Psychiatric Nursing Concepts

SELF-CONCEPT
A. Self-concept: all beliefs, convictions, and ideas that constitute an individual’s knowledge of himself or herself and influence the individual’s relationships with others.
B. Self-esteem: an individual’s personal judgment of his or her own worth obtained by analyzing how well his or her behavior conforms to his or her self-ideal.
C. Self-ideal: an individual’s perception of how he or she should behave based on certain personal standards.

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

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

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

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

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

Nursing Interventions
A. Expand self-awareness.
   1. Promote an open, trusting relationship.
   2. Work and expand on whatever ego strength the client possesses.
   3. Maximize the client’s participation in the therapeutic relationship.
B. Self-exploration.
   1. Encourage the client to accept his or her own feelings and thoughts.
   2. Help the client clarify his or her concept of self and relationship with others through appropriate self-disclosure.
   3. Explore with the client maladaptive thinking patterns such as:
      a. Catastrophizing: thinking that the worst will happen.
      b. Minimizing and maximizing: tendency to minimize the positive and maximize the negative.
      c. Black-and-white thinking: tendency to look at situations in extremes; no middle ground.
      d. Overgeneralization: thinking that if something happens once, it will happen again.
      e. Self-reference: tendency to believe that other people are particularly aware of the client’s own mistakes.
      f. Filtering: selectively taking certain details out of context while neglecting to look at more positive facts.
   4. Communicate empathically, not sympathetically, and remind the client that he or she has the power to change himself or herself.
C. Self-evaluation.
   1. Encourage client to define and identify problem.
   2. Identify irrational beliefs such as:
      a. “I must be loved by everyone.”
      b. “I must be competent and never make mistakes.”
      c. “My whole life is a disaster if it doesn’t turn out exactly as planned.”
   3. Identify areas of strength by exploring the client’s hobbies, skills, work, school, character traits, personal abilities, etc.
4. Explore client’s adaptive and maladaptive coping responses.
   a. Determine “pay-offs” for maintaining self-defeating behaviors such as:
      (1) Procrastination.
      (2) Avoiding risks and commitments.
      (3) Retreating from the present situation.
      (4) Not accepting responsibility for one’s actions.
   b. Identify the disadvantages of the maladaptive coping responses.

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

D. Realistic planning.
   1. Help client identify alternative solutions.
   2. Encourage creative visualization to enhance self-esteem through goal setting.
   3. Help client set realistic goals by encouraging him or her to participate in new experiences.

E. Commitment to action.
   1. Providing an opportunity for client to experience success is essential.
   2. Reinforce strengths, abilities, and skills.

**BODY IMAGE**

**Evaluation of Body Image Alteration**

A. Types of body image disturbances.
   1. Changes in body size, shape, or appearance (rapid weight gain or loss, plastic surgery, pregnancy).
   2. Pathologic processes causing changes in structure or function of one’s body (e.g., Parkinson’s disease, cancer, heart disease).
   3. Failure of a body part to function properly (paraplegia or stroke).
   4. Physical changes associated with normal growth and development (puberty, aging process).
   5. Threatening medical or nursing procedures (catheterization, radiation therapy, organ transplantation).

B. Principles.
   1. Body characteristics that have been present from birth or acquired early in life seem to have less emotional significance than those arising later.
   2. Body image changes, handicaps, or changes in body function that occur abruptly are far more traumatic than ones that develop gradually.
   3. The location of a disease or injury greatly affects the emotional response to it; internal diseases are generally less threatening than external diseases (trauma, disfigurement).
   4. Changes in genitals or breasts are perceived as a great threat and reawaken fears about sexuality and virility.

**Alterations of Body Image: Four Phases**

A. Impact phase.
   1. Shows behaviors of despair, discouragement, and passive acceptance.
   2. Often projects guilt onto others.
   3. Senses failure in one’s own body.
   4. Anger and hostility often turned inward.

B. Retreat phase.
   1. Becomes aware of the injury, illness, loss, or disfigurement.
   2. Children and older adults retreat into regressive behavior.
   3. Adolescents and adults retreat into denial.

C. Acknowledgment phase.
   1. A period of mourning the loss.
   2. Acknowledges loss, regardless of the degree involved; no longer can hide or retreat from situation.
   3. Begins to focus on strengths rather than losses.

D. Reconstruction phase.
   1. Adapts to changes in body image.
   2. Encouraged to try new approaches to life.

**SPECIFIC SITUATIONS OF ALTERED BODY IMAGE AND NURSING INTERVENTIONS**

**Alert** Facilitate client’s adjustment to changes in body image.

**Obesity**

**Assessment**

A. Body weight exceeds 20% above the normal range for age, sex, and height.
B. Feeding behavior is gauged according to external environmental cues (i.e., odors, stress, availability of food) rather than hunger (increased gastrointestinal motility).
C. Increased incidence of diabetes, cardiovascular disease, and poor healing.
D. Obese client often has symptoms of depression, fatigue, dyspnea, tachycardia, and hypertension.

**Nursing Interventions**

A. Encourage behavior modification programs.
B. Promote activities and interests not related to food or eating.
C. Identify client’s need to eat and relate the need to preceding events or situations.
D. Decrease guilt and anxiety related to being obese.
E. Provide long-range nutritional counseling.
F. Encourage an exercise program.
**Stroke**

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

**Nursing Interventions**
A. Decrease frustration related to speech problems by encouraging speech effort, speaking slowly, and clarifying statements.
B. Promote reintegration of altered body image caused by paralyzed body part by means of tactile stimulation and verbal reminders of the existing body part.

**Amputation**

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

**Nursing Interventions**
A. Anticipatory guidance and therapeutic preparation of a client who is to undergo amputation.
B. Discussion of phantom limb phenomenon and exploration of client’s fears regarding amputation.
C. Assist family members to work through their feelings and to accept client as a whole person.
D. Acknowledge phantom limb pain; reassure client that this is a normal process.
E. Provide pain medication as needed.

**Pregnancy**

**Assessment**
A. Produces marked changes in a woman’s body, resulting in major alterations in body configuration within a short period of time.
B. Second trimester: woman becomes aware that her body is widening and requires more space.
C. Third trimester: woman is very much aware of increased size; may feel ambivalent about the changes in her body.
D. Woman perceives her body as vulnerable, yet also as a protective container for the unborn.
E. Mate experiences changed body image and sympathetic symptoms during woman’s pregnancy.

**Nursing Interventions**
A. Explain and offer reassurance about the normal physiologic changes that are occurring.
B. Provide discussions of alterations in body image for both mates.
C. Encourage verbalization of feelings relating to changed body image.

**Cancer**

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

**Nursing Interventions**
A. Provide anticipatory guidance to help client cope with crisis of changed body image.
B. Set long-term goals to help client with cancer adjust to physiologic and psychologic changes.

**Enterostomal Surgery**

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

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

**HUMAN SEXUALITY**

**Key Nursing Concepts**
A. Growth and development.
1. Observable differences in male and female behavior are seen as early as infancy.
2. Core gender identity develops in the healthy child at about 3 or 4 years of age.
3. Sexual problems seen in childhood are as follows: sexual misconception, gender identity disturbances, and home settings that cause sexual confusion.
4. Rapid biologic changes seen in adolescence result in anxiety about maturation.
5. The adolescent is faced with the following: establishing his or her identity; accepting a changed body image; coping with new energy; and resolving reappearing Oedipal conflict.
6. Sexual problems seen in adolescents include the following: guilty feelings regarding masturbation; integration of transient homosexual experiences into heterosexual relationship; resolution of conflicts related to premarital intercourse; and obtaining sex-related health services (e.g., birth control).
7. The young adult faces the task of establishing a pattern of heterosexual intimacy.
8. The middle-age adult faces the task of adjusting to physiologic changes in sexual function and the responsibilities of parenting.
9. Sexual activity and interest may continue into old age, provided the individual is healthy and has an interesting partner.

B. Principles.
1. Human sexuality is best understood when approached holistically (i.e., from psychologic, sociologic, and cultural perspectives).
2. The process of hospitalization alters one's concept of self as a sexual being.
3. Sexual role identity may be altered during the illness process.
5. Hospitalized clients may act out sexually to test the response of others to their sexuality, to gain control of a situation, or to attract attention.
6. Sexual problems are addressed through short-term, behavior-oriented treatment; the goal is to decrease fear of performance and to facilitate communication.
7. Nursing plays a key role in sex-health education; nurses need to be aware of their own attitudes toward sex to respond helpfully to clients.

Changes in Sexuality
A. Effect of illness and injury on sexuality.
1. Depressive episodes often precipitate a decrease in libido.
2. Sexual preoccupations and overtones may be experienced by the client with psychosis.
3. Certain medications contribute to sexual dysfunction, failure to reach orgasm in women, and impotence or failure to ejaculate in men (e.g., reserpine, phenothiazine, and estrogen use in men decreases libido; androgen use in women increases libido).
4. Clients with spinal cord injuries may lose sexual functioning.
5. Trauma and disfigurement may precipitate an alteration in sexuality.
B. Effect of the aging process on sexuality.
1. Physiologic changes in women are frequently caused by decreasing estrogen supply, which results in decreased vaginal lubrication, shrinkage and loss of elasticity in vaginal canal, and decrease in breast size.
2. Physiologic changes in men include a decrease in testosterone, decrease in spermatogenesis, and a longer length of time to achieve erection, along with a decrease in the firmness of erection.
3. Prolonged abstinence from sexual activity can lead to disuse syndrome in which the physiologic changes are experienced to a greater degree.

CONCEPT OF LOSS

A. Definition.
1. Includes both biologic and physiologic aspects; loss of function.
2. Components of loss include death, dying, grief, and mourning.
   a. Death: represents finality, the end of one's biologic being.
   b. Dying: the social process of organizing activities that prepare for death; provides others, as well as the client, a way to prepare for the future.
   c. Grief: the sequence of subjective states that follow loss and accompany mourning.
   d. Mourning: the psychologic processes that are aroused by the loss of a loved object or person.
   e. Disenfranchised grief: loss that is not or cannot be openly expressed and acknowledged by others (e.g., miscarriage, birth of a disabled child, death of an ex-spouse, loss of hair during chemotherapy, death of a pet).
B. Nursing care of the dying client (see Chapter 3).

Coping and Reactions to Death Throughout the Life Cycle

A. Infant-toddler (ages 1-3).
   1. Reactions to death and dying.
      a. No specific concept of death: thinks only in terms of living.
      b. Reacts more to pain and discomfort of illness and immobilization; separation anxiety; intrusive procedures; change in ritualistic routine.
   2. Nursing interventions.
      a. Assist parents to deal with their feelings.
      b. Encourage parents’ participation in child’s care.
      c. Promote decreased separation anxiety by providing arrangements for parents to stay with child.

B. Preschooler (ages 3-5).
   1. Reactions to death and dying.
      a. Death is viewed as a departure, a kind of sleep.
      b. No real understanding of the universality and inevitability of death.
      c. Life and death can change places with one another.
d. Death is viewed as gradual or temporary; the person is still alive but under a different set of conditions.
e. Often views illness and death as a punishment for his or her own thoughts or actions.
f. If a pet dies, may request a funeral, burial, or some other type of ceremony to symbolize the loss.

2. Nursing interventions.
   a. Use play therapy for expression of thoughts and feelings regarding death and dying.
   b. Provide a clear explanation of what death is; death is final and not sleep.
   c. Permit a choice of attending a funeral; if child decides to attend, explain what will take place.

**PEDIATRIC PRIORITY** A young child’s fear of death is often a fear ofaloneness, of being away from the parents. It is important for parents to interact with the nurse in the child’s presence so that the nurse can be identified as a trustworthy substitute caretaker.

C. School-age child (ages 5-12).
1. Reactions to death and dying.
   a. Death is personified; fantasies of a separate person or distinct personality (e.g., skeleton-man, devil, ghost, or death-man).
   b. Fantasies about the unknown are often very frightening.
   c. Fear of mutilation and punishment is often associated with death; anxiety is released by nightmares and superstitions.
2. Nursing interventions.
   a. Respond to questions regarding funerals, burials, and memorial services.
   b. Accept regressive or protest behavior.
   c. Encourage verbalization of feelings and emotional reactions.

D. Adolescent (ages 12-18).
1. Reactions to death and dying.
   a. Has a mature understanding of death.
   b. Concerned more with the here and now (i.e., the present).
   c. May have strong emotions about death (anger, frustration, despair); silent, withdrawn.
   d. Often worries about physical changes in relationship to terminal illness.
   e. May ask very difficult, open questions regarding death.
2. Nursing interventions.
   a. Support maturational crises relating to identity.
   b. Encourage verbalization of feelings.
   c. Promote peer and parental emotional support.
   d. Respect need for privacy and personal expressions of anger, sadness, or fear.
   e. Model appropriate grieving behavior.

E. Adult.
1. Concerned about death as a disruption in lifestyle and its effect on significant others.
2. Adults tend to think about loss in terms of unmet goals and/or an impediment to future plans; often experience delayed grief and threat to emotional integrity.

F. Older adult.
   1. Aware of death as inevitable; life is over.
   2. Emphasis on religious belief for comfort; a time of reflection, rest, and peace.

**CULTURAL DIVERSITY**

**Special Considerations**
A. Cultures vary widely in their traditions.
B. In the United States, each particular ethnic group has its own cultural system and specific way of behaving and evaluating illness and wellness.

**NURSING PRIORITY** Certain psychopathologic conditions may change diagnostic category entirely in different cultures. Misinterpretation and misunderstanding of clients’ presenting symptoms can lead to problems in the nurse-client relationship (e.g., notion of possession [in a positive sense] by the Holy Ghost among American Pentecostal groups might be viewed by health care providers as a symptom of a mental disorder).

C. *Culture shock* occurs whenever a person leaves a familiar country, region, lifestyle, or occupation and enters a radically different environment.

Examples: Entering the hospital; moving to a new neighborhood.

**Assessment of Cultural Aspects**
A. Communication styles.
   1. Does the client speak English fluently? If not, what language is preferred?
   2. Is an interpreter needed?

**NURSING PRIORITY** If an interpreter is needed, it is preferable to avoid using family members. Also, learning some key words from the interpreter will help the nurse in implementing care.

B. Ethnic or religious group.
   1. What particular group does client identify with?
   2. How closely does the client adhere to the traditional beliefs of the group?

C. Nutrition.
   1. Are there certain ethnic or religious preferences about the selection or preparation of foods?
   2. Are there foods to be encouraged (or avoided) when a person is ill?
D. Family relationships.
   1. Is the family matriarchal or patriarchal?
   2. What role in the family does the client hold?
E. Health beliefs.
   1. Does the client rely on folk medicine practices?
   2. Has the client been recently treated by a curandero, shaman, Voodoo doctor, medicine man, or Chinese herbalist?

**PSYCHOSOCIAL ASSESSMENT**

[NURSING PRIORITY] Strong evidence suggests that factors such as genetics, environment, diet, and cultural beliefs are responsible for ethnic variations in psychotropic drug use (e.g., poor metabolism of certain psychotropic drugs because of genetic factors has been found to be responsible for drug effects in some ethnic groups).

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

[ALERT] Assess client’s response to illness, identify coping mechanisms of client and family, and assess the family’s emotional reaction to client’s illness.

**Psychiatric History**

Purpose: To obtain data from multiple sources (e.g., client, family, friends, police, mental health personnel) as a means of identifying patterns of functioning that are healthy, as well as patterns that create problems in the client’s everyday life.

[OLDER ADULT PRIORITY] Allow ample time to gather psychosocial data from older clients, because they are often starved for someone to listen to them.

A. General history of client.
   1. Demographic information: address, age, religious affiliation, occupation, insurance company, etc.
   2. Pertinent personal history such as birth, growth and development, illness, and marital history.
   3. Previous mental health hospitalizations or treatment.
B. Components of psychiatric history.
   1. Chief complaint: main reason client is seeking psychiatric help.
      a. Use client’s own words as to why he or she is hospitalized or seeking help.
      b. Check for recent difficulties or alterations in relationships, level of functioning, behavior, perceptions, or cognitive abilities.
   2. Presenting symptoms: onset and development of symptoms or problems.
      a. Check for increased feelings of depression, anxiety, hopelessness, suspiciousness, confusion, fear.
      b. Assess for changes in bowel habits, insomnia, lethargy, weight loss or gain, anorexia, palpitations, pruritus, headaches.
   3. Family history.
      a. Have any of client’s family members sought psychiatric treatment?
      b. Who was important to client in childhood? In adolescence?
      c. Was there physical, emotional, or sexual abuse?
      d. Did parents drink or use drugs?
   4. Personality profile.
      a. Assess client’s interests, feelings, mood, and usual leisure activities or hobbies.
      b. How does client cope with stress?
      c. Inquire about sexual patterns: sexually active? sexual orientation? sexual difficulties?
      d. Have client describe social relationships: Who are client’s friends? Who is important to client? What is a usual day like?

**Mental Status Examination**

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

[ALERT] Identify changes in client’s mental status.

**Aspects of the Examination**

[NURSING PRIORITY] First, assess client’s level of consciousness, vision, and hearing (e.g., alert, lethargic, stuporous, or comatose) and ability to comprehend the interview.

A. Mini-Mental State Examination (MMSE): developed by Folstein, Folstein, and McHugh, 1975.
   1. Widely used common mental status assessment for cognitive function.
   2. Quickly administered - questions related to orientation (person, place and time), registration (repeating items, give client 3 common words and ask him to repeat the words), naming (point to a chair or object and ask client to name it), and reading (ask client to read and follow directions from a simple sentence).
   3. Excludes assessment of mood, abnormal psychologic experiences (hallucinations, delusions, illusions), and content and process of thinking.
B. General appearance, attitude, and behavior.
   1. Descriptors: posture, gait, activity, facial expression, mannerisms.
   2. Disturbances include deviations of activity, distortions in mobility (waxy flexibility or dyskinesia), uncooperativeness, and changes in personal hygiene.
C. Characteristics of talk and stream of thought.
   1. Descriptors: emphasis on form, rather than content, of client’s verbal communication; loudness, flow, speed, quality, logic, level of coherence.
   2. Disturbances include the following patterns:
      b. Circumstantiality: cumbersome detail in client’s communication.
c. Perseveration: pattern of repeating same words or movements.
d. Flight of ideas: rapid speech, loosely connected thoughts.
e. Blocking: sudden silence, often associated with intrusion of delusional thoughts or hallucinations.
f. Echolalia: repeating the last word heard.
g. Neologism: coining of new words.
h. Verbigeration: repeating words, sentences, or phrases several times.
i. Pressured speech: an increase in the quantity of speech, usually becoming loud, rushed, and emphatic.

D. Emotional state.
1. Descriptors: client’s report of subjective feelings (mood or affect) and examiner’s observation of client’s pervasive or dominant emotional state.
2. Disturbances include deviations such as elation, depression, apathy, incongruence, and disassociation.

E. Content of thought.
1. Descriptors: What is central theme? How does client view himself or herself (self-concept)? Is suicidal or homicidal ideation present? If so, what is potential lethality?
2. Disturbances include special preoccupations and experiences such as hallucinations, delusions, illusions, depersonalization, obsessions or compulsions, phobias, fantasies, and daydreams.

F. Sensorium and intellect.
1. Determine the degree of client’s awareness and level of intellectual functioning; general ability to grasp information and calculate; abstract thinking; memory (recall of remote past experiences or recent past experiences, retention and recall of immediate impressions); reasoning and judgment.
2. Disturbances of orientation in terms of time, place, person, and self; memory, retention, attention, information, and judgment are assessed through use of standardized tests and questions.

G. Insight evaluation—Determine whether the client can understand and appreciate the nature of his or her condition and the need for treatment.

STRESS AND ADAPTATION

Stress is a state produced by a change in the environment that is perceived as challenging, threatening, or damaging to the individual’s equilibrium.

Adaptation is a constant, ongoing process that occurs along the time continuum, beginning with birth and ending with death.

Stressors

A. Physiologic stressors.
4. Faulty immune mechanisms.
5. Genetic disorders.
7. Hypoxia.

B. Psychosocial stressors.
1. Accidents and the survivors (e.g., airplane crash, hurricane, and earthquake survivors).
2. Death of a close friend; neighbor being robbed and/or beaten.
3. Horrors of history: Auschwitz, Hiroshima, Chernobyl, etc.
4. Fear of aggression, mutilation, and destruction.
5. Events of history brought into our living rooms through various media.
7. Inherent conflicts in all social relations.

