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PSYCHIATRIC *and* BEHAVIORAL HEALTH

NCLEX Study Guide

PSYCHIATRIC NURSING

First thing to ask in a psych question is:
"Is the patient psychotic or non-psychotic?"

- It must determine the care plan, treatment, length of stay, legality, etc.

Non-psychotic

A **Non-psychotic** person has **insight** and is **reality based**.

: What kinds of answers do you pick for these people? What techniques do you use?

- **Good therapeutic communication** (looks like a Med/Surge patient)

Therapeutic Communication Techniques		
Technique	**Definition**	**Example**
Listening	An active, nonverbal process that involves receiving & interpreting	Lean forward, maintain eye contact, nod appropriately
Restating	Repeating the major theme	"You say that your coworkers never invite you to lunch."
Broad opening	A general statement that allows the client to choose the topic of discussion	"What are you contemplating now?"
Clarification	Asking the client for further explanation of a vague or confusing comment	"I'm not sure I understand. Could you repeat that?"
Reflection	Repeating back the feeling, idea, or message conveyed	"You're feeling anxious because of your job?"
Sharing perceptions	Stating an observation or summation that the client can validate or reject	You say that you don't care, but I sense that you are upset."
Suggesting	Offering alternate options	"Have you considered using sleep hygiene techniques?"
Focusing	Using statements to encourage exploration of a particular topic	"I think we should talk more about the pain you have."
Theme identification	Exploring overarching or repeated topics	"I've noticed that you fear areas with crowds."

Psychotic

The **Psychotic** person has **no insight** and is **not reality based.** Everyone else has a problem but they don't think they're sick.

The Delusions, Hallucination and Illusion are the examples and Psychotic symptoms.

A. **Delusions—**a false, fixed belief or **idea** or it is all your **thought** on your head and there is no sensory component. **Delusional disorder** is a type of psychosis characterized by isolated delusions that last for at least a month in a client who is otherwise highly functional. The symptoms of other psychotic disorders, such as those associated with schizophrenia (eg, hallucinations, bizarre behavior, disorganized thought processes), are not present. The delusions can be bizarre (out of the realm of possibility) or non-bizarre (possibly true but not).

Types of Delusions	
Erotomaniac	A belief that another person, usually someone famous or powerful, is in love with the individual
Grandiose	Irrational ideas about self-worth, power, knowledge. Identity, or a special relationship to a deity or famous person. *Ex. "I'm Christ"; "I am the President"; "I am the world's smartest"*
Jealous	Delusions that the sexual partner is unfaithful
Persecutory	The belief of being treated in a malicious way
Somatic	The delusions of having some physical defect or disease. *Ex. Body part (I have x-ray vision, there are worms inside my arm)*
Paranoid	The delusion that causes obsessive anxiety, suspicion, and mistrust. *Ex. People are out to get/kill me*

Typical characteristics of perpetrators of child abuse include:

1. Unrealistic expectations of the child's performance, behavior, and/or accomplishments; overly critical of the child.
2. Confusion between punishment and discipline; having a stern, authoritative approach to discipline.
3. Having to cope with ongoing stress and crises such as poverty, violence, illness, lack of social support, and isolation.
4. Low self-esteem – a sense of incompetence or unworthiness as a parent.
5. A history of substance abuse, use of alcohol or drugs at the time the abuse occurs.
6. Punitive treatment and/or abuse as a child.
7. Lack of parenting skills, inexperience, minimal knowledge about child care and child. development, and young parental age.
8. Resentment or rejection of the child.
9. Low tolerance for frustration and poor impulse control.
10. Attempts to conceal the child's injury or being evasive about an injury;

B. **Hallucination—** it is **a sensory experience.** Hallucinations are false sensory perceptions that have no external stimuli. And the priority nursing action is to explore the content of the hallucinations. They can occur in any of the five (5) senses.

Types of Hallucinations	
Auditory (Hearing)	Voices telling you to harm yourself
Visual (Seeing)	Imagining things that only you can see. *Ex. "I see bugs on the wall"*
Tactile (Touch)	Creating a sensation of physical contact with something that is imaginary. *Ex. "I feel bugs on my arm"*
Gustatory (Taste)	Hallucinating any kind involving the sense of taste. Ex. A strong, unpleasant metallic taste in one's mouth
Olfactory (Smell)	Detecting smells that are not really there.

