Ministry of Higher Education

& Scientific Research

University of Mosul / College of Nursing

Psychiatric and Mental Health Nursing

Undergraduate Studies

BSc. in Nursing Sciences / Fourth Stage

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Unit One: Foundations of Mental Health

- **Mental Health** The World Health Organization (WHO) defines health as a state of complete physical, mental, and social wellness, not merely the absence of disease or infirmity. This definition emphasizes health as a positive state of well-being, not just absence of disease. People in a state of emotional, physical, and social well-being fulfill life responsibilities, function effectively in daily life, and are satisfied with their interpersonal relationships and themselves.

Mental health components:

1. **Autonomy and independence:** The person can look within for guiding values and rules by which to live. The person who is autonomous and independent can work interdependently or cooperatively with others without losing his or her autonomy.
2. **Tolerance of life's uncertainties:** The person can face the challenges of day-to-day living with hope and a positive outlook despite not knowing what lies ahead.
3. **Self-esteem:** The person has a realistic awareness of his or her abilities and limitations.
4. **Mastery of the environment:** The person can deal with and influence the environment in a capable, competent, and creative manner.
5. **Reality orientation:** The person can distinguish the real world from a dream, fact from fantasy, and act accordingly.
6. **Stress management:** The person can tolerate life stresses, appropriately handle anxiety or grief, and experience failure without devastation. He or she uses support from family and friends to cope with crises, knowing that the stress will not last forever.

Mental disorder: is defined as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. It is an abnormal mental condition or disorder that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning.

History of the mental health:

1. Ancient Times: people of ancient times believed that any sickness indicated displeasure of the gods and, in fact, was a punishment for sins and wrongdoing. Those with mental disorders were viewed as either divine or demonic, depending on their behavior. Individuals seen as divine were worshipped and adored; those seen as demonic were ostracized, punished, and sometimes burned at the stake.

2. Later, Aristotle (382–322 BC) attempted to relate mental disorders to physical disorders and developed his theory that the amounts of blood, water, and yellow and black bile in the body controlled the emotions. These four substances, or humors, corresponded with happiness, calmness, anger, and sadness. Imbalances of the four humors were believed to cause mental disorders; therefore, treatment was aimed at restoring balance through bloodletting, starving, and purging. Such "treatments" persisted well into the 19th century.
3. In early Christian times (1–1000 AD), primitive beliefs and superstitions were strong. All diseases were again blamed on demons, and the mentally ill were viewed as possessed. Priests performed exorcisms to rid sufferers of evil spirits. When that failed, they used more severe and brutal measures, such as incarceration in dungeons, flogging, and starving.
4. In England during the Renaissance (1300–1600), people with mental illness were distinguished from criminals. Those considered harmless were allowed to wander the countryside or live in rural communities, but the more dangerous lunatics" were thrown in prison, chained, and starved. In 1547, the Hospital of St. Mary of Bethlehem was officially declared a hospital for the insane, the first of its kind.
5. By 1775, visitors at the institution were charged a fee for the privilege of viewing and ridiculing the inmates, who were seen as less than human animals.
6. During this same period in the colonies (later the United States), the mentally ill were considered evil or possessed and were punished. Witch hunts were conducted, and offenders were burned at the stake.
7. In the 1790s, a period of enlightenment concerning persons with mental illness began. Philippe Pinel in France and William Tuke in England formulated the concept of **asylum** as a safe refuge or haven offering protection at institutions where people had been whipped, beaten, and starved because they were mentally ill.
8. With this movement began the moral treatment of the mentally ill. In the United States, Dorothea Dix (1802–1887) began a crusade to reform the treatment of mental illness after a visit to Tuke's institution in England. She was instrumental in opening 32 state hospitals that offered asylum to the suffering. Dix believed that society was obligated to those who were mentally ill; she advocated adequate shelter, nutritious food, and warm clothing.
9. The period of enlightenment was short-lived. Within 100 years after the establishment of the first asylum, state hospitals were in trouble. Attendants were accused of abusing the residents, the rural locations of hospitals were viewed as isolating patients from their families and homes, and the phrase *insane asylum* took on a negative connotation.

10. A great leap in the treatment of mental illness began in about 1950 with the development of **psychotropic drugs**, or drugs used to treat mental illness. Chlorpromazine (Thorazine), an antipsychotic drug, and lithium, an antimanic agent, were the first drugs to be developed. Over the following 10 years, monoamine oxidase inhibitor antidepressants; haloperidol (Haldol), an antipsychotic; tricyclic antidepressants; and antianxiety agents, called benzodiazepines, were introduced. For the first time, drugs actually reduced agitation, psychotic thinking, and depression. Hospital stays were shortened, and many people became well enough to go home. The level of noise, chaos, and violence greatly diminished in the hospital setting.
11. **Move toward Community Mental Health:** The movement toward treating those with mental illness in less restrictive environments gained momentum in 1963 with the enactment of the Community Mental Health Centers Construction Act.

- **Deinstitutionalization**, a deliberate shift from institutional care in state hospitals to community facilities, began. Community mental health centers served smaller geographic catchment, or service, areas that provided less restrictive treatment located closer to individuals' homes, families, and friends. These centers provided emergency care, inpatient care, outpatient services, partial hospitalization, screening services, and education. Thus, deinstitutionalization accomplished the release of individuals from long-term stays in state institutions, the decrease in admissions to hospitals, and the development of community-based services as an alternative to hospital care.
- In addition to deinstitutionalization, federal legislation was passed to provide an income for disabled persons: supplemental security income (SSI) and Social Security disability income (SSDI). This allowed people with severe and persistent mental illness to be more independent financially and to not rely on family for money. States were able to spend less money on care of the mentally ill than they had spent when these individuals were in state hospitals because this program was federally funded. Also, commitment laws changed in the early 1970s, making it more difficult to commit people for mental health treatment against their will. This further decreased the state hospital populations and, consequently, the money that states spent on them.

➢ PSYCHIATRIC NURSING PRACTICE

1. In 1873, Linda Richards graduated from the New England Hospital for Women and Children in Boston. She went on to improve nursing care in psychiatric hospitals and organized educational programs in state mental hospitals in Illinois.
2. Richards is called the first American psychiatric nurse; she believed that "the mentally sick should be at least as well cared for as the physically sick".
3. The first training of nurses to work with persons with mental illness was in 1882 at McLean Hospital in Belmont, Massachusetts. The role of psychiatric nurses expanded as somatic therapies for the treatment of mental disorders were developed.
4. Treatments, such as insulin shock therapy (1935), psychosurgery (1936), and electroconvulsive therapy (1937), required nurses to use their medical–surgical skills more extensively.
5. The first psychiatric nursing textbook, *Nursing Mental Diseases* by Harriet Bailey, was published in 1920.
6. In 1913, Johns Hopkins was the first school of nursing to include a course in psychiatric nursing in its curriculum. It was not until 1950 that the National League for Nursing, that accredits nursing programs, required schools to include an experience in psychiatric nursing.
7. Two early nursing theorists shaped psychiatric nursing practice: Hildegard Peplau and June Mellow. Peplau published *Interpersonal Relations in Nursing* in 1952 and *Interpersonal Techniques: The Crux of Psychiatric Nursing* in 1962. She described the therapeutic nurse–client relationship with its phases and tasks and wrote extensively about anxiety.
8. The interpersonal dimension that was crucial to her beliefs forms the foundations of practice today.
9. Mellow's 1968 work, *Nursing Therapy*, described her approach of focusing on clients' psychosocial needs and strengths. Mellow (1986) contended that the nurse as a therapist is particularly suited to working with those with severe mental illness in the context of daily activities, focusing on the here and now to meet each person's psychosocial needs. Both Peplau and Mellow substantially contributed to the practice of psychiatric nursing.
10. The American Nurses Association (ANA) develops standards of care, which are revised as needed. **Standards of care** are authoritative statements by professional organizations that describe the responsibilities for which nurses are accountable.
11. The American Psychiatric Nurses Association (APNA) has standards of practice and standards of professional performance.
12. The standards of care incorporate the phases of the nursing process, including specific types of interventions for nurses in psychiatric settings.

Areas of Practice:

A. Basic-Level Functions

1. Counseling
• Interventions and communication techniques
• Problem-solving
• Crisis intervention
• Stress management
• Behavior modification
2. Milieu therapy
• Maintain therapeutic environment
•Teach skills
• Encourage communication between clients and others
• Promote growth through role modeling
3. Self-care activities
• Encourage independence
• Increase self-esteem
• Improve function and health
4. Psychobiologic interventions
• Administer medications
• Teach
• Observe
5. Health teaching
6. Case management
7. Health promotion and maintenance

B. Advanced-Level Functions

• Psychotherapy
• Prescriptive authority for drugs (in many states)
• Consultation and liaison
• Evaluation and program development and management
• Clinical supervision

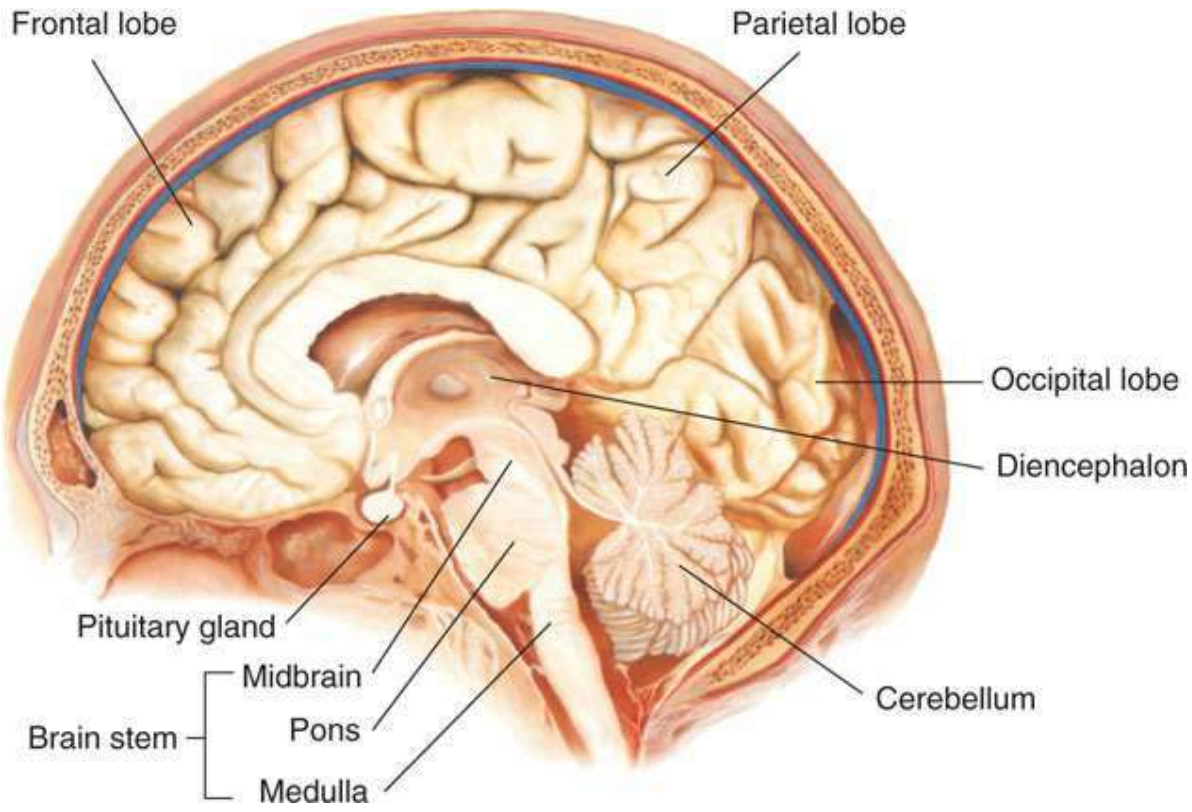
- **Factors contributing to mental illness:**

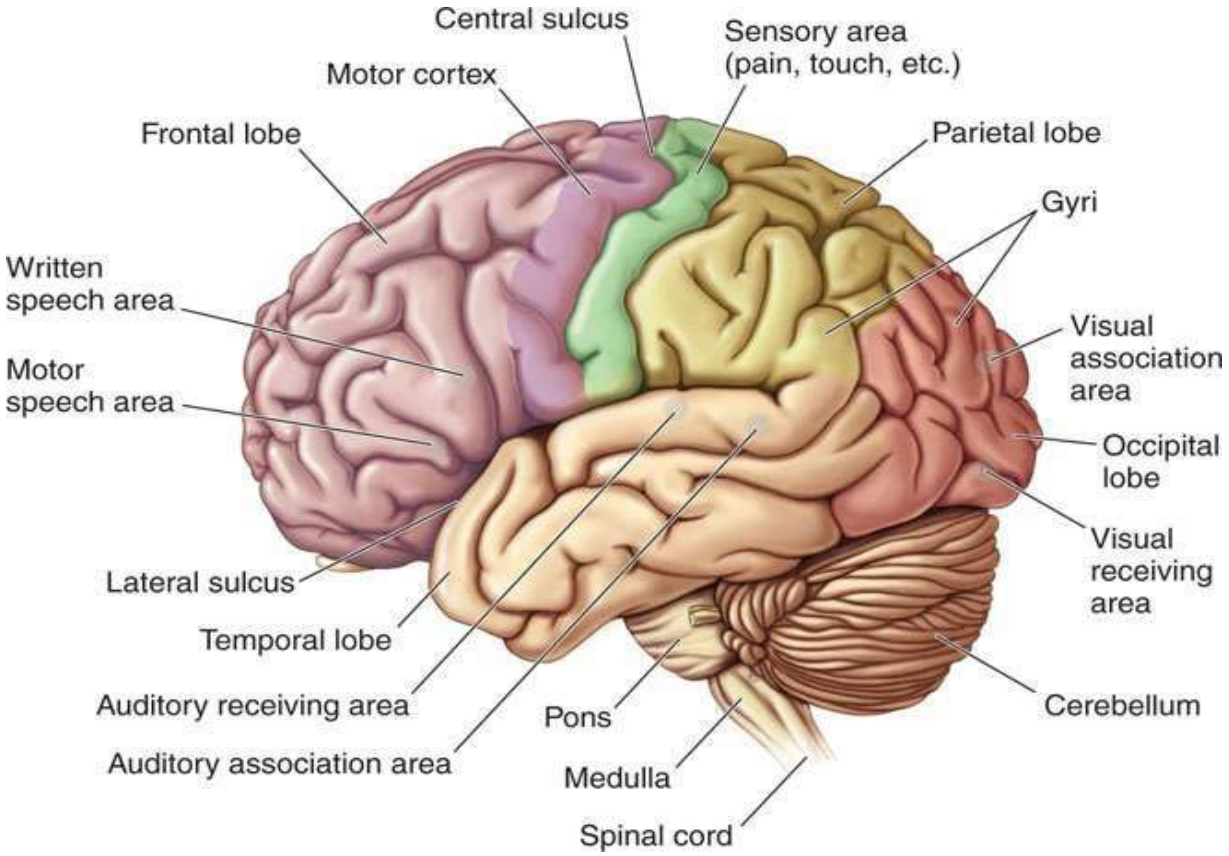
1. Biologic makeup.
2. Anxiety, worries, and fears.
3. Ineffective communication.
4. Excessive dependence or withdrawal from relationships.
5. Loss of emotional control.

6. Lack of resources.
7. Violence, homelessness, poverty, and discrimination.

Central Nervous System

The CNS comprises the brain, the spinal cord, and associated nerves that control voluntary acts. Structurally, the brain consists of the cerebrum, cerebellum, brain stem, and limbic system.





Cerebrum

The cerebral hemispheres are divided into four lobes: frontal, parietal, temporal, and occipital. Some functions of the lobes are distinct; others are integrated.

- The frontal lobes control the organization of thought, body movement, memories, emotions, and moral behavior. The integration of all this information regulates arousal, focuses attention, and enables problem-solving and decision-making. Abnormalities in the frontal lobes are associated with schizophrenia, attention-deficit/hyperactivity disorder (ADHD), and dementia.
- The parietal lobes interpret sensations of taste and touch and assist in spatial orientation.
- The temporal lobes are centers for the senses of smell and hearing and for memory and emotional expression.
- The occipital lobes assist in coordinating language generation and visual interpretation, such as depth perception.

Cerebellum

The cerebellum is located below the cerebrum and is the center for coordination of movements and postural adjustments. It receives and integrates information from all areas of the body, such as the muscles, joints, organs, and other components of the CNS.

Research has shown that inhibited transmission of dopamine, a neurotransmitter, in this area is associated with the lack of smooth coordinated movements in diseases such as Parkinson disease and dementia.

Brain Stem

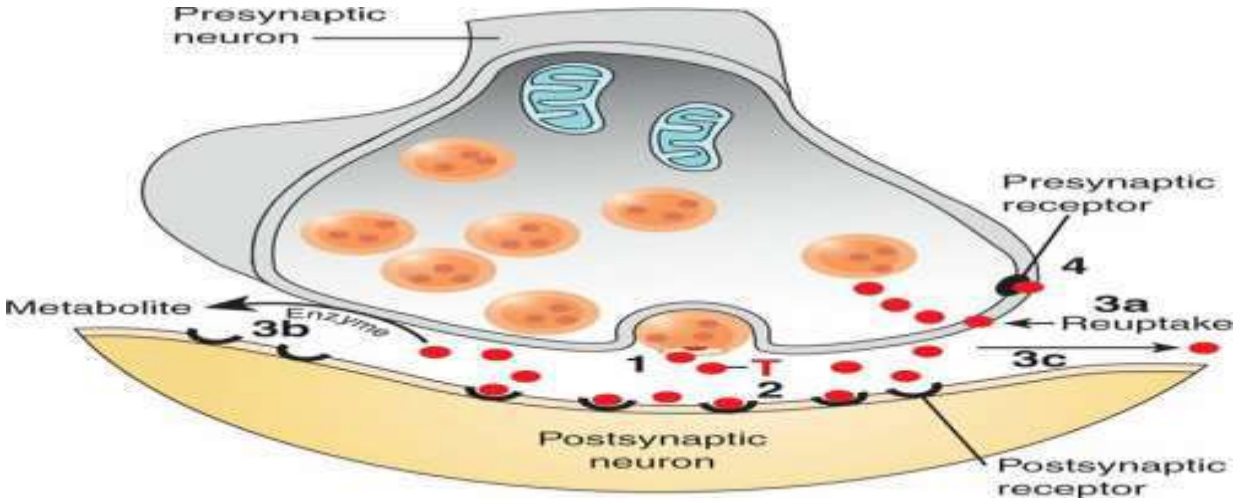
The reticular activating system influences motor activity, sleep, consciousness, and awareness. The extrapyramidal system relays information about movement and coordination from the brain to the spinal nerves. The locus coeruleus, a small group of norepinephrine producing neurons in the brain stem, is associated with stress, anxiety, and impulsive behavior.

Limbic System

The **limbic system** is an area of the brain located above the brain stem that includes the thalamus, hypothalamus, hippocampus, and amygdala.

- The thalamus regulates activity, sensation, and emotion.
- The hypothalamus is involved in temperature regulation, appetite control, endocrine function, sexual drive, and impulsive behavior associated with feelings of anger, rage, or excitement.
- The hippocampus and amygdala are involved in emotional arousal and memory.
- Disturbances in the limbic system have been implicated in a variety of mental illnesses, such as the memory loss that accompanies dementia and the poorly controlled emotions and impulses seen with psychotic or manic behavior.

Neurotransmitters: are the chemical substances manufactured in the neuron that aid in the transmission of information throughout the body. They either excite or stimulate an action in the cells (**excitatory**) or inhibit or stop an action (**inhibitory**). These neurotransmitters fit into specific receptor cells embedded in the membrane of the dendrite, just like a certain key shape fits into a lock. After neurotransmitters are released into the synapse and relay the message to the receptor cells, they are either transported back from the synapse to the axon to be stored for later use (reuptake) or metabolized and inactivated by enzymes, primarily monoamine oxidase (MAO).



Schematic illustration of (*1*) neurotransmitter (*T*) release; (*2*) binding of transmitter to postsynaptic receptor; termination of transmitter action by (*3a*) reuptake of transmitter into the presynaptic terminal, (*3b*) enzymatic degradation, or (*3c*) diffusion away from the synapse; and (*4*) binding of transmitter to presynaptic receptors for feedback regulation of transmitter release. These neurotransmitters are necessary in just the right proportions to relay messages across the synapses. Studies are beginning to show differences in the amount of some neurotransmitters available in the brains of people with certain mental disorders compared with those who have no signs of mental illness.

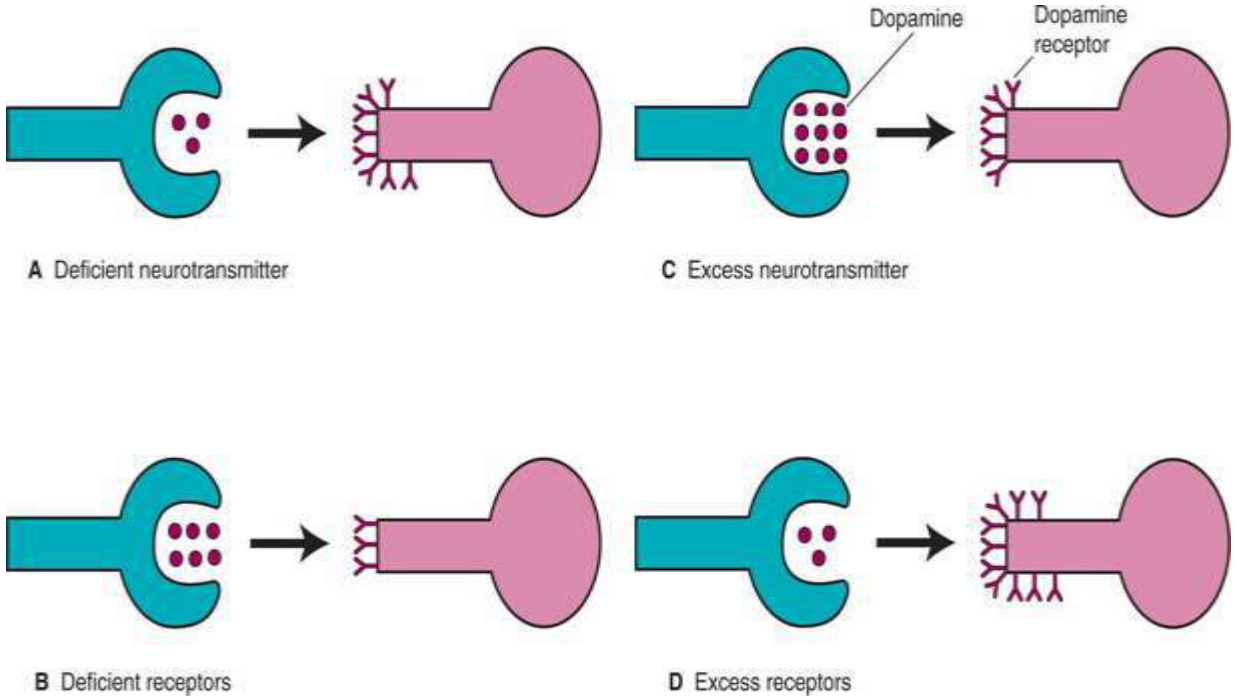
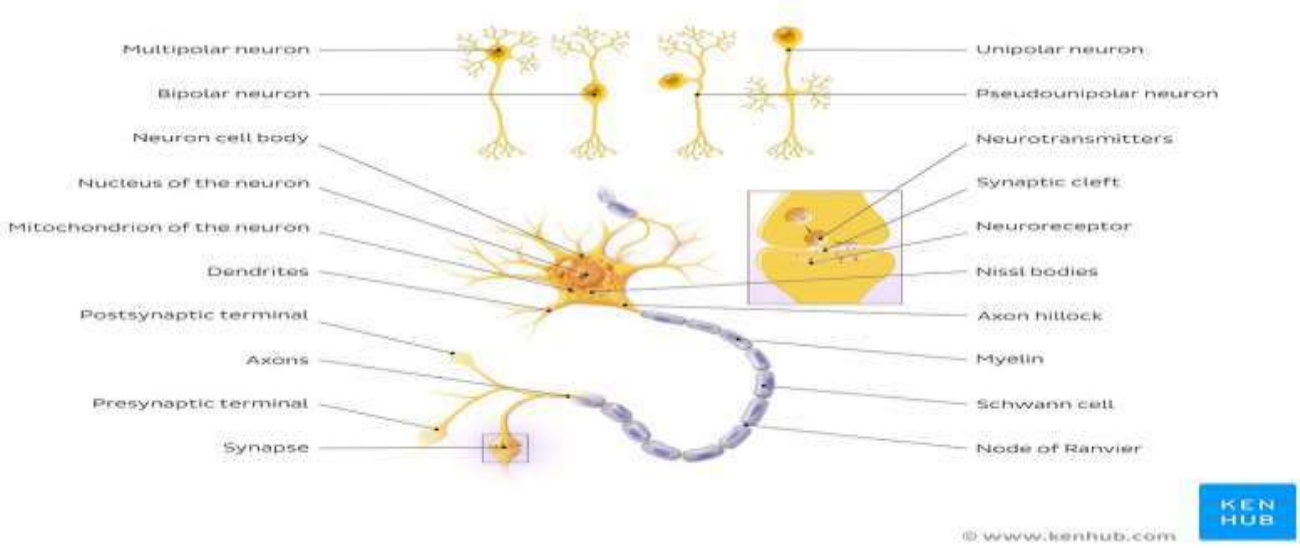


FIGURE 2.4. Abnormal neurotransmission causing some mental disorders because of excess transmission or excess responsiveness of receptors.