C. Environmental stressors.
1. Noise pollution.
2. Temperature pollution.
3. Air and chemical pollution.

ALERT Implement measures to reduce environmental stressors and assist client in identifying strategies to deal with stress.

Stress Response

A. Sympathetic: adrenal medullary response; fight-or-flight response (Box 9-1).
1. Increased pulse, blood glucose level, and coagulability of blood.
2. Pupils dilated.
3. Mental activity enhanced.
4. Cold, clammy skin.
5. Respirations rapid and shallow.

Box 9-1 SELYE’S GENERAL ADAPTATION SYNDROME

Stage I: Alarm Reaction
Mobilization of the body’s defensive forces (antiinflammatory) and activation of the fight-or-flight mechanism.

Stage II: Stage of Resistance
Optimal adaptation to stress within a person’s capabilities.

Stage III: Stage of Exhaustion
Loss of the ability to resist stress because of depletion of body resources; failure to adapt leads to death.
B. Pituitary-adrenal cortical response.
   1. Increased production of adrenocorticotropic hormone (ACTH) and mineralocorticoids (aldosterone); increased release of glucagon.
   2. The sympathetic-adrenal medullary response occurs within seconds.
   3. The pituitary-adrenal cortical response (also, called the Selyean response, after Hans Selye) includes the fight-or-flight response and takes minutes to hours to produce a desired effect.

**Stress Reduction Methods**
A. Proper nutrition.
B. Regular exercise, physical activity, and recreation.
C. Meditation, breathing exercises, creative imagery.
D. Communication, time management.
E. Biofeedback, rolfing (massage of deep connective tissue to achieve realignment of body structure), therapeutic touch, bioenergetics (decrease muscle tension by releasing feelings through physical exertion and verbal techniques).
F. Relaxation response.
   1. Quiet environment.
   2. Passive attitude.
   3. Comfortable position.
   4. A mental device or object, such as a word, sound, or phrase, to occupy the mind and keep out thoughts.
G. Group process and social support.
H. Thought-stopping, self-hypnosis, refuting irrational self-talk.

**CONCEPT OF ANXIETY**
An emotion, a subjective experience; a feeling state that is experienced as vague uneasiness, tension, or apprehension; occurs when the ego is threatened; provoked by the unknown; precedes all new experiences.
A. Assessment (Table 9-1).
B. Nursing management (Table 9-2).

**Table 9-1 ASSESSMENT OF ANXIETY**

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<td>Behavioral Responses</td>
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<td>Restlessness</td>
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<tr>
<td>Elevated blood pressure</td>
<td>Agitation</td>
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<tr>
<td>Increased perspiration</td>
<td>Tremors (fine to gross shaking of the body)</td>
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<td>Dilated pupils</td>
<td>Startle reaction</td>
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<td>Hyperventilation with difficulty</td>
<td>Rapid speech</td>
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<td>breathing</td>
<td>Lack of coordination</td>
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<td>Cold, clammy skin</td>
<td>Withdrawal</td>
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<td>Dry mouth</td>
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<td>Parasympathetic Responses</td>
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<td>Urinary frequency</td>
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<td>Blocking of thought</td>
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<td>Decreased perceptual field</td>
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<td>Decreased productivity</td>
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<td>Confusion</td>
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<tr>
<th>Related Responses</th>
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<td>Fear</td>
</tr>
<tr>
<td></td>
<td>Panic</td>
</tr>
<tr>
<td></td>
<td>Fear of impending doom</td>
</tr>
</tbody>
</table>

2. Discuss alternative coping mechanisms and problem-solving techniques.
3. Assist the client in learning new or alternative coping patterns for a healthier adaptation.
4. Use techniques to decrease anxiety.

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

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

**Interview Process**
A. Establish rapport with the client.
B. Obtain pertinent client data.
C. Initiate client assessment.
D. Make practical arrangements for treatment.

**Coping/Defense/Ego/Mental Mechanisms**
Specific defense processes used by individuals to relieve or decrease anxieties caused by uncomfortable situations that threaten self-esteem.
A. Related principles.
   1. Primary functions are to decrease emotional conflicts, provide relief from stress, protect from feelings of inadequacy and worthlessness, prevent awareness of anxiety, and maintain an individual’s self-esteem.
   2. Everyone uses defense mechanisms to a certain extent. If used to an extreme degree, defense mechanisms distort reality, interfere with interpersonal relationships, limit one’s ability to work productively, and may lead to pathologic symptoms.
B. Common defense mechanisms (see Appendix 9-1).
C. Nursing management.
   1. Accept coping mechanisms.
Table 9-2 NURSING MANAGEMENT OF ANXIETY

<table>
<thead>
<tr>
<th>Level of Anxiety</th>
<th>Assessment</th>
<th>Goal</th>
<th>Nursing Management</th>
</tr>
</thead>
</table>
| Mild             | Increased alertness, motivation, and attentiveness. | To assist client to tolerate some anxiety. | 1. Help client identify and describe feelings.  
2. Help client develop the capacity to tolerate mild anxiety and use it consciously and constructively. |
| Moderate         | Perception narrowed, selective inattention, physical discomforts. | To reduce anxiety; directed toward helping client understand cause of anxiety and new ways of controlling it. | 1. Provide outlet for tension, such as walking; crying; working at simple, concrete tasks. |
| Severe           | Behavior becomes automatic; connections between details are not seen; senses are drastically reduced. | To assist in channeling anxiety. | 1. Recognize own level of anxiety.  
2. Link client's behavior with feelings.  
3. Protect defenses and coping mechanisms.  
4. Identify and modify anxiety-provoking situations. |
| Panic            | Overwhelmed; inability to function or communicate; potential for bodily harm to self and others; loss of rational thought. | To be supportive and protective. | 1. Provide nonstimulating, structured environment.  
2. Avoid touching.  
4. Medicate client with tranquilizers if necessary. |

Phases

A. Initial phase: Goal is to build trust.
   1. Explore the client's perceptions, thoughts, feelings, and actions.
   2. Identify the problem.
   3. Assess levels of anxiety of self and client.
   4. Mutually define specific goals to pursue.

B. Working phase: Goal is to establish objectives or a working agreement (contract).
   1. Encourage client participation.
   2. Focus on problem-solving techniques; choose between alternate courses of action and practice skills.
   3. Explore thoughts, feelings, and emotions.
   4. Develop constructive coping mechanisms.
   5. Increase independence and self-responsibility.

C. Termination phase: Goal is to evaluate goals set forth and terminate relationship.
   1. Plan for termination early in formation of relationship (in initial phase).
   2. Discuss client's feelings about termination.
   3. Evaluate client's progress and goal attainment.

Communication Theory

A. Levels of communication.
   1. Verbal communication: occurs through the medium of words—spoken or written.
   2. Nonverbal communication: includes everything that does not involve the spoken or written word; involves the five senses.
      b. Action cues: body movement, posture, facial expressions, gestures, mannerisms.
      c. Object cues: dress, appearance to convey a certain “look” or message.
      d. Space: distance between two people; intimate, personal, public space.
      e. Touch: universal and basic to all nurse–client relationships; response to touch is influenced by the setting, cultural background (of client and of nurse), type of relationship, sex of communicators, and expectations.

B. Therapeutic nurse–client communication techniques.
   1. Planning and goals.
      a. Demonstrate active listening; face-to-face contact.
      b. Demonstrate unconditional positive regard, interest, congruence, respect.
      c. Develop trusting relationship; accept client's behavior and display nonjudgmental, objective attitude.
      d. Be supportive, honest, authentic, genuine.
      e. Focus on emotional needs and emotionally charged area.
      f. Focus on here-and-now behavior and expression of feelings.
      g. Attempt to understand the client's point of view.

NURSING PRIORITY To effectively interview a client, be sure to start with a broad, empathetic statement; explore normal behaviors before discussing maladaptive behaviors; phrase inquiries or questions sensitively to decrease client's anxiety; ask client to clarify vague statements; refocus on pressing problems when client begins to ramble; interrupt nonstop talking by client as tactfully as possible; express empathy toward client while he or she is expressing feelings.
h. Develop an awareness of the client’s likes and dislikes.
i. Encourage expression of both positive and negative feelings.
j. Use broad openings and ask open-ended questions; avoid questions that can be answered by yes or no.
k. Use reflections of feelings, attitudes, and words.
l. Explore alternatives rather than answers or solutions.
m. Focus feedback on what is said rather than why it is said.
n. Paraphrase to assist in clarifying client’s statements.
o. Promote sharing of feelings, information, and ideas instead of giving advice.

2. Examples of therapeutic communication responses (Table 9-3).

3. Examples of nontherapeutic communication responses (Table 9-4).

### Table 9-3  THERAPEUTIC COMMUNICATION

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

### Table 9-4  NONTHERAPEUTIC COMMUNICATION

<table>
<thead>
<tr>
<th>Response</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. False reassurance</td>
<td>“Don’t worry; you will be better in a few weeks.”</td>
</tr>
<tr>
<td></td>
<td>“Don’t worry. I had an operation just like it; it was a snap.”</td>
</tr>
<tr>
<td>2. Giving advice</td>
<td>“What you should do is …”</td>
</tr>
<tr>
<td></td>
<td>“If I were you, I would do …”</td>
</tr>
<tr>
<td>3. Rejecting</td>
<td>“I don’t like it when you …”</td>
</tr>
<tr>
<td></td>
<td>“Please, don’t ever talk about …”</td>
</tr>
<tr>
<td>4. Probing</td>
<td>“Everybody feels that way.”</td>
</tr>
<tr>
<td></td>
<td>“Why, you shouldn’t feel that way.”</td>
</tr>
<tr>
<td>5. Overloading</td>
<td>“Tell me more about your relationships with other men.”</td>
</tr>
<tr>
<td></td>
<td>“Hi, I am JoAnn, your student nurse. How old are you? What brought you to the hospital? How many children do you have? Do you want to fill out your menu right now?”</td>
</tr>
<tr>
<td>7. Underloading</td>
<td>Not giving enough information so that the meaning is clear; withholding information.</td>
</tr>
<tr>
<td>8. Clichés</td>
<td>“Gee, the weather is beautiful outside.”</td>
</tr>
<tr>
<td></td>
<td>“Did you watch that new TV show last night? Everybody’s talking about it.”</td>
</tr>
</tbody>
</table>

### ALERT  Listen to client’s concerns and use therapeutic interventions to increase client’s understanding of his or her behavior.

### INTERVENTION MODALITIES

#### Crisis Intervention

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

A. A crisis offers opportunities for growth and renewal.

B. Crisis intervention strategy views people as capable of personal growth and able to control their own lives.

C. Types of crisis intervention strategies.

   1. Individual crisis counseling.
   2. Crisis groups.
   3. Telephone counseling.

D. Crisis intervention requires support, protection, and enhancement of the client’s self-image.

### GROUP THERAPY

A structured or semistructured process in which individuals (7 to 12 members is an ideal size) are interrelated and interdependent and may share common purposes and norms.
A. Emphasis on clear communication to promote effective interaction.
B. Disturbed perceptions can be corrected through consensual validation.
C. Socially ineffective behaviors can be modified through peer pressure.
D. See Table 10-2: Group Modalities for Older Adult Clients.

**NURSING PRIORITY** Determining a client’s perception of reality is an important consideration when selecting the client to be a member of a group. For instance, a person who is psychotic would not be a good selection as a group member.

**Family Therapy**

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

A treatment modality designed to bring about a change in communication and interactive patterns between and among family members.
A. A family can be viewed as a system that is dynamic. A change or movement in any part of the family system affects all other parts of the system.
B. Family seeks to maintain a balance or “homeostasis” among various forces that operate within and on it.
C. Emotional symptoms or problems of an individual may be expression of the emotional symptoms or problems in the family.
D. Therapeutic approaches involve helping family members look at themselves in the here and now and recognize the influence of past models on their behavior and expectations.

**Milieu**

**ALERT** Maintain a therapeutic milieu/environment.

A scientifically planned, purposeful manipulation in the environment aimed at causing changes in the behavior and personality of the client.
A. Nurse is viewed as a facilitator and a helper to clients rather than as a therapist.
B. The therapeutic community is a very special kind of milieu therapy in which the total social structure of the treatment unit is involved as part of the helping process.
C. Emphasis is placed on open communication, both within and between staff and client groups.

**Mind-Body-Spirit Therapies**

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

A. Acupuncture: movement of energy through meridians of the body to restore energy balance.
B. Imagery: change reality by creating a different mental picture.
C. Therapeutic touch: manipulate and direct client’s energy through the use of the practitioner’s hands and direct energy from the practitioner to the client to enhance healing.
D. Massage: use of touch unblocks energy flow and connects client with practitioner.
E. Relaxation: imagery and progressive tensing and relaxing of muscle groups throughout the body.
F. Bioenergetics: removes blockages to promote the flow of bioenergy or Ch'i.
G. Transcendental meditation: quiet meditation, focusing on getting beyond the self and becoming one with the universal energy source.
H. Others: exercise, nutrition, prayer, religious practices.

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

**Somatic Therapies**

A. Restraints.
   1. Must consider client’s civil liberties.
   2. Mechanical restraints include camisoles, wrist and ankle restraints, and sheet restraints.

**ALERT** Legal requirements for the nursing care of the client in seclusion vary from state to state, and specifics are usually not tested on the NCLEX-RN examination.

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

**Psychosurgery**

Surgical interruption of selected neural pathways that govern transmission of emotion between the frontal lobes of the cerebral cortex and the thalamus.
A. Recent resurgence of interest in psychosurgery as knowledge of neuroanatomy and “mapping” the cerebral cortex has become more sophisticated.
B. Area of moral and ethical debate, especially because nerve tissue, once damaged, cannot regenerate.

**Electroconvulsive Therapy**

See Chapter 10.
Other Therapies
A. Psychodrama: the use of structured and directed dramatization of client’s emotional problems and experiences.
B. Activities therapy: a number of vital programs belong in this category, such as music therapy, occupational therapy, art therapy, recreational therapy, ROPES therapy, dance or movement therapy, etc.

COMMON BEHAVIORAL PATTERNS

**ALERT** Identify inappropriate behavior, use client behavior modification techniques, and use therapeutic interventions to increase client’s understanding of his or her behavior.

Interpersonal Withdrawal
Behavior characterized by avoidance of interpersonal contact and a sense of unreality.
A. Physical withdrawal: client sits or stands apart from others; may hide, assume a catatonic posture, or (in extreme form) attempt suicide.
B. Verbal withdrawal: avoidance through silence or (in extreme form) mutism; silence may indicate resistance, a pensive moment, or the indication that nothing more is to be said.

**Nursing Interventions**
A. Avoid punishment of client.
B. Decrease isolation.
C. Invite the client to speak.
D. State the amount of time you are willing to stay with the client, whether he or she chooses to speak or not.
E. Change the context of the contact (e.g., go for a walk together).
F. Encourage the client to share responsibility for the continuance of the relationship.

Regression
A selective, defensive operation in which the individual resorts to earlier, childish, or less complex patterns of behavior that once brought the client attention or pleasure.

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

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

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

**NURSING PRIORITY** Nontherapeutic responses to a client’s anger include defensiveness, retaliation, condescension, and avoidance.

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

**Nursing Interventions**

**ALERT** Plan interventions to assist client to control aggressive behavior.

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

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

Violence
Behavior that is physically assaultive and risks injury to the self, others, and environment.
Nursing Interventions

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

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

   1. *Why* questions are threatening and decrease self-esteem.
   2. Open-ended questions seek to identify the problem, convey concern, and elicit more information.

C. Speak to the client softly, slowly, and with assurance.

D. Give directions clearly and concisely. Tell the client what you want him or her to do.

E. Encourage client to verbalize feelings.
   1. Give the client an outlet for the physical tension—“Walk with me. Tell me what happened.”
   2. Keep the conversation slow; pace yourself—“Wait, I can’t follow that. Tell me what you said.”
   3. Listen more than talk.
   4. Give the client walk or move around or provide something for the client to safely “pound” on to release the tension before you talk.

F. Position yourself near the door.
   1. Don’t block the door.
   2. Don’t box the client into a corner.

G. Self-protection and protection of other clients are primary concerns.
   1. Keep a comfortable distance from client; don’t intrude on his or her personal space.
      a. With a client experiencing mild or moderate anxiety: sit near, about 2 feet away.
      b. With a client experiencing severe anxiety or panic: stay 4 to 6 feet away (or farther).
   2. Be prepared to move quickly; violent clients act quickly and unpredictably.
   3. Determine that the client has no weapons before approaching him or her.
   4. Be supportive and intervene to increase client’s self-esteem.
   5. Be honest; tell the client you are concerned that he or she is out of control, but you are not going to let anyone get hurt.

**OLDER ADULT PRIORITY** Expect some older clients to have vision problems; they may not know who you are. Hearing problems occur often with older adults; don’t shout or talk rapidly.

7. Stay with the client, but don’t touch him or her until you’ve asked permission and it has been given to you.

H. Once the client is in control of their behavior, review and process the situation in order to alleviate client’s guilt and to discuss alternatives in case the client becomes anxious or angry in the future.

**Manipulation/Acting Out**
A type of controlling behavior in which an individual uses others to meet his or her own needs or to achieve specific goals; often disguises underlying feelings of inadequacy, inferiority, and unworthiness; an attempt to protect against failure or frustration and to gain power over another.

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

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

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

**Shame**
The inner sense of being completely diminished or insufficient as a person (e.g., feeling “less than”).
Nursing Interventions
A. Assist client to begin to externalize rather than internalize feelings of shame.
B. Encourage client to share feelings honestly with individuals he or she feels “safe” with.
C. Involve client in “debriefing,” which is writing and talking about past experiences with shame.
D. Encourage client to make positive self-affirmations and to engage in creative visualization activities to improve self-concept.

Detachment
A behavioral process characterized by aloofness, superficiality, denial, and intellectualization during interpersonal contact.

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

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

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

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

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

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

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

Child Abuse
A. Child neglect: the failure to provide a child with the basic necessities; may be classified as physical or emotional neglect.
1. Failure to thrive: infant or child is below the normal ranges on the growth chart.
2. Infant or child does not appear to be physically cared for. Inappropriate diapering, diaper rash, strong urine smell to the body may be seen in infants who have been neglected.
3. Evidence of malnutrition.
4. Lack of adequate supervision; child is allowed to engage in dangerous play activities and sustains frequent injuries.
5. Language development may be delayed.
6. Withdrawal; inappropriate fearfulness.
7. Parents may be apathetic and unresponsive to the child's needs. The nurse is most often able to observe the parent-child interaction in school situations, in a doctor's office, or in the emergency department.

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

Nursing Interventions

Goal: To establish a safe environment.
A. It is important for the nurse to be knowledgeable of the legal responsibilities in regard to state practice acts and child abuse laws (Box 9-2).
B. All 50 states have a designated agency that is available on a 24-hour basis for reporting child abuse.
C. All states have mechanisms for removing the child from the immediate abusive environment.

Box 9-2  DOCUMENTATION FOR SUSPECTED ABUSE

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

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

Physical Examination
1. Be very specific in describing the location, size, and shape of bruises and lacerations. If possible, photograph the client to demonstrate the extent of the injuries.
2. If possible, describe the location and extent of injuries on an anatomic diagram.
3. Identify presence of other injuries.
4. Describe the victim's reaction to pain, level of pain, and location of pain.
Goal: To educate the parents and help them to identify assistance for long-term supportive care.
A. Educate parents in regard to normal growth and development of children, the role of discipline, and the necessity for having realistic expectations.
B. Become familiar with available community resources such as crisis centers, crisis hotlines, parent effectiveness training groups, Parents Anonymous groups, etc.