This client maybe experiencing command auditory hallucinations that could lead to self-directed or other-directed injury and harm. After the content of the hallucinations has been explored, implementing an intervention may be necessary to reduce the potential for violence.

There are additional ways to deal with hallucinations include the following:

- Telling the client that you know they are real but that you do not hear the voices (or see the vision, feel the sensation)
- Not arguing with or challenging the client about hallucinations
- Directing the client to a reality-oriented topic of conversation or activity
- The mnemonic **SAD PERSONS** uses known risk factors and the concept of their accumulation to help predict who is at a higher risk of committing suicide.

SAD PERSONS Mnemonic	
S	Sex (men kill themselves more often than woman; women make more attempts)
A	Age (teenagers/young adults, age >45)
D	Depression (and hopelessness)
P	Prior history of suicide attempt
E	Ethanol and/or drug abuse
R	Rational thinking loss (hearing voices to harm self)
S	Support system loss (living alone)
O	Organized plan; having a method in mind (with lethality and availability)
N	No significant other
S	Sickness (terminal illness)

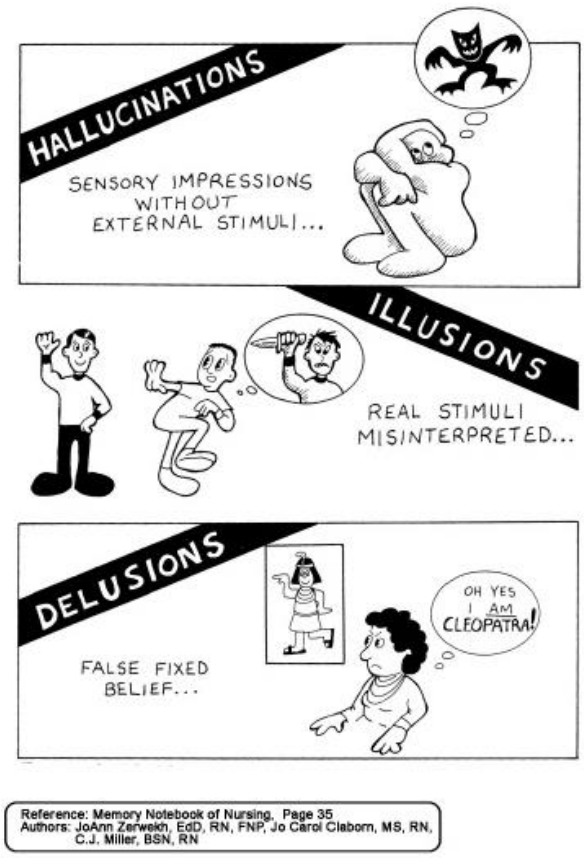
C. **Illusion** - it is a sensory and a misinterpretation of reality.

Differentiation between hallucination and illusion

- With illusion there is a **referent** in reality, while with the Hallucination is there's nothing.
  - ✓ A **referent** is something that both the clinician and the patient can refer to. There is actually something there

Example:
The patient staring at the empty wall says, "Listen, I hear demon voices.".
Question: Is the statement from the patient a hallucination or an illusion?
Answer: This is **Hallucination**, because there is no referent there.

Example:
The same patient overhears nurses and doctors laughing and talking at the nursing station, and says, "I hear demon voices.".
Question: Is that statement from the patient a hallucination or an illusion?
Answer: This is **Illusion**, because there is actually a referent *(real people)* there.



Reference: Memory Notebook of Nursing, Page 35
Authors: JoAnn Zerwekh, EdD, RN, FNP, Jo Carol Claborn, MS, RN, C.J. Miller, BSN, RN

Other examples:

- A patient looks with a blank stare and says, "I see a bomb."
  - This is a **hallucination**.
- A patient is looking at the fire extinguisher on the wall and says look, "I see a bomb."

How do you deal with these Psychotic patients?

- To deal with psychotic patients, you should ask first what type of psychosis the patient has?

There are 3 types of PSYCHOSIS

A. Functional Psychosis - they can function in everyday life.

- 90% of the followings make up this category
- Chemical imbalance in the brain
- They are "Skeezo, Skeezo, Major, Manics"
  Schizophrenia, Schizoaffective disorder, Major depression (not depression), Mania (chemicals out of whack)

➢ This patient has the potential to learn reality (no brain damage)
➢ Your role as a nurse is to teach reality by using the (four) 4 steps.
  - Acknowledge feeling
  - Present reality
  - Set limits
  - Enforce these limits

What does this look like in a question?

