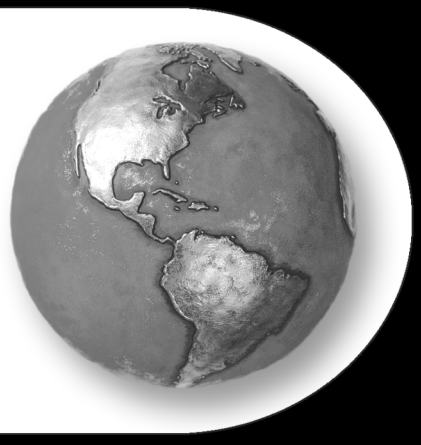
UNIT 7

PSYCHIATRIC–MENTAL HEALTH NURSING



An important aspect of professional nursing is the use of therapeutic intervention for clients who are experiencing emotional distress. A client does not have to have a psychiatric diagnosis to be in emotional distress, and often clients and their families may respond to illness or injury with anxiety and fear that can be manifested in a variety of behaviors. The principles of psychiatric-mental health nursing and therapeutic interventions can be applied to any client, family, or group in need.

To plan appropriate interventions, nurses need to have an understanding and knowledge of personality development and other theories to analyze behaviors of the client or others. Theories, principles, the nursing process, and treatment modalities are the science of psychiatric-mental health nursing.

The manner the nurse selects to use the science of mental health nursing is based in part on that nurse's personal attributes. Personal experiences, the ability to implement principles and theories, and the willingness to use therapeutic communication constitute the art of psychiatric-mental health nursing. This creative aspect of each nurse is the therapeutic use of self involved in planning and implementing effective nursing interventions for dealing with clients who are experiencing emotional distress.

UNIT OUTLINE

Implementing the art of psychiatric-mental health nursing is an important way to convey to clients the caring aspect of nursing. Perceiving clients' concerns and responding therapeutically will encourage clients to share more information with the nurse. Awareness of the client's attitudes, values, and fears will enable the nurse to individualize client care. Physical, psychologic, social, and spiritual needs should be the concern of a nurse who wants to provide holistic care. Nurses can determine specific client needs by assessing verbal and nonverbal behaviors. Application of the nursing process to meet client needs will ensure comprehensive nursing care.

The following principles of psychiatric-mental health nursing help form the basis of the therapeutic use of self:

- *Be aware of your own feelings and responses*
- *Maintain objectivity while being aware of your own needs*
- *Use empathy (recognizing/identifying somewhat with client's emotions to understand behavior), not sympathy (close identification/duplication of client's emotions)*
- *Focus on the needs of the client, not on your own needs; be consistent and trustworthy*
- *Accept clients as they are; be nonjudgmental*
- *Recognize that emotions influence behaviors*
- *Observe a client's behaviors to analyze needs/problems*
- *Accept client's needs to use defenses/behaviors to deal with emotional distress*
- *Accept client's negative emotions*
- *Avoid verbal reprimands, physical force, giving advice, or imposing your own values on clients*
- *Avoid intimate relationships while maintaining a caring attitude*
- *Assess clients in the context of their social/cultural group*
- *Recognize that client communication patterns (verbal and nonverbal) vary with different cultural groups*
- *Teach/explain on client's level of capability*
- *Treat clients with respect, caring, and compassion*

Asking yourself, "What is this client's need at this time?" can assist you in determining the best response to questions.

Overview of Psychiatric–Mental Health Nursing

THEORETICAL BASIS

Medical–Biologic Model

A. Emotional distress is viewed as illness.
B. Symptoms can be classified to determine a psychiatric diagnosis.
C. DSM-IV-TR*
  1. Description of disorders
  2. Criteria (behaviors) that must be met for diagnosis to be made
  3. Axis: the dimensions and factors included when assessing a client with a mental disorder
    a. I and II: clinical syndromes (e.g., bipolar, antisocial personality, mental retardation)
    b. III: physical disorders and symptoms (e.g., cystic fibrosis, hypertension)
    c. IV: psychosocial and environmental problems: acute and long-term severity of stressors
    d. V: functioning of client, rating of symptoms and their effect on activities of daily living (ADLs) or violence to self/others
D. Diagnosed psychiatric illnesses are within the realm of medical practice and have a particular course, prognosis, and treatment regimen.
E. Treatment can include psychotropic drugs, electroconvulsive therapy (ECT), hospitalization, and psychotherapy.
F. There is no proven cause, but theory is that biochemical/genetic factors play a part in the development of mental illness. Theories with schizophrenia and affective disorders include:
  1. Genetic: increased risk when close relative (e.g., parent, sibling) has disorder
  2. Possible link to neurotransmitter activity

Psychodynamic/Psychoanalytic Model (Freud)

A. Instincts (drives) produce energy.
B. There are genetically determined drives for sex and aggression.
C. Human behavior is determined by past experiences and responses.
D. All behavior has meaning and can be understood.
E. Emotionally painful experiences/anxiety motivate behavior.
F. Client can change behavior and responses when made aware of the reasons for them.
G. Freud's theory of personality
  1. Id: present at birth; instinctual drive for pleasure and immediate gratification, unconscious. Libido is the sexual and/or aggressive energy (drive). Operates on pleasure principle to reduce tension or discomfort (pain). Uses primary process thinking by imagining objects to satisfy needs (hallucinating).
  2. Ego: develops as sense of self that is distinct from world of reality; conscious, preconscious, and unconscious. Operates on reality principle which determines whether the perception has a basis in reality or is imagined. Uses secondary process thinking by judging reality and solving problems.
    a. Functions of the ego
      1) Control and regulate instinctual drives
      2) Mediate between id drives and demands of reality; id drives versus superego restrictions
      3) Reality testing: evaluate and judge external world
      4) Store up experiences in "memory"
      5) Direct motor activity and actions
      6) Solve problems
      7) Use defense mechanisms to protect self
    b. Levels of awareness
      1) Preconscious: knowledge not readily available to conscious awareness but can be brought to awareness with effort (e.g., recalling name of a character in a book)
      2) Unconscious: knowledge that cannot be brought into conscious awareness without interventions such as psychoanalysis, hypnotism, or drugs
      3) Conscious: aware of own thoughts and perceptions of reality
  3. Superego: develops as person unconsciously incorporates standards and restrictions from parents to guide behaviors, thoughts, and feelings. Conscious awareness of acceptable/unacceptable thoughts, feelings, and actions is "conscience."
H. Freud's psychosexual developmental stages
  1. Oral
    a. 0–18 months
    b. Pleasure and gratification through mouth
    c. Behaviors: dependency, eating, crying, biting

*American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), Text Revision.

d. Distinguishes between self and mother
e. Develops body image, aggressive drives

2. Anal
a. 18 months–3 years
b. Pleasure through elimination or retention of feces
c. Behaviors: control of holding on or letting go
d. Develops concept of power, punishment, ambivalence, concern with cleanliness or being dirty

3. Phallic/Oedipal
a. 3–6 years
b. Pleasure through genitals
c. Behaviors: touching of genitals, erotic attachment to parent of opposite sex
d. Develops fear of punishment by parent of same sex, guilt, sexual identity

4. Latency
a. 6–12 years
b. Energy used to gain new skills in social relationships and knowledge
c. Behaviors: sense of industry and mastery
d. Learns control over aggressive, destructive impulses
e. Acquires friends

5. Genital
a. 12–20 years
b. Sexual pleasure through genitals
c. Behaviors: becomes independent of parents, responsible for self
d. Develops sexual identity, ability to love and work

Psychosocial Model (Erikson)

A. Emphasis on psychosocial rather than psychosexual development
B. Developmental stages have goals (tasks)
C. Challenge in each stage is to resolve conflict (e.g., trust versus mistrust)
D. Resolution of conflict prepares individual for next developmental stage
E. Personality develops according to biologic, psychologic, and social influences
F. Erikson's psychosocial development tasks

1. Trust versus mistrust
a. 0–18 months
b. Learn to trust others and self versus withdrawal, estrangement

2. Autonomy versus shame and doubt
a. 18 months–3 years
b. Learn self-control and the degree to which one has control over the environment versus compulsive compliance or defiance

3. Initiative versus guilt
a. 3–5 years
b. Learn to influence environment, evaluate own behavior versus fear of doing wrong, lack of self-confidence, overrestricting actions

4. Industry versus inferiority
a. 6–12 years
b. Creative; develop sense of competency versus sense of inadequacy

5. Identity versus role diffusion
a. 12–20 years
b. Develop sense of self; preparation, planning for adult roles versus doubts relating to sexual identity, occupation/career

6. Intimacy versus isolation
a. 18–25 years
b. Develop intimate relationship with another; commitment to career versus avoidance of choices in relationships, work, or lifestyle

7. Generativity versus stagnation
a. 21–45 years
b. Productive; use of energies to guide next generation versus lack of interests, concern with own needs

8. Integrity versus despair
a. 45 years to end of life
b. Relationships extended, belief that own life has been worthwhile versus lack of meaning of one's life, fear of death

Interpersonal Model (Sullivan)

A. Behavior motivated by need to avoid anxiety and satisfy needs
B. Sullivan's developmental tasks

1. Infancy
a. 0–18 months
b. Others will satisfy needs

2. Childhood
a. 18 months–6 years
b. Learn to delay need gratification

3. Juvenile
a. 6–9 years
b. Learn to relate to peers

4. Preadolescence
a. 9–12 years
b. Learn to relate to friends of same sex

5. Early adolescence
a. 12–14 years
b. Learn independence and how to relate to opposite sex

6. Late adolescence
a. 14–21 years
b. Develop intimate relationship with person of opposite sex

Therapeutic Nurse-Client Relationship (Peplau)

A. Based on Sullivan's interpersonal model
B. Therapeutic relationship is between nurse (helper) and client (recipient of care). The goal is to work

together to assist client to grow and to resolve problems.

C. Differs from social relationship in which both parties form alliance for mutual benefit.

D. Therapeutic use of self
  1. Focus is on client needs but nurse is also aware of own needs.
  2. Self-awareness enables nurse to avoid having own needs influence perception of client.
  3. Determine what client/family needs are at the time.

E. Three phases of nurse-client relationship
  1. Orientation
    a. Nurse explains relationship to client, defines both nurse's and client's roles.
    b. Nurse determines what client expects from the relationship and what can be done for the client.
    c. Nurse contracts with client about when and where future meetings will take place.
    d. Nurse assesses client and develops a plan of care based on appropriate nursing diagnoses.
    e. Limits/termination of relationship are introduced (e.g., "We will be meeting for 30 minutes every morning while you are in the hospital.").
  2. Working phase
    a. Client's problems and needs are identified and explored as nurse and client develop mutual acceptance.
    b. Client's dysfunctional symptoms, feelings, or interpersonal relationships are identified.
    c. Therapeutic techniques are employed to reduce anxiety and to promote positive change and independence.
    d. Goals are evaluated as therapeutic work proceeds, and changed as determined by client's progress.
  3. Termination
    a. Relationship and growth in nurse and client are summarized.
    b. Client may become anxious and react with increased dependence, hostility, or withdrawal.
    c. These reactions are discussed with client.
    d. Feelings of nurse and client concerning termination should be discussed in context of finiteness of relationship.

F. Transference and countertransference
  1. Transference: occurs when client transfers conflicts/feelings from past to the nurse. For example: Client becomes overly dependent, clinging to nurse who represents (unconsciously to client) the nurturing desires from own mother.
  2. Countertransference: occurs when nurse responds to client emotionally, as if in a personal, not professional/therapeutic, relationship. Countertransference is a normal occurrence, but must be recognized so that supervision or consultation can keep it from undermining the nurse-client relationship. For example: Nurse is sarcastic and judgmental to client who has history of drug abuse. Client represents (unconsciously to nurse) the nurse's brother who has abused drugs.
  3. Interventions
    a. Reflect on reasons for behaviors of client or nurse.
    b. Establish therapeutic goals for this relationship.
    c. If unable to control these occurrences, transfer client to another nurse.

Human Motivation/Need Model (Maslow)

A. Hierarchy of needs in order of importance
  1. Physiologic: oxygen, food, water, sleep, sex
  2. Safety: security, protection, freedom from anxiety
  3. Love and belonging: freedom from loneliness/alienation
  4. Esteem and recognition: freedom from sense of worthlessness, inferiority, and helplessness
  5. Self-actualization: aesthetic needs, self-fulfillment, creativity, spirituality

B. Primary needs (oxygen, fluids) need to be met prior to dealing with higher-level needs (esteem, recognition).

C. Focus on provision of positive aspects such as feeling safe, having someone care, affiliation

Behavioral Model (Pavlov, Skinner)

A. Behavior is learned and retained by positive reinforcement (e.g., more studying produces higher grades).

B. Motivation for behavior is not considered.

C. Behaviors that are not adequate can be replaced by more adaptive behaviors.

Community Mental Health Model

A. Emotional distress stems from personal and social factors
  1. Family problems (e.g., divorce, single parenthood)
  2. Social factors (e.g., unemployment, lack of support groups, changing mores)

B. Health care a right

C. Decreased need for hospitalization, increased community care

D. Collaboration of social and health care services

E. Comprehensive services
  1. Emergency care
  2. Inpatient/outpatient services

3. Substance-abuse treatment
4. Transitional living arrangements (temporary residence instead of inpatient care)
5. Consultation and education to increase knowledge of mental health

F. Prevention
1. Primary prevention
   a. Minimize development of serious emotional distress: promote mental health, identify persons at risk.
   b. Anticipate problems such as developmental crises (e.g., birth of first child, midlife crisis, death of spouse).
2. Secondary prevention: early case finding and treatment (drug therapy, outpatient, short-term hospitalization).
3. Tertiary prevention: restore client to optimal functioning; facilitate return of client to home and community by use of social agencies.

NURSING PROCESS

A. Applies to all clients, not only to those with psychiatric diagnosis; incorporates holism.
B. Utilized in a unique manner for psychosocial assessment.
C. Sets goals (with client, whenever possible) that can be measured in behavioral terms (e.g., client will dress self and eat breakfast before 9 A.M.).
D. Uses principles of therapeutic communication for interventions.
E. Evaluates whether, how well goals were met.

Physical Assessment

A. Subjective reporting of health history
B. Objective data (general status and appearance)
1. Age: client's appearance in relation to chronologic age
2. Attire: appropriateness of clothing to age/situation
3. Hygiene: cleanliness and grooming, or lack thereof
4. Physical health: weight, physical distress
5. Psychomotor: posture, movement, activity level
6. Sleep and rest

C. Neurologic assessment/level of consciousness

Mental Status Assessment

Emotional Status Assessment

Observation of mood (prolonged emotion) and affect (physical manifestations of mood). That is, sad mood may be evidenced by crying or downcast appearance; joyful mood may be expressed by smiling or happy affect.

A. Appropriateness
B. Description: flat, sad, smiling, serious
C. Stability
D. Specific feelings and moods

Cognitive Assessment

Evaluation of thought, sensorium, intelligence

A. Intellectual performance
1. Orientation to person, place, and time
2. Attention and concentration
3. Knowledge/educational level
4. Memory: short and long term
5. Judgment
6. Insight into illness
7. Ability to use abstraction

B. Speech
1. Amount, volume, clarity
2. Characteristics: pressured, slow or fast, dull or lively
3. Specific aberrations, i.e., echolalia (imitating and repeating another's words or phrases) or neologisms (making up of own words that have special meaning to client).

C. Thoughts
1. Content and clarity
2. Characteristics: spontaneity, speed, loose associations, blocked, flight of ideas, repetitions

Social/Cultural Considerations

A. Age: assess for developmental tasks and developmental crises, age-related problems.
1. 0–18 months: development of trust and sense of self, dependency
2. 18 months–3 years: development of autonomy and beginning self-reliance, toilet training
3. 3–6 years: development of sexual identity, relationships with peers, adjustment to school
4. 6–12 years: mastery of skills, beginning self-esteem, identification with others outside family, social relationships
5. 12–18 years: sense of self solidifies, separation and individuation often follow some disorganization and rebellion, substance abuse
6. 18–25 years: identification with peer group, setting of personal and career goals to master future
7. 25–38 years: take place in adult world, commitments made relating to career, marriage, parenthood
8. 38–65 years: review of past accomplishments; may set new and reasonable goals; midlife crises when present achievements have not met goals set in earlier stages of development

9. 65/70 to death: loss of friends/spouse, retirement, loss of some social/physical functions

B. Family/community relationships
1. Role of client in family
2. Family harmony, family support for or dependency on client
3. Client's perception of family
4. Availability of community support groups to client (include government social agencies; religious, ethnic, and volunteer agencies)

C. Socioeconomic group/education
1. Factors that relate to how client is approached and how client perceives own present state
2. Determination of level of teaching and need for social services

D. Cultural/spiritual background
1. Assess behaviors in context of client's culture.
2. Avoid stereotyping persons as having attributes of their culture/subculture.
3. Note client's religious/philosophic beliefs.

ANALYSIS

Select nursing diagnoses based on collected data. Decide which is most important. Specific nursing diagnoses will be given when discussing particular disorders, but those nursing diagnoses generally appropriate to the client with psychiatric-mental health disorders include:

A. Anxiety
B. Chronic sorrow
C. Decisional conflict
D. Defensive coping
E. Deficient knowledge
F. Disturbed body image
G. Disturbed sleep pattern
H. Disturbed through processes
I. Dysfunctional family processes
J. Fatigue
K. Fear
L. Hopelessness
M. Impaired adjustment
N. Impaired social interaction
O. Impaired verbal communication
P. Ineffective coping
Q. Ineffective denial
R. Ineffective role performance
S. Ineffective therapeutic regimen management
T. Low self-esteem
U. Noncompliance
V. Powerlessness
W. Rape-trauma syndrome
X. Risk for injury
Y. Risk for violence
Z. Risk-prone health behavior
AA. Self-mutilation
BB. Social isolation
CC. Spiritual distress
DD. Stress overload

PLANNING AND IMPLEMENTATION

Goals

A. Client will:
1. Participate in treatment program.
2. Be oriented to time, place, and person and exhibit reality-based behavior.
3. Recognize reasons for behavior and develop alternative coping mechanisms.
4. Maintain or improve self-care activities.
5. Be protected from harmful behaviors.

B. There will be mutual agreement of nurse and client whenever possible.

C. Short-term goals are set for immediate problems; they should be feasible and within client's capabilities.

D. Long-term goals are related to discharge planning and prevention of recurrence or exacerbation of symptoms.

Interventions

The nurse will use therapeutic intervention and the nurse-client relationship to help the client achieve the goals of therapy. Interventions must be geared to the level of the client's capability and must relate to the specific problems identified for the individual client, family, or group.

Therapeutic Communication

A. Facilitative: use the following approaches to intervene therapeutically
1. Silence: client able to think about self/problems; does not feel pressure or obligation to speak.
2. Offering self: offer to provide comfort to client by presence (*Nurse:* "I'll sit with you." "I'll walk with you.").
3. Accepting: indicate nonjudgmental acceptance of client and his perceptions by nodding and following what client says.
4. Giving recognition: indicate to client your awareness of him and his behaviors (*Nurse:* "Good morning, John. You have combed your hair this morning.").
5. Making observations: verbalize what you perceive (*Nurse:* "I notice that you can't seem to sit still.").
6. Encouraging description: ask client to verbalize his perception (*Nurse:* "Tell me when you need to get up and walk around." "What is happening to you now?").
7. Using broad openings: encourage client to introduce topic of conversation (*Nurse:* "Where shall we begin today?" "What are you thinking about?").

8. Offering general leads: encourage client to continue discussing topic (*Nurse:* "And then?" "Tell me more about that.").
9. Reflecting: direct client's questions/statements back to encourage expression of ideas and feelings (*Client:* "Do you think I should call my father?" *Nurse:* "What do you want to do?").
10. Restating: repeat what client has said (*Client:* "I don't want to take the medicine." *Nurse:* "You don't want to take this medication?").
11. Focusing: encourage client to stay on topic/point (*Nurse:* "You were talking about . . .").
12. Exploring: encourage client to express feelings or ideas in more depth (*Nurse:* "Tell me more about . . ." "How did you respond to . . . ?").
13. Clarification: encourage client to make idea or feeling more explicit, understandable (*Nurse:* "I don't understand what you mean. Could you explain it to me?").
14. Presenting reality: report events/situations as they really are (*Client:* "I don't get to talk to my doctor." *Nurse:* "I saw your doctor talking to you this morning.").
15. Translating into feelings: encourage client to verbalize feelings expressed in another way (*Client:* "I will never get better." *Nurse:* "You sound rather hopeless and helpless.").
16. Suggesting collaboration: offer to work with client toward goal (*Client:* "I fail at everything I try." *Nurse:* "Maybe we can figure out something together so that you can accomplish something you want to do.").

B. Ineffective communication styles: the following nontherapeutic approaches tend to block therapeutic communication and are sometimes used by nurses to avoid becoming involved with client's emotional distress; often a protective action on part of nurse.
1. Reassuring: telling client there is no need to worry or be anxious (*Client:* "I'm nervous about this test." *Nurse:* "Everything will be all right.").
2. Advising: telling client what you believe should be done (*Client:* "I am going to . . ." *Nurse:* "Why don't you do . . . instead?" or "I think you should do . . .").
3. Requesting explanation: asking client to provide reasons for his feelings/behavior. The use of "why" questions should be avoided (*Nurse:* "Why do you feel, think, or act this way?").
4. Stereotypical response: replying to client with meaningless clichés (*Client:* "I hate being in the hospital." *Nurse:* "There's good and bad about everything.").
5. Belittling feelings: minimizing or making light of client's distress or discomfort (*Client:* "I'm so depressed about . . ." *Nurse:* "Everyone feels sad at times.").
6. Defending: protecting person or institutions (*Client:* "Ms. Jones is a rotten nurse." *Nurse:* "Ms. Jones is one of our best nurses.").
7. Approving: giving approval to client's behavior or opinion (*Client:* "I'm going to change my attitude." *Nurse:* "That's good.").
8. Disapproving: telling client certain behavior or opinions do not meet your approval (*Client:* "I am going to sign myself out of here." *Nurse:* "I'd rather you wouldn't do that.").
9. Agreeing: letting client know that you think and feel alike; nurse verbalizes agreement.
10. Disagreeing: letting client know that you do not agree; telling client that you do not believe he is right.
11. Probing: questioning client about a topic he has indicated he does not want to discuss.
12. Denial: refusing to recognize client's perception (*Client:* "I am a hopeless case." *Nurse:* "You are not hopeless. There is always hope.").
13. Changing topic: letting client know you do not want to discuss a problem by introducing a new topic (*Client:* "I am a hopeless case." *Nurse:* "It's time to fill out your menu.").

Therapeutic Groups

Table 7-1 lists types of therapeutic groups.

A. Groups of clients meet with one or more therapists. They work together to alleviate client problems in:
1. Interpersonal relations/communication
2. Coping with particular stressors (e.g., ostomy groups)
3. Self-understanding

B. Purposes
1. Increase self-awareness
2. Improve interpersonal relationships
3. Make changes in behavior
4. Deal with particular stressors
5. Enhance teaching/learning

Table 7-1 Types of Therapeutic Groups

Type	Goal(s)	Example
Task	Accomplish outcome	Select field trip
Teaching/ learning	Gain knowledge/ skills	Identify side effects of medications
Social/support	Give and receive support	Postmastectomy clients
Psychotherapy	Insight/behavioral change	Resolve loss
Activity	Increase social interaction/ self-esteem	Grooming, manicures

C. Structure of groups
  1. Leader(s) chosen
  2. Selection of members
  3. Size: 5 to 10 members
  4. Physical arrangements
  5. Time/place of meetings
  6. Open: accept members anytime
  7. Closed: do not add new members

D. Group dynamics
  1. System of interactions
  2. Collective activity
  3. Process: all activities/interactions
  4. Content: topics discussed

E. Stages of group development
  1. Beginning stage
    a. Anxiety in new situation
    b. Information given
    c. Group norms established
  2. Middle stage
    a. Group cohesiveness
    b. Members confronting each other
    c. Reliance on group member leading to self-reliance
    d. Sense of trust established
  3. Termination stage
    a. Individual member may leave abruptly
    b. Group decides work is done
    c. Ambivalence felt about termination
    d. Ideally, group members have met goals

F. Role of the nurse
  1. Explain purpose and rules of group
  2. Introduce group members
  3. Promote group cohesiveness
  4. Focus on problems of group and group process
  5. Encourage participation
  6. Role model
  7. Facilitate communication
  8. Set limits

Family Therapy

A. Client is whole family, although a family member may be "identified client."

B. Purposes
  1. Improve relationships among family members
  2. Promote family function
  3. Resolve family problem(s)

C. Process
  1. Problem(s) are identified by each family member.
  2. Members discuss their involvement in problem(s).
  3. Members discuss how problem(s) affect them.
  4. Members explore ways each of them can help resolve problem(s).

