BASIC CONCEPTS IN PSYCHIATRIC NURSING

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, &
Substance Abuse Services

This course is designed to assess the basic competency of Registered Nurses employed in DMH/DD/SAS psychiatric hospitals in the state of North Carolina.To assure quality psychiatric services to the citizens of North Carolina, it is important for Registered Nurses to be competent in the basic concepts of psychiatric nursing and interventions used in the delivery of care. This course will provide a foundation of theory for the RN to draw upon in the practice setting.

The " Basic Concepts in Psychiatric Nursing " is to be completed prior to the start of your assignment. *Successful completion of the course is defined as a grade of 80% on the examination. The participant will be given up to two opportunities to complete the exam (different versions).*

An outline of the required content has been provided for you to study. Participants are to review the content. If there are areas in which you do not feel competent, you should secure a current psychiatric nursing text and study. The Learning Resource Center located on the second floor of the Mildred Brown Staff Development Building has a number of current texts that may be checked out for several weeks.

This course is part of a series of required competency based training. Failure to complete this program successfully within the required time frame will result in separation from employment. If you have questions about any of the content, the Education Coordinator and/or the Clinical Nurse Specialist on your assigned unit will be good resources.

Developed By

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DEFINITIONS

***Nurse-patient relationship**-a time-limited interpersonal process with definable phases.*

***Self-awareness**-the process of understanding one's own beliefs, thoughts, motivations, biases, and physical and emotional limitations and recognizing how they affect others with whom we interact.*

***Therapeutic Communication**-the ongoing process of interaction in which meaning emerges.*

***Verbal Communication**-principally achieved through the spoken words, including the underlying emotion, context, and connotation of what is said. Involves a sender, message and a receiver.*

***Nonverbal Communication**-includes gestures, expressions and body language.*

***Boundaries**-defining limits of persons, objects, or relationships. Personal boundaries include physical,psychological and social dimensions.*

Peplau's Nurse –Patient Relationship Model-

a. ***Orientation phase**-introductions and getting to know each other. The nurse discusses patient expectations, explains the purpose of the relationship, and its boundaries and facilitates development of the relationship.*
b. ***Working phase**-consists of problem identification and exploration. The patient is the one who examines the problems. The nurse can use a variety of verbal and nonverbal techniques to facilitate the process.*
c. ***Resolution phase**-begins when problems are resolved and ends With termination of the relationship. The patient begins to connect with community resources and assumes responsibility for follow-up appointments. New problems are not explored during this phase.*

Milieu Therapy**-focuses on the patient environment usually within the long-term inpatient psychiatric setting. Aims to provide a stable and coherent social organization that facilitates an individual's treatment. Characterized by: **Containment** which is the process of providing safety and security and involves patient access to food and shelter; **Support** is the attention, praise and reassurance given by staff to the patients that improves self-esteem and increases confidence; **Validation** or the affirmation of patient individuality and humanness; **Structured interaction**, the purposeful interaction that allows patients to interact with others in a way that is useful to them; **Open communication** where information is willingly shared between patient and staff and there is patient self-disclosure within the support of the nurse-patient relationship ;Therapeutic environment** which includes a family-like physical environment,involvement of families;patient responsibility for some of the care of the environment and their own clothes and possessions, and group and social interactions.*

COMMUNICATION TECHNIQUES

Technique	Definition	Example	Use
Acceptance	Encouraging and receiving information in a nonjudgmental and interested manner	Pt: I have done something terrible. Nurse: I would like to hear about it. It's OK to discuss it with me.	Used in establishing trust and developing empathy
Confrontation	Presenting the patient with a different reality of the situation	Pt: My best friend never calls me. She hates me. Nurse: I was in the room yesterday when she called.	Confrontation is used cautiously to immediately redefine the patient's reality. However, it can alienate the patient if used inappropriately. A nonjudgmental attitude is critical for confrontation to be effective.
Doubt	Expressing or voicing doubt when a patient relates a situation	Pt: My best friend hates me. She never calls me. Nurse: From what you have told me, that does not sound like her. When did she call you last?	Doubt is used carefully and only when the nurse feels confident about the details. It is used when the nurse wants to guide the patient toward other explanations.
Interpretation	Putting into words what the patients is implying or feeling	Pt: I could not sleep because someone would come in my room and rape me. Nurse: It sounds like you were scared last night.	Used in helping patient identify underlying thoughts or feelings
Observation	Stating to the patient what is being observed by the nurse.	Nurse: You are trembling and perspiring. When did this start?	Used when a patient's behaviors (verbal or nonverbal) are obvious and are unusual for that patient
Open-ended statements	Introducing an idea and letting the patient respond	Nurse: Trust means. . . . Pt: That someone will keep you safe.	Used when helping patient explore feelings or gain insight
Reflection	Redirecting idea back to the patient.	Pt: Should I go home for the weekend? Nurse: Should you go home for the weekend?	Used when patient is asking for the nurse's approval or judgment. Use of reflecting helps nurse maintain a nonjudgmental approach.
Restatement	Repeating the main idea expressed; lets patient know what was heard	Pt: I hate this place. I don't belong here. Nurse: You don't want to be here.	Used when trying to clarify what patient has said
Silence	Remaining quiet, but nonverbally expressing interest during an interaction	Pt: I am angry!! Nurse: (Silence) Pt: My wife had an affair.	Used when patient needs to express ideas but may not know quite how to do it. With silence, patient can focus on putting thoughts together.
Validation	Clarifying the nurse's understanding of the situation	Nurse: Let me see if I understand.	Used when nurse is trying to understand a situation the patient is trying to describe

Source: Boyd,M.A. and Nihart,M.A. Psychiatric Nursing..Contemporary Practice, 1998,New York,Lippencott-Raven

The following defense mechanisms and coping styles are identified in the *DSM-IV* as being used when the individual deals with emotional conflict or stressors (either internal or external):

Defense Mechanism	Definition	Example
Acting out	Using actions rather than reflections or feelings during periods of emotional conflict	A teenager gets mad at parents and begins staying out late at night.
Affiliation	Turning to others for help or support (sharing problems with others without implying that someone else is responsible for them)	An individual has a fight with spouse and turns to best friend for emotional support.
Altruism	Dedicating life to meeting the needs of others (receives gratification either vicariously or from the response of others)	After being rejected by boyfriend, a young girl joins the Peace Corps.
Anticipation	Experiencing emotional reactions in advance or anticipating consequences of possible future events and considering realistic, alternative responses or solutions	A parent cries for 3 weeks before the last child leaves for college. On the day of the separation, the parent spends the day with friends.
Autistic fantasy	Excessive daydreaming as a substitute for human relationships, more effective action, or problem solving	A young man sits in his room all day and dreams about being a rock star instead of attending a baseball game with a friend.
Denial	Refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others (*psychotic denial* used when there is gross impairment in reality testing)	A teenager's best friend moves away, but the adolescent says he does not feel sad.
Devaluation	Attributing exaggerated negative qualities to self or others	A boy has been rejected by his long time girlfriend. He tells his friends that he realizes that she is stupid and ugly.
Displacement	Transferring a feeling about, or a response to, one object onto another (usually less threatening) substitute object	A child is mad at her mother for leaving for the day, but says she is really mad at the sitter for serving her food she does not like.
Dissociation	A breakdown in the usually integrated functions of consciousness, memory, perception of self or the environment, or sensory and motor behavior	An adult relates severe sexual abuse experienced as a child, but does it without feeling. She says that the experience was as if she were outside her body watching the abuse.
Help-rejecting complaining	Complaining or making repetitious requests for help that disguise covert feelings of hostility or reproach toward others, which are then expressed by rejecting the suggestions, advice, or help that others offer (complaints or requests may involve physical or psychological symptoms or life problems)	A college student asks a teacher for help after receiving a bad grade on a test. Every suggestion the teacher has is rejected by the student.
Humor	Emphasizing the amusing or ironic aspects of the conflict or stressor	A person makes a joke right after experiencing an embarrassing situation.
Idealization	Attributing exaggerated positive qualities to others	An adult falls in love and fails to see the negative qualities in the other person.
Intellectualization	Excessive use of abstract thinking or the making of generalizations to control or minimize disturbing feelings	After rejection in a love relationship, the rejected explains about the relationship dynamics to a friend.
Isolation of affect	Separation of ideas from the feelings originally associated with them	The individual loses touch with the feelings associated with a rape while remaining aware of the details.
Omnipotence	Feeling or acting as if one possesses special powers or abilities and is superior to others	An individual tells a friend about personal expertise in the stock market and the ability to predict the best stocks.
Passive aggression	Indirectly and unassertively expressing aggression toward others. There is a facade of overt compliance masking covert resistance, resentment, or hostility.	Passive aggression often occurs in response to demands for independent action or performance or the lack of gratification of dependent wishes but may be adaptive for individuals in subordinate positions who have no other way to express assertiveness more overtly.
Projection	Falsely attributing to another one's own unacceptable feelings, impulses, or thoughts	A child is very angry at a parent, but accuses the parent of being angry.

Defense Mechanism	Definition	Example
Projective identification	Falsely attributing to another one's own unacceptable feelings, impulses, or thoughts. Unlike simple projection, the individual does not fully disavow what is projected. Instead, the individual remains aware of his or her own affect or impulses but misattributes them as justifiable reactions to the other person. Not infrequently, the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first.	A child is mad at a parent, who in turn becomes angry at the child, but may be unsure of why. The child then feels justified at being angry with the parent.
Rationalization	Concealing the true motivations for one's own thoughts, actions, or feelings through the elaboration of reassuring or self-serving but incorrect explanations	A man is rejected by his girlfriend, but explains to his friends that her leaving was the best because she was beneath him socially and would not be liked by his family.
Reaction formation	Substituting behavior, thoughts, or feelings that are diametrically opposed to one's own unacceptable thoughts or feelings (this usually occurs in conjunction with their repression)	A wife finds out about her husband's extramarital affairs and tells her friends that she thinks his affairs are perfectly appropriate. She truly does not feel, on a conscious level, any anger or hurt.
Repression	Expelling disturbing wishes, thoughts, or experiences from conscious awareness (the feeling component may remain conscious, detached from its associated ideas)	A woman does not remember the experience of being raped in the basement, but does feel anxious when going into that house.
Self-assertion	Expressing feelings and thoughts directly in a way that is not coercive or manipulative	An individual reaffirms to another that going to a ball game is not what he or she wants to do.
Self-observation	Reflecting feelings, thoughts, motivation, and behavior and responding to them appropriately	An individual notices an irritation at his friend's late arrival and decides to tell the friend of the irritation.
Splitting	Compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images.	Self and object images tend to alternate between polar opposites: exclusively loving, powerful, worthy, nurturant, and kind—or exclusively bad, hateful, angry, destructive, rejecting, or worthless. One friend is wonderful and another former friend, who was at one time viewed as being perfect, is now believed to be an evil person.
Sublimation	Channeling potentially maladaptive feelings or impulses into socially acceptable behavior	An adolescent boy is very angry with his parents. On the football field, he tackles someone very forcefully.
Suppression	Intentionally avoiding thinking about disturbing problems, wishes, feelings, or experiences	A student is anxiously waiting test results, but goes to a movie to stop thinking about it.
Undoing	Words or behavior designed to negate or to make amends symbolically for unacceptable thoughts, feelings, or actions	A man has sexual fantasies about his wife's sister. He takes his wife away for a romantic weekend.

Vocabulary Associated With Schizophrenia

Delusions are erroneous fixed beliefs that usually involve a misinterpretation of experience. For example, the client believes someone is reading his or her thoughts, monitoring him or her, or plotting against him or her. There are many types of delusions, for example:

- Grandiose—the belief that one has exceptional powers, wealth, skill, influence, or destiny
- Nihilistic—beliefs that one is dead or a calamity is impending
- Persecutory—beliefs that one is being watched, ridiculed, harmed, or plotted against
- Somatic—beliefs about abnormalities in bodily functions or structures

Hallucinations are perceptual experiences that occur in absence of actual external sensory stimuli. They involve any of the five senses, but may be auditory or visual in nature. Auditory hallucinations are more common than visual.

Illusions occur when the person misperceives or exaggerates stimuli that actually exist in the external environment.

The following are examples of confused speech and thinking patterns:

Echolalia—repetition of another's words that is parrotlike and inappropriate
Circumstantiality—extremely detailed and lengthy discourse about a topic
Loose associations—absence of the normal connectedness of thoughts, ideas, and topics; sudden shifts without apparent relationship to preceding topics
Tangentiality—the topic of conversation is changed to an entirely different topic that is a logical progression but causes a permanent detour from the original focus
Flight of ideas—the topic of conversation changes repeatedly and rapidly, generally after just one sentence or phrase
Word salad—string of words that are not connected in any way

Neologisms—words that are made up that have no common meaning and are not recognized
Paranoia—suspiciousness and guardedness that are unrealistic and often accompanied with grandiosity
Referential thinking—belief that neutral stimuli have special meaning to the individual, such as the television commentator speaking directly to the individual
Autistic thinking—restricts thinking to the literal and immediate so that the individual has private rules of logic and reasoning that make no sense to anyone else
Concrete thinking—lack of abstraction in thinking, unable to understand punch lines, metaphors, and analogies
Verbigeration—purposeless repetition of words or phrases
Metonymic speech—use of words interchangeably with similar meanings
Clang association—repetition of word or phrases that are similar in sound but in no other way, for example, right, light, sight, might
Stilted language—overly and inappropriately artificial formal language
Pressured speech—speaking as if the words are being forced out

Disorganized behavior (which may manifest as very slow, rhythmic, or ritualistic movement) coupled with disorganized speech makes it difficult for the person to partake in daily activities. Examples of disorganized behavior include:

Aggression—behaviors or attitudes that reflect rage, hostility, and the potential for physical or verbal destructiveness (usually comes about if the person believes someone is going to do him or her harm)
Agitation—inability to sit still or attend to others, accompanied by heightened emotions and tension
Catatonic excitement—a hyperactivity characterized by purposeless activity and abnormal movements like grimacing and posturing
Echopraxia—involuntary imitation of another person's movements and gestures
Regressed behavior—behaving in a manner of a less mature life stage, childlike and immature
Sterotypy—repetitive, purposeless movements that are idiosyncratic to the individual and to some degree outside of the individual's control
Hypervigilance—sustained attention to external stimuli as if expecting something important or frightening to happen
Waxy flexibility—posture held in odd or unusual fixed position for extended periods of time

Source: Boyd,M.A. and Nihart,M.A. Psychiatric Nursing..Contemporary Practice, 1998,New York,Lippencott-Raven

Upon completion of this section, the participant will be able to identify basic concepts related to care of the psychiatric patient.