1. The answer acknowledges **patient's feeling** (look for the word "feel") "You seem upset. That is so sad. It's been so difficult. Tell me more about how you're feeling"
2. Now, **present reality:** "I know you see that demon, but I don't see a demon" or, "I am a nurse, this is hospital, this is your breakfast"
3. **Set limit.** "We are not going to address that. Stop talking about.".
4. **Enforce limit.** "I see you're too ill, so our *conversation is over*." Ends the conversation. You're not punishing the client by taking away privileges

Example:

- Bipolar = Depression and Mania
  - Bipolar patients are psychotic in acute mania.

➢ **Acute Mania**
  - In developing a care plan for a client experiencing **acute mania**, the nurse is aware that an acute manic episode is characterized by the following:

- Excessive psychomotor activity
- Euphoric mood
- Poor impulse control
- Flight of ideas, non-stop talking
- Poor attention span, distractibility
- Hallucinations and delusions
- Insomnia
- Wearing bizarre or inappropriate clothing, jewelry, and makeup
- Neglected hygiene and inadequate nutritional intake

The care plan for a client experiencing an acute manic episode includes the following:

1. Reduction of environmental stimuli
   - Providing a quiet, calm environment
   - Limiting the number of people who come in contact with the client
   - One-on-one interactions rather than group activities
   - Low lighting
2. A structured schedule of activities to help the client stay focused
3. Physical activities to help relieve excess energy
4. Providing high-protein, high-calorie meals and snacks that are easy to eat
5. Setting limits on behavior

B. Psychosis of Dementia - what is their problem?

- Actual Brain destruction/damage
  - Due to Alzheimer, stroke, organic brain syndrome
  - Anything that says Senile/Dementia falls in the category
- They cannot learn reality. Thus, frustrates them, and may discourage you!
- Deal with their problems in 2 steps
  - Acknowledge their feeling,
  - Redirect them *(give them something they can do).*

  Do not confuse not **presenting reality** with **reality orientation** (Person, place, and time)
- Reality orientation = Patient is oriented to person, place, and time

Example:

- Alzheimer lady is the lobby of waiting area of her nursing home. It is Sunday and she is all dressed up. You day to her, "Mrs. Smith, you are all dressed up." She said, "Yeah! My husband is going to pick me up. We are going to church." The problem is that the husband has been dead for 10 years.
  » She has a false, fixed belief
  » She is delusional (or she is psychotic)
  What do you say to her?
  First, *acknowledge her*. You say, "That sounds nice." **(acknowledging)**
  Second, *redirect her*. You say, "Why don't we sit down here and talk about church? Which church do you go to?" **(redirecting)**
  » Don't tell her husband is dead, which is presenting reality.

C. Psychotic Delirium

- This is temporary, sudden, dramatic, episodic, secondary loss to reality. Usually due to some chemical imbalance in the body.

Causes:

✓ UTI, thyroid imbalance, adrenal crisis, electrolytes, medications/drugs

- To manage these patients, treat the underlying cause
  - Acknowledge feeling
  - Reassure them of **safety** and **temporariness** of their condition
- They lost touch with of reality—Redirect them is futile

Examples:

➢ A patient with schizoaffective disorder who points to two people talking across the room. The patient says,
"Those people are plotting to kill me!". What would you say? What is the most important word in the vignette?

- **Schizoaffective**—psychosis

- I can see that would be frightening. They are not plotting.
- We are not going to talk about that. I can see you are too ill. We are ending the conversation

➢ A patient with Alzheimer disease who during your conversation points to two people talking across the room and says, "You see these people, they are plotting to kill me"

- **Alzheimer Disease**—category is dementia

- Acknowledge feeling - "I understand you seem to be scared".
- Redirect – "Let's go somewhere you feel safe".

➢ A patient with delirium tremens who during your conversation points to 2 people talking across the room and says, "You see these people, they are plotting to kill me".