Neurotransmitters



Key facts about neurotransmitters

Excitatory neurotransmitters	Glutamate (Glu) Acetylcholine (ACh) Histamine Dopamine (DA) Norepinephrine (NE); also known as noradrenaline (NAd) Epinephrine (Epi); also known as adrenaline (Ad)
Inhibitory neurotransmitters	*gamma*-Aminobutyric acid (GABA) Serotonin (5-HT) Dopamine (DA)
Neuromodulators	Dopamine (DA) Serotonin (5-HT) Acetylcholine (ACh) Histamine Norepinephrine (NE)
Neurohormones	Releasing hormones from hypothalamus Oxytocin (Oxt) Vasopressin; also known as antidiuretic hormone (ADH)

Dopamine, a neurotransmitter located primarily in the brain stem, has been found to be involved in the control of complex movements, motivation, cognition, and regulation of emotional responses. It is generally excitatory and is synthesized from tyrosine, a dietary amino acid. Dopamine is implicated in schizophrenia and other psychoses as well as in

movement disorders such as Parkinson disease. Antipsychotic medications work by blocking dopamine receptors and reducing dopamine activity.

Norepinephrine: the most prevalent neurotransmitter in the nervous system, is located primarily in the brain stem and plays a role in changes in attention, learning and memory, sleep and wakefulness, and mood regulation. Norepinephrine and its derivative.

Epinephrine, are also known as noradrenaline and adrenaline, respectively. Excess norepinephrine has been implicated in several anxiety disorders; deficits may contribute to memory loss, social withdrawal, and depression. Some antidepressants block the reuptake of norepinephrine, while others inhibit MAO from metabolizing it. Epinephrine has limited distribution in the brain but controls the fight or flight response in the peripheral nervous system.

Serotonin is derived from tryptophan, a dietary amino acid. The function of serotonin is mostly inhibitory, and it is involved in the control of food intake, sleep and wakefulness, temperature regulation, pain control, sexual behavior, and regulation of emotions. Serotonin plays an important role in anxiety, mood disorders, and schizophrenia. It has been found to contribute to the delusions, hallucinations, and withdrawn behavior seen in schizophrenia. Some antidepressants block serotonin reuptake, thus leaving it available longer in the synapse, which results in improved mood.

Histamine: The role of histamine in mental illness is under investigation. It is involved in peripheral allergic responses, control of gastric secretions, cardiac stimulation, and alertness. Some psychotropic drugs block histamine, resulting in weight gain, sedation, and hypotension.

Acetylcholine is a neurotransmitter found in the brain, spinal cord, and peripheral nervous system, particularly at the neuromuscular junction of skeletal muscle. It can be excitatory or inhibitory. It is synthesized from dietary choline found in red meat and vegetables and has been found to affect the sleep–wake cycle and to signal muscles to become active. Studies have shown that people with Alzheimer disease have decreased acetylcholine secreting neurons, and people with myasthenia gravis (a muscular disorder in which impulses fail to pass the myoneural junction, which causes muscle weakness) have reduced acetylcholine receptors.

Glutamate is an excitatory amino acid that can have major neurotoxic effects at high levels. It has been implicated in the brain damage caused by stroke, hypoglycemia, sustained hypoxia or ischemia, and some degenerative diseases such as Huntington or Alzheimer.

Gamma-aminobutyric acid (γ-aminobutyric acid, or GABA), an amino acid, is the major inhibitory neurotransmitter in the brain and has been found to modulate other

neurotransmitter systems rather than to provide a direct stimulus. Drugs that increase GABA function, such as benzodiazepines, are used to treat anxiety and to induce sleep.

Type Mechanism of Action Physiologic Effects

Type	Mechanism of Action	Physiologic Effects
Dopamine	Excitatory	Controls complex movements, motivation, cognition; regulates emotional response
Norepinephrine (noradrenaline)	Excitatory	Causes changes in attention, learning and memory, sleep and wakefulness, mood
Epinephrine (adrenaline)	Excitatory	Controls fight or flight response Serotonin inhibitory Controls food intake, sleep and wakefulness, temperature regulation, pain control, sexual behaviors, regulation of Emotions
Histamine	Neuromodulator	Controls alertness, gastric secretions, cardiac stimulation, peripheral allergic responses
Acetylcholine	Excitatory or inhibitory	Controls sleep and wakefulness cycle; signals muscles to become alert Neuropeptides Neuromodulators Enhance, prolong, inhibit, or limit the effects of principal neurotransmitters
Glutamate	Excitatory	Results in neurotoxicity if levels are too high γ-Aminobutyric acid Inhibitory Modulates other neurotransmitters

Several Disorders associated with neurotransmitters

1. **Alzheimer's disease:** is a neurodegenerative disorder characterized by learning and memory impairments. It is associated with a lack of acetylcholine in certain regions of the brain.
2. **Depression**: is believed to be caused by a depletion of norepinephrine, serotonin, and dopamine in the central nervous system. Hence, pharmacological treatment of depression aims at increasing the concentrations of these neurotransmitters in the central nervous system.
3. **Schizophrenia**: which is a severe mental illness, has been shown to involve excessive amounts of dopamine in the frontal lobes, which leads to psychotic episodes in these patients. The drugs that block dopamine are used to help schizophrenic conditions.

4. **Parkinson's disease:** the destruction of the substantia nigra leads to the destruction of the only central nervous system source of dopamine. Dopamine depletion leads to uncontrollable muscle tremors seen in patients suffering from Parkinson's disease.
5. **Epilepsy**: some epileptic conditions are caused by the lack of inhibitory neurotransmitters, such as GABA, or by the increase of excitatory neurotransmitters, such is glutamate. Depending on the cause of the seizures, the treatment is aimed to either increase GABA or decrease glutamate.
6. **Huntington's disease** Besides epilepsy, a chronic reduction of GABA in the brain can lead to Huntington's disease. Even though this is an inherited disease related to abnormality in DNA, one of the products of such disordered DNA is the reduced ability of the neurons to take up GABA.
7. **Myasthenia gravis**: is a rare chronic autoimmune disease characterized by the impairment of synaptic transmission of acetylcholine at neuromuscular junctions, leading to fatigue and muscular weakness without atrophy.

(Some) Neurotransmitters

Neurotransmitter	Function	Examples of malfunctions
Acetylcholine (ACh)	Enables muscle action, learning & memory	Alzheimer's disease ☑ less ACh production
Dopamine	Influences movement, learning, attention, & emotion	Excess ☑ schizophrenia Undersupply ☑ Parkinson's disease
Serotonin	Affects mood, hunger, sleep, and arousal	Undersupply ☑ depression
Norepinephrine	Helps control alertness & arousal	Undersupply ☑ depressed mood
Glutamate	Excitatory neurotransmitter involved in memory	Excess ☑ overstimulation of brain, seizures

General Symptomology of Psychiatric Disorders

I. Disorder of Thinking (Thought)

A. **Disorder of form of thinking**: - When the order, sequence, attraction and alternations are lacking, thoughts do not fulfill their function, and ideas are just put together in a disconnected and loose manner. This is the basic defect in formal thought disorder. Clinical manifestations of formal thought disorder:-

1. **Concrete thinking**: described when using the literal thinking, without understanding the implicit meaning behind sentences. Concreteness versus abstractness.
2. **Abstract thinking**: is the ability to understand concepts that are real, such as freedom or vulnerability, but which are not directly tied to concrete physical objects and experiences.
3. **Autistic thinking**: is the thinking that gratifies unfulfilled desires but has no regard for reality, egocentric (self-centered) fantasy.

B. **Disorders of stream of thinking** are not separable from formal thought disorders. They are also related to the association and the goal directed sequence as well as to the speed of production, expression and succession of thoughts.

1. Tangentially: an association disturbance in which the speaker goes off the topic. When it happens frequently and the speaker does not return to the topic.
2. Circumstantially: Before getting to the point or answering a question, the person gets caught up in countess details and explanation.
3. Looseness of association: Thinking is haphazard illogical, and confused. Connections in thought are interrupted. Seen mostly in schizophrenic disorders.
4. Flight of ideas: rapid jumping from one idea to another. The connection between ideas is through last idea or external stimuli.
5. Clang association: The meaningless rhyming of words.
6. Incoherence or word salad**:** A mixture of words and phrases that have no meaning.
7. Pressure of speech: forceful energy hard in a manic individual's frantic, jumbled speech as he or she struggles to keep pace with racing thoughts.
8. Poverty of speech: speech that is brief and uncommunicative.

9. Retardation: refers to slow speech and prolonged latent period before response.

10. Blocking: sudden cessation of a thought in a middle of a sentence person is unable to continue the stream of thought.

11. Perseveration: psychopathological repetition of the same word or idea in response to different questions.

12. Palilalia: it is the pathological repetition of the last word said.

13. Echolalia: repetition the speech of another person.

14. Verbigeration: continual repetition of stereotyped phrases

15. Irrelevant answer: answer that is not in harmony with question asked.

16. Neologisms: Words a person makes up that only have meaning for the person himself.

C. Disorder of the content of thinking: it includes:

1. Delusion

2. Overvalued ideas.

3. Obsession.

4. Preoccupation

5. Suicidal ideation

1. Delusion

- It is false fixed believe, not consistent with patient's educational, religion and cultural background, that cannot be corrected by logic or reasons.
- It is based on incorrect inferences about reality.
- It cannot be corrected by experience or reasoning.

Categorization of delusions:

1. Paranoid delusion.
2. Influence delusion.

3. depressive delusion.
4. Hypochondriacally delusion.

Paranoid delusion: it is an intense strongly defended irrational suspicious belief.

It includes the following:

1. Delusion of grandeur: false belief that one is a very powerful and important person
2. Delusion of persecution: false belief that one is chased by others.
3. Delusion of reference: false belief that the behavior of others refers to one self (by people in street, radio, and newspaper are referring to him).
4. Erotic delusion: false belief that there is a love story between oneself and famous person.
5. Delusion of jealousy: conviction that the spouse has some definite relation with someone else
6. Delusion of infidelity: false belief derives from pathological jealousy that one's lover is unfaithful. (It's an extreme of the jealousy delusion).
7. Litigious delusion: patient writes complaints and sends them to responsible person
8. Delusion of influence (delusion of control) false belief that one is being controlled by others or agencies.

Depressive delusion:

1. Delusion of self–blame, guilt or sin: in which the patient believes that he is wicked, full of sins and unfit to live with other people (unworthiness).
2. Delusion of poverty: false belief that he lost everything in life.
3. Nihilistic delusion: false belief that a part of his body does not exist (dead).

hypochondriacally delusion: patient has false belief that he has physical disease e.g. cancer stomach, that is not based on real organic pathology.

2. Overvalued ideas: are similar to delusions, but are not maintained to the same degree and may seem less strange than delusions. Overvalued ideas may have an element of truth. For example, a person who works at a company may rigidly maintain the idea that he or she is the most valuable member of the company, that he/she will save the company from ruin, or that he/she will soon be made president of the company. People do not obsess over

overvalued ideas to the same degree that they obsess over delusions, but still become preoccupied by them to such a degree that they interfere with normal functioning. A person with no computer science training might, for example, believe he is going to write the next great computer program and fixate on this idea rather than pursuing training in computer science or going to work.

3.Obsessive thoughts: are intrusive invading the conscious awareness against the resistance of the person in an involuntary way that is fully aware that they are unnecessary and absurd. If the patient's resistance succeeds to temporarily or partially control this intrusion, tension accumulates unit it reaches an intolerable degree that compels the individual to yield and act out the obsessive behavior.

N.B. the difference between delusion and obsession is that the latter is more absurd and the patient is aware of the absurdity and resists it most of the time

4. Preoccupation: Centering of thought content around a particular idea associated with strong affective tone

5. Suicidal ideation: it is a recurrent idea affecting the individual to put an end by himself to his own life

II. Perception Disorders:

1. Hallucination.
2. Illusion.
3. Unreality status.

1.Hallucinations: False perception for which no external stimuli exist. Hallucinations can have an organic or a functional etiology

Visual: seeing things that are not there

Auditory: hearing voices when none are present

Olfactory: smelling smells that do not exist

Tactile: feeling touch sensations in the absence of stimuli

Gustatory: experiencing taste in the absence of stimuli

2. Illusion: It is a false perception with an external stimulus

N.B. it may affect any of the special senses (auditory. Olfactory, etc…..)

3.Unreality status

a. Depersonalization: a phenomenon whereby a person experiences a sense of unreality or self-estrangement.
b. Derealization: the false perception by a person that his or her environment changed. Also they can be categorized under affect and perception

III. Disorder of Memory

1- Amnesia: is loss of memory and may be partial or complete the following are the different types of amnesia

a. Anterograde amnesia: loss of memory for recent events

b. Retrograde amnesia: loss of memory for remote events.

c. Total amnesia: loss of memory for recent and remote events

d. Circumscribed amnesia: loss of memory for limited time

2-Paramnesia: it denotes false recall

a. Confabulation: patient fills the gaps in his memory by fabrication

b. Falsification: patient adds false details to a true memory

3.Hypermnsia: it's excessive memory, the patient mentions even unnecessary details

4.Déjà vu phenomena (already seen): in which new situation is experienced as previously

5.Jamais vu phenomena (never seen): in which familiar situation is not experienced.

IV. Orientation disorder

1- Orientation: the ability to relate the self correctly to time place and person.

2- Disorientation: confusion and impaired ability to identify time place and person

V. Judgment: it is the ability to assess a situation correctly and act appropriately within that situation.

VI. Insight: it is the ability to understand the objective condition of his illness.

N.B. a patient with no insight will have poor judgment towards his social financial and domestic problems.

VII. Attention and Concentration: it is the direction of the focus of awareness and perception to a particular stimulus

Destructibility: inability to maintain attention, shifting from one area or topic to another with minimal provocation.

VIII. Disorder of Consciousness: Between conscious and unconscious there are various degrees of disturbed consciousness, some of them are:

1. Confusion: there is dimming or clouding of consciousness. All mental processes are slow.

2. Delirium: there is clouding of consciousness, the mental function show quantitative changes:

3. Intellect: hallucination, illusion and disorientation.

4. Affect: fear and apprehension

5. Behavior: restlessness

6. Stupor: there is complete suppression of motor activity, the patient does not respond to any stimuli neither external nor internal

7. Fugue: it involve memory loss as does psychogenic amnesia but it also includes traveling away from home or from one's usual work locale. Therefore fugue involve flight forgetfulness.

IX. Disorder of Affect

Affect is an objective manifestation of an experience of emotion accompanying an idea or feeling. The observation one would makes on assessment e.g. a client may be said to have a flat affect.

1- Appropriate affect: (congruity) it is a harmony of affect and ideation.

2- Inappropriate affect: (incongruity) it is disharmony of affect and ideation.

3- Restricted affect involves slightly restrained expression.

4- Inadequate affect:

- Flat affect (Apathy): it is the absence of both emotional experience and expression.
- Ambivalence: the holding at the same time of two opposed emotion, attitude, idea or wishes toward the same person, situation or object.

5- Blunted affect is a step above flat, with some mild expression present on occasion. Any emotional display is severely restrained.

X. Mood Disorders:

Mood: a pervasive an sustained emotion that in the extreme markedly colors the person's perception of the world. It may be pleasant or unpleasant.

Pleasurable (Pleasant Mood):

1. Euphoria: it is a heightened feeling of psychological wellbeing inappropriate to apparent events.(subjective feeling).
2. Elation: it is feeling of happiness with air of confidence and enjoyment associated with increased motor activity.(objectively observed)
3. Exaltation: it is intense elation with feelings of grandeur and sarcasm. (objectively observed)

Unpleasant affect:

1.Grief: it is feeling of sadness appropriate to a real loss.

2.Depression: it is a psychopathological feeling of sadness.

XI. Disorder of Behavior:

1. Hyperactivity: it includes:

1. Agitation: it some of hyper activity characterized by pacing and accompanied with restlessness.

2. Excitement: it is severe form of hyper activity excessive purposeless motor activity and the patient may destruct himself or others.

2. Psychomotor retardation: extremely slow & difficult movement that in the extremes can entire complete inactivity &incontinence.

3. Repetitive activities:

1.Stereotypy: it is a monotonous repetition of certain movement without purpose.

2.Mannerism: it is a repeated movement, which is not monotonous & keeping with the personality character.

3.Perseveration: the involuntary repetition of the same thought, phrase, or motor response (brushing teeth, walking).

4.Waxy flexibility: it is the maintenance of imposed posture however abnormal with order they may be (arm up,) the absence of fatigue in such cases is remarkable.

5.Catalepsy: it is sustained immobility. The patient initiate the posture by himself.

6.Echopraxia: imitating the movement of another person.

7.Negativism: frequent opposition to suggestion e.g.

A) Motor: when he was asked to look up, he looks down.

B) Speech: when he asked question he did not answer.

C) Visceral: retention of saliva, urine & feces

4. Impulsiveness: is an action that is sudden, abrupt, unplanned & directed toward immediate gratification.

5. Compulsion: uncontrollable impulse to perform an act repetitively.

Unit Two: Mental Health History and Theories

Psychoanalytic Theories

Sigmund Freud: The Father of Psychoanalysis

Sigmund Freud (1856–1939) developed psychoanalytic theory in the late 19th and early 20th centuries in Vienna, where he spent most of his life. Psychoanalytic theory supports the notion that all human behavior is caused and can be explained (deterministic theory).

Personality Components: Id, Ego, and Superego. Freud conceptualized personality structure as having three components: the id, ego, and superego (Freud, 1923, 1962). The **id** is the part of one's nature that reflects basic or innate desires such as pleasure-seeking behavior, aggression, and sexual impulses. The **superego** is the part of a person's nature that reflects moral and ethical concepts, values, and parental and social expectations; therefore, it is indirect opposition to the id. **Ego**, is the balancing or mediating force between the id and the superego. The ego represents mature and adaptive behavior that allows a person to function successfully in the world. Freud believed that anxiety resulted from the ego's attempts to balance the impulsive instincts of the id with the stringent rules of the superego.

Freud's Dream Analysis. Freud believed that a person's dreams reflect his or her **subconscious** and have significant meaning, though sometimes the meaning is hidden or symbolic. **Dream analysis**, a primary technique used in psychoanalysis, involves discussing a client's dreams to discover their true meaning and significance.

Note: **Psychoanalysis** focuses on discovering the causes of the client's unconscious and repressed thoughts, feelings, and conflicts believed to cause anxiety and on helping the client gain insight into and resolve these conflicts and anxieties. The analytic therapist uses the techniques of free association, dream analysis, and interpretation of behavior.

Ego Defense Mechanisms. Freud believed that the self, or ego, uses **ego defense mechanisms**, which are methods of attempting to protect the self and cope with basic drives or emotionally painful thoughts, feelings, or events.

1. Compensation: Overachievement in one area to offset real or perceived deficiencies in another area.
2. Conversion: Expression of an emotional conflict through the development of a physical symptom, usually sensorimotor in nature.
3. Denial: Failure to acknowledge an unbearable condition; failure to admit the reality of a situation or how one enables the problem to continue.
4. Displacement: Ventilation of intense feelings toward persons less threatening than the one who aroused those feelings.
5. Dissociation: Dealing with emotional conflict by a temporary alteration in consciousness or identity.
6. Fixation: Immobilization of a portion of the personality resulting from unsuccessful completion of tasks in a developmental stage.
7. Identification: Modeling actions and opinions of influential others while searching for identity, or aspiring to reach a personal, social, or occupational goal.
8. Intellectualization: Separation of the emotions of a painful event or situation from the facts involved; acknowledging the facts but not the emotions.
   (e.g. Person shows no emotional expression when discussing serious car accident)
9. Introjection Accepting another person's attitudes, beliefs, and values as one's own. (e.g. Person who dislikes guns becomes an avid hunter, just like a best friend).
10. Projection: Unconscious blaming of unacceptable inclinations or thoughts on an external object. (e.g. Man who has thought about same-gender sexual relationship but never had one beats a man who is gay). (e.g. Person with many prejudices loudly identifies others as bigots).
11. Rationalization: Excusing own behavior to avoid guilt, responsibility, conflict, anxiety, or loss of self-respect. E.g. Student blames failure on teacher being mean. E.g.Man says he beats his wife because she does not listen to him.

12. Reaction: formation acting the opposite of what one thinks or feels. E.g. Woman who never wanted to have children becomes a supermom. E.g. Person who despises the boss tells everyone what a great boss she is.
13. Regression: Moving back to a previous developmental stage to feel safe or have needs met. E.g. A 5-year-old asks for a bottle when new baby brother is being fed e.g. Man pouts like a 4-year-old if he is not the center of his girlfriend's attention.
14. Repression: Excluding emotionally painful or anxiety-provoking thoughts and feelings from conscious awareness. E.g. Woman has no memory of the mugging she suffered yesterday. E.g.Woman has no memory before age 7, when she was removed from abusive parents.
15. Resistance: Overt or covert antagonism toward remembering or processing anxiety-producing information. E.g. Nurse is too busy with tasks to spend time talking to a dying patient. E.g. Person attends court-ordered treatment for alcoholism but refuses to participate.
16. Sublimation: Substituting a socially acceptable activity for an impulse that is unacceptable. E.g. Person who has quit smoking sucks on hard candy when the urge to smoke arises. E.g. Person goes for a 15-minute walk when tempted to eat junk food Substitution Replacing the desired gratification with one that is more readily available. E.g. Woman who would like to have her own children opens a day care center.
17. Suppression: Conscious exclusion of unacceptable thoughts and feelings from conscious Student decides not to think about a parent's illness to study for a test. E.g. Woman tells a friend she cannot think about her son's death right now.
18. Undoing: Exhibiting acceptable behavior to make up for or negate unacceptable behavior. E.g. Person who cheats on a spouse brings the spouse a bouquet of roses.

Transference and Countertransference

Freud developed the concepts of transference and countertransference. **Transference** occurs when the client displaces onto the therapist attitudes and feelings that the client

originally experienced in other relationships. **Countertransference** occurs when the therapist displaces onto the client attitudes or feelings from his or her past. For example, a female nurse who has teenage children and who is experiencing extreme frustration with an adolescent client may respond by adopting a parental tone. The nurse is counter transferring her own attitudes and feelings toward her children onto the client. Nurses can deal with countertransference by examining their own feelings and responses, using self-awareness, and talking with colleagues.

Developmental Theories

Erik Erikson and Psychosocial Stages of Development

Erik Erikson (1902–1994) was a German-born psychoanalyst, who extended Freud's work on personality development across the life span while focusing on social and psychological development in the life stages. In 1950, Erikson published *Childhood and Society*, in which he described eight psychosocial stages of development. In each stage, the person must complete a life task that is essential to his or her well-being and mental health. These tasks allow the person to achieve life's virtues: hope, purpose, fidelity, love, caring, and wisdom.

Erikson's Stages of Psychosocial Development

Stage	**Virtue**	**Task**
Trust vs. mistrust (infant)	Hope	Viewing the world as safe and reliable; relationships as nurturing, stable, and dependable
Autonomy vs. shame and doubt (toddler)	Will	Achieving a sense of control and free will
Initiative vs. guilt (preschool)	Purpose	Beginning development of a conscience; learning to manage conflict and anxiety
Industry vs. inferiority (school age)	Competence	Emerging confidence in own abilities; taking pleasure in accomplishments

Identity vs. role confusion (adolescence)	Fidelity	Formulating a sense of self and belonging
Intimacy vs. isolation (young adult)	Love	Forming adult, loving relationships, and meaningful attachments to others
Generativity vs. stagnation(middle adult)	Care	Being creative and productive; establishing the next generation
Ego integrity vs. despair (maturity)	Wisdom	Accepting responsibility for oneself and life

Jean Piaget and Cognitive Stages of Development

Jean Piaget (1896–1980) explored how intelligence and cognitive functioning develop in children. He believed that human intelligence progresses through a series of stages based on age, with the child at each successive stage demonstrating a higher level of functioning than at previous stages. In his schema, Piaget strongly believed that biologic changes and maturation were responsible for cognitive development.

Piaget's four stages of cognitive development are as follows:

1. *Sensorimotor*—birth to 2 years: The child develops a sense of self as separate from the environment and the concept of object permanence, that is, tangible objects do not cease to exist just because they are out of sight. He or she begins to form mental images.
2. *Preoperational*—2 to 6 years: The child develops the ability to express self with language, understands the meaning of symbolic gestures, and begins to classify objects.
3. *Concrete operations*—6 to 12 years: The child begins to apply logic to thinking, understands spatiality and reversibility, and is increasingly social and able to apply rules; however, thinking is still concrete.
4. *Formal operations*—12 to 15 years and beyond: The child learns to think and reason in abstract terms, further develops logical thinking and reasoning, and achieves cognitive maturity.

Note: Piaget's theory suggests that individuals reach cognitive maturity by middle to late adolescence. Piaget's theory is useful when working with children. The nurse may better

understand what the child means if the nurse is aware of his or her level of cognitive development. Also, teaching for children is often structured with their cognitive development in mind.

