they perceive are superior. The patient strives to over-achieve and is obsessed with perfection. The patient panics whenever there is a threat to their ego from any kind of failure.

What Went Wrong?

The cause of narcissistic personality disorder is unknown. Some researchers feel that narcissistic behavior is a defense mechanism protecting an underlying feeling of insecurity stemming from unmet needs during childhood such as encouragement by adults.

Prognosis

The prognosis for a patient diagnosed with a narcissistic personality disorder is poor primarily because they are likely to be noncompliant with long-term treatment. The narcissistic behavior prevents the patient from seeking treatment except in crisis. During a crisis, the patient seeks treatment, but then stops treatment once the crisis is over.

Hallmark Signs and Symptoms

- Exaggerated achievements
- No empathy for others
- Arrogance
- Manipulates others
- Attention-seeking behavior
- **Grandiose behavior**
- Expects special treatment
- **Self-centered behavior**
- Focuses on power and success

Common/Interpreting Test Results

There is no test that is used to diagnose narcissistic personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of narcissistic personality disorder requires the patient to have at least five of the following:

- Sense of entitlement
- Arrogant behavior
- Grandiose behavior
- Envy of others or perception that others envy the patient
- No empathy for others
- Seeks admiration

Treatment

- Psychotherapy: Individual psychotherapy with focus on bringing a sense of reality to the patient's self-perception without appearing threatening to the patient. The goal is to help the patient change behavior. However, the patient may feel that narcissistic behavior is normal and therefore they do not require treatment.

Nursing Diagnoses

- Chronic low self-esteem related to grandiose behavior
- Risk for ineffective relationship related to demeaning others
- Ineffective role performance related to manipulative behavior

Nursing Interventions

- Set expectations for the patient's behavior. Convey what is acceptable and unacceptable behavior.
- Help the patient develop acceptable behavior and avoid unacceptable behavior.
- Reinforce acceptable behavior.
- Develop a therapeutic rapport with the patient.
- Encourage the patient to discuss their underlying insecurity.
- Use a matter-of-fact approach to correct unacceptable behavior.
- Be nonjudgmental.
- Do not argue with the patient.

7. Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder occurs when a patient sees everything as good or bad and is focused on perfection, leading to inflexibility in thought and actions. The patient has a sense of righteousness and becomes angry when challenged. The patient demonstrates poor social skills and is unable to accept anyone who has a different opinion. The patient is unable to make a decision for fear of making the wrong decision. Focus is on rules and order and not the task at hand.

NURSING ALERT

There are overlaps between obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder; however, these are two different diagnoses. The key difference is that a patient with OCD has true obsessions and compulsions. Obsessions are recurrent unwanted intrusive thoughts, and compulsions are repetitive behaviors used to address obsessions. A patient with obsessive-compulsive personality disorder does not have true obsessions and compulsions. Symptoms of OCD patients are experienced as periods of exacerbation and remission. In contrast, the symptoms of patients with obsessive-compulsive personality disorder are chronic. Furthermore, the patient with OCD rarely seeks treatment, whereas the patient with obsessive-compulsive personality disorder will seek treatment to handle specific situations.

What Went Wrong?

The cause of obsessive-compulsive personality disorder is unknown. Researchers report there is a genetic tendency for obsessive-compulsive personality disorder. Other researchers believe that obsessive-compulsive personality disorder is a defensive response to an underlying feeling of powerlessness and shame at being seen as a failure.

Prognosis

The patient is unlikely to seek treatment except when a situation becomes overwhelming and the patient is unable to cope with it. Without treatment, the patient may experience depression and increased anxiety. With treatment, the patient can learn coping skills to handle a specific situation. Once the situation is resolved, the patient is unlikely to continue treatment. The patient can experience a productive life.

Hallmark Signs and Symptoms

- Overly focused on orderliness
- Constricted emotions
- Formal mannerism
- Perfectionism
- Inability to relax
- Angry when things are not what they should be
- Impatience
- Lack of humor
- Rigid thinking
- Unable to make decisions
- Unable to express feelings
- Unable to accept new information
- Hypochondriasis
- Competitiveness
- Wants to control every situation
- Hoarding
- Constantly under time pressure
- Depression

Common/Interpreting Test Results

There is no test that is used to diagnose obsessive-compulsive personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of obsessive-compulsive personality disorder requires the patient to have at least four of the following:

- Overly devoted to work
- Stubbornness
- Overly conscientiousness
- Preoccupied with order and details, preventing focus on the goals of the activity
- Perfectionism that interferes with the activity
- Reluctance to delegate tasks unless rules are strictly followed
- Hoards money
- Unable to discard nonsentimental items

Treatment

- Psychotherapy: Individual psychotherapy with focus on bringing short-term relief by helping the patient resolve a specific problem in a matter-of-fact approach. The therapist should help the patient develop appropriate coping skills.

Nursing Diagnoses

- Ineffective individual coping related to repetitive behaviors
- Ineffective role performance related to inability to perform activities of daily living
- Powerlessness related to the inability to stop performing repetitive behaviors

Nursing Interventions

- Develop a trusting therapeutic rapport.
- Use a formal professional approach. The patient expects you to follow rules.

- Tolerate the patient's behavior.
- Do not argue with the patient.
- Be persistent.
- Remain attentive.
- Discourage inappropriate behavior.
- Reinforce acceptable behavior.
- Allow the patient to be distant.
- Give the patient a choice of treatment to make them feel like they are in control of their treatment.
- Avoid focusing on feelings at the beginning of therapy. Doing so might anger the patient.

8. Paranoid Personality Disorder

Paranoid personality disorder occurs when the patient has unreasonable mistrust of others and assumes that others have hostile intentions against them. The patient feels others are conspiring to undermine the patient and would rather rely on their ability than on others. Loyalty to the patient is always being questioned, and suspicion of being disloyal leads to breaking off or distancing from the relationship.

NURSING ALERT

There are overlaps between paranoid schizophrenia disorder and paranoid personality disorder; however, these are two different diagnoses. The key difference is that a patient with paranoid schizophrenia disorder has hallucinations and delusions. A patient with paranoid personality disorder does not have hallucinations. The patient does have delusions; however, the delusions are not excessive.

What Went Wrong?

There is no known cause of paranoid personality disorder. There is a genetic factor where a patient who has a close relative diagnosed with paranoid personality disorder is more likely to develop the disorder. Some researchers believe a threatening upbringing might be an underlying factor in developing paranoid personality disorder.

Prognosis

Prognosis is poor because a patient diagnosed with paranoid personality disorder rarely seeks treatment based on suspicion of the therapist. Some patients are able to have a productive life, while others experience dysfunctional relationships and are unable to hold down a job.

Hallmark Signs and Symptoms

- Low self-esteem
- Anger
- Unable to confide in others
- Irritability
- Controlling
- Detached
- Hypervigilant
- No support system
- Poor social skills
- Isolation
- No sense of humor
- Cold

Common/Interpreting Test Results

There is no test that is used to diagnose paranoid personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of paranoid personality disorder requires four of the following:

- Holding grudges
- Reluctance to confide in others
- Unjustified suspicion that others are trying to harm the patient
- Looking for negative meaning in remarks made by another to the patient
- Unjustified questioning of fidelity
- Counterattacking others based on suspicion that others are attacking the patient's reputation
- Unjustified questioning on the trustworthiness of friends and relatives

Drug Alert

The practitioner will postpone prescribing medication until later in the treatment after a therapeutic trust is built with the patient because the patient will likely be suspicious of taking medications.

Treatment

- Psychotherapy: The focus of psychotherapy is to develop a therapeutic trust with the patient that enables the therapist to use a matter-of-fact professional approach to help the patient cope with their current problem.
- Administer: Prozac (fluoxetine), low doses of Zyprexa (olanzapine) or Risperdal (risperidone)

Nursing Diagnoses

- Ineffective individual coping related to fear of triggers
- Risk for social isolation related to inability to engage in social events and visit public areas
- Risk for powerlessness related to disruption in activities of daily living

Nursing Interventions

- Minimize contact with staff and other patients until the patient begins to develop trust.
- Approach the patient calmly.
- Build trust by making only promises that you can deliver.
- Give the patient options rather than giving firm directions to give them limited control over environment.
- Avoid situations that lead to arguments and mistrust. Remain neutral if the patient is demanding and condescending.
- Remain in control but give the patient some control of the situation.
- Set limits. Provide factual explanation of situations.
- Encourage social interactions.
- Help the patient identify negative behaviors.
- Encourage positive behaviors.
- Be persistent.

- Be nonjudgmental.
- Be supportive.
- Hold the patient accountable for their actions.
- Help the patient analyze their behavior and help them learn to change the behavior.
- Do not challenge the patient's autonomy.
- Do not try to change the patient's paranoid beliefs.

9. Schizoid Personality Disorder

Schizoid personality disorder occurs when a patient is withdrawn from social involvement and prefers to be alone than to be with others. The patient's focus is on activities that they can perform alone. The patient is not concerned about criticism or the feelings of others.

NURSING ALERT

There is no relationship between schizophrenia disorder and schizoid personality disorder.

What Went Wrong?

There is no known cause of schizoid personality disorder. Some researchers believe there is a genetic factor, whereas others think a detached relationship with parents during early childhood is the underlying cause of schizoid personality disorder. Some researchers believe schizoid personality behavior is a defense mechanism for dealing with social stimulus that overwhelms the patient.

Prognosis

The patient succeeds in areas where they do not have to interact with others but will function poorly in tasks that require teamwork.

Hallmark Signs and Symptoms

- Loneliness
- Indifference to others

- No close friends
- Prefers activities that can be performed alone
- Uneasiness with people
- No interest in participating in social events
- Detached from society
- Poor self-esteem
- Uncomfortable with intimacy
- Limited range of mood

Common/Interpreting Test Results

There is no test that is used to diagnose schizoid personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of schizoid personality disorder requires four of the following:

- Indifference to praise or criticism
- No close friends
- Social detachment
- Prefers solitary activities
- Does not enjoy close relationships
- No desire for intimate relationships
- Participates in few pleasurable activities

Treatment

- Psychotherapy: The focus of psychotherapy is to develop a therapeutic trust with the patient that enables the therapist to provide stable support while the patient is helped to cope with their current problem.

Nursing Diagnoses

- Loneliness related to social isolation
- Low self-esteem related to feeling unworthy to be with others
- Impaired social interaction related to emotional detachment

Nursing Interventions

- Be persistent.
- Develop a therapeutic trusting relationship.
- Respect the patient's boundaries since the patient is uncomfortable in a social setting.
- Acknowledge the patient's boundaries.
- Do not argue with the patient.
- Introduce activities that gradually increase the patient's social interactions.
- Allow the patient to perform solitary activities, but gradually introduce the patient to activities involving another person.
- Encourage behavior that helps the patient cope with change.
- Avoid confrontation.
- Help the patient feel secure.
- Encourage the patient to express feelings.
- Help the patient process their feelings.
- Perform activities that help the patient overcome the fear of building relationships.
- Do not pressure the patient to participate as they will participate when they are ready.
- Create a situation where the patient can try new coping skills.

10. Schizotypal Personality Disorder

Schizotypal personality disorder occurs when a patient displays eccentric behavior and has severe social anxiety based on an underlying belief that others are trying to do harm. The patient may exhibit short periods of minimum psychotic symptoms during periods of stress.

NURSING ALERT

Schizophrenia disorder differs from schizotypal personality disorder in that a patient diagnosed with schizotypal personality disorder does not have psychotic symptoms.

What Went Wrong?

There is no known cause of schizotypal personality disorder. Some researchers believe there is a genetic factor, especially when a close family member has been diagnosed with schizophrenia disorder. Other researchers believe schizotypal personality disorder is a mild form of schizophrenia disorder where factors such as stress determine if a patient develops schizotypal personality or schizophrenia disorder. Still other researchers feel that schizotypal personality disorder is related to attention deficit and inability to process information. Researchers have found that a patient diagnosed with schizotypal personality disorder has poor regulation of dopamine.

Prognosis

A patient diagnosed with schizotypal personality disorder may develop schizophrenia disorder. The patient can improve coping skills if they are compliant with treatment.

Hallmark Signs and Symptoms

- Eccentric behavior
- Magical thinking
- Isolation
- Social anxiety
- **Vague speech**
- Constricted affect
- Feelings of not fitting in with others
- Feelings of persecution
- **Stereotypical thinking**

Common/Interpreting Test Results

There is no test that is used to diagnose schizotypal personality disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of schizotypal personality disorder requires five of the following:

- Odd speech and thinking
- Unusual perceived experience

- Suspicious
- Social anxiety that remains after the patient becomes familiar with others
- No close friends
- Eccentric behavior
- Constricted affect
- Incorrect interpretation of events
- Odd perception of an experience

Treatment

- Psychotherapy: Psychotherapy focuses on helping the patient process events that form their odd beliefs and behavior.
- Administer: Clozaril (clozapine) in low doses

Nursing Diagnoses

- Risk for loneliness related to social anxiety
- Risk for isolation related to eccentric behavior
- Risk for ineffective communication related to odd speech

Nursing Interventions

- Develop a therapeutic trusting relationship.
- Create a safe, stressless environment for the patient.
- Acknowledge the patient's boundaries.
- Remain calm.
- Do not argue with the patient.
- Do not challenge the patient's delusions.
- Allow the patient time to make decisions.
- Redirect the patient using clear short statements.
- Help the patient develop coping skills.
- Reinforce positive behavior.

CASE STUDY

CASE 1

A 39-year-old heavy set man is using the psychiatric unit's pay telephone. A 19-year-old slender woman is standing a few feet away from the phone waiting impatiently for a phone call from her boyfriend. Five minutes into his phone call, she begins pacing the floor staring at him. She asks him when he plans to get off the phone. He politely tells her that he is talking to his son and will be off shortly. He reminds her that each patient gets 10 minutes to use the phone and that he has only been on the phone for 5 minutes. She becomes irritable and shouts that she is waiting for an important call and the caller is calling now. The man tells his son that he will call back, slams down the phone, turns to the woman, and punches her in the face. She falls to the floor on her butt. He then moves 20 feet away from her, quietly staring at her, and is visibly agitated.

QUESTION 1. What should you do first?

ANSWER: Call for support from the facility's psychiatric emergency response team who are trained in crisis intervention and trained to physically restrain patients. Although the violence has subsided at the moment, the situation is unpredictable, and you need to have support on the unit to assist in handling any situation that may arise.

QUESTION 2. What should you do next?

ANSWER: Direct the staff to tell patients other than the patients involved in the confrontation to go to an enclosed area such as the day room or television room. A staff member must supervise them in each location. This action prevents other patients from becoming involved in the situation and protects them from any confrontation that may ensue.

QUESTION 3. What should you do next?

ANSWER: Ask one or more staff members to therapeutically talk with the male patient. This distracts the male patient from the situation and gives him the opportunity to debrief with staff. Furthermore, the staff is in position to block further violent acts without threatening the male patient.

QUESTION 4. What should you do next?

ANSWER: Assess the woman for injuries. It might seem unusual to assess for injuries last; however, the goal is to call for help, control the situation by preventing other patients from becoming involved in the situation, and prevent the attacker from further acts of aggression. Typically, all these steps occur within 2 minutes or less because the staff is trained to react immediately whenever a violent situation develops.

FINAL CHECK-UP

1. **A family member of a patient who was diagnosed with paranoid personality disorder is annoyed that the practitioner is not prescribing medication for the patient. What is the best response?**
   A. Ask the practitioner to explain the reason for not prescribing medication.
   B. The patient is unlikely to take medication fearing that the practitioner is trying to harm the patient.
   C. The practitioner is likely waiting for the patient to trust the practitioner before prescribing medication.
   D. There is no medication to treat paranoid personality disorder.

2. **The sister of a patient who was recently diagnosed with schizoid personality disorder is worried that her daughter will develop schizophrenia disorder. What is the best response?**
   A. Schizophrenia disorder has a genetic tendency, but there is no guarantee that your daughter will develop schizophrenia disorder.
   B. Schizophrenia disorder is more prominent in men than in women.
   C. Your sister is not a close enough relation to your daughter to pass along the schizophrenia disorder trait.
   D. Schizoid personality disorder is not related to schizophrenia.

3. **A 45-year-old neighbor asks you for a name of a psychiatrist for her 23-year-old son. She has lost confidence in the current psychiatrist after the psychiatrist diagnosed her son as having obsessive-compulsive personality disorder. Your neighbor does not see any of the obsessions or compulsions that she sees in her favorite television police drama about a detective with OCD. She feels that the psychiatrist is wrong. What is your best response?**
   A. Television dramatizes symptoms.
   B. Obsessive-compulsive disorder and obsessive-compulsive personality disorder are different diagnoses. A patient diagnosed with obsessive-compulsive personality disorder does not have true obsessions and compulsions.
   C. Ask her to discuss her concerns with the psychiatrist.
   D. Give her the name of a few psychiatrists.

4. **A patient on your psychiatric unit diagnosed with histrionic personality disorder walks to the nurse's station with a steady gait saying he has excruciating back pain. What is the best response?**
   A. Call the on-call practitioner immediately.
   B. Call a rapid response.
   C. Take vital signs and tell the attending practitioner when she arrives on the unit.
   D. Tell the patient to return to bed.

5. A new patient comes to your psychiatric unit and asks, "What's your role here?" You tell him you are a nurse. He then says, "Tell the doc I want to see him." What is the best response?

A. Avoid a power struggle and call the resident-on-call.
B. Set limits and expectations.
C. Do not argue.
D. Reinforce appropriate behaviors.

6. Your neighbor tells you that her son's diagnosis of paranoid personality disorder is wrong because everyone gets paranoid from time to time and there is nothing wrong with him. What is the best response?

A. Everyone has a paranoid personality trait, but the practitioner believes that your son's paranoid behavior is extreme and your son is unable to modify his behavior.
B. Ask your practitioner to explain why your son was diagnosed with paranoid personality disorder.
C. Ask your practitioner to explain his diagnosis. It is true that everyone exhibits paranoid behavior; however, a person with paranoid personality disorder exhibits extreme paranoid behavior that cannot be controlled.
D. It is difficult to diagnose paranoid personality disorder.

7. A nurse orienting on your psychiatric unit tells you that the new admission has schizophrenia schizotypal type. What is the best response?

A. There is no such diagnosis.
B. You are mistaken. Read the patient's chart and look up the definition of the diagnosis.
C. Report the new orientee to nurse education.
D. Psychiatric diagnosis can be confusing. Schizophrenia disorder differs from schizoid personality disorder in that a patient diagnosed with schizoid personality disorder does not have psychotic symptoms.

8. A 21-year-old female patient demands to use the desk phone in your psychiatric unit. Unit policy prohibits use of the desk phone by patients except when authorized by the social worker who has given the patient permission to use the phone. The patient reaches over the desk to grab the phone. A staff member disconnects the phone wire and directs the patient to step away from the desk. The patient continues to become agitated and curses at the staff member. The nurse warns the patient that the incident will be reported to the attending practitioner. How would you respond to the nurse's action?

A. Tell the nurse that he acted appropriately by warning the patient about the consequences of her actions.
B. Tell the nurse that warning the patient about the consequences of her actions will not change the patient's behavior because the patient is not concerned about the consequences.

C. Tell the nurse that the best approach is to set limits and enforce those limits without arguing or threatening the patient.
D. Tell the nurse that the patient is going through a mood swing and should return to a more stable mood in a few minutes.

9. During admission to your psychiatric unit, a 43-year-old male patient tells you that at one time he was one of the youngest stockbrokers on Wall Street and made millions of dollars a year for one of the most prestigious financial firms. He says the chief executive officer of the firm personally asked him to come in for a "checkup" because he felt the patient was "stressed out" from teaching all the new stockbrokers the "tricks of the trade." The patients states, "There's nothing wrong with me, but I agreed to spend the night and see the doctor in the morning." As you continue asking admission questions, he keeps interrupting. "I'll need a quiet room, and can you call the kitchen for me and ask them to send up a snack?" After gathering admission information from the patient, what is the next best thing to do?

A. Set limits for the patient.
B. Set expectations for the patient.
C. Gather more information from the admission documents.
D. Ask the mental health aide to get the patient settled in his room.

10. A 25-year-old female patient started an argument with a 32-year-old female patient on your psychiatric unit. They were in each other's face when a mental health aide separated them. The 25-year-old woman was consistently giving the other patient intimidating looks and gestures throughout the day. Dinner is in an hour and is served in a relatively small community dining room where the two women will be close to each other. What is your first concern?

A. Making sure everyone is safe.
B. Medicating the 25-year-old female patient prior to dinner.
C. Warning the 25-year-old female patient about the consequences should she antagonize another patient.
D. Preventing the 25-year-old female patient from entering the dining room.

CORRECT ANSWERS AND RATIONALES

1. C. The practitioner is likely waiting for the patient to trust the practitioner before prescribing medication.
2. D. Schizoid personality disorder is not related to schizophrenia.
3. B. Obsessive-compulsive disorder and obsessive-compulsive personality disorder are different diagnoses. A patient diagnosed with obsessive-compulsive personality disorder does not have true obsessions and compulsions.

4. C. Take vital signs and tell the attending practitioner when she arrives on the unit. Rationale: The patient is unlikely to be in excruciating back pain because he walked to the nurse's station. A patient with excruciating back pain probably would not be able to get out of bed. The patient's complaint is likely an exaggerated gesture. However, a patient diagnosed with histrionic personality disorder can have a medical disorder and needs to be assessed by the nurse and the practitioner.
5. B. Set limits and expectations. Rationale: The patient is exhibiting antisocial personality behavior by attempting to control the admission process. Although you should not argue with the patient and avoid a power struggle, the best response is to set limits and expectations.
6. C. Ask your practitioner to explain his diagnosis. It is true that everyone exhibits paranoid behavior; however, a person with paranoid personality disorder exhibits extreme paranoid behavior that cannot be controlled. Rationale: It is best to refer the person to the practitioner because you were not present when she was told about the diagnosis. You can educate her on the difference between paranoid behavior and paranoid personality disorder.
7. D. Psychiatric diagnosis can be confusing. Schizophrenia disorder differs from schizoid personality disorder in that a patient diagnosed with schizoid personality disorder does not have psychotic symptoms. Rationale: Always let the orientee save face while helping them correct the error.
8. C. Tell the nurse that the best approach is to set limits and enforce those limits without arguing or threatening the patient. Rationale: This is a good nursing intervention to address the situation because the patient learns to change behavior to conform to the limits. The patient is likely to change to a more stable mood quickly. The patient acts impulsively without regard for the consequences of her actions.
9. C. Gather more information from the admission documents. Rationale: The nurse must make a judgment about a patient after reviewing all the available patient information. The patient's statements may be accurate, exaggerated, or fabricated.
10. A. Making sure everyone is safe. Rationale: Although the confrontation involves two women, other patients may become involved either defending the 30-year-old female patient or trying to intervene in the confrontation. Likewise, staff members too can become injured should violence break out. All patients, including the 25-year-old female patient, must be fed; so medicating the patient or preventing the patient from entering the dining room is inappropriate. Warning the 25-year-old female patient about the consequences of her actions will not prevent violent behavior, which usually begins impulsively.

This page intentionally left blank

chapter 7

Mood Disorders

LEARNING OBJECTIVES

1. Bipolar disorder
2. Cyclothymic disorder
3. Dysthymic disorder
4. Major depressive disorder (MDD)

KEY TERMS

Antidepressant medication
Atypical antidepressants
Bipolar I disorder
Bipolar II disorder
Clinical depression
Depressive mood
Electroconvulsive therapy (ECT)
Emotion
Hypomanic mood
Lithium toxicity
Manic mood
Monoamine oxidase inhibitors (MAOI)
Mood
Mood swings
Most recent episode mixed
Most recent episode unspecified
Selective serotonin reuptake inhibitor (SSRI)
Single manic episode
Temperament
Tricyclic antidepressants

Mood

A **mood** is a temporary feeling generally described as positive or negative; people are commonly referred to as being in a good or bad mood. The origin of a mood is vague. A person cannot explain why they are in a good or bad mood. Good moods are associated with less stress such as when a task is completed and there is a pause before the next task begins. The origin of a bad mood is usually unclear, although sometimes a person associates a bad mood with an adverse event. However, there are times when a person is in a good mood after the same adverse event.

Mood swings occur when people alternate between good and bad moods. Sometimes mood swings occur without any cogitative trigger. It just happens. Other times a person can do something to change moods. For example, a person in a bad mood can change to a good mood by listening to music or watching an uplifting movie.

A mood is different from emotions and temperament. An **emotion** is a specific intense feeling that is triggered by an event. For example, a person feels grief when a loved one passes away. There is a cause-and-effect basis for the emotion. The effect may last weeks, months, or years. **Temperament** is commonly referred to as a personality trait (see Chapter 6, Personality Disorders) that lasts long periods of time or a lifetime. A mood lacks intensity and is not triggered by an event. Likewise, a mood is normally short lasting.

A mood is internal to a person but can exhibit as an affect or behavior. For example, a person may smile and be hypertalkative when the person is in a

good mood. Or a person may be irritable and grumpy and want to be alone when in a bad mood.

Mood Disorder

A mood disorder is disruption of a normal mood and mood swing. A person diagnosed with a mood disorder is in a positive or negative mood for long periods of time. Moods change slowly or rapidly depending on the mood disorder.

A person diagnosed with a mood disorder exhibits extreme affect and behavior called manic, hypomanic, and depressive moods. Manic occurs when the patient is highly frustrated, possible leading to violent behavior. The patient has difficulty controlling themself. Hypomanic occurs when the patient is hyperactive but can control themself. **Depressive mood** is when the patient has lost interest in life and has difficulty performing activities of daily living.

Generally a person diagnosed with a mood disorder cannot return to normal mood swings without treatment that usually involves taking **antidepressant medication**. Antidepressant medication influences neurotransmitters, which enable the patient to return to a more stable mood. However, some patients are noncompliant with medication due to undesired side effects of the medication. Signs of mood disorders return once the patient stops taking medication.

1. Bipolar Disorder

Bipolar disorder occurs when a patient experiences extreme mood swings that are exhibited by manic or hypomanic mood and depressive mood. A **manic mood** is when a patient shows intense irritation and agitation along with psychotic features. **Hypomanic mood** is a less intense manic mood without psychotic features. Depressive mood is when the patient shows signs of c**linical depression**. The patient will have periods of exacerbations and periods of stable moods. Mood swings can occur rapidly, called rapid cycling, or vary overtime. A patient may experience episodes 10 times per year that can last for 7 days. Bipolar disorder is categorized as:

- **Bipolar I Disorder**: Periods of severe mania and severe depression
- **Bipolar II Disorder**: Periods of hypomania and severe depression

Bipolar I disorder is further classified by a description of the episode. There are six descriptions; these are:

- Bipolar I, **Single Manic Episode**: The patient experiences only one manic episode and no signs of a depressive mood.
- Bipolar I, Most Recent Episode Hypomanic: The patient's current or last episode was hypomanic.
- Bipolar I, Most Recent Episode Manic: The patient's current or last episode was manic.
- Bipolar I, **Most Recent Episode Mixed**: The patient's current or last episode was manic and depressive.
- Bipolar I, Most Recent Episode Depressed: The patient's current or last episode was depressive with no manic signs during the last episode.
- Bipolar I, **Most Recent Episode Unspecified**: The patient's current or last episode did not meet the clinical definition of manic, hypomanic, or depressive moods.

What Went Wrong?

There is no known cause of bipolar disorder; however, some researchers believe there is autosomal dominant genetic tendency with first-degree relations. Other researchers believe abnormalities of neurotransmitters and neuroreceptors are factors. Researchers feel that a bipolar exacerbation can be triggered by fatigue and stress, although episodes can occur without triggers.

Prognosis

The prognosis depends on whether the patient has a severe or mild form of bipolar disorder. A patient is at higher risk for cardiac disorders and suicide than the general population. However, the risk decreases if the patient is compliant with treatment.

Hallmark Signs and Symptoms

- Manic Episode
  - Impulsiveness
  - Decreased appetite
  - Flight of ideas

- Impaired judgment
- Delusions
- Highly irritable
- Pacing
- Decreased sleep
- Paranoid
- Grandiosity
- Agitation

- Depressive Episode
  - Isolation
  - Hopelessness
  - Insomnia
  - Weight loss
  - Sluggish
  - Sexual dysfunction
  - Overwhelmed
  - Low self-esteem

Common/Interpreting Test Results

There is no test that is used to diagnose bipolar disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of bipolar disorder requires the following:

Manic Episode

- Symptomatic for at least 1 week
- Experiences at least three of the following:
  - Easily distracted
  - Excessively participates in activities that are pleasurable and has a high risk for painful outcomes
  - Flight of ideas
  - Excessive talkativeness
  - Grandiosity

  - Psychomotor agitation
  - Decreased sleep
- Results in the following:
  - Psychotic features
  - Impairment of activities of daily living
  - Hospitalization for safety reasons

Hypomanic Episode

- Symptomatic for at least 4 days
- Noticeable change in mood
- No impairment of activities of daily living
- No psychotic features
- At least three of the following:
  - Flight of ideas
  - Easily distracted
  - Excessive talkativeness
  - Grandiosity
  - Decreased sleep
  - Psychomotor agitation
  - Excessively participates in activities that are pleasurable and has a high risk for painful outcomes

Bipolar I, Single Manic Episode

- Signs of manic episode (see Manic Episode)
- One manic episode and no history of depressive episode

Bipolar I, Most Recent Episode Hypomanic

- Signs of hypomanic episode (see Hypomanic Episode)
- History of manic or mixed episode
- Impedes activities of daily living

Bipolar I, Most Recent Episode Manic

- Signs of manic episode (see Manic Episode)
- History of manic, mixed, or depressive episode

Bipolar I, Most Recent Episode Mixed

- Signs of mixed episode (see Manic Episode, Hypomanic Episode, and Depressive Episode)
- History of manic, mixed, or depressive episode

Bipolar I, Most Recent Episode Depressed

- Signs of depressive episode (see Depressive Episode)
- History of manic or mixed episode

Bipolar I, Most Recent Episode Unspecified

- Signs of manic, hypomanic, mixed, or depressive episode (see Manic Episode, Hypomanic Episode, and Depressive Episode)
- History of manic or mixed episode

Bipolar II

- Current signs of depressive episode (see Depressive Episode) or history of one or more depressive episodes
- No history of manic or mixed episodes
- Current signs of hypomanic episode (see Hypomanic Episode) or history of one or more hypomanic episodes

Drug Alert

Lithium reduces hyperactive behavior and racing thoughts without a sedating effect. The desired effect occurs 10 days after treatment begins. Treatment begins with a low dose that is gradually adjusted to reach the therapeutic level. A high blood level of lithium is toxic; therefore, the patient requires frequent blood tests. The first test is 12 hours after the first dose. For the first month, the blood test must be taken three times a week. The patient must have the blood test performed monthly if the patient is on lithium maintenance. Blood tests are also required for patients who are administered Depakote to ensure that the medication is at therapeutic level. Avoid stomach upset by taking lithium with food or after eating.

Treatment

Administer: Lithium, Depakote (valproic acid), Tegretol (carbamazepine)

NURSING ALERT

If a patient is prescribed lithium, make sure the patient's kidneys are functioning and the patient can undergo frequent blood tests. Lithium is excreted by the kidneys. Lithium causes sodium depletion; however, the patient should not increase salt intake. Increased salt intake increases lithium excretion, decreasing the effect of lithium. The patient must maintain a normal diet. Be alert for **lithium toxicity**; symptoms are muscle weakness, uncoordinated voluntary muscle movement (ataxia), tremors, diarrhea, and vomiting.

Nursing Diagnoses

- Risk for self-injury related to manic and depressive behaviors
- Risk for low self-esteem related to depressive behavior
- Risk for impaired social interaction related to manic and depressive behaviors

Nursing Interventions

Manic Episode

- Create a calm quiet environment.
- Ensure the patient's safety and the safety of others.
- Be alert for escalating behavior from frustration to violent acts.
- Call for support immediately when the patient acts out and behavior escalates.
- Help the patient control their behavior by placing the patient in a quiet controlled environment away from others.
- Reinforce appropriate behavior and discourage inappropriate behavior.
- Debrief the patient and staff when the patient returns to calm controlled behavior.
- Set limits.
- Do not argue.
- Do not engage in power struggles.
- Be alert that the patient is manipulative.
- Help the patient set realistic goals.
- Give high-protein finger-food that the patient can eat while walking around.

- Distract the patient by engaging them in short gross motor activities.
- Provide support for hygiene; however, let the patient perform as many hygienic tasks as possible.

Depressive Episode

- Ensure the patient's safety and remove all objects that can be used for self-injury.
- Place the patient on suicide protocol.
- Provide support for hygiene; however, let the patient perform as many hygienic tasks as possible.
- Provide positive reinforcement.
- Encourage the patient to express their feelings.
- Set realistic expectations for the patient.
- Be alert for mood swings.
- Make sure that the patient is compliant with treatment.

2. Cyclothymic Disorder

Cyclothymic disorder occurs when a patient has brief alternating moods of hypomania and depression within a 2-month period with periods of stability between mood swings. Episodes of hypomania and depression are not as intense as in bipolar disorder.

What Went Wrong?

There is no known cause of cyclothymic disorder; however, some researchers believe there is a genetic tendency with first-degree relations who are diagnosed with bipolar disorder, major depressive disorder, or substance abuse disorder. Other researchers believe there is correlation between a close relation who committed suicide and patients diagnosed with cyclothymic disorder.

Prognosis

The patient is likely to experience swings in activities of daily living such as being very successful at activities during periods of hypomania and being unsuccessful during periods of depression. The patient may self-medicate with alcohol or street drugs to cope with these mood swings. The patient may develop

bipolar disorder (see Bipolar Disorder) or major depressive disorder (see Major Depressive Disorder).

Hallmark Signs and Symptoms

- Abrupt personality changes
- Push–pull relationships, where the patient is close to someone then suddenly pushes away from the person
- Suspicious personality
- Antisocial personality
- Hypomanic Episode
  - Grandiosity
  - Rapid speech
  - Restlessness
  - Hyperactivity and increased productivity
  - Decreased sleep
- Depressive Episode
  - Isolation
  - Hopelessness
  - Crying
  - Sadness
  - Low self-esteem
  - Decreased productivity
  - Insomnia
  - Oversleeping
  - Sluggish
  - Sexual dysfunction

Common/Interpreting Test Results

There is no test that is used to diagnose cyclothymic disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of cyclothymic disorder requires the following:

- Two years or more of hypomanic and depressive signs not compatible with signs of bipolar disorder or major depressive disorder
- Significant disruption of activities of daily living

Treatment

Administer: Lithium, Depakote (valproic acid), Tegretol (carbamazepine), Calan (verapamil) (see Drug Alert and Nursing Alert regarding lithium)

Nursing Diagnoses

- Risk for ineffective coping related to mood swings
- Risk for impaired social interaction related to mood swings
- Risk for ineffective activity planning related to mood swings

Nursing Interventions

- Help the patient cope with mood swings.
- Explore ways the patient can change activities of daily living to adjust to mood swings.

3. Dysthymic Disorder

Dysthymic disorder occurs when a patient has mild depression for 2 years that may or may not disrupt activities of daily living. Dysthymic disorder can also affect children; however, the child exhibits signs of dysthymic disorder for 1 year or more. In many cases, the patient is unaware that they have dysthymic disorder.

What Went Wrong?

There is no known cause of dysthymic disorder; however, some researchers believe the patient has a low level of serotonin. Other researchers believe an inability to cope with increased stress may lead to dysthymic disorder.

Prognosis

The patient may experience major depressive disorder if dysthymic disorder is untreated. Otherwise, the patient is likely to continue with undisrupted

activities of daily living. The patient is at risk for self-medicating with alcohol and street drugs.

Hallmark Signs and Symptoms

- Poor concentration
- Suicidal ideations
- Emptiness
- Body aches
- Insomnia
- Oversleeping
- Irritability
- Sluggish

Common/Interpreting Test Results

There is no test that is used to diagnose dysthymic disorder. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of dysthymic disorder requires the following:

- Depressive symptoms for at least 2 years that last most of the day
- No signs of major depressive disorder in 2 years
- No manic, hypomanic, or mixed episodes
- Does not meet the criteria for cyclothymic disorder
- At least two of the following:
  - Fatigue
  - Decreased appetite or overeating
  - Hopelessness
  - Low self-esteem
  - Difficulty sleeping or increased need to sleep

Treatment

- Psychotherapy: Focus is on helping the patient resolve short-term current problems and resolving the underlying cause of any suicidal ideations.

- Behavioral therapy: The goal is to help the patient identify inappropriate behavior that leads to problems with relationships and then help the patient modify those behaviors.

Nursing Diagnoses

- Risk for self-injury related to depressive behaviors
- Risk for low self-esteem related to depressive behavior
- Risk for impaired social interaction related to manic and depressive behaviors

Nursing Interventions

- Assess for suicidal ideations and signs of suicide attempts.
- Create activities where the patient will succeed and develop a sense of accomplishment.
- Help the patient make appropriate decisions.

4. Major Depressive Disorder

Major depressive disorder (MDD) occurs when the patient has persistent depressive symptoms for 2 or more weeks. The patient is unlikely aware that the patient has MDD and therefore does not seek treatment. Major depressive disorder is different from situational depression. In situational depression, the person is able to return to a normal mood without treatment. Major depressive disorder has periods of remission. Occurrences of MDD increase with age.

What Went Wrong?

There is no known cause of MDD; however, some researchers believe there are multiple genes that can predispose a person to MDD and that symptoms of MDD occur when a patient is exposed to severe stress. Other researchers believe that the hypothalamic–pituitary–adrenal system influences MDD, in addition to the influence of abnormal cortisol levels.

NURSING ALERT

Medical disorders and medications can cause symptoms that resemble MDD.

Prognosis

The patient will have long periods of normal mood without signs of MDD. Episodes of MDD can last for a month or longer. Major depressive disorder can disrupt the patient's activities of daily living.

Hallmark Signs and Symptoms

- Sexual dysfunction
- Changes in eating (increased or decreased)
- Insomnia
- Sluggish
- Suicidal ideation
- Low self-esteem
- Hopelessness
- Apathy

Common/Interpreting Test Results

There is no test that is used to diagnose MDD. The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of MDD requires the following:

Five of the following are present daily for 2 weeks:

- Fatigue
- Insomnia or hypersomnia
- Worthlessness
- Depressed mood
- Weight loss or gain
- Uninterested in daily activities
- Agitated to retardation movement
- Unable to concentrate

Drug Alert

Selective serotonin reuptake inhibitor (SSRI) medication affects a narrow set of neurotransmitters, resulting in fewer side effects than non-SSRI medication.

Side effects of other medications are related to the medication affecting a broad set of neurotransmitters. Monoamine oxidase inhibitors (MAOI) have dangerous adverse effects with various foods and medications.

Treatment

- Administer:
  - **Selective Serotonin Reuptake Inhibitors (SSRIs)**: Celexa (citalopram), Prozac (fluoxetine), Luvox (fluvoxamine), Paxil (paroxetine), Zoloft (sertraline), Effexor (venlafaxine)
  - **Atypical Antidepressants**: Remeron (mirtazapine), Desyrel (trazodone), Wellbutrin (bupropion), Serzone (nefazodone)
  - **Tricyclic Antidepressants**: Tofranil (imipramine), Elavil (amitriptyline), Sinequan (doxepin)
  - **Monoamine Oxidase Inhibitors (MAOI)**: Nardil (phenelzine), Parnate (tranylcypromine)
- **Electroconvulsive Therapy (ECT)**: ECT applies electrical current through electrodes into the patient's brain, resulting in 30- to 60-second seizures. Treatment is given three times a week for 6 weeks and is an alternative to medications when the patient does not react positively to medication.
- Psychotherapy: Focus is on helping the patient cope with symptoms of MDD and perform activities of daily living. Psychotherapy is used in conjunction with medication.

Nursing Diagnoses

- Risk for low self-esteem related to depressive behavior
- Risk for imbalanced nutrition related to changes in eating
- Disturbed sleep pattern related to insomnia or oversleeping

Nursing Interventions

- Assess for suicidal ideations and signs of suicide attempts.
- Provide patient safety and remove all objects that can be used for self-injury.
- Place the patient on suicide protocol, if appropriate.
- Encourage the patient to express their feelings.

- Provide positive reinforcement.
- Engage the patient frequently throughout the day to prevent the patient from becoming anxious.
- Provide support for hygiene; however, let the patient perform as many hygienic tasks as possible.
- Set realistic expectations for the patient.
- Create activities where the patient will succeed and develop a sense of accomplishment.
- Help the patient make appropriate decisions.
- Review how the patient is to take medication and describe the side effects and adverse effects. Tell the patient what to do if they experience side effects or adverse effects.
- Be alert to identify medication side effects and adverse effects.
- Make sure that the patient is compliant with treatment.

CASE STUDY

CASE 1

You are admitting a 54-year-old man who is diagnosed with bipolar disorder. He has a pleasant affect and is very willing to cooperate with admission assessment. This is his first time in an inpatient lock-down psychiatric unit. He looks around the unit, and smiles and nods hello to patients and staff. A few patients walk up and introduce themselves, and he greets them with a handshake. He has an appropriate affect, appears well nourished, is dressed appropriately, and has good hygiene. After getting him settled into his room, you return to the chart room to review information provided to you by the emergency department. You learn that the patient's wife passed away 3 months ago after a long battle with cancer. He has been living alone in a house; however, his three adult children call daily and each visit once a week on a different day. The patient was taken to the emergency department by the police after a neighbor saw the patient walking to the garage with a rope and small ladder. The patient denied suicidal ideation to the police but could not give the police a reasonable explanation for his actions. The patient agreed to be taken to the emergency department and agreed to be voluntarily admitted to the unit. During your assessment interview, the patient denied suicidal ideations and contracted for safety. The patient agreed to talk to the staff if he has any thoughts of injuring himself.

QUESTION 1. Did the police overreact by taking the patient to the emergency department?
ANSWER: No. The patient's actions can be interpreted as a suicidal gesture and might have become a suicide attempt if the police did not intervene. The police erred on the side of caution and brought the patient to the emergency department where practitioners could assess the patient.

QUESTION 2. What should you do now that you completed your assessment of the patient?
ANSWER: Place the patient on suicide protocol and alert the practitioner of your assessment of the patient. Nursing assessment is usually the first assessment of the patient on the unit. Any concerns related to patient safety must be addressed by the nurse first; then the concerns are relayed to the practitioner who has the ability to continue or discontinue the nurse's intervention.

QUESTION 3. Why would you be concerned about the patient's safety on the inpatient, locked down unit?
ANSWER: Although the patient's positive affect may be attributed to bipolar disorder mood swing, the patient may be looking for opportunities to attempt suicide on the unit. In a depressive mood, the patient may have suicidal ideations but lack the energy to carry out a suicide attempt. In a normal mood, the patient has the energy to carry out the attempt. The patient's positive affect may indicate less stress because the patient has decided to go through with the attempt. Furthermore, the patient may exhibit nonthreatening behavior to mislead the staff into a false sense of security. The patient is also in a high-risk category for successful suicide attempts.

QUESTION 4. Why might the patient not be suicidal?
ANSWER: The patient is diagnosed with bipolar disorder. The patient will have depressive episodes. It is during the depressive episode when the patient is at high risk for suicide. Suicidal ideations are likely to dissipate once the patient returns to a stable mood. The practitioner must assess whether the patient's suicidal gesture occurred during a depressive episode or if the patient was suicidal because of the loss of his wife. Regardless of the underlying cause, the nurse always intervenes on the side of caution.

FINAL CHECK-UP

1. **A 34-year-old male patient on your psychiatric unit is seen pacing the halls. His diagnosis is bipolar disorder. Occasionally, you notice that he pounds the wall with his closed fist. However, frequency is increasing. What is the first thing you should do?**
   A. Call the practitioners.
   B. Approach the patient cautiously and say, "It looks like something is bothering you. Is there something I can do to help you?"

C. Notify the staff.
D. Assess the patient's hand for injury.

2. **A 53-year-old man who has been on your psychiatric unit for 3 weeks is calm and controlled and socializes with other patients. He goes to off-unit recreation. He is diagnosed with major depressive disorder (MDD). You overhear the patient tell another patient that he wants to kill himself. He shows no signs of wanting to hurt himself and continues to socialize. You confront the patient, and he says it was just a joke and he has no desire to kill himself. What do you do first?**
   A. Ignore the comment as a meaningless statement.
   B. Place the patient on constant observation.
   C. Call the practitioner to assess the patient.
   D. Move the patient's room closer to the nurse's station.

3. **A patient is taking lithium for manic behavior and refuses to let you take a blood sample, saying he had blood taken a few days ago. What is the best response?**
   A. The test results will tell the practitioner if you are receiving the appropriate amount of medication.
   B. The practitioner wants to make sure that lithium is the proper medication for you.
   C. The test results will tell the practitioner if you are getting too much lithium. Too much lithium is poisonous to your body.
   D. The practitioner ordered the test so you must let me take your blood.

4. **As an admitting nurse to an outpatient psychiatric clinic, you are presented with a 68-year-old woman who reports insomnia, decreased eating, low self-esteem, hopelessness, and sluggishness. She says she always had an active life and was never depressed, but her family thinks she has depression, which is why she presents at the psychiatric clinic. What would you do first?**
   A. Note her remarks and tell the psychiatrist that her next patient is ready to be seen.
   B. Review the patient's current medications.
   C. Ask to speak to the patient's family.
   D. Assess if the patient experienced memory loss or symptoms of dementia.

5. **A patient diagnosed with MDD arrives on your unit. After the admission process is completed, the patient goes to his room and does not come out except for meals and medication. What would you do?**
   A. Provide positive reinforcement.
   B. Notify the practitioner and suggest a medication change.
   C. Place the patient on constant observation.
   D. Place the patient on constant observation and notify the practitioner immediately.

6. **A 32-year-old female patient diagnosed with bipolar disorder demands to see the practitioner immediately after leaving the practitioner's office 10 minutes ago. She continues this behavior each time she is seen by the practitioner. What do you do first?**
   A. Tell the patient that the practitioner will see her next.
   B. Tell the patient that you will tell the practitioner that she is waiting, once the practitioner is finished seeing the current patient.
   C. Tell the patient that she has seen the practitioner for today and that she will have an opportunity to see the practitioner tomorrow during rounds.
   D. Alert the staff that the patient's manic behavior is escalating.
7. **Your neighbor tells you about her mood swings. Sometimes she is the happiest person in the room, and other times she wants to be left alone. She wonders aloud if she has developed a mental illness. What is the best response?**
   A. Ask her if she is on any new medications.
   B. Ask her to describe her range of moods.
   C. Keep her on constant observation while you call for medical assistance.
   D. Tell her to go immediately to see her practitioner.
8. **A 45-year-old male patient has just started on lithium for manic episodes of bipolar disorder. He tells you that he no longer wants to take lithium because the medication upsets his stomach. What is the best response?**
   A. You must take lithium.
   B. Tomorrow we will give your lithium after you eat.
   C. This is a normal side effect of lithium.
   D. Lithium will make you less manic.
9. **A 30-year-old male patient diagnosed with MDD is reluctant to take Zoloft. After speaking with the patient, you learn that he has been experiencing sexual problems, which is a side effect of Zoloft. What is your best response?**
   A. Stop taking the medication immediately and consult your practitioner.
   B. Sexual problems are a known side effect of Zoloft.
   C. Continue to take the medication and ask your practitioner about ways to address this problem.
   D. Do not suddenly stop taking Zoloft. Speak with your practitioner to gradually decrease the dose.
10. **Family members of a 32-year-old female patient who is diagnosed with MDD feel that the patient is lazy and does not want to work. She mopes around and sleeps all day. Her father says sometimes he too gets depressed, but he picks himself up and gets moving. What is the best response?**
   A. You do not have depression. You have normal mood swings.
   B. Major depressive disorder is a chemical imbalance in the brain that prevents the person from picking themself up and getting moving without help.
   C. Your daughter needs professional help to feel normal again.
   D. Your daughter is not lazy. She has a chemical imbalance in her brain.

CORRECT ANSWERS AND RATIONALES

1. C. Notify the staff. Rationale: The patient could become violent at any time. It is better to alert the staff so there is enough support on the unit to control the patient safely. Once the staff is alerted, you can approach the patient and assess for injuries. The practitioner may be called if the staff is unable to resolve the issue.
2. B. Place the patient on constant observation. Rationale: The first step is to protect the patient. Always assume suicidal ideation is real until there is evidence to the contrary. The practitioner must be notified and assess the patient. Other interventions can be implemented based on the practitioner's assessment.
3. A. The test results will tell the practitioner if you are receiving the appropriate amount of medication. Rationale: Although too much lithium is toxic, telling the patient about toxicity in this situation may cause the patient to refuse to take the medication. It is better to ask the practitioner to discuss toxicity with the patient. The patient always has the right to refuse treatment. The other responses are incorrect because the blood test does not determine if the medication is right for the patient.
4. B. Review the patient's current medications. Rationale: Side effects of some medications can resemble depressive symptoms. The admitting nurse should gather a database of patient information before presenting the patient to the practitioner. Asking to speak with the patient's family is not the first thing to do. The patient is not showing any indication of memory loss or dementia.
5. A. Provide positive reinforcement. Rationale: This is a nursing intervention that enables the nurse to build a therapeutic rapport with the patient. The patient has not made suicidal ideations to indicate a need for constant observation. There is no indication that a medication change is necessary since the patient just arrived on the unit.
6. C. Tell the patient that she has seen the practitioner for today and that she will have an opportunity to see the practitioner tomorrow during rounds. Rationale: You must set limits to the patient's behavior. The patient has a pattern of attention-seeking behavior, and there is no sign that her condition changed since being assessed by the practitioner. Alerting the staff is appropriate, but this would not be the first thing to do.
7. B. Ask her to describe her range of moods. Rationale: Mood swings are normal. Moods become concerning if they lead to extreme affect and behaviors and last for a long period of time. Medications may cause mood swings, but the best approach is to gather more information about the mood swings. There is nothing to indicate there is an urgent medical condition.
8. B. Tomorrow we will give your lithium after you eat. Rationale: Lithium can cause an upset stomach unless the patient takes the medication with food or after meals. The patient has the right to refuse medication. The other statements are true but not the best response.

9. C. Continue to take the medication and ask your practitioner about ways to address this problem. Rationale: It is always best to encourage the patient to openly discuss medication problems with the practitioner. There are many techniques used to enable the patient to remain sexually active while maintaining medication compliance. Telling the patient that sexual problems are known side effects of Zoloft is correct but does not help the patient address those problems. There is no need for the patient to stop taking Zoloft because of this side effect.
10. B. Major depression disorder is a chemical imbalance in the brain that prevents the person from picking themself up and getting moving without help. Rationale: The nurse should always educate the patient and the patient's family about the nature of the patient's diagnosis.

This page intentionally left blank

chapter 8

Substance Abuse

LEARNING OBJECTIVES

1. Alcohol dependence disorder
2. Amphetamine abuse disorder
3. Anxiolytic, hypnotic, sedative dependent disorder
4. Cannabis abuse disorder
5. Cocaine abuse disorder
6. Hallucinogen abuse disorder
7. Inhalant abuse disorder
8. Nicotine dependent disorder
9. Opioid dependent disorder

KEY TERMS

Abuse
Addiction
Alcohol metabolism
Blood alcohol level (BAL)
Cravings
Delirium tremens (DT)
Dependency
Detoxification
Hallucinogen
Narcotics Anonymous (NA)
Neurotransmitter
Physical dependency
Psychological dependency
Recovery
Substance dependency
Tetrahydrocannabinol (THC)
Tolerance
Triggers
Withdrawal

Abuse, Dependency, and Addiction

Substance abuse occurs when a person continues to use a substance knowing that the substance will have an adverse effect on their health and activities of daily living. For example, a person may use the substance to "relax" on Friday and Saturday and then abstain on Sunday with hopes of returning to normal and being fully functional for work on Monday.

Substance dependency occurs when a person uses a substance to feel normal. Initially, the person uses the substance to "relax." However, the person goes through **withdrawal** symptoms as the level of the substance in the bloodstream decreases and the body attempts to compensate for the missing substance. Withdrawal symptoms are uncomfortable and may cause serious health problems, such as seizures, depending on the substance. The person reuses the substance to alleviate the withdrawal symptoms. In addition, the person builds a **tolerance** for the substance, requiring a higher dose to achieve "relaxation" and to prevent withdrawal symptoms.

There are two types of substance dependency. These are physical dependency and psychological dependency. Physical dependency occurs when the person experiences withdrawal symptoms when abstaining from the substance. Psychological dependency occurs when the person exhibits drug-seeking behaviors after the physical dependency has dissipated.

Addiction is a psychiatric disorder that occurs when a person is psychologically dependent on a substance. A person who is addicted to a substance will spend most of their waking hours focused on obtaining and using the substance

with total disregard to activities of daily living including family and employment responsibilities.

Dependency and Pain Medication

Some medications, such as opioids for pain and benzodiazepine for anxiety, have shown a high risk for **dependency**. Practitioners balance the therapeutic needs of a patient with the risk of dependency when prescribing medication and are careful to reduce the dose or change to a different class of medication at the first sign of the patient becoming dependent on the medication.

Patients who are in severe pain will become dependent on opioids if prescribed for a relatively long period of time. However, the practitioner will employ pain management protocols to reduce the dependency on a particular medication and alter medication to ensure that the patient does not build a tolerance to the medication. The patient will then be detoxed from opioids after the underlying cause of the pain is resolved. Proper pain management prevents a patient from becoming addicted to the medication.

Detoxification

Detoxification is a process of removing the substance from the patient's body. Once the substance is removed and the patient's body is stabilized, the patient is no longer physically dependent on the substance. Detoxification begins when the patient stops taking the substance and ends when all traces of the substance are removed from the body.

The patient experiences withdrawal symptoms once they stop taking the substance. The time when withdrawal symptoms begin depends on many factors, including the nature of the substance, the amount of substance taken, and the patient's health.

Typically, the practitioner lets the patient's body naturally remove the substance. The liver is the major organ that detoxifies substances from the **bloodstream**. The liver neutralizes the substance, which is then excreted through the kidneys or during a bowel movement.

The body then gradually returns to the normal **neurotransmitter** as the nervous system is no longer influenced by the substance. During this adjustment, the patient's neural transmission continues to malfunction until the body's adjustment is completed. It is during this period that the patient feels uncomfortable and shows signs of withdrawal. Alcohol and anxiolytic withdrawal

places the patient at risk for seizures and other serious medical conditions in addition to making the patient feel uncomfortable.

During the detoxification process, the practitioner will order medications to ease withdrawal symptoms and to reduce the risk of medical complications. For example, the practitioner will likely order anxiolytic medication for a patient who is dependent on an anxiolytic and then taper the dose over several days to prevent the patient from having a seizure.

The practitioner may order extraordinary measures to detoxify a patient if the substance is at a critical level in the bloodstream because of a high dose ingested by the patient or poor health preventing the body from naturally removing the substance from the body. For example, the practitioner may order kidney dialysis for a patient who has acute alcohol poisoning.

NURSING ALERT

Withdrawal symptoms usually have the opposite effect of the substance taken by the patient. For example, a patient who is dependent on an anxiolytic will feel relaxed and sedated while under the influence of the drug. Withdrawal symptoms are increased agitation, anxiety, and insomnia. Likewise a patient dependent on amphetamines is highly alert and energetic while under the influence of amphetamines. The patient experiences depression, lethargy, and increased sleep during withdrawal.

Recovery, Cravings, and Triggers

Recovery is the process of coping with life's challenges without the assistance of the substance. Recovery begins when detoxification ends. However, there is no end to recovery. The patient is in recovery for the rest of their life. Although the patient is no longer physically dependent on the substance because detoxification is completed, they remain psychologically dependent on the substance and will have ongoing **cravings** to use the substance.

The patient faces the same challenges as those who want to lose weight. Both sincerely want to succeed and have a plan to prevent a relapse back to old habits. However, the craving to relapse is strong. Events called **triggers** can cause cravings. A trigger can be a song, memories of a place, or meeting certain people who the patient associates with using the substance or binging on junk food. For example, walking into a fast food restaurant triggers the craving to go off a diet, and the person may experience a relapse. Patients call this "people, places, and things."

A patient can expect to relapse many times during their life. The goal of recovery is to increase periods between relapses. Drug treatment programs are designed to help the patient avoid relapse. At the beginning of recovery, the patient is helped to identify triggers and to recognize cravings and how long cravings last. The patient is then helped to identify ways to cope with triggers and cravings. For example, the patient may realize that a craving lasts 30 minutes. The patient must distract themself for 30 minutes until the craving goes away. There are self-help groups, most notably Alcoholics Anonymous and Narcotics Anonymous (NA), that are run by people in recovery and provide support 24/7 for those in recovery. Each member has a sponsor who provides one-on-one help and is available to help the patient deal with cravings.

Social Support Problems

Dependency on a substance typically affects the patient's activities of daily living. The combination of withdrawal symptoms and cravings results in drug-seeking behavior where the patient's daily activities are focused around acquiring and using the substance. As a result, the patient forgoes family and employment obligations, resulting in loss of income.

The lack of income leads to the patient stealing to pay for drugs and encounters with the law. Home life is ruined. The patient burns bridges with family and friends. The patient's entire support system is destroyed, leaving them homeless and penniless. The patient has challenges reclaiming their life. Finding employment becomes increasingly difficult even during recovery because many substance abuse patients have a criminal record. No employment. No support system. No home. These are factors that increase despair and depression, leading the patient to relapse and continue the cycle of substance abuse.

Common Signs of Substance Abuse

Substance abuse does not occur overnight but develops gradually, beginning with social or recreational use of the substance occasionally. The periods between use narrow from occasionally to Fridays and Saturdays and then occasionally during weekday nights. Eventually, use of the substance prevents the patient from going to work on time and performing their work. As stress increases, the patient increasingly uses the substance to cope with stress. The patient moves from abusing the substance to becoming dependent on the substance.

Here are signs of substance abuse:

- Poor hygiene
- Secretive behavior
- Missing money
- Items missing from home
- Stolen credit cards
- Eyes less responsive to changes in light
- Inappropriately wearing sunglasses
- Pupils fixed, dilated, or pinpoint
- Frequent unnecessary trips outside the house
- Change in weight
- Change in appetite
- Dress in long sleeves on hot days
- Sinus congestion
- Frequent missed days from school or work
- Not being able to function normally
- Agitated behavior when confronted with behavior change

1. Alcohol Dependence Disorder

Alcohol dependence disorder occurs when the patient develops a physical dependency on alcohol. The patient has developed a tolerance for alcohol that requires them to increase alcohol intake to achieve the desired physiologic effect. Furthermore, the absence of alcohol results in the patient becoming increasingly uncomfortable and displaying withdrawal symptoms that are relieved by ingesting alcohol. A patient frequently reports needing an alcoholic drink in the morning to feel normal. The patient totally focuses on obtaining and ingesting alcohol during waking moments.

Alcohol alters inhibitions. Patients tend to exhibit behavior different from behavior when sober. For example, the patient may become overly friendly and the life of the party, commonly referred to as a happy drunk. Other patients demonstrate violent uncontrollable behavior, commonly referred to as a nasty drunk. Since the patient is always at some level of intoxication, they are unlikely to maintain activities of daily living including employment. It is not uncommon for a patient diagnosed with alcohol dependency disorder to be unemployed,

homeless, and without family and friends who have distanced themselves from the patient's abnormal behavior. The patient continues ingesting alcohol regardless of the consequences of their actions.

The patient likely tried to stop drinking alcohol without success because of psychological dependency on alcohol. Psychological dependency occurs when the patient associates a pleasurable feeling with the use of alcohol. The patient may report that all their troubles go away when intoxicated.

When a patient seeks treatment for alcohol dependency disorder, they are likely unemployed, homeless, malnourished, and without a support system. Treatment is difficult because the patient experiences withdrawal symptoms and a structured lifestyle that they do not control. Patients tend to report there are too many rules and they are not permitted to sleep beyond 8 hours. The psychological dependency is compulsive. The patient believes they can handle the requirements of treatment if they have one drink. It is not uncommon for the patient to discontinue treatment and return to using alcohol. The patient typically has attempted treatment many times, with subsequent relapses.

Characteristics of alcohol use are:

- Current use: At least one drink in the past 30 days
- Binge use: Five or more drinks on the same occasion at the same time or within a couple of hours of each other on at least 1 day in the past 30 days
- Heavy use: Five or more drinks on the same occasion on each of 5 or more days in the past 30 days
- **Abuse**: The patient uses alcohol frequently but does not experience withdrawal symptoms and does not have a physical or psychological dependency on alcohol.
- **Physical dependency**: The patient experiences withdrawal symptoms that subside when they ingest alcohol. The patient is unable to stop drinking alcohol regardless of its consequences.
- **Psychological dependency**: The patient has compulsive thoughts about acquiring and ingesting alcohol. The patient views alcohol as a means to achieve a positive feeling and avoid negative feelings. The patient is preoccupied with acquiring alcohol.

Alcohol Metabolism

Alcohol passes from the stomach into the intestine where the alcohol is absorbed into the bloodstream. Blood vessels transport alcohol to the liver

where the liver enzymes convert alcohol into carbon dioxide and water. A small amount of alcohol is not metabolized and is excreted in urine and is exhaled by the lungs.

Alcohol remains in the body until the liver converts alcohol into carbon dioxide and water. The amount of alcohol in the blood is called the blood alcohol concentration (BAC). The speed at which conversion occurs is called the alcohol metabolism rate. The rate of **alcohol metabolism** depends on the amount of ADH enzymes available in the liver. Alcohol absorption is faster than alcohol metabolism. One drink of alcohol, defined as 12 oz of beer, 1.5 oz of 80 proof liquor, or 5 oz of wine, results in a BAC of approximately 0.45 after a half hour and takes about 4.5 hours to fully metabolize.

The following are factors that influence alcohol absorption and metabolism:

- Food: The higher the fat content of food recently ingested with alcohol, the longer the time it takes for alcohol to be absorbed into the bloodstream. The emptier the stomach, the shorter the time it takes for alcohol to be absorbed into the bloodstream.
- Gender: Women tend to have a higher concentration of alcohol in their blood after consuming the same amount of alcohol as men.
- Liver: Metabolism depends on the availability of ADH. Liver disease decreases the availability of ADH and therefore affects the metabolism of alcohol.

NURSING ALERT

A patient may ingest any form of alcohol including mouthwash, lighter fluid, and aftershave lotion. Ingestion of these forms of alcohol can lead to acute kidney failure and require kidney dialysis.

What Went Wrong?

There is no known cause of alcohol dependence disorder; however, some researchers believe there is genetic predisposition to alcoholism, although other factors influence whether or not the person develops alcohol dependency. Other researchers believe a person who is impulsive and uses alcohol as self-medication for anxiety and to escape from responsibilities and facing life's challenges is at risk for alcoholism. Peer pressure combined with an active social life increases the risk for a person to become alcohol dependent.

NURSING ALERT

As a general rule, a blood alcohol level of 0.016 takes 1 hour to decrease to a level of zero; however, other factors can affect a person's metabolism of alcohol.