- **Delirium tremens …**

- "That must be scary"
- "But you are safe. Your fear will go away when you get better"

Psychotic Symptoms

Loose associations

- **Flight of Ideas:** Rapid flow of though
- **Word Salad:** Throw words together and toss out … (Sicker than flight of ideas)
- **Neologisms:** Make it up
- **Narrowed self-concept:** When a psychotic refuse to change their clothes or leave the
- room. Leave them alone.
  - This is a functional psychosis
  "Don't make a psychotic do something they don't want to do"
- **Idea of reference:** You think everyone is talking about you

- **Dementia hallmark:** Memory loss, inability to learn
  - Always acknowledge **feeling**
  - 2nd step always **begins with "Re": Re**assure, **Re**direct, **Re**ality

Schizophrenia

Negative Symptoms of Schizophrenia	
• Impaired social & interpersonal functioning • Inappropriate or blunt affect • Apathy • Inadequate motivation • Inability to make decisions	• Poor personal hygiene • Bizarre posturing • Pacing & rocking • Regression • Inability to experience pleasure

Clients with schizophrenia often become anxious when around other individuals and will seek to be alone to relieve anxiety. Impaired social and interpersonal functioning (eg, social withdrawal, poor social interaction skills) are common negative symptoms of schizophrenia. These are more difficult to treat than the positive symptoms (eg, hallucinations, delusions) and contribute to a poor quality of life.

Nursing interventions directed at improving the social interaction skills of a client with schizophrenia include the following:

- Making brief, frequent contacts
- Accepting the client unconditionally by minimizing expectations and demands

- Assessing the client's readiness for longer contacts with the nurse and/or other staff and clients
- Being with or close by the client during group activities
- Offering positive reinforcement when the client interacts with others

Social isolation and impaired social interaction are common negative symptoms of schizophrenia. The client will seek to be alone to relieve anxiety associated with being around others. The nurse needs to be accepting of the client's behavior and continue attempts at brief contact until the client is comfortable.

Educational objective:

Disturbance in logical form of thought is characteristic and one of the positive symptoms of schizophrenia. The client will often have trouble concentrating and maintaining a train of thought. Thought disturbances are often accompanied by a high level of functional impairment, and the client may also be agitated and behave aggressively. The nurse needs to be able to recognize and identify the various types of thought disturbances experienced by clients with schizophrenia. These include loose associations, neologisms, word salad, echolalia, tangentiality, clang association, and perseveration.

Types of impaired thought processes seen in individuals with Schizophrenia	
Neologisms	• Made-up words or phrases usually of a bizarre nature; the words have meaning to the client only. Example: "I would like to have a phjinox."
Concrete thinking	• Literal interpretation of an idea; the client has difficulty with abstract thinking. Example: the phrase, "the grass is always greener on the other side," would be interpreted to mean that the grass somewhere else is literally greener.
Loose associations	• Rapid shifting from one idea to another, with little or no connection to logic or rationality.
Echolalia	• Repetition of words, usually uttered by someone else.
Tangentiality	• Going from one topic to the next without getting to the point of the original idea or topic.

Word salad	• A mix of words and/or phrases having no meaning except to the client. Example: "here what comes table, sky, apple."
Clang associations	• Rhyming words in a meaningless, illogical manner. Example: "the pike likes to hike and mike fed the bike near the tyke."
Perseveration	• Repeating the same words or phrases in response to different questions.

DEFENSE MECHANISMS		
Defense Mechanisms	**Definition**	**Example**
Rationalization	Using excuses to explain away threatening circumstances	"I did poorly on the test because the questions were so tricky"
Displacement	Transferring thoughts & feelings toward one person or object onto another person or object	A person who is angry with a boss comes home & yells at the spouse
Regression	Returning to a previous level of development	An adult has a "temper tantrum" when stuck in traffic
Introjection	Talking on the qualities or attitudes of others without thought or examination	A person may take on the political views of a famous, admired actor
Reaction formation	Behaving in a manner or expressing a feeling opposite of one's true feelings	A parent who is resentful of an "unplanned" child becomes overprotective of that child
Repression	Keeping unacceptable thoughts or traumatic events buried in the unconscious	A person who was raped cannot recall the event
Sublimation	Transforming unacceptable thoughts or needs into acceptable actions	A person may turn to boxing to deal with aggression

Educational Objective:

Defense mechanisms are strategies or responses, usually unconscious, used by individuals to distance themselves from a full awareness of unpleasant thoughts, internal conflicts, and external stresses. Defense mechanisms protect the ego from threatening thoughts and anxiety.

Denial is the refusal to accept the reality of threatening situations, or painful thoughts, feelings, or events. It is the most frequent defense mechanism used by clients with alcoholism; the client may deny that drinking is a significant problem and that any issues or problems can be handled alone.