D. Role of the nurse
  1. Assess interactions among family members
  2. Make observations to family members
  3. Encourage expression of feelings by family members to one another
  4. Assist family in resolving problems

Milieu Therapy

A. Total environment (milieu) has an effect on individual's behavior, including:
  1. Physical environment (i.e., cleanliness, noise, colors, fresh air, light)
  2. Relationships of staff to staff, staff to clients, and client to clients
  3. Atmosphere of safety, caring, mutual respect (e.g., client-run community meeting, community-set standards for behaviors)

B. Purposes
  1. Improve client's behavior
  2. Involve client in decision making of unit
  3. Increase client's sense of autonomy
  4. Increase communication among clients and between clients and staff
  5. Set structure of unit and behavioral limits
  6. Form a sense of community

C. Role of the nurse
  1. Involve clients in decision making
  2. Promote involvement of all staff
  3. Promote development of social skills of individual clients (e.g., nurse serves as role model)
  4. Encourage sense of community in staff and clients

Crisis Intervention

A. Client cannot resolve problem with usual problem-solving skills. Problem is so serious that functioning (homeostasis) is threatened. Crisis can be developmental (e.g., birth of first child), a sudden death (e.g., car accident), a result of interpersonal violence (e.g., arson), terrorist attacks and war (e.g., September 11, 2001), or situational (e.g., home destroyed by fire). Adapting to and coping with the crisis can be considered within the normal range up to 1 year.

B. Purposes
  1. Support client during time of crisis
  2. Resolve crisis
  3. Restore client at least to precrisis level of functioning or assist client to integrate the crisis and reinvest in life
  4. Allow client to attain higher level of functioning through acquiring greater skill in problem solving

C. Process
  1. Crisis event occurs: client unable to solve problem.
  2. Increase in level of client's anxiety.
  3. Client may use trial and error approach.
  4. If problem unresolved, anxiety escalates and client seeks help.

D. Role of the nurse
  1. Assess client's perception of problem: realistic/distorted

2. Determine situational supports (e.g., family, neighbors, agencies)
3. Explore previous coping behaviors of client
4. Offer support and education in resolving crisis
5. Enlist help of situational supports
6. Help client develop new, more effective coping behaviors
7. Convey hope to client that crisis can be resolved
8. Work with client as he resolves crisis
9. Encourage the client to attend a debriefing session (if one is available and appropriate for the crisis)

Behavior Modification

A. Based on theory that all behavior is learned as a result of positive reinforcement. Behaviors can be changed by substituting new behaviors.
B. Purpose: change unacceptable or maladaptive behaviors
C. Process
1. Determine the unacceptable behavior.
2. Identify more adaptive behavior to replace the unacceptable behavior.
3. Apply learning principles.
   a. Respond to unacceptable behavior by negative reinforcement (punishment) or by withholding positive reinforcement (ignore behavior).
   b. Determine what client views as reward.
4. When desired behavior occurs, present positive reinforcement (reward).
5. Consistently reward desired behavior.
6. Consistently respond to unacceptable behavior with negative reinforcement/ignoring behavior.

D. Types
1. Counterconditioning: specific stimulus evokes a maladaptive response that is replaced with a more adaptive response.
2. Systematic desensitization
   a. Expose to small amount of stimulus while ensuring relaxation (client cannot be anxious and relaxed at same time).
   b. Continue relaxing client while increasing amount of stimulus.
   c. Fear response to stimulus is eventually extinguished.
3. Token economy: Tokens (rewards such as candy) are used to reinforce desired behaviors.

Psychotropic Medications

A variety of agents is used to control disordered thinking, anxiety, and mood disorders. Effects, side effects, and nursing implications are summarized with each disorder.

EVALUATION

A. How well have goals been met? If not met, why not?
1. Review prior steps of nursing process.
   a. Do you need more assessment data?
   b. Were nursing diagnoses prioritized?
   c. Were goals feasible and measurable?
   d. Were interventions appropriate?
2. Revise goals as necessary.

B. Client
1. Enrolled/participates in appropriate treatment program.
2. Expresses concerns/needs and develops a therapeutic relationship with nurse.
3. Identifies causes for behavior; learns and uses alternative coping mechanisms.
4. Demonstrates ability to care for self at optimum level and to identify areas where assistance is needed.
5. Does not engage in harmful behaviors; shows increased ability to control destructive impulses.

C. Client's behavior demonstrates optimal orientation to reality (e.g., can state name, place); interacts appropriately with others.

BEHAVIORS RELATED TO EMOTIONAL DISTRESS

Anxiety

A. General information
1. One of the most important concepts in psychiatric-mental health nursing.
2. Anxiety is present in almost every instance where clients are experiencing emotional distress/have a diagnosed psychiatric illness.
3. Experienced as a sense of emotional or physical distress as the individual responds to an unknown threat or thwarting of unmet needs.
4. The ego protects itself from the effects of anxiety by the use of defense mechanisms (see Table 7-2).
5. Physiologic responses are related to autonomic nervous system response and to level of anxiety.
   a. Subjective: client experiences feelings of tension, need to act, uneasiness, distress, and apprehension or fear.
   b. Objective: client exhibits restlessness, inability to concentrate, tension, dilated pupils, changes in vital signs (usually increased by sympathetic nervous system response, may be decreased by parasympathetic reactions).

Table 7-2 Defense Mechanisms

Type	Characteristics	Examples
Denial	Refusal to acknowledge a part of reality	A client on strict bed rest is walking down the hall; shows refusal to acknowledge need to stay in bed because of illness. A client states admission to the mental hospital is for reasons other than mental illness.
Repression	Threatening thoughts are pushed into the unconscious, anxiety and other symptoms are observed; client unable to have conscious awareness of conflicts or events that are source of anxiety	"I don't know why I have to wash my hands all the time, I just have to."
Suppression	Consciously putting a threatening/distressing thought out of one's awareness.	A nurse must study for the NCLEX, but she has had a heated argument with her boyfriend. She decides not to think about the problem until she finishes studying, then she will attempt to resolve it.
Rationalization	Developing an acceptable, justifiable (to self) reason for behavior	A friend tells you that he has been in an automobile accident because the car skidded on wet leaves in the road; you go to the scene of the accident, but there are no leaves; friend admits to you and to self that he was probably driving too fast.
Reaction-formation	Engaging in behavior that is opposite of true desires	A man has an unconscious desire to view pornographic films; he circulates a petition to close the theater where such films are shown.
Sublimation	Anxiety channeled into socially acceptable behavior	A student is upset because she received a failing grade on a test; she knows that she will feel better if she goes jogging and runs a few miles.
Compensation	Making up for a deficit by success in another area	A young man who cannot make any varsity teams becomes the chess champion in his school.
Projection	Placing own undesirable trait onto another; blaming others for own difficulty	A student who would like to cheat on an exam states that other students are trying to cheat; a paranoid client claims that the FBI had him committed to the mental hospital.
Displacement	Directing feelings about one object/person toward a less-threatening object/person	The head nurse reprimands you; you do not argue even though you do not agree with her reprimand; when you return home that evening you are hostile toward your roommate.
Identification	Taking onto oneself the traits of others that one admires	You greatly admire the clinical specialist in your hospital; unconsciously you begin to use the approaches she uses with clients.
Introjection	Symbolic incorporation of another into one's own personality	John becomes depressed when his father dies; John's feelings are directed to the mental image he has of his father.
Conversion	Anxiety converted into a physical symptom that is motor or sensory in nature	A young woman unconsciously desires to strike her mother; she develops sudden paralysis of her arms.
Symbolization	Representing an idea or object by a substitute object or sign	A man who was spurned by a librarian develops a dislike of books and reading.
Dissociation	Separation or splitting off of one aspect of mental process from conscious awareness	A student who prides herself on being prompt does not recall the times that she arrived late for class.

(continues)

Table 7-2 Defense Mechanisms *(continued)*

Type	Characteristics	Examples
Undoing	Behavior that is opposite of earlier unacceptable behavior or thought	Joan tells an ethnic joke to a coworker, Sally; Sally, a member of that ethnic group, is offended; the following week Joan offers to work the weekend for Sally.
Regression	Behavior that reflects an earlier level of development; adults hospitalized with serious illnesses sometimes will engage in regressive behaviors	When a new baby is brought home, 5-year-old Billy begins to wet his pants although he had not done this for the past 2½ years.
Isolation	Separating emotional aspects of content from cognitive aspects of thought	A client discusses his terminal diagnosis in clinical terms. He does not express any emotion.
Splitting	Viewing self, others, or situations as all good or all bad	A client tells you that you are the best nurse. Later tells you that you are incompetent and she will report you.

6. Anxiety can be viewed positively (motivates us to change and grow) or negatively (interferes with problem-solving ability and affects functioning).
   a. Trait anxiety: individual's normal level of anxiety. Some people are usually rather intense while others are more relaxed; may be related to genetic predisposition/early experiences (repressed conflicts).
   b. State anxiety: change in person's anxiety level in response to stressors (environmental or any internal threat to the ego).
7. Levels of anxiety
   a. Mild: increased awareness; ability to solve problems, learn; increase in perceptual field; minimal muscle tension
   b. Moderate: optimal level for learning, perceptual field narrows to pay attention to particular details, increased tension to solve problems or meet challenges
   c. Severe: sympathetic nervous system (flight/fight response); increase in blood pressure, pulse, and respirations; narrowed perceptual field, fixed vision, dilated pupils, can perceive scattered details or only one detail; difficulty in problem solving
   d. Panic: decrease in vital signs (release of sympathetic response), distorted perceptual field, inability to solve problems, disorganized behavior, feelings of helplessness/terror

B. Nursing interventions
1. Determine the level of client's anxiety by assessing verbal and nonverbal behaviors and physiologic symptoms.
2. Determine cause(s) of anxiety with client, if possible.
3. Encourage client to move from affective (feeling) mode to cognitive (thinking) behavior (e.g., ask client, "What are you thinking?"). Stay with client. Reduce anxiety by remaining calm yourself; use silence, or speak slowly and softly.
4. Help client recognize own anxious behavior.
5. Provide outlets (e.g., talking, psychomotor activity, crying, tasks).
6. Provide support and encourage client to find ways to cope with anxiety.
7. In panic state nurse must make decisions.
   a. Do not leave client alone.
   b. Encourage ventilation of thoughts and feelings.
   c. Use firm voice and give short, explicit directions (e.g., "Sit in this chair. I will sit here next to you.").
   d. Engage client in motor activity to reduce tension (e.g., "We can take a brisk walk around the day room. Let's go.").

Defense Mechanisms

Usually unconscious processes used by ego to defend itself from anxiety and threats (see Table 7-2).

Disorders of Perception

Occur with increased anxiety, disordered thinking/impaired reality testing

A. Illusions
1. General information: stimulus in the environment is misperceived (e.g., car backfiring is perceived as a gunshot; a bathrobe in an open closet is perceived as a person in the closet); may be visual, auditory, tactile, gustatory, olfactory.

2. Nursing intervention: show/explain stimulus to client to promote reality testing.

B. Delusions
1. General information: fixed, false set of beliefs that are real to client.
   a. Grandiose: false belief that client has power, wealth, or status or is famous person
   b. Persecutory: false belief that client is the object of another's harassment or harmful intent
   c. Somatic: false belief that client has some physical/physiologic defect
2. Nursing interventions
   a. Avoid arguing: client cannot be convinced, even with evidence, that the belief is false.
   b. Determine client's need (grandiose delusion may indicate low self-esteem; provide opportunities to succeed at task that will enhance self-concept).
   c. Reduce anxiety to encourage decreased need to use delusions.
   d. Accept client's need for delusion, present (but do not insist that client accept) reality.
   e. After therapeutic relationship has been established, you can express doubt about delusions to client.
   f. Direct client's attention to nondelusional, nonthreatening topics (e.g., current events, client's hobbies or interests).

C. Ideas of reference
1. General information: belief that events or behaviors of others relate to self (e.g., telephone rings in nurse's station, client believes "they" are calling for him; two nurses are talking and laughing, client believes nurses are talking/laughing at him).
2. Nursing interventions are the same as for Delusions.

D. Hallucinations
1. General information: sensory perceptions that have no stimulus in environment; most common hallucinations are auditory and visual (e.g., hearing voices; seeing persons, animals, objects).
2. Nursing interventions
   a. Encourage client to describe hallucination.
   b. Accept that this is a real experience for client.
   c. Present reality.
   d. Example: nurse sees client in listening attitude or responding to auditory hallucinations. *Nurse:* "You seem to be listening/talking." *Client:* "The voices are telling me to hurt myself." *Nurse:* "I don't hear the voices. Tell me what the voices are saying to you."

Withdrawal

A. General information: withdrawal from social interaction by not talking, walking away, turning away, sleeping, or feigning sleep

B. Nursing interventions
1. Use silence.
2. Offer self.
3. Discuss nonthreatening topics that will not provoke increased anxiety.
4. Be consistent; keep promises, promote trust.

Hostility and Aggression

A. General information
1. Hostile behavior: responding to nurse with anger, insults, threats.
2. Assaultive behavior: attempting to physically harm others.
3. Usually nurse is not real object of client's anger, but is convenient target for angry feelings/verbalizations.

B. Nursing interventions
1. Hostility
   a. Recognize own response of anger or defensiveness.
   b. Determine source of client's anger (e.g., intoxicated, psychotic, recent argument with parent).
   c. Accept angry feelings.
   d. Attempt to have client verbalize feelings and channel into acceptable behaviors.
   e. Assess the need for prn medications based on the possible source of the hostility.
2. Physical aggression/assaultive behaviors (client may act on increased anxiety by throwing objects or attempt to physically harm others)
   a. Assess for increased anxiety.
   b. Maintain distance, at least arm's length.
   c. Attempt to have client verbalize feelings.
   d. Talk client down.
   e. Obtain help if client becomes assaultive.

Self-Mutilation

A. General information: behaviors cause physical injury but are not motivated by the desire to die.

B. Nursing interventions
1. Assess for suicide risk.
2. Offer support.
3. Protect client from carrying out self-mutilation actions.
4. Remove objects that can be used for self-harm.
5. Observe for changes in behaviors and attitudes.

Suicide

A. General information
- **1.** Ideation: verbalization of wish to die (overt or disguised)
- **2.** Gestures: engaging in nonlethal behaviors (e.g., superficial scratches, ingestion of medication in amounts that are not likely to cause serious injury/death)
- **3.** Actions: engaging in behaviors or planning to engage in behaviors that have potential to cause death
- **4.** May or may not be associated with a psychiatric disorder
- **5.** Groups at risk (see Table 7-3)

B. Assessment findings
- **1.** Verbal cues
  - **a.** Overt: "I'm going to kill myself."
  - **b.** Disguised: "I have the answer to my problems."
- **2.** Behavioral cues
  - **a.** Giving away prized possessions
  - **b.** Getting financial affairs in order, making a will
  - **c.** Suicidal ideation/gestures
  - **d.** Indications of hopelessness, depression
  - **e.** Behavioral and attitudinal changes (e.g., neat person becomes sloppy, depressed person suddenly becomes alert/positive, increased use of drugs and/or alcohol, alcohol withdrawal).
- **3.** For lethality assessment, see Table 7-4.

C. Nursing interventions
- **1.** Contract with client to report suicide ideation with intent and/or suicide attempt.
- **2.** Assess suicide risk.
  - **a.** Ask client if he thinks about, intends to harm himself.
  - **b.** Ask client if he has formulation of plan; if details are worked out, when? where? how?
  - **c.** Check availability of method (e.g., gun, pills).
- **3.** Keep client under constant observation.
- **4.** Remove any objects that can be used in suicide attempt (e.g., shoe laces, sharp objects).
- **5.** Therapeutic intervention
  - **a.** Support aspects of wish to live; clients often ambivalent: wish to live and wish to die.
  - **b.** Use one-to-one nurse/client relationship (let client know you care for him).
  - **c.** Allow client to express feelings of hopelessness, helplessness, worthlessness.
  - **d.** Provide hope.
  - **e.** Provide diversionary activities.
  - **f.** Utilize support groups (e.g., family, clergy).
  - **g.** Notify psychiatrist or responsible practitioner for the medical management of the client to evaluate medications and precaution level.
- **6.** Following a suicide
  - **a.** Encourage survivors to discuss client's death, their feelings and fears.
  - **b.** Provide anticipatory guidance to family who may experience problems at holidays, anniversaries.
  - **c.** Hold staff meetings to ventilate feelings and provide a debriefing to process the event.

Table 7-3 Groups at Increased Risk for Suicide

- Adolescents/young adults (ages 15–24)
- Elderly
- Terminally ill
- Persons who have experienced loss/stress
- Survivors of persons who have committed suicide
- Individuals with bipolar disorders
- Depressed persons (when depression begins to lift)
- Substance abusers
- Persons who have attempted suicide previously
- Schizophrenics
- More women attempt suicide; more men complete suicide

Table 7-4 Lethality Assessment

- Plans for suicide: when? where? how?
- Means available: what will be used? Is it available to client?
- Lethality of means (e.g., tranquilizers are less lethal when used alone than when combined with alcohol; guns are more lethal than plan to cut wrists)
  - Most lethal: gunshot, hanging, jumping from high places, carbon monoxide, potent poisons (e.g., cyanide)
  - Less lethal: nonprescription drugs, wrist cutting, tranquilizers without CNS depressants
  - Males tend to use more lethal means
- Possibility of "rescue"
- Support systems available or sense of isolation
- Availability of alcohol or drugs
- Severe/panic level of anxiety
- Hostility
- Disorganized thinking
- Preoccupation with thought of suicide plan
- Prior suicide attempts

Sample Questions

1. The nurse is talking with a mother to assess her child. A positive response to which question would indicate the child is in the anal stage of psychosexual development as described by Freud?
   1. "Does he put everything in his mouth?"
   2. "Does he say 'No!' to everything you say?"
   3. "Does he like to dress up and pretend to be his father?"
   4. "Does he seem jealous when you show affection to his father?"

2. The nurse is assessing a 70-year-old woman. Which statement by the client indicates that she has achieved integrity according to Erickson's stages of personality development?
   1. "My life has been wasted."
   2. "My children no longer visit me. I am just waiting to die."
   3. "I was a good nurse when I was younger, but now I am nothing."
   4. "I have a good life and I still enjoy it, but I feel ready to go when it is time."

3. Which cognitive skill would the nurse expect a 6-year-old child to be in the process of developing?
   1. Understanding of basic rules.
   2. Ability to understand abstract concepts.
   3. Recognition of object permanence.
   4. Imitation of others' actions.

4. The nurse is meeting a new client on the unit. Which action, by the nurse, is most effective in initiating the nurse-client relationship?
   1. Introduce self and explain the purpose and the plan for the relationship.
   2. Describe the nurse's family and ask the client to describe his family.
   3. Wait until the client indicates a readiness to establish a relationship.
   4. Ask the client why he was brought to the hospital.

5. An adult has just been brought to the psychiatric unit and is pacing up and down the hall. The nurse is to admit him to the hospital. To establish a nurse-client relationship, which approach should the nurse try first?
   1. Assign someone to watch him until he is calmer.
   2. Ask him to sit down and orient him to the nurse's name and the need for information.
   3. Check his vital signs, ask him about allergies, and call the physician for sedation.
   4. Explain the importance of accurate assessment data to him.

6. A woman has been referred for help in managing her children. The woman arrives late for appointments and focuses on her busy schedule, the difficulty in parking, and other reasons for being late. How would the nurse best interpret this behavior?
   1. Transference.
   2. Counter-transference.
   3. Identification.
   4. Rationalization.

7. A woman has remained at the side of the nurse all day. When the nurse talked with other clients during dinner, the client tried to regain the nurse's attention and then began to shout, "You're just like my mother! You pay attention to everyone but me!" What is the best interpretation of this behavior?
   1. She is exhibiting sublimation.
   2. She has been spoiled by her family.
   3. The nurse has failed to meet her needs.
   4. She is demonstrating transference.

8. A nurse is part of a community task force on teenage suicide. The task force is considering all of the following steps in an effort to reduce teen suicide. Which action represents primary prevention?
   1. Encourage emergency room staff to request psychiatric consultation for adolescents who overdose.
   2. Educate teachers, counselors, and school nurses in recognition and early intervention with suicidal teens.
   3. Provide community programs, such as Scouts, which increase self-esteem for children and adolescents.
   4. Increase the number of inpatient adolescent psychiatric beds available in the community.

9. Two nurses are discussing plans for their client group. What should be in the plan to promote group cohesiveness?
   1. Let the group know which clients are behaving in ways approved by the nurses.
   2. Help the group identify group goals that are consistent with the individual members' goals.

3. Make most decisions about the group in advance and make each group member aware of the nurses' decisions.
4. Seat the most talkative members nearest the nurses where they can be more clearly heard by the group.

10. The nurse is the leader of a client group. The members of the group test each other and the group's rules, as well as compete for the nurse's attention. This behavior is typical of which phase of the nurse-client relationship?
1. Orientation.
2. Working.
3. Feedback.
4. Termination.

11. A family was referred to family therapy after their teenage son experienced behavioral problems in school. Which statement by the father indicates that he understands the purpose of family therapy?
1. "Our son will realize the consequences of his actions and try harder to behave."
2. "It will help us learn to communicate and problem solve better as a group."
3. "I expect the therapist to tell my wife how to discipline our son."
4. "The therapist will tell us how to make our son behave better in school."

12. A client walks in to the mental health outpatient center and states, "I've had it. I can't go on any longer. You've got to help me." The nurse asks the client to be seated in a private interview room. Which action should the nurse take next?
1. Reassure the client that someone will help him soon.
2. Assess the client's insurance coverage.
3. Find out more about what is happening to the client.
4. Call the client's family to come and provide support.

13. The nurse is caring for a client with anorexia nervosa who is to be placed on behavior modification. Which is appropriate to include in the nursing care plan?
1. Remind the client frequently to eat all the food served on the tray.
2. Increase phone calls allowed the client by one per day for each pound gained.
3. Include the family with the client in therapy sessions 2 times per week.
4. Reduce the client's TV time for any weight loss.

14. An adult is pacing about the unit and wringing his hands. He is breathing rapidly and complains of palpitations and nausea and he has difficulty focusing on what the nurse is saying. He says he is having a heart attack but refuses to rest. How would the nurse interpret his level of anxiety?
1. Mild.
2. Moderate.
3. Severe.
4. Panic.

15. Each time a client is scheduled for a therapy session she develops a headache and nausea. How would the nurse interpret this behavior?
1. Conversion.
2. Reaction formation.
3. Projection.
4. Suppression.

16. A man is admitted to the intensive care unit with chest pain, an abnormal ECG, and elevated enzymes. When the significance of this is explained to him, he says, "I can't be having a heart attack. No way. You must be mistaken." The nurse suspects the client is using which defense mechanism?
1. Sublimation.
2. Regression.
3. Dissociation.
4. Denial.

17. An adult is admitted for panic attacks. He frequently experiences shortness of breath, palpitations, nausea, diaphoresis, and terror. What should the nurse include in the care plan when he is having a panic attack?
1. Calm reassurance, deep breathing, and medication as ordered.
2. Teach him problem solving in relation to his anxiety.
3. Explain the physiologic responses of anxiety.
4. Explore alternate methods for dealing with the cause of his anxiety.

18. A client on an inpatient psychiatric unit refuses to eat and states that the staff is poisoning her food. Which action should the nurse include in the client's care plan?
1. Explain to the client that the staff can be trusted.
2. Show the client that others eat the food without harm.
3. Offer the client factory-sealed foods and beverages.
4. Institute behavior modification with privileges dependent on intake.