Incest
A. Assessment.
1. Victim is usually female; perpetrator of abuse is primarily male, usually between ages 30 and 50, and often the victim’s father or other member of the immediate family.
2. Incest is a symptom of severe dysfunction in an individual and within the family.
3. Perpetrators of sexual exploitation.
   a. Emotionally dependent men.
   b. Feelings of inferiority and low self-esteem.
   c. Perpetrators frequently seduce their victims by being endearing and “good” to the child.
   d. Often, these men are pillars of the community and are involved in many youth activities.
   e. Frequently, the mother is unaware of the problem. If she suspects it, she may feel guilty for having such ideas.
4. Sexually exploited child.
   a. Child may fear retaliation if anyone finds out; may fear that she will not be believed if she tells anyone.
   b. Child may feel guilty for participating in the sexual activity and afraid of disruption of the family if it is revealed.
   c. Violence rarely accompanies the incest relationship.
   d. The child may be emotionally and physically dependent on the abusing parent.

Nursing Interventions
Goal: To educate children that their bodies belong to themselves and are private.
A. Instruct children to report any type of touching, fondling, or caressing that makes them feel uncomfortable.
B. Provide educational material to help parents talk about sexual assault and inappropriate fondling with their children.

Goal: To support the parents and the child and to help them identify assistance for long-term supportive care.
A. Provide support and the opportunity for the child and family members to discuss their feelings.
B. Assist the family to identify community resources; strongly encourage involvement in family counseling.

Older Adult Abuse
A. Types of older adult abuse (Box 9-3).
B. Typical victim.

Box 9-3 OLDER ADULT CARE FOCUS

Older Adult Abuse

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

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

1. Woman of advanced age with few social contacts.
2. At least one physical or mental impairment, limiting the person’s ability to perform activities of daily living.

C. Assessment of elder abuse.
1. Symptoms: contusions, abrasions, sprains, burns, bruising, human bite marks, sexual molestation, untreated or previously treated conditions, erratic hair loss from hair pulling, fractures, dislocations, head and face injuries (especially orbital fractures, black eyes, and broken teeth).
2. Behavior: clinging to the abuser, extreme guardedness in the presence of the abuser, wariness of strangers, expression of ambivalence toward family/caregivers, depression, social or physical isolation, denial of abuse for fear of retaliation.

Nursing Interventions
Goal: To assess for older adult abuse.
A. Use a private, separate setting for interviewing victim and perpetrator.
B. The interview must be unbiased, accurate, and appropriately documented.
C. Avoid signs of disapproval that might evoke shame or anger in the older client; be nonjudgmental.

Goal: To establish a safe environment.
A. It is important for the nurse to be knowledgeable of the legal responsibilities in regard to state practice acts and reporting of abuse (see Box 9-2).
B. Client and family teaching in the areas of nutrition, general physical care, etc.

Spouse Abuse
A. Most often the spouse abused is the wife; frequently, the violence is a pattern in the woman’s life. The violence in
the family is frequently associated with alcohol; often, there is a history of the woman’s parents having a violent relationship.

B. It is not uncommon for the husband or abuser to have been exposed to violent family dynamics during childhood.

C. After the violent attack, the husband is frequently remorseful, kind, and loving. He may promise that he will never do it again.

D. Women tend to stay in abuse situations. Retaliation, loss of home and children, and additional abuse are just a few of the consequences they fear if they try to escape the situation. Abuse may increase if they express a desire to become more independent.

**Physical Assessment**

A. Traumatic injury to the upper body, especially the face and breasts.

B. Signs of fear and an expression of helplessness.

C. May avoid friends and family for fear they will find out.

D. May exhibit feelings of shame, guilt, and embarrassment that she must seek treatment for her injuries.

**Nursing Interventions**

**Goal:** Primary prevention—education of the community regarding the risks of abuse.

**Goal:** Secondary prevention—screening activities that occur within the community.

**Goal:** Tertiary prevention—emergency treatment, counseling, and work that goes on in shelters.

**NURSING PRIORITY** When working with an abused woman, avoid anything that sounds like blaming her for her situation.

**Rape**

A. Legal definition of rape (varies from state to state): forced, violent sexual attack on an individual without his or her consent. Includes sex acts other than forced intercourse as rape; some states do not recognize rape by the husband.

B. Sexual assault is not a means of sexual gratification; it is a violent physical and emotional attack. Men attack women in an attempt to demonstrate their power and dominance; attempt to control, terrify, and degrade the woman.

C. Victims: in all age ranges; highest-risk age group is 12 to 20 years old.

D. Majority of rapes are not sudden and impulsive; they are well planned.

E. Most women know the rapist; most rape assaults occur between people of the same race.

F. Rape-trauma syndrome: variant of posttraumatic stress disorder; has two phases, an acute phase and a long-term reorganization phase.

**Assessment**

A. Acute phase: may last a couple of weeks.

1. Woman may experience a wide range of emotional responses: fear, shock, disbelief, anger, denial, guilt, embarrassment, etc. (there is no “normal response” to rape).

2. Somatic reaction: physical trauma, skeletal muscle tension, GI and genitourinary symptoms/discomfort.

B. Long-term reorganization phase: occurs 2 weeks or more after rape.

1. Intrusive thoughts (flashbacks, violent dreams, insomnia), fears, phobias.

2. Increased motor activity (moving, taking trips, changing phone numbers) and emotional lability.

C. Advise the woman to not “clean up” after a rape, because the physical evidence may be destroyed; advise the woman to come immediately to the ED.

D. Complete physical assessment (Box 9-4).

**NURSING PRIORITY** Five components essential in treating rape victim: treat and document injuries, treat and evaluate for sexually transmitted diseases, evaluate and prevent pregnancy risk, arrange for follow-up counseling, and collect evidence according to protocols.

**NURSING PRIORITY** When working with an abused woman, avoid anything that sounds like blaming her for her situation.

**Goal:** To assist the client through the acute phase after the rape experience.

A. Encourage the client to verbalize her feelings regarding the attack.

B. Assist her to set priorities and determine immediate needs.

C. Respond to the client in a warm, respectful, accepting manner; protect the client from becoming overwhelmed and distressed from the initial physical examination and questioning.

D. Discuss need for follow-up care and physical examination regarding possible pregnancy and sexually transmitted disease.

E. Provide information regarding physical and emotional responses to rape.

F. Provide referral information and plan for follow-up contact within the next week.

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

A. Encourage mental health counseling during the first few days after the assault.

B. Assist the client to understand and recognize the period of long-term reorganization that frequently follows a sexual attack.

1. Victim may experience sexual problems.

2. May experience a strong urge to discuss the incident and feelings related to the attack.

3. During the reorganization phase, client should have professional counseling to assist her to positively cope with the situation.
Box 9-4  CHECKLIST OF NURSING MANAGEMENT FOR THE RAPE VICTIM

Medical-Legal
• Valid written consent for examination, photographs, lab tests, release of information, and laboratory samples.
• Appropriate “chain of evidence” documentation: follow agency protocol.
• Protect legal rights.

Assist With Physical Examination
• Vital signs and general appearance.
• Examine for extragenital trauma: mouth, breasts, neck.
• Examine for cuts, bruises, scratches; photograph.

Pelvic Examination
• Vulvar trauma; erythema; hymen, anal, and rectal status.
• Matted hair or free hairs.
• Vaginal examination: use unlubricated speculum; look for foreign body, discharge, blood, lacerations; uterine size; adnexa, especially hematomas.

Implement Medical Treatment
• Care for injuries and emotional trauma.
• Antibiotic prophylaxis for STDs.
• Antipregnancy measures: postcoital dose of Ovral.

Document History
• Age, marital status, and parity.
• Menstrual and contraceptive history.
• Time of last coitus before assault.
• Change of clothes, bath, douche?
• Use of drugs or alcohol.
• Who, what, when, where?
• Penetration, ejaculation, condom, extragenital acts.

Obtain Laboratory Samples
• Use appropriate evidence collection kits and label carefully.
• Saline irrigation of vagina: 2 mL and swab; acid phosphatase, blood group antigen of semen, and precipitin test against human sperm and blood.
• Vaginal smears: Pap smear and Gram stain.
• Oral or rectal swabs and smears.
• Blood tests for serology, blood type, alcohol level.
• Cultures: cervix plus other areas, if indicated.
• Urine: pregnancy test, drugs.
• Hair: comb and clip; obtain fingernail scrapings; comb pubic hairs; client’s pubic hair or any matted hairs.

Follow-Up and Referral
• Recommend continued follow-up and services of rape crisis center.
• Repeat serology testing for gonorrhea, chlamydia, and HIV at later date.

HIV, Human immunodeficiency virus; STD, sexually transmitted disease.

Appendix 9-1  UNDERSTANDING DEFENSE MECHANISMS

<table>
<thead>
<tr>
<th>NAME OF DEFENSE MECHANISM</th>
<th>DEFINITION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>Attempting to make up for or offset deficiencies, either real or imagined, by concentrating on or developing other abilities</td>
<td>An adolescent who perceives herself as unattractive focuses her energies on cultivating her intellectual abilities and is on the honor roll at school.</td>
</tr>
<tr>
<td>Conversion</td>
<td>Symbolic expression of intrapsychic conflict expressed in physical symptoms</td>
<td>A man develops blindness after watching his friend get seriously injured in a race car accident.</td>
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<tr>
<td>Denial</td>
<td>Blocking out or disowning painful thoughts or feelings</td>
<td>A young mother with a newborn who has a cleft palate tells her friends everything is okay with her baby.</td>
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<tr>
<td>Displacement</td>
<td>Feelings are transferred, redirected, or discharged from the appropriate person or object to a less threatening person or object</td>
<td>A man gets reprimanded by his boss. Later, he yells at his wife when dinner is not ready.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Separating and detaching an idea, situation, or relationship from its emotional significance; helps the individual put aside painful feelings and often leads to a temporary alteration of consciousness or identity</td>
<td>A young adolescent who was the lone survivor of an airplane crash now experiences amnesia.</td>
</tr>
<tr>
<td>Identification</td>
<td>Attempting to pattern or resemble the personality of an admired, idealized person</td>
<td>A young man chooses to become a professional football player like his father.</td>
</tr>
<tr>
<td>Introjection</td>
<td>Acceptance of another’s values and opinions as one’s own</td>
<td>A young woman takes on the values and opinions of her peer group.</td>
</tr>
<tr>
<td>NAME OF DEFENSE MECHANISM</td>
<td>DEFINITION</td>
<td>EXAMPLE</td>
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<tr>
<td>Projection</td>
<td>Attributing one’s own unacceptable feelings and thoughts to others</td>
<td>A student who feels like a failure after getting an F on an important examination says, “It’s the teacher’s fault. He doesn’t know how to write a test.”</td>
</tr>
<tr>
<td>Rationalization</td>
<td>Attempting to justify or modify unacceptable needs and feelings to the ego, in an effort to maintain self-respect and prevent guilt feelings</td>
<td>A man drinks several alcoholic beverages each evening, saying, “I work hard, so I need to relax when I get home.”</td>
</tr>
<tr>
<td>Reaction formation</td>
<td>Assuming attitudes and behaviors that one consciously rejects</td>
<td>A man is extremely polite and courteous to his mother-in-law, whom he intensely dislikes.</td>
</tr>
<tr>
<td>Regression</td>
<td>Retreating to an earlier, more comfortable level of adjustment</td>
<td>A young preschool child begins to suck his thumb and wet the bed shortly after the birth of a sibling.</td>
</tr>
<tr>
<td>Repression</td>
<td>An involuntary, automatic submerging of painful, unpleasant thoughts and feelings into the unconscious</td>
<td>A woman is unable to remember being sexually abused as a child.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Diversion of unacceptable instinctual drives into personally and socially acceptable areas to help channel forbidden impulses into constructive activities</td>
<td>A man who has strong competitive or aggressive drives channels his energy into building a successful business.</td>
</tr>
<tr>
<td>Suppression</td>
<td>Intentional exclusion of forbidden ideas and anxiety-producing situations from the conscious level; a voluntary forgetting and postponing mechanism</td>
<td>A young man is thinking so much about his date that it is interfering with his work. He decides to put it out of his mind until he leaves the office.</td>
</tr>
<tr>
<td>Undoing</td>
<td>Actually or symbolically attempting to erase a previous consciously intolerable experience or action; an attempt to repair feelings and actions that have created guilt and anxiety</td>
<td>A mother who has unjustly punished her child decides to bake the child’s favorite cookies.</td>
</tr>
</tbody>
</table>

**NURSING PRIORITY** Recognize client’s use of defense mechanisms.
1. A 23-month-old has been admitted to the hospital. The child's mother works in a factory at night and says that if she misses any more work, she will be fired. She is worried about leaving her child in the hospital at night because he is so young. What would be an appropriate nursing response?
   1. “He is really too young to suffer any untoward consequences.”
   2. “It's okay to leave; just leave a favorite toy.”
   3. “It would be better if you could stay, but we will take good care of him.”
   4. “You will have a lot of expenses in the future, so you better go to work.”

2. A 9-year-old client with leukemia asks, “Will I die?” What is an initial therapeutic response based on the needs of the dying child?
   1. “Think about getting well instead of dying.”
   2. “Tell me what you are thinking about dying.”
   3. “You need to ask your doctor.”
   4. “I really don't know.”

3. In response to information that a 5-year-old's death is imminent, the parents express intense anger at the staff, and they are critical of the care their son is receiving. What is the purpose of therapeutic intervention on the parents' behalf?
   1. Assure them that the doctor will be told about their concerns.
   2. Determine their attitude toward the child's impending death.
   3. Inform them that their behavior will upset their child.
   4. Allow them to express their emotions about their son dying.

4. During a client care conference, there is a discussion regarding the anxiety of a 9-year-old client with leukemia. In addition to anxiety related to his death, the child might also experience anxiety about:
   1. Concerns about missing school
   2. Fear of separation from his family
   3. Concerns about being dependent on staff
   4. Knowledge of the disease process

5. An infant is scheduled for a pyloromyotomy. The mother begins to cry and says, “I'm such a bad mother.” What is an appropriate response by the nurse?
   1. “Tell me what makes you think you are a bad mother.”
   2. “Don't cry; your baby will be fine.”
   3. “You are really having a bad time, aren't you?”
   4. The nurse says nothing and puts her arms around the mother.

6. In order for a terminally ill client to receive quality nursing care, the charge nurse needs to plan for which of the following when she assigns staff to care for the client?
   1. Assign a different staff nurse to the client every day.
   2. Assign the same full-time staff nurses every day.
   3. Use part-time nursing staff.
   4. Assign a different staff nurse every other day.

7. The nurse notes that a client is quite suspicious during an assessment interview and believes that her family is under investigation by the CIA. What would be appropriate nursing interventions with this client? Select all that apply:
   ____ 1. Use active listening skills to seek information from the client.
   ____ 2. Encourage the client to describe the problem as she sees it.
   ____ 3. Ask the client to tell you exactly what she thinks is happening.
   ____ 4. Tell the client that she is delusional and you can help her.
   ____ 5. Explain to the client that most people are not investigated by the CIA or FBI.
   ____ 6. Reassure the client that you are not with the CIA.

8. Which is an appropriate initial nursing measure in caring for a female who has been raped?
   1. Cleanse body wounds and apply cool compresses.
   2. Obtain written informed consent for examination.
   3. Determine whether the woman has bathed or drenched.
   4. Obtain laboratory specimens.

9. When a child feels responsible for physical abuse inflicted upon him or her, the nurse knows the child is experiencing which of the following?
   1. Fear
   2. Hostage response
   3. Anxiety response
   4. Guilt

10. A nurse case worker suspects older adult neglect. What assessment findings would confirm this?
    1. Confusion and disorientation
    2. Recent hip fracture
    3. Poor nutrition and hygiene
    4. Dirty dishes in the sink

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

It is important to note that emotional disturbances must be evaluated within the context and framework of normal growth and development, since behavior that is acceptable at one age may be a symptom of disease at another age.

**Alert** Modify approaches to care in accordance with client’s development stages.

**Child-Related Disorders**

**Mental Retardation**

A child who is mentally retarded has an IQ of 70 or below, which is associated with deficits or impairments in adaptive behavior before the age of 18 years.

**Assessment**

A. Causes.
   1. Down syndrome, phenylketonuria, rubella.
   2. Kernicterus (elevated bilirubin level), anoxia.
   3. Lead poisoning, meningitis, encephalitis.
B. Diagnostic criteria.
   1. IQ below 70.
   2. Deficit or impairment in adaptive behavior.
   3. Present before the age of 18 years.
C. Additional characteristics.
   1. Irritability, temper tantrums, stereotyped movements.
   2. Multiple neurologic abnormalities: dysfunction in vision or hearing or seizure activity.

**Nursing Interventions**

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

A. Promote feelings of self-esteem, worth, and security.
B. Educate the parents about developmental stages and tasks; deal with child’s developmental, not chronologic, age.

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

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

### Down Syndrome

Down syndrome is a common chromosomal abnormality characterized by an extra chromosome 21 (trisomy 21); incidence increases with maternal age.

**Assessment**

A. Physical characteristics criteria.
   1. Head: small in size; face has flat profile, sparse hair.
   2. Eyes: inner epicanthal folds; short and sparse eyelashes.
   3. Nose: small and depressed nasal bridge (saddle nose).
   5. Mouth: protruding tongue; high arched palate.
B. Mental characteristics.
   1. Mental retardation.
   2. Slow development.

**Nursing Interventions**

**Goal:** To promote optimal development.

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

**Goal:** To encourage early identification of Down syndrome.

It is common for pregnant women at risk (older than 35 years, family history of Down syndrome, or previous birth of a child with Down syndrome) to have an amniocentesis before the 16th week to rule out Down syndrome.

**Home Care**

A. Prevent respiratory tract infections by teaching parents about postural drainage and percussion.
B. Encourage use of cool mist vaporizer.
C. Stress importance of changing infant’s position frequently.
D. Explain to parents about feeding difficulties; encourage small, frequent feedings; feed solid food by pushing food back inside of mouth; provide foods that will form bulk to prevent constipation.
E. Discuss with parents alternative options to home care.
F. Individuals with Down syndrome develop a clinical syndrome of dementia that has almost identical clinical and neuropathologic characteristics of Alzheimer's disease as described in individuals without Down syndrome.
1. The main difference is the age of onset of Alzheimer’s disease in individuals with Down syndrome.
2. These clients present with clinical symptoms in their late 40s or early 50s.

**Attention-Deficit/Hyperactivity Disorder**

Attention-deficit/hyperactivity disorder is a developmental disorder characterized by inappropriate inattention and impulsivity, which usually appear between ages 3 and 7 years. Names previously used: hyperkinetic syndrome, minimal brain damage, minimal brain dysfunction.

**Assessment**

A. Diagnostic criteria.
1. Inattention.
   a. Fails to finish things he or she starts.
   b. Often doesn’t seem to listen.
   c. Is easily distracted.
   d. Has difficulty concentrating.
   e. Has difficulty sticking to play activity.
2. Impulsivity.
   a. Often acts before thinking.
   b. Shifts excessively from one activity to another.
   c. Has difficulty organizing work.
   d. Needs frequent supervision.
   e. Frequently calls out in class.
   f. Has difficulty waiting turn in games or group activities.
3. Hyperactivity.
   a. Runs about or climbs on things.
   b. Has difficulty sitting still; fidgets.
   c. Has difficulty staying seated.
   d. Moves about excessively during sleep.
   e. Is always “on the go.”
4. Onset before the age of 7 years.
5. Duration of at least 6 months.

B. Additional characteristics.
1. Obstinacy, negativism, mood lability.
2. Low frustration tolerance.
3. Soft neurologic signs: motor perceptual dysfunctions (e.g., poor hand–eye coordination).

**Nursing Interventions**

**Goal:** To keep child from harming self or others.
A. Assist child to recognize when he or she feels angry.
B. Help the child to accept his or her feelings of anger.
C. Teach child appropriate expression of angry feelings.
D. Redirect violent behavior with physical outlets for child’s anxiety (e.g., use of punching bag, jogging).
E. Confront child; withdraw attention when interactions with others are manipulative or exploitative.
F. Use time-out, isolation room, and restraints only when other interventions are unsuccessful.

**Goal:** To encourage age-appropriate, socially acceptable coping skills.
A. If child is hyperactive, make environment safe for continuous large muscle movement.
B. Provide large motor skill activities for child to participate in.
C. Provide frequent, nutritious snacks for child to “eat on the run.”

