Psychiatric Nursing

## THERAPEUTIC COMMUNICATION

Therapeutic communication is the hallmark of psychiatric nursing.

Description: It includes both verbal and nonverbal interactions that involve facial expressions, as well as body language among the nurse, clients, colleagues, and health care providers. This involves a reciprocal process that can create either a therapeutic
interaction or communication barriers.

A. Communication is the primary tool used in the deliver of
   psychiatric nursing care and all nurse-client interactions (Table 7.1)
B. Face-to-face communication involves both the verbal and nonverbal expression of the sender's thoughts or feelings.

    1. Voice inflection, rate of speech, and words convey cognitive and affective messages.
    2. Nonverbal messages are communicated via body language, eye movements, facial expressions, and gestures (Fig. 7.1). Thus, it is important that the nurse is always aware that clients are greatly influenced by nonverbal communication.
    3. Messages are conveyed by the sender to the recipient through sight, sound, touch, and smell. Nonverbal messages can be very powerful; for example, wrinkling your nose at a malodorous client conveys a negative and rejecting message (Fig. 7.2).
    4. The focus of therapeutic interaction is to establish a constructive relationship.
    5. It is the means through which nurses influence the behavior of others; therefore, it is critical to the successful outcome of nursing interventions (Table 7.2).

## COPING STYLES (DEFENSE MECHANISMS)

Description: Coping styles are automatic psychological processes that protect the individual against anxiety and awareness of internal and external dangers and stressors. The individual may or may not be aware of these processes (Table 7.3).

## TREATMENT MODALITIES

Description: Psychiatric and mental health treatment modalities used to promote mental health

**Types of Treatment Modalities**

A. Milieu therapy

1.The planned use of people, resources, and activities in the environment to assist in improving interpersonal skills, social functioning, and performing the activities of daily living (ADLs), as well as safety and protection for all clients.

2. Milieu therapy occurs in inpatient and outpatient settings by providing clients an opportunity to actively participate in treatment, decrease social isolation, encourage appropriate social behaviors, and educate clients in basic living skills.

3. Clients are provided a safe place to learn and adopt mature and responsible behavior through staff limit setting and client responses to maladaptive social responses.

4. Limit setting is a component that requires consistent setting of appropriate limits by all staff, nurses, physicians, and health care workers to work with one another via shared communication to maintain and reestablish limit setting

5. Milieu therapy also uses activities that support group sharing, cooperation, and compromise (e.g, unit-gov-erning groups).

6. Nursing interventions in milieu therapy support client privacy and autonomy and provide clear expectations.

B. Behavior modification

1. This process attempts to change ineffective or maladaptive behavioral patterns; it focuses on the consequences of the client's actions rather than on peer pressure.

2. Positive reinforcement is used to strengthen desired behavior (e.g., a client is praised or given a token that can be exchanged for a treat or desired activity).

3. Negative reinforcement is used to decrease or eliminate inappropriate behavior (e.g., ignoring undesirable behavior, removing a token or privilege, giving a "time out").

4. Role modeling and teaching new behaviors are import- ant interventions.

C. Family therapy

1. This form of group therapy identifies the entire family as the client.

2. It is based on the concept of the family as a system of interrelated parts forming a whole.

3. The focus is on the patterns of interaction within the family, not on any individual member.

4. The therapist assists the family in identifying the roles assigned to each member based on family rules.

5. Congruent and incongruent communication patterns and behaviors are identified.

6. Life scripts (living out parents' dreams) and self-fulfilling prophecies (unconsciously following what one thinks should happen, therefore setting it up to happen) are identified.

7. The goal is to decrease family conflict and anxiety and to develop appropriate role relationships.

D. Crisis intervention

1. A crisis may develop when previously learned coping mechanisms are ineffective in dealing with the current problem.

2. This form of therapy is directed at the resolution of and immediate crisis, which the individual is unable to handle alone.