Interpersonal Theories

Harry Stack Sullivan: Interpersonal Relationships and Milieu Therapy

Harry Stack Sullivan (1892–1949) was an American psychiatrist who extended the theory of personality development to include the significance of interpersonal relationships. Sullivan believed that one's personality involves more than individual characteristics, particularly how one interacts with others. He thought that inadequate or nonsatisfying relationships produce anxiety, **which he saw as the basis for all emotional problems Therapeutic Community or Milieu.** Sullivan envisioned the goal of treatment as the establishment of satisfying interpersonal relationships. The concept of **milieu therapy**, originally developed by Sullivan, involved clients' interactions with one another, including practicing interpersonal relationship skills, giving one another feedback about behavior, and working cooperatively as a group to solve day-to-day problems.

Hildegard Peplau: Therapeutic Nurse–Patient Relationships

Hildegard Peplau (1909–1999)defined anxiety as the initial response to a psychic threat (**Four Levels of Anxiety)**. She described four levels of anxiety: mild, moderate, severe, and panic. She developed the concept of the **therapeutic nurse–patient relationship**, which includes four phases: orientation, identification, exploitation, and resolution:

Peplau's Stages and Tasks of Relations

1. The *orientation phase* is directed by the nurse and involves engaging the client in treatment, providing explanations and information, and answering questions.
2. The *identification phase* begins when the client works interdependently with the nurse, expresses feelings, and begins to feel stronger.
3. In the *exploitation phase*, the client makes full use of the services offered.
4. In the *resolution phase*, the client no longer needs professional services and gives up dependent behavior. The relationship ends.

Roles of the Nurses in the Therapeutic Relationship

The primary roles she identified are as follows:

1. *Stranger*—offering the client the same acceptance and courtesy that the nurse would to any stranger
2. *Resource person*—providing specific answers to questions within a larger context.
3. *Teacher*—helping the client learn either formally or informally
4. *Leader*—offering direction to the client or group.
5. *Surrogate*—serving as a substitute for another, such as a parent or sibling
6. *Counselor*—promoting experiences leading to health for the client, such as expression of feelings.

Humanistic Theories

Abraham Maslow: Hierarchy of Needs

Abraham Maslow (1921–1970) was an American psychologist who studied the needs or motivations of the individual. Maslow (1954) formulated the **hierarchy of needs**.

1. The most basic needs—the physiologic needs of food, water, sleep, shelter, sexual expression, and freedom from pain—must be met first.
2. The second level involves safety and security needs, which include protection, security, and freedom from harm or threatened deprivation.
3. The third level is love and belonging needs, which include enduring intimacy, friendship, and acceptance.
4. The fourth level involves esteem needs, which include the need for self-respect and esteem from others.
5. The highest level is self-actualization, the need for beauty, truth, and justice.

Carl Rogers: Client-Centered Therapy

Carl Rogers (1902–1987) was a humanistic American psychologist who focused on the therapeutic relationship and developed a new method of client centered therapy. Rogers was one of the first to use the term *client* rather than *patient.*

The therapist must promote the client's self-esteem as much as possible through three central concepts:

1. *Unconditional positive regard*—a nonjudgmental caring for the client that is not dependent on the client's behavior. Unconditional positive regard promotes the client's self-esteem and decreases his or her need for defensive behavior.
2. *Genuineness*—realness or congruence between what the therapist feels and what he or she says to the client.
3. *Empathetic understanding*—in which the therapist senses the feelings and personal meaning from the client and communicates this understanding to the client.

Ivan Pavlov: Classical Conditioning

Laboratory experiments with dogs provided the basis for the development of Ivan Pavlov's theory of classical conditioning: Behavior can be changed through conditioning with external or environmental conditions or stimuli. e.g. The dogs had been "conditioned," or had learned a new response, to salivate when they heard the bell.

B.F. Skinner: Operant Conditioning

One of the most influential behaviorists was B.F. Skinner (1904–1990), an American psychologist. He developed the theory of:

- **operant conditioning**, which says people learn their behaviors from their history or past experiences, particularly those experiences that were repeatedly reinforced.
- **Behavior modification** : behavioral principles of rewarding or reinforcing behaviors are used to help people change their behaviors in a therapy known.
- **positive reinforcement** by giving the client attention and positive feedback.
- **Negative reinforcement** involves removing a stimulus immediately after a behavior occurs so that the behavior is more likely to occur again. For example, if a client

becomes anxious when waiting to talk in a group, he or she may volunteer to speak first to avoid the anxiety.

- **Systematic desensitization** can be used to help clients overcome irrational fears and anxiety associated with phobias. The client is asked to make a list of situations involving the phobic object, from the least to the most anxiety-provoking.

Existential Theories: Existential theorists believe that behavioral deviations result when a person is out of touch with him or herself or the environment. The person who is self-alienated is lonely and sad and feels helpless. Lack of self-awareness, coupled with harsh self-criticism, prevents the person from participating in satisfying relationships. The person is not free to choose from all possible alternatives because of self-imposed restrictions. Existential theorists believe that the person is avoiding personal responsibility and is giving in to the wishes or demands of others.

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Unit Three: Ethical and Legal Issues

Ethics is a branch of philosophy that deals with values of human conduct related to the rightness or wrongness of actions and to the goodness and badness of the motives and ends of such actions.

Ethical theories are sets of principles used to decide what is morally right or wrong. Which are:

1. **Utilitarianism** is a theory that bases decisions on "the greatest good for the greatest number." Decisions based on utilitarianism consider which action would produce the greatest benefit for the most people.
2. **Deontology** is a theory that says decisions should be based on whether an action is morally right with no regard for the result or consequences.
3. **Autonomy** refers to a person's right to self-determination and independence.
4. **Beneficence** refers to one's duty to benefit or to promote the good of others.
5. **Non-maleficence** is the requirement to do no harm to others either intentionally or unintentionally.
6. **Justice** refers to fairness, treating all people fairly and equally without regard for social or economic status, race, sex, marital status, religion, ethnicity, or cultural beliefs.
7. **Veracity** is the duty to be honest or truthful.
8. **Fidelity** refers to the obligation to honor commitments and contracts.

Ethical Decision-Making

The ANA published a revised *Code of Ethics for Nurses* in 2015 to guide choices about ethical actions.

Content Areas for Ethical Code

1. Compassion, respect, human dignity, and worth
2. Primary commitment to patients
3. Promotion of health, safety, and patient rights
4. Responsible, accountable provision of care
5. Professional growth, integrity, and competence of the nurse
6. Promotion of safe, ethical health care/work environment
7. Advancement of the nursing profession
8. Collaboration with others
9. Maintain integrity of profession, include social justice

Bill Rights for Psychiatric patients:

1. The right to appropriate treatment and related services in the setting that is most supportive and least restrictive to personal freedom.
2. The right to an individualized, written treatment or service plan; the right to treatment based on such plan; and the right to periodic review and revision of the plan based on treatment needs.
3. The right, consistent with one's capabilities, to participate in and receive a reasonable explanation of the care and treatment process.
4. The right to refuse treatment except in an emergency situation or as permitted by law.
5. The right not to participate in experimentation in the absence of informed, voluntary, written consent.
6. The right to freedom from restraint or seclusion except in an emergency situation.
7. The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy.

8. The right to confidentiality of medical records (also applicable following patient's discharge).
9. The right of access to medical records except information received from third parties under promise of confidentiality and when access would be detrimental to the patient's health .
10. The right of access to use of the telephone, personal mail, and visitors, unless deemed inappropriate for treatment purposes.
11. The right to be informed of these rights in comprehensible language.
12. The right to assert grievances if rights are infringed.
13. The right to referral as appropriate to other providers of mental health services upon discharge.

Torts

A **tort** is a wrongful act that results in injury, loss, or damage. Torts may be either unintentional or intentional.

1. **Unintentional Torts: Negligence and Malpractice. Negligence,** is an unintentional tort that involves causing harm by failing to do what a reasonable and prudent person would do in similar circumstances.
2. **Malpractice** is a type of negligence that refers specifically to professionals such as nurses and physicians. Clients or families can file malpractice lawsuits in any case of injury, loss, or death. For a malpractice suit to be successful, that is, for the nurse, physician, or hospital or agency to be liable, the client or family needs to prove four elements:
   A. **Duty:** A legally recognized relationship (i.e., physician to client, nurse to client) existed. The nurse had a duty to the client, meaning that the nurse was acting in the capacity of a nurse.

B. **Breach of duty:** The nurse (or physician) failed to conform to standards of care, thereby breaching or failing the existing duty. The nurse did not act as a reasonable, prudent nurse would have acted in similar circumstances.

C. **Injury or damage:** The client suffered some type of loss, damage, or injury.

D. **Causation:** The breach of duty was the direct cause of the loss, damage, or injury. In other words, the loss, damage, or injury would not have occurred if the nurse had acted in a reasonable, prudent manner.

Not all injury or harm to a client can be prevented, nor do all client injuries

Intentional Torts. Psychiatric nurses may also be liable for intentional torts or voluntary acts that result in harm to the client. Examples include assault, battery, and false imprisonment.

1. **Assault** involves any action that causes a person to fear being touched in a way that is offensive, insulting, or physically injurious without consent or authority. Examples include making threats to restrain the client to give him or her an injection for failure to cooperate.
2. **Battery** involves harmful or unwarranted contact with a client; actual harm or injury may or may not have occurred. Examples include touching a client without consent or unnecessarily restraining a client.
3. **False imprisonment** is defined as the unjustifiable detention of a client, such as the inappropriate use of restraint or seclusion.

Ethical Dilemmas in Mental Health

An **ethical dilemma** is a situation in which ethical principles conflict or when there is no one clear course of action in a given situation. For example, the client who refuses medication or treatment is allowed to do so on the basis of the principle of autonomy. If the client presents an imminent threat of danger to him or herself or others, however, the principle of non-maleficence (do no harm) is at risk.

Points to Consider When Confronting Ethical Dilemmas

1. Talk to colleagues or seek professional supervision. Usually, the nurse does not need to resolve an ethical dilemma alone.
2. Spend time thinking about ethical issues, and determine what your values and beliefs are regarding situations before they occur.
3. Be willing to discuss ethical concerns with colleagues or managers. Being silent is condoning the behavior.

Prevention of the Liability:

1. Practice within the scope of state laws and nurse practice act
2. Collaborate with colleagues to determine the best course of action.
3. Use established practice standards to guide decisions and actions.
4. Always put the client's rights and welfare first.
5. Develop effective interpersonal relationships with clients and families.
6. Accurately and thoroughly document all assessment data, treatments, interventions, and evaluation of the client's response to care.

Unit Four: Anxiety and Related Disorders

Anxiety can be described as an uncomfortable feeling of dread that is a response to extreme or prolonged periods of stress. Anxiety is an unpleasant feeling of tension, apprehension, and uneasiness or a diffuse feeling of dread or unexplained discomfort. It is a vague feeling of dread or apprehension; it is a response to external or internal stimuli that can have behavioral, emotional, cognitive, and physical symptoms. Anxiety is unavoidable in life and can serve many positive functions such as motivating the person to take action to solve a

problem or to resolve a crisis. It is considered normal when it is appropriate to

the situation and dissipates when the situation has been resolved.

Anxiety disorders comprise a group of conditions that share a key feature of excessive anxiety with ensuing behavioral, emotional, cognitive, and physiological responses. Clients suffering from anxiety disorders can demonstrate unusual behaviors such as panic without reason, unwarranted fear of objects or life conditions, or unexplainable or overwhelming worry. They experience significant distress over time, and the disorder significantly impairs their daily routines, social lives, and occupational functioning.

ASSESSMENT DATA

- Decreased attention span
- Restlessness, irritability
- Poor impulse control
- Feelings of discomfort, apprehension, or helplessness
- Hyperactivity, pacing
- Wringing hands
- Perceptual field deficits
- Decreased ability to communicate verbally

The four commonly levels of anxiety are:

Anxiety Level	Psychological Responses	Physiologic Responses
Mild	1. Wide perceptual field 2. Sharpened senses 3. Increased motivation 4. Effective problem-solving 5. Increased learning ability 6. Irritability	1. Restlessness 2. Difficulty sleeping 3. Hypersensitivity to noise
Moderate	1. Perceptual field narrowed to immediate task 2. Selectively attentive 3. Cannot connect thoughts or events independently 4. Increased use of automatisms	1. Muscle tension 2. Diaphoresis 3. Pounding pulse 4. Headache 5. Dry mouth 6. High voice pitch 7. Faster rate of speech 8. GI upset 9. Frequent urination
Severe	1. Perceptual field reduced to one detail or scattered details 2. Cannot complete tasks 3. Cannot solve problems or learn effectively 4. Behavior geared toward anxiety relief and usually ineffective 5. Doesn't respond to redirection 6. Feels awe, dread, or horror 7. Crying 8. Ritualistic behavior	1. Severe headache 2. Nausea, vomiting, and diarrhea 3. Trembling 4. Rigid stance 5. Vertigo 6. Pale 7. Tachycardia 8. Chest pain
Panic	1. Perceptual field reduced to focus on self 2. Cannot process any environmental stimuli 3. Distorted perceptions 4. Loss of rational thought 5. Doesn't recognize potential danger 6. Can't communicate verbally 7. Possible delusions and hallucination 8. May be suicidal	1. Totally immobile and mute 2. Dilated pupils 3. Increased blood pressure and pulse 4. Flight or fight or freeze

ANXIETY AS A RESPONSE TO STRESS

Stress is the wear and tear that life causes on the body. It occurs when a person has difficulty dealing with life situations, problems, and goals. Each person handles stress differently; one person can thrive in a situation that creates great distress for another.

Three stages of reaction to stress:

1. **The *alarm reaction stage***, stress stimulates the body to send messages from the hypothalamus to the glands (such as the adrenal gland, to send out adrenaline and norepinephrine for fuel) and organs (such as the liver, to reconvert glycogen stores to glucose for food) to prepare for potential defense needs.
2. **The *resistance stage***, the digestive system reduces function to shunt blood to areas needed for defense. The lungs take in more air, and the heart beats faster and harder so that it can circulate this highly oxygenated and highly nourished blood to the muscles to defend the body by fight, flight, or freeze behaviors. If the person adapts to the stress, the body responses relax, and the gland, organ, and systemic responses abate.
3. **The *exhaustion stage*** occurs when the person has responded negatively to anxiety and stress; body stores are depleted or the emotional components are not resolved, resulting in continual arousal of the physiological responses and little reserve capacity.

Working with Anxious Clients

1. The nurse must assess the person's anxiety level because that determines what interventions are likely to be effective.
2. Mild anxiety is an asset to the client and requires no direct intervention.

3. People with mild anxiety can learn and solve problems and are even eager for information.
4. Teaching can be effective when the client is mildly anxious.
5. With moderate anxiety, the nurse must be certain that the client is following what the nurse is saying. The client's attention can wander, and he or she may have some difficulty concentrating over time.
6. Speaking in short, simple, and easy-to-understand sentences is effective; the nurse must stop to ensure that the client is still taking in information correctly.
7. The nurse may need to redirect the client back to the topic if the client goes off on a tangent.
8. During **panic anxiety**, the person's safety is the primary concern.
9. Diazepam (Valium), Clonazepam, Meprobamate, Buspirone may give to patient.

INCIDENCE

Anxiety disorders have the highest prevalence rates of all mental disorders in the United States for both children and adults. Nearly one in four adults in the United States is affected, and the magnitude of anxiety disorders in young people is similar. Anxiety disorders are more prevalent in women, people younger than 45 years of age, people who are divorced or separated, and people of lower socioeconomic status.

RELATED DISORDERS

1. *Selective mutism* is diagnosed in children when they fail to speak in social situations even though they are able to speak. They may speak freely at home with parents but fail to interact at school or with extended family. Lack of speech interferes with social communication and school performance. There is high level of social anxiety in these situations.

2. *Anxiety disorder due to another medical condition* is diagnosed when the prominent symptoms of anxiety are judged to result directly from a physiological condition. The person may have panic attacks, generalized anxiety, or obsessions or compulsions. Medical conditions causing this disorder can include endocrine dysfunction, chronic obstructive pulmonary disease, congestive heart failure, and neurologic conditions.
3. *Substance/medication-induced anxiety disorder* is anxiety directly caused by drug abuse, a medication, or exposure to a toxin. Symptoms include prominent anxiety, panic attacks, phobias, obsessions, or compulsions.
4. *Separation anxiety disorder* is excessive anxiety concerning separation from home or from persons, parents, or caregivers to whom the client is attached. It occurs when it is no longer developmentally appropriate and before 18 years of age.

ETIOLOGY

1. Biologic Theories - *Genetic Theories*

Anxiety may have an inherited component because first-degree relatives of clients with increased anxiety have higher rates of developing anxiety. *Heritability* refers to the proportion of a disorder that can be attributed to genetic factors:

• High heritabilities are greater than 0.6 and indicate that genetic influences dominate.

• Moderate heritabilities are 0.3 to 0.5 and suggest an even greater influence of genetic and nongenetic factors.

• Heritabilities less than 0.3 mean that genetics are negligible as a primary cause of the disorder.

2. Neurochemical Theories:

Gamma-aminobutyric acid (GABA) is the amino acid neurotransmitter believed to be dysfunctional in anxiety disorders. GABA, an inhibitory neurotransmitter, functions as the body's natural antianxiety agent by reducing cell excitability, thus decreasing the rate of neuronal firing.

3. Psychodynamic Theories

A. *Intrapsychic/Psychoanalytic Theories*

Freud (1936) saw a person's innate anxiety as the stimulus for behavior. He described defense mechanisms as the human's attempt to control awareness of and to reduce anxiety.

B. ***Interpersonal Theory***

Harry Stack Sullivan (1952) viewed anxiety as being generated from problems in interpersonal relationships. Caregivers can communicate anxiety to infants or children through inadequate nurturing, agitation when holding or handling the child, and distorted messages. Such communicated anxiety can result in dysfunction, such as the failure to achieve age-appropriate developmental tasks. She identified the four levels of anxiety and developed nursing interventions and interpersonal communication techniques.

C. ***Behavioral Theory***

Behavioral theorists view anxiety as being learned through experiences. Conversely, people can change or "unlearn" behaviors through new experiences. Behaviorists believe that people can modify maladaptive behaviors without gaining insight into their causes.

TREATMENT: Treatment for anxiety disorders usually involves medication and therapy.

1. An anxiolytic, Antidepressants may use.
2. Cognitive–behavioral therapy (CBT) is used successfully to treat anxiety disorders.
3. Positive reframing means turning negative messages into positive messages. The therapist teaches the client to create positive messages for use during panic episodes. For example, instead of thinking, "My heart is pounding. I think I'm going to die," the client thinks, "I can stand this. This is just anxiety. It will go away." The client can write down these messages and keep them readily accessible, such as in an address book, a calendar, or a wallet**.**

Types of Anxiety and Anxiety-Related Disorders:

First: Generalized Anxiety Disorder (GAD):is the anxiety (also referred to as "excessive worry" or "severe stress") itself is the expressed symptom. It is diagnosed when excessive worry feels highly anxious at least 50% of the time for 6 months or more. Unable to control this focus on worry, the person has three or more of the following symptoms: uneasiness, irritability, muscle tension, fatigue, difficulty thinking, and sleep alterations. More people with this chronic disorder are seen by family physicians than by psychiatrists.

Treatment:

1. Buspirone (BuSpar) and SSRI or serotonin–norepinephrine reuptake inhibitor antidepressants are the most effective treatmentspeople and places where previous events occurred.
2. Nurses must understand what and how anxiety behaviors work, not just for client care but to help understand the role anxiety plays in performing nursing responsibilities.
3. Nurses are expected to function at a high level and to avoid allowing their own feelings and needs to hinder the care of their clients. But as emotional beings, nurses are just as vulnerable to stress and anxiety as others, and they have needs of their own.

Second: Fear: Response to perceived threat that is consciously recognized as a danger, characterized by:

- Refuses to leave own home alone
- Refuses to eat in public
- Refuses to speak or perform in public]
- Refuses to expose self to (specify phobic object or situation)
- Identifies object of fear

Nursing interventions:

1. Reassure client of his or her safety and security.
2. Explore the client's perception of threat to physical integrity or threat to self-concept.
3. Discuss reality of the situation with client in order to recognize aspects that can be changed and those that cannot.
4. Include client in making decisions related to selection of alternative coping strategies. (Example: Client may choose either to avoid the phobic stimulus or attempt to eliminate the fear associated with it.
5. If the client elects to work on elimination of the fear, the techniques of desensitization may be employed.
6. Encourage client to explore underlying feelings that may be contributing to irrational fears.

7. Help client to understand how facing these feelings, rather than suppressing them, can result in more adaptive coping abilities.

Third: Panic disorder is composed of discrete episodes of **panic attacks**, that is, 15 to 30 minutes of rapid, intense, escalating anxiety in which the person experiences great emotional fear as well as physiological discomfort. During a panic attack, the person has overwhelmingly intense anxiety and displays four or more of the following symptoms: palpitations, sweating, tremors, shortness of breath, sense of suffocation, chest pain, nausea, abdominal distress, dizziness, paresthesias, chills, or hot flashes. Panic disorder is diagnosed when the person has recurrent, unexpected panic attacks followed by at least 1 month of persistent concern or worry about future attacks or their meaning or a significant behavioral change related to them.

Clinical Course

The onset of panic disorder peaks in late adolescence and the mid-30s. Although panic anxiety might be normal in someone experiencing a life-threatening situation, a person with panic disorder experiences these emotional and physiological responses without this stimulus. The memory of the panic attack, coupled with the fear of having more, can lead to avoidance behavior.

Primary gain is the relief of anxiety achieved by performing the specific anxiety-driven behavior, such as staying in the house to avoid the anxiety of leaving a safe place. **Secondary gain** is the attention received from others as a result of these behaviors. For instance, the person with agoraphobia may receive attention and caring concern from family members who also assume all the responsibilities of family life outside the home (e.g., work and shopping).

Treatment

1. Panic disorder is treated with CBTs and deep breathing and relaxation.
2. Medications such as benzodiazepines, SSRI antidepressants, tricyclic antidepressants, and antihypertensives such as clonidine (Catapres) and propranolol (Inderal).

3. Provide a safe environment and ensure the client's privacy during a panic attack.
4. Remain with the client during a panic attack.
5. Help the client focus on deep breathing.
6. Talk to the client in a calm, reassuring voice.
7. Teach the client to use relaxation techniques.
8. Help the client use cognitive restructuring techniques. Engage the client to explore how to decrease stressors and anxiety provoking situations.

CLIECLIENT AND FAMILY EDUCATIONNT

1. Review breathing control and relaxation techniques.
2. Discuss positive coping strategies.
3. Encourage regular exercise.
4. Emphasize the importance of maintaining prescribed medication regimen and regular follow-up.
5. Describe time management techniques such as creating "to do" lists with realistic estimated deadlines for each activity, crossing off completed items for a sense of accomplishment, and saying "no."
6. Stress the importance of maintaining contact with community and participating in supportive organizations.

Fourth: Phobia: is an illogical, intense, and persistent fear of a specific object or a social situation that causes extreme distress and interferes with normal functioning. Phobias usually do not result from past negative experiences. In fact, the person may never have had contact with the object of the phobia. People with phobias have a reaction that is out of proportion to the situation or circumstance. Some individuals may even recognize that their fear is unusual and irrational but still feel powerless to stop it.

Some Common of Phobias

A. **Agoraphobia:** there is a fear of being in places or situations from which escape might be difficult, or in which help might not be available.

B. **Social phobia**: also known as social anxiety disorder, the person becomes severely anxious to the point of panic or incapacitation when confronting situations involving people.

C. **Specific phobia**: which is an irrational fear of an object or situation. It divides to:

1. **Acrophobia**: Fear of height
2. **Ailurophobia**: Fear of cats
3. **Carcinomatophobia**: Fear of cancer
4. **Decidophobia**: Fear of making decisions
5. **Nyctophobia**: Fear of darkness
6. **Odontophobia**: Fear of teeth or dental surgery
7. **Scoleciphobia**: Fear of worms
8. **Animal phobia:** fear of animals or insects (usually a specific type; often, this fear develops in childhood and can continue through adulthood in both men and women; cats and dogs are the most common phobic objects).
9. **Thanatophobia**: Fear of death
10. **Natural environmental phobias:** fear of storms, water, heights, or other natural phenomena
11. **Blood-injection phobias:** fear of seeing one's own or others' blood, traumatic injury, or an invasive medical procedure such as an injection.
12. **Situational phobias:** fear of being in a specific situation such as a bridge, tunnel, elevator, small room, hospital, or airplane

Onset and Clinical Course

Specific phobias usually occur in childhood or adolescence. In some cases, merely thinking about or handling a plastic model of the dreaded object can create fear. Specific phobias that persist into adulthood are lifelong 80% of the time. The peak age of onset for social phobia is middle adolescence; it sometimes emerges in a person who was shy as a child. The course of social phobia is often continuous, though the disorder may become less severe during adulthood. Severity of impairment fluctuates with life stress and demands.