**Goal:** To decrease anxiety and increase self-esteem.
A. Encourage child to seek out staff to discuss true feelings.
B. Offer support during times of increased anxiety; ensure physical and psychologic safety.

**Goal:** To administer prescribed medication.
A. Ritalin (methylphenidate) may be used; is usually discontinued when child enters adolescence.
B. Prolonged administration may produce a temporary suppression of normal weight gain. Child may be taken off medication during summer months when school is out.
C. Administer in morning (to prevent insomnia) and 30 to 45 minutes before meals.

**Autistic Disorder**

The lack of responsiveness to other people (autism), lack of involvement with others, lack of verbal communication, preoccupation with inanimate objects, and ritualistic behavior are characteristic of infantile autism.

**Assessment**

A. Diagnostic criteria.
1. Onset before 3 years of age.
2. Impairment in social interactions—lack of responsiveness and involvement with others.
3. Impairment in communication and imaginative activity.
   a. Gross deficits in language development: speech is characterized by echolalia, parrot speech (i.e., the automatic repetition of words).
   b. Pronominal reversal (the tendency to use you for I).
   c. Lack of spontaneous make-believe play.
4. Markedly restricted, stereotypical patterns of behavior, interest, and activities.
   a. Rigid adherence to routines and rituals.
   b. Repetitive motor mannerisms—hand flapping, clapping, rocking, or rhythmic body movements.
5. Absence of delusions, hallucinations, and associative looseness, which are characteristics of childhood schizophrenia.
Nursing Interventions

**Goal:** To increase social awareness.
A. Encourage a significant one-to-one relationship with an adult.
B. Promote and engage in peer interaction.
C. Develop play and self-care skills.
D. Do not force interactions. Begin with positive reinforcement for eye contact. Gradually introduce touch, smiling, and hugging.

**Goal:** To teach verbal (oral) communication.
A. Respond to verbalization by telling the child what you do not understand.
B. Respond to nonverbal cues with verbal (oral) interpretation.
C. Observe and record context in which lack of clarity of spoken word occurred.
D. Use “en face” approach (face-to-face, eye-to-eye) to convey correct nonverbal expressions by example.

**Goal:** To decrease unacceptable behavior.
A. Encourage child to recognize and respond to own physiologic needs and urges.
B. Encourage verbalization of body needs, but do not make an issue of it.
C. Offer fluids and encourage exercise to prevent constipation.
D. Offer the bathroom at appropriate intervals throughout the day.
E. Prevent child from hurting self or others by setting firm limits and recognizing feelings of anger, fear, and frustration.

**Separation Anxiety Disorder**

Child demonstrates persistent and excessive anxiety on separation from parent or familiar surroundings.

**Assessment**

A. Diagnostic criteria.
   1. Excessive distress when separated from home or parents.
   2. Unrealistic worry about harm occurring.
   3. Refusal to sleep unless near parent.
   4. Refusal to attend school or other activities without parent.
   5. Physical symptoms as a response to anxiety (e.g., stomachache, vomiting, headache, etc).
B. Additional characteristics.
   1. Fear of the dark.
   2. Excessive conformity; often demonstrates need for constant attention; may be demanding.
   3. Usual age of onset any time between preschool years and 11 or 12 years.

**Nursing Interventions**

**Goal:** To reduce the level of anxiety in anxiety-provoking situations.
A. Identify factors that produce anxiety.
B. Turn night lights on to allay night fears.
C. Offer calm reassurance.

**Goal:** To differentiate between normal separation anxiety, which is seen in early childhood, and excessive anxiety, which is seen in separation anxiety disorders.
A. To be labeled as a separation anxiety disorder, the disturbance must have a duration of at least 2 weeks.
B. Children with this disorder tend to come from close-knit families.

**Specific Disorders With Physical Symptoms**

**Assessment**

A. Stuttering.
   1. Frequent repetitions or prolongations of sounds, syllables, or words.
   2. Unusual hesitations and pauses that disrupt the flow of speech.
   3. Speech may be very rapid or very slow.
   4. Stuttering is often absent during singing or talking to inanimate objects.
B. Functional enuresis.
   1. Repeated involuntary voiding of urine during the day or night.
   2. The involuntary voiding occurs after the age at which it is expected and is not due to any physical disorder.
C. Functional encopresis (fecal incontinence).
   1. Repeated voluntary or involuntary passage of feces of normal consistency in inappropriate places.
   2. Smearing feces, which should be differentiated from the smearing that takes place involuntarily and in the younger child (age 1 or 2 years).

**Nursing Interventions**

**Goal:** To assess and medically evaluate for any physiologic cause related to stuttering, enuresis, or encopresis.
**Goal:** To promote a positive self-concept by helping child overcome feelings of shame and guilt associated with disorder.
**Goal:** To identify various approaches to controlling enuresis.
A. Administer imipramine (Tofranil).
B. Restrict fluids before going to bed.
C. Encourage behavioral intervention therapies (a buzzer that wakes child when he or she starts to urinate; bladder training programs).
**Goal:** To identify various approaches to controlling fecal incontinence.
A. If child is retaining feces, initiate a bowel-cleaning regimen.
B. If child has loose stools, he or she needs a daily bulk laxative.
C. If soiling is deliberate, help child to express feelings through other means.
D. Educate child about bodily signals (rectal pressure).
E. Teach child to sit on toilet for 10 to 15 minutes after eating to establish regular elimination pattern.

**Alert** Initiate a toileting schedule.
Specific Developmental Disorders

Assessment
A. Developmental reading disorder.
   1. Impairment in the development of reading skills.
   2. Often referred to as dyslexia.
   3. Slow reading speed and reduced comprehension.
B. Developmental arithmetic disorder: impairment in the development of arithmetic skills.
C. Developmental language disorder.
   1. Three major types.
      a. Failure to acquire any language.
      b. Acquired language disability.
      c. Delayed language acquisition.
   2. Often the result of trauma or a neurologic disorder.

Nursing Interventions
Goal: To identify specific developmental disorders in relationship to chronologic age in preschool testing.
Goal: To refer child to appropriate developmental program in school.

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

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

Nursing Interventions
Goal: To exhibit no signs or symptoms of malnutrition.
A. If client is unable or unwilling to maintain adequate oral intake, a liquid diet may be administered through a nasogastric tube.
B. Consult with dietitian; determine number of calories required to provide adequate nutrition and realistic weight gain.
C. Explain to client details of behavior modification program.
D. Sit with client during mealtime for support and to observe amount ingested. A limit (usually 30 minutes) should be imposed on time allotted for meals.
E. Observe client for at least 1 hour after meals.
F. Accompany client to bathroom, if self-induced vomiting is suspected.
G. Carefully document intake and output.
H. Weigh client immediately after he or she arises and after first voiding, usually once or twice each week, but not more often to avoid focusing on weight. Always use same scale, if possible.
I. Do not discuss food or eating with client, once protocol has been established. Do, however, offer support and positive reinforcement for obvious improvements in eating behaviors.
J. Offer support and use nonjudgmental approach with the client.
K. Administer antidepressants as ordered.
Goal: To increase self-esteem, as manifested by verbalizing positive aspects of self and exhibiting less preoccupation with own appearance, by discharge.
A. Assist client to reexamine negative perceptions of self and to recognize positive attributes.
B. Offer positive reinforcement for independently made decisions influencing client’s life.
C. Offer positive reinforcement when honest feelings related to autonomy/dependence issues remain separated from maladaptive eating behaviors.
D. Help client to develop a realistic perception of body image and relationship with food.
E. Promote feelings of control within the environment through participation and independent decision making.
F. Allow client to make decisions when appropriate and realistic.
G. Help client realize that perfection is unrealistic and explore this need with the client.
H. Help client claim ownership of angry feelings and recognize that expressing them is acceptable if it is done in an appropriate manner. Be an effective role model.
Goal: To identify an eating disorder and rule out a physiologic cause.
Goal: To recognize complications.
A. Anorexia nervosa—refeeding syndrome can result if system is replenished too quickly, leading to cardiovascular collapse.
B. Bulimia nervosa—if syrup of ipecac is used to induce vomiting, and vomiting does not occur, the absorption of the ipecac can lead to cardiotoxicity and heart failure. Watch for edema and check breath sounds.

ORGANIC MENTAL DISORDERS
A. Organic brain syndrome is used to refer to a constellation of psychologic or behavioral signs and symptoms without reference to causes (e.g., delirium, dementia).
CHAPTER 10  Psychiatric Disorders

B. **Organic mental disorder** designates a particular organic brain syndrome in which the cause is known or presumed (e.g., alcohol withdrawal or delirium) (Box 10-1).

### Box 10-1  KEY POINTS: ORGANIC MENTAL SYNDROMES

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

### Nursing Interventions

**Goal:** To diminish effect of causative agent such as drugs, infectious organisms, or a circulatory-metabolic disorder.

A. Administer medications: antipyretics, antibiotics, or sedatives.
B. Assess for contributing factors/agents and eliminate when possible.
C. Prevent further damage by assessing for possible complications.

**Goal:** To provide adequate nutrition.

A. Encourage diet high in calories, protein, and vitamins, especially thiamine (vitamin B₁).
B. Encourage adequate intake and output.

**Goal:** To prevent complications.

A. Provide a quiet, nonstimulating environment to prevent hallucinations.
B. Ensure that safety needs are met (may fall out of bed).
C. Remove potentially harmful articles from a client’s room: cigarettes, matches, lighters, sharp objects.
D. Pad side rails and headboard of bed for client with a seizure disorder.

### Dementia

Dementia is a syndrome characterized by loss of intellectual abilities to such an extent that social and occupational functioning are negatively affected; involves memory, judgment, abstract thought, and changes in personality. Often, the disorders are progressive and follow an irreversible course in which the damage remains permanent (Box 10-2).

A. Diagnostic criteria.
   1. Loss of intellectual abilities that interfere with social and occupational functioning.
   2. Memory impairment.
   3. Impairment in abstract thinking, judgment, and language.

### Delirium

Delirium is a syndrome that usually develops over a short period of time. The constellation of symptoms typically fluctuates and is often reversible and temporary.

#### Assessment

A. Diagnostic criteria.
   1. A clouded sensorium or state of consciousness.
   2. Memory loss for both recent and remote events; disorientation.
   3. Signs and symptoms develop over a short period of time and tend to fluctuate during the day.
   5. Sleep disturbances.
   6. Motor activity may be increased or decreased.
   7. Speech may be incoherent.

B. Additional characteristics.
   1. Emotional disturbances: anxiety, fear, depression, anger.
   2. Age at onset: common in children and after the age of 60 years.

### Etiologic factors.

1. **Systemic infection:** meningitis, encephalitis, respiratory and urinary infection.
2. **Metabolic disorders:** fluid or electrolyte imbalance.
   a. Hypoglycemia.
   b. Dehydration, vomiting.
3. **Hepatic or renal disease; thiamine deficiency.**
4. **Drug intoxication and withdrawal.**
5. **Circulatory problems associated with hypertension.**
6. **Head trauma:** seizure activity.

**Nursing Interventions**

**Goal:** To diminish effect of causative agent such as drugs, infectious organisms, or a circulatory-metabolic disorder.

A. Administer medications: antipyretics, antibiotics, or sedatives.
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C. Remove potentially harmful articles from a client’s room: cigarettes, matches, lighters, sharp objects.
D. Pad side rails and headboard of bed for client with a seizure disorder.

#### Box 10-2  ASSESSING CHANGES IN SENILE DEMENTIA

<table>
<thead>
<tr>
<th>J</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Affect</td>
</tr>
<tr>
<td>M</td>
<td>Memory</td>
</tr>
<tr>
<td>C</td>
<td>Confusion</td>
</tr>
<tr>
<td>O</td>
<td>Orientation</td>
</tr>
</tbody>
</table>
4. Personality change demonstrated by exaggeration of previous personality traits.
5. Mini-Mental State Examination shows disorientation and lack of recall.

B. Additional characteristics.
1. Anxiety or depression may be apparent.
2. Behavior may demonstrate excessive orderliness, social withdrawal, or the tendency to relate an event in excessive detail.
3. Age at onset: found predominantly in older adults.

C. Etiologic factors.
3. Central nervous system infections: tertiary neurosyphilis, tuberculosis, fungal meningitis, viral encephalitis.
5. Toxic effects: metabolic disturbance.
   a. Pernicious anemia, hypothyroidism.
   b. Bromide intoxication.

### Older Adult Priority

The cardinal rule: do not push too fast in getting information, assisting with activities of daily living, or insisting that the person socialize. Continued pressure and insistence on a task may result in combative behavior. Watch for reasons for confusion; it could be due to dehydration and electrolyte imbalance, not just "old age."

#### Table 10-1 STAGES OF ALZHEIMER'S DISEASE

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

(5) Wandering behavior.
   (a) Restlessness and activity-seeking behavior.
   (b) The "stalking of old haunts."
(6) Disorientation and inability to sustain intentions; the person forgets what he or she set out to do.
(7) Catastrophic reactions: heightened anxiety occurring during interviewing or questioning, when a person cannot answer or perform.
(8) Combative behavior.
   b. Pick’s disease or frontotemporal dementia (FTD): characterized by marked personality and behavioral changes and a decline in the ability to speak coherently.

7. Alteration in intracranial pressure.
   a. Hydrocephalus.
   b. Brain tumor.

**OLDER ADULT PRIORITY** Situations that can lead to combative behavior are threats to self-image, new things or people in environment, illusions, pressure to remember, and direct confrontation.

**NURSING PRIORITY** The 3 Rs—routine, reinforcement, and repetition—are key aspects of care, not only for the mentally retarded, but for the older adult client with dementia as well.

**Nursing Interventions**

**Goal:** To administer medication to slow the dementia disease process (see Appendix 10-1).

**Goal:** To provide a quiet, structured environment to increase consistency and promote feelings of security.

<table>
<thead>
<tr>
<th>Table 10-2</th>
<th>GROUP MODALITIES FOR OLDER ADULT CLIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remotivation Therapy</td>
<td>Reminiscing Therapy</td>
</tr>
<tr>
<td><strong>Purpose of Group</strong></td>
<td></td>
</tr>
<tr>
<td>Resocialize regressed and apathetic older adult clients</td>
<td>Share memories</td>
</tr>
<tr>
<td></td>
<td>Increase socialization</td>
</tr>
<tr>
<td></td>
<td>Enhance self-esteem</td>
</tr>
<tr>
<td><strong>Format</strong></td>
<td></td>
</tr>
<tr>
<td>10-15 clients in a group</td>
<td>6-8 clients in a group</td>
</tr>
<tr>
<td>Meet 1-2 times per week</td>
<td>Meet 1-2 times per week</td>
</tr>
<tr>
<td>Meetings highly structured in a classroom setting</td>
<td>Topics include holidays, travel</td>
</tr>
<tr>
<td>Each session has a specific topic</td>
<td></td>
</tr>
<tr>
<td><strong>Desired Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Increases group members’ sense of reality</td>
<td>Assists in alleviating depression</td>
</tr>
<tr>
<td>Encourages a more objective self-image</td>
<td>Use of process of reorganization and reintegration provides an avenue for older adults to achieve a sense of identity and positive self-concept</td>
</tr>
<tr>
<td></td>
<td>Provides group support for increasing self-esteem</td>
</tr>
</tbody>
</table>

**Alarming** Orient client to reality and monitor activities of the confused client. (Knowledge about providing care for the older client, especially the client with Alzheimer’s disease, is often tested).

**Goal:** To promote contact with reality.
A. Make brief and frequent contact.
B. Give feedback.
C. Supply stimulation to motivate client to engage in activities.
D. Use concrete ideas in communication.
E. Maintain reality orientation by encouraging client to reminisce (Table 10-2).

F. Orient client frequently to reality and surroundings.
1. Allow client to have familiar objects around him or her.
2. Use other items such as clocks, calendars, and daily schedules.
G. Use simple explanations and face-to-face interaction.
H. Do not shout message into client’s ear.
I. Allow sufficient time for client to complete projects.
J. Reinforce reality-oriented comments and orientation to time, place, and date.

NURSING PRIORITY Speaking slowly and in a face-to-face position is most effective when communicating with an older adult experiencing a hearing loss. Visual cues facilitate understanding. Shouting causes distortion of high-pitched sounds, and in some instances, creates a feeling of discomfort for the client.

Goal: To provide diversion activities that enhance self-esteem.
A. Provide occupational therapy, physical therapy, and recreational therapy that client enjoys.
B. Maintain a flexible schedule; keep client from becoming bored and easily distracted.
C. Recognize specific accomplishments.
D. Encourage family involvement and provide emotional support.
E. Devise methods for assisting client with memory deficit.
   1. Name sign and picture on door identifying client’s room.
   2. Identifying sign on outside of dining room door.
   3. Large clock, with oversized numbers and hands, appropriately placed.
   4. Large calendar, indicating one day at a time, with month, day, and year identified in bold print.

NURSING PRIORITY The 3 Ps for clients with dementia: protecting dignity, preserving function, and promoting quality of life.

Anxiety Disorders
In the past, anxiety disorders were grouped together as neuroses. Anxiety can be a predominant disturbance (panic and generalized anxiety), or anxiety can be experienced as a person attempts to confront a dreaded situation (phobic disorder) or resist the obsessions and compulsions of an obsessive-compulsive disorder. In general, these are common responses to emotional problems that are very seldom treated in a psychiatric setting, because the person does not have a great defect in reality testing and does not demonstrate severe antisocial behavior. Pressures of decision making and decisions that are made in the early adult years seem to act as precipitating events in the development of anxiety disorders (Table 10-3).

Nursing Interventions
Goal: To promote techniques to reduce anxiety.
A. Desensitization: client is exposed serially to a specific list of anxiety-provoking situations; through techniques of progressive relaxation, the client becomes desensitized to each stimulus.
B. Reciprocal inhibition: the anxiety-provoking stimulus is paired with another stimulus that is associated with an opposite feeling to diminish the effect of the anxiety.
C. Cognitive therapy: internal dialogue or self-talk on feelings, emotions, and behavior.
D. Regular daily exercise.
E. Other therapy: hypnosis, meditation, imagery, yoga, biofeedback training.

Somatoform Disorders
Somatoform disorders are disorders in which the person has physical symptoms suggesting a physiologic etiology; however, after in-depth assessment and diagnostic testing, no organic disease or physiologic abnormalities are found.

Assessment
A. Somatization disorder: recurrent, multiple complaints (from the following four areas) for which medical treatment has been sought; the client must display:
   1. Four pain symptoms (e.g., head, abdomen, back, shoulder, joints).
   2. Two gastrointestinal symptoms (e.g., nausea, bloating, diarrhea, flatulence).
   3. One sexual symptom (e.g., sexual indifference, erectile dysfunction, abnormal menses, painful menstruation, excessive bleeding).
   4. One symptom suggesting a neurologic problem (e.g., loss of sensation, blindness, double vision).
B. Conversion disorder: a loss of, or alteration in, physical functioning that suggests a physical disorder but is related to expression of a psychologic conflict or need; person appears calm while experiencing symptoms.
   1. A loss of alteration in physical function, suggesting a physical disorder.
   2. Symptoms are not under voluntary control.
   3. La belle indifference: an attitude toward the symptoms in which there is a lack of concern.
   4. Not a deliberate faking (malingering).
   5. “Classic conversion symptoms” usually suggest neurologic disease: paralysis, aphonia, blindness, and paresthesias.
C. Pain disorder: preoccupied with pain for which there is no physical cause.
   1. Severe and prolonged pain.
   2. Pain is nonanatomic in distribution.
   3. Evidence of a stressful life situation.
   4. Complaint excessive in relation to the observable symptoms.
   5. History of frequent visits to physician (“doctor shopping”).
   6. Excessive use of analgesics without relief of pain, along with frequent requests for surgery.