Micro-objectives	Content Outline
I. Therapeutic Relationship A. Define the term therapeutic relationship. B. Differentiate between social, intimate, and therapeutic relationship. C. Describe the characteristics of a therapeutic relationship. D. Identify the anxieties of the nurse and patient in a therapeutic relationship. E. Discuss the expectations of the nurse and patient in a therapeutic relationship. F. Describe the ways in which the nurse facilitates the growth of patients.	I. Therapeutic Relationship A. Relationships 1. Definition 2. Purpose B. Types of Relationships 1. Social Relationship 2. Intimate Relationship 3. Therapeutic Relationship C. Characteristics of a Therapeutic Relationship 1. Goal Directed 2. Facilitates Development and Appropriate Coping Skills 3. Offers Patient Potential to Grow 4. Relationship Boundaries 5. Nurses Characteristics: a. Genuineness b. Honesty c. Authenticity d. Respectful of Client e. Supportive f. Consistent g. Accepting (Unconditional) D. Phases of Therapeutic Relationship 1. Introductory Phase a. Establish Caring Relationship b. Communicates Interest c. Demonstrate Acceptance d. Establish Rapport e. Establish Trust

Micro-objectives	Content Outline
	1. Introductory Phase (Cont.) f. Nursing Focus: 1. Respond to Emergency Situations 2. Set up parameters for interaction 3. Explain nurse-patient interactions 4. Gather data 5. Assist patient in identifying problems & plan use of resources/services 6. Reduce patients anxiety g. Collaboratively Nurse Identifies Patient's : 1. Needs 2. Desires 3. Coping Styles 4. Expectations of relationship 2. Middle or Working Phase a. Actively involved in Meeting Goals Established in Introductory Phase b. Encourage Expression of Feelings c. Attempt New Adaptation Approaches d. Reinforce Effective Problem Solving e. Avoid over-helping, controlling, or being narcissistic f. Reinforce trust through acceptance g. Increase functioning of patient h. Therapeutic Tasks Include: 1. Increase patients awareness and perception 2. Develop realistic self-concept & promote self-confidence 3. Recognize discomfort & verbalize feelings

Micro-objectives	Content Outline
	2. Middle or Working Phase (Cont.) 4. Make comparisons of ineffective behavior in & outside relationship, draw conclusions regarding these comparisons 5. Develop a plan of action, implement the plan, & evaluate the results to alter behavior 6. Assess patient's readiness and provide opportunities for independent functioning 3. Termination Phase a. Bound by Time Restrictions established in Orientation Phase b. May be Traumatic for Patient 1. Nurse helps patient adapt 2. Regression may occur c. Supportive of Coping Behavior d. Sensitive to Patient Needs e. Maintain Boundaries f. Involve Patients Families g. Assist in Socialization with Others h. Primary Nursing Tasks: 1. Decrease contact time with patient 2. Be more relaxed, less intense 3. Focus on future 4. Discourage new exploration 5. Provide necessary referrals E. Nursing Expectations 1. Support Patients Own Healing Resources 2. Ensure Relationship Goals Are Based On Patients Needs, Not Nurses Needs

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Micro-objectives	Content Outline
	F. Patient Expectations 1. Relief from Anxiety 2. Feel Open to Verbalize Needs, Fears, & Anxieties 3. Have Opportunities to Test New Adaptive Skills 4. Goal is Independence G. Attitudes of the Nurse 1. Self-Awareness is Essential 2. Avoid Conveying Attitudes of Hopelessness or Helplessness 3. Actively Accepts the Patient 4. Caring and Compassionate
II. Communication A. Define communication and describe the components within the communication process. B. Define therapeutic communication and identify purpose as it relates to the nurse/patient relationship. C. Assess the communication needs and problems of clients. D. Identify sender/receiver impairments affecting communication. E. Discuss non-verbal communication variables affecting communication. F. Discuss verbal communication variables affecting communication. G. Recognize environmental/cultural/educational factors and their impact on communication. H. Identify barriers to therapeutic communication.	II. Communication A. Communication Process 1. Definitions 2. Components a. Sender b. Receiver c. Message d. Message variables 1. Verbal 2. Non-verbal 3. Use of space & territory 4. Culture 5. Perceptions and Values 6. Environmental Factors 7. Feedback

Micro-objectives	Content Outline
II. Communication (Cont.) I. Apply techniques of therapeutic communication: 1. Restating/Paraphrasing 2. Focusing 3. Providing Feedback 4. Stating Observations 5. Connecting Islands of Info. 6. Summarizing 7. Silence 8. Humor 9. Listening 10. Client Self-disclosure 11. Broad Openings 12. Reflection (Feelings & Content) 13. Clarifying (Feelings & Content) 14. Confronting (Feelings & Content) 15. Directing 16. Giving Information 17. Questioning 18. Empathy 19. Touch (use judiciously) J. Strategies for intervening in psychotic communication.	B. Therapeutic Communication 1. Definition/Purpose 2. Therapeutic Communication & the Nurse/Patient Relationship 3. Assessment of Communication a. Sender or Receiver Impairments 1. Sense Deficits: hearing, sight, smell, touch, taste 2. Vocabulary/Composition Deficits 3. Loss/Impaired functions (Ex: speech, writing) 4. Drugs b. Message Variables (Non-verbal) 1. Facial expression 2. Gestures 3. Body movements 4. Affect 5. Tone of voice 6. Posture 7. Eye contact 8. Voice volume, quality pitch c. Message Variables (Verbal) 1. Blocking 2. Slow 3. Rapid 4. Quiet 5. Aphasic 6. Excessive 7. Detailed 8. Stammering 9. Circumstantial 10. Tangential

Micro-objectives	Content Outline
	c. Message Variable (Verbal Cont.) 11. Loose Association 12. Flight of Ideas 13. Word Salad 14. Neologisms 15. Incoherent 16. Echolalia 17. Other 18. Verbigeration 19. Metonymic 20. Clang Association 21. Stilted Language 22. Pressured Speech 4. Congruency between verbal and non-verbal 5. Environment a. External Influences 1. Temperature 2. Physical Arrangement 3. Lighting 4. Noise Level 5. Other b. Internal influences 1. Beliefs 2. Experiences 3. Thoughts 4. Attitudes 5. Other c. Cultural Influences d. Level of Education 6. Barriers to Communication a. Related to Nursing Process 1. Inadequate data collection 2. Inappropriate Nursing Diagnosis 3. Inappropriate outcome criteria b. Organizational 1. Lack of planning 2. Inadequate physical environment

Micro-objectives	Content Outline
	c. Inhibitors to Communication 1. Interrupting 2. Advising 3. False reassurance 4. Giving directions 5. Belittling 6. Being judgmental 7. Using emotionally charged words 8. Challenging 9. Stereotypical comments 10. Closed-ended questions 11. Changing the subject 12. Probing 13. Approving 14. Moralizing 15. Social Response d. Non-Therapeutic Use of Self 1. Self focusing behavior 2. Double blind messages 3. Lack of positive regard 4. Lack of respect 5. Lack of mutual goal setting with client 7. Therapeutic Communication Interventions/Skills A. Restating/Paraphrasing B. Focusing C. Providing Feedback D. Stating Observations E. Connecting Islands of Information F. Summarizing G. Silence

Micro-objectives	Content Outline
	Therapeutic Communication Interventions/Skills (Cont H. Humor I. Listening J. Client self-disclosure K. Broad openings L. Reflection 1. Feelings 2. Content M. Clarifying 1. Feelings 2. Content N. Confronting 1. Feelings 2. Content O. Directing P. Giving Information Q. Questioning R. Empathy S. Touch (Use Judiciously) 8. Intervening in Psychotic Communication A. Do not reinforce psychotic communication B. Show interest and concern C. Utilize activities D. Recognize feelings and messages E. Avoid long periods of silence F. Use statements such as, "I can't follow or understand your words". G. Use statements to return to reality/express doubt. 9. Communicating with the Aggressive Client A. Non-verbal Techniques B. Verbal Techniques

Micro-objectives	Content Outline
III. Mental Health Continuum A. Define the terms mental health and mental illness. B. Differentiate between stress and distress. C. Explain the stages of the General Adaptation Syndrome. D. Discuss coping mechanisms and identify them in situations: 1. Denial 2. Regression 3. Displacement 4. Projection 5. Reaction Formation 6. Repression 7. Suppression 8. Identification 9. Rationalization 10. Fantasy 11. Intellectualization 12. Compensation 13. Dissociation 14. Fixation 15. Restitution 16. Splitting 17. Sublimation 18. Substitution 19. Symbolization 20. Undoing	III. Mental Health Continuum A. Mental Health 1. Definition 2. Components a. Self-governance b. Growth orientation c. Tolerance of uncertainty d. Self-esteem e. Mastery of the environment f. Reality orientation g. Stress management 3. Characteristics a. Psychosocial Resilience b. Demonstration of Freedoms c. Hardiness d. Androgyny e. Balance in Life 1. Physical 2. Spiritual 3. Emotional 4. Social 5. Maslow's Hierarchy of Needs B. Mental Illness/Disorder 1. Definition a. Neurosis b. Psychosis 1. Hallucinations 2. Delusions 3. Illusions C. Stress vs. Distress 1. General Adaptation Syndrome a. Alarm reaction

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Micro-objectives	Content Outline
	b. Stage of resistance c. Stage of exhaustion D. Coping/Defense Mechanisms 1. Denial 2. Regression 3. Displacement 4. Projection 5. Reaction Formation 6. Repression 7. Suppression 8. Identification 9. Rationalization 10. Fantasy 11. Intellectualization 12. Compensation 13. Dissociation 14. Fixation 15. Restitution 16. Splitting 17. Sublimation 18. Substitution 19. Symbolization 20. Undoing E. Manipulative Behavior - Definition-process whereby one individual attempts to influence another to respond in such a way as to meet his needs without consideration of the needs of the other person.

Micro-objectives	Content Outline
	1. Process of Manipulation a. One person has needs not being met by the other person. b. Unmet needs cause the person's anxiety levels to rise. c. The needs of the other person are not regarded. d. Manipulation is attempted; if the manipulative behavior succeeds, the anxiety level is reduced. 2. Nurses self-awareness of feelings evoked by manipulation. 3. Nursing Goal a. Assist patient to become aware of his/her manipulative behavior. b. Assist patient in learning more appropriate forms of interaction. 4. Nursing Interventions a. Treating clients with dignity and respect. b. Using assertive communication. c. Holding firmly to reasonable limits. d. Expecting that all rules apply to all clients with consistent consequences.

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Micro-objectives	Content Outline
IV. Factors that Influence Mental Health and Illness	IV. Factors that Influence Mental Health and Illness
A. Discuss the significance of the nervous system as it relates to psychiatric mental health nursing.	A. Nervous System 1. Central Nervous System a. Composition and Function of 1. Cerebrum 2. Limbic System 3. Brain Stem
B. Discuss the significance of the endocrine system as it relates to psychiatric mental health nursing.	2. Autonomic Nervous System a. Sympathetic b. Parasympathetic a. Dopamine b. Epinephrine c. Norepinephrine
C. Discuss the significance of the immune system as it relates to psychiatric mental health nursing.	3. Neurotransmitters (May be classified differently)
D. Discuss the significance of heredity as it relates to psychiatric mental health nursing.	a. Monoamines 1. Catecholamines 2. Indoleamines (a) Serotonin
E. Discuss the significance of the environment as it relates to psychiatric mental health nursing.	b. Acetylcholine
F. Discuss the significance of culture as it relates to psychiatric mental health nursing.	c. Amino Acids 1. Gamma Amino-Butyric Acid (GABA) 2. Glutamate 3. Glycine 4. Aspartate
G. Discuss the significance of religion/spirituality as it relates to psychiatric mental health nursing.	d. Peptides a. Substance P b. Endorphins and Enkephalins
H. Discuss developmental theories: 1. Freud 2. Sullivan 3. Erikson 4. Piaget	
I. Identify risk factors in Children, Adolescents, and the Elderly that may be related to mental illness.	
J. List factors to be considered during the assessment of a child.	
K. Discuss the changes that take place during adolescence and their effect on mental health.	
L. Discuss the changes that take place in the elderly and their effect on mental health.	

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Micro-objectives	Content Outline
	B. Endocrine System 1. Hypothalmic-Pituitary Thyroid a. Function b. Relevance to Psychiatric Symptoms 2. Hypothalmic-Pituitary Adrenal a. Function b. Relevance to Psychiatric Symptoms 3. Hypothalmic-Pituitary Gonadal a. Function b. Relevance to Psychiatric Symptoms C. Immune System (Neuroimmunology) D. Heredity 1. Depression and Mania 2. Schizophrenia 3. Dementia 4. Personality, Conduct, and Character Disorders E. Environmental 1. Toxic Substances a. Lead and other metals b. Prescription drugs c. Alcohol d. Caffeine 2. Illness and Injury a. Diabetes Mellitus b. Head Injury 3. Seasonal Affective Disorder F. Sociocultural 1. Concepts a. Demographics b. Difference c. Enculturation

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Micro-objectives	Content Outline
	2. Nursing Responsibilities a. Sensitivity b. Reflection c. Introspection 3. Family Involvement 4. Spiritual Delusions 5. Self-Awareness G. Developmental Issues 1. Developmental Theories a. Sigmund Freud 1. Intrapsychic Theory a. Oral Phase b. Anal Phase c. Phallic Phase d. Latent Phase e. Genital Phase b. Harry Sullivan 1. Interpersonal Theory c. Erik Erikson 1. Eight Stages of Man a. Trust vs. Mistrust (Infancy) b. Autonomy vs. shame and doubt (Toddlerhood) c. Initiative vs. guilt (Pre-school years) d. Industry vs. inferiority (Schoolage) e. Identity vs. Role confusion (Adolescence) f. Intimacy vs. isolation (Young adulthood) g. Generativity vs. stagnation (middle adulthood)

Micro-objectives	Content Outline
	h. Playing i. Suicidal intent 3. Adolescents A. Biological/Pubertal Changes B. Psychological/Cognitive Changes C. Social Redefinition D. Contextual Changes 1. Family Relationships 2. Peer Relationships 3. Effects of the School 4. Effects of working E. Secondary Changes 1. Identity 2. Achievement 3. Sexuality 4. Intimacy 5. Autonomy 6. Attachment F. Risk Factors 4. Elderly A. Physiological Changes of Aging 1. Safety Issues (a) Falls (b) Wandering B. Social Adaptation to Aging 1. Retirement 2. Bereavement 3. Relocation C. Risk Factors

Micro-objectives	Content Outline
	1. Eight Stages of Man (Cont.) h. Integrity vs. despair (Older adulthood) d. Jean Piaget 1. Cognitive Theory a. Sensorimotor (0-2 years) b. Preoperational (2-7 years) c. Concrete operational (7-11 years) d. Formal operational (11-15 years) 2. Children a. Mental Illness in Children 1. Risk Factors a. Poverty b. Mentally Ill &/or substance abusing parents c. Abuse (Physical, Sexual) d. Minority/Ethnic Status e. Teenage Parents f. Parental Conflict/Divorce g. Disabilities/Chronic Illness 2. Assessment in Children a. Family Functioning & Relationships b. Sources of Information c. Communication Patterns d. Perceptions of the Child e. Sociocultural influences f. Sharing with parents g. Physical/Mental Assessment

Basic Concepts in Psychiatric/ Mental Health Nursing Curriculum

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
Upon Completion of this module, the participant should be able to:	
1. Give a goal and definition of *Milieu Therapy* (according to the ANA *STANDARDS* of psychiatric nursing practice.)	I. Milieu Therapy A. Definition 1. Total Therapeutic Environment a. Stable, Coherent, Social Organization to facilitate individual treatment. b. Responsibility of the nurse in collaboration with the client and other health care providers. 2. Goal – maximize treatment effects of patient environment.
2. Explain the processes and nursing functions of *Milieu Therapy*.	B. Processes of *Milieu Therapy* 1. Containment a. Safety –food, shelter, etc. b. Support –improves self-esteem 2. Validation a. Human Rights, patient Respect b. Staff Interactions 3. Structured Interaction a. Community Meetings b. Consistent Staff attitudes 4. Open Communication a. Staff Roles and Modeling b. Self- Disclosure

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Basic Concepts in Psychiatric/ Mental Health Nursing Curriculum

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
	5. Arrangement of the Environment a. Allows Freedom b. Promotes Individual Responsibility
3. Compare the use of Milieu Therapy in Short-term, Long-term, and Day Treatment Centers.	C. Activities of Daily Living 1. Setting Limits 2. Flexibility D. Milieu Treatments 1. Group Activities 2. Educational Activities
4. Describe the Critical Elements for nurses in Milieu Therapy	E. Critical Elements 1. Surveillance a. Ongoing b. Based on Risks 2. Area Restriction a. Levels of Restriction b. Least Restrictive to Provide Safety 3. Seclusion a. Defined b. Parameters for Use 4. Restraint a. Chemical versus Physical b. Appropriate uses

Basic Concepts in Psychiatric/ Mental Health Nursing Curriculum

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
Upon Completion of this Module the Participant should be able to:	II. Counseling Interventions
1. State the *ANA STANDARD* for *Counseling Interventions.*	A. ANA Standard 1. Specific Interaction 2. Time-limited Interaction 3. Involves client, family, or group who experiences immediate, or ongoing difficulties related to their health or well-being.
2. Differentiate between psychotherapy and counseling.	B. Psychotherapy versus Counseling 1. Psychotherapy a. Requires a specialist in mental health b. Short-Term Intervention c. Focuses on improving coping abilities and reinforcing healthy behaviors or interaction patterns.
3. Explain the types of Counseling Interventions and nursing implementation techniques required.	C. Types of Counseling Interventions 1. Conflict Resolution a. Resolves disagreements or disputes (Crisis Intervention) b. Requires a trusting nurse-patient relationship and problem-solving skills-- "win-win model": - Identify problem - Develop Expectations for "win-win Situation" - Identify interests - Foster Creative Brainstorming - Combine options into a "win-win situation" c. Boundry Issues -Transference 2. Bibliotherapy

Basic Concepts in Psychiatric/ Mental Health Nursing Curriculum

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
	a. Reading of selected written material for therapeutic purposes. b. Nurses select book, story, or article-- based on patient's reading level-- that has a therapeutic benefit for the patient. 3. Reminiscence a. Thinking about or relating past experiences to enhance life review in elderly patients. b. Patients discuss their past and review their life: -Identify past coping strategies that support current stressful situations -Maintain self-esteem, stimulate thinking, and support the healing process of life review c. Activities -Explain pictures in old family albums -Write accounts of past events -Write to old friends

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Basic Concepts in Psychiatric/ Mental Health Nursing Curriculum

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
Upon Completion of this module, the participant should be able to:	III. Behavior Therapy
1. Define and give the basic premise for behavior therapy. 2. Describe the focus and interventions for behavior therapy.	A. Defined 1. Interventions that reinforce or promote desirable behaviors or alter undesirable ones. 2. Premise that all behaviors are learned, new behaviors can also be learned. B. Focus 1. Behavioral responses 2. Consequences C. Interventions 1. Problematic Behavior a. Reward behavior with positive reinforces b. Will produce same response again 2. All Behaviors- Token Economy a. Reward for selected desired behaviors with tokens to purchase things. -Less Restrictive- tokens purchase privileges -Effective with aggressive and severe and persistent mentally ill psychiatric patients b. Nursing Responsibilities -Careful Assessment of patient's cognitive and behavioral abilities to participate in the program Support patient attempts to carry out positive behaviors
3. Discuss the "privilege system" as a behavior modification approach to patient	3. Privilege System- Regulates amount of freedom persons have a. Used in lieu of token economy

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
Treatment.	-Effective in shaping appropriate social activity -Most restrictive --patients stay on unit -Least restrictive --patients go outside the hospital and into community for short periods -Unit/ward Rules --facilitates comfortable safe living environment - privileges may be lost for violation b. Nursing Considerations -Careful and thorough patient assessment of risk to harm themselves or others -Communicate Unit/Ward Rules and expectations clearly -Reward Valued Responses -Never punish negative behavior; removing the privilege was a natural consequence for a rule violation ***-Ensure approaches are ethically sound, appropriate for the patient, and a consequence of voluntary behavior.***
4. Describe the components of Dialectical Behavior Therapy (DBT) as a treatment option.	D. Components 1. Patient participation a. Collect own data about behavior b. Formulate ***own treatment goals and targets in individual therapy*** d. Work with therapists to change target behaviors 2. Nursing Considerations a. Teach patients to describe emotions without judging them b. Support patients in controlling, managing, and changing behaviors, thoughts, or emotional responses to events.