Treatment

1. Behavioral therapy works well. Behavioral therapists initially focus on teaching what anxiety is, helping the client identify anxiety responses, teaching relaxation techniques, setting goals, discussing methods to achieve those goals, and helping the client visualize phobic situations.
2. Therapies that help the client develop self-esteem and self-control are common and include positive reframing and assertiveness training (explained earlier).
3. One behavioral therapy often used to treat phobias is systematic (serial) desensitization, in which the therapist progressively exposes the client to the threatening object in a safe setting until the client's anxiety decreases.
4. **Flooding** is a form of rapid desensitization in which a behavioral therapist confronts the client with the phobic object (either a picture or the actual object) until it no longer produces anxiety.

Drugs Used to Treat Anxiety Disorders

Generic (Trade) Drug	Name Classification	Used to Treat
Alprazolam (Xanax)	Benzodiazepine Anxiety	panic disorder, social phobia, agoraphobia
Buspirone (BuSpar)	Nonbenzodiazepine	anxiolytic Anxiety, social phobia, GAD
Clorazepate (Tranxene)	Benzodiazepine	Anxiety
Chlordiazepoxide (Librium)	Benzodiazepine	Anxiety
Clonazepam (Klonopin)	Benzodiazepine	Anxiety, panic disorder
Clonidine (Catapres)	Beta-blocker	Anxiety, panic disorder
Diazepam (Valium)	Benzodiazepine	Anxiety, panic disorder
Fluoxetine (Prozac)	SSRI antidepressant	Panic disorder, GAD
Hydroxyzine (Vistaril, Atarax)	Antihistamine	Anxiety

Imipramine (Tofranil)	Tricyclic antidepressant	Anxiety, panic disorder, agoraphobia
Meprobamate (Miltown, Equanil)	Nonbenzodiazepine anxiolytic	Anxiety
Oxazepam (Serax)	Benzodiazepine	Anxiety
Paroxetine (Paxil)	SSRI antidepressant	Social phobia, GAD
Propranolol (Inderal)	Alpha-adrenergic agonist	Anxiety, panic disorder, GAD
Sertraline (Zoloft)	SSRI antidepressant	Panic disorder, social phobia, GAD

Unit Five: Mood Disorders and Related Disorders

INTRODUCTION

Everyone occasionally feels sad, low, and tired, with the desire to stay in bed and shut out the world. These episodes are often accompanied by **anergia** (lack of energy), exhaustion, agitation, noise intolerance, and slow thinking processes, all of which make decisions difficult. While an elated mood, stamina for work, family, and social events is untiring. This feeling of being "on top of the world" also recedes in a few days to a **euthymic** mood (average affect and activity).

Mood disorders, also called affective disorders, are pervasive alterations in emotions that are manifested by depression or mania or both. They interfere with a person's life, plaguing him or her with drastic and long-term sadness, agitation, or elation. Accompanying self-doubt, guilt, and anger alter life activities, especially those that involve self-esteem, occupation, and relationships.

ETIOLOGY

Various theories for the etiology of mood disorders exist. The most recent research focuses on **chemical biologic imbalances as the cause**.

1. Biologic Theories - Genetic Theories

For all mood disorders, monozygotic (identical) twins have a concordance rate (both twins having the disorder) two to four times higher than that of dizygotic (fraternal) twins. There are also indications of a genetic overlap between early-onset bipolar disorder and early-onset alcoholism.

2. Neurochemical Theories

Neurochemical influences of neurotransmitters (chemical messengers) focus on serotonin and norepinephrine as the two major biogenic amines implicated in mood disorders.

- Deficits of serotonin occur in people with depression.
- Norepinephrine levels may be deficient in depression and increased in mania.
- Dysregulation of acetylcholine and dopamine is also being studied in relation to mood disorders.

3. Neuroendocrine Influences

Hormonal fluctuations are being studied in relation to depression. Mood disturbances have been documented in people with endocrine disorders, such as those of the thyroid, adrenal, parathyroid, and pituitary glands. Elevated glucocorticoid activity is associated with the stress response, and evidence of increased cortisol secretion is apparent in about 40% of clients with depression, with the highest rates found among older clients. Postpartum hormone alterations precipitate mood disorders such as postpartum depression and psychosis. About 5% to 10% of people with depression have thyroid dysfunction, notably an elevated thyroid-stimulating hormone. This problem must be corrected with thyroid treatment, or treatment for the mood disorder is adversely affected.

4. Psychodynamic Theories

Many psychodynamic theories about the cause of mood disorders seemed to "blame the victim" and his or her family. They include the following beliefs or suppositions:

- The self-depreciation of people with depression becomes self-reproach and "anger turned inward" related to either a real or perceived loss. Feeling abandoned by this loss, people are then angry while both loving and hating the lost object.
- A person's ego (or self) aspires to be ideal (i.e., good and loving, superior or strong), and that to be loved and worthy, must achieve these high standards. Depression results when, in reality, the person is not able to achieve these ideals all the time.
- The state of depression is like a situation in which the ego is a powerless, helpless child who is victimized by the superego, much like a powerful and sadistic parent who takes delight in torturing the child.
- Most psychoanalytical theories of mania view manic episodes as a "defense" against underlying depression, with the ID taking over the ego and acting as an undisciplined hedonistic being (child).
- Depression is a reaction to a distressing life experience, such as an event with psychic causality.

- Children raised by rejecting or unloving parents are prone to feelings of insecurity and loneliness, making them susceptible to depression and helplessness.
- Depression is a result of specific cognitive distortions in susceptible people. Early experiences shape distorted ways of thinking about oneself, the world, and the future; these distortions involve magnification of negative events, traits, and expectations and simultaneous minimization of anything positive.

CATEGORIES OF MOOD DISORDERS

1. **The primary mood disorders** are major depressive disorder and bipolar disorder (formerly called manic-depressive illness).
2. **A major depressive episode** lasts at least 2 weeks, during which the person experiences a depressed mood or loss of pleasure in nearly all activities. Symptoms include changes in eating habits, resulting in unplanned weight gain or loss; hypersomnia or insomnia; impaired concentration, decision-making, or problem-solving abilities; inability to cope with daily life; feelings of worthlessness, hopelessness, guilt, or despair; thoughts of death and/or suicide; overwhelming fatigue; and rumination with pessimistic thinking with no hope of improvement. These symptoms result in significant distress or impairment of social, occupational, or other important areas of functioning. About 20% have delusions and hallucinations; this combination is referred to as psychotic depression.

Onset and Clinical Course

An untreated episode of depression can last from a few weeks to months or even years, though most episodes clear in about 6 months. Some people have a single episode of depression, while 50% to 60% will have a recurrence of depression. Approximately 20% will develop a chronic form of depression. Depressive symptoms can vary from mild to severe. The degree of depression is comparable with the person's sense of helplessness and hopelessness. Some people with severe depression (about 20%) have psychotic features.

Treatment and Prognosis

Psychopharmacology

1. Major categories of antidepressants include cyclic antidepressants, monoamine oxidase inhibitors (MAOIs), and atypical antidepressants.
2. In clients who have acute depression with psychotic features, an antipsychotic is used in combination with an antidepressant.
3. Evidence is increasing that antidepressant therapy should continue for longer than the 3 to 6 months originally believed necessary. Fewer relapses occur in people with depression who receive 18 to 24 months of antidepressant therapy. As a rule, the dosage of antidepressants should be tapered before being discontinued.
4. **Selective Serotonin Reuptake Inhibitors.** SSRIs, are effective for most clients. Their action is specific to serotonin reuptake inhibition; these drugs produce few sedating, anticholinergic, and cardiovascular side effects, which make them safer for use in older adults. Because of their low side effects and relative safety, people using SSRIs are more apt to be compliant with the treatment regimen than clients using more troublesome medications.
5. **Electroconvulsive Therapy.** Psychiatrists may use **electroconvulsive therapy (ECT)** to treat depression in select groups, such as clients who do not respond to antidepressants or those who experience intolerable side effects at therapeutic doses (particularly true for older adults). In addition, pregnant women can safely have ECT while many medications are not safe for use during pregnancy. Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication. It has also shown a high degree of efficacy.
6. Cognitive therapy focuses on how the person thinks about the self, others, and the future and interprets his or her experiences. This model focuses on the person's distorted thinking, which, in turn, influences feelings, behavior, and functional abilities.

NURSING INTERVENTIONS For Depression

1. Provide for the safety of the client and others.

2. Institute suicide precautions if indicated.

3. Begin a therapeutic relationship by spending non demanding time with the client.

4. Promote completion of activities of daily living by assisting the client only as necessary.

5. Establish adequate nutrition and hydration.

6. Promote sleep and rest.

7. Engage the client in activities.

8. Encourage the client to verbalize and describe emotions.

9. Work with the client to manage medications and side effects.

10. Teach about the illness of depression.

11. Identify early signs of relapse.

12. Discuss the importance of support groups and assist in locating resources.

13. Teach the client and family about the benefits of therapy and follow up appointments.

3. Mania is a distinct period during which mood is abnormally and persistently elevated, expansive, or irritable. Typically, this period lasts about 1 week (unless the person is hospitalized and treated sooner), but it may be longer for some individuals. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexuality) or psychomotor agitation (i.e., purposeless non–goal directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

A. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

B. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

NURSING INTERVENTIONS For Mania

1. Provide for the client's physical safety and those around.

2. Set limits on the client's behavior when needed.

3. Remind the client to respect distances between self and others.

4. Use short, simple sentences to communicate.

5. Clarify the meaning of the client's communication.

6. Frequently provide finger foods that are high in calories and protein.

7. Promote rest and sleep.

8. Protect the client's dignity when inappropriate behavior occurs.

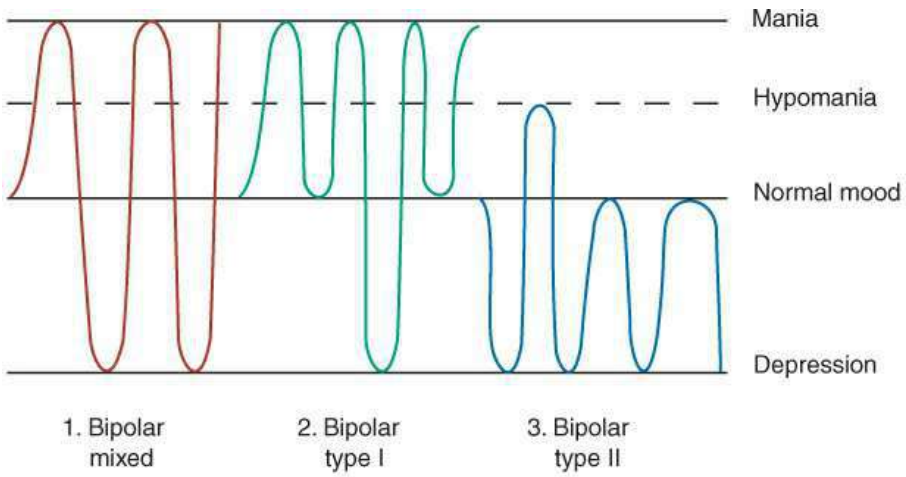
9. Channel the client's need for movement into socially acceptable motor activities.

4. **Hypomania** is a period of abnormally and persistently elevated, expansive, or irritable mood and some other milder symptoms of mania. The difference is that hypomanic episodes do not impair the person's ability to function (in fact, he or she may be quite productive), and there are no psychotic features(delusions and hallucinations).
5. **Rapid cycling** a mixed episode is diagnosed when the person experiences both mania and depression nearly every day for at least 1 week.
6. **Bipolar disorder** is diagnosed when a person's mood fluctuates to extremes of mania and/or depression. Bipolar disorder involves extreme mood swings from episodes of mania to episodes of depression. (Bipolar disorder was formerly known as manic depressive illness.) During manic phases, clients are euphoric, grandiose, energetic, and sleepless. They have poor judgment and rapid thoughts, actions, and speech. During

depressed phases, mood, behavior, and thoughts are the same as in people diagnosed with major depression.

Purpose of medical diagnosis, bipolar disorders are described as follows:

- Bipolar I disorder - one or more manic or mixed episodes usually accompanied by major depressive episodes.
- Bipolar II disorder - one or more major depressive episodes accompanied by at least one hypomanic episode



1. Bipolar mixed—Cycles alternate between periods of mania, normal mood, depression, normal mood, mania, and so forth.

2. Bipolar type I—Manic episodes with at least one depressive episode.

3. Bipolar type II—Recurrent depressive episodes with at least one hypomanic episode.

Onset and Clinical Course

The first manic episode generally occurs in a person's teens, 20s, or 30s. Currently, debate exists about whether or not some children diagnosed with attention-deficit/hyperactivity disorder actually have a very early onset of bipolar disorder. Manic episodes typically begin suddenly with rapid escalation of symptoms over a few days, and they last from a few weeks to several months. They tend to be briefer and end more suddenly than depressive episodes.

Treatment

Psychopharmacology

An antimanic agent called lithium or anticonvulsant medications used as mood stabilizers. Lithium's action peaks in 30 minutes to 4 hours for regular forms and in 4 to 6 hours for the slow-release form. It crosses the blood–brain barrier and placenta and is distributed in sweat and breast milk. Lithium use during pregnancy is not recommended because it can lead to first-trimester developmental abnormalities. Onset of action is 5 to 14 days; with this lag period, antipsychotic or antidepressant agents are used carefully in combination with lithium to reduce symptoms in acutely manic or acutely depressed clients. The half-life of lithium is 20 to 27 hours.

Psychotherapy

Psychotherapy can be useful in the mildly depressive or normal portion of the bipolar cycle. It is not useful during acute manic stages because the person's attention span is brief and he or she can gain little insight during times of accelerated psychomotor activity. Psychotherapy combined with medication can reduce the risk for suicide and injury, provide support to the client and family, and help the client accept the diagnosis and treatment plan.

SUICIDE

Suicide is the intentional act of killing oneself. Suicidal thoughts are common in people with mood disorders, especially depression. Clients with psychiatric disorders, especially depression, bipolar disorder, schizophrenia, substance abuse, posttraumatic stress disorder, and borderline personality disorder, are at increased risk for suicide. Chronic medical illnesses associated with increased risk for suicide include cancer, HIV or AIDS, diabetes, cerebrovascular accidents, and head and spinal cord injury. Environmental factors that increase suicide risk include isolation, recent loss, lack of social support, unemployment, critical life events, and family history of depression or suicide. Behavioral factors that increase risk include impulsivity, erratic or unexplained changes from usual behavior, and unstable lifestyle.

Suicidal ideation means thinking about killing oneself. Active suicidal ideation is when a person thinks about and seeks ways to commit suicide. Passive suicidal ideation is when a

person thinks about wanting to die or wishes he or she were dead but has no plans to cause his or her death. People with active suicidal ideation are considered more potentially lethal. **Attempted suicide** is a suicidal act that either failed or was incomplete. In an incomplete suicide attempt, the person did not finish the act because (1) someone recognized the suicide attempt and responded or (2) the person was discovered and rescued.

RELATED DISORDERS

Other disorders classified with similarities to mood disorders include:

- **Persistent depressive (dysthymic)** disorder is a chronic, persistent mood disturbance characterized by symptoms such as insomnia, loss of appetite, decreased energy, low self-esteem, difficulty concentrating, and feelings of sadness and hopelessness that are milder than those of depression.
- **Disruptive mood dysregulation disorder** is a persistent angry or irritable mood, punctuated by severe, recurrent temper outbursts that are not in keeping with the provocation or situation, beginning before age 10.
- **Cyclothymic disorder** is characterized by mild mood swings between hypomania and depression without loss of social or occupational functioning.
- **Substance-induced depressive or bipolar disorder** is characterized by a significant disturbance in mood that is a direct physiological consequence of ingested substances such as alcohol, other drugs, or toxins.
- **Seasonal affective disorder (SAD)** has two subtypes. In one, most commonly called winter depression or fall-onset SAD, people experience increased sleep, appetite, and carbohydrate cravings; weight gain; interpersonal conflict; irritability; and heaviness in the extremities beginning in late autumn and abating in spring and summer. The other subtype, called spring-onset SAD, is less common, with symptoms of insomnia, weight loss, and poor appetite lasting from late spring or early summer until early fall. SAD is often treated with light therapy.
- Postpartum or “maternity” blues is a mild, predictable mood disturbance occurring in the first several days after delivery of a baby. Symptoms include labile mood and affect,

crying spells, sadness, insomnia, and anxiety. The symptoms subside without treatment, but mothers do benefit from the support and understanding of friends and family.

- Postpartum depression is the most common complication of pregnancy in developed countries. The symptoms are consistent with those of depression (described previously), with onset within 4 weeks of delivery.
- Postpartum psychosis is a severe and debilitating psychiatric illness, with acute onset in the days following childbirth. Symptoms begin with fatigue, sadness, emotional lability, poor memory, and confusion and progress to delusions, hallucinations, poor insight and judgment, and loss of contact with reality. This medical emergency requires immediate treatment. Women who have a history of serious mental illness are at higher risk for a postpartum relapse, even if they were well during pregnancy.
- Premenstrual dysphoric disorder is a severe form of premenstrual syndrome and is defined as recurrent, moderate psychological and physical symptoms that occur during the week before menses and resolving with menstruation. Approximately 20% to 30% of premenopausal women are affected by affective and/or somatic symptoms that can cause severe dysfunction in social or occupational functioning, such as labile mood, irritability, increased interpersonal conflict, difficulty concentrating, feeling overwhelmed or unable to cope, and feelings of anxiety, tension, or hopelessness.
- Non-suicidal self-injury involves deliberate, intentional cutting, burning, scraping, hitting, or interference with wound healing. Some persons who engage in self-injury (sometimes called self-mutilation) report reasons of alleviation of negative emotions, self-punishment, seeking attention, or escaping a situation or responsibility. Others report the influence of peers or the need to "fit in" as contributing factors.

Unit Six: Trauma and Stressor-Related Disorders

Posttraumatic stress disorder (PTSD) is a disturbing pattern of behavior demonstrated by someone who has experienced, witnessed, or been confronted with a traumatic event such as a natural disaster, combat, or an assault. A person with PTSD was exposed to an

event that posed actual or threatened death or serious injury and responded with intense fear, helplessness, or terror.

Clinical Course

- The subcategories of symptoms in PTSD include re-experiencing the trauma through dreams or recurrent and intrusive thoughts, avoidance, negative cognition or thoughts, being on guard, or **hyperarousal.** The person persistently re-experiences the trauma through memories, dreams, flashbacks, or reactions to external cues about the event and therefore avoids stimuli associated with the trauma.
- The victim feels a numbing of general responsiveness and shows persistent signs of increased arousal such as insomnia, hyperarousal or hypervigilance, irritability, or angry outbursts.
- He or she reports losing a sense of connection and control over his or her life. This can lead to avoidance behavior or trying to avoid any places or people or situations that may trigger memories of the trauma.
- The person seeks comfort, safety, and security, but can actually become increasingly isolated over time, which can heighten the negative feelings he or she was trying to avoid.
- **NOTE**: In PTSD, the symptoms occur 3 months or more after the trauma, which distinguishes PTSD from acute stress disorder, which may have similar types of symptoms but lasts 3 days up to 1 month. The onset can be delayed for months or even years. PTSD can occur at any age, including during childhood. Estimates are that up to 60% of people at risk, such as combat veterans and victims of violence and natural disasters, develop PTSD. Complete recovery occurs within 3 months for about 50% of people. The severity and duration of the trauma and the proximity of the person to the event are the most important factors affecting the likelihood of developing PTSD. One-fourth of all victims of physical assault develop PTSD. Victims of rape have one of the highest rates of PTSD at approximately 70%.

Related Disorders

- **Adjustment disorder** is a reaction to a stressful event that causes problems for the individual. Typically, the person has more than the expected difficulty coping with or assimilating the event into his or her life. Financial, relationship, and work-related stressors are the most common events. The symptoms develop within a month, lasting no more than 6 months. At that time, the adjustment has been successful, or the person moves on to another diagnosis.
- **Acute stress disorder** occurs after a traumatic event and is characterized by re-experiencing, avoidance, and hyperarousal that occur from 3 days to 4 weeks following a trauma. It can be a precursor to PTSD. Cognitive–behavioral therapy (CBT) involving exposure and anxiety management can help prevent the progression to PTSD.
- **Reactive attachment disorder (RAD)** and **disinhibited social engagement disorder (DSED)** occur before the age of 5 in response to the trauma of child abuse or neglect, called grossly pathogenic care. The child shows disturbed inappropriate social relatedness in most situations. Rather than seeking comfort from a select group of caregivers to whom the child is emotionally attached, the child with RAD exhibits minimal social and emotional responses to others, lacks a positive effect, and may be sad, irritable, or afraid for no apparent reason. The child with DSED exhibits unselective socialization, allowing or tolerating social interaction with caregivers and strangers alike. They lack the hesitation in approaching or talking to strangers evident in most children their age. Grossly deficient parenting and institutionalization are the two most common situations leading to this disorder.

Etiology

- PTSD and acute stress disorder had long been classified as anxiety disorders, though they differ from other diagnoses in that category; they are now classified in their own category. There has to be a causative trauma or event that occurs prior to the development of PTSD, which is not the case with anxiety disorders. PTSD is a disorder

associated with event exposure, rather than personal characteristics, especially with the adult population. In other words, the effects of the trauma at the time, such as being directly involved, experiencing physical injury, or loss of loved ones in the event, are more powerful predictors of PTSD for most people. This is particularly true of single-event trauma, or triggering event, such as natural disasters. However, lack of social support, peri-trauma dissociation, and previous psychiatric history or personality factors can further increase the risk of PTSD when they are present pre-trauma. In addition, people who participate in post-trauma counseling right after the event decrease their risk of PTSD.

- Studies of adolescents with PTSD indicate they are more likely to develop PTSD than children or adults.
- PTSD may disrupt biologic maturation processes contributing to long-term emotional and behavioral problems experienced by adolescents with this disorder that would require ongoing or episodic therapy to deal with relevant issues. Children are more likely to develop PTSD when there is a history of parental major depression and childhood abuse. Psychopathology in the parents results in a stress-laden environment for the child and is much more likely to end in a PTSD diagnosis.

Treatment

- There are some medications that may also contribute to successful resolution, especially when targeting specific issues, such as insomnia. A combination of both therapies produces the best results. Inpatient treatment is not indicated for clients with PTSD; however, in times of severe crisis, short inpatient stays may be necessary. This usually occurs when the client is suicidal or is being overwhelmed by re-experiencing events, such as flashbacks.
- CBT and specialized therapy programs incorporating elements of CBT are the most common and successful types of formal treatment. The choice of therapy can depend on the type of trauma, as well as the choice to seek formal individual or group counseling. Self-help groups offer support and a safe place to share feelings.

- **Exposure therapy** is a treatment approach designed to combat the avoidance behavior that occurs with PTSD, help the client face troubling thoughts and feelings, and regain a measure of control over his or her thought sand feelings. The client confronts the feared emotions, situations, and thoughts associated with the trauma rather than attempting to avoid them. Various relaxation techniques are employed to help the client tolerate and manage the anxiety response. The exposure therapy may confront the event in reality, for example, returning to the place where one was assaulted, or may use imagined confrontation, that is, mentally placing oneself in the traumatic situation. Prolonged exposure therapy has been particularly effective for both active military personnel and veterans.
- **Adaptive disclosure** is a specialized CBT approach developed by the military to offer an intense, specific, short-term therapy for active-duty military personnel with PTSD. It incorporates exposure therapy as well as the empty chair technique, in which the participant says whatever he or she needs to say to anyone, alive or dead. This is similar to techniques used in Gestalt therapy. Despite the short six-session format, this approach seems well tolerated and effective in reducing PTSD symptoms and promoting post-trauma growth.
- **Cognitive processing therapy** has been used successfully with rape survivors with PTSD as well as combat veterans. The therapy course involves structured sessions that focus on examining beliefs that are erroneous or interfere with daily life, such as guilt and self-blame; for example, "It was my fault, I should have fought harder" or "I should have died with my fellow Marines;" reading aloud a written account of the worst traumatic experience; recognizing generalized thinking, that is, "No one can be trusted" and regaining more balanced and realistic ways of appraising the world and themselves.
- Medications may be used for clients with PTSD to deal with symptoms such as insomnia, anxiety, or hyperarousal. Studies show that selective serotonin reuptake inhibitor (SSRI) and serotonin and norepinephrine reuptake inhibitor antidepressants are most effective, followed by second generation antipsychotic, such as risperidone.

Evidence is lacking for the efficacy of benzodiazepines, though they are widely used in clinical practice. A combination of medications and CBT is considered to be more effective than either one alone.

CLIENT AND FAMILY EDUCATION

- Ask for support from others.
- Avoid social isolation.
- Join a support group.
- Share emotions and experiences with others.
- Follow a daily routine.
- Set small, specific, achievable goals.
- Accept feelings as they occur.
- Get adequate sleep.
- Eat a balanced, healthy diet.
- Avoid alcohol and other drugs.
- Practice stress reduction techniques.