19. A woman is being treated on the inpatient unit for depression. She tells the nurse, "I don't see how I can go on. I've been thinking of ways to kill myself. I can see several ways to do it." What is the best initial action for the nurse to perform?
    1. Notify her family about her statements.
    2. Explain to the client the consequences of suicide on her family.
    3. See that someone is with the client at all times.
    4. Help the client identify alternate means of coping.

20. An adult has been admitted to the inpatient unit with a diagnosis of depression. He states that he continues to think of suicide. Which is most essential for the nurse to include in his nursing care plan?
    1. Encourage the client to participate in all unit activities.
    2. Ask the client if he has a knife.
    3. Allow the client time alone to relax and think.
    4. Have someone stay with the client 24 hours a day.

Answers and Rationales

1. **2.** Negativism is common to the toddler in the anal stage of development (age 1 to 3) who is learning to assert his independence and mastery.

2. **4.** Integrity includes acceptance of changes; a sense of continuity of past, present, and future; and acceptance of death.

3. **1.** Preoperational-preconceptual children (5 to 7 years old) are learning to integrate concepts based on relationships and can comprehend the basic rules.

4. **1.** The client needs orientation to the nurse and the situation. An open, honest approach in sharing these initial data will set the tone for the relationship.

5. **2.** Many clients are anxious at the time of admission and are often reassured by a calm, competent professional approach, which should always be tried first. If the client is unable to respond to this, then other measures, such as medication, may be necessary.

6. **4.** Rationalization is characterized by providing the client acceptable reasons (to her) why she is having some difficulty.

7. **4.** Transference is the unconscious transfer of qualities originally associated with another relationship to the nurse. These are often qualities associated with a parent or sibling and may provoke responses from the client that are not appropriate to the situation.

8. **3.** Primary prevention involves making changes in the community that promote health and prevent disease.

9. **2.** Goals that are best met by a group and that are consistent with the goals of the individual members foster cohesive groups.

10. **1.** During the orientation phase, group members demonstrate these behaviors as they try to identify and develop trust with the group.

11. **2.** Family therapy is aimed at improving communication and problem solving within the family group. The focus is on the family as a group, not on correcting the behavior of any one.

12. **3.** The nurse must assess the client and his situation before the appropriate action can be determined.

13. **2.** In behavior modification, rewards are tied to specific goals.

14. **4.** Terror, physiologic changes, and inability to focus on the real world are characteristic of the most extreme form of anxiety, panic.

15. **1.** Conversion changes anxious feelings into somatic symptoms.

16. **4.** Denial helps the person escape unpleasant or intolerable reality by refusing to perceive the facts. It can serve as a normal protection in the early stages of crisis, but if the denial persists it will prevent the client from coping.

17. **1.** Before any other interventions can be used, the client in panic must reduce his anxiety to a manageable level. The other interventions might be used when the client is less anxious.

18. **3.** The client may be able to eat food if she knows the staff has not handled it.

19. **3.** Maintaining client safety is the first priority. When a client is actively suicidal, one to one observation is necessary.

20. **4.** The client who is actively suicidal needs constant observation to prevent him from carrying out his plan. Any objects that could be used in a suicide attempt would be automatically removed at admission.

Psychiatric Disorders (DSM-IV-TR)

DISORDERS OF INFANCY, CHILDHOOD, AND ADOLESCENCE

Overview

A. A specific group of disorders beginning in infancy, childhood, or adolescence.
B. Clients in these age groups may also evidence other disorders such as depression or schizophrenia.
C. Intellectual, behavioral, and/or emotional dysfunction of the young client also has an effect on the family, which may require nursing intervention.

Assessment

Newborn/Infants

A. Maturation
B. Developmental level
C. Sensorimotor capabilities
D. Bonding
E. Response to cuddling

Children/Adolescents

A. Motor skills
B. Communication abilities
C. Vocational/academic skills
D. Social and behavioral problems
E. Behavioral changes
F. Growth and development: physical/emotional
G. Self-concept
H. Knowledge of disorder

Parent/Family

A. Response to infant/child/adolescent with disorder
B. Guilt, sense of loss
C. Sibling jealousy/resentment
D. Knowledge of disorder
E. Expectations
F. Plans for future (home care/institutionalization)

Analysis

Nursing diagnoses for a child/family with a psychiatric-mental health disorder may include:

A. Client
  1. Anxiety
  2. Deficient knowledge
  3. Deficient self-care
  4. Disturbed sensory-perceptual
  5. Fear
  6. Ineffective coping
  7. Low self-esteem
  8. Risk for injury
  9. Risk for violence
  10. Sexual dysfunction
  11. Total incontinence
B. Parents/family
  1. Anticipatory grieving
  2. Anxiety
  3. Deficient knowledge
  4. Disabled family coping
  5. Dysfunctional family process
  6. Impaired parenting
  7. Interrupted family processes
  8. Parental role conflict
  9. Risk for care-giver role strain

Planning and Implementation

Goals

A. Client will:
  1. Communicate thoughts and feelings about self-concept.
  2. Perform tasks at optimal level of capability.
  3. Develop trusting relationship with caregivers.
B. Parents/family will:
  1. Communicate feelings and responses to child and to disorder.
  2. Demonstrate knowledge of disorder.
  3. Formulate plans for child's care.

Interventions

A. Client
  1. Establish a therapeutic relationship by accepting client and client's limitations.
  2. Promote communication by use of therapeutic techniques, play therapy.
  3. Encourage independence in task performance with guidance and support.
B. Parents/family
  1. Promote communication by accepting family responses.
  2. Provide information about disorder.
  3. Contact appropriate person/agency for consultation with family about care and assistance with the child.

Evaluation

A. Client
  1. Demonstrates trust in caregivers.

2. Relates feelings about self verbally or symbolically.
3. Performs activities of daily living (ADLs) and tasks at optimal level.

B. Parents/Family
1. Relate positive/negative responses to child.
2. Demonstrate understanding of disorder and child's potential.
3. With consultant, formulate a plan for child's care.

Specific Disorders

Mental Retardation

Note: This is coded on Axis II.

A. General information
1. Significant subaverage intelligence (IQ of 70 or below) resulting in maladaptive behaviors with onset before age of 18 years
2. Etiology
   a. Heredity 5%
   b. Early alterations in embryonic development 30%
   c. Perinatal problems 10%
   d. Acquired in infancy/early childhood 5%
   e. Environmental/other mental disorders 15–20%
   f. Unknown etiology 30–40%
3. Degrees of retardation
   a. Mild mental retardation (IQ 50–70)
      1) 85% of cases
      2) Educable to 6th grade level
      3) Able to become self-supporting
   b. Moderate mental retardation (IQ 35–49)
      1) 10% of cases
      2) Educable to 2nd grade level
      3) Able to perform skills but will need supervision at work
   c. Severe mental retardation (IQ 20–34)
      1) 3–4% of cases
      2) May learn to talk/communicate
      3) Able to perform simple tasks and elementary hygiene
   d. Profound mental retardation (IQ below 20)
      1) 1–2% of cases
      2) Some speech/communication possible

B. Assessment findings
1. Intellectual impairment (determine degree)
2. Sensorimotor impairment
3. Communication, social, behavioral impairment
4. Lack of self-esteem and poor self-image
5. Sense of loss, guilt, nonacceptance or unrealistic expectations on part of parents/family

C. Nursing interventions
1. Promote optimal functioning in ADL and feelings of accomplishment, self-worth.
2. Provide opportunities for client/family to communicate thoughts, feelings.
3. Provide positive reinforcement for every success.
4. Accept client's limitations and set goals accordingly.
5. Provide support and information about disorder to family.
6. Accept family's response to client.

Other Disorders of Childhood/Adolescence

A. General information
1. Separation anxiety: excessive anxiety and worry about being separated from person(s)/places to which child has become attached (e.g., refusal to leave mother/home to attend school)
2. Reactive/attachment disorder: reluctance to enter social relationships with others, creating an interference with social growth
3. Overanxious disorders: pervasive, unrealistic worry or concern about competency; somatic complaints without physical basis

B. Assessment findings: excessive anxiety related to separation, social interaction, and achievements

C. Nursing intervention: provide information regarding available mental health services for child and family.

Disorders with Physical Manifestations

A. General information
1. Important to rule out any physiologic cause
2. Often related to stress or conflict in the family
3. May affect child's family/social interactions and development

B. Assessment findings
1. Enuresis: urinary incontinence (bedwetting) after age 5 not caused by physical disorder
2. Encopresis: fecal incontinence after age 4 not caused by physical disorder
3. Tics: involuntary, repetitive movements
4. Stuttering: repetition of sounds, words or frequent hesitations in speaking

C. Nursing interventions
1. Provide information about the disorders and emphasize that they are treatable.
2. Determine whether family therapy may be indicated, as well as individual therapy for child.
3. Offer support and help child/family overcome feelings of shame or guilt.
4. For enuresis and encopresis, utilize toilet training techniques.
5. Encourage discussion of client/family response to symptoms.

PERVASIVE DEVELOPMENTAL DISORDERS

Autistic Disorder

A. General information
1. Usually develops prior to 3 years of age
2. Categorized with a group of disorders known as autism spectrum disorders (ASD)
3. 1 in 150 individuals is diagnosed with disorder; more common than pediatric cancer, diabetes, and AIDS combined
4. Occurs in all racial, ethnic, and social groups; affects males to females 4:1
5. Symptoms range from very mild to quite severe
6. Fastest-growing serious developmental disability in the United States
7. No known medical detection or cure
8. Special education is necessary.

B. Assessment findings
1. Infant not responsive to cuddling; may even show an aversion to being touched
2. No eye contact or facial responsiveness
3. Impaired or no verbal communication
4. Echolalia (repetition of words/phrases spoken by others)
5. Inability to tolerate change
6. Ritualistic or repetive behavior
7. Fascination with movement, spinning objects
8. Labile moods
9. Unresponsive or overresponsive to stimuli
10. Symptoms may appear from 6 months to 2 years of age
11. High risk for developing seizure disorders
12. Medications that have been used to assist in treatment of behavior are haloperidol, clomipramine, and SSRIs.

C. Nursing interventions
1. Provide parents/family with support and information about the disorder, opportunities for therapy and education for the child.
2. Assist child with ADLs.
3. Promote reality testing.
4. Encourage child to develop a relationship with another person.
5. Maintain regular schedule for activities.
6. Provide constant routine for child (place for eating, sitting, sleeping).
7. Controversial issues: Maintain a gluten-free or casein-free diet; multiple vaccines given at 18 months.
8. Protect child from self-injury.
9. Provide safe environment.
10. Institute seizure precautions if necessary.
11. Refer parents to support groups and websites.

Eating Disorders

A. General information
1. Gross disturbances in eating behaviors
2. Pica: persistent eating of nonfood substances such as, paint, sand, ice, paper
3. Bulimia nervosa: binge eating; the ingestion of large amounts of food in short time, often followed by self-induced vomiting. May be accompanied by affective disorders and fear of being unable to stop this behavior. Manifested by fluctuations in weight caused by binges of eating and fasting. Antidepressant medications can be used in the treatment of bulimia.
4. Anorexia nervosa: refusal to eat or aberration in eating patterns, resulting in severe emaciation that can be life threatening. Characterized by a fear of becoming fat, and a body-image disturbance in which clients claim to feel fat even when extremely thin. This disorder is most common (95%) in adolescent and young adult females. There is a mortality rate of 7–18%. Antidepressant medications can be used in the treatment of anorexia.

B. Assessment findings (anorexia nervosa)
1. Weight loss of 15% or more of normal body weight for age and height
2. Electrolyte imbalance
3. Depression
4. Preoccupation with being thin; inability to recognize degree of own emaciation (distorted body image)
5. Social withdrawal and poor family and individual coping skills
6. History of high activity and achievement in academics, athletics
7. Amenorrhea

C. Nursing interventions
1. Monitor vital signs.
2. Measure I&O.
3. Weigh client 3 times per week at the same time (check to be sure client has not hidden heavy objects or water loaded before being weighed, weigh in hospital gown).
4. Do not comment on weight loss or gain.
5. Set limits on time allotted for eating.
6. Record amount eaten.
7. Stay with client during meals, focusing on client, not on food.
8. Accompany client to bathroom for at least ½ hour after eating to prevent self-induced vomiting.
9. Individual/family therapy may be necessary.
10. Encourage client to express feelings.
11. Help client to set realistic goal for self and to reduce need for being perfect.
12. Encourage client to discuss own body image; present reality; do not argue with client.
13. Teach relaxation techniques.
14. Help client identify interests and positive aspects of self.

DELIRIUM, DEMENTIA, AND OTHER COGNITIVE DISORDERS

Overview

A. A group of disorders with a known or presumed etiology.
B. Frequently manifest as dementia or delirium.
C. May be substance induced (drugs or alcohol) or caused by a disease process; etiology may be unknown.
D. It is important for the nurse to assess behaviors rather than focus on medical diagnoses.
E. Behaviors related to impaired brain functioning may be temporary or permanent, with increasing degeneration and eventual loss of brain function.
F. Not exclusive to old age, may complicate illnesses in any age group.

Types

A. Delirium/rapid development
  1. Manifested by reduced awareness of environment, disorders of perception, thought, speech, and attention deficits.
  2. Usually of brief duration.
  3. May occur postoperatively or following head injury, intoxication from drugs/alcohol, acute disease, or injury.
B. Dementia/gradual development
  1. Loss of intellectual abilities resulting in impaired social and occupational functioning.
  2. May be temporary, or progressive loss may occur.
  3. Found predominantly in elderly.
  4. Personality changes are usually an exaggeration of former character traits (e.g., suspicious, nontrusting person becomes paranoid); but alteration can also occur (e.g., formerly neat and orderly person pays no attention to hygiene, becomes sloppy and dirty).
  5. Memory impairment; short-term memory loss may be most obvious.
  6. Organic etiology may be known; conditions include intoxication, infections, tumors, circulatory disorders (cerebral atherosclerosis), trauma, Huntington's chorea, Korsakoff's syndrome, Creutzfeld-Jakob disease, neurosyphilis.
  7. Specific etiology may not be known (e.g., Alzheimer's disease, Pick's disease).
  8. Frequently these clients cannot perform basic ADLs.

Assessment

A. Mental status assessment, especially orientation to time and place, memory, and judgment
B. Nutritional status
C. Ability to perform ADLs, self-care
D. Presence of confabulation (making up information to fill in memory gaps)
E. Behavioral/social changes
F. Disorders of perception
G. Impaired motor skills, coordination
H. Change in sleep patterns
I. Elimination: constipation/incontinence
J. Family response to client's condition

Analysis

Nursing diagnoses for clients with these disorders may include:
A. Anxiety
B. Impaired verbal communication
C. Ineffective individual/family coping
D. Altered family processes
E. Risk for fluid volume deficit
F. Risk for injury
G. Imbalanced nutrition: less than body requirements
H. Self-care deficits
I. Low self-esteem
J. Disturbed sleep pattern
K. Disturbed thought processes
L. Risk for violence

Planning/Implementation

Goals

A. Client will:
  1. Be protected from injury.
  2. Retain optimal cognitive function and self-care abilities.
  3. Have fear/anxiety minimized.
  4. Maintain adequate nutrition/hydration.
B. Family will communicate feelings about client.

Interventions

A. Institute safety measures: side rails, appropriate lighting in room, bed should be at lowest setting, frequent checks. Restraints should only be used as a last resort and for protection of client as ordered by physician and based on state and federal regulations.
B. Maintain reality orientation
  1. Client may not be capable of reality testing.
  2. Continue to address client by name.
  3. Maintain awareness of client's limitations in this area.
  4. Do not tell client to "remember"; severe memory loss may make client incapable of memory.
C. Assist/support with self-care needs; arrange for necessary assistive devices, help with feeding; encourage fluids.

D. Avoid "insight" therapy and discussion of impaired mental functioning as this may increase anxiety.
E. Provide spouse/family with information about client's capabilities.
F. Provide support for spouse/family; encourage continued interaction with client.
G. Administer ordered medications (based on etiology), assess response, and provide education to the client and family. Medications might include short-acting benzodiazepines, antidepressants, cholinesterase inhibitors, or low-dose antipsychotics.
H. Provide information on support organizations or groups.

Evaluation

A. Client
  1. Remains free from injuries.
  2. Retains cognitive functions and self-care ability as far as possible; interacts with others appropriately.
  3. Maintains appropriate weight.
B. Family
  1. Expresses sense of loss or frustration related to client's condition.
  2. Continues contact with client.
  3. Participates in support or group organizations.

SUBSTANCE USE DISORDERS

Overview

A. The use of chemical agents (alcohol and drugs) to change behavior and mood
B. Abuse: continued use despite problems (social, occupational, psychologic) that are caused by substance or continued use in hazardous situations (e.g., operating machinery, driving)
C. Dependence
  1. Need for larger amounts (tolerance)
  2. Unsuccessful attempts to decrease/ discontinue use
  3. Inability to function as usual in work, social activities
  4. Withdrawal symptoms (psychologic/physical distress when substance is reduced/ discontinued)
D. Addiction: compulsive use of a substance; physiologic and psychologic dependence

PSYCHOACTIVE SUBSTANCE–INDUCED ORGANIC MENTAL DISORDERS

The use of substances that result in intoxication or withdrawal syndromes, delirium, hallucinations, delusions, mood disorders.

Assessment

A. Determine substances used, amount and last time taken, and if combined with other drugs
B. Pupillary changes, changes in vital signs or level of consciousness
C. Presence of dehydration
D. Presence of nutritional and vitamin deficiencies
E. Suicide potential: ideation, gestures
F. Level of anxiety
G. Use of denial/projection
H. Symptoms of overdose (will be drug-specific; see Table 7-5)
I. Drug-use patterns: what, when, why substances are used

Analysis

Nursing diagnoses for clients with a psychoactive substance abuse disorder may include:
A. Anxiety
B. Ineffective coping
C. Fear
D. Risk for fluid volume deficit
E. Risk for injury
F. Imbalanced nutrition: less than body requirements
G. Self-care deficit
H. Low self-esteem
I. Disturbed sensory-perceptual
J. Sleep deprivation
K. Disturbed thought processes
L. Risk for violence
M. Ineffective denial

Planning and Intervention

Goals

Client will:
A. Be protected from injury.
B. Receive adequate hydration and nutrition.
C. Terminate use of substance being abused without withdrawal symptoms; emergency care will be provided if symptoms cannot be avoided.

Table 7–5 Commonly Abused Drugs

Drug	Effect	Dependence	Assessment Findings	Overdose	Nursing Interventions for Overdose
Barbiturates					
Antianxiety drugs, hypnotics	Reduction in anxiety, escape from stress	Psychologic at first, then physiologic; withdrawal similar to alcohol withdrawal, to point of delirium; cross-tolerance to other depressants	Irritability, weight loss, changes in mood or motor coordination	Slurred speech, lethargy, respiratory depression, coma; use combined with alcohol can be lethal	Keep person awake and moving to prevent coma; maintain airway.
Opioids/Narcotics					
Heroin, morphine, meperidine, methadone	Euphoria, dysphoria, and/or apathy	Psychologic dependence rapidly leading to physical; signs of withdrawal: cramps, nausea, vomiting, diarrhea; sleep disturbance, chills and shaking	Pinpoint pupils, mental clouding, lethargy, impaired memory and judgment, evidence of needle tracks, inflamed nasal mucosa if drug is snorted	Depressed consciousness and respirations, dilated pupils with anoxia or polydrug use	Provide emergency support of vital functions. In withdrawal, administer methadone or Narcan as ordered.
Stimulant					
Cocaine/crack	Increased self-esteem, energy, sexual desire, euphoria; decreased anxiety	Dopamine deficiency results in psychologic dependency to produce feelings of well-being	Increased vital signs, headache, chest pain, depression and/or paranoia, inflamed nasal passages if snorted	Delirium, tremors, high fever (106+) convulsions, cardiac/respiratory arrest	Emergency support of vital functions, reduce CNS stimulation.
Amphetamines					
Amphetamine, dextroamphetamine, methamphetamine	Depressed appetite; increased activity, awareness, sense of well-being	Long-term use or high doses may produce delirium, paranoid-like delusions, withdrawal, depression, fatigue, sleep disturbances	Same as cocaine, plus suicidal ideation	Same as cocaine	Same as cocaine, plus suicide precautions. Observe for increased anxiety to panic, which may potentiate assaultive behavior.
Phencyclidine (PCP)	Euphoria, psychomotor agitation, emotional lability	Not reported	Vomiting, hallucinations, paranoid ideation, agitation	Violent behavior, suicide, respiratory arrest, delirium, coma, increased blood pressure and pulse	Monitor vital signs. Observe for suicidal or assaultive behavior. Provide nonthreatening environment, reality orientation, support.
Hallucinogens					
LSD, mescaline	Disordered perceptions, depersonalization	Not reported	"Bad trip," high anxiety to panic; hallucinations may occur long after drug has been metabolized; flashbacks may produce long-lasting psychotic diorders	Reduced LOC	Same as PCP, plus talk client down.

(continues)

Table 7–5 Commonly Abused Drugs *(continued)*

Drug	Effect	Dependence	Assessment Findings	Overdose	Nursing Interventions for Overdose
Cannabis Marijuana, hashish, THC	Euphoria, intense perceptions, relaxation, lethargy	Not reported	Increased pulse rate and appetite; impaired judgment and coordination	Panic reaction, nausea, vomiting, depression and disorders of perception	In panic, talk down. In severe depression, institute suicide precautions.
Benzodiazepines Anti-anxiety drugs, muscle relaxants: clonazepam, diazepam, and others	Reduction in anxiety; anticonvulsant, reduces muscle spasms, reduces insomnia	Physical: dependence is low with oral dosing Psychologic: withdrawal syndrome may resemble an anxiety disorder Must differentiate withdrawal syndrome from anxiety disorders	Calm effect unless drug withdrawn abruptly Mild withdrawal including confusion, anterograde amnesia (impaired recall of events after dosing), anxiety, diaphoresis, tremors Effect may resemble alcohol intoxication	Mild sedation to stupor dependent on dose CNS depression, sedation to stupor, dose dependent Oral unlikely to cause significant respiratory depression without concomitant agents such as alcohol Intravenous may cause severe respiratory depression and death	Support vital body functions. Provide nonthreatening environment. Administer Narcan as ordered. Must be closely monitored.

D. Have decreased feelings of anxiety.
E. Receive information and consider help for substance-abuse disorder (e.g., AA or NA).

Interventions

A. Assess drug use pattern: identity, recent use, and frequency of use of prescription and nonprescription drugs, other substances (e.g., alcohol, nicotine).
B. Support client during acute phase of detoxification or withdrawal.
  1. Stay with client; reassure that current manifestations are temporary.
  2. Monitor vital signs, level of consciousness.
  3. Institute suicide precautions (if appropriate).
  4. Administer medications (to prevent withdrawal) as ordered.
  5. If client is experiencing panic, talk down, possibly with assistance of family/friends.
  6. If client is hallucinating, reinforce reality, speak in a calm voice.
  7. Confront client's use of denial.
  8. Monitor your own responses of sympathy/anger.
  9. Be aware of transference/countertransference.
  10. Maintain course of action in plan of care; client must follow plan.
  11. Involve staff in negotiating care plan revisions.
C. Rehabilitation/longer-term care
  1. Provide nonthreatening environment.
  2. Set limits on unacceptable behavior.
  3. Provide adequate diet and fluids.
  4. Provide information relating to substance abuse and rehabilitation programs.

Evaluation

A. Client experiences no injury.
B. Vital signs are stable.
C. Withdrawal proceeded without symptoms; client remains drug/alcohol free.
D. Client can discuss substance-abuse problem and requests or agrees to consider rehabilitation/therapy for problem.