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
5. Explain the purpose, target groups, basis and components for ***psychoeducation***.	E. Psychoeducation 1. Purpose a. Education of individuals about their disorders and emotional responses. b. Supporting positive coping mechanisms. 2. Target Groups a. Individuals b. Groups c. Families d. Communities 3. Basis a. Teaching learning models that inform patients about their condition b. Identifying symptoms and personal strengths c. Using Strengths to cope with illnesses 4. Components a. Assessment and goal setting b. Developing learning activities c. Evaluating changes in knowledge and behavior
6. Give a definition and list nursing responsibilities for psychosocial rehabilitation (PSR).	F. Psychosocial Rehabilitation (PSR) 1. Definition- Strategies that help the severe and persistent mentally ill cope with their environment. 2. Nursing Responsibilities a. Assist patient to increase functioning in the major life or role areas. -Assist to cope with stress factors -Support them to engage in successful relationships -Promote success in managing a job b. Education

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

	-Problem - solving skills -Personal maintenance skills -Interpersonal skills -Social behavior in work and leisure

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
Upon completion of this module the participant should be able to:	
1. Explain the characteristics of a group.	IV. Groups and Group Therapy A. Characteristics 1. Physical Environment 2. Leadership 3. Decision making 4. Trust 5. Cohesion 6. Power and Influence
2. Analyze group dynamics as related to working with patients and colleagues.	B. Groups Dynamics 1. Roles and Functions of Members 2. Communication Network 3. Norms/ Standards of behavior 4. Group themes
3. State examples of techniques used when leading therapeutic groups.	C. Nursing Leadership Techniques 1. Support 2. Confrontation 3. Advice and suggestions 4. Summarizing 5. Clarification 6. Questioning 7. Repeating/ Paraphrasing 8. Reflecting feeling 9. Reflecting behavior

Boyd, Mary A., & Nihart, Mary A. (1998) *Psychiatric Nursing: Contemporary Practice.* Philadelphia: Lippincott.

Upon completion of this section, the participant will be able to demonstrate knowledge of the various interventions/therapies utilized in the management of psychiatric disorders.

Micro-objectives	Content Outline
Upon Completion of this module, the participant should be able to:	
1. Define and give examples of "Family."	V. Family Interventions A. Definition-- two or more people characterized by mutual attachment, caring, long-term commitment, and responsibility to provide individual growth, supportive relationships, health of members and of the unit, and maintenance of the organization and system during constant individual, family and societal change.
2. Explain family relationship patterns as a basis for engaging in therapeutic interaction.	B. Examples of family relationships 1. Single Parent 2. Multigenerational 3. Same- gender relationships C. Family Relationship Patterns 1. Detached/ avoidant family pattern 2. Chaotic/ ambivalent family pattern 3. Competent/ secure family pattern
3. Discuss nursing intervention categories for families functioning as caregivers.	D. Nursing Interventions 1. Caregiver support-- provide information to facilitate care by someone other than a professional 2. Promote family values, interests 3. Minimize family process disruption 4. Promote family cohesion/ unity 5. Identify and use family strengths to promote patient's health 6. Facilitate family participation in care 7. Assist siblings to cope with brother's or sister's illness

Bibliography

MOOD DISORDERS

Upon completion of this module, the participant will be able to explain the basic concepts related to the care of a patient experiencing Mood Disorder.

Micro Objectives	Content Outline
I. Define mood.	I. Definition: DSM IV, APA, 1994 defines mood as a pervasive and sustained emotion that colors the perception of the world. Variations in mood are a normal response to specific life experiences, are transient, and not associated with significant functional impairment. (see Table 1.)
II. Explain Mood Disorders.	II. Mood disorders A. Persistent or recurrent alterations in mood. B. Continually cause psychological stress and behavior impairment. C. Chronic nature D. Types 1. Euphoria 2. Dysphoria
III. Describe Major Depressive Disorder.	III. Definition: DSM IV, APA, 1994 criteria for Major Depression include: depressed mood or anhedonia (loss of interest or pleasure in activities for at least to weeks). Other criteria include: significant weight loss or change in appetite, sleep disturbances, fatigue and loss of energy, psychomotor agitation or retardation, feelings of worthlessness and guilt, difficulty concentrating or making decisions. Some individuals report or exhibit increased irritability such as persistent anger, an exaggerated frustration over minor matters and/or a tendency to respond to events with angry outbursts. MDD is characterized by clusters of symptoms that define each episode as well as patterns of episodes that define the longitudinal course of the disease. A major depressive episode is considered melancholic if the client experiences either andehonia in relation to all activities, or lack of mood reactivity to usually pleasurable stimuli. Individuals with melancholy appear depressed and exhibit many of the neurovegetative signs of depression such as fatigue, sleeping difficulties, constipation and psychomotor retardation.

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IV. Discuss the epidemiology of Major Depressive Disorder.

V. Review the symptoms of Major Depressive Disorder.

VI. Explain current theories of etiology.

IV. Demographics of Mood Disorder
- A. Prevalence: estimated 11 million people per year suffer from clinical depression.
- B. Age of onset: 25 to 44 years most commonly affected
- C. Gender differences: MDD twice as common in adolescent and adult females as in males
- D. Ethnic/cultural differences DSM IV Criteria and symptoms (see Table 1)

V. DSM IV Criteria and symptoms (see Table 1)

VI. Theories of causation
- A. Biological theories of causation
  1. Genetic transmission: MDD is 1.5 to 3 times more common in first degree biological relatives
  2. Neurotransmission: proposes deficit in the neurotransmitters norepinephrine and seratonin
  3. Kindling theory: proposes that the first episode of depression occurs as a result of external, environmental stressors activating internal physiological stress responses resulting in alterations in the neurotransmission process.
  4. Neuroendocrine disregulation: research has shown that changes in the hypothalmic, pituitary, adrenal HPA (axis) appears to result in increased serum cortisol levels.
- B. Psychosocial
  1. Life events as trigger for disease
  2. Distorted attitudes and irrational beliefs
- C. Social: major depression may follow a traumatic life event such as sexual or physical abuse, or the death of a child, parent or spouse.

VII. Discuss and explain the components of nursing assessment of a patient with the diagnosis of Major Depressive Disorder.

VII. Initial and On-going assessment

A. Review of systems as symptoms of depression may be related to a medical problem.

B. Physical level of functioning
1. weight changes: gain or loss
2. eating habits: changes, eating more or less
3. sleep: more or less
4. usual activities: what is the patient doing?

C. Psychological
1. Problems with mood and affect: "down in the dumps", anhedonia, hopelessness
2. Cognition: may report inability to think, concentrate or make decisions.
3. Behavior changes: social withdrawal, changes in occupational functioning may be present
4. Risk of suicide: according to literature, 15% of depressed persons commit suicide
5. Support systems: what is available to patient; what are his/her patterns of social interaction?

VIII. Examine current interventions used in the treatment of Major Depressive Disorder.

VIII. Interventions

A. Psychopharmacologic agents: See section on Psych drugs and Medication Education Package.
1.Cyclic Antidepressants
2.Selective seratonin reuptake inhibitors
3.Monoamine oxidase inhibitors

B. Safety and physical needs
1. safe environment: assess suicide risk.
2. nutrition: encourage well balanced diet.
3. sleep: promote restful environment.
4. social interaction: offer options.

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VIII (Cont.)

Current Theories of etiology continued

5. promote positive self esteem and success.
6. exercise: encourage to increase sense of well being and help with sleep.

C. Electroconvulsive Therapy
   1. Procedure – passing brief electrical current through the brain to produce brief seizure.
      a) Seizure required for positive outcome.
      b) Treatment required 2 to 3 times per week; 6 – 12 treatments.
      c) Adverse effects: may include brief episodes of hypotension or hypertension, brady cardia or tachy cardia, and minor arrythmia during or immediately following procedure. Memory loss is most troublesome long term effect.
      d) Patient education/preparation.

D. Patient/Family Education
   1. Content areas
      a) disease process
      b) symptom management
      c) education on specific medications
      c) specific medications patient is taking
      d) wellness activities
   2. Considerations
      a) co-existing psychiatric diagnosis
      b) strength/availability of support system

IX. Define Bipolar (Manic – Depressive) Disorder

IX. Definition:

A. Manic depressive disorders are categorized into two major groups:
   1. Bipolar I: combinations of major depression and full manic episodes.
   2. Bipolar II: combinations of major depression and hypomania, a less severe manifestation of manic symptoms.

B. Mania: a distinct period of at least one week or less if hospitalized during which there is abnormal and persistent elevated, expansive, or irritable mood.

X. Review symptoms associated with Bipolar Disorders.

X. DSM IV Diagnostic Criteria and symptoms (See Table 1).

XI. Discuss the epidemiology of Bipolar Disorder.

XI. Demographics of bipolar disorder.
- A. Prevalence: 0.4% to 1.6% in general adult populations
- B. Ethnic/cultural differences: none reported
- C. Gender differences: women frequently experience first manic episode in postpartum period
- D. Age of onset: mean age of onset 21 to 30 years of age

XII. Describe current theories of causation of Bipolar Disorder.

XII. Biological theories of causation
- A. CNS dysfunction
  1. structural brain abnormalities
  2. functional CNS abnormalities
- B. Sleep Deprivation: believed to be final common pathway in the pathophysiology of mania.
- C. Secondary mania: mania caused by other physical disorders or problems such as metabolic abnormalities, CNS tumors, medications.
- D. Genetic hypothesis: generally thought to be genetically transmitted based on research findings.

XIII. Discuss and explain the components of nursing assessment of a patient with Bipolar Disorder.

XIII. Initial and On-going assessment
- A. Bipolar disorder I – assessment similar to patient with major depression
- B. Changes in circadian rhythms
- C. Impact of mania on family/interpersonal relationships
- D. Risk of injury to self and/or others; careful assessment for risk of suicide
- E. Assess for cues to self-injurious behavior

XIV. Examine current treatment options used to treat patients with Bipolar Disorder I

XIV. Treatment Options
- A. Outpatient
  1. Psychopharmacological agents: see section on Psych Drugs and Medication Education Package.
     - a) mood stabilizing drugs
     - b) anticonvulsants
  2. Intensive outpatient program with acute episodes.
  3. Individual psychosocial interventions.
- B. Hospitalization
  1. High risk of suicide: danger to self
  2. Psychotic mania: danger to others
  3. Brief re-stabilization: return to out patient services

XV. Explain nursing interventions used in caring for a patient with Bipolar Disorder

XV. Interventions
- A. Safety and physical needs
  1. prevent injury to self and/or others
  2. facilitate rest/sleep
  3. provide adequate nutrition
  4. monitor closely for side effects if on Lithium
- B. ECT: may be used in severely manic patients with unrelenting, frenzied physical activity.
- C. Psychosocial interventions
  1. self care
  2. cognitive theory
  3. behavior therapy
  4. family therapy
- D. Patient/Family Education
  1. chronic nature of disease process
  2. recognition of mood changes

outline2mood

Nursing Interventions continued	3. relapse prevention 4. education on specific medication patient is taking a) compliance issues b) lithium toxicity c) food/drug interactions 5. wellness activities

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TABLE 1 DIAGNOSTIC CHARACTERISTICS...MOOD DISORDERS

Key Diagnostic Characteristics for Bipolar I Disorder 296.xx		
Bipolar I, single episode 296.0x Bipolar I, most recent episode hypomanic 296.40 Bipolar I, most recent episode, manic 296.4x Bipolar I most recent episode, mixed 296.6x Bipolar I most recent episode, depressed 296.5x Bipolar I most recent episode unspecified 296.7	Presence of one or more manic episodes or mixed episodes including one or more major depressive episodes. <u>Manic episode</u> • Abnormally and persistently elevated, expansive or irritable mood for at least 1 week • Persistence of inflated self esteem and grandiosity • Decreased need for sleep • More talkative than usual or pressure to keep talking • Flight of ideas or racing thoughts • Distractability • Increased goal directed activity or psychomotor agitation • Excessive involvement in pleasurable activities with high potential for painful results (such as unrestrained buying sprees, foolish business investments) • Marked impairment in occupational functioning or in occupational functioning or in usual social activities or relationships; possible hospitalization to prevent harm; psychotic features <u>Major depressive episode</u> (symptoms appear nearly every day) • Depressed mood most of the day • Markedly diminished interest or pleasure in all or most all activities for most of the day • Significant weight loss when not dieting; weight gain or increase or decrease in appetite • Insomnia or hypersomnia • Psychomotor agitation or retardation	• Fatigue or loss of energy *Associated Behavioral Findings* <u>Manic episode</u> • Resistive to efforts for treatment • Disorganized or bizarre behavior • Change in dress or appearance • Possible gambling and antisocial behavior <u>Major depressive episode</u> • Tearfulness, irritability • Obsessive rumination • Anxiety • Phobias • Excessive worry over physical symptoms • Complaints of pain • Possible panic attacks

Major depressive disorder 296.xx

Major depressive disorder, singe episode,296.2x

Major depressive disorder, recurrent 296.3x

Change from previous level of functioning during a 2 week period

- Depressed mood
- Markedly diminished interest or pleasure in all or almost all activities
- Significant weight loss when not dieting or weight gain or change in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide.

**At least one symptom is depressed mood or loss of interest or pleasure

**Significant distress or impairment of social, occupational or other important areas of functioning.

**Not a direct physiologic effect of substance or medical condition.

**Not better accounted for by bereavement, schizoaffective disorder; nor superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

Associated Behavioral Findings

- Tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain
- Possible panic attacks
- Difficulty with intimate relationships
- Difficulties with sexual functioning
- Marital problems
- Occupational problems
- Substance abuse, such as alcohol
- High mortality rate; death by suicide
- Increased pain and physical illness
- Decreased physical, social and role functioning
- May be preceded by dysthymic disorder

Associated Physical Examination Findings

- Chronic general medical conditions

Associated Laboratory Findings

- Sleep electroencephalographic abnormalities
- Altered levels of neurotransmitters (norepinephrine, serotin, acetylcholine, dopamine, and GABA)

Table 1 (Cont.)