DISSOCIATIVE DISORDERS

- **Dissociation** is a subconscious defense mechanism that helps a person protect his or her emotional self from recognizing the full effects of some horrific or traumatic event by allowing the mind to forget or remove itself from the painful situation or memory. Dissociation can occur both during and after the event. As with any other protective coping mechanism, dissociating becomes easier with repeated use. **Dissociative disorders** have the essential feature of a disruption in the usually integrated functions of consciousness, memory, identity, or environmental perception. This often interferes with the person's relationships, ability to function in daily life, and ability to cope with the realities of the abusive or traumatic event. This disturbance varies greatly in intensity in different people, and the onset may be sudden or gradual, transient, or chronic. Dissociative symptoms are seen in clients with PTSD.

- **Dissociative amnesia***:* The client cannot remember important personal information (usually of a traumatic or stressful nature). This category includes a fugue experience where the client suddenly moves to a new geographic location with no memory of past events and often the assumption of a new identity.
- **Dissociative identity disorder** (formerly *multiple personality disorder*): The client displays two or more distinct identities or personality states that recurrently take control of his or her behavior. This is accompanied by the inability to recall important personal information.
- **Depersonalization/derealization disorder**: The client has a persistent or recurrent feeling of being detached from his or her mental processes or body (**depersonalization**) or sensation of being in a dream-like state in which the environment seems foggy or unreal (**derealization**). The client is not psychotic nor out of touch with reality. Dissociative disorders, relatively rare in the general population, are much more prevalent among those with histories of childhood physical and sexual abuse. Some believe the recent increase in the diagnosis of dissociative disorders in the United States is the result of more awareness of this disorder by mental health professionals. Whether dissociative identity disorder is a legitimate diagnosis is still a controversy among psychiatrists in the field. If a person comes to a mental health professional experiencing serious problems in relationships, symptoms of PTSD, or flashbacks involving abuse, the mental health professional may help the person remember or recover those memories of abuse. Some mental health professionals believe there is danger of inducing false memories of childhood sexual abuse through imagination in psychotherapy. This so-called ***false memory syndrome*** has created problems in families when clients made groundless accusations of abuse.

Nursing Interventions for PTSD Patients

- **Promote Client's Safety**

1. Discuss self-harm thoughts.

2. Help the client develop a plan for going to a safe place when having destructive thoughts or impulses.

- **Help Client Cope with Stress and Emotions**

1. Use grounding techniques to help client who is dissociating or experiencing flashbacks.
2. Validate client's feelings of fear, but try to increase contact with reality.
3. During dissociative experience or flashback, help the client change body position, but do not grab or force the client to stand up or move.
4. Use supportive touch if the client responds well to it.
5. Teach deep breathing and relaxation techniques.
6. Use distraction techniques such as participating in physical exercise, listening to music, talking with others, or engaging in a hobby or other enjoyable activity.
7. Help to make a list of activities and keep materials on hand to engage the client when the client's feelings are intense.

- **Help Promote Client's Self-Esteem**

1. Refer to the client as "survivor" rather than "victim." Establish social support system in community.
2. Make a list of people and activities in the community for the client to contact when he or she needs help.

Obsessive–compulsive Disorder (OCD)

Obsessions are recurrent, persistent, intrusive, and unwanted thoughts, images, or impulses that cause marked anxiety and interfere with interpersonal, social, or occupational function. The person knows these thoughts are excessive or unreasonable but believes he or she has no control over them.

Compulsions are ritualistic or repetitive behaviors or mental acts that a person carries out continuously in an attempt to neutralize anxiety.

Common compulsions include the following:

1. Checking rituals (repeatedly making sure the door is locked or the coffeepot is turned off)
2. Counting rituals (each step taken, ceiling tiles, concrete blocks, or desks in a classroom)
3. Washing and scrubbing until the skin is raw
4. Praying or chanting
5. Touching, rubbing, or tapping (feeling the texture of each material in a clothing store; touching people, doors, walls, or oneself)
6. Ordering (arranging and rearranging furniture or items on a desk or shelf into perfect order; vacuuming the rug pile in one direction)
7. Hoarding involves excessive acquisition of animals or apparently useless things, cluttered living spaces that become uninhabitable, and significant distress or impairment for the individual
8. Exhibiting rigid performance (getting dressed in an unvarying pattern)
9. Having aggressive urges (for instance, to throw one's child against a wall)

Note: OCD is diagnosed only when these thoughts, images, and impulses consume the person or he or she is compelled to act out the behaviors to a point at which they interfere with personal, social, and occupational functions. Examples include a man who can no longer work because he spends most of his day aligning and realigning all items in his apartment or a woman who feels compelled to wash her hands after touching any object or person.

Onset and Clinical Course

OCD can start in childhood, especially in males. In females, it more commonly begins in the 20s. Overall, distribution between the sexes is equal. Individuals with early-onset OCD (average age of 11) and those with late onset OCD (average age of 23) differ in several ways. Early onset is more likely to affect males, has more severe symptoms, more comorbid diagnoses, and a greater likelihood of a family history of OCD.

Related Disorders

1. **Excoriation** disorder, skin-picking, also known as **dermatillomania**, is categorized as a self-soothing behavior; that is, the behavior is an attempt of people to soothe or comfort themselves, not that picking itself is necessarily a positive sensation.
2. **Trichotillomania**, or chronic repetitive hair-pulling, is a self-soothing behavior that can cause distress and functional impairment. Onset in childhood is most common, but it can also persist into adulthood with development of anxiety and depression. It occurs more often in females than in males.
3. BDD is a preoccupation with an imagined or slight defect in physical appearance that causes significant distress for the individual and interferes with functioning in daily life.
4. **Onychophagia**, or chronic nail-biting, is a self-soothing behavior. Typical onset is childhood, with a decrease in behavior by age 18. However, some nail-biting persists into adulthood. It may lead to psychosocial problems or cause complications involving the nails and oral cavity. SSRIs have proven effective in the treatment of onychophagia.
5. Kleptomania, or compulsive stealing, is a reward-seeking behavior. The reward is not the stolen item, but rather the thrill of stealing and not getting caught. Kleptomania is different than stealing items needed for survival, such as a parent stealing food for a hungry child. Kleptomania is more common in females with frequent comorbid diagnoses of depression and substance use. It is associated with significant legal repercussions.
6. **Oniomania**, or compulsive buying, is an acquisition type of reward seeking behavior. The pleasure is in acquiring the purchased object rather than any subsequent enjoyment of its use. Spending behavior is often out of control, well beyond the person's financial means. And, once acquired, the object may be infrequently or never used. Approximately 80% of compulsive buyers are females with onset of the behavior in the early 20s; it is often seen in college students.
7. **Body identity integrity disorder** (BIID) is the term given to people who feel "over complete," or alienated from a part of their body and desire amputation. This condition is also known as amputee identity disorder and apotemnophilia or "amputation love.".

People with BIID resort to actions such as packing the limb in dry ice until the damage is so advanced that amputation becomes a medical necessity, or in some cases, amputation is done with a power tool by nonmedical persons, leaving a physician to save the person's life and mitigate with the damage.

Treatment

1. Optimal treatment for OCD combines medication and behavioral therapy. SSRI antidepressants, such as fluvoxamine (Luvox) and sertraline (Zoloft), are first-line choices, followed by venlafaxine (Effexor). Treatment-resistant OCD may respond to second-generation antipsychotics such as risperidone (Risperdal), quetiapine (Seroquel), or olanzapine (Zyprexa). Children and adolescents with OCD also respond well to behavioral therapy and SSRI antidepressants, even when symptoms are treatment refractory. Behavioral therapy specifically includes exposure and response prevention.
2. **Exposure** involves assisting the client in deliberately confronting the situations and stimuli that he or she usually avoids.
3. **Response prevention** focuses on delaying or avoiding performance of rituals. The person learns to tolerate the thoughts and the anxiety and to recognize that it will recede without the disastrous imagined consequences.

Nursing Intervention For OCD

1. Offer encouragement, support, and compassion.

2. Be clear with the client that you believe he or she can change.

3. Encourage the client to talk about feelings, obsessions, and rituals in detail.

4. Gradually decrease time for the client to carry out ritualistic behaviors.

5. Assist the client in using exposure and response prevention behavioral techniques.

6. Encourage the client to use techniques to manage and tolerate anxiety responses

7. Assist the client in completing daily routine and activities within agreed-upon time limits.

8. Encourage the client to develop and follow a written schedule with specified times and activities.

Unit Seven: Psychotic and Related Disorder

Schizophrenia is a psychotic disorder (or a group of disorders) marked by severely impaired thinking, emotions, and behaviors.

Schizophrenic patients are typically unable to filter sensory stimuli and may have enhanced perceptions of sounds, colors, and other features of their environment. Most schizophrenics, if untreated, gradually withdraw from interactions with other people, and lose their ability to take care of personal needs and grooming.

Psychosis

A severe mental condition in which there is disorganization of the personality, deterioration in social functioning, and loss of contact with, or distortion of, reality. There may be evidence of hallucinations and delusional thinking. Psychosis can occur with or without the presence of organic impairment.

Prevalence of schizophrenia

The peak incidence of onset is 15 to 25 years of age for men and 25 to 35 years of age for women. The prevalence of schizophrenia is estimated at about 1% of the total population. In the United States that translates to nearly 3 million people who are have been, or will be affected by the disease.

Approximately one-third to one-half of clients with schizophrenia relapse within 1 year of an acute episode. Higher relapse rates are associated with nonadherence to medication, persistent substance use, caregiver criticism, and negative attitude toward treatment

Symptoms of Schizophrenia

1) POSITIVE OR HARD SYMPTOMS:

- **Ambivalence:** Holding seemingly contradictory beliefs or feelings about the same person, event, or situation.
- **Associative looseness:** poorly related thoughts and ideas.
- **Delusions:** Fixed false beliefs that have no basis in reality.
- **Echopraxia:** Imitation of the movements and gestures of another person whom the client is observing.
- **Flight of ideas:** Continuous flow of verbalization in which the person jumps rapidly from one topic to another.
- **Hallucinations:** False sensory perceptions or perceptual experiences that do not exist in reality.

- **Ideas of reference:** False impressions that external events have special meaning for the person.
- **Perseveration:** Persistent adherence to a single idea or topic; verbal repetition of a sentence, word, or phrase; resisting attempts to change the topic.

2) NEGATIVE OR SOFT SYMPTOMS

- **Alogia:** Tendency to speak very little or to convey little substance of meaning (poverty of content).
- **Anhedonia:** Feeling no joy or pleasure from life or any activities or relationships.
- **Apathy:** Feelings of indifference toward people, activities, and events.
- **Blunted affect:** Restricted range of emotional feeling, tone, or mood.
- **Catatonia:** Psychologically induced immobility occasionally marked by periods of agitation or excitement; the client seems motionless, as if in a trance.
- **Flat affect:** Absence of any facial expression that would indicate emotions or mood.
- **Lack of volition:** Absence of will, ambition, or drive to take action or accomplish tasks.

Etiology of schizophrenia :

1-**GENETIC FACTORS:** a genetic risk or tendency for schizophrenia,

- schizophrenia is at least partially inherited: twins have a 50% risk for schizophrenia, whereas fraternal twins have only a 15% risk.
- Children with one biologic parent with schizophrenia have a 15% risk; the risk rises to 35% if both biologic parents have schizophrenia.

2- Neuroanatomy (brain structure):

- less brain tissue and cerebrospinal fluid than people who do not have schizophrenia: this could represent a failure in development or a subsequent loss of tissue.
- glucose metabolism and oxygen are diminished in the frontal cortical structures of the brain.
- Decreased brain volume and abnormal brain function in the frontal and temporal areas of persons with schizophrenia.
- Poor nutrition, tobacco, alcohol and other drugs, and stress also are being studied as possible causes of the brain pathology found in people with schizophrenia.

3- Neurochemical (brain activity):

- **Excess dopamine as a cause:**

Drugs that increase activity in the dopaminergic system, such as amphetamine sometimes induce a paranoid psychotic reaction similar to schizophrenia.

Drugs blocking postsynaptic dopamine receptors reduce psychotic symptoms; the greater the ability of the drug to block dopamine receptors, the more effective it is in decreasing symptoms of schizophrenia.

4- Immunovirologic factors :

- exposure to a virus or the body's immune response to a virus could alter the brain physiology of people with schizophrenia.
- Infections in pregnant women as a possible origin for schizophrenia.
- higher rates of schizophrenia among children born in crowded areas in cold weather, conditions that are hospitable to respiratory ailments.

RELATED DISORDERS

Other disorders are related to but distinguished from schizophrenia in terms of presenting symptoms and the duration or magnitude of impairment.

• ***Schizophreniform disorder:*** The client exhibits an acute, reactive psychosis for less than the 6 months necessary to meet the diagnostic criteria for schizophrenia. If symptoms persist over 6 months, the diagnosis is changed to schizophrenia. Social or occupational functioning may or may not be impaired.

• ***Catatonia:*** Catatonia is characterized by marked psychomotor disturbance, either excessive motor activity or virtual immobility and motionlessness. Motor immobility may include catalepsy (waxy flexibility: decreased response to stimuli) or stupor. Excessive motor activity is apparently purposeless and not influenced by external stimuli. Catatonia can occur with schizophrenia, mood disorders, or other psychotic disorders.

• ***Delusional disorder:*** The client has one or more nonbizarre delusions that is, the focus of the delusion is believable. The delusion may be persecutory, erotomanic, grandiose, jealous, or somatic in content. Psychosocial functioning is not markedly impaired, and behavior is not obviously odd or bizarre.

• ***Brief psychotic disorder:*** The client experiences the sudden onset of at least one psychotic symptom, such as delusions, hallucinations, or disorganized speech or behavior, which lasts from 1 day to 1 month. The episode may or may not have an identifiable stressor or may follow childbirth.

• **Shared psychotic disorder (folie à deux):** Two people share a similar delusion. The person with this diagnosis develops this delusion in the context of a close relationship with someone who has psychotic delusions, most commonly siblings, parent and child, or husband and wife. The more submissive or suggestible person may rapidly improve if separated from the dominant person.

• ***Schizotypal personality disorder*****:** This involves odd, eccentric behaviors, including transient psychotic symptoms. Approximately 20% of persons with this personality disorder will eventually be diagnosed with schizophrenia.

TREATMENT

A- Psychopharmacology

Antipsychotic medications:

1. ***Typical antipsychotics*** have been around since the 1950s and work by blocking postsynaptic dopamine receptors. These agents are generally used to treat the positive symptoms of schizophrenia. e.g Chlorpromazine(Thorazine), Fluphenazine (Prolixin), Haloperidol (Haldol).

2. ***Atypical antipsychotics*** have been available since the 1990s and are weaker dopamine receptor antagonists but more potent antagonists of serotonin receptors. These drugs treat Both the positive and negative symptoms and generally have fewer side effects. e.g Aripiprazole (Abilify), Asenapine (Saphris), Clozapine (Clozaril).

B- Psychosocial Treatment:

Individual and group therapy, family therapy, family education, and social skills training can be instituted for clients in both inpatient and community settings.

1- **Individual and group therapy** sessions are often supportive in nature, giving the client an opportunity for social contact and meaningful relationships with other people. Groups that focus on topics of concern such as medication management, use of community supports, and family concerns also have been beneficial to clients with schizophrenia (Adams, Wilson, & Bagnell, 2000).

2-Social skills training: Clients with schizophrenia can improve their social competence with social skills training, which translates into more effective functioning in the community. three forms of social skills training: the basic model; the social problem-solving model; and the cognitive remediation model.

3- Family education and therapy are known to diminish the negative effects of schizophrenia and reduce the relapse rate**.** While inclusion of the family is a factor that improves outcomes for the client, family involvement often is neglected by health care

professionals**.** Family members can benefit from a supportive environment that helps them cope with the many difficulties presented when a loved one has schizophrenia.

C-Nursing interventions:

General Nursing Interventions

• Watch for clues that patient is hallucinating, e.g., darting eyes, mumbling to self, staring at a vacant wall for long periods. You can also ask the patient if he is hearing voices.

• If the patient is hallucinating, your response could be, "I don't see the devil standing there, but I understand how upsetting this is for you." In this way you are acknowledging what the patient is experiencing without reinforcing it as your reality.

• If your patient is delusional, reinforce reality, "that man works for the hospital not the FBI," "Yes, there was a man at the nurse's station, but I did not hear him talk about you." Remind the patient he has some control to look at alternative ways to view reality.

• Work to slowly build trust in small ways. Avoid overreacting to patient's bizarre behavior or appearance

• Maintain a calm, consistent environment with a regular routine.

• Even though he/she appears to be in another world, continue to include the patient in conversations and activities. Acknowledge his/her presence and importance.

• Focus on reality, e.g., rather than listen to a long monologue about a delusion, talk about the schedule for the day.

• Never argue with the patient about what he or she is experiencing.

• Incorporate Quality and Safety Education for Nurses (QSEN) competencies to maintain a safe environment for the psychotic patient e.g., remove sharp objects, provide adequate supervision.

• Take action to provide medications before agitation escalates. Make sure there are orders for prn medications for agitation.

• Never reinforce hallucinations, delusions, or illusions. An example of an inappropriate response is, “Jesus wants you to take these pills," That response reinforces the delusion about Jesus.

• Avoid whispering or laughing when the patient cannot hear the whole conversation; such behavior can promote paranoia.

• Avoid putting the patient into situations that are competitive or embarrassing.

• Build trust by using therapeutic communication skills.

• If the patient is catatonic, provide for basic physical needs and safety, and make brief supportive contacts with the patient without pressuring the patient to communicate.

N.B: It is important for the nurse to avoid reinforcing psychotic thinking, as in delusions. For example, avoid asking the patient what “they” are telling the patient. Rather, let the patient know you are concerned but do not hear these voices.

N.B: Remember that schizophrenic patients are often very concrete thinkers, so it is important to speak clearly and plainly. Make only one request at a time.

Unit Eight: Somatic Symptom Illnesses

INTRODUCTION

In the early 1800s, the medical field began to consider the various social and psychological factors that influence illness. The term **psychosomatic** began to be used to convey the connection between the mind (*psyche*) and the body (*soma*) in states of health and illness. Essentially, the mind can cause the body either to create physical symptoms or to worsen physical illnesses. Real symptoms can begin, continue, or be worsened as a result of

emotional factors. Examples include diabetes, hypertension, and colitis, all of which are medical illnesses influenced by stress and emotions. When a person is under a lot of stress or is not coping well with stress, symptoms of these medical illnesses worsen. In addition, stress can cause physical symptoms unrelated to a diagnosed medical illness. After a stressful day at work, many people experience "tension headaches" that can be quite painful. The headaches are a manifestation of stress rather than a symptom of an underlying medical problem.

OVERVIEW OF SOMATIC SYMPTOM ILLNESSES

1. **Somatization** is defined as the transference of mental experiences and states into bodily symptoms. Somatic symptom illnesses can be characterized as the presence of physical symptoms that suggest a medical condition without a demonstrable organic basis to account fully for them. The three central features of somatic symptom illnesses are as follows:
   - Physical complaints suggest major medical illness but have no demonstrable organic basis.
   - Psychological factors and conflicts seem important in initiating, exacerbating, and maintaining the symptoms.
   - Symptoms or magnified health concerns are not under the client's conscious control. Nurses must remember that these clients really experience the symptoms they describe and cannot voluntarily control them.
2. **Hysteria** refers to multiple physical complaints with no organic basis; the complaints are usually described dramatically. People with hysteria, usually women, were considered evil or possessed by evil spirits.
3. **Somatic symptom disorder** is characterized by one or more physical symptoms that have no organic basis. Individuals spend a lot of time and energy focused on health concerns, often believe symptoms to be indicative of serious illness, and experience significant distress and anxiety about their health.
4. **Conversion disorder**, sometimes called conversion reaction, involves unexplained, usually sudden deficits in sensory or motor function (e.g., blindness, paralysis). These deficits suggest a neurologic disorder but are associated with psychological factors. There is usually significant functional impairment.

5. **Pain disorder** has the primary physical symptom of pain, which is generally unrelieved by analgesics and greatly affected by psychological factors in terms of onset, severity, exacerbation, and maintenance.
6. **Illness anxiety disorder**, formerly **hypochondriasis**, is preoccupation with the fear that one has a serious disease (**disease conviction**) or will get a serious disease (**disease phobia**). It is thought that clients with this disorder misinterpret bodily sensations or functions. Somatic symptom illnesses are more common in women than in men; they may represent about 5% to 7% of the general population, but estimates can vary greatly. Because most people with illness anxiety are seen in general medical or family practice settings, it is difficult to make accurate estimates of occurrence.

Onset and Clinical Course

Clients with somatic symptom disorder often experience symptoms in adolescence, though these diagnoses may not be made until early adulthood (about 25 years of age). Conversion disorder usually occurs between the ages of 10 and 35 years. Pain disorder and illness anxiety disorder can occur at any age. All somatic symptom illnesses are either chronic or recurrent, lasting for decades for many people.

Related Disorders

1. **Fabricated or induced illness**, in which people feign or intentionally produce symptoms for some purpose or gain. In malingering and factitious disorders, people willfully control the symptoms. In somatic symptom illnesses, clients do not voluntarily control their physical symptoms.
2. **Malingering** is the intentional production of false or grossly exaggerated physical or psychological symptoms; it is motivated by external incentives such as avoiding work, evading criminal prosecution, obtaining financial compensation, or obtaining drugs. People who malinger have no real physical symptoms or grossly exaggerate relatively minor symptoms. Their purpose is some external incentive or outcome that they view

as important and results directly from the illness. People who malinger can stop the physical symptoms as soon as they have gained what they wanted.

3. **Factitious disorder, imposed on self**, occurs when a person intentionally produces or feigns physical or psychological symptoms solely to gain attention. People with factitious disorder may even inflict injury on themselves to receive attention. The common term for factitious disorder imposed on self is **Munchausen syndrome.**
4. **Ineffective Denial:** unsuccessful attempt to ignore or minimize reality of events or situations that are unpleasant to confront **Medically unexplained symptoms** (MUS) and **functional somatic syndromes** are terms used more frequently in general medical setting. They refer to physical symptoms and limitations of function that has no medical diagnoses to explain their existence. MUS is often more acceptable to the patient because it doesn't have the connotation of "it's all in your head" as do psychosomatic descriptors. Many patients are seen by general practitioners and are not involved in mental health settings. Effective treatment from patients' perspectives includes being listened to and heard regarding symptoms, learning to cope with symptoms and limitations, learning to ignore some symptoms when possible, and positive response and support from providers.

ETIOLOGY

1. Psychosocial Theories

Psychosocial theorists believe that people with somatic symptom illnesses keep stress, anxiety, or frustration inside rather than expressing them outwardly. This is called **internalization**. Clients express these internalized feelings and stress through physical symptoms (somatization). Both internalization and somatization are unconscious defense mechanisms. Clients are not consciously aware of the process, and they do not voluntarily

control it. People with somatic symptom illnesses do not readily and directly express their feelings and emotions verbally. Some experience alexithymia, or the inability to identify emotions. This is different than an unwillingness or refusal to identify emotions. They have tremendous difficulty dealing with interpersonal conflict.

Somatization is associated most often with women, as evidenced by the old term *hysteria* (Greek for "wandering uterus"). Ancient theorists believed that unexplained female pains resulted from migration of the uterus throughout the woman's body. Psychosocial theorists posit that increased incidence of somatization in women may be related to various factors:

- Women seek medical treatment more often than men, and it is more socially acceptable for them to do so.
- Childhood sexual abuse, which is related to somatization, happens more frequently to girls.
- Women more often receive treatment for psychiatric disorders with strong somatic components such as depression.

2. Biologic Theories

Research has shown differences in the way clients with somatoform disorders regulate and interpret stimuli. These clients cannot sort relevant from irrelevant stimuli and respond equally to both types. In other words, they may experience a normal body sensation such as peristalsis and attach a pathologic rather than a normal meaning to it.

For example, minor discomfort such as muscle tightness becomes amplified because of the client's concern and attention to the tightness. This amplified sensory awareness causes the person to experience somatic sensations as more intense, noxious, and disturbing.

TREATMENT

1. Treatment focuses on managing symptoms and improving quality of life. The health care provider must show empathy and sensitivity to the client's physical complaints.
2. A trusting relationship helps ensure clients stay with and receive care from one provider instead of "doctor shopping."

3. For many clients, depression and anxiety may accompany or result from somatic symptom illnesses. Thus, antidepressants help in some cases.
4. Selective serotonin reuptake inhibitors such as fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil) are most commonly used.
5. For clients with pain disorder, referral to a chronic pain clinic may be useful. Clients learn methods of pain management, such as visual imaging and relaxation. Services such as physical therapy to maintain and build muscle tone help improve functional abilities. Providers should avoid prescribing and administering narcotic analgesics to these clients because of the risk for dependence or abuse. Clients can use nonsteroidal anti-inflammatory agents to help reduce pain.
6. Involvement in therapy groups is beneficial for some people with somatic symptom illnesses. Clients with somatic symptom disorder and anxiety illness disorder who participated in a structured cognitive–behavioral group showed evidence of improved physical and emotional health. The overall goals of the group were offering peer support, sharing methods of coping, and perceiving and expressing emotions.
7. Clients with hypochondriasis who were willing to participate in cognitive–behavioral therapy and take medications were able to alter their erroneous perceptions of threat (of illness) and improve. Cognitive– behavioral therapy also produced significant improvement in clients with somatic symptom disorder.
8. Education or providing information has also been effective for clients with somatic illness or symptoms. Reading both internet-based educational material and books were other effective therapies.