Prognosis

- Brain: Alcohol can have a long-term effect on communication pathways within the brain, leading to disruption in coordination and clear thinking, resulting in behavior and mood changes. The patient may experience alcoholic dementia and seizure disorders such as Wernicke encephalopathy.
- Cardiovascular: The patient may experience esophageal varices and hypertension.
- Cancer: Alcohol abuse and dependence is linked to breast, mouth, esophagus, throat, and liver cancer.
- Heart: Over time, alcohol abuse and dependency can lead to cardiomyopathy and arrhythmias related to hypertension. Cardiac arrhythmias can lead to blood clots and stroke.
- Immune system: Alcohol decreases the ability of the body to absorb nutrients that are required to energize elements in the immune system. Alcohol also suppresses the growth of white blood cells. A decrease in white blood cells decreases the body's ability to fight infection.
- Liver: Alcohol is metabolized in the liver. Alcohol abuse and dependency overworks the liver, resulting in an abnormal destruction of liver cells. Fat deposits develop in the liver, and liver cells are replaced by scar tissue, leading to liver fibrosis and liver cirrhosis. With decreased liver cells, metabolism of alcohol and other chemicals decreases, leading to an increase of those substances in the blood. Blood alcohol levels, can reach critical levels, leading to alcohol poisoning and death. When liver cells in the blood fall below a normal range, the patient possibly has liver failure and may require a liver transplant to live. Alcohol can also cause inflammation of the liver, called alcoholic hepatitis.
- Pancreas: Alcohol abuse and dependence can cause inflammation of the pancreatic duct, preventing unobstructed flow of active pancreatic enzymes into the duodenum. As a result, active pancreatic enzymes remain in the pancreatic duct causing pancreatitis.
- Fetal alcohol spectrum disorder (FASD): Drinking alcohol at any stage of pregnancy can have an adverse effect on the fetus and lead to fetal alcohol

spectrum disorder. First trimester: Alcohol may disrupt fetal brain cell formation. Second trimester: Facial features may be affected by alcohol. Third trimester: Hippocampus formation may be affected, resulting in problems with vision and hearing. Fetal alcohol spectrum disorder results in delayed intellectual development, visual problems, hearing problems, abnormal behavior, and neurologic problems that can lead to an abnormal gait. The fetus can experience facial deformities such as thin upper lip, missing groove in the upper lip, flattened mid-face, or shortened eye openings.

NURSING ALERT

Alcohol withdrawal begins as early as 2 hours after the last drink and can last for 10 days. Alcohol withdrawal worsens quickly, and the patient should be treated immediately to reduce the risk of developing seizures and **delirium tremens (DT)**.

Hallmark Signs and Symptoms

- Patient response when alcohol is discussed with the patient:
  - Denies having a problem
  - Blames others for the problem
  - Angry when confronted about alcohol use
  - Avoids discussion about alcohol use
- Blood alcohol level and related behavior/impairment measured as BAC (% of volume of blood)
  - 0.01–0.029
    - Normal
  - 0.03–0.059
    - Talkativeness
    - Decreased inhibition
    - Relaxed
    - Impaired concentration
    - Mild euphoria
  - 0.06–0.09
    - Impaired reasoning
    - Impaired vision

- Emotional
- Assertive
- Excitable
- Disregard for social conventions
- Tactless
- Disregard for feelings of others
- Impaired recovery when a light source is shone into the eyes

- 0.1–0.19
  - Anger
  - Emotional swings
  - Sadness
  - Loud
  - Impaired reflexes
  - Staggering
  - Erectile dysfunction
  - Slurred speech
  - Decreased libido
- 0.2–0.29
  - Blackout
  - Stupor
  - Motor impairment
  - Impaired sensations
- 0.3–0.39
  - Unconsciousness
  - Impaired breathing
  - Depressed central nervous system
  - Impaired heart rate
  - Impaired bladder function
  - Risk of death
- 0.4–0.5
  - Impaired breathing
  - Impaired heart rate

    - Unconsciousness
    - Visible jerkiness in eye movement (positional alcohol nystagmus)
    - Risk of death
  - >0.5
    - Alcohol poisoning
    - Risk of death
- Withdrawal symptoms:
  - 0–6 hours since last drink
    - Slurred speech
    - Anxiety
    - Unsteady gait
    - Anorexia
    - Lack of coordination
    - Insomnia
    - Impaired judgment
    - Nausea
    - Impaired memory
    - Fever
    - Labile mood
  - 6–24 hours since last drink
    - Delusions
    - Restlessness
    - Vomiting
    - Hallucinations
    - Poor concentration
    - Tremors
    - Excessive sweating
    - Increased anxiety
    - Hypertension
    - Tachycardia
  - 12–24 hours since last drink
    - Grand mal seizure

    - Loss of consciousness
    - Violent muscle contractions
  - 24–72 hours since last drink
    - Delirium tremens (DT)
      - Tachycardia
      - Increased temperature
      - Severe agitation
      - Disorientation
      - Restlessness
      - Unable to recognize others and self
- Ingesting alcohol while taking Antabuse (disulfiram)
  - Respiratory distress
  - Hypotension
  - Palpitations
  - Blurred vision
  - Flush
  - Confusion
  - Sweating
  - Increased thirst
  - Nausea
  - Vomiting
  - Tachycardia
  - Weakness
  - Chest pain

Common/Interpreting Test Results

- **Blood Alcohol Level (BAL)**: Reported in tenths of one percent of the person's blood volume that is alcohol. For example, a level of 0.1 means one-tenth of one percent of the tested blood volume is alcohol. A blood alcohol test is typically reported as a whole number such as 290. This means 0.29 of the tested blood volume is alcohol.
- Alcohol Use Disorder Identification Test (AUDIT): 10-item assessment scored by a range of 0–40

- Alcohol Use Disorder Identification Test—Consumption (AUDIT-C): 4-item assessment scored by a range of 0–12
- Alcohol Use Disorder Identification Test—Primary Care (AUDIT-PC): 5-item assessment scored by a range of 0–20
- CAGE Test: 4-item assessment scored as yes or no
- Michigan Alcoholism Screening Test (MAST): 25-item assessment scored as yes or no
- Brief Michigan Alcoholism Screening Test (BMAST): 10-item assessment scored as yes or no
- Short Michigan Alcoholism Screening Test (SMAST): 13-item assessment scored as yes or no
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of alcohol dependency disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:
    - Required increased amounts of alcohol to reach the desired effect or experienced a decrease in the desired effect when using the same amount of alcohol
    - Experienced withdrawal symptoms or used alcohol to relieve or prevent withdrawal symptoms
    - Ingested large amounts or over longer periods than intended
    - Persistently tried to reduce the use of alcohol without success
    - Spent a significant time acquiring alcohol, using alcohol, or recovering from the effects of alcohol
    - Reduced or eliminated social or occupational activities due to alcohol use
    - Continually used alcohol despite physical or psychological problems caused by alcohol use

NURSING ALERT

A patient diagnosed with alcohol dependency may have a dual diagnosis of another psychiatric disorder. These patients are referred to as mentally ill/chemically addicted (MICA) patients. Some researchers believe that if the patient is compliant with the appropriate psychiatric medication and treatment, then they will not self-medicate with alcohol.

Treatment

Chronic

- Group Therapy: The goal of group therapy is to focus on underlying psychiatric problems that may be present.
- Alcoholics Anonymous (AA): Alcoholics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering alcoholics. In addition to the 12-step program, a member of Alcoholics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Alcoholics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever the patient feels the urge to relapse.
- Al-Anon: Al-Anon is a family self-help group that focuses on encouraging family members not to blame themselves for the patient's addiction to alcohol.
- Alateen: Alateen is a self-help group for children of patients who are addicted to alcohol and has the same focus as Al-Anon.
- Administer:
  - For aversion: Antabuse (disulfiram)
  - For cravings: Vivitrol (naltrexone), Revia (naltrexone IM), Campral (acamprosate)

Withdrawal

- Administer:
  - Thiamin and other B-complex vitamins to assist in glucose metabolism and nutritional deficiency
  - Benzodiazepines: Librium (chlordiazepoxide), Ativan (lorazepam), Xanax (alprazolam), Serax (oxazepam) to reduce the risk of seizures
  - Barbiturates: Phenobarbital for sedation
  - Anticonvulsants: Neurontin (gabapentin), Tegretol (carbamazepine), Trileptal (oxcarbazepine) to prevent psychosis and hyperactivity
  - Antipsychotics: Haldol (haloperidol) to prevent psychosis and hyperactivity
  - Beta blockers: Inderal (propranolol), Tenormin (atenolol) to treat hypertension and tremors

- Lasix (furosemide) for overhydration
- Magnesium sulfate to reduce central nervous system irritability

Nursing Diagnoses

- Risk for memory impairment related to increased ingestion of alcohol
- Risk for altered nutrition lesser than body requirements related to decreased food intake while intoxicated
- Risk for impaired social interaction related to intoxication

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Acknowledge that the patient's addiction to alcohol resulted in a breakdown in their health, welfare, family, and support structure.
  - Help the patient realize that their addiction is the root cause of their problem. No one is to blame but themself.
  - Explain the physiology of addiction.
  - Tell the patient that they will be in recovery for the rest of their life.
  - Discuss options of Alcoholics Anonymous (AA), Al-Anon, Alateen, inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to drink lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when they have the urge to drink (e.g., call a sponsor and friends who are in recovery).
- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Develop a therapeutic rapport.
  - Assess how much alcohol the patient ingested.
  - Determine the last time the patient ingested alcohol. This will give you an idea when the patient will begin withdrawing.

- Monitor the patient's vital signs.
- Place the patient in a quiet environment.
- Place the patient on seizure precaution.
- Be alert for signs of delirium tremens (see Hallmark Signs and Symptoms).
- Monitor the patient for safety. The patient may have an unsteady gait and be confused.
- Monitor the patient's blood pressure. The patient may be hypotensive as a result of medication and not be able to walk without assistance.
- Place the patient on constant observation if they are violent. Some patients exhibit aggression when intoxicated and during withdrawal.

NURSING ALERT

Do not attempt to confront the patient about their denial of being addicted to alcohol or address treatment and recovery until they are near the end of or have finished detox.

2. Amphetamine Abuse Disorder

An amphetamine is a stimulant that increases alertness and decreases fatigue, resulting in a temporary pleasurable rush. Amphetamines are prescribed for a number of disorders including ADHD, narcolepsy, and sleep disorder. Amphetamines are dextroamphetamine, methamphetamine, and amphetamine sulfate. Commonly prescribed amphetamines are: Ritalin, Adderall, and Dexedrine. Street names for amphetamine are: Bennies, Black Beauties, Crank, Crystal, Glass, Ice, Krystal Meth, Louee, Meth, Shabu, Speed, and Uppers.

Amphetamine abuse disorder occurs when a person self-medicates with amphetamine to experience a pleasurable high or to improve performance or stay awake for long periods. The effects of amphetamines will vary based on the person's size, weight, health, and tolerance to the drug and the route with which the drug is administered. Injecting and smoking amphetamine produces an immediate effect. Snorting or swallowing produces an effect in approximately 30 minutes.

The patient increases stress on the body by combining amphetamines with cocaine, ecstasy, alcohol, cannabis, benzodiazepines, and heroin. Using amphetamines with cocaine and ecstasy can lead to a stroke. Patients typically will

binge on amphetamines, which is called a run. For days, the patient injects or smokes amphetamines every 3 hours, forgoing sleep and food. The run ends when the patient has exhausted money for amphetamines or is physically unable to continue.

What Went Wrong?

Amphetamine releases dopamine, norepinephrine, and serotonin, creating a pleasurable high related to high levels of dopamine within the area of the brain that regulates pleasure. Feeling high lasts several minutes; afterward irritability, depression, and radical mood swings can occur during withdrawal from the drug. A combination of feeling uncomfortable during withdrawal and the desire to feel a pleasurable high results in becoming physically dependent on amphetamines.

Prognosis

The effects of amphetamine abuse resolve several days after the patient stops using it. The patient can develop amphetamine psychosis, resulting in delusions, hallucinations, and bizarre behavior, if the patient uses frequent high doses of amphetamines. Long-term effects of amphetamine use can lead to hypertension, cardiac disease, kidney failure, malnutrition, insomnia, dental disease, memory loss, depression, risk of stroke, paranoia, panic, weak immune system, and shortness of breath. These symptoms can last years after the patient stops taking amphetamines.

Hallmark Signs and Symptoms

Under the Influence

- Feeling of euphoria and sense of well-being
- Alert
- Need for less sleep
- Sense of superiority
- Talkativeness
- Increased libido
- Dilated pupils
- Sweating
- Increased temperature

- Itching/scratching
- Picking at skin, thinking insects are crawling on the body (formication)
- Palpitations
- Increase in blood pressure
- Decrease in appetite

Overdose

- Irregular breathing
- Blurred vision
- Seizures
- Hallucinations
- Aggressive behavior
- Loss of coordination
- Collapse
- Stroke
- Coma
- Tachycardia

Withdrawal

- Irritable
- Restless
- Aggression
- Mood swings
- Exhaustion
- Depression
- Paranoia
- Lethargy

Common/Interpreting Test Results

- Urine Toxicology: Positive for amphetamine
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of amphetamine abuse disorder requires the following:

- A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:
  - Required increased amount of amphetamine to reach the desired effect or experienced a decrease in the desired effect when using the same amount of amphetamine
  - Experienced withdrawal symptoms or used amphetamine to relieve or prevent withdrawal symptoms
  - Ingested large amounts or over longer periods than intended
  - Persistently tried to reduce the use of amphetamine without success
  - Spent significant time acquiring amphetamine, using amphetamine, or recovering from the effects of amphetamine
  - Reduced or eliminated social or occupational activities due to amphetamine use
  - Continually used amphetamine despite physical or psychological problems caused by amphetamine use

Treatment

Chronic

- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with amphetamine.
- **Narcotics Anonymous (NA)**: Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug abusers. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever the patient feels the urge to relapse.

Withdrawal

- Amphetamine withdrawal is treated symptomatically.
- Monitor vital signs.
- Gastric lavage is performed to remove amphetamines that were ingested, if needed.

- Apply a cooling blanket, if needed.
- Administer:
  - IV fluids to restore fluids
  - Nutritional supplements for malnutrition
  - Vitamins for malnutrition
  - Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam) to prevent seizures and induce sleep
  - Imodium for diarrhea
  - Osmitrol (mannitol) to increase urination related to acute kidney failure
  - Benadryl (diphenhydramine), Cogentin (Benztropine) for muscle relaxation

Nursing Diagnoses

- Risk for self-injury related to aggressive behavior
- Risk for confusion related to the effects of amphetamine
- Risk for malnutrition related to decreased eating

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Help the patient realize that their addiction is the root cause of their problem. No one is to blame but themself.
  - Explain the physiology of addiction.
  - Tell the patient that they will be in recovery for the rest of their life.
  - Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to use amphetamine lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to use amphetamine (e.g., call a sponsor and friends who are in recovery).

- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Monitor the patient's vital signs. The patient may have tachycardia, hypertension, and increased temperature.
  - Place the patient in a quiet environment.
  - Place the patient on seizure precaution.
  - Be alert for signs of seizures.
  - Monitor the patient for safety. The patient may be confused and agitated.
  - Monitor and treat symptoms of withdrawal.

3. Anxiolytic, Hypnotic, Sedative Dependent Disorder

Anxiolytic, hypnotic, sedative dependent disorder occurs when the patient becomes dependent on anxiolytic, hypnotic, or sedative medication. Collectively these classes of drugs reduce anxiety and induce sleep and can be taken orally or injected intramuscularly or intravenously. Depending on the route, the effect can be immediate or may take several minutes and lasts up to 8 hours.

Medication includes Librium (chlordiazepoxide), Ativan (lorazepam), Klonopin (clonazepam), Xanax (alprazolam), Valium (diazepam), Ambien (zolpidem), and Sonata (zaleplon). Street names for these drugs include yellow jackets, dolls, and roaches.

What Went Wrong?

Anxiolytics, hypnotics, and sedatives decrease the potential of the GABA neurotransmitter, resulting in slowing the actions of the central nervous system and producing a relaxing feeling. Over time, the patient develops a tolerance to the medication, requiring a higher dose to achieve the calming effect. The patient experiences a jittery feeling and becomes irritable during withdrawal, leading them to take the drug to avoid withdrawal symptoms.

Prognosis

Long-term use may lead to irritability, depression, memory impairment, sleep disorder, and personality changes. The patient may become psychologically and physiologically dependent on the medication and may not be able to cope with stress without using the medication.

Hallmark Signs and Symptoms

Under the Influence

- Slurred speech
- Increase in appetite
- Aggression
- Personality changes
- Anxiety
- Decreased muscle coordination
- Drowsiness
- Hypotension
- Memory loss
- Insomnia

Overdose

- Blurred vision
- Unresponsiveness
- Coma
- Decreased muscle tone
- Depressed respiration
- Hallucinations
- Uncontrolled body movement

Withdrawal

- Confusion
- Seizures
- Hypertension
- Paranoia
- Panic attacks
- Headache
- Sweating
- Abdominal pain
- Insomnia
- Decrease in appetite

NURSING ALERT

Withdrawal symptoms begin within 4 days after the last dose and may reoccur intermittently for a year after the last dose.

Common/Interpreting Test Results

- Urine Toxicology: Positive for anxiolytic, hypnotic, or sedative
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of anxiolytic, hypnotic, or sedative dependency disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:
    - Required increased amounts of anxiolytic, hypnotic, or sedative to reach the desired effect or experienced a decrease in the desired effect when using the same amount of an anxiolytic, hypnotic, or sedative
    - Experienced withdrawal symptoms or used an anxiolytic, hypnotic, or sedative to relieve or prevent withdrawal symptoms
    - Ingested large amounts or over longer periods than intended
    - Persistently tried to reduce the use of anxiolytic, hypnotic, or sedative without success
    - Spent significant time acquiring anxiolytic, hypnotic, or sedative; using anxiolytic, hypnotic, or sedative; or recovering from the effects of anxiolytic, hypnotic, or sedative
    - Reduced or eliminated social or occupational activities due to anxiolytic, hypnotic, or sedative use
    - Continually used an anxiolytic, hypnotic, or sedative despite physical or psychological problems caused by anxiolytic, hypnotic, or sedative use

NURSING ALERT

The patient is treated with benzodiazepine in tapering doses to prevent seizures.

Treatment

Chronic

- Group Therapy: The goal of group therapy is to focus on underlying psychiatric problems that may be present.
- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with an anxiolytic, hypnotic, or sedative.
- Narcotics Anonymous (NA): Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug users. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever they feel the urge to relapse.

Withdrawal

- Administer:
  - Benzodiazepines: Librium (chlordiazepoxide), Ativan (lorazepam), Xanax (alprazolam), Serax (oxazepam) to reduce the risk of seizures

Nursing Diagnoses

- Risk for impaired social interaction related to the sedative effect of the medication
- Ineffective coping related to self-administering medication to cope with stress
- Ineffective denial related to denial that the patient is dependent on medication

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Acknowledge that the patient's addiction to an anxiolytic, hypnotic, or sedative resulted in a breakdown in their health, welfare, family, and support structure.

- Help the patient realize that their addiction is the root cause of the patient's problem. No one is to blame but themself.
- Explain the physiology of addiction.
- Tell the patient that they will be in recovery the rest of their life.
- Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
- Acknowledge that the patient has tried and failed at treatment.
- Tell the patient the goal is to extend the length of time between relapses.
- Ask the patient how long their urge to use drugs lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when they have the urge to use drugs (e.g., call a sponsor and friends who are in recovery)

- If the patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Develop a therapeutic rapport.
  - Monitor the patient's vital signs.
  - Place the patient in a quiet environment.
  - Place the patient on seizure precaution.
  - Monitor the patient for safety. The patient may have an unsteady gait and be confused.
  - Monitor the patient's blood pressure. The patient may be hypotensive due to medication and may not be able to walk without assistance.

4. Cannabis Abuse Disorder

A patient diagnosed with cannabis abuse disorder ingests cannabis for recreational purpose to induce euphoria. Cannabis is a drug that is extracted from the hemp plant in leaf form, called marijuana, and as resin, called hashish. In leaf form, cannabis is smoked or ingested as tea. Leaves are rolled to form cigarettes. Alternatively, a cigar is opened and the tobacco is replaced with marijuana to form a blunt. In resin form, cannabis is smoked using water pipes called bongs. Street names for cannabis are 420, Acapulco gold, Aunt Mary, baby, bale, bomber, weed, joint, doobee, hooch, Jane, Jay, smoke, loco, tea, roach, reefer, and blunt. The onset of cannabis effects is within 2 hours of ingestion and can have a diminishing effect for up to 12 hours. Researchers believe that cannabis is psychologically addictive, and some cannabis users experience withdrawal symptoms.

Drug Alert

Patients who use cannabis may combine cannabis with other drugs such as crack cocaine, phencyclidine (PCP), and opioid to achieve a combined effect from both drugs.

NURSING ALERT

Medical cannabis is used as an antiemetic for patients undergoing chemotherapy to prevent nausea and vomiting.

What Went Wrong?

The active ingredient in cannabis is **tetrahydrocannabinol (THC)**. THC enters the bloodstream when cannabis is ingested by the patient and is carried to the brain. THC attaches to cannabinoid receptors in the brain, leading to the sense of pleasure and affecting coordination, learning, perception, and memory.

Prognosis

Some researchers believe long-term use of cannabis can lead to anxiety, depression, decrease in memory, and psychosis. Other researchers believe that cannabis is a gateway drug and that use of cannabis may encourage a patient to experiment with other prescribed and street drugs. Regular use of cannabis may lead to disruptions of activities of daily living including employment, resulting in financial hardship.

Hallmark Signs and Symptoms

Cannabis Use

- Dry mouth
- Hypertension
- Red eyes
- Decreased reaction time
- Increased heart rate
- Increased breathing
- Increased appetite
- Paranoia
- Short-term memory loss

- Depression
- Grandiose
- Euphoria
- Perceptual distortion
- Hyperalertness
- Poor coordination
- Time distortion
- Depression
- Magical thinking

Cannabis Overdose

- Aspiration pneumonia
- Respiratory distress
- Hypotension
- Pulmonary edema

Cannabis Withdrawal

- Mood swings
- Restlessness
- Craving for cannabis
- Insomnia
- Weight change (loss/gain)
- Increase in appetite
- Headaches

Common/Interpreting Test Results

- Urine Toxicology: Positive for THC
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of cannabis abuse disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:

- Required increased amounts of cannabis to reach the desired effect or experienced a decrease in the desired effect when using the same amount of cannabis
- Experienced withdrawal symptoms or used cannabis to relieve or prevent withdrawal symptoms
- Ingested large amounts or over longer periods than intended
- Persistently tried to reduce the use of cannabis without success
- Spent significant time acquiring cannabis, using cannabis, or recovering from the effects of cannabis
- Reduced or eliminated social or occupational activities due to cannabis use
- Continually used cannabis despite physical or psychological problems caused by cannabis use

Treatment

Chronic

- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with cannabis.
- Narcotics Anonymous (NA): Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug abusers. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever they feel the urge to relapse.

Withdrawal

- Cannabis withdrawal is treated symptomatically.
- Monitor vital signs.
- Administer:
  - Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam) to reduce restlessness and insomnia

Nursing Diagnoses

- Risk for self-injury related to poor coordination

- Ineffective individual coping related to the use of cannabis to cope with life's challenges
- Risk for disturbed personal identity related to grandiose behavior

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Help the patient realize that cannabis can be psychologically addicting.
  - Tell the patient that they will be in recovery the rest of their life.
  - Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to use cannabis lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to use cannabis (e.g., call a sponsor and friends who are in recovery).
- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Monitor the patient's vital signs.
  - Place the patient in a quiet environment.
  - Monitor the patient for safety. The patient may be confused and agitated.
  - Monitor and treat symptoms of withdrawal.

5. Cocaine Abuse Disorder

Cocaine abuse disorder occurs when a patient takes cocaine to experience a feeling of hyperalertness, euphoria, and energy. Cocaine is contained in coca leaves. The effects of cocaine can be felt by chewing coca leaf. Cocaine abusers use a purified form of cocaine called cocaine hydrochloride. Cocaine can be prescribed as an anesthetic for eye, ear, and throat surgeries. Cocaine is known

on the street as coke, snow, blow, flake, or C and is usually diluted with cornstarch, sugar, or talcum powder, or combined with amphetamine, procaine, or heroin. The combination of cocaine and heroin is called a speedball.

Two forms of cocaine are abused. These are water-soluble hydrochloride salt and water-insoluble cocaine base. Water-soluble hydrochloride salt cocaine is injected IV or snorted. Water-insoluble cocaine base, called freebase, is processed into a smokable substance called crack.

The effect of cocaine occurs immediately and can last up to an hour. During that period, the patient experiences decrease in food intake and sleep. The patient experiences an immediate down feeling once the effect of cocaine wears off.

NURSING ALERT

The most commonly used drug combination is cocaine and alcohol. The combination is converted into cocaethylene, which increases the duration of the effects of the drugs and increases the toxic level of the drugs and can result in death.

What Went Wrong?

Cocaine enters the bloodstream through the nasal mucous membrane when cocaine is sniffed. Cocaine that is smoked (crack) enters the lungs in vapor form and is absorbed by the lung tissue into the bloodstream. Cocaine travels through the bloodstream into the ventral tegmental area (VTA) of the brain where neurons are affected, leading to an increase in dopamine in the pleasure centers of the brain.

Prognosis

The patient develops a tolerance for cocaine with prolonged use that results in the patient increasing the amount of cocaine used to achieve the initial euphoric feelings, called chasing the high. The patient will become increasingly restless, irritable, and develop paranoid psychosis. In addition, the patient is at risk for cardiac disorders, stroke, seizures, and respiratory failure with long-term use of cocaine because cocaine overtaxes the cardiorespiratory system.

NURSING ALERT

Prolonged snorting of cocaine may result in damage to the nasal septum.

Hallmark Signs and Symptoms

Cocaine Use

- Dilated pupils
- Euphoria
- Increased sociability
- Vertigo
- Runny nose
- Energetic
- Increased alertness
- Nasal congestion
- Decrease in pain
- Abnormal ECG

Cocaine Withdrawal

- Restlessness
- Nausea and vomiting
- Agitation
- Craving for cocaine
- Pain
- Insomnia
- Fatigue

Common/Interpreting Test Results

- Urine Toxicology: Positive for cocaine
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of cocaine abuse disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:
    - Required increased amounts of cocaine to reach the desired effect or experienced a decrease in the desired effect when using the same amount of cocaine

- Experienced withdrawal symptoms or used cocaine to relieve or prevent withdrawal symptoms
- Ingested large amounts or over longer periods than intended
- Persistently tried to reduce the use of cocaine without success
- Spent significant time acquiring cocaine, using cocaine, or recovering from the effects of cocaine
- Reduced or eliminated social or occupational activities due to cocaine use
- Continually used cocaine despite physical or psychological problems caused by cocaine use

Treatment

Chronic

- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with amphetamine.
- Narcotics Anonymous (NA): Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug abusers. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous (NA) has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever the patient feels the urge to relapse.

Withdrawal

- Cocaine withdrawal is treated symptomatically.
- Monitor vital signs.
- Administer:
  - Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam) to reduce restlessness and insomnia
  - Thiamin and other B-complex vitamins to assist in glucose metabolism and nutritional deficiency
  - Benzodiazepines: Librium (chlordiazepoxide), Ativan (lorazepam), Xanax (alprazolam), Serax (oxazepam) to reduce the risk of seizures

- Barbiturates: Phenobarbital for sedation
- Antipsychotics: Haldol (haloperidol) to prevent psychosis and hyperactivity
- Beta blockers: Inderal (propranolol), Tenormin (atenolol) to treat hypertension
- Magnesium sulfate to reduce central nervous system irritability

Nursing Diagnoses

- Risk for altered nutrition lesser than body requirements related to decreased food intake while intoxicated
- Risk for self-injury related to aggressive behavior
- Ineffective individual coping related to the use of cocaine to cope with life's challenges

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Help the patient realize that cocaine can be physiologically and psychologically addicting.
  - Tell the patient that they will be in recovery for the rest of their life.
  - Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment options.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to use cocaine lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to use cocaine (e.g., call a sponsor and friends who are in recovery).
- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Monitor the patient's vital signs.
  - Place the patient in a quiet environment.

- Monitor the patient for safety. The patient may be confused and agitated.
- Monitor and treat symptoms of withdrawal.
- Monitor for long-term physiologic effects of cocaine on the cardiorespiratory system.

6. Hallucinogen Abuse Disorder

Hallucinogen abuse disorder occurs when the patient uses a hallucinogen to cause distortion of reality. A hallucinogen may produce a feeling of detachment from the patient's body or produce visual and spatial distortions. Patients may report being able to see sound and hear color. Most hallucinogens are ingested, although some can be administered by injecting intravenously or intramuscularly. There is no known medical use for most hallucinogens, although psilocybin is used for religious rites in Mexico and peyote is used by some Native Americans. Dextromethorphan is also used for cough suppression. Common hallucinogens are:

- Dextromethorphan (DXM): Dextromethorphan is an ingredient in over-the-counter cough medication and produces a detachment effect in high doses that can last upward of 6 hours. Street names for dextromethorphan include red devils, dex, vitamin D, orange crush, robo, and triple Cs.
- Methylenedioxy-methamphetamine (MDMA, Ecstasy): Ecstasy is a synthetic hallucinogen that also has the effects of a stimulant. Ecstasy takes effect almost immediately and lasts upward of 6 hours. Street names for Ecstasy include: club drug, Adam, bean, XTC, X, New Yorkers, love drug, and clarity.
- Lysergic Acid Diethylamide (LSD): LSD is a synthetic hallucinogen distributed in the form of microdots or gelatin squares. The effects of LSD are almost immediate and may last upward of 12 hours. Street names for LSD include acid, microdot, sunshine, pink robots, boomers, and superman.
- Ketamine: Ketamine causes the patient to feel detached from themself and is used at rave parties. Ketamine is called the date rape drug because it is odorless and tasteless and can be slipped into a drink without the knowledge of the person who ingests the drink. The effects of ketamine can last upward of 12 hours. Street names for ketamine include K, special K, bump, vitamin K, super acid, ket, and psychedelic heroin.
- Mescaline: Mescaline is a natural hallucinogen found in the peyote and San Pedro species of cactus and causes visual hallucinations and distorted

perception of space that can last upward of 12 hours. Street names for mescaline include cactus, mescal, peyote, buttons, mesc, and mezc.

- Phencyclidine (PCP): Phencyclidine is a synthetic hallucinogen that causes a feeling of detachment for up to 12 hours. Street names for phencyclidine include angel dust, Peter Pan, magic, black wack, crystal join, and zoom.
- Psilocybin: Psilocybin is a natural hallucinogen found in the *Psiloybe mexicana* mushroom. Psilocybin causes a feeling of detachment from the body. Street names for psilocybin include Mexican mushrooms, mushrooms, silly putty, magic mushroom, and shrooms.

What Went Wrong?

Hallucinogens are chemicals that disrupt serotonin neurotransmitter, resulting in the disruption of behavioral control, muscle control, sensory perception, regulatory control, and sexual behavior.

Prognosis

The long-term effects of hallucinogens are unpredictable. Some patients experience increased anxiety and paranoia. Others have flashbacks of effects of hallucinogens weeks and years after they stop taking hallucinogens. There is a risk of long-term psychoses.

Hallmark Signs and Symptoms

Dextromethorphan Use

- Paranoia
- Sensation of floating
- Distorted perception of time
- Audio and visual hallucinations

Ecstasy Use

- Euphoria
- Mental clarity
- Increased sexuality
- Increased alertness
- Confusion
- Dilated pupils

- Fever
- Sweating
- Distractibility
- Dehydration

Ketamine Use

- Feeling of detachment from body
- Hypertension
- Amnesia
- Depression
- Delirium
- Impaired learning ability

LSD and Mescaline Use

- Mystical experience
- Distorted perception
- Grandiose
- Hallucinations
- Sweating
- Increased salivation
- Fever
- Chills
- Tachycardia
- Arrhythmias
- Hypertension
- Muscle aches
- Loss of appetite

Phencyclidine Use

- Depersonalization
- Hallucinations
- Euphoria
- Aggressive behavior
- Numbness

- Unsteady gait
- Bloodshot eyes
- Bizarre violence

Psilocybin Use

- Visual hallucinations
- Euphoria
- Fever
- Hypertension
- Mood swings
- Seeing sound
- Hearing color
- Personality changes

Hallucinogen Withdrawal

- Diarrhea
- Hyperthermia
- Depression
- Flashbacks
- Hypertension
- Tachycardia
- Aggressive behavior
- Muscle spasms
- Psychosis
- Seizures

Common/Interpreting Test Results

- Urine Toxicology: Positive for specific hallucinogen
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of hallucinogen abuse disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:

- Required increased amounts of hallucinogen to reach the desired effect or experienced a decrease in the desired effect when using the same amount of hallucinogen
- Experienced withdrawal symptoms or used hallucinogen to relieve or prevent withdrawal symptoms
- Ingested large amounts or over longer periods than intended
- Persistently tried to reduce the use of hallucinogen without success
- Spent significant time acquiring hallucinogen, using the hallucinogen, or recovering from the effects of hallucinogen
- Reduced or eliminated social or occupational activities due to hallucinogen use
- Continually using hallucinogen despite physical or psychological problems caused by hallucinogen use

Treatment

Chronic

- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with hallucinogen.
- Narcotics Anonymous (NA): Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug abusers. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever the patient feels the urge to relapse.

Withdrawal

- Hallucinogen withdrawal is treated symptomatically.
- Monitor vital signs.
- Administer:
  - Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam) to reduce restlessness and insomnia
  - Benzodiazepines: Librium (chlordiazepoxide), Ativan (lorazepam), Xanax (alprazolam), Serax (oxazepam) to reduce the risk of seizures

- Barbiturates: Phenobarbital for sedation
- Antipsychotics: Haldol (haloperidol) to prevent psychosis and hyperactivity
- Beta blockers: Inderal (propranolol), Tenormin (atenolol) to treat hypertension
- Magnesium sulfate to reduce central nervous system irritability

Nursing Diagnoses

- Risk for self-injury related to aggressive behavior
- Risk for confusion related to the effects of hallucinogens
- Ineffective individual coping related to the use of hallucinogens to cope with life's challenges

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Help the patient realize that their addiction is the root cause of their problem. No one is to blame but themself.
  - Explain the physiology of addiction.
  - Tell the patient that they will be in recovery for the rest of their life.
  - Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment options.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to use hallucinogens lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to use hallucinogens (e.g., call a sponsor and friends who are in recovery).
- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Monitor the patient's vital signs. The patient may have tachycardia, hypertension, and increased temperature.

- Place the patient in a quiet environment.
- Place the patient on seizure precaution.
- Be alert for signs of seizures.
- Monitor the patient for safety. The patient may be confused and agitated.
- Monitor and treat symptoms of withdrawal.

7. Inhalant Abuse Disorder

Inhalant abuse disorder occurs when a patient inhales chemical vapors that create an altered mental state, creating a euphoric feeling commonly referred to as a buzz. The vapor is released into a bag in a process called bagging or huffing. The patient inhales vapors from the bag through the nose or mouth. Some patients soak a rag with the chemical and either place the rag into the bag or inhale vapors directly from the rag. The euphoric effect lasts briefly, causing the patient to increase the use of the inhalant to seek the high.

There are many types of inhalants used by patients who are diagnosed with inhalant abuse disorder. Inhalants are categorized as aerosol, gases, nitrites, and volatile solvents. Commonly used inhalants are:

- Aerosols: Paint, cooking sprays, hair sprays, and spray paint
- Gases: Nitrous oxide, butane lighters, chloroform, and propane
- Nitrites: Cyclohexyl nitrite, room deodorizers, butyl nitrite, and amyl nitrite
- Volatile solvents: Nail polish, glue, correction fluid, paint thinner, nail polish remover, and felt-tip markers

Commonly used street names for inhalants are head cleaner, bopper, poor man's pot, gluey, climax, rush, and hippie crack.

What Went Wrong?

Researchers believe that inhalants use the same mechanism as central nervous system depressants to produce a sedated and anesthetic effect. Inhalants activate the dopamine system, which produces the rewarding effect when the chemical in the inhalant interacts with neurotransmitters. Other researchers believe chemicals in the inhalant increase the potentiation of the GABA neurotransmitter to reduce inhibitions.

Prognosis

The patient is likely to continue to use inhalants in an effort to achieve the initial euphoric feeling. Continued use interferes with the patient's activities of daily living including the ability to hold a job and respond to family demands. Furthermore, decreased appetite may leave the patient malnourished, leading to medical disorders. The patient is exposed to sudden sniffing death where repeated inhalations build up in the patient's body displacing oxygen and resulting in asphyxiation. The patient may also experience suffocation if the patient places the vapor-filled plastic bag over their head. Since the inhalant has a sedative effect, the patient may experience a coma or choking. The patient is also at risk for seizures. Continued use can also have a neurotoxic effect, impeding the patient's vision, hearing, and cognitive ability.

NURSING ALERT

Inhalants produce signs and symptoms similar to alcohol intoxication.

Hallmark Signs and Symptoms

Under the Influence

- Stains on body or clothes
- Odor of inhalant on breath or clothes
- Disoriented
- Slurred speech
- Irritable
- Depressed
- Uncoordinated movements
- Inattentiveness
- Nausea
- Decreased appetite
- Lightheadedness
- Drowsiness
- Belligerence
- Impaired functioning
- Confusion

- Muscle weakness
- Euphoria
- Increase in heart rate
- Flush

Overdose

- Delirium
- Coma
- Seizures

Inhalant Withdrawal

- Insomnia
- Aggression
- Muscle pains
- Sweating
- Headaches
- Psychosis
- Hallucinations
- Irritability
- Tremors

Common/Interpreting Test Results

- Blood Test: The blood test reveals the level of the active ingredient in the inhalant, if the laboratory tested for specific active ingredients.
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of inhalant abuse disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:
    - Required increased amounts of inhalant to reach the desired effect or experienced a decrease in the desired effect when using the same amount of inhalant
    - Experienced withdrawal symptoms or used inhalant to relieve or prevent withdrawal symptoms

- Ingested large amounts or over longer periods than intended
- Persistently tried to reduce the use of inhalant without success
- Spent significant time acquiring the inhalant, using the inhalant, or recovering from the effects of inhalant
- Reduced or eliminated social or occupational activities due to inhalant use
- Continually used inhalant despite physical or psychological problems caused by inhalant use

Treatment

Chronic

- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with inhalants.
- Narcotics Anonymous (NA): Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug abusers. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever the patient feels the urge to relapse.

Withdrawal

- Administer:
  - Thiamin and other B-complex vitamins to assist in glucose metabolism and nutritional deficiency
  - Benzodiazepines: Librium (chlordiazepoxide), Ativan (lorazepam), Xanax (alprazolam), Serax (oxazepam) to reduce the risk of seizures
  - Barbiturates: Phenobarbital for sedation
  - Anticonvulsants: Neurontin (gabapentin), Tegretol (carbamazepine), Trileptal (oxcarbazepine) to prevent psychosis and hyperactivity
  - Antipsychotics: Haldol (haloperidol) to prevent psychosis and hyperactivity
  - Lasix (furosemide) for overhydration
  - Magnesium sulfate to reduce central nervous system irritability

Nursing Diagnoses

- Risk for altered nutrition lesser than body requirements related to decreased food intake while intoxicated
- Risk for impaired social interaction related to intoxication
- Risk for self-injury related to aggressive behavior

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be empathetic with the patient.
  - Acknowledge that the patient's addiction to inhalants resulted in a breakdown in their health, welfare, family, and support structure.
  - Help the patient realize that their addiction is the root cause of their problem. No one is to blame but themself.
  - Explain the physiology of addiction.
  - Tell the patient that they will be in recovery for the rest of their life.
  - Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment options.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to use the inhalant lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to use the inhalant (e.g., call a sponsor and friends who are in recovery).
- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Monitor the patient's vital signs.
  - Place the patient in a quiet environment.
  - Place the patient on seizure precaution.
  - Monitor the patient for safety. The patient may have an unsteady gait and be confused.
  - Monitor the patient's blood pressure. The patient may be hypotensive due to medication and not be able to walk without assistance.

- Place the patient on constant observation if they are violent. Some patients exhibit aggression when intoxicated and during withdrawal.

8. Nicotine Dependent Disorder

Nicotine dependent disorder occurs when the patient requires nicotine to perform activities of daily living. Nicotine is found in tobacco. The patient inhales nicotine when smoking a cigarette, pipe, or cigar. Nicotine can also enter the body by sniffing snuff and chewing tobacco. Each cigarette contains a minimum of 10 mg of nicotine and delivers 2 mg of nicotine to the bloodstream.

Nicotine is a sedative and stimulant. Long draws of a cigarette produce a sedative effect while short draws produce a stimulating effect. The effect is realized within 15 seconds and last upward of 50 minutes for many smokers; afterward, the patient experiences withdrawal effects.

A patient diagnosed with nicotine dependent disorder has both a psychological and physical dependence on nicotine. Psychological dependency occurs when the patient associates activities with smoking such as getting up from bed, eating, and drinking alcohol. These situations trigger the desire to smoke. Physical dependency occurs when decreased levels of nicotine in the bloodstream cause withdrawal symptoms requiring the patient to increase the nicotine level in the bloodstream to feel normal (i.e., make the withdrawal symptoms go away).

What Went Wrong?

Nicotine is absorbed in the lungs and in the mucosal tissues of the mouth and travels through the bloodstream to the brain where nicotine increases dopamine levels, stimulating the reward centers of the brain and resulting in the feeling of pleasure. Nicotine also causes increased production of endorphins and the adrenocorticotropic hormone that causes the adrenal glands to release epinephrine into the bloodstream. Arginine vasopressin levels also increase in the bloodstream. The patient experiences hypertension, increased glucose levels, fast pulse, and an increase in the rate of respiration commonly called an epinephrine rush.

Prognosis

Nicotine and smoking are associated with cancer of the lung, mouth, pancreas, esophagus, bladder, stomach, kidney, ureter, and cervix. There is also an increase in cardiovascular disease among patients diagnosed with nicotine dependent disorder.

Hallmark Signs and Symptoms

Under the Influence

- Normal behavior

Withdrawal

- Irritability
- Increased appetite
- Restlessness
- Unable to concentrate
- Craving
- Seeks sweets
- Anxiety
- Coughing

Common/Interpreting Test Results

- Urine Toxicology Test: Nicotine is detected in the patient's urine.
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of nicotine dependency disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:
    - Required increased amounts of nicotine to reach the desired effect or experienced a decrease in the desired effect when using the same amount of nicotine
    - Experienced withdrawal symptoms or uses nicotine to relieve or prevent withdrawal symptoms
    - Ingested large amounts or over longer periods than intended
    - Persistently tried to reduce the use of nicotine without success
    - Spent significant time acquiring nicotine, using nicotine, or recovering from the effects of nicotine
    - Reduced or eliminated social or occupational activities due to nicotine use
    - Continually used nicotine despite physical or psychological problems caused by nicotine use

Treatment

Chronic

- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with nicotine.
- Smoking Cessation Therapy: Smoking cessation therapy is a combination of individual and group therapy that helps the patient develop alternatives to smoking when experiencing psychological and physiologic withdrawal symptoms.
- Administer:
  - Nicotine antagonist: Inversine (mecamylamine), Vivitrol (naltrexone), Revia (naltrexone) to block nicotine receptors
  - Silver acetate gum results in foul taste when the patient smokes.
  - Antidepressant: Zyban (bupropion)
  - Chantix (varenicline)

Withdrawal

- Administer:
  - Nicotine transdermal patch, gradually lowering the dose of nicotine
  - Nicotine gum
  - Benzodiazepines: Ativan (lorazepam), Xanax (alprazolam) to reduce irritability

Nursing Diagnoses

- Risk for impaired gas exchange related to smoking
- Risk for chronic low self-esteem related to social aversion to secondhand smoke
- Impaired comfort related to nicotine withdrawal

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be emphatic with the patient.

- Explain the physiology of addiction.
- Tell the patient that they will be in recovery for the rest of their life.
- Discuss treatment options.
- Acknowledge that the patient has tried and failed at treatment options.
- Tell the patient the goal is to extend the length of time between relapses.
- Ask the patient how long their urge to smoke lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to smoke (e.g., call a sponsor and friends who are in recovery).

- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Monitor the patient's vital signs.
  - Place the patient in a quiet environment.
  - The patient may become severely agitated and exhibit aggression during withdrawal.

9. Opioid Dependent Disorder

Opioid dependent disorder occurs when a patient becomes psychologically and physiologically dependent on opioids. Opioids are narcotic analgesics that bind to the opioid receptors in the central nervous system, peripheral nervous system, and gastrointestinal tract that result in the decreased perception of pain. Some opioids such as codeine are also used to suppress coughing and stop diarrhea.

Opioids can be taken orally, transdermally, or as intramuscular or intravenous injections. Patients diagnosed with opioid dependent disorder may also snort opioids. The initial sense of euphoria, called a rush, occurs immediately when the opioid reaches the bloodstream. The fastest route is with intravenous injection. The effect may last up to 6 hours depending on the dose.

Commonly prescribed opioids are: morphine, Demerol (meperidine), Dilaudid (hydromorphone), Alfenta (alfentanil), fentanyl, Ultiva (remifentanil), Sufenta (sufentanil), Suboxone (buprenorphine and naloxone), codeine, Vicodin (hydrocodone), Lorcet (hydrocodone bitartrate acetaminophen), Dolophine (methadone), OxyContin (oxycodone and acetaminophen), Oxycodan (oxycodone and aspirin), Vicoprofen (hydrocodone bitartrate ibuprofen), Subutex (buprenorphine), and Roxicodone (oxycodone hydrochloride).

All prescribed opioids are available illegally on the streets. In addition, heroin (diamorphine), called smack, scat, horse, and H on the street, is sold as a relatively inexpensive opioid. However, the quality of heroin is questionable.

Drug Alert

Narcan (naloxone) is an opioid antagonist and is used to immediately reverse the effect of opioids; thus, it is used in emergencies when the patient is overly medicated with opioids. Suboxone (buprenorphine and naloxone) is an opioid that is administered for opioid withdrawal. Suboxone contains naloxone and therefore should not be administered until the patient shows the first signs of opioid withdrawal. Suboxone will place the patient in immediate withdrawal if given before they show signs of withdrawal.

NURSING ALERT

The terms opiate and opioid are used to describe opioid dependency. An opiate is a natural narcotic analgesic that comes from opium poppy. An opioid is not natural and is a synthetic narcotic analgesic. Often, opiate and opioid are used synonymously.

NURSING ALERT

There may be confusion between Subutex and Suboxone. Both are opioids used to treat opioid dependency. Subutex and Suboxone both contain buprenorphine hydrochloride. However, Suboxone also contains naloxone, which is an opioid antagonist used to prevent the misuse of Suboxone.

What Went Wrong?

Endorphins are neurotransmitters that inhibit neurons from transmitting impulses. Levels of endorphins increase at times when the patient may experience pain such as during child birth and exercise. Morphine is the active ingredient of opioids and has a structure similar to that of endorphins. Both endorphins and morphine adhere to endorphin receptors in the body, producing a euphoric feeling with an analgesic effect commonly known as a high. Opioids, like endorphins, make a person feel good. The body regulates the amount of endorphins produced by lowering the amounts during less painful situations such as watching television. The desire to feel good encourages the patient to self-medicate with opioids even during less painful situations,

resulting in dependency. As morphine is metabolized and excreted from the body, the patient experiences an uncomfortable feeling of opioid withdrawal that is relieved by self-medicating with opioids.

Prognosis

Use of opioids several times a day for weeks or more may lead to physical dependency and produce withdrawal symptoms if the same level of opioids is not maintained in the bloodstream. Some patients use heroin as a recreational drug. Other patients follow a common progression to the use of heroin. The progression begins with an injury that leads to chronic pain. The patient is prescribed opioids and gradually abuses opioids by taking increased doses without the practitioner's approval. The practitioner may prescribe a 30-day supply and ask the patient not to return prior to 30 days. The patient may exhaust the 30-day supply in a few days and then seek other practitioners who will prescribe opioids unbeknown to the original practitioner. This process is referred to as doctor shopping. The patient may exhaust available prescribers and then turn to street dealers to procure opioids. Prescription opioids are costly. The patient then resorts to snorting and then injecting heroin, which is less costly and produces a similar effect; however, the quality of heroin is unknown. The patient is at risk for overdosing. If the patient shares IV needles, then the patient is at risk for hepatitis, HIV, and infection.

Hallmark Signs and Symptoms

Under the Influence

- Pinpoint pupils
- Uncontrollable eye movement
- Euphoria
- Clammy skin
- Constipation
- Impaired judgment
- Drowsiness
- Sweating
- Slow breathing
- Slurred speech
- Decreased appetite

Withdrawal

- Muscle aches
- Sweating
- Agitation
- Dilated pupils
- Insomnia
- Chills
- Anxiety
- Anorexia
- Nausea
- Goose bumps
- Vomiting
- Runny nose
- Abdominal cramping
- Diarrhea
- Body pain

Overdose

- Decreased level of consciousness
- Slow breathing
- Bluish coloring on lips and nail beds
- Muscle spasms
- Seizures
- Unable to be aroused

Common/Interpreting Test Results

- Urine Toxicology: Positive for opioids
- Blood Test: Positive for opioids
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of opioid dependency disorder requires the following:
  - A patient must exhibit a maladaptive pattern that has caused significant impairment indicated by at least three of the following over the previous 1 month:

- Required increased amounts of opioid to reach the desired effect or experienced a decrease in the desired effect when using the same amount of opioid
- Experienced withdrawal symptoms or used opioid to relieve or prevent withdrawal symptoms
- Ingested large amounts or over longer periods than intended
- Persistently tried to reduce the use of opioid without success
- Spent significant time acquiring opioid, using opioid, or recovering from the effects of opioid
- Reduced or eliminated social or occupational activities due to opioid use
- Continually used opioids despite physical or psychological problems caused by opioid use

NURSING ALERT

Opioid withdrawal is very uncomfortable as the body adjusts to the absence of opioids; however, the patient is not in any life-threatening danger. Opioid withdrawal symptoms resolve within 10 days.

Treatment

Chronic

- Group Therapy: The goal of group therapy is to focus on underlying psychiatric problems that may be present.
- Cognitive Behavioral Therapy: The goal is for the patient to change behavior and develop alternative coping mechanisms other than self-medicating with opioids.
- Narcotics Anonymous (NA): Narcotics Anonymous is a 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug users. In addition to the 12-step program, a member of Narcotics Anonymous volunteers to sponsor the patient. The sponsor provides one-on-one support and advice 24/7. Narcotics Anonymous has a meeting 24/7 in practically every area of the country. An 800 number is available to the patient and is to be called whenever the patient feels the urge to relapse.
- Administer:
  - For cravings:
    - Vivitrol (naltrexone), Revia (naltrexone IM)
    - Suboxone (buprenorphine and naloxone) for maintenance

Withdrawal

- Administer:
  - Suboxone (buprenorphine and naloxone)
  - Benzodiazepines: Ativan (lorazepam), Xanax (alprazolam) for agitation
  - Catapres (clonidine) for hypertension
  - Baclofen for muscle relaxation

Overdose

- Administer: Narcan (naloxone)

Nursing Diagnoses

- Risk for ineffective relationships related to addictive behavior
- Ineffective coping skills related to self-medicating with opioids
- Risk for injury related to use of opioids

Nursing Interventions

- If patient is not withdrawing:
  - Develop a therapeutic rapport with the patient.
  - Be emphatic with the patient.
  - Acknowledge that the patient's addiction to opioid resulted in a breakdown in the patient's health, welfare, family, and support structure.
  - Help the patient rationalize that the patient's addiction is the root cause of the patient's problem. No one is to blame but themself.
  - Explain the physiology of addiction.
  - Tell the patient that they will be in recovery for the rest of their life.
  - Discuss options of Narcotics Anonymous (NA), inpatient rehabs, outpatient rehabs, partial hospital programs, and other treatment options.
  - Acknowledge that the patient has tried and failed at treatment options.
  - Tell the patient the goal is to extend the length of time between relapses.
  - Ask the patient how long their urge to use opioids lasts (e.g., 20 minutes, 60 minutes, 2 hours). Devise a plan that the patient can enact when the patient has the urge to use opioids (e.g., call a sponsor and friends who are in recovery).

- If patient is withdrawing:
  - Focus on the physiologic aspect of withdrawal.
  - Develop a therapeutic rapport.
  - Assess how much opioids the patient has taken.
  - Monitor the patient's vital signs.
  - Monitor the patient's signs of opioid withdrawal.
  - Place the patient in a quiet environment.
  - Place the patient on constant observation if the patient is violent. Some patients exhibit aggression during withdrawal.

CASE STUDY

CASE 1

A 43-year-old woman arrives on your unit. Her diagnosis is alcohol dependence disorder. She has been dependent on alcohol since she was 18 years old. During admission, she tells you she has been on a bender for the past 2 weeks. When she woke up, she drank four cans of beer and called it her breakfast. She tells you that she never feels normal unless she has her Wheaties every morning. She smiles and winks. Before noon, she finishes a six pack of beer. She then tells you that she and Johnnie Walker keep each other company for the rest of the day. You ask what time she goes to sleep, but she shrugs her shoulders saying she drinks until she blacks out. The patient reports being diagnosed with cirrhosis of the liver and esophageal varices last year. Her last drink was a few hours before she was admitted to the hospital. Her gait is steady. She speaks clearly and is alert X3, cooperative, and able to follow directions. Her BAL is 0.04.

QUESTION 1. Why should the practitioner be concerned about the patient's diagnosis of cirrhosis of the liver?
ANSWER: Cirrhosis of the liver reduces the liver's ability to function. The practitioner must prescribe medication that is not metabolized by the liver because the liver is not able to metabolize the medication, resulting in a buildup of the medication in the patient's body.

QUESTION 2. Why doesn't the patient show signs of intoxication?
ANSWER: The patient has a high tolerance for alcohol. The patient requires a higher level of alcohol before signs of intoxication are exhibited.

QUESTION 3. When would you place the patient under close observation?
ANSWER: The patient should be observed closely for 24 to 72 hours after the patient's last drink. It is during this period when the patient can experience delirium tremens, resulting in tachycardia, severe agitations, restlessness, disorientation, and increased temperature.

QUESTION 4. Why would a practitioner order thiamin and other B-complex vitamins and nutritional supplements for the patient?
ANSWER: The patient is likely malnourished. During the admissions interview, the patient described her activities of daily living, which excluded meals. Alcoholics normally eat poorly. Furthermore, alcohol inhibits breakdown of nutrients and impairs absorption in the stomach and intestines by damaging cells.

FINAL CHECK-UP

1. **A patient who completed detoxing from heroin tells you that her family members who are not substance abusers don't understand how it feels to go through withdrawal. She asks you for advice. Which of the following is the best response?**
   A. Tell your family members to attend Alcoholics Anonymous.
   B. Ask your family members if they ever had the flu. Tell them that withdrawal is like having the worst flu they ever had.
   C. Tell your family members that going through withdrawal is like going on a diet.
   D. Tell your family members to try heroin once.

2. **A patient in heroin withdrawal comes to the nurse's station demanding a narcotic saying he is going to die from the withdrawal. The patient received detox medication 30 minutes ago. What is the best response?**
   A. Call a rapid response before the patient has a seizure.
   B. Tell the patient he is not going to die from opioid withdrawal and that you will see if there are any PRN medications available.
   C. Tell the patient to speak with the practitioner in the morning.
   D. Tell the patient that you will call the practitioner now to see if the practitioner will order a narcotic.

3. **A patient who has completed detox is ready to start recovery. He asks for advice. Which of the following is the best advice to give the patient?**
   A. Focus on one day at a time. Identify your triggers and learn ways to avoid them.
   B. The goal of recovery is to lengthen periods between relapses.
   C. You'll be in recovery all your life.
   D. Ask the practitioner to recommend a rehab program.

4. A patient is brought into the ER. The patient's BAL is 0.48, and the patient is unconscious. What is the first thing you do?

A. Place the patient in a quiet area and wait until the patient begins to sober up before continuing your assessment.
B. Call the ER practitioner immediately.
C. Administer Narcan to the patient.
D. Send the patient to ICU immediately.

5. A patient is admitted to the ER and presents as very talkative and highly alert. The patient has dilated pupils and a relatively high temperature and is sweating. He tells you he never needs to sleep anymore. What do you suspect is causing the patient's condition?

A. The patient is under the influence of heroin.
B. The patient is under the influence of amphetamines.
C. The patient is under the influence of Oxycodone.
D. The patient is under the influence of Oxycodan.

6. A new medical resident assessed a patient who is starting withdrawal from benzodiazepine. The resident writes orders for Ativan. What is your best response?

A. Ask the attending physician to review the orders.
B. Administer the medication as prescribed.
C. Ask the resident to clarify the orders.
D. Point out to the resident that the patient is dependent on benzodiazepine.

7. A student nurse arrives on the unit and asks you what the rationale for treatment of withdrawal is. What is the best response?

A. To protect the patient while the body removes the drug from the patient's bloodstream
B. To protect the patient from relapsing during withdrawal
C. To treat the patient's psychological dependency on the substance
D. To treat the symptoms of withdrawal while the body removes the substance from the patient's bloodstream

8. During a family meeting, the patient's father calls his son a bum because of his drug use and law-breaking behavior. What is your best response?

A. Anyone can become physiologically and psychologically dependent on drugs, which can result in drug-seeking behaviors that can lead to health, financial, family, and legal problems.
B. Your son realizes his problem and is trying to change.
C. Have you thought about going to family therapy?
D. Have you heard about Nar-Anon or Al-Anon?

9. **A 43-year-old man came to the ER reporting that for short periods of time he feels detached from his body and sometimes feels like he is floating. The patient states he has not taken any drugs, and his drug toxicology test results are negative. What is your best response?**
   A. Does this condition interfere with activities of daily living?
   B. Did you ever take hallucinogens at any time in your life?
   C. Let me ask our psychiatrist to assess you.
   D. Do you have any other symptoms?

10. **Your neighbor tells you about her preteen son. It seems that he has an ongoing head cold. His sinuses are congested, and he is not eating regularly and is losing weight. Your neighbor reports that his head cold is so bad that he has to wear sunglasses even in the house. She asks him to remove the glasses, but he becomes agitated. You notice her son is around the neighborhood during school hours when the rest of the family is working. What is your best response?**
    A. You better take your son to your doctor immediately. He might have more than a head cold.
    B. Have you noticed any money missing in your house?
    C. Is your son going to school?
    D. Your son's condition and behavior don't seem normal. Why don't you ask your practitioner to assess your son?

CORRECT ANSWERS AND RATIONALES

1. B. Ask your family members if they ever had the flu. Tell them that withdrawal is like having the worst flu they ever had. Rationale: Alcoholics Anonymous is a self-help group for people who are dependent on alcohol. Dieting is similar to addiction and not withdrawal. No one should ever try an addictive substance.
2. B. Tell the patient he is not going to die from opioid withdrawal and that you will see if there are any PRN medications available. Rationale: The patient is unlikely to have a seizure related to opioid withdrawal. The other two responses are not appropriate because they don't address the patient's immediate needs. The practitioner may have already ordered PRN medication that the nurse can administer to the patient.
3. A. Focus on one day at a time. Identify your triggers and learn ways to avoid them. Rationale: The other recommendations are true, but this doesn't help the patient begin recovery now.
4. B. Call the ER practitioner immediately. Rationale: The patient may have alcohol poisoning and requires immediate interventions. Narcan is administered to reverse opioids. The patient will likely be transferred to the ICU; however, only a practitioner can order the transfer.

5. B. The patient is under the influence of amphetamines.
6. B. Administer the medication as prescribed. Rationale: The resident is tapering benzodiazepine, which is appropriate because stopping benzodiazepine abruptly may cause the patient to have a seizure.
7. D. To treat the symptoms of withdrawal while the body removes the substance from the patient's bloodstream.
8. D. Have you heard about Nar-Anon or Al-Anon? Rationale: These are self-help organizations designed to help the family of substance abusers. This is the more therapeutic response.
9. B. Did you ever take hallucinogens at any time in your life? Rationale: The patient reports symptoms consistent with hallucinogen intoxication. A patient can experience flashbacks of symptoms of hallucinogens for years after the patient has stopped taking the drug.
10. D. Your son's condition and behavior don't seem normal. Why don't you ask your practitioner to assess your son? Rationale: The best response is to tell her to have her son assessed by a practitioner who is the proper professional to assess if her son is experimenting with drugs or has an underlying medical condition.

This page intentionally left blank

chapter 9

Eating Disorders

LEARNING OBJECTIVES

1. Anorexia nervosa disorder
2. Bulimia nervosa disorder

KEY TERMS

Binge
Electrolyte imbalance
Force vomiting
Nonpurging bulimia
Obsessive-compulsive personality
Purging
Purging bulimia
Safe foods
Self-image
Self-imposed starvation
Self-induced vomiting

An eating disorder is a psychiatric disorder that can lead to medical complications, which can result in death. The underlying cause of an eating disorder is the misperception by the patient of their body image; that is, the patient perceives themself to be too fat based on their understanding of normal weight for their age and height.

Food becomes an obsession with the patient. Some patients diagnosed with an eating disorder also have a co-psychiatric diagnosis, which may include depression, anxiety, or obsessive-compulsive disorder. The patient strives to look perfect based on peer pressure or society's definition of the perfect body and ignores the reality of body image.

Although eating disorders affect both men and women, there is a higher prevalence of eating disorders in adolescent girls who fall prey to peer pressure. Young boys and girls also develop eating disorders when trying to improve performance in sports. For example, high school and college wrestlers and gymnasts try to decrease weight to excel in sports. Adult women can also develop eating disorders when they focus on regaining a youthful appearance.

1. Anorexia Nervosa Disorder

Anorexia nervosa disorder occurs when the patient has the delusion that they are overweight even if they are within a normal weight range for their age and height. Anorexia nervosa is a psychiatric disorder because the patient has a negative misperception about their **self-image** and copes with the negative misperception using excessive exercise and **self-imposed starvation**. The patient is likely to skip meals or eat foods low in calories, commonly called **safe foods**. The patient may cook meals for others but makes excuses when they have to eat their meals. When pushed, the patient may cut their food into tiny pieces and stall while others finish eating. The patient may chew food but only actually swallow a small amount.

What Went Wrong?

The cause of anorexia nervosa disorder is unknown. Some researchers believe traits of **obsessive-compulsive personality** may contribute to the disorder as the patient strives to have what the patient believes is the perfect body. Other researchers believe peer pressure and the perception created by advertisers and the entertainment industry that thin is beautiful also are contributing factors for developing anorexia.

Prognosis

The patient may experience life-threatening malnutrition and may be at risk for suicide. Patients diagnosed with anorexia nervosa disorder are at high risk for cardiac arrest and complication from **electrolyte imbalance**. The patient may be hospitalized and fed using a tube inserted into the patient's stomach. Some researchers believe that half of the patients diagnosed with anorexia nervosa disorder will recover if treated early in the disorder.

Hallmark Signs and Symptoms

- Refuses to eat
- Social withdrawal
- Increased use of laxatives
- Focus on food
- Denies being hungry
- Fatigue
- Thin appearance
- Dramatic weight loss
- Soft hair covering the body
- Dehydration
- Hypotension
- Brittle hair
- Dizziness
- Dry skin
- Fainting
- Leg swelling
- Arrhythmia

- No menstruation
- Constipation
- Unable to tolerate cold
- Depressed
- Irritable

Common/Interpreting Test Results

- There is no definitive test to diagnose anorexia nervosa disorder.
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of anorexia nervosa disorder requires the following:
  - The patient has an intense fear of weight gain even though the patient is underweight.
  - The patient refuses to maintain their normal weight.
  - The patient missed at least three consecutive menstrual cycles.
  - The patient weighs less than 85% of expected normal weight.
  - The patient has a distorted perception of their weight and image.
  - The patient denies the serious nature of being underweight.

Treatment

- Cognitive Behavioral Therapy (CBT): The focus is to encourage the patient to change the abnormal behavior.
- Group Therapy: The goal is to share experiences with others who have been diagnosed with anorexia nervosa disorder and collectively support each other during treatment.
- Inpatient Treatment: Patients who are in denial are likely to become noncompliant with outpatient treatment and require inpatient programs where the patient can be medically monitored to ensure that the patient is receiving proper nutrition. During the stay, the patient will undergo one-on-one therapy, CBT, and group therapy.