• Feelings of worthlessness or excessive or inappropriate guilt • Diminished ability to think or concentrate, or indecisiveness • Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide. • Not bereavement • Clinically significant distress or impairment in social, occupational or other important areas of functioning		• Difficulty with intimate relationships • Marital, occupational or academic problems • Substance abuse • Increased use of medical services • Attempted or complete suicide attempts
<u>Mixed episode</u> • Criteria for both manic and major depressive episodes nearly every day for at least 1 week • Hospitalization to prevent harm; psychotic features		<u>Mixed episode</u> • Similar to those for manic and depressive episodes
<u>Hypomanic episode</u> • Distinct period of persistently elevated, expansive, or irritable mood through at least 4 days • Clearly different from usual nondepressed mood • Same symptoms as that for manic episode • Unequivocal change in function, uncharacteristic of person when asypmtomatic • Change observable by others • Not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization; no psychotic features		<u>Hypomanic episodes</u> • Sudden onset with rapid escalation within 1 – 2 days • Possibly precede or followed by major depressive episode
*Episode not better accounted for by other disorders such as schizoaffective disorder and		*Associated Physical Examination Findings* • Manic episodes • Age of onset for first manic episode after age 40 years • Possible child abuse, spouse abuse, or other violent behavior during severe manic episodes • Associated problems involving school truancy, school failure, occupational failure, divorce, or episodic anti-social behavior

are not superimposed on schizophrenia, schizophreniform, delusional or psychotic disorders
*Not a direct physiologic effect of substance or other medical condition
problems involving school truancy, school failure, occupational failure, divorce, or episodic anti-social behavior

Associated Laboratory Findings
Manic Episodes
- Polysomnographic abnormalities
- Increased cortisol secretion
- Absence of dexamethasone nonsuppression
- Possible abnormalities with norepinephrine, serotin, acetylcholine, dopamine, or GABA neurotransmitter

Major Depressive Episode
- Sleep EEG abnormalities
- Possible abnormalities with norepinephrine, serotin, acetylcholine, dopamine, or GABA neurotransmitter systems

SCHIZOPHRENIA

Upon completion of this module, the participant will be able to identify the basic concepts related to the care of the patient with schizophrenia.

Micro Objectives

I. Define schizophrenia using DSM IV criteria.

A. Describe positive symptoms.

Content outline

I. Definition: Schizophrenia is a mixture of both positive and negative symptoms that present for a significant portion of a 1 month period, but with continuous signs of disturbances persisting for at least six months, (DSM IV, APA, 1994) (Table 1).

A. **Positive symptoms**-Reflect an excess or distortion of normal function.
   1. Delusions: erroneous fixed beliefs that usually involve a misinterpretation of experience.
      a) Grandiose
      b) Nihilistic
      c) Persecuatory
      d) Somatic
   2. Hallucinations: perceptual experiences that occur in absence of actual external sensory experience
      a) Auditory
      b) Visual
   3. Disorganized symptoms
      a) confused speech pattern
      b) confused thinking pattern
      c) disorganized behavior
         1) Aggression
         2) Agitation
         3) Catatonic excitement
         4) Echopraxia
         5) Regressed behavior
         6) Stereotypy
         7) Hypervigilance
         8) Waxy Flexibility
      d) disorganized perceptions

SCHIZOPHRENIA

B. Describe negative symptoms.

II. Define Psychosis.

III. Identify schizophrenia subtypes in DSM IV.

IV. Discuss the epidemiology of schizophrenia.

B. **Negative Symptoms** - reflect lessening or loss of normal function.
1. Affective Bunting
2. Alogia
3. Avolition
4. Anhedonia

II. **Psychosis**: state in which individual is experiencing one or more of the positive symptoms.

III. Subtypes
A. Paranoid
B. Catatonic
C. Undifferentiated
D. Residual

IV. Demographics of Schizophrenia
A. Incidence: 1 in 10,000 per year; prevalence: 0.5% to 1.0%.
B. Ethnic/Cultural differences: occurs in all countries and cultures.
C. Gender differences: men diagnosed at an earlier age.
D. Age of onset: usually late adolescence or early adulthood; late onset age 45 to 50.

SCHIZOPHRENIA

v. Identify current theories of causation of schizophrenia.

v. Neurobiological Models
- A. Biological theories - proposes cause may be genetic, infectious , or a combination of both.
- B. Neuroanatomical changes – Brain studies reveal three consistent structural changes: 1) enlarged lateral ventricles, 2) enlarged 3rd ventricles, 3) enlarged sulci.
- C. Neurochemical hypothesis – Symptoms thought to be caused by dysregulation of one or more neurotransmitter systems.
  1. Dopamine hypothesis
  2. Modified dopamine hypothesis

vi. Discuss and explain the components of nursing assessment with schizophrenic patients.

vi. Findings on Initial and On-going assessment
- A. Appearance: may present with bizarre dress, disheveled with poor hygiene.
- B. Behavior: regressed behavior and retardation or agitation and aggression may be present at admission.
- C. Cognitive abilities: impairments may include hypervigilance, diminished information processing and illogical conclusions.
- D. Social functioning: difficulties with social relations; may be socially isolated.
- E. Risk for self injury: 20 to 50 % of all people with schizophrenia attempt suicide; 10% die.
- F. Substance use: frequently associated with disease; high use of tobacco.

vii. Examine current interventions used in the treatment of schizophrenia.

vii. Current Interventions
- A. Psychopharmacologic agents: See section on Antipsychotic drugs in the Medication Education Package.
  1. Antipsychotics
  2. Atypical Antipsychotics
- B. Meeting the patient's physical and safety needs
  1. Physical and cognitive limitations: provide safe environment.

VII. Current Interventions continued

2. ADLs, hygiene: may require assistance in acute phase.
3. Nutritonal status: acute stage maintain adequate calories; once on antipsychotic medications; weight gain may be an issue.
4. Provide structure with daily schedule.
5. Exercise: to increase well being and combat weight gain.
6. Prevent victimization: nonviolent patients may be at risk from other aggressive patients.
7. Management of agitation and aggression: respect for patient and personal space may decrease agitation; use redirection and NCI interventions and PRN medications
8. Sleep/rest: decrease external stimuli; redirection

C. Patient/Family Education
   1. Content Areas
      a. Disease as lifelong disorder
      b. Importance of medication in control of disease
      c. Action and side effects of current medications
      d. Symptom management
      e. Relapse prevention
   2. Consideration
      a. Assess readiness to learn
      b. Adjust teaching techniques to cognitive ability of the patient
      c. Teaching aids should be in large print; simply stated; white space between concepts.

VIII. Discuss the role of psychiatric rehabilitation in the management of the long term chronic schizophrenic client.

VIII. Psychiatric Rehabilitation

- A. Multidisciplinary Approach
- B. Skills Teaching
  1. Illness management
  2. Crisis management
  3. Community living skills
  4. Managing relationships
  5. Work and leisure activities
- C. Wellness
  1. Exercise
  2. Music
  3. Meditation
  4. Nutrition education

TABLE 1

SCHIZOPHRENIA

Diagnostic Criteria

Two or more of the following characteristic symptoms present for a significant portion of time during a one month period: delusions; hallucinations; disorganized speech; grossly disorganized or catatonic behavior; negative symptoms.One or more major areas of social or occupational functioning(such as work, interpersonal relations, self-care) markedly below previously achieved level.
Continuous signs persisting for at least 6 months;
No presence or insignificant duration of major depressive, manic, or mixed episodes occurring concurrently with active symptoms. Not a direct physiologic effect of a substance or medical condition. Prominent delusions or hallucinations also present, with history of autistic disorder or another pervasive developmental disorder. (DSM IV, 1994)

Target Symptoms and Associated Findings

Inappropriate affect
Loss of interest or pleasure
Dysmorphic mood (anger, anxiety, or depression)
Disturbed sleep patterns
Lack of interest in eating or refusal of food
Difficulty concentrating
Some cognitive dysfunction, such as confusion, disorientation, memory impairment
Lack of insight
Motor abnormalities

Associated Physical Examination Findings
Physically awkward
Poor coordination or mirroring
Motor abnormalities
Cigarette related pathologies such as emphysema and other pulmonary and cardiac problems.

Associated Laboratory Findings
Enlarged ventricular system and prominent sulci in the brain cortex
Decreased temporal and hippocampal size
Increased size of basal gangli
Decreased cerebral size
Slowed reaction times
Abnormalities in eye tracking

Key Diagnostic Characteristics for Schizophrenia Subtypes

Paranoid Type: DSM IV 295.30
Preoccupation with delusions or auditory hallucinations
Lacks disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect

Catatonic Type: DSM IV 295.20

(at least two of the following characteristics present)
Motor immobility or stupor
Excessive purposeless motor activity
Extreme negativism
Posturing, stereotyped movements, prominent mannerisms, or prominent grimacing
Echolalia or echopraxia

Undifferentiated Type: DSM IV 295.50
Only characteristic symptoms present but does not meet criteria for other subtypes

Residual Type: DSM IV 295.60
Absence of prominent delusions, hallucinations, disorganized speech,
and grossly disorganized or catatonic behavior.
Negative symptoms persist or two or more positive symptoms are present in attenuated form such as odd beliefs or unusual perceptual experiences

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AUDIO VISUAL RESOURCES

Agitation and Aggression in Psychosis Promedia Research Center, Tucker, GA

Olanzapine Promedia Research Center, Tucker, GA

Women and Schizophrenia Promedia Research Center, Tucker, GA

Schizophrenia: Out of the Darkness, Moving Back into the Light Promedia Research Center, Tucker, GA

OTHER PSYCHOTIC DISORDERS

Upon completion of this module, the participant will be able to identify the basic concepts related to Schizophreniform Disorder, Brief Psychotic Disorder, Shared Psychotic (Folie a` Deux)

MICRO OBJECTIVE	CONTENT OUTLINE
I. Define Schizophreniform Disorder.	I. **Definition** A. Psychotic disorder characterized by symptoms which are identical to schizophrenia except the duration of the illness is at least one month but less than six months. (Table 1) B. Alteration of one or more areas of daily functioning. **Prognosis** A. One third recover B. Two thirds progress to diagnosis of schizoaffective disorder
II. Discuss Brief Psychotic Disorder.	II. **Definition** Presence of at least one of the following: delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior. **Duration** A. one day, but less than a month B. return to pre illness level of functioning **Assessment** A. Safety Concerns B. Risk of suicide C. Ethnic/cultural background

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III. Shared Psychotic Disorder (Foile a`Deux)	III. **Definition** A. One person who is in close relationship with a person who already has a psychotic disorder with prominent delusions also develops the delusion. B. The person believes and shares part or all of the individual's delusional beliefs. C. Usually shared by persons who have lived together for a long period of time in social isolation; shared delusions disappear or decrease if individuals are separated.
IV. Psychotic Disorder due to general medical conditions	IV. **Definition** A. Prominent hallucinations or delusions that result from a general medical condition. B. Confirmed by history, physical exam or laboratory results. C. Does not occur exclusively during delirium.
V. Substance induced Psychotic Disorders	V. **Definition** A. Prominent hallucinations or delusions that occur during or within one month of substance intoxication or withdrawal or medication use related to the disturbance. B. Does not occur exclusively during delirium. C. Not explained by other disorders.

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DELUSIONAL DISORDER

Upon completion of this module, the participant will be able to identify the basic concepts related to the care of patient with delusional disorder.

MICRO OBJECTIVE

I. Define Delusional Disorder.

II. Discuss the subtypes.

CONTENT OUTLINE

I. Definition

A psychotic disorder, occurring in the absence of other psychotic disorders, characterized by stable, well systemized and logical, nonbizarre delusions. (see Table 1)

- A. Nonbizarre delusions are characterized by adherence to possible situations that could occur in real life and are plausible in the context of the person's ethnic and cultural background.
- B. Factors which make diagnosis unclear:
  1. Person continues to functions at a high level.
  2. Generally only those with the somatic type visit physician and adamantly deny need for psychiatric consult.
  3. Delusions vary in presentation.
  4. The person denies having a delusion, which makes them tense, wary, and suspicious.
  5. Often not seen by health care provider unless acting out a delusion.

II. Subtypes

- A. Erotomanic Delusions
- B. Grandiose Delusions
- C. Jealous Delusions
- D. Somatic Delusions

III. identify the epidemiology of Delusional Disorder.

III. Epidemiology
- A. Prevalence 0.3% of population
- B. Risk factors
  1. Lower socioeconomic status
  2. Hearing deficiencies
  3. Psychosocial stressors
- C. Age of onset
  1. usually middle age to later adulthood
  2. 2 –4% prevalence rate in elderly
- D. Gender differences
  1. Studies report women more likely to develop delusional disorders.
  2. Women are more likely to seek medical care and follow up
  3. Men more likely to be in conflict with law.
- E. Ethnic/ Cultural differences
  1. The content of what is delusional varies between cultures and sub cultures.
  2. More frequently seen in foreign born or first generation born in the U.S.
- F. Comorbidity
  1. Mood disorder
  2. Obsessive – compulsive disorder
  3. Dysmorphic disorder
  4. Paranoid, schizophrenia or avoidant personality disorder
  5. Alcohol and substance abuse

DELUSIONAL DISORDER

IV. List theories of causation.

IV. Biological Theories
- A. Neuropathic: possible neurogenic component
- B. Biochemical: delusions may be related to circuit malfunction involving the dopaminergic system.

V. Describe assessment of a patient with Delusional Disorder.

V. Assessment
- A. Biological assessment
  1. Complete physical assessment
  2. Past history of treatment of symptoms
  3. History of past and present medications
- B. Psychological assessment
  1. Psychological deficits-few
  2. Intelligence average or marginally low
  3. Mental status usually normal
- C. Social assessment
  1. Social function generally impaired
  2. Social isolation common
  3. Marital dysfunction may be present
  4. Consider ethnic/cultural beliefs

VI. Discuss current interventions.

VI. Interventions
- A. Nursing
  1. Flexible approach
  2. Trusting, therapeutic relationship
  3. Respond to person's concern rather than the delusion
  4. Provide practical help
- B. Biological
  1. Identify problems identified from assessment
  2. Promote healthy functioning
  3. Develop mechanism to manage medication regimen

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VI. Current interventions continued

C. Psychological
   1. Supportive therapy to decrease anxiety
   2. Fostering effective coping skills
   3. Cognitive therapy along with supportive therapy
   4. Educational interventions

D. Social
   1. Social skills training
   2. Family therapy
   3. Family education

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SCHIZOAFFECTIVE DISORDER

Upon completion of this module the participant will be able to explain the concepts related to care of a patient with Schizoaffective Disorder.

Micro Objectives

I. Define schizoaffective disorder.

II. Identify characteristics of two subtypes.

III. Discuss the epidemiology of schizoaffective disorder.

IV. Review the symptoms of schizoaffective disorder.

Content Outline

I. Definition: Uninterrupted period of illness during which at some time there is a major depressive, manic or mixed episode along with two of the following symptoms of schizophrenia: delusions, hallucinations, disorganized speech, disorganized behavior or catatonic behavior, or negative symptoms (affective flattening, alogia or avolition). For at least two weeks, the positive symptoms (delusions or hallucinations) have to be present without the mood symptoms (DSM IV, APA, 1994). (Table 1).

II. Subtypes
- A. Bipolar type
- B. Depressive type

III. Demographics of schizoaffective disorder
- A. Incidence: 0.5% to 13.6% lifetime prevalence
- B. Ethnic/cultural differences: one study found increased incidence among whites of high socioeconomic status
- C. Gender differences: occurs more frequently in females; females develop disease at older age than males.
- D. Age of onset: late adolescence to late life

IV. DSM IV Diagnostic characteristics and target symptoms. (See Table 1_).

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V. Describe current theories of causation of schizoaffective disorder.

VI. Discuss and explain the components of nursing assessment of a patient with the diagnosis of schizoaffective disorder.

VII. Examine current interventions used in the treatment of schizoaffective disorder.

V. Biological theories of causation
- A. Neuropathologic: midline structural abnormalities may contribute to schizoaffective disorder.
- B. Genetic: relatives of patients with schizoaffective disorder have increased risk of developing a psychotic disorder.
- C. Biochemical: over activity of dopamine pathways is prevailing hypothesis.

VI. Initial and on-going assessment
- A. Similar assessment as for patient with schizophrenia
- B. Duration of symptoms

VII. Interventions
- A. Psychopharmacologic agents
  1. Combination therapy
  2. Antipsychotics
  3. Atypical antipsychotics
- B. Meeting the patient's physical and safety needs
  1. Intervention based on identified deficits
  2. Provide safe environment
  3. ADLs, hygiene
  4. Nutritional status
  5. Structured schedule
  6. Sleep/rest
  7. Exercise
- C. Patient/Family education
  1. Content areas
     a) episodic nature of disease
     b) importance of medication compliance
     c) education on specific medication patient is taking
     d) symptom management
     e) relapse prevention stressing early recognition of psychosis

TABLE 1

Key Diagnostic Characteristics for Selected Psychiatric Disorders

Disorder	Diagnostic Criteria and Target Symptoms	Associated Findings
Schizoaffective Disorder 295.70	• Uninterrupted period of illness with concurrent major depressive episode, manic episode or mixed episode • Bipolar type: manic or mixed episode or manic or mixed episode and major depressive episode. • Depressive type: only major depressive episode • Characteristic symptoms of schizophrenia (two or more) during a 1 month period. • Delusions • Hallucinations • Disorganized speech • Grossly disorganized or catatonic behavior or negative symptoms • Delusions or hallucinations for at least 2 weeks without prominent mood symptoms • Symptoms of mood episode present for major portion of the active and residual periods of illness. • Not a direct physiologic effect of a substance or medical condition.	*Associated Behavioral Findings* • Poor occupational functioning • Restricted range of social contact • Difficulties with self care • Increased risk of suicide

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Delusional Disorder 297.1

- Nonbizarre delusions of at least 1 month's duration
- No presence of characteristic symptoms of schizophrenia
- Functioning not markedly impaired; behavior not odd or bizarre
- If concurrent with delusions, mood disorders relatively brief in comparison with delusional periods
- Not a direct physiologic effect of a substance or medical condition

Ergotmanic type: delusion that another person of usually higher status in love with the person.
Grandiose type: delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
Jealous type: delusion that individual's sexual partner is unfaithful.
Persecutory type: delusion that person or someone close to person being malevolently treated in some way.
Somatic type: delusion that person has some physical defect or general medical condition.
Mixed type: delusions characteristic of more than one of the above types; no one theme predominates.
Unspecified type: delusion cannot be clearly identified or described.