Client and Family Education

1. Establish daily health routine, including adequate rest, exercise, and nutrition.
2. Teach about relationship of stress and physical symptoms and mind– body relationship.
3. Educate about proper nutrition, rest, and exercise.
4. Educate client in relaxation techniques: progressive relaxation, deep
5. breathing, guided imagery, and distraction such as music or other activities.

6. Educate client by role-playing social situations and interactions.
7. Encourage family to provide attention and encouragement when client has fewer complaints.
8. Encourage family to decrease special attention when client is in "sick" role.

Nursing Interventions for Somatic Symptom Illnesses

1. Health teaching
2. Establish a daily routine.
3. Promote adequate nutrition and sleep.
4. Expression of emotional feelings
5. Recognize relationship between stress/coping and physical symptoms.
6. Limit time spent on physical complaints.
7. Limit primary and secondary gains.
8. Coping strategies.
9. Emotion-focused coping strategies such as relaxation techniques, deep breathing, guided imagery, and distraction
10. Problem-focused coping strategies such as problem-solving strategies and role-playing.

Unit Nine: Disruptive Behavior Disorders

DBD include problems with the person's ability to regulate his or her own emotions or behaviors. They are characterized by persistent patterns of behavior that involve anger, hostility, and/or aggression toward people and property.

The primary disorders in this category include:

1. Oppositional defiant disorder (ODD).
2. Conduct disorder.
3. Intermittent explosive disorder (IED).

NOTE: It has been posited by some psychiatrists that ODD and conduct disorder can be viewed on a continuum concept that would include antisocial personality disorder.
Others believe that ODD is a milder variant of conduct disorder. IED is viewed as an impulse control disorder. The age of onset for IED can occur after age 6, but is often diagnosed from adolescence to young adulthood.

1. **Oppositional defiant disorder (ODD)** consists of an enduring pattern of uncooperative, defiant, disobedient, and hostile behavior toward authority figures without major antisocial violations. A certain level of oppositional behavior is common in children and adolescents; indeed, it is almost expected at some phases such as 2 to 3 years of age and in early adolescence. ODD is diagnosed only when behaviors are more frequent and intense than in unaffected peers and cause dysfunction in social, academic, or work situations. The disruptive, defiant behaviors usually begin at home with parents or parental figures and are more intense in this setting than settings outside the home.

Acceptable Characteristics and Abnormal Behavior in Adolescence

Acceptable Behavior	Abnormal Behavior
Occasional psychosomatic complaints	Fears, anxiety, guilt about sex, health, and education
Inconsistent and unpredictable behavior	Defiant, negative, or depressed behavior
Eagerness for peer approval	Frequent hypochondriacally complaints
Competitive in play	Learning irregular or deficient
Erratic work–leisure patterns	Poor personal relationships with peers
Critical of self and others	Inability to postpone gratification
Highly ambivalent toward parents	Unwillingness to assume greater autonomy
Anxiety about lost parental nurturing	Acts of delinquency, ritualism, obsessions

Verbal aggression to parents	Sexual aberrations
Strong moral and ethical perceptions	Inability to work or socialize

PREVALANCE OF ODD:

The prevalence rates of ODD vary from 2% up to 15% of the adolescent population, which highlights the difficulty of distinguishing negative behavior from ODD and conduct disorder–type behaviors. It occurs more often in males; however, ODD in female adolescents has increased in recent years. Most authorities believe that genes, temperament, and adverse social conditions interact to create ODD. ODD is often comorbid with other psychiatric disorders such as attention deficit/ hyperactivity disorder (ADHD), anxiety, and/or mood disorders that need to be treated as well.

Symptoms of ODD:

Children with ODD have lower self-concept.

a. Lack competence in social situations.
b. Limited abilities to make associations between their behavior and consequences of behavior—both negative and positive, indicative of a reduced sensitivity to reward and punishment.
c. Learning appropriate behavior and learning to refrain from inappropriate behavior are impaired.
d. They also exhibit impaired problem-solving abilities.
e. Deficiencies in attention, flexibility of thinking, and decision-making.

Treatment for ODD:

Based on parent management training models of behavioral interventions.

a. Reinforced in the home and school.
b. A hierarchy of problem behaviors is developed, and the most disruptive or problematic behaviors are targeted for intervention.
c. Parents learn to ignore maladaptive behaviors rather than giving the behaviors negative attention.

d. Positive behaviors are rewarded with praise and reinforces, and consistent consequences for the child's defiant behavior are implemented every time the behavior occurs.
e. Adolescent children benefit from interventions that use enhancement of personal strengths to improve behavioral and social functioning.
f. Older children may also benefit from individual therapy in addition to the behavioral program.

2. **Intermittent explosive disorder (IED):** involves repeated episodes of impulsive, aggressive, violent behavior, and angry verbal outbursts, usually lasting less than 30 minutes. During these episodes, there may be physical injury to others, destruction of property, and injury to the individual as well. The intensity of the emotional outburst is grossly out of proportion to the stressor or situation. In other words, a minor issue or occurrence may result in rage, aggression, and assault of others. The episode may occur with seemingly no warning. Afterward, the individual may be embarrassed and feel guilty or remorseful for his or her actions. But that does not prevent future impulsive, aggressive outbursts.

Onset and clinical course of IED

The onset of IED can occur at any time in life but is most common in adolescence and young adulthood. It is more common in males than in females. Many people with IED have a comorbid psychiatric disorder, most commonly substance use/abuse, ADHD, ODD, conduct disorder, anxiety disorders, and depression. IED is related to childhood exposure to trauma, neglect, or maltreatment. Other potential etiologic factors include neurotransmitter imbalances, especially serotonin; plasma tryptophan depletion; and frontal lobe dysfunction. Some have postulated that IED is correlated with adverse physical outcomes, such as coronary heart disease, hypertension, stroke, diabetes, arthritis, back/neck pain, ulcer, headache, and other chronic pain.

Treatment for IED:

a. Medications, such as fluoxetine (Prozac); lithium; and anticonvulsant mood stabilizers such as valproic acid (Depakote), phenytoin (Dilantin), topiramate (Topamax), and oxcarbazepine (Trileptal). Selective serotonin reuptake inhibitor antidepressants particularly seem to reduce aggressive tendencies.
b. Cognitive behavioral therapy, anger management strategies.
c. Avoidance of alcohol and other substances, and relaxation techniques.
d. The best outcomes involve a combination of these interventions and treatment.

3. **Conduct disorder** is characterized by persistent behavior that violates societal norms, rules, laws, and the rights of others. These children and adolescents have significantly impaired abilities to function in social, academic, or occupational areas.

Symptoms of CD:

1. Aggression to people and animals.
2. Destruction of property.
3. Deceitfulness and theft.
4. Serious violation of rules.
5. Children with conduct disorder often exhibit **callous and unemotional traits**, similar to those seen in adults with antisocial personality disorder.
6. They have little empathy for others, do not feel "bad" or guilty or show remorse for their behavior, have shallow or superficial emotions, and are unconcerned about poor performance at school or home.
7. These children have low self-esteem, poor frustration tolerance, and temper outbursts.
8. Academic underachievement, learning disabilities.
9. Hyperactivity, and problems with attention span are all associated with conduct disorder.
10. Children with conduct disorder have difficulty functioning in social situations. They lack the abilities to respond appropriately to others and to negotiate conflict, and they

lose the ability to restrain themselves when emotionally stressed. They are often accepted only by peers with similar problems.

Onset of CD:

Conduct disorder is frequently associated with early onset of sexual behavior, drinking, smoking, use of illegal substances, and other reckless or risky behaviors. Conduct disorder behaviors before age 10 occurs primarily in boys; onset after age 10 occurs in girls and boys. As many as 30% to 50% of these children are diagnosed with antisocial personality disorder as adults.

Behaviors associated with conduct disorders fall into categories of aggression, destruction, deceit/theft, and rule violation, but they can vary in intensity. They are often described as mild, moderate, or severe.

A. Mild: The child has some conduct problems that cause relatively minor harm to others. Examples include repeated lying, truancy, minor shoplifting, and staying out late without permission.

B. Moderate: The number of conduct problems increases as does the amount of harm to others. Examples include vandalism, conning others, running away from home, verbal bullying and intimidation, drinking alcohol, and sexual promiscuity.

C. Severe: The person has many conduct problems that cause considerable harm to others. Examples include forced sex, cruelty to animals, physical fights, cruelty to peers, use of a weapon, burglary, robbery, and violation of previous parole or probation requirements.

Etiology

1. Genetic vulnerability.
2. Environmental adversity.
3. Poor coping interact to cause the disorder.
4. Risk factors include poor parenting.
5. Low academic achievement.

6. Poor peer relationships.
7. Low self-esteem. protective factors include resilience, family support, positive peer relationships, and good health.
8. Conduct disorder had their first experience with alcohol and other drugs before age 12 years and were more likely to engage in higher risk behaviors, including, but not limited to, continued alcohol and substance use.
9. Prenatal exposure to alcohol causes an increased risk for conduct disorder.
10. Child abuse is an especially significant risk factor.

Related Problems: externalizing behaviors and internalizing behaviors

Children respond in different ways to environmental pressures and adversity. Some children externalize their emotional issues by directing anger and frustration into aggressive or delinquent behavior, putting them at risk for diagnoses of ODD and conduct disorder. Other children experiencing the same pressures may internalize their emotions, resulting in somatic complaints, withdrawal, isolative behavior, and problems with anxiety and depression. These behavioral patterns correspond to the
problems with self-regulation of emotions (internalizing) and behavior (externalizing).

Externalizing Behaviors	Internalizing Behaviors
Lying	Prefers to be alone , Withdraws
Cheating at school	Crying spells
Swearing	Sulks
Truancy	Won't talk
Vandalism	Is secretive
Setting fires	Overly shy
Bragging	Stares in lieu of verbal response
Screaming	Physically underactive
Inappropriate attention-seeking	Somatic aches and pains

Arguing	Dizziness, Nausea, vomiting, stomach problems
Threatening	Fatigue, lethargy
Demanding	Nervous
Relentless teasing	Feels worthless, unloved
Anger outbursts	Guilt feelings

RELATED DISORDERS

1. **Kleptomania** is characterized by impulsive, repetitive theft of items not needed by the person, either for personal use or monetary gain. Tension and anxiety are high prior to the theft, and the person feels relief, exhilaration, or gratification while committing the theft. The item is often discarded after it is stolen. Kleptomania is more common in females and often has negative legal, career, family, and social consequences.
2. **Pyromania** is characterized by repeated, intentional fire-setting. The person is fascinated about fire and feels pleasure or relief of tension while setting and watching the fires. There is neither any monetary gain or revenge or other reason, such as concealing other crimes, nor is it associated with another major mental disorder. Pyromania as a primary disorder is rare. Persons, if caught, become part of the legal rather than mental health system.

Treatment of CD:

1. Early intervention is more effective, and prevention is more effective than treatment.
2. Dramatic interventions, such as “boot camp” or incarceration, have not proved effective and may even worsen the situation.
3. Treatment must be geared toward the client’s developmental age; no one treatment is suitable for all ages.
4. Preschool programs result in lower rates of delinquent behavior and conduct disorder through use of parental education about normal growth and development, stimulation for the child, and parental support during crises.

5. For school-aged children with conduct disorder, the child, family, and school environment are the focus of treatment.
6. Techniques include parenting education, social skills training to improve peer relationships, and attempts to improve academic performance and increase the child's ability to comply with demands from authority figures.
7. The most promising treatment approach includes keeping the client in his or her environment with family and individual therapies.
8. The plan usually includes conflict resolution, anger management, and teaching social skills.
9. Medications alone have little effect, but may be used in conjunction with treatment for specific symptoms. For example, the client who presents a clear danger to others (physical aggression) may be prescribed an antipsychotic medication, such as risperidone (Risperdal). Clients with labile moods may benefit from lithium or another mood stabilizer such as carbamazepine (Tegretol) or valproic acid (Depakote).

Intervention

The nurse must protect others from the manipulative or aggressive behaviors common with these clients. He or she must set limits on unacceptable behavior at the beginning of treatment. Limit setting involves the following three steps:

1. Inform clients of the rule or limit.
2. Explain the consequences if clients exceed the limit.
3. State expected behavior.
4. Providing consistent limit enforcement with no exceptions by all members of the health.
5. Decreasing violence and increasing compliance with treatment
6. Protect others from client's aggression and manipulation.
7. Set limits for unacceptable behavior.
8. Provide consistency with the client's treatment plan.
9. Institute time-out.
10. Provide a routine schedule of daily activities.

11. Improving coping skills and self-esteem
12. Show acceptance of the person, not necessarily the behavior.
13. Encourage the client to keep a diary.
14. Teach and practice problem-solving skills.
15. Promoting social interaction.
16. Teach age-appropriate social skills.
17. Role model and practice social skills.
18. Provide positive feedback for acceptable behavior.
19. Providing client and family education.
20. **Improving Coping Skills and Self-Esteem**

    The nurse must show acceptance of clients as worthwhile individuals even if their behavior is unacceptable. This means that the nurse must be matter of fact about setting limits and must not make judgmental statements about clients. He or she must focus only on the behavior. For example, if a client broke a chair during an angry outburst, the nurse would say, "John, breaking chairs is unacceptable behavior. You need to let staff know you're upset so you can talk about it instead of acting out." The nurse must avoid saying things like, "What's the matter with you? Don't you know any better?"
21. **Promoting Social Interaction.**
22. **Providing Client and Family Education.**

Parents Education For CD:

1. Teach parents social and problem-solving skills when needed.
2. Encourage parents to seek treatment for their own problems.
3. Help parents identify age-appropriate activities and expectations.
4. Assist parents with direct, clear communication.
5. Help parents avoid "rescuing" the client.
6. Teach parents effective limit-setting techniques.

7. Help parents identify appropriate discipline strategies.
8. Remember to focus on the client's strengths and assets, as well as their problems.
9. Avoid a "blaming" attitude toward clients and/or families; rather, focus on positive actions to improve situations and/or behaviors.

KEY POINTS

- Disruptive behavior disorders are characterized by persistent patterns of behavior involving anger, hostility, and aggression toward people and property, including ODD, conduct disorder, and IED.
- ODD involves an enduring pattern of uncooperative, defiant, disobedient, and hostile behavior toward authority figures that far exceeds periodic negative behavior seen in adolescence. Children and adolescents with ODD do not associate their behavior with consequences but blame others for their problems.
- Treatment goals for ODD involve learning appropriate behavior and refraining from inappropriate behavior.
- Parent management training is based on behavioral principles of decreasing reinforcing attention for negative behaviors, rewarding positive behaviors, and consistent expectations and consequences for both. This training is used for parents of children with ODD and conduct disorder.
- Conduct disorder, the most common disruptive behavior disorder, is characterized by aggression to people and animals, destruction of property, deceitfulness and theft, and serious violation of rules.
- Interventions for conduct disorder include decreasing violent behavior, increasing compliance, improving coping skills and self-esteem, promoting social interaction, and educating and supporting parents.
- Children and adolescents with ODD and conduct disorder may be diagnosed with antisocial personality disorders as adults. Most at risk are clients with more severe conduct behaviors and early onset (before age 10 years) of those behaviors.

- Time-out is retreat to a neutral place so that clients can regain self-control.

Unit Ten: Treatment Modalities

Mental Health Treatments

- People who have alterations to their mental health have special needs.
- When emotional health is threatened, many other daily activities can be altered as well.
- Cognitive ability can be decreased.
- Emotional responses can be decreased or even absent in some conditions.
- These alterations can be extremely frightening to a patient who may already feel unable to control his or her life; this can lead to a deepening of the mental disorder or even the development of another disorder.
- Patients can develop a sense of helplessness and hopelessness about themselves and their conditions.
- Nurses can be the tools that help the patient regain control.
- A nurse may be observing the patient's treatments and therapies or may be an active part of them.

- Either way, the nurse will be making observations about the patient's reactions and participating in the plan of care.
- We will discusses some of the more frequently used methods for treating alterations in mental health.

Mental Health Treatments include:

1. Psychopharmacology
2. Milieu
3. Psychotherapies

- Since the introduction of the phenothiazine's in the 1950s, the number of medications available for treating patients who have mental health disorders, comprising the field of psychopharmacology, has increased greatly.
- **The reasons for using medications are twofold:**

1. The medications control symptoms, thus helping the patient to feel more comfortable emotionally.
2. The medications are usually used in connection with some other type of therapy.

Psychopharmacology include:

A. Antipsychotics (Neuroleptics/ Major Tranquilizers)
B. Antiparkinsonian Agents (Anticholinergics)
C. Antianxiety Agents (Anxiolytics/ Minor Tranquilizers)
D. Antidepressants (Mood Elevators)
E. Antimanic Agents (Mood Stabilizing Agents)
F. Stimulants

Action:

- Typical antipsychotic agents act on the central nervous system (CNS). Their main action is to **block the dopamine receptors**. However, if it is overproduced or utilized incorrectly, it can cause someone to exhibit psychotic behavior.
- Atypical antipsychotic agents block both serotonin (a neurochemical) and dopamine.

Uses:

- Antipsychotics are used to treat psychotic behavior such as schizophrenia and other disorders.
- The antipsychotic will treat schizophrenia and other acute or chronic psychotic behavior including violent or potentially violent behavior.
- Antipsychotics are classified as typical or atypical.
- **Typical** antipsychotic agents treat the **positive** symptoms of schizophrenia, such as hallucinations, delusions, and suspiciousness.

- **Atypical** antipsychotic agents reduce the **negative** symptoms of schizophrenia, such as flat affect, social withdrawal, and difficulty with abstract thinking.
- **Side Effects:** Antipsychotics have many unpleasant side effects. Sometimes people are reluctant to take these medications because they are afraid that the side effects will be worse than the illness. Some of these side effects are photosensitivity, darkening of the skin from increased pigmentation, anticholinergic effects such as dry mouth, and a group of side effects called extrapyramidal symptoms (EPS).
- There is less risk of EPS with the atypical agents, but early observation and reporting of any possible EPS are crucial to minimizing these effects on the patient. The **EPS** include: Drug-induced parkinsonism (**pseudoparkinsonism**). Symptoms appear 1 to 8 weeks after the patient begins the medication. The major symptom is akinesia (muscle weakness).

1. **Akathisia**. Symptoms appear 2 to 10 weeks after the patient starts taking the medication. Symptoms are agitation and motor restlessness, and they seem to appear more frequently in women.
2. **Dystonia**. Symptoms appear 1 to 8 weeks after the patient starts taking the medication. Symptoms manifest as bizarre distortions or involuntary movements of any muscle group. Tongue, eyes, face, neck, or any larger muscle mass can become tightened into an unnatural position.
3. **Tardive dyskinesia (TD).** Symptoms appear within 1 to 8 weeks after the patient starts taking the medication. The frequently seen manifestations are rhythmic, involuntary movements that look like chewing, sucking, or licking motions.

- Neuroleptic malignant syndrome (NMS) is an uncommon but potentially fatal reaction to treatment with neuroleptic medications. Symptoms include muscle rigidity, hyperpyrexia, fluctuations in blood pressure, and altered level of consciousness.
- Early recognition and immediate medical care are important. Some antipsychotics, such as Clozaril, are known to cause serious blood dyscrasias and require regular monitoring of blood counts.
- **Contraindications**: Antipsychotics should be used carefully in patients who are hypersensitive to medications or who have brain damage or blood dyscrasias.

1. Careful teaching by doctors and nurses can help the patient to understand that these are very strong medications.
2. The possibility of seizures increases in patients who require antipsychotic medications.
3. Observe for any sign of EPS or NMS and carefully monitor blood work for abnormal results.

4. Careful instruction to the patient and family regarding wearing a wide-brimmed hat, covering all exposed skin, especially if the patient is using Thorazine.
5. Patients should be taught to avoid alcohol.
6. Over-the-counter (OTC) medication and other products should not be taken without doctor approval.
7. It is important to instruct the patient not to alter the dose without first discussing it with the doctor.
8. Occasionally, the patient might experience some gastric distress with oral antipsychotics, so give them to the patient with food or milk.
9. Antipsychotic medication should be discontinued slowly. If medication is ordered once daily, teaching patients to take the medication 1 to 2 hours before going to bed works well and promotes sleep.
10. Antacids decrease the absorption of antipsychotics, so these types of medications should be taken 1 to 2 hours after oral administration of antipsychotics.

- **Action**: Antiparkinson agents (anticholinergics) inhibit the action of acetylcholine.
- Acetylcholine increases as dopamine decreases at its receptor sites (the cholinergic effect). When the amount of acetylcholine available to interact with dopamine is decreased, there is a better **balance** between the two neurochemicals, and the symptoms of parkinsonism decrease.
- **Uses**: Antiparkinson agents help decrease the effects of drug-induced and non–drug induced symptoms of parkinsonism that often occur with antipsychotics.
- **Side Effects**: Blurred vision, dry mouth, dizziness, drowsiness, confusion, tachycardia, urinary retention, constipation, and changes in blood pressure.
- **Contraindications**: Patients with known hypersensitivity should not use these medications. Glaucoma, peptic ulcers.
- **Nursing Considerations:**

1- Monitor blood pressure carefully (at least every 4 hours when beginning treatment).
2- Encourage using hard, sugarless candy or saliva substitute to combat the effects of dry mouth.

- **Action**: Antianxiety agents depress activities of the cerebral cortex.
- **Uses**: Antianxiety agents decrease the effects of stress, anxiety, and mild depression. They can be used preoperatively to help promote sedation.
- **Side Effects**: The use of antianxiety agents can cause physical and psychological dependence. Other side effects include drowsiness, lethargy, fainting, postural hypotension, nausea, and vomiting. If discontinued abruptly, severe side effects, including

nausea, hypotension, and fatal grand mal seizures, can occur anywhere from 12 hours to 2 weeks after the drug is stopped.

- **Contraindications**: Patients with known hypersensitivity should not use these medications. People with a history of chemical dependency are not good candidates for this classification of drug because of the potential for addiction.

1. Nurses should monitor blood pressure before and after giving this medication and monitor for signs of orthostatic hypotension, especially if taking tricyclics.
2. The patient should rise slowly from sitting or lying positions to prevent a sudden drop in blood pressure.
3. When possible, these types of drugs should be given at bedtime to help promote sleep, minimize side effects, and allow a more normal daytime routine.
4. Administer intramuscular (IM) dosages deeply and slowly into large muscle masses.
5. It is important to teach the patient and family that it is not safe for the patient to drive or use alcohol while using this classification of medication.

- **Action**: to prevent, cure, or alleviate mental depression. Antidepressants generally take several weeks to see a change in mood.
- **Uses**: Treatment of depression and some anxiety disorders.
- **Side Effects**: Drowsiness, dry mouth, agitation, postural hypotension, weight gain, blurred vision, photosensitivity, and suicidal tendencies.
- **Nursing Considerations:**

1. Encourage patients to continue taking the medication during this time, although they may not feel any change in their mood for up to 3 weeks after beginning the medication.
2. Discontinue slowly.
3. Observe for suicidal ideation.

D. Antidepressants (Mood Elevators) include:

1. Selective Serotonin Reuptake Inhibitors (SSRIs) (Bicyclic Antidepressants)
2. Tricyclic Antidepressants
3. Tetracyclic Antidepressants (Heterocyclic Antidepressants)
4. Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
5. Monoamine Oxidase Inhibitors (MAOIs)
6. Alternative Treatments for Depression

- **Action**: These drugs increase the availability of serotonin, which is decreased in the brains of depressed individuals.
- **Uses**: Treatment of depression, anxiety, obsessive disorders, impulse control disorders.

- **Side Effects**: Potential for increased suicidal tendencies, dry mouth, postural hypotension, headache, insomnia, and tremors.
- **Contraindications**: Patients with known hypersensitivity should not use these medications. People using (MAOIs) or who are within 14 days of discontinuing MAOIs should not use these medications.

1. Do not abruptly discontinue the medication, except under the supervision of a health-care provider. Serotonin syndrome, which includes altered mental status, restlessness, tachycardia, and labile blood pressure, can occur with abrupt discontinuation.
2. Caution should be used with driving or activities that require alertness.
3. Alcohol and CNS depressants should be avoided.
4. Hard, sugarless candy or saliva substitute can be used to treat dry mouth.
5. The patient should change positions slowly to avoid a sudden drop in blood pressure.
6. Monitor the patient for suicide ideation.

- **Action**: These drugs increase the level of serotonin and norepinephrine, thereby increasing the ability of the nerve cells to pass information to each other. Patients with depressive disorders generally have decreased amounts of these two neurochemicals.
- **Uses**: Treatment of symptoms of depression, including sleep disturbances, sexual function disturbances, changes in appetite, and cognitive changes.
- **Side Effects**: dry mouth, tachycardia, postural hypotension, blurred vision, weight gain, and changes in blood glucose.
- **Contraindications**: Patients with known hypersensitivity should not use these medications. Women who are pregnant or breastfeeding and individuals with kidney disease, liver disease, or a recent myocardial.

1. Patients should not stop using these medications abruptly.
2. Medications (including over-the-counter medications such as cold preparations) that contain antihistamines, alcohol, sodium bicarbonate, and benzodiazepines can increase the effects of tricyclic antidepressants.
3. Nicotine, barbiturates, and the hypnotic chloral hydrate decrease the effect of the tricyclic antidepressant.