Nursing Diagnoses

- Body image disturbance related to self-starvation
- Nutrition: Altered, less than body requirements related to self-starvation
- Risk for altered body temperature related to risk for hypothermia

Nursing Interventions

- Monitor vital signs.
- Monitor intake and output.
- Monitor the patient for suicidal ideation.
- Work with the patient to collectively decide on a target weight.
- The dietician should prescribe a diet that will cause the patient to gain 1 pound per week.
- Weigh the patient daily before breakfast, using the same scale, with the patient wearing a hospital gown and facing away from the reading of the scale.
- Do not tell the patient their weight.
- Permit the patient to control the types and amount of food.
- Provide small meals frequently throughout the day.
- Explore with the patient why they have a misperception about their body image. Encourage the patient to talk about their feelings.
- Reward positive behaviors that lead to achieving the patient's goals.
- Do not reinforce negative behaviors.

2. Bulimia Nervosa Disorder

Bulimia nervosa disorder occurs when the patient eats large amounts of food, which is called a **binge**, and then purges. **Purging** is done by **force vomiting** or exercising heavily. The goal for the patient is to decrease the calorie intake. The patient has poor self-image manifested by the fear of becoming overweight. The patient's weight was likely normal before they became bulimic.

There are two categories of bulimia nervosa disorder; these are:

- **Purging Bulimia**: The patient binges on food and then uses enemas, laxatives, diuretics, or self-induced vomiting to purge food or partially digested food from the body.
- **Nonpurging Bulimia**: The patient binges on food, and then goes on a strict diet, exercises heavily, or fasts to prevent weight gain.

What Went Wrong?

The cause of bulimia nervosa disorder is unknown. Some researchers believe first-degree relatives are at risk for bulimia nervosa if a parent or

sibling is diagnosed with bulimia nervosa. Other researchers believe traits of obsessive-compulsive personality may contribute to the disorder as the patient strives to have what the patient believes is the perfect image. Still other researchers believe peer pressure and the perception created by advertisers and the entertainment industry that thin is beautiful are contributing factors for developing bulimia. In addition, the desire to perform well in sports can lead to bulimia nervosa.

Prognosis

In the long term, the patient is at risk for drug and alcohol abuse, depression, and suicide. The patient may experience kidney failure related to dehydration and irregular heart beat from imbalance in electrolytes. Self-induced vomiting leads to gum disease and tooth decay. The patient may become dependent on laxatives, leading to digestive disorders. Female patients may have no menstruation.

Hallmark Signs and Symptoms

- Fear of weight gain
- Inappropriate use of enemas, diuretics, and laxatives following eating
- Excessive exercise
- Self-induced vomiting
- The perception that the patient is unable to control eating habits
- Excessively focused on body image and weight
- Eating to the point when the patient feels uncomfortable (binge eating)
- Goes to the bathroom immediately after eating
- Does not eat in public
- Damaged teeth and gums from **self-induced vomiting**
- Scars and sores on hands from self-induced vomiting

Common/Interpreting Test Results

- There is no definitive test to diagnose bulimia nervosa disorder.
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of bulimia nervosa disorder requires the following:

- The patient must have recurrent episodes of binge eating defined as:
  - Lack of control over eating
  - Eating more food than would normally be eaten within a 2-hour period
- Binge eating at least twice a week for 3 months
- The patient is extremely focused on body image and weight.
- The patient is extremely focused on body weight and weight before, during, and after episodes of bulimia nervosa.
- The patient performs inappropriate behavior to prevent weight gain including self-vomiting, excessive exercising, fasting, or using enemas, laxatives, or diuretics.
- The patient missed at least three consecutive menstrual cycles.
- The patient weighs less than 85% of expected normal weight.
- The patient has a distorted perception of their weight and image.
- The patient denies the serious nature of being underweight.

Treatment

- Cognitive Behavioral Therapy: The focus is to encourage the patient to change the abnormal behavior.
- Dialectical Behavior Therapy (DBT): The focus is for the patient to learn behavioral skills to cope with stress and emotions.
- Group Therapy: The goal is to share experiences with others who have been diagnosed with bulimia nervosa disorder and collectively support each other during treatment.
- Inpatient Treatment: Patients who are in denial are likely to become non-compliant with outpatient treatment and require inpatient programs where the patient can be medically monitored to ensure that the patient is receiving proper nutrition. During the stay, the patient will undergo one-on-one therapy, CBT, and group therapy.

Nursing Diagnoses

- Body image disturbance related to self-starvation
- Nutrition: Altered, less than body requirements related to self-starvation
- Risk for self-injury related to self-induced vomiting

Nursing Interventions

- Meals should be constantly supervised.
- Keep the patient in constant observation for 1 hour following meals.
- Limit the amount of time the patient spends eating meals.
- Reward positive behaviors that lead to achieving the patient's goals.
- Do not reinforce negative behaviors.
- Contract with the patient on the kinds of food that must be eaten during meals.
- Develop a therapeutic rapport with the patient.
- Explore with the patient why the patient has a misperception about the patient's body image. Encourage the patient to talk about their feelings.
- The dietician should set a weight goal and prescribe a diet that will cause the patient to gain 1 pound per week until the goal is achieved.
- Monitor vital signs.
- Monitor the patient's hands for signs of injury related to self-induced vomiting.
- Monitor the patient for suicidal ideation.
- Weigh the patient daily before breakfast, using the same scale, with the patient wearing a hospital gown and facing away from the reading of the scale.
- Do not tell the patient their weight.

CASE STUDY

CASE 1

A 28-year-old female patient is admitted to your psychiatric unit for depressive disorder. She is 68 inches tall and weighs 90 pounds in a hospital gown. The patient casually glances at her weight displayed on the scale. The patient is cooperative and reports that she does not have any suicidal ideations. There is nothing remarkable about the admission. The patient is shown her room and introduced to the staff. The patient's mother calls the unit social worker the next day to provide additional information about the patient. The patient had been diagnosed and

treated for anorexia nervosa disorder since she was 15 years old. The social worker passes along this information to the patient's healthcare team. The attending practitioner writes orders to monitor her nutrition intake and weight. The patient is indifferent to the orders but voluntarily complies. Throughout the next week, the staff notices that the patient is minimally eating her meals. The staff also notices that she gives away food to other patients when the staff is not looking. After a week, she is noticed giving away most of her food. She then begins to eat minimally the following week. After 30 days, the patient is discharged at a weight of 95 pounds.

QUESTION 1. What is the objective measurement used to determine if the patient is of appropriate weight? Is this patient within normal body weight?
ANSWER: The body mass index (BMI) is used to determine if the patient's body weight is within normal limits. The Centers for Disease Control and Prevention has an online BMI calculator that can be used to calculate a person's BMI (http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html). This patient's BMI is 13.7, which is underweight. The normal weight range for this patient is between 122 and 164 pounds.

QUESTION 2. What kind of orders would you anticipate the attending practitioner to write to monitor the patient's intake and weight?
ANSWER: The patient will be weighed the same time each day in a hospital gown with her back facing the readout of the scale. The staff will monitor the amount of each meal that the patient eats. The patient will not be permitted to go to the bathroom or her room for 1 hour after each meal. The dietician will be asked to assess the patient and recommend a diet and any dietary supplements.

QUESTION 3. How would you prevent the patient from giving her food away to other patients during meal time?
ANSWER: Staff could provide her meals in the dining room a half hour before other patients. During the half hour, the staff can prepare meals for the other patients while monitoring and interacting with the patient.

QUESTION 4. Why do you think the patient eats minimally one week and then fasts the next week?
ANSWER: The patient has been treated inpatient several times for anorexia nervosa disorder and realizes that if her weight falls below a certain weight, the practitioner will order that a nasogastric (NG) tube be inserted through her nostril through which she will be fed. The patient eats to be slightly above the weight threshold for the NG tube. Although the patient does not know her weight, she has mastered maintaining a low weight by managing her intake.

FINAL CHECK-UP

1. **A 23-year-old female patient was admitted to your unit for depression. She reports that this is her first admission to any hospital. The patient presents with a positive affect and is cooperative during the admission interview. You notice sores on her left hand. She tries to hide her hands. You comment, "I noticed that you injured your hand." She replies that she fell. Otherwise, there is nothing remarkable in her appearance. What do you do next?**
   A. Ask the practitioner if he wants to order a drug toxicology screening test.
   B. Help the patient settle down on the unit.
   C. Point out your findings to the practitioner and ask the practitioner to assess for bulimia nervosa disorder.
   D. Ask the patient if she abuse drugs.

2. **You are treating a patient diagnosed with anorexia nervosa disorder for depression. You ask a new nurse to weigh the patient. You tell the new nurse that the patient must have her back to the face of the scale and that she should not be told her weight. The new nurse asks why. What is the best response?**
   A. This is to comply with practitioner's orders.
   B. The patient wants to know her weight to adjust her food intake to achieve whatever the patient feels is a normal weight.
   C. The practitioner wants to distract the patient from focusing on her weight.
   D. The patient's weight is proprietary medical information that is not accessible by the patient.

3. **During a quiet time on the unit, you tell a patient diagnosed with anorexia nervosa disorder that she is at risk for cardiac arrhythmia and cardiac arrest. She asks how that could happen. Which of the following is the best response?**
   A. Anorexia nervosa disorder results in an electrolyte imbalance that disturbs the nerve impulses and contractions of the heart, leading to an irregular heart rate.
   B. Medication used to treat anorexia nervosa disorder can cause an electrolyte imbalance, leading to heart problems.
   C. Anorexia nervosa disorder leads to increased anxiety that places stress on the heart.
   D. Continuous vomiting disturbs cardiac activity.

4. **An 18-year-old female patient diagnosed with anorexia nervosa disorder is looking through a magazine and stopping to look at pictures of young models. You have developed a therapeutic rapport with the patient. What is your best intervention?**
   A. Tell the patient that no one looks like those pictures. Those pictures are airbrushed.
   B. Ask the patient, "Do you want to be a model?"

C. Ask the patient, "Do any of your friends really look like those models?"
D. Ask the patient what she is thinking.

5. A 22-year-old man on your unit is seen swiftly walking the halls stopping every so often to do pushups against the wall. He then goes into a corner of the day room and shadow boxes. You notice that he is very careful about what he eats during meals. What is the best response?

A. Ask the nurse to medicate the patient for increased agitation.
B. Alert the staff for potential violence from the patient.
C. Say to the patient, "You seem to be focused on something. Would you like to talk about it?"
D. Say to the patient, "I realize you are exercising, but other patients are concerned that you are looking for a fight."

6. A parent of a 15-year-old girl tells you that she thinks her daughter may have cancer because suddenly she is losing weight. The parent tells you that her pediatrician refuses to order tests to determine if she has cancer. What is the best question to ask the parent?

A. Does cancer run in your family?
B. Does your daughter confide in you?
C. Is there anything different happening at school?
D. Does your daughter have any sores on her hands?

7. A parent of a 24-year-old female patient diagnosed with anorexia nervosa disorder tells you that her daughter has been on group therapy for several months and sees a psychiatric practitioner for one-on-one counseling. She asks you why the psychiatric practitioner suggests cognitive behavioral therapy for her daughter. What is the best response?

A. That question is better answered by the practitioner.
B. Cognitive behavioral therapy is a form of group therapy where your daughter is in a group of other patients diagnosed with anorexia nervosa disorder and collectively they help each other cope with their problem.
C. Here is a website that will provide you with all the information you need to know about cognitive behavioral therapy.
D. Cognitive behavioral therapy uses techniques to help your daughter change her behavior.

8. A parent of a 19-year-old female patient tells you that her daughter has bulimia nervosa disorder. She lets her daughter prepare meals and does not say anything when she cuts her meal into little pieces and barely eats anything. The parent says that no one says anything before anyone finishes the meal; her daughter always leaves to use the bathroom. The parent states that no one wants to say anything to embarrass her daughter. What is the best response?

A. As long as your daughter is seeing a psychiatric practitioner, continue with what you are doing with your daughter.

B. You are not helping your daughter. You are reinforcing your daughter's negative behaviors. Ask your daughter's psychiatric practitioner how you can assist in her treatment at home.
C. Do not let your daughter prepare meals and distract her from going to the bathroom immediately after meals.
D. Reinforce good behaviors not bad behaviors.

9. A 20-year-old woman diagnosed with anorexia nervosa disorder was told by her practitioner that she should be admitted to the hospital for several days. She tells you that she does not want to go back to the hospital. What is your best response?

A. Did you ask your doctor why she wanted you to go to the hospital?
B. Your doctor knows what is best for you.
C. It seems like you are concerned about going to the hospital. Would you like to tell me about your concerns?
D. You lost too much weight this time, and you are at risk of doing serious harm to your body.

10. A 25-year-old female patient was admitted to your unit yesterday. She is social and cooperative. After breakfast, you see her quietly leave the dining room and go to her room. A few minutes later, she returns to the dining room. You notice this behavior after every meal. What is the best response?

A. Confront the patient about her behavior.
B. Tell the staff to monitor her behavior.
C. Tell the practitioner about the behavior.
D. Review the patient's medical records to determine if the patient's BMI is within normal range and assess the patient for sores on her hands and teeth decay.

CORRECT ANSWERS AND RATIONALES

1. C. Point out your findings to the practitioner and ask the practitioner to assess for bulimia nervosa disorder. Rationale: Sores on the patient's hands are signs of self-induced vomiting, which is a hallmark sign of bulimia nervosa disorder. Patients who are diagnosed with bulimia nervosa disorder have episodes of self-induced vomiting. Between episodes, patients have relatively normal weight. The patient shows no signs of drug abuse.
2. B. The patient wants to know her weight to adjust her food intake to achieve whatever the patient feels is a normal weight.
3. A. Anorexia nervosa disorder results in an electrolyte imbalance that disturbs the nerve impulses and contractions of the heart, leading to an irregular heart rate. No medication is prescribed to treat anorexia nervosa disorder. Self-induced vomiting is a sign of bulimia nervosa disorder.

4. D. Ask the patient what she is thinking. Rationale: An open-ended question encourages the patient to share her feelings, which is the best therapeutic approach to use with the patient. The other responses challenge the patient's beliefs.
5. C. Say to the patient, "You seem to be focused on something. Would you like to talk about it?" Rationale: This is the best therapeutic response because the patient is given the opportunity to explain his behavior. The patient is likely seeing himself in training for boxing or mixed martial arts competition. It is best to assess the patient before medicating the patient. Although the patient seems agitated, his behavior leans more toward exercising at this point.
6. C. Is there anything different happening at school? Rationale: A sudden eating disorder may stem from peer pressure; trying to impress a new boyfriend; or trying to join an athletics team at school. The practitioner probably does not have any supporting evidence to support tests for cancer. Sores on her hand would be a sign of bulimia nervosa disorder but not anorexia nervosa disorder.
7. D. Cognitive behavioral therapy uses techniques to help your daughter change her behavior. Rationale: This response is most informative and encourages the parent to ask further questions.
8. B. You are not helping your daughter. You are reinforcing your daughter's negative behaviors. Ask your daughter's psychiatric practitioner how you can assist in her treatment at home. Rationale: This response points out a problem with how the parent is coping with her daughter's behavior and refers the parent to the proper medical professional to advise the parent. The practitioner can incorporate the parent into the practitioner's treatment plan for the patient.
9. C. It seems like you are concerned about going to the hospital. Would you like to tell me about your concerns? Rationale: This is a therapeutic response that encourages the patient to express her feelings and tell you more about her concerns.
10. D. Review the patient's medical records to determine if the patient's BMI is within normal range and assess the patient for sores on her hands and teeth decay. Rationale: The patient is not diagnosed with an eating disorder. Her behavior is a sign of bulimia nervosa disorder but could also be an indication of other disorders such as irritable bowel syndrome. The best response is to gather information about the patient.

This page intentionally left blank

chapter 10

Sleeping Disorders

LEARNING OBJECTIVES

1. Breathing-related sleep disorder
2. Circadian rhythm sleep disorder
3. Narcolepsy disorder
4. Primary hypersomnia disorder
5. Primary insomnia disorder

KEY TERMS

Advanced sleep phase syndrome (ASPS)
Brain plasticity theory
Brain waves
Bright light therapy
Chronotherapy
Circadian rhythm
Delayed sleep phase disorder (DSPD)
Dreams
Electroencephalogram (EEG)
Electromyogram (EMG) machine
Electrooculogram (EOG)
Hypocretin
Irregular sleep–wake rhythm
Melatonin
Multiple sleep latency test (MSLT)
Night terror
Nightmares
Non-24-hour sleep–wake syndrome
Non-rapid eye movement (NREM)
Obstructive sleep apnea syndrome (OSAS)
Polysomnogram
Rapid eye movement (REM)
Restorative theory
Sleep
Sleep cycle
Sleep deprivation
Sleep hygiene

Sleep

Sleep is an absence of consciousness and inactivity of voluntary muscles and sensory activities that occurs for approximately 8 hours each day. The ability of a person to react to stimuli is diminished but not totally absent during sleep, enabling the person to be aroused. Brain activity, breathing, and other psychological functions change but remain active. The amount of physiologic activity depends on the stage of sleep.

The reason for sleep is unknown, although researchers have put forth several theories of why a person sleeps. **Restorative theory** states that sleep provides an opportunity for the body to repair. This is supported by studies that show that major restorative functions occur during sleep such as tissue repair, muscle growth, release of growth hormone, and protein synthesis.

Researchers also believe that a person becomes tired as a result of accumulation of adenosine in the brain. Adenosine is produced as a by-product of neural activity. A high volume of adenosine impedes wakefulness, leading to the feeling of being tired. Adenosine is removed from the body during sleep, enabling a person to feel alert when awakened. Caffeine blocks the action of adenosine, making a person feel alert after ingesting it.

Brain plasticity theory proposes that the structure of the brain changes when a person sleeps, resulting in improved memory. Some researchers believe that consolidation of information acquired during waking hours occurs during sleep to form memory.

Measuring Sleep

Three methods are used to measure sleep; these are:

- **Electroencephalogram (EEG)**: Measures brain wave activity
- **Electromyogram (EMG) machine**: Measures muscle tone activity
- **Electrooculogram (EOG)**: Measures eye movement

Brain waves are classified as alpha, beta, theta, and delta waves. A wave has two characteristics. The up/down characteristic is called the amplitude. The number of waves (up/down) is called a frequency. During waking activities, brain waves display an inconsistent pattern of amplitude and frequency indicating mental activity associated with activities of daily living. This is referred to as a beta wave. Brain waves are more consistent when a person is relaxing, which is referred to as an alpha wave.

During the first stage of sleep, the frequency of waves is slower and amplitude is higher than alpha waves. These are called theta waves. During the second stage of sleep, theta waves are interspersed with increased frequency called sleep spindles and increased amplitude called K complexes every minute.

During the third and fourth stages of sleep, brain waves are at the slowest frequency and highest amplitude. This is called the delta wave. Less than 50% of waves in stage 3 are delta waves. More than 50% of waves in stage 4 are delta waves.

A normal **sleep cycle** begins with stage 1 and continues through stage 4 and then reverses the stages. However, the person experiences rapid eye movement (REM) sleep instead of stage 1 each time the sleep cycle is reversed. At the end of the sleep cycle, there is no delta wave as the person begins to awaken.

Missed Sleep

Missed sleep is called **sleep deprivation** and can have a negative impact on a person. Depending on the length of sleep deprivation, the person can experience the following:

- Impaired immune system
- Memory lapses

- Irritability
- Yawning
- Decreased accuracy
- Increased reaction time
- Impaired judgment
- Risk for type 2 diabetes
- Risk for obesity

The body tries to recover during REM sleep and stage 4 sleep. Only a few hours of lost sleep can be recovered.

Sleeping Habits

Sleeping habits are called **sleep hygiene** and refer to how a person prepares for sleep. A person should maintain a regular sleep schedule every day. Everyone needs 7 to 9 hours of sleep per day. Some people believe the older a person is, the less sleep they require. This may seem true because an older person is awake during the night and early morning hours. However, an older person's sleep pattern changes, resulting in periods of sleep during the day.

Good sleeping habits lead to good quality sleep. Here are examples of good sleep hygiene:

- Go to bed at the same time every day
- Awaken at the same time every day
- Only lie in bed if you are going to sleep
- No naps unless necessary; if necessary, no naps longer than 20 minutes
- No caffeine after 3 pm
- Limit caffeine when you awaken
- No bright lights (i.e., computers, television) before bed
- Exercising should be completed 3 hours before bedtime. Although exercise will make a person tired, exercise also increases the body temperature. A cool body temperature is conducive to sleeping.
- Keep the bedroom cool
- Leave the bedroom if you are unable to fall asleep after 20 minutes
- No alcohol before going to bed
- No smoking before bedtime

Stages of Sleep

Rapid eye movement (REM): REM is called paradoxical sleep that occurs four or five times during a sleep cycle of about 8 hours in a 24-hour period. It is during REM sleep that a person's eyes moves rapidly. Brain activity increases. REM sleep is associated with dreaming. The reason for dreams remains unknown. REM sleep lasts for a period of 10 to 30 minutes.

Non-rapid eye movement (NREM): NREM is the period of sleep when there is no rapid eye movement. There are three phases of NREM, these are:

- N1: Occurs at the beginning of the sleep cycle when the person's eyes move slowly. A person believes they have completed a full sleep cycle if awakened during N1.
- N2: Eye movement is absent. The person can easily be awakened.
- N3: This is the beginning of deep sleep where some dreaming may occur; however, the dreams are not as memorable as in REM.

Physiology During Sleep

Physiologic demands decrease during sleep. Kidney functions decrease, leading to decreased urine production. However, the rate of cell repair, cell growth, and digestion increases. During NREM, oxygen, carbon dioxide, temperature, glucose, and blood pressure remain constant. During REM, breathing, heart rate, blood pressure, and body temperature vary.

Respiration varies during sleep. In NREM sleep, respiration is regular with a slight decrease in respiration rate. In REM sleep, respiration rate varies with periods of increased breathing.

The brain is active during sleep. Neuron firing rate changes during the sleep process. During wakefulness, neurons seem to fire randomly. During NREM, neurons fire in a coordinated pattern. During REM, neuron firing rate is random and increases more than when the person is awake. Some researchers believe dreaming is the underlying activity of the brain during REM.

Cardiovascular functions consisting of heart rate and blood pressure decrease during NREM sleep. During REM sleep, cardiovascular functions increase, leading to swelling of the clitoris in females and erections in males.

Temperature decreases slightly before falling asleep, resulting in the need for less energy when sleeping. Temperature remains constant during NREM sleep; however, temperature falls during REM sleep, causing the person to move into a curled position and cover themself with a blanket.

Dreams

Dreams primarily occur during REM sleep, although researchers believe some dreams occur during NREM sleep. Researchers are unsure of the reason for dreams. Some dreams appear to be illogical and of bizarre thoughts, whereas other dreams are based on the person's experiences. Researchers disagree on the purpose of dreams. Some researchers believe dreams are a way a person forms permanent memory, whereas other researchers view dreams as random brain activity. There are two common types of bad dreams. These are:

- **Nightmares** are considered bad dreams that occur during REM sleep.
- **Night terror** is a type of dream that occurs during NREM sleep during which the person awakens in a state of terror screaming and frightened. The person may experience the physiologic signs of terror such as sweating, increased breathing, and increased heart rate. Furthermore, the person is unable to describe what has occurred. Night terrors are common in young children but can occur at any age.

1. Breathing-Related Sleep Disorder

Breathing-related sleep disorders occur when there is disruption in a patient's breathing during normal sleeping hours that results in excessive sleepiness during the daytime. The patient is able to fall asleep; however sleep is frequently interrupted and the patient reports that sleep does not refresh them. In some cases, the patient may fall asleep during relaxing activities. In other cases, the person may fall asleep during active activities. Breathing-related sleep disorders occur gradually over years and are not reported to the practitioner until the disorder interferes with activities of daily living.

NURSING ALERT

Typically a family member reports that the patient frequently awakens at night or has periods when they seem to stop breathing because the patient is unaware of the behavior.

What Went Wrong?

The most commonly reported cause is **obstructive sleep apnea syndrome (OSAS),** where increased size of the tongue or soft palate blocks the airway for

up to a minute when the patient sleeps. The blocked airway increases the level of carbon dioxide in the blood, causing the brain to arouse the patient. The patient awakens briefly to reposition, causing the airway to open, and then falls back to sleep and the cycle repeats. However, the patient does not remember awakening during the night. Children may experience breathing-related sleep disorders if they have enlarged tonsils.

Prognosis

Breathing-related sleep disorder is reversible by treating the underlying cause of OSAS. A common cause of OSAS is obesity. A weight reduction program lowers the tissue size, preventing the tissue from blocking the airway.

Hallmark Signs and Symptoms

- Irritability
- Daytime sleepiness
- Snoring (caused by partial airway blockage)
- Inability to focus
- Fatigue
- Obesity
- Physiologic obstruction
- Long silent periods between gasps and loud snores
- Memory problems
- Naps
- Headaches

Common/Interpreting Test Results

- **Polysomnogram (PSG)**: Electronically monitors psychological activities when the patient is sleeping
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of breathing-related sleep disorder requires the following:
  - The patient must have a sleep disruption related to a breathing condition that leads to insomnia or excessive sleepiness.
  - The sleep disturbance must not be caused by drug abuse or medication.

Treatment

- Treat the underlying cause of the obstruction.
- Continuous Positive Airway Pressure (CPAP) Therapy: A high-pressure blower delivers continuous air flow through a nasal mask while the patient sleeps.

NURSING ALERT

Many patients are noncompliant with CPAP therapy because of difficulty sleeping with the nasal mask.

Nursing Diagnoses

- Impaired gas exchanged related to airway obstruction
- Disturbed sleep pattern related to airway obstruction
- Risk for injury related to sleepiness during daytime hours

Nursing Interventions

- Encourage the patient to lose weight, if that is the underlying cause of breathing-related sleep disorders.
- Help the patient overcome the challenges of CPAP therapy.
- Make sure that the patient does not perform activities that require alertness during periods of sleepiness.

2. Circadian Rhythm Sleep Disorder

Circadian rhythm sleep disorder occurs when the patient is unable to sleep or awaken for normal activities of daily living due to disruption in their circadian rhythm. The patient is able to have sufficient quality sleep. However, the time that the patient sleeps interferes with activities of daily living such as work and school.

What Went Wrong?

A patient's circadian rhythm controls when the patient sleeps and awakens. There are intrinsic and extrinsic factors that can disrupt a patient's circadian rhythm.

Intrinsic factors include:

- **Advanced sleep phase syndrome (ASPS)**: ASPS occurs when the patient has difficulty staying awake in the evening and is unable to remain asleep in the morning.
- **Delayed sleep phase disorder (DSPD)**: DSPD occurs when the patient sleeps and awakens much later than normal.
- **Irregular sleep–wake rhythm**: Irregular sleep–wake rhythm occurs when the patient sleeps at different times during the day and commonly multiple times a day.
- **Non-24-hour sleep–wake syndrome** (Non-24): Non-24 occurs when the patient sleeps later each day.

Extrinsic factors include:

- Jet lag: The patient changes time zones.
- Shift work sleep disorder: Shift work sleep disorder occurs when the patient rotates shifts or works during the night.
- Parental sleep deprivation: Parental sleep deprivation occurs when a parent's circadian rhythm is disrupted as the newborn adjusts to the parent's circadian rhythm.

Prognosis

The patient diagnosed with circadian rhythm sleep disorder will experience decreased alertness and inappropriate secretion of hormones that may lead to body temperature and appetite changes. The patient will also experience changes in the desire to fall asleep and the ability to sleep.

Hallmark Signs and Symptoms

- Use of multiple means to wake up (e.g., alarm clock)
- Impaired activities of daily living
- Sleeping at work
- Insufficient sleep
- Fatigue
- Malaise
- Unable to fall asleep before midnight

Common/Interpreting Test Results

- Sleep study: A sleep study consists of overnight and daytime sleep observation and electronic monitoring to assess the patient's sleep.
- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of circadian rhythm sleep disorder requires the following:
  - The patient must have a persistent or recurrent sleep disruption that leads to insomnia or excessive sleepiness caused by disruption of the circadian rhythm.
  - The sleep disturbance causes clinically significant distress and impaired activities of daily living.

Treatment

- Behavior Therapy: Behavior therapy focuses on changing behaviors that lead to circadian rhythm sleep disorder.
- **Chronotherapy**: Chronotherapy focuses on adjusting the patient's sleep cycle by an hour or two each day until the patient's circadian rhythm is in tune with the patient's activities of daily living.
- **Bright Light Therapy**: Bright light therapy uses a high-intensity light to adjust the patient's sleep cycle by an hour or two each day.

Drug Alert

Melatonin is a hormone that some patients take to treat circadian rhythm sleep disorders. The patient may have unpredictable effects when taking melatonin. Furthermore, there is no conclusion that melatonin is effective and safe for long-term use.

Nursing Diagnoses

- Risk for activity intolerance related to insufficient sleep
- Sleep pattern disturbance related to disruption in sleep patterns
- Risk for injury related to not being alert to perform activities of daily living

Nursing Interventions

- Encourage the patient to keep a sleep diary.
- Educate the patient about the undesired consequences of taking sleeping aids.

- Encourage the patient to be compliant with treatment.
- Make sure that the patient is aware of the risks of operating heavy equipment such as driving a car when they are fatigued.

3. Narcolepsy Disorder

Narcolepsy disorder occurs when the patient experiences sleep attacks that suddenly and without warning cause them to fall into a deep sleep for up to 20 minutes. The sleep attack may begin with sudden loss of voluntary muscle tone, causing the patient to go limp (cataplexy). The patient may also be paralyzed immediately before sleeping or immediately upon awakening. During sleep, the patient may experience hallucinations or vivid dreams.

What Went Wrong?

Patients diagnosed with narcolepsy disorder have decreased levels of hypocretin neurotransmitter. **Hypocretin** is involved in wakefulness. The decrease is related to loss of brain cells that produce hypocretin and leads to sudden loss of muscle tone. Some researchers believe an autoimmune disorder causes the destruction of cells that produce hypocretin. Other researchers believe there is a low concentration of hypocretin due to genetic traits. There are physiologic causes of narcolepsy disorder including traumatic brain injuries, tumor growth, and infections.

Prognosis

There is no cure. Narcolepsy disorder has remissions and exacerbations. Symptoms worsen and then stabilize over time. Medication and nonmedication treatment will help in the management of symptoms of narcolepsy disorder.

Hallmark Signs and Symptoms

- Sudden loss of muscle tone (cataplexy)
- Sleep paralysis
- Excessive daytime sleepiness (EDS)
- Disruption of nighttime sleep

Common/Interpreting Test Results

- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of narcolepsy disorder requires the following:
  - The patient has daily sleep attacks for at least 3 months.
  - The patient experiences at least one of the following:
    - Sudden loss of voluntary muscle tone
    - Sleep paralysis or hallucinations at onset of sleep or immediately after the patient awakens
- Polysomnography: PSG monitors the patient when they are sleeping to determine abnormalities in their sleep cycle.
- **Multiple Sleep Latency Test (MSLT)**: MSLT measures the patient's tendency to fall asleep during the day. The patient takes five naps each separated by 2 hours of being awake. The study determines if elements of REM sleep occur at inappropriate times when the patient is awake.

Treatment

- There is no known treatment to reverse narcolepsy disorder. The treatment goal is to control the symptoms.
- Administer: Provigil (modafinil), Xyrem (sodium oxybate), Ritalin (methylphenidate)
- Group Therapy: The goal of group therapy is to have the patient share feelings with group members who are also diagnosed with narcolepsy disorder. Group therapy also helps the patient to avoid becoming isolated.

Drug Alert

Do not use alcohol when using Provigil (modafinil). Watch for allergic reactions.

Nursing Diagnoses

- Risk for injury related to sudden sleep attacks
- Risk for self-esteem disturbance related to sleep attacks
- Risk for isolation related to the social impact of sleep attacks

Nursing Interventions

- Encourage the patient to develop a regular sleep schedule.
- Instruct the patient:
  - No caffeine before going to bed
  - No alcohol before going to bed
  - No smoking at night
  - No large meals before going to bed
  - Create an environment conducive to sleeping before going to bed
  - Perform relaxing activities before going to bed
- Encourage the patient to exercise 20 minutes a day 5 hours before bed.
- Warn the patient about the risks of operating heavy equipment such as a car because sleep attacks are sudden.
- Explain the hazards of sudden sleep attacks related to the patient's activities of daily living.

4. Primary Hypersomnia Disorder

Primary hypersomnia disorder occurs when a patient has excessive sleepiness in the daytime that is not caused by secondary hypersomnia disorder. Secondary hypersomnia disorder occurs as a result of an underlying factor such as shift work, insomnia, depression, or a medical disorder.

There are two types of hypersomnia disorder; these are:

- Primary hypersomnia disorder (idiopathic hypersomnia): Symptoms occur all the time.
- Recurring hypersomnia disorder (Kleine–Levin syndrome): Periods of remission occur several times a year, and exacerbations can last for weeks.

What Went Wrong?

Some researchers believe disruption of nighttime sleep prevents REM sleep, leading to the patient feeling tired after sleeping through the night and resulting in the patient sleeping during the day. Other researchers believe a viral infection is the underlying cause. Still other researchers feel that an autonomic nervous system dysfunction is the cause.

Prognosis

Treatment can reduce symptoms of primary hypersomnia disorder; however, occurrences can worsen if the patient is noncompliant with treatment.

Hallmark Signs and Symptoms

- Monosymptomatic form:
  - Excessive daytime sleepiness without difficulty in awakening from nighttime sleep
- Polysymptomatic form:
  - Excessive nighttime sleep
  - Difficulty awakening from sleep
  - Disoriented
  - Slow to respond when awakened
  - Irritable when awakened

Common/Interpreting Test Results

- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of primary hypersomnia disorder requires the following:
  - The patient has excessive sleepiness for 1 month or less or daily daytime sleep.
  - The patient has excessive sleepiness for at least 3 days several times a year for 2 or more years (recurrent hypersomnia).
  - The patient experiences clinical distress or impairment in activities of daily living caused by excessive sleepiness.
  - The patient does not experience insomnia or lack of sleep.
- Polysomnography: PSG monitors the patient when the patient is sleeping to determine abnormalities in the patient's sleep cycle.

Drug Alert

Medication is titrated during the day to enable the patient to sleep normally at night.

Treatment

- Administer: Cylert (pemoline), Dexedrine (dextroamphetamine), Provigil (modafinil), Xyrem (sodium oxybate), Ritalin (methylphenidate)

Nursing Diagnoses

- Risk for injury related to drowsiness
- Risk for imbalanced nutrition lesser than body requirements related to excessive sleeping
- Risk for activity intolerance related to excessive sleeping

Nursing Interventions

- Warn the patient about the risks of operating heavy equipment such as a car when they feel tired.
- Explain that the patient should not overly self-medicate with caffeine. Caffeine may increase irritability and cause anxiety.

5. Primary Insomnia Disorder

Primary insomnia disorder occurs when the patient is unable to go to sleep, is unable to remain asleep, or awakens too early, resulting in nonrestorative sleep. Primary insomnia is not caused by an underlying medical or psychiatric disorder or medication. Insomnia caused by these factors is referred to as secondary insomnia.

What Went Wrong?

Primary insomnia is caused by bad sleep habits, stress, jet lag, or an environmental disturbance such as noise.

Prognosis

The patient diagnosed with primary insomnia disorder will likely return to a normal sleep cycle when the underlying cause of primary insomnia disorder is resolved.

Hallmark Signs and Symptoms

- Fatigue
- Decreased concentration

- Unable to fall asleep
- Disruptive sleep
- Unable to go back to sleep
- Irritable
- Nonrefreshing sleep
- Awakening too early

Common/Interpreting Test Results

- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of primary insomnia disorder requires the following:
  - The patient experiences clinical distress or impairment in activities of daily living caused by insomnia.
  - The patient reports difficulty going to sleep or maintaining sleep for 1 month or longer.
  - The patient reports nonrestorative sleep for at least 1 month or longer.

Treatment

- Relaxation Therapy: The goal of relaxation therapy is to train the patient to relieve stress by using relaxation techniques.
- Behavioral Therapy: The goal of behavioral therapy is to change the patient's bad sleeping habits.
- Administer: Ambien (zolpidem), Restoril (temazepam), or Benadryl (diphenhydramine)

NURSING ALERT

Medication for sleep should be used short-term only. The patient should not rely on medication for sleep. Instead, the patient should focus on nonmedication treatment of primary insomnia disorder.

Nursing Diagnoses

- Risk for activity intolerance related to fatigue
- Risk for powerlessness related to insomnia
- Ineffective role performance related to fatigue

Nursing Interventions

- Encourage the patient to use the bedroom for sleep only.
- Encourage the patient to develop a regular sleep schedule.
- Instruct the patient:
  - No caffeine before going to bed
  - No alcohol before going to bed
  - No smoking at night
  - No large meals before going to bed
  - No naps
  - Create an environment conducive to sleeping before going to bed
  - Perform relaxing activities before going to bed
- The patient should leave the bedroom if the patient is unable to fall asleep after 20 minutes.
- Have the patient take a bath 2 hours before going to bed.
- Tell the patient to remove all distractions from the bedroom.
- Educate the patient regarding side effects of medication.
- Ask the patient to keep a sleep diary.

CASE STUDY

CASE 1

A 45-year-old small business owner visits his practitioner and reports that his workers and his family are finding him irritable and unable to focus during conversation. The patient states that he is fatigued but sleeps throughout the night without any difficulty. Around noon each day, he closes the door to his office and takes a power nap. He admits being forgetful in recent months, but he thinks it is part of growing older. His wife and his coworkers suggested that he visit the practitioner to get checked out.

QUESTION 1. What questions do you expect the practitioner to ask the patient?
ANSWER: The practitioner is likely to ask questions that help rule in or rule out breathing-related sleep disorder. Some questions will be: Do you snore when you sleep? Has your wife ever raised concerns about you when sleeping? Family members such as the patient's wife are in a better position to answer sleeping questions because they observe the patient sleeping. For example, the patient's

wife might wake up the patient if he is snoring or if there are long silent periods between breaths.

QUESTION 2. Why would the practitioner want to rule out anemia before reaching a diagnosis?
ANSWER: The patient's symptoms indicate decreased oxygenation in the patient's blood. One cause can be decreased red blood cells and decreased hemoglobin in the patient's blood, which is seen in anemia. Oxygen and carbon dioxide attach to hemoglobin in red blood cells and are transported to cells throughout the body. Decreased red blood cells and decreased hemoglobin result in decreased oxygenation of blood and increased carbon dioxide. The practitioner needs to first rule out causes other than psychiatric causes for the patient's symptoms.

QUESTION 3. The practitioner asks the patient to show her all his prescribed and over-the-counter medications. Why is this question asked?
ANSWER: Medication, including over-the-counter medication, can have side effects that produce symptoms reported by the patient. Practitioners will ask to see medication rather than asking the patient to tell the practitioner what medications they are taking because they may not be a good reporter. In addition the patient is reporting memory problems. It is important for the practitioner to read the ingredients of over-the-counter medication including supplements because an ingredient may be the cause of the symptoms.

QUESTION 4. The practitioner determines that the patient has breathing-related sleep disorder. What do you expect the practitioner to do next?
ANSWER: The practitioner will likely explain the disorder to the patient and ask him to undergo a sleep study using a PSG. The practitioner will also ask the patient to undergo a weight reduction program to reduce the tissue size of tissue that is blocking the patient's airway when the patient is sleeping. Furthermore, the practitioner may order continuous positive airway pressure (CPAP) when the patient sleeps.

FINAL CHECK-UP

1. **A patient arrives on your unit reporting that she is unable to get a good night's sleep. She tells you that her husband has lost his job, the bills are piling up, and they may have to file for bankruptcy. Her family practitioner sent her to the emergency department for acute anxiety, and she was later admitted to your unit. What would you expect her diagnosis to be?**

   A. Depressive disorder
   B. Primary insomnia disorder

C. Secondary insomnia disorder
D. Schizophrenia

2. **A 25-year-old man reports that he suddenly falls asleep at work for periods of about 10 minutes once or twice a day. He tells you that his muscles go limp. His practitioner wants him to take the MSLT and he asks you how long he would have to wear the MSLT monitor. What is the best response?**
   A. There is no monitor. MSLT requires the patient to take five naps each separated by 2 hours of being awake to measure REM sleep.
   B. The monitor is worn for 24 hours on the patient's belt. Leads are attached to the patient to monitor electrical impulses.
   C. There is no monitor. MSLT uses leads placed on the patient to monitor them when sleeping to identify abnormal sleep cycles.
   D. The monitor is worn only when the patient sleeps at night.

3. **A 53-year-old neighbor tells you that she was diagnosed with Kleine–Levin syndrome. She was not sure what the practitioner was saying when the practitioner told her about the syndrome. The patient believes she is dying because all she does is sleep. What is the best response?**
   A. Call your practitioner and ask your practitioner to tell you more about Kleine–Levin syndrome.
   B. Kleine–Levin syndrome is a viral infection that will go away in a few weeks.
   C. Kleine–Levin syndrome is a form of primary hypersomnia disorder.
   D. Kleine–Levin syndrome is a sleep disorder that comes and goes several times a year. Make sure that you follow treatment recommended by your practitioners.

4. **A friend reports that her 70-year-old father has more energy now than he had when he was 50 years old. He does not need much sleep any more. What is the best response?**
   A. The pressure of not having to go to work each day lessens the fatigue for your father.
   B. Your father needs the same amount of sleep. He probably sleeps more during the day than at night.
   C. There is increased pressure on your father because he is no longer employed. Anxiety can keep anyone awake for long hours.
   D. Most older adults need less sleep.

5. **A student nurse on your unit tells you that her grandmother always says that you'll get sick if you don't get a good night's sleep. What is the best response?**
   A. That is an old wives, tale that has been passed down through generations. My grandmother told me the same thing.
   B. There is no scientific basis for that statement. As a nurse, we must only recognize evidence-based practice.

C. There is evidence to support your grandmother's claim. There are studies that show that major restorative functions occur during sleep. The immune system is active when you are sleeping.
D. There is truth to what she says.

6. Your adult sister tells you she hasn't been able to get a good night's sleep in months. She wants to know the best sleeping medication. Your sister asks you what medication she should ask the practitioner to prescribe. What is the best response?

A. Benadryl because it is not addictive.
B. A low dose of Ambien.
C. None. Sleeping medications are addictive.
D. Try using good sleep hygiene first.

7. A patient comes to your outpatient clinic reporting that he has frequent night terrors. He says someone is chasing him in the woods and he is unable to find his way home. He does not remember being in a wooded area, and he has never been chased by anyone in his life. What is the patient's likely disorder?

A. Nightmares
B. Night terror
C. Posttraumatic stress disorder (PTSD)
D. Anxiety disorder

8. An obese patient comes to your outpatient clinic reporting that he always feels tired. He reports sleeping throughout the night without any problem. He goes to bed early and stays asleep until it is time to go to work. His vital signs are normal. What test do you expect from the practitioner?

A. Complete blood count
B. EEG
C. EMG
D. Liver function test

9. A nurse working the overnight shift says she has three alarm clocks set throughout her bedroom away from her bed. Each is set to go off 5 minutes after the next, and each is further away from her bed. When they go off, she has to get out of bed to turn each off. She said that her husband gets angry with her when she is unable to fall asleep before 1 am on her days off. She reports that even if she uses good sleep hygiene, she always feels as if she has insufficient sleep. What is your best response?

A. Maintain your sleep schedule on your days off.
B. Talk to your practitioner about circadian rhythm sleep disorder.
C. It sounds like you have circadian rhythm sleep disorder. Chronotherapy is likely to make you feel better.
D. Move to the day or evening shift.

10. A 34-year-old man reports that he is unable to get a good night's sleep. For the past 6 months, he jogs on his treadmill for an hour before bed to tire himself, and then immediately takes a hot shower and jumps into bed. He then lies there watching television waiting to fall asleep. He does not fall asleep for hours. What is your best response?

A. Exercise 2 hours before going to bed.
B. Never watch television in bed.
C. Do not exercise or take a cold shower before going to bed.
D. Open the bedroom window before going to bed.

CORRECT ANSWERS AND RATIONALES

1. C. Secondary insomnia disorder. Rationale: The patient is likely to have a primary diagnosis of anxiety disorder. Insomnia is related to the patient's anxiety and therefore would not be the primary disorder. There are no symptoms for depressive disorder or schizophrenia.
2. A. There is no monitor. MSLT requires the patient to take five naps each separated by 2 hours of being awake to measure REM sleep. Rationale: Answer C describes the PSG test.
3. D. Kleine–Levin syndrome is a sleep disorder that comes and goes several times a year. Make sure that you follow treatment recommended by your practitioners. Rationale: You should educate the patient once the practitioner has discussed the diagnosis with the patient. Some researchers believe that the underlying cause is a viral infection, but there is no agreement that this is true. Kleine–Levin syndrome is a form of primary hypersomnia disorder; however, always give the patient as much information as is feasible.
4. B. Your father needs the same amount of sleep. He probably sleeps more during the day than at night.
5. C. There is evidence to support your grandmother's claim. There are studies that show that major restorative functions occur during sleep. The immune system is active when you are sleeping.
6. D. Try using good sleep hygiene first. Rationale: It is always best to try nonmedication treatments before using medication. Although sleep medication may be abused, abuse can be avoided by following the practitioner's instructions.
7. A. Nightmares. Rationale: A nightmare is a bad dream. This is not night terror because the patient is able to describe the experience. Patients are unable to describe a night terror. The patient did not report any traumatic event, so PTSD is unlikely the problem. There are no symptoms of anxiety disorder.
8. A. Complete blood count. Rationale: Although the patient is likely to have breathing-related sleep disorder related possibly to obstructive sleep apnea syndrome (OSAS), the practitioner needs to rule out anemia and other medical conditions that can cause this symptom.

9. B. Talk to your practitioner about circadian rhythm sleep disorder. Rationale: In this response, you are giving the nurse direction without making a medical diagnosis. The practitioner can perform a full assessment and make a medical diagnosis. The nurse seems to be maintaining her sleep schedule on her days off. Changing shift may address the problem but does not address the nurse's immediate concerns.
10. C. Do not exercise or take a cold shower before going to bed. Rationale: While all responses are correct, this is the best response because cooler temperatures—not warm temperatures—are conducive to sleeping. Exercising and taking a hot shower before bed increase body temperature.

chapter 11

Sexual Disorders

LEARNING OBJECTIVES

1. Gender identity disorder
2. Paraphilia disorder
3. Sexual dysfunction disorder

KEY TERMS

12-Step Sexual Addiction Program
Couples therapy
Dyspareunia
Erectile disorder
Exhibitionism
Female sexual arousal disorder
Fetishism
Hypoactive sexual desire disorder
Orgasmic disorder
Pedophilia
Premature ejaculation
Sex therapy
Sexual aversion disorder
Sexual masochism
Sexual sadism
Transvestitism
Vaginismus
Voyeurism

A sexual disorder means that a person is having an ongoing abnormal sexual experience that is causing distress in the person's life, resulting in disruption of relationships with family and friends, employment issues, or legal issues. There are three areas of sexual disorders. These are sexual activity, gender identity, and paraphilia.

A person can be diagnosed with a sexual disorder any time in their life. Some sexual disorders such as gender identity disorders tend to occur early rather than later in life. Other sexual disorders such as paraphilia can progress through life as a person loses impulse control and begins to act out sexual fantasies.

The cause of many sexual disorders is unknown. Some researchers believe psychological trauma or a problematic early development period may be the root course of the sexual disorder. Other researchers feel there is a biological or physiologic basis for a sexual disorder.

Sexual Activity

Sexual activity is a natural behavior that begins with flirting during which there is sexual arousal, which leads to physiologic changes. Flirting is sometimes followed by foreplay and may eventually lead to sexual intercourse. Researchers found that most people engage in sexual activity to experience pleasure. Many do so because of an emotional attachment to their partner, whereas others engage in sexual activities for their own pleasure. Researchers report that married couples engage in sexual intercourse two to three times a week, with the frequency decreasing with age.

There are four phases of sexual activity:

- The first phase is called the excitement phase, which is characterized by increased respiration and blood flow leading to lubrication of the vagina and swelling of the clitoris and erection of the penis.
- The plateau phase follows with increased muscle tension. The man's urinary bladder closes, preventing urine from mixing with semen. There is increased lubrication of the vagina as the muscles tighten.
- The orgasm phase is reached when there are rhythmic contractions of the pelvic muscles and ejaculation by the man resulting in pleasure.
- The refractory period follows during which muscles relax and the body returns to a normal state. During this period, women may experience additional orgasms.

Absence of sexual activity or disruption of sexual activity is referred to as sexual dysfunction and can be caused by an underlying medical or psychiatric disorder.

Gender Identity

There is a distinction between sex and gender. Sex refers to the biological and physiologic characteristics of a man and a woman. For example, women menstruate and develop breasts that lactate after giving birth. Men have small breasts and have a penis. Sex does not vary between societies. Gender refers to society's expectations of behaviors defined as masculine and feminine. For example, men typically earn more money than women in the United States. Men drive cars and women do not in Saudi Arabia.

Gender identity is a person's identification of himself or herself as masculine or feminine. As a result, the person behaves within society's expectations of masculine or feminine. That is, boys play with boys and girls with girls in elementary school. Boys and girls go on dates in high school. Each takes on the expected masculine and feminine role as defined by society.

A person may experience a psychological disturbance if the person changes a gender-defined role. An example is when a husband stays home to care for the house and family, whereas his wife works outside the home providing financial support for the family. This change can make the husband feel less masculine and possibly causes family, friends, and acquaintances to doubt his ability to fulfill his expected masculine role as bread winner for the family. Conversely, his wife might be experiencing similar social challenges regardless of the wife's professional training and capabilities.

Gender identity disorder occurs when a person is more comfortable with behaving like the opposite gender. That is, a man desires to be feminine and a woman masculine. Researchers report that gender identity disorder may have a biological or psychiatric basis.

Paraphilia

Paraphilia is abnormal and extreme sexual behavior whereby a person is sexually aroused and engages sexually with inanimate objects or children; inflects self-suffering and humiliation; or imposes suffering and humiliation on the sexual partner.

A person with paraphilia has intense sexual fantasies and is unable to control the impulse to engage in those sexual fantasies. As a result, the person's sexual behavior may not be known to others or the person may be considered perverted by others once they become aware of the behavior. A person who acts on sexual fantasies may experience legal and social consequences as a result of their actions.

There is a distinction between acceptable sexual behavior and paraphilia. For example, watching a sexually explicit video, talking dirty, or watching a partner disrobe are common ways some people become aroused and are followed by normal sexual activity with their partner. The person is neither dependent on nor obsessed with these behaviors for sexual gratification.

1. Gender Identity Disorder

Gender identity disorder occurs when a patient is uncomfortable with the patient's anatomic gender, leading the patient to present as a person of the opposite gender. The patient may dress and take on mannerisms of the opposite sex and desire to have surgery to change the patient's body image. A patient shows signs of gender identity disorder by adolescence.

What Went Wrong?

The cause of gender identity disorder is unknown. Some researchers believe there is a chromosomal abnormality or a hormonal imbalance during the patient's prenatal and early childhood. Other researchers feel defects in child rearing and parental bonding are possible causes.

Prognosis

The patient may experience social isolation, anxiety, poor self-image, and depression that prevents the patient from functioning in school and work. Treatment can minimize the negative impact of gender identity disorder.

Hallmark Signs and Symptoms

- Isolation
- Depression
- Anxiety
- Wants to remove genitals
- Shows signs of disliking their genitals
- Rejection by peers
- Dresses like the opposite sex
- Adopts mannerisms of the opposite sex
- States a desire to be the opposite sex

Common/Interpreting Test Results

- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of gender identity disorder requires the following:
  - Discomfort with one's own sex
    - Male children:
      - Asserts that the penis or testes are disgusting or does not want them
      - Does not play boy games or indulge in any boy activities
    - Female children:
      - Persistent attempts to urinate while standing
      - Asserts she will grow a penis and not menstruate or have breasts
      - Prefers male clothing over female clothing
    - Adolescent/adults:
      - Believes they were born the wrong sex
      - Preoccupied with changing primary and secondary sex characteristics

- Cross-gender identification
  - A child demonstrates four or more of the following:
    - Persistent desire to be the opposite sex
    - Persistent fantasies of being the opposite sex
    - Persistent playing of stereotypical games of the opposite sex
    - Persistent playing with the opposite sex
    - Cross-dressing by males
    - Persistent wearing of masculine clothes by girls
  - Adolescent/adult
    - Passes as opposite sex
    - The patient wants to be the opposite sex
    - Wants to be treated as the opposite sex

Treatment

- Individual Therapy: Therapy focuses on the patient's self-image.
- Family Therapy: Therapy focuses on family adjustment to the patient's desires and behaviors.
- Group Therapy: Therapy focuses on self-help from patients who have the same or similar diagnosis.
- Gender Reassignment Surgery: Surgical alteration of the patient's body to resemble sexual characteristics of the opposite sex.
- Hormone Therapy: Hormone therapy enhances or suppresses selected sexual characteristics.

NURSING ALERT

Gender reassignment surgery is performed only after the patient completes extensive evaluation.

Nursing Diagnoses

- Disturbed body image related to the patient's perception of their sexual orientation
- Impaired social interaction related to the perception of the patient by others
- Sexual dysfunction related to the desire to be the opposite sex

Nursing Interventions

- Develop a therapeutic relationship with the patient.
- Be nonjudgmental.
- Focus on the patient's feeling and not your feelings about gender identity disorder.
- Help the patient process their feelings and those of their family and friends.
- Help the patient identify social stressors and help them develop skills to cope with those stressors.
- Help the patient explore treatment alternatives.

2. Paraphilia Disorder

Paraphilia disorder occurs when a patient has intense recurrent sexual fantasies with uncontrollable urges to engage in behaviors that are not sexually arousing to others. As a result, the patient incurs or is at risk of incurring significant social, legal, or employment problems. Sexual fantasies and behaviors become paraphilia disorder if they harm the patient or others and prevent development of normal, healthy relationships for the patient.

Paraphilia disorders include the following types:

- **Exhibitionism**: Exhibitionism occurs when the patient exposes their genitals to strangers.
- **Fetishism**: Fetishism occurs when the patient has sexual urges for nonliving objects such as underwear and shoes.
- Frotteurism: Frotteurism occurs when the patient rubs their genitals against a nonconsenting stranger.
- **Pedophilia**: Pedophilia occurs when the patient has sexual urges or behaviors involving a child.
- **Sexual masochism**: Sexual masochism occurs when the patient experiences sexual pleasure by causing suffering to themselves or others, such as cutting, burning, or verbal humiliation.
- **Sexual sadism**: Sexual sadism occurs when the patient experiences sexual pleasure by inflicting suffering on their sexual partner.
- **Transvestitism**: Transvestitism occurs when a person typically a man is sexually aroused by dressing in female clothes.

- **Voyeurism**: Voyeurism occurs when a patient is sexually aroused by watching an unwitting stranger undress or perform sexual activity.
- Not otherwise specified: Not otherwise specified includes sexual activities that do not fit in with a defined diagnosis such as sex with the dead and sexual gratification from enemas.

What Went Wrong?

The cause of paraphilia disorder is unknown. Some researchers believe sexual abuse or other childhood trauma may be the underlying cause of paraphilia disorder. Other researchers feel that association of situations and objects with sexual pleasure is related to paraphilia disorder.

Prognosis

A patient diagnosed with paraphilia disorder in adolescence is likely to continue with paraphilia disorder as an adult. Treatment can help the patient modify their behavior. Paraphilia disorder fantasies and behaviors diminish with age.

Hallmark Signs and Symptoms

- Sexual dysfunction
- Guilt
- Visiting paraphilia-related websites
- Purchasing paraphilia material
- Depression
- Engaging in paraphilic activities
- Anxiety

Common/Interpreting Test Results

- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of paraphilia disorder requires the following:
  - Exhibitionism:
    - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors related to exposing their genitals to unwitting strangers.

- The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

- Fetishism:
  - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors involving nonliving objects.
  - Nonliving objects are not limited to cross-dressing or objects that stimulate the genitals.
  - The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.
- Frotteurism:
  - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors involving rubbing their genitals against a nonconsenting stranger.
  - The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.
- Pedophilia:
  - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors related to engaging in sexual activity with a prepubescent child.
  - The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.
  - The patient is at least 16 years of age and 5 years older than the child.
- Sexual masochism:
  - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors involving causing suffering to themselves or others, such as cutting, burning, or verbal humiliation.
  - The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.
- Sexual sadism:
  - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors involving inflict suffering on the patient's sexual partner.
  - The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.
- Transvestitism:
  - For 6 months, the patient, who is a heterosexual male, has recurrent sexual fantasies, urges, or behaviors involving cross-dressing.

- The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.
- Voyeurism:
  - For 6 months, the patient has recurrent sexual fantasies, urges, or behaviors involving watching an unwitting stranger undress or perform sexual activity.
  - The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Treatment

- Group Therapy: Group therapy focuses on self-help from patients who have the same or similar diagnosis.
- **12-Step Sexual Addiction Program**: This program is a structured self-help group based on the Alcoholics Anonymous 12-Step Program that helps the patient work through steps of recovery.
- Cognitive Behavioral Therapy: Cognitive behavioral therapy focuses on helping the patient change their behavior.

Nursing Diagnoses

- Disturbed body image related to the patient's sexual behaviors
- Impaired social interaction related to the patient's inability to develop a healthy relationship with others
- Ineffective coping related to the patient's diminished impulse control

Nursing Interventions

- Help the patient identify triggers that lead to sexual fantasies, urges, or behaviors.
- Help the patient devise a plan to avoid triggers and use corrective actions if the patient encounters a trigger.
- Develop a therapeutic relationship with the patient.
- Be nonjudgmental.
- Focus on the patient's feelings and not your feelings about paraphilia disorder.

- Help the patient process their feelings and those of their family and friends.
- Help the patient identify social stressors and help them develop skills to cope with those stressors.
- Help the patient explore treatment alternatives.

3. Sexual Dysfunction Disorder

Sexual dysfunction disorder occurs when the patient experiences disturbance during the sexual response cycle. There are five categories of sexual dysfunction disorder; these are:

- Sexual desire disorders:
  - **Hypoactive sexual desire disorder**: Decrease or absence of the desire for sexual activity
  - **Sexual aversion disorder**: Dislike and avoidance of sexual contact
- Sexual arousal disorders:
  - Erectile disorder: Unable to attain or maintain an erection throughout a sexual encounter
  - **Female sexual arousal disorder**: Unable to attain or maintain lubrication or swelling during sexual arousal
- Orgasmic disorders:
  - Premature ejaculation: Ejaculation with minimal stimulation
  - **Orgasmic disorder**: Delay or absence of an orgasm
- Sexual dysfunction due to a medical disorders:
  - Hormonal deficiencies
  - Diabetes
  - Cardiovascular disorder
  - Neurologic disorders
  - Medication
- Sexual pain disorders:
  - **Dyspareunia**: Pain related to intercourse
  - **Vaginismus**: Involuntary contraction of the vaginal muscles during penetration

What Went Wrong

Nerve endings in the genitalia signal the brain through the spinal cord that the genitalia are being touched. The pleasure/reward center of the brain is stimulated, causing the person to increase sexual activity and resulting in further stimulation. The pituitary gland releases oxytocin, which produces the feeling of trust. The pituitary gland also produces beta-endorphins to decrease pain and vasopressin to increase bonding. In women, activity in the amygdala and hippocampus decreases, resulting in a decrease in anxiety and feelings of relaxation and security. An orgasm occurs at peak stimulation. Portions of the brain release dopamine. Researchers who used a PET scan to study the brain report that neural activity in the brain during an orgasm resembles the same neural activity of a person who is under the influence of heroin. Disruption of the physiology of the sexual cycle may cause sexual dysfunction. For example, antidepressant medication such as Paxil, Celexa, and Zoloft decreases production of dopamine. Cardiovascular disorders may disrupt the flow of blood to the genitalia. Neurologic disorders may disrupt neural transmission.

Prognosis

The prognosis depends on the underlying cause of the sexual dysfunction. The sexual dysfunction can be improved if the underlying cause can be resolved. Prognosis is poor if the underlying cause is chronic and cannot be resolved.

Hallmark Signs and Symptoms

- Unable to attain or maintain an erection
- Loss of interest in sexual activities
- Painful intercourse
- No sexual arousal
- Unable to attain or maintain lubrication or swelling during sexual arousal
- **Premature ejaculation**
- No orgasm

Common/Interpreting Test Results

- The initial step is to rule out physiologic and other mental disorders causing the symptoms before reaching a psychiatric diagnosis. The psychiatric diagnosis of sexual dysfunction disorder requires the following:

- Hypoactive sexual desire disorder:
  - The patient must have diminished or no sexual fantasies or sexual activity.
  - The patient rarely initiates sexual activity or is reluctant to participate in sexual activity.
  - The patient has distress or interpersonal difficulty related to the disturbance.
- Sexual aversion disorder:
  - The patient avoids sexual contact with the partner's genitals.
  - The patient has distress or interpersonal difficulty related to the disturbance.
- Female sexual arousal disorder:
  - The patient is unable to attain or maintain adequate lubrication and swelling in response to sexual arousal.
  - The condition must be recurring or persistent.
  - The patient has distress or interpersonal difficulty related to the disturbance.
- Erectile disorder:
  - The patient is unable to attain or maintain an erection during sexual activity.
  - The condition must be recurring or persistent.
  - The patient has distress or interpersonal difficulty related to the disturbance.
- Orgasmic disorder:
  - The patient has delay or absence of an orgasm after the sexual arousal phase of the sexual response cycle.
  - The condition must be recurring or persistent.
  - The patient has distress or interpersonal difficulty related to the disturbance.
- Premature ejaculation:
  - The patient experiences ejaculation and orgasm with minimal sexual stimulation.
  - The condition must be recurring or persistent.
  - The patient has distress or interpersonal difficulty related to the disturbance.

- Sexual dysfunction due to a general medical condition:
  - The sexual dysfunction is explained by the medical condition.
  - The patient has distress or interpersonal difficulty related to the disturbance.
- Sexual pain disorder:
  - Dyspareunia:
    - The patient experiences pain in the genital during sexual intercourse.
  - Vaginismus:
    - The patient experiences involuntary muscle constrictions of the vagina during penetration.

Drug Alert

Patients who are treated with nitrates for coronary heart disease should not take Viagra (sildenafil).