Alert Identify effects of environmental stressors on client; plan measures to deal with client’s anxiety; encourage client to use problem-solving skills; teach stress reduction techniques; and provide support to client who is upset or distraught.
## Table 10-3  SELECTED ANXIETY DISORDERS

<table>
<thead>
<tr>
<th>Problem</th>
<th>Description</th>
<th>Nursing Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panic disorder</strong> (with or without agoraphobia): an extreme level of anxiety.</td>
<td>Agoraphobia (fear of being in places or situations; crowds, traveling). May experience shortness of breath, dizziness, diaphoresis, palpitations.</td>
<td><strong>Goal:</strong> To reduce panic level anxiety feelings by reinterpreting the feelings correctly (see Table 9-2). 1. Anticipate administration of a tricyclic antidepressant. 2. Reduce amount of caffeine in diet.</td>
</tr>
<tr>
<td><strong>Phobia:</strong> an intense, irrational fear of a specific object, activity, or situation.</td>
<td>Fear of being alone or in public places. Claustrophobia (fear of enclosed spaces). Acrophobia (fear of heights). Social phobia (fear of circumstances that may be humiliating, e.g., speaking in public, eating in restaurants).</td>
<td><strong>Goal:</strong> To reduce phobic behavior. 1. Do not force client to come in contact with the feared object or source of anxiety. 2. Have client focus on awareness of self. 3. Distract client's attention from phobia.</td>
</tr>
</tbody>
</table>
| **Obsessive-compulsive disorder:** unconscious control of anxiety by the use of rituals, thoughts, obsessions, or compulsions. | **Obsessions:** recurrent, persistent ideas, thoughts, or impulses that are not voluntarily produced.  
*Most common obsessions include thoughts of violence, contamination, and doubt.*  
**Compulsions:** repetitive, ritualistic behaviors that are performed in a certain fashion to relieve an unbearable amount of tension.  
*Most common compulsions include handwashing, counting, checking.* | **Goal:** To assist in coping with the compulsive behavior. 1. Accept rituals and avoid punishment or criticism; do not interrupt ritual, because this will increase anxiety. 2. Plan for extra time because of slowness and client's need for perfection. 3. Prevent physical deterioration or harm, and set limits only to prevent harmful acts (such as handwashing so excessively that it removes the skin from the hand surface). **Goal:** To encourage client to develop different ways of handling anxiety. 1. Reduce demands on the individual. 2. Convey acceptance of client, regardless of behavior. 3. Encourage alternative activity. |
| **Post-traumatic stress disorder:** involves the development of characteristic symptoms after a traumatic psychologic event in which the individual is unable to adapt or adjust (e.g., rape, military combat, airplane crashes, torture, or abuse). | Client reexperiences the traumatic event. Client withdraws, becomes isolated, and restricts emotional response. Experiences hyperalertness, insomnia, nightmares, depression, and anxiety. | **Goal:** To determine precipitating stress factor in client's reaction. 1. Reduce and prevent chronic disability. 2. Encourage verbalization of the traumatic event. **Goal:** To maintain personal integrity. 1. Provide physical, social, or occupational rehabilitation. 2. Somatic therapies are used to decrease anxiety (e.g., antianxiety agents, etc.). **Goal:** To reduce level of anxiety. 1. Administer antianxiety agent. 2. Teach anxiety-reducing techniques. 3. Reduce anxiety-provoking situations around client. 4. Divert attention from symptoms. |
| **Generalized anxiety disorder:** unrealistic or excessive anxiety and worry about life's circumstances; differs from panic disorder in that it never remits and onset is at early age. | Physical symptoms associated with disorder are restlessness, apprehension, tension, irritability, “free-floating” anxiety. | **Goal:** To maintain personal integrity. 1. Provide physical, social, or occupational rehabilitation. 2. Somatic therapies are used to decrease anxiety (e.g., antianxiety agents, etc.). **Goal:** To reduce level of anxiety. 1. Administer antianxiety agent. 2. Teach anxiety-reducing techniques. 3. Reduce anxiety-provoking situations around client. 4. Divert attention from symptoms. |

D. Hypochondriasis: distorted interpretation of existing physical signs or bodily sensations, which leads the client to an unrealistic belief and preoccupation with the fear or belief of having a serious, debilitating disease.  
1. Preoccupied with bodily functioning: focusing on heart beat, breathing, digestion, or a minor aliment, such as a small scratch or a cough.  
2. Physical evaluation does not support the diagnosis of any physical problem.  
3. Fear or belief of having medical illness despite medical reassurance.  
E. Body dysmorphic disorder: preoccupation with an imagined flaw in appearance in a normal-appearing person.
1. Excessive concern and focus on facial defect; less commonly on other parts of the body; preoccupies and dominates client’s life.
2. Social isolation and depression leading to suicidal threats and repeated hospitalizations.
3. May seek plastic surgery.

**Nursing Interventions**

**Goal:** To divert attention from preoccupation with self and symptomatology.

A. Encourage purposeful activity that promotes interest and success.
B. Promote attitude that acknowledges personal integrity and self-worth.
C. Provide for client’s physical needs as necessary.
D. Correct any misinformation and give correct information.
E. Encourage client to develop new interests and gain satisfaction from them.
F. Promote a good sense of humor.

**Goal:** To identify primary or secondary gain.

A. Primary gain: symptom has symbolic meaning to client; keeps client unaware of internal conflict and anxiety.
B. Secondary gain: a gain of attention and sympathy along with reinforcement of maladjusted behavior.

**Goal:** To avoid secondary gains as a source of reward and reinforcement for the disorder.

A. Focus on the individual and his or her feelings, not on the symptoms.
B. A calm, warm, supportive approach promotes understanding and acceptance.

**Goal:** To avoid reinforcing the client’s symptoms.

A. Focus on feelings, not on symptoms.
B. Reduce pressure and anxiety-provoking situations around client.
C. Divert attention from symptoms.
D. Provide recreational activity.
E. Avoid pity and sympathetic approach to client’s “illnesses” or “symptoms.”

**Goal:** To be aware of personal response to the client.

A. Recognize and understand the client’s self-perception as unable to cope.
B. Promote a nonjudgmental, understanding attitude.

**Goal:** To provide a supportive approach that does not focus on physical condition.

A. Help client to understand how he or she uses illness to avoid dealing with life’s problems.
B. Offer empathy without sympathy.

**Goal:** To support alternative therapy.

A. Behavior modification.
B. Insight-oriented psychotherapy.
C. Hypnosis.
D. Acupuncture.

**Psychophysiologic Disorder**

A psychophysiologic disorder is a physical illness that is strongly influenced by psychologic factors. It was previously called psychosomatic disorder. It is thought that stress and anxiety arouse specific conflicts in an individual, which result in damaging effects on particular organs or organ systems that are under the control of the autonomic nervous system (Figure 10-1).

**Assessment**

A. Respiratory.
   1. Hyperventilation syndrome.
   2. Asthma.
B. Cardiovascular.
   1. Essential hypertension.
   2. Angina.
   3. Migraine headaches.
   4. Tachycardia.
C. Gastrointestinal.
   1. Peptic ulcer.
   2. Ulcerative colitis.
   3. Colic.
D. Integumentary.
   1. Dermatitis.
   2. Pruritus.
   3. Excessive sweating.
   4. Atopic dermatitis.
E. Musculoskeletal.
   2. Rheumatoid arthritis.
F. Endocrine.
   1. Diabetes mellitus.
   2. Sexual dysfunction.
   3. Hyperemesis gravidarum.
   4. Hyperthyroidism.
G. Genital/urinary.
   1. Amenorrhea.
   2. Impotence.

**Nursing Interventions**
Pathophysiology of, and nursing interventions for, the psychophysiologic disorders are discussed under the appropriate body system affected.

**Dissociative Disorders**
Dissociative disorders involve five primary symptoms: amnesia (memory loss), derealization (objects in external environment take on a quality of unreality and estrangement), depersonalization (alteration in the perception or experience of self), identity confusion (sense of conflict, puzzlement, or uncertainty in relation to one's identity), and identity alteration (organized shift in personality that occurs without the individual's awareness).

**Assessment**
A. Dissociative amnesia.
   1. A sudden inability to recall important personal information.
   2. Usually begins suddenly, after severe psychosocial stress.
   3. Most often observed in the adolescent and young adult female, rarely in older adults.
B. Dissociative fugue.
   1. Sudden, unexpected travel away from home with the assumption of a new identity.
   2. An inability to recall one's previous identity or past.
   3. No recollection of events that took place during the fugue state.
C. Dissociative identity disorder (multiple personality).
   1. The existence of two or more distinct personalities, each of which determines the nature of his or her behavior and attitudes while uppermost in the person's consciousness.
   2. Transition from one personality to another is sudden and often stressful.
   3. Best-known examples found in literature: *Sybil* and *The Three Faces of Eve*.
D. Depersonalization disorder.
   1. An alteration in the perception of the self so that the usual sense of one's own reality is temporarily lost or changed.
   2. Sensations of unreality (e.g., feelings that one's extremities have changed size).
   3. Onset is rapid; disappearance is gradual.

**Nursing Interventions**
Goal: To assist in ruling out a physical or organic disease as the cause of the dissociative disorder.
A. Many behaviors exhibited resemble postconcussive amnesia and temporal lobe epilepsy.
B. Accurate observation and description of character, duration, and frequency of the symptoms are important.
Goal: To minimize anxiety.
A. Redirect client's attention away from self.
B. Increase socialization activities.
C. Include family members in learning new ways to deal with client's behavior.
Goal: To provide insight into past traumatic experiences and learn new coping methods.
A. Long-term therapy is aimed at insight into pain of past experiences and conflicts that have been repressed.
B. Encourage awareness that dissociative behaviors are reactivated by current situations that arouse emotional pain.

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

**Common Characteristics**
A. Problems are expressed through behavior rather than as physical symptoms of stress.
B. Disruptive lifestyle is deeply ingrained and quite difficult to change; usually related to some form of abnormal behavior or the development of a particular pattern or trait.
C. Often comes in conflict with others.
D. Pleasure principle is dominant with inadequate superego control; has difficulty with problem solving.
E. Unable to develop meaningful relationships with others and communicate effectively.
F. Rarely acknowledges that there is a problem.

**Assessment**
See Table 10-4 on personality disorder clusters.

**NURSING PRIORITY** Personality disorders occur when traits become rigid and manipulative.

**Nursing Interventions**
Goal: To promote communication and socialization in the paranoid personality.
A. Decrease social isolation.
B. Verbal and nonverbal messages should be clear and consistent.
C. To decrease anxiety, plan several brief contacts, rather than one prolonged contact.
D. Promote trust by following through on commitments.
E. Be open and honest to avoid misinterpretation.
### Table 10-4 PERSONALITY DISORDER CLUSTERS

<table>
<thead>
<tr>
<th>Cluster A</th>
<th>Cluster B</th>
<th>Cluster C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paranoid Personality</strong></td>
<td><strong>Anti-social Personality</strong></td>
<td><strong>Avoidant Personality</strong></td>
</tr>
<tr>
<td>Suspicious and mistrustful of people</td>
<td>Violates rights of others</td>
<td>Fear of criticism or disapproval</td>
</tr>
<tr>
<td>Secretive</td>
<td>Lacks responsibility</td>
<td>Hypersensitive to potential rejection</td>
</tr>
<tr>
<td>Questions loyalty of others</td>
<td>Manipulative</td>
<td>Views self as socially inept, personally</td>
</tr>
<tr>
<td>Jealous</td>
<td>Unable to sustain a job; frequent job changes</td>
<td>unappealing, and inferior to others</td>
</tr>
<tr>
<td>Overconcerned with hidden motives and</td>
<td>and lengthy periods of unemployment</td>
<td>Inhibited in interpersonal relationships</td>
</tr>
<tr>
<td>special meanings</td>
<td>Financial dependency</td>
<td>Reluctant to take personal risks</td>
</tr>
<tr>
<td>Hypersensitive and alert</td>
<td>Common behaviors observed—lying, stealing,</td>
<td>Unwilling to get involved with people</td>
</tr>
<tr>
<td>Exaggerates</td>
<td>truancy</td>
<td>unless certain of being liked</td>
</tr>
<tr>
<td>Unable to relax</td>
<td>Aggressive sexual behavior</td>
<td></td>
</tr>
<tr>
<td>Takes offense quickly</td>
<td>Sexual promiscuity</td>
<td></td>
</tr>
<tr>
<td>Impaired affect</td>
<td>Excessive drinking and drug use</td>
<td></td>
</tr>
<tr>
<td>Unemotional and cold</td>
<td>Criminality</td>
<td></td>
</tr>
<tr>
<td>No sense of humor</td>
<td>Vagrancy</td>
<td></td>
</tr>
<tr>
<td>Absence of soft, tender, sentimental</td>
<td>Lack of remorse</td>
<td></td>
</tr>
<tr>
<td>feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distorts reality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses projection</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Schizoid Personality</strong></td>
<td><strong>Borderline Personality</strong></td>
<td><strong>Dependent Personality</strong></td>
</tr>
<tr>
<td>Unable to form social relationships</td>
<td>Unstable interpersonal relationships and</td>
<td>Submissive, clinging behavior</td>
</tr>
<tr>
<td>Cold and aloof; flat affect</td>
<td>moods</td>
<td>Fear of separation</td>
</tr>
<tr>
<td>Indifferent to praise or criticism</td>
<td>Impulsiveness and unpredictability that may</td>
<td>Difficulty making everyday decisions</td>
</tr>
<tr>
<td>Has little or no desire for social</td>
<td>be self-damaging (e.g., spending, sex,</td>
<td>Needs others to assume responsibility</td>
</tr>
<tr>
<td>involvement</td>
<td>reckless driving, drug use)</td>
<td>Wants others to take care and nurture</td>
</tr>
<tr>
<td>Appears reserved, withdrawn, and</td>
<td>Identity disturbance</td>
<td>Feels uncomfortable or helpless when left</td>
</tr>
<tr>
<td>exclusive</td>
<td>Recurrent suicidal behavior, gestures, or</td>
<td>alone</td>
</tr>
<tr>
<td></td>
<td>threats</td>
<td>Difficulty initiating projects</td>
</tr>
<tr>
<td></td>
<td>Self-mutilating behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inappropriate, intense anger; lack of anger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>control; shifts in mood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic feelings of emptiness</td>
<td></td>
</tr>
<tr>
<td><strong>Schizotypal Personality</strong></td>
<td><strong>Histrionic Personality</strong></td>
<td><strong>Obsessive-Compulsive Personality</strong></td>
</tr>
<tr>
<td>Magical thinking (e.g., telepathy,</td>
<td>Excessive emotionality and attention-seeking</td>
<td>Preoccupation with rules, lists,</td>
</tr>
<tr>
<td>superstitiousness)</td>
<td>behavior</td>
<td>organization, schedules</td>
</tr>
<tr>
<td>Ideas of reference</td>
<td>Uncomfortable when not center of attention</td>
<td>Perfectionistic</td>
</tr>
<tr>
<td>Social isolation</td>
<td>Uses physical appearance to draw attention to</td>
<td>Excessive devotion to work</td>
</tr>
<tr>
<td>Recurrent illusion</td>
<td>self</td>
<td>Overconscientious and inflexible</td>
</tr>
<tr>
<td>Oddities of thought, perception, speech,</td>
<td>Self-dramatization, theatrical, and</td>
<td>Reluctant to delegate tasks</td>
</tr>
<tr>
<td>and behavior</td>
<td>exaggerated expression of emotion</td>
<td>Hoards money; frugal</td>
</tr>
<tr>
<td>Inappropriate affect</td>
<td>Easily suggestible</td>
<td>Rigid and stubborn in thoughts</td>
</tr>
<tr>
<td>Excessive social anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Narcissistic Personality</strong></td>
<td><strong>Obsessive-Compulsive Personality</strong></td>
<td></td>
</tr>
<tr>
<td>Grandiose self-importance</td>
<td>Preoccupation with rules, lists,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>organization, schedules</td>
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<td></td>
<td>Perfectionistic</td>
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<td></td>
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</tbody>
</table>
**Goal:** To convey to the schizoid or schizotypal client the idea that you do not perceive reality the same way as he or she does but are willing to listen, learn, and offer feedback about his or her experiences.

**Goal:** To promote a positive, therapeutic, interpersonal relationship.
A. Set realistic expectations.
B. Provide a model of mature behavior.
C. Use problem-solving techniques to encourage a client to make changes.
D. Anticipate and deal with depression in a client who gradually acquires enough insight to realize and accept responsibility for his or her behavior.
E. Common sources of frustration for nurses.
   1. Client's immature behavior.
   2. Poor communication skills.

**Goal:** To minimize manipulation and “acting out” behaviors and encourage verbal communication.
A. Set firm, consistent limits without being punitive.
B. Be aware of how client may manipulate other staff members (e.g., playing one against the other or splitting).
C. Promote expression of feelings versus acting out.
D. Promote client's acceptance of responsibility for his or her own actions and a social responsibility to others.

**NURSING PRIORITY** A client with borderline personality disorder has a tendency to cling to one staff member, if allowed, transferring his or her maladaptive dependency to that individual. This dependency can be avoided if the client is able to establish therapeutic relationships with two or more staff members who encourage independent self-care activities.

**Goal:** To assist client to manage anxiety.
A. Anticipate client's needs before he or she demands attention.
B. Teach client to express his or her ideas and feelings assertively.
C. Watch for signs of defensiveness, because a client is unlikely to recognize this as a mechanism of anxiety.

**Goal:** To set realistic limits.
A. Break the health-attention-avoidance cycle that usually exists in relating to this type of client.
B. Support the client who is gradually making more decisions on his or her own.
C. Offer assistance only when needed.

**SUBSTANCE USE DISORDERS**

Substance use disorders are characterized by behavior changes, regular use of a substance (alcohol or another drug) that affects the central nervous system, and withdrawal symptoms when the substance is not taken.

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

**ALERT** Identify signs and symptoms of substance abuse/chemical dependency.

A. Substance abuse.
   1. A pattern of pathologic use.
      a. Intoxication during the day.
      b. Inability to cut down or stop drinking.
      c. Daily need of the substance in order to function.
      d. Blackouts and medical complications from use.
   2. Impairment of social or occupational functioning.
      a. Failure to meet important obligations to friends, family, and employer.
      b. Inappropriate display of erratic and impulsive behavior.
      c. Inappropriate expression of aggressive feelings.
   3. Minimum duration of at least 1 month of substance use.

B. Substance dependence: more severe than substance abuse; requires physiologic dependence as evidenced by either tolerance or withdrawal.
   1. Tolerance.
      a. Increased amounts of the substance are required to achieve the desired effect.
      b. Markedly diminished effect with regular use of the same dose.
   2. Withdrawal: a specific syndrome of symptoms, which develops when the person abruptly stops ingesting the substance.

C. Psychologic dependence.
   1. Habituation: the need to take the substance.
   2. Physiologic dependence is not necessary.
   3. No physiologic symptoms on withdrawal.

D. Common health problems.
   1. Acute problems.
      a. Poor nutritional status, loss of appetite, nausea, vomiting, and diarrhea.
      b. Central nervous system dysfunction and irritability, seizures, tremors, motor restlessness, sensitivity to light, auditory or visual disturbances, insomnia.
      c. Susceptibility to recurrent respiratory tract infections.
   2. Chronic problems.
      a. Liver dysfunction, cirrhosis, pancreatitis, hypertension.
      b. Chronic brain damage and mental deterioration, poor hygiene, dermatologic changes.
      c. Human immunodeficiency virus (HIV) seropositivity.

E. Dysfunctional behavior patterns.
   1. Manipulation.
      *Examples: Legal difficulties, crime, physical assault, taking advantage of generosity.*
   2. Impulsiveness.
      *Examples: Inconsistent work patterns, overdose, recklessness.*
   3. Dysfunctional anger.
      *Example: Belief that nobody has done worse things or has lost as much or taken drugs or drunk as much.*
5. Denial.
6. Codependency: extreme emotional, social, or physical focus on another person, place, or thing.

F. Treatment modalities.
1. Detoxification: controlled withdrawal from alcohol or drugs by means of a medical protocol.
2. Drug treatment and rehabilitation: comprehensive program based on client outcomes; may include detoxification, family education, group counseling, and 12-step programs.
3. 12-step self-help groups: recovery built on abstinence as a daily process; requires peer support and acknowledgment that client has addiction.
4. Drug-free residential communities: therapeutic community based on a hierarchical community structure and governance, peer support, and a disciplined lifestyle.
5. Pharmacologic therapy: use of dolophine (Methadone) for opiate abuse to eliminate craving for drug.
6. Psychotherapy: may be individual, group, family, or a combination of all three; facilitates behavioral and lifestyle changes by dealing with personality issues and psychologic conflicts.

