Psychiatric Nursing

WORKBOOK

N85A and N85AL

By

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Instructor of Psychiatric Mental-Health Nursing
DeAnza College/Cupertino, California

2015-2016

Week-1

Nursing 69P / Psychosocial
Instructor: Rebecca Sherwood

Name: _____
Date: _____

STUDENT-SUCCESS QUESTIONNAIRE

1. Any previous education or experience in this area?

_____
_____
_____
_____
_____
_____

2. Any special concerns / fears / anxiety etc.?

_____
_____
_____
_____
_____
_____

3. Any special learning needs you wish to communicate?

_____
_____
_____
_____
_____
_____

4. Do you have a good support system in place?

yes_____ no_____ not sure_____

5. Would you like to make an appointment with Rebecca to discuss your individual strategies for success in the course? If so please state whether before or after class is better and what date you prefer:

Best time and date for appointment:_____

"KNOW THYSELF" -- CLASS EXERCISE

Due to my own lived experience so far, which may include personal losses and disappointments as well as joys and satisfactions, I feel I bring the following traits and abilities to my work as a nurse to help others.

My greatest concerns about being able to work effectively with anxious patients and their families who are facing "loss" (e.g., a change in body image such as losing a leg or breast, a life-threatening illness, or the grief of losing a loved one) are:

Nursing 69P / Psychosocial
Instructor: Rebecca Sherwood

Name: _____
Date: _____

Individual Class Exercise
"SILENCE"

1. Briefly explain the use of silence as a therapeutic technique. Refer to the course text.

2. What is your own current "comfort level" with silence? How will this affect your therapeutic ability with patients?

Guidelines for Preparation of Case Study: Nursing 85A

1. Give the medical diagnosis, age, gender, ethnicity, reason for current admission, voluntary vs involuntary status, suicide risk, past history, current medications and medication history as appropriate, and other pertinent information such as occupation/education. Don't report on the basic information about the disease itself (i.e definition of disease, etiology, terminology) because Rebecca will go over that information and/or the class should have already read the text so as to be familiar with the basic theoretical information about the disorder. Your purpose is to ***teach your classmates the nursing application*** for the disorder you are presenting.. Please provide a paper copy of the case study to the class.

2. Assessment of the patient: Include the pertinent data for the following:
   Universal SCR's
   Developmental SCR's
   Health Deviation SCR's
3. Nurse's Subjective Response: Consider common or individual prejudices, fears, and concerns, positive or negative or judgmental feelings of the nurse.
4. Nursing Diagnoses (Formulate three nsg diagnoses that relate to the disorder being studied for example, Major Depression, Schizophrenia, etc.)
5. Goals (May be short-term or long-term)
6. Interventions (should be tailored to your specific case)
7. Evalutation (Outcomes, progress toward the goal, next steps in planning care)

8. Discussion/Class Involvement: (Can be done at any one or more steps of the presentation. Try to incorporate an aspect of the presentation that requires the class to use critical thinking skills to arrive at conclusions.) Consider for example, how your case is similar to, or differs from, the "textbook picture" for your disorder. Also consider what aspects of the case were problematic to address or that required "trial and error" approaches until a solution was found. What about the case is still unresolved? Use critical thinking skills and try to involve the class in applying critical thinking to any aspect of the case.

General Notes:

A variety of presentation methods may be used. These may involve role-playing, videos of role playing, video clips from movies, educational videos, panel discussions, etc. as desired. The most important thing, however, is to ***try to make the case an interesting and challenging learning experience for the class***. Case studies are a good way to learn and they can be very interesting, when presented in a stimulating manner. Allow approximately 45 minutes, but more time can be used if desired or needed -- based on the group's decision (in that case, please let Rebecca know in order to plan for the time needed). Note: If you use audiovisual equipment, please do .a "dry run" and be sure everything works properly and can be seen and heard clearly by the class!!!

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OVER ▸

(for reference purposes not required to turn in)

Nursing-54K
Psychiatric Mental Health

Student's Name: _____
Instructor: Rebecca Sherwood, RNCS, DNSc

Suggested FORMAT FOR STUDY OF REQUIRED READINGS

I. DSM Diagnosis _____
or Major Concept

II. Terminology (list and define pertinent terms)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

III. Theory (examine biopsychosocial theories)

1. **biological:** _____
2. **psychological:** _____
3. **sociological:** _____

IV. Nursing Process

1. Assessment (Orem's Self-Care Requisites)
   a. **universal:**
   b. **developmental:**
   c. **health-deviation:**
2. Process Level (nurse's own response / reaction / feelings)
   a. _____
   b. _____
   c. _____

3. Nursing Diagnoses (list 3 common ones)
   a. _____
   b. _____
   c. _____

4. Patient Goals (list 3 common ones)
   a. _____
   b. _____
   c. _____

5. Nursing Interventions (consider the following)
   a. **psychotherapeutic (therapeutic N-P relationship actions):** _____
   _____
   _____
   b. **health teaching:** _____
   _____
   _____
   c. **somatic therapies (nursing implications for medications, ECT, etc.):** _____
   _____
   _____
   d. **activities of daily living (self care ability, safety):** _____
   _____
   _____
   e. **therapeutic environment (collaboration with other health team members, unit activities, milieu therapy):** _____
   _____
   _____

6. Evaluation (ask questions R/T patient response to goals)
   a. _____
   _____
   b. _____
   _____
   c. _____
   _____

V. Review Activities
   1. Study case presentations at end of each assigned chapter in Varcarolis text.
   2. Answer test questions at end of each assigned chapter.
   3. Determine whether you have met Chapter Objectives (Varcarolis) listed at beginning of each chapter.