The actions, uses, contraindications, side effects, and nursing considerations for the tetracyclic antidepressants are similar to those for SSRIs.

Action: These drugs increase the availability of serotonin and norepinephrine, which are decreased in the brains of depressed individuals.

The uses, contraindications, side effects, and nursing considerations for the tetracyclic antidepressants are similar to those for SSRIs.

- **Action**: (MAOIs) prevent the metabolism of neurotransmitters by an enzyme, monoamine oxidase. Too much monoamine oxidase can lead to destructive, psychotic behaviors.
- **Uses**: are generally used for patients with varied types of depression who have not been helped by other antidepressants.
- **Side Effects**: Postural hypotension, photosensitivity, headache, memory impairment, tremors, insomnia, weight gain, and sexual dysfunction.
- **Contraindications**: Patients with known hypersensitivity should not use these medications. MAOI medications should be given carefully to patients who have asthma, congestive heart failure, cerebrovascular disease, glaucoma, blood pressure, schizophrenia, alcoholism, liver or kidney disorders, or severe headaches, and who are over 60 years old or pregnant.
- Teach patients to avoid foods containing the amino acid tyramine, a precursor of norepinephrine, while taking these medications. MAOIs block the metabolism of tyramine, resulting in increased norepinephrine. A hypertensive crisis may occur. Foods containing significant amounts of tyramine include:

1. Aged cheese (cheddar, Swiss, blue cheese)
2. Avocados (guacamole)
3. Yogurt, cream, soy sauce, Yeast supplements
4. Chicken, beef livers, smoked and processed meat, corned beef
5. Bean pods
6. Chocolate and Bananas, raisins, and figs
7. Beer, red wines, and caffeine

- Lithium carbonate was the drug of choice for treatment and management of bipolar mania for many years. In recent years, several other antimanic agents have become treatment options.
- Other medications being used as mood stabilizers include some anticonvulsants and calcium channel blockers.
- **Action**: The exact action of lithium is not completely known at this time. It is not metabolized by the body. **One hypothesis** about the action of lithium is that there seems to be a connection between lithium and constancy of sodium concentration, which might help regulate and moderate information along the nerve cells, thus preventing mood swings. **Another possibility** is that lithium increases the reuptake of norepinephrine and serotonin, thereby decreasing hyperactivity.
- **Uses**: Lithium is used for the manic phase of bipolar disorder and sometimes for other depressive or schizoaffective disorders.

- **Side Effects**: Side effects can be numerous. Some of the more common ones are thirst and dry mouth, nausea and vomiting, abdominal pain, and fatigue.
- **Contraindications**: Consistent with those of the other categories listed earlier.

1. Encourage patients to keep all appointments for blood work and evaluation of drug effectiveness. Therapeutic serum levels are between 0.5 and 1.2 mEq/L for most patients (1.0 to 1.5 in acute mania). Symptoms of lithium toxicity begin to appear at blood levels greater than 1.5 mEq/L. **Signs of toxicity** include severe diarrhea, persistent nausea and vomiting, muscle weakness, tremors, blurred vision, slurred speech, and seizures.
2. Lithium crosses the placenta and milk barriers, so women of childbearing years may need to be counseled regarding the effects of this drug on their pregnancy and breastfeeding.
3. Dehydration and fevers can cause increased danger of toxicity.
4. Adequate fluid and sodium intake are essential. Patients should not decrease their dietary intake of salt (unless instructed to do so by the physician) and should be taught to inform the physician immediately if they are ill.
5. Hard, sugarless candy can be helpful to decrease dry mouth and thirst.

- **Action**: The action of anticonvulsants in the treatment of bipolar disorder is not clear.
- **Uses**: These drugs stabilize the manic episodes in bipolar disorders.
- **Side Effects**: Nausea, vomiting, indigestion, drowsiness, dizziness, prolonged bleeding, headache, confusion.
- **Contraindications**: Patients with known hypersensitivity or with bone marrow suppression should not use these medications. **Caution** should be used with patients with renal, cardiac, or liver disease also with the elderly and children.

1. Do not stop the medication abruptly.
2. The medication should be tapered when therapy is discontinued.
3. Teach patients to avoid alcohol.
4. Nonprescription medications should not be used without doctor approval.
5. Patients should not drive or operate dangerous equipment until the effects of the medication are known.

- **The action, uses, side effects, contraindications, and nursing considerations** are similar to those for **anticonvulsants**.
- Postural hypotension and bradycardia are additional side effects.
- The patient should rise slowly from sitting or lying positions to prevent a sudden drop in blood pressure.
- Commonly used calcium channel blockers are Calan or Isoptin (verapamil).

- Stimulants are readily available over the counter as well as by prescription. They are found over the counter in diet preparations, pills to prevent sleep, cigarettes, and caffeinated beverages, energy drinks, and soda.
- Amphetamines are one type of stimulant. Amphetamines can be abused, and they have many "street names," including "uppers," and "speed." The ease with which they are available should not diminish the power and potential danger of the drug.
- **Action**: provide direct stimulation of the (CNS).
- **Uses**: These drugs promote alertness, diminish appetite, and combat narcolepsy (sleep disorder related to abnormal rapid eye movement sleep). They are used in the treatment of (ADHD).
- **Side Effects**: irregular heartbeat, hypertension, hyperactivity, dry mouth, hand tremor, rapid speech, diaphoresis, depression, seizures, suicidal ideation, and insomnia.
- **Contraindications**: Patients with known hypersensitivity should not use these medications. Pregnant or lactating women should not use this drugs. Because these are chemicals that increase stimulation of the CNS and respiratory systems, they should not be given to people who are heart disease or glaucoma, alcoholic, manic, or who display suicidal or homicidal ideations. Elderly people and patients who have diabetes, hypertension, or other cardiovascular conditions should use these drugs cautiously and with careful monitoring.

1. Tolerance and physical and psychological dependence can occur with CNS stimulants, especially with long-term use.
2. Do not discontinue medication abruptly.
3. Monitor for suicide potential.
4. Diabetic patients who take amphetamines should be informed that the amphetamines may cause changes in their insulin requirements.
5. These medications can also cause changes in judgment; therefore, people should be counseled to use extreme caution when driving or operating equipment.
6. Encourage frequent rinsing of the mouth with water or use of hard, sugarless candy or saliva substitute to relieve dry mouth.

- Psychotherapy is the term used to describe the form of treatment chosen by the psychologist or psychiatrist or other mental health therapist to treat an individual. The goals of psychotherapy are to:

1. Decrease the patient's emotional discomfort.
2. Increase the patient's social functioning.
3. Increase the patient's ability to behave or perform in a manner appropriate to the situation.

4. **Psychoanalysis**: **include** (Free Association, Dream Analysis, Hypnosis, Catharsis, Behavior Modification)

5. **Cognitive Therapies: include (**Rational-Emotive Therapy (RET), Person-Centered/Humanistic Therapy, Unconditional Positive Regard)

6. **Counseling**: **include** (Pastoral or Cultural Counseling, Group Therapy, Electroconvulsive Therapy, Humor Therapy, Pet Therapy, Crisis Intervention)

- Psychoanalysis is the form of therapy that originated from the theories of Sigmund Freud. In psychoanalysis, the focus is on the cause of the problem, which is buried somewhere in the unconscious.
- The therapist tries to take the patient into the past in an effort to determine where the problem began. Chances are, according to Freud, that the problem is related to poor parent child relationships and ineffective psychosexual development. It is typical for the psychoanalyst to be positioned at the head of the patient and slightly behind, so that the patient cannot see the therapist. This decreases any kind of nonverbal communication between the two people.
- The patient is typically on the "couch," relaxed and ready to focus on the therapist's instructions. Some of the techniques used in psychoanalysis are as follows.
- In free association, the patient is allowed to say whatever comes to mind in response to a word that is given by the therapist.
- For example, the therapist might say "mother" or "blue," and the patient would give a response, also typically one word, to each of the words the therapist says. The therapist then looks for a theme or pattern to the patient's responses. So, if the patient responds "evil" to the word "mother" or "dead" to the word "blue," the therapist might pick up one potential theme, but if the patient responds "kind" and "true" to the words "mother" and "blue," the therapist might hear a completely different theme.
- The theme may give the therapist an idea of the cause of the patient's emotional disturbance.
- Because Freudians believe that behavior is rooted in the unconscious and that dreams are a manifestation of the troubles people repress.
- The patient is asked to keep a "dream log." He/she is asked to awaken immediately after a dream and to write down the dream details right away in a notebook kept next to the bed. This is easier said than done, as many people remember only bits and pieces of a dream upon awakening.
- Psychoanalysts believe that dreams truly are the mirror to the unconscious and that it is possible to train the self to awaken long enough to record the dream. The dreams are then interpreted in much the same way as free association.

- Significant people or situations in the dreams are explored with the patient, and possible meanings are offered by the therapist.
- Many people are afraid of hypnosis. For many years, it was reputed to be quackery and presented in stage shows in which people did things such as cluck like chickens, which served as entertainment.
- Hypnotherapy, as professional therapists prefer to call it, is used for certain people in certain instances. It is not a magic solution to problems. It takes practice on the part of the patient. It can, however, be a very effective tool for unlocking the unconscious or for searching further into a technique called "past life regression."
- Catharsis is "the act of purging" or "elimination of a complex (problem) by bringing it to consciousness and affording it expression". In psychoanalysis, the therapist helps the patient see the root of the problem and then, by talking or expressing feelings, allows the patient to learn to evacuate this problem from the psyche.
- This can take place in conjunction with other forms of psychotherapy. Psychoanalysis is undertaken on a one-one basis between patient and therapist.
- The nurse can be helpful in the treatment process by allowing the patient to talk about the experiences in therapy and by carefully documenting the patient's responses.
- Behavior modification is based on the theories of the behavioral theorists (Skinner, Pavlov, and others).
- **The purpose** of behavior modification is to eliminate or greatly decrease the frequency of identified negative behaviors.
- One of the basic beliefs of behavior modification is that whenever a behavior is removed, it must be replaced by another behavior.
- Therefore, replacing the negative behaviors with ones that are more desirable is a major function of this type of psychotherapy.
- **3.1.e Behavior Modification cont.**
- As Skinner and Pavlov showed, behaviors can be learned and unlearned. The process of finding the appropriate stimuli and reinforcers determines the effectiveness of the change in behavior. According to some behaviorists, it takes approximately 20 repetitions of a behavior to make it a part of a person's lifestyle.
- The patient must have the ability to understand the ramifications of the behavior to be changed and the purpose for the type of consequence that is chosen. If the person is not capable of understanding the situation or is not able to remember due to some other problem, behavior modification could be considered a questionable alternative to other kinds of treatment.

3.2.a Rational-Emotive Therapy (RET)

- **Uses**: For any mental health alteration that is consciously controlled.
- Cognitive therapy emphasizes ways of rethinking situations. The therapist confronts the patient with certain behaviors and then works out ways of thinking about them differently. Rational-emotive therapy (RET) is one of the best-known cognitive therapies. Dr. Ellis's theory is based on an A-B-C format:

1. is the activating event, or the subject of the faulty thinking.
2. is the belief system a person has adopted about the activating event.
3. is the consequence to continuing the belief system.

3.2.a Rational-Emotive Therapy (RET)

- CBT is a type of psychotherapy that is different from traditional psychodynamic psychotherapy in that the therapist and the patient will actively work together to help the patient recover from the mental illness. People who seek CBT can expect their therapist to be problem-focused and goal-directed in addressing the challenging symptoms of mental illnesses. Because CBT is an active intervention, one can also expect to do homework or practice outside of sessions.
- RET and other forms of cognitive therapies are gaining in popularity because usually they are significantly more short-term than psychoanalysis and therefore less costly to the patient.

3.2.b Person-Centered/Humanistic Therapy

- Theorists Abraham Maslow and Carl Rogers are most frequently credited with the concept of person-centered, or humanistic, therapy.
- In this form of treatment, all caregivers are to focus on the whole person and to work in the "present." It is not important in humanistic treatment to understand the cause of the problem or what happened in the person's past; what is important is the here and now.
- **3.2.c Unconditional Positive Regard**
- This is the phrase used by therapists who follow Rogerian theory. Unconditional positive regard means full, non judgmental acceptance of the patient as a person. It also means that the patient must work at accepting himself or herself.
- Rogers believed that people who care for other people must have three qualities. These qualities are:

1. Empathy (the ability to identify with the patient's feelings without actually experiencing them with the patient)
2. Unconditional positive regard
3. Genuineness (honesty)

- Although nurses may not be active participants in the actual therapy sessions with their patients, it is important for nurses to maintain these three qualities in all therapeutic relationships.
- Counseling is licensed and regulated differently not only state by state, but also sometimes municipality by municipality.
- Some states require that a person be prepared at a PhD level to practice therapy independently; in some areas, only certain types of therapy are licensed.
- Nurses prepared at an LPN/LVN level or at an RN level can, in some localities, practice forms of treatment.
- **Uses**: All forms of mental health alterations.
- **Desired Outcomes:** Patient will gain insight to situation and receive tools to make changes in his or her life.

3.3.a Pastoral or Cultural Counseling

- Some people prefer to obtain assistance or counseling from their church or spiritual leaders. Sessions are often free, or on a "free-will" or "ability to pay" status. The person who provides therapy in this time or circumstance may or may not be trained in traditional mental health theories and modalities.
- In some Christian faiths, nurses may have an opportunity to serve in ways they could not in a traditional setting.
- Nurses may be in a position to counsel patients of their cultural or religious groups when the patient enters the health-care system.
- **Desired Outcomes**: Patient gains tools from a religious/cultural background to be able to make changes in his or her life.

3.3.b Group Therapy

- Group therapy is a very broad topic. Groups are formed for many reasons; they can be ongoing or short-term, depending on the needs of the patients or the type of disorder. Group therapy can include formal psychotherapy groups where patients meet with a therapist regularly as part of their treatment. Self-help programs are also a form of group therapy. For example, Alcoholics Anonymous (AA).
- Meeting times are established and published so that people know when and how to access them. As a rule, AA meetings are "closed" meetings; that is, only alcoholics are welcome. Sometimes, maybe once a month or once quarterly.
- Group therapy also includes family therapy. Family counseling sessions are often set up with individual therapists with a specialty in the problem area for that family.

- **Nurses** can help patients by reinforcing the good work they do in learning to keep themselves healthy. Nurses can also help by reminding patients gently that they do their own healing

3.3.c Electroconvulsive Therapy

- Electroconvulsive therapy (ECT), or electroshock therapy, as it is sometimes still called, is a form of treatment that is frightening to some patients.
- **Uses**: Depression or schizophrenia that does not respond to other treatments.
- **Side Effects:** ECT has a few side effects that can be fairly unpleasant. The patient may feel confused and forgetful immediately after the treatment.
- **Desired Outcomes:** Patient will state and exhibit appropriate mood and affect or a measurable improvement in mood and affect.
- **Nursing Considerations:**

1. Monitor vitals before and after treatment.
2. Maintain safety after the treatment.
3. Premedicate if ordered.

3.3.d Humor Therapy

- Many studies have been done over the years showing the effects of smiles, hugs, and laughter on mental health as well as physical conditions such as cancer.
- Humor therapy uses many modalities, from clowns to movies to just 10 good daily. Whatever the medium, laughter alters outlooks and neurochemical production. Patients can show remarkable progress.
- **Uses**: All forms of mental health alterations and physical conditions.
- **Desired Outcomes:**

1. Patients respond and react to the humor.
2. Patients interact.
3. Patients may show improvement in physical condition

- **Nursing Considerations:**

1. Assist in determining appropriate patients.
2. Assist in humor “application.”

3.3.e Pet Therapy

- Pet therapy has been found to reduce stress in patients. Unfortunately, not everyone can have a pet, due to finances, allergies, or living arrangements.
- According to the National Institutes of Health (NIH), pet therapy can be used in several health-care settings, including mental health units and long-term care facilities. Pet therapy benefits children, adolescents and adults with therapeutic effects.

3.3.f Crisis Intervention

- Crisis can happen at any time to anyone. It can involve one's child, next-door neighbor, or patient. Crisis is defined in several ways. In the health fields, a crisis is a sudden, unexpected event in a person's life that drastically changes his or her routine. Crisis has been defined as a state in which the body is out of homeostasis.
- **Uses**: For states of extreme emotional or physical turmoil in which patients feel out of control of self or situation.
- **Desired Outcomes:** Patient returns to pre-crisis (or higher) level of functioning.
- **Nursing Considerations:**

1. Assess for the level of crisis patient is experiencing.
2. Assess suicide potential.
3. Use verbal and nonverbal communication skills to diffuse situation.

Unit Eleven: Personality Disorder and Related Disorders

Personality: is a complex pattern of characteristics, largely outside of the person's awareness, that comprise the individual's distinctive pattern of perceiving, feeling, thinking, coping, and behaving. The personality emerges from a complicated interaction of biologic dispositions, psychological experiences, and environmental situations.

Personality disorders: Personality disorders occur when these traits become inflexible and maladaptive, and cause either significant functional impairment or subjective distress. Maladaptive or dysfunctional personality traits exhibited by individuals with a personality disorder may include:

- Negative behaviors toward others, such as being manipulative, dishonest, deceitful, or lying.
- Anger and/or hostility.
- Irritable, labile moods.
- Lack of guilt or remorse, emotionally cold and uncaring.
- Impulsivity, distractibility, poor judgment.

• Irresponsible, not accountable for own actions.

• Mistrust.

• Dependency, insecurity.

• Eccentric perceptions.

Note: Personality disorders are not diagnosed until adulthood, that is, at age 18, when personality is more completely formed. Nevertheless, maladaptive behavioral patterns can often be traced to early childhood or adolescence.

Onset and Clinical Course

Personality disorders are relatively common, occurring in 10% to 20% of the general population. Incidence is even higher for people in lower socioeconomic groups and unstable or disadvantaged populations. Of all psychiatric inpatients, 15% have a primary diagnosis of a personality disorder.

Clients with personality disorders have a higher death rate, especially as a result of suicide; they also have higher rates of suicide attempts, accidents, and emergency department visits, and increased rates of separation, divorce, and involvement in legal proceedings regarding child custody. Personality disorders have been highly correlated with criminal behavior, alcoholism, and drug abuse.

Etiology:

1- Genetics

• Heritability is 40 to 60%.

• Higher concordance rates in monozygotic twins over dizygotic twins.

• Cluster A personality disorders are more common in first degree relative of patients with schizophrenia.

2- Neurochemistry

• Low level of serotonin metabolite 5-hydroxyindoleacetic acid (5-HIAA) is associated with low mood, self-harm, suicidal behaviour in patients with borderline personality disorder.

3- Environmental factors

• Low socio-economic status.

• Social isolation.

4- Parenting styles

• Low parental affection or lack of care is associated with borderline personality disorder and dependent personality disorder.

• Aversive parenting is associated with antisocial personality disorder.

5- Childhood abuse

• People with personality disorder are more likely to have childhood maltreatment and trauma. For example, sexual and emotional abuse may lead to personality disorder.

Differences between personality disorder and other psychiatric disorders:

1. People with personality disorder may present with psychotic features. Personality disorder is different from schizophrenia because people with personality disorder have relatively intact capacity for reality testing, expression of emotion and the ability to distinguish between thoughts of their own and others.

2. People with personality disorder may complain of mood swings. Personality disorder is different from bipolar disorder because people with personality disorder should not have hypomanic or manic episodes. The mood swings they refer to is from normal mood to irritability.

3. Anxiety disorder is different from personality disorder because people with personality disorder use immature, defenses such as projection or denial.

DSM-5 Personality Disorder Categories

1. Cluster A: Behaviors described as odd or eccentric

a. Paranoid personality disorder

b. Schizoid personality disorder

c. Schizotypal personality disorder

2. Cluster B: Behaviors described as dramatic, emotional, or erratic

a. Antisocial personality disorder

b. Borderline personality disorder

c. Histrionic personality disorder

d. Narcissistic personality disorder

3. Cluster C: Behaviors described as anxious or fearful

a. Avoidant personality disorder

b. Dependent personality disorder

c. Obsessive-compulsive personality disorder

Cluster A

Type	Symptoms	Nursing Interventions
Paranoid	Mistrust and suspicions of others; Guarded, restricted affect.	• Avoid situation that the patient may perceive as demeaning. • Encourage trusting relationship • Encourage verbalizing one's perceptions of the situations • Reinforce trusting behaviors • Acknowledge other possible explanations for others motives.
Schizoid	Detached from social relationships; restricted affect; involved with things more than people.	• Acceptance of behavior. • Encourage appropriate brief social Interactions.

		•Help patient understand how behaviors may contribute to satisfactory relationships.
Schizotypal	Acute discomfort in relationships; cognitive or perceptual distortions; eccentric behavior.	Develop self-care skills; improve community functioning; social skills training.

Cluster B

Type	Symptoms	Nursing Interventions
Antisocial	Disregard for rights of others, rules, and laws.	Provide positive feedback or reward for acceptable behaviors. Increase the length of time required for acceptable behavior in order to achieve the reward. confrontation; teach client to solve problems effectively and manage emotions of anger or frustration.
Borderline	• Substance abuse • Suicide attempts • Anhedonia •Difficulty handling strong emotion • Fear of being alone. Unstable relationships, impulsivity; self-mutilation.	Promote safety; help client to cope and control emotions; structure time; teach social skills.
Histrionic	Excessive emotionality and attention seeking.	Teach social skills; provide factual feedback about behavior.
Narcissistic	Grandiose; lack of empathy; need for admiration.	Matter-of-fact approach; gain cooperation with needed treatment; teach client any needed self-care skills. • Recognize the patient is very sensitive to hurt feelings.

Cluster C

Type	Symptoms	Nursing Interventions
Avoidant	Social inhibitions; feelings of inadequacy; hypersensitive to negative evaluation.	• Promote self-esteem by acknowledging any success. • Encourage participation in supportive social situations. • Provide emotional support. • Teach calming techniques to use to deal with anxiety. • Reinforce strengths.
Dependent	• Dependent and submissive. • Want others to make decisions for them. • Tend to appear helpless and avoid responsibility. •Submissive and clinging behavior; •excessive need to be taken care.	• Allow patient to make some decisions for his or her treatment. • Reinforce the patient's decisions. • Encourage patient to make truthful, positive self-statements each shift • Recognize patient's insecurities and anxieties.
Obsessive-Compulsive	• Rigid behavior • Preoccupied with rules. • Formal. • Intense fear of making mistakes.	• Understand patient's fears and be flexible as to his/her needs. • Allow patient to make simple decisions with limited choices. • Establish trusting, supportive relationship. • Discuss alternative strategies for dealing with new situations. • Support healthy coping mechanisms to deal with stress.

Treatment of Personality disorders

A. Interpersonal Psychotherapy

Interpersonal psychotherapy may be particularly appropriate because personality disorders largely reflect problems in interpersonal style.

Long-term psychotherapy attempts to understand and modify the maladjusted behaviors, cognition, and affects of clients with personality disorders that dominate their personal lives and relationships.

The core element of treatment is the establishment of an empathic therapist-client relationship based on collaboration and guided discovery in which the therapist functions as a role model for the client.

Interpersonal psychotherapy is suggested for clients with paranoid, schizoid, schizotypal, borderline, dependent, narcissistic, and obsessive-compulsive personality disorders.

B. Psychoanalytical Psychotherapy

The treatment of choice for individuals with histrionic personality disorder has been psychoanalytical psychotherapy.

Treatment focuses on the unconscious motivation for seeking total satisfaction from others and for being unable to commit oneself to a stable, meaningful relationship.

C. Milieu or Group Therapy

This treatment is especially appropriate for individuals with antisocial personality disorder, who respond more adaptively to support and feedback from peers.

In milieu or group therapy, feedback from peers is more effective than in one-to-one interaction with a therapist.

Group therapy—particularly homogenous supportive groups that emphasize the development of social skills may be helpful in overcoming social anxiety and developing interpersonal trust and rapport in clients with avoidant personality disorder.

D. Cognitive/Behavioral Therapy

Behavioral strategies offer reinforcement for positive change.

Social skills training and assertiveness training teach alternative ways to deal with frustration.

Cognitive strategies help the client recognize and correct inaccurate internal mental schemata.

This type of therapy may be useful for clients with obsessive-compulsive, passive-aggressive, antisocial, and avoidant personality disorders.

E. Psychopharmacology

1.Antipsychotic medications are helpful in the treatment of psychotic decompensations experienced by clients with paranoid, schizotypal, and borderline personality disorders.

2. The selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs) have been successful in decreasing impulsivity and self-destructive acts in these clients.

3. Lithium carbonate and propranolol (Inderal) may be useful for the violent episodes observed in clients with antisocial personality disorder.

Unit Twelve: Neurocognitive Disorders (NCDs)

Introduction

Cognition is the brains ability to process, retain, and use information.

Cognitive abilities include reasoning, judgment, perception, attention comprehension, and memory. These cognitive abilities are essential for many important tasks, including making decisions, solving problems, interpreting the environment, and learning new information.

A cognitive disorder is a disruption or impairment in these higher level functions of the brain. Cognitive disorders can have devastating effects on the ability to function in daily life. They can cause people to forget the names of immediate family members, be unable to perform daily household tasks, and neglect personal hygiene.