3. The individual is usually in a state of disequilibrium.

4. If a client is in a panic state as a result of the disorganization, be very directive.

5. Focus on the problem, not the cause.

6. Identify support systems.

7. Identify past-coping patterns used in other stressful situations.

8. The goal is to return the individual to precrisis level of functioning.

9. Crisis intervention is usually limited to 6 weeks.

| TABLE 7.1 Helpful Techniques | |
|---|---|
| Acknowledgment | Recognizing the client's opinions and statements without imposing your own values and judgment |
| Clarifying | The process of making sure you have understood the meaning of what was said |
| Confrontation | Should be used judiciously, calling attention to inconsistent behavior |
| Focusing | Assisting the client to explore a specific topic. which may include sharing perceptions and theme identification |
| Information giving | Feedback about client's observed behavior |
| Open-ended questions | Questions that require more than a yes or no response |
| Refflecting/restating | Paraphrasing or repeating what the client has said (be careful not to overuse; client will feel as though you are not listening) |
| Silence | Can be therapeutic or can be used to control interaction; use carefully with paranoid client, may be misinterpreted or could be used to support paranoid ideation |
| Suggesting | Offering alternatives, such as, "Have you ever considered ...?" |

**TABLE 7.2 Useful and Forbidden Phrases**

| Description | Example |
|---|---|
| **Useful Phrases** | |
| • These are phrases that are useful in therapeutic interaction.<br>• Keep the interaction open, genuine, and client centered.<br>• Keep the client as the focus.<br>• Be aware of your own feelings and anxiety level. | - "Tell me about …"<br>- "Go on …"<br>- "I'd like to discuss what you're thinking ..."<br>- "What are your thoughts …?"<br>- "Are you saying that …?"<br>- "What are you feeling?"<br>- "It seems as if …" |
| **Forbidden Phrases** | |
| • These are phrases that should not be used when interacting with clients. Avoid them at all costs (especially if they appear on an examination).<br>• Avoid social interaction, cliches, and saying too much<br>• Avoid changing subjects.<br>• Avoid words like good, bad, right, wrong, and nice. | - "You should …"<br>- "You'll have to"<br>- "You can't …"<br>- "If it were me, I'd …"<br>- "Why don't you …"<br>- "I think you …"<br>- "It's the policy on this unit."<br>- "Don't worry"<br>- "Everyone …"<br>- "Why …?"<br>- "Just a second …"<br>- "I know …" |

| TABLE 7.3 Coping Styles (Defense Mechanisms) | | |
|---|---|---|
| Style | Description | Example |
| Denial | Unconscious failure to acknowledge an event, thought. or feeling that is too painful for conscious awareness | A women diagnosed with cancer tells her family all the tests were negative |
| Displacement | The transference of feelings to another person or object | After being scolded by his supervisor at work, a man home and kicks the dog for barking. |
| Identification | Attempt to be like someone or emulate the personality. traits, or behaviors of another person | A teenage boy dresses and behaves like his favorite singer. |
| Intellectualization | Using reason to avoid emotional conflicts | The wife of a substance abuser describes in detail the dynamics of enabling behavior yet continues to call her husband's to report his Monday morning absences as an illness. |
| Introjection | Incorporation of values or qualities of an admired person or group into one's own ego structure | A young man deals with a business client in the same fashion his father deals with business clients. |
| Isolation | Separation of an unacceptable feeling, idea, or impulse from one's thought process | A nurse working in an emergency room is able to care for the seriously injured by isolating or separating the nurse's feelings and emotions related to the clients' pain, injuries, or death. |
| Passive-aggression | Indirectly expressing aggression toward others; a façade of overt compliance masks covert resentment | An employee arrives late to a meeting and disrupts others after being reminded of the meeting earlier that day and promising to be on time |
| Projection | Attributing one's own thoughts or impulses to another person | A student who has sexual feelings toward a teacher tells friends the |

| | | |
|---|---|---|
| | | teacher is “coming on to the student” |
| Rationalization | Offering an acceptable, logical explanation to make unacceptable feelings and behavior acceptable | A student who did not do well in a course say it was poorly taught and the course content was not important anyway. |
| Reaction formation | Development of conscious attitudes and behaviors that are the opposite of what is really felt | A person who dislikes animals does volunteer work for the Humane Society. |
| Regression | Reverting to an earlier level of development when anxious or highly stressed | After moving to a new home, a 6-year-old starts wetting the bed. |
| Repression | The involuntary exclusion of a painful thought or memory from awareness | A young client whose parent died when the client was 12 years old cannot tell you how old the client was or the year the parent died. |
| Sublimation | Substitution of an unacceptable feeling with a more socially acceptable one | A student who feels too small to play football becomes a champion marathon swimmer. |
| Suppression | The intentional exclusion of feeling and ideas | When about to lose their car, the couple says, “I’ll think about it tomorrow” |
| Undoing | Communication or behavior done to negate a previously unacceptable act | A young person who used to hunt wild animals now chair a committee for the protection of animals. |