Rationalization, regression, displacement, sublimation, and reaction formation are not the primary defense mechanisms used by the client. This client displays no symptoms of depression.

Cognitive behavioral therapy (CBT) can be effective in treating anxiety disorders, eating disorders, depressive disorders, and medical conditions such as insomnia and smoking. These types of disorders are characterized by **maladaptive reactions to stress, anxiety, and conflict**. CBT requires that the client learn the skill of self-observation and to apply more adaptive coping interventions.

5 Basic Components of CBT

- Education about the client's specific disorder
- Self-observation and monitoring - the client learns how to monitor anxiety, identify triggers, and assess the severity
- Physical control strategies – deep breathing and muscle relaxation exercises
- Cognitive restructuring – learning new ways to reframe thinking patterns, challenging negative thoughts
- Behavioral strategies – focusing on situations that cause anxiety and practicing new coping behaviors, desensitization to anxiety-provoking situations or events.

Psychomotor Retardation

- is a clinical symptom of major depressive disorder. Manifestations of psychomotor retardation include slowed speech, decreased movement, and impaired cognitive function. The individual may not have the energy or ability to perform activities of daily living or to interact with others. Psychomotor retardation may range from severe (total immobility and speechlessness -catatonia) or mild (slowing of speech and behavior).

Specific clinical findings of psychomotor retardation include the following:

- **Movement impairment** - body immobility, slumping posture, slowed movement, delay in motor activity, slow gait
- **Lack of facial expression**
- **Downcast gaze**

- **Speech impairment** – reduced voice volume, slurring of speech, delayed verbal responses, short responses
- **Social interaction** – reduced or non-interaction

**Clients with major depressive disorder may also show symptoms of psychomotor agitation, characterized by increased body movement, pacing, hand wringing, muscle tension, and erratic eye movement.

Borderline Personality Disorder (BPD)

Individuals with **borderline personality disorder** (BPD) live in fear of rejection and abandonment. To avoid abandonment, they use manipulation and control, often unconsciously, to prevent a person from leaving. The **manipulative behavior** may be of a positive nature, such as the use of flattery, or a negative nature, such as distancing from the other person. An individual with BPD may also engage in **self harm or suicidal behaviors** in an attempt to gain attention from the other person and keep that person from leaving.

For this client, the nursing care plan must include the assignment of different staff members. This will help diminish the client's dependence on a particular individual and help the client learn to relate to more than one person.

Clients with borderline personality disorder, in an attempt to prevent abandonment and control their environment, may flatter and cling to one staff member while making derogatory remarks about others. The best nursing action is to rotate staff members assigned to care for the client.

Many clients with advanced Alzheimer disease reside in long-term care centers; therefore, most routine care activities can be delegated to the licensed practical nurse (LPN) and unlicensed assistive personnel (UAP).

The Role of the LPN includes:	The Role of the UAP includes:
• Administration of enteral feedings (if prescribed) • Administration of medications • Monitoring for safety hazards • Monitoring for behavioral changes	• Assisting with activities of daily living (eg, toileting, bathing, skin care, oral care, personal hygiene) • Assisting with feeding • Reporting changes in ability to eat or difficulty swallowing • Reporting changes in behavior • Placing bed alarms to reduce risk of falls

ADHD

A key feature of **attention-deficit hyperactivity disorder (ADHD)** is hyperactivity; however, some children with ADHD behave aggressively and have **difficulty controlling anger**, especially when frustrated or if unable to meet demands and challenges.

An immediate intervention to help settle an out-of-control child is deep breathing. Taking slow, deep breaths relaxes the body, slows the heart rate, and distracts the child from inappropriate behaviors. Asking the child to blow up a balloon provides an easy mode of distraction and engages the child in a deep breathing exercise. After the child is calm, the nurse and the child can further discuss the disruptive behavior.

Nursing interventions include the following:

- Stay calm and remove the child from the source of frustration/anger
- Assist the child in calming down with deep breathing exercises
- Discuss what precipitated the behavior and why the behavior is wrong
- Discuss acceptable ways of expressing anger and frustration
- Acknowledge that controlling anger is difficult
- Provide rewards for appropriate behavior
- Discuss the consequences of inappropriate behavior

Hypomagnesemia

- a low blood magnesium level (normal 1.5-2.5 mEq/L [0.75-1.25 mmol/L]), is associated with alcohol abuse due to poor absorption, inadequate nutritional intake, and increased losses via the gastrointestinal and renal systems. It is associated with 2 major issues:

1. **Ventricular arrhythmias** (torsades de pointes): This is the **most serious** concern (priority).
2. **Neuromuscular excitability**: Clients who abusef alcohol often have low magnesium levels that manifest as ventricular arrhyrthmias and/or neuromuscular excitablity that similar to hypocalcemia which include tremors, hyperactive reflexes, positive Trousseau and Chvostek signs, and seizures.