Alcohol Dependence (Alcoholism)
A chronic pattern of pathologic alcohol use is characterized by impairment in social or occupational functioning, along with tolerance or withdrawal symptoms.

General Concepts
A. Incidence.
1. An estimated 20 million Americans have alcoholism; of those who consume alcohol, 1 in 10 is an alcoholic.
2. Each year, 80 billion dollars is spent on alcohol-related illnesses, which lead to lost wages, reduced productivity, and property damage.
3. Chronic alcoholism shortens the life span by 12 years.

B. Effects of use.
1. Central nervous system depressant drug.
2. Requires no digestion; 20% is absorbed unchanged from the stomach; 80% is absorbed from the small intestine.
3. Absorbed slowly in a full stomach.
4. Measured in the bloodstream by the blood alcohol level (BAL).
5. Can be measured within 15 to 20 minutes after ingestion; reaches a peak in 60 to 90 minutes; is completely metabolized by 12 to 24 hours after the last drink.
6. Decreases inhibitions and enhances mood; slows motor reactions and subsequently prolongs reaction time.
7. In low doses, tends to increase sexual arousal; in high doses, tends to decrease it.
8. Affects critical thinking, judgment, and memory.
9. BAL of 8% to 10% (depending on the state) or more is considered intoxication.

Assessment
A. Risk factors.
1. History of alcoholism in family.
2. History of total abstinence.
3. Broken or disrupted home.
4. Last or near-last child in a large family.
5. Heavy smoking.
6. Cultural groups: Irish, Eskimo, Scandinavian, Native American.

B. Diagnostics.
1. BAL.
   a. BAL is determined by how much alcohol is consumed, how fast it is consumed, and body weight.
   b. The larger the person, the more alcohol he or she can tolerate.
   c. Usual legal guidelines for intoxication: BAL greater than 100 to 150 mg/dL.
2. Breathalyzer.
   a. About 5% to 10% of the alcohol is excreted through breathing.
   b. Used for monitoring the use of alcohol and to identify persons who are driving while intoxicated (DWI) or driving under the influence (DUI).

C. General personality characteristics of alcoholics.
1. Dependent behavior along with resentment of authority.
2. Demanding and domineering with a low tolerance for frustration.
3. Dissatisfied with life; tendency toward self-destructive acts, including suicide.

D. Signs and symptoms of possible alcohol abuse.
1. Sprains, bruises, and injuries of questionable origin.
2. Diarrhea and early morning vomiting.
3. Chronic cough, palpitations, and infections.
4. Frequent Monday morning illnesses; blackouts (inability to recall events or actions while intoxicated).

E. Alcohol withdrawal syndrome. Consuming one-fifth of whiskey daily for 1 month is generally considered sufficient to produce alcohol withdrawal. The withdrawal syndrome develops in heavy drinkers who have increased, decreased, or interrupted the intake of alcohol.
1. Alcohol withdrawal.
   a. Anorexia, irritability, nausea, and tremulousness.
   b. Insomnia, nightmares, irritability, hyperalertness.
   c. Tachycardia, increased blood pressure, and diaphoresis.
   d. Onset within 8 hours after cessation of drinking (usually 48 to 72 hours); clears up within 5 to 7 days.
2. Delirium tremens.
   a. Autonomic hyperactivity: tachycardia, sweating, increased blood pressure.
   b. Vivid hallucinations, delusions, confusion.
   c. Coarse, irregular tremor is almost always seen; fever may occur.
d. Onset within 24 to 72 hours after the last ingestion of alcohol; delirium tremens usually lasts 2 to 3 days.

e. Convulsions/seizures may occur (“rum fits”).

f. First episode occurs after 5 to 15 years of heavy drinking.

3. Alcohol hallucinosis.
   a. Auditory hallucinations.
   b. Occurs within 48 hours after heavy drinking episode.
   c. Often includes persecutory delusions.
   d. Client may be suicidal or homicidal.
   e. Spontaneous recovery within 1 week.
   f. Wernicke’s encephalopathy.
      (1) An acute, reversible neurologic disorder.
      (2) Triad of symptoms: global confusion, ataxia, and eye movement abnormality (nystagmus).
      (3) Occurs primarily in clients with chronic alcoholism; may develop in illnesses that interfere with thiamine (vitamin B₁) absorption (e.g., gastric cancer, malabsorption syndrome, regional enteritis).
      (4) Treatment: high doses of thiamine; 100 mg, given intramuscularly, usually reverses eye signs within 2 to 3 hours of treatment.

F. Korsakoff’s syndrome (alcohol amnesiac disorder).
   1. A chronic, irreversible disorder, often following Wernicke’s encephalopathy.
   2. Triad of symptoms: memory loss, learning deficit, confabulation (filling in of memory gaps with plausible stories).

G. Other disorders associated with chronic alcoholism: pneumonitis, esophageal varices, cirrhosis, pancreatitis, diabetes (these are discussed in the appropriate chapter discussing the system).

Nursing Interventions

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

A. Frequently used acronym—CAGE—suggests asking the following four questions. An answer of “yes” to any question can indicate a problem.
   1. Have you ever felt the need to: Cut down on your drinking?
   2. Have you ever felt: Annoyed by criticism of your drinking?
   3. Have you had: Guilty feelings about drinking?
   4. Do you ever take a morning: Eye-opener?

B. Identify the alcoholic client in the preoperative period.
   1. Often, alcoholics are undiagnosed at the time of surgery and may go into withdrawal or delirium tremens after the NPO (nothing by mouth) period.
   2. Preoperative medication doses need to be adjusted; usually, if tolerant of alcohol, clients are also tolerant of other medications, including anesthetics.
   3. Client usually takes longer to be fully responsive during postoperative period; client is susceptible to severe respiratory complications; client has more difficulty with healing because of poor nutritional state.

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

A. Benzodiazepines for agitation (see Appendix 10–2).

B. Thiamine (vitamin B₁) to prevent Wernicke’s encephalopathy.

C. Magnesium sulfate to increase effective of vitamin B₁. It helps reduce postwithdrawal seizures.

D. Anticonvulsant (phenobarbital), if necessary, for seizure control.

E. Encourage use of multivitamins, especially folic acid, B₁₂, and vitamin C.

F. Alpha-adrenergic blockers (clonidine) to decrease withdrawal symptoms.

G. Beta-adrenergic blockers (atenolol, propranolol) to improve vital signs and decrease cravings.

H. Encourage intake of fluids, but do not force.

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

A. Safety measures, such as bed rest and use of bed rails, may be necessary.

B. If client is experiencing delirium tremens, stay with him or her.

C. Have room adequately lit to help reduce confusion and avoid shadows and unclear objects.

D. Monitor vital signs every 1 to 4 hours.

E. Encourage a high-carbohydrate, soft diet.

Goal: To recognize complications of alcohol use.

A. Obstetrical implications.
   1. Two ounces of alcohol per day may produce a BAL, leading to fetal alcohol syndrome.
   2. Chronic alcoholism can lead to maternal malnutrition, especially folic acid deficiency, bone marrow suppression, infections, and liver disease.
   3. Alcohol withdrawal syndrome may occur in the intrapartal period as early as 12 to 48 hours after the last drink.
   4. Delirium tremens may occur in the postpartum period.

B. Neonatal implications (fetal alcohol syndrome).
   1. Teratogenic effects may be seen along with growth and developmental retardation.
   2. Increased risk for anomalies of the heart, head, face, and extremities.
   3. Withdrawal symptoms can occur shortly after birth and are characterized by tremors, agitation, sweating, and seizure activity.
   4. Maintain seizure precautions.

C. Medical complications of alcohol abuse.
   1. Trauma-related to falls, burns, hematomas.
   2. Liver disease: cirrhosis, esophageal varices, hepatic coma.
   4. Nutritional disease: malnutrition, anemia caused by iron or vitamin B₁₂ deficiency, thiamine deficiency.
5. Infections, especially pneumonia.

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

**Polydrug Dependence**

The regular use of three or more psychoactive substances over a period of at least 6 months.

**General Concepts**
A. Effects of use.
1. Relieves anxiety.
2. Overdose can occur.
3. Factors affecting the degree of dependence.
   a. Physiologic and psychologic makeup of the abuser.
   b. Drug’s pharmacologic action.
   c. External social and cultural factors.
B. General personality characteristics.
1. Inability to cope with stress, frustration, or anxiety.
2. Rebellious, immature, desire for immediate gratification.
4. Difficulty forming warm, personal relationships.
5. Uses defense mechanisms: denial, rationalization, intellectualization.

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

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

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

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

1. Street names: Peter (chloral hydrate); green and whites, roaches (Librium); red birds, red devils (secobarbital); blue birds (Amytal capsules); yellow birds (Nembutal); downers, rainbow, 7145 (barbiturates; tranquilizers).
2. Administration: oral or injected.
3. Symptoms of use.
   a. Alterations in mood, thought, behavior.
   b. Impairment in coordination, judgment.
   c. Signs of intoxication: slurred speech, unsteady gait, decreased attention span or memory.
   d. Barbiturate use: often violent, disruptive, irresponsible behavior.
4. Withdrawal symptoms.
   a. Insomnia, anxiety, profuse sweating, weakness.
   b. Severe reactions of delirium, grand mal seizures, cardiovascular collapse.
D. Cocaine abuse.
   2. Administration: intranasal (“snorting”) or by intravenous or subcutaneous injection; also smoked in pipe (free-basing).
   3. Symptoms of use.
      a. Euphoria, grandiosity, and a sense of well-being.
      b. Amphetamine-like or stimulant-like effects such as increased blood pressure, racing of the heart, paranoia, anxiety.
      c. Used regularly, cocaine may disrupt eating and sleeping habits, leading to irritability and decreased concentration.

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

4. Withdrawal symptoms.
   a. Severe craving.
   b. Coming down from a “high” often leads to a severe “letdown,” depressed feeling.
   c. Psychologic dependence often leads to cocaine becoming a total obsession.
E. Amphetamine dependence.
   \[ \text{Example: dextroamphetamine (Dexedrine).} \]
   1. Street names: crank, bennies, wake-ups, uppers, speed (amphetamines).
   2. Administration: oral or injected.
   3. Symptoms of use.
      a. Elation, agitation, hyperactivity, irritability.
      b. Increased pulse, respiration, and blood pressure.
      c. Fine tremor, muscle twitching, and mydriasis (pupillary dilation).
      d. Large doses: convulsions, cardiovascular collapse, respiratory depression, coma, death.
4. Withdrawal symptoms.
   a. Appear within 2 to 4 days after the last dose.
   b. Depression, overwhelming fatigue, suicide attempts.
F. PCP (phencyclidine hydrochloride) abuse.
   1. Street names: peace pill, hog, super pill, elephant tranquilizer, angel dust, rocket fuel, primo.

2. Administration: snorted, smoked, or orally ingested; usually smoked along with marijuana.
3. Symptoms of use.
   a. Euphoria, feeling of numbness, mood changes.
   b. Diaphoresis, eye movement changes (nystagmus), hypertension, catatonic-like stupor with eyes open.
   c. Seizures, shivering, decerebrate posturing, possible death.
   d. Synesthesias: experiencing one sense when another is actually being stimulated—e.g., seeing colors when a loud sound occurs.
4. Overdose symptoms (“bad trip”): psychosis, possible death.
   a. User may become violent, destructive, and confused.
   b. Users have been known to go berserk; users may harm themselves and others.
   c. Intoxicating symptoms lighten and worsen over a period of 48 hours.
G. Hallucinogen abuse.
   \[ \text{Example: LSD (lysergic acid diethylamide), psilocybin (“magic mushroom”), mescaline (peyote), DMT, MDA.} \]
   1. Street name: acid.
   2. Administration: usually oral, but LSD and mescaline can be injected.
   3. Symptoms of use.
      a. Pupillary dilation, tachycardia, sweating.
      b. Visual hallucinations, depersonalization, impaired judgment and mood.
      c. Flashbacks and “bad trips.”
      d. Usually no signs of withdrawal symptoms after use has been discontinued.
H. Marijuana dependence.
   \[ \text{Example: marijuana, hashish, tetrahydrocannabinol (THC).} \]
   1. Street names: joints, reefer, reefers, reefers, pot, grass, shit, Mary Jane (marijuana), hash (hashish).
   3. Symptoms of use.
      a. Euphoria, relaxation, tachycardia, and conjunctival congestion.
      b. Paranoid ideation, impaired judgment.
      c. Rarely, panic reactions and psychoses.
      d. Heavy use leads to apathy and general deterioration in all aspects of living.
      e. Overdose effects: flashbacks, bronchitis, personality changes.
4. Withdrawal symptoms.
   a. Anxiety, sleeplessness, sweating.
   b. Lack of appetite, nausea, general malaise.
I. Designer drugs.
   1. Street names: Ecstasy, Adam (MDMA [methylene-dioxy-methamphetamine]), China White (MTPT).
   2. Called analog drugs because they retain the properties of controlled drugs (e.g., MTPT is an analog of Demerol).
   3. Symptoms of use and side effects are similar to those associated with the controlled substance from which they are derived.
Nursing Interventions

**Goal:** To assess the drug use pattern.

**Goal:** To assist in medical treatment during detoxification or withdrawal.

A. Narcotics.
   1. Narcotic antagonists, such as naloxone (Narcan), naltrexone (Nalline), or levallophan (Lorfan), are administered intravenously for narcotic overdose.
   2. Withdrawal is managed with rest and nutritional therapy.
   3. Substitution therapy with propoxyphene (Darvon) may be instituted to decrease withdrawal symptoms for longer effects.

B. Depressants.
   1. Substitution therapy with a long-acting barbiturate, such as phenobarbital (Luminal), may be instituted to decrease withdrawal symptoms.
   2. Some physicians prescribe oxazepam (Serax) as needed for objective symptoms, gradually decreasing the dosage until the drug is discontinued.

C. Stimulants.
   1. Treatment of overdose is geared toward stabilization of vital signs.
   2. IV antihypertensives may be used, along with IV diazepam (Valium), to control seizures.
   3. Chlordiazepoxide (Librium) may be administered orally for the first few days while client is “crashing.”

D. Hallucinogens and cannabinoids.
   1. Medications are normally not prescribed for withdrawal from these substances.
   2. In the event of overdose, diazepam (Valium) or chlor Diazepoxide (Librium) may be given as needed to decrease agitation.

E. Awareness that gradual withdrawal, detoxification, or dechemicalization is necessary for the client addicted to barbiturates, narcotics, and tranquilizers.

F. Abrupt withdrawal, or quitting “cold turkey,” is often dangerous and can be fatal.

G. Maintain a patent airway; have oxygen available.

H. Provide a safe, quiet environment (i.e., remove harmful objects, place bed in low position).

**Goal:** To decrease problem behaviors of manipulation and “acting out.”

A. Set firm, consistent limits.

B. Confront client with manipulative behaviors.

**Goal:** To promote alternative coping methods.

A. Encourage responsibility for own behavior.

B. Encourage the use of hobbies, exercise, or alternative therapies as a means to deal with frustration and anxiety.

**Goal:** To recognize complications of substance abuse.

A. Obstetrical implications.
   1. Narcotic addiction.
      a. Increased risk for pregnancy-induced hypertension, malpresentation, and third-trimester bleeding.
      b. Provide methadone maintenance therapy for the duration of the pregnancy—withdrawal is not advisable because of the risk to the fetus.
   2. Use of other drugs causes increased risk to mother and fetus.

B. Neonatal complications.
   1. Withdrawal symptoms depend on type of drug mother used.
   2. Restlessness, jitteriness, hyperactive reflexes, high-pitched shrill cry, feeds poorly.
   3. Maintain seizure precautions.
   4. Administer antiepileptics to treat withdrawal and prevent seizures.
   5. Swaddle infant in snug-fitting blanket.
   6. Increased risk for congenital malformations and prematurity.

C. Medical implications.
   1. Increased risk for hepatitis, malnutrition, and infections in general.

**Goal:** To assist in the long-term process of drug rehabilitation.

A. Refer client to drug rehabilitation programs.

B. Promote self-help residential programs that foster self-support systems and use ex-addicts as rehabilitation counselors.

C. Methadone maintenance programs.
   1. Must be 18 years old and addicted for more than 2 years, with a history of detoxification treatments.
   2. Methadone is a synthetic narcotic that appeases desire for opiates.
      a. Controlled substance; given only under urinary surveillance.
      b. Administered orally; prevents opiate withdrawal symptoms.

D. 12-step self-help groups.
   1. Narcotics Anonymous: support group for clients who are addicted to narcotics and other drugs.
   2. Nar-Anon: support group for relatives and friends of narcotic addicts.

AFFECTIVE DISORDERS

The major affective disorders are characterized by disturbances of mood.

**General Concepts**

A. Incidence.
   1. Approximately 1% of the adult population has had an episode of bipolar disorder.
   2. More prevalent among family members when there is a positive family history.
   3. Major depression is seen more often in women.
   4. More common in higher socioeconomic groups.

B. Causes.
   1. A variety of theories may explain affective disorders.
   2. Depressive: loss of significant others or objects; changes in levels of norepinephrine (decrease) and steroids (increase); loss of self-esteem leading to hopelessness, helplessness, and pessimism towards self and others.
3. Manic: unresolved diffuse anger and hostility; denial of depression; may develop from early childhood as a result of high parental expectations.

C. Personality characteristics associated with affective disorders.
1. Depressive: lacking in confidence, introverted, unassertive, dependent, pessimistic, feelings of inadequacy.

Psychodynamics
A. Manic.
1. During infancy, needs and narcissistic goals are not met, which leads to impairment in the development of self-esteem.
2. Low self-esteem and helplessness lead to need for excessive attention, affection, warmth, and appreciation.
3. Usually a massive denial of depression.
4. The air of happiness and self-confidence is a defense against dependency feelings.

B. Depressive.
1. Loss, either real or perceived, of a loved person or object.
2. Turning aggressive feelings inward and displacing them onto the self; accompanied by feelings of guilt.
3. Ambivalent feelings toward the valued/lost object.
4. Repressive guilt, which leads to feelings of helplessness and hopelessness.

Assessment
A. Bipolar disorder (Figure 10-2).
1. Manic.
   a. Onset before the age of 30 years.
   b. Mood: elevated, expansive, or irritable.

B. Major depression.
1. May occur at any age.
2. Differentiated as either a single episode or a recurring type.
3. Symptoms the same as those listed above, under "Bipolar disorder, Depressive."
4. Severity and type of depression vary with the ability to test reality.
   a. Psychotic: feels worse in the morning and better as the day goes on.
   b. Neurotic: wakes up feeling optimistic; mood worsens as the day passes.

C. Other disorders (not considered part of the major affective type classification).
1. Cyclothymic.
   a. Chronic mood disturbance of at least 2-year duration.
   b. Numerous periods of mild depression and mania.
   c. Depressive mood periods: feelings of inadequacy, social withdrawal, sleeping too much, diminished work productivity.
   d. Hypomanic: inflated self-esteem; uninhibited, people-seeking behavior; decreased need for sleep; increased work productivity; and sharpened or unusually creative thinking.
2. Dysthymic disorder (depressive neurosis).
   a. Depressed mood with loss of interest in most usual daily activities.
b. No delusions or hallucinations.
c. Common disorder with an increased incidence in females; chronic course.

**Nursing Interventions (Manic Episode)**

**Goal:** To provide for basic human needs of safety and rest/activity.
A. Reduce outside stimuli and provide a nonstimulating environment.
B. Monitor food intake: provide a high-calorie, high-vitamin diet with finger foods, to be eaten as the client moves about.

<table>
<thead>
<tr>
<th>NURSING PRIORITY</th>
<th>Physiologic needs are the first priority in providing client care.</th>
</tr>
</thead>
</table>

C. Encourage noncompetitive solitary activities such as walking, swimming, or painting.
D. Assist with personal hygiene.

<table>
<thead>
<tr>
<th>NURSING PRIORITY</th>
<th>During the manic phase, the client’s physical safety is at risk because the hyperactivity may lead to exhaustion, and ultimately, cardiac failure.</th>
</tr>
</thead>
</table>

**Goal:** To establish a therapeutic nurse-client relationship.
A. Use firm, consistent, honest approach.
B. Assess client’s abilities and involve client in his or her own care planning.
C. Promote problem-solving abilities; recognize that a false sense of independence is often demonstrated by loud, boisterous behavior.
D. Do not focus on or discuss grandiose ideas.