E. Cognitive therapy

1. It is directed at replacing a client's irrational beliefs and distorted attitudes.

2. It is focused, problem-solving therapy.

3. 1 The therapist and client work together to identify and solve problems and overcome difficulties

4. It is short-term therapy of 2 to 3 months' duration.

5. It involves cognitive restructuring.

F. Electroconvulsive therapy (ECT)

1. ECT involves the use of electrically induced seizures for psychiatric purposes. It is used with severely depressed clients who fail to respond to antidepressant medications and therapy. It may be used with extremely suicidal clients because 2 weeks are needed for antidepressants to take effect.

2. Nursing care before ECT

a. Prepare client by teaching what the treatment involves.

b. Avoid using the word “shock” when discussing the treatment with client and family.

c. An anticholinergic (e.g., atropine sulfate) is usually given 30 minutes before treatment to dry oral secretion.

d. A quick-acting muscle relaxant (e.g., succinylcholine [Anectine] ) or a general anesthetic agent is given to the client before the ECT. This helps to relax the client, thus preventing bone or muscle damage.

e. Provide an emergency cart, suction equipment, and oxygen available in the room.

3. Nursing care after ECT

a. Maintain patent airway; the client is in an unconscious state immediately after ECT.

b. Check vital signs every 15 minutes until the client is alert.

c. Reorient the client after ECT (mild confusion is likely upon awakening, and short-term memory impairment may occur, as is usual when any anesthetic is administered)

d. The client may or may not complain after ECT. However, common complaints that often occur after anesthesia is administered may include

1. Modest Headache
2. Mild Muscle soreness
3. Moderate Nausea
4. Retrograde amnesia

G. Group intervention

1. This process is used with two or more clients who develop interactive relationships and share at least one common goal or issue.

2. The types of groups are as follows:

a. The group may be closed (set group) or open (new members may join).

b. The group may be small or large (>10 members).

c. There are many types of groups (psychoeducation, supportive therapy. psychotherapy, self-help).

d. Common nurse-led intervention groups include those that focus on medications, symptom management, anger management, and self-care.

3. The phases in groups are as follows:

a. The initial, or orientation, phase is characterized by:

1. High anxiety
2. Superficial interactions
3. Testing the therapist to see if therapist can be trusted

b. The middle, or working. phase is characterized by:

1. Problem identification
2. The beginning of problem solving
3. The beginning of the group sense of "we"

c. The termination phase is characterized by:

1. Evaluation of the experience
2. The expression of feelings ranging from anger to joy

4. The advantages of groups are:

a. The development of socializing techniques

b. The opportunity to try new behaviors

c. The promotion of a feeling of universality (i.e., not The opportunity for feedback from the group, w being alone with problems)

d. The opportunity for feedback from the group, which may correct distorted perceptions

e. The opportunity for clients to look at alternative ways of analyzing and dealing with problems

REVIEW OF THERAPEUTIC COMMUNICATION AND TREATMENT MODALITIES

1. After the fourth group meeting, the informal leader makes the statement that she believes she can help the group more than the assigned facilitator and has better credentials. Identify the group dynamics and stage of development.
2. On an inpatient psychiatric unit, clients are expected to get up at a certain time, attend breakfast at a certain time, and arrive for their medications at the correct time. what from of therapy is incorporated into this unit?
3. The wife of a man killed in a motor vehicle accident has just arrived at the emergency department and is told of her husband's death. What nursing actions are appropriate for dealing with this crisis?

4. A 10-year-old is admitted to the children's unit of the psychiatric facility after stabbing a sibling. The client's behavior is extremely aggressive with the other children on the unit. Using a behavior-modification approach with positive reinforcement, design a treatment plan for this child.
5. The 10-year-old, his sister, his mother, and the mother's live-in boyfriend are asked to attend a therapy meeting. Who is the "client" who will be treated during this session?
6. A 66-year-old client is admitted to the psychiatric unit with agitated depression. Client has not responded to antidepressants in the past. What would be the medical treatment of choice for this client?
7. Describe the nurse's role in preparing clients for ECT.
8. Describe the nursing interventions used to care for a client during and after ECT.