Hypercalcemia: Constipation and polyuria indicate **hypercalcemia**. Calcium has a diuretic effect.

Hypernatremia: Increased thirst with dry mucous membranes indicates **hypernatremia.**

Hypokalemia: Is a results in muscle weakness/paralysis and soft, flabby muscles. Paralytic ileus (abdominal distension, decreased bowel sounds) is also common with hypokalemia. However, the most serious complication is cardiac arrhythmias.

Bulimia nervosa

- is characterized by episodes of uncontrollable binge eating (consuming very large amounts of food) followed by inappropriate behaviors to prevent weight gain. Self-induced vomiting within 1-2 hours of binge eating is the more typical behavior; use of enemas and laxatives, and frequent, intense exercise are also characteristic behaviors of the client with bulimia nervosa.

Signs that a parent or friend of someone with this disorder might notice include the following:

- Trips to the bathroom after meals
- Disappearance of large amounts of food
- Finding hidden wrappers and empty containers of food, especially foods that are sweet and easily consumed
- Smells of vomit; finding packages of laxatives or enemas
- Getting up in the middle of the night followed by a trip to the bathroom some time later
- Engaging in intense physical exercise despite fatigue or pain
- Swelling of the cheeks due to parotid gland damage and enlargement; staining of the teeth
- Periods of starvation
- Preoccupation with weight, food, and dieting

Panic Attack

This client is experiencing the symptoms of a **panic attack** and should not be left alone. The priority nursing action is to stay with the client to offer support and reassurance that the client is safe and secure.

Additional nursing actions while the client is experiencing panic symptoms include:

- Trips to the bathroom after meals
- Maintaining a calm, matter-of-fact approach

- Speaking calmly and using simple, clear words and phrases when providing information on emergency department procedures
- Placing the client in a room with as little stimuli as possible
- Administering an anti-anxiety medication such as a benzodiazepine (per health care provider prescription)
- Having the client breathe into a paper bag if hyperventilation is a problem

Alzheimer disease

Alzheimer Disease & Eating Problems	
Earlier Stages	• Forgetting that a meal was consumed due to short-term memory loss • Anorexia & weight loss secondary to depression &/or recognition of the disease
Middle stages	• Forgetting to eat at all • Not recognizing the sensations of hunger & thirst • Forgetting how to use utensils • Consuming non-food items • Refusing to eat • Restlessness – inability to sit long enough to consume a meal
Later stages	• Inability to feed oneself • Dysphagia

Sjögren's syndrome

- is a chronic autoimmune disorder in which moisture-producing exocrine glands of the body are attacked by white blood cells. The most commonly affected glands are the salivary and lacrimal glands, leading to **dry eyes** (xerophthalmia) and **dry mouth** (xerostomia). Dryness in these areas can lead to **corneal ulcerations, dental caries**, and oral thrush. Other areas that can be affected and their symptoms include:

- Skin - dry skin and rashes
- Throat and bronchi - chronic dry cough
- Vagina - vaginal dryness and painful intercourse

Treatment is focused on **alleviating symptoms** as there is currently no cure for Sjögren's syndrome. Over-the-counter or prescribed drops are used to relieve itching, burning, dryness, and gritty sensation in the eyes. Wearing goggles may offer further protection from drying caused by the wind. Dry mouth is treated with sugarless gum and candy or artificial saliva. Regular dental appointments to prevent dental caries are recommended. Lubricants (eg, K-Y Jelly) help to ease

vaginal dryness. Use of lukewarm water and mild soap when showering can prevent dry skin. Avoiding low-humidity environments (eg, centrally heated houses, airplanes) and using humidifiers to maintain adequate humidity (mainly at night) are also recommended.

PSYCHIATRIC DRUGS

- **ALL** psychiatric drugs cause **low BP** and **weight changes**—usually weight gain.