Treatment

- **Couples Therapy**: The goal of couples therapy is to help couples mutually explore their bodies to reduce any shame.
- Sensate Focus Exercises: The patient focuses on sexual sensation. Each sexual partner touches the other and gives the other a message without touching the genitals or breasts. The receiver shows the giver where to touch by placing the receiver's hands over the giver's hands. Eventually the genitals and breasts are touched.
- **Sex Therapy**: The goal of sex therapy is to become reassured about sexual activities.
- Cognitive Behavioral Therapy: The goal of behavioral therapy is to desensitize maladaptive behavior toward sex.
- Psychotherapy: The goal of psychotherapy is to become aware of sexual feelings and eliminate the fear of rejection.
- Sexual arousal disorder:
  - Behavioral therapy
  - Sensate focus exercises
  - Psychotherapy
  - Relaxation exercises

- Orgasmic disorder
  - Self-touching exercises
  - Breathing exercises to reduce anxiety
- Vaginismus:
  - Kegel exercises to strengthen the pubococcygeal muscle and increase blood flow to the vulva and vagina
  - Progressively stretch the vagina with contracted muscles using a finger or plastic dilator
- Dyspareunia:
  - Lubrication gels or creams
  - Reduce deep penetration by changing coital position
  - Treat underlying infection
  - Remove vaginal scars
  - Sensate focus exercises
- Premature ejaculation:
  - Stop and start technique: The female is in the superior position. Pelvic thrusting continues until the beginning of the sensation of orgasm. Thrusting stops, preventing premature ejaculation. Thrusting begins again.
  - Squeeze technique: When the urge to ejaculate is felt, the patient or partner squeezes the top and bottom of the head of the penis to prevent ejaculation. The patient should feel pressure only. Pressure should be applied and released every few minutes.
- **Erectile disorder**
  - Administer: Viagra (sildenafil) to attain and maintain an erection
  - Sex therapy
  - Couples therapy

Nursing Diagnoses

- Ineffective role performance related to sexual dysfunction
- Risk for chronic low self-esteem related to sexual dysfunction
- Ineffective sexuality pattern related to sexual dysfunction

Nursing Interventions

- Develop a therapeutic rapport with the patient.
- Encourage the patient to express feelings about the sexual dysfunction.
- Accept what the patient tells you. Do not be judgmental.
- Help the patient understand treatments that are available for sexual dysfunction.

CASE STUDY

CASE 1

A 37-year-old patient who is in the process of undergoing gender reassignment surgery is admitted to your psychiatric unit and assigned to you for admission. He calls himself Brandi, although his name on the admission paperwork is Robert Johnson. He insists that the staff call him Brandi and becomes hostile if he is called by his male name. Brandi looks around the unit and recognizes a few staff members calling them by name. He tells you that he wants only female staff members to perform the required body search. Brandi's breasts are developing due to estrogen therapy; however, he has a penis. Brandi displays feminine behavior and speech and usually associates with female patients. Most female patients are accepting of him, and those who are not usually accept him after a few days. Most male patients mock him behind his back but avoid confrontation because Brandi is over 6 feet tall, weighs 300 pounds, and is quick to physically confront anyone. One male patient is outwardly hostile to Brandi. Apparently they know each other from the streets. Brandi is a "female" prostitute.

QUESTION 1. How would you address Brandi's request to be searched by a female?

ANSWER: Female nurses can search a male patient since nurses perform full patient care for both genders. The unit typically has a same-sex staff member conduct a body search for the convenience of the patient. Brandi prefers to be searched by a female nurse. Therefore, two or more female nurses should conduct the search.

QUESTION 2. The patient wants to be called Brandi. How would you address the patient?

ANSWER: Patients are addressed by the name on the admission paperwork. Although the staff tries to accommodate patient requests, the staff should not call him Brandi. Each staff member has to explain that the staff must call each patient by their name that appears on the admission paperwork. The staff can offer to call

him by a variation, such as Bobby. The patient may being open to be called Bobby since some women with the name Roberta are called Bobby. It is important that all staff members call the patient by the same name.

QUESTION 3. After reviewing the patient's admission orders, you notice there is no order for estrogen. What should you do?
ANSWER: You should mention to the practitioner that the patient told you he is in the pre-stages of gender reassignment surgery and is on estrogen therapy. The practitioner needs to verify with the patient's surgeon that he is actually scheduled for gender reassignment surgery. The patient may not be scheduled for gender reassignment surgery and is taking estrogen from a street source rather than taking prescribed estrogen.

QUESTION 4. A male patient gives Brandi threatening looks. Brandi returns with a verbal assault. Both patients walk toward each other. You and another staff member intervene, separating both patients. The other staff member walks Brandi to one end of the unit and you walk the male patient to the other end of the unit. What do you say to the male patient?
ANSWER: Use a therapeutic technique to encourage the patient to express his feelings. Open the conversation by saying something like, "It looks like you are upset. Can you tell me about it?" Provide an opening for the patient to freely respond to your question. Stay quiet and give the patient time to formulate his response. The patient is likely hesitant on sharing his feelings with you, primarily because his encounter with Brandi on the street is embarrassing for him to share with you. Encourage but do not push a response from the patient. Before leaving the patient, help him refocus on his treatment and the progress he is making toward recovery.

FINAL CHECK-UP

1. **A 53-year-old male patient on your psychiatric unit is wearing a hospital gown. During group therapy, a patient sitting across from him tells you he can see the patient's genitals when the patient is sitting. What is your best response?**
   A. The patient is diagnosed with paraphilia, the exhibitionism type. I will speak to him about your concern.
   B. Ask to speak with the male patient at the nurse's station and tell him to dress appropriately when going to a group therapy.
   C. Ask to speak with the male patient at the nurse's station and assess the patient.
   D. Ask to speak with the male patient at the nurse's station and offer the patient clothes.

2. **A 32-year-old patient came to the outpatient psychiatric clinic reporting to you that he still has episodes of depression. During your assessment, you noticed that the practitioner had prescribed antidepressant medication. You asked the patient if he is still taking antidepressants. He said no because of the sexual dysfunction that occurred when he took the medication. What is your best response?**
   A. You should never stop taking antidepressant medication. You will have to cope with side effects.
   B. Ask the practitioner about taking a medication vacation.
   C. Continue taking antidepressant medication. The side effects will decrease over time.
   D. Stopping antidepressant medication suddenly probably caused the side effect.

3. **During the admission interview to your psychiatric unit, a 44-year-old male patient tells you that he has been diagnosed with paraphilia disorder pedophilia type. You feel repulsed by the thought of being in the presence of the patient. What is the best response?**
   A. Complete the admissions interview and tell the charge nurse that you are unable to remain on the unit and ask to be transferred to a different unit.
   B. Stop the admissions interview and ask the charge nurse to assign the admission to a different nurse and then ask to be transferred to a different unit.
   C. Continue with the admissions interview and care for the patient as you would care for any patient on the unit.
   D. Complete the admissions interview and ask the charge nurse to reassign the patient to another nurse.

4. **You are a female nurse assigned to a 34-year-old female patient who dresses and behaves like a man. You have developed a therapeutic rapport with the patient over the past several days. The patient makes sexual advances toward you. What is your best response?**
   A. Tell the patient that her advances are inappropriate.
   B. Ignore the advances with hopes that she will realize you are not interested.
   C. Acknowledge the patient's intent and state that you are heterosexual.
   D. Ignore the patient's advances and report the event to the practitioner.

5. **As you walked through the hallway checking rooms on your psychiatric unit, you noticed a male patient looking out the window across the courtyard into a female patient's room. The female patient was changing clothes. What is your best response?**
   A. Ignore the incident.
   B. Tell the patient to stop looking into other patients' rooms.
   C. Ask to speak with the patient in the hallway to assess the situation.
   D. Ask to speak with the patient in the hallway to determine if the patient has relapsed and is having an episode of paraphilia disorder voyeurism type.

6. Your neighbor mentions to you that her husband seems to have lost interest in having sexual relations. She asks you if she should attend a sex therapy session advertised in the newspaper by a psychologist. What is your best response?

A. First discuss your concerns with your husband.
B. Both of you should attend the session.
C. Encourage your husband to discuss this situation with his practitioner. There may be an underlying medical issue.
D. You should ask your practitioner to recommend a couples therapist. Never respond to a newspaper advertisement for therapy.

7. You floated to a psychiatric unit. A 32-year-old patient asks you if he can have four or five individualized plastic bottles of liquid soap that are given to the patients for body washing. As you are giving them to him, a nurse who is regularly assigned to the unit tells you to stop. The patient quickly goes to his room without the soap. What might be happening?

A. The patient is diagnosed with paraphilia fetishism type. The patient uses the body wash as a lubricant for having sex with nonliving objects in his room.
B. The patient is at risk for drinking body wash.
C. The patient uses the body wash to clean his room.
D. The patient spills the body wash in an other patient's room.

8. Your neighbor who is the mother of a 16-year-old boy tells you that she overheard him say that he wants to cut off his genitals when he was in the bathroom. She asks you what she should do. What is your best response?

A. Tell her to ignore the comments. This is a natural part of growing up.
B. Ask her if he is being rejected by his friends and classmates.
C. Ask her if he has been acting strangely lately.
D. Suggest that she discuss the situation with her practitioner. The practitioner can further assess the child.

9. A 35-year-old male patient who calls himself Crystal arrives on your general psychiatric unit, which is co-ed. Except for four private rooms near the nurse's station, all rooms have two beds and one bathroom. Crystal has developed breasts, dresses like a woman, and has a penis. All four private rooms are taken. One female bed and one male bed are open. What is the best room assignment?

A. The female bed
B. The male bed
C. Relocate the male patient currently assigned to a private room to the male room.
D. Notify the nursing supervisor that you are unable to accommodate the patient.

10. A patient who is self-diagnosed with erectile disorder tells you that he is going to take Viagra. What is your best response?

A. Never take medication that is not prescribed to you.
B. Ask if the patient has coronary heart disease and is taking nitrate medication.
C. Tell the patient to talk to his practitioner.
D. Tell the patient that Viagra conflicts with other medications and that he should talk to his practitioner.

CORRECT ANSWERS AND RATIONALES

1. C. Ask to speak with the male patient at the nurse's station and assess the patient. Rationale: The initial step is to assess the reason for the patient's behavior. The patient may be unaware that he is exposing himself based on the patient's mental state or the effect of medication. You would determine if the patient has clothes before telling the patient to dress appropriately. If the patient does not have clothes, the clothes should be offered to the patient. It is inappropriate to discuss a patient's diagnosis with another patient.
2. B. Ask the practitioner about taking a medication vacation. Rationale: Some practitioners recommend that the patient miss a dose of antidepressant medication before having sexual relations and then return to the scheduled medication regimen after sexual relations. There are other alternatives to address the sexual dysfunction side effect of antidepressant medication; therefore the patient does not have to cope with this side effect. The other responses are inaccurate.
3. C. Continue with admissions interview and care for the patient as you would care for any patient on the unit. Rationale: As a professional, you are expected to care for any patient who is assigned to you regardless of their psychiatric or medical disorder.
4. A. Tell the patient that her advances are inappropriate. Rationale: You are setting boundaries without inferring judgment on the patient's sexual dysfunction. Ignoring the patient's advances is not therapeutic since the patient does not realize that her behavior is inappropriate. The only correct response is to set boundaries.
5. C. Ask to speak with the patient in the hallway to assess the situation. Rationale: Always gather information about an incident before drawing a conclusion. Always speak with the patient outside the patient's room unless you are with another staff member. It might appear to you that the patient is looking a cross the courtyard; however the patient may be looking down at the courtyard and not into the patient's room. Ignoring the incident does not help the patient correct inappropriate behavior. Telling the patient to stop looking is not a therapeutic response.
6. A. First discuss your concerns with your husband. Rationale: It is best for the wife to assess if her perceptions are true and then openly discuss the issue with her husband. Afterward she and her husband can consult a practitioner for a medical and psychiatric assessment.

7. A. The patient is diagnosed with paraphilia fetishism type. The patient uses the body wash as a lubricant for having sex with nonliving objects in his room.
8. D. Suggest that she discuss the situation with her practitioner. The practitioner can further assess the child. Rationale: The child's comments may be a sign of gender identity disorder. Only further assessment by a practitioner will determine the diagnosis. Ignoring the comments does not address the issue. Seeking further signs of gender identity disorder may help you assess if the child may have gender identity disorder; however, that assessment should be made by a practitioner who can make a medical diagnosis and prescribe treatment.
9. C. Relocate the male patient currently assigned to a private room to the male room. Rationale: Moving the male patient from the private room is appropriate to avoid potential conflict with other patients. Moving patients is a common practice to accommodate a new patient who has a special need.
10. D. Tell the patient that Viagra conflicts with other medications and that he should talk to his practitioner. Rationale: Educating the patient about medication conflict is likely to prevent the patient from taking Viagra. The patient is then told an appropriate step for addressing his problem.

This page intentionally left blank

chapter 12

Therapeutic Communications

LEARNING OBJECTIVES

1. A therapeutic relationship
2. Therapeutic communication
3. Therapeutic interventions
4. Mediating conflicts
5. Crisis
6. Developing a therapeutic relationship
7. Running groups
8. Addiction intervention
9. Legal considerations
10. Nurse process report
11. Milieu

KEY TERMS

Adventitious crises
Adverse behavior
Barriers to effective communication
Chemical restraint
Command presence
Communication
Constant observation
Distorted communication
Effective listening
Family crises
Group dynamics
Incompetence
Involuntary status
Maturational crises
Methods of communication
Patient rights
Relationship
Restraint
Seclusion
Stages of adoption
Suicide assessment
The process of relapse

1. A Therapeutic Relationship

For a moment, imagine being a patient brought from the emergency department in a wheelchair to a locked-down unit. You are wearing a hospital gown. Your street clothes and other belongings are in a clear plastic bag on your lap. This may or may not be your first time being admitted to a psychiatric unit. As you are wheeled into the unit, you notice patients walking around dressed in street clothes. You are greeted by a nurse who looks down toward you from over the nurse's station. Your relationship with your nurse begins.

The nurse is a key member of the patient's treatment team along with the psychiatrist, social workers, nursing assistants, recreational therapist, and others whose goal is to stabilize the patient and enable them to return to activities of daily living. The therapeutic goal is achieved through medication, one-on-one counseling, therapy groups, therapeutic activities, and informal interaction between the patient and staff and among other patients. Collectively these activities enable the patient to return to the life prior to the most recent episode of their illness.

A **relationship** is the way two people connect with each other. There are various types of relationships, such as a causal, friendly, professional, collegial, business, and intimate relationships. All of us engage in relationships. Some relationships are stable and do not change over time, such as a business relationship with the owner of a local store. Other relationships change over time, such as a collegial relationship that develops into friendship.

A therapeutic relationship is a connection between a member of the patient's treatment team and the patient whose goal is to follow a prescribed course of

treatment to help them return to activities of daily living. A therapeutic relationship is a stable relationship and must not develop into another kind of relationship. That is, the nurse must never become the patient's colleague or friend even after the patient is discharged from the nurse's care.

The patient develops a trusting relationship with the nurse and may reveal personal feelings and other information that creates a special bond between the patient and nurse. Sharing personal feelings and trusting another person occurs as a natural progression from a causal relationship to a close friendship relationship that sometimes leads to an intimate relationship. The nurse must take steps to set boundaries in a therapeutic relationship with a patient to prevent any natural transformation of the relationship into an inappropriate relationship.

The patient and the nurse must know that the nurse is part of the patient's treatment team whose goal is to help improve the patient's health. Setting and maintaining the relationship boundary is challenging because the nurse and the patient may develop a close connection with each other.

2. Therapeutic Communication

Communication is a major element in a therapeutic relationship. Communication is transmission of information from the sender to a receiver using shared symbols. A symbol is a word, phrase, or body language used in communication. The meaning of the symbol must be shared between the sender and receiver.

In a nontherapeutic relationship such as the one you have with friends and colleagues, communication is usually successful. That is, the information that is transmitted is usually received intact because symbols are mutually understood. For example, your friend may accept a glass of water that you offer and drink the water. Both of you understand the words that are expressed and recognize the glass and water.

In a therapeutic relationship such as between a nurse and a psychiatric patient, communication may not be successful because there is a misunderstanding of symbols. The misunderstanding is likely caused by the patient misinterpreting symbols transmitted by the nurse due to the patient's psychiatric disorder.

Let us say that the patient is diagnosed with schizophrenia paranoid type. Schizophrenia is an illogical pattern of thinking that results in distortion of reality. Simply, the patient has difficulty interpreting reality. A patient who has schizophrenia paranoid type has a mistaken belief that someone is out to harm them. This is referred to as a delusion. Communicating with a patient who has

schizophrenia paranoid type is challenging because some symbols are not shared. For example, using the glass of water example, the patient may believe that you placed poison in the water and refuse to drink the water even if the patient is thirsty.

The challenge for the psychiatric nurse is to develop skills that recognize the breakdown in communication—symbols that are not shared—and develop a way to effectively communicate with the patient. For example, the nurse who is aware that the patient is paranoid may let the relationship with the patient develop slowly and give the patient time to realize that the patient can trust the nurse. Once a trusting relationship is developed, the nurse can then have a more natural interaction with the patient.

Methods of Communication

Information is communicated through speech and nonverbal behavior. The receiver observes the sender's behavior in addition to listening to the words to fully understand the information being transmitted. You probably have seen comedians use nonverbal behavior to get a laugh. They make a statement, pause, and then give a contradictory pose and facial expression. No punch line is necessary because the comedian's body language conveys the message.

Let us say you are being interviewed. The interviewer asks reasonable questions and replies to your responses; however, the interviewer frequently breaks eye contact with you to read their email. Their behavior communicates a stronger message than their words. Even if the interviewer listens to everything you say, you still have the feeling that the interviewer is disinterested in what you are saying.

The psychiatric nurse must be aware of the two ways messages can be sent through body language: messages the nurse sends the patient through body language, and messages the patient sends to the nurse through body language.

The psychiatric nurse must be sensitive to the transmission of nonverbal communication when interacting with a patient because the patient's psychiatric condition may cause them to misunderstand the nurse's body language. Let us say you are having an informal conversation with a friend and you text on your cell phone as you are conversing. Your friend may not take offense because they know that both of you regard your conversation as important, and therefore, your friend will disregard your nonverbal communication.

Conversely, let us say you are conversing with a patient who is diagnosed with a major depressive disorder and who feels hopeless and helpless because they believe they have been rejected by their friends and relatives. You are

constantly distracted by other activities on the unit that frequently cause you to turn your head away from the patient. The patient can easily interpret your body language as rejection regardless of what you say to the patient.

Here are a few techniques you can use to ensure that your body language conveys the proper message.

- Be aware how your posture, facial expressions, and physical movement may be interpreted. Remember that the psychiatric condition may cause the patient to misinterpret acceptable body language.
- Observe the patient's body language in response to what you are saying. Immediately clarify any possible misinterpretation at the first sign that your message is not being received by the patient as you intended. Explain your behavior so there is no misinterpretation.
- Anticipate and prevent anything that may disrupt or distract you from effectively communicating with the patient.
- Maintain eye contact at all times during your conversation with the patient. Eye contact is the primary body language that conveys interest and sincerity.
- Use a tone that complements the information that is being communicated. Avoid hesitation. Hesitation implies that you are unsure of what you are saying. Avoid a carefree tone when discussing a topic that the patient considers serious. You can use a carefree tone during informal conversations with the patient.

Written Communication

Written communication is another mode of transmitting information to a patient and the patient's treatment team. Written communication includes the treatment plan, the patient's discharge instructions, and entries in the patient's chart.

Written communication eliminates the problem of body language interfering with the message that is being sent by the nurse. However, written communication introduces new challenges to transmitting information. The foremost challenge is that the reader must interpret the document without the opportunity for clarification, which can lead to misunderstanding. For example, a patient's discharge instructions may be confusing to them. But because the patient has been discharged, they do not have the opportunity to ask the nurse questions about the instructions.

Written communication is also influenced by the patient's eye sight, reading, and language skills. These factors can disrupt the message from being received

by the patient. In addition, the patient may be embarrassed to acknowledge these weaknesses and therefore will not follow up per the treatment plan.

Barriers to Effective Communication

The nurse must be aware of barriers that prevent effective communication regardless of the method the nurse uses to communicate with the patient. A goal in therapeutic communication is to remove all communication barriers, which can be a daunting task because the patient's diagnosis can itself be a barrier to communication.

Here are common barriers that should be avoided:

- Shared symbols: The patient may not understand the vocabulary used in the message. Likewise, the nurse may not understand the patient's vocabulary, which can occur if the patient is experiencing psychosis that impairs the patient from processing reality. For example, the patient may use word salad to express their thoughts. The nurse hears their message as a mixture of seemingly random phrases that do not make sense, yet the patient believes they are successfully communicating with the nurse.
- Personalities: The patient's or nurse's distinctive character, commonly referred to as a personality, may clash with the other person's personality, which distracts from the message that is being transmitted.
- Defensive position: The patient may perceive that the nurse's communication is attacking them, resulting in the patient becoming defensive rather than listening and understanding the message. This is particularly concerning if the patient has schizophrenia paranoid type because they are distrusting of everyone.
- Timing: Both the nurse and the patient must be in the proper mindset to communicate with each other. For example, the nurse might be busy when a patient attempts to communicate with the nurse. In a therapeutic relationship, the nurse must engage the patient each time the patient wants to communicate with the nurse. The nurse needs to listen and assess if the patient requires the nurse to intervene at that moment or if the intervention can be postponed. If the intervention is postponed, the nurse must clearly acknowledge that they heard what the patient was saying and that they will reengage the patient at a specific time in the future. For example, the nurse can momentarily stop and actively listen to the patient and then tell the patient that they will continue the conversation in 5 minutes when the nurse is finished with the current task.

- Skills: Be sure that the patient is able to communicate. Some patients may lack sufficient reading, writing, and language skills to communicate with the nurse. The nurse must be particularly sensitive to patients for whom English is their second language. Sometimes patients use body language that indicates they understand the message when in fact the message is lost in translation.
- Distribution: The nurse must communicate directly with the patient and avoid asking another staff member or patient to pass along the message. An intermediary might inadvertently miscommunicate the message.

Communicate Effectively

Careful consideration must be given to how a message is structured and delivered to communicate effectively. Here are best practices to follow when communicating:

- State the main point at the beginning of the message and then follow up with secondary points.
- Pause and give the patient time to digest the points and react to your message.
- Politely ask questions to determine if the patient understood your message.
- Encourage the patient to ask questions and provide you with new information.
- Listen and understand the patient's point of view. Do not jump to conclusions and assume that the patient's response is irrelevant.
- Keep the discussion on the message that you are sending. Other topics may arise during the conversation, but agree to address those topics at another time.
- Summarize the conversation, acknowledging areas of agreement and disagreement. Also acknowledge areas that still need to be explored.
- Define the next step by giving the patient an idea of how you expect them to react to the message. An important element of a therapeutic relationship is to help the patient process information.

NURSING ALERT

Psychiatric patients may have difficulty communicating their thoughts; however, they do have thoughts that they want to communicate. The nurse must be proactive and help the patient communicate those thoughts.

Effective Listening

The nurse needs information to properly assess the patient. Twice the amount of information is gained by listening than by talking; therefore it is critical that the nurse become an effective listener. An effective listener uses observations (e.g., body language), in addition to listening to the words, to identify and interpret the message that the patient is trying to convey. Keep in mind that the patient may not be a good communicator, requiring the nurse to use listening skills to decipher the message in the information transmitted by the patient.

Here are good practices to become a good listener:

- Focus on the patient: Give the patient your full attention. Avoid distractions.
- Maintain eye contact: Eye contact infers that the patient has your full attention.
- Use positive body language: Stop what you are doing. Face the patient. Do not have anything in your hands. Be relaxed during the conversation.
- Listen to the message: Focus on what you can learn from the message rather than on the words or how the message is being communicated.
- Evaluate the message: Separate facts from the noise of the message.
- Ask probing questions: Questions help you know if you understood the message correctly.
- Provide constructive feedback: Tell the patient how you feel about the message, without embarrassing the patient. Always let the patient save face.

Distorted Communication

Avoid losing your message through distorted communication. **Distorted communication** is communication when only part of the entire message is received. This occurs when:

- There are too many distractions for the patient. For example, they may be involved in other activities while the nurse is talking.
- The message is sent too quickly, such as the nurse talking while walking away from the patient toward the nurse's station.
- The patient does not have time to digest the information, such as the patient unexpectedly being told that the physician wants to see the patient.

- The message may be difficult to comprehend, or the patient is given incomplete information.
- There is a cultural difference between the nurse and patient. For example, the patient may nod, so the nurse considers that the patient is nodding in agreement when in fact the patient is nodding in acknowledgment that they understood the nurse's question.
- The patient is embarrassed to admit that they did not understand the message.

Situation, Background, Assessment, Recommendation (SBAR)

The patient's treatment team must communicate effectively, and the best way to do that is to use the SBAR form of communication. SBAR was developed by the US Navy during World War II to help officers quickly make informed decisions. SBAR has since been adopted by the medical community as the preferred form of communication among the patient's treatment team.

The goal of SBAR is to channel the decision maker's focus on factors that influence a decision rather than on a problem. When a problem arises, a decision maker uses a structured approach to reach a decision. That structure begins with an understanding of the situation (i.e., the problem). Next is to understand the background of what happens. Attention then turns to assessing the impact of the problem in the near and long term. And finally, recommendations for solving the problem are given.

The SBAR format is designed so that the person asking the decision maker for a decision presents the decision maker with all the information that is needed to make a decision; that is:

- Situation
- Background
- Assessment
- Recommendation

Let us say that the nurse is caring for a patient who is diagnosed with alcohol dependency and the patient is in her room trying to catch bugs that are crawling on her bed. However, there are no bugs. The nurse recognizes that the patient is experiencing delirium tremens. The nurse calls the practitioner and says:

Mrs. Jones is trying to catch bugs that are crawling on her bed but there are no bugs. (Situation)

Mrs. Jones is a 53-year-old, married, Caucasian woman admitted to the unit 48 hours ago for alcohol dependency. She has been drinking four six-packs of beer daily for the past 20 years. Her liver enzymes are elevated and vital signs are within normal range. She was asymptomatic when admitted to the unit and placed on the Librium protocol. Her last dose of Librium was at 4 pm. (Background)

Mrs. Jones seems to be showing symptoms of delirium tremens and is a high risk for falls and self-injury. (Assessment)

Do you want Mrs. Jones transferred to the critical care unit, do you want to change her medication, or should we continue to monitor her condition until you arrive to assess the patient? (Recommendations)

You can see in this example how the nurse anticipated information that the practitioner needs to make a decision. The nurse's recommendations are based on alternative interventions that the nurse has implemented in similar situations. Notice that the practitioner is focused on the decision and does not have to spend time gathering information to make the decision.

Stages of Adoption

An important factor in therapeutic communication is to help the patient think through solutions to the patient's problems. Some patients' diagnoses may impede their capability to think through a problem and arrive at a likely conclusion. Therefore, the nurse must help the patient think through the problem.

Before the patient or anyone enacts a solution, the patient goes through **stages of adoption**. Each stage of the adoption process provides a foundation to justify a specific solution. The nurse should focus on helping the patient through each stage.

There are five stages of adoption; these are:

- Awareness: Awareness is when the patient realizes there is a problem and that there is a possible solution to the problem.
- Exploration: Exploration is when the patient takes a superficial look at a solution to determine if the solution is feasible.
- Examination: Examination is when the patient takes a detailed look at a solution to try to uncover reasons why the solution is invalid.
- Test: Test is when the patient tests the solution under various scenarios.
- Adoption: Adoption is when the patient enacts a solution.

For example, a patient diagnosed with substance dependency is told that Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) have programs that can help the patient during recovery. The patient may first learn about these programs from the social worker (awareness). The patient may then ask other patients on the unit if they have heard about those programs (exploration). The nurse may give the patient a brochure about NA and AA (examination). The patient may attend an NA and AA meeting when the meetings are run on the unit (test). The patient may then go to the meetings after being discharged from the unit (adoption).

Bad News Bear

At times, the nurse will be required to deliver bad news to a patient, which can become distressing for the nurse. However, there are steps that can be taken to minimize the negative impact of bad news both on the patient and on the nurse; these are:

- Gauge the impact the bad news will have on the patient.
- Identify options for the patient.
- Present the bad news objectively.
- Do not minimize or overstate the situation.
- Explain the facts related to the problem and options in one sitting.
- Spend time helping the patient process the problem and to explore options.
- Try to leave the patient with hope.

Command Presence

A psychiatric unit can become chaotic unless the nurse controls activities on the unit. Control has to be accomplished by balancing leadership with therapeutic relationships. The best way to achieve control is through a command presence. **Command presence** is the appearance that the nurse is in charge of the unit or situation. Command presence can be conveyed by actions, words, body language, tone of voice, or a combination of these factors. Here are best practices for implementing a command presence:

- Stay objective and avoid becoming emotionally involved.
- Take control over the situation.
- Assess the situation and act only after you have an action plan.

- Make yourself appear different from others and maintain this higher status.
- Stay at arm's length from disputes.
- Find facts.
- Avoid the gotcha mentality where the goal is to catch someone making an error.
- Do not take patients' words personally.
- Enforce rules of the unit uniformly.
- Set expectations for patients and staff.
- Be aware that some patients will try to manipulate you so they can avoid rules.

3. Therapeutic Interventions

The success of a therapeutic rapport with a patient greatly depends on the perception they have of the nurse. Realize that a psychiatric patient is likely to have a distorted perception of their environment due to their psychiatric disorder. The patient may have difficulty processing events that are routine for the nurse. Therefore the nurse needs to follow a few guidelines when intervening with a patient to ensure that the therapeutic rapport is not disrupted by misperceptions of the patients.

Here are a few practices that will help to build a good therapeutic rapport with the patient.

Anxiety and Panic Disorders

- Stay calm.
- Do not touch the patient.
- Permit the patient to pace as a way to cope with the anxiety.
- Reduce noise, lights, and anything that increases stimulation.
- Stay with the patient continually to establish trust.
- Use the patient's first name or nickname to establish a rapport.
- Speak in an authoritative voice using short simple phrases, and then use therapeutic communication once the patient is calm and trusts you.
- Explain your actions before performing those actions.
- Explain events taking place on the unit.
- Ask the patient to express their feelings.

Posttraumatic Stress disorder (PTSD)

- Avoid anything that might remind the patient of the event.

Obsessive-Compulsive Disorder (OCD)

- Do not interrupt the compulsive behavior.
- Schedule a time when the patient can perform the behavior.
- Ask the patient to write down events that trigger compulsive behavior. Writing helps to distract the patient from the behavior.

Mood Disorders

- General:
  - Provide realistic positive feedback and encouragement.
  - Monitor the patient's ability to tolerate frustration and individual situations.
  - Always respect the patient and be nonjudgmental.
  - Encourage expression of feelings and needs.
  - Help the patient to become involved with activities on the unit.
- Manic episode:
  - Engage the patient in conversation at the first indication of agitation and anxiety to prevent their mood from escalating.
  - Encourage the patient to express their feelings.
  - Ask the patient what you can do to help them stay in control.
  - Help the patient think through options available to them.
  - Medicate the patient before the manic episode escalates.
  - Protect the patient from self-injury and injuring others.
  - Identify acceptable behaviors.
  - In a calm moment, help the patient identify triggers of unacceptable behavior.
  - Decrease environmental stimuli when the patient becomes agitated, and then increase environmental stimulation gradually when they regain self-control.
  - Provide a safe environment.

- Depressive episode:
  - Encourage the patient to discuss their concerns.
  - Help the patient develop hope by identifying positive elements of their life.
  - Help the patient focus on things that they can control and not to focus on things that they cannot control.
  - Help the patient develop realistic goals and steps to achieve those goals.
  - Encourage the patient to focus on strengths rather than weaknesses.
  - Encourage identification of persons who are supportive.

Schizophrenia

- Be honest.
- Do not confront the patient.
- Help the patient interact with one other patient to introduce them to real-life situations.
- Focus on making the patient feel safe on the unit.
- Establish and enforce rules.

Abuse Victims

- Promote a trusting relationship.
- Do not force answers.
- For children, offer play for expression.
- Explain that your purpose as a professional is to help provide safety and assistance.
- Do not give false assurances to victims.
- Speak to caregivers/possible abusers privately.
- Remain neutral, nonthreatening, and supportive.
- Do not judge.
- Use open-ended questions requiring descriptive responses followed by more direct, specific questions.
- Remain objective.
- Clarify that abuse is never acceptable.
- Develop a detailed safety plan with the victim that includes financial resources necessary to carry out the plan.

Alzheimer Disease

- Plan for the patient to have a pleasant experience that does not rely on memory and learning.
- Provide the patient with predictable routines that ensures patient safety.
- Use simple, direct, complete sentences.
- Be aware that the patient is picking up your body language.
- Avoid topics that disturb the patient.

4. Mediating Conflicts

Conflict with a patient cannot be avoided; however, the nurse can take steps to minimize the opportunity for conflict to arise. These steps include:

- Keep lines of communication open: Free flow of accurate information is critical to avoiding conflict, and information can only flow if lines of communication among patients and the nurse remain open during the duration of the patient's stay on the unit.
- One-on-one conversations: The nurse should converse individually with each patient on the psychiatric unit to identify potential conflicts and to ensure that each patient is working with accurate information.
- Hold regular meetings with patients: Meetings provide a forum for exploration and discussion on challenges faced by patients and possible strategies to meet those challenges. A meeting is also the place when issues are clarified (see Group Dynamics).
- Participation in the decision process: A patient who participates in a decision develops a feeling of ownership in the decision. Conflicts between the patient's opinions and recommendations and the decision are resolved if they help to make the decision.
- Feedback: Each patient should be encouraged to speak openly and honestly during one-on-one conversations and during meetings (see Group Dynamics).
- Test the waters: Discuss potential changes with each patient. The patient will learn about and can address potential conflicts before the recommendation is put forth.
- Make small changes: Conflicts decrease when change is made incrementally.
- Be honest: Truthfulness can avoid conflicts. A patient may not embrace what is said but can appreciate that the nurse made an honest statement.

NURSING ALERT

The mediation process is dependent on the premise that both parties' in a conflict are rational and can process facts logically. Some psychiatric patients are able to benefit from mediation, whereas other psychiatric patients are not capable of logically processing facts, and therefore, the mediation process is not appropriate for those patients.

Mediate a Conflict

When conflicts arise, the nurse takes on the role of a mediator. A mediator's role is to create an environment where parties to the conflict can resolve their differences. Facts in dispute tend to overshadow facts that are in agreement. Parties tend to become emotional over the conflict that clouds their rational thought process.

The nurse must remain calm and be a neutral party to the conflict. Give a 1- to 2-hour cooling off period so that the parties can regain composure. Call a meeting at a neutral place away from the flow of traffic so there will be no interruptions. The goal is to have parties revisit the issue that caused the conflict with an open mind. The nurse must focus attention on the issue and not on the personalities of the parties.

Begin by helping the parties identify facts that are in agreement. This list is usually much longer than the list of disputed facts. An objective is to make this list long.

Next, help the parties identify facts that are in dispute. Make a list of those facts. This tends to be small. An objective is to make this list short.

Reviewing both lists should make it obvious that the parties are in agreement except for a very few facts. The nurse should reinforce this observation by saying, "Looks like your differences are small when looking at the big picture."

Next, dissect each fact in dispute into elements. List elements of each fact that is in agreement and of each fact in dispute. The list of elements of the disputed fact tends to be longer than the list of elements in dispute. The process of identifying elements that are disputed helps to place the conflict in perspective for the parties. Each party can see that they agree on most things including a lot of elements in the disputed fact.

At the end of this exercise, there is a list of a few facts that the parties agreed are in dispute. The nurse then focuses everyone's attention on the first disputed fact. Each party is invited to explain their position while others are asked to listen and avoid interruptions. Each party is then invited to respond.

It is important for the nurse to listen carefully to each position and counter position in an effort to identify common ground. The nurse should restate each position and opposing argument in a calm deliberate voice saying, "Here's what I heard you say…." Give each party time to correlate your understanding.

Summarize the status of the disagreement and open the floor to possible solutions. Help each side think through the proposal by exploring the advantages and disadvantages, and provide a reality check. A reality check separates theory from practice and helps the parties focus on a realistic solution to the conflict.

The mediation process provides parties with a realistic view of the conflict and helps them stay focused on finding an acceptable solution. Parties may agree to disagree, but they will come up with a way to continue to work as a team.

5. Crisis

A crisis is an unexpected stressful event in a patient's life; the patient is unable to problem solve to address the crisis. Tension increases with each failed attempt to cope. Coping is the conscious attempt by the patient to manage anxiety. With no alternatives available, the patient becomes hopeless of finding a solution to the crisis and feels helpless. The patient depends on the nurse to assist them in dealing with the crisis. The patient will experience major disruptions in their life if the problem remains unresolved for longer than 4 weeks.

Here are four common types of crises:

- **Adventitious crisis**: An adventitious crisis is an unpredictable catastrophic external event.
- Situational crisis: A situational crisis is an event that impacts the patient directly such as loss of a job.
- **Family crisis**: A family crisis is an event that disrupts a family such as divorce.
- **Maturational crisis**: A maturational crisis is an event of normal life changes such as changes that occur with aging.

When the patient is in crisis, the nurse has to take on a supportive role and help patient cope with the event. The nurse begins by assessing the patient and the situation and determining their perception of the problem and their capability to cope with the problem; the nurse should identify any faulty thinking by the patient.

Help the patient focus on the immediate problem and avoid any connection to previous problems. Let the patient express their feelings. Validate those feelings by acknowledging that the patient has grounds for those feelings. Express that you will help the patient work through the crisis but that they will make their own decisions.

The goals of intervention in a crisis are to

- Identify the real problem
- Identify the perceived problem as expressed by the patient
- Help the patient analyze the event objectively
- Help the patient identify options to address the crisis
- Help the patient process each option
- Provide a framework within which the patient will decide on how to address the problem

Suicide Assessment

A patient in crisis can feel hopeless and helpless, and such feelings can lead to suicidal ideation or a suicide attempt. Suicidal ideation is the thought of killing oneself. Suicide attempt is acting on those thoughts. All suicide attempts must be considered seriously; however, some attempts are considered suicidal gestures. A suicidal gesture is when a patient commits a suicide attempt only to get attention. For example, the patient may take a lot of pills 5 minutes before a family member arrives. The patient knows the quantity of pills is not enough to cause death.

NURSING ALERT

Always consider suicidal ideation or suicide attempt a critical situation even if the patient tells you that they are not serious.

Assess the patient for suicide risk by asking them:

- Have you had any thoughts about life not being worth living?
- Do you have any thoughts of hurting or killing yourself?
- Have you ever tried to harm yourself or kill yourself in the past?
- If the patient answers yes, then determine if they have any current thoughts or plans to harm themself.
- Ask the patient if they have any means of harming or killing themself such as with a gun or medications.

If the patient answers these questions positively, then ask them if they agree to contract for safety. A contract for safety is an agreement between the patient and the treatment team where the patient agrees not to harm themself while on the unit and to speak with any staff member if they have suicidal ideations.

NURSING ALERT

The risk for suicide is high when the patient has a sudden sense of peace and has sufficient energy to commit suicide.

There are steps the nurse can take to decrease the risk of a suicide attempt for a patient who is a high risk for suicide. Here is what the nurse should do:

- Place the patient on constant observation until the risk of suicide decreases.
- Once off constant observation, make sure a staff member sees the patient every 15 minutes 24 hours a day. The staff must know the patient's location at all times.
- Remove all items from the patient, their room, and the unit that can be used by the patient to harm themself.
- Develop a therapeutic relationship with the patient and encourage them to explore their feelings.
- Assign the patient to a shared room so they are not alone.
- Make sure that the patient takes prescribed medication. A psychiatric diagnosis such as major depressive disorder can lead to suicidal ideations. Medication can improve the patient's depression.
- Ask the patient to work with the treatment team to develop a safety plan for them.

Adverse Behavior

Psychiatric patients can become aggressive toward other patients and staff without any warning. A patient who is calm and controlled can suddenly turn threatening and violent. There are many underlying causes for aggressive behavior such as the patient misinterpreting reality or trying to manipulate, intimidate, or control their environment. Regardless of the underlying cause, the nurse and staff must take precautions to reduce the likelihood of being injured by a patient.

The nurse must have a plan when approaching a patient or when a patient approaches the nurse. Here are a few steps to incorporate into the plan.

- Position yourself in a nonthreatening and nonchallenging stance. Remember that your body transmits a message long before you say anything.
- Do not be confrontational. The patient reacts to your demeanor. Challenging the patient will likely escalate the situation.
- Always keep the patient in sight and make and maintain eye-to-eye contact.
- Identify an escape route. Never be in a position where the door is blocked. Always stay close to the door and keep the door slightly open so you can quickly escape and call for help.
- Define your personal space and do not let the patient enter your personal space. A personal space is the distance around you where you feel comfortable to engage in conversation. This is typically 1.5 to 4 feet.
- Position yourself in an "L" stance where your front foot points toward the patient and your rear foot is at a 30-degree angle creating an "L." This enables you to change your weight from the front to the back foot to escape the patient.
- If the patient attempts to enter your personal space, raise your hand indicating that you want the patient to stop and say, "I can hear you from there." Back up if the patient continues to move closer to you.
- Watch the patient's body language and listen to the tone in their voice and what they are saying for signs that their anxiety is escalating and they are becoming increasingly irrational, impulsive, and unable to maintain self-control.

NURSING ALERT

Take all threats seriously. Do not be alone with the patient. Get help from other staff members immediately.

Responding to a Crisis

The nurse's goal is to de-escalate a crisis situation during which a patient is overwhelmed and unable to retain enough control to think through and react to a problem rationally. A crisis typically lasts a few minutes if the nurse intervenes and de-escalates the situation. The goal is to encourage the patient to verbalize

their concerns and to indicate to the patient that their message is being received by the nurse intact. Here are steps to take to control a crisis situation:

- You must appear in control even if you are unsure of yourself. Walk to the crisis.
- Remain calm and isolate the patient from other patients. The patient can be taken to a quiet part of the hallway or to the seclusion room.
- In a sincere tone, ask the patient to explain the event and their feelings. Keep your conversation with the patient moving at a steady cadence and tone.
- Keep a command presence while actively listening to the patient's response. Encourage the patient to talk about the situation and their feelings.
- Give the patient honest feedback. Help the patient focus on the facts and think through the situation. Restate what the patient is saying. This helps the patient to understand that their message is being received. Do not be judgmental.
- Enforce limits. Tell the patient that you will listen to them only if they control themself. If they are unable to control themself, then steps will be taken to prevent them from hurting themself. Do not threaten. Simply state facts and give the patient options. Remain objective. Do not lose control. Follow through on setting those limits. The patient must know there are consequences for their actions.
- The patient is likely to challenge the nurse's limitations. Ignore the challenge. Continue to encourage the patient to talk and express their feelings. Help the patient think through options.
- Watch for nonverbal cues that indicate that the patient is regaining control and is calming down. Give the patient positive statements when they begin regaining control.

NURSING ALERT

Often a patient vents and acts out as a mechanism to cope with an overwhelming situation. The nurse should isolate the patient and let them blow off steam.

After the Crisis

The patient has to cope with the embarrassment of acting out once the patient regains self-control. The patient is likely to rationalize that their behavior was

inappropriate. It is not unusual for the patient to cry and apologize to the staff and to other patients, especially if they have developed a therapeutic rapport with some staff.

The nurse who has a good therapeutic rapport should debrief the patient. Debriefing is a process whereby the nurse and the patient reflect on what has occurred. Debriefing should be conducted to allow the patient time to regain full composure. During debriefing, the patient needs to understand that there will be no retaliation by the staff against them. However, the patient must be told that their behavior is inappropriate and that any consequences such as losing off-unit recreational privileges will occur.

The nurse and the patient should develop a verbal contract that specifies what the patient should do if they encounter a similar situation. For example, the patient will agree to speak with their nurse the first moment they feel as if they are becoming overwhelmed. Debriefing brings closure to the crisis, and afterward, the patient and staff should go about their normal activities on the unit.

The nurse should also debrief the staff in an effort to bring closure and address any concerns of the staff. In addition, the staff should devise a plan for intervening with the patient at the first indication that the patient is becoming overwhelmed.

Patient Observations

All psychiatric patients are observed when on a psychiatric unit as an element of the patient's treatment plan. Observation means that a staff member must see the patient at least once in a specified period of time. The time between observations depends on the patient's diagnosis and stability. A stable patient may be required to be observed every 30 minutes. A patient who is in an acute but not crisis stage may be observed every 15 minutes. And a patient who is unstable is placed on constant observation.

Observations are conducted round the clock—even when the patient sleeps. The patient's location is then noted on paper, commonly referred to as a headcount. The headcount is referenced if an incident related to the patient occurs to determine their movement prior to the incident.

NURSING ALERT

A psychiatric unit may be under constant video surveillance. Video monitors are usually available at the nurse's station and in the security department. Activities are recorded and referenced after an incident occurs on the unit.

Constant Observation

A patient is placed on **constant observation** when the patient is considered a danger to themself or others. In a crisis, the nurse is usually permitted to order constant observation pending assessment of the patient by a practitioner. The practitioner then writes an order to have the patient constantly observed.

Once constant observation is initiated, a staff member is assigned to monitor the patient constantly including when they shower and use the bathroom. The staff member must see the patient's face at all times and be within an arm's length of the patient. The only exception is if the patient is paranoid or assaultive. The staff member stays 5 feet away from the patient in those situations.

The staff member is required to note the location of the patient, the patient's behavior, and the staff interventions every 15 minutes, depending on the facility's policy. Furthermore, the nurse is required to assess and document the nurse's findings in the patient's chart every hour. The patient must be reassessed by a practitioner every shift, at which time the practitioner determines if the patient remains a danger to themself or others. The patient is removed from constant observation when they are determined to be safe.

NURSING ALERT

The nurse is ultimately responsible for the overall care of a patient who is under constant observation. A patient who is under constant observation may not be permitted visitors, depending on the policies of the facility.

Seclusion and Restraint

When a patient acts out and demonstrates aggressive behavior, the nurse, with the help of staff members, must gain control of the situation immediately and reduce the risk of the patient injuring themself or others. The nurse must do so using the least restricted technique required to control the situation.

The initial step is trying to de-escalate the crisis by talking with the patient. This is referred as talking down the patient (see Crisis). When this technique fails, the nurse offers the patient quiet time. Quiet time occurs when the patient voluntarily goes to an area of the unit where there are no distractions, no noise, and no other patients. Typically the area is the **seclusion** room. The nurse continues the therapeutic conversation with the patient while they are in quiet time. The patient is told that they are free to leave the quiet time area at any time. Quiet time is to give the patient time to regain composure.

If the patient refuses to go into quiet time and their agitation and aggressive behavior continue, then the nurse orders them to be placed in seclusion. Seclusion is involuntary confinement that separates the patient from other patients and staff. Seclusion usually occurs in a specially designed room called the seclusion room. The room typically has a bed and an overhead light controlled from outside the room. The patient has nothing in the seclusion room that can be used to hurt themself. Even the walls and the door of the seclusion room have padding to lessen the risk of injury should the patient try to assault the walls and door. The door to the seclusion can be locked. The patient is not free to leave seclusion.

Before placing the patient in seclusion, the nurse must examine the seclusion room to be sure there are no means for the patient to injure themself in the seclusion room. Shoes should be removed and the patient searched for any contraband. Limit closeness for maximum safety.

If the patient is violent and continues to be violent while in seclusion, then they are placed in four-point restraints. The patient is placed on the bed, and their arms and legs are tied to the bed with leather straps.

NURSING ALERT

The patient has the right to be free from seclusion and restraints and be treated with dignity and respect. Seclusion and restraint can only be used when ordered by a practitioner and can last only as long as clinically necessary.

Depending on the facility's policy, the nurse may initiate seclusion and restraints in an emergency. The practitioner must be notified and must assess the patient within an hour. The practitioner's order specifies the date and time and the clinical reason for the seclusion and restraint. Furthermore, the order must specify the body parts that are to be restrained and the behavior criteria for discontinuing seclusion or restraint.

A restraint order expires in 4 hours for an adult, 2 hours for a child who is 9 years or older but less than 18 years old, and 1 hour for a child under 9 years old. The practitioner must reassess the patient at those times and determine whether to reissue the order or discontinue the order.

The nurse must supervise the application of restraints by the staff. The patient's shoes and socks must be removed and the patient's head must be free to rotate and be elevated. The nurse must be able to place two fingers between the restraint and the patient's body to ensure that their circulation is not disrupted.

The patient is placed under constant observation while in seclusion and restraints. The patient's condition is documented every 15 minutes by the staff member who observes the patient. The staff member who is observing the patient must be the same sex as the patient. The staff member must offer the patient food, water, and the opportunity to void.

The nurse must assess the patient every 2 hours and document the assessment. The nurse assesses for signs of injury, range of motion for limbs and head, vital signs, circulation, the patient's hygiene, and need for elimination (defecation and urination). The nurse also assesses the physical and psychological status of the patient to determine if the patient is ready for the restraints to be removed. The nurse informs the practitioner if they feel that the patient is stable. The practitioner assesses the patient to determine if the restraints can be discontinued.

Restraints include

- 4 quarter fall side rails
- 2 full fall side rails
- Hand mitts
- Chest vest
- Locked wrist bands
- Locked ankle bands
- Posey vest for geriatric patients
- Seat belt that the patient cannot easily remove

NURSING ALERT

The nurse is not permitted to use a five-point restraint.

A chemical restraint is prohibited. A **chemical restraint** is considered medication administered to the patient for the sole purpose of preventing them from moving. However, medication can be administered to reduce agitation if the medication is part of the patient's treatment plan. For example, some practitioners order Ativan, Haldol, and Cogentin to be administered to the patient if they become agitated. The combination of Ativan and Haldol has a relaxing effect on the patient. Cogentin may be ordered to prevent side effects of Haldol.

In an emergency, the restraints are removed from the patient. The patient is moved to a safe area under constant observation. The nurse must notify the

practitioner immediately if the patient shows any signs of injury at any time while they are in restraints.

Restraints are discontinued when

- The order expires and is not renewed.
- The patient is sleeping.
- The patient is no longer a danger to themself and others.

The patient must be debriefed by the nurse after restraints are discontinued. Debriefing occurs in private between the patient and the nurse and possibly others on the patient's treatment team.

During the debriefing, the nurse reviews the behavior that led to the restraint order being issued by the practitioner. The nurse also discusses other options that were available to the patient before being placed in restraints. Together the patient and nurse explore ways in which the incident that caused the patient to become agitated could be handled differently in the future.

NURSING ALERT

Any time a patient is held is considered a **restraint**. The nurse must have an order from a practitioner to hold a patient. Restraining or holding a patient without a practitioner's order is considered battery and false imprisonment. Threatening a patient is an assault.

6. Developing a Therapeutic Relationship

A therapeutic relationship has three phases; these are:

- Preorientation phase: The preorientation phase is when the nurse prepares to speak with the patient.
- Orientation phase: The orientation phase is initially engaging the patients, during which the nurse is introduced to the patient, boundaries are established, and the nurse and patient set objectives.
- Working phase: The working phase is when the nurse and patient are fully engaged and work toward the mutual goal. The length of the working phase continues until the patient is discharged.
- Termination phase: The termination phase concludes the therapeutic relationship usually when the patient is discharged. It is during this phase that the nurse summarizes the achievements and prepares the patient for the next level of care.

The nurse must look for signs of transference during the therapeutic relationship. Transference is when the patient experiences feelings toward the nurse that are originally associated with a person in the patient's life. For example, the patient may feel the nurse represents their mother and therefore reacts to the nurse as they would react to their mother. Sometimes transference can lead to insight into the patient. That is, the patient may feel more open to expressing feelings if they feel that the nurse is their mother. However, transference can be negative and become a barrier to a therapeutic rapport between the nurse and the patient. For example, the patient may have had a disruptive relationship with their mother and therefore continue that disruptive relationship with the nurse.

NURSING ALERT

It is critical that the nurse defines the boundaries of the therapeutic relationship with the patient. The nurse must reinforce the boundaries whenever the patient has transference with the nurse.

The nurse must also look for signs of countertransference. Countertransference occurs when the nurse experiences nontherapeutic feelings for the patient. That is, the nurse becomes emotionally involved and loses objectivity. The nurse may invite the patient into their life by engaging the patient outside of the therapeutic environment.

Sometimes, a patient's actions during a conversation with the nurse may reflect defense mechanisms. A defense mechanism is a way for the patient to cope with a stressful situation. Here are common defense mechanisms.

- Reaction formation: Reaction formation occurs when the patient acts counter to the patient's feelings. For example, the patient resents being admitted to a locked-down psychiatric unit but acts as if they welcome the experience.
- Projection: Projection occurs when the patient voices unrealistic reasons for their own failure rather than acknowledging failure. For example, the patient blames his wife for his negative behavior.
- Displacement: Displacement occurs when the patient misdirects anger to an incident person. For example, the patient becomes angry with the nurse after he argues with his wife on the phone.
- Regression: Regression occurs when the patient acts younger than their age. For example, a patient throws a tantrum when they do not get their way.

- Denial: Denial occurs when the patient denies facts. For example, the patient who is diagnosed with substance dependency denies that they are addicted to drugs, claiming they can stop anytime they want.
- Compensation: Compensation occurs when the patient's actions contradict their feelings. For example, a patient who has a fear of heights goes skydiving.
- Rationalization: Rationalization occurs when the patient justifies a failure. For example, a patient says he relapsed because his wife left him home alone for a few hours.
- Identification: Identification occurs when a patient takes on the characteristics of another person. For example, the patient takes on some attributes of their councilor.
- Undoing: Undoing occurs when the patient reverses a previous action. For example, the patient has an argument with another patient and then later in the day both are playing cards.
- Suppression: Suppression occurs when the patient internalizes feelings. For example, the patient has a disturbing phone call and refuses to share their feelings with the nurse.
- Isolation: Isolation occurs when the patient does not socialize with others. For example, the patient refuses to answer the front door when the social worker arrives to assess the patient.

NURSING ALERT

Never tell a patient that everything with be alright since this is belittling the patient. Focus on developing an honest, trusting, and open therapeutic relationship.

A therapeutic relationship is challenging for the nurse to maintain, especially when the nurse is unsure how to respond to a patient. A good response is to say to the patient, "Tell me about it." This reply encourages the patient to continue to express feelings and offers the nurse the opportunity to gain insight into the patient's problem.

7. Running Groups

Group interaction is a key component of many psychiatric patients' treatment plans. Group interaction enables each patient to explore common problems

and receive a diverse response from patients who have experienced similar problems. The group enhances self-esteem because the patient takes on two roles: a person responding to concerns of others and a person receiving input from others about the patient's concerns. Patients in groups have a balanced role where they help others while also being helped themselves.

Each member of the group is encouraged to freely interact with the group. They can share what they please and withhold whatever information that they feel uncomfortable sharing. New members may sit and listen for several meetings before feeling comfortable sharing any information or offering a view on information presented by another member of the group. No member is forced to share or offer an opinion, although the nurse will encourage everyone to participate.

A group consists of patients who have diverse personalities and are at various stages of their own treatment. In many ways, the group is a microcosm of society. Each patient has to adjust behavior and interactions to accommodate the group as a whole.

The group is a place where the patient can practice new behaviors. For example, a patient may be working with the treatment team to improve the patient's coping skills. The group provides the forum to practice those new skills within an environment where staff can intervene with a midcourse adjustment.

A critical benefit of a group is that each patient is able to put their feelings into words and share those words with others. Frequently, a member of the group acknowledges that they too have those feelings. Both patients realize they are not alone. The awareness of someone else having the same feelings validates a patient's feelings, decreases anxiety associated with those feelings, and helps them focus on dealing with those feelings.

NURSING ALERT

A patient should not offer advice to other patients. A patient may share a feeling or respond to another patient's feelings, but the response should be in the form of feedback. Advice should only be given to the patient by their treatment team.

Group Topics

The nurse must select a topic for the group to discuss based on the needs of members of the group. The nurse can assess the needs by one-on-one

conversation with patients, discussion with staff, and listening and observing patients on the unit. For example, the nurse may have overheard two patients conversing about a troublesome phone call with a relative. The nurse might select a group topic that explores situations with relatives and discuss ways of dealing with the situation in a positive way.

As the nurse, begin the group with an open-ended question that indirectly introduces the topic that you want to discuss with the group. For example, you might say, "What is most troubling for you today?" You ask this question because you overheard a patient on the phone arguing with a relative. However, you never know what responses you will receive from the group. There are times when you set the stage for a patient to share their feelings and later discover another patient expresses their problems.

Your objective is to help the patient think through all options to identify the best option. The patient identifies facts of the situation and reaches their own conclusion. You help them through this process by bringing up information that helps the patient reach this goal. This process is similar to helping a youngster draw a picture by laying out dots on the page then having the child connect them. In the case of a group, you are laying out dots of information that a group member can connect to reach a conclusion. The group member will have a sense of accomplishment by making a decision on their own. No one told them what to do.

Here are goals that can be used for your group:

- Reaching out to others can really help when you are struggling with strong emotions.
- Wait 10 minutes before reacting to your emotions. Strong emotions peak within 10 minutes.
- Accept your emotions for what they are and let your emotions go. Do not hold in your emotions.
- When you are feeling down, play music or engage in activities that are distracting.
- Do something nice for someone.
- Stay in the present by identifying things in the room that you can see, feel, hear, and smell.
- Write a list of things that bother you. Divide the list into things you can control and things you cannot control. Place the list of things you cannot control in an envelope and address the envelope to God. Never open God's mail. Devise a plan to address things you can control.

- Write a personal inventory. List everything good and bad about yourself. Help the patient identify good things. The goal is for the patient to see that they are more good than bad and help them build self-esteem.
- Write a journal where you express your feelings. This helps the patient express feelings without having to discuss feelings openly with the nurse.
- What makes you feel panicky? Help the patient identify misinterpreting facts that lead to a panic attack and come up with a plan to deal with the situation.
- Is the glass half empty or half full? Focus the patient on things that they can do rather than on things that they cannot do.
- Share a problem and the problem becomes smaller. The goal is for the patient to recognize that they need help to solve a problem.
- Be objective. Not everything is your fault. Explore events that occur beyond the control of the patient.
- Give yourself permission not to think about a situation right now. The goal is to help the patient compartmentalize problems.
- Ask the group to provide affirmations about a fellow group member who is being discharged. Write the affirmations on the board and on paper. Afterward, ask the patient to check off affirmations that they agree with and disagree with. Present the patient with list of affirmations when they are discharged. The patient can refer to this list every time they feel depressed.
- Begin each group with the serenity prayer.

God, give me grace to accept with serenity
the things that cannot be changed,
Courage to change the things
which should be changed,
and the Wisdom to distinguish
the one from the other.

Group Dynamics

Although we tend to think of a group as a cohesive entity, a group is composed of patients each of whom has a personality, beliefs, and a way they interact with others. This is referred to as **group dynamics**. A nurse who facilitates meetings needs to be aware of group dynamics and use the dynamics of the group to help the group achieve the meeting goals.

Each patient in a group naturally takes on one or more definable roles within the group during the course of the meeting. None of these roles are assigned to

them by the nurse. Instead, the group member is drawn into the role by changing dynamics of others who attend the meeting.

Here are the roles commonly found in a group:

- Initiator/contributor: The initiator/contributor proposes various ways the group can achieve the group's goal. The person has a positive, can-do attitude.
- Information seeker: The information seeker evaluates information presented at the meeting by the nurse and others to assess if the information is relevant, asks for clarification, and then determines information that is missing and necessary to address the group's goal.
- Information giver: The information giver is an authority on the subject matter and provides the group with factual information.
- Opinion seeker: An opinion seeker encourages everyone in the group to voice an opinion.
- Opinion giver: An opinion giver offers an opinion to the group.
- Elaborator: An elaborator expands on ideas of others in the group by providing facts and voicing consequences of a proposal.
- Coordinator: A coordinator consolidates various suggestions into one cohesive suggestion.
- Orienter: An orienter brings the discussion back on track by summarizing information that has been discussed.
- Evaluator/critic: The evaluator/critic assesses the reasonableness of a suggestion and considers when the suggestion is achievable.
- Energizer: The energizer stimulates the group into action by focusing on progress made toward the goal.
- Procedural technician: The procedural technician makes all arrangements for the meeting. This can be the patient who is the president of the unit.
- Recorder: The recorder keeps the minutes of the meeting and distributes minutes following the meeting.

Positive Roles

Some group members take on roles that help the group move toward the goal. These roles are referred to as positive roles. The nurse should encourage those group members whose efforts foster the group to work cohesively to reach a viable outcome.

Here are positive roles within a group:

- Encourager: The encourager voices support for group members whose participation moves the group along toward reaching a goal.
- Harmonizer: The harmonizer diffuses tension by finding common ground among competing opinions to keep the discussion positive (see Mediating Conflicts).
- Compromiser: The compromiser changes a position to come closer to an opposite position to move the group toward the goal.
- Gatekeeper/expediter: The gatekeeper/expediter keeps communication among group members flowing by encouraging quiet members to voice an opinion and limiting participation by group members who dominate the conversation.
- Observer/commentator: The observer/commentator gives group members feedback on how well the group is functioning to reach the goal.
- Follower: The follower listens but does not contribute to the group discussion and does not voice an opinion on the group's conclusion except to go along with the group's decision.

Disruptive Roles

Some group members disrupt the cohesiveness of the group and the progress toward reaching a consensus. This is referred to as a disruptive role. The nurse must take steps to reduce the effectiveness of group members who are disruptive to the group.

Here are disruptive roles:

- Aggressor: The aggressor belittles, insults, and personally attacks one or more members of the group.
- Blocker: The blocker objects to every opinion and does not offer an original suggestion.
- Recognition seeker: The recognition seeker focuses attention on themself by exaggerating their importance and expertise.
- Self-confessor: The self-confessor expresses personal issues during the meeting.
- Playboy/playgirl: The playboy/playgirl sees the meeting as a way to avoid working on the patient's problems and focuses on personal interactions with colleagues.

- Dominator: The dominator controls the meeting and group members even though they are not the project manager.
- Help seeker: The help seeker poses as being helpless and looks for sympathy from group members.
- Special interest pleader: The special interest pleader conceals their opinion and voices stereotypical views that they feel are acceptable by group members.

8. Addiction Intervention

A growing number of patients have a dual diagnosis of mental illness and substance abuse, commonly referred to as mentally ill chemically addicted (MICA). The patient compensates for mental illness by self-medicating with prescribed or illicit drugs, resulting in a physical and psychological dependence on the addicted drug.

Physical dependency occurs when the patient experiences withdrawal symptoms when they stop taking the drug. That is, the patient's body aches until they self-medicate with drugs. Psychological dependency occurs when the patient is drawn to the drug to make them feel good in the absence of withdrawal symptoms.

There are three treatment goals for a MICA patient:

1. Remove the physical dependency through detoxification
2. Treat the mental illness, usually through medication
3. Treat the psychological dependency on the drugs

Psychological dependency on drugs is the most difficult goal to achieve because there is no medication to stop the cravings for the drug. Although the patient has stopped taking the drug, they forever know how good the drug makes them feel—and that feeling is always a few minutes away.

The best way to appreciate the draw of psychological dependency is to use the example of going on a diet. The diet always starts tomorrow or right after the weekend party. If the diet ever starts, the diet probably does not last very long. After 2 hours, the psychological pressures increase, causing a slip—especially when no one is looking. And once you slip, you probably say, "Well another piece isn't going to hurt." Finally you likely say, "I'll start the diet tomorrow." After a few weeks, the cycle begins again.

Occasionally, the diet is successful for months—and the cravings become strong. You go to a gathering, and all your favorite food is on the table. Then

you tell yourself, "I deserve a reward for all my good efforts on the diet" and then you slip. One bite is not enough. You feel embarrassed and angry at yourself for the slip, and you look for something that will make you feel good—food, commonly referred to as comfort food. Before you realize it, you are back to your old eating habits.

If this example seems familiar, then you can appreciate the power of psychological dependency. Substitute an addictive drug for food in this example and you will understand the challenges that face a substance abuse patient, such as a MICA patient.

The MICA patient experiences a cycle of recovery and relapse. Recovery is being off the substance, and relapse is being one the substance. Recovery is a lifelong process with episodes of relapse. A goal of recovery is to increase the length of time between relapses by hours, days, weeks, months, or years.

However, physical dependency compounds the challenge of starting recovery. Recall a time that you had the flu. You probably stayed in bed, miserable, irritable, and barking at anyone who tried to help you. You could not sleep or get comfortable and every body part ached. You may have felt like you wanted to die. This is similar to going through drug withdrawal, except drug withdrawal is 100 times worse than the flu. If there was one dose of medication that would instantaneously make you feel better, would you take it? No doubt you would. However, when that dose wears off, flu symptoms return. This is how it feels to be physically addicted to drugs. The drug enables you to feel normal.