The *Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)* previously categorized adult cognitive disorders as dementia, delirium, and amnestic disorders. Those categories have been reconceptualized in the *DSM-5* as **neurocognitive disorders (NCDs)**. This now includes delirium, major NCD, mild NCD, and their subtypes by etiology. The term *dementia* is still used, even in the *DSM-5*, and also in the literature and by practitioners.

Delirium

Delirium is a syndrome that involves a disturbance of consciousness accompanied by a change in cognition.

Delirium usually develops over a short period, sometimes a matter of hours, and fluctuates, or changes, throughout the course of the day. Clients with delirium have **difficulty paying attention**, are **easily distracted and disoriented**, and may have **sensory disturbances** such as **illusions**, **misinterpretations**, or **hallucinations**.

At times, they also experience disturbances in the sleep–wake cycle, changes in psychomotor activity, and emotional problems such as anxiety, fear, irritability, euphoria, or apathy.

Elderly patients are the group most frequently diagnosed with delirium.

Between 14% and 24% of people admitted to the hospital for general medical conditions are delirious, which may worsen in the hospital.

Delirium is reported in 10% to 15% of general surgical patients, 30% of open heart surgery patients, and more than 50% of patients treated for fractured hips.

Delirium develops in 80% of terminally ill patients. In many cases, the causes of delirium are **multiple stressors**, such as trauma to the central nervous system (CNS), **drug toxicity or withdrawal**, and **metabolic disturbances related to organ failure**.

Risk factors for delirium

Include increased severity of physical illness, older age, hearing impairment, decreased food and fluid intake, medications, and baseline cognitive impairment such as that seen in dementia.

Children may be more susceptible to delirium, especially that related to a febrile illness or certain medications such as anticholinergic.

Most Common Causes of Delirium

1- Physiological or metabolic: Hypoxemia; electrolyte disturbances; renal or hepatic failure; hypoglycemia or hyperglycemia; dehydration; thyroid or glucocorticoid disturbances; thiamine or vitamin B12 deficiency; vitamin C.

2- Infection: Systemic: Sepsis, urinary tract infection, pneumonia.

Cerebral: Meningitis, encephalitis, HIV, syphilis.

3- Drug related: Intoxication: Anticholinergic, lithium, alcohol, sedatives, and hypnotics.

4- Withdrawal: Alcohol, sedatives, and hypnotics.

Reactions to anesthesia, prescription medication, or illicit (street) drugs.

Treatment and Prognosis

An antipsychotic medication, such as **haloperidol (Haldol**), may be used in doses of 0.5 to 1 mg to decrease agitation and psychotic symptoms, as well as to facilitate sleep. The exception is delirium induced by alcohol withdrawal, which is usually treated with **benzodiazepines.**

Clients may also need other supportive physical measures.

Adequate nutritious food and fluid intake speed recovery. IV fluids or even total parenteral nutrition may be necessary if a client's physical condition has deteriorated and he or she cannot eat and drink.

If a client becomes agitated and threatens to dislodge IV tubing or catheters, physical restraints may be necessary so that needed medical treatments can continue. Restraints are used only when necessary and stay in place no longer than warranted because they may increase the client's agitation.

Client and Family Education for Delirium

• Monitor chronic health conditions carefully.

• Visit physician regularly.

• Tell all physicians and health care providers what medications are taken, including OTC medications, dietary supplements, and herbal preparations.

• Check with physician before taking any nonprescription medication.

• Avoid alcohol and recreational drugs.

• Maintain a nutritious diet.

• Get adequate sleep.

• Use safety precautions when working with paint solvents, insecticides, and similar products.

Nursing Interventions for Delirium

1- Promoting client's safety

• Teach the client to request assistance for activities (getting out of bed, going to bathroom).

• Provide close supervision to ensure safety during these activities.

• Promptly respond to the client's call for assistance.

2- Managing client's confusion

• Speak to the client in a calm manner in a clear low voice; use simple sentences.

• Allow adequate time for the client to comprehend and respond.

• Allow the client to make decisions as much as he or she is able to.

• Provide orienting verbal cues when talking with the client.

• Use supportive touch if appropriate.

3- Controlling environment to reduce sensory overload

• Keep environmental noise to minimum (television, radio).

• Monitor the client's response to visitors; explain to family and friends that the client may need to visit quietly one-on-one.

• Validate the client's anxiety and fears, but do not reinforce misperceptions.

4- Promoting sleep and proper nutrition

• Monitor sleep and elimination patterns.

• Monitor food and fluid intake; provide prompts or assistance to eat and drink adequate amounts of food and fluids.

• Provide periodic assistance to bathroom if the client does not make requests.

• Discourage daytime napping to help sleep at night.

• Encourage some exercise during the day, such as sitting in a chair, walking in hall, or other activities the client can manage.

Dementia

Dementia refers to a disease process marked by progressive cognitive impairment with no change in the level of consciousness. It involves multiple cognitive deficits, initially, memory impairment, and later, the following cognitive disturbances may be seen:

• **Aphasia**, which is deterioration of language function.

• **Apraxia**, which is impaired ability to execute motor functions despite. intact motor abilities

• **Agnosia**, which is inability to recognize or name objects despite intact sensory abilities (inability to interpret sensations).

• **Disturbance in executive functioning**, which is the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior.

These cognitive deficits must be sufficiently severe to impair social or occupational functioning and must represent a decline from previous functioning.

In the *DSM-5*, **mild NCD** refers to a mild cognitive decline, and a modest impairment of performance that doesn't prevent independent living but may require some accommodation or assistance.

A major NCD refers to a significant cognitive decline and a substantial impairment in performance that interferes with activities of daily independent living.

As people progress from mild to major NCD, it is not always easy for the diagnostician to decide which one to use multiple cognitive defects of dementia.

Dementia must be distinguished from delirium; if the two diagnoses coexist, the symptoms of dementia remain even when the delirium has cleared.

Classifications of Dementia

1. **Primary dementias** are those in which the dementia itself is the major sign of some organic brain disease not directly related to any other organic illness.

2. **Secondary dementias** are used by or related to another disease or condition, such as HIV disease or a cerebral trauma.

Etiological Implications

The disorders of dementia are differentiated by their etiology, although they share a common symptom presentation. Categories of dementia include the following:

1. Dementia of the Alzheimer's type.

2. Vascular dementia.

3. Dementia due to HIV disease.

4. Dementia due to head trauma.

5. Dementia due to Parkinson's disease.

6. Dementia due to Pick's disease.

7. Dementia due to other general medical conditions.

8. Substance-induced persisting dementia.

9. Dementia due to multiple etiologies**.**

Related Disorders

Long-term use of alcohol that results in dementia is called **Korsakoff syndrome** or dementia. It was previously known as an **amnestic disorder** since amnesia and confabulation are common.

Mild or major NCD due to another medical condition is caused by diseases such as brain tumor, brain metastasis, subdural hematoma, arteritis, renal or hepatic failure, seizures, or multiple sclerosis.

Neurocognitive deficits due to stroke, head injuries, carbon monoxide poisoning, or brain damage from other medical causes were previously classified as amnestic disorders.

An estimated 5 million people in the United States have moderate-to-severe dementia from various causes. It is estimated that there are 4.6 million new cases each year worldwide. Prevalence rises with age; estimated prevalence of moderate-to-severe dementia in people older than 65 years is about 5%, and 20% to 40% of the general population older than 85 years have dementia.

Dementia of the Alzheimer type is more common in women; vascular dementia is more common in men.

Nursing Interventions

1. **Promoting client's safety and protecting from injury**

A. Offer unobtrusive assistance with or supervision of cooking, bathing, or self-care activities.

B. Identify environmental triggers to help client avoid them.

2. Promoting adequate sleep, proper nutrition and hygiene, and activity

A. Prepare desirable foods and foods client can self-feed; sit with client while eating.

B. Monitor bowel elimination patterns; intervene with fluids and fiber or prompts.

C. Remind client to urinate; provide pads or diapers as needed, checking and changing them frequently to avoid infection, skin irritation, unpleasant odors.

D. Encourage mild physical activity such as walking.

3. Structuring environment and routine

A. Encourage client to follow regular routine and habits of bathing and dressing rather than impose new ones.

B. Monitor amount of environmental stimulation, and adjust when needed.

4. Providing emotional support

A. Be kind, respectful, calm, and reassuring; pay attention to client.

B. Use supportive touch when appropriate.

5. Promoting interaction and involvement

A. Plan activities geared to client's interests and abilities.

B. Reminisce with client about the past.

C. If client is nonverbal, remain alert to nonverbal behavior.

D. Employ techniques of distraction, time away, going along, or reframing to calm clients who are agitated, suspicious, or confused.

Unit Thirteen: Substance Abuse and Related Disorders

Worldwide, 3 million deaths result from the harmful use of alcohol annually. Alcohol is a causal factor in more than 200 disease and injury conditions. Absenteeism at work is higher for employees who have alcohol related problems, and they use more health benefits as well. The number of infants suffering the physiological and emotional consequences of prenatal exposure to alcohol or drugs (e.g., fetal alcohol syndrome, neonatal abstinence syndrome, "crack babies") is increasing at alarming rates. Chemical abuse also results in increased violence, including domestic abuse, homicide, and child abuse and neglect. These rising statistics regarding substance abuse do not bode well for future generations.

Substance Abuse Concepts:

- **Intoxication** is use of a substance that results in maladaptive behavior. Short term psychological and physiological changes caused by psychoactive substances.
- **Withdrawal syndrome** refers to the negative psychological and physical reactions that occur when use of a substance ceases or abruptly discontinued or dramatically decreases.
- **Abuse**: long term effect of psychoactive substance.
- **Polysubstance abuse**: is abuse of more than one substance.

- **Hazardous use**: consumption of alcohol or psychoactive substance that carries a high risk of long term damage to health.
- **Dependence syndrome**: is a psycho physiological phenomena caused by repeated administration or a psychoactive substance.
- **Detoxification** is the process of safely withdrawing from a substance.
- **Tolerance** is the needs more alcohol to produce the same effect.
- **Tolerance break** means that very small amounts of alcohol intoxicate the person. This happen for person after continued heavy drinking.
- **Spontaneous remission** or natural recovery is happening when people with alcohol-related problems can modify or quit drinking on their own without a treatment program.
- **Codependence** is a maladaptive coping pattern on the part of family members or others resulting from a prolonged relationship with the person who uses substances. Characteristics of codependence are poor relationship skills, excessive anxiety and worry, compulsive behaviors, and resistance to change. Family members learn these dysfunctional behavior patterns as they try to adjust to the behavior of the substance user. One type of codependent behavior is called **enabling**, which is a behavior that seems helpful on the surface but actually perpetuates the substance use. For example, a wife who continually calls in to her husband's job to report that he is sick when he is really drunk or hungover prevents the husband from having to face the true implications and repercussions of his behavior. What appears to be a helpful action really just assists the husband in avoiding the consequences of his behavior and to continue abusing the substance.

Categories of drugs include:

Many substances can be used and abused; some can be obtained legally, while others are illegal. This discussion includes alcohol and prescription medications as substances that can be abused.

1. Alcohol

2. Sedatives, hypnotics, and anxiolytics
3. Stimulants
4. Cannabis
5. Opioids
6. Hallucinogens
7. Inhalants

ONSET AND CLINICAL COURSE

The early course of alcoholism typically begins much earlier, with the first episode of intoxication between the ages of 12 and 14 years; the first evidence of minor alcohol-related problems is seen in the late teens. Episodes of "sipping" alcohol may occur as early as 8 years. A pattern of more severe difficulties for people with alcoholism begins to emerge in the mid-20s to the mid-30s; these difficulties can be the alcohol-related breakup of a significant relationship, an arrest for public intoxication or driving while intoxicated, evidence of alcohol withdrawal, early alcohol-related health problems, or significant interference with functioning at work or school. During this time, the person experiences his or her first **blackout**, which is an episode during which the person continues to function but has no conscious awareness of his or her behavior at the time or any later memory of the behavior.

RELATED DISORDERS

1. **Gambling disorder** is a non–substance-related diagnosis. It is characterized by problem gambling, spending money one cannot afford to lose, lying about gambling, getting money from others, and an inability to refrain from gambling for any specific time. Attempts to quit or cut down result in restless, anxious, and irritable behavior.
2. **Caffeine and tobacco or nicotine are substances** that are addictive and are included in DSM-5 but are not considered mental health problems.
3. There has also been discussion of possible **addiction to the internet**, noting that some people spend more than half of their waking hours on the computer and become upset and irritable if use is limited or curtailed.

4. **Substances can induce symptoms** that are similar to other mental illness diagnoses, such as anxiety, psychosis, or mood disorders. They are called substance-induced anxiety, substance-induced psychosis, and so forth. The symptoms may subside once the substance is eliminated from the body, though this is not always the case. For example, methamphetamine can cause substance-induced psychosis, but the psychotic symptoms may persist due to damage to the brain.
5. **Delirium**, which may be seen in severe alcohol withdrawal.

ETIOLOGY

The exact causes of drug use, dependence, and addiction are not known, but various factors are thought to contribute to the development of substance related disorders:

1. Biologic Factors

Children of alcoholic parents are at higher risk for developing alcoholism and drug dependence than are children of nonalcoholic parents.

2. Psychological Factors

Family dynamics are thought to play a part. Children of alcoholics parents are four times as likely to develop alcoholism compared with the general population. The inconsistency in the parent's behavior, poor role modeling, and lack of nurturing pave the way for the child to adopt a similar style of maladaptive coping, stormy relationships, and substance abuse.

3. Social and Environmental Factors

Cultural factors, social attitudes, peer behaviors, laws, cost, and availability all influence initial and continued use of substances.

Alcohol

Intoxication and Overdose

Alcohol is a central nervous system depressant that is absorbed rapidly into the bloodstream. Initially, the effects are relaxation and loss of inhibitions. With intoxication, there is slurred speech, unsteady gait, lack of coordination, and impaired attention, concentration, memory, and judgment. Some people become aggressive or display inappropriate sexual behavior when intoxicated. The person who is intoxicated may experience a blackout. An overdose, or excessive alcohol intake in a short period, can result in vomiting, unconsciousness, and respiratory depression. This combination can cause

aspiration pneumonia or pulmonary obstruction. Alcohol-induced hypotension can lead to cardiovascular shock and death.

Treatment of an alcohol overdose is similar to that for any central nervous system depressant - gastric lavage or dialysis to remove the drug, and support of respiratory and cardiovascular functioning in an intensive care unit. The administration of central nervous system stimulants is contraindicated.

Physiological Effects of Long-Term Alcohol Use

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

Withdrawal and Detoxification

Symptoms of withdrawal usually begin **4 to 12 hours** after cessation or marked reduction of alcohol intake. Symptoms include coarse hand tremors, sweating, elevated pulse and blood pressure, insomnia, anxiety, and nausea or vomiting. Severe or untreated withdrawal may progress to transient hallucinations, seizures, or delirium, called delirium tremens. Alcohol

withdrawal usually **peaks on the second day and is over in about 5 days**. This can vary, however; and withdrawal may take 1 to 2 weeks. Because alcohol withdrawal can be life-threatening, detoxification needs to be accomplished under medical supervision. Safe withdrawal is usually accomplished with the administration of **benzodiazepines**, such as

lorazepam (Ativan), chlordiazepoxide (Librium), or diazepam (Valium), to **suppress the withdrawal symptoms.**

Treatment:

1. Medication.
2. Detoxification: is the process of safely withdrawing from a substance.
3. Education: information about consequence (physical, psychological and social) of continued alcohol abuse.
4. Cognitive behavioral therapy: learn instead of using alcohol in social situation to reduce anxiety management and assertiveness techniques.
5. Group therapy: provide an opportunity for frank and accurate feedback from other member of the group concerning the problem that the patient faces.

Nursing intervention

1. Client and family teaching:

A. Substance abuse is an illness.

B. Dispel myths about substance abuse.

C. Any alcohol, whether beer, wine, or liquor, can be an abused substance.

D. Prescribed medication can be an abused substance.

E. Feedback from family about a return to previous maladaptive coping mechanisms is vital.

F. Continued participation in an aftercare program is important.

G. Nurses can encourage clients to identify problem areas in their lives and to explore the ways that substance use may have intensified those problems.

3. The nurse also can help clients to find ways to relieve stress or anxiety that do not involve substance use.

4. Relaxation, exercise, listening to music, or engaging in activities may be effective.

5. Clients also may need to develop new social activities or leisure pursuits if most of their friends or habits of socializing involved the use of substances.

6. The nurse can help clients to focus on the present not the past. It is not helpful for clients to dwell on past problems and regrets.

7. The nurse can encourage clients to set attainable goals such as "What can I do today to stay sober?" .

8. Communicate honestly.

9. Assist patient in identifying thoughts and feelings.

10. Monitor for withdrawal syndromes and complications from substance abuse

Sedatives, Hypnotics, and Anxiolytics Addiction

This class of drugs includes all central nervous system depressants: barbiturates, non-barbiturate hypnotics, and anxiolytics, particularly benzodiazepines.

Intoxication:

The intensity of the effect depends on the particular drug. Intoxication symptoms include slurred speech, lack of coordination, unsteady gait, labile mood, impaired attention or memory, and even stupor and coma.

Overdose:

They can cause coma, respiratory arrest, cardiac failure, and death. Treatment in an intensive care unit is required using lavage or dialysis to remove the drug from the system and to support respiratory and cardiovascular function. **Barbiturates**, in contrast, can be lethal when taken in overdose. They can cause coma, respiratory arrest, cardiac failure, and death. Treatment in an intensive care unit is required using lavage or dialysis to remove the drug from the system and to support respiratory and cardiovascular function.

Benzodiazepines alone, when taken orally in overdose, are rarely fatal, but the person is lethargic and confused. Treatment includes gastric lavage followed by ingestion of activated charcoal and a saline cathartic; dialysis can be used if symptoms are severe.

Detoxification from sedatives, hypnotics, and anxiolytics is often medically managed by tapering the amount of the drug the client receives over a period of days or weeks, depending on the drug and the amount the client had been using. **Tapering**, or

administering decreasing doses of a medication, is essential with barbiturates to prevent coma and death that occur if the drug is stopped abruptly. For example, when tapering the dosage of a benzodiazepine, the client may be given Valium, 10 mg four times a day; the dose is decreased every 3 days, and the number of times a day the dose is given is also decreased until the client safely withdraws from the drug.

Stimulants (Amphetamines, Cocaine)

Stimulants are drugs that stimulate or excite the central nervous system and have limited clinical use. Amphetamines used by people who wanted to lose weight or to stay awake. Cocaine, an illegal drug with virtually no clinical use in medicine, is highly addictive and a popular recreational drug because of the intense and immediate feeling of euphoria it produces. Brain damage related to its use is frequent.

Intoxication

Intoxication from stimulants develops rapidly; effects include the high or euphoric feeling, hyperactivity, hyper-vigilance, talkativeness, anxiety, grandiosity, hallucinations, stereotypic or repetitive behavior, anger, fighting, and impaired judgment. Physiologic effects include tachycardia, elevated blood pressure, dilated pupils, perspiration or chills, nausea, chest pain, confusion, and cardiac dysrhythmias.

Overdose

Overdoses of stimulants can result in seizures and coma, lowers blood pressure, and relieves nausea; deaths are rare.

Withdrawal and Detoxification

Withdrawal from stimulants occurs within a **few hours to several days** after cessation of the drug and is not life-threatening. Marked dysphoria is the primary symptom and is accompanied by fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, and psychomotor retardation or agitation. Marked withdrawal symptoms are

referred to as "crashing"; the person may experience depressive symptoms, including suicidal ideation, for several days. Stimulant withdrawal is not treated pharmacologically.

Cannabis (Marijuana)

Cannabis sativa is the hemp plant that is widely cultivated for its fiber used to make rope and cloth and for oil from its seeds. It has become widely known for its psychoactive resin. This resin contains more than 60 substances, called cannabinoids, of which is thought to be responsible for most of the psychoactive effects. Cannabis is often smoked in cigarettes and it can also be eaten.

Intoxication and Overdose

Cannabis begins to act less than 1 minute after inhalation. Peak effects usually occur in 20 to 30 minutes and last at least 2 to 3 hours. Users report a high feeling similar to that with alcohol, lowered inhibitions, relaxation, euphoria, and increased appetite. Symptoms of intoxication include impaired motor coordination, inappropriate laughter, impaired judgment and short-term memory, and distortions of time and perception. Anxiety, dysphoria, and social withdrawal may occur in some users. Physiological effects, in addition to increased appetite, include conjunctival injection (bloodshot eyes), dry mouth, hypotension, and tachycardia. Excessive use of cannabis may produce delirium or rarely, cannabis-induced psychotic disorder, both of which are treated symptomatically. Overdoses of cannabis do not occur.

Withdrawal and Detoxification

Although some people have reported withdrawal symptoms of muscle aches, sweating, anxiety, and tremors, no clinically significant withdrawal syndromeis identified.

Opioids

Opioids are popular drugs of abuse because they desensitize the user to both physiologic and psychological pain and induce a sense of euphoria and well-being. Opioid compounds include both potent prescription analgesics such as morphine, meperidine (Demerol), and codeine, as well as illegal substances such as heroin and normethadone. People who abuse

opioids spend a great deal of their time obtaining the drugs; they often engage in illegal activity to get them.

Intoxication

Opioid intoxication develops soon after the initial euphoric feeling; symptoms include apathy, lethargy, listlessness, impaired judgment, psychomotor retardation or agitation, constricted pupils, drowsiness, slurred speech, and impaired attention and memory.

Overdose

Opioid overdose can lead to coma, respiratory depression, pupillary constriction, unconsciousness, and death.

Withdrawal and Detoxification

Opioid withdrawal develops when drug intake ceases or decreases markedly, or it can be precipitated by the administration of an opioid antagonist. Initial symptoms are anxiety, restlessness, aching back and legs, and cravings for more opioids. Short-acting drugs such as heroin produce withdrawal symptoms in 6 to 24 hours; the symptoms peak in 2 to 3 days and gradually subside in 5 to 7 days. Longer acting substances such as methadone may not produce significant withdrawal symptoms for 2 to 4 days, and the symptoms may take 2 weeks to subside. Methadone can be used as a replacement for opioids, and the dosage is then decreased over 2 weeks.

Hallucinogens

Hallucinogens are substances that distort the user's perception of reality and produce symptoms similar to psychosis, including hallucinations (usually visual) and depersonalization. Hallucinogens also cause increased pulse, blood pressure, and temperature; dilated pupils; and hyperreflexia. Examples of hallucinogens are mescaline, psilocybin, lysergic acid diethylamide, and "designer drugs" such as ecstasy. Phencyclidine (PCP), developed as an anesthetic, is included in this section because it acts similarly to

hallucinogens. Hallucinogens distort reality.

Intoxication

Hallucinogen intoxication is marked by several maladaptive behavioral or psychological changes: anxiety, depression, paranoid ideation, ideas of reference, fear of losing one's mind, and potentially dangerous behaviors such as jumping out a window in the belief that one can fly. Physiological symptoms include sweating, tachycardia, palpitations, blurred vision, tremors, and lack of coordination.

Overdoses

as such do not occur. These drugs are not a direct cause of death, although fatalities have occurred from related accidents, aggression, and suicide.

Inhalants

Inhalants are a diverse group of drugs that include anesthetics, nitrates, and organic solvents that are inhaled for their effects. The most common substances in this category are aliphatic and aromatic hydrocarbons found in gasoline, glue, paint thinner, and spray paint. Less frequently used halogenated hydrocarbons include cleaners, correction fluid, spray can propellants, and other compounds containing esters, ketones, and glycols. Inhalants can cause significant brain damage, peripheral nervous system damage, and liver disease.

Intoxication

Inhalant intoxication involves dizziness, lack of coordination, slurred speech, unsteady gait, tremor, muscle weakness, and blurred vision. Stupor and coma can occur. Significant behavioral symptoms are belligerence, aggression, apathy, impaired judgment, and inability to function. Acute toxicity causes anoxia, respiratory depression, vagal stimulation, and dysrhythmias. Death may occur from bronchospasm, cardiac arrest, suffocation, or aspiration of the compound or vomitus.

Nursing Intervention For Substance Abuse

• Health teaching for the client and family

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

Dual diagnosis:

The client with both substance abuse and another psychiatric illness is said to have a **dual diagnosis**. Dual diagnosis clients who have schizophrenia, schizoaffective disorder, or bipolar disorder present the greatest challenge to health care professionals.

Traditional methods for treatment of major psychiatric illness or primary substance abuse often have limited success in these clients for the following reasons:

1. Clients with a major psychiatric illness may have impaired abilities to process abstract concepts; this is a major barrier in substance abuse programs.
2. Substance use treatment emphasizes avoidance of all psychoactive drugs. This may not be possible for the client who needs psychotropic drugs to treat his or her mental illness.
3. The concept of "limited recovery" is more acceptable in the treatment of psychiatric illnesses, but substance abuse has no limited recovery concept.
4. The notion of lifelong abstinence, which is central to substance use treatment, may seem overwhelming and impossible to the client who lives "day to day" with a chronic mental illness.
5. The use of alcohol and other drugs can precipitate psychotic behavior; this makes it difficult for professionals to identify whether symptoms are the result of active mental illness or substance abuse.