Major Classes

1. **Phenothiazines**
   - First generation or typical antipsychotics
   - All end in **"ZINE"**
     - *Example:* Thora**zine**, Compa**zine**
   - They don't cure … They just reduce symptoms
   - We use **ZINEs** for the **ZANY** (Cuckoos) … Antipsychotics
   - In small doses, they are antiemetics (to treat vomiting)

   Phenothiazines are major tranquilizers
   - Major tranquilizers—big guns psych meds—are Antipsychotics
   - **Analogy**
     - **Aminoglycoside** are to **Antibiotics** what **Phenothiazines** are to **Antipsychotics**
   - Antipsychotics S/Es = **"ABCDEFG"**
     - **A**nticholinergic (dry mouth, urinary retention)
     - **B**lurred vision
     - **C**onstipation
     - **D**rowsiness
     - **E**PS (tremors, Parkinson)
     - **F**oto sensitivity
     - a**G**ranulocytosis (low WBC count, immunosuppressed)
       Teach patient how to recognize and report sore throat and symptoms of infection

Question:

❖ What is the nursing action when someone presents with a **S/E**?
- Educate

Question:

❖ What is the nursing action when someone presents with a **Toxic** effect?
- HOLD the drug →Notify HCP

Remember!

- ✓ The #1 nursing diagnosis for **"ABCDF" S/Es** is to teach patient about **SAFETY**
- ✓ The #1 nursing diagnosis for "G" S/Es is to teach patient to **report** signs of infections to HCP

2. **Decanoate** or "*Caprate*" form of a medication
   - The long-acting form of a drug
   - Sometimes denoted with the letter "D"
   - IM form given for non-compliance
   - Often Court-ordered

3. **Tricyclic Antidepressants**
   - Grandfathered into the NSSRI (Non-selective serotonin reuptake inhibitor) group
   - Mood elevators (Happy pills)
   - Elavil (elevates), **Trofranil**, Aventyl, Desyrel
     - Elevates the mood
     - Side effects of TCA are
       Anticholinergic (especially, dry mouth)
       Blurred Vision
       Constipation
       Drowsiness
       Euphoria (happy)
   - **Must take meds for 2 to 4 weeks for beneficial effects**
   - So, after the first week of antidepressant therapy, patient will complain the drug is not working
   - Teach patient that the medication takes about 2 to 4 weeks to reach therapeutic effects

4. **Benzodiazepines**
   - Anti-anxiety, minor tranquilizers
   - Always have ZEP in the name
   - Remember ZZzzs for falling/going to sleep
     Naming of antipsychotics
     - **Zines** for the Zany (major antipsychotics)
     - **Zeps** for the minor antipsychotics
     - If you are old enough, you may answer that question, "What do you find at a **Zeppelin** concert?"
     - **Minors on tranquilizers**
   - Many benzodiazepines end in **"Pam"** or **"Lam"**
   - Prototype: Valium, induction of anesthetic, muscle relaxant, alcohol

- Can be used as
  - Seizures medications
  - Preop induction of anesthesia
  - Muscle relaxants
  - EtOH withdrawal medications
  - Ventilation—medication to relax and calm down pts on a ventilator
  - Benzos work quickly but do not take them for more than 2 to 4 weeks

Remember!

✓ Administer major and minor tranquilizers at the same time. Why?
~ The major antipsychotics take a long time to start working
~ The minor antipsychotics start working right away
~ Both are administered at the same time
Example: Patient is usually put on Valium and Elavil at the same time
~ Valium is discontinued in 2 to 4 weeks once Elavil kicks in

A similar example for giving major and minor tranquilizers together is the concurrent use of
Heparin and Coumadin (warfarin).

- ✓ Heparin works right away but a patient should not be on it for a long time
- ✓ Coumadin takes a few days to start working but a patient can be on it for the rest of his life

- Side effects of Benzodiazepines are "ABCD"
  Anticholinergic
  Blurred Vision
  Constipation
  Drowsiness

5. Monamine Oxidase (MAO) Inhibitors

- Antidepressant
- Depression is thought to be caused by norepinephrine, dopamine, and serotonin in brain
- Name of MAOIs starts with
- MARplan, NARdil, PARnate the beginnings—all rhyme
- Side effects of MAOIs
  Anticholinergic
  Blurred Vision
  Constipation
  Drowsiness