Anyone Can Become Addicted

The nurse must develop a therapeutic relationship with MICA and substance abuse patients to help these patients through their battle with addiction. Realize that anyone—including you—can become addicted to drugs. Addiction may begin recreationally and then gradually increase into dependency. That is, you take a drug and the drug makes you feel good. Any time you want to feel good, you take the drug instead of engaging in other activities that also make you feel good.

Addiction can also occur through treatment. For example, you experience a painful injury and the practitioner prescribes opioids such as oxycodone. Opioids take the pain away and make you feel good. After the treatment is completed, the practitioner weans you off the opioids gradually to reduce the withdrawal symptoms. Some patients, however, develop a psychological dependency on opioids and try to manipulate the practitioner to maintain or increase

the dose. If this fails, the patient goes to other practitioners, commonly known as doctor shopping. The patient goes out of the way to use different pharmacies to hide the patient's addiction to opioids. Eventually practitioners uncover the patient's plan and refuse to renew prescriptions for opioids. The patient then purchases prescribed opioids illegally on the street. This becomes very expensive. Before long, the "street vendor" introduces the patient to heroin, which is more potent and much less expensive than prescribed opioids. The patient tries sniffing a bag. As the patient's tolerance builds, the patient requires more bags, more frequently to feel normal. Eventually, the patient is introduced to injecting heroin intravenously.

Addiction takes over the patient's life gradually. For example, the patient may begin to use drugs recreationally on Friday and Saturday nights, using Sunday to recover so the patient is fresh for work on Monday. Usage then happens on Sunday. The patient goes to work on Monday with what is commonly referred to as a hangover. Eventually the patient shows up late for work or calls out sick. Patterns of absences continue until the patient loses their job. Without employment, the patient has no funds to pay bills—and to pay for drugs. Family tension builds, relationships strain, and the patient's support system collapses. The patient steals from family members for money to purchase drugs and eventually commits crimes for drug money. Arrests, convictions, and incarcerations follow, making finding a job during recovery nearly impossible. Frustration, hopelessness, and helplessness build, leading to relapse.

Be Empathetic, Not Sympathetic

MICA patients and substance abuse patients can develop a sense of hopelessness and helplessness that is based on a true sense of loss and numerous failures attempting to stay in recovery and regain their life. Staying in recovery is not easy, but slipping back into addiction results in devastating repercussions that may include homelessness, incarceration, acquiring life-threatening diseases, the risk of violence, and destruction of a support system.

The challenge for the nurse is to instill hope in what many regard as a hopeless situation that is brought about by the patient's own actions time and again. To meet this challenge, the nurse must be empathetic and not sympathetic toward the patient. Empathy means that you can appreciate the physical and emotional experience of the patient but look at the patient's situation objectively. Sympathy means that you feel sorry for the patient because they have become addicted and have a troubled life.

MICA patients may blame others for the patient's addiction; for example, the patient might say, "My boyfriend pressured me into using drugs" or "The pressures of growing up in a dysfunctional family caused me to use drugs." The nurse could respond sympathetically by saying, "That must have been very hard on you and I can see why you became addicted." A more appropriate response might be to say, "I understand those challenges. Others in your situation said options other than drugs were available to them. Can you tell me about other options that were available to you?"

Sympathizing with the patient does not help the patient look objectively at the situation, making it difficult for the patient to see and acknowledge poor choices that the patient made in the past. The empathetic approach acknowledges the physical and emotional problems that confront the patient and helps the patient explore distorted views of the past.

Applying the empathetic approach in a therapeutic relationship is at times difficult because there is a natural tendency to either be sympathetic and feel sorry for the patient's situation or have no compassion at all for the patient because they are seen as having caused their situation—and they may have committed crimes (e.g., robbery, burglary, assaults) that involved innocent people.

A goal is for the nurse to acknowledge that the patient is experiencing physical and psychological challenges and help them recognize and accept that they contributed to causing those problems. Once that goal is achieved, the nurse focuses the patient on steps that they can take to rebuild their life. The nurse helps the patient set realistic goals and ways to achieve those goals.

The Process of Relapse

Knowing the relapse process provides the nurse with a basis for a therapeutic conversation with the patient. The relapse process is a series of situations that leads the patient to relapse. Each situation places the patient at a high risk for relapse. Each situation is a relapse warning sign; collectively, these signs are called a relapse warning sign list, and ignoring this list results in the patient relapsing.

At some point in addiction, the patient decides to stop using drugs and devises a recovery plan that usually begins with detoxing to overcome the physical dependency of the drug. However, the collateral problems associated with addiction exist such as homelessness, unemployment, and a broken support system. Family does not want to help, and the only friends are those addicted to drugs. In addition, patients may have medical problems. For a moment, picture yourself on the street corner with no money, no job, no place to go, and all you have is your Social Security card and the clothes on your back.

This is how some MICA and substance abuse patients begin recovery. The patient becomes overwhelmed and begins to encounter situations that place them at high risk for relapse.

Instead of asking for help, some patients deny they are having a problem. They focus on denying the problem rather than dealing with the problem. The problem does not go away, stresses build, and the patient returns to compulsive behaviors to cope with stress, looking for a way to feel good and escape the problem for a few moments. The easiest way to feel good is to return to drugs, but just one time to take the edge off. The problem remains after the momentary escape from the problem.

Triggers

A trigger is an event—usually a situation—that causes the person to have an urge to use drugs. Triggers are usually people, places, or things. For example, associating with friends who use drugs will trigger the patient to use drugs. Going to a party where drugs are being used will trigger the patient to use drugs. Visiting a neighborhood where the patient purchased drugs is also a trigger. Triggers remind the patient of perceived good times when the patient was using drugs. Emotions take control and the patient enters risky situations at a most vulnerable time, looking to feel good at any cost. The patient relapses.

All of us have triggers that bring back memories, such as a song playing on the radio or a fragrance that brings you back to a good time in your life. For a moment, you may want to relive that time. Let us say you are feeling depressed and a trigger brings recollections of an enjoyable time with friends. You begin to feel normal. For some, memories alone are sufficient to make them feel better, whereas others follow through on those triggers, such as calling and getting together with friends.

Losing Control

The patient begins to rebuild positive relationships the longer the patient remains in recovery. Family members see a change and gradually lend support. The patient is able to find minimum work sufficient to prove to themself and an employer that they are worth another chance.

However, change occurs slowly. Although the patient may feel very successful staying sober, few rush to acknowledge that success. Problems are not quickly solved. However, some patients' expectations may be unrealistic, and thus, they become disappointed, frustrated, and miserable. Then the triggers start.

The patient convinces themself that they can hang out with their old friends. Sure their friends still drink alcohol and use drugs, but they are sober and will not use them. While with friends, the friends offer the patient a drink or drugs. Initially the patient refuses until the patient says to themself, "I've been sober for a while. I can handle just one beer. I deserve a reward for being sober." Soon, the patient is back abusing substances.

Deserving a reward for being sober is like a nurse who is on a diet. In the break room, there are boxes of donuts. Seeing the donuts, the nurse probably says, "I've been good with my diet. I can have one. It is not going to hurt." We all know the nurse had more than one donut—and in want of the diet.

NURSING ALERT

Relapse is the most dangerous time for a recovering addict because tolerance for the drug has decreased and the patient tends to use the same amount of drug as during prior use. This increases the risk of an overdose.

9. Legal Considerations

A patient is admitted to a psychiatric unit in either a voluntary or involuntary status. A voluntary status means that the patient agrees to be admitted and treated. An **involuntary status** means that the patient has not agreed to be admitted and two practitioners independently determined that the patient is a danger to themself, others, or property. Within 72 hours, the patient must appear before a judge to determine if they should be committed for care. Committed means that the patient remains a danger to themself, others, or property based on 72 hours of observation and treatment of the psychiatrist. The patient is represented by legal counsel. The patient is then reassessed periodically based on statute. A patient can also be admitted as temporarily involuntary, commonly referred to as a 23-hour hold. A temporarily involuntary status is used when the patient is intoxicated and deemed a danger to themself, others, or property related to the intoxication. The influence of the intoxicating substance is likely to resolve within 23 hours, and the patient is no longer a danger.

Patient Rights

A voluntary patient has the right to be discharged from the healthcare facility. However, discharge can be delayed for up to 48 hours to allow the practitioner

to assess if the patient is a danger to themself, others, or property. That is, the patient cannot simply walk out of the healthcare facility. Nonpsychiatric patients can leave at will.

The voluntary patient who seeks discharge signs a document that informs the practitioner of their desire to be discharged. The practitioner may agree and immediately discharge the patient or wait until the end of the 48-hour assessment period to discharge them. If the practitioner determines that the patient is not dangerous, then the practitioner must discharge them even if treatment is not completed. The practitioner may suggest that the patient remain to complete treatment; however, the patient has the right to refuse treatment. The practitioner then may ask the patient to sign a form acknowledging that discharge is against medical advice, or AMA.

Involuntary Status

An involuntary patient has the same rights as a voluntary patient except that the patient cannot be voluntarily discharged from the healthcare facility. These rights are:

- Right to least restrictive treatment
- Right to prompt medical care
- Freedom from hazardous treatments
- Right to dignity, privacy, and humane care
- Right to refuse treatment
- Right to communication (phone, mail, visitors)
- Right to freedom from harm
- Right to respect
- Right to confidentiality
- Right to participate in plan of care

NURSING ALERT

An involuntary status does not mean that the patient is incompetent.

Incompetence

A patient is incompetent if the patient lacks the capacity to make decisions. The practitioner must present a rationale to the courts who will then appoint a guardian should the courts agree with the practitioner. The guardian then

makes decisions for the patient. A child under the age of 18 is not competent to make decisions, depending on jurisdiction.

The patient must be competent to give informed consent to treatment. Informed consent requires the patient to

- Act voluntarily
- Be able to repeat elements of condition
- Be able to repeat treatment options
- Know benefits and consequences of each treatment
- Know consequences of no treatment

NURSING ALERT

The nurse must assess the competency of the patient before the patient signs an informed consent. Medication and results of some treatments may cause the patient to be temporarily incompetent. Informed consent is not required to treat a patient in an emergency that results in the patient becoming temporarily incompetent. The presumption is the patient would agree to treatment if they were able to give informed consent.

Required Treatment

A psychiatric patient has the right to refuse treatment unless they are declared incompetent, in which case their appointed guardian makes treatment decisions on their behalf. However, in some jurisdictions, treatment can be required even if the patient is competent and refuses treatment. This is sometimes referred to as a three-step treatment where the patient is first offered medication by mouth. If the patient refuses, then they are offered medication by intramuscular injection. If the patient refuses, then their right to consent is overridden, and they are given the injection.

To perform the required treatment, two practitioners must independently assess the patient and agree that the treatment is necessary to restore the patient to normal activities of daily living. Keep in mind that the stability of some psychiatric patients depends on the patient to be compliant with medication. The patient becomes unstable when they are noncompliant with medication.

NURSING ALERT

The nurse must have a practitioner's order to hold a patient to give an injection.

10. Nurse Process Report

Developing a therapeutic rapport comes naturally for some patients, whereas others find it beneficial to use a nurse process report, sometimes called a process recording, to polish communication skills. A nurse process report is a transcription of a conversation between the patient and the nurse as noted by the nurse. The nurse process report is divided into four columns (see Table 12–1). These are the nurse's comments, the patient's comments, an evaluation of the comment, and interpretation of the comment.

TABLE 12–1 A Sample of a Segment of a Nurse Process Report

Barriers to communication	Major medical diagnosis
None	Depression
Description of patient's appearance	**Goal for the interaction at time of interaction (Purpose of the interaction)**
Well groomed, fully engaged	To help the patient to express their feelings and thoughts about their drug addiction

Nurse's Comments	Patient's Comments	Evaluation of Comment	Interpretation of Comment
"Ivan, I'm Jim, your nurse. Can we chat for a few minutes?"		Introduction. Therapeutic	I wanted to introduce myself in a nonthreatening way
	[He nodded yes and walked toward chairs in the corner of the TV room]		He seemed surprised
"Tell me about what brought you here?"		Therapeutic–general leads	I wanted to explore if he understood why he was here in the unit
	"My back and legs were hurting. I was in pain so I walked into the emergency room a couple of nights ago to get something for my pain."		His remarks were confusing: – He was in pain, but walked into the ER – Instead of releasing him after treating his pain, he was admitted to the MICA unit
"I'm a little confused. I understand this is the substance abuse rehabilitation unit."		Therapeutic—clarifying	I wanted to learn if he understood why he was here in the unit

TABLE 12–1 A Sample of a Segment of a Nurse Process Report (*Continued*)

Nurse's Comments	Patient's Comments	Evaluation of Comment	Interpretation of Comment
	"I've been using coke and heroin on and off for years for the pain. You see I'm an amateur boxer. Been fighting in clubs for 15 years. It's taken a toll on my body. That and I've worked in construction all my life. The body can't take the pain when you get old."		He seemed to be rationalizing his addiction
"The pain must be awful. Were you under a physician's care during those years?"		Therapeutic—asking questions	I acknowledged his pain and wanted to explore if he was under a physician's care
	"I was going to this doc and then they busted him. I'd go fight at a club, then go to the doc. He'd sell me anything I wanted and any amount. He never wrote a script. Then they got him for selling steroids."		It seemed that the patient was more interested in medicating the pain rather than dealing with the underlying cause—the boxing
"It sounds as if you're finding boxing painful."		Therapeutic—redirecting	I wanted to focus the conversation on what seemed to be the reason that he self-medicates
	"Between boxing and construction, I'm in a lot of pain but I need the money. I don't want to fight anymore, but it pays you know."		It seems that he is not recognizing that he is in a vicious cycle. Money from boxing goes to pay for drugs needed to medicate the pain caused by boxing
"Tell me more about how you started with drugs."		Therapeutic—asking questions	I wanted to gain insight into his perception of why he abused drugs

TABLE 12–1 A Sample of a Segment of a Nurse Process Report (*Continued*)

Nurse's Comments	Patient's Comments	Evaluation of Comment	Interpretation of Comment
	"As a kid I grew up in Paterson. Everyone was smoking and experimenting. I was clean from 25 to about 33. My brother and I had a construction company. I could stop anytime I wanted."		He is describing the experimental and abuse stages of addiction
[Silence]		Silence—therapeutic	He was freely elaborating on his explanation, so I didn't want to interrupt with a question
	"Then there was pressure of the business and pressure in a relationship with my girlfriend. Things were not going well. So I started back with coke and then heroin."		He was describing another pain that he relieved by self-medicating
"How did these drugs help you?"		Therapeutic—clarifying	I wanted see if he recognized that he was experiencing emotional pain
	"They numbed me. For those few minutes I was high, everything was fine. I needed that break."		He was rationalizing his self-medication
"What happened next?"		Therapeutic—clarifying	I wanted to see if he understood that the situation that caused the pain still existed after he came down from his high
	"Nothing. Nothing really changed."		He recognized that drugs didn't solve his problem
"Tell me more about the period when you were clean."		Therapeutic—refocusing	I wanted to explore the events that kept him away from self-medicating

TABLE 12–1 A Sample of a Segment of a Nurse Process Report (*Continued*)

Nurse's Comments	Patient's Comments	Evaluation of Comment	Interpretation of Comment
	"During those years things were going well. Making money. Flipping houses. Had a nice home and a beautiful girl. A few run-ins with the cops but all was pretty good."		His expression seemed as if he was bringing back good memories
"Run-ins with the police?"		Therapeutic—delving further in subject	He seemed to breeze over this situation
	"I was arrested 12 times for fighting, but only convicted six times. Once for beating up on some cops. I was in a deli across from a job and these cops were called for a domestic dispute in the apartment above the store. They came into the deli and started with some words. We started mouthing off and they said something that set me off. Once I get started I do a good job. I'm trained to do it. I shouldn't do it, but say those words and I can't control myself."		He seems to have an anger management problem
"Let's talk more about why you are here."		Therapeutic—refocusing	I wanted to focus away from words that might agitate him and focus on why he was in this unit

The nurse's comments column is where the nurse records what they say to the patient. The patient's comments column is where the nurse records what the patient says. The evaluation comment is where the nurse determines if their remarks are either therapeutic or nontherapeutic and the purpose of their remarks. And the interpretation of comment column is where the nurse reflects on the purpose of the comment and remarks made by the patient.

The beginning of the nurse process report describes the patient by diagnosis, barriers to communication, the appearance of the patient, and the purpose of

the interaction with the patient. This is followed by the transcript and analysis of the conversation.

11. Milieu

A key element of a psychiatric patient's treatment is the group of people they associate with and the activities that occur while they receive inpatient treatment. A psychiatric unit is designed to create a social environment for all patients on the unit, which is referred to as a milieu. Psychiatric patients tend to have difficulty integrating with society due to their psychiatric diagnosis. For example, a patient diagnosed with major depression tends to withdraw from others. A patient with a mood disorder or episodes of mania might find others shying away due to their behavior.

In a milieu, the patient is able to explore interactions with others in a safe and controlled environment where positive social behaviors are rewarded and negative social behaviors are identified and focused for improvement with the assistance of the patient treatment team.

A milieu is a microcosm of society. There is a schedule of activities and unit rules that every patient is to follow regardless of diagnosis. Rules set expectations for the patient. Others in the milieu encourage patients to follow rules by camaraderie and by example. Some facilities pair off patients in a buddy system where a new patient is helped by a more stable patient. Patients tend to form their own buddy system, coming to the aid of newer or less stable patients.

The milieu also has a reward system to encourage desirable behavior such as compliance with the treatment plan. Rewards are extended privileges and are identified by levels. Each level has clear expectations. If the patient meets those expectations, then they are granted the corresponding privileges.

All patients are on level 1 when they arrive on the unit. Level 2 requires the patient to conform to the schedule of activities, comply with treatment, and perform activities of daily living. Activities of daily living include showering, grooming, changing bed linens, and washing clothes. These are challenges for some patients who because of their diagnosis have foregone self-care.

When a patient achieves level 2 expectations, the patient asks the community of patients to move to level 2 and presents to the community evidence that the patient meets the requirements for level 2. The community then votes to grant or deny the level 2 status to the patient.

Achieving level 2 status is a major accomplishment for the patient. First, the patient has shown that they can follow structured activities and can care for themself. In addition, the patient recognizes for themself that this is an achievement and they can share their achievement with the community. Most importantly, the community formally recognizes that achievement and bestows the honor of level 2 to the patient. The patient is accepted by the community, which may not happen frequently outside the healthcare facility for the patient. The patient becomes a role model for patients who are at level 1.

Level 2 rewards might be permission to participate in off-unit activities, telephone privileges, pizza on Friday nights, and the right to run for community office. The milieu has elected leadership consisting of a president, vice president, secretary, and sergeant of arms. The president presides over community meetings. The vice president assigns patients to assist with daily activities such as greeting new patients and clean-up duties after meals. The secretary records minutes. And the sergeant of arms gathers patients for activities and issues the wakeup call.

The staff is an observer during community meetings. Elected officers run the meeting and follow an agenda. The agenda opens by acknowledging new members of the community and having everyone introduce themselves. In the morning meeting, each patient is asked to share their goal for the day. The goal is progress toward stabilization and discharge such as meeting with the social worker. In the evening meeting, each patient is asked if the goal was achieved. The agenda also has opportunities for each member of the community to express issues. For example, a patient may complain that other patients are not cleaning up after themselves in the shower or raise an issue with the staff. Likewise, there is an opportunity in the agenda for the staff to raise issues with the community.

Level 3 expectations may involve a community project. That is, doing something that helps other patients such as with a poster or a written story. The patient who meets expectations comes before the community and presents their case. Level 3 privileges may be daily walks to the coffee shop to get coffee and snacks or an off-unit on-campus visit with relatives.

Levels and reward systems may differ by facility and by unit; however, the underlying philosophy remains the same, which is to encourage the patient to comply with treatment, care for themself, and become comfortable interacting in a social setting.

CASE STUDY

CASE 1

A 52-year-old man is brought to your unit from the emergency department. He has poor hygiene and is unkempt. His beard and hair are long and clothes are worn and need washing. All belongings are in two large green garbage bags. He clutches two inches of paper with hand writing on the paper held together with large elastic bands that he won't let anyone see or touch. Police found him living in an abandoned house. There was half-eaten food throughout one room of the house. The police had to forcefully bring the patient to the emergency department where two practitioners assessed he was a danger to himself and admitted the patient involuntarily. You introduce yourself and welcome the patient to the unit. He says, "I don't know you. How do you know me? Go away." He looks down at this paper. You ask the patient if he can answer a few questions so you can admit the patient to the unit. He says, "I don't know you. How do you know me? Go away." The aide begins to inventory items in the two garbage bags. The patient grabs the bags and stares threateningly at the aide.

QUESTION 1. What is your initial assessment of the patient?
ANSWER: The patient has a distorted perception of reality and is showing signs of schizophrenia paranoid type. His mistrust seems to have resulted in the patient isolating himself from society and inhibiting him from performing activities of daily living.

QUESTION 2. What is your initial response?
ANSWER: Avoid confrontation. Do not approach the patient. Maintain the patient in sight and give the patient time to adjust to the unit. Go about normal unit activities. The goal is to build trust with the patient, which can only come from the patient.

QUESTION 3. What do you do when the patient grabs the two garbage bags?
ANSWER: Tell the patient that no one is going to open the bags but they need to be left at the nurse's station until the patient settles into his room. Tell the patient that no one is going to touch the bags. Keep the bags in plain sight and do not allow anyone, including the staff, to touch the bags. You must keep your promise to the patient to build trust. However, unit rules must be enforced. That is, all property is searched and inventory taken before being given to the patient.

QUESTION 4. After a few minutes, the patient sits on the floor in a corner of the hallway with his back to the wall reading his papers. Unit activity continues uninterrupted. What do you do next?

ANSWER: Place a juice container (preferably sealed) on the counter of the nurse's station along with several stacked cups. Casually mention to the patient that he is free to pour himself juice. You want to make sure that the patient receives nourishment. However, the patient is unlikely to trust the staff to prepare his food. The patient can see that the juice container is sealed and has not been tampered with and he can select any cup in the stack. Give enough time so that the patient can analyze the situation and determine for himself that it is safe to pour and drink the juice.

FINAL CHECK-UP

1. **A 33-year-old man diagnosed with schizophrenia starts to slowly dance in the hallway babbling and every so often looking at the ceiling. He is not hurting himself or others by ignoring everything around him. What is your best response?**
   A. Walk toward the patient and ask him what he is doing.
   B. Call the staff to bring the patient into the seclusion room.
   C. Try to engage the patient behind the nurse's station.
   D. Immediately medicate the patient.

2. **After an angry phone call with her mother, a 41-year-old woman diagnosed with substance abuse tells you no one supports her in her recovery. What is your best response?**
   A. I am sorry to hear that. Tell the doctor tomorrow.
   B. Is your mother familiar with the recovery process?
   C. I understand this is upsetting. Tell me more about what your mother said to you.
   D. Your mother has a right to be upset because of your behavior over the years.

3. **Two patients start a heated argument over a card game. Both stand and face off. No physical violence has yet occurred. What is your best response?**
   A. Take control over the situation.
   B. Stay at arm's length from the dispute and let the patients resolve the issue.
   C. Observe and assess the patients.
   D. Medicate the patients.

4. **An 18-year-old patient shows increasing anxiety. He paces the floor then stops to do hand-stands against the wall. The staff has informed him many times not to do hand-stands, but he ignores the staff. What is your best response?**

A. Order the staff to place the patient in restraints.
B. Ignore the patient's actions since he is not hurting anyone.
C. Speak calmly to the patient and explain the risk that the patient might injure himself.
D. Acknowledge the patient is anxious and ask the patient if he wants medication to reduce anxiety.

5. **A new admission arrives on the unit. At the end of the admissions interview, the nurse helps the patient develop a goal for being on the unit. The patient is confused. What is the problem?**
   A. The relationship is in the orientation phase because the admissions interview is completed.
   B. The relationship is in the orientation phase.
   C. The relationship is in the preorientation phase.
   D. The nurse is moving into the working phase of the therapeutic relationship.

6. **Why would a nurse use the serenity prayer to refocus the patient's attention when a patient becomes upset?**
   A. Prayer helps calm most patients.
   B. The patient is frustrated trying to control something that they can control.
   C. The patient can ask for guidance from above.
   D. The patient is frustrated trying to control something that they cannot control.

7. **A patient diagnosed with schizophrenia is admitted involuntary because of his bizarre behavior. You offer him scheduled medication, but the patient refuses to take the medication. What is your best response?**
   A. Tell the patient he cannot refuse because he has an involuntary status.
   B. Ask the patient why he refuses to take the medication.
   C. Call the practitioner.
   D. Call the staff to help you force the patient to take the medication.

8. **A 34-year-old woman diagnosed with mood disorder is admitted to your unit. During the admissions interview, you explain the leveling system to the patient. The patient tells you she is not interested in levels. After a week of treatment, the patient continues to tell staff and patients that she does not care about levels. What is your best response?**
   A. Ignore that the patient has not worked toward earning level 2.
   B. Privately ask the patient if there is any reason why she is not interested in working toward level 2.
   C. Ask the president of the unit to encourage the patient to work toward earning level 2.
   D. Make it obvious that the patient is not able to participate in level 2 activities.

9. A 54-year-old man tells you that other patients plan to vote for him to become secretary of the unit. He is embarrassed because he can't read or write. What is your best response?

A. Quietly tell the other patients not to elect him to office.
B. Teach the patient to read and write.
C. Suggest that the patient tell the other patients that he does not have his reading glasses on the unit and therefore is unable to read or write.
D. Tell him to ask another patient to read and write for him.

10. A 46-year-old man nervously walks the hallway, closing the doors to patients' rooms when all the patients leave for lunch. A float nurse yells down the hall telling him to stop going to other patients' rooms. He ignores her. The nurse is about to call staff from other units to help restrain the patient. What is your best response?

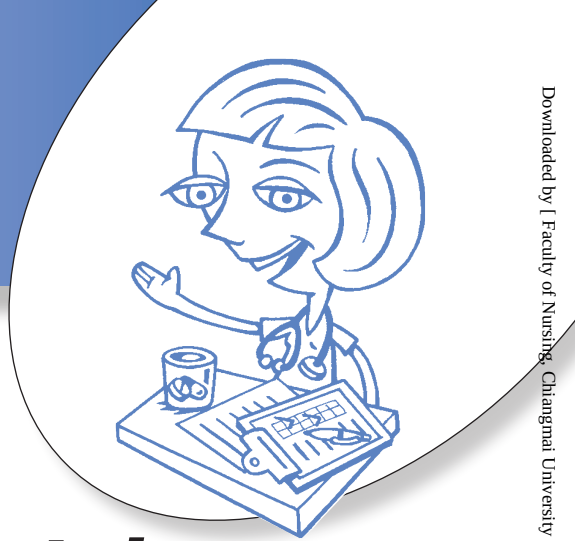
A. Keep other patients in the dining room until the patient is restrained.
B. Tell the nurse to let the patient finish closing the doors.
C. Prepare to medicate the patient.
D. Tell the nurse to go and speak with the patient and not to yell down the hall.

CORRECT ANSWERS AND RATIONALES

1. C. Try to engage the patient behind the nurse's station. Rationale: The initial step is to attempt to talk to the patient from a safe position. Approaching the patient may be perceived as a threat by the patient. If talking does not provide results, then attempt to medicate the patient. If the patient shows any signs of danger or refuses medication, then the staff should intervene by bringing the patient to the seclusion room and calling the practitioner.
2. C. I understand this is upsetting. Tell me more about what your mother said to you. Rationale: This encourages the patient to express her emotions and provides an opening for an empathetic discussion. Telling the patient that you are sorry to hear of her situation is not a therapeutic response. That patient's mother is probably very familiar with the recovery process since the patient is likely to have been in recovery most of her adult life. Justifying the mother's response is not appropriate at this time.
3. A. Take control over the situation. Be objective and don't be drawn into the dispute. Rationale: Your intervention will likely de-escalate the confrontation. Observe and assess the patients throughout the shift to determine if the dispute rekindles.
4. D. Acknowledge the patient is anxious and ask the patient if he wants medication to reduce anxiety. Rationale: The patient is pacing and doing hand-stands to cope with anxiety. Offering to medicate the patient is an appropriate means to achieve the patient's goal to reduce anxiety. Ignoring the patient's actions does not address

the risk for self-injury or enforce unit rules. Explaining the reasons for the rules does not address the patient's underlying anxiety problem. Restraints are not called for because this is not the least restricted treatment at this stage in the situation.

5. D. The nurse is moving into the working phase of the therapeutic relationship. Rationale: The nurse is moving into the working phase of the therapeutic relationship before the preorientation phase and orientation phase of the therapeutic relationship are completed, which will probably take several days.
6. D. The patient is frustrated trying to control something that they cannot control. Rationale: The serenity prayer is designed to help the patient realize that there are things beyond the patient's control and that trying to control them increases frustration.
7. B. Ask the patient why he refuses to take the medication. Rationale: An involuntary patient has the right to refuse treatment. The initial step is to assess why the patient refuses to take medication and then try to convince the patient to take the medication. If the patient continues to refuse, then the practitioner needs to be notified the next time the practitioner is on the unit. The practitioner needs to be notified immediately if the medication is urgently needed.
8. B. Privately ask the patient if there is any reason why she is not interested in working toward level 2. Rationale: Usually rewards for achieving the next level are desirable for a patient. Therefore, the nurse should assess if there is a reason why the patient is not participating in the level system. Never embarrass the patient. Always help the patient save face.
9. C. Suggest that the patient tell other patients that he does not have his reading glasses on the unit and therefore is unable to read or write. Rationale: This helps the patient solve his problem and enables him to save face with other patients. Afterward, explore with the social worker if there is any program available in the healthcare facility to help the patient learn to read and write. You probably don't have time or the skills to personally teach the patient to read or write. Never share patient information with another patient.
10. B. Tell the nurse to let the patient finish closing the doors. Rationale: The patient is diagnosed with obsessive-compulsive disorder. Closing doors is his obsessive-compulsive behavior and should not be interrupted as long as the behavior is not dangerous to the patient or other patients. Once all the doors are closed, the patient then goes to the dining room. The nurse should not yell at a patient and not engage a patient from a distance; however your focus should be on the patient first.



chapter 13

Patient Psychiatric Assessment and Patient Psychiatric Care Plans

LEARNING OBJECTIVES

1. Mental health diagnosis
2. Psychiatric nursing process
3. Behavioral assessment
4. Psychiatric nursing diagnosis
5. Psychiatric care plan

KEY TERMS

American Psychiatric Association
Baseline psychiatric assessment
Daily psychiatric assessment
Diagnostic and Statistical Manual of Mental Disorders (DSM)
DSM-5
Evaluation
Global Assessment of Functioning (GAF) scale
Implementation
Interdisciplinary psychiatric care plan
Long-term psychiatric goal
Malingerer
Medical diagnosis
Mental health
Multi-axial system
North American Nursing Diagnosis Association (NANDA)
Positive/negative findings
Psychiatric care plan
Psychiatric intervention
Psychiatric outcome
Self-care deficiency
Short-term psychiatric goal
Treatment plan

1. Mental Health Diagnosis

There is no universal consensus on the definition of **mental health** primarily because there is no way to objectively measure mental health. The inability to definitively diagnose a mental disorder is unique in medicine because the science of medicine is founded on an objective assessment followed by laboratory and imaging tests that collectively enable the practitioner to arrive at a medical diagnosis. Once diagnosed, the practitioner prescribes treatment that will likely correct the patient's disorder.

Mental health is different because there are no laboratory or imaging tests that confirm the practitioner's assessment that the patient is experiencing a specific mental health disorder. That is, there is no blood test or computed tomography (CT) scan that will confirm a patient is bipolar or has, major depression, or one of the many psychiatric diagnoses.

The challenge is for the practitioner to know what is normal and abnormal. This is true for any disorder. For example, the practitioner can review the results of a liver function test to know if the liver is functioning normally. Likewise, a pulmonary function test provides insight into the functioning of the lungs. Normal is defined by researchers who tested both healthy and unhealthy individuals and then compared results. Certain test results were found in healthy

individuals, whereas different test results were found in individuals who were ill. Their findings provided a basis for using the test to diagnose patients. There is also a physiologic understanding for test results. For example, the level of liver enzymes in the blood correlates to the number of liver cells that are dying because liver enzymes are inside liver cells.

Knowing what is normal and abnormal in mental health is even more challenging than in other fields of medicine because normal and abnormal mental health is subjective. Behavior is a key indicator of a patient's mental health; however, behavior that seems normal to you may be abnormal to me. We make judgments, based on our experiences and beliefs, many of which are influenced by our family, community, education, and culture.

Let us say a man walking down the street goes out of his way to compliment attractive ladies. Is this abnormal behavior and a sign of mental illness? The answer depends on many factors, one of which is the man's culture and the location of the street. In parts of the United States, it may seem abnormal to approach strangers of the opposite sex on the street. Yet, this is appropriate behavior in some island communities where women see this as flattering. There is no blood test to determine if this behavior is normal or abnormal.

Diagnostic and Statistical Manual of Mental Disorders

In 1952, the **American Psychiatric Association** set out to differentiate between relatively normal and pathological behavior. Abnormal behavioral characteristics and frequency of episodes were grouped, and the groups were identified by a diagnosis. These were published in the ***Diagnostic and Statistical Manual of Mental Disorders*** **(DSM)**, which became the standard for defining mental illness. **DSM-5** is the latest edition.

The American Psychiatric Association formed a task force of more than 160 leading clinicians and researchers in psychiatry, psychology, pediatrics, nursing, and social work. The task force considered advances in science behind mental disorders and clinical experience when revising diagnoses and definitions.

For example, the DSM-5 states that the following behavior is diagnosed as illness anxiety disorder:

A. The person is preoccupied with having an illness.
B. The person does not have symptoms that mimic the physical disease (somatic symptoms).
C. The person is excessively preoccupied with an existing medical condition disproportionate to the severity of the medical condition.

D. The person is anxious about the person's health.
E. The person displays either excessive (i.e., continually seeking medical advice) or avoidance (i.e., not seeking medical advice) behaviors to the person's health.
F. The person has been preoccupied about the medical condition or other medical conditions for at least 6 months.
G. Preoccupation is not better explained by other mental disorders.

Type:

Care-seeking type: The person is preoccupied with seeking medical advice.
Care-avoidant type: The person avoids seeking medical advice.

Impact of DSM-5

As can be seen from the previous example, the DSM-5 guidelines for diagnosing mental illness are based on the practitioner's subjective assessment that elements of the diagnostic criteria specified in the DSM-5 are present in the patient. Elements are subjective. For example, what does being preoccupied mean? Why must a condition exist for at least 6 months?

Although the DSM-5 makes an honorable attempt to define mental illness, there remains ongoing controversy because of the lack of objectivity in the diagnosis. That is, a group of psychiatrists determined that certain behavioral characteristics are abnormal based on subjective observations. The initial challenge for the psychiatrist who contributed to the DSM-5 is differentiating abnormal behavior from behavior that is different from behaviors of others. For example, a different behavior might be dressing down when everyone else is dressed up. An abnormal behavior may be appearing disheveled and slow to respond to others in the same setting.

A challenge for a practitioner is to apply the DSM-5 guidelines when diagnosing a patient. The practitioner must interview and observe the patient within a short time period and then reach a diagnosis and develop and implement a treatment plan. There is no objective test to scientifically confirm the diagnosis. Some patients have been known to pretend to have symptoms of mental illness for ulterior purposes such as qualifying for disability.

The impact of DSM-5 definitions is far reaching, especially since there remains a stigma attached to having a mental illness. The stigma is assigned based on a practitioner following the definition of mental illness decided by the opinion that certain behavior is pathologically based. If it is, then the patient may experience negative consequences of the diagnosis.

The Positive Side

Mental illness exists, and psychiatrists applying the DSM-5 guidelines for diagnosis and treatment are able to reverse the signs and symptoms of mental illness regardless of the subjective nature of the diagnosis. The DSM-5 and associated treatment represent the state of behavioral health and psychiatry that enables practitioners to apply criteria consistently.

Increasingly patients are being assessed and treated holistically. Primary care practitioners focus on behavioral health along with the patient's medical condition.

2. Psychiatric Nursing Process

The nurse plays an important role in assessing the patient, primarily because the nurse observes the patient constantly throughout the shift and notices whether the patient's behavior improves or degrades from the baseline assessment. The baseline assessment is the assessment made by the nurse at the beginning of the shift and serves as a reference for changes in behavior. The nurse also compares current behavior to behavior reported to the nurse from the previous shift. This is referred to as secondary data because the information is not from first-hand observation.

NURSING ALERT

Secondary data are informative but may lack objectivity because the nurse reporting may inadvertently embellish facts about the behavior.

The psychiatric nursing process is followed when caring for a patient diagnosed with a psychiatric diagnosis. The psychiatric nursing process is a framework within which the nurse assesses the patient and determines if the patient has a problem. The problem is referred to as a psychiatric nursing diagnosis. A psychiatric nursing diagnosis is different from a medical diagnosis. A psychiatric nursing diagnosis is a standard statement that describes an aspect of the patient's mental health, which is the foundation for providing nursing care to the patient. A **medical diagnosis** is also a standard statement that describes the patient's mental health based on a physiologic or medical condition and provides the foundation to provide medical treatment.

The differences between a psychiatric nursing diagnosis and a medical diagnosis can be confusing to understand. A good way to understand the

difference is to focus on psychiatric interventions. A **psychiatric intervention** is an activity that is performed to address the diagnosis. For example, major depressive disorder is a medical diagnosis. The practitioner's intervention is to prescribe medication. The patient also experiences social isolation and disturbed sleep pattern because the patient stays in their room and sleeps most of the day. These are nursing psychiatric diagnoses. The nurse's psychiatric intervention is providing a way for the patient to become more interactive with staff and other patients.

The psychiatric nursing process begins with an assessment of the patient to identify **self-care deficiency**. A self-care deficiency is something that the patient is unable to do for themself. In the previous example, social isolation and impaired sleep pattern are self-care deficiencies.

Based on the assessment, the nurse reaches one or more nursing psychiatric diagnoses. Psychiatric nursing diagnoses are standardized by the **North American Nursing Diagnosis Association (NANDA)**. NANDA defines requirements for each nursing diagnosis.

The nurse develops a care plan that addresses each psychiatric nursing diagnosis. The **psychiatric care plan** specifies the desired outcome for nursing care. A **psychiatric outcome** is the goal for the patient and for the nursing staff. There are two types of psychiatric outcomes; these are **long-term psychiatric goals** and **short-term psychiatric goals**. A long-term psychiatric goal is an outcome that typically requires multiple steps to achieve the psychiatric outcome. A short-term psychiatric goal is one of those steps. For example, a long-term psychiatric goal is for the patient to effectively socialize with other patients as measured by expressing less time isolated in their room and more time engaging with staff and other patients. A short-term psychiatric goal might be that the patient will attend at least one community meeting each day for 3 days.

Once the psychiatric outcome is established, the nurse determines how to reach the outcome, which is referred to as **implementation**. The implementation portion of the care plan identifies psychiatric interventions that the nurse will do to accomplish the short-term psychiatric goal. The corresponding long-term psychiatric goal is met when all short-term psychiatric goals are achieved. A psychiatric intervention is an activity that the nursing staff performs. For example, the staff will engage the patient for a total of 60 minutes per shift and personally invite the patient to each community meeting. Likewise, the staff will encourage the patient to respond by waiting for the patient to respond.

The last component of the care plan is to evaluate the effectiveness of the intervention, which is referred to as the **evaluation**. The evaluation component of the care plan specifies how the intervention will be measured. For example,

did the patient attend at least one community meeting each day for 3 days? Was the patient given sufficient time to respond to the staff?

Multi-axial System

Behavioral health assessments use a **multi-axial system** to describe a patient's assessment. The multi-axial system consists of five elements each referred to as an axis; these are:

- Axis I: Clinical disorders and other conditions that may be a focus of clinical attention
- Axis II: Personality disorders and mental retardation
- Axis III: General medical conditions
- Axis IV: Psychosocial and environment problems
- Axis V: Global assessment of functioning rate on the **Global Assessment of Functioning (GAF) scale**

NURSING ALERT

DSM-5 has discontinued the use of the multi-axial system. Axes I, II, and III are combined, and Axis IV and Axis V are notated separately.

3. Behavioral Assessment

The psychiatric nurse must perform a baseline assessment and daily assessment every day. A baseline assessment is an informal assessment that determines general mental status of the patient at the beginning of the shift with a brief conversation with the patient. The nurse can compare the baseline assessment with the previous day's daily assessment, if the nurse interacted with the patient the previous day. Sometimes the **baseline psychiatric assessment** is the nurse's initial encounter with the patient because the patient is new to the nurse. Therefore, the nurse has nothing to compare to the baseline psychiatric assessment. Throughout the shift, the nurse compares the current mental status of the patient with the patient's baseline psychiatric assessment to determine if the patient is stable, improving, or decompensating.

NURSING ALERT

The nurse should engage the patient for at least 15 minutes per shift.

The **daily psychiatric assessment** is a formal assessment of the patient that is made once per shift and represents the culmination of the nurse/patient interactions and observation of the patient throughout the shift. The daily psychiatric assessment determines many aspects of the patient's mental health (see Daily Psychiatric Assessment) each of which is charted by the nurse. Both **positive and negative findings** are charted, enabling the patient's treatment team to determine if the treatment plan is achieving the desired goal or needs to be revised.

Electronic medical record systems typically provide a convenient way to chart a daily psychiatric assessment such as dividing the assessment into categories and listing common findings beneath each category. The nurse charts by checking the appropriate findings. The nurse is also able to write a narrative of the assessment in a free-form progress note, which is similar to writing the assessment in a word processing software such as Microsoft Word. It is better to use the electronic medical record system's predefined assessments rather than a progress note because the predefined assessments make the assessment findings uniform. That is, the quality of the results does not depend on the nurse's writing capabilities. A free-form progress note requires a degree of writing skills.

Free-form progress notes are ideal for charting uncommon findings. For example, the nurse may notice that the patient is decompensating after the nurse completed a baseline assessment of the patient. The nurse's findings are immediately brought to the attention of the practitioner. Both the findings and the nurse's interventions are best documented in a progress note.

Daily Psychiatric Assessment

The psychiatric assessment focuses on identifying normal behavior and positive and negative signs of mental illness by engaging the patient and observing the patient during activities on the unit. The combination of speaking with and observing the patient provides sufficient information for the nurse to document the assessment findings.

Normal: Normal means that the patient's behavior or thought process is within acceptable limits. Acceptable limits are subjective and are based on what is considered normal for the patient considering the influence of culture and society.

Positive sign: A positive sign of mental illness is a behavior or thought process that is an outward sign that the patient has mental illness. For example, the patient is reacting to stimuli that are not present (hallucination). For instance, there are no bugs crawling on the walls, yet the patient reports to the nurse that there are bugs on the walls.

Negative sign: A negative sign of mental illness is a behavior or thought process that is absent from expected behavior or thought process. For example, the patient stares without responding to the nurse's greeting. A normal response is acknowledgment of the nurse by speech or gesture.

It is important for the nurse to compare the way the patient interacts with the nurse and staff with the interactions the patient has with other patients. The patient may display a specific behavior and thought process with the staff and a different behavior and thought process with other patients. At times patients exaggerate signs of mental illness to avoid being discharged. These patients are called **malingerers**. The patient is social and displays normal behavior with other patients, yet displays moderate abnormal signs of mental illness when the treatment team is present. Always document the patient's aggregate behavior.

NURSING ALERT

A positive or negative sign can indicate a medical disorder and not mental illness. For example, a hallucination can be a sign of delirium tremens in a patient detoxing from alcohol abuse. A silent stare in response to the nurse's greeting could be a sign of a cerebrovascular accident, commonly referred to as a stroke.

Assessment Categories

The psychiatric assessment is divided into assessment categories. These are speech, attitude, mood/affect, thinking process, thinking, judgment/insight, body movement, and dress, grooming, and hygiene. Collectively these factors provide clues into the patient's mental health.

Speech is the way the patient verbally expresses themself to the nurse and others. Table 13–1 contains elements of the speech assessment. Here are the meanings of signs that can be confusing to understand.

- Pressured speech: Pressured speech is when a patient speaks rapidly in frenzy because the patient feels there is a sense of urgency when there is no urgency.
- Distractible speech: Distractible speech occurs when the patient changes the subject in the middle of their statement.
- Clanging speech: Clanging speech occurs when the patient's choice of words is based on sound rather than concepts.

TABLE 13–1 Elements of the Speech Assessment

Speech			
Normal	Slow	Rapid/pressured	Fair eye contact
Normal volume	Loud volume	Soft volume	Distractible speech
Muted speech	Hesitancy	Good eye contact	Clanging
Poor eye contact	Poverty of speech	Facial expression changes with/topic	Talkativeness

- Hesitant speech: Hesitant speech occurs when the patient falters when speaking.
- Muted speech: Muted speech occurs when the patient is expressive without speaking.
- Poverty of speech: Poverty of speech occurs when the patient provides brief, empty replies to the nurse with minimal elaborations.

Attitude is a feeling about something. The nurse needs to assess the patient's attitude about themself. Table 13–2 lists signs that help the nurse assess the patient's attitude. Here are meanings of terms that may be confusing to understand.

- Cooperative: Cooperative is when the patient follows directions of staff, rules of the unit, and requirements of the patient's treatment plan.
- Brighter: Brighter is when the patient displays a clear, vibrant attitude compared with the patient's attitude during previous assessments.
- Hopeless: Hopeless is when the patient has no expectations that their life can be better than it is.
- Helpless: Helpless is when the patient is unable to change without assistance from others.
- Warm: Warm is when the patient invites engagement with staff.

TABLE 13–2 Elements of the Attitude Assessment

Attitude			
Cooperative	Uncooperative	Warm	Friendly
Brighter	Hopeful	Thankful	Apathetic
Hopeless	Helpless		Worried

- Apathetic: Apathetic is when the patient is disinterested and unemotional about the patient's treatment and surroundings.
- Thankful: Thankful is when the patient is appreciative of the treatment team's efforts to help the patient recover from the episode of mental illness.

Mood is a temporary state of mind that changes based on events. For example, the patient may be elated when his favorite sports team wins a game and depressed if they lose. Mood should correspond to the situation that the patient experiences. Affect is the observable expression of emotion. That is, the nurse assesses the patient's mood by observing the patient's emotions. Table 13–3 contains elements of mood/affect to include in your assessment. Here are some terms that may be confusing to understand.

- Impulsive: A patient is impulsive when the patient acts without forethought.
- Hyperactive: A patient is hyperactive when the patient is abnormally extremely active compared with the situation.
- Aloof: A patient is aloof when the patient is not friendly or forthcoming and remains distant.
- Flat: A patient's affect is flat when the patient shows lack of emotions.
- Irritable: A patient is irritable when the patient is easily annoyed.
- Disorganized: A patients is disorganized when the patient acts without proper planning and control.
- Evasive: A patient is evasive when the patient avoids self-revelation.

TABLE 13–3 Elements of the Mood/Affect Assessment

Mood/Affect			
Controlled	Disorganized	Guarded	Preoccupied
Impulsive	Evasive	Refused meals	Refused activities of daily living
Hyperactive	Psychomotor retardation	Hostile	Sexual
Aloof	Verbally abusive	Facial movements jaw/lip smacking	Distant
Flat	Ambivalence	Suspicious	Restless
Anxiety	Euphoria	Depression	Depersonalization
Irritable	Aggressive/combative	Labile	Uninhibited

- Psychomotor retardation: Psychomotor retardation occurs when thought and physical movement are slowed.
- Ambivalence: Ambivalence occurs when the patient has mixed contradictory feelings.
- Euphoria: Euphoria occurs when a patient is in a state of intense happiness.
- Guarded: A patient is guarded when a patient is cautious.
- Suspicious: A patient is suspicious when they show distrust.
- Labile: A patient is labile when the patient can easily change thoughts or behavior.
- Preoccupied: A patient is preoccupied when they focus on one thing with the exclusion of other thoughts.
- Distant: A patient is distant when they are emotionally disconnected with an event.
- Restless: A patient is restless when they are unable to relax.
- Depersonalization: Depersonalization occurs when a patient has divested of human characteristics such as feeling emotions for another person.
- Uninhibited: A patient is uninhibited when the patient expresses feelings without restraint.

The thinking process is the way a patient perceives and interprets everything around them based on logic and personal experience or experience from others (i.e., being taught). The thinking process is used to accomplish a goal. For example, a person learns that turning and pulling the door knob will cause the door to open. Therefore, the person turns and pulls the door knob to open the door when the person wants to leave the room.

Mental illness can interrupt the thinking process, resulting in abnormal behavior. That is, the patient may stand behind a closed door unable to process that turning and pulling the door knob will open the door. Table 13–4 lists characteristics of disruption in the thinking process that may be signs of mental illness. Here are some terms that may be confusing to understand.

- Loose association: Loose association is when the patient expresses a sequence of unrelated or remotely related ideas.
- Clang association: Clang association occurs when the patient uses two or more words based on the sound of the words rather than the meaning of the words.
- Logical: Logical is when a patient expresses an idea using reasoning.

TABLE 13–4 Elements of the Thinking Process Assessment

Thinking Process			
Loose association	Concrete thinking	Circumstantial	Tangential
Clang association	Flight of ideas	Preservation	Echolalia
Logical	Blocking	Word salad	Incoherence
Illogicality	Thought broadcasting	Derailment	

- Illogicality: Illogicality is when a patient expresses an idea based on invalid reasoning.
- Concrete thinking: Concrete thinking occurs when a patient is unable to generalize between two similar situations. For example, a patient may take a cold shower when the staff tells an excited patient to cool down.
- Flight of ideas: Flight of ideas occurs when the patient changes topics without concluding the previous topic.
- Blocking: Blocking occurs when the patient stops speaking in the middle of a sentence and is unable to finish the thought.
- Thought broadcasting: Thought broadcasting occurs when the patient believes they communicate by sending their thoughts through the air.
- Circumstantial: Circumstantial thought process occurs when the patient delays getting to the point of their conversation.
- Preservation: Preservation occurs when the patient keeps returning to the same set of ideas.
- Word salad: Word salad occurs when the patient expresses a mixture of random words.
- Derailment: Derailment occurs when the patient slips off the topic during a conversation.
- Tangential: Tangential thought process occurs when the patient wanders from topic to topic without returning to the original topic.
- Echolalia: Echolalia occurs when the patient repeats whatever is said to them, resulting in an echoing effect.
- Incoherence: Incoherence occurs when the patient lacks clarity in their statement.

Thinking determines how we react to events around us. Mental illness can cause a patient to react strangely based on misperception of stimuli in the environment. For example, a patient may see themself as superior because their

TABLE 13–5 Elements of the Thinking Assessment

Thinking			
Guilty	Ashamed	Delusional	Grandiose
Magical thinking	Hallucination: audio, gustatory, olfactory, tactile, visual	Homicidal ideation	Idea of reference
Religiously preoccupied	Obsessions	Paranoia	Persecutory
Phobias	Suicidal ideation	Impaired memory	

friend calls them "boss." Table 13–5 contains elements to consider when assessing the patient's thinking. Here are some terms that may be confusing to understand.

- Guilty: A patients feel guilty when the patient feels responsible for a wrong doing when in fact the patient had little or nothing to do with the event.
- Magical thinking: Magical thinking occurs when the patient believes that merely thinking about a situation will alter the situation such as wishing for something.
- Ashamed: A patient feels ashamed when the patient is embarrassed about an action that the patient may or may not have performed.
- Delusional: A patient is delusional when the patient has a firm belief that contradicts reality.
- Grandiose: A patient is grandiose when the patient is pretentious, considers themself at a higher status than their colleagues, and has an exaggerated self-importance.
- Homicidal ideation: Homicidal ideation occurs when the patient has thoughts of killing another person.
- Religiously preoccupied: A patient is religiously preoccupied when a patient is preoccupied with religious subjects that are not within the patient's experiences of religion.
- Obsessions: Obsessions occur when the patient is compulsively preoccupied with a fixed idea.
- Paranoia: Paranoia occurs when the patient loses touch with reality and expresses delusions of persecution.
- Suicidal ideation: Suicidal ideation occurs when the patient has thoughts of suicide.

- Phobias: A phobia occurs when a patient has an irrational aversion to something.
- Idea of reference: An idea of reference occurs when the patient believes that an irrelevant event refers to them directly.
- Impaired memory: Impaired memory occurs when the patient has difficulty recalling information or an event.
- Hallucination:
  - Audio: Audio hallucination occurs when the patient hears something that is not present.
  - Gustatory: Gustatory hallucination occurs when the patient tastes something that is not present.
  - Olfactory: Olfactory hallucination occurs when the patient smells something that is not present.
  - Tactile: Tactile hallucination occurs when the patient feels something that is not present.
  - Visual: Visual hallucination occurs when a patient sees something that is not present.

Judgment is the ability to arrive at a sensible conclusion about a situation. Mental illness may impair the patient's judgment, and therefore, the nurse needs to assess the patient's capacity to judge a situation. Assessing judgment is challenging because a sensible conclusion is subjective and requires the nurse to compare the nurse's judgment with that of the patient's judgment given the facts of a situation. First, the nurse must have the same facts as the patient about the situation. Next, the nurse must be perceptive to those facts in the way the patient is perceptive to the facts. Finally, the nurse must also have the capability to make a sensible conclusion about the situation.

Let us say the patient is delusional and runs from their room because the patient believes there are bugs in their bed. There are no bugs in the bed. The nurse may deem the patient's decision to leave the room to be based on poor judgment. Yet the patient displays good judgment given the patient's perception of the facts. That is, there are bugs in the patient's bed. The patient's judgment is intact, but the patient has misperceived the facts of the situation.

Another example is when a mentally ill chemically addicted (MICA) patient tells the practitioner in the emergency department that they want to kill themself with a gun. The patient denies suicidal ideation when they arrive on the unit and interact positively with the staff and patients. Some nurses might question the patient's judgment for what seems like pretending to want to kill

TABLE 13–6 Elements of the Judgment/Insight Assessment

Judgment/Insight			
Intact	Impaired	Denies problems	Understands reason for admission
Recognizes illness			

themself. However, the patient is homeless and living in a shelter. The shelter requires clients to leave the shelter at 6 am, and they are not permitted back into the shelter until 4 pm. The patient realizes that they can stay on the unit for up to 10 days if they claim suicidal ideation in the emergency department. Therefore, the patient's judgment is intact.

Table 13–6 contains common assessment of a patient's judgment. Before reaching a conclusion, the nurse should probe for facts by asking the patient to explain the basis for the patient's action in a specific situation. Knowing what the patient believes are facts of a situation provides a basis for the nurse to consider if the patient's decision was reasonable given the perceived facts and the time frame to make the decision. Compare the patient's judgment to what you believe a reasonable person would decide in that circumstance.

Our body language is the first means of communicating to another person, causing us to react accordingly. If the person has a relatively open, freely flowing body movement, we tend to feel less threatened and respond in a friendly manner. In contrast, tense body movement places us in a cautious mode. Initially we are defensive as we gather more information. Once we determine the person is nonthreatening, our mind focuses on what is troubling the person and how can we help.

Because body movement may indicate the emotional state of the patient, the nurse needs to observe and assess the patient's body language. The patient's body language may or may not coincide with the patient's verbal expression of the patient's feelings. For example, the patient may be restless, yet tell the staff that he is fine.

Table 13–7 lists elements of the body movement assessment. Here are some terms that may be confusing to understand.

- Deliberate: A patient's movements are deliberate when the patient moves with intent.
- Fidgety: A patient is fidgety when the patient is unable to remain in one position for a period of time.
- Coordinated: A patient is coordinated when all parts of the patient's body move in sync.

TABLE 13–7 Elements of Body Movement Assessment

Body Movement			
Deliberate	Fidgety	Unsteady gait	Smooth
Coordinated	Restless	Voluntary	Uncoordinated
Even	Facial grimace		

- Facial grimace: Facial grimace occurs when the patient displays distorted facial expression.
- Unsteady gait: Unsteady gait occurs when the patient has difficulty walking and at times is offbalance.
- Even: Even movement occurs when all parts of the patient's body moves at an even distance from the body.
- Restless: Restless occurs when the patient is unable to relax.
- Voluntary: Voluntary movements occur when the patient is able to move all parts of the body freely and at will.
- Smooth: Smooth movements occur when the patient is able to move the body without interruption of movement.

The patient's appearance is described as dressing, grooming, and hygiene. The patient is expected to dress appropriately for the situation, shower daily, brush their teeth, and keep their hair and nails clean and at an appropriate length. A patient with mental illness may forgo these basic activities of daily living. For example, a patient diagnosed with major depressive disorder may lack the energy and motivation to wash and keep up their appearance.

When assessing the appearance, the nurse must keep in mind the resources that are available to the patient. Let us say that the patient was evicted from a homeless shelter because of their behavior, causing the patient to live on the street. The patient is likely to be wearing dirty clothes and appear unkempt and unclean; however, this condition is likely caused by lack of resources rather than an inability to dress appropriately and keep clean and well groomed.

Regardless of the patient's circumstances, the nurse must chart what the nurse sees. The nurse should inquire why the patient appears unkempt and then note the patient's response in the chart. Keep in mind that the nurse reports findings regardless of whether those findings have a basis in the patient's mental illness. The patient's healthcare team will assess all the findings and reach a conclusion.

NURSING ALERT

The nurse should see improvement in the patient's appearance and grooming as treatment reverses the symptoms of mental illness.

Table 13–8 lists elements of the dress, grooming, and hygiene assessment. Here are some terms that may be confusing to understand.

- Disheveled: A patient appears disheveled when the patient's appearance is untidy and disorganized.
- Poor hygiene: Poor hygiene occurs when the patient does not shower and wash regularly.
- Unilateral neglect: Unilateral neglect occurs when the patient fails to care for one side of their body.
- Ungroomed: Ungroomed occurs when the patient does not maintain the appearance of their body.
- Lack of concern about dress: Lack of concern about dress occurs when the patient is disinterested in the type and condition of clothes that are worn by them.

4. Psychiatric Nursing Diagnosis

A psychiatric assessment will result in the nurse determining if the patient is within normal limits for the assessment category or if the patient has a deficit. A deficit means that the patient is outside normal limits and is in need of treatment that helps the patient return to normal limits. The nurse defines the deficit as a nursing diagnosis. A nursing psychiatric diagnosis is different from a medical or psychiatric diagnosis in that a medical or psychiatric diagnosis focuses on a physiologic deficit such as major depressive disorder. A nursing

TABLE 13–8 Elements of Dress, Grooming, and Hygiene Assessment

Dress, Grooming, and Hygiene			
Appropriate	Facial hair well groomed	Nails clean	Unilateral neglect
Disheveled	Hair is neat and clean	Poor hygiene	Ungroomed
Clothing does not fit	Inappropriate	Clothing fits	Lack of concern about dress

psychiatric diagnosis is a deficit in the way the patient responds to a disorder. Practitioners make a medical or psychiatric diagnosis. A nurse makes a nursing psychiatric diagnosis. Table 13–9 contains a sample of nursing diagnosis used in behavior health.

NURSING ALERT

A nursing psychiatric diagnosis can be treated by the nurse usually without a practitioner's order.

TABLE 13–9 Sample of Nursing Psychiatric Diagnosis Used in Behavior Health

Category	Diagnosis
Communicating	
	Impaired verbal communication
Relating	
	Impaired social interaction
	Social isolation
	Risk for loneliness
	Infective role performance
	Impaired parenting
	Risk for impaired parenting
	Sexual dysfunction
	Interrupted family process
	Caregiver role strain
	Risk for caregiver role strain
	Dysfunctional family process: alcoholism
	Parental role conflict
	Ineffective sexuality patterns
Valuing	Spiritual distress
	Risk for spiritual distress
	Readiness for enhanced spiritual well-being
Choosing	Ineffective coping
	Impaired adjustment
	Defensive coping
	Ineffective denial
	Disabled family coping
	Compromised family coping
	Readiness for enhanced family coping

TABLE 13–9 Sample of Nursing Psychiatric Diagnosis Used in Behavior Health (*Continued*)

Category	Diagnosis
	Readiness for enhanced community coping
	Ineffective therapeutic regimen management
	Noncompliance or nonadherence
	Ineffective family therapeutic regimen management
	Effective therapeutic regimen management
	Decisional conflict
	Health seeking behaviors
Moving	Fatigue
	Disturbed sleep pattern
	Deficient diversional activity
	Delayed growth and development
	Risk for delayed development
	Relocation stress syndrome
Perceiving	Disturbed body image
	Chronic low self-esteem
	Situational low self-esteem
	Risk for situational low self-esteem
	Disturbed personal identity
	Disturbed sensory perception—visual, auditory, kinesthetic, gustatory, tactile, olfactory
	Unilateral neglect
	Hopelessness
	Powerlessness
	Risk for powerlessness
Knowing	Knowledge deficit
	Impaired environmental interpretation syndrome
	Acute confusion
	Chronic confusion
	Disturbed thought processes
	Impaired memory
Feeling	Acute pain
	Chronic pain

TABLE 13–9 Sample of Nursing Psychiatric Diagnosis Used in Behavior Health *(Continued)*

Category	Diagnosis
	Dysfunctional grieving
	Anticipatory grieving
	Chronic sorrow
	Risk for other-directed violence
	Risk for self-mutilation
	Risk for self-directed violence
	Posttrauma syndrome
	Rape-trauma syndrome
	Rape-trauma syndrome—compound reaction
	Risk for posttrauma syndrome
	Anxiety
	Death anxiety
	Fear
	Risk for falls
	Self-mutilation
	Risk for suicide

5. Psychiatric Care Plan

A psychiatric care plan, sometimes referred to as a **treatment plan**, is developed based on the patient's psychiatric diagnosis. A psychiatric care plan determines the course of action followed by the patient's treatment team that will return the patient to within normal limitations. The psychiatric care plan contains an outcome consisting of long-term and short-term psychiatric goals. Interventions are specified for each short-term psychiatric goal. An intervention is a task performed by the treatment team that will help move the treatment and the patient toward completing the corresponding short-term psychiatric goal. Periodically the treatment team evaluates the progress and then determines if goals have been met; if interventions should be continued; or if interventions need to be modified.

Interdisciplinary Psychiatric Care Plan

The patient's healthcare team works from an interdisciplinary psychiatric care plan used to guide the healthcare team through diagnostic tests, medical

procedures, and routines that assure that the patient receives the best possible care. There are many forms of care plans, all of which contain the same key information to direct the healthcare team.

- The patient's problem
- Interventions to address each problem
- The expected outcome or goal of these interventions
- Evaluation of the intervention

Interdisciplinary Psychiatric Care Plan Objective

An **interdisciplinary psychiatric care plan** contains the patient's healthcare problems that were identified when the patient was assessed and the actions for the healthcare team to take to minimize or resolve those problems. The action is proven to work, and the healthcare team can measure whether the action minimized or resolved the patient's problem. Each action

- Must be based on a scientific rationale
- Must have a measurable outcome
- Must be patient specific

For example:

- Problem: A patient on total bed rest is at risk for decubitus ulcers (bed sores).
- Action: The healthcare team will turn the position of the patient in bed every 2 hours.
- Scientific rationale: It has been proven that turning the position of the patient frequently will reduce the risk for decubitus ulcers.
- Evaluation: Examining the patient for decubitus ulcers at the beginning of each shift determines if repositioning the patient every 2 hours prevented decubitus ulcers.