Specific Disorders

Alcohol Abuse/Dependence

A. General information
  1. Alcohol is a legal substance and there are millions of social drinkers.

2. Alcohol is classified as a central nervous system depressant.
3. Alcohol abuse/dependence is a major problem in this country with over 18 million adults identified as alcohol abusers (see Table 7-6)
4. Only approximately 5% of alcohol abusers are the "skid row" type.
5. Incidence is increasing in women and adolescents.
6. Considered a disease that can be arrested but not cured.
7. Important to assess history of alcohol consumption for clients admitted to hospital for non–alcohol-related disorders, because they may go into withdrawal.
8. Socioeconomic as well as a physiologic problem, resulting in increased health care costs and loss of productivity if ability to maintain a job is impaired.
9. Alcohol used with other substances (barbiturates, antianxiety drugs) may have lethal consequences.
10. Long-term use may result in loss of health (gastritis, pancreatitis, cirrhosis, hepatitis, malnutrition, cardiac and neural disorders) and life (suicide, automobile accidents).
11. Directly related problems include withdrawal, delirium tremens, and alcohol-related dementia
    a. Withdrawal
        1) Alcohol consumption reduced/discontinued following continuous consumption for many days or longer
        2) Withdrawal is progressive and has four stages:
            I: At least 8 hours after last drink; symptoms include mild tremors, tachycardia, increased blood pressure, diaphoresis, nervousness
            II: Gross tremors, hyperactivity, profound confusion, loss of appetite, insomnia, weakness, disorientation, illusions, auditory and visual hallucinations
            III: 12–48 hours after last drink: symptoms include (in addition to those found in I and II) severe hallucinations, grand mal seizures
            IV: 3–5 days after last drink (24–72 hours if untreated): delirium tremens, confusion, agitation, severe psychomotor activity, hallucinations, insomnia, tachycardia
        3) Withdrawal may last less than a week or may evolve into alcohol withdrawal delirium (delirium tremens).
        4) 10–15% mortality rate from hypoglycemia/electrolyte imbalances.
    b. Delirium tremens (DTs)
        1) History of alcohol abuse usually for more than 5 years.
        2) May be preceded by seizures.
        3) Symptoms occur 2–3 days after alcohol reduced/discontinued.
        4) Signs include tachycardia, increased blood pressure, agitation, delusions, hallucinations.
    c. Alcohol hallucinosis: hallucinations only
    d. Alcohol-related dementia: caused by poor nutrition
        1) Korsakoff's psychosis is sometimes preceded by Wernicke's encephalopathy. Confusion and ataxia are predominant symptoms.
        2) Thiamine deficiency results in Korsakoff's dementia/psychosis; symptoms include chronic disorientation, confabulation. It is irreversible.
        3) Large doses of thiamine may prevent the development of Korsakoff's psychosis.

B. Medical management
1. Vitamin and nutrition therapy
2. Antianxiety drugs (Librium or Ativan)
3. Disulfiram (Antabuse)
    a. Produces unpleasant reaction (thirst, sweating, palpitations, vomiting, dyspnea, respiratory and cardiac failure) when taken with alcohol.
    b. 500 mg/day for 1–2 weeks; usual maintenance dose is 250 mg/day.
    c. Duration of action is ½ to several hours; no alcohol should be taken at least 12 hours before taking drug.
    d. Increases effects of antianxiety drugs and oral anticoagulants.

Table 7-6 Phases of Alcohol Addiction

Phase	Features
Prealcoholic	Drink almost every day to reduce tension Increase in amount of alcohol ingested
Addiction	Blackouts Secret drinking Large amounts ingested
Dependence	Physical craving for alcohol Makes up reasons for drinking Reduced nutrition Aggressive behavior Pressure from family and/or employer to reduce/stop drinking
Chronic	Long periods of intoxication Impaired thinking Less alcohol produces sedation tremors

e. Side effects include headache, dry mouth, somnolence, flushing.
f. Nursing responsibilities
1) Teach client the nature of severe reaction and importance of avoiding all alcohol (including cough medicine, foods prepared with alcohol, etc.).
2) Teach client to carry an identification card in case of accidental alcohol ingestion.
3) Monitor effects of antianxiety drugs if being taken at the same time.
4) Monitor for bleeding if taking oral anticoagulants.

4. High doses of chlordiazepoxide (Librium) to control withdrawal in acute detoxification.

C. Assessment findings
1. Dependent personality; often using denial as a defense mechanism
2. Tendency to minimize and underreport amount of alcohol consumed
3. Intoxication: blood alcohol level 0.15 (150 mg alcohol/100 mL blood). Legal level 0.08–0.10.
4. Signs of impaired judgment, motor skills, and slurred speech
5. Behavior may be boisterous, euphoric, aggressive, or may be depressed, withdrawn
6. Signs of withdrawal, DTs, or alcohol-related dementias

D. Nursing interventions
1. Stay with client.
2. Monitor vital signs and blood sugar levels.
3. Observe for tremors, seizures, increased agitation, anxiety, disorders of perception.
4. Administer medications as ordered; observe effects/side effects of tranquilizers carefully.
5. If disorders of perception occur, explain that these are part of the withdrawal process.
6. Provide fluids, adequate nutrition, and quiet environment.
7. When client is stable, provide information about rehabilitation programs (Alcoholics Anonymous); at this stage client may be willing to consider a program to stop drinking.
8. Provide information about Alanon (for spouse and adult family members), Alateen (for children), and ACOA (for adult children of alcoholics).

Psychoactive Drug Use

A. General information
1. Drugs abused may be prescription or "street" drugs
2. Types of drugs frequently abused
a. Barbiturates, antianxiety drugs, hypnotics
b. Opioids (narcotics): heroin, morphine, meperidine, methadone, hydromorphone
c. Amphetamines (speed): amphetamine, dextroamphetamine, methamphetamine, some appetite suppressants
d. Cocaine, hydrochloride cocaine (crack)
e. Phencyclidine (PCP)
f. Hallucinogens: LSD, mescaline, DMT
g. Cannabis: marijuana, hashish, THC

B. Assessment findings and nursing interventions for overdoses vary with particular drug; see Table 7-5

C. Polydrug abusers
1. Common pattern of drug use.
2. Synergistic effect: drugs interact so that effect is greater than if each drug is taken separately.
3. Additive effect: two or more drugs with same action are taken together (e.g., barbiturates with alcohol will result in heavy sedation).

Impaired Nurses

A. General information
1. Most nursing licenses are suspended or revoked for substance abuse while on duty.
2. Substances include alcohol and/or prescription drugs stolen from unit drug stocks.
3. Stealing drugs may result in criminal prosecution.
4. Work-related stress and easy access to drugs are factors relating to nurses' substance abuse.
5. Substance use results in impaired judgment and psychomotor abilities, resulting in unsafe nursing practice.

B. Assessment of impairment
1. Alcohol odor on breath
2. Frequent lateness/absences
3. Shortages in narcotics
4. Clients do not experience pain relief after "receiving" pain reduction medication from nurse
5. Nurse makes frequent trips to bathroom/locker room
6. Changes in locomotion, psychomotor skills, pupil size, and mood/affect

C. Nurses' responsibilities related to impaired nurse colleague
1. Client safety is first priority.
2. ANA code of ethics (and most state laws) require nurse to safeguard clients.
3. Interventions for suspected substance abuse by coworker
a. Obtain information about legal issues, treatment options, and institutional policies.
b. Document observations related to behaviors and narcotic charting.
c. If possible, have other coworkers verify your information.
d. Arrange meeting with peer(s), nurse, supervisor, nurse advocate (where possible) and confront nurse with documentation.
e. Let nurse know you care and will help.
f. Help nurse work through denial.
g. Provide plan to offer recovery program (e.g., include "recovering" nurse buddy).
h. Offer hope, support (moral and financial) to aid nurse in treatment.

i. Explain institutional policies regarding future employment.
j. If nurse continues to deny substance abuse, consider following steps:
   1) Advocate should protect nurse's rights.
   2) Suspension/dismissal from job.
   3) Report to licensing board.
   4) If theft of drug from unit has occurred, report to law enforcement agency.

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Overview

A. Characterized by disordered thinking, delusions, hallucinations, depersonalization (feeling of being strange, not oneself), impaired reality testing (psychosis), and impaired interpersonal relationships.
B. Regression to the earliest stages of development is often noted (e.g., incontinence, mutism).
C. Onset is usually in adolescence/early adulthood (15 to 35 years of age).
D. Client may be seriously impaired and unable to perform ADLs.
E. Etiology is not known; theories include:
   1. Genetic: 1% of population.
   2. Biochemical: neurotransmitter dysfunction i.e., dopamine, serotonin.
   3. Interaction of predisposing risk and environmental stress.
F. Prior to onset (premorbid) client may have been suspicious, eccentric, or withdrawn.

Classifications

A. Disorganized: incoherent; delusions are not organized; social withdrawal; affect blunted, silly, or inappropriate
B. Catatonic: psychomotor disturbances
   1. Stupor: mute, little reaction or movement
   2. Excitement: purposeless, excited motor activity
   3. Posturing: voluntary, inappropriate, bizarre postures
C. Paranoid: delusions and hallucinations of persecution/grandeur
D. Undifferentiated: disorganized behaviors, delusions, and hallucinations

Assessment

A. Assess—"Four As"
   1. Affect: flat, blunted
   2. Associative looseness: verbalizations are disorganized
   3. Ambivalence: cannot choose between conflicting emotions
   4. Autistic thinking: thoughts on self, extreme withdrawal, unable to relate to outside world
B. Any changes in thoughts, speech, affect
C. Ability to perform self-care activities, nutritional deficits
D. Suicide potential
E. Aggression
F. Regression
G. Impaired communication

Analysis

Nursing diagnoses for clients with schizophrenic disorders may include:
A. Anxiety
B. Disturbed sensory-perceptual
C. Disturbed sleep pattern
D. Disturbed thought process
E. Imbalanced nutrition; less than body requirements
F. Impaired verbal communication
G. Ineffective coping
H. Low self-esteem
I. Powerlessness
J. Risk for injury
K. Risk for violence
L. Self-care deficit
M. Social isolation

Planning and Implementation

Goals

Client will:
A. Develop a trusting/therapeutic relationship with nurse.
B. Be oriented, able to test reality.
C. Be protected from injury.
D. Be able to recognize impending loss of control.
E. Adhere to medication regimen.
F. Participate in activities.
G. Increase ability to care for self.

Interventions

A. Offer self in development of therapeutic relationship.
B. Use silence.
C. Set time for interaction with client.
D. Encourage reality orientation but understand that delusions/hallucinations are real to client.
E. Assist with feeding/dressing as necessary.
F. Check on client frequently, remove potentially harmful objects.
G. Contract with client to tell you when anxiety is becoming so high that loss of control is possible.
H. Administer antipsychotic medications as ordered (see Table 7-7 for side effects and dosages); observe for effects.
   1. Reduction of hallucinations, delusions, agitation
   2. Postural hypotension
      a. Obtain baseline blood pressure and monitor sitting/standing.

Table 7-7 Antipsychotic Medications

Drug Classification	Dosages			Significant Side Effects
	Acute Symptoms	Maintenance/Day	Range/Day	
Chlorpromazine (Thorazine)	25–100 mg IM q1–4h prn	200–600 mg PO	25–2000 mg PO	Sedation Anticholinergic effects: dry mouth, blurred vision, constipation, urinary retention, postural hypotension
Fluphenazine HCl (Prolixin)	1.25 mg IM, max 10 mg IM, divided doses	1–5 mg PO	1–30 mg PO	Extrapyramidal effects
Fluphenazine decanoate/enanthate (Prolixin)	—	25 mg IM q2wk	25–100 mg IM	Extrapyramidal
Trifluoperazine (Stelazine)	1–2 mg IM q4h; 2–4 mg PO, max 10 mg qd	2–4 mg PO	2–80 mg PO	Extrapyramidal
Haloperidol (Haldol)	2–10 mg IM in divided doses	2–8 mg PO	1–100 mg PO	Extrapyramidal
Thiothixene (Navane)	8–16 mg IM in divided doses	6–10 mg PO	6–60 mg PO	Extrapyramidal
Loxapine (Loxitane)	—	60–100 mg PO	30–250 mg PO	Extrapyramidal
Olanzapine (Zyprexa)	10–20 mg PO	5–20 mg PO	2.5–20 mg PO	Sedation, weight gain, increased glucose and lipid levels
Quetepine (Seroquel)	400–800 mg PO	200–600 mg PO	25–800 mg PO	Sedation, may accelerate cataract formation
Ziprasidone (Geodon)	40–80 mg PO BID with food or 10-20 mg IM BID	20–80 mg PO BID	20–80 mg PO BID 10–40 mg IM	Nausea, anxiety, insomnia (transient); QTC prolongation
Aripiprazole (Abilify)	10–30 mg PO	10–30 mg PO	10–30 mg PO	Nausea, insomnia
Clozapine (Clozaril)	—	300–450 mg PO	75–700 mg PO	Agranulocytosis; sedation
Risperidone (Risperdal)	2–6 mg PO	2–6 mg PO	0.25–8 mg PO	Increased prolactin levels, EPS at higher doses, sedation

   b. Client must lie prone for 1 hour following injection.
   c. Teach client to sit up or stand up slowly.
   d. Elevate client's legs while seated.
   e. Withhold drug if systolic pressure drops more than 20–30 mm Hg from previous reading.
3. Photosensitivity
   a. Advise use of sun screen.
   b. Avoid exposure to sunlight.
4. Agranulocytosis
   a. Instruct client to report sore throat or fever.
   b. Institute reverse isolation if necessary.
5. Elimination
   a. Measure I&O.
   b. Check bladder distension.
   c. Keep bowel record.
6. Sedation
   a. Avoid use of heavy machinery.
   b. Do not drive.
7. Extrapyramidal symptoms (EPS)
   a. Dystonic reactions
      1) Sudden contractions of face, tongue, throat, extraocular muscles
      2) Administer antiparkinson agents prn (e.g., benztropine [Cogentin] 1–8 mg PO, IM, IV; diphenhydramine [Bendadryl] 10–50 mg PO, IM, IV; trihexyphenidyl [Artane] 3–15 mg PO only).
      3) Remain with client; this is a frightening experience and usually occurs when medication is started.

b. Parkinson syndrome
  1) Occurs within 1–3 weeks
  2) Tremors, rigid posture, masklike facial appearance
  3) Administer antiparkinson agents prn.
c. Akathisia
  1) Motor restlessness
  2) Need to keep moving
  3) Administer antiparkinson agents.
  4) Do not mistake this for agitation; do not increase antipsychotic medication.
  5) Reduce medications to see whether symptoms decrease.
  6) Determine if movement is under voluntary control.
d. Tardive dyskinesia
  1) Involuntary movements of tongue, face, extremities
  2) May occur after prolonged use of antipsychotics
e. Neuroleptic malignant syndrome
  1) Occurs days/weeks after initiation of treatment in 1% of clients
  2) Elevated vital signs, rigidity, and confusion followed by incontinence, mutism, opisthotonos, retrocollis, renal failure, coma, and death
  3) Discontinue medication, notify physician, monitor vital signs, electrolyte balance, I&O
f. Elderly clients should receive doses reduced by one-half to one-third of recommended level

I. Encourage participation in milieu, group, art, and occupational therapies when client able to tolerate them.

Evaluation

Client

A. Stays with nurse prescribed period of time.
B. Is oriented to reality, can state name, place, and date.
C. Can feed/dress self with specified amount of assistance.
D. Has not attempted/will not attempt to injure self or others.
E. Adheres to medication regimen with minimal side effects.
F. Participates in activities.

MOOD DISORDERS

Overview

A. Characterized by disturbance in mood (affect) that is either depression or elation (mania); occur in a variety of patterns, alone or together (see Figure 7-1). Disturbance is beyond normal range of mood experienced by most people.
B. Bipolar disorder: components of both depression and elation (formerly called manic-depression)
C. Cyclothymic disorder: milder symptoms of both mania and depression, often separated by long periods of normal mood
D. Dysthymic disorder: long-standing symptoms of depression alternating with short periods of normal mood; client usually able to maintain roles in job, school, etc.
E. Etiology is unknown; theories include:
  1. Genetic: approximately 7% of general population; risk is 20% if a close relative has depression
  2. Biochemical: dysregulation in norepinephrine and serotonin
  3. Psychoanalytic: anger turned inward (i.e., anger toward significant other is turned into anger toward self)

Assessment

A. Mood: dysphoric; blue/sad or elated/aggressive
B. Presence of psychomotor agitation, retardation, or hyperactivity
C. Disorders of cognition: narrowed perception and interests, impaired concentration, grandiose delusions, flight of ideas in elation stage
D. Sexual functioning changes
E. Appropriateness of appearance/dress
F. Appetite
G. Potential for suicide

Analysis

Nursing diagnoses for clients with affective disorders may include:

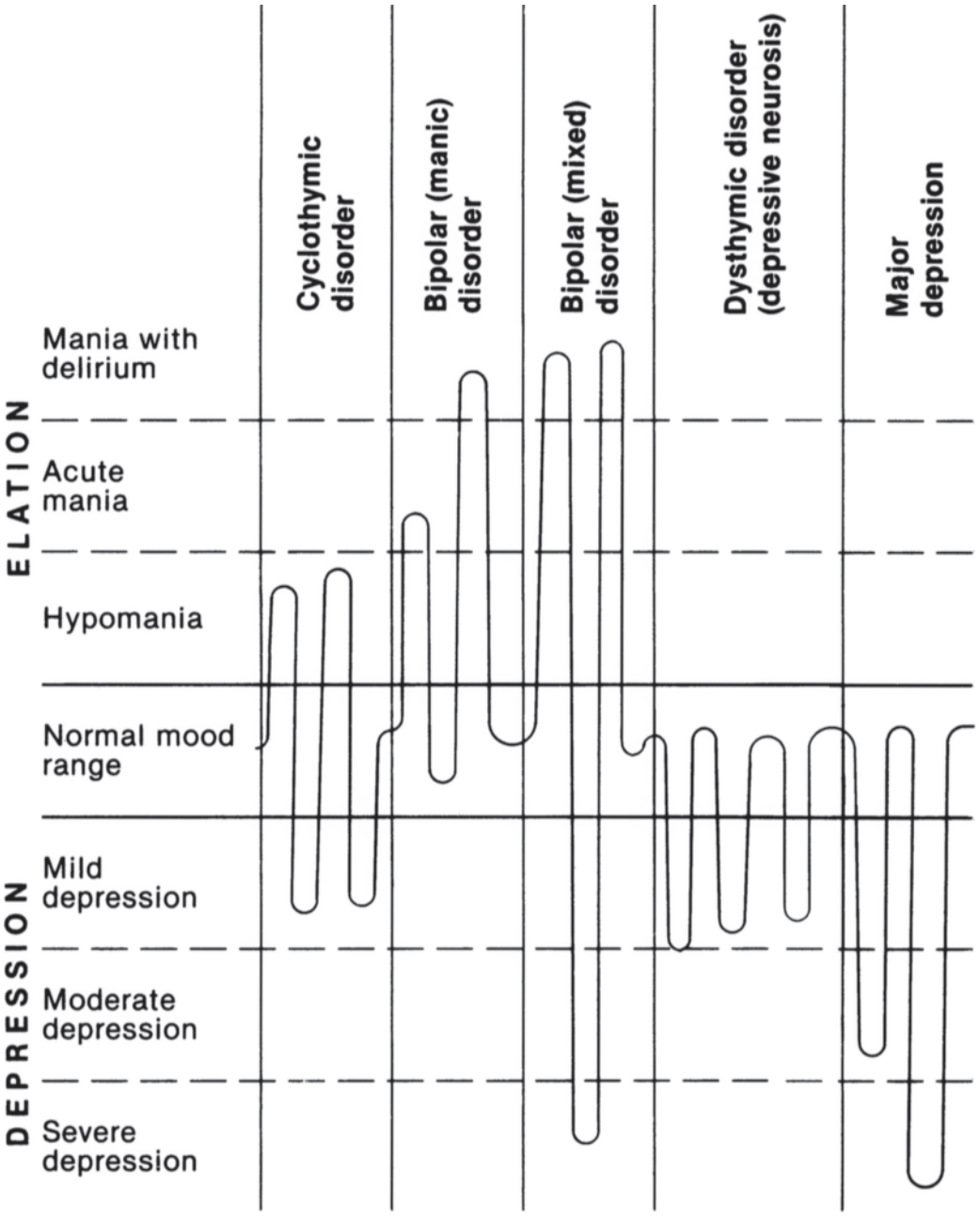
A. Constipation
B. Impaired verbal communication
C. Ineffective coping
D. Risk for injury
E. Imbalanced nutrition: less than body requirements
F. Self-care deficit
G. Disturbed self-esteem
H. Disturbed sleep pattern
I. Disturbed thought processes

Planning and Implementation

Goals

Client will:

A. Be protected from injury.
B. Receive adequate rest and sleep.
C. Maintain adequate intake of fluids and nutrients, regular elimination.
D. Develop trusting/therapeutic relationship with nurse.
E. Be oriented to reality.
F. Participate in planned activities.



Mania with delirium: persecutory delusions, grandiose delusions, hallucinations
Acute mania: flight of ideas, impulsive behavior, bizarre dress and behavior, distractibility
Hypomania: decreased sleep, inflated self-esteem, increased activity, irritability
Mild depression: sadness, irritability, sleep disorders, social withdrawal, crying and tearful, low energy
Moderate depression: recurring thoughts of suicide, hopelessness, helplessness
Severe depression: delusions, hallucinations, psychomotor retardation and stupor, agitation (in depression with melancholia)

Figure 7-1 Patterns of mood disturbances in affective disorders

Interventions

A. Assess for suicide potential.
B. Encourage verbalization of feelings of hopelessness and helplessness.
C. Provide quiet environment for rest and sleep.
D. Provide small, attractive meals; encourage intake of fluids.
E. Maintain bowel record.
F. Use silence and broad openings, focus on client's verbal/nonverbal behaviors.
G. Present reality but accept client's need for delusions.
H. Accept client's negative responses, hostility.
I. Provide activities and tasks to raise client's self-esteem.
J. Assist with self-care as needed.
K. If client is agitated
  1. Work with client on a one-to-one basis.
  2. Walk with client; provide some diversional activity.
  3. Reduce environmental stimuli (e.g., quiet room, dim lights).

Evaluation

Client
A. Has gained or maintained weight.
B. Reports any suicidal ideation.
C. Sleeps a specified number of hours.
D. Can meet own needs for ADLs.
E. Has realistic appraisal of self.

Specific Disorders

Bipolar Disorder (Manic Episode)

A. General information
  1. Onset usually before age 30
  2. Characterized by hyperactivity and euphoria that may become sarcasm or hostility
B. Assessment findings
  1. Hyperactivity to the point of physical exhaustion
  2. Flamboyant dress/makeup
  3. Sexual acting out
  4. Impulsive behaviors
  5. Flight of ideas: inability to finish one thought before jumping to another
  6. Loud, domineering, manipulative behavior
  7. Distractibility
  8. Dehydration, nutritional deficits
  9. Delusions of grandeur
  10. Possible short-term depression (risk of suicide)
  11. Hostility, aggression
C. Medical management
  1. Lithium carbonate (Eskalith, Lithobid, Lithotabs)
    a. Initial dosage levels: 600 mg TID, to maintain a blood serum level of 1.0–1.5 mEq/liter; blood serum levels should be checked 12 hours after last dose, twice a week.
    b. Maintenance dosage levels: 300 mg TID/QID, to maintain a blood serum level of 0.4–1.0 mEq/liter; checked monthly.
    c. Toxicity when blood levels higher than 2.0 mEq/liter: tremors, nausea and vomiting, thirst, polyuria, coma, seizures, cardiac arrest
  2. Antipsychotics may also be given for hyperactivity, agitation, psychotic behavior. Chlorpromazine (Thorazine) and haloperidol (Haldol) are most commonly used (see Table 7-7).
D. Nursing interventions
  1. Determine what client is attempting to tell you; use active listening.
  2. Assist client in focusing on a topic.
  3. Offer finger foods, high-nutrition foods, and fluids.
  4. Provide quiet environment, decrease stimuli.
  5. Stay with client, use silence.
  6. Remove harmful objects.
  7. Be accepting of hostile statements.
  8. Do not argue with client.
  9. Use distraction to divert client from behaviors that are harmful to self or others.
  10. Administer medications as ordered and observe for effects/side effects.
    a. Teach clients early signs of toxicity.
    b. Maintain fluid and salt intake.
    c. Avoid diuretics.
    d. Monitor lithium blood levels.
  11. Assist in dressing, bathing.
  12. Set limits on disruptive behaviors.