Teaching Points

- Avoid tyramine-containing food … May cause Hypertensive Crisis
- Food with tyramine
  - Fruits/Veggies—Avoid salad **"BAR"**: **B**ananas, **A**vocados (guacamole), **R**aisins (dried fruit)
  - Grains—Ok to have, except Yeast
  - Meats—No organs liver, kidney, tripe, heart, no preserved meats (smoked, dried, cured, pickled, hot dogs)
  - Dairy—No cheese except for mozzarella, cottage cheese (no aged cheese)
  - No EtOH, elixirs, tinctures (iodine/betadine) caffeine, chocolate, licorice, soy sauce

6. Lithium

- Used for treating Bipolar disorder—*it decreases the mania,* LI = BI
- S/E: Very Unique—acts more like an electrolyte—think: Potassium/Lithium
  The 3 Ps as side effects
  - Peeing (Polyuria)
  - Pooping (diarrhea)
  - Paresthesia (earliest sign of electrolyte imbalance)
    The earliest sign of electrolyte imbalance is Paresthesia - Numbness and Tingling

Toxic effects of lithium

- Tremors
- Metallic taste
- Severe diarrhea

Question:

- ❖ What is the #1 nursing intervention in a patient on lithium presenting with peeing/pooping all the time?
  - Intervention: Give patient fluids
  - The above S/Sx are S/Es (expected)
  - Monitor sodium
  - Low sodium makes lithium toxic
  - High makes lithium ineffective
  - Sodium needs to be normal

Question:

- ❖ What is the #1 nursing intervention in a pt on lithium presenting with metallic taste and severe diarrhea?
  - Intervention: Give patient fluids
  - Notify the HCP—this is a toxic effect

7. **Prozac (fluoxetine)**
   - **SSRI, mood elevator**
   - Side effects of Prozac are
     Anticholinergic
     Blurred Vision
     Constipation
     Drowsiness
     Euphoria (happy)
   - **Causes insomnia so give before noon. If bid, give at 6 a.m. and noon**
   - **When *changing* doses, watch for suicidal risk in *adolescents***
     ~ Must recently **change** the dose and be an **adolescent** of **young adult**

8. **HALDOL (haloperidol)**
   - Tranquilizers (basically same as Thorazine)
   - S/E of Haldol
     Anticholinergic (dry mouth, urinary retention)
     Blurred vision
     Constipation
     Drowsiness
     EPS (tremors, Parkinson)
     Foto sensitivity
     a**G**ranulocytosis (low WBC count, immunosuppressed)
     ~Teach patient how to recognize and report sore throat and symptoms of infection
   - First generation antipsychotics
   - Pts may develop NMS (neuroleptic malignant syndrome) from overdose
     - Seen in elderly and young white schizophrenic pts
     - High fever over 105
     - Their doses should be about ½ usual adult dose

Question:

- ❖ A patient is being treated with an antipsychotic medication. Pt becomes anxious and presents with tremors. What is the nurse intervention to differentiate NMS (neuroleptic malignant syndrome) from EPS (extrapyramidal syndrome)?
  - Measure the pts' temperature
  - ✓ If temperature is WNL, this is EPS
  - ✓ If temperature is 102 and rising, call the emergency response team and notify HCP …NMS is life threatening
  - NMS presents with anxiety and tremors, and so does EPS

Remember!
- ✓ With Haltol, there are safety concerns related to the S/Es.

9. Clozaril (clozapine)
- Atypical antipsychotic
- Advantage it does not have A-F side effects
- Don't confuse it with Klonopin/Clonazepam!
- S/Es of clozapine:

Remember!
- ✓ Geodon (ziprasidone) has a black box warning
- ✓ Prolong the QT interval, which can cause sudden cardiac arrest
- ✓ Do not use in pts with cardiac condition
- ✓ **Second generation antipsychotics end in "Zapine"**

Question:
- ❖ What is the #1 nursing intervention in a pt taking Clozaril (clozapine)
  - Monitor the WBC

10. Zoloft (Sertraline)
- Antidepressant
- Can cause insomnia
- Interact with the followings because they are not metabolized in the liver
  - St. John's Wort and cause serotonin syndrome
  - Warfarin and cause bleeding
- S/E of serotonin syndrome is **"SAD Head"**
  Sweating
  Apprehensive (impending sense of doom)
  Dizzyness
  Headache

Remember!
- ✓ The nurse should anticipate lowering the dose of sertraline (Zolof) of a patient on St. John's Wort and Warfarin.

*****END*****