Defining a Problem

Assessment of the patient's signs and symptoms enables the healthcare team to define the patient's problem(s). Each problem is described as a nursing psychiatric diagnosis or a medical diagnosis. The problem is described in the interdisciplinary psychiatric care plan using the diagnosis. There are many styles of

interdisciplinary psychiatric care plans. Some interdisciplinary psychiatric care plans will use the PES format to identify a problem. The PES format has three components:

- P is the diagnosis.
- E is the etiology—origin of the problem.
- S are the signs/symptoms that led to the diagnosis.

The PES format is written as:

- P: Diagnosis
- E: Related to the patient's condition
- S: As evidenced by list of signs/symptoms

For example, a patient who is being treated for major depressive disorder experiences social isolation. Here is one way to describe this problem using the PES format:

- P: Social isolation
- E: Related to major depressive disorder
- S: As evidenced by the patient staying in their room except for meals

Setting Goals

Goals are set for each patient problem. A goal is a measurable outcome that is expected after the healthcare team performs the action. The number of goals defined depends on the nature of the patient's problem.

Each goal is assessed after the action is performed to determine if the desired result was achieved. The assessment is made using a standard measurement, which often involves the patient reporting a condition or performing a behavior. A measurement can be subjective or objective. For example, measuring whether or not the patient is engaging with staff is subjective based on the staff's definition of engaging. A temperature of 100°F is objective and is not influenced by interpretation. Both subjective and objective measurements can be used to set goals. Goals for the patient with major depressive disorder are:

1. Patient will engage with staff for 60 minutes during each shift as reported by staff.
2. Patient will attend one community meeting each day as observed by staff.
3. Patient will converse with one fellow patient for 10 minutes each shift as observed by staff.

Planning Action

An action (intervention) is something done to achieve goals that were set for the patient with regard to the diagnosis. Actions are related to goals. Each goal could have one or more actions. An action can achieve one or more goals depending on the goal and action. Each action begins with a verb such as assess, assist, explain, and teach and is followed by the description of the action. Here are a few actions for the patient with major depressive disorder. Table 13–10 lists commonly used interventions for common psychiatric diagnoses.

1. Assess the patient's location every 15 minutes.
2. Converse with the patient for 60 minutes per shift.
3. Encourage the patient to attend a community meeting.
4. Teach the patient how engage with other patients.
5. Encourage the patient to leave their room and explore the unit.

TABLE 13–10 Commonly Used Interventions by Psychiatric Nurses

Diagnosis	Intervention
Risk for suicide	Ask the patient if they have thoughts of harming themself and ask if they have a plan to harm themself
	Place the patient on close supervision
	Removal all potentially harmful objects from the environment
	Ask the patient to agree to a contract for safety where the patient promises to tell the staff if they had thoughts to harm themself
	Conduct a frequent room search for items that the patient might use to harm themself
Depression	Develop trust
	Help the patient explore their feelings
	Help the patient develop a balanced, honest view of their life
	Help the patient focus on strengths and accomplishments
	Promote simple accomplishments
	Encourage independence
	Teach assertiveness
	Help the patient identify areas that they need to improve and then teach them how to improve
Powerlessness	Encourage the patient to participate in setting goals and make decisions about their care
	Help the patient set realistic goals that the patient can achieve on their own
Hopelessness	Encourage the patient to express feelings about things they cannot control
	Help the patient identify stressors in their life

TABLE 13–10 Commonly Used Interventions by Psychiatric Nurses (*Continued*)

Diagnosis	Intervention
	Help the patient identify coping skills that they used and help the patient assess the effectiveness of those coping skills
	Encourage the patient to explore feelings
	Help the patient regain control over small aspects of their life
	Help the patient identify areas of their life that they can control successfully
	Provide the patient with sources that can be used when the patient is overwhelmed by life's challenges
Manic	Reduce environmental stimuli
	Remove hazardous objects
	Provide the patient with physical activities to reduce stress and use energy
	Remain with the patient who is hyperactive and agitated
	Maintain a calm attitude
	Respond in concrete terms
Manipulative behavior	Set limits
	Explain expectations and consequences if expectations are not met
	Ignore arguing
	Reinforce positive behavior
	Do not bargain
	Do not reinforce negative behavior
	Help the patient think through consequence of their actions

Scientific Rationale

There must be a scientific basis for each action even if the scientific rationale is not specified in the care plan. The scientific basis is a recognized standard of practice that is documented in a healthcare facility's policy or by an authoritative source. An institutional care plan will not include a scientific rationale for interventions. Student care plans will specify a scientific rationale. Healthcare facilities standardize care plans according to a patient's profile. Goals, actions, and other components of the care plan are predefined based on scientific rationale and can be modified as needed to address the needs of the patient. The scientific rationale is a sentence or paragraph that justifies the action followed by a reference. Rationales are numbered according to the number of the corresponding action.

Evaluating the Outcome

The outcome of every action is evaluated to determine whether the action impacted the patient and whether or not the goal was achieved. The outcome is described in a sentence or paragraph that usually begins with *The patient* followed by an explanation of how the patient reacted to the action and if the goal associated with the action was reached. Goals are not always 100% achieved. The level of achievement is indicated in the evaluation. An outcome may not be observed for a number of reasons. In these cases, write "not observed." Each evaluation is numbered to correspond with the goal. Here are evaluations for the patient with a major depressive disorder.

1. The patient states that they are too tired to attend a community meeting.
2. The patient conversed with one patient during lunch in the dining room.
3. The patient asked the nurse about unit activities.
4. The patient verbalized that they need to get out of bed more often.
5. The patient walked the hallway for 5 minutes.

CASE STUDY

CASE 1

A 32-year-old female patient diagnosed with bipolar disorder is brought to your unit and you have been assigned to admit the patient to the unit. She gets up from the wheelchair and holds on to the wall railing as she makes her way to the room where you will be doing her assessment. She says the police came to her house and brought her in handcuffs to the hospital for no reason. She called the police because there were burglars outside her house trying to get in. They would wait until the police left and then try to break in again. She says each time she called the police, the burglars would run away. You ask her if she has ever been admitted to a hospital for psychiatric treatment. She begins to answer and then stops in mid-sentence for a long pause. You re-ask the question, and she tells you about her brother who was diagnosed with bipolar disorder. During the interview, the patient frequently changes position in the chair and intermittently picks her skin. She demands to know when she can go to her room, expressing that the interview has gone on long enough.

QUESTION 1. What is your assessment of the patient's mood/affect?
ANSWER: You assess the patient as irritable, anxious, and restless because the patient is demanding that the interview be over soon.

QUESTION 2. What is your assessment of the patient's thinking process?
ANSWER: The patient is demonstrating blocking since the patient stopped in the middle of her response and did not continue even with your encouragement. The patient is also delusional about burglars breaking into her house based on the determination of the police. The patient also shows signs of paranoia over the police bringing her to the hospital.

QUESTION 3. What is your assessment of the patient's judgment?
ANSWER: The patient shows impaired judgment based on her inability to recognize her illness and implication that she has a psychiatric problem.

QUESTION 4. What is your assessment of the patient's body movement?
ANSWER: The patient is restless and fidgety and has an unsteady gait based on the patient's movement in the chair during the interview and holding on to the railing in the hallway.

FINAL CHECK-UP

1. **A 43-year-old female patient was admitted for major depressive disorder. She explains to you that this is her first admission to a psychiatric unit. Her family called the ambulance when the patient did not show up for work for a week and stopped answering her phone. The patient asks what blood tests the practitioner will order to confirm that she has major depressive disorder. What is your best response?**
   A. The practitioner will order a Chem 7 panel.
   B. There is no blood test used to diagnose major depressive disorder.
   C. The practitioner will likely order blood tests to rule out causes for your symptoms of major depressive disorder.
   D. The practitioner will likely order an hCG test; however, there is no blood test used to diagnose major depressive disorder.

2. **A new nurse is admitting her first patient. The electronic medical record screen prompts her to enter a multi-axial assessment for the patient. She tells you that the multi-axial assessment has been discontinued by the DSM-5. What is your best response?**
   A. Tell her she is wrong and to complete the assessment as indicated by the electronic medical record system.
   B. Tell her that she is correct but that your facility will continue to use the multi-axial system until the policy and procedure committee changes the policy.
   C. Tell her that she should do whatever she thinks is the proper thing to do.
   D. Tell her to fill out the screen until the nurse manager tells her differently.

3. A float nurse tells you that she is unable to chart on the patients because she doesn't really know the patients. What is your best response?

A. Tell the float nurse that you will chart on his patients.
B. Brief the nurse on each patient sufficiently so he can chart the daily assessment.
C. Tell the nurse to read the patient's chart.
D. Tell the nurse to engage his patients in conversation.

4. As a preceptor, you ask the new nurse how her patient is doing. She tells you that he is fine and shows no signs of mental illness. He has been sleeping all day. What is your best response?

A. Give her encouragement to continue with her good assessment skills.
B. Educate the nurse on the negative signs of mental illness.
C. Encourage the nurse to observe the patient 15 minutes per shift.
D. Educate the nurse on the positive signs of mental illness.

5. A new admission arrives on the unit. All his clothes are in a dark green garbage bag. An odor comes from the bag. The patient has poor hygiene and is disheveled. What is your best response to the patient?

A. You need a shower.
B. Let me show you around the unit. Here is the shower. Times when the shower is open are here. I'll give you soap and other items you'll need to shower.
C. Do your clothes need washing? I can wash them for you.
D. You'll probably feel better after showering. Here's a hospital gown and soap. While you shower, I'll wash your clothes.

6. A new nurse tells you that she does not feel her assessments are important to the treatment team. What is your best response?

A. Your assessment is added to the patient's database of information. Each morning the patient's psychiatrist reviews new data and then determines if treatment goals are being met.
B. The nurse manager audits each patient's nurse's assessment daily.
C. Your assessment is passed along to the patient's psychiatrist every morning. If you notice anything abnormal with the patient, then the psychiatrist talks to the patient.
D. Knowing that a nursing assessment is of little use to the treatment team is frustrating, but we must do our assessments.

7. A new nurse asks why each goal and intervention must have a scientific rationale since many patients receive the same treatment. What is your best response?

A. Tell the nurse that this is the policy of the facility.
B. Tell her that having a scientific rationale for treatment is required for reimbursement by third-party payers.

C. Tell her that a scientific rationale is required by government regulators.
D. Tell her that treatment is evidence-based. That is, there is scientific evidence that a specific course of treatment will improve a specific set of signs and symptoms.

8. A new nurse asks you why some nursing diagnoses begin with *Risk for*. What is your best response?

A. Tell her that the nurse can anticipate that a deficit will occur unless the treatment team intervenes to prevent the deficit from occurring.
B. Tell her that these are conditions that haven't developed as yet but will develop in the future.
C. Tell her that these are conditions that the nurse should prepare to treat in the future.
D. Tell her that these are conditions that the nurse should prepare the patient to expect in the future.

9. The new nurse is puzzled by discussing a patient's problems as self-deficits. What is your best response?

A. Tell the nurse that nursing is about helping others do things that they cannot do themselves.
B. Tell the nurse that a deficit is something that the patient can't do themself.
C. Explain that the treatment team's overall goal is to have the patient be able to manage problems with as little assistance as possible.
D. Tell the nurse that self-deficit means that the nurse must decide what the patient is unable to do for themself.

10. A new nurse charts that a patient diagnosed with major depressive disorder is without pain because the patient has been sleeping in bed all day. What is your best response?

A. Educate the nurse that a patient who is sleeping may have pain and needs to be assessed for pain.
B. Complement him on making a reasonable assessment of the patient.
C. Educate the nurse that a patient who is sleeping may have pain and needs to be assessed for pain using the FLACC pain scale.
D. Tell the nurse to look in on the patient before documenting his assessment.

CORRECT ANSWERS AND RATIONALES

1. C. The practitioner will likely order blood tests to rule out causes for your symptoms of major depressive disorder. Rationale: The hCG test will likely be ordered to rule out pregnancy since psychotropic medication is not administered to patients who are pregnant; however, this is not the best response because blood tests are more likely to be ordered to rule out a medical cause of the patient's symptoms. Stating there is no blood test used to diagnose major depressive disorder is true, but the nurse should give a more complete explanation for why blood tests are ordered.

2. B. Tell her that she is correct but that your facility will continue to use the multi-axial system until the policy and procedure committee changes the policy. Rationale: A nurse must continue to follow policy when documenting assessments.
3. D. Tell the nurse to engage his patients in conversation. Rationale: A nurse must assess each patient assigned to the nurse following standard nursing practice.
4. B. Educate the nurse on the negative signs of mental illness. Rationale: The patient may be showing negative signs of mental illness by staying in bed all day and requires intervention by the patient's treatment team.
5. D. You'll probably feel better after showering. Here's a hospital gown and soap. While you shower, I'll wash your clothes. Rationale: This is a positive response that helps the patient make the best decision without embarrassing the patient.
6. A. Your assessment is added to the patient's database of information. Each morning the patient's psychiatrist reviews new data and then determines if treatment goals are being met. Rationale: Nursing assessments are important because nurses assess the patient 24 hours 7 days a week and the psychiatrist depends on the nurse's assessment to know if treatment goals are being achieved.
7. D. Tell her that treatment is evidence-based. That is, there is scientific evidence that a specific course of treatment will improve a specific set of signs and symptoms.
8. A. Tell her that the nurse can anticipate that a deficit will occur unless the treatment team intervenes to prevent the deficit from occurring. Rationale: The goal is to prevent deficits from occurring.
9. C. Explain that the treatment team's overall goal is to have the patient be able to manage problems with as little assistance as possible. Rationale: This is the only response that discusses the purpose of self-deficit.
10. C. Educate the nurse that a patient who is sleeping may have pain and needs to be assessed for pain using the FLACC pain scale. Rationale: The nurse should not assume that the psychiatric patient who is sleeping is without medical problems.

chapter 14

Physiologic Basis of Mental Illness

LEARNING OBJECTIVES

1. Neurologic system
2. Neurotransmitters
3. Nervous system and mental illness
4. Medication
5. Substance abuse

KEY TERMS

Acetylcholine
Amygdala
Anterior cingulate cortex (ACC)
Autonomic nervous system (ANS)
Axon
Central nervous system (CNS)
Cytoplasm
Dendrites
Dopamine
Gamma-aminobutyric acid (GABA)
Ganglion
Glutamate
Hippocampus
Neural pathway
Neurons
Neurotransmitter
Noradrenaline
Organelles
Parasympathetic nervous system
Peripheral nervous system (PNS)
Prefrontal cortex (PFC)
Receptor
Reuptake pump
Serotonin
Somatic nervous system (SNS)
Sympathetic nervous system
Synapse

Mental Illness

Mental health is a continuum that begins with structure and function of the brain at the physical level. Next is the personal level where each of us cares about ourselves; this leads to the interpersonal level where we interact with others. The continuum ends at the societal level where we embrace social and cultural beliefs. Mental illness has been defined as the inability to see oneself as others see you and the lack of the ability to conform to what culture and society considers normal.

Until DSM-5 (see Chapter 13), mental health was assessed using the multi-axial system. Each element of the multi-axial system is of part of the mental health continuum. The multi-axial system begins with the clinical disorder. The clinical disorder is the focus of the psychiatric clinician.

Next are personal disorders and mental retardation. A personal disorder is a maladaptive pattern of behavior that is deeply ingrained, manifesting during adolescence. This maladaptive pattern of behavior results in long-term challenges for functioning in society. Mental retardation is the lack of normal intellectual development.

General medical conditions are considered when assessing mental health because an underlying medical disorder can mimic symptoms of mental illness. For example, hypothyroidism may result in fatigue and lack of energy, which is

a sign of clinical depression. In contrast, hyperthyroidism may have signs of anxiety, nervousness, increased irritability, and difficulty in sleeping, which may mistakenly lead the clinician to focus on mood disorder or anxiety disorder. Psychosocial and environmental problems with family and support groups, educational challenges, lack of a job and job skills, housing issues, and financial and legal problems have to be addressed.

There is a blurred line between mental illness and neurologic disorders since researchers are discovering that mental illness is the result of changes in chemistry in the brain. Such changes could be considered a neurologic disorder since these chemical changes occur in the brain and affect the neurologic system.

1. Neurologic System

The brain and nervous system are composed of highly specialized cells called **neurons** whose main purpose is to transmit messages. The neuron has three components. These are the cell body, **dendrites**, and **axon**. The cell body contains **organelles** within the **cytoplasm** that collectively causes the cell to function. Dendrites are extensions of the cell bodies that receive impulses from nearby cells. Axons are also extensions from the cell body that send impulses to another cell. Axons can extend an inch or several feet in length. An axon carries impulses away from the cell body. Larger axons are surrounded by fatty insulating material called myelin that enables the impulse to be transmitted without interference from other cells. Myelin also ensures that only the destination cell receives the impulse.

A neuron is enclosed in a cell membrane that insulates the cell from the environment. The cell membrane controls chemicals that enter and leave the cell in addition to controlling the neuron's response to impulses. The axon is divided into branches called presynaptic terminals that are located near the dendrites of a neuron. The gap between the axon and the dendrite is called a **synapse**. The synapse is an intercellular space (see Figure 14–1). There is no physical connection between neurons. One neuron can have over 1000 synapses with the neighboring neurons. Neurons are dynamic in that the number of synapses can change based on changes in the environment, commonly referred to as learning.

Neurons communicate in two ways: electrical impulse and a chemical message. An electrical impulse is generated by the neuron when a chemical message is received by the neuron's dendrites. The electrical impulse is unable to cross the synapse; therefore, the electrical impulse triggers the neuron to produce one

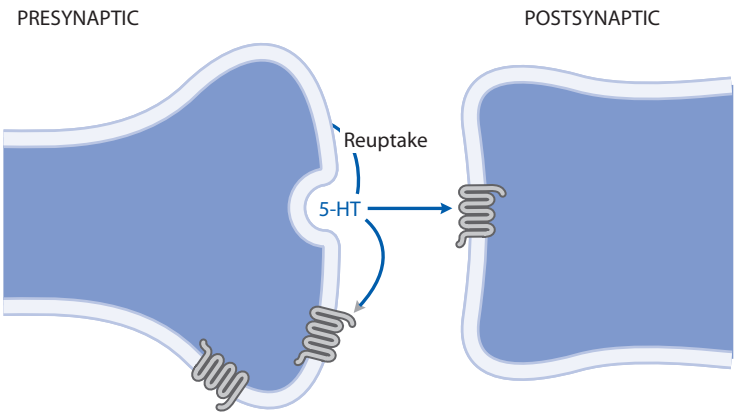


FIGURE 14–1 • Neurotransmitters cross the synapse between neurons to send messages to another neuron. The reuptake pump then recovers the neurotransmitter. (Reproduced with permission from Brunton LL, Chabner BA, Knollmann BC, eds. *Goodman & Gilman's The Pharmacological Basis of Therapeutics.* 12th ed. New York: McGraw-Hill; 2011. Figure 15-1.)

or more chemical messengers, called neurotransmitters, from the axon. The neurotransmitter enters the synapse and drifts to a **receptor** on the dendrite. A neurotransmitter binds with a corresponding receptor. The neurotransmitter causes the receiving neuron to generate an electrical impulse.

The dendrite releases the neurotransmitter from the receptor, and the neurotransmitter drifts back into the synapse. A **reuptake pump** causes the neurotransmitter to be taken back into the axon that originally released the neurotransmitter for reuse. Not all neurotransmitters are retrieved by the axon. Neurotransmitters that remain in the synapse are degraded by enzymes in the synapse.

Researchers believe that symptoms of mental illness are caused by an abnormal increase or decrease in neurotransmitters. Medication used to treat mental illness is called psychotropic medication, and many of these medications interfere with the reuptake of neurotransmitters by blocking the reuptake, resulting in increasing the neurotransmitter in the synapse, or increasing the reuptake, resulting in decreasing the neurotransmitter in the synapse. As a result, the symptoms of mental illness are minimized.

DNA and Genes

DNA is information that defines who we are based on genetic traits inherited from our parents. DNA is composed of segments called genes that make protein and chemicals that cause cells to express or not to express genetic traits. Cells reproduce. Each new cell has a copy of the original set of DNA. Sometimes

the duplication process is flawed, resulting in a gene mutation that produces a modified protein rather than the original protein. Mutation may be harmless or cause a disorder. Genes can also be affected by environmental factors including stress. Environmental factors determine whether or not the gene is activated or not activated to procure a specific protein. Researchers believe that environmental factors are the underlying causes of mental disorders and may lead to detection and treatment of mental disorders.

Researchers have seen a correlation between specific genes and specific groups of genes and signs and symptoms of mental illness. Furthermore researchers are exploring how this correlation can be used to predict the risk for mental illness and possibly develop gene-based treatment to reverse the effects of these genes.

Neural Pathways

A **neural pathway** is a specific route through the network of neurons that carries an impulse to a specific destination. For example, sound vibrates membranes in the ear that convert the vibrations to impulses that travel over the neural pathway to the auditory cortex where sound is compared to learned sounds; either the sound is ignored or new impulses are sent to other parts of the body to react to the sound. This is considered the auditory neural pathway.

Some neural pathways bypass the brain and direct the impulse directly to cells to react to the initial impulse. These are commonly referred to as reflex pathways. For example, a practitioner taps your knee causing the impulse to travel to the spinal cord and then directly to the muscles in the leg to cause your knee to jerk in a reflex reaction.

According to researchers, learning is the process of developing neural pathways based on collective simulation of the senses. Through learning, we are able to relate actions and consequences; for example, we know that increasing the temperature on the skin will destroy skin cells (i.e., result in a burn). Once this neural pathway is established and we sense increased temperature, then an impulse is sent to contract muscle cells in the limb, causing us to move away from the heat.

Neural pathways are degraded because of lack of use. Some researchers describe this as forgetting. The more the neural pathway is used, the more predominant is the neural pathway. For example, the more we speak publicly, the more we feel at ease because we have developed neural pathways to respond to events that commonly occur during public speaking.

Changing a behavior that has been performed many times is challenging for a person because the neural pathways are strongly defined. That is, we react

predictably when a specific set of stimuli interacts with our senses because we are conditioned (i.e., well-defined neural pathways) to do so. To change, we need to develop new neural pathways so that we respond differently to the same set of stimuli, which can be challenging to accomplish.

Personality disorders are based on neural pathways that produced abnormal behaviors that were learned by the patient in childhood. Dialectical behavior therapy is commonly used to treat the patient. During dialectical behavior therapy, the patient is taught to replace abnormal behaviors with more acceptable behaviors when presented with a specific set of stimuli. That is, the neural pathway that produces unacceptable behavior is replaced with a new neural pathway.

NURSING ALERT

Some mental illness is caused by misinterpreting stimuli and not due to learned unacceptable behavior. For example, a patient diagnosed with schizophrenia paranoid type displays fright and possibly aggressive behavior because the patient believes environmental stimuli are threatening. The patient's neural pathway that is used to respond is proper if the patient was truly in a threatening situation. It is abnormal only because the situation is not threatening.

2. Neurotransmitters

Neurons communicate by sending impulses when the neuron is activated. A small electrical charge occurs when a neuron is activated. This is referred to as an action potential that is caused by the concentration of ions across the cell membrane and travels along the axon. A chemical message called a **neurotransmitter** is released when the action potential reaches the end of the axon. The neurotransmitter crosses the synapse and binds to the receptor on the dendrites of the receiving neuron. This communication process continues until the impulse reaches the final destination at which the last neuron stimulates nonneuron cells (e.g., muscle, endocrine) or causes another impulse to be generated. Mental illness may occur when the neuron transmission process malfunctions. The neurotransmitter is then removed from the synapse and returns to the sending neuron in a process called reuptake and then is recycled and used to transmit another impulse.

Figure 14–2 illustrates the influence of three key neurotransmitters (**noradrenaline**, **serotonin**, and dopamine) on specific behavior and function of the brain. A proper balance of these and other neurotransmitters is necessary for normal behavior. An imbalance of neurotransmitters may result in signs and symptoms of abnormal behavior.

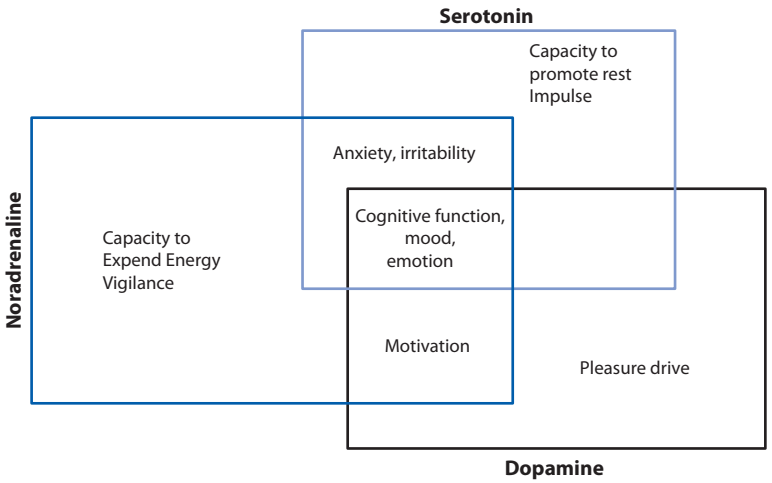


FIGURE 14–2 • Here are the influences of noradrenaline, serotonin, and dopamine on a patient's behavior. (Reproduced with permission from Brunton LL, Chabner BA, Knollmann BC, eds. *Goodman & Gilman's The Pharmacological Basis of Therapeutics.* 12th ed. New York: McGraw-Hill; 2011. Figure 18-7.)

The following neurotransmitters are the focus of treatment for mental illness:

- Serotonin: Serotonin helps control mood, appetite, and sleep. Decreased levels of serotonin may result in depression. Antidepressant medication blocks the reuptake of serotonin, causing the serotonin to remain in the synapse leading to a more stable mood.
- **Dopamine**: Dopamine helps control movement, thought, emotion, and the reward system. Decreased levels of dopamine play a role in schizophrenia and attention deficit hyperactivity disorder (ADHD). In addition, decreased levels of dopamine can produce symptoms of Parkinson disease, such as tremors and stiffness. Medications control dopamine by either blocking the reuptake of dopamine, causing an increased level of dopamine at the synapses, or increasing the reuptake of dopamine, resulting in a decreased level of dopamine at the synapses.
- **Glutamate**: Glutamate is an excitatory neurotransmitter and the most common neurotransmitter in the body. Glutamate increases the probability that a neuron will send an impulse. Glutamate has a role in learning and memory and in early development of the brain. Decreased levels of glutamate are associated with schizophrenia, depression, obsessive-compulsive disorder (OCD), and autism. Medication controls glutamate by either blocking the reuptake of glutamate to increase glutamate levels or increasing the reuptake to decrease glutamate levels.

- Norepinephrine: Norepinephrine is a neurotransmitter and hormone that influences alertness. An increase in norepinephrine increases alertness, whereas a decrease in norepinephrine decreases alertness. Norepinephrine also plays a role in the fight-or-flight response.
- **Gamma-aminobutyric acid (GABA)**: GABA is a neurotransmitter that inhibits activities at the synapses. Antianxiety medication increases the availability of GABA, resulting in decreased impulse activity of neurons. Decreased GABA neurotransmitter results in increased impulse activity of neurons.
- **Acetylcholine**: Acetylcholine is a neurotransmitter that is common in transmitting neuromuscular impulses. Increased acetylcholine increases neuromuscular impulses. Decreased acetylcholine decreases neuromuscular impulses.

NURSING ALERT

A neurotransmitter such as norepinephrine can have a dual role, such as being a hormone and neurotransmitter.

3. Nervous System and Mental Illness

Mental illness is defined by the DSM-5 based on a consensus that certain signs and symptoms are abnormal behavior and, collectively, the signs and symptoms are given a name. Behavior is controlled by a complex network of neurons in the brain. The brain controls practically all behaviors and body functions by receiving and transmitting signals to stimulate or impede parts of the body through the nervous system.

The nervous system divisions are:

- **Central nervous system (CNS)**: The CNS has two components. These are the brain and the spinal cord.
- **Peripheral nervous system (PNS)**: The PNS consists of neurons outside of the brain and spinal cord. There are two subdivisions of the peripheral nervous system; these are:
  - **Somatic nervous system (SNS)**: The SNS interacts with skeletal muscles to produce conscious movement and respiration.
  - **Autonomic nervous system (ANS)**: The ANS controls involuntary movement such as the endocrine system, cardiovascular system, respiratory

system, and gastrointestinal system. The autonomic nervous system is further subdivided into:

- **Sympathetic nervous system**: The sympathetic nervous system is also referred to the adrenergic system and is used to increase activities of the body such as increasing the heart rate.
- **Parasympathetic nervous system**: The parasympathetic nervous system is also referred to as the cholinergic system and is used to inhibit activities of the body such as decreasing the heart rate.

The nervous system contains neurologic pathways. A neurologic pathway is a bundle of neurons called a **ganglion** that forms a neural network connecting the central nervous system to different parts of the body. Neurologic pathways in the sympathetic nervous system stem from the thoracic and upper lumbar segments of the spinal cord. The parasympathetic nervous system stems from cranial nervous systems III, VII, IX, and X and the sacral segments of the spinal cord.

There are two types of fibers in the neurologic pathway. These are:

- Preganglionic: The preganglionic nerve fibers are long fibers that carry messages away from the spinal cord.
- Postganglionic: The postganglionic nerve fibers are short fibers that carry messages to the target cells of the impulse.

The brain is organized into systems, each of which is a subnetwork of neurons. These systems are the commonly referred regions of the brain, each providing a specific function (see Figure 14–3). The regions that are suspected of influencing mental health are:

- **Amygdala**: The amygdala is involved with associating fear or safety with an event, and based on that experience, it causes activation of the fight-or-flight

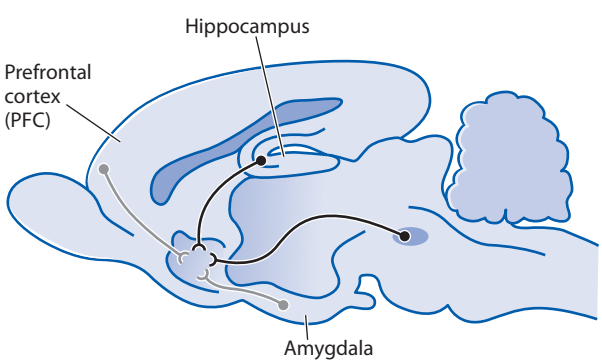


FIGURE 14–3 • Shown are regions of the brain that researchers believe influence mental health.

response. Researchers believe that the amygdala is involved in signs and symptoms of anxiety disorder, phobias, and posttraumatic stress disorder (PTSD).

- **Prefrontal cortex (PFC)**: The prefrontal cortex is involved in judgment, problem solving, and decision making. In addition, the PFC is involved in short-term memory and retrieving long-term memory. During stress, the PFC helps to control the amygdala. Researchers have seen that decreased activity in the PFC occurs in patients who display signs and symptoms of ADHD and PTSD.
- **Anterior cingulate cortex (ACC)**: The ACC is involved in managing emotions. The ACC is also involved in motivation and staying focused. Researchers have found that decreased activity in the ACC is seen in patients who show signs of depression, ADHD, and schizophrenia.
- **Hippocampus**: The hippocampus is involved in creating new memories and controls the hypothalamic–pituitary–adrenal (HPA) axis, which influences moods. Decreased activity in the hippocampus is seen in patients who have signs and symptoms of mood disorders.

Schizophrenia and Psychotic Disorders

Researchers believe that dopamine may contribute to the positive and negative symptoms of schizophrenia. Increase in dopamine receptors in the limbic system is believed to affect language comprehension because connection between the Broca area of the brain and the Wernicke area of the brain is disrupted and may cause positive signs of schizophrenia. The Broca area is where language is produced. The Wernicke area of the brain is where language is comprehended. Decrease in dopamine receptors in the mesocortical pathway may be the cause of negative signs of schizophrenia.

The mesolimbic pathway is a dopamine pathway in the brain that begins in the ventral tegmental area of the midbrain and connects to the limbic system. Some researchers believe the mesolimbic dopamine pathway is the reward pathway, although this is not totally accepted by the scientific community. The mesocortical pathway is essential to normal cognitive function and is thought to be involved in motivation and emotional responses.

Mood Disorders

Mood disorders compose a category of mental illness that encompasses depression, anxiety, mania, and bipolar disorder, which is characterized by mood

swings between depression and mania. Researchers believe that positive moods are controlled by serotonin and noradrenaline neurotransmitters. Decrease in serotonin and noradrenaline neurotransmitters is believed to be a cause of depression.

Researchers believe that a manic mood is influenced by a decrease in the GABA neurotransmitter. GABA is involved in producing a calming mood. A decrease in the amount of GABA may result in a patient displaying signs and symptoms of mania such as increased agitation and aggravation.

Attention Deficit Hyperactivity Disorder (ADHD)

Researchers believe that ADHD might be caused by a genetic link that affects neurotransmitters and other factors that trigger signs and symptoms of ADHD. Some researchers feel that inattentiveness is the result of a decrease in norepinephrine and dopamine. Furthermore, decreased impulse control and aggression are influenced by a decrease in serotonin. Medication prescribed to treat signs and symptoms of ADHD increase norepinephrine, dopamine, and serotonin. As a result, some patients show decreased signs and symptoms of ADHD.

NURSING ALERT

Medication treats the signs and symptoms of mental illness and not the underlying cause of the psychiatric disorder. That is, a medication may increase or decrease one or more neurotransmitters but not treat the reason for the decrease or increase of that neurotransmitter.

4. Medication

Medication used to treat mental illness focuses on increasing or decreasing neurotransmitters based on the patient's psychiatric diagnosis. A challenge for pharmaceutical researchers is to identify medication that affects specific neurotransmitters and specific parts of the neurologic system.

Researchers believe that abnormal behavior and mental function are related to increases or decreases in one or more specific neurotransmitters in the part of the brain that controls that function. Older classes of psychiatric medications targeted the specific area of the brain that related to the abnormal signs and symptoms as well as other areas that were working normally. The result was that the patient's abnormal signs and symptoms improved; however, the patient also experienced undesirable side effects of the medication. Table 14–1 shows common side effects of older classes of psychiatric medications.

TABLE 14–1 Common Side Effects of Psychotropic Medications

Medication Classification	Medication	Side Effect
Antipsychotics	Chlorpromazine (Thorazine) Haloperidol (Haldol) Perphenazine Fluphenazine	Drowsiness Dizziness when changing positions Blurred vision Rapid heartbeat Sensitivity to the sun Skin rashes Menstrual problems Tardive dyskinesia (TD) Rigidity Persistent muscle spasms Tremors Restlessness
Atypical antipsychotics	Risperidone (Risperdal) Olanzapine (Zyprexa) Quetiapine (Seroquel) Ziprasidone (Geodon) Aripiprazole (Abilify) Paliperidone (Invega) Clozapine (Clozaril)	Weight gain Increased risk for diabetes Increased risk for cholesterol Low white blood cell count (clozapine)
Selective serotonin reuptake inhibitor (SSRI) antidepressants	Fluoxetine (Prozac) Citalopram (Celexa) Sertraline (Zoloft) Paroxetine (Paxil) Escitalopram (Lexapro)	Headache (goes away within a few days) Nausea (goes away within a few days) Sleeplessness or drowsiness (goes away within a few days) Agitation (feeling jittery) Sexual problems
Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants	Venlafaxine (Effexor) Duloxetine (Cymbalta)	Headache (goes away within a few days) Nausea (goes away within a few days) Sleeplessness or drowsiness (goes away within a few days) Agitation (feeling jittery) Sexual problems

TABLE 14–1 Common Side Effects of Psychotropic Medications (*Continued*)

Medication Classification	Medication	Side Effect
Tricyclic antidepressants	Elavil (amitriptyline) Anafranil (clomipramine)	Dry mouth Constipation Bladder problems (hard to empty the bladder, weak urine stream) Sexual problems Blurred vision (goes away within a few days) Drowsiness (take medication at bedtime)
MAOI antidepressants	Isocarboxazid (Marplan) Phenelzine (Nardil) Selegiline (Emsam) Tranylcypromine (Parnate)	Dry mouth Nausea, diarrhea, or constipation Headache Drowsiness Insomnia Skin reaction at the patch site Dizziness or lightheadedness Involuntary muscle jerks Low blood pressure Reduced sexual desire or difficulty reaching orgasm Sleep disturbances Weight gain Difficulty starting a urine flow Muscle aches Prickly or tingling sensation in the skin (paresthesia)
Mood stabilizers	Divalproex sodium (Depakote) Carbamazepine (Tegretol) Lamotrigine (Lamictal) Oxcarbazepine (Trileptal) Lithium	Loss of coordination (lithium) Excessive thirst (lithium) Frequent urination (lithium) Blackouts (lithium) Seizures (lithium) Slurred speech (lithium) Fast, slow, irregular, or pounding heartbeat (lithium) Hallucinations (lithium)

TABLE 14–1 Common Side Effects of Psychotropic Medications (*Continued*)

Medication Classification	Medication	Side Effect
		Changes in vision (lithium) Itching, rash (lithium) Swelling (lithium) Changes in weight (Depakote) Nausea (Depakote) Stomach pain (Depakote) Vomiting (Depakote) Anorexia (Depakote) Loss of appetite (Depakote)
Antianxiety	Clonazepam (Klonopin) Lorazepam (Ativan) Alprazolam (Xanax) Buspirone (BuSpar) Propranolol (Inderal)	Dizziness (BuSpar, Inderal) Headaches (BuSpar, Klonopin, Ativan, Xanax) Nausea (BuSpar) Nervousness (BuSpar) Lightheadedness (BuSpar) Excitement (BuSpar) Trouble sleeping (BuSpar) Upset stomach (Klonopin, Ativan, Xanax) Blurred vision (Klonopin, Ativan, Xanax) Confusion (Klonopin, Ativan, Xanax) Grogginess (Klonopin, Ativan, Xanax) Nightmares (Klonopin, Ativan, Xanax) Fatigue (Inderal) Cold hands (Inderal) Weakness (Inderal)
ADHD	Methylphenidate (Ritalin, Metadate, Concerta, Daytrana) Amphetamine (Adderall) Dextroamphetamine (Dexedrine, Dextrostat)	Decreased appetite Sleep problems Stomach aches Headaches

Undesirable side effects are not life threatening, but some patients consider the side effects to be unpleasant causing the patient to stop taking the medication. Unfortunately, sometimes these patients do not share their concerns with the practitioner, who can change the dose or medication or prescribe an additional medications that controls the unpleasant side effects. Some of these patients can then cycle through periods of improved signs and symptoms when taking medication and periods of reverting to abnormal behavior when they stop taking medication because of the side effects.

Newer classes of psychiatric medication have narrowed the focus to neurotransmitters that are thought to be the cause of the abnormal behavior, leading to fewer side effects and increased compliance with medication treatment. Table 14–2 shows commonly prescribed medications and how they work.

TABLE 14–2 Commonly Prescribed Medications to Treat Mental Illness

Medication	Classification	How It Works
Abilify (aripiprazole)	Atypical antipsychotic	Blocks dopamine receptors, decreasing dopamine and resulting in decrease in positive signs of schizophrenia such as hallucinations, delusions, and hostility Stimulates dopamine receptors by mimicking dopamine in other parts of the brain, resulting in decreased negative signs of schizophrenia such as lack of emotions and social isolation
Adderall (amphetamine and dextroamphetamine)	Amphetamine	Blocks the reuptake of dopamine, resulting in lessening signs and symptoms of inattention
Anafranil (clomipramine)	Tricyclic antidepressant (TCA)	Clomipramine works by preventing serotonin and noradrenaline from being reabsorbed, thereby increasing serotonin and noradrenaline availability and contracting depressive signs and symptoms
Ativan (lorazepam)	Benzodiazepines	Lorazepam increases the availability of GABA, resulting in increased calming
BuSpar (buspirone)	Anxiolytic	Buspirone increases dopamine and noradrenaline and decreases serotonin and acetylcholine, resulting in decreased anxiety
Celexa (citalopram)	SSRI antidepressant	Citalopram prevents serotonin from being reabsorbed, resulting in increased serotonin and decreased depressive signs and symptoms

TABLE 14–2 Commonly Prescribed Medications to Treat Mental Illness (*Continued*)

Medication	Classification	How It Works
Clozaril (clozapine)	Atypical antipsychotic	Used for patients who do not respond well to lithium. Clozapine blocks dopamine receptors, reducing dopamine and resulting in decreased psychotic signs and symptoms
Cylert (pemoline)	Amphetamine	Pemoline is similar to dopamine and has the effect of increased dopamine, resulting in decreased hyperactivity and increased efficiencies in the memory centers of the brain, which results in increased attention span
Cymbalta (duloxetine)	SNRI antidepressant	Duloxetine blocks reuptake of serotonin and noradrenaline, leading to decreased depressive signs and symptoms
Depakote (valproic acid)	Anticonvulsant Mood stabilizer	Valproic acid increases GABA by inhibiting the enzyme that breaks down GABA, resulting in increased calming
Desyrel (trazodone)	Atypical antidepressant	Trazodone prevents the reuptake of serotonin, leading to decreased depressive signs and symptoms
Dexedrine (dextroamphetamine)	Amphetamine	Dextroamphetamine prevents the reuptake of dopamine and norepinephrine
Effexor (venlafaxine)	SNRI antidepressant	Venlafaxine blocks reuptake of serotonin and noradrenaline, leading to decreased depressive signs and symptoms
Elavil (amitriptyline)	Tricyclic antidepressant	Amitriptyline blocks reuptake of serotonin and noradrenaline, leading to decreased depressive signs and symptoms
Fluphenazine	Antipsychotic	Fluphenazine blocks dopamine receptors, reducing dopamine and resulting in decreased psychotic signs and symptoms
Geodon (ziprasidone)	Atypical antidepressant	Ziprasidone blocks the reuptake of noradrenaline and serotonin, resulting in decreased signs and symptoms of depression
Haldol (haloperidol)	Antipsychotic	Haloperidol blocks dopamine receptors. Psychotic illness is caused by increased dopamine
Invega (paliperidone)	Antipsychotic	Paliperidone blocks dopamine receptors, reducing dopamine and resulting in decreased psychotic signs and symptoms
Klonopin (clonazepam)	Benzodiazepine	Clonazepam increases the availability of GABA, resulting in increased calming
Lexapro (escitalopram)	SSRI antidepressant	Escitalopram blocks reuptake of serotonin and noradrenaline, leading to decreased depressive signs and symptoms

TABLE 14–2 Commonly Prescribed Medications to Treat Mental Illness (*Continued*)

Medication	Classification	How It Works
Librium (chlordiazepoxide)	Benzodiazepine	Chlordiazepoxide increases the availability of GABA, resulting in increased calming
Lithium	Antimanic	Lithium interferes with the dopamine receptors, decreasing the amount of dopamine neurotransmitters reaching the dopamine receptors and resulting in decreased manic behavior
Luvox (fluvoxamine)	SSRI antidepressant	Fluvoxamine prevents serotonin from being reabsorbed, resulting in increased serotonin and decreased depressive signs and symptoms
Nardil (phenelzine)	MAOI antidepressant	Researchers believe that depression can be caused by a decrease in monoamines that are released by neurons in the brain. Monoamines are broken down by the enzyme monoamine oxidase. Phenelzine prevents monoamine oxidase from breaking down monoamines, thereby increasing monoamines and decreasing the signs and symptoms of depression
Neurontin (gabapentin)	Anticonvulsants	Gabapentin decreases the neurotransmitter glutamate, which is released when an electrical signal builds in the nerve cells causing other nerve cells to excite
Parnate (tranylcypromine)	MAOI antidepressant	Researchers believe that depression can be caused by a decrease in monoamines that are released by neurons in the brain. Monoamines are broken down by the enzyme monoamine oxidase. Tranylcypromine prevents monoamine oxidase from breaking down monoamines, thereby increasing monoamines and decreasing the signs and symptoms of depression
Paxil (paroxetine)	SSRI antidepressant	Paroxetine prevents serotonin from being reabsorbed, resulting in increased serotonin and decreased depressive signs and symptoms
Perphenazine	Antipsychotic	Perphenazine blocks dopamine receptors, reducing dopamine and resulting in decreased psychotic signs and symptoms
Phenobarbital	Barbiturate	Phenobarbital increases the activity of GABA and decreases the activity of glutamate in the brain. Increased GABA results in increased calming. Decreased glutamate results in decreased nerve impulses
Prozac (fluoxetine)	SSRI antidepressant	Fluoxetine prevents serotonin from being reabsorbed, resulting in increased serotonin and decreased depressive signs and symptoms

TABLE 14–2 Commonly Prescribed Medications to Treat Mental Illness (*Continued*)

Medication	Classification	How It Works
Remeron (mirtazapine)	Atypical antidepressant	Mirtazapine blocks the reuptake of noradrenaline and serotonin, resulting in decreased signs and symptoms of depression
Risperdal (risperidone)	Antipsychotic	Risperidone blocks dopamine receptors, decreasing the amount of dopamine neurotransmitters reaching the dopamine receptors and resulting in decreased manic behavior
Ritalin (methylphenidate)	Central nervous system stimulant	Methylphenidate increases dopamine and noradrenaline in areas of the brain that control attention and behavior
Serax (oxazepam)	Benzodiazepine	Oxazepam increases GABA, resulting in increased calming
Seroquel (quetiapine)	Antipsychotic	Quetiapine blocks dopamine receptors, decreasing the amount of dopamine neurotransmitters reaching the dopamine receptors and resulting in decreased manic behavior
Serzone (nefazodone)	Atypical antidepressant	Nefazodone blocks the reuptake of noradrenaline and serotonin, resulting in decreased signs and symptoms of depression
Tegretol (carbamazepine)	Anticonvulsant and mood stabilizer	Carbamazepine prevents rapid and repetitive electrical signals from being released by the brain by preventing sodium from entering neurons when nerve cells fire rapidly. Sodium is necessary for neurons to fire
Thorazine (chlorpromazine)	Phenothiazine antidepressant; antianxiety	Chlorpromazine blocks dopamine receptors, decreasing the amount of dopamine neurotransmitters reaching the dopamine receptors and resulting in decreased manic behavior
Tofranil (imipramine)	Tricyclic antidepressant	Imipramine blocks the reuptake of noradrenaline and serotonin, resulting in decreased signs and symptoms of depression
Trileptal (oxcarbazepine)	Anticonvulsant	Oxcarbazepine prevents sodium from entering nerve cells when neurons begin to fire rapidly, resulting in reduction in excessive neural electrical activity
Valium (diazepam)	Benzodiazepine	Diazepam increases the availability of GABA, resulting in increased calming
Wellbutrin (bupropion)	Atypical antidepressant	Bupropion blocks the reuptake of noradrenaline and serotonin, resulting in decreased signs and symptoms of depression
Xanax (alprazolam)	Benzodiazepines	Alprazolam increases the availability of GABA, resulting in increased calming

TABLE 14–2 Commonly Prescribed Medications to Treat Mental Illness (*Continued*)

Medication	Classification	How It Works
Zoloft (sertraline)	SSRI antidepressant	Sertraline prevents serotonin from being reabsorbed, resulting in increased serotonin and decreased depressive signs and symptoms
Zyprexa (olanzapine)	Atypical antipsychotic	Olanzapine blocks dopamine receptors, decreasing the amount of dopamine neurotransmitters reaching the dopamine receptors and resulting in decreased manic behavior

NURSING ALERT

Patients diagnosed with mental illness tend to stop taking medication when they begin to feel normal and then relapse. This is a natural response since we typically take medication when we feel bad and stop taking medication when we feel good. It is important that the patient realizes that they are feeling good because they are taking the medication.

Undesirable Side Effects

An ideal medication will target only the affected area of the body that is causing the abnormal signs and symptoms reported by the patient. Few medications achieve this goal, and as a result, medications can affect other areas and cause undesired side effects, as shown in Table 14–1.

Here are side effects produced by some psychiatric medications:

- Anticholinergic effects: Anticholinergic effects include dry mouth (xerostomia), decreased mucus production in the nose and throat, increased body temperature, double vision (diplopia), decreased urination, tachycardia, and tremors; in addition, patients can be easily startled. Anticholinergic effects are caused by anticholinergics such as Cogentin (benztropine) and Benadryl (diphenhydramine) that block the acetylcholine neurotransmitter in the central and peripheral nervous system. The treatment is to discontinue using the anticholinergic medication.
- Extrapyramidal symptoms (EPS): Extrapyramidal symptoms include the inability to initiate movement (akinesia), inability to remain motionless (akathisia), slow movement (bradykinesia), and stiffness or tremors. These are commonly referred to as Parkinson-like symptoms and are caused by blockage of dopamine receptors at the basal ganglia. EPS are seen in

patients taking SSRI antidepressants and Haldol. Patients who display EPS should be administered Cogentin (benztropine) or Benadryl (diphenhydramine). The practitioner will likely adjust the patient's medication.

- Tardive dyskinesia (TD): Tardive dyskinesia is involuntary, repetitive body movements that occur after long-term use of antipsychotic medication. The patient displays a grimacing face, lip smacking, rapid eye blinking, pursed lips, and protruding tongue. Some researchers believe that the patient becomes oversensitive to dopamine. Tetrabenazine is administered to the patient who shows signs and symptoms of TD, which decreases dopamine. The practitioner is likely to discontinue the medication and prescribe the patient an alternative medication.
- Hypertensive crisis: Hypertensive crisis can occur if the patient is taking a monoamine oxidase inhibitor (MAOI) antidepressants. MAOI antidepressants interfere with the metabolism of tyramine. Some cheeses, wines, pickles, and over-the-counter cold medicines contain tyramine and therefore cannot be properly metabolized by patients who are taking MAOI antidepressants, resulting in a hypertensive crisis.

5. Substance Abuse

A patient is diagnosed with substance abuse when they continue to self-administer mood-altering drugs for nontherapeutic reasons. Mood-altering drugs may cause an abnormal increase in neurotransmitters such as dopamine, which can cause a surge that stimulates the reward pathway in the brain resulting in euphoria (i.e., fast pleasure commonly referred to as a high).

The speed at which the patient experiences the high and the duration of the high depend on the route used to administer the drug and the dose of the drug. The most direct route is through intravenous injection. That is, the medication is placed into the bloodstream and is quickly available to cells throughout the body. Generally the higher the dose, the greater effect the drug has on the body. However, too high of a dose may result in an overdose, leading to the destruction of cells and possibly death.

The body tends to develop a tolerance to medication. The brain adapts to the increase in the drug by reducing the number of dopamine receptors. The patient needs to increase the dose to receive the expected response. Patients who abuse substances experience a euphoric feeling when the initial dose is administered. The patient will receive less than the initial euphoric experience in subsequent doses as the body adjusts to the drug level.

Some researchers believe the reward pathway in the brain is designed for survival. For example, eating makes a person feel good; therefore, the person will eat again to feel good. Likewise, sexual intercourse makes a person feel good, which encourages partners to engage in sexual intercourse to reproduce the species.

Some drugs are designed to stimulate the reward pathway and amplify the reward itself. The reward is so strong that a person diagnosed with substance abuse has altered judgment, learning, and memory that focus mainly on achieving the reward—the euphoric feeling. Some researchers believe there are physical changes to neurons that are outside the reward pathway caused by abuse of some drugs.

The reward is so strong that the goal of the patient is to get the next high even though the euphoric feeling is never like the initial dose. This is commonly referred to as chasing the high. The patient is considered addicted to the drug because when levels of the drug in the patient's body fall below the therapeutic level, the body adjusts to the absence of the drugs. This adjustment is called withdrawal and makes the patient feel very uncomfortable (see Detoxification). The patient then self-administers another dose of the drug to avoid withdrawal symptoms and to feel normal.

Table 14–3 contains a list of commonly abused substances and the effect each has on the body.

TABLE 14–3 A List of Commonly Abused Substances

Drug	Reaction	How It Works
Nicotine	Increases blood pressure and heart rate	Causes release of glucose from the liver and epinephrine from the adrenal medulla, resulting in relaxation and sharpness. Stimulates release of many neurotransmitters including norepinephrine, acetylcholine, dopamine, and serotonin
Alcohol	Low dose: Euphoria, relaxation, lowered inhibitions High dose: Slurred speech, drowsiness, impaired memory, emotional volatility, loss of coordination, sexual dysfunction, loss of consciousness	Increases GABA and dopamine neurotransmitters in the brain's reward center, creating the feeling of pleasure

TABLE 14–3 A List of Commonly Abused Substances (*Continued*)

Drug	Reaction	How It Works
Cannabinoids	Euphoria, relaxation, distorted sensory perception, impaired learning, panic attacks, psychosis, slow reaction time, increased appetite	Causes an increase of anandamide neurotransmitters that is involved in regulating feelings and in the generation of motivation and pleasure
Opioids, heroin	Euphoria, dizziness, confusion, impaired coordination, sedation, nausea, slowed respiration	Endorphins flood the synapses, preventing neurons from firing and leading to an analgesic effect (pain relief, euphoric feeling). Endorphins are produced naturally. Opioids are synthetics that flood the endorphin receptor sites continuing the pleasurable feeling
Stimulants, cocaine, amphetamine, methamphetamine	Increased heart rate, increased blood pressure, increased metabolism, increased energy, mental alertness, irritability, panic, anxiety, violent behavior, psychosis, exhilaration, increased body temperature	Causes an increase in dopamine neurotransmitter. Large doses of a stimulant result in a euphoric feeling
MDMA, Ecstasy, flunitrazepam, GHB	Mild hallucinogenic effect, empathetic feelings, lowered inhibition, chills, sweating, muscle cramping, increased tactile sensitivity	Causes serotonin to increase, resulting in elevated mood. Eventually there is a depletion of serotonin, leading to negative behavior until serotonin levels are naturally restored
PCP, ketamine, *Salvia divinorum*, DXM	Separation from one's body, impaired motor function, psychosis, aggression, hallucinations	Causes dopamine, norepinephrine, and serotonin to increase by blocking its reuptake as well as affecting other neurotransmitters
LSD, mescaline, psilocybin	Altered perception, hallucinations, nausea, increased body temperature, increased blood pressure, increased heart rate	Causes serotonin to increase by blocking its reuptake

Detoxification

A patient diagnosed with substance abuse usually has unbalanced chemistry in the brain and throughout the body that results in altered mood and possibly hallucinations. When the patient stops taking the abused substance, the patient's body goes through a period during which the body rebalances the chemistry. This process is referred to as detoxification and continues until the chemistry is balanced and the patient feels normal again.

Once the patient stops taking the drug, the body produces a surge of neurotransmitters in an effort to balance the body's chemistry. There is a temporary drought and then flood of neurotransmitters that were affected by the drug, causing the patient to have abnormal feelings commonly referred to as withdrawal symptoms. Typically withdrawal symptoms are the opposite of symptoms experienced by taking the drug. For example, a patient taking drugs that have a calming effect will likely be restless, irritable, and have insomnia as withdrawal symptoms. Likewise, a patient who uses a stimulant is likely to experience depression, poor concentration, and lethargy.

Withdrawal makes the patient uncomfortable. There are two ways for the patient to become comfortable: administer the drug or wait until the body rebalances its chemistry. Many substance abuse patients administer the drug so they feel "normal" again. "Normal" is when the patient can function without discomfort. "Normal" does not mean that the patient experiences the altered mood. Usually the patient has developed a tolerance for the drug, requiring increased doses to achieve the altered mood.

Withdrawal symptoms can be managed through a detoxification process. During the detoxification process, the patient is tapered off the abused substance, giving the body time to gradually balance the chemistry. Furthermore, medications such as muscle relaxers and medication to lower blood pressure are administered to decrease withdrawal symptoms.

NURSING ALERT

Patients who are withdrawing from alcohol and barbiturates are monitored carefully during detoxification since these patients are at high risk for seizures.

CASE STUDY

CASE 1

The practitioner asks you to meet with the parents of a 24-year-old woman who has had repeated suicidal ideations. After confirming with the patient, the practitioner makes a preliminary diagnosis of clinical depression and suggests that she be admitted to an inpatient facility for approximately 10 days for observation and treatment. The patient has given written consent that her condition be shared with her parents. The practitioner wants you to educate the patient's parents about their daughter's diagnosis and planned treatment. Until now her parents thought she had a personality disorder with borderline traits. They had sought psychotherapy for their daughter since she was 17 years of age, but there has been no change in their daughter's behavior. Here are questions asked by the parents. What is the best response?

QUESTION 1. What did we do wrong as parents that caused her to be depressed?
ANSWER: Researchers believe that a decrease in chemicals in the brain—serotonin and noradrenaline—can cause signs and symptoms of depression. Researchers are unsure what causes the decrease in these chemicals; however, some researchers are looking into the effect of environmental factors such as stress on genes related to mental illness. There is no indication that upbringing caused your daughter's clinical depression.

QUESTION 2. Can clinical depression be cured with medication?
ANSWER: There is no known cure for clinical depression; however, antidepressant medication can increase the amount of serotonin and noradrenaline at the connection between certain nerve cells. This decreases the signs and symptoms of clinical depression as long as your daughter continues to take the medication.

QUESTION 3. Will the medication work forever, ensuring that our daughter does not relapse into clinical depression?
ANSWER: The effectiveness of a medication depends on many factors. There are occasions when a medication loses effectiveness over time and the patient experiences recurrent signs and symptoms of depression. In such situations, the practitioner will likely discontinue the medication and prescribe a different medication. Researchers are not sure why some medications lose effectiveness.

QUESTION 4. Why must our daughter be admitted inpatient to an acute psychiatric unit if she has already been diagnosed with clinical depression?
ANSWER: Clinical depression is the preliminary diagnosis. The practitioner needs to assess your daughter in a milieu environment where she can be observed

interacting with the clinical community before reaching a final diagnosis. During this period the practitioner will prescribe antidepressant medication. Antidepressant medication takes several days before the medication reaches a therapeutic threshold at which point signs and symptoms of depression improve. The practitioner will also be assessing how well your daughter tolerates the prescribed medication. The practitioner can treat any undesirable side effects and change to a more acceptable medication. The goal is to discharge your daughter with the medication that has been demonstrated to improve her signs and symptoms of depression.

FINAL CHECK-UP

1. **A 32-year-old man who is diagnosed with substance abuse arrives on your mentally ill chemically addicted (MICA) unit. He tells you that he feels miserable like he is going to die. What is your best response?**
   A. I'll call the doctor immediately.
   B. You are not dying. You are experiencing withdrawal symptoms.
   C. You are experiencing withdrawal symptoms. Your body is adjusting to the absence of the drugs that you were self-administering.
   D. This is the pain you must suffer because you abused drugs.

2. **A 53-year-old woman who is administered to your acute psychiatric unit for suicidal thoughts is diagnosed with major depressive disorder. She asks, "What does it mean that I have a chemical imbalance in the brain?" What is your best response?**
   A. Nerve impulses in your brain are transmitted by chemicals called neurotransmitters. Depression is related to a decrease in serotonin and noradrenaline neurotransmitters.
   B. Depression is caused by having too much of the chemical GABA.
   C. You need the appropriate amount of neurotransmitters in your brain; otherwise you will have symptoms of mental illness.
   D. Sometimes your brain does not produce enough chemicals to balance your mood.

3. **A 28-year-old woman was brought to your acute psychiatric unit for manic symptoms of bipolar disorder. After several treatments of medication, she reports feeling calm. She asks how the medication works. What is the best response?**
   A. The medication increases noradrenaline neurotransmitters, which helps calm you down.
   B. The medication adjusts the chemical balance in your brain.

C. The medication makes more of the GABA neurotransmitter available. GABA is the chemical that helps to produce a calming effect.
D. You have been prescribed a sedative, which has a calming effect.

4. A 20-year-old woman diagnosed with a borderline personality disorder asks why the practitioner cannot give her a pill to control her behavior. What is your best response?

A. There is no medication to treat borderline personality disorder.
B. Your behavior is encoded into neural pathways in your brain, and there is no medication to change it.
C. Your behavior is learned and can be changed by psychotherapy called dialectical behavior therapy and not by medication.
D. Researchers are yet to find the cure for borderline personality disorder.

5. A 45-year-old patient who has been diagnosed with bipolar disorder for more than 20 years is wondering why his medication does not cure him of his mental illness. What is your best response?

A. Mental illness is not curable.
B. Bipolar disorder is caused by an imbalance of neurotransmitters in your brain.
C. Medication takes time to work.
D. Medication helps to rebalance neurotransmitters that cause signs and symptoms of bipolar disorder but does not fix the reason for the imbalance.

6. A 42-year-old woman who was recently admitted to your acute psychiatric unit tells you that she cannot continue taking her medication and she does not care if she has a relapse of schizophrenia. What is your best response?

A. Discuss your concerns with your practitioner.
B. Ask your practitioner for different medication.
C. Your medication is making it possible for you to function normally.
D. Would you like to talk about how you feel?

7. A 52-year-old woman diagnosed with alcohol abuse comes to your unit for detoxification. She seems to be doing well for the first day. What should you do?

A. Tell the staff to observe the patient closely for the next several days.
B. Tell the patient that you expect that she will be discharged within the next few days.
C. Counsel the patient on seeking long-term help for alcohol abuse.
D. Make sure that the patient continues to eat healthy meals.

8. **A 34-year-old man diagnosed with bipolar disorder tells you that he is frustrated. He takes his medication, then stops when he feels better, and then a few days later he relapses. What is your best response?**
   A. Don't stop taking your medication.
   B. You built a tolerance to the medication and need to ask your practitioner for different medication.
   C. You must take your medication for the rest of your life.
   D. Your medication is balancing the chemistry in your brain. The chemistry becomes unbalanced once you stop taking your medication.

9. **A 35-year-old man tells you that the practitioner changed his medication from a tricyclic antidepressant to an SSRI antidepressant. He asks why the change was made. What is your best response?**
   A. SSRI medications are less costly than tricyclic medications.
   B. SSRI medications have fewer side effects than tricyclic medications.
   C. SSRI medications focus on specific areas of the brain and therefore have fewer side effects than tricyclic medications, which focus on a broader area of the brain.
   D. SSRI medications stop the reuptake of serotonin.

10. **A 41-year-old man diagnosed with schizophrenia is seen in the day room having difficulty starting to move and reports stiffness. What is your best response?**
   A. Help the patient move.
   B. Call the practitioner and ask if she wants you to give the patient Benadryl I.M. immediately.
   C. Call the practitioner and ask if she wants to order a physical therapy consultant to ask about the patient's risk for falls.
   D. Make sure to tell the practitioner to reassess the patient's medication the next time the practitioner is on the unit.

CORRECT ANSWERS AND RATIONALES

1. C. You are experiencing withdrawal symptoms. Your body is adjusting to the absence of the drugs that you were self-administering.
2. A. Nerve impulses in your brain are transmitted by chemicals called neurotransmitters. Depression is related to a decrease in serotonin and noradrenaline neurotransmitters.
3. C. The medication makes more of the GABA neurotransmitter available. GABA is the chemical that helps to produce a calming effect.
4. C. Your behavior is learned and can be changed by psychotherapy called dialectical behavior therapy and not by medication.

5. D. Medication helps to rebalance neurotransmitters that cause signs and symptoms of bipolar disorder but does not fix the reason for the imbalance.
6. D. Would you like to talk about how you feel? Rationale: You should explore why the patient is not taking medication because there might be alternatives that will overcome those objections.
7. A. Tell the staff to observe the patient closely for the next several days. Rationale: The patient is a high risk for seizures and should be monitored carefully.
8. D. Your medication is balancing the chemistry in your brain. The chemistry becomes unbalanced once you stop taking your medication. Rationale: This is the response that provides a complete answer to the patient's concerns.
9. C. SSRI medications focus on specific areas of the brain and therefore have fewer side effects than tricyclic medications, which focus on a broader area of the brain.
10. B. Call the practitioner and ask if she wants you to give the patient Benadryl I.M. immediately. Rationale: The patient is showing signs of extrapyramidal symptoms (EPS) likely caused by antipsychotic medication such as Haldol.