- Social, marital or work problems
- Ideas of reference
- Irritable mood
- Marked anger and violent behavior (especially with jealous type)

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Basic concepts in Psychiatric/Mental Health Nursing Curriculum

Upon completion of this section, the participant will be able to demonstrate knowledge related to the care of patients with anxiety as their diagnosis.

I. Anxiety/Anxiety Disorder A. Define the term Anxiety/ Anxiety Disorder	I. Anxiety/Anxiety Disorders A. Definitions 1.Anxiety- Initial response to a psychic threat. 2. Anxiety Disorder- A psychiatric condition characterized by the emotion of intense terror.
B. Explain the degrees of anxiety.	B. Degrees of Anxiety 1. Mild- heightened sensitivity to environmental stimuli and overall alertness. 2. Moderate- decreased attentiveness and physical signs such as tremulousness, sweating palms, dry mouth or restlessness. 3. Severe- disturbance in thought processes, ability to make decisions and to act. 4. Panic
C. Describe the types/subtypes of anxiety.	C. Types/Subtypes of Anxiety 1. Generalized anxiety disorder 2. Panic disorder 3. Agoraphobia 4. Obsessive-compulsive disorder 5. Post-traumatic stress disorder 6. Separation-anxiety disorder - child and adolescent 7. Over-anxious disorder - child and adolescent 8. Acute Stress Disorder
II. Discuss the etiology/possible causes of anxiety disorders	II. Etiology/possible causes of anxiety disorders A. Hereditary predisposition B. Neurochemical abnormalities C. Physical conditions producing continual fear of death (mitral valve prolapse) D. Developmental traumas E. Inadequate social/ interpersonal experiences F. Counterproductive cognitive patterns G. Exposure to extreme psychological stressors H. Chronic physical illness I. Continuous exposure to toxic substances, harsh environment J. Repeated exposure to physical/psychological danger K. External stressors that impinge on emotional vulnerabilities.

III. Explain the Incidence of Anxiety and Related Disorders in: A. Adults	III. Incidence A. Adults 1. Anxiety disorders affect twice as many women as men. 2. Anxiety disorders tend to run in families
B. Children/ Adolescents	B. Children and Adolescents 1. Generalized anxiety disorder; social phobia more common among males 2. Agoraphobia more common in females 3. Separation anxiety disorder; equally common in both sexes, peak incidence around age 11
IV. List Symptoms/Characteristics of Anxiety/Anxiety Disorders A. Physiologic	IV. Symptoms/Characteristics A. Physiologic 1. increased heart rate 2. elevated blood pressure 3. increased rate and depth of respiration 4. excessive perspiration 5. increased muscle tension 6. sexual dysfunction 7. nausea and/or vomiting 8. withdrawal
B. Emotional	B. Emotional 1. irritability 2. feelings of worthlessness 3. depression 4. diminished initiative 5. reduced personal involvement with others 6. tendency to cry 7. helplessness 8. withdrawal
C. Cognitive	C. Cognitive 1. lack of concentration 2. lack of attention to details 3. lack of awareness of external stimuli 4. preoccupation 5. rumination 6. reduced creativity 7. diminished productivity 8. reduced interest 9. ritualistic behaviors

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V. Nursing Care of the patient with Anxiety Disorder A. Identify the components of Nursing Assessment for a patient with the diagnosis of Anxiety Disorder.	V. Nursing Care A. Nursing Assessment 1. Physical Symptoms 2. Emotional/ Cognitive Responses 3. History/ pattern of attacks 4. Coping Mechanisms 5. Social Supports 6. Ideation of Self Harm
B. List the nursing intervention used in caring for the patient with anxiety. 1. Adult	C. Nursing Interventions 1. Nursing interventions with adults a. Assess awareness of own level of anxiety b. Identify patient's level of anxiety c. Select interventions based on level on anxiety d. Maintain safe environment e. Administer Medications 1. anti-anxiety agents 2. antidepressants 3. antiparkinson/anticholinergic 4. antihistamines f. Patient Education 1. problem-solving 2. self-help skills
2. Young Child	3. Nursing Interventions with children a. Establish trusting relationship b. Maintain a safe environment 1. degree of anxiety 2. age/developmental level of the child c. High degree of structure in activities of daily living d. Milieu therapy e. Role Play f. Non-directive play therapy g. Administer Medications

3. Adolescent	**3. Nursing Interventions with Adolescents** a. Identify patient level of anxiety b. Select appropriate interventions c. Maintain safe environment d. Patient/Family education 1. behavior modification 2. limit-setting e. Administer Medications f. Encourage participation in family, group and individual therapies
VI. Discuss differences in symptoms of post traumatic stress disorder in children.	**VI. Symptom Differences** 1. Disorganized or agitated behavior 2. Respective play themes 3. Repetitive dreams 4. Re-enactment

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PERSONALITY DISORDERS

Upon completion of this module, the participant will be able to explain the concepts related to care of the patient with a personality disorder.

I. Personality Disorder **A. Define Personality** **B. Define Personality Disorder**	A. Personality – the totality of emotional and behavioral traits that characterize the person in day-to-day living under ordinary conditions; it is relatively stable and predictable. B. Personality disorder – Abnormal,inflexible pattern of behavior that deviates markedly from the expectation of the individual's culture; pervasive and stable over time.
C. List the classifications of personality disorder.	C. Classifications 1. Cluster A disorders-Odd –eccentric a. Paranoid, suspicious pattern. b. Schizoid personality disorder, asocial c. Schizotypal disorder,eccentric pattern 2. Cluster B –Dramatic,emotional a. Borderline, unstable pattern b. Antisocial personality disorder,aggrandizing pattern c. Narcissistic personality disorders,egotistic pattern 3. Cluster C – Anxious,fearful a. Avoidant personality disorder, withdrawal pattern b. Dependent personality disorder,submissive pattern c. Obsessive compulsive disorder, 4.Impulse control disorders a. Intermittent explosive disorder b. Kleptomania c. Pyromania d. Pathologic gambling e. Trichotillomania

II. Discuss personality disorders of Childhood/Adolescence	II. Personality disorders of childhood/adolescence A. Attention – deficit disorder 1. Inattention a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities b. often has difficulty sustaining attention in tasks or play activities c. often does not seem to listen when spoken to directly d. often does not follow through on instructions and fails to finish schoolwork, chores or other duties in the workplace (not due to oppositional behavior or failure to understand instructions) e. often has difficulty organizing tasks and activities f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools) h. is often easily distracted by extraneous stimuli i. is often forgetful in daily activities 2. Hyperactivity a. often fidgets with hands or feet or squirms in seat b. often leaves seat in classroom or in other situations in which remaining seated is expected c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) d. often has difficulty playing or engaging in leisure activities quietly

	e. is often "on the go" or often acts as if "driven by a motor" f. often talks excessively 3. Impulsivity a. often blurts out answers before questions have been completed b. often has difficulty awaiting turn c. often interrupts or intrudes on others (e.g., butts into conversations or games) B. Conduct 1. Aggression to people and animals a. often bullies, threatens, or intimidates others b. often initiates physical fights c. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun) d. has been physically cruel to people e. has been physically cruel to animals f. has stolen while confronting a victim (e.g., mugging, purse, snatching, extortion, armed robbery) g. has forced someone into sexual activity 2. Destruction of property a. has deliberately engaged in fire setting with the intention of causing serious damage b. has deliberately destroyed others' property (other than by fire setting) 3. Deceitfulness or theft a.. has broken into someone else's house, building, or car b. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)

	c. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery) 4. Serious Violations of rules a. often stays out at night despite parental prohibitions, beginning before age 13 b. has run away from home overnight at least twice while living in parental surrogate home (or once without returning for a lengthy period) c. is often truant from school, beginning before age 13 year C. Oppositional-Defiant 1. often loses temper 2. often argues with adults 3. often actively defies or refuses to comply with adults' request or rules 4. often deliberately annoys people 5. often blames others for his or her mistakes or misbehavior 6. is often touchy or easily annoyed by others 7. is often angry and resentful 8. is often spiteful or vindictive **Note:** Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level. D. Autistic 1. Marked impairment in the use of multiple nonverbal behaviors such as eye to eye gaze, facial expression, body postures, and gestures to regulate social interaction 2. failure to develop peer relationships appropriate to developmental level 3. a lack of spontaneous seeking to share enjoyment,

III. Define the Etiology/Possible Causes of Personality Disorder.	III. Etiologies A. Genetic factors B. Temperamental factors C. Biosocial 1. Emotional dysfunction 2. Invalidating environment D. Biological factors E. Physical maturation and development F. Psychoanalytical 1. Maladaptive cognitive processes 2. Psychoanalytical G. Defense mechanisms H. Cultural influences/conditioning
IV. Discuss the incidence of Personality Disorder	IV. Incidence A. Paranoid- more common in men than women; Increased incidence among minority groups B. Antisocial- onset before age 15; most common in poor urban areas C. Borderline- twice as common in women than men D. Histrionic- seen more frequently in women E. Dependent- more common in women than men; more common in young children than older children F. Attention Deficit- prevalence estimated at 3-5% in school age children G. Conduct- for males under age 18 years, rates range from 6-16%; for female 2-9%

	interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest. 4. lack of social or emotional reciprocity 5. delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime) 6. in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others 7. stereotyped and repetitive use of language or idiosyncratic language 8. lack of varied, spontaneous make believe play or social imitative play appropriate to developmental level 9. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus 10. apparently inflexible adherence to specific, nonfunctional routines or rituals. 11. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements) 12. persistent preoccupation with parts of objects.

V. Describe the symptoms/Characteristics of Personality Disorder.	V. Symptoms/Characteristics A. Borderline Personality Disorder 1. Abnormal, inflexible behavior patterns of long duration, usually beginning in adolescence or early childhood in two or more areas: a. Maladaptive **cognitive schema** which results in misinterpretation of other people's actions or reactions thus causing the person to respond in dysfunctional ways. b. Dysfunction in **affectivity** or the range, intensity, liability, and appropriateness of emotional response. c. Inadequate **self-identity** and impaired **interpersonal functioning.** d. Lack of **impulse control,** which may result in destructive behavior. 2. Dysfunctional behaviors resulting in injury to the person. a. Parasuicidal behavior b. Compulsive self-injurious behavior. c. Episodic self-injurious behavior.

VI. Describe behavior patterns commonly seen in patients with BPD.	VI. Behavior patterns A. Failure to engage in problem-solving; seek help from others in helpless,hopeless manner. B. Impulse driven, act in the moment and clean up the mess later. C. Unsuccessful in interpersonal and social relationships. D. Move from crisis to crisis , live in constant turmoil. E. Parasuicidal behavior-deliberate self-injurious behavior accompanied by intent to harm self.

VII. Assessment	For the patient with a personality disorder, the nurse must assess and evaluate the particular personality features displayed by the individual patient. Assessment can be complicated by the fact that the characteristics that define Personality Disorder may not be considered problematic by the individual. Assessment for these patients include: a. recognition of the continuous possibility for patient self-injury and methods used to maintain a safe patient environment. b. recognition of manipulative techniques and coping mechanisms used by the patient c. identification of individual characteristics that may impact on the patient's ability to function d. exploration of the patient's and family's interest in and the ability to learn in order to gain cooperation in mental health treatment
VIII List the nursing interventions used in caring for the adult patient with a personality disorder	a. Planning and implementing nursing care for personality disordered clients is one of the greatest challenges in psychiatric-mental health nursing. These clients inevitably trigger a negative counter-transference in therapists and other caregivers. The associated behavior patterns are not only annoying but also difficult to change. Consequently, nurses and other mental health personnel often become irritated, frustrated, and rejecting while working with these clients. (1) **Self-Awareness** To plan and implement effective care for personality-disordered clients, the nurse needs to develop a high degree of self-awareness (2) **Trust Development** Because many personality-disordered clients tend to mistrust others, the nurse needs to exercise special care to establish trust

(3) **Counter-projection**
When working with a suspicious personality-disordered client who uses projection extensively, the nurse needs to avoid interjecting doubt into the client's assertions

(4) **Delaying Interactions**
Breaking off interactions or postponing the next interaction is referred to as taking time out and may be useful for clients who either refuse to help themselves or use passive-aggressive tacts to gain attention or sympathy.

(5) **Confrontation**
Confrontation may be necessary to work effectively with some personality-disordered clients who attempt to use manipulation.

(6) **Limit-Setting**
A client's manipulative, dependent, and acting-out behaviors may necessitate the use of limit setting. The nurse must remember that limit setting includes more than merely telling a client to stop a particular behavior. Specifically, limit setting involves:

1. identifying the behavior that the client needs to control
2. offering an appropriate, alternative behavior for the client to pursue
3. anticipating that the client will test nurses to determine if they will back down
4. remaining steadfast and consistent in the use of limit setting

	(7) **Cognitive Behavior Therapy** Behavioral Techniques go hand in hand with cognitive techniques: Behavioral Techniques are used to test and change maladaptive and inaccurate cognitions. Among the behavioral techniques used are: a. scheduling activities b. mastery and pleasure c. graded task assignments d. cognitive rehearsal e. self-reliance training f. role-playing g. diversion techniques (8) **Safety** The nurse must constantly be aware of the potential for self-harm by the patient. Measures that can be employed to insure patient safety are: (a) patient and/or room searches for potentially harmful objects (b) restrictive procedures including room plans, one-to-one observation and restraints (9) **Patient/Family Teaching** Patient/family teaching can enhance the patient's ability to function effectively. Teaching principles include: (a) requiring the patient to be responsible for his/her own behavior (b) encouraging the patient to become involved in self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous (c) Presenting the idea that behavioral change is in the realm of possibility

	(d) asking questions that assist the patient to think through actual or intended behaviors (10) The nurse administers medications, usually in small doses. The drugs used to treat personality disorders include the antipsychotics, anxiolytics, anti-convulsants, psychostimulants, MAOI's, and the antidepressants.
IX. List the nursing interventions used in caring for the child/adolescent with a personality disorder	a. Attention deficit disorder (1) providing individual psychotherapy by qualified professionals (2) employing behavior modification principles (3) counseling parents (4) recognizing and helping treat any co-existing learning disorder (5) administering and monitoring the effects of CNS stimulants (6) maintaining a safe environment based on the degree of hyperactivity and age and developmental level of the child b. Conduct disorder (1) if hospitalized , provide environmental (milieu) structure through the use of consistent rules and expected consequences (2) family counseling and teaching (3) teaching child problem-solving skills (4) administering psychotropic medications (5) maintain a safe environment for the child (a) allow to "role-play" situations that make him angry (b) encourage verbal rather than physical expression for anger

	(c) establish rules about not hurting self, others or property (d) use physical restraints when necessary (e) interrupt a physical outburst before an aggressive act occurs c. Oppositional – defiant disorder (1) employing behavior – modification therapy (2) family education and counseling in child-management skills (3) provide activity to help increase child's self-esteem (4) maintain a safe environment with firm but fair limit-setting d. Autistic (1) provide a consistent behavior modification program (2) teach parent's behavior – modification techniques (3) provide a structured environment (4) administer Haldol as ordered. Lithium can also be given for aggressive or self-injurious behaviors when other medications fail (5) maintain a safe environment (a) be aware of limited ability to understand the spoken language (b) remember that toys/objects are often manipulated in a way that was not intended (c) be aware these children frequently have aggressive outbursts for no apparent reason and will engage in self-injurious behaviors, i.e., head banging, biting

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NEUROPSYCHIATRIC DISORDERS

Upon completion of this section, the participate will be able to demonstrate an understanding of Neuropsychiatric Disorders.