Major Depression

A. General information
  1. Characterized by loss of ambition, lack of interest in activities and sex, low self-esteem, and feelings of boredom and sadness.
  2. Etiology may be physiologic or response to an actual or perceived loss.
  3. These clients are at high risk for suicide, especially when depressed mood begins to lift and/or energy level increases.
B. Medical management (see Table 7-8)
  1. Tricyclic antidepressants: amitriptyline HCl, etc.
  2. Monoamine oxidase inhibitors (MAOIs): isocarboxazid (Marplan), etc.
  3. Atypical antidepressants: fluoxetin (Prozac), sertraline (Zoloft), etc.
  4. Electroconvulsive therapy (ECT)
C. Assessment findings
  1. Feelings of helplessness, hopelessness, worthlessness
  2. Reduction in normal activities or agitation
  3. Slowing of body functions/elimination
  4. Loss of appetite
  5. Inappropriate guilt
  6. Self-deprecation, low self-esteem

Table 7-8 Antidepressant Medications

Drug	Initiating	Dosage Maintenance	Side Effects
SSRIs			
Fluoxetine (Prozac, Prozac Weekly)	20 mg PO	20–40 mg/day or 90 mg once per week (once stable)	Sexual dysfunction; nausea, diarrhea, headache, anxiety (transient)
Sertraline (Zoloft)	50 mg PO	50–200 mg/day	As above
Paroxetine (Paxil, Paxil CR)	20 mg PO 25 mg PO	20–40 mg/day 25–50 mg/day	As above
Citalopram (Celexa)	20 mg PO	20–80 mg/day	Sexual dysfunction; nausea, headache, nervousness (transient)
Escitalopram (Lexapro)	10 mg PO	10–20 mg/day	As above
Fluvoxamine (Luvox)	50 mg PO HS	50–300 mg HS	Tiredness, sexual dysfunction; headache, nausea, nervousness (transient) (used in treatment of OCD)
Atypical Antidepressants			
Bupropion (Wellbutrin SR)	100 mg PO	150 mg BID	Anxiety, insomnia; can lower seizure threshold in overdose
Mirtazapine (Remeron)	15 mg PO HS	30–45 mg HS	Sedation at 15 mg (less at higher doses); increased appetite
Nefazodone (Serzone)	50 mg PO HS	50–600 mg HS	Sedation, dry mouth, postural hypotension; liver toxicity
Venlafaxine (Effexor XR)	37.5 mg PO	75–375 mg	Sexual dysfunction; headache, nausea, nervousness; can increase BP at doses > 300 mg/day
Trazodone (Desyrel)	150 mg PO in divided doses	150–400 mg PO in divided doses	Sedation, anxiety, hypotension, priapism (commonly used as sleep aid)
Tricyclics			
Amitriptyline (Elavil, Endep)	75–100 mg PO	50–150 mg PO at bedtime; 80–100 mg IM in divided doses	Constipation, blurred vision, drowsiness, orthostatic hypotension, urinary retention, dry mouth, increased appetite, sexual dysfunction
Doxepine (Apo-Doxepin, Novo-Doxepin)	25 mg PO TID (or up to 150 mg can be given at bedtime)	75–150 mg/day	Sedation, confusion, constipation, decreased libido
Clomipramine (Anafranil)	75–250 mg PO in divided doses at HS	50–150 mg PO at HS	As above
Desipramine (Norpramin)	50 mg HS	100–150 mg HS	As above
Nortriptyline	50 mg HS	50–125 mg HS	As above
Monoamine Oxidase Inhibitors (MAOIs)			
Isocarboxazid (Marplan)	30 mg PO in divided doses	10–30 mg PO	As for tricyclics, plus angina, hypoglycemia, hypertensive crisis precipitated by ingestion of foods with tyramine or concurrent use of tricyclics
Phenalizine (Nardil)	60 mg PO in divided doses	30–60 mg PO	As above

7. Inability to concentrate, disordered thinking
8. Poor hygiene
9. Slumped posture
10. Crying, ruminating (relates same incident over and over)
11. Dependency
12. Depressed children: possible separation anxiety
13. Elderly clients: possible symptoms of dementia
14. Somatic and persecutory delusions and hallucinations

D. Nursing interventions
1. Monitor I&O.
2. Weigh client regularly.
3. Maintain a schedule of regular appointments.
4. Remove potentially harmful articles.
5. Contract with client to report suicidal ideation, impulses, plans; check on client frequently.
6. Assist with dressing, hygiene, and feeding.
7. Encourage discussion of negative/positive aspects of self.
8. Encourage change to more positive topics if self-deprecating thoughts persist.
9. Administer antidepressant medications (see Table 7-8) as ordered.
   a. Tricyclic antidepressants (TCAs)
      1) Effectiveness increased by antihistamines, alcohol, benzodiazepines
      2) Effectiveness decreased by barbiturates, nicotine, vitamin C
   b. Monoamine oxidase inhibitors (MAOIs)
      1) Effectiveness increased with antipsychotic drugs, alcohol, meperidine
      2) Avoid foods containing tyramine (e.g., beer, red wine, aged cheese, avocados, caffeine, chocolate, sour cream, yogurt); these foods or MAOIs taken with TCAs may result in hypertensive crisis.
   c. Be sure client swallows medication. If side effects disappear suddenly, cheeking/hoarding may have occurred. These medications can be used to attempt suicide.
   d. Antidepressant medications do not take effect for 2–3 weeks. Encourage client to continue medication even if not feeling better. Be aware of suicide potential during this time.
   e. Warn client not to take any drugs without consulting physician.
10. Assist with electroconvulsive therapy as ordered.
   a. Give normal pre-op preparation, including informed consent (see Perioperative Nursing).
   b. Remove all hairpins, dentures.
   c. Ensure client is wearing loose clothing.
   d. Check vital signs after the procedure.
   e. Reorient and assure that any memory loss is temporary.
   f. Assist to room or to care of responsible party if outpatient.

Dysthymic Disorder

A. General information: chronic mood disturbance of at least 2 years' duration for adults, 1 year for children

B. Assessment findings
1. Normal moods for a period of weeks, followed by depression
2. Insomnia/hypersomnia
3. Social withdrawal
4. Loss of interest in activities
5. Recurrent thoughts of suicide and death

C. Nursing interventions: same as for major depression.

NEUROTIC DISORDERS

In DSM-IV-TR, the disorders formerly categorized as neurotic disorders are included in Anxiety, Somatoform, and Dissociative Disorders. Reality testing is intact.

ANXIETY DISORDERS

Overview

A. Common element is anxiety, manifested in a variety of behaviors (see also Behaviors Related to Emotional Distress).

B. Therapy relates to reduction of anxiety; when anxiety is reduced, the symptoms will be alleviated.

C. Types include generalized anxiety disorder, panic disorder, phobic disorders, and obsessive-compulsive disorders.

Assessment

A. Level of anxiety: may be to point of panic

B. Vital signs: may be elevated

C. Reality testing: should be intact; can recognize that thoughts are irrational but cannot control them

D. Physical symptoms: no organic basis

E. Memory: possible memory loss or loss of identity

F. Pattern of symptoms: chronic with a pattern of waxing and waning or sudden onset

Analysis

Nursing diagnoses for the client with an anxiety disorder may include:

A. Anxiety

B. Deprivation of sleep

C. Disturbed thought processes
D. Fear
E. Ineffective coping
F. Ineffective tissue perfusion
G. Powerlessness

Planning and Implementation

Goals

Client will:
A. Develop a trusting/therapeutic relationship with nurse.
B. Recognize causes of anxiety and develop alternative coping mechanisms.
C. Reduce/alleviate symptoms of anxiety.

Interventions

A. Encourage discussion of anxiety and relationship to symptoms.
B. Provide calm, accepting atmosphere.
C. Administer antianxiety medications (for short-term use only) as ordered and monitor effects/side effects.
  1. Diazepam (Valium): 5–20 mg PO daily; 2–10 mg IM or IV daily
  2. Chlordiazepoxide (Librium): 20–100 mg PO daily; 50–100 mg IM or IV daily
  3. Alprazolam (Xanax) 0.75–4 mg PO daily
  4. Oxazepam (Serax) 30–120 mg PO daily
  5. Triazolam (Halcion) 0.25–0.5 mg, PO HS
  6. Side effects
    a. Client may become addicted.
    b. Additive effect with alcohol.
    c. Dizziness may occur when treatment initiated.
    d. Lower doses for elderly client.
    e. Do not stop abruptly; taper doses.
D. Teach client about self-medication regimen and side effects.

Evaluation

Client
A. Can discuss causes of anxiety with nurse.
B. Demonstrates constructive coping mechanisms and ability to reduce anxiety.
C. Demonstrates knowledge of effects and hazards of antianxiety medications.

Specific Disorders

Phobic Disorders

A. General information
  1. Irrational fears resulting in avoidance of objects or situations.
  2. Repressed conflicts are projected to outside world and eventually are displaced onto an object or situation.
  3. Client can recognize that fear of these objects/situations is irrational, but cannot control emotional response when confronting or thinking about confronting the particular object/situation.
B. Assessment findings
  1. Agoraphobia: most serious phobia; fear of being alone or in public places; may reach point where client panics at thought of being in public places and cannot leave home.
  2. Social phobias: fear of being in situations where one may be scrutinized and embarrassed by others.
  3. Specific phobias: irrational fear of specific objects/situations (e.g., snakes, insects, heights, closed places).
C. Nursing interventions
  1. Know that behavior modification and systematic desensitization most commonly used; client cannot be "reasoned" out of behavior.
  2. Do not force contact with feared object/situation; may result in panic.
  3. Administer benzodiazepines (alprazolam or clonazepam), SSRIs, venlafaxine, or buspirone as ordered.
  4. Instruct in and encourage use of relaxation techniques.

Generalized Anxiety Disorder

A. General information
  1. Persistent anxiety for at least 1 month
  2. Cannot be controlled by client or displaced, remains free-floating and diffuse
B. Assessment findings
  1. Motor tensions: trembling, muscle aches, jumpiness
  2. Autonomic hyperactivity: sweating, palpitations, dizziness, upset stomach, increased pulse and respirations
  3. Affect: worried and fearful of what might happen
  4. Hyperalert: insomnia, irritability
C. Nursing interventions
  1. Stay with client.
  2. Encourage discussion of anxiety and its source.
  3. Provide calm, relaxing atmosphere.
  4. Administer antianxiety drugs, as ordered.
  5. Observe for effects and side effects.
  6. Monitor vital signs.
  7. Assess for level of anxiety.

Panic Disorder (with/without Agoraphobia)

A. General information: acute, panic-like attack lasting from a few minutes to an hour.
B. Assessment findings
  1. Sudden onset of intense fear/terror
  2. Symptoms: include dyspnea, palpitations, chest pain, sensation of smothering or choking, faintness, fear of dying, dizziness

3. When severe, symptoms mimic acute cardiac disease that must be ruled out.
4. Client may be seen in ER.

C. Nursing interventions: same as for generalized anxiety disorder.

Obsessive-Compulsive Disorder (OCD)

A. General information
1. Obsession
   a. Recurrent thoughts that client cannot control; often violent, fearful, or doubting in nature (e.g., fear of contamination).
   b. Client cannot keep thoughts from intruding into consciousness; eventually resort to defense of undoing (performing ritual behavior).
2. Compulsion
   a. Action (ritual behavior) that serves to reduce tension from obsessive thought.
   b. Client may not desire to perform behavior but is unable to stop, as this is the only relief from distress.
   c. May interfere with social/occupational functioning.

B. Nursing interventions
1. Allow compulsive behavior, but set reasonable limits.
2. Permit client to complete behavior once started; aggression may result if behavior is not allowed or completed.
3. Engage client in alternative behaviors (client will not be able to do this alone).
4. Provide opportunities to perform tasks that meet need for perfectionism (e.g., stacking and folding linens).
5. As compulsive behavior decreases, help client to verbalize feelings, concerns.
6. Help client to make choices, participate in decisions regarding own schedule.
7. Administer clomipramine (Anafranil) as ordered. Gradual decrease in symptoms may take 2–3 months. Often used with behavior modification therapy (see Table 7-8).

Post-Traumatic Stress Disorder (PTSD)

A. General information
1. Disturbed/disintegrated response to significant trauma
2. Symptoms can occur following crisis event such as war, earthquake, flood, airplane crash, rape, or assault
3. Reexperiencing of traumatic event in recollections, nightmares

B. Assessment findings
1. Psychic numbing: not as responsive to persons and events as to the traumatic experience
2. Sleep disturbances (e.g., nightmares)
3. Avoidance of environment/activities likely to arouse recall of trauma
4. Symptoms of depression
5. Possible violent outbursts
6. Memory impairment
7. Panic attacks
8. Substance abuse

C. Nursing interventions
1. Arrange for individual or group psychotherapy with others who experienced same trauma (e.g., Iraq or Vietnam war veterans).
2. Provide crisis counseling, family therapy as needed.
3. Provide referrals.

SOMATOFORM DISORDERS

Overview

A. Anxiety is manifested in somatic (physical) symptoms.

B. There is organic pathology but no organic etiology.

C. Symptoms are real and not under voluntary control of the client.

D. Defense used is somatization or conversion: anxiety is transformed to a physical symptom.

Specific Disorders

Somatization Disorder

A. General information
1. Multiple, recurrent somatic complaints (fatigue, backache, nausea, menstrual cramps) over many years
2. No organic etiology for these complaints

B. Assessment findings
1. Complaints chronic but fluctuating
2. History of seeking medical attention for many years
3. Symptoms of anxiety and depression
4. Somatic complaints may involve any organ system

C. Nursing interventions
1. Be aware of own response (irritation/impatience) to client.
2. Rule out organic basis for current complaints.
3. Focus on anxiety reduction, not physical symptoms.
4. Minimize secondary gain.

Conversion Disorder

A. General information
1. Sudden onset of impairment or loss of motor or sensory function.
2. No physiologic cause.
3. Defenses used are repression and conversion; anxiety is converted to a physical symptom.
4. Temporal relationship between distressing event and development of symptom

(e.g., unconscious desire to hit another may produce paralysis of arm).
5. Primary gain: client is not conscious of conflict. Anxiety is converted to a symptom that removes client from anxiety-producing situation.
6. Secondary gain: gain support and attention that was not previously provided. Tends to encourage client to maintain symptoms.

B. Assessment findings
1. Sudden paralysis, blindness, deafness, etc.
2. "La belle indifférence": inappropriately calm when describing symptoms
3. Symptoms not under voluntary control
4. Usually short term; symptoms will abate as anxiety diminishes

C. Nursing interventions
1. Focus on anxiety reduction, not physical symptom.
2. Use matter-of-fact acceptance of symptom.
3. Encourage client to discuss conflict.
4. Do not provide secondary gain by being too attentive.
5. Provide diversionary activities.
6. Encourage expression of feelings.

Pain Disorder

A. General information: complaint of severe and prolonged pain

B. Assessment findings
1. Pain impairs social/occupational function
2. Pain often severe
3. Sleep may be interrupted by experience of pain

C. Nursing interventions
1. Pain management
2. Encourage participation in activities.

Hypochondriasis

A. General information
1. Unrealistic belief of having serious illnesses.
2. Belief persists despite medical reassurance.
3. Defenses used are regression and somatization.

B. Assessment findings
1. Preoccupation with bodily functions, which are misinterpreted.
2. History of seeing many doctors, many diagnostic tests.
3. Dependent behavior: desires/demands great deal of attention.

C. Nursing interventions
1. Rule out presence of actual disease.
2. Focus on anxiety, not physical symptom.
3. Set limits on amount of time spent with client.
4. Reduce anxiety by providing diversionary activities.
5. Avoid negative response to client's demands by discussing in staff conferences.
6. Provide client with correct information.

DISSOCIATIVE DISORDERS

Overview

A. Sudden change in client's consciousness, identity, or memory.

B. Loss of memory, knowledge of identity, or how individual came to be in a particular place.

C. Defenses are repression and dissociation.

Specific Disorders

Dissociative Amnesia

A. General information: inability to recall information about self with no organic reason

B. Assessment findings
1. No history of head injury
2. Retrograde amnesia, may extend far into past

C. Nursing interventions
1. Rule out organic causes.
2. Reassure client that personal identity will be made known to client.
3. Provide safe environment.
4. Establish nurse-client relationship to reduce anxiety.

Dissociative Fugue

A. General information
1. Client travels to strange, often distant place; unaware of how he traveled there, and unable to recall past.
2. May follow severe psychologic stress.

B. Assessment findings
1. Memory loss
2. May have assumed new identity
3. No recall of fugue state when normal functions return

C. Nursing interventions: same as for psychogenic amnesia.

PERSONALITY DISORDERS

Note: This is coded on Axis II.

Overview

A. Patterns of thinking about self and environment become maladaptive and cause impairment in social or occupational functioning or subjective distress.

B. Usually develop by adolescence.

C. Most common is borderline personality disorder.

Specific Disorders

Borderline Personality Disorder

A. General information: clients are impulsive and unpredictable, have difficulty interacting; characterized by behavior problems

B. Assessment findings
- **1.** Unstable, intense interpersonal relationships
- **2.** Impulsive, unpredictable, manipulative behavior; prone to self-harm
- **3.** Marked mood shifts from anger to dysphoric
- **4.** Uncertainty about self-image, gender identity, values
- **5.** Chronic intolerance of being alone, feelings of boredom
- **6.** Splitting: distinct separation of love and hate; views others as *all* good or *all* bad.
- **7.** Use of projection and regression

C. Nursing interventions
- **1.** Protect from self-mutilation, suicidal gestures.
- **2.** Establish therapeutic relationship, be aware of own responses to manipulative behaviors.
- **3.** Maintain objectivity.
- **4.** Use a calm approach.
- **5.** Set limits.
- **6.** Apply plan of care consistently.
- **7.** Interact with clients when they demonstrate appropriate behavior.
- **8.** Teach relaxation techniques.

Antisocial Personality Disorder

A. General information
- **1.** Chronic history of antisocial behaviors (e.g., fighting, stealing, aggressive behaviors, substance abuse, criminal behaviors).
- **2.** These behaviors usually begin before the age of 15 and continue into adult life.
- **3.** May be hospitalized for injuries.

B. Assessment findings
- **1.** Manipulative behavior, may try to obtain special privileges, play one staff member against another
- **2.** Lack of shame or guilt for behaviors
- **3.** Insincerity and lying
- **4.** Impulsive behavior and poor judgment

C. Nursing interventions
- **1.** Provide model for mature, appropriate behavior.
- **2.** Observe strict limit-setting by all staff.
- **3.** Monitor own responses to client.
- **4.** Demonstrate concern, interest in client.
- **5.** Reinforce positive behaviors (socialization, conforming to limits).
- **6.** Avoid power struggles.

Sample Questions

21. A 6-year-old has been diagnosed with enuresis after tests revealed no organic cause of bed wetting. The child's mother is upset and blames the problem on his father. "It's all his father's fault!" What is your initial response?
- **1.** "Why do you say that?"
- **2.** "It's usually nobody's fault."
- **3.** "You seem really upset by this."
- **4.** "Why are you blaming his father?"

22. An adolescent is admitted with anorexia nervosa. You have been assigned to sit with her while she eats her dinner. The client says to you, "My primary nurse trusts me. I don't see why you don't." What is your best response?
- **1.** "I do trust you, but I was assigned to be with you."
- **2.** "I'd like to share this time with you."
- **3.** "OK. When I return, I'll check to see how much you have eaten."
- **4.** "Who is your primary nurse?"

23. A teenager is hospitalized for the treatment of anorexia nervosa. She is 64 inches tall and weighs 100 pounds. What is the primary objective in the treatment of the hospitalized anorexic client?
- **1.** Decrease the client's anxiety.
- **2.** Increase insight into the disorder.
- **3.** Help the mother to relinquish control.
- **4.** Get the client to eat and gain weight.

24. A female adolescent is hospitalized for treatment of anorexia nervosa. While admitting the client, the nurse discovers a bottle of pills. She states they are antacids and she takes them because her stomach hurts. What would be the nurse's best initial response?
- **1.** "Tell me more about your stomach pain."
- **2.** "These do not look like antacids. I need to get an order for you to have them."
- **3.** "Tell me more about your drug use."
- **4.** "Some girls take pills to help them lose weight."

25. The nurse assesses an adolescent who has dropping grades, low motivation, somatic complaints, and dental caries. What disorder would the nurse suspect?
- **1.** Anxiety.
- **2.** Depression.

3. Acute mania.
4. Dissociative fugue.

26. An elderly client was recently admitted to a nursing home because of confusion, disorientation, and negativistic behavior. Her family states that she is in good health. The woman asks you, "Where am I?" What would be the best response from the nurse?
1. "Don't worry. You're safe here."
2. "Where do you think you are?"
3. "What did your family tell you?"
4. "You're at the community nursing home."

27. Which of the following would be an appropriate strategy in reorienting a confused client to where her room is?
1. Place pictures of her family on the bedside stand.
2. Put her name in large letters on her wristband.
3. Remind the client where her room is.
4. Let the other residents know where the client's room is.

28. An elderly client was recently admitted to a nursing home because of confusion, disorientation, and negativistic behavior. Which activity would you engage the client in at the nursing home?
1. Reminiscence groups.
2. Sing-alongs.
3. Discussion groups.
4. Exercise class.

29. A 78-year-old was recently admitted to a nursing home because of confusion, disorientation, and negativistic behavior. She has had difficulty sleeping since admission. Which of the following would be the best intervention?
1. Provide her with a glass of warm milk.
2. Ask the physician for a mild sedative.
3. Do not allow her to take naps during the day.
4. Ask her family what they prefer.

30. A middle aged client is on the verge of losing his job because of a drinking problem. He voluntarily enters an alcohol detoxification program. Along with the amount and type, what information is most important that he needs to inform the staff?
1. Time substances were taken over the past 24 hours.
2. Frequency of substances taken over the past week.
3. Frequency of substances taken over the past 2 weeks.
4. Frequency of substances taken over the past month.

31. What is a characteristic common to most substance abusers that is difficult for them to achieve?
1. Coping with stress and anxiety.
2. Interacting socially.
3. Performing in work-related settings.
4. Setting goals.

32. A client is developing impending alcohol withdrawal delirium. Besides tremors, what other signs and symptoms would be present?
1. Bradycardia and hypertension.
2. Bradycardia and hypotension.
3. Tachycardia and hypertension.
4. Tachycardia and hypotension.

33. What is the most widely accepted treatment modality for substance abuse?
1. Individual therapy with a psychodynamically oriented therapist.
2. Individual therapy with a systems-oriented therapist.
3. Group therapy with others with personality disorders.
4. Group therapy with other substance abusers.

34. A client was voluntarily admitted to the inpatient unit with a diagnosis of paranoid schizophrenia. As the nurse approaches the client, he says, "If you come any closer, I'll die." Which disorder of perception does this client exhibit?
1. Hallucination.
2. Delusion.
3. Illusion.
4. Idea of reference.

35. The nurse is approaching an adult client who is admitted with a diagnosis of paranoid schizophrenia. As the nurse approaches the client, he says, "If you come any closer, I'll die." What is the best response for the nurse to make to this behavior?
1. "How can I hurt you?"
2. "I am your nurse today."
3. "Tell me more about this."
4. "You're not going to die."

36. A young man admitted with a diagnosis of paranoid schizophrenia is pacing the halls and is agitated. The nurse hears him saying, "I have

to get away from those doctors! They are trying to commit me to the state hospital!" The nurse's continued assessment should include:

1. Clarifying information with the doctor.
2. Observing the client for rising anxiety.
3. Reviewing history of involuntary commitment.
4. Checking dosage of prescribed medication.

37. After 2 days in the hospital, the nurse assesses a client diagnosed with schizophrenia as exhibiting flat affect with little interest in other clients. What describes this characteristic of the schizophrenic process?

1. Paranoia.
2. Ambivalence.
3. Cyclothymic.
4. Undifferentiated.

38. What would be an appropriate activity for the nurse to recommend for a client who is extremely agitated?

1. Competitive sports.
2. Bingo.
3. Trivial Pursuit.
4. Daily walks.

39. A client who is diagnosed with a bipolar disorder is admitted to the hospital in the manic phase. What is the initial plan of care?

a. Put the client in seclusion.
b. Put the client on one to one for safety.
c. Provide a quiet environment for the client.
d. Stabilize the client on medication.