Final Exam

1. **A 45-year-old woman feels like she's going to die and has sweating and palpitations. You learn that she lives alone and her father recently died. What is the best response?**
   A. Tell her that she is likely experiencing depressive disorder.
   B. Tell her that she is likely experiencing panic attacks.
   C. Tell her that she is likely experiencing panic attacks and that she should tell her primary practitioner about it so she can be treated soon.
   D. Tell her that she is likely experiencing panic attacks and will develop depressive disorder.

2. **Your former patient walks the streets in the early morning hours chasing cars out of his neighborhood. The patient lives alone in assisted living. The case worker asks if other medication can be prescribed to the patient. What is your best response?**
   A. Ask the practitioner for alternative medications.
   B. Maybe it is time for the patient to live with a relative.
   C. Is the patient taking his medication?
   D. You should take the patient to the emergency room and have his medications adjusted.

3. **A patient diagnosed with bipolar disorder demands to immediately see the psychiatrist. The patient left the psychiatrist's office 10 minutes ago. She does this every day. What do you do first?**
   A. Tell the patient that she has seen the practitioner for today and that she will have an opportunity to see the practitioner tomorrow during rounds.
   B. Tell the patient that you will tell the practitioner that she is waiting once the practitioner is finished seeing the current patient.

C. Alert the staff that the patient's manic behavior is escalating.
D. Tell the patient that the practitioner will see her next.

4. A 35-year-old divorced mother is diagnosed with anxiolytic-induced mood disorder. She has been taking Xanax for many years and has become addicted to benzodiazepines and is now on the addiction unit. She claims that she is not a drug addict because all her medications are prescribed by several practitioners. What is your understanding of the patient's response?

A. An expression of the undoing defense mechanism
B. An expression of the dissociation defense mechanism
C. An expression of the distorted defense mechanism
D. The patient is delusional

5. Your friend is worried. He says he has depersonalization disorder because he felt like he was viewing himself from afar during a party last night. What's your best response?

A. You should see your practitioner immediately.
B. You are probably under too much stress.
C. Were you drinking alcohol or using recreational drugs at the party?
D. Ask your practitioner about taking anafranil.

6. A 34-year-old man reports that he is unable to get a good night's sleep. For the past 6 months, he has been jogging on his treadmill for an hour before bed to tire himself; he then immediately takes a hot shower and jumps into bed. He then lies there watching television waiting to fall asleep. He doesn't fall asleep for hours. What is your best response?

A. Exercise 2 hours before bedtime.
B. Never watch television in bed.
C. Don't exercise or take a hot shower before bedtime.
D. Open the bedroom window before going to bed.

7. A 27-year-old male involuntary patient has been on your unit for 4 weeks after showing bizarre behavior related to noncompliance with medication prior to admission. The patient has demonstrated normal behavior for the past week. You are asked to have the patient sign a consent form. What is your best response?

A. Assess the patient to determine if the patient is competent. If so, then explain the consent form to the patient and ask the patient to sign the form.
B. Say that you are not comfortable asking the patient to sign the document.
C. State that the patient is not competent to sign the form because he is an involuntary patient.
D. Explain the consent form to the patient and ask the patient to sign the form.

8. **The father of a 43-year-old woman is concerned about his daughter. He reports that she keeps her neck covered all the time even while in the house. He asks you if she needs treatment. What is your best response?**
   A. She should seek treatment as soon as possible. There is a risk that she may isolate herself and avoid intimate relationships.
   B. Ignore her behavior and eventually she will be fine.
   C. She is at high risk for suicide.
   D. She should eventually see a cosmetic surgeon who can improve the appearance of her neck.

9. **A patient in heroin withdrawal says the he is going to die from the withdrawal. The patient received detox medication 30 minutes ago. What is your best response?**
   A. Tell the patient he is not going to die from opioid withdrawal and that you will see if he has any PRN medications available.
   B. Call a rapid response before the patient has a seizure.
   C. Tell the patient that you will call the practitioner now to see if the practitioner will order a narcotic.
   D. Tell the patient to speak with the practitioner in the morning.

10. **You ask a new nurse to weigh the patient diagnosed with anorexia nervosa disorder and tell the nurse that the patient must have her back to the face of the scale and not be told her weight. What is the reason for giving this direction?**
    A. The patient's weight is proprietary medical information that is not accessible to the patient.
    B. This is to comply with the practitioner's orders.
    C. The practitioner wants to distract the patient from focusing on her weight.
    D. The patient wants to know her weight to adjust her food intake to achieve whatever the patient feels is a normal weight.

11. **The wife of a patient who was recently diagnosed with catatonic schizophrenia disorder asks you if antipsychotic medication will help her husband. What is your best response?**
    A. The practitioner knows what is best for the patient.
    B. Yes, that is a good suggestion. I will mention this to the practitioner.
    C. Yes, that is a good suggestion. Please mention this to the practitioner.
    D. Antipsychotic medication is not prescribed because the medication may increase the catatonic symptoms, which is why the practitioner has not ordered the medication for the patient.

12. **A 68-year-old female patient reports insomnia, decreased eating, low self-esteem, hopelessness, and sluggishness. She says she was always active and never depressed. She comes to your psychiatric clinic because her family thinks she has depression. What do you do first?**

A. Ask to speak to the patient's family.
B. Note her remarks and tell the psychiatrist that her next patient is ready to be seen.
C. Review the patient's current medications.
D. Assess if the patient has experienced memory loss or symptoms of dementia.

13. A patient is very talkative and highly alert; his pupils are dilated and he has a relatively high temperature. He tells you he never needs to sleep any more. What would you suspect is causing the patient's condition?

A. The patient is under the influence of heroin.
B. The patient is under the influence of amphetamines.
C. The patient is under the influence of oxycodone.
D. The patient is under the influence of oxycodan.

14. A patient diagnosed with major depressive disorder arrives on your unit. After the admission process is completed, the patient goes to his room and does not come out except for meals and medication. What do you do?

A. Provide positive reinforcement.
B. Notify the practitioner and suggest a medication change.
C. Place the patient on constant observation.
D. Place the patient on constant observation and notify the practitioner immediately.

15. A mother of a 21-year-old man tells you her son has undiagnosed schizophrenia. She reports that he appears normal and then suddenly takes on the characteristics of an 8-year-old boy called Billy Bob. Other times, he appears to be a British rockstar called Reggie. And then suddenly he is back to being himself. What is the best response?

A. He has undifferentiated schizophrenia disorder. You should have your son assessed by a psychiatrist as soon as possible.
B. He has undifferentiated schizophrenia disorder. Take your son to the emergency room immediately.
C. You should have your son assessed by a psychiatrist as soon as possible to determine if he has dissociative identity disorder.
D. You son is probably pretending to be those personalities.

16. A patient is afraid he will never be able to sleep again because of flashbacks of seeing a person being hit by a train a few weeks ago. He has been to therapy for the last 3 weeks and was prescribed Inderal. What is the best response?

A. Tell him that with the treatment he is receiving that he should be able to sleep normally at the end of the treatment period.
B. Tell him to ask the practitioner about posttraumatic stress disorder.
C. Tell him that he has acute stress disorder and is being treated properly.
D. Tell him to report signs of depression to his practitioner immediately.

17. A patient on your acute unit has been staring out the window for 10 minutes. What should you do first?

A. Use therapeutic communication to assess the situation.
B. Medicate the patient.
C. Call the practitioners.
D. Escort the patient to his room.

18. A patient who is recovering from heroin addiction says that her family does not understand how it feels to withdraw from heroin. What is the best response?

A. Tell your family members that going through withdrawal is like going on a diet.
B. Ask your family members if they ever had the flu. Tell them that withdrawal is like having the worst flu they ever had.
C. Tell your family members to try heroin once.
D. Tell your family members to attend Alcoholics Anonymous.

19. A nurse working the overnight shift says she has three alarm clocks set throughout her bedroom away from her bed. Each is set to go off 5 minutes after the next and each is further away from her bed. When they go off, she has to get out of bed to turn each off. She says that her husband gets angry with her when she is unable to fall asleep before 1 am on her days off. She reports that even if she uses good sleep hygiene she always feels as if she has insufficient sleep. What is your best response?

A. Maintain your sleep schedule on your days off.
B. Talk to your practitioner about circadian rhythm sleep disorder.
C. It sounds like you have circadian rhythm sleep disorder. Chronotherapy is likely to make you feel better.
D. Move to the day or evening shift.

20. Your friend laughs at the practitioner diagnosis that her son has paranoid personality disorder because she says that all of us get paranoid from time to time and there is nothing wrong with him. What is your best response?

A. It is difficult to diagnose paranoid personality disorder.
B. Ask your practitioner to explain why your son was diagnosed with paranoid personality disorder.
C. Everyone has a paranoid personality trait, but the practitioner believes that your son's paranoid behavior is extreme and your son is unable to modify his behavior.
D. Ask your practitioner to explain his diagnosis. It is true that everyone exhibits paranoid behavior; however, a person with paranoid personality disorder exhibits extreme paranoid behavior that cannot be controlled.

21. A 54-year-old man is unable to relax. He is irritable, has not slept for 2 days, and has not left the house in 2 weeks. There are empty beer cans all over his house. What problem does the patient exhibit?

A. Alcohol abuse
B. Agoraphobia
C. Substance abuse anxiety disorder
D. Panic attack

22. A friend reports that her 70-year-old father has more energy now than he had when he was 50 years old. He does not need much sleep any more. What is the best response?

A. The pressure of not having to go to work each day lessens the fatigue for your father.
B. Your father needs the same amount of sleep. He probably sleeps more during the day than at night.
C. There is increased pressure on your father since he is no longer employed. Anxiety can keep anyone awake for long hours.
D. Most older adults needs less sleep.

23. A young female patient admitted to your clinic yesterday leaves the dining room quietly after breakfast, goes to her room, and then returns to the dining room. This happens after every meal. What is your best response?

A. Tell the practitioner about the behavior.
B. Review the patient's medical records to determine if the patient's body mass index is within normal range and assess the patient for sores on her hands and teeth decay.
C. Confront the patient about her behavior.
D. Tell the staff to monitor her behavior.

24. An argument erupts between two female patients. They stare down each other displaying intimidating gestures. A half hour later, dinner will be served where both will be sitting near each other. What is your best response?

A. Warn the patients about the consequences should they antagonize another patient.
B. Prevent the patients from entering the dining room.
C. Make sure everyone is safe.
D. Medicate the patients prior to dinner.

25. Your neighbor who has persistent pain was told by his physician to see a psychiatrist because there is no medical cause for the patient's pain. What might be the cause?

A. He is probably experiencing pain disorder. Some researchers believe patients diagnosed with pain disorder are unable to express feelings.
B. He is manipulative.
C. He is depressed.
D. He is seeking attention.

26. A student nurse on your unit tells you that her grandmother always says that you'll get sick if you don't get a good night's sleep. What is the best response?

A. That is an old wives tale that has been passed down to generations. My grandmother told me the same thing.
B. There is no scientific basis for that statement. As a nurse, we must only recognize evidence-based practice.
C. There is evidence to support your grandmother's claim. There are studies that show that major restorative functions occur during sleep. The immune system is active when you are sleeping.
D. There is truth to what she says.

27. A patient diagnosed with schizophrenia paranoid type stands at the nurse's station and silently glares in all directions. What do you do first?

A. Calmly walk the patient into the seclusion room.
B. Calmly ask the patient if you can help him.
C. Call the practitioner.
D. Medicate the patient.

28. Why shouldn't the nurse have a goal to eliminate symptoms of somatization disorder when treating a patient?

A. The patient believes symptoms are real.
B. Eliminating symptoms tends to impact the relationship between the patient, the nurse, and the patient's support system.
C. Symptoms cannot be eliminated.
D. The patient knows that symptoms are not real, and therefore there is nothing to eliminate.

29. A nurse orienting on your psychiatric unit tells you that the new admission has schizophrenia schizotypal type. What is your best response?

A. There is no such diagnosis.
B. You are mistaken. Read the patient's chart and look up the definition of the diagnosis.
C. Report the new orientee to nurse education.
D. Psychiatric diagnosis can be confusing. Schizophrenia disorder differs from schizoid personality disorder in that a patient diagnosed with schizoid personality disorder does not have psychotic symptoms.

30. A patient arrives on your unit reporting that she is unable to get a good night's sleep. She tells you that her husband has lost his job, the bills are piling up, and they may have to file for bankruptcy. Her family practitioner sent her to the emergency department for acute anxiety, and she was later admitted to your unit. What would you expect to be her diagnosis?

A. Depressive disorder
B. Primary insomnia disorder
C. Secondary insomnia disorder
D. Schizophrenia

31. A mother is worried that her son who was recently diagnosed with schizoid personality disorder will develop schizophrenia disorder. What is your best response?

A. Your son does not have the schizophrenia disorder trait.
B. Schizophrenia disorder is more prominent in women than men.
C. Schizophrenia disorder has a genetic trait, but there is no guarantee that your son will develop schizophrenia disorder.
D. Schizoid personality disorder is not related to schizophrenia.

32. A family is concerned about their father. He recently became irritable, short tempered, and cannot sleep; however, the medical practitioner reports that he doesn't have any medical problems. What is your best response?

A. Tell me more about your father.
B. Is your father married?
C. Did your father stop smoking recently?
D. How old is your father?

33. The mother of a 7-year-old boy wants her son to be medicated for attention deficit hyperactivity disorder (ADHD) before starting kindergarten. She reports that for the past 3 months he can't sit still and pushes his 2-year-old brother away so he can get to the toy box first. He never stops talking. What is your best response?

A. Ask your pediatrician to assess him. This behavior could be normal for his age.
B. Ask your pediatrician about prescribing Ritalin.
C. He probably doesn't have ADHD.
D. Symptoms of ADHD are present before age 7.

34. A 55-year-old woman tells you she was one of the youngest financial executives to make a lot of money at her company. She tells you that the chairman of the board asked her to come to your psychiatric unit for a checkup. She is too stressed. She plans to spend the night and see the doctor tomorrow, but for tonight she needs a private room in a quiet area of the unit. What is your best response?

A. Set limits for the patient.
B. Set expectations for the patient.

C. Gather more information from the admission documents.
D. Ask the mental health aide to get the patient settled in her room.

35. A patient who has completed detox is ready to start recovery and asks you for advice. What is the best response?

A. Ask the practitioner to recommend you to a rehab program.
B. You will be in recovery all your life.
C. The goal of recovery is to lengthen periods between relapses.
D. Focus on one day at a time. Identify your triggers and learn ways to avoid them.

36. The mother of a 33-year-old woman diagnosed with paranoid personality disorder tells you that her daughter should go to a different psychiatrist because her psychiatrist is not prescribing medication for the patient. What is your best response?

A. The practitioner is likely waiting for the patient to trust the practitioner before prescribing medication.
B. The patient is unlikely to take medication fearing that the practitioner is trying to harm the patient.
C. There is no medication to treat paranoid personality disorder.
D. Ask the practitioner to explain the reason for not prescribing medication.

37. Your adult sister tells you she has not been able to get a good night's sleep in months. She asks you what medication she should ask the practitioner to prescribe. What is the best response?

A. Ask your practitioner to prescribe Benadryl because it is not addictive.
B. Ask your practitioner to prescribe a low dose of Ambien.
C. None. Sleeping medications are addictive.
D. Try using good sleep hygiene first.

38. A 2-year-old girl ignores her mother's friend when the friend enters the house. She just stays in the corner filling a bag of blocks and then emptying them and starting over. Usually she runs to hug her mother's friend. She has been like this for a few weeks, according to the mother. What is your best response?

A. Ask the mother to describe other changes in the child's behavior.
B. Ask the mother to have her pediatrician assess the child.
C. Tell the mother to ignore the child's behavior.
D. Tell the mother to take the child to the emergency room immediately.

39. Emergency medical services (EMS) brought a patient to the emergency department. Your initial assessment reveals that the patient is mute, immobile, and resistant to movement. What do suspect?

A. The patient has catatonic schizophrenia disorder.
B. The patient is faking an illness so the patient will be admitted to the hospital because the patient is homeless.
C. The patient may have a medical condition or adverse drug reaction.
D. The patient has some form of schizophrenia.

40. A neighbor has lost confidence in the psychiatrist after the psychiatrist diagnosed her daughter as having obsessive-compulsive personality disorder. She feels that the psychiatrist is wrong based on what she sees on television. What is your best response?

A. Give her the name of a few psychiatrists.
B. Ask her to discuss her concerns with the psychiatrist.
C. Obsessive-compulsive disorder and obsessive-compulsive personality disorder are different diagnoses. A patient diagnosed with obsessive-compulsive personality disorder does not have true obsessions and compulsions.
D. Television dramatizes symptoms.

41. A patient diagnosed with depression presents with a positive affect and is cooperative during the admission interview. She tries to hide sores on her left hand. When you point this out, she says that she fell. What do you do next?

A. Point out your findings to the practitioner and ask the practitioner to assess for bulimia nervosa disorder.
B. Ask the practitioner if he wants to order a drug toxicology screening test.
C. Help the patient settle down on the unit.
D. Ask the patient if she abuses drugs.

42. What is the first line of treatment for pain disorder?

A. Antidepressants
B. Benzodiazepine
C. Nonpharmacologic therapy
D. Celexa

43. After 3 weeks on your psychiatric unit, a patient diagnosed with major depressive disorder is calm and controlled, socializes with other patients, and goes to off-unit recreation. You hear from other patients that the patient wants to kill himself. The patient tells you that he has no desire to kill himself. What do you do first?

A. Move the patient's room closer to the nurse's station.
B. Ignore the comment as a meaningless gesture.
C. Call the practitioner to assess the patient.
D. Place the patient on constant observation.

44. A patient comes to your outpatient clinic reporting that he has frequent night terrors. He says someone is chasing him in the woods and he is unable to find his way home. He does not remember being in a wooded area, and he has never been chased by anyone in his life. What is the patient's likely disorder?

A. Nightmares
B. Night terror
C. Posttraumatic stress disorder
D. Anxiety disorder

45. A friend is anxious about her job interview tomorrow and says, "I really need a drink." She tells you that she is anxious meeting people for the first time. She can't sleep, her muscles tighten, and she is restless. What is she experiencing?

A. Drug abuse
B. Acute stress disorder
C. Generalized anxiety disorder
D. Agoraphobia

46. Parents of a patient who is diagnosed with major depressive disorder feel that the patient is lazy because she mopes around the house and sleeps all day. What is your best response?

A. Your daughter needs professional help to feel normal again.
B. Your daughter is not lazy. She has a chemical imbalance in her brain.
C. Your daughter does not have depression. She has normal mood swings.
D. Major depressive disorder is a chemical imbalance in the brain that prevents your daughter from picking herself up and getting motivated without help.

47. Your neighbor is frantic because she is unable to leave the house during 4 days of heavy downpour. What is the first thing you should do?

A. Play CDs of her favorite songs.
B. Sit quietly and listen to her.
C. Tell her that everything will be fine. The rain will stop.
D. Take her to the hospital.

48. A 54-year-old patient on your psychiatric unit is walking the hallway looking into rooms for his dog Mike. He is not wearing shoes or socks. What do you do first your first?

A. Call security to report an attempted elopement.
B. Prevent the patient from self-injuring behavior.
C. Sternly direct the patient back into his room.
D. Tell him that his dog is safe at home.

49. A 43-year-old male patient comes to the ED reporting that for short periods of time he feels detached from his body and sometimes he feels like he is floating. The patient states he has not taken any drugs, and his drug toxicology test results are negative. What is your best response?

A. Does this condition interfere with activities of daily living?
B. Have you ever taken hallucinogens at any time in your life?
C. Let me ask our psychiatrist to assess you.
D. Do you have any other symptoms?

50. A father is concerned that his son will develop schizophrenia disorder. He tells you that his son's grandmother is diagnosed with paranoid schizophrenia disorder. What is your best response?

A. Watch for symptoms of paranoid schizophrenia disorder when he reaches 16 years of age.
B. There is no known cause of paranoid schizophrenia disorder; however, there is a genetic predisposition to developing the disorder if a close relative has been diagnosed with paranoid schizophrenia disorder.
C. There is little chance that he will develop paranoid schizophrenia disorder.
D. There is a genetic predisposition; however, a predisposition does not mean that your son will develop paranoid schizophrenia disorder.

51. A female arrived on your psychiatric unit from the ER. On report, you learned that she said that she felt like killing herself. You noticed superficial lacerations on her left forearm. Her toxicology study was positive for cocaine. After your assessment interview was completed, she said that she had court in the morning and wondered if you could ask the social worker to fax a letter to the court saying that she won't be able to attend her court hearing. What do you suspect is occurring?

A. The patient is likely experiencing symptoms of a dissociative disorder.
B. Lacerations are a sign of attention seeking.
C. The patient is a high risk for suicide related to the pending court hearing.
D. The patient is malingering to avoid the court hearing, during which the patient would test positive for an illegal substance.

52. After being admitted to your unit for suicidal ideations yesterday, a 20-year-old female patient tells you this morning that she is ready for discharge. What is your best response?

A. Talk to the psychiatrist.
B. I'll get your paperwork ready now. You'll be discharged in a couple of hours.
C. You and the psychiatrist can decide if you are ready to go home.
D. You cannot be discharged for 48 hours.

53. A 53-year-old neighbor tells you that she was diagnosed with Kleine–Levin syndrome. She was not sure what the practitioner was saying when the practitioner told her about the syndrome. The patient believes she is dying because all she does is sleep. What is the best response?

A. Call your practitioner and ask your practitioner to tell you more about Kleine–Levin syndrome.
B. Kleine–Levin syndrome is a viral infection that will go away in a few weeks.
C. Kleine–Levin syndrome is a form of primary hypersomnia disorder.
D. Kleine–Levin syndrome is a sleep disorder that comes and goes several times a year. Make sure that you follow the treatment recommended by your practitioner.

54. A 36-year-old nurse who has worked in an inner city emergency department for 10 years feels burnt out. She seems to be taking more sick time than normal over the past 2 years. What might be the underlying cause of her situation?

A. The nurse probably was exposed to a virus or bacteria and has not been diagnosed yet.
B. The nurse is bored after 10 years of being in an emergency department and needs to change to a different specialty.
C. The nurse is showing signs of posttraumatic stress disorder (PTSD).
D. The nurse is experiencing the effects of chronic anxiety.

55. A father tells you that his 2-year-old daughter constantly refuses to do what she is told to do and throws a tantrum in public when she doesn't get her way. He feels she has oppositional defiant disorder. What is your best response?

A. The child should be taken to her pediatrician to rule out underlying medical conditions that might be causing the problem.
B. Treatment for oppositional defiant disorder does not begin until age 3.
C. Refer the father to a psychiatrist.
D. The child is demonstrating normal behavior consistent with a child struggling with emerging independence.

56. Every time the sanitation department picks up garbage in front of the house, a female resident who is diagnosed with schizophrenia barricades herself in her house and calls the police. Neighbors don't understand her behavior. What is your best response?

A. She is misinterpreting reality and behaving as if her perception of reality is real.
B. She is experiencing delusions.
C. The sanitation workers scare her.
D. She is experiencing hallucinations.

57. A patient is brought into the ED with a blood alcohol level (BAL) of 0.48. The patient is unconscious. What is the first thing you do?

A. Place the patient in a quiet area and wait until the patient begins to sober up before continuing your assessment.
B. Send the patient to the ICU immediately.
C. Administer Narcan to the patient.
D. Call the ED practitioner immediately.

58. An obese patient comes to your outpatient clinic reporting that he always feels tired. He reports sleeping throughout the night without any problem. He goes to bed early and stays asleep until it is time to go to work. His vital signs are normal. What test do you expect from the practitioner?

A. Complete blood count
B. EEG
C. EMG
D. Liver function test

59. A patient diagnosed with major depressive disorder is reluctant to take Zoloft after learning that Zoloft can cause sexual side effects. What is your best response?

A. Stop taking the medication immediately and consult your practitioner.
B. Continue to take the medication and ask your practitioner about ways to address this problem.
C. Sexual problems are a known side effect of Zoloft.
D. Don't suddenly stop taking Zoloft. Speak with your practitioner to gradually decrease the dose.

60. A man tells you that his 44-year-old sister goes to doctors all the time reporting various symptoms. No one has been able to diagnose her. He asks if there is something wrong with her mind. What is your best response?

A. She might have hypochondriasis. She believes that her symptoms are real. She should seek psychiatric care.
B. She might have somatization disorder. Her symptoms are a way that she gains attention. No psychiatric care is necessary.
C. She might have factitious disorder. Her symptoms are a way that she gains attention. No psychiatric care is necessary.
D. She might have somatization disorder. She believes that her symptoms are real. She should seek psychiatric care.

61. A male patient diagnosed with bipolar disorder is pacing the halls and occasionally pounds the wall. The frequency increases. What do you do first?

A. Call the practitioner.
B. Assess the patient's hand for injury.

C. Approach the patient cautiously and say, "It looks like something is bothering you. Is there something I can do to help you?"
D. Notify the staff.

62. A 60-year-old male patient was admitted 15 days ago for chronic depression. The patient doesn't want to give up his subsidized apartment for a group home. How should you respond to the patient?

A. Encourage the patient to move to the group home.
B. Help the patient process her options.
C. Encourage the patient to live independently if he can be trusted to take medication as prescribed by the practitioner.
D. Discuss the patient's concerns with the social worker.

63. A patient diagnosed with bipolar disorder is prescribed lithium for manic behavior. The patient refuses to have a blood sample taken, saying that blood was taken a few days ago. What is your best response?

A. The practitioner orders the test so you must let me take your blood.
B. The test results will tell the practitioner if you are getting too much lithium. Too much lithium is poisonous to your body.
C. The practitioner wants to make sure lithium is the right medication for you.
D. The test results will tell the practitioner if you are receiving the appropriate amount of medication.

64. Police receive a call from a woman missing for 7 years and who was legally declared dead. She came across a story on the Internet that reported she was declared dead. She tells police that she has been living in a different state but seems confused because she can't remember what has happened in the past 7 years. Which of the following explains her situation?

A. The woman is malingering to avoid family responsibilities.
B. Authorities should investigate for insurance fraud.
C. Authorities should perform a test to determine if the woman experienced a dissociative fugue or is malingering.
D. The woman probably experienced a dissociative fugue.

65. As a psychiatric nurse, you conducted an admissions assessment of a 52-year-old man in a conference room. The door was open. The patient was seated with his back to the door, and you were seated off to one side. The nurse manager walked by and immediately called you to the hallway to reprimand your admission assessment. What do you believe was the cause of the reprimand?

A. There was no cause for the reprimand.
B. You violated the HIPAA law.
C. You were using the conference room for the assessment.
D. You placed yourself at risk.

66. A 25-year-old man reports that he suddenly falls asleep at work for periods of about 10 minutes once or twice a day. He tells you that his muscles go limp. His practitioner wants him to take the MSLT, and he asks you how long he would have to wear the MSLT monitor. What is the best response?

A. There is no monitor. MSLT requires the patient to take five naps each separated by 2 hours of being awake to measure REM sleep.

B. The monitor is worn for 24 hours on the patient's belt. Leads are attached to the patient to monitor electrical impulses.

C. There is no monitor. MSLT uses leads placed on the patient to monitor the patient when sleeping to identify abnormal sleep cycle.

D. The monitor is worn only when the patient sleeps at night.

67. A new patient diagnosed with paranoid schizophrenia disorder arrives on your unit. How should you react?

A. Perform the admission assessment immediately and show the patient to her room.

B. Welcome the patient while standing behind the nurse's station and engage in an informal conversation with the patient.

C. Welcome the patient while standing behind the nurse's station and avoid any conversation with the patient.

D. Take the patient by the hand and lead her into the examination room.

68. Your neighbor is concerned that her daughter, who is diagnosed with bulimia nervosa disorder, has developed a strange habit. Her daughter prepares the family meals but plays with her food, not eating anything. She is the first one to leave the dinner table. The family does not say anything to her. What is your best response?

A. Reinforce good behaviors not bad behaviors.

B. You are not helping your daughter. You are reinforcing your daughter's negative behaviors. Ask your daughter's psychiatric practitioner how you can assist her in treatment at home.

C. Don't let your daughter prepare meals and distract her from going to the bathroom immediately after meals.

D. As long as your daughter is seeing a psychiatric practitioner, continue with what you are doing with your daughter.

69. A woman comes to you concerned that her 52-year-old mother no longer drives her car. Two weeks ago, someone backed out of a driveway and hit her mother's driver-side door while she was driving past the driveway. No one was injured. What is your best response?

A. She is experiencing chronic posttraumatic stress disorder. Encourage your mother to drive short distances for routine trips such as food shopping.

B. She is experiencing acute posttraumatic stress disorder. Your mother is at risk for self-medicating. Don't let her drive until she sees her primary care practitioner.
C. She is experiencing acute posttraumatic stress disorder. Encourage your mother to drive short distances for routine trips such as food shopping.
D. She is experiencing chronic posttraumatic stress disorder. Your mother should see her primary care practitioner and be administered a low dose of Xanax.

70. A patient withdrawing from benzodiazepine is ordered Ativan by a new medical resident. What is your best response?

A. Point out to the resident that the patient is dependent on benzodiazepine.
B. Ask the attending physician to review the orders.
C. Ask the resident to clarify the orders.
D. Administer the medication as prescribed.

71. Several years ago, the daughter of your friend was diagnosed with schizophrenia. You ask your friend how her daughter is doing. Your friend reports no violent behavior. She eats well and watches television quietly all day. How should you respond?

A. Medication takes several months to have an effect on behavior.
B. Television is a good way to occupy her time.
C. You should tell your daughter's practitioner about her behavior.
D. The medication seems to be working well.

72. A 15-year-old boy is irritable, stays in bed in his room with the door closed, and is unable to concentrate at school. His mother asks you what she should do. What is your best response?

A. Suggest that she should take her son on a weekend vacation for a change of scenery.
B. Suggest that she should take her son to the school's child psychologist.
C. Suggest that she should take her son to a medical practitioner for an assessment.
D. Suggest that she should take her son to a child psychiatrist.

73. A patient who is prescribed lithium for manic episodes states that he no longer wants to take lithium because the medication upsets his stomach. What is your best response?

A. Lithium will make you less manic.
B. Tomorrow we will give your lithium after you eat.
C. This is a normal side effect of lithium.
D. You must take lithium.

74. A child psychologist diagnosed a 12-year-old girl with major depressive disorder (MDD). The daughter's father is devastated. He asks you for advice. What is your best response?

A. Tell the father to be on the alert for suicidal behavior and substance abuse.
B. Tell the father that MDD is caused by an imbalance of neurotransmitters in the brain.
C. Tell the father that his daughter may experience psychosocial developmental problems.
D. Tell the father to ask the pediatrician about medication and therapy treatment.

75. A teenager is upset and tells you that he is embarrassed. He has unpredictable twitches and blurts out meaningless words. What is your best response?

A. You have Tourette syndrome.
B. Ask your parents to take you to see a doctor who may be able to help you.
C. The doctor has medication that will make your problem go away.
D. The doctor has medication that may make your problem go away.

76. A father brings his 38-year-old daughter to the emergency department. She missed work for a week. Her apartment is in disarray. She is single and lives alone. She told her father that all she wanted to do was sleep for the past month. What should you do first as the emergency department nurse?

A. Prepare for a thyroid test panel.
B. Prepare for the practitioner to commit the patient.
C. Prepare for the patient to be placed on constant observation.
D. Prepare for a CT scan of the brain.

77. The father of a 42-year-old man who was diagnosed with undifferentiated schizophrenia disorder many years ago tries to control his son's bizarre behavior by yelling at him and limiting his movements within the house. Which recommendation is best to give the father?

A. Create a calm supportive environment at home. Stress and emotional family environments tend to increase signs and symptoms of undifferentiated schizophrenia disorder.
B. Send your son to a group home where he will experience a less stressful home environment.
C. Avoid limiting your son's movement because this is a violation of the Americans with Disabilities Act.
D. Ask your son's practitioner to increase his medication.

78. Your neighbor fears her 16-year-old daughter is severely ill because of a recent dramatic weight loss. What is the best question to ask the parent?

A. Does your daughter confide in you?
B. Does cancer run in your family?

C. Does your daughter have any sores on her hands?
D. Is there anything different happening at school?

79. A wife tells you that her husband spends an hour every morning cleaning the inside and outside of his car before going to work even if the car is already clean. She wants to know what she can do to help him. What is your best response?

A. Your husband shows signs of complex obsessive-compulsive disorder. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might recommend cognitive behavioral therapy.
B. Your husband shows signs of complex obsessive-compulsive disorder. You should not be overly concerned because he will experience periods of exacerbation and remission. Consult with your primary care practitioner who might recommend cognitive behavioral therapy.
C. Your husband shows signs of simple obsessive-compulsive disorder. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might prescribe medication.
D. Your husband shows signs of simple obsessive-compulsive disorder. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might recommend cognitive behavioral therapy.

80. The mother of an 8-year-old girl tells you that her daughter is bipolar and she plans to take her to her pediatrician to get a medical test to confirm the diagnosis. What is your best response?

A. Inquire about other signs and symptoms experienced by the child.
B. Inquire if others in the family have bipolar disorder.
C. Suggest that the pediatrician will likely assess for medical conditions that mimic symptoms of bipolar disorder. Also tell her there is no medical test to diagnose most psychiatric disorders.
D. Tell the mother that bipolar disorder occurs only in adults and not children.

81. After a verbal altercation with another patient, a 46-year-old female patient walks the hallway shouting. What is your first response?

A. Place the patient in the seclusion room in four-point restraints.
B. Place the patient in the seclusion room.
C. Use active listening and therapeutic communication to de-escalate the patient.
D. Medicate the patient.

82. What type of therapy is used to treat somatization disorder?

A. There is no therapy since the patient believes the symptoms are real
B. Talk therapy

C. Group therapy
D. Cogitative therapy

83. A young female patient is studying pictures of young models in a magazine. She is diagnosed with anorexia nervosa disorder. What is your best intervention?

A. Tell the patient, "No one looks like the models in the pictures. Those pictures are airbrushed."
B. Say to the patient, "Tell me what you are thinking."
C. Ask the patient, "Do you want to be a model?"
D. Ask the patient, "Do any of your friends really look like those models?"

84. Your neighbor tells you about her pre-teen son. It seems that he has an ongoing head cold. His sinuses are congested, and he is not eating regularly and is losing weight. Your neighbor reports that his head cold is so bad that he has to wear sunglasses even in the house. She asks him to remove the glasses, but he becomes agitated. You notice her son is around the neighborhood during school hours when the rest of the family is working. What is your best response?

A. You better take your son to your doctor immediately. He might have more than a head cold.
B. Do you notice any money missing in your house?
C. Is your son going to school?
D. Your son's condition and behavior do not seem normal. Why don't you ask your practitioner to assess your son?

85. Your neighbor has mood swings and wonders aloud if she has developed a mental illness. What is your best response?

A. Ask her if she is on any new medication.
B. Tell her to go immediately to see her practitioner.
C. Keep her on constant observation while you call for medical assistance.
D. Ask her to describe her range of moods.

86. A patient diagnosed with histrionic personality disorder walks to the nurse's station saying he has excruciating back pain. What is your best response?

A. Call a rapid response.
B. Call the on-call practitioner immediately.
C. Tell the patient to return to bed.
D. Take vital signs and tell the attending practitioner when she arrives on the unit.

87. Your neighbor asks you about what causes dissociative identity disorder. Which of the following is your best response?

A. Some researchers believe 6 years of treatment are necessary to improve dissociative identity disorder.
B. Some researchers believe this is a multiple personality disorder.

C. Some researchers believe dissociative identity disorder is untreatable.
D. Some researchers believe dissociative identity disorder is a survival mechanism related to a traumatic event in early childhood.

88. A 19-year-old female patient becomes agitated when she is denied access to the desk phone at the nurse's station. Policy prohibits patients from using the desk phone without permission from a social worker. The patient reaches to grab the phone and a nurse disconnects the phone telling the patient to move away. What is your best response?

A. Tell the nurse that the best approach is to set limits and enforce those limits without arguing or threatening the patient.
B. Tell the nurse that the patient is going through a mood swing and should return to a more stable mood in a few minutes.
C. Tell the nurse that he acted appropriately by warning the patient about the consequences of her actions.
D. Tell the nurse that warning the patient about the consequences of her actions will not change the patient's behavior because the patient is not concerned about the consequences.

89. A practitioner tells a young female diagnosed with anorexia nervosa disorder that she should be admitted to the hospital for several days. She doesn't want to go back to the hospital. What is your best response?

A. It seems like you are concerned about going to the hospital. Would you like to tell me about your concerns?
B. Your doctor knows what is best for you.
C. Did you ask your doctor why she wanted you to go to the hospital?
D. You lost too much weight this time, and you are at risk of doing serious harm to your body.

90. A young patient shadow boxes in the day room and walks quickly along the corridors on the unit occasionally doing pushups against the wall. He monitors his meals carefully. What is your best intervention?

A. Alert the staff for potential violence from the patient.
B. Ask the nurse to medicate the patient for increased agitation.
C. Say to the patient, "You seem to be focused on something. Would you like to talk about it?"
D. Say to the patient, "I realize you are exercising, but other patients are concerned that you are looking for a fight."

91. A new patient asks, "What's your role here?" You tell her you are a nurse. She then says, "Tell the doc I want to see him." What is your best response?

A. Don't argue.
B. Avoid a power struggle and call the resident-on-call.
C. Set limits and expectations.
D. Reinforce appropriate behaviors.

92. Parents just learned that their child has autism disorder and wonder how they should interact with the child. What is your best response?

A. Refer the parents to an autism disorder website.
B. Tell them to treat the child as they would treat other children.
C. Tell the parents to speak with the child face-to-face, maintain a safe environment, give rewards for good behaviors, and do not punish for bad behaviors because this may lead to self-injury by the child.
D. Refer the parents to their pediatrician.

93. The principal tells a father that his 7-year-old son and a few other boys were fighting before school. The father tells you his son has a conduct disorder. How should you response?

A. Tell the father to bring the child for a medical assessment to rule out an underlying medical problem.
B. Suggest that the child be brought for a psychiatric assessment.
C. Tell the father that the son was just playing and there is nothing to be concerned about.
D. Inquire about how frequently his son fights with others.

94. A 56-year-old male patient diagnosed with dementia is wandering the hallway at breakfast. What should you do first?

A. Ask the patient if he is a confused.
B. Tell the patient to go to the dining room.
C. Take the patient to the dining room.
D. Ask the patient if he needs help to go to the dining room.

95. A 25-year-old woman diagnosed with acute stress disorder is prescribed Inderal. She asks you why Inderal was ordered. What is your response?

A. It is best to ask your primary care practitioner.
B. Inderal is a heart medication that can reduce the symptoms of acute stress disorder.
C. When you have acute stress disorder, you have palpitations and your blood pressure is high, causing you to feel uncomfortable. This is the same feeling performers have when they have stage fright. Inderal is used for stage fright.
D. Inderal is a drug called a beta-blocker that slows your heart rate and lowers your blood pressure, which are signs of acute stress disorder.

96. A mother is concerned that her daughter's IQ is 62. She read that an IQ under 70 means the child has mental retardation. What is your best response?

A. An IQ of 62 means that she is moderately retarded and will have limited interaction with others.
B. She will be able to acquire skills where she can be employed, live on her own, and care for herself.

C. She will be better served in a group home where a professional staff can care for her needs a round the clock.
D. She should start home schooling as soon as possible.

97. The psychiatrist recommended that a young female patient diagnosed with anorexia nervosa disorder undergo cognitive behavioral therapy. She asks you why this was recommended. What is your best response?

A. Cognitive behavioral therapy is a form of group therapy where your daughter is in a group of other patients diagnosed with anorexia nervosa disorder and collectively they help each other cope with their problem.
B. That question is better answered by the practitioner.
C. Here's a website that will provide you with all the information that you need to know about cognitive behavioral therapy.
D. Cognitive behavioral therapy uses techniques to help your daughter change her behavior.

98. A patient diagnosed with anorexia nervosa disorder asks how she is at risk for cardiac arrhythmia and cardiac arrest. What is your best response?

A. Anorexia nervosa disorder leads to increased anxiety, which places stress on the heart.
B. Medication used to treat anorexia nervosa disorder can cause an electrolyte imbalance, leading to heart problems.
C. Anorexia nervosa disorder results in an electrolyte imbalance that disturbs the nerve impulses and contractions of the heart, leading to an irregular heart rate.
D. Continuous vomiting disturbs cardiac activity.

99. A student nurse arrives on the unit and asks you what the rationale for treatment of withdrawal is. What is the best response?

A. To protect the patient while the body removes the drug from the patient's bloodstream
B. To protect the patient from relapsing during withdrawal
C. To treat the patient's psychological dependency on the substance
D. To treat the symptoms of withdrawal while the body removes the substance from the patient's bloodstream

100. During a family meeting, the patient's father calls his son a bum because of his drug use and running afoul of the law. What is the best response?

A. Anyone can become physiologically and psychologically dependent on drugs, which can result in drug-seeking behaviors that can lead to health, financial, family, and legal problems.
B. Your son realizes his problem and is trying to change.
C. Have you thought about going to family therapy?
D. Have you heard about Nar-Anon or Al-Anon?

CORRECT ANSWERS AND RATIONALES

1. C. Tell her that she is likely experiencing panic attacks and that she should tell her primary practitioner about it so she can be treated soon. Rationale: The patient may develop depressive disorder, but this is unlikely if the patient is treated for panic disorder. The nurse should educate the patient on the next course of action, which is to speak with the primary practitioners about the panic attacks.
2. C. Is the patient taking his medication? Rationale: A common problem is that patients diagnosed with schizophrenia disorder are noncompliant with medication treatment especially if they are not monitored daily. Signs and symptoms of schizophrenia can return.
3. A. Tell the patient that she has seen the practitioner for today and that she will have an opportunity to see the practitioner tomorrow during rounds. Rationale: You must set limits to the patient's behavior. The patient has a pattern of attention-seeking behavior, and there is no sign that her condition changed since being assessed by the practitioner. Alerting the staff is appropriate, but this would not be the first thing to do.
4. C. An expression of the distorted defense mechanism. Rationale: The patient redefines reality to justify the patient's perception of reality.
5. C. Were you drinking alcohol or using recreational drugs at the party? Rationale: Symptoms of depersonalization disorder can be caused by alcohol or recreational drugs and therefore are not considered depersonalization disorder. The other responses are not the best response.
6. C. Don't exercise or take a hot shower before bedtime. Rationale: While all responses are correct, this is the best response because cooler temperatures—not warm temperatures—are conducive to sleeping. Exercising and taking a hot shower before bed increase body temperature.
7. A. Assess the patient to determine if the patient is competent. If so, then explain the consent form to the patient and ask the patient to sign the form. Rationale: An involuntary status does not make a patient incompetent.
8. A. She should seek treatment as soon as possible. There is a risk that she may isolate herself and avoid intimate relationships. Rationale: Although there is a potential risk for suicide for a patient who has symptoms of body dysmorphic disorder, there isn't a high risk. Ignoring the behavior is not treating the disorder. Since the father has not identified any deformity of the neck, there is no basis to suggest cosmetic surgery.
9. A. Tell the patient he is not going to die from opioid withdrawal and that you will see if he has any PRN medications available. Rationale: The patient is unlikely to have a seizure related to opioid withdrawal. The other two responses are not appropriate because they don't address the patient's immediate needs. The practitioner may have already ordered PRN medication that the nurse can administer to the patient.
10. D. The patient wants to know her weight to adjust her food intake to achieve whatever the patient feels is a normal weight.
11. D. Antipsychotic medication is not prescribed because the medication may increase the catatonic symptoms, which is why the practitioner has not ordered the medication for the patient. Rationale: The nurse has the responsibility to educate the family about medication.

12. C. Review the patient's current medications. Rationale: Side effects of some medications can resemble depressive symptoms. The admitting nurse should gather a database of patient information before presenting the patient to the practitioner. Asking to speak with the patient's family is not the first thing to do. The patient isn't showing any indication of memory loss or dementia.
13. B. The patient is under the influence of amphetamines.
14. A. Provide positive reinforcement. Rationale: This is a nursing intervention that enables the nurse to build a therapeutic rapport with the patient. The patient has not made any suicidal ideations to indicate a need for constant observation. There is no indication that a medication change is necessary since the patient has just arrived on the unit.
15. C. You should have your son assessed by a psychiatrist as soon as possible to determine if he has dissociative identity disorder. Rationale: A common myth is that schizophrenia disorder is exhibited as multiple personalities.
16. A. Tell him that with the treatment he is receiving that he should be able to sleep normally at the end of the treatment period. Rationale: Although his symptoms correlate with acute stress disorder and he is being treated for acute stress disorder, his question is about resuming normal sleep habits. His symptoms are not indicative of posttraumatic stress disorder. He is unlikely to develop depression related to the traumatic event because he is being treated for acute stress disorder.
17. A. Use therapeutic communication to assess the situation. Rationale: The patient is displaying anxiety that can easily escalate to agitation. Therapeutic communication helps to explore and address the underlying cause of anxiety.
18. B. Ask your family members if they ever had the flu. Tell them that withdrawal is like having the worst flu they ever had. Rationale: Alcoholics Anonymous is a self-help group for people who are dependent on alcohol. Dieting is similar to addiction and not withdrawal. No one should ever try an addictive substance.
19. B. Talk to your practitioner about circadian rhythm sleep disorder. Rationale: In this response, you are giving the nurse direction without making a medical diagnosis. The practitioner can perform a full assessment and make a medical diagnosis. The nurse seems to be maintaining her sleep schedule on her days off. Changing her shift may address the problem but does not address the nurse's immediate concerns.
20. D. Ask your practitioner to explain his diagnosis. It is true that everyone exhibits paranoid behavior; however, a person with paranoid personality disorder exhibits extreme paranoid behavior that cannot be controlled. Rationale: It is best to refer the person to the practitioner because you were present when she was told about the diagnosis. You can educate her on the difference between paranoid behavior and paranoid personality disorder.
21. C. Substance abuse anxiety disorder. Rationale: The patient may be abusing alcohol; however, the signs and symptoms of anxiety indicate alcohol withdrawal. The patient may have agoraphobia, but more evidence is required to support this diagnosis. The family may not know if the patient had left the house for short periods to buy alcohol. The patient's anxiety is not from a panic attack.
22. B. Your father needs the same amount of sleep. He probably sleeps more during the day than at night.

23. B. Review the patient's medical records to determine if the patient's body mass index is within normal range and assess the patient for sores on her hands and teeth decay. Rationale: The patient isn't diagnosed with an eating disorder. Her behavior is a sign of bulimia nervosa disorder but could also be an indication of other disorders such as irritable bowel syndrome. The best response is to gather information about the patient.
24. C. Make sure everyone is safe. Rationale: Although the confrontation involves two women, other patients may become involved trying to intervene in the confrontation. Likewise, staff members too can become injured should violence break out. All patients must be fed, so medicating the patients or preventing the patients from entering the dining room is inappropriate. Warning about consequences of their actions will not prevent violent behavior, which usually begins impulsively.
25. A. He is probably experiencing pain disorder. Some researchers believe patients diagnosed with pain disorder are unable to express feelings. Rationale: The other answers are not complete responses.
26. C. There is evidence to support your grandmother's claim. Rationale: There are studies that show that major restorative functions occur during sleep. The immune system is active when you are sleeping.
27. B. Calmly ask the patient if you can help him. Rationale: You should appear nonthreatening and make no movement that could be misinterpreted as a threat. Explaining what the patient is seeing helps the patient to recognize that those activities are nonthreatening. The patient will become less paranoid and more functional in due course.
28. B. Eliminating symptoms tends to impact the relationship between the patient, the nurse, and the patient's support system.
29. D. Psychiatric diagnosis can be confusing. Schizophrenia disorder differs from schizoid personality disorder in that a patient diagnosed with schizoid personality disorder does not have psychotic symptoms. Rationale: Always let the orientee save face while help the orientee correct the error.
30. C. Secondary insomnia disorder. Rationale: The patient is likely to have a primary diagnosis of anxiety disorder. Insomnia is related to the patient's anxiety and therefore would not be the primary disorder. There are no symptoms of depressive disorder or schizophrenia.
31. D. Schizoid personality disorder is not related to schizophrenia.
32. C. Did your father stop smoking recently? Rationale: The father is showing signs of substance abuse anxiety disorder, and nicotine is likely the drug if the father is a smoker. The other responses do not help rule out symptoms of substance abuse anxiety disorder.
33. A. Ask your pediatrician to assess him. This behavior could be normal for his age. Rationale: The psychiatric nurse is educating the mother that her son's behavior might be normal and also providing sound advice to have the child assessed by the pediatrician who will provide a full assessment of the child. Although the child has demonstrated this behavior consistently for 3 months, the child might continue the behavior for another 3 months, which could lead a practitioner to consider an ADHD diagnosis. While the other statements are true, the best response is to educate based on the diagnosis at hand, which is none, and refer the parent to the pediatrician to formally assess the child.

34. C. Gather more information from the admission documents. Rationale: The nurse must make a judgment about a patient after reviewing all the available patient information. The patient's statements may be accurate, exaggerated, or fabricated.
35. D. Focus on one day at a time. Identify your triggers and learn ways to avoid them. Rationale: The other recommendations are true, but this doesn't help the patient begin recovery now.
36. A. The practitioner is likely waiting for the patient to trust the practitioner before prescribing medication.
37. D. Try using good sleep hygiene first. Rationale: It is always best to try nonmedication treatments before using medication. Although sleep medication may be abused, abuse can be avoided by following the practitioner's instructions.
38. B. Ask the mother to have her pediatrician assess the child. Rationale: The child's behavior may indicate sudden regression from previously normal behavior. The child seems to have loss of social skills and language skills, which are early signs of autistic disorder. The best response is to have the pediatrician formally assess the child.
39. C. The patient may have a medical condition or adverse drug reaction. Rationale: The patient is showing signs of catatonic schizophrenia; however, catatonic schizophrenia is rare. The same signs can be caused by a medical disorder or adverse reaction to medication.
40. C. Obsessive-compulsive disorder and obsessive-compulsive personality disorder are different diagnoses. A patient diagnosed with obsessive-compulsive personality disorder does not have true obsessions and compulsions.
41. A. Point out your findings to the practitioner and ask the practitioner to assess for bulimia nervosa disorder. Rationale: Sores on the patient's hands are signs of self-induced vomiting, which is a hallmark sign of bulimia nervosa disorder. Patients who are diagnosed with bulimia nervosa disorder have episodes of self-induced vomiting. Between episodes, patients have relatively normal weight. The patient shows no signs of drug abuse.
42. C. Nonpharmacologic therapy.
43. D. Place the patient on constant observation. Rationale: The first step is to protect the patient. Always assume suicidal ideation is real until there is evidence to the contrary. The practitioner must be notified and assess the patient. Other interventions can be implemented based on the practitioner's assessment.
44. A. Nightmares. Rationale: A nightmare is a bad dream. This isn't night terror because the patient is able to describe the experience. Patients are unable to describe a night terror. The patient didn't report any traumatic event so PTSD is unlikely the problem. There are no symptoms of anxiety disorder.
45. C. Generalized anxiety disorder. Rationale: The patient is experiencing generalized anxiety disorder because she has episodes whenever she is presented with the trigger of meeting new people. She is misinterpreting the events. Acute stress disorder occurs following a traumatic event. She isn't afraid of leaving home or being in public places; therefore, agoraphobia is not correct. Although she self-medicates with alcohol and may show signs of abuse, the patient is exhibiting signs of generalized anxiety disorder.
46. D. Major depressive disorder is a chemical imbalance in the brain that prevents your daughter from picking herself up and getting motivated without help. Rationale: The nurse should always educate the patient and the patient's family about the nature of the patient's diagnosis.

47. A. Play CDs of her favorite songs. Rationale: This has a distracting and calming effect. Her favorite songs are triggers to more calming moments. Telling her that everything will be fine does not provide a therapeutic response to the situation. Quietly listening is appropriate but does not proactively address the situation. Taking her to the hospital does not address the current situation.
48. B. Prevent the patient from self-injuring behavior. Rationale: Safety is the first goal.
49. B. Have you ever taken hallucinogens at any time in your life? Rationale: The patient reports symptoms consistent with hallucinogen intoxication. A patient can experience flashbacks of symptoms of hallucinogens for years after the patient has stopped taking the drug.
50. D. There is a genetic predisposition; however, a predisposition does not mean that your son will develop paranoid schizophrenia disorder. Rationale: The first signs and symptoms of schizophrenia disorder occur as early as 16 years of age; however, this is not the best response to tell new parents.
51. D. The patient is malingering to avoid the court hearing, during which the patient would test positive for an illegal substance. Rationale: Lacerations are likely self-inflicted to give credence to the patient's suicidal ideation and not to gain attention. The patient is not a high risk for suicide related to the pending court hearing because the patient is asking that the social worker contact the court on her behalf. There are no symptoms of a dissociative disorder.
52. C. You and the psychiatrist can decide if you are ready to go home. Rationale: You explained that both the patient and the psychiatrist are involved in the patient's discharge.
53. D. Kleine–Levin syndrome is a sleep disorder that comes and goes several times a year. Make sure that you follow the treatment recommended by your practitioner. Rationale: You should educate the patient once the practitioner has discussed the diagnosis with the patient. Some researchers believe that the underlying cause is a viral infection, but there is no agreement that this is true. Kleine–Levin syndrome is a form of primary hypersomnia disorder; however, always give the patient as much information as is feasible.
54. D. The nurse is experiencing the effects of chronic anxiety. Rationale: Stressors stimulate the HPA axis. The stressor of the emergency department is not resolved over time, resulting in the body being unable to adapt to the stressor. Release of cortisol in response to the HPA axis decreases the immune response and can lead to infection. Although the nurse was probably exposed to a virus or bacteria that caused the nurse to be sick at times, the underlying problem is chronic anxiety. The nurse does not show signs of PTSD.
55. D. The child is demonstrating normal behavior consistent with a child struggling with emerging independence. Rationale: Early onset of oppositional defiant disorder is at age 3. The child is likely being taken to a pediatrician for regular checkups.
56. A. She is misinterpreting reality and behaving as if her perception of reality is real.
57. D. Call the ED practitioner immediately. Rationale: The patient may have alcohol poisoning and requires immediate intervention. Narcan is administered to reverse opioids. The patient will likely be transfered to the ICU; however, only a practitioner can order the transfer.
58. A. Complete blood count. Rationale: Although the patient is likely to have breathing-related sleep disorder related to possible obstructive sleep apnea syndrome (OSAS), the practitioner needs to rule out anemia and other medical conditions that can cause this symptom.

59. B. Continue to take the medication and ask your practitioner about ways to address this problem. Rationale: It is always best to encourage the patient to openly discuss medication problems with the practitioner. There are many techniques used to enable the patient to remain sexually active while maintaining medication compliance. Telling the patient that sexual problems are known side effects of Zoloft is correct but does not help the patient address those problems. There is no need for the patient to stop taking Zoloft because of this side effect.
60. C. She might have somatization disorder. She believes that her symptoms are real. She should seek psychiatric care. Rationale: Hypochondriasis requires the patient to focus on one disorder. No single disorder was identified in the question, which is a symptom of somatization disorder. She is unlikely faking the symptoms.
61. D. Notify the staff. Rationale: The patient could become violent at any time. It is better to alert the staff so there is enough support on the unit to safely control the patient. Once the staff is alerted, you can approach the patient and assess for injuries. The practitioner may be called if the staff is unable to resolve the issue.
62. B. Help the patient process her options. Rationale: Don't give advice or make a decision for the patient. Help the patient reach a decision.
63. D. The test results will tell the practitioner if you are receiving the appropriate amount of medication. Rationale: Although too much lithium is toxic, telling the patient about toxicity in this situation may cause the patient to refuse medication. It is better to ask the practitioner to discuss toxicity with the patient. The patient always has the right to refuse treatment. The other response is incorrect because the blood test does not determine if the medication is right for the patient.
64. D. The woman probably experienced a dissociative fugue. Rationale: There is no information in the question to support malingering. There is no test to diagnose a dissociative fugue. There is no information to support that the person was involved in insurance fraud.
65. D. You placed yourself at risk. Rationale: Position yourself closest to the door and the patient farthest from the door for safety. The patient should not be able to block your egress from the room should the patient become aggressive during the interview.
66. A. There is no monitor. MSLT requires the patient to take five naps each separated by 2 hours of being awake to measure REM sleep. Rationale: Answer C describes the polysomnography (PSG) test.
67. B. Welcome the patient while standing behind the nurse's station and engage in an informal conversation with the patient. Rationale: The goal is to develop trust. Standing behind the nurse's station acknowledges the patient's personal space. An informal conversation facilitates developing trust.
68. B. You are not helping your daughter. You are reinforcing your daughter's negative behaviors. Ask your daughter's psychiatric practitioner how you can assist her in treatment at home. Rationale: This response points out a problem with how the parent is coping with her daughter's behavior and refers the parent to the proper medical professional to advise the parent. The practitioner can incorporate the parent into the practitioner's treatment plan for the patient.

69. C. She is experiencing acute posttraumatic stress disorder. Encourage your mother to drive short distances for routine trips such as food shopping. Rationale: Gradually being exposed to the trigger—driving—helps her to cope with the stress of the accident. Although she is at risk for self-medicating, she should return to driving as soon as possible.
70. A. Although lesser dose of benzodiazepine might be given to ease the withdrawal symptoms, other medications might be more appropriate. The resident may not be aware that the patient is addicted to benzodiazepin.
71. C. You should tell your daughter's practitioner about her behavior. Rationale: Your friend is describing negative symptoms of schizophrenia. Your friend's daughter should be reevaluated by the practitioner. The patient may be in the residual phase of schizophrenia.
72. C. Suggest that she should take her son to a medical practitioner for an assessment. Rationale: Although the child presents with some symptoms of major depressive disorder, the initial step is to rule out any underlying medical condition that might also cause those symptoms. Therefore, assessment by a medical practitioner is more appropriate at this stage than being assessed by a psychiatrist or psychologist. A change of scenery will not address any medical or psychiatric causes for those symptoms.
73. B. Tomorrow we will give your lithium after you eat. Rationale: Lithium can cause an upset stomach unless the patient takes the medication with food or after meals. The patient has the right to refuse medication. The other statements are true but not the best response.
74. D. Tell the father to ask the pediatrician about medication and therapy treatment. Rationale: The psychiatric nurse should advise the father to ask the pediatrician for treatment options. The other responses are correct but don't respond to the father's question as to what to do to help his daughter.
75. B. Ask your parents to take you to see a doctor who may be able to help you. Rationale: The best response is to recommend that he ask his parents to take him to a practitioner who can properly assess him. Although he seems to have symptoms of Tourette syndrome, only a practitioner can make a medical diagnosis. Also medication is not the first course of treatment, so telling him about the medication treatment is inappropriate.
76. A. Prepare for a thyroid test panel. Rationale: Determine if the patient has a thyroid disorder. Hypothyroidism mimics symptoms of depression.
77. A. Create a calm supportive environment at home. Stress and emotional family environments tend to increase signs and symptoms of undifferentiated schizophrenia disorder. Rationale: Sending his son to a group home will likely increase stress because his son will be in unfamiliar surroundings.
78. D. Is there anything different happening at school? Rationale: A sudden eating disorder may stem from peer pressure, trying to impress a new boyfriend, or trying to join an athletics team at school. The practitioner probably doesn't have any supporting evidence to support tests for cancer. Sores on her hand would be a sign of bulimia nervosa disorder but not anorexia nervosa disorder.
79. D. Your husband shows signs of simple obsessive-compulsive disorder. You should not be overly concerned because he continues to go to work. Consult with your primary care practitioner who might recommend cognitive behavioral therapy. Rationale: Medication is usually prescribed as a second line of treatment. Complex obsessive-compulsive disorder requires that the obsession interferes with the patient's activities of daily living.

80. C. Suggest that the pediatrician will likely assess for medical conditions that mimic symptoms of bipolar disorder. Also tell her there is no medical test to diagnose most psychiatric disorders. Rationale: The psychiatric nurse is correcting the parent's misperception of tests for mental disorders and supporting the parent's plan to have the pediatrician assess the child. The psychiatric nurse is also teaching the parent that symptoms can also be caused by an underlying medical condition and not a mental disorder. Asking the parent to describe systems is not appropriate because it implies that the psychiatric nurse is going to make a medical diagnosis, which is beyond the psychiatric nurse's scope of practice. Responses that explore bipolar disorder are inappropriate because the parent needs to have a practitioner diagnose the child as having bipolar disorder.
81. C. Use active listening and therapeutic communication to de-escalate the patient. Rationale: The psychiatric nurse must use the least restricted technique to control the situation such as therapeutic communication, medication by mouth, open seclusion (give the patient time out away from distractions), intramuscular medication, and four-point restraints.
82. A. There is no therapy since the patient believes the symptoms are real.
83. B. Say to the patient, "Tell me what you are thinking." Rationale: An open-ended question encourages the patient to share her feelings, which is the best therapeutic approach to use with the patient. The other responses challenge the patient's beliefs.
84. D. Your son's condition and behavior doesn't seem normal. Why don't you ask your practitioner to assess your son? Rationale: The best response is to have her son assessed by a practitioner who is the proper professional to assess if her son is experimenting with drugs or has an underlying medical condition.
85. D. Ask her to describe her range of moods. Rationale: Mood swings are normal. Moods become concerning if they lead to extreme affect and behaviors and last for a long period of time. Medications may cause mood swings, but the best approach is to gather more information about the mood swings. There is nothing to indicate there is an urgent medical condition.
86. D. Take vital signs and tell the attending practitioner when she arrives on the unit. Rationale: The patient is unlikely to be in excruciating back pain because he walked to the nurse's station. A patient with excruciating back pain probably would not be able to get out of bed. The patient's complaint is likely an exaggerated gesture. However, a patient diagnosed with histrionic personality disorder can have a medical disorder and needs to be assessed by the nurse and by the practitioner.
87. D. Some researchers believe dissociative identity disorder is a survival mechanism related to a traumatic event in early childhood. Rationale: The other answers are not appropriate responses.
88. A. Tell the nurse that the best approach is to set limits and enforce those limits without arguing or threatening the patient. Rationale: This is a good nursing intervention to address the situation because the patient learns to change behavior to conform to the limits. The patient is likely to change to a more stable mood quickly. The patient acts impulsively without regard for the consequences of her actions.

89. A. It seems like you are concerned about going to the hospital. Would you like to tell me about your concerns? Rationale: This is a therapeutic response that encourages the patient to express her feelings and tell you more about her concerns.
90. C. Say to the patient, "You seem to be focused on something. Would you like to talk about it?" Rationale: This is the best therapeutic response because the patient is given the opportunity to explain his behavior. The patient is likely seeing himself in training for boxing or mixed martial arts competition. It is best to assess the patient before medicating the patient. Although the patient seems agitated, his behavior leans more toward exercising at this point.
91. C. Set limits and expectations. Rationale: The patient is exhibiting antisocial personality behavior by attempting to control the admission process. Although you should not argue with the patient and avoid a power struggle, the best response is to set limits and expectations.
92. C. Tell the parents to speak with the child face-to-face, maintain a safe environment, give rewards for good behaviors, and do not punish for bad behaviors because this may lead to self-injury by the child. Rationale: Since the child was diagnosed with autism disorder, the psychiatric nurse can educate the parents on how to interact with the child. The other responses are inappropriate.
93. D. Inquire about how frequently his son fights with others. Rationale: The child would have to demonstrate three symptoms within a year and one symptom in the past 6 months. An 8-year-old fighting with a group of boys one time is not considered conduct disorder.
94. D. Ask the patient if he needs help to go to the dining room. Rationale: Ask simple, concrete questions that leave no room from misunderstanding by the patient.
95. D. When you have acute stress disorder, you have palpitations and your blood pressure is high causing you to feel uncomfortable. Inderal is a drug called a beta-blocker that slows your heart rate and lowers your blood pressure, which are signs of acute stress disorder. Rationale: Since the primary care practitioner already diagnosed the patient and ordered treatment, the nurse should educate the patient about the treatment. The explanation of the medication should focus on how the medication will help the patient. Although Inderal is used for stage fright, the patient is not experiencing stage fright.
96. B. She will be able to acquire skills where she can be employed, live on her own, and care for herself.
97. D. Cognitive behavioral therapy uses techniques to help your daughter change her behavior. Rationale: This response is most informative and encourages the parent to ask further questions.
98. C. Anorexia nervosa disorder results in an electrolyte imbalance that disturbs the nerve impulses and contractions of the heart, leading to an irregular heart rate. Rationale: No medication is prescribed to treat anorexia nervosa disorder. Self-induce vomiting is a sign of bulimia nervosa disorder.
99. D. To treat the symptoms of withdrawal while the body removes the substance from the patient's bloodstream.
100. A. Anyone can become physiologically and psychologically dependent on drugs, which can result in drug-seeking behaviors that can lead to health, financial, family, and legal problems.