ANXIETY AND RELATED DISORDERS

ANXIETY

Description: Anxiety is unexplained discomfort, tension, apprehension, or uneasiness, which occurs when a person feels a threat to self. The threat may be real or imagined and is a very subjective experience.

Levels of Anxiety

A. Mild anxiety
    1. Is associated with daily life; motivates learning
    2. Produces increased levels of sensory awareness and alertness
    3. Allows for thoughts that are logical; client is able to concentrate and problem-solve
    4. Allows client to appear calm and in control
B. Moderate anxiety
    1. Continues to motivate learning with assistance from others
    2. Allows client to be attentive and able to focus and problem-solve but not at an optimal level
    3. Dulls perceptions of sensory stimuli; client becomes hesitant
    4. Causes client's speech rate and volume to increase; client becomes wordy
    5. Causes client to become restless (frequent body move- ments and gestures)
    6. May be converted into physical symptoms, such as headaches, nausea, diarrhea, and tachycardia
C. Severe anxiety
    1. Stimulates fight-or-flight response
    2. Causes sensory stimuli input to be disorganized
    3. May cause perceptions to be distorted
    4. Impairs concentration and problem-solving ability
    5. Results in selective attention, focusing on only one detail

6. Results in the verbalization of emotional pain (e.g., "I need help, I can't stand this.")

2. Causes physiologic changes.

a. Increased heart rate and blood pressure (BP)

b. Rapid, shallow respirations

c. Dry mouth and tight feeling in throat

d. Muscle tension, tremors, pacing

e. Anorexia

f. Urinary frequency

g. Palmar sweating

3. Panic

1. Causes perceptions to be grossly distorted; client is unable to differentiate real from unreal

2. Causes client to be unable to concentrate or problem-solve, causes loss of rational, logical thinking, Client may have hallucinations.

3. Causes client to feel overwhelmed, helpless

4. Causes loss of control, inability to function

5. Can client behavior that may be angry and aggressive or withdrawn, with clinging and crying

6. Requires immediate intervention

## ANXIETY DISORDERS, OBSESSIVE-COMPULSIVE AND RELATED DISORDERS, AND TRAUMATIC AND STRESSOR RELATED DISORDERS

### Generalized Anxiety Disorders

Decription: Unrealistic, excessive, or persistent (lasting 6 months
or longer) anxiety and worry about two or more life circumstances, Previously learned coping mechanisms are inadequate to deal with this level of anxiety must be out of proportion to the actual danger or theat in the situation (DSM-5).

Nursing Assessment

A. Severe anxiety
B. Motor tension
    1. Restlessness
    2. Quickly fatigued
    3. Feelings of “shakiness”
    4. Tension
C. Autonomic hyperactivity
    1. Shortness of breath
    2. Heart palpitations
    3. Dizziness
    4. Diaphoresis
    5. Frequent urination
D. Vigilance and scanning
    1. Difficulty concentrating
    2. Sleep disturbance
    3. Irritability, quick to become angry
E. On edge, appearance of being nervous
F. Low self-esteem

Nursing Plans and Interventions

A. Assess client so as to recognize anxiety and label the feeling Musde tension, tremors, pacing (e.g, "What are you feeling now?").

B. Help client to identify the relationship between the stressor and the level of anxiety.

C. Provide opportunities to learn and test various adaptive coping responses.

D. Encourage exercise, deep-breathing techniques, visualization relaxation techniques, and biofeedback.

E. Decrease environmental stimuli.

Panic Disorders and Phobias

A. Discrete periods of intense fear or discomfort that are unexpected and may be incapacitating.
B. It is characterized by an irrational fear of an external object, activity, situation, and feeling of impending doom.
C. It is a chronic condition that has exacerbations and remissions
D. The client transfers anxiety or fear from its source to a symbolic object, idea, or situation.
E. The client recognizes that the fear is excessive and unrealistic but "can't help it."