40. A 34-year-old is hospitalized with bipolar disorder. At 2 A.M. the nurse finds him phoning friends all across the country to discuss his new plan for eradicating world hunger. His excited explanations are keeping the entire unit awake, but he won't quiet down. Which drug is most likely to be prescribed for this client?

1. A tricyclic antidepressant.
2. An MAO-inhibitor antidepressant.
3. Lithium carbonate (Eskalith).
4. An antianxiety drug.

41. Which supportive therapy for a client who is exhibiting manic behavior would be inappropriate to use as treatment?

1. Psychoanalysis.
2. Cognitive therapy.
3. Interpersonal therapy.
4. Problem-solving therapy.

42. A 38-year-old was admitted to the psychiatric service after a failed suicide attempt by drug overdose. The client sought help when her husband informed her of his decision to leave her and the children after 19 years of marriage. Her suicide attempt was made after she and her husband had had a fierce argument about property settlement. Upon initial contact with the nurse, the client looked exhausted, affect was sad, movements and responses were slowed, and self-care impairments were evident. She is convinced that a blemish on her face is a melanoma that is invading her brain and eating away at the tissue. What type of disorder is being shown?

1. Bipolar disorder.
2. Depression with melancholia.
3. Dysthymic disorder.
4. Major depression.

43. An adult is admitted to the psychiatric service after a failed suicide attempt by drug overdose. She presents with a sad affect and moves and responds slowly. Which nursing diagnosis is of greatest priority at the time of her admission?

1. Imbalanced in nutrition: less than body requirements.
2. Ineffective coping.
3. Risk for violence: self-directed.
4. Bathing/hygiene self-care deficit.

44. An adult is admitted following a suicide attempt. She took sleeping pills. She has been receiving therapy for depression since her husband left her after 23 years of marriage. Upon admission she looks very tired, has a sad affect, and moves slowly. What intervention would be a priority in helping to stabilize the client?

1. Allow her to catch up on lost sleep for the first 3 days of her hospitalization.
2. Have her fully involved in all therapeutic activities.
3. Encourage her husband to visit for brief periods of time.
4. Schedule balanced periods of rest and therapeutic activity.

45. When a client is experiencing severe anxiety, what would be the priority nursing intervention?

1. Give the client medication immediately.
2. Offer the client psychotherapy to calm her down.
3. Isolate the client in a quiet environment.
4. Put the client in seclusion temporarily.

46. A client is admitted to the hospital because her family is unable to manage her constant handwashing rituals. Her family reports she washes her hands at least 30 times each day. The nurse noticed the client's hands are reddened, scaly, and cracked. What is the main nursing goal?

1. Decrease the number of hand washings a day.
2. Provide a milder soap.
3. Provide good skin care.
4. Eliminate the handwashing rituals.

47. An adult is admitted to the psychiatric hospital for handwashing rituals. The day after admission she is scheduled for lab tests. How will the nurse ensure that the client is there on time?

1. Remind the client several times of her appointment.
2. Limit the number of hand washings.
3. Tell her it is her responsibility to be there on time.
4. Provide ample time for her to complete her rituals.

48. An adult who is hospitalized with an obsessive-compulsive disorder washes her hands many times a day. Which of the following is an appropriate treatment for this client?

1. An unstructured schedule of activities.
2. A structured schedule of activities.
3. Intense counseling.
4. Negative reinforcement every time she performs the ritual.

49. A woman is admitted to the psychiatric hospital. She was found walking on a highway. She is unkempt and appears thin and dirty. What is the most thorough way to conduct a nursing assessment of her nutritional status?

1. Observe her at mealtime.
2. Request a medical consult.
3. Explore her recent dietary intake.
4. Compare current weight with her usual weight.

50. A client is admitted to the psychiatric unit. She was found wandering on a major four-lane highway and cannot recall her activities from the past 3 days. During the assessment, the nurse observes that her face and hands are very red and excoriated, her hair is matted and dirty, her clothing is dirty, and she is quite thin. When the client asked to be excused, she went directly to her room, and washed her hands and face. Within a very short while, it became apparent to the nurse that the hand and face washing was quite repetitive and ritualistic. However, she refused to bathe or wash her clothing. Which nursing diagnosis describes the most prominent difficulty that the client is experiencing?

1. Impaired skin integrity.
2. Disturbed thought processes.
3. Ineffective coping.
4. Social isolation.

51. An adult is admitted because of ritualistic behavior. She is also constipated and dehydrated. Which nursing intervention would the client be most likely to comply with?

1. Drinking Ensure between meals.
2. Drinking extra fluids with meals.
3. Drinking 8 oz water every hour between meals.
4. Drinking adequate amounts of fluid during the day.

52. An adult is admitted because of excessive hand and face washing rituals. What would be the most effective way for the nurse to intervene with her hand and face washing?

1. Allow her a certain amount of time each shift to engage in this behavior.
2. Interrupt the activity briefly and frequently.
3. Lock the door to her room and restrict access to the bathroom.
4. Tell her to stop each time she is observed doing it.

53. A client was admitted for ritualistic behavior involving frequent hand and face washing. Upon admission, the client was also dehydrated and underweight. When will the nurse know to initiate discharge planning for this client?

1. The client's normal body weight is regained.
2. The client will express a desire to leave the hospital.
3. The client is able to start talking about her guilt and anxiety.
4. The client limits her hand and face washing to a few times a day.

54. A young adult was admitted on a voluntary basis to psychiatric services. During the last 3 years, he has been under psychiatric care and has a long history of petty crimes. Once on the unit, the client is difficult to manage because he is arrogant and manipulative. When a scheduled group therapy session is announced, he refuses to go. He uses other clients to his own ends and often pioneers causes that are disruptive to the

milieu. What diagnostic title best describes his behavior?

1. Antisocial personality disorder.
2. Borderline personality disorder.
3. Somatization disorder.
4. Bipolar disorder.

55. An adult is admitted to a psychiatric unit with a diagnosis of antisocial personality disorder. In planning care for the client, which of the following would be least likely to occur?

1. Staff and client agree when setting treatment goals.
2. Staff and client are in a constant struggle for control of the milieu.
3. Allow client to set limits.
4. Staff and client use the same defense mechanisms when interacting.

56. A client is admitted with an antisocial personality disorder. Which key intervention would be contraindicated with this client?

1. Assisting him to identify and clarify his feelings.
2. Changing staff assigned to a client at his request.
3. Making expectations about his behavior clear as well as consequences for same.
4. Setting firm limits with clear consequences.

57. A client has been hospitalized with an antisocial personality disorder on a voluntary basis as an alternative to serving a jail sentence. Following discharge, what will be the most likely result of the client?

1. Be committed to another facility for a longer length of stay.
2. Be committed to a virtuous and socially acceptable lifestyle.
3. Continue to use sublimation.
4. Revert to pre-hospitalization behaviors.

58. A 28-year-old is admitted to the psychiatric unit under an involuntary petition after a perceived suicide attempt. Initially, she presented as very tearful and highly anxious. As the staff became more familiar with her, it became apparent that she had had many episodes of self-mutilation and would do so "so I can feel something." While she could appear quite intact most of the time, when stressed she would respond very impulsively, express anger, report hearing voices of a depreciative nature, and require a high level of observation. This client's symptoms can best be described as fitting which of the following diagnostic categories?

1. Antisocial personality disorder.
2. Borderline personality disorder.
3. Generalized anxiety disorder.
4. Post-traumatic stress disorder.

59. A client is admitted to the psychiatric unit with a diagnosis of borderline personality disorder. Which of the following components would be needless to obtain for the history/data base?

1. Ego-strength assessment.
2. Social history.
3. Cognitive aspect of mental status exam.
4. Past psychiatric treatment history.

60. An adult was admitted to the psychiatric unit after cutting herself on the forearm. She has numerous scars which are from prior self-mutilation. Should the client attempt self-mutilation while in the hospital, which implementation should the nurse execute?

1. Focus on the how, when, and where of the injury.
2. Care for the injury and explore the client's activities and feelings immediately before the episode.
3. Care for the injury and leave the client alone for awhile to let her settle down.
4. Care for the injury and seclude, and possibly restrain, the client to prevent further injury.

61. A female client was admitted with a borderline personality disorder following an episode of self-mutilation. Her husband recently left her and she reports that she has injured herself in the past so she could feel something. Which of the following would be excluded during the discharge planning?

1. Cognition.
2. Identity.
3. Dealing with anger.
4. Separation/individuation.

62. While collecting data about a 7-year-old boy, the school nurse learned that he has minimal verbal skills and expresses his needs by acting out behaviors. The communication capabilities of this boy indicate which of the following levels of mental retardation?

1. Mild
2. Moderate.
3. Severe.
4. Profound.

63. What nursing care would be included for a 4-year-old boy with severe autistic disorder?

1. Psychotropic medications.
2. Social skills training.
3. Play therapy.
4. Group therapy.

64. The nurse makes the following assessment of a 14-year-old gymnast: underweight, hair loss, yellowish skin, facial lanugo, and peripheral edema. These findings are suggestive of which of the following disorders?

1. Anorexia nervosa.
2. Bulimia nervosa.
3. Acquired immunodeficiency.
4. Ulcerative colitis.

65. An adolescent gymnast presents in the eating disorders clinic severely emaciated, with sallow skin color, 20% body weight loss, amenorrhea for the past 12 months, and facial lanugo. Based on these findings, which one of the following nursing diagnoses would be most appropriate for the nurse to make?

1. Impaired nutrition: less than body requirements.
2. Impaired tissue integrity.
3. Ineffective individual coping.
4. Deficient knowledge, nutritional.

66. Which observation of the client with anorexia indicates the client is improving?

1. The client eats meals in the dining room.
2. The client gains 1 pound per week.
3. The client attends group therapy sessions.
4. The client has a more realistic self-concept.

67. A client with severe Alzheimer's disease has violent outbursts, wanders, and is incontinent. He can no longer identify familiar people or objects. In developing the nursing care plan, the nurse would give highest priority to which nursing diagnosis?

1. High risk for injury.
2. Impaired verbal communication.
3. Self-care deficits.
4. Altered pattern of urinary elimination: incontinence.

68. A client with Alzheimer's disease has a self-care deficit related to his cognitive impairment. Because the client has difficulty dressing himself, what would be the best action for the nurse to take?

1. Have the client wear hospital gowns.
2. Explain to the client why he should dress himself.
3. Give the client step-by-step instructions for dressing himself.
4. Allow enough time for the client to dress himself.

69. Which question made by the family of a client with Alzheimer's disease indicates to the nurse an understanding of the prognosis?

1. "Does another hospital have a better treatment?"
2. "Will a change in diet help his memory?"
3. "Won't his new medicine cure him?"
4. "What supports are available for the future?"

70. A 75-year-old man was brought to the emergency room confused, incoherent, and agitated after painting his lawn furniture earlier in the day. He has no current history of illness. Which one of the following interpretations would be appropriate for the nurse to make about his condition?

1. Depression related to aging.
2. Dementia related to organic illness.
3. Delirium related to toxin exposure.
4. Distress related to unaccomplished tasks.

71. A student with a history of barbiturate addiction is brought to the infirmary with suspected overdose. Which of the following assessments is the nurse likely to make?

1. Watery eyes, slow and shallow breathing, clammy skin.
2. Dilated pupils, shallow respirations, weak and rapid pulse.
3. Constricted pupils, respirations depressed, nausea.
4. Responsive pupils, increased respirations, increased pulse and blood pressure.

72. A teenage girl is admitted to a detoxification unit with a history of cocaine abuse. Her pupils are dilated and she complains of nausea and feeling cold. She states that she is not addicted, but uses cocaine occasionally with friends. Which one of the following nursing diagnoses is appropriate for the nurse to make?

1. Impaired verbal communication related to substance use as evidenced by giving untrue information.
2. Altered growth and development related to substance use as evidenced by age of client.
3. Perceptual alteration related to substance use as evidenced by distortion of reality.
4. Ineffective denial related to substance use as evidenced in refusal to admit problem.

73. The nurse is caring for a client in early alcohol withdrawal. What would most likely be included in the nursing care plan?

1. Using physical restraints.
2. Providing environmental stimulation.
3. Taking pulse and blood pressure.
4. Administering antipsychotic medications.

74. A client in a detox program is being manipulative by trying to split staff. The client tells the nurse that he is the "best" staff member on the unit. What would be the best response from the nurse?

1. Thank the client for the compliment.
2. Identify the client's manipulative behavior.
3. Ignore the client's comment.
4. Ask the client why he feels that way.

75. In developing a teaching plan for adolescents on the topic of cocaine abuse, the nurse would highlight which of the following?

1. Cocaine is a naturally occurring depressant.
2. Cocaine's physical effects differ according to the method of ingestion.
3. The body's peak reaction occurs 30 minutes after it is taken.
4. Smoking cocaine is particularly dangerous to the cardiovascular system.

76. A 14-year-old male client is admitted to the emergency room after ingesting a high dose of PCP and subsequently injuring himself in a fall. What would be an effective action for the nurse to take?

1. Attempt to talk the client down.
2. Withhold fluids.
3. Place the client in a quiet, dimly lit room.
4. Administer a prn phenothiazine.

77. The nurse on a medical unit smells alcohol and notices that the relief nurse's words are slurred and she is giggling inappropriately. What is the best initial action for the nurse to take?

1. Double assign the nurse's clients.
2. Ask the relief nurse if she has been drinking.
3. Report the nurse to the licensing board.
4. Refer the nurse to an employee assistance program.

78. A nurse's coworker is argumentative and resistant to change. Her appearance has become sloppy over the last 6 months; she is frequently late for work and often calls in sick. When she is at work, she complains about everything. Which of the following is the most likely cause of these problems?

1. The nurse is dissatisfied with her job.
2. The nurse is having problems at home.
3. The nurse may be abusing drugs or alcohol.
4. The nurse realizes she is in the wrong profession.

79. A nurse is evaluating an adult client from the substance abuse unit. Which statement by the client reveals that the client may be ready for discharge?

1. "I'll take my Antabuse when I need it."
2. "I can't wait to hang out with my old buddies."
3. "I'll drink in moderation and only on the weekend."
4. "Attending daily AA meetings will help me not drink again."

80. Which of the following assessment findings would the nurse observe in a client with schizophrenia?

1. Associative looseness, affect disturbance, ambivalence, autistic thinking.
2. Euphoria, distractibility, dramatic mannerisms, energetic.
3. Argumentative, anhedonia, poor judgment, manipulative.
4. Psychomotor retardation, intense sadness, loss of energy, suicidal.

81. A client with a diagnosis of paranoid schizophrenia reports to the nurse that he hears a voice that says, "Don't take those poisoned pills from that nurse!" Which one of the following nursing diagnoses would it be appropriate for the nurse to make regarding this statement?

1. Disturbed sensory perceptual: auditory, related to anxiety as evidenced by auditory hallucination.
2. Disturbed thought processes related to anxiety as evidenced by delusions of persecution.
3. Defensive coping related to impaired reality testing as evidenced by paranoid ideation.
4. Impaired verbal communication related to disturbances in form of thinking as evidenced by use of symbolic references.

82. An adult is admitted with a diagnosis of catatonic schizophrenia, excited phase. She shouts and paces continuously and seems to be

responding to internal stimuli. What would be a short-term goal for the nurse to formulate?

1. The client will groom self daily.
2. The client will maintain adequate nutrition.
3. The client will sleep 8 hours per night.
4. The client will attend unit social activities.

83. A client with schizophrenia stops talking mid sentence and tilts her head to one side. The nurse suspects that the client is experiencing auditory hallucinations. What is an appropriate response from the nurse?

1. Ask the client what she is experiencing.
2. Change the topic of conversation.
3. Explain that hallucinations are not real.
4. Deny that she hears anything.

84. In teaching a client for whom clozapine (Clozaril) has been prescribed, the nurse would include which of the following?

1. The drug will be given every 4 weeks by intramuscular injection.
2. The drug will probably cause weight reduction.
3. There is a high incidence of extrapyramidal side effects.
4. Blood work may be required weekly.

85. An adult is to go on a 3-day pass and has his maintenance supply of chlorpromazine (Thorazine). Which statement indicates to the nurse that he understands instructions regarding his medication?

1. "I'll take my pills when I hear those voices."
2. "I'll drink beer but no wine while I'm away."
3. "I'll cover up when I go to the beach."
4. "I'll stop taking it if my mouth stays dry."

86. Which of the following behaviors indicates to the nurse that the client's antipsychotic medication is having a desired effect?

1. The client states that her "voices" are not as threatening.
2. The client reports having inner feelings of restlessness.
3. The client sleeps all day.
4. The client reports muscular stiffening in her face and arms.

87. A client taking trifluoperazine (Stelazine) exhibits severe extrapyramidal symptoms, a temperature of 40.5°C (105°F), and diaphoresis. The nurse suspects neuroleptic malignant syndrome. What is the nurse's best action?

1. Administer an antiparkinsonism medication.
2. Stop the neuroleptic medication.
3. Withhold fluids.
4. Administer an antianxiety medication.

88. A client with paranoid schizophrenia has a delusion of persecution. He tells the nurse, "The CIA is out to get me. They're spying on me." What is the nurse's best initial response?

1. "I don't want to hurt you."
2. "How would they spy on you here?"
3. "Tell me how they're trying to get you."
4. "I know the CIA wouldn't want to hurt you."

89. Which of the following statements indicates to the nurse that a client with obsessive-compulsive disorder has developed insight into her problem?

1. "I realize that the dangers are more in my mind."
2. "I don't hear the voices anymore."
3. "I check on my family 12 times every day."
4. "I slept 8 hours last night."

90. An adult is brought to the emergency room after he attempted to walk across the roof of a building in an attempt to "fly like a jet plane." In addition to impulsiveness, which of the following behaviors would the nurse assess in a client diagnosed as bipolar, manic type?

1. Hallucinations and delusions.
2. Euphoria and increased motor activity.
3. Paranoia and ideas of reference.
4. Splitting and manipulation.

91. During the focused assessment of a client with major depression, the nurse may ask which of the following questions?

1. "You seem to have a lot of energy; when did you last have 6 or more hours of sleep?"
2. "You seem to be angry with your family now; when was it that you last got along?"
3. "Have you had any thoughts of harming yourself?"
4. "You seem to be listening to something. Could you tell me about it?"

92. Which of the following nursing diagnoses would be most appropriate for a client who is diagnosed as bipolar I disorder, single manic episode and is intrusive, argumentative, and severely critical of peers?

1. Impaired social interaction related to narcissistic behavior as evidenced by inability to sustain relationships.

2. Risk for injury related to extreme hyperactivity as evidenced by increased agitation and lack of control over behavior.
3. Social isolation related to feelings of inadequacy in social interaction as evidence by problematic interaction with others.
4. Defensive coping related to social learning patterns as evidenced by difficulty interacting with others.

93. An adult is in an acute manic phase of bipolar disorder. He talks and paces incessantly, frequently shouting and threatening other clients. The nurse expects the client's care plan to include which of the following?
1. Monitor blood lithium levels.
2. Monitor client during phototherapy.
3. Monitor client after electroconvulsive therapy.
4. Teach client to avoid foods with tyramine.

94. The nurse is preparing to administer lithium (Eskalith) to a client with bipolar disorder. The client complains of nausea and muscle weakness, and his speech is slurred. His lithium level is 1.6 mEq/liter. What would be the nurse's best action?
1. Chart the client's symptoms after giving the lithium.
2. Explain that these are common side effects.
3. Withhold the client's lithium.
4. Administer a prn antiparkinsonism drug.

95. Which of the following behaviors indicates to the nurse that the client understands teaching related to lithium treatment?
1. Taking lithium 1 hour after meals.
2. Stopping taking her lithium when her mania subsides.
3. Going on a low-salt diet to counter weight gain.
4. Withholding her lithium if episodes of diarrhea, vomiting, and diaphoresis occur.

96. An adult is recovering from a severe depression. Which of the following behaviors alerts the nurse to a risk for suicide?
1. The client sleeps most of the day.
2. The client has a plan to kill herself.
3. The client loses 5 pounds.
4. The client does not attend unit activities.

97. A man has been severely depressed for 2 weeks. He had mentioned "ending it all" prior to admission. Which of the following questions should the nurse ask during the prescreen assessment?
1. "How long have you thought about harming yourself?"
2. "What is it that makes you think about harming yourself?"
3. "How has your concentration been?"
4. "What specifically have you thought about doing to harm yourself?"

98. A 19-year-old recently broke off her 1-year engagement. Her mother states, "She does nothing but cry and sit and stare into space. I can't get her to eat or anything!" She feels she can't go on without her boyfriend. The nurse should make which priority nursing diagnosis?
1. Impaired nutrition: less than body requirements.
2. Dysfunctional grieving.
3. Risk for self-directed violence.
4. Social isolation.

99. A client is admitted for treatment of a major depression. She is withdrawn, appears disheveled, and states, "No one could ever love me." What would the nurse expect to be ordered for this client?
1. Antiparkinsonism medication.
2. Suicide precautions.
3. A low-salt diet.
4. Phototherapy.

100. A man's wife complains that her husband's depression isn't any better after 1 week on amitriptyline (Elavil). What is the nurse's best response?
1. Tell her she will contact the physician.
2. Question the wife about what response she expects.
3. Explain that it may take 1 to 3 weeks to see any improvement.
4. Suggest that the client change antidepressants.

101. Which of the following behaviors indicates to the nurse that a client's major depression is improving?
1. Displaying a blunted affect
2. Losing an additional 2 pounds
3. Stating one "good" thing about himself
4. Sleeping about 16 hours per day

102. An adult is hospitalized for treatment of obsessive-compulsive disorder (OCD). The nurse recognizes which of the following as an

indication that the client's sertraline (Zoloft) is having the desired effect?

1. The client experiences nervousness and drowsiness.
2. The client's delusions are less entrenched.
3. The client engages in fewer rituals.
4. The client sleeps 4 hours per night.

103. A client with major depression is scheduled for electroconvulsive therapy (ECT) tomorrow. The nurse would plan for which of the following activities?

1. Force fluids 6 to 8 hours before treatment.
2. Administer succinylcholine (Inestine, Anectine) during pretreatment care.
3. Encourage the client's spouse to accompany him.
4. Reorient the client frequently during posttreatment care.

104. A severely depressed client received ECT this morning. Which of the findings listed below would the nurse *least* expect to assess posttreatment?

1. Headache.
2. Memory loss.
3. Paralytic ileus.
4. Disorientation.

105. A client for whom Nardil was prescribed for depression is brought to the ER with severe occipital headaches after eating pepperoni pizza for lunch. Which of the following interpretations is it important for the nurse to make regarding these findings?

1. Allergic reaction related to ingestion of processed food.
2. Hypertensive crisis related to drug and food reaction.
3. Panic anxiety related to unresolved issues.
4. Conversion disorder related to uncontrolled anxiety.

106. The nurse explains the major difference between neurotic and psychotic disorders. What is a major difference in clients with psychotic disorders?

1. The clients are aware that their behaviors are maladaptive.
2. The clients are aware they are experiencing distress.
3. The clients experience no loss of contact with reality.
4. The clients exhibit a flight from reality.

107. A client is prescribed buspirone hydrochloride (BuSpar). Which statement alerts the nurse that additional medication teaching is required?

1. "I'll take my drugs as soon as I feel anxious."
2. "I won't drink any alcohol."
3. "I'll report any troubles with my heart or seeing."
4. "I'll have my blood checked every month."

108. In teaching a client about her new antianxiety medication, alprazolam (Xanax), the nurse should include which of the following?

1. Caution the client to avoid foods with tyramine.
2. Caution the client not to drink alcoholic beverages.
3. Instruct the client to take the Xanax 1 hour after meals.
4. Instruct the client to double up a dose if she forgets to take her medication.

109. A client experiencing thanataphobia is afraid to leave her aging, ailing husband alone for any reason. She has not left her husband alone since her mother and sister died 4 years ago. Which of the following statements would be appropriate for the nurse to make during the initial assessment of this client?

1. "Are you afraid that your husband might die while you are away from him?"
2. "There must be someone you are able to trust to stay with your husband."
3. "Don't you have children who are willing to stay with your husband when you need to be away?"
4. "It must be very confining to have constantly attended to your husband for so long."

110. A newly admitted client is fearful of elevators. She needs to take one in 10 minutes to attend therapy on the 10th floor. Which of the following actions would be best for the nurse to take?