Glossary

12-Step Sexual Addiction Program: A structured self-help group based on the Alcoholics Anonymous 12-Step Program that helps the patient work through steps of recovery.

Abuse: The patient uses a substance frequently but does not experience withdrawal symptoms and does not have a physical or psychological dependency on alcohol.

Acetylcholine: Acetylcholine is a neurotransmitter that is common in transmitting neuromuscular impulses. Increased acetylcholine increases neuromuscular impulses. Decreased acetylcholine decreases neuromuscular impulses.

Acting out: A patient expresses destructive behavior to themself or others in an effort to gain attention because of the patient's inability to cope with reality such as a patient who self-inflicts superficial cuts on their wrist to gain the attention of the staff.

Active listening: Active listening requires the psychiatric nurse to be attentive to what the patient is saying and use nonverbal communication to demonstrate that the nurse is listening.

Active phase: The patient demonstrates positive or negative signs of schizophrenia disorder. This may occur continuously or as periods of exacerbation and remission, which is referred to as episodic. Two-thirds of patients diagnosed with schizophrenia disorder have multiple active phases in their lifetime.

Activities of daily living: These are activities of self-care that a person performs every day such as personal hygiene, dressing, eating, feeding, and bathroom activities.

Acute/chronic lithium toxicity: Symptoms of weakness, uncoordinated voluntary muscle movement (ataxia), hand tremors, nausea, stomach pains, dizziness, diarrhea, and vomiting.

Acute memory loss: Sudden inability to remember.

Acute stress disorder: Acute stress disorder occurs when a patient is unable to bring immediate closure to a traumatic event. Signs and symptoms of acute stress

disorder begin within 4 weeks following the traumatic event and should resolve during the same period.

Addiction: A psychiatric disorder that occurs when a person is psychologically dependent on a substance. A person who is addicted to a substance will spend most of their waking hours focused on obtaining and using the substance with total disregard to activities of daily living including family and employment responsibilities.

Advanced sleep phase syndrome (ASPS): Occurs when the patient has difficulty staying awake in the evening and is unable to remain asleep in the morning.

Adventitious crisis: An adventitious crisis is an unpredictable catastrophic external event.

Adverse behavior: A patient who is calm and controlled can suddenly turn threatening and violent without any warning.

Agoraphobia: Agoraphobia is the fear of leaving home related to posttraumatic stress disorder, fear of germs, or feeling unsafe in unfamiliar surroundings. Some researchers believe that agoraphobia is the result of repeated panic attacks where the patient creates a safety zone at home.

Alcohol dependence disorder: Alcohol dependence disorder occurs when the patient develops a physical dependency on alcohol. The patient has developed a tolerance for alcohol that requires them to increase alcohol intake to achieve the desired physiologic effect. Furthermore, the absence of alcohol results in the patient becoming increasingly uncomfortable, and the patient displays withdrawal symptoms that are relieved by ingesting alcohol. The patient frequently reports the need for an alcoholic drink in the morning to feel normal. The patient totally focuses on obtaining and ingesting alcohol during waking moments.

Alcohol metabolism: The physiologic process of absorbing and breaking down a substance within the body.

Altruism: A patient experiences personal satisfaction by helping others such as serving food to residents of a homeless shelter.

American Psychiatric Association: An organization that defines the difference between relatively normal behavior and pathological behavior.

Amphetamine abuse disorder: An amphetamine is a stimulus that increases alertness and decreases fatigue, resulting in a temporary pleasurable rush. Amphetamines are prescribed for a number of disorders including ADHD, narcolepsy, and sleep disorder. Amphetamines are dextroamphetamine, methamphetamine, and amphetamine sulfate. Commonly prescribed amphetamines are: Ritalin, Adderall, and Dexedrine. Street names for amphetamines are: Bennies, Black Beauties, Crank, Crystal, Glass, Ice, Krystal Meth, Louee, Meth, Shabu, Speed, and Uppers.

Amygdala: An almond-shaped group of cells in the temporal lobe that is involved with learning fear and safety from an event and based on that experience causes activation of the fight-or-flight response. Researchers believe that the amygdala is involved in signs and symptoms of anxiety disorder, phobias, and posttraumatic stress disorder.

Anhedonia: The inability to experience pleasure.

Anorexia nervosa disorder: Anorexia nervosa disorder occurs when the patient has the delusion that they are overweight even if they are within normal weight for their age and height. Anorexia nervosa is a psychiatric disorder because the patient has a negative misperception about their self-image and copes with the negative misperception by excessively exercising and self-imposed starvation. The patient is likely to skip meals or eat foods low in calories, commonly called safe foods. The patient may cook meals for others but make excuses when the patient doesn't eat the meal. When pushed, the patient may be seen cutting foods into tiny pieces and stall while others finish eating. The patient may chew foods but only finishes a small amount of food.

Anterior cingulate cortex (ACC): The ACC is involved in managing emotions. The ACC is also involved in motivation and staying focused. Researchers have found that decreased activity in the ACC is seen in patients who show signs of depression, ADHD, and schizophrenia.

Anticipation: A patient plans on how to handle a discomfort that will occur in the future, such as planning for the death of a pet.

Antidepressant medication: Antidepressant medication influences neurotransmitters, which enable the patient to return to a more stable mood.

Antisocial personality disorder: Antisocial personality disorder occurs when the patient is impulsive, aggressive toward others, and lacks remorse. The patient violates rules and has no respect for other people's rights, leading to poor performance in school, work, or family life.

Anxiety: Anxiety becomes a disorder when a person is unable to cope with stressors and they interfere with the person's activities of daily living. Central to anxiety disorder is the person's misinterpretation of stressors and their exaggerated response to the stressors. A stressor is a situation that triggers a stress response.

Anxiolytic, hypnotic, sedative dependent disorder: Anxiolytic, hypnotic, sedative dependent disorder occurs when the patient becomes dependent on anxiolytic, hypnotic, or sedative medication. Collectively, these classes of drugs reduce anxiety and induce sleep and can be taken orally or injected intramuscularly or intravenously. Depending on the route, the effect can be immediate or take several minutes and lasts up to 8 hours.

Apathy: The decreased interest in activities, people, and things.

Assertiveness training: Assertiveness training shows the patient how to express feelings and actions without developing guilt over their feelings or actions.

Attention deficit hyperactivity disorder (ADHD): Attention deficit hyperactivity disorder is developmentally inappropriate behavior in school-aged children that results in the inability of the child to focus on the task at hand. More boys than girls are diagnosed with ADHD.

Auditory hallucinations: Hearing sounds when none exist.

Autistic disorder: Autistic disorder is a pervasive developmental disorder characterized by impairment in social interactions, communication, and repetitive behavior. The child diagnosed with autistic disorder exhibits inappropriate responses

and impaired language when interacting with others and the environment. The child is unable to understand what is happening around them, leading to the child being aloof and isolated from peers and family.

Autonomic nervous system (ANS): Part of the peripheral nervous system that controls involuntary movement such as the endocrine system, cardiovascular system (heart rate), respiratory system, and gastrointestinal system (digestion).

Aversion therapy: Aversion therapy introduces a painful stimulus whenever the patient has an undesirable behavior with the expectation that the patient will avoid the undesirable behavior to avoid the painful stimulus.

Avoidant personality disorder: Avoidant personality disorder occurs when the patient exaggerates the negative as a reason for avoiding new situations. The patient has low self-esteem and an underlying feeling of inadequacy that leads to social withdrawal. The patient is very sensitive to being judged by others, which results in extreme social anxiety with a fear of being rejected by others.

Axis: A psychiatric diagnosis is divided into five sections, each called an axis. Each section provides specific information about a patient's condition.

Axon: Axons are extensions from the cell body that send impulses to another cell. Axons can extend an inch or several feet in length. An axon carries impulses away from the cell body. Larger axons are surrounded by fatty insulating material called myelin that enables the impulse to be transmitted without interference from other cells. Myelin also ensures that only the destination cell receives the impulse.

Barrier to effective communication: A barrier to communication is something that impairs transmission of the message or receiving the message for either the psychiatric nurse or the patient.

Basal ganglia: The basal ganglia are located outside the thalamus and are involved in obsessive-compulsive disorder and worrying.

Baseline psychiatric assessment: The initial psychiatric assessment of the patient.

Beck Depression Inventory: Beck Depression Inventory is a self-administered and self-scored test that asks the patient to identify symptoms of depression that the patient may have experienced in the past week. This is the most widely used instrument to measure severity of depression.

Behavior therapy: Behavior therapy is a therapeutic approach that focuses on unlearning unacceptable behaviors and replacing them with acceptable behaviors through training.

Behavioral model: Behavior is learned through rewards for positive behavior and punishment for negative behaviors. Mental illness is considered a behavior.

Binge: An episode of eating a large amount of food.

Bipolar disorder: Bipolar disorder occurs when a patient experiences extreme mood swings that are exhibited by manic or hypomanic moods and depressive moods. A manic mood is when a patient shows intense irritation and agitation along with psychotic features. Hypomanic mood is a less intense manic mood without psychotic features. Depressive mood is when the patient shows signs of clinical depression.

The patient will have periods of exacerbations and periods of stable moods. Mood swings can occur rapidly, called rapid cycling, or vary over time.

Bipolar I disorder: Characterized by periods of severe mania and severe depression.

Bipolar II disorder: Characterized by periods of hypomania and severe depression.

Bizarre behavior: Behavior that is inappropriate to reality but appropriate to the patient's misperception of reality.

Blood alcohol level (BAL): Reported in tenths of 1% of the person's blood volume that is alcohol. For example, a level of 0.1 means one-tenth of 1% of the tested blood volume is alcohol. A blood alcohol test is typically reported as a whole number such as 290. This means 0.29% of the tested blood volume is alcohol.

Blunted affect: The patient is unable to show emotions, although they continue to feel emotions.

Body dysmorphic disorder: Body dysmorphic disorder occurs when a patient dislikes their physical appearance, usually the face, head, or skin. Any slight defect causes distress to a point where the patient is unable to perform activities of daily living. Flaws can be scars or the shape or size of the body or body features.

Borderline personality disorder: Borderline personality disorder occurs when a patient has significant emotional instability expressed by frequent mood swings and periods of impulsiveness that can lead to violent behavior in reaction to criticism. The patient has a distorted sense of self and feels mistreated, misunderstood, and empty, which can lead to self-destructive behaviors. The patient uses splitting as a defense mechanism whenever the patient perceives dangerous anxiety. Splitting is when the patient sees another person as either all good or all bad, and this view alternates swiftly. A patient diagnosed with a borderline personality disorder presents with impulsive behavior with disregard to consequences of the behavior. Fear of abandonment can lead to substance abuse and suicide attempts.

Brain plasticity theory: This theory proposes that the structure of the brain changes when a person sleeps, resulting in improved memory. Some researchers believe that consolidation of information acquired during waking hours occurs during sleep to form memory.

Brain waves: Tracings of electrical signs generated by the brain.

Breathing-related sleep disorders: Breathing-related sleep disorders occur when there is disruption in a patient's breathing during normal sleeping hours that results in excessive sleepiness during the daytime. The patient is able to fall asleep; however, sleep is frequently interrupted and the patient reports that sleep does not refresh them. In some cases, the patient may fall asleep during relaxing activities. In other cases, the person may fall asleep during active activities. Breathing-related sleep disorders occur gradually over years and are usually not reported to the practitioner until the disorder interferes with activities of daily living.

Bright light therapy: Uses a high-intensity light to adjust the patient's sleep cycle by an hour or two each day.

Bulimia nervosa disorder: Bulimia nervosa disorder occurs when the patient eats large amounts of food, called a binge, and then purges. Purging is done by forced

vomiting or excessive exercising. The patient's goal is to decrease the caloric intake. The patient has poor self-image manifested by the fear of becoming overweight as defined by the patient. The patient's weight was likely within normal range until the patient developed bulimia nervosa.

Cannabis abuse disorder: A patient diagnosed with cannabis abuse disorder ingests cannabis for recreational purposes to induce euphoria. Cannabis is a drug that is extracted from the hemp plant in leaf form called marijuana and resin called hashish. In leaf form, cannabis is smoked or ingested as tea. Leaves are rolled to form marijuana cigarettes.

Catatonic schizophrenia disorder: Catatonic schizophrenia disorder occurs when a patient experience periods of being in a daze and unable to move or speak. The patient also experiences periods of hyperactivity such as bizarre behavior and spurts of talkativeness. A patient diagnosed with catatonic schizophrenia disorder has a propensity for destructive behavior.

Central nervous system (CNS): The CNS consists of the brain and spinal cord.

Cheeking medication: A patient pretends to take medication but instead places the medication between the cheek and gums. The patient then removes the medication when not being observed.

Chemical restraint: A chemical restraint is medication administered to the patient for the sole purpose of preventing them from moving, which is illegal.

Chronotherapy: Focuses on adjusting the patient's sleep cycle by an hour or two each day until the patient's circadian rhythm is in tune with the patient's activities of daily living.

Circadian rhythm: A daily cycle of rhythmic activities based on a 24-hour interval commonly referred to as the body clock.

Circadian rhythm sleep disorder: Circadian rhythm sleep disorder occurs when the patient is unable to sleep or awaken for normal activities of daily living due to disruption in the patient's circadian rhythms. The patient is able to have sufficient quality sleep for an appropriate period of time; however, the time period is not appropriate for activities of daily living such as work and school.

Circumstantial thinking: The conversation drifts off the point of discussion and then eventually returns and addresses the point.

Clinical depression: Another name for major depressive disorder.

Cocaine abuse disorder: Cocaine abuse disorder occurs when a patient takes cocaine to realize a feeling of hyperalertness, euphoria, and energy. Cocaine is contained in coca leaves. The effects of cocaine can be felt by chewing coca leave. Cocaine abusers use a purified form of cocaine called cocaine hydrochloride. Cocaine can be prescribed as an anesthetic for eye, ear, and throat surgeries.

Cognitive ability: Cognitive ability is the patient's capacity to remember, understand, reason, and problem solve.

Cognitive Assessment Scale: Cognitive Assessment Scale measures the patient's cognitive ability by testing the patient's psychomotor functions, general knowledge, and mental capability.

Cognitive capacity screening examination: Cognitive capacity screening examination assesses the patient's cognitive ability by testing the patient's memory, language, and calculation skills.

Cognitive therapy: Cognitive therapy is a therapeutic approach that identifies and alters the patient's negative feelings about themself.

Command presence: The appearance that the nurse is in charge of the unit or situation. Command presence can be conveyed by actions, words, body language, tone of voice, or a combination of these factors.

Communication: Transmission of information from a sender to a receiver using shared symbols. A symbol is a word, phrase, or body language used in communication. The meaning of the symbol must be shared between the sender and receiver.

Communication model: The meaning of behavior is dependent on successful communication. Abnormal behavior occurs when communication is clouded. Normal behavior occurs when communication is clear. Degrees in clarity of communication explain degrees of abnormal behavior.

Conduct disorder: A child diagnosed with conduct disorder violates the rights of others and demonstrates antisocial behaviors that result in discipline in school, arrests, and possibly incarceration. Conduct disorder occurs before age 18 and can occur before age 10, which is referred to as early-onset conduct disorder.

Confusion: The patient experiences thought disorder that leads to disorganized speech and is unable to converse with others.

Constant observation: When the patient is considered a danger to themself or others, one staff member is assigned to constantly monitor the patient 24 hours a day, 7 days a week.

Conversion: A patient presents with physiologic symptoms with no explanation, such as a patient who suddenly limps for no known medical reason. Conversion is also known as hysteria.

Conversion disorder: Conversion disorder occurs when a patient experiences neurologic symptoms such as paralysis, numbness, and blindness that are not caused by an underlying medical disorder. There are periods of exacerbation brought on by stress and periods of remission during less stressful times during which there are no neurologic symptoms. Symptoms of conversion disorder are real and not caused by the patient faking symptoms. Some researchers believe there is no formal evidence that rules out a physiologic cause for symptoms of conversion disorder.

Counseling therapy: Counseling therapy is a therapeutic approach where the therapist helps the patient think through problems by presenting a logical approach to problem solving and encouraging the patient to consider consequences of potential decisions before making the decision.

Couples therapy: Helps couples mutually explore their bodies to reduce any shame.

Cravings: The desire to use a substance.

Crisis intervention: A crisis is a situation where the patient becomes overwhelmed and lacks the coping skills to address the crisis. Crisis intervention is a therapeutic approach that helps the patient deal with the crisis.

Cyclothymic disorder: Cyclothymic disorder occurs when a patient has brief alternating moods of hypomania and depression within a 2-month period with periods of stability between mood swings. Episodes of hypomania and depression are not as intense as in bipolar disorder.

Cytoplasm: Fluid-like substance within the cell.

Daily psychiatric assessment: A formal assessment of the patient that is made once per shift and represents the culmination of the nurse–patient interactions and observation of the patient throughout the shift.

Deep breathing exercise: Increasing the depth of breathing slows respiration and relieves stress.

Defense mechanism: Defense mechanism is a behavior that helps the patient cope with anxiety.

Degrees of schizophrenia: The variation of symptoms of schizophrenia during the patient's life.

Delayed sleep phase disorder (DSPD): Occurs when the patient sleeps and awakens much later than normal.

Delirium: A patient who is delirious is confused and disoriented and responds inappropriately because the patient misinterprets the psychiatric nurse's statements.

Delirium tremens (DT): An acute episode of delirium resulting from alcohol withdrawal that can occur 48 hours after the patient stops ingesting alcohol.

Delusion: A patient who has delusions has an irrational, false beliefs even when presented with evidence to the contrary. The patient believes their beliefs are rationale and will aggressively defend them. The psychiatric nurse should help the patient focus on reality without agreeing or arguing about their delusion.

Delusional projection: A patient has delusions of being persecuted such as a patient who states the staff is picking on them.

Dementia: Dementia is irreversible deterioration of the patient's mental capacity affecting memory, language, and logical thinking.

Dendrites: Dendrites are extensions of cell bodies that receive impulses from a nearby cell.

Denial: A patient refuses to accept reality such as the patient who denies that they have a chronic illness.

Dependency: Occurs when a person uses a substance to feel normal.

Dependent personality disorder: Dependent personality disorder occurs when a patient displays consistent needy behavior where the patient transfers their responsibility to others and seeks protection from others. The patient rushes from one relationship to another when a relationship fails. The patient requires validation from others since the patient has self-doubt about their capabilities and is sensitive to criticism.

Depersonalization: The patient loses all sense of identity and expresses feelings that are different from their normal feelings. For example, the patient may feel as if they are outside their body.

Depersonalization disorder: Depersonalization disorder occurs when the patient's self-awareness is temporarily altered, giving them the feeling of detachment from their body or mental process. Depersonalization disorder can occur after a life-threatening event. Detachment can involve the entire body or a part of the body. The patient remains in touch with reality, although they may feel like they are viewing themselves from the outside rather than from the inside.

Depressive mood: The patient has lost interest in life and has difficulty performing activities of daily living.

Desensitization: Desensitization is used to treat patients who experience phobias by gradually exposing the patient to situations that cause the patient's anxiety while coaching the patient to relax.

Detoxification: A process of removing a substance from the patient's body. Once the substance is removed and the patient's body is stabilized, they are no longer physically dependent on the substance. Detoxification begins when the patient stops taking the substance and ends when all traces of the substance are removed from the body.

***Diagnostic and Statistical Manual of Mental Disorders* (DSM):** The standard for defining mental illness.

***Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5):** DSM-V is published by the American Psychiatric Association and provides guidelines to determine if a person is experiencing a mental disorder. The DSM-5 lists categories of mental disorders and clinically significant behaviors that are associated with a diagnosis.

Dialectical behavior therapy (DBT): Provides individual therapy and group therapy during which participants work on skills training. Skills training focuses on coping techniques.

Disorganized schizophrenia disorder: Disorganized schizophrenia disorder occurs when a patient demonstrates disorganized behavior such as inappropriate responses to situations and decreased ability to perform activities of daily living. The patient may not make sense when speaking.

Displacement: A patient redirects an emotional response to a less threatening person such as a wife yelling at her husband when she received a traffic ticket rather than at the police officer who issued the ticket.

Dissociation: A patient temporarily postpones feelings to avoid emotional distress such as a patient who shows no emotions following a motor vehicle accident.

Dissociative amnesia: Dissociative amnesia occurs when the patient has acute memory loss related to stress, causing them to be unable to recall personal information. Researchers have found that many patients realize they experienced amnesia. Some patients are unaware that they experienced amnesia but realize that a period of time has passed during which they are unable to recall what occurred.

Dissociative fugue: Dissociative fugue occurs when the patient leaves home to escape from a stressful event during which they temporarily assume a new identity. During an episode of dissociative fugue, the patient is able to perform activities of daily living under their new identity, which is more outgoing than their normal behavior. The patient may experience amnesia of the episode. Episodes can last a few hours or months.

Dissociative identity disorder: Dissociative identity disorder occurs when a patient has two or more personalities, each of which can control their behavior, relationships, and memories. Dissociative identity disorder was known as multiple personality disorder. Researchers have found that the primary personality has a strong moral sense and subsequent personalities have opposing personality traits such as being overly sexual or aggressive. The primary personality may be unaware of subsequent personalities. A stressful or social event can trigger change in personality.

Distorted communication: Communication where part, but not the entire, message is received.

Distortion: A patient redefines reality to justify their perception of reality such as the patient didn't abuse prescribed medication. He only took a few extra pills to make them feel better.

Distraction: Attention is temporarily given to a different situation, resulting in decreased anxiety from a stressful situation.

Doctor shopping: A patient engages a series of practitioners looking for practitioners who will give the treatment requested by the patient.

Dopamine: A neurotransmitter that has a role in pleasure, cognition, attention, attention deficit disorder, Parkinson disease, and schizophrenia.

Dream-like state: A strange feeling of detachment from the real world.

Dreams: Primarily occur during REM sleep, although researchers believe some dreams occur during NREM sleep. Researchers are unsure of the reason for dreams. Some dreams appear to be illogical and of bizarre thoughts, whereas other dreams are based on the person's experiences. Researchers disagree about the purpose of dreams. Some researchers believe dreams are a way a person forms permanent memory, whereas other researchers view dreams as random brain activity.

Drug therapy: Drug therapy is a therapeutic approach that uses medications to modify the chemical balance in the brain that results in change in behavior and attitudes.

Dysfunctional sensory: There is a disconnect causing a misinterpreting of sensory signals to the brain.

Dyspareunia: Pain related to intercourse.

Dysthymic disorder: Dysthymic disorder occurs when a patient has a mild depression for 2 years that may or may not disrupt activities of daily living. Dysthymic disorder can also affect children; however, the child exhibits signs of dysthymic disorder for 1 year or more. In many cases, the patient is unaware that they have dysthymic disorder.

Eccentric behavior: Unusual, odd behavior.

Effective listening: Uses observations (e.g., body language) and understanding words to identify and interpret the message that the patient wants to convey.

Electroconvulsive therapy (ECT): ECT applies electrical current into the patient's brain, resulting in 30- to 60-second seizures. Treatment is given three times a week for 6 weeks and is an alternative when the patient does not respond to antidepressive medication.

Electroencephalogram (EEG): Measures brain wave activity.

Electrolyte imbalance: An imbalance in minerals required to maintain bodily functions.

Electromyogram (EMG) machine: Measures muscle tone activity.

Electrooculogram (EOG): Measures eye movement.

Emotion: A specific intense feeling that is triggered by an event.

Environmental conditions: Environmental conditions are distance (the space between the nurse and the patient during the communication process); territoriality (who "owns" the space where the communication takes place. For example, the patient "owns" the space in their room. The nurse "owns" the space at the nurse's station. A conference room is a neutral territory where no one "owns" the space); and density (the number of participants in the communication).

Erectile disorder: The patient is unable to attain or maintain an erection during sexual activity. The condition must be recurring or persistent. The patient has distress or interpersonal difficulty related to the disturbance.

Evaluation: Determine the effectiveness of the intervention.

Exhibitionism: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors related to exposing their genitals to unwitting strangers. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Existential model: A person should be in contact with their emotions and needs based on current experience. A person focused on past experiences may become self-alienated and is likely to display abnormal behavior.

Family crisis: A family crisis is an event that disrupts a family such as divorce.

Family therapy: Family therapy is a therapeutic approach that focuses on behavior that interferes with a working family relationship. One or more members of the family may have psychiatric problems, which are resolved during family therapy sessions.

Fantasy: A patient enters into unrealistic beliefs when they are unable to cope with reality such as a patient who believes they do not have a mental illness.

Fear of abandonment: A persistent anxiety over being without a group or persons who provide support.

Female sexual arousal disorder: Unable to attain or maintain lubrication or swelling during sexual arousal.

Fetishism: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors involving nonliving objects. Nonliving objects are not limited to cross-dressing or objects that stimulate the genitals. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Fight or flight response: The fight or flight response is also referred to as the alarm reaction stage. According to the general adaptation syndrome, the body attempts to adapt to the stressor by either confronting the stressor (fight) or avoiding the stressor (flight).

Fixity of Beliefs Questionnaire: This questionnaire is used to measure the ability of a patient to change a belief.

Flashback: This is an involuntary recurrent memory of powerful experience that can result in the person reliving the experience.

Flight of ideas: The conversation changes quickly to a series of unrelated topics.

Flooding therapy: Flooding is used to treat phobias by exposing the patient to the situation that causes the patient's anxiety and allowing them to experience anxiety. The patient remains in the situation without coaching and is expected to confront the problem. The patient's anxiety will reduce over time, and they will be able to cope with situation.

Force vomiting: The patient induces vomiting.

Frotteurism: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors related to rubbing their genitals against a nonconsenting stranger. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Functional Dementia Scale: Functional Dementia Scale measure's the patient's ability to perform activities of daily living. During the test, the patient is asked to do things such as put on clothes and pour juice to assess how well the patient can care for themself.

GABA neurotransmitter: Decrease in GABA is related to increased symptoms of anxiety. Alcohol and benzodiazepines modify GABA, thereby lowering anxietys

Gamma-aminobutyric acid (GABA): A neurotransmitter that slows down activities of nerve cells.

Ganglion: Is a group of nerve cells that form a nerve center outside the central nervous system.

Gender identity disorder: Gender identity disorder occurs when a patient is uncomfortable with their anatomic gender, leading them to present as a person of the opposite gender. The patient may dress and take on mannerisms of the opposite sex and desire to have surgery to change their body image. A patient shows signs of gender identity disorder by adolescence.

General anxiety disorder (GAD): GAD is a chronic disorder that develops over time. General anxiety disorder occurs when a patient becomes overwhelmed by disproportionally anticipating future events, leading them to become dysfunctional. The patient is unable to cope with anxiety because they misinterpret events. The patient is at risk for self-medication with alcohol or medication that is not prescribed to them.

Global Assessment of Functioning scale: Global Assessment of Functioning scale is a subjective scale assigned to a patient based on their social, occupational, and psychological functioning.

Global Deterioration Scale: Global Deterioration Scale assesses primary degenerative dementia. The patient is tested for neurologic function such as memory and orientation.

Glutamate: A excitatory neurotransmitter and the most common neurotransmitter in the body. Glutamate increases the probability that a neuron will send an impulse. Glutamate has a role in learning and memory and in early development of the brain. Decreased levels of glutamate are associated with schizophrenia, depression, obsessive-compulsive disorder , and autism.

Grandiose behavior: Unrealistic sense of superiority.

Group dynamics: A group is composed of people each of whom has a personality, beliefs, and a way they interact with others.

Group therapy: Group therapy is a therapeutic approach where a therapist works with a small group of patients who experience the same or similar psychiatric problems to resolve those problems with assistance from other members of the group.

Gustatory hallucinations: Tasting something without anything being in the patient's mouth.

Hallucinations: A hallucination occurs when a patient hears or sees something that is not real such as hearing voices or seeing bugs.

Hallucinogen: A hallucinogen causes distortion of reality. A hallucinogen may produce a feeling of detachment from the patient's body or produce visual and spatial distortions. Patients may report being able to see sound and hear color.

Hallucinogen abuse disorder: Hallucinogen abuse disorder occurs when the patient purposely uses a hallucinogen to cause distortion of reality. There is no known medical use for most hallucinogens, although psilocybin is used for religious rites in Mexico and peyote is used by some Native Americans.

Hippocampus: The hippocampus is involved in creating new memories and controls the hypothalamic–pituitary–adrenal (HPA) axis, which influences moods. Decreased activities in the hippocampus are seen in patients who have signs and symptoms of mood disorder.

Histrionic personality disorder: Histrionic personality disorder occurs when a patient is excessively emotional and exaggerates gestures and language to gain attention and dominate the conversation. Emotions are shallow and can change quickly to extremes. The patient is focused on outward appearance and dress to become the center of attention.

Hot/cold application: Applying heat for 20 minutes then cold for 20 minutes.

HPA axis: The HPA axis involves interaction with the hypothalamus, pituitary gland, and adrenal gland. When a stimulus is seen as a threat (stressor), the hypothalamus releases corticotrophin-releasing hormone (CRH) into the bloodstream. CRH causes the pituitary gland to secrete adrenocorticotropic hormone (ACTH) into the bloodstream, signaling the adrenal gland to secrete cortisol into the bloodstream. Cortisol decreases inflammation and increases the use of glucose, leading to the body adapting to the stressor (adaptive response).

Humanistic model: Maslow Hierarchy identifies six levels of need. A person needs to meet lower-level needs before striving for higher-level needs.

Humor: A patient uses witticism or self-deprecation to express feelings that are too unpleasant to address seriously such a making light of death.

Hypoactive sexual desire disorder: The patient must have diminished or no sexual fantasies or sexual activity. The patient rarely initiates sexual activity or is reluctant to participate in sexual activity. The patient has distress or interpersonal difficulty related to the disturbance.

Hypochondriasis: Hypochondriasis is a disorder where the patient believes that they have a medical disorder despite no evidence to support the belief. The patient believes symptoms of the suspected medical disorder are real. The patient excessively focuses on having an illness and frequents a physician asking the physician to authorize unnecessary medical tests. Furthermore, the patient is not attention seeking.

Hypocretin: Is a neurotransmitter involved in wakefulness. The decrease is related to loss of brain cells that produce hypocretin and leads to sudden loss of muscle tone.

Hypomanic mood: A less intense manic mood without psychotic features.

Hypothalamus: This is a the portion of the brain that is responsible for thirst, hunger, sleep, and body temperature and influences hormonal production that affects behavior.

Idealization: A patient perceives that another individual has more positive attributes than the individual has, such as a patient who perceives that a nurse is better than them.

Ideas of reference: The patient believes that the patient was involved in an event that has occurred, although the patient has no involvement in the event, such as a patient who feels they caused an airplane to crash.

Identification: A patient unconsciously adopts the characteristics and behaviors of another person such as a patient adopting the perceived characteristics of a celebrity.

Implementation: Implementation portion of the care plan identifies psychiatric interventions that the nurse will do to accomplish the short-term psychiatric goal.

Impulsive behavior: Acting without little forethought about the consequences of an action.

Incompetence: The patient lacks the capacity to make decisions.

Individual therapy: Individual therapy is a therapeutic approach where a therapist works one-on-one with the patient to identify and resolve the patient's psychiatric problems.

Inhalant abuse disorder: Inhalant abuse disorder occurs when a patient inhales chemical vapors that create an altered mental state, creating a euphoric feeling commonly referred to as a buzz. The vapor is released into a bag in a process called bagging or huffing. The patient inhales vapors from the bag through their nose or mouth. Some patients soak a rag with the chemical and either place the rag into the bag or inhale vapors directly from the rag. The euphoric effect lasts briefly, causing the patient to increase use of the inhalant to seek the high.

Intellectualization: A patient distances himself from emotional distress by focusing on the intellectual components of a situation through rituals, magical thinking, and rationalization such as a patient who procedurally describes a traumatic event.

Interdisciplinary psychiatric care plan: Contains the patient's healthcare problems that were identified when the patient was assessed by each member of the healthcare team and contains actions for the healthcare team to take to minimize or resolve those problems.

Interpersonal model: A person's behavior is governed by the desire to be satisfied and to avoid anxiety. The nurse's therapeutic relationship with the patient develops trust that is used to satisfy the patient's needs.

Introjection: A patient identifies with an object to the extent that the object becomes part of the person such as car that brings perceived social status to the patient.

Involuntary status: An involuntary patient has the same rights as a voluntary patient except that the patient cannot be voluntarily discharged from the healthcare facility.

Irregular sleep–wake rhythm: Occurs when the patient sleeps at different times during the day and commonly multiple times a day.

Isolation: A patient separates feelings from an emotional event while describing the event such as a patient who describes the death of his parent in concrete terms.

Lack of motivation: The patient is unable to begin activities.

Legal commitment: Legal commitment is a process by which a judge requires a patient to undergo treatment. Commitment laws are set by state statute and are therefore unique to each state.

Limbic system: A system within the brain that controls emotions, sex, and hunger.

Locked seclusion: Locked seclusion is placing the patient in the seclusion room and locking the door, preventing them from leaving the room if they become violent.

Long-term psychiatric goal: A long-term psychiatric goal is an outcome that typically requires multiple steps to achieve the psychiatric outcome.

Looking at self from afar: A dream-like state where the patient feels detached from their body.

Loose associations: The conversation moves to a different but related topic.

Magical thinking: The patient has an irrational belief about what causes an event, such as placing a spell on a person will cause the person to experience an adverse event.

Major depression disorder: Occurs when a person is persistently depressed, leading to loss of appetite and an inability to get sufficient sleep. The person is unable to experience joy. The person has one or more depressive episodes lasting 2 weeks or more. The patient is unlikely aware that they have major depression disorder and therefore does not seek treatment. Major depressive disorder is different from situational depression. In situational depression, the person is able to return to a normal mood without treatment. Major depressive disorder has periods of remission. Occurrence of major depression disorder increases with age.

Malingerer: A patient exaggerates signs of mental illness to avoid being discharged.

Manic mood: A patient shows intense irritation and agitation along with psychotic features.

Maturational crisis: A maturational crisis is an event of normal life changes such as changes that occur with aging.

Medical diagnosis: A diagnosis of a medical condition based on signs, symptoms, and test results.

Medical model: Abnormal behavior is caused by an underlying disease that affects neurochemicals in addition to socioenvironmental factors. Treatment of the abnormal behavior focuses on addressing the underlying disease.

Melatonin: A hormone that some patients take to treat circadian rhythm sleep disorders.

Mental health: There is no universal consensus on the definition of mental health primarily because there is no way to objectively measure mental health.

Mental Health Systems Act of 1980: This act created a bill of rights for psychiatric patients.

Mental illness: Mental illness is a psychological or behavioral disorder that alters thinking, mood, and the ability to perform activities of daily living and to relate to others.

Mental retardation: Mental retardation is a disorder where a child's general intellectual function is below an IQ of 70, resulting in the child developing slower than other children of their age.

Mental status examination: Mental status examination is used to assess the patient's psychological function and dysfunction that might have led them to ask for help. The mental status examination focuses on the patient's cognitive functions such as judgment, reasoning, problem solving, thought pattern, and other factors that can provide insight into their mental function.

Methods of communication: Ways in which the nurse and patient communicate with each other.

Milieu therapy: Milieu therapy is a therapeutic approach that uses shared responsibilities and rules within a therapeutic community to influence changes in the patient's behavior and attitudes.

Minnesota Multiphasic Personality Inventory (MMPI): The MMPI is a written test that assesses the patient's personality traits to help identify if they are potentially violent or a risk for suicide.

Misinterpreting signs and symptoms: The practitioner recognizes signs and symptoms but associates them with a wrong diagnosis.

Models of human behavior: Models of human behavior are used collectively in caring for a patient rather than basing care on a particular model. The psychiatric nurse can apply the appropriate model to help meet the patient's needs.

Monoamine oxidase inhibitors (MAOI): A type of antidepressant that requires diet restrictions because of the risk of hypertension when taken with certain foods or medication.

Mood: A temporary feeling generally described as positive or negative, commonly referred to as a good or bad mood.

Mood swings: Alternating between good and bad moods.

Most recent episode: The patient's current or last episode.

Most recent episode mixed: The patient's current or last episode was manic and depressive.

Most recent episode unspecified: The patient's current or last episode did not meet the clinical definition of manic, hypomanic, or depressive moods.

Multi-axial system: Used to describe the patient's behavioral health assessment based on clinical disorders, personality disorders, mental retardation, and general medical medication. DSM-5 has discontinued the use of the multi-axial system.

Multiple personality disorder: The original name for dissociative identity disorder.

Multiple sleep latency test (MSLT): Measures the patient's tendency to fall asleep during the day. The patient takes five naps each separated by 2 hours of being awake. The study determines if elements of REM sleep occur at inappropriate times when the patient is awake.

Narcissistic personality disorder: Narcissistic personality disorder occurs when a patient creates a perception of superiority and is preoccupied with self-absorption. The patient wants only to associate with others who they perceive are superior. The patient strives to overachieve and is obsessed with perfection. The patient panics whenever there is a threat to their ego from any kind of failure.

Narcolepsy disorder: Narcolepsy disorder occurs when the patient experiences sleep attacks that suddenly and without warning cause the patient to fall into a deep sleep for up to 20 minutes. The sleep attack may begin with sudden loss of voluntary muscle tone leading to the patient going limp (cataplexy). The patient may also be paralyzed immediately before sleeping or immediately upon awakening. During sleep, the patient may experience hallucinations or vivid dreams.

Narcotics Anonymous (NA): A 12-step program that helps the patient stay in recovery. The 12-step program is facilitated by recovering drug abusers.

Negative symptom: A normal behavior that is absent.

Neural pathway: A specific route through the network of neurons that carries an impulse to a specific destination.

Neurons: Specialized cells that compose the brain and nervous system.

Neurotransmitter: A chemical message that transmits neural impulses between neurons.

Nicotine dependent disorder: Nicotine dependent disorder occurs when the patient requires nicotine to perform activities of daily living. Nicotine is found in tobacco. The patient inhales nicotine when smoking a cigarette, pipe, or cigar. Nicotine can also enter the body by sniffing snuff and chewing tobacco. Each cigarette contains a minimum of 10 mg of nicotine and delivers 2 mg of nicotine to the bloodstream.

Nightmares: Bad dreams that occur during REM sleep.

Night terror: A type of dream that occurs during NREM sleep during which the person awakens in a state of terror screaming and frightened. The person may experience the physiologic signs of terror such as sweating, increased breathing, and increased heart rate. Furthermore, the person is unable to describe what has occurred.

Non-24-hour sleep–wake syndrome: Occurs when the patient sleeps later each day.

Nonpurging bulimia: The patient binges on food, and then goes on a strict diet, exercises heavily, or fasts to prevent weight gain.

Non-rapid eye movement (NREM): The period of sleep when there is no rapid eye movement.

Nonverbal communication: Nonverbal communication factors are facial expressions, maintaining eye contact, posture, appearance, and paralanguage that conveys emotion (volume, intonation of speech, pitch that modifies meaning of the verbal message).

Noradrenaline: A neurotransmitter that influences alertness. An increase in noradrenaline increases alertness, and a decrease in noradrenaline decreases alertness.

Norepinephrine neurotransmitter: This is a hormone and neurotransmitter secreted by the adrenal medulla that causes vasoconstriction, and increased blood pressure, heart rate, and glucose levels.

North American Nursing Diagnosis Association (NANDA): The organization that defines requirements for each nursing diagnosis.

Nursing Model: A holistic approach is used to care for the person. The nurse develops a therapeutic relationship with the person that focuses on the person's bio-psychosocial needs. Nursing interventions are determined by the person's reaction to the therapeutic relationship with the nurse.

Obsession: The patient is unable to stop thinking about an idea such as becoming a billionaire.

Obsessive-compulsive disorder (OCD): OCD occurs when a patient has obsessions, which are recurrent unwanted intrusive thoughts, and compulsions, which are repetitive behaviors used to address obsessions.

Obsessive-compulsive personality: A person's personality causes recurrent unwanted intrusive thoughts (obsessions) and repetitive behaviors used to address obsessions (compulsions).

Obsessive-compulsive personality disorder: Obsessive-compulsive personality disorder occurs when a patient sees everything as good or bad and is focused on perfection, leading to becoming inflexible in thoughts and actions. The patient has a sense of righteousness and becomes angry when challenged. The patient demonstrates poor social skills and is unable to accept anyone who has a difference of opinion. The patient is unable to make a decision for fear of making the wrong decision. Focus is on rules and order and not the task at hand.

Obstructive sleep apnea syndrome (OSAS): Increased size of the tongue or soft palate blocks the airway for up to a minute when the patient sleeps. The blocked airway increases the level of carbon dioxide in the blood causing the brain to arouse the patient. The patient awakens briefly to reposition, causing the airway to open, and then falls back to sleep and the cycle repeats. However, the patient does not remember awakening during the night.

Olfactory hallucinations: Smelling an odor that does not exist.

Open seclusion: Open seclusion can be used to give the patient a time-out to compose themself away from the distraction and stimulus of the unit. In this scenario, the seclusion door is open and the patient is free to leave the seclusion room at any time.

Opioid dependent disorder: Opioid dependent disorder occurs when a patient becomes psychologically and physiologically dependent on opioids. Opioids are narcotic analgesics that bind to the opioid receptors in the central nervous system, peripheral nervous system, and gastrointestinal tract that result in the decreased perception of pain. Some opioids such as codeine are also used for suppressing cough and stopping diarrhea.

Oppositional defiant disorder: A child has a pattern of defiant, hostile, and disobedient behavior to parents, family, teachers, and any authoritative figure. Defiance is part of normal development and occurs related to an event such as the child being overtired and hungry. Oppositional defiant disorder occurs without an event triggering an episode.

Organelles: Specialized parts of the cell that conduct cell activities and are analogous to organs within the body.

Orgasmic disorder: The patient has delayed or absence of orgasm after the sexual arousal phase of the sexual response cycle.

Orientation phase: The nurse is introduced to the patient and defines the nurse's role and the patient's role in the therapeutic relationship.

Overly dependent on others: A person becomes less self-sufficient and depends on others for activities of daily living.

Pain disorder: Pain disorder occurs when the patient reports persistent pain that results in disruption of the patient's activities of daily living. However there is either no medical basis for the pain or the medical cause of pain is not as debilitating as presented by the patient. Pain disorder is caused by underlying psychological factors. There may be exacerbations and remissions of symptoms of pain disorder.

Panic attack: This is an unexpected period of high anxiety and feeling of doom resulting in the patient being unable to perform activities of daily living. The patient is preoccupied between panic attacks anticipating the next panic attack because panic attacks occur without a triggering event.

Panic disorder: Panic disorder occurs when a patient experiences unexpected periods of high anxiety and feelings of doom resulting in them being unable to perform activities of daily living. The patient is preoccupied between panic attacks anticipating the next panic attack because panic attacks occur without a triggering event.

Paranoid personality disorder: Paranoid personality disorder occurs when the patient has unreasonable mistrust of others and assumes that others have hostile intentions against the patient. The patient feels others have conspired to undermine them, and they would rather rely on their ability than rely on others. Loyalty to the patient is always being questioned, and suspicion of being disloyal leads to breaking off or distancing from the relationship.

Paranoid schizophrenia disorder: Paranoid schizophrenia disorder occurs when the patient has delusions of grandiosity or persecution that are not based in reality. The patient may experience auditory hallucinations and hear voices that are not present. Stress can increase symptoms of paranoid schizophrenia.

Paranoid thinking: Paranoid thinking occurs when a patient is mistrusting of the psychiatric nurse and others. The psychiatric nurse should appear nonthreatening and make no movement that could be misinterpreted as a threat.

Paraphilia: Paraphilia is abnormal and extreme sexual behavior whereby a person is sexually aroused and sexually engages with inanimate objects, or children, inflicts self-suffering and humiliation, or imposes suffering and humiliation on the sexual partner.

Paraphilia disorder: Paraphilia disorder occurs when a patient has intense recurrent sexual fantasies with uncontrollable urges to engage in behaviors that are not sexually arousing to others. As a result, the patient incurs or is at risk of incurring significant social, legal, or employment problems. Sexual fantasies and behaviors become paraphilia disorder if they harm the patient or others and prevent development of normal, healthy relationships for the patient.

Parasympathetic nervous system: The parasympathetic nervous system is also referred to as the cholinergic system and is used to inhibit activities of the body such as decreasing the heart rate.

Partial hospital program: Day programs during which the patient is assigned to one group during the course of treatment. The group has five sessions daily. Each session focuses on coping skills or psychotherapy. Each patient receives one-on-one counseling.

Passive aggression: A patient is an obstructionist demonstrated by procrastination, learned helplessness, stubbornness, and a deliberate attempt to fail such as a patient who refuses to speak with the physician because they dislike medication that the physician prescribed to them.

Patient rights: Legal rights that govern how a patient is treated in a hospital.

Pedophilia: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors related to engaging in sexual activity with a prepubescent child. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function. The patient is at least 16 years of age and 5 years older than the child.

Peripheral nervous system (PNS): The PNS consists of neurons outside of the brain and spinal cord. There are two subdivisions of the PNS; these are the somatic nervous system (SNS) and the autonomic nervous system (ANS).

Persecutory delusions: Persecutions that are not based in reality.

Phobia: Phobia is persistent disproportionate fear of a situation or object that causes the patient significant distress that disrupts their activities of daily living. For example, a patient may have a fear that an elevator will fall when they ride an elevator.

Physical dependency: The patient experiences withdrawal symptoms that subside when they use a substance. The patient is unable to stop ingesting the substance regardless of its consequences.

Polysomnogram: Monitors the patient when the patient is sleeping to determine abnormalities in the patient's sleep cycle.

Positive conditioning: Positive conditioning exposes a patient to positive reinforcement while gradually exposing the patient to situations that cause the patient's anxiety.

Positive symptom: A symptom that appears when the patient has an episode of schizophrenia disorder.

Positive/negative findings: The daily psychiatric assessment determines positive signs of mental illness and negative signs of mental illness.

Posttraumatic stress disorder (PTSD): PTSD occurs when a patient experiences severe anxiety, flashbacks, and nightmares about a previous traumatic event in their life. The traumatic event may directly involve the patient, such as being involved in a severe automobile accident, or indirectly involve the patient, such as witnessing a severe automobile accident.

Poverty of speech: The patient provides terse replies when someone tries to converse with them.

Preexisting condition: Preexisting conditions are beliefs, knowledge, developmental level, culture, social status, and religion.

Prefrontal cortex (PFC): The PFC is involved in judgment, problem solving, and decision making. In addition the PFC is involved in short-term memory and retrieving long-term memory. During stress, the PFC helps to control the amygdala. Researchers have seen that decreased activity in the PFC occurs in patients who display signs and symptoms of ADHD and PTSD.

Preinteraction phase: The nurse assesses unresolved problems presented by the patient with or without their active participation.

Premature ejaculation: The patient experiences ejaculation and orgasm with minimum sexual stimulation. The condition must be recurring or persistent. The patient has distress or interpersonal difficulty related to the disturbance.

Preservation: The patient uses few words to respond to questions.

Primary hypersomnia disorder: Primary hypersomnia disorder occurs when a patient has excessive sleepiness in the daytime that is not caused by secondary hypersomnia disorder. Secondary hypersomnia disorder occurs as a result of an underlying factor such as shift work, insomnia, depression, or a medical disorder.

Primary insomnia disorder: Primary insomnia disorder occurs when the patient is unable to either go to sleep or unable to remain asleep or awakens too early, resulting in nonrestorative sleep. Primary insomnia is not caused by an underlying medical or psychiatric disorder or medication. This is referred to as secondary insomnia.

Process recording: Process recording is a document that contains a verbatim record of the conversation between the psychiatric nurse and the patient and is used by the psychiatric nurse to assess whether the conversation was therapeutic. Information in the processing recording is not part of the patient's chart.

Prodromal phase: The patient shows decreased functionality such as poor hygiene, lack of motivation, and withdrawal from society. The patient is able to work, although there is a marked decrease in performance. This stage occurs about a year before the patient is hospitalized.

Protection: A patient shifts their unacceptable feelings, such as prejudice and jealousy, to someone else, such as a patient saying that a politician was elected because of their race.

Psychiatric assessment test: These tests may provide insight into a patient's problem the moment they are administered the test. A psychiatric test is not used to definitively diagnose a psychiatric disorder.

Psychiatric care plan: A plan to treat a psychiatric disorder by the healthcare team.

Psychiatric intervention: Activities that will be performed by the nurse to accomplish short-term psychiatric goals.

Psychiatric outcome: The results of a psychiatric intervention.

Psychiatric status rating scale for body dysmorphic disorder: A measurement tool used to assess the degree of body dysmorphic perception of a patient diagnosed with body dysmorphic disorder.

Psychoanalytic model: Freud proposed five stages of psychosexual childhood development (oral, anal, phallic, latency, and genital). Disruption in psychosexual childhood development results in deviated behavior as an adult.

Psychological dependency: The patient has compulsive thoughts about acquiring and using a substance. The patient views the substance as a means to achieve a positive feeling and avoid negative feelings. The patient is preoccupied with acquiring the substance.

Psychotherapy: Psychotherapy is a therapeutic approach that explores the underlying cause of the psychiatric disorder with the goal of changing behavior and attitudes.

Purging: Force vomiting.

Purging bulimia: The patient binges on food and then uses enemas, laxatives, diuretics, or self-induced vomiting to purge food or partially digested food from the body.

Rapid eye movement (REM): The period of sleep when there is rapid eye movement. REM is called paradoxical sleep and occurs four or five times during a sleep cycle of about 8 hours in a 24-hour period. It is during REM sleep that a person's eyes move rapidly. Brain activity increases. REM sleep is associated with dreaming. The reason for dreams remains unknown. REM sleep lasts for a period of 10 to 30 minutes.

Rationalization: A patient makes excuses through faulty reasoning that a wrongful act was either not done or the patient was justified for performing the wrongful act, such as a patient who states that they had to take their sister's car without permission because they had a job interview.

Reaction formation: A patient displays a behavior opposite to the behavior that the patient wants to display such as being calm when the patient faces a dangerous situation.

Receptor: A component of the dendrite that binds to a specific neurotransmitter causing the receiving neuron to generate an electrical impulse.

Recovery: The process of coping with life's challenges without the assistance of a substance. Recovery begins when detoxification ends. However, there is no end to recovery.

Recurring hypersomnia disorder (Kleine–Levin syndrome): During exacerbation that lasts for weeks, the patient experiences excessive tiredness and prolong sleep for up to 21 hours a day.

Regression: A patient temporarily reverts to an earlier stage of development rather than coping with a situation in an age-appropriate way such as a patient who throws a tantrum when they don't get a room change.

Relationship: The way two people connect with each other. There are various types of relationships, such as a causal, friendly, professional, collegial, business, and intimate relationships.

Repression: A patient moves thoughts of a disturbing event to the unconscious, preventing the thoughts from entering consciousness, such as lack of awareness or memory lapse; for example, a patient says they don't recall if their father abused medication when their father died of a drug overdose.

Residual phase: The patient demonstrates more negative signs of schizophrenia disorder than positive signs. Positive signs do not have a material effect on the patient's behavior. The patient's baseline functionality stabilizes.

Residual schizophrenia disorder: Residual schizophrenia disorder occurs when the patient, after experiencing an episode of schizophrenia, continues to exhibits less pronounced symptoms such as delusions and hallucinations.

Response prevention therapy: Response prevention is used to treat patients who experience compulsive behavior by redirecting or distracting the patient when they are about to express the compulsive behavior.

Restorative theory: Sleep provides an opportunity for the body to repair. This is supported by studies that show that major restorative functions occur during sleep such as tissue repair, muscle growth, release of growth hormone, and protein synthesis.

Restraint: Involuntary confinement where arms and legs of the patient are strapped to the bed to prevent the patient from self-injury.

Reuptake pump: A component of the sending neuron that causes the neurotransmitter to be taken back into the axon that originally released the neurotransmitter for reuse.

Rorschach Test: Rorschach Test is similar to the Thematic Apperception Test except that the patient is shown 10 ink blots and is asked to describe what they see.

Safe foods: Foods low in calories.

Schizoid personality disorder: Schizoid personality disorder occurs when a patient is withdrawn from social involvement and prefers to be alone than to be with others. The patient's focus is on activities that the patient can perform alone. The patient is not concerned about criticism or the feelings of others.

Schizophrenia: Schizophrenia is a mental illness characterized by a person's abnormal misinterpretation of reality referred to as psychosis. The person's behavior seems bizarre to others because the behavior is inappropriate to reality. However, the behavior is appropriate to the person based on the person's misperception of reality.

Schizotypal personality disorder: Schizotypal personality disorder occurs when a patient displays eccentric behavior and has severe social anxiety based on an underlying belief that others are trying to do harm. The patient may exhibit short periods of minimum psychotic symptoms during periods of stress.

Seclusion: Seclusion is placing the patient in a room that isolates the patient from other patients when the patient becomes agitated and is at risk of injuring themself or others.

Selective serotonin reuptake inhibitors (SSRI): Medication that affects a narrow set of neurotransmitters resulting in fewer side effects than non-SSRI medication.

Self-awareness: The patient is aware of their body and mental process.

Self-care deficient: Activities of self-care that cannot be performed by the patient such as hygiene.

Self-centered behavior: A person who is engrossed in themself with little or no regard for the feelings of others.

Self-destructive behavior: Behavior that negatively impacts a person's well-being.

Self-image: A person's image of themself.

Self-imposed starvation: A person intentionally refuses to ingest food.

Self-induced vomiting: A person intentionally causes vomiting.

Sensory perception: The patient experiences misperceptions referred to as illusions or hallucinations. An illusion is caused by the presence of an external stimulus such as reflection of the sun on the desert giving the illusion of water. A hallucination occurs in the absence of an external stimulus such as hearing voices when no one is speaking (auditory); seeing things that are not there (visual); touching things that are not there (tactile); tasting things that are not present (gustatory); and smelling things that are not there (olfactory).

Sentence Completion Test: Sentence Completion Test is used to assess the patient's anxieties, aspirations, and other elements of the patient's personality. During the test, the test administrator asks the patient to complete a series of sentences such as, "When I am angry I. . . ."

Serotonin: A neurotransmitter that helps control mood, appetite, and sleep. Decreased levels of serotonin may result in depression. Antidepressant medication blocks the reuptake of serotonin, causing the serotonin to remain in the synapse and leading to a more stable mood.

Sex therapy: The goal of sex therapy is to become reassured about sexual activities.

Sexual aversion disorder: Dislike and avoidance of sexual contact.

Sexual dysfunction disorder: Sexual dysfunction disorder occurs when the patient experiences disturbance during the sexual response cycle.

Sexual masochism: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors related to causing suffering to themselves or others, such as cutting, burning, or verbal humiliation. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Sexual sadism: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors related to inflicting suffering on the patient's sexual partner. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Short-term psychiatric goal: A short-term psychiatric goal is a clinical goal that achieves a portion of a long term psychiatric goal.

Single manic episode: The patient experiences only one manic episode and no signs of a depressive mood.

Sleep: A absence of consciousness, inactivity of voluntary muscles, and absence of sensory activities that occurs for approximately 8 hours each day. The ability of a person to react to stimuli is diminished but not totally absent, enabling the person to be aroused. Brain activity, breathing, and other psychological functions change but remain active. The amount of physiologic activity depends on the stage of sleep.

Sleep cycle: Four stages of brain activity that occur when the person is sleeping.

Sleep deprivation: A condition where the patient does not have sufficient sleep, leading to fatigue, decreased cognitive function, and daytime sleepiness.

Sleep hygiene: How a person prepares for sleep.

Social model: Abnormal behavior is defined by the patient's sociocultural environment. A behavior may be acceptable in one society but considered abnormal in another society.

Social phobia: Social phobia is the fear of being scrutinized by others such as when speaking in public speaking and engaging with people in a social setting.

Somatic nervous system (SNS): The SNS interacts with skeletal muscles to produce conscious movement and respiration.

Somatization: Negative feelings toward others are transformed into a patient's pain, anxiety, or illness, such as a patient who becomes anxious when seeing a staff member they dislike.

Somatization disorder: Somatization disorder occurs when a patient reports recurring physical complaints that suggest an underlying medical disorder but none exists. Onset is usually under the age of 30, and the disorder is more common in females. The patient goes from one practitioner to the other trying to find a diagnosis and treatment. Practitioners are unlikely to find a medical disorder causing the patient's physical complaints. The patient is needy, dependent on others, and demands and manipulates others to support the patient. The patient uses physical complaints to avoid responsibilities. Periods of exacerbation brought on by stress can last for years. Somatization disorder differs from hypochondriasis. Somatization disorder focuses on physical complaints.

Specific phobia: Specific phobia is the fear of a specific object or situation such as flying, bugs, or heights.

Splitting: A patient views a person or situation as either good or bad, such as when a patient tells the nurse that the physician is not a capable medical practitioner.

Stages of adoption: The process a person uses to justify a specific solution.

Stereotypical thinking: Judging another person based on beliefs that may not reflect reality.

Sublimation: A patient transforms a negative emotion into a positive emotion, such as when a patient learns new job skills after losing employment.

Substance abuse: Using a substance in amounts that are harmful to the patient.

Substance abuse anxiety disorder: Substance abuse anxiety disorder occurs when the patient experiences anxiety either when intoxicated or when withdrawing from drugs. Drugs include alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogens, inhalants, phencyclidine (PCP), and prescribed medications.

Substance dependency: See Dependency.

Suicidal gestures: Actions that simulate a suicide attempt but the intention is to gain attention.

Suicidal ideations: Thoughts of killing oneself.

Suicide assessment: Assessment of a patient for the risk of suicide.

Sympathetic nervous system: The sympathetic nervous system is also referred to as the adrenergic system and is used to increase activities of the body such as increasing the heart rate.

Synapse: A synapse is an intercellular space. There is no physical connection between neurons. One neuron can have over 1000 synapses with the neighboring neurons. Neurons are dynamic in that the number of synapses can change based on changes in the environment, commonly referred to as learning.

Systematized: The patient is unable to recall a specific type of information.

Tactile hallucinations: Feeling something that does not exist.

Tangential thinking: The patient's response makes no reference to the question.

Temperament: A personality trait that consists of emotional characteristics such as thinking, behavior, and reacting that lasts for long periods of time or a lifetime.

Termination phase: The nurse ends the therapeutic relationship by summarizing accomplishments and unachieved goals of the working phase and exploring why any goal was not met.

Tetrahydrocannabinol (THC): The active ingredient in cannabis.

The process of relapse: A series of situations that leads the patient to relapse.

Thematic Apperception Test: The Thematic Apperception Test is used to assess the patient's interpersonal relationships and conflicts as well as personality traits. During the test, the patient is presented with pictures of ambiguous situations and asked to tell the examiner what the patient believes is happening in the picture.

Therapeutic communication: Therapeutic communication is the primary tool used in a therapeutic relationship and involves both verbal and nonverbal communication.

Therapeutic relationship: Therapeutic relationship is a relationship between a patient and nurse that provides the framework to help the patient resolve clinical problems using interpersonal communication techniques.

Thought blocking: The patient's speech is interrupted before the patient completes the thought.

Thought broadcasting: The patient believes their thoughts are being transmitted into the environment.

Thought disorders: A patient who has a thought disorder is unable to correctly understand the message sent by the psychiatric nurse.

Thought insertion: The patient believes someone is inserting thoughts into their mind.

Thought stopping: Thought stopping requires the patient to realize they are having unacceptable, to say "stop," and then to refocus on positive thoughts.

Thought suppression: A patient consciously avoids coping with an unpleasant event by pushing thoughts of the event into the preconscious, such as a patient who is faced with credit card bills.

Thought switching: Thought switching requires the patient to substitute positive thoughts for unacceptable thoughts.

Token economy: Token economy is a behavior therapy technique that rewards a patient with a token each time the patient performs an acceptable behavior. At some point during the day, the patient is able to exchange tokens for a privilege or something that the patient values.

Tolerance: The dose of a substance no longer achieves the desired result. The patient requires a higher dose to achieve the desired effect and to prevent withdrawal symptoms.

Tourette syndrome: A child with Tourette syndrome displays involuntary muscle movements and vocal sounds that occur gradually between 2 and 15 years of age. Muscle movements are commonly referred to as motor tics and can affect any part of the body. Vocal sounds are called vocal tics and may involve inappropriate words.

Transactional theory model: Transactional theory model is a model for therapeutic communication. The transactional model is a communication process where a message is sent using face-to-face communication, enabling transmission of verbal and nonverbal messages simultaneously by the psychiatric nurse and the patient.

Transvestitism: For 6 months the patient, who is a heterosexual male, has recurrent sexual fantasies, urges, or behaviors related to cross-dressing. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Traumatic event: A distressing event as a result of trauma that may disrupt the patient's emotions and normal responses.

Treatment plan: A plan to treat medical and psychiatric disorders by the healthcare team.

Tricyclic antidepressants: One of the first types of antidepressants; tricyclic antidepressants have more side effects than the atypical antidepressants that are commonly prescribed for depression.

Trigger: A trigger is an event that can bring about cravings.

Undifferentiated schizophrenia disorder: Undifferentiated schizophrenia disorder occurs when a patient displays general signs and symptoms of schizophrenia such as hallucinations; however, collectively the signs and symptoms do not meet the standards for a specific type of schizophrenia disorder.

Undoing: A patient attempts to reverse an unacceptable behavior by doing an acceptable behavior, such as a patient who acts out and then behaves like an ideal patient.

Vaginismus: Involuntary contraction of the vaginal muscles during penetration.

Vague speech: Unclear use of langue that unintentionally or intentionally is misleading.

Visual hallucinations: Seeing something that is not there.

Voyeurism: For 6 months the patient has recurrent sexual fantasies, urges, or behaviors related to watching an unwitting stranger undress or perform sexual activity. The recurrent sexual fantasies, urges, or behaviors have caused significant distress to the patient's ability to function.

Withdrawal: A patient removes themself from an interaction because they are fearful that the interaction will cause the patient to recall painful thoughts, such as a mother who lost her only son who now refrains from attending family gatherings.

Withdrawal symptoms: As the level of a substance in the bloodstream decreases and the body attempts to compensate for the missing substance, the patient experiences withdrawal symptoms. Withdrawal symptoms are uncomfortable and may cause serious health problems such as seizures depending on the substance. The person reuses the substance to alleviate the withdrawal symptoms.

Word salad: The patient responds using real words but sentences are incoherent.

Working phase: The nurse helps the patient examine unresolved problems and helps the patient achieve goals defined during the orientation phase.

Worthlessness: The patient is unable to recognize their value to themself, or their family, friends, and community.

Index

Note: Page numbers followed by *f* or *t* indicate figures or tables, respectively.

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Z