Micro-objective	Content Outline
I. Delirium	I. Delirium
A. Define the term delirium	A. Definition: A clinical state characterized by fluctuating disturbances in cognition, mood, attention, arousal and self-awareness, which arises acutely either with or without intellectual impairment or superimposed on chronic intellectual impairment. Reduced ability to maintain attention, disorganized thinking, and apathy are symptoms. Potentially reversible.
B. Discuss prevalence	B. Prevalence: 1. Elderly more susceptible because of an aging neurological system. 2. Up to 80% of hospitalized elderly will experience this disorder.
C. List common causes	C. Common causes (often caused by toxic or metabolic factors that impair brain cell function) 1. Metabolic or toxic causes (e.g., electrolyte imbalance, chronic endocrine abnormalities, anoxia, transient Ischemia, postictal state, postconcussion, drugs with anticholinergic properties, other drugs(benzodiazepines, alcohol, narcotics, digoxin, cimetidine, antihypertensives) encephalopathy, hypoxia, hypoglycemia. 2. Structural causes (e.g., vascular occlusion and cerebral infarction, subarachoid hemorrhage, CVA, malignant brain tumors, brain abscesses). 3. Infections (e.g., meningitis, encephalitis, fever, seizures, strokes, pneumonia, urinary tract infections, septicemia, fever from viral infections).
D. Describe the characteristics and symptoms	D. Characteristics and symptoms: 1. Rapid onset of cognitive dysfunction 2. Attention deficits 3. Reduced levels of consciousness 4. Perception deficits 5. Impaired cognition 6. Hallucinations and illusions 7. Disturbances in sleep pattern 8. Disorganized thought process
E. Discuss treatment measures	E. Treat underlying cause and provide supportive therapy: 1. Fluids and nutrition 2. Quiet, calm environment 3. Reinforce orientation 4. Safety a priority 5. Judicious use of mind-mood altering drugs
II. Dementia	II. Dementia
A. Define the term dementia	A. Definition: a deterioration of intellectual function and other cognitive skills leading to a decline in the ability to perform activities of daily living.
B. Describe characteristics and symptoms	B. Characteristics and symptoms: 1. Insidious onset 2. Usually permanent memory loss, particularly short-term memory. 3. Impairment in abstract thinking, problem solving 4. Impaired judgement

	5. Confusion. 6. Personality changes. 7. Affect disturbances (e.g., sad, (usually seen in elderly), inappropriate, flat). 8. Classic symptoms/signs. a. Agnosic=failure to recognize or identify familiar objects such as parts of the telephone. b. Aphasia=inability to use the forgotten words, requiring a painstaking game of charades until others guess forgotten word. c. Apraxia= inability to carry out motor tasks, such as brushing the teeth and combing the hair despite intact motor function.
C. List causes of dementia	C. Causes of dementia (Organic changes in the brain) 1. Metabolic –toxic: Anoxia, folic acid deficiency, hypothyroidism, hypoglycemia, hypocalcemia associated with hyperparathyroidism, chronic drug-alcohol-nutritional abuse. 2. Structural: Multi-infarct dementia, dementia associated with Huntington's chorea, multiple sclerosis, Pick's disease, Parkinson's disease, brain tumors, irradiation of frontal lobes, surgery, etc. 3. Infectious: Neurosyphilis (general paresis), tuberculus and fungal meningitis, viral encephalitis HIV-related disorders, Creutzfeldt-Jakob.
D. Discuss demographics of Alzheimer's dementia.	D. Alzheimer's: Primary degenerative dementia with atrophy of the cerebral cortex. 1. Progressive neuropsychiatric disease that affects brain matter. 2. Fourth or fifth leading cause of death in Americans over 65. 3. Twice as common in women than men (women live longer). 4. Four million people in America affected. 5. Annual estimated cost of about $90 million. a. Medical and nursing home care. b. Social services. c. Lost productivity. d. Early death. 6. Etiology a. Genetics (e.g., runs in some families (particularly early onset type), most Down's Syndrome patients develop Alzheimer's disease). b. Neurotransmitter deficiency (e.g., choline acctyltransferaace deficiency, possible deficiencies in norepinephirine and somatostatin). c. Environmental toxins (e.g., slow viruses). d. Infections (e.g., slow viruses).
E. Discussing the Nursing Care appropriate to the patient with Alzheimer.	E. Nursing Process 1. Assessment a. Subjective Data: Behavioral changes, emotional changes, social changes, intellectual changes. b. Objective Data: Level of consciousness, appearance, attention, language, memory, constructional ability, cortical function. 2. Nursing diagnosis/plan.

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a. Altered thought processes related to inaccurate interpretation of the environment.
b. Altered nutrition (less than body requires) related to failure to remember mealtime and/or loss of appetite.
c. Potential for injury related to disorientation and confusion.
d. Ineffective family coping related to the family's inability to deal with changes in the patient's personality.

3. Interventions
   a. Medications.
   b. Non-medication.
      1. Safety
         a. Remove harmful objects.
         b. Clearly mark steps with colored strips.
         c. Provide patient identification.
      2. Wandering indicates increased impairment.
         a. Locks on door at ground level.
         b. Alarms.
         c. Locked courtyard for outside activity.
         d. Marked wandering trails where available.
      3. Sleep
         a. Short naps twice a day.
         b. Provide bright lighting a couple of hours before bedtime to minimize Sundowning.
         c. Avoid stimulating foods or drinks right before bedtime.
         d. Minimize environmental noises.
      4. Fall prevention
         a. Lower bed to the floor.
         b. Provide uncluttered environment.
         c. Use nonskid mats and rugs.
         d. Paint commode seats with florescent paint.
         e. Place near to the bathroom.
         f. Use restraints as a last resort.
      5. Bowel and bladder
         a. Use pictures to label commode and bathroom.
         b. Use Velcro as fasteners on pants.
         c. Use incontinence buzzers if available.
      6. Nutrition
         a. Provide well-balanced meals.
         b. Provide only the utensils the person is able to use.
         c. Provide adaptive feeding equipment needed.
         d. Allow to feed self as much as possible.
      7. Bathing
         a. Bathe 3-4 times a week.
         b. Allow patient as much choice as possible; if patient refuses come back later.
         c. Allow rest period after bathing.

8. Communication
   a. Call by Mr., Mrs., or Miss unless person asks otherwise.
   b. Answer questions with "yes" or "no".
   c. Avoid confusing directions or choices, be concrete.
   d. Speak slowly, directly to the person and keep voice low.
   e. Use same word for object each time.
   f. Keep non-verbal and verbal consistent.
   g. Answer same question asked repeatedly without reprimanding.
   h. DO NOT ARGUE
   i. LISTEN
9. Anxiety
   a. Use calm, unhurried, undemanding approach.
   b. Simplify routines.
   c. Explain procedures before doing.
   d. Use reality orientation carefully, it may cause agitation.
   e. Encourage simple exercises and relaxation techniques.
10. Anger/aggression/catastrophic responses
   a. Give clear, one step at a time instruction.
   b. Allow plenty of personal space.
   c. Approach from the front.
   d. Avoid over responding to cursing; how the caregiver responds IS VERY IMPORTANT.
   e. Keep changes to a minimum.
11. Stimulation
   a. Decrease amount of stimulation in environment including knick knacks, and noise.
   b. Provide sufficient lighting without using fluorescent lights.
   c. Mark door knobs and steps with contrasting colors if possible.
12. Orientation
   a. Use Orientation Board.
   b. Display seasonal decorations.
   c. Listen to emotional content versus factual content.
   d. Provide large faced clocks and calendars.
13. Perceptions
   a. Distract as necessary.
   b. Avoid use of mirrors (may be disorienting to the person).
   c. Observe for misinterpretation of art work.
14. Sexual: Allow masturbation in own room
15. Family and friends
   a. Be supportive.
   b. Watch for signs of depression.
   c. Encourage them to participate in care of family member/friend.
   d. Encourage them to take care of themselves.
16. Patient and family education
   a. Make simple and clear.
   b. Explain reason for doing and benefit.

III. AIDS Dementia

A. Describe symptoms of AIDS dementia

B. Apply nursing process to care of a patient with AIDS dementia.

IV. Discuss differences in dementia associated with Perkinson's disease.

c. Involve family/friend.
d. Document.
1. What was discussed.
2. What was used to teach.
3. What the person and/or friend/family member's responses were to material.

III. AIDS Dementia

A. Symptoms

1. General slowing of cognition functions e.g., difficulty concentrating, forgetfulness, inability to do familiar tasks.
2. Decreased sensory motor functions e.g., clumsiness with or without weakness of arms, or legs clumsiness in handwriting and speech, absence of spontaneous speech or motor responses.
3. Social withdrawal, apathy, personality changes, depression.

B.Nursing process

1. Assessment
   a. Knowledge deficits.
   b. Physical well-being.
   c. Safety.
   d. Nutritional status.
   e. Support systems.
   f. Emotional status.
   g.Spiritual support.
2. Plan
   a. Encourage independence.
   b. Provide ADLs as needed.
   c. Keep physically safe from injury and infections.
   d. Be supportive, encourage family/friend involvement .
3. Intervention (based on patient's ability to function)
   a. Intellectual functioning.
      1. Verbal directions with visual or written cues.
      2. Short, simple instructions.
      3. Reminders.
      4. Consistency with no abrupt changes.
      5. Labels on surroundings (e.g., large print signs on rooms).
   b. Sensory/motor
      1. Requires special safety measures and support (e.g., check bath water temperature).
      2. Immobility issues (e.g., awareness of potential skin breakdown and deep vein thrombosis.
      3. Bowel and bladder problems (e.g., incontinence, infections, skin breakdown.

C. Personality or behavioral disturbances

1. Redirection versus control
2. Remove agitating stimuli while providing safety
3. Encourage stress management techniques
4. Unconditional positive regard for patient

IV. Parkinson's disease

a. Between 25% - 50% of patients with Parkinson have deme
b. Some of the same neuropathological brain findings and biochemical changes found in Alzheimer's patients.
c. Less sever subcortical dementia is also associated with Parkinson's.
d. Clinical diagnosis based on whether motor signs were present before or after the cognitive decline. (tremors not usually associated with Alzheimer's disease.

V. Discuss differences	V. Huntington's chorea a. May present with dementia, but diagnosis clarified by family history. b. Young age of onset. c. Characteristic motor abnormalities (chorea).

Somatoform Disorders

Upon completion of this section, the participant will be able to:

Micro-objectives	Content Outline
I. Define the term somatoform.	I. Define somatoform disorders A. A group of mental disorders in which an individual displays significant physical signs and symptoms without any organic disease that causes disruption of the individual's life experiences. 1. Somatization disorder (has been called hysteria or Briquets' Syndrome). a. Begins before age 30 with persistent, recurring patterns of somatic complaints, polysymptomatic, involving various body systems. b. Exaggerated, inconsistent medical histories. Seek treatment from numerous health care providers. c. Individual's emotional well being is interrelated with his physical symptoms: 2/3 of individuals with somatization disorder have suffered major depression. See DSM-IV criteria for somatization disorder 2. Undifferentiated somatoform a. Lasts for at least 6 months b. Don't fully meet criteria for somatization disorder or other somatoform disorders. Common complaints - fatigue loss of appetite, GI, or urinary system. c. Symptoms not feigned have negative effect on interpersonal, occupational functioning. d. H & P, lab tests don't explain or verify physical symptoms or disruption in life experiences. 3. Conversion disorder a. Loss of voluntary motor or sensory functioning that appears to represent physiological dysfunction but instead relates to psychological conflicts or need. 1) Onset follows event or experience perceived as major stressor. 2) Symptoms help individual protect self against intraspsychological anxiety generated by unconscious mechanism. Psychological conflict expressed symbolically through physical conflict.

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3) Pseudoneurological symptoms unexplainable by localized weakness, impaired balance, aphonia, urinary retention, difficulty swallowing.
4) "La belle indifference" little anxiety or lack of concern regarding symptoms and disruption to life.
5) Less long term morbidity and disability than with somatization disorders.

b. Provides primary and secondary signs
1) Primary - psychological conflict/anxiety blocked.
2) Secondary - released from responsibilities with increased attention from others.

4. Pain disorder
a. Non-intentional presence of physical pain.
b. Major focus of life - frequent visits to health care services and takes medications for symptoms.
b. No definable medical condition appears, linked with mood and anxiety disorders.

5. Hypochondriasis
a. Unwarranted fear or belief that individual has a serious disease in the absence of significant pathology.
1) Over attention and preoccupation to body and bodily sensations that lead to misrepresentation and overreaction to physical signs and symptoms.
2) Expects others to focus on his/her well being.
3) Psychic energy wound up in unrealistic fears that serious disease being missed by health care professionals.
4) Seek medical care from numerous sources.
5) Disrupts social relationships and work.
6) Can appear anxious and can acknowledge their fear of disease is unfounded.
7) Unaware of underlying psychic conflicts causing symptoms.
8) Variable outcome - more severe, longer duration and co-anxiety illness - poorer prognosis.
9) Lasts at least 6 months.

6. Body dysmorphic disorder
a. Preoccupation with imagined defect in appearance when one is not present.

1) Obsesses about imagined defects such as facial flaws, wrinkles, spots, etc.
2) Distress, embarrassment over body parts such as hands, feet, genitals, breasts, etc. and thinks others note the flaws.

b. Retreats from usual activities - social isolation.
1) Obsessive/compulsive disorder observed in a number of individuals.
2) Research limited.

7. Somatoform disorder not otherwise specified
a. Physical symptoms present less than 6 months.
b. Include false pregnancy, unexplained symptoms of weakness, or fatigue.

II. Psychological factors affecting medical conditions.

II. Psychological Factors Affecting Medical Conditions

A. Refers to clinical associations between psychological factors and clinically diagnosed medically conditions.
1. Depression -strongest psychological factor affecting physical outcome, physical dysfunction.
2. Depression adversely affects conditions such as multiple scleroses, epilepsy, MI, certain cancers, rheumatoid, arthritis, psoriasis, irritable bowel syndrome, peptic ulcer disease.

III. Describe possible psychological,neurological, and familial etiologies of somotoform disorders.

III. Etiology of somatoform disorders

A. Multifactorial causation with a complex interaction of psychological, neurobiological, and familial factors is at the root of somatoform disorders.
1. Psychological factors
a. Careful history taking about the physical illness can reveal stressful life changes
b. Various illnesses correlate positively with a high life change profile-marriage, death, divorce, etc
c. Life change units (LCU) - the higher the number of LCUs the greater the likelihood the person will develop a physical illness.
d. How the person perceives life change events is crucial to his or her reaction to these events. The person may interpret a life changing event as a debilitating burden or growth/change opportunity
e. In some cases physical suffering becomes primary way for person to obtain gratification and attention.
f. Unresolved experiences of abuse, loneliness, bereavement may be

hidden by physical illness.

g. Person may have extreme difficulty with direct expression of dependency language and anger with in interpersonal relationships so physical illness is manifestation.

h. Depression is commonly the root of somatoform disorders.

2. Neurobiological factors

a. General Adaptation Syndrome (GAS) is a biological theory postulating that physiology plays a role in development of somatoform disorders. "If the body experiences prolonged adaptive struggles to combat stress the person is likely to develop a physical disease of adaptation."

b. In some cases, abnormal CNS regulation of incoming sensory information may be a key factor.

1) Inhibition of sensory input, causing a decreased awareness in the connection between mind and body.

2). Exaggerated focus on bodily symptoms.

3) Another neurobiological theory postulates a deficiency in communication between brain hemispheres that impedes awareness and expression of emotion.

3. Familial Factors-Mechanisms for adapting to stress are learned in the family. Children influenced by parental role models.

a. In some families the primary mode of adaptation to emotional tension is physical disorders. One child has physical symptoms that communicate the emotional pain of the system (family).

b. These families frequently overly involved with one another, deny existence of conflict, have poor ability to resolve differences, and a narrow, rigid, often ineffective range of responses to change.

IV. Application of the Nursing Process

A. Assessment – primary prevention

1. Family unit where learned patterns of behavior are dysfunctional--- one or both parents express psychological distress through physical symptoms. Nurses assess and analyze risk factors and intervene early.

2. Those who have experienced multiple life changes to offer assistance for learning functional coping.

B. Nursing Diagnosis

1. Ineffective coping family.

2. Ineffective coping individual.

IV. Apply steps of the nursing process to the care of a patient with somatoform disorders.

C. Planning – Intervention
   1. Assists others in discovering ways of adapting that facilitate emotional and physical well being. Some people adapt to stress or express emotion by becoming physically ill.
      a. Bottle up feelings.
      b. Frightened or unsure how to express needs.
      c. Receive reinforcement for physical illness.
   2. Assists families to discover ways to interact that do not foster the use of somatoform behavior.
      a. Create caring family atmosphere that is safe, accepting, and supportive.
      b. Develop open honest communication patterns that permit direct expression of feelings.
      c. Accept, encourage, and respect differences and opinions.
      d. Negotiates and cooperate at times of conflict.
      e. Flexible approach to problem solving.
      f. Achieve a balance between belonging needs and separation needs.
      g. Establish supportive relationships outside
   3. Promote functional adaptation to life changes.
      a. May occur in various settings such as speaking at community gatherings, PTA, pre-and post-natal classes.
      b. Directly working with people experiencing life transitions to help prepare them for changes and explore options for coping with mounting stress.