**Goal:** To set limits on behavior.
A. Instructions should be clear and concise.
B. Initiate regularly scheduled contacts to demonstrate acceptance.
C. Maintain some distance between self and client to allow freedom of movement and to prevent feelings of being overpowered.
D. Maintain neutrality and objectivity: realize that client can be easily provoked by harmless remarks and may demonstrate a furious reaction but calm down very quickly.
E. Use measures to prevent overt aggression (e.g., distraction, recognition of behaviors of increased excitement).

**Goal:** To promote adaptive coping with constructive use of energy.
A. Do not hurry client; this leads to anxiety and hostile behavior.

<table>
<thead>
<tr>
<th>NURSING PRIORITY</th>
<th>In a hyperactive state, the client is extremely distractible, and responses to even the slightest stimuli are exaggerated.</th>
</tr>
</thead>
</table>

B. Provide activities and constructive tasks that channel the agitated behavior (e.g., cleaning game room, going for a walk, gardening, playing catch).

**Goal:** To assist in the medical treatment.
A. Administer lithium (Lithane or Eskalith).
B. Teach client about lithium medication instructions (see Appendix 10-3).
C. Divalproex or valproic acid (Depakote) is used to treat lithium nonresponders.
D. Carbamazepine (Tegretol) can be used with Lithium or an antipsychotic for treatment-resistant bipolar disorder.
E. Antipsychotic drugs such as olanzapine (Zyprexa) and quetiapine (Seroquel) may be better tolerated than Lithium.

**Nursing Interventions (Depressive Episode)**

<table>
<thead>
<tr>
<th>NURSING PRIORITY</th>
<th>Depression and suicidal behaviors may be viewed as anger turned inward on the self. If this anger can be verbalized in a nonthreatening environment, the client may be able to resolve these feelings, regardless of the discomfort involved.</th>
</tr>
</thead>
</table>

**Goal:** To assess for suicide potential.
A. Recognition of suicidal intent.
   1. Self-destructive behaviors are viewed as attempts to escape unbearable life situations.
   2. Anxiety and hostility are overwhelmingly present.
   3. There is the presence of ambivalence; living versus self-destructive impulses.
   4. Depression, low self-esteem, and feelings of hopelessness are critical to evaluate, because suicide attempts are often made when the client feels like giving up.
   5. Assess for indirect self-destructive behavior: any activity that is detrimental to the physical well-being of the client in which the potential outcome is death.
      a. Eating disorders: anorexia nervosa, bulimia, obesity, and overeating.
      b. Noncompliance with medical treatment (e.g., diabetic who does not take insulin).
      c. Cigarette smoking, gambling, criminal and/or socially deviant activities.
      d. Alcohol and drug abuse.
      e. Participation in high-risk sports (e.g., automobile racing; skydiving).
B. Suicide danger signs (Box 10-3).
   1. The presence of a suicide plan: specifics relating to method, its lethality, and likelihood for rescue.
   2. Change in established patterns in routines (e.g., giving away personal items, making a will, saying good-bye).
   3. Anticipation of failure: loss of a job, preoccupation with physical disease, actual or anticipated loss of a significant other.
   4. Change in behavior, presence of panic, agitation, or calmness; often, as depression lifts, client has enough energy to act on suicidal feelings.
   5. Hopelessness: feelings of impending doom, futility, and entrapment.
CHAPTER 10  Psychiatric Disorders

Goal: C. May feel better and act on suicidal ideations.

During a busy routine day. When drug therapy is started, client may feel better and act on suicidal ideations.

Goal: D. Administer lamotrigine (Lamictal), if ordered.

Goal: A. Assess for changes in weight (weight loss may indicate deepening depression).

B. Encourage increased bulk and roughage in diet along with sufficient fluids if client is constipated.

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

C. Provide for adequate amount of exercise and rest; encourage client not to sleep during the day.

D. Assist with hygiene and personal appearance.

Goal: A. Encourage expression of angry, guilty, or depressed feelings.

B. Convey a kind, pleasant, interested approach to promote a sense of dignity and self-worth in the client.

C. Support the client’s expression of feelings by allowing the client to respond in his or her own time.

D. Seek out client; initiate frequent contact.

E. Assist with decision making when depression is severe.

Goal: To provide for meaningful socialization activities.

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

A. Encourage participation in activities (e.g., plan a work assignment with client to do simple tasks: straightening game room, picking up magazines).

B. Assess hobbies, sports, or activities client enjoys; encourage client’s participation.

C. Encourage client to participate in small-group conversation or activity; practice social skills through role playing and psychodrama.

D. Encourage activities that promote a sense of accomplishment and enhance self-esteem.

Goal: To assist in medical treatment.

A. Administer antidepressant medication (see Appendix 10-4).

B. Assist in electroconvulsive therapy (ECT) (Box 10-5).

SCHIZOPHRENIC DISORDERS

NURSING PRIORITY The schizophrenic disorders constitute the largest group of psychotic disorders in society (approximately 1% of the U.S. population).

Box 10-3  SAD PERSONS SCALE

One of the most popular and easy-to-use tools available to help assess suicide risk. The more areas checked, the higher the risk.

Sex (males are more likely to successfully commit suicide)
Age (younger than 19 or older than 45)
Depression
Previous suicide attempt
Ethanol (alcohol) abuse
Rational thinking (impaired)
Social support lacking (including recent loss of loved one)
Organized plan
No spouse
Sickness (especially chronic)

Total score ranges from 0 (lowest risk) to 10 (highest risk). This scale should be used as a guideline only; use your judgment and don’t neglect unspecified factors.

Box 10-4  ADOLESCENT SUICIDE

Characteristics
- History of suicide ideation
- Previous suicide attempt
- Long-term use of drugs
- Acting-out behaviors: delinquency, stealing, vandalism, academic failure, promiscuity, loss of boyfriend/girlfriend

Family Characteristics
- Unproductive, conflictual communication
- Impaired problem-solving ability
- Inconsistent positive reinforcements, plus a greater number of negative reinforcements
- Unstable home environment

C. Clients at risk (Box 10-4).

1. Adolescents and older adults; males more likely to complete the suicide act.

2. Clients experiencing recent stress of a maturational or situational crisis.

3. Clients with chronic or painful illnesses.

4. Clients with previous suicide attempts or suicidal behavior.

5. Withdrawn, depressed, or hallucinating clients.

6. Clients with sexual identity conflicts and those who abuse alcohol and drugs.

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

A. Remove all potentially harmful objects (e.g., belts, sharp objects, matches, lighters, strings, etc.).

B. Maintain a one-to-one relationship and close observation.

NURSING PRIORITY Be aware of special times when client might be suicidal (e.g., when suddenly cheerful, when there are fewer staff members available, upon arising in the morning, or during a busy routine day). When drug therapy is started, client may feel better and act on suicidal ideations.

CHAPTER 10  Psychiatric Disorders

Goal: C. Have client make a written contract agreeing not to harm himself or herself; provide an alternative plan of coping.

D. Administer lamotrigine (Lamictal), if ordered.

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

A. Assess for changes in weight (weight loss may indicate deepening depression).

B. Encourage increased bulk and roughage in diet along with sufficient fluids if client is constipated.

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

C. Provide for adequate amount of exercise and rest; encourage client not to sleep during the day.

D. Assist with hygiene and personal appearance.

Goal: A. Encourage expression of angry, guilty, or depressed feelings.

B. Convey a kind, pleasant, interested approach to promote a sense of dignity and self-worth in the client.

C. Support the client’s expression of feelings by allowing the client to respond in his or her own time.

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A. Encourage participation in activities (e.g., plan a work assignment with client to do simple tasks: straightening game room, picking up magazines).

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SCHIZOPHRENIC DISORDERS

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**Box 10-5 ELECTROCONVULSIVE THERAPY (ECT)**

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

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

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

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**Schizophrenia**

Schizophrenia is a maladaptive disturbance characterized by a number of common behaviors involving disorders of thought content, mood, feeling, perception, communication, and interpersonal relationships. Onset of symptoms usually occurs in early adulthood (ages 19 to 21 years) with a duration of symptoms of at least 6 months.

**General Concepts**

A. Loss of ego boundaries.
   1. Organic or physiologic: genetic, biochemical (overactivity of dopamine, an insufficiency of norepinephrine, or an imbalance of both; decreased monamine oxidase activity), immunologic imbalance, a structural deviation of brain tissue, or enlarged brain ventricles.
   2. Psychosocial: individual adaptive patterns to stress, double-bind communication pattern, poor family relationships, past traumatic experiences, lack of ego strength, or a deficit in cognitive development caused by perinatal, nutritional, and maturational factors.

B. Primary mental mechanisms are repression, regression, projection, and denial.
C. Failure or inability to trust self or others.
D. Security and identity are threatened, prompting the client to withdraw from reality.

**Prepsychotic Personality Characteristics**

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

**Psychodynamics of Maladaptive Disturbances**

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

B. Disturbed affect.
   1. Difficulty expressing emotions.
   2. Absent, flat, blunted, or inappropriate affect.
   3. Inappropriate affect makes it difficult to form close relationships.

C. Disturbance in psychomotor behavior.
   1. Display of disorganized, purposeless activity.
   2. Behavior may be uninhibited and bizarre; abnormal posturing (agitated or retardation catatonia); waxy flexibility.
   3. Often appears aloof, disinterested, apathetic, and lacking motivation.

D. Disturbance in perception.
   1. Hallucinations and delusions; auditory forms are most common.
   2. Abnormal bodily sensations and hypersensitivity to sound, sight, and smell.

E. Disturbance in interpersonal relationships.
   1. Establishment of interpersonal relationships is difficult because of inability to communicate clearly and react appropriately.
   2. Difficulty relating to others.
      a. Unable to form close relationships.
      b. Has difficulty trusting others and experiences ambivalence, fear, and dependency.
c. “Need-fear dilemma”: withdraws to protect self from further hurt and consequently experiences lack of warmth, trust, and intimacy.

d. “As if” phenomenon: feels rejected by others, which leads to increased isolation, perpetuating further feelings of rejection.

**Types of Schizophrenia**

A. Schizophrenia, disorganized.
   1. Inappropriate affect; giggling and silly laughter.
   2. Regressive behavior.
   3. Severe thought disturbance, incoherent speech, “word salad.”
   4. Withdrawn, fragmentary hallucinations and delusions.

B. Schizophrenia, catatonic.
   1. Stupor and excitement phases of catatonia, bizarre posturing, waxy flexibility.

C. Schizophrenia, paranoid.
   1. Delusions of persecution and grandeur.
   2. Extreme suspiciousness.
   3. Anger, argumentativeness, and violence.
   4. Doubts about gender identity.

D. Schizophrenia, undifferentiated.
   1. Mixed psychotic symptoms.
   2. Unclassifiable; either does not meet the criteria of one of the subtypes or meets the criteria of more than one.

E. Schizophrenia, residual.
   1. History of exhibited psychotic symptoms of schizophrenia, but not psychotic at present.
   2. Continued difficulty in thinking, mood, and perception.

**Assessment**

A. Four A’s: Eugene Bleuler’s classic symptoms.
   1. Associative looseness: lack of logical thought progression, resulting in disorganized and chaotic thinking.
   2. Affect: emotion or feeling tone is one of indifference or is flat, blunted, exaggerated, or socially inappropriate.
   3. Ambivalence: conflicting, strong feelings (e.g., love and hate) that neutralize each other, leading to psychic immobilization and difficulty in expressing other emotions.
   4. Autism: extreme retreat from reality characterized by fantasies, preoccupation with daydreams, and psychotic thought processes of delusion and hallucination (Figure 10-3).
      a. Hallucinations: false sensory perceptions with no basis in reality; may be auditory, olfactory, tactile, visual, gustatory.
      b. Delusions: fixed, false beliefs not corrected by logic; develop as a defense against intolerable feelings or ideas that cause anxiety.
         (1) Delusions of grandeur: related to feelings of power, fame, splendor, magnificence.

B. Additional characteristics.
   1. Regression: extreme withdrawal and social isolation.
   2. Negativism: doing the opposite of what is asked; typical behavior is to speak to no one and answer no one; used to cover feelings of unworthiness and inadequacy.
   4. Lack of social awareness: crudeness and social insensitivity; neglectful of personal grooming and hygiene.

**Nursing Interventions**

**Goal:** To build trust.

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

A. Encourage free expression of feelings (either negative or positive) without fear of rejection, ridicule, or retaliation.
B. Use nonverbal level of communication to demonstrate warmth, concern, and empathy because client often distrusts words.
C. Consistency, reliability, acceptance, and persistence build trust.
D. Allow client to set pace; proceed slowly in planning social contacts.

Goal: To provide a safe and secure environment.
A. Maintain familiar routines. Make sure persons who come in contact with the client are recognizable to the client.
B. Avoid stressful situations or increasing anxiety.

Goal: To clarify and reinforce reality.
A. Involve client in reality-oriented activities.
B. Help client find satisfaction in the external environment and ways of relating to others.
C. Focus on clear communication and the immediate situation.

Goal: To promote and build self-esteem.
A. Encourage simple activities with limited concentration and no competition.
B. Provide successful experiences with short-range goals realistic for client’s level of functioning.
C. Relieve client of decision making until he or she is ready.
D. Avoid making demands.

Goal: To encourage independent behavior.
A. Anticipate and accept negativism.
B. Avoid fostering dependency.
C. Encourage client to make his or her own decisions, using positive reinforcement.

Goal: To provide care to meet basic human needs.
A. Determine client’s ability to meet responsibilities of daily living.
B. Attend to nutrition, elimination, exercise, hygiene, and signs of physical illness.

Goal: To assist in medical treatment.
A. Administer antipsychotic medications (see Appendix 10-5).
   1. Assist with ECT; may be useful in some instances to modify behavior.

NURSING PRIORITY As the client’s symptoms lessen, he or she will often discontinue therapy and medication, which can lead to recurrence of symptoms.

Goal: To deal effectively with withdrawn behavior.
A. Establish a therapeutic one-to-one relationship.
   1. Initiate interaction by seeking out client at every opportunity.
   2. Maintain a nonjudgmental, accepting manner in what is said and done.
   3. Attempt to draw client into a conversation without demanding a response.
B. Promote social skills by helping client feel more secure with other people.
   1. Accept one-sided conversations.
   2. Accept client’s negativism without comments.
C. Attend to physical needs of client as necessary.
D. Have client focus on reality.
E. Protect and restrain client from potential destructiveness to self and others.

Goal: To deal effectively with hallucinations.
A. Clarify and reinforce reality.
   1. Help client recognize hallucination as a manifestation of anxiety.
   2. Provide a safe, secure environment.
   3. Avoid denying or arguing with client when he or she is experiencing hallucinations.
   4. Acknowledge client’s experience but point out that you do not share the same experience.
   5. Do not give attention to content of hallucinations.
   6. Direct client’s attention to real situations, such as singing along with music.
   7. Protect client from injury to self or others when he or she is prompted by “voices” or “visions.”
B. Encourage social interaction to help client find satisfactory ways of relating with others.
   1. Increase interaction gradually.
   2. Respond verbally to anything real that client talks about.

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

General Concepts
A. Primary mental mechanism is projection.
B. Onset of paranoid behavior may be precipitated by stressful events.
   1. Loss of a real or imaginary love object.
   2. Experience of failure, leading to loss of self-esteem and feelings of inadequacy.
C. Delusional behavior.
   1. An attempt to cope with stress and reality.
   2. Associated with an extreme need to maintain self-esteem.
   3. Delusions are a symbolic way to communicate with others.
   4. Delusions are very real to client.
   5. Delusional system usually incorporates denial of reality, followed by projection and rationalization.

Psychodynamics
A. Lack of security and trust is evident.
B. Inconsistency and failure to meet infant’s basic needs lead to suspiciousness.
C. Conflicting messages and double-bind communication lead to low self-esteem.

Assessment
A. Extreme suspiciousness and withdrawal from emotional contact with others.
B. Aloof, distant, hypercritical of others.
CHAPTER 10  Psychiatric Disorders

A. Maintain calm, matter-of-fact attitude.
B. Keep promises made; be honest.
C. Avoid whispering or acting secretive.
D. Allow a choice of activities and foods; involve client in treatment plan.

Goal: To increase self-esteem by providing successful experiences.
A. Allow client to set pace in closeness with others.
B. Avoid involvement in competitive, aggressive activities requiring physical contact (e.g., football, basketball).
C. Involve client in solitary activities (e.g., drawing, photography, typing) and progress to intellectual activities with others using games (e.g., chess, bridge, Scrabble).
D. Reward completion of meaningful tasks.

Goal: To help client deal effectively with delusions.
A. Clarify and focus on reality; use reality testing.
B. Avoid confirming or approving false beliefs.
C. Point out that client’s beliefs are not shared.
D. Divert attention from delusions to reality; focus on here and now.

Disorders of Impulse Control
In disorders of impulse control, there is failure to resist an impulse, drive, or temptation to perform some act that may be harmful to others; the failure to resist is usually preceded by an increasing amount of tension before the act is committed but is followed by an outcome of pleasure or gratification.

Assessment
A. Pathologic gambling.
   1. Diagnostic criteria.
      a. A chronic and progressive failure to resist impulses to gamble.
      b. Disrupts, damages, or compromises family, personal, and vocational pursuits.

   (1) Evidence of forgery, fraud, embezzlement.
   (2) Unable to pay debts or meet other financial obligations.
   (3) Borrows money, either legally or illegally.
   (4) Loss of work because of frequent absenteeism.

2. Additional characteristics.
   a. Overconfident, very energetic, “big spender.”
   b. Often begins in adolescence.
B. Kleptomania (shoplifting).
   1. Recurrent impulse to steal objects.
   2. Characterized by increasing tension before stealing and a feeling of pressure or release after the act is committed.
   3. Usually done without long-term planning.
C. Pyromania (setting fires).
   1. Recurrent impulse to set fires.
   2. Usually characterized by increased amount of tension before the fire is set, with subsequent release after the act is committed.
   3. Individual usually describes “spells” or “attacks;” usually regrets the display of aggression.

Nursing Interventions
Goal: To encourage client to develop alternative ways of dealing with stress.
A. Refer client to self-help groups: Gamblers Anonymous (GAM-ANON).
B. Assist client in determining when anxiety and tension are increasing and provide a plan of action to prevent acts of stealing, setting fires, or destroying property.

Adjustment Disorders
Assessment
A. Adjustment disorders can appear at any developmental stage and are related to the developmental task at hand.
B. Usually, there is no underlying mental disorder or disease.
C. Present behavior is usually disturbed and characterized by distortions in the situation and difficulty in decision making.

Nursing Interventions
Goal: To return client to homeostasis with the fullest possible functioning level.
A. Provide empathetic understanding and support.
B. Encourage identification of specific problems and promote new problem-solving coping skills.
C. Enlist family and community support as necessary.
Appendix 10-1 ALZHEIMER’S MEDICATIONS

**General Nursing Implications**
- Two types: (1) *cholinesterase inhibitors*, which prevent the breakdown of acetylcholine, thus making it available at the cholinergic synapses and resulting in enhanced transmission of nerve impulses and (2) a new drug—an *NMDA receptor antagonist*—which blocks calcium influx and modulates the effects of glutamate (major excitatory transmitter in CNS).
- Drugs do not cure and do not stop disease progression, but they may slow down the progression by a few months.