Common Phobias

A. Acrophobia: fear of heights
B. Agoraphobia: fear of crowds or open places
C. Claustrophobia: fear of closed-in places
D. Hydrophobia: fear of water
E. Social anxiety disorder
F. Thanatophobia: fear of death

Nursing Assessment

A. Coping styles used (see Table 7.3):
    1. Displacement
    2. Projection
    3. Repression
    4. Sublimation
B. Autonomic hyperactivity
C. Panic attacks that usually peak at 10 minutes but can last up to 30 minutes, with a gradual return to normal functioning
D. Disruption in personal life as well as work life
E. Possible use of alcohol and drugs to decrease anxiety

Nursing Plans and Intervention

A. Establish trust; listen, use a calm approach and direct, simple questions, Remain with client; do not leave alone.
B. Provide a safe environment with reduced stimuli.

C. Draw client's attention away from feared object or situation.

D. Assist client to recognize the factors associated with feared stimuli that precipitate a phobic response.

E. Discuss with the client alternative coping strategies and encourage use of such alternatives.

1. Thought substitution (replacing a fearful thought with a pleasant thought)
2. Relaxation techniques. (Role-playing is useful when the client is in a calm state.)

F. Suggest substitution of positive thoughts for negative ones.

G. Assist in desensitizing client.

H. Gradually and systematically introduce the client to the anxiety-producing stimuli.

I. Pair the anxiety-producing stimuli with another response such as relaxation or exercise.

J. Encourage the sharing of fears and feelings with others.

K. Provide positive reinforcement whenever a decrease in phobic reaction occurs.

L. Administer antianxiety medications as prescribed (Table 7.4).

M. Administer selective serotonin reuptake inhibitors (SSRIs) or other medications as prescribed (Table 7.5).

N. Teach to decrease intake of caffeine and nicotine.

Obsessive Compulsive and Related Disorders

Description: DSM-5 no longer considers Obsessive-Compulsive and Related Disorders a component of Anxiety Disorders; it is now a component of Personality Disorders. Anxiety associated with repetitive thoughts (obsession) or irresistible impulses (compulsion) to perform an action.

A. Fear of losing control is a major symptom of this disorder.
B. New disorders introduced in DSM-5 include
    1. Hoarding
    2. Excoriation (skin-picking)
    3. Trichotillomania (hair-pulling disorder)
    4. Obsessive-compulsive and related disorder due to a medical condition
    5. Substance-or medication-induced obsessive-compulsive and related disorder

Nursing Assessment

A. Use of coping styles to control anxiety (see Table 7.3)
    1. Repression
    2. Isolation

3. Undoing

B. Magical thinking (belief that one's thoughts or wishes can control other people or events)

C. Evidence of destructive, hostile, aggressive, and delusional thought content

D. Difficulty with interpersonal relationships

E. Interference with normal activities (e.g., a client who "must" wash her hands all morning and cannot take her children to school)

F. Safety issues involved in repetitive performance of the ritualistic activity (e.g., dermatitis occurring as a result of the continuous washing of hands)

TABLE 7.4 Antianxiety Drugs

| Drugs | Indications | Reactions | Nursing Implications |
|---|---|---|---|
| **Benzodiazepines** | | | |
| • Chlordiazepoxide | - Reduce anxiety | - Sedation | - Administer at bedtime to alleviate daytime sedation. |
| • Diazepam | - Induce sedation, relax muscles, inhibit convulsions | - Drowsiness<br>- Ataxia | - Greatest harm occurs when combined with alcohol or other central nervous system depressant. |
| • Clorazepate dipotassium | - Treat alcohol and drug withdrawal symptoms | - Dizziness<br>-Irritability<br>-Blood dyscrasias | - Instruct to avoid driving or working around equipment.<br>- Gradually taper drug therapy due to withdrawal effects; do not stop suddenly. |
| • Lorazepam | - Safer than sedative-hypnotics | -Habituation and increased tolerance | - Used only as short-term drug and as supplement to other medications. |
| **Nonbenzodiazepines** | | | |
| • Buspirone | - Reduce anxiety<br>-Help to control symptoms | - Dizziness | - Takes several weeks for antianxiety effects to |

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| | such as insomnia, sweating, and palpitations associated with anxiety | | become apparent.<br>- Intended for short-term use. |
| • Zolpidem | - Used for short-term treatment of insomnia | - Daytime drowsiness | - Give with food 1-1.5 hr. before bedtime. |
| • Ramelteon | - Approved for long-term treatment of insomnia<br>-Selectively binds to melatonin receptors | - Dizziness | - Appropriate for clients with delayed sleep onset. |