D. Assessment – Secondary prevention
   1. Holistic approach – assess whole person not just physical complaint -- psychological, social, and family influences.
      a. Physical exam.
      b. Health history
         1) Focus on relationship between bodily dysfunction and psychosocial and familial factors
         2) Do psychosociocultural assessment.
      c. Emotional themes.
   2. Nursing diagnoses
      a. Must address client's holistic nature. These diagnoses reflect physical and emotional responses and may include:

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1) Anxiety
2) Ineffective individual coping
3) Ineffective denial
4) Self-esteem disturbance
5) Spiritual distress
6) Diarrhea or constipation
7) Pain

b. Ineffective Individual Coping is usually most relevant diagnosis of any somatoform disorder.

3. Planning and intervention
   a. Prioritize nursing diagnosis. If client acutely physically ill, physical care comes first.
   b. Specific outcomes and interventions may need to be directed toward care of affected body systems such as cardiovascular, gastrointestinal, etc.
   c. Outcomes of care must also address client's emotional life.
   d. Nurse must remember the therapeutic principle, "never remove a client's defense unless a replacement that is more functionally sustaining is offered".
   e. Specific nursing interventions for unmet dependency needs.
      1) Accept client's feelings
      2) Meet client's dependency needs, then gradually help them meet more of their own.
      3) Anticipate client's dependency needs.
      4) Support and encourage any cues of functional independence.
      5) Use self to model and facilitate open communication.
   f. Nursing intervention for unexpressed anger
      1) Be aware of your own feelings.
      2) Accept client's feelings. Nonacceptance reinforces fear of rejection and abandonment
      3) Assist clients to recognize their anger, identify the sources and explore other ways to handle it.
      4) When client direct anger toward you, set limits while accepting them and their feelings.
   g. Family must be a focus of nursing care.
      1) Nurse develops a therapeutic relationship with family and intervenes as needed.

ADDICTIVE DISORDERS

Upon completion of this section, the participant will be able to demonstrate an understanding of Addictive Disorders.

I. Definitions A. Substance Abuse	I. Definitions A. Substance Abuse: "A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following occurring within a 12 month period." (DSM-IV): 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home. 2. Recurrent substance use in situations in which it is physically hazardous. (e.g., driving an automobile or operating a machine while impaired by a substance.) 3. Recurrent substance related legal problems. (e.g., arrests for substance related disorderly conduct.) 4. Continued substance use despite having persistent or recurring social or interpersonal problems caused or exacerbated by the effects of the substance. a. Arguments with spouse about consequences of intoxication. b. Physical fights.
B. Substance Dependence	B. Substance Dependence: "A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12 month period." (DSM-IV): 1. Tolerance: need for marked increased amounts of substance to gain original effect. 2. Withdrawal: occurrence of symptoms when substance is removed. 3. Substance is often taken in larger amounts or over a longer period than was intended. 4. Persistent desire or inability to cut down or control substance use. 5. A great deal of time is spent in obtaining, using, or recovering from use of a substance. 6. Important social, occupational, or recreational activities are given up or reduced to accommodate substance use. 7. Use of substance is continued despite recurring problems e.g., physical, psychological, or social.

C. Substance Intoxication	C. Substance Intoxication: 1. Development of reversible substance specific syndrome due to recent ingestion of (or exposure to) a substance. (NOTE: Different substances may produce similar or identical syndromes.) 2. Existence of clinically significant, maladaptive behavioral or psychological changes that are due to the effects of the substance to the central nervous system (e.g., belligerence; mood liability; impairment in cognitive, social or occupational functioning; or judgment impairment) and which develop during or shortly after use of the substance. 3. Symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
D. Delirium	D. Delirium: 1. Clouding of consciousness, inability to shift, focus, and sustain attention to stimuli. 2. Illusions or hallucinations which are usually visual and vivid.
E. Amnesic Disorder	E. Amnesic Disorder: Impaired ability to learn new information (short-term memory) and to recall remote information (long term memory).
II. Describe symptoms of withdrawal seen with: A. Alcohol	A. Alcohol Withdrawal Syndrome: 1. Develops within 4 – 12 hours after last drink. 2. Symptoms include: nausea, vomiting, general malaise, increased blood pressure and pulse; orthostatic hypertension; sleep disturbances; and nightmares; course tremors of tongue and eyelids; and vivid auditory hallucinations usually lasting a few hours or days.
B. Withdrawal Delirium with Alcohol	B. Withdrawal Delirium: 1. Can develop within 72 hours or as long as 1 week after last drink. 2. Occurs primarily in those who have been heavy drinkers for at least 5 years. 3. Symptoms include: clouding of consciousness; inability to shift, focus and sustain attention; illusions or hallucinations which are usually visual and vivid; increased blood pressure and temperature; sweating; seizures. 4. If untreated, medical complications, distortions of body image, aggressiveness, and agitation which may last up to a year.
C. Opiates	C. Opiate Withdrawal: 1. Occurs after cessation or reduction in use and includes depression, fatigue, disturbed sleep (related to increased rapid eye movement sleep), and agitation. 2. Withdrawal occurs within 3 days of last cessation or reduction and may last for months.
D. Cocaine	Cocaine Withdrawal: Symptoms occur after cessation or reduction after prolonged use, lasts for more than 24 hours, and include depression, irritability, agitation, paranoia, and sleep changes.

III. Discuss the common etiologic theories related to substance abuse and dependency disorders. A. Biological Theory B. Psychological Theory C. Sociocultural Theory D. Learning Theory	III. Common etiologic factors: A. Biological theory: 1. Genetic link: High incidence of alcohol abuse and dependency (alcoholism) in children and family members of alcoholics. 2. Brain chemistry alteration: a deficiency in Dopamine and Norepinephrine in apparent cocaine abusers. B. Psychological theory: self-medicating to lift depression, decrease tension and frustration, and/or increase self-esteem by feeling empowered. C. Sociocultural theory: 1. Individuals become addicted during adolescence when peer pressure is strong. 2. Social expectations and encouragement of consumption promote irresponsible use. D. Learning theory: 1. Conditioned response is always positive in the beginning and includes: pleasant physical responses, desired social consequences, increased feelings of self-confidence, relief from tension and anxiety. 2. The repetitive or learned behavior continued even after severe negative consequences occur.
IV. Discuss the incidence and significance of substance abuse and dependency. A. Abuse of Alcohol and Drugs B. Cost of Addiction C. Gender Differences	IV. Incidence and significance of substance abuse and dependence. A. Abuse of alcohol and drugs represents a major public health problem for the U.S. 1. 18 million Americans have alcohol problems. 2. Approximately 5 – 6 million Americans have drug problems. 3. More than half of all adults have a family history of alcoholism or problem drinking. 4. More than 9 million children live with a parent dependent on alcohol and/or illicit drugs. B. Cost of Addiction 1. Alcohol and drug abuse costs American economy an estimated $276 billion per year in cost productivity, health care expenses, crime, automobile crashes and other conditions. 2. Every American adult pays nearly $1,000 per year for the damages of addiction. C. Gender Differences 1. Nearly 4 million American women 18 and older may be classified as alcoholic or problem drinkers (1/3 of the number of men). 2. Research suggests that women may be at higher risk for developing alcohol-related problems at lower levels of consumption than men. 3. Women with drinking problems are at increased risk for depression, low self-esteem, alcohol-related physical problems, marital discord or divorce, spouses with alcohol problems, a history of sexual abuse, and drinking in response to life crisis. 4. The death rate is higher among female alcoholics because of their increased risk for suicide, alcohol-related accidents, cirrhosis and hepatitis.

IV. Continued C. Gender Differences	5. More than 4 million women need treatment for drug-abuse related problems.
V. Describe the relationship between substance abuse and mental illness.	V. <u>Dual diagnosis – Substance abuse and mental illness</u>. A. 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. B. 29% of all people diagnosed with mental illness abuse either alcohol or drugs. C. It is often difficult to tell which illness developed first. 1. Symptoms of severe substance abuse mimic other psychotic conditions. 2. Person must go through withdrawal before accurate assessment possible. 3. Treatment: a. Detoxification b. Substance Abuse Rehab c. Treatment of psychiatric condition
A. Apply the nursing process to alcohol and substance abuse.	A. Assessment: Nurses feelings and attitudes: 1. Important that the nurse assess own value system and possible negative reactions to alcohol and substance abusers and work through these so can approach the client in a positive, non-judgmental manner. B. Recognize emergency conditions which may require immediate attention. C. Assessment should include: 1. History and current use pattern of substances. 2. Reason for coming for treatment. 3. Appearance 4. Vital signs 5. Mood 6. Potential for violence and suicide. 7. Use of defense mechanisms. 8. Orientation to time, place, and person and how clear the client's perceptions are. 9. Physical and safety needs such as sleep without nightmares, depression, anxiety, etc. D. Nursing Interventions 1. Based on needs of the individuals. a. Acute Detoxification 1. Safety-Prevent falls/injuries 2. Monitor physical and mental status 3. Administer medications 4. Maintain adequate nutrition/fluid intake 5. Supportive communication 6. Provide for adequate rest/sleep

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A. Apply the nursing process to alcohol and substance abuse. (Continued)	b. Treatment Program 1. Support nutrition/fluid intake 2. Assess level of anxiety 3. Reinforce treatment program goals 4. Medication education (if on meds.) 5. Support patient progress 6. Patient/Family education/Relapse prevention E. Current Treatment Modalities 1. Psychoeducational groups 2. Cognitive therapy 3. Behavioral interventions 4. Group therapy 5. Individual therapy 6. 12-Step programs

EATING DISORDERS

Upon completion of this section, the participant will be able to demonstrate an understanding of Eating Disorders.

Micro-objective	Content Outline
I. Define the terms anorexia and bulimia and list behavioral characteristics and physiological changes that may occur.	I. Definition, behavioral characteristics and physiological changes A. Anorexia Nervosa - voluntary refusal to eat. 1. Behavioral characteristics a. Distorted body image, sees self as fat b. obsessive physical activity to burn calories c. Obsessed with food, cooking for others. 2. Physiological changes a. Amenorrhea b. Lanugo hair c. Hypotension d. Constipation e. Bradycardia f. Hypothermia g. Polyurea h. Electrolyte imbalances B. Bulimia = binge eating accompanied by self-induced vomiting, obsessive exercise, or use of laxatives/diuretics. 1. Behavioral characteristics: consume large number of calories (3415 average) per binge episode. 2. Physiological changes a. Dental caries b. EKG changes c. Parotid gland enlargement, gastric dilation d. Esophagitis e. Menstrual irregularity f. Electrolyte imbalance 3. May occur alone or in conjunction with anorexia nervosa.

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II. Describe the incidence of eating disorders.	II. Incidence A. Adolescent and young females. B. Age of onset 12 and 25 years old, rare after age 30. C. Manifestations may not disappear after young adulthood.
III. Compare the types of anorexia and bulimia.	III. Types A. Anorexia nervosa 1. Restricting type 2. Binge eating and purging B. Bulimia 1. Purging - vomiting, misuse of laxatives, diuretics, or enemas. 2. Nonpurging - fasting or excessive exercise
IV. Discuss the proposed etiology of Eating Disorders.	IV. Etiological theories A. Psychodynamic theory 1. Unresolved conflict in early childhood. 2. Unfulfilled tasks of trust, autonomy, and separation individuation 3. Child develops into overly compliant person with strong need to please others 4. Self-esteem dependent on approval from others B. Biological theory 1. Hypothalmic, hormonal, neurotransmitter or biochemical disturbances 2. Genetic 3. Malnutrition may affect mental status 4. Depression 5. Increased levels of vasopressins C. Behavior and cultural theories. 1. Rewarded for losing weight, continued attention for weight loss 2. American cultural/societal expectation of sliminess D. Family systems. 1. Control issue – passive father, controlling mother, dependent child 2. Father's lack of connection to daughter

	3. Family values achievement 4. Characteristics of family interactions a. Enmeshment – lack of clear boundaries b. Over protectiveness, lack of autonomy c. Rigidity and conflict avoidance
V. Apply the nursing process to the care of patients with an eating disorder.	V. Nursing Process A. Assessment 1. Client may be secretive 2. May have disturbances in all functional health patterns a. Health perception/management 1) Does not perceive self as ill 2) Resists treatment b. Nutritional-metabolic 1) Obtain accurate current weight. 2) Chronology of current weight loss 3) Associated causes of weight loss 4) Observe for signs of preoccupation with food 5) Symptoms of fluid volume deficit impaired skin integrity, hypokalemia, altered oral mucus membranes, cardiac changes, hypothermia, downy lanugo hair. c. Elimination 1) Constipation 2) Diarrhea 3) Laxative dependency 4) Polyurea 5) Vomiting d. Activity, exercise, and sleep-rest 1) Very active 2) Exercise compulsively 3) Insomnia with early awakening. 4) Decreased pulse rate e. Cognitive-perceptual

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1) Unaware of connection between eating behaviors and underlying feelings, needs, and conflicts.
2) Intellectualizes
3) Perfectionist
4) Over generalizes

f. Self-perception and self-concept
1) anxiety about obesity
2) Distorted body image
3) Low self-esteem
4) Rigid and high expectations of self
5) Seeks approval
6) Perceive a lack of control over self and situations.

g. Role-relationship
1) Isolates from family and friends
2) Immature interaction patterns
3) Decreased social skills

h. Sexuality-reproductive
1) Reproductive hormones regress to prepubertal levels.
2) Amenorrhea, infertility
3) Breast atrophy lanugo
4) Loss of axillary and pubic hair
5) Anorectic = sexually inactive
6) Bulimic = impulsive sexual behavior

i. Coping-stress tolerance
1) Inability to ask for help and nurturance
2) Inability to make decisions
3) Inability to meet role expectations of adolescence
4) Inability to express emotions
5) Perceived powerlessness.

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Developmental Disorder (Mental Retardation)

Upon completion of this section, the participant should be able to identify basic concepts related to mental retardation

Micro-objective	Content Outline
I. Define the term mental retardation	I. Define mental retardation (MR) A. Sub-average general intellectual functioning and deficits in adaptive behavior manifesting during the developmental period. B. Impairments in at least two of the following: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. C. Onset before age 18 years.
II. Identify the levels of mental retardation used by the DSM-IV.	II. Levels of mental retardation A. Mild: IQ level 50-75. B. Moderate: IQ level of 35-55 C. Severe: IQ level of 20 to 40 D. Profound: IQ level below 25 E. Severity unspecified: intelligence is not testable F. Labels impact care, treatment, and education of people with MR 1. Poor achieving minority children from financially disadvantaged environments are disproportionately classified with MR. 2. Tests a. Weschler Preschool, children and adult. b. Standford-Binet Intelligence Scale: c. Adaptive skills testing in ten categories (see I-B) d. Assessments done by qualified professionals and include a second rater so averages are obtained.

III. Discuss the impact of mental retardation on daily living.

IV. Understand the incidence of mental retardation.

1) Case histories, interviews with significant others, observations in usual environment.
2) Consent for assessment is given by client, parent or guardian.

III. Impact of retardation levels on daily living.
- A. Mild
  1. Academic skills up to 6th grade.
  2. Independent self-care and home maintenance.
  3. With opportunities and instruction, may work.
- B. Moderate
  1. Basic self-care.
  2. Academic skills to grade school level.
  3. Unskilled or semiskilled work.
- C. Severe
  1. Controlled environment or learn self-care and communication skills.
  2. Sheltered workshop vocation.
  3. Requires daily living assistance.
- D. Profound
  1. Daily care and supervision throughout life span.
  2. Motor and speech impairment.

IV. Incidence
- A. American Association of Mental Retardation (AAMR) redefined MR and raised IQ cutoff level to 75, increasing the number of individuals who have MR.
  a. 1 in 10 people (Americans) have a person with MR in their family.
  b. MR approximately 1.5 times more common in boys than in girls.
  c. 40% to 70% of individuals with MR

V. Identify the leading causes of mental retardation.	have psychiatric disorders. V. Causes A. Genetic 1. Chromosomal abnormalities 2. Hereditary 3. Endocrine disorders (thyroid) B. Acquired factors 1. Prenatal factors e.g. irradiation, infection, toxins, drugs, and unknown causes. 2. Perinatal factors e.g. prematurity, anoxia, brain damage, infection caused by intrauterine disorders or abnormal labor and delivery. 3. Postnatal factors e.g. childhood diseases, accidents, infections, anoxia, poisoning, hormonal problems and environmental factors. 4. Birth defects e.g. cerebral palsy, deafness, and blindness. 5. Psychiatric disorders - problematic behavior impedes learning 6. Child abuse - trauma and deprivation.
VI. Discuss the vulnerability of the mentally retarded to mental illness.	VI. Vulnerability of persons with MR to mental disorders.