1. Explain to her that she needs to attend therapy.
2. Have another client go with her.
3. Accompany her to the 10th floor.
4. Explore with her why she is afraid of elevators.

111. A man, with a family of five, was recently laid off and now has financial concerns. He is experiencing muscle tension, breathlessness, and sleep disturbances. Which one of the following nursing diagnoses would be

appropriate for the nurse to make regarding his condition?

1. Post-trauma response related to loss of economic support as evidenced by job loss.
2. Parental role conflict related to perceived inability to meet his family's economic and physical needs as evidenced by job loss.
3. Ineffective individual coping related to recent unemployment as evidenced by physical manifestations.
4. Powerlessness related to inability to deal with anxiety as evidenced by physical manifestations.

112. A woman appears to be having a panic attack during group therapy. She is agitated, pacing rapidly, and not responding to verbal stimuli. What would be the nurse's initial intervention?

1. Remove her from the group.
2. Encourage her to express her feelings.
3. Facilitate her recognizing her anxiety.
4. Ignore her.

113. The nurse is assessing a client who presents with OCD. In addition to gathering information about the client's anxiety and rituals, the nurse should assess for which of the following?

1. Handwringing and foot-tapping behaviors.
2. Use of abusive substances and gambling.
3. Tics, stuttering, or other unusual speech patterns.
4. Diaphoresis and rapid breathing.

114. Which of the following statements by a client with delusions indicates to the nurse that the client is improving?

1. "I don't feel those crawling bugs anymore."
2. "I won't talk about my crazy thoughts at work."
3. "I feel less jumpy inside."
4. "I must check my room for bugs."

115. During the assessment phase of the nurse-client interaction, which of the following statements made by the client is suggestive of post-traumatic stress disorder?

1. "My dad had trouble swallowing before he died and I always feel as if I have a lump in my throat."
2. "After I contracted meningitis on vacation last summer, I can't control this horrible thought that all people who work in park restaurants are dirty."
3. "I continue to have the same dream over and over again."
4. "I had another horrible nightmare last night and went through the same trauma and anxiety all over again."

116. A client with OCD has an elaborate handwashing and touching ritual that interferes with her activities of daily living. She misses meals and therapy sessions. What effective strategy could the nurse initiate to limit her ritual?

1. Teach thought stopping techniques.
2. Prevent the ritualistic behavior.
3. Use adjunctive therapies for distraction.
4. Facilitate insight regarding the need for the ritual.

117. A client with an OCD has checking rituals and thoughts that her family will be harmed. Which of the following indicates to the nurse that the client is improving?

1. Obsessing about her family's health.
2. Adhering to the unit schedule.
3. Losing 2 pounds in 1 week.
4. Awakening 8 times during the night.

118. A 4-year-old girl, who is a victim of a bomb blast that demolished the building which housed her daycare, constantly builds block houses and blows them up. She also has nightmares frequently. Which one of the following diagnoses is appropriate for the nurse to make regarding this child?

1. Post-trauma response related to terrorist attack as evidenced by destructive behaviors and sleep disturbances.
2. Explosive disorder related to dysfunctional personality as evidenced by destructive behaviors.
3. Sleep disturbance related to emotional trauma as evidenced by nightmares.
4. Ineffective individual coping related to internal stressors as evidenced by destructive behaviors and nightmares.

119. The nurse recognizes that the client with post-traumatic stress disorder (PTSD) is improving when which of the following occurs?

1. States he feels "numb" most of the time.
2. Drinks alcohol to cope with his feelings.
3. Talks about a benefit of the traumatic experience.
4. Attends weekly group therapy.

120. A young woman is found wandering on campus after a fraternity party. She is disheveled and does not know who she is. She has no recollection of

the evening. At the student health service she is diagnosed with dissociative amnesia subsequent to a rape. What is the most appropriate nursing diagnosis for the nurse to formulate?

1. Ineffective individual coping.
2. Personal identity disturbance.
3. Anxiety related to alteration in memory.
4. Risk for violence, self-directed.

121. The nurse finds, during the initial assessment of the star player on the basketball team, that he is not concerned about the sudden paralysis of his "shooting arm." What is this behavior known as?

1. Secondary gain
2. La belle indifférence
3. Malingering
4. Hypochondriasis

122. A man's family brought him into the hospital because of his many somatic complaints. He has been seen by many medical specialists in the past without discovery of organic pathology. The nurse assesses that the client is probably experiencing which of the following problems?

1. Conversion disorder
2. Body dysmorphic disorder
3. Malingering
4. Hypochondriasis

123. An adult is hospitalized for treatment of a conversion disorder. She complained of paralysis of her right side after her husband threatened to leave her and their children. She seems unconcerned about her paralysis. What would be an appropriate long-term goal for the nurse to formulate for the client?

1. Cope effectively with stress without using conversion
2. Identify stressors
3. Express feelings about the conflict
4. Develop an increased sense of relatedness to others

124. An adult has hypochondriasis—believing he is dying of stomach cancer despite repeated and extensive diagnostic testing that has all been negative. He has become reclusive and is preoccupied with his physical complaints. The nurse would include which of the following in the nursing care plan as a client outcome?

1. Focus on the signs and symptoms of stomach cancer
2. Attend a support group for persons with cancer
3. Complete a contract to attend social and diversional activities daily
4. Receive secondary gain from his physical symptoms

125. A man is brought into the police station after he ran toward a boy who resembled his son. At the police station he was unable to recall any personal information. The prescreening nurse inferred that the man has which one of the following dissociative disorders?

1. Amnesia
2. Fugue
3. Personality disorder
4. Stress disorder

126. Which of the behaviors listed below would assist the nurse in establishing the diagnosis of borderline personality disorder?

1. Impulsivity
2. Hallucinations
3. Self-mutilation
4. Narcissism

127. A woman is admitted to the unit with a diagnosis of borderline personality disorder. She has angry outbursts and is impulsive and manipulative. She has lacerations on her arm from self-mutilation. Which of the following would be a priority nursing diagnosis?

1. Ineffective individual coping.
2. Disturbed body image.
3. Disturbed personal identity.
4. Risk for violence to self.

128. A client with borderline personality disorder tells the nurse she hates her doctor because he denied her a pass because she returned "high" from her last pass. What would be the nurse's best action?

1. Ask the client why she is feeling so angry.
2. Suggest that the client bring it up in community meeting.
3. Offer to contact the doctor and discuss the situation.
4. Set limits and point out that the denial is a consequence of her inappropriate behavior.

129. The nurse would formulate which of the following outcome criteria for a client with borderline personality disorder?

1. Displays anger frequently.
2. Acts out neediness.
3. Experiences troubling thoughts without self-mutilation.
4. Idolizes assigned nurse.

130. A client with antisocial personality disorder is charming, seductive, and highly manipulative. He has a history of multiple jobs and marriages, which have all failed, and problems with the law. Which of the following is an appropriate short-term goal for the nurse to formulate in relation to a nursing diagnosis of ineffective individual coping?

1. The client will avoid situations that provoke aggressive acts.
2. The client will adhere to unit rules.
3. The client will assume a leadership role in unit governance.
4. The client will acknowledge manipulative behaviors pointed out by staff.

131. Which of the following indicates to the nurse that a client with antisocial personality disorder is improving?

1. Complimenting the nurse for on outstanding job on the unit.
2. Testing the limits on personal behavior.
3. Acknowledging some manipulative behavior.
4. Sleeping 8 hours per night.

Answers and Rationales

21. 3. Upon hearing her son's diagnosis, the mother is experiencing emotional turmoil and projecting blame. Acknowledging her feelings would build further trust and encourage her to discuss her thoughts and feelings.

22. 2. The nurse can offer himself to the client to establish trust. The nurse will stay with the client while eating.

23. 4. Because the anorexic client is experiencing starvation, her well-being is dependent on establishing an adequate nutritional state. Eating and gaining weight are the primary goals of hospitalization.

24. 1. While there might be some concern that the client is abusing drugs and possibly using them to induce further weight loss, the primary concern is that the client is experiencing abdominal pain. This may be a clue to an impending medical crisis needing further assessment.

25. 2. Dropping grades, low motivation, somatic complaints, and poor mouth hygiene are signs and symptoms of depression.

26. 4. Responding factually helps to orient the client.

27. 3. The nurse should be someone the client can turn to for guidance.

28. 4. Providing the client with structured activities will allow her to release tension. Exercises also help older people with balance and mobility and reduce falls.

29. 4. Including the family in the plan of care ensures a more effective plan.

30. 1. Although a complete substance abuse history is necessary eventually, on admission the most important information is the type and amount of substances taken by the client in the past 24 hours.

31. 1. While a substance abuser has difficulty in all areas listed, problems handling stress and anxiety underlie all the others.

32. 3. Delirium tremens is characterized by increased blood pressure, pulse, and respirations, and an increase in psychomotor activity.

33. 4. Group therapy with other substance abusers is the most highly prescribed therapy. It is the model for Alcoholics Anonymous, the most effective treatment group.

34. 2. A delusion is a fixed false belief.

35. 2. The nurse needs to present reality to the client and not encourage the delusion.

36. 2. Assessing increasing signs of anxiety and agitation gives clues to the client's ability to maintain control and suggests further nursing interventions to protect the client and others.

37. 2. There are four characteristics of schizophrenia that help in an assessment. One of the key indicators is the overwhelming attitude of ambivalence toward the environment and any emotional involvement with others. The other three indicators are affect, associative looseness, and autistic thinking.

38. 4. Daily walks provide time for the nurse to develop trust. Walking allows expenditure of energy without increasing paranoia.

39. 3. This client does not need additional stimuli from the environment.

40. 3. A drug frequently used to treat manic clients is lithium carbonate (Eskalith).

41. 1. Psychoanalysis is an in-depth, insight-oriented psychotherapy, not appropriate in treatment of bipolar disorders.

42. 4. The client shows many signs of classic depression as evidenced by psychomotor retardation, impairment of self-care, inability to sleep, a suicide attempt, and somatic delusion.

43. 3. The priority at this time is maintenance of client safety. This client is at particular risk for self-directed violence because of her recent failed suicide attempt and her obsession with what she perceives to be her impending death.

44. 4. Even though the client is probably exhausted, the most therapeutic plan would allow for both rest and activity.

45. 3. The client who is experiencing severe panic needs a quiet environment with supportive care to decrease anxiety enough to cope.

46. 1. Obsessive-compulsive behavior represents displacement of anxiety. A concrete measurable goal is to decrease the number of handwashings.

47. 4. Providing ample time for the client to complete her handwashing rituals will lessen her anxiety.

48. 2. Planning a structured schedule of activities provides the client with ways other than handwashing to reduce anxiety.

49. 4. Current weight as it relates to usual weight is the best determinant of nutritional status and weight change when the client is unable to be specific about recent activities and eating habits.

50. 3. Ineffective individual coping encompasses all of the other nursing diagnoses. This area will be the primary focus of nursing interventions, and positive changes in the client's ability to cope will be the criteria for discharge readiness.

51. 3. Building the intake of a specified amount of liquid into a daily schedule of activities is very consistent with the obsessive-compulsive client's need to control as many aspects of her life as possible.

52. 1. Allowing the client a certain amount of time to engage in the activity alleviates some of the client's anxiety.

53. 4. The major issue is control of behavior and thoughts. When the client is able to control her compulsive behavior, i.e., limit her hand and face washing to a few times a day, she will then be able to resume normal activities of daily living.

54. 1. A long history of petty crimes, a high level of manipulative behavior, use of other clients to his own end, and fostering behavior that is disruptive to the milieu are all signs of the diagnosis of antisocial personality disorder.

55. 1. The staff and client will most likely disagree when setting treatment goals.

56. 2. The client will compare and attempt to "split" staff, so it is very important to keep staff assignments as consistent as possible.

57. 4. People who have this type of personality disorder typically seek psychiatric care as a lesser of two evils. In this case in-hospital care is preferable to jail. The chances of this client making any great change in his lifestyle as a result of short-term hospitalization are slim. The client will likely be committed to another facility when he is again arrested for deviant behavior.

58. 2. The clustering of self-mutilation, impulsivity, transient psychosis, intense anger, and feeling empty is most typically found in borderline personality disorder.

59. 3. The mental status exam is conducted when the nurse suspects a client is disoriented. The client with a borderline personality disorder has, for the most part, intact reality testing.

60. 2. A matter-of-fact approach to the injury with emphasis on the events leading to the episode of mutilation is the most therapeutic approach.

61. 1. Impairments involving cognition are most commonly found in psychoses.

62. 3. Individuals with severe mental retardation possess minimal verbal skills. They often communicate wants and needs by acting out behaviors.

63. 3. Play therapy would be most effective given his developmental level and autism. In autistic disorder, communication with others is severely impaired. Through one-to-one play therapy, the therapist may establish rapport through nonverbal play.

64. 1. Anorexia nervosa, usually occurring in individuals ages 13–22 years, is an eating disorder characterized by self-starvation, weight loss (25% below normal weight), disturbance in body image, and physiologic and metabolic changes.

65. 1. The assessment data and history of the client support the diagnosis of altered nutrition related to anorexia.

66. 2. Weight gain is the best indication that the client's anorexia is improving. A realistic expectation is for the client to gain 1 pound per week.

67. 1. Safety is of highest concern for this client. His wandering and memory loss pose hazards for accidents, falls, and injuries.

68. 3. The client may need step-by-step instructions so he can focus on small amounts of information. This allows him to perform at his optimal level. Clients with dementia may not remember how to dress themselves.

69. 4. This response indicates that the family is expecting to need support during the process of the client's increasing cognitive impairment.

70. 3. Paint is a toxin that could cause delirium. Delirium is a state of mental confusion and excitement. The mind wanders, speech is incoherent, and the client is often in a state of continual, aimless physical activity. The onset is rapid (hours to days).

71. 2. The effects of overdose of barbiturates are shallow respirations, cold and clammy skin, dilated pupils, weak and rapid pulse, coma, and possible death.

72. 4. Denial is the minimizing or disavowing of symptoms or a situation to the detriment of health.

73. 3. Pulse and blood pressure should be checked hourly for the first 8–12 hours after admission. They are usually elevated during withdrawal and the pulse is a good indication of progress through withdrawal. Elevation may indicate impending alcohol withdrawal delirium.

74. 2. A priority in intervening in manipulative behavior is to identify it and then set limits by stating expected behaviors.

75. 4. A total cardiac collapse may occur. Smoking "crack" cocaine is the method that most often leads to myocardial infarction.

76. 3. Environmental stimuli need to be reduced for the client in PCP intoxication to reduce danger to self, paranoia, delusions, and hallucinations. These clients are sensitive to stimuli and quickly become combative and assaultive.

77. 2. There is usually a chain of command policy that begins with a direct discussion of the involved parties. If the relief nurse denies drinking, the nurse has a duty to intervene.

78. 3. Signs of possible substance abuse are social isolation; requesting to work nights; changes in appearance and mood; excessive tardiness, accidents, and absences; excuses for being unavailable when on duty; resistance to change; defensive when questioned about client complaints or drug discrepancies; failure to meet schedules and deadlines; and inaccurate and sloppy documentation. The situation requires further professional assessment. The nurse should follow agency policies and board of nursing guidelines to report his suspicions.

79. 4. Daily attendance at AA meetings is necessary for most discharged clients to remain sober and continue their rehabilitation.

80. 1. Eugen Bleuler's 4 As of schizophrenia are loosening of associations (L.O.A.), which are representative of thought disorders, disturbance in affect, ambivalence, and autistic thinking.

81. 1. Hallucinations are sensory experiences of perception without corresponding stimuli in the environment.

82. 2. It is important for the nurse to monitor dietary intake and weight so the person does not lose calories and fluids due to hyperactivity. "Finger foods" may need to be provided, e.g., sandwiches and fruit.

83. 1. The best initial action is to focus on the cues and elicit the client's description of her experience. It is important for the nurse to determine that she is hallucinating and the content. This is vital in relation to safety issues and command hallucinations.

84. 4. Weekly white blood cell counts may be required due to the side effects of possible life-threatening agranulocytosis.

85. 3. The client should avoid the sun or cover up and use sunscreen to protect himself from severe photosensitivity.

86. 1. A desired effect of the antipsychotics is to reduce the disturbing quality of hallucinations and delusions.

87. 2. The neuroleptic should be immediately discontinued. Medical treatment should be instituted because this is a potentially fatal syndrome.

88. 1. The nurse should first clarify her intent and then empathize with the underlying feeling.

89. 1. This statement indicates that the client has some insight into the underlying reason for her rituals.

90. 2. The client diagnosed as bipolar, manic exhibits behaviors of elation, euphoria, and is full of energy, which may lead to exhaustion.

91. 3. Clients with major depression are often suicidal. The first concern of assessment is the risk of suicide potential in the immediate future.

92. 2. The client who invades the space of others, creates arguments, and attacks others is at risk for injury by those in the environment.

93. 1. Lithium is the drug of choice for manic clients with an antimanic effectiveness of 78%. It reduces the intensity, duration, and frequency of manic and depressive episodes. Blood levels are monitored for therapeutic levels in the acute phase (1.0–1.5 mEq/liter) and during maintenance.

94. 3. The client is exhibiting symptoms and signs of lithium toxicity. Another blood level should be drawn and the dose evaluated.

95. 4. These are early signs of lithium toxicity. The drug should be withheld and a lithium blood level drawn and evaluated to determine an appropriate dosage.

96. 2. Having a suicide plan is a risk factor. The lethality needs to be assessed. When a depression is "lifting," the client may have the energy and resources to carry out a plan. Behavioral, somatic, and emotional cues may be overt or covert.

97. 4. This question assists in determining suicidal intent and lethality.

98. 3. The depressed client often feels hopeless and helpless with self-directed anger. Suicidal ideations are often expressed and warrant immediate intervention.

99. 2. Maintaining safety for the client is a priority because she may have suicidal ideation and/or a plan.

100. 3. The client may need to take Elavil 1 to 3 weeks before any improvement or a therapeutic effect is noticed.

101. 3. This behavior may indicate an increase in self-esteem that accompanies an improvement in depression. A depressed person often cannot problem solve or acknowledge any positive aspects of their lives.

102. 3. Zoloft is a selective serotonin reuptake inhibitor (SSRI) that is effective in treating clients with obsessive-compulsive disorder. Using fewer rituals would indicate an improvement.

103. 4. Common side effects of bilateral treatment include confusion, disorientation, and short-term memory loss. The nurse should provide frequent orientation statements that are brief, distinct, and simple.

104. 3. ECT is treated as an operative procedure; however, paralytic ileus (intestinal obstruction, especially failure of peristalsis) frequently accompany peritonitis and usually result from disturbances in the bowel.

105. 2. Severe occipital and/or temporal pounding headaches, manifestations of hypertensive crisis, occur when processed meats are eaten by individuals currently taking Nardil (MAOI).

106. 4. In psychotic responses to anxiety, clients escape from reality into hallucination and/or delusional behavior.

107. 1. BuSpar must be taken as a maintenance drug, not as a prn response to symptoms. Improvement may be noted in 7–10 days, but it may take 3 to 4 weeks to note therapeutic effects.

108. 2. The depressant effects of alcohol and alprazolan will be potentiated and may cause harmful sedation.

109. 1. Confronting fear diminishes the phobic response and the anticipatory anxiety that precedes it.

110. 3. This is the best action because the nurse is conveying her support. Later, she would need to further assess the client's fear of elevators and respond accordingly.

111. 2. Parental role conflict is the state in which a parent experiences role confusion and conflict in response to crisis. Loss of economic base constitutes a crisis state.

112. 1. The nurse should remove the client from the group to provide a safe environment for her and others. The nurse should stay with the client and provide comfort and reality orientation.

113. 3. There is comorbidity between Tourette's syndrome and obsessive-compulsive disorder.

114. 2. Improvement in relation to delusional content includes a reduction in the disturbing quality of the delusions and the client's ability to control and/or not respond to them.

115. 4. Symptoms of post-traumatic stress disorder range from emotional "numbness" to vivid nightmares in which the traumatic event is recalled.

116. 1. Thought stopping techniques, flooding, and response prevention have proven effective in treating clients with OCD. Clients may shout or think "stop" or snap a rubber band on their wrist to dismiss the obsessive thought.

117. 2. If the client adheres to the unit schedule, it is likely that her obsessions and compulsive rituals have lessened. They no longer preoccupy her to the point of interfering with activities.

118. 1. Post-trauma response is the state of an individual experiencing a sustained painful response to an overwhelming traumatic event.

119. 3. Cognitive treatment for PTSD includes redefining the event by considering benefits of the experience and finding meaning in the experience.

120. 2. The client's behavior is indicative of personal identity disturbance related to a traumatic event, the rape. The client is unable to recall her identity, which is a factor in dissociative disorders. The person loses the ability to integrate consciousness, memory, identity, or motor behavior.

121. 2. This lack of concern is identified as "la belle indifference" and is often a clue that the problem may be psychological rather than physical.

122. 4. Hypochondriasis is excessive preoccupation with one's physical health, without organic pathology.

123. 1. This is an appropriate long-term goal related to the client's ineffective coping (use of conversion symptom, paralysis) related to unresolved conflicts and anxiety.

124. 3. This goal is related to the client's impaired social interaction in response to his preoccupation with illness.

125. 1. In dissociative amnesia, an individual is unable to recall important personal information such as name, occupation, and relatives.

126. 3. Self-mutilation is characteristic of borderline personality disorder.

127. 4. A safe environment for the client is a priority. Her self-mutilation, poor impulse control, and temper are characteristic of persons with borderline personality disorder who have self-directed violence.

128. 4. The client's acting out and demanding behavior indicates her need for ego boundaries and control, which the nurse provides.

129. 3. Clients with borderline personality disorder frequently engage in impulsive suicidal or self-mutilating behaviors. The behavior described in choice 3 indicates less "acting-out" of feelings and less impulsiveness in response to more effective coping.

130. 4. This is an appropriate short-term goal in relation to his use of manipulative behavior to meet his needs.

131. 3. This would indicate that the client may be improving related to recognizing his manipulative behavior. This is a first step in reducing the need for manipulation and attaining more effective coping strategies.

Psychologic Aspects of Physical Illness

STRESS-RELATED DISORDERS

Overview

A. Actual physiologic change in structure/function of organ or system
B. May be referred to as psychosomatic or psychophysiologic disorders
C. Theorized that client's response to stress is a factor in etiology of disease
D. Stress/anxiety not the sole cause but may be a causative factor in the development/exacerbation of physical symptoms
E. See Table 7-9 for types of disorders with a stress component.

Assessment

A. Health history, family history
B. Physical symptoms
C. Social/cultural considerations
D. Coping behaviors

Analysis

Nursing diagnoses for stress-related disorders may include any nursing diagnosis specific to the physiologic problem as well as:
A. Ineffective coping
B. Deficient knowledge
C. Health-seeking behaviors

Planning and Implementation

Goals

Client will:
A. Receive appropriate treatment for any physical symptoms (e.g., maintenance of blood pressure within normal range).
B. Recognize relationship of stress to physical symptom(s).
C. Acknowledge coping patterns that may affect recurrence of physical symptoms.
D. Recognize relationship of self-concept, self-esteem, role performance to disorder.
E. Develop alternative coping behaviors.

Table 7-9 Types of Stress-Related Disorders

Systems	Examples
Respiratory	Asthma, common cold
Circulatory	Hypertension, migraine headaches
Digestive	Peptic ulcers, colitis
Skin	Hives, dermatitis
Musculoskeletal	Rheumatoid arthritis, chronic backache
Nervous	Fatigue
Endocrine	Dysmenorrhea, diabetes mellitus

Interventions

A. Provide nursing care specific to physical symptoms.
B. Establish nurse-client relationship.
C. Encourage discussion of psychosocial problems.
D. Explain relationship of stress to physiologic symptoms.
E. Encourage client to devise alternative coping behaviors, changes in environment, attitude.
F. Role play new behaviors with client.

Evaluation

A. Goals specific to client's physical symptoms have been met.
B. Client
  1. Is able to relate stress to physical symptoms.
  2. Develops alternative coping behaviors.
  3. Engages in role playing of new behaviors.