Table 7.5 Antidepressant Drugs

| Drugs | | | |
|---|---|---|---|
| **Tricyclics** | **Indications** | **Adverse Reactions** | **Nursing Implications** |
| • Amitriptyline HCL<br>• Desipramine HCL<br>• Imipramine HCL<br>• Nortriptyline HCL<br>• Protriptyline HCL<br>• Maprotiline | - Depression<br>- Clients with morbid fantasies do not respond well to these drugs. | - Anticholinergic effects: dry mouth, blurred vision constipation, and urinary retention<br>- CNS effect: sedation, psychomotor slowing, and poor concentration<br>-Cardiovascular effect: tachycardia, orthostatic hypotension, quinidinelike effect on the heart (assess history of myocardial infarction), prolongation of QTc interval | - Administer at bedtime to minimize sedative effect.<br>- Takes 2-6 wk. to achieve therapeutic effects<br>- 2-3 wk. should elapse between discontinuing tricyclics and initiating MAO inhibitors.<br>- Teach client to avoid alcohol.<br>- Avoid concurrent use of antihypertensive drugs.<br>- Carefully evaluate suicide risk. |

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| | | | - Lethal in overdose. |
| | | -GI effect: nausea and vomiting<br>-Narrow therapeutic index (can be lethal in overdose) | |
| **MAO Inhibitors (Monoamine Oxidase Inhibitors)** | | | |
| • Isocarboxazid<br>• Phenelzine sulfate<br>• Tranylcypromine sulfate<br>• Selegiline | - Depression<br>- Phobias<br>- Anxiety | - Tachycardia<br>- Urinary hesitancy, constipation<br>- Impotence<br>- Dizziness<br>-Insomnia<br>- Muscle twitching<br>- Drowsiness<br>- Dry Mouth<br>- Fluid retention<br>- Hypertensive crisis: severe hypertension, severe headache, chest pain, fever, sweating, nausea and vomiting<br>-Confusion | - Must not be used with tricyclics<br>- Major concern is need for dietary restrictions-certain drug and food interactions can cause hypertensive crisis.<br>- Instruct client not to eat foods with high tyramine content: aged cheese, red wine, beer, aged beef and chicken, liver, yeast, yogurt, soy sauce, chocolate, bananas.<br>- Must not be used with SSRIs<br>- Teach client not to take over-the-counter drugs without physician approval<br>-Teach the warning signs of hypertensive crisis: headaches, palpitations, increased BP.<br>-Teach client to use caution around m |
| **SSRIs (Selective Serotonin Reuptake Inhibitors)** | | | |
| • Fluoxetine HCL<br>• Paroxetine | - Depression<br>- Anxiety | - Drowsiness<br>- Dizziness, lightheadedness | - Effective 2-6 wk. after treatment is initiated.<br>- Should not be used with |

| | | | |
|---|---|---|---|
| • Sertraline<br>• Fluvoxamine<br>• Citalopram | - Panic disorder<br>- Aggression<br>- Anorexia nervosa<br>-OCD | - Headache<br>- Insomnia<br>- Depressed appetite | MAO inhibitor: cause hypertensive crisis (violent reaction)<br>- Should wait at least 14 days between discontinuing MAO inhi fluoxetine (Prozac). |
| • Escitalopram<br>• Vilazodone | - Depression<br>- Anxiety | - Serotonin syndrome<br>- Sexual dysfunction | - At least 5 wk. should lapse between discontinuing fluoxetine and initiating a inhibitor. |
| | - Panic disorder<br>- Aggression<br>- Anorexia nervosa<br>- OCD | - Allergic reaction or rash; withhold drug if occurs<br>- Weight gain | - May be given in evening if sedation occurs.<br>- Monitor for serotonin syndrome (defined by at least three sy<br>- Rapid onset of altered mental states<br>- Agitation<br>- Myoclonus<br>- Hyperreflexia<br>- Fever<br>- Shivering<br>- Diaphoresis<br>- Ataxia<br>- Diarrhea<br>- Caution client about OTC use of St. j<br>- Must be tapered slowly if discontinui from one SSRI to another. |
| **Atypical Antidepressants** | | | |
| • Trazodone | - Depression<br>-With trazodone: insomnia, dementia with agitation | - Safer than tricyclics and MAO inhibitor in terms of side effects | - Effective 4-6 wk. after treatment is initiated. |