A. Dual diagnosis predisposes to emotional disturbance .
B. Less able to relate to family and community.
C. Unrecognized and therefore untreated behavioral and psychiatric disturbances.
D. Thomas S
    1. Class membership
        a. Mental illness and also MR.
        b. Class-action lawsuit (1988) which decided an individual who resided in one of NC's State psychiatric hospitals before 1984 as an adult, and must have a diagnosis to become a member of the Thomas S class.
        c. MR diagnosis must be substantiated.
        d. Court order requirements for class members.
        1. Safety, free from harm
        2. Freedom from undue restraint
        3. The right to living arrangements to meet their needs.
    2. Class action suit resolved.
    3. Care/Treatment of MR/MI patients assigned to local area Mental Health, Developmental Disabilities and Substance Abuse Services program.
        a. Admission to state psychiatric hospital by special exception.
        b. Diverted to other mental health facilities.

VII. Apply the nursing process to the care of the dually diagnosed patient, MR/MI.

VII. Nursing Process: Meeting developmental needs
    A. Assessment
    1. MR children at greater risk of having

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Unmet needs.

a. Emotional adjustment met through affection, acceptance, and approval.
b. MR children need special services to become independent and autonomous. Can become functional part of society rather than an adult "child".
c. MR population is aging – nurses must consider changing needs of patients.

2. Dual diagnosis
   a. Those with diagnoses may exhibit negative behavior such as head banging, violent aggression, smearing of feces, sleep disorders, chronic pacing, hand wringing, and screaming out at people or things not present.
   b. Assess behavior for inability to deal with delayed gratification, impulsiveness, irresponsibility and failure to adjust socially.
   c. Assessments difficult in presence of MR as the cognitive deficiency may mask certain behaviors that are often found in psychiatric disorders.
   d. Frequent types of mental illness in this population include schizophrenic disorders, personality disorders, adjustment disorders, and affective disorders.

B. Planning and Intervention for MR/MI
   1. Include parents, guardian, and client.
   2. May require parent counseling, individual,

	Or group counseling. 3. Activities therapy such as play therapy, music recreational therapy and art therapy. 4. Role modeling e.g. demonstrate behavior needing correction, model the corrected behavior. C. Evaluation 1. Must show accountability through recorded plans, interventions and reports of client progress. 2. Plans include how goals and objectives are evaluated i.e., use of videotapes, progress notes. 3. Meticulous record keeping of client's behavior and legal consents. 4. Discharge summary to accompany patient at time of discharge.
VIII. Understand the role of the nurse in the care of this population.	VIII. Nurse's attitude A. Client advocate. B. Prepare for increase of persons with MR moving into the community. C. Purse professional development. D. Promote public awareness of MR

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Upon completion of this section, the participant will be able to demonstrate an understanding of psychosocial problems and neuropsychiatric complications of HIV by:

A. Identify the effects of HIV on the immune system	A. Impact of HIV on the immune system 1. Invade host's CD4 cells which protect against primitive fungi, yeast and other viral infections and replicate. 2. HIV positive diagnosed when antibodies produced by the host's intact immune system are detected by lab test. 3. Patient diagnosed with AIDS after suffered several specific opportunistic infections.
B. Discuss the HIV spectrum	B. HIV spectrum 1. Conversion reaction occurs 4-6 week after initial infection although lab testing remains HIV negative because antibodies undetectable. 2. Sufficient antibodies detected after 8-12 weeks for lab testing to indicate HIV positive results. 3. Latency (several years after conversion) a. Physical signs present. b. Psychological effects: 1. Living with life threatening illness 2. Punishment for life style 3. Worry, impending doom 4. Grief for loss of future a. Career b. Relationship 5. Compromised immune system causes changes in health status. c. Fatigue, fever, swollen lymph nodes. d. Obsession with CD4 count. As CD4 count decreases, anger, helplessness and depression increase. e. Denial of illness no longer effective defense mechanism. 4. Increase in the number and severity of illnesses. a. Increase stress related to financial problems and caring for dependent family members or partners. b. Increase in social isolation which can hasten development of physical illness. c. Change in self-image related to weight loss, and/or Karposi's Sarcoma lesions. 5. Progression to AIDS diagnosis about ten years after initial infection: a. Resolve grief b. Life review c. Face approaching death
C. Discuss attitudes related to HIV	C. Attitudes about HIV 1. Myths a. Punishment for wrongdoing or immorality. b. New age messenger sent to teach new ways to reach out in love and acceptance which must be learned before AIDS will disappear.

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	c. Results of sick earth; illness and disease occur because the earth is so contaminated. d. Convert activity by government or business: 1. Germ warfare, 2. Inferior hepatitis vaccine shipped to Africa started disease there, 3. Deception by pharmaceutical companies to reap huge profits expensive treatments.
D. Evaluate your own feelings about caring for someone on the HIV spectrum.	D. Nurse's attitude 1. Early phase a. Maintain health status and quality of life while helping client cope with the reality of the disease. b. Understand nurse – client relationship may end in client's death. 2. As disease progresses: a. Help client cope with dignity. b. Sustain quality of life. 3. Facing client's death a. Nurse's sense of frustration as prevention of disease progression fails. b. Nurse's feelings of grief at client's impending death.
E. Identify potential psychosocial problems	E. Psychosocial aspects of HIV infection 1. Those at special risk for psychosocial problems: a. Anxiety about discussing status or being tested. b. Counseling pre- and post- testing: 1. What does the client understand about the meaning of the test? 2. How will the client deal with positive results-coping mechanisms? 3. Will positive results increase risk of suicide? (rate 66% higher in men with AIDS than in the general population) c. Caregivers at risk for psychosocial difficulties. 1. Maybe HIV positive themselves. 2. Part of alternative family structure. 2. Psychosocial factors a. Early stage 1. Anxiety a. Loss of employment b. Loss of primary relationship c. Fear of dying 2. Grief a. Loss of dreams b. Decreased self esteem due to inability to achieve goals 3. Developmental stage of client at onset of illness a. Younger client-career dreams b. Middle age-retirement dreams 4. Sense of shame a. Stigmatization by society; nurse assists to confront feelings by casting doubt on their validity.

b. How client contracted disease (esp. homosexuals); Nurse helps client cope by helping him or her understand HIV caused the disease not the client and role models unconditional positive regard.
c. Interpersonal relationships. Feels unlovable because client can transmit HIV. Nurse must be able to counsel, clients in ways to decrease risk of transmittal.

5. Denial may be appropriate reaction at this stage

b. Middle stage
1. Denial can no longer prevent distress.
2. Central nervous system involvement causing client to respond differently to stimuli.
3. Loss of control over health. Nurse assists client to identify positive aspects of life.
4. Must realistically accept health status.
5. Self esteem and body image changes related to changes in appearance and loss of independence. Nurse acts as a bridge between client and caregiver.
6. Loss of illusion that client might not get sick and might have more time. Nurse helps client maintain positive attitude to sustain health-promoting behaviors.
7. Family's psychosocial needs:
   a. Nurse provides information and allows family to share grief and anger.
   b. Family that one rejected client's lifestyle now is forced to care for client.
   c. Family, once rejected by client, are now asked to help client.
   d. Absent family members may appear and try to usurp client's or primary caregiver's autonomy.
   e. Nurse acts as a mediator in these cases and a client advocate.
8. Facing death
   a. Encourage client to verbalize feelings before life threatening complications occur.
   b. Assist client to see death as a natural and inevitable part of life.
   c. Allow client to make their own decision about things within their control.
   d. Help client verbalize fear of pain and reassure client concerning pain control.
   e. Help client to address preferences about where client wishes to die and assist client or family to fulfill that desire.
   f. Encourage client to verbalize what life sustaining measures client wishes and assist client with a living will.

c. Late stage
1. Client reaches realistic level of acceptance:
   a. Continued sense of loss as health and memory decline.
   b. Continued acceptance by nurse.

	c. Environmental stressors such as money, housing, relationships, and health care. 2. Life review: a. Client achieves a sense of completion about their life. b. Family recalls past and makes peace with what has occurred.
F. Discuss the neurophysiological aspects of HIV.	F. Neurophysilogical aspects 1. Incidence: a. 10% have neurological complaints. b. 40% develop serious neurological problems. c. 80%-90% exhibit CNS damage on autopsy. 2. Early signs of CNS involvement difficult to distinguish from clinical depression: a. Irritability b. Forgetfulness c. Decreased ability to think and do self-care. d. Slow withdrawal from family and friends. e. Decreased intimacy between client and caregiver. 1. Increased burden on the caregiver. 2. Nurse must support and encourage caregiver.
G. List four main causes of Central Nervous System Involvement.	G. Four main causes of Central Nervous System involvement 1. Direct infection by HIV a. AIDS Dementia Complex (ADC) 1. Cerebral atrophy 2. White matter pallor 3. Vacuoles-cavities in the brain or spinal cord 4. Ventricles enlarge b. Neuropsychological findings 1. General slowing of cognitive and sensory motor functions consistent with a progressive subcortical dementia. 2. Clumsiness with or without weakness in the extremities. 3. Social withdrawal, apathy, and personality changes. 4. Early symptoms: a. Difficulty concentrating b. Forgetfulness or inability to do familiar tasks c. Depression and withdrawal as walking becomes difficult d. Changes in handwriting, speech e. Absence of motor responses. 2. Opportunistic Infections a. Toxoplasmosis – protozoan route of transmission – GI tract. 1. In HIV clients causes multiple abscesses in the brain. 2. Specific unilateral focal neurological findings including hemiparesis, dysphasia, and sensory deficits. 3. Weakness, lethargy, seizures. b. Herps virus

1. Three types
   a. Cytomegalovirus
   b. Herpes simplex I and II
   c. Herpes varicella
2. CNS involvement
   a. Stiff neck
   b. Headache
   c. Confusion
   d. Lethargy which may progress to coma and death.
   e. CMV affects retina and may cause blindness.
   d. Cryptococcal meningitis – fungus route of transmission
      1. Affects up to 10% of all AIDS clients.
      2. Early symptoms – headache, stiff neck.
      3. Progresses to lethargy and focal problems if intracranial pressure increases.
      4. Primary symptoms – ever present severe frontal headache unrelieved by pain reliever.
3. Lymphomas
   a. Occur nearly as often in HIV clients as noncancerous brain tumors in the general population.
   b. Tumor grows in thalamus, corpus callosum, ventricles or between cerebral hemispheres.
   c. Produce symptoms associated with localized functions such as one-sided weakness, visual loss, or confusion.
   d. One third of clients experience seizures.
4. Toxic effects of treatment
   a. Drugs that cross and blood-brain barrier can cause neurological effects
      1. Frequently changing medications to treat other problems
      2. Over the counter drugs added by client interacting with other medications.
      3. Stronger or different effects of medications on HIV clients

H. Apply the Nursing Process to the care of clients with HIV.

H. Application of the Nursing Process to clients on the HIV spectrum
1. Assessment
   a. Knowledge deficits
   b. Physical well-being
   c. Safety
   d. Nutritional status
   e. Support system
   f. Emotional status
   g. Spiritual support
2. Plan
   a. Encourage independence.

b. Provide ADLs as needed.
c. Keep physically safe from injury and infections.
d. Be supportive, encourage family/friend involvement.

3. Intervention (based on patient's ability to function):
   a. Intellectual functioning
      1. Verbal directions with visual or written cues.
      2. Short, simple instructions.
      3. Reminders
      4. Consistency with no abrupt changes.
      5. Decision-making at patient's level of problem-solving.
      6. Labels on surroundings (e.g., large print signs on rooms).

   b. Sensory/motor
      1. Requires special safety measures and support (e.g. check bath water temperature).
      2. Immobility issues (e.g., awareness of potential skin breakdown and deep vein thrombosis).
      3. Bowel and bladder problems (e.g., incontinence, infections, skin breakdown).
   c. Personality or behavioral disturbances
      1. Redirection versus control.
      2. Remove agitating stimuli while providing safety.
      3. Encourage stress management techniques.
      4. Unconditional positive regards for patient.
4. Evaluation
   a. Nurse-preceived as facilitator of life-sustaining care in nurse-client-physician relationship.
      1. Client may not express concerns fearing nurse may obstruct access to physician.
      2. Evaluation valid only if client openly expresses concerns about care.
   b. Goal setting takes into account client's prognosis, and is realistic and obtainable.

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ORIENTATION CHECKLIST/COMPETENCY ASSESSMENT
TEMPORARY POOL/AGENCY/TRAVEL NURSE

NAME:_____ ENTRY ON DUTY DATE:_____

		DATE	EC INITIAL	COMMENTS	N/A
I.	PERSONNEL PACKAGE				
	A. Assurance of confidentiality/Patient Rights: signed statement.				
	B. Drug Alcohol Free Workplace: signed for receipt.				
	C. Orientation checklist completed and signed.				
II.	UNIT ORIENTATION				
	A. Discussion of patient population and nursing interventions.				
	B. Unit Program Manual				
	C. Orientation Notebook				
	D. Notification of Nursing Office of tardiness or absence 575-7941				
III.	RESOURCE PERSONS				
	A. Shift Supervisor				
	B. Paging System				
	C. On-Call Physician				
	D. Nursing Coordinator				
	E. Pharmacy				
	F. Laboratory/X-Ray				
IV.	SAFETY				
	A. CPR Certification (Expiration Date:_____)				
	B. Code Blue Policy				
	1. Emergency Cart				
	2. Emergency Oxygen				
	3. Emergency Suctioning				
	4. Emergency IV				
	C. Fire Regulations				
	D. Disaster Plan				
	E. Smoking Policies				
	F. Precautions				
	1. Escape				
	2. Suicide				
	3. Seizure				
	4. Assault/Homicidal				
	G. Interventive Procedures				
	1. Policy Review				
	2. Nursing Assessments				
	3. Obtaining Order				
	4. NCI Completed _____				
V.	DEMONSTRATES COMPETENCY IN MEDICATION ADMINISTRATION				
	A. Passes medication test date: _____				
	B. Transcription of orders				
	C. Medication administration documentation				
	D. PRN medication documentation				
	E. Controlled substances policy				
	F. Administration of psychotropic medications to non-consenting patients.				
	G. Glucometer				
	H. Admixture of parenteral products (Medical Only)				
	I. Use of Night Closet				
	J. Medication clinical performance evaluation completed				

ORIENTATION CHECKLIST/COMPETENCY ASSESSMENT
TEMPORARY POOL/AGENCY/TRAVEL NURSE

VI. POLICIES

A. Accounting for Patients
B. Patient Education/Discharge Planning
C. Incident Reporting
D. Unauthorized Absence Reporting
E. Shift/Unit Nursing Report
F. Patient Care Assignments
G. Privilege levels or structure/unstructured activities
H. Death/Autopsy

VII. DEMONSTRATES COMPETENCIES IN PROCEDURES/ TREATMENTS AS RELATED TO UNIT

A. Catheterization
    1. Straight and Foley
    2. Supra-public (Medical Only)
B. Enemas
C. Nasogastric tube insertion and feedings (Medical Only)
D. Venipuncture (include blood culture) Yes ___ No ___
E. Tracheal aspiration (Medical Only)
F. IV medical administration (Medical Only)
G. EKG performance (Medical Only)
H. Connecting patient to monitor/MSU
I. RN responsibilities Code Blue/MSU
    1. Location/use of related equipment
        a. Life Pak 12
        b. Pulse oximetry
    2. Completing documentation
    3. Responsibilities of MSU
J. RN responsibilities to other units
K. Application of Mechanical Restraints

VIII. DEMONSTRATES COMPETENCY IN THE FOLLOWING AREAS:

A. Ability to assess, plan, direct, implement and evaluate Nursing Care appropriate to developmental level, physical and psychological needs of _____ patients.
B. Utilization of therapeutic communication that is respectful of age and cognitive function.
C. Documentation per JUH policy including:
    1. Nursing Assessments-Initial, 24, 48, weekly
    2. Nursing Assessments-Monthly, Annual
    3. Suicidality Assessments and shift notes
    4. Nursing Care Plans
    5. Treatment Team Plans
    6. Interventive Procedures

Completes Basic Psychiatric Concepts Exam _____
date

I acknowledge that I have been oriented to and received instructions in the above documented areas.

Signed_____ Date_____ Date_____
Temporary Pool/Agency/Travel Nurse Ed Coordinator

Copy: Nurse Recruiter
Shift Supervisor
Educational Coordinator