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>SIDE EFFECTS</th>
<th>NURSING IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cholinesterase Inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donepezil (Aricept): PO</td>
<td>GI symptoms: nausea, vomiting, dyspepsia, diarrhea</td>
<td>1. Abrupt withdrawal of medication can lead to a rapid progression of symptoms.</td>
</tr>
<tr>
<td>Galantamine (Razadyne): PO</td>
<td>Dizziness and headache</td>
<td>2. Monitor for side effects since drug is typically given in high doses to produce the greatest benefit.</td>
</tr>
<tr>
<td>Rivastigmine (Exelon): PO</td>
<td>Tacrine: high risk for liver damage</td>
<td></td>
</tr>
<tr>
<td>Tacrine (Cognex): PO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **NMDA Receptor Antagonist** | | |
| Memantine (Namenda): PO | Dizziness, headache, confusion, constipation | 1. Used for moderate to severe cases. |
| | | 2. Better tolerated than cholinesterase inhibitors. |

Appendix 10-2 ANTIANXIETY AGENTS

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

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>SIDE EFFECTS</th>
<th>NURSING IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td>Reduce anxiety by enhancing the action of the inhibitory neurotransmitter GABA on its receptor; also promote anticonvulsant activity and skeletal muscle relaxation.</td>
<td></td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium): PO, IM, IV</td>
<td>CNS depression, drowsiness (decreases with use), ataxia, dizziness, headaches, dry mouth</td>
<td>1. May cause paradoxical effects and should not be taken by mothers who are breastfeeding.</td>
</tr>
<tr>
<td>Diazepam (Valium): PO, IM, IV</td>
<td>Adverse effects: tolerance commonly develops, physical dependency</td>
<td>2. Assess for symptoms of leukopenia, such as sore throat, fever, and weakness.</td>
</tr>
<tr>
<td>Clonazepam (Klonopin): PO</td>
<td></td>
<td>3. Encourage client to rise slowly from a supine position and to dangle feet before standing.</td>
</tr>
<tr>
<td>Chlorazepate dipotassium (Tranxene): PO</td>
<td></td>
<td>4. Librium: Do not inject or add IV Librium to an existing IV infusion; inject directly into a large vein over a 1-minute period.</td>
</tr>
<tr>
<td>Midazolam (Versed): IM, IV</td>
<td></td>
<td>5. Do not mix Librium or Valium with any other drug in a syringe or add to existing IV fluids.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Versed is commonly used for induction of anesthesia and sedation before diagnostic tests and endoscopic exams.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Flumazenil (Romazicon) is approved for the treatment of benzodiazepine overdose; has an adverse effect of precipitating convulsions, especially in clients with a history of epilepsy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Uses: anxiety and tension, muscle spasm, preoperative medication, acute alcohol withdrawal, and to induce sleep.</td>
</tr>
</tbody>
</table>
### Appendix 10-2  ANTIANXIETY AGENTS—cont’d

<table>
<thead>
<tr>
<th><strong>MEDICATIONS</strong></th>
<th><strong>SIDE EFFECTS</strong></th>
<th><strong>NURSING IMPLICATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonbenzodiazepine Agents</strong></td>
<td>Interact with serotonin and dopamine receptors in the brain to decrease anxiety; lack muscle-relaxant and anticonvulsant effects; do not cause sedation or physical or psychologic dependence; do not increase CNS depression caused by alcohol or other drugs.</td>
<td></td>
</tr>
</tbody>
</table>
| **Buspirone (BuSpar):** PO | Dizziness, drowsiness, headache, nausea, fatigue, insomnia | 1. Not a controlled substance.  
2. Some improvement can be noted in 7-10 days; however, usually takes 3-4 weeks to achieve effectiveness.  
3. **Uses:** short-term relief of anxiety and anxiety disorders. |

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

### Appendix 10-3  ANTIMANIC MEDICATIONS

<table>
<thead>
<tr>
<th><strong>MEDICATIONS</strong></th>
<th><strong>SIDE EFFECTS</strong></th>
<th><strong>NURSING IMPLICATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lithium Carbonate</strong></td>
<td>Acts to lower concentrations of norepinephrine and serotonin by inhibiting their release; believed to alter sodium transport in both nerve and muscle cells. <strong>Uses:</strong> bipolar affective disorder (manic episode).</td>
<td></td>
</tr>
</tbody>
</table>
| **Lithium (Eskalith, Lithane):** PO | **High incidence:** increased thirst, increased urination (polyuria)  
**Frequent:** 1.5 mEq/L levels or less: dry mouth, lethargy, fatigue, muscle weakness, headache, GI disturbances, fine hand tremors  
**Adverse effects:** 1.5-2.0 mEq/L may produce vomiting, diarrhea, drowsiness, incoordination, coarse hand tremors, muscle twitching  
2.0-2.5 mEq/L may result in ataxia, slurred speech, confusion, clonic movements, high output of dilute urine, blurred vision, hypotension  
**Acute toxicity:** seizures, oliguria, coma, peripheral vascular collapse, death | 1. Monitor lithium blood levels: blood samples are obtained 12 hours after dose was given.  
2. Teach client the following:  
a. Symptoms of lithium toxicity.  
b. Importance of frequent blood tests (every 2-3 days) to check lithium levels at the beginning of treatment (maintenance blood levels done every 1-3 months).  
c. Importance of taking dose at same time each day, preferably with meals or milk.  
3. Encourage a diet containing normal amounts of salt and a fluid intake of 3 L per day; avoid caffeine because of its diuretic effect.  
4. Report polyuria, prolonged vomiting, diarrhea, or fever to physician (may need to temporarily reduce dosage or discontinue use).  
5. Do not crush, chew, or break the extended-release or film-coated tablets.  
6. Assess clients at high risk for developing toxicity: postoperative, dehydrated, hyperthyroid, those with renal disease, or those taking diuretics.  
7. **Blood levels:**  
a. Extremely narrow therapeutic range: 0.5-1.5 mEq/L.  
b. Toxic serum lithium level is greater than 2 mEq/L.  
8. Management of lithium toxicity: possible hemodialysis.  
9. Long-term use may cause goiter; may be associated with hypothyroidism. |

*Continued*
### Appendix 10-3  ANTIMANIC MEDICATIONS—cont’d

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>SIDE EFFECTS</th>
<th>NURSING IMPLICATIONS</th>
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</thead>
<tbody>
<tr>
<td><strong>Other Agents</strong></td>
<td>Both medications listed below were originally developed and used for seizure disorders. Both have mood-stabilizing abilities.</td>
<td></td>
</tr>
</tbody>
</table>
| Carbamazepine (Tegretol): PO | Drowsiness, dizziness, visual problems (spots before eyes, difficulty focusing, blurred vision), dry mouth | 1. Used primarily for clients who have not responded to lithium or who cannot tolerate the side effects.  
2. Avoid tasks that require alertness and motor skills until response to drug is established.  
3. Monitor CBC frequently during initiation of therapy and at monthly intervals thereafter. |
| Valproic acid (Depakene; Depakote): PO | Nausea, GI upsets, drowsiness, may cause hepatotoxicity | 1. Monitor liver function studies. |

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

### Appendix 10-4  ANTIDEPRESSANT MEDICATIONS

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

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>SIDE EFFECTS</th>
<th>NURSING IMPLICATIONS</th>
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<tbody>
<tr>
<td><strong>Tricyclic Antidepressants (TCA)</strong></td>
<td>Prevent the reuptake of norepinephrine or serotonin, which results in increased concentrations of these neurotransmitters.</td>
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</tr>
</tbody>
</table>
| Imipramine hydrochloride (Tofranil): PO, IM | Drowsiness, dry mouth, blurred vision, constipation, weight gain, and orthostatic hypotension | 1. Should not be given at the same time as an MAOI; a time lag of 14 days is necessary when changing from one drug group to the other.  
2. Because of marked sedation, client should avoid activities requiring mental alertness (driving or operating machinery).  
3. Instruct client to move gradually from lying to sitting and standing positions to prevent postural hypotension.  
4. *Sinequan* is tolerated better by older adults; has less effect on cardiac status; dilute the concentrate with orange juice.  
5. Contraindicated in clients with epilepsy, glaucoma, and cardiovascular disease.  
6. Usually given once daily at bedtime.  
7. *Uses:* depression; *Tofranil* is also used to treat enuresis in children. |
| Nortriptyline hydrochloride (Aventyl): PO |  |
| Doxepin hydrochloride (Sinequan): PO |  |
| Amitriptyline hydrochloride (Elavil): PO, IM |  |
## CHAPTER 10  Psychiatric Disorders

### Medications Side Effects Nursing Implications

**Selective Serotonin Reuptake Inhibitors (SSRI)** Cause selective inhibition of serotonin uptake and produce CNS excitation rather than sedation; have no effect on dopamine or norepinephrine.

<table>
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<tr>
<th>Medications</th>
<th>Side Effects</th>
<th>Nursing Implications</th>
</tr>
</thead>
</table>
| Fluoxetine (Prozac): PO      | Nausea, headache, anxiety, nervousness, insomnia, weight gain, skin rash, sexual dysfunction | 1. Medication is usually given once a day.  
| Sertraline (Zoloft): PO      |                                                                             |                                                                                      |
| Paroxetine (Paxil): PO       |                                                                             |                                                                                      |

**Monoamine Oxidase Inhibitors (MAOI)** Inhibit the enzyme monoamine oxidase, which breaks down norepinephrine and serotonin, increasing the concentration of these neurotransmitters.

<table>
<thead>
<tr>
<th>Medications</th>
<th>Side Effects</th>
<th>Nursing Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isocarboxazid (Marplan): PO</td>
<td>Drowsiness, insomnia, dry mouth, urinary retention, hypotension</td>
<td>1. Potentiate many drug actions: narcotics, barbiturates, sedatives, and atropine-like medications.</td>
</tr>
<tr>
<td>Phenelzine sulfate (Nardil): PO</td>
<td></td>
<td>2. Have a long duration of action; therefore 2-3 weeks must go by before another drug is administered while a client is taking an MAOI.</td>
</tr>
<tr>
<td>Tranylcypromine (Parnate): PO</td>
<td></td>
<td>3. Interact with specific foods and drugs (ones containing tyramine or sympathomimetic drugs). May cause a severe hypertensive crisis characterized by marked elevation of blood pressure, increased temperature, tremors, and tachycardia. Foods and drugs to avoid: coffee, tea, cola beverages, aged cheeses, beer and wine, pickled foods, avocados, and figs and many over-the-counter cold preparations, hay fever medications, and nasal decongestants.</td>
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<tr>
<td></td>
<td></td>
<td>5. <em>Parnate</em>: most likely to cause hypertensive crisis; onset of action is more rapid.</td>
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</table>

**Miscellaneous Antidepressants**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Side Effects</th>
<th>Nursing Implications</th>
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</thead>
<tbody>
<tr>
<td>Trazodone (Desyrel): PO</td>
<td>Sedation, orthostatic hypotension, nausea, vomiting, can cause priapism (prolonged, painful erection of the penis)</td>
<td>1. See General Nursing Implications.</td>
</tr>
<tr>
<td>Bupropion (Wellbutrin): PO</td>
<td>Weight loss, dry mouth, dizziness</td>
<td>1. See General Nursing Implications.</td>
</tr>
</tbody>
</table>

*CNS*, Central nervous system; *IM*, intramuscularly; *MAOIs*, monoamine oxidase inhibitors; *PO*, by mouth (orally); *SSRIs*, selective serotonin reuptake inhibitors; *TCAs*, tricyclic antidepressants.
Appendix 10-5  ANTIPSYCHOTIC (NEUROLEPTIC) MEDICATIONS

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

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
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<th>NURSING IMPLICATIONS</th>
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<tbody>
<tr>
<td><strong>Phenothiazines</strong></td>
<td>Block dopamine receptors and also thought to depress various portions of the reticular activating system; have peripherally exerting anticholinergic properties (atropine-like symptoms: dryness of mouth, stuffy nose, constipation, blurring of vision).</td>
<td></td>
</tr>
<tr>
<td>Aliphatic types:</td>
<td></td>
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</tr>
<tr>
<td>Chlorpromazine hydrochloride (Thorazine): PO, IM, IV suppository</td>
<td>Extrapyramidal effects (movement disorder): occur early in therapy and are usually managed with other drugs</td>
<td></td>
</tr>
<tr>
<td>Promazine hydrochloride (Sparine): PO, IM, IV suppository</td>
<td>Acute dystonia—spasm of muscles of tongue, face, neck, or back; oculogyric crisis (upward deviation of the eyes); opisthotonus</td>
<td></td>
</tr>
<tr>
<td>Piperazine types:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prochlorperazine (Compazine): PO, IM, IV suppository</td>
<td>Parkinsonism—muscle tremors, rigidity, spasms, shuffling gait, stooped posture, cogwheel rigidity</td>
<td></td>
</tr>
<tr>
<td>Fluphenazine hydrochloride (Prolixin): PO, IM</td>
<td>Akathisia—motor restlessness, pacing.</td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine (Stelazine): PO, IM</td>
<td>Tardive dyskinesia: occurs late in therapy; symptoms are often irreversible—earliest symptom is slow, wormlike movements of the tongue; later symptoms include fine twisting, writhing movements of the tongue and face, grimacing; lip smacking; involuntary movements of the limbs, toes, fingers, and trunk</td>
<td></td>
</tr>
<tr>
<td>Other Antipsychotic Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol (Haldol): PO, IM</td>
<td>Neuroleptic malignant syndrome: rare problem, fever (&gt;41°C, 105°F), “leadpipe” muscle rigidity, agitation, confusion, delirium, respiratory and acute renal failure</td>
<td></td>
</tr>
<tr>
<td>Mesoridazine besylate (Serentil): PO</td>
<td>Endocrine—amenorrhea, increased libido in women, decreased libido in men, delayed ejaculation, increased appetite, weight gain, hypoglycemia, and edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dermatologic: photosensitivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypersensitivity reaction: jaundice, agranulocytosis</td>
<td></td>
</tr>
</tbody>
</table>

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

1. May reduce prothrombin time.
2. Often used as the initial drug for treatment of psychotic disorders.
Appendix 10-5  ANTIPSYCHOTIC (NEUROLEPTIC) MEDICATIONS—cont’d

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>SIDE EFFECTS</th>
<th>NURSING IMPLICATIONS</th>
</tr>
</thead>
</table>
| **Risperidone (Risperdal):** | Anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, GI upset, rhinitis. | 1. *Uses*: tics, vocal disturbances, and psychotic schizophrenia.  
2. *Risperdal* is the most frequently prescribed antipsychotic because of less serious side effects. |
| **Clozapine (Clozaril):**   | Blood dyscrasias (agranulocytosis), sedation, weight gain, orthostatic hypotension, seizures, diabetes. | 1. Used with caution in clients with diabetes and those with history of seizures.  
2. Treatment is started slowly and gradually increased; it is important that the client not stop taking medication. |

---

### Study Questions  Psychiatric Disorders

1. A client’s feelings of despair and depression have lifted, and she tells the nurse, “I feel better now.” The nurse understands that this client is:
   1. No longer a suicide risk  
   2. Less of a suicide risk than when she was deeply depressed  
   3. More of a suicide risk than when she was deeply depressed  
   4. A suicide risk only in the evening
2. Which of the following nursing interventions should be instituted for a client experiencing a manic episode?
   1. Place the client in a quiet area, separate from others.  
   2. Encourage the client to engage in some physical activity.  
   3. Establish firm, set limits on behavior.  
   4. Include the client in the group’s activities.
3. A client demonstrates an inappropriate affect by giggling while talking about her brain being destroyed. This behavior serves what purpose for this client?
   1. Helps her to convince the staff that her problem is physical and not psychologic.  
   2. Allows her to avoid the nurse’s questions about the problems that resulted in her admission.  
   3. Hides that she is angry with her parents for bringing her to the hospital.  
   4. Protects her against the painful emotional impact of what she fears is happening to her.
4. A client experiencing severe depression is admitted to the inpatient psychiatric unit. During the initial assessment, she says, “I feel like killing myself, but I wouldn’t do that because of my kids.” The nurse’s priority action would be to:
   1. Explore the reasons that the client might want to take her life.  
   2. Determine the severity of her suicidal risk.  
   3. Prevent the client from harming herself.  
   4. Guide her to consider alternative ways of coping.
5. Which of the following signs and symptoms would the nurse assess for in a client with possible lithium toxicity?
   1. Hypotension, bradycardia, polyuria  
   2. Tachycardia, hypertension, convulsions  
   3. Diarrhea, ataxia, seizures, lethargy  
   4. Urinary frequency, vomiting, fever
6. A client with schizophrenia is incontinent and urinates on the floor. The nurse’s best response would be to:
   1. Ask the client to clean up after herself.  
   2. Tell her that ward privileges will be withheld if it happens again.  
   3. Ignore the client until her behavior improves.  
   4. Clean up the urine without communicating displeasure.
7. A client’s husband reports that over the past month his wife has become increasingly agitated and hyperexcitable, with a marked increase in verbal and physical activity. Based on these symptoms, the nurse concludes that the client may be experiencing which of the following?
   1. Panic attacks  
   2. Paranoid behavior  
   3. Free-floating anxiety  
   4. Manic episode
8. When caring for a client admitted for medically monitored detoxification from alcohol, the nurse would assess for which of the following signs and symptoms of withdrawal?
   1. Anorexia, irritability, nausea, and tremulousness  
   2. Bradycardia, hypotension, diaphoresis, and fever  
   3. Vivid hallucinations, coarse irregular tremor  
   4. Severe craving, euphoria, profuse sweating, and paranoid ideation
9. Which of the following defects is most commonly associated with Down syndrome?
   1. Deafness
   2. Congenital heart disease
   3. Hydrocephaly
   4. Muscular hypertonicity

10. When attempting to establish trust and rapport with a client experiencing schizophrenia, the priority action for the nurse would be to:
   1. Make emotional contact.
   2. Take a careful nursing history.
   3. Increase voluntary motor activity.
   4. Mutually agree to a contract.

11. Chlorpromazine (Thorazine) is ordered for a client. Which of the following signs or symptoms would the nurse include in the medication teaching about this drug?
   1. Weight loss
   2. Drowsiness
   3. Hypertension
   4. Insomnia

12. The nurse knows that which of the following is the most important factor in the successful adjustment of parents of an infant with Down syndrome?
   1. Their response to the reactions of family and friends to their infant
   2. Their ability to give physical care to their infant
   3. Their ability to talk about caring for their child and anticipated changes in their lifestyle
   4. Their understanding of the factors causing Down syndrome

13. A client is admitted to the inpatient psychiatric unit for medically monitored detoxification from alcohol. Which of the following actions would be included in the client’s plan of care?
   1. Encourage increased fluid intake.
   2. Order a high-protein, high-fat diet.
   3. Provide a high-sodium, low-carbohydrate diet.
   4. Encourage ambulation and deep breathing.

14. A client with a diagnosis of schizophrenia repeatedly states, “There are flies eating my brain and making me feel weird.” The client is most likely experiencing which of the following?
   1. Ideas of reference
   2. Grandiose delusions
   3. Somatic delusions
   4. Persecutory delusions

15. When preparing a client for electroconvulsive therapy (ECT), the nurse would include which of the following actions?
   1. Provide orientation to time.
   2. Assess vital signs for 30 minutes to 1 hour.
   3. Remove dentures and maintain NPO status.
   4. Encourage problem solving in social settings.

16. A client is experiencing a lack of logical thought progression, resulting in disorganized and chaotic thinking. The nurse understands this to be:
   1. Delusions of grandeur
   2. Ideas of reference
   3. Depersonalization
   4. Associative looseness

17. A client taking lithium (Eskalith) would most likely experience which of the following signs and symptoms?
   1. Increased thirst, increased urination
   2. Drowsiness, dizziness
   3. Dry mouth, blurred vision
   4. Headache, anxiety

18. A client receiving phenelzine sulfate (Nardil) must be taught to avoid which of the following foods?
   1. Chicken, eggs, and celery
   2. Aged cheeses, beer, and avocados
   3. Pasta, candy bars, and ice cream
   4. Beef, potatoes, and corn

19. A client says, “I think everyone is out to get me. I don’t trust you at all.” The nurse’s best response would be:
   1. “I really don’t think everyone is out to get you. You just think so.”
   2. “I don’t understand why you think everyone is out to get you. I know I am not one of those people.”
   3. “How could you think everyone is out to get you when everyone is trying to help you?”
   4. “I know you think everyone is out to get you, but I don’t see it that way.”

20. Characteristics of borderline personality disorder include which of the following? Select all that apply:
   _____ 1 Self-mutilating behavior
   _____ 2 Impulsiveness
   _____ 3 Submissive, clinging behavior
   _____ 4 Grandiose self-importance
   _____ 5 Suspiciousness and mistrust of others
   _____ 6 Perfectionistic

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