| TABLE 7.5 Antidepressant Drugs-cont'd | | | |
|---|---|---|---|
| **Drugs** | **Indications** | **Adverse Reactions** | **Nursing Implications** |
| **S/NRIs (Serotonin/Norepinephrine Reuptake Inhibitors)** | | | |
| • Duloxetine<br>• Venlafaxine<br>• Desvenlafaxine | - Depression<br>- Anxiety<br>- Panic disorder<br>-Aggression<br>- Anorexia nervosa<br>- OCD<br>- Management of diabetic neuropathic pain | - Nausea<br>- Dry mouth<br>- Insomnia<br>- Headache<br>- Fatigue<br>- Depression appetite<br>- Increased sweating<br>- Sexual dysfunction<br>- Withdrawal symptoms with abrupt cessation | - Should not be used with MAO inhibitors: cases hypertensive crisis .<br>- Should wait at least 14 days between discontinuing MAO inhibitor and starting S/NRIs.<br>- Take baseline blood pressure and monitor periodically.<br>-Monitor for worsening of pretreatmen inform client of possibility.<br>- See the previous section in this table Implications for SSRIs. |
| **Norepinephrine Dopamine Reuptake Inhibitors (NDRIs)** | | | |
| • Bupropion<br>• Mirtazapine | - Second line of antidepressant when SSRI and S/NRI are not effective for depression and smoking cessation<br>-Anxiety and sleep disturbances | - Insomnia, tremor, anorexia and weight loss, dry mouth<br>- Sleep disturbances, poor appetite, pain, sexual dysfunction, sedation | - Lowers seizure threshold not be used for patients with seizure disorders or eating disorders because of increased seizure incidence in this group.<br>- Herbal considerations: Ephedra may cause hypertensive crisis.<br>-Inform client: exaggerated with alcohol use or other CNS depressant. Medication taken in |

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|---|---|
| | sedative effects |

G. Recurring intrusive thoughts

H. Recurring, repetitive behaviors that interfere with normal functioning

**Nursing Plans and Interventions**

A. Actively listen to the client's obsessive themes.

B. Acknowledge the effects that ritualistic acts have on the client.

C. Demonstrate empathy.

D. Avoid being judgmental.

E. Provide for client's physical needs.

F. Allow performance of the compulsive activity with attention given to safety (e.g., skin integrity of a hand washer).

G. Explore meaning and purpose of the behavior with client.

H. Avoid punishing and criticizing.

I. Establish routine to avoid anxiety-producing changes.

J. Assist client with learning alternative methods of dealing with stress.

K. Avoid reinforcing compulsive behavior.

L. Limit the amount of time for performance of ritual and encourage client to gradually decrease the time.

M. Administer antianxiety medications as prescribed (see Table 7.4).

N. Administer SSRIs or tricyclic antidepressants as prescribed (see Table 7.5)

**Traumatic and Stressor Related Disorders**

Description: DSM-5 no longer considers posttraumatic stress disorder (PTSD) as a component of anxiety disorders. New nomenclature is "traumatic and stressor related disorders." These disorders include severe anxiety, which results from experiencing or witnessing a traumatic event (e.g., war, earthquake, rape. incest) directly or indirectly and can include a persistent re-experiencing of the trauma. Symptoms include intrusion, negative mood, dissociation, and arousal.

**Nursing Assessment**

PTSD redefined in DSM-5 with four symptom clusters. They are:

A. Avoidance of events or situations that are reminders.

B. Persistent negative alterations in cognitions and mood.

C. Mood, including numbing symptoms, as well as persistent negative emotional states.

D. Alterations in arousal and reactivity, including irritable or aggressive behavior and reckless or self-destructive behavior (suicidal ideation and substance abuse).