VICTIMS OF ABUSE

Overview

A. Abuse is physical or sexual assault, emotional abuse, or neglect.
B. Victims are helpless or powerless to prevent the assault on their bodies or personalities.
C. Sometimes victims blame themselves for the assault.
D. The abusers often blame the victims, have poor impulse control, and use their power (physical strength or weapon) to subject victims to their assaults.
E. Victims include children, spouse, elderly, or rape victims; each will be described separately.

Child Abuse

Overview

A. Over one million cases reported each year
B. Suspected child abuse must be reported

C. Abusing adults (parents) often have been victims of abuse, substance abusers, have poor impulse control
D. Battered-child syndrome: multiple traumas inflicted by adult
E. Sexual abuse/incest: common types of child abuse
F. Health care workers often experience negative feelings toward abuser
G. See Child Abuse, Unit 5

Assessment

A. Physical signs/behaviors of physical/sexual abuse (see Table 7-10)
B. Signs of neglect: hunger, poor hygiene/nutrition, fatigue
C. Signs of emotional abuse: habitual behaviors (thumb sucking, rocking, head banging), conduct/learning disorders

Analysis

A. Situational low self-esteem
B. Fear
C. Pain
D. Altered parenting
E. Post-trauma response
F. Powerlessness
G. High risk for injury

Planning and Implementation

A. Goals
  1. Client (child) will be safe until home assessment made by child welfare agency.
  2. Child will participate with nurse (therapist) for emotional support.
  3. Client (parent[s]) will be able to contact agencies to deal with own rage/helplessness.
  4. Parent(s) will participate in therapy (group or other required).
B. Interventions
  1. Provide nursing care specific to physical/emotional symptoms.
  2. Conduct interview in private with child and parent(s) separated.
  3. Inform parent(s) of requirement to report suspected abuse.
  4. Do not probe for information or try to prove abuse.
  5. Be supportive and nonjudgmental.
  6. Provide referrals for assistance and therapy.
C. Evaluation
  1. Physical symptoms have been treated.
  2. Child safety has been ensured.
  3. Parent(s) have agreed to seek help.

Table 7-10 Symptoms of Child Abuse

Physical Abuse	Sexual Abuse
Pattern of bruises/welts	Pain/itching of genitals
Burns (cigarette, scalds, rope)	Bruised/bleeding genitals
Unexplained fractures/ dislocations	Stains/blood on underwear
Withdrawn or aggressive behavior	Withdrawn or aggressive behavior
Unusual fear of parent/desire to please parent	Unusual sexual behaviors

Spouse Abuse

Overview

A. Estimates of five million women assaulted by mate each year
B. Stages
  1. Tension builds: verbal abuse, minor physical assaults
    a. Abuser: often reduces tension with alcohol/drugs
    b. Abused: blames self
  2. Acute battering: brutal beating
    a. Abuser: does not recall incident
    b. Abused: depersonalizes, may seek separation/divorce
    c. Both parties in shock
  3. Honeymoon: make-up stage
    a. Abuser: apologizes and promises to control self
    b. Abused: feels loved/needed; forgives/believes abuser
  4. Cycle repeats with subsequent battering, usually more severe

Assessment

A. Headache
B. Injury to face, head, body, genitals
C. Reports "accidents"
D. Symptoms of severe anxiety
E. Depression
F. Insomnia
G. X-rays reveal previously healed fractures/broken bones

Analysis

A. Risk for injury
B. Anxiety
C. Pain
D. Disabled family coping
E. Ineffective coping
F. Spiritual distress
G. Fear

Planning and Implementation

A. Goals
  1. Client will admit self and/or children are victims of abuse
  2. Client will describe plan(s) for own/children's safety
  3. Client will name agencies that will assist in maintaining a safe environment
B. Interventions
  1. Crisis stage
    a. Provide safe environment
    b. Treatment of physical injuries; document
    c. Encourage verbalization of actual home environment
    d. Provide referral to shelters
    e. Encourage decision making
  2. Rebuilding stage: therapy (individual, family and/or group)

Evaluation

Client will be protected from further injury.

Elder Abuse

Overview

A. Estimates one-half million to over one million cases per year.
B. Women, over age 70, with some physical/psychological disability are most frequent victims.
C. Neglect is most common, followed by physical abuse, financial exploitation, and sexual abuse/abandonment.
D. Victims do not always report abuse because of fear of more abuse/abandonment by caretaker(s).

Assessment

A. Malnutrition
B. Poor hygiene, decubiti
C. Omission of medication/overmedication
D. Welts, bruises, fractures

Analysis

A. Risk for injury
B. Fear
C. Anxiety
D. Imbalanced nutrition: less than body requirements
E. Powerlessness
F. Situational low self-esteem

Planning and Implementation

A. Goals
  1. Client will be free from injury.
  2. Client will receive adequate nutrition, hydration, prescribed medication.
  3. Client will notify nurse if further abuse takes place.
  4. Caregiver will verbalize plans to meet own needs.
  5. Caregiver will seek assistance to meet client's needs when necessary.
B. Interventions
  1. Refer to state laws for reporting elder abuse and nurse's liability.
  2. Obtain client's consent for treatment and/or transfer.
  3. Document physical/emotional condition of client.
  4. Refer client/caregiver to agencies for assistance.
  5. Encourage client and caregiver to discuss problems.
  6. Encourage communication between client and caregiver.

Evaluation

A. Client will remain free of injury, effects of neglect.
B. Caregiver will utilize support systems for self.

Rape

Overview

A. Estimates of occurrence vary; only 10% reported
B. Most victims are female between ages of 15 and 24 years
C. Response to rape
  1. Shock: panic to overly controlled
  2. Outward adjustment: "manages" life but may make drastic changes (e.g., moves, leaves school/job)
  3. Integration: acknowledges response (e.g., depression, fear, rage)

Assessment

A. Physical injury
B. Emotional response: controlled/hysterical

Analysis

A. Rape trauma syndrome
  1. Compound reaction: immediate to 2 weeks (anger, fear, self-blame)
  2. Long-term: nightmares, phobias, seeks support
B. Silent reaction: anxiety, changes in relationships with men, physical distress, phobias
C. Post-trauma response

Planning and Implementation

A. Goals
  1. Client will express response to assault
  2. Client will verbalize plan to handle immediate needs

3. Client will seek assistance from rape counselor
4. Client will discuss need for follow-up counseling
5. Client will report (long-term) reduction of physical and emotional symptoms.

B. Interventions
1. Give emotional support in nonjudgmental manner.
2. Maintain confidentiality: client must give consent for reporting rape and for medical examination.
3. Listen to client, encourage expression of feelings.
4. Document physical findings. Put evidentiary garments in paper bag.
5. Provide referral to rape counselor and follow-up care.

Evaluation

A. Client seeks support from family/agencies.
B. Client verbalizes emotional response to rape.
C. Long-term: client reports return to prerape lifestyle.

CRITICAL ILLNESS

Overview

A. Individuals in critical life-threatening situations have realistic fears of death or of permanent loss of function.
B. Clients and their families may respond to these crises with denial, anger, hostility, withdrawal, guilt, and/or panic.
C. Loss of control and a sense of powerlessness can be overwhelming and detrimental to chance of recovery.

Assessment

A. Physiologic needs (first priority)
B. Anxiety level of client/family
C. Client/family fears
D. Coping behaviors of client/family
E. Social and cultural considerations

Analysis

Nursing diagnoses for the psychologic component of critical illness may include:
A. Anxiety
B. Hopelessness
C. Ineffective coping
D. Deficient knowledge
E. Fear
F. Powerlessness

Planning and Implementation

Goals

A. Client will:
1. Receive treatment for physiologic problems.
2. Experience decrease in level of anxiety/fear.
3. Discuss anxiety/fears with nurse.

B. Family will:
1. Be informed of client's condition on regular basis.
2. Discuss anxiety/fears with nurse.
3. Provide appropriate support to client.

Interventions

A. Provide nursing care specific to physiologic problems.
B. Stay with client.
C. Explain all procedures slowly, clearly, concisely.
D. Provide opportunities for client to discuss fears.
E. Provide opportunities for client to make decisions, have as much control as possible.
F. Encourage family to ask questions.
G. Recognize negative family responses as coping behaviors.
H. Encourage family members to support each other and client.

Evaluation

A. Goals specific to client's physiologic status have been met.
B. Client
1. Demonstrates a decrease in anxious behaviors.
2. Is able to express fears verbally.
3. Has participated in decisions whenever possible.

C. Family members
1. Have discussed fears.
2. Demonstrate support for each other and for client.

CHRONIC ILLNESS

Overview

A. Chronic illnesses, such as diabetes mellitus, multiple sclerosis, or illnesses/injuries resulting in loss of function or loss of a body part necessitate adaptation to the inherent changes imposed.
B. Clients/families may respond to the losses associated with chronic illness with a variety of behaviors and defenses, including recurrent depression, anger and hostility, denial, or acceptance.

Assessment and Analysis

Same as stress-related disorders as well as:

A. Ineffective coping
B. Risk for violence, self-directed
C. Spiritual distress

Planning and Intervention

Goals

A. Client will:
  1. Receive appropriate treatment for any physiologic symptoms.
  2. Be able/willing to discuss responses to illness.
  3. Recognize effect of illness on aspects of self-concept.
  4. Develop realistic plans for activities and role functions.
  5. Contract with nurse to report depression/suicidal ideation.
B. Family will:
  1. Be able to discuss responses to client illness.
  2. Develop plans to deal with alterations in client's behaviors and functions.

Interventions

A. Provide nursing care specific to physiologic problems.
B. Develop nurse/client relationship through active listening, acceptance of positive and negative client responses.
C. Encourage client to plan activities within present capabilities.
D. Provide information about illness, suggestions for activities.
E. Contract with client to request support in times of depression and to report suicidal ideation.
F. Encourage family members to discuss their response to client's illness.
G. Be accepting and nonjudgmental of negative responses (e.g., anger, hopelessness).
H. Support family efforts to develop plans for their participation in client's care.

Evaluation

A. Client
  1. Receives appropriate treatment for any physiologic problems.
  2. Recognizes/discusses positive and negative responses to illness.
  3. Understands effects of feelings about body image, self-esteem, role function.
  4. Agrees to report depression or suicidal thoughts.
B. Family
  1. Discusses positive and negative responses to client's illness.
  2. Plans/engages in appropriate activities with client.

AIDS

Overview

A. In the United States, many thousands of reported cases and deaths, estimates between 1 and 2 million infected.
B. Highest risk populations: homosexual/bisexual men, IV drug users and their sexual partners, hemophiliacs, newborns from infected mothers, and black females between the ages of 15 and 44 years.
C. Approximately 60% of persons with AIDS develop neurological symptoms.
D. Health care workers may have difficulty caring for these clients because of fear of contagion, knowledge deficit, bias against lifestyle, or burnout.
E. Families/partners will require support, education, and counseling.

Assessment

A. Physical symptoms
  1. Fever
  2. Fatigue
  3. Weight loss
  4. Diarrhea
  5. Opportunistic infections
B. Neurological and emotional responses
  1. Depression
  2. Panic disorders
  3. Paranoid reaction
  4. HIV dementia complex
C. See AIDS (Unit 4) for other physical assessment findings.

Analysis

A. Anxiety
B. Fear
C. Ineffective denial
D. Anticipatory grieving
E. Ineffective coping
F. Powerlessness
G. Risk for violence, self-directed
H. Social isolation

Planning and Implementation

Goals

A. Client will:
  1. Communicate responses (physical and psychologic) to disease process
  2. Maintain ADLs as long as possible
  3. Report suicidal ideation/impulses
B. Family/partners will:
  1. Seek support and education relating to care of HIV-positive client
  2. Communicate responses to client's illness to nurse/support group
C. Health care workers will:
  1. Discuss feelings of homophobia, addictophobia, and fear of infection
  2. Attend groups for education and support

Interventions

A. Monitor cognitive and affective domain.
B. Encourage communication of fears and concerns.
C. Maintain nonjudgmental attitude.
D. Assist client/family through grieving process.
E. Provide opportunities for decision making to client and/or caregivers.

Evaluation

A. Client participates in care decisions.
B. Client and caregivers discuss responses to illness.
C. Client expresses anger but does not harm self.

DEATH AND DYING

Overview

A. One of the most difficult issues in nursing practice
B. Often difficult for nurses to maintain objectivity because of identification and response to death based on own value system and personal experiences

Assessment

A. Stage of dying (Kubler-Ross); see Table 7-11
B. Physical discomfort
C. Emotional reaction (withdrawal, anger, acceptance) and stage of dying

Table 7-11 Stages of Dying

1. Denial and isolation
2. Anger
3. Bargaining
4. Depression
5. Acceptance

D. Desire to discuss impending death, value of own life
E. Level of consciousness
F. Family needs

Analysis

Nursing diagnoses for the dying client may include:
A. Anxiety
B. Pain
C. Ineffective coping
D. Fear
E. Anticipatory grieving
F. Hopelessness
G. Impaired mobility
H. Powerlessness
I. Self-care deficit
J. Social isolation

Planning and Implementation

Goals

A. Client will:
  1. Be maintained in optimum comfort.
  2. Not be alone.
  3. Have opportunity to discuss what death means and to progress through stages of dying.
B. Family will have opportunity to be with client as much as they desire.

Interventions

A. Recognize clients/families have own way of dealing with death and dying.
B. Support clients/families as they work through dying process.
C. Accept negative responses from clients/families.
D. Encourage clients/families to discuss feelings related to death and dying.
E. Support staff and seek support for self when dealing with dying client and grieving family.

Evaluation

A. Client
  1. Takes opportunity to discuss feelings about impending death and eventually acknowledges inevitable outcome.
  2. Is comfortable and participates in self-care for as long as possible.
B. Family discusses feelings about loss of loved one.

GRIEF AND MOURNING

Overview

A. Response to loss (person, body part, role)
B. Biologic, psychologic, social implications
C. Family system effects

D. Mourning is process to resolve grief
  1. Shock, disbelief are short term
  2. Resentment, anger
  3. Concentration on loss
    a. Possible auditory, visual hallucinations
    b. Possible guilt
    c. Possible fear of becoming mentally ill
  4. Despair, depression
  5. Detachment from loss
  6. Renewed interest, investment in others/interests

Assessment

A. Weight loss
B. Sleep disturbance
C. Thoughts centered on loss
D. Dependency, withdrawal, anger, guilt
E. Suicide potential

Analysis

A. Ineffective coping
B. Hopelessness
C. Sleep pattern disturbance
D. Disturbed thought processes
E. Risk for violence, self-directed

Planning and Implementation

Goals

Client/family will:
A. Discuss responses to loss.
B. Resume normal sleeping/eating patterns.
C. Resume ADLs as they accept loss.

Interventions

A. Encourage client/family to express feelings.
B. Accept negative feelings/defenses.
C. Employ empathic listening.
D. Explain mourning process and relate to client/family responses.
E. Refer client/family to support groups.

Evaluation

Client/family
A. Express feelings.
B. Progress through mourning process.
C. Seek necessary support groups.

Sample Questions

132. An 18-month-old has been admitted for second-degree burns surrounding the genital area. Her mother told the nurse that the child grabbed for the hot coffee cup and spilled it on herself. Legally, what is the nurse required to do?
  1. Testify in court on the injuries.
  2. Report suspected child abuse.
  3. Have the mother arrested.
  4. Refer the mother to counseling.

133. A toddler was admitted for second-degree burns surrounding the genital area. Her mother told the nurse that the child grabbed the hot coffee cup and spilled it on herself. The toddler's mother is 17 years old. In which of the areas would the nurse provide health teaching?
  1. Normal growth and development.
  2. Bonding techniques.
  3. How to childproof the apartment.
  4. Parenting skills.

134. A young woman was returning home from work late and was sexually assaulted. She was brought to the emergency room upset and crying. What is the nurse's main goal?
  1. Assist her in crisis.
  2. Notify the police of the alleged assault.
  3. Understand she will have a long recovery period.
  4. Provide support and comfort.

135. The nurse is caring for a young woman who was sexually assaulted. Which of the following is indicative of successful adjustment to the trauma?
  1. She moves to another city.
  2. She resumes her work and activities.
  3. She takes classes in the martial arts.
  4. She remains silent about the assault.

136. A young man has recently begun experiencing forgetfulness, disorientation, and occasional lapses in memory. The client was diagnosed with AIDS dementia. His family began sobbing on hearing the diagnosis. What would be an appropriate response from the nurse?
  1. "You must never give up hope."
  2. "He was in a high-risk group for AIDS."
  3. "I can understand your grief."
  4. "This must be very difficult for you."

137. The nurse is planning care for a young man who has AIDS dementia. What is the primary goal in his care?
  1. Enhance the quality of life.
  2. Teach him about AIDS.
  3. Discuss his future goals.
  4. Provide him with comfort and support.

138. What is one of the major fears experienced by people with AIDS?

1. Dying.
2. Debilitation.
3. Stigma.
4. Poverty.

139. A school nurse is assessing a second-grade child for symptoms of sexual abuse. Which of the following behavioral symptoms would support the possibility of sexual abuse?

1. Enuresis, impulsivity, decline in school performance.
2. Thumb sucking, isolating self from peers on playground, excessive fearfulness.
3. Hyperactivity, rocking, isolating self from peers on playground.
4. Stuttering, rocking, impulsivity.

140. A 21-year-old college student is seen in the ER following an incident of date rape. During the nursing assessment, the client describes the entire chain of events with a blank facial expression. She ends her comments by saying, "It's like it didn't happen to me at all." Which of the following statements most accurately explains that patient's reaction?

1. This client is using dissociation/isolation as a defense mechanism to cope with the attack.
2. This client is using denial as a defense mechanism to cope with the attack.
3. This client is in the shock phase of a crisis and is repressing feelings associated with the traumatic event.
4. This client is using reaction formation to manage the hostility she feels toward the attacker.

141. A 38-year-old mother of three children is seen in the medical clinic with complaints of chronic fatigue. The woman looks sad, makes only brief eye contact, and startles easily. The nurse acknowledges these observations and the woman says, "My husband has started to hold a gun to my head when I don't do exactly what he wants." Which of the following is the most appropriate response by the nurse?

1. "What is it you won't do that makes him do this?"
2. "Tell me what has influenced your decision to stay with your husband?"
3. "That is abusive behavior; there are resources which can help you."
4. "How often does this happen?"

142. Which of the following statements made by a victim of spouse abuse would indicate to the nurse that the woman was admitting that she was a victim of spousal abuse?

1. "It would be nice to be out of the situation, but I cannot afford to leave. I have no skills."
2. "My husband has never visited me when I've been in the hospital. He even said he will take me out more often."
3. "Last time it happened I tried to talk to his mother. She said he was never like this growing up."
4. "I have the shelter number and I've decided to work on my high school diploma while the kids are in school each day."

143. A 78-year-old male with a history of cancer of the prostate is admitted to the medical unit for the fourth time in 6 weeks. On admission, the client is confused and has a decubitis ulcer the size of a fifty cent piece on the sacral area. The client did not have this breakdown on discharge 10 days ago. The nurse also notes what appear to be friction burns on both wrists. Which of the following nursing diagnosis statements takes priority in the care of this patient?

1. Impaired skin integrity.
2. Disturbed thought processes.
3. Ineffective health maintenance.
4. Risk for injury.

144. A 27-year-old is admitted to the medical unit with severe abdominal pain, dehydration, and renal insufficiency associated with substance abuse. The patient's admitting chest X-ray shows diffuse interstitial infiltrates and the physician asks that the client give consent for HIV testing. The client consents and the test returns positive. After learning of the positive results, the client says to the nurse, "I never thought this would happen to me. I don't know if I can go through this." Which of the following nursing diagnosis statements is of highest priority for this patient?

1. Anticipatory grieving.
2. Risk for infection.
3. Risk for self-directed violence.
4. Thought process, altered.

145. The nurse is changing the dressing on a client who has had a modified radical mastectomy 2 days ago. The client refuses to look in the direction of the nurse or the operative site. The nurse notices a tear running down the client's cheek. Which of the following responses would most appropriately facilitate the client's grief resolution?

1. "You look very sad, it might help you feel better if you let yourself cry."
2. "Tell me what's the worst part about losing your breast."
3. "Everything is going to be all right; you can be fitted for a new bra and no one will notice."
4. "Are you crying because you are concerned about how your partner will respond?"

146. A 42-year-old male is admitted to the medical unit for insertion of an access site for hemodialysis. The client relates that his transplant graft failed, he has lost his job due to corporate downsizing, and his wife left him recently. He has now moved back into his parents' home. Which of the following nursing diagnosis statements takes priority in planning nursing care for this client?

1. Fluid volume deficit.
2. Ineffective denial.
3. Ineffective tissue perfusion; renal.
4. Powerlessness.

147. The condition of a client diagnosed with chronic obstructive pulmonary disease (COPD) and cor pulmonale is deteriorating. The client is very hypoxemic, obtunded, and easily fatigued by any activity. The nurse who has been working with this client throughout this hospitalization is repositioning the client. Which of the following remarks made by the client indicates that the client has come to terms with death?

1. "It is finally spring and that is my favorite time of year."
2. "Am I going to die?"
3. "I'm very tired, but content and ready to go."
4. "I'm feeling stronger by the moment today."

148. A family member whose mother is terminally ill asks to speak to the nurse. Which of the following statements made by this family member should indicate to the nurse that this family member understands the emotional response to death and dying?

1. "Mother seems very comfortable; so we're able to recall some of our good times spent together."
2. "My mother is irate because she says you all told her she had to have an advanced directive."
3. "My mother is talking about redoing her bedroom when she's discharged. Doesn't she know she's dying?"
4. "My mother is crying so much these days. Where's all this sadness coming from?"

Answers and Rationales

132. 2. Legal statutes require health professionals to report suspected cases of child abuse. The burn pattern described is consistent with being placed in a tub of very hot water.

133. 4. Because the toddler's mother is only 17 years old, she needs information and role modeling on how to provide an emotionally and physically safe environment for her child. This response is more inclusive and includes the other responses.

134. 1. A sexual assault is a crisis situation that requires crisis intervention.

135. 2. The goal of adjustment is to have the woman return to her precrisis level of functioning.

136. 4. AIDS is an illness that generates intense emotional reactions and fears. Acknowledging these feelings allows the family to discuss them with the nurse in a nonthreatening environment.

137. 1. Because the client's illness has no cure and the progression is dependent on the body system affected, the primary goal is to ensure his personal dignity and make plans to fulfill personal goals.

138. 2. Research has found that many clients with AIDS are most fearful of the debilitating effects of the disease.

139. 2. Behavioral symptoms of children who are victims of sexual abuse include: regression (thumb sucking would be regressive behavior in a second-grade child who is probably around 7 years old), disturbed sleep patterns, clinging behaviors, lack of peer friendships, sexual acting out, running away or threats to do so, and suicide attempts.

140. 1. One of the defense mechanisms that a person can use to manage the anxiety associated with an attack/rape is dissociation/isolation in which the client strips an event of its emotional significance and affective content.

141. 3. This response identifies the husband's behavior as abusive and offers help for the wife if she is ready to consider other options. It does not cast judgment on her or question why she stays.

142. 4. This statement acknowledges that the victim has admitted the need for protection in case of emergency and is making plans to work on

establishing some degree of autonomy, which is a factor that keeps many women in abusive relationships.

143. 4. The highest priority for this client based on the available data is the increased risk for injury because of confusion. The nurse's immediate concern must be the client's safety in the present environment.

144. 3. Based on the patient's comment, the highest priority of care for this client immediately is the risk of suicide. He states he doesn't know if he can go through this. Suicide is a common reaction of persons who learn they are HIV-positive, which is associated with stigma and many losses. The client does not have a history of positive coping, which increases the risk of suicide.

145. 1. This acknowledges the client's mood and gives her permission to cry. Crying puts the client in touch with the sadness/pain over the loss. Offering permission to cry facilitates expression of feelings related to the loss.

146. 4. Powerlessness, or feelings of uncertainty about the future, may be present in this client due to the uncertainty about his future in several areas: job, another transplant, long-term hemodialysis, reconciliation in his marriage, whether he will have to be dependent on parents long term, and concern about their own possible declining health.

147. 3. This response indicates that the client is exhausted and ready to let the natural processes take their course. The client is at peace.

148. 1. This statement indicates that the family member and mother have been able to reminisce about good times together, acknowledging that there may be few remaining times to share these memories. This sharing indicates both have accepted death of mother and its finality.

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