Other stressor related disorders include

A. Anxiety level is proportional to the perceived degree threat experienced by the client.

B. Anxiety is manifested in symptomatic behaviors

1. Intrusive thoughts
2. Flashbacks of the experience
3. Nightmares
4. Emotional detachment

C. Responses to anxiety include shock, anger, panic, or denial.

D. May manifest as self-destructive behavior such as suicidal ideation and substance abuse.

**TABLE 7.6 Antipsychotic Drugs**

| Traditional Drugs | Indications | Adverse Reactions | Nursing Implication |
|---|---|---|---|
| **Phenothiazines** | | | |
| • Chlorpromazine HCl<br>• Trifluoperazine HCl<br>• Thioridazine HCl<br>• Perphenazine<br>• Triflupromazine<br>• Loxapine | - To control psychotic behavior: hallucination, delusions, and bizarre behavior | - Drowsiness<br>- Orthostatic hypotension<br>- Weight gain<br>- Anticholinergic effects<br>- Extrapyramidal effects<br>- Pseudoparkinsonism<br>-Akathisia<br>- Dystonia<br>- Tardive dyskinesia<br>- Photosensitivity<br>- Blood dyscrasias: granulocytosis, leukopenia<br>-Neuroleptic malignant syndrome | - Extrapyramidal effects are major concern.<br>- Monitor older clients closely.<br>- Takes 2-3 wk. to achieve therapeutic effect.<br>- Keep client supine for 15 minutes after administration and advise to change positions slowly because of effects of orthostatic hypotension.<br>- Teach client to avoid<br>- Alcohol<br>-Sedatives (potentiate effect of CNS depressant) |

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| | | | - Antacids (reduce absorption of drug) |
| • Fluphenazine HCl | - To control psychotic behavior<br>-Useful in treatment of psychomotor agitation associated with thought disorders | - Same as other phenothiazines | - Absorbed slowly<br>- Used with noncompliant client because it can be administered IM once every 14 days. |
| **Nonphenothiazines** | | | |
| • Haloperidol<br>• Thiothixene HCl<br>• Pimozide | - To control psychotic behavior<br>- Less sedative than phenothiazines | - severe extrapyramidal reactions<br>- Leukocytosis<br>- Blurred vision<br>-Dry mouth<br>- Urinary retention | - Teach client to avoid alcohol.<br>- Pimozide (Orap) is used only for Tourette syndrome. |
| **Long-Acting Drugs** | | | |
| • Fluphenazine decanoate<br>• Haloperidol decanoate | - Clients who require supervision with medication regimens | - Similar to fluphenazine and haloperidol | - Similar to Haldol and Prolixin.<br>- Prolixin can be given every 7-28 days.<br>-Haldol can be given every 4 weeks.<br>-Requires several months to reach steady-state drug levels. |
| **Atypical Antipsychotic Drugs** | | | |
| • Risperidone<br>• Olanzapine<br>• Quetiapine<br>• Aripiprazole | - Treat position and negative symptoms of schizophrenia without significant EPS. | - Risperdal: neuroleptic malignant syndrome (NMS), EPS, dizziness, GI symptoms (nausea, constipation), anxiety | - Monitor WBC weekly for first 6 am, them biweekly.<br>- Baseline vital signs (VS) and ECG: report abnormal VS. |
| • Ziprasidone<br>• clozapine | - Clients who have not responded well to | - Zyprexa: drowsiness, EPS, agitation | - Monitor for symptoms of NMS and EPS. |

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| | typical antipsychotics or have side effects | - Seroquel drowsiness, dizziness, headache, | - Teach to change position slowly. |
| with typical | EPS, weight gain, antipsychotics<br>- Fewer side effects<br>- Clozapine has superior efficacy in clients who have been treatment resistant | anticholinergic effects<br>- Clozaril agranulocytosis, drowsiness, dizziness, GI symptoms, NMS | - Ability is a new class of antipsychotic drugs, dopamine system stabilizer (DSSs) for schizophrenia and acute bipolar mania.<br>- Seroquel: Monitor lipids, especially for obese, diabetic, or hypertensive clients. |

E. Visible reminders of the trauma (e-g, scars, physical disabilities) may trigger reactions.

Nursing Plans and Interventions

A. Provide consistent, nonthreatening environment.
B. Implement suicidal and homicidal precautions if assessment indicates risk.
C. Listen to client's details of events to identify the most troubling aspect of events.
D. Assist client to develop objectivity in perceiving event and identify areas of no control.
E. Assist client to regain control by identifying past situations that have been handled successfully.
F. Administer antianxiety and antipsychotic medications as prescribed so as to decrease anxiety, manage behavior, and provide rest (Table 7.6; and see Table 7.3).
G. Encourage group therapy with clients who have similar experiences and needs.

# Reference

Cuellar, Tina E., Editor.(2020).Comprehensive Review for the NCLEX-RN Examination.