NOTES REGARDING LEGAL STATUS

Right to Due Process in Civil Commitment – in Ca Law = Lanterman – Petris – Short act

- See grid

Right to Confidentiality –
A Legal right & an
ANA code of ethics requirement

Exceptions to Confidentiality
Tarasoff – in Ca refers to Duty To Warn/report pt threats of harm against specified victims

Child/Elder Abuse Reporting - mandatory

Additional <u>Civil Rights</u>
Least Restrictive Treatment (not just restraint)

Right to Treatment–

Right to Refuse Treatment –
Exception is if Reise Hearing Upheld (Cal Case Law)

Nurses held to certain <u>Standards of Care</u>
Professional associations – ANA web site (for interpretive statements: www.nursingworld.org
Specialty Nursing Organizations – APNA web site: www.apna.org
State Boards of Nursing – http://www.ncbn.org
Federal Organizations –
Federal and State Regulatory Bodies – HCFA (now Centers for Medicare and Medicaid Services or CMC)- www.access.gpo.govOR www.hcfa.gov
Hospital Policy/Procedure
Professional Journals
Instruction Manuals for equipment
Other - i.e. JACHO –www.jcaho.org

CALIFORNIA CIVIL COMMITMENT REFERENCE GUIDE

DETENTION TYPE	CRITERIA	BEGINS	WHO MAY INITIATE	NOTICE/SERVICE
5150: 72-HOUR HOLD	ALL: 1. Mental disorder (DSM IV) 2. Danger to self or others, or gravely disabled. 3. Unable or unwilling to accept voluntary treatment	1. Date and time hold is written 2. If person receiving voluntary inpatient treatment, date and time legal status is changed to involuntary.	1. Police 2. Attending staff psychiatrists at designated facilities 3. Mobile crisis unit 4. Other mental health professionals designated by the county	Oral & written advisement upon admission: 1. Name & position of admitting staff. 2. Statement explaining reason for hold. 3. Time hold begins. 4. Rights advisement and copy of patient's rights booklet
5250: 14-DAY CERTIFICATION	Same as 5150 above, with the inclusion of chronic alcoholism	At or before expiration of 5150. 14 days includes any intervening periods of voluntary treatment after the expiration of 5150.	1. Treating psychiatrist 2. Psychologist with 5 years experience in the evaluation and treatment of persons with mental disorders.	1. Written = copy of 5250 to pt. 2. Oral: a. Right to cert. hrng. in 4 days b. Right to advocate assistance c. Explain right to judicial review by writ of habeas corpus d. Right to legal counsel
5260: ADDITIONAL 14-DAY HOLD FOR SUICIDE	1. Mental disorder or chronic alcoholism and, 2. Imminently suicidal and refuses vol. tx.	At expiration of 5250.	1. Professional person in charge of facility 2. Treating psychiatrist	1. Written = copy of 5260 to pt. 2. Oral (same as c, d (above)
5300: 180-DAY POST-CERT. FOR IMMINENTLY DANGEROUS PERSONS	1. Mental disorder 2. "Imminently dangerous" to others (see definition)	At expiration of 5250	1. By court order based on the written declaration of treating psychiatrist	1. Written = copy of 5300 to pt. 2. At initial hearing notified of right to court/jury trial
5350: TEMPORARY CONSERVATORSHIP FOR 30 DAYS "T-CON"	1. Grave disability or chronic alcoholism and, 2. Unwilling or unable to accept voluntary treatment.	At expiration of 5250. (law allows 3-day grace period when necessary for filing petion for T-con)	1. Psychiatrist's written affidavit and, 2. Ex Parte order from superior court	1. Written notice to patient by psychiatrist 2. Written notification from court of appointment of temporary conservator
5350: CONSERVATORSHIP FOR 1 YEAR	1. Same as 1 & 2 above for T-Con.	At expiration of T-Con.	1. Court order based on petition from conservatorship investigator	1. Written notification from court of time, date & place of hearing 2. Notification from court at least 60 days before conservatorship terminates

Prepared by the: SAN MATEO COUNTY PATIENTS' RIGHTS ADVOCACY PROGRAM

ALTERNATIVES TO RESTRAINT

Patients have the right to be free from restraint. Prior to initiating behavioral restraint one must be certain that appropriate less restrictive alternatives have been considered and/or attempted. Alternative measures should be tailored to the causes underlying the problem identified and may include one or more of the following:

1. <u>Physiologic interventions</u>:
   a. Provide pain relief/comfort measures.
   b. Schedule position changes.
   c. Assess medications to determine if a medication may be contributing to or may alleviate the underlying problem.
   d. Alter treatment regimens (e.g., saline or heparin lock vs. continuous IV when it is not necessary for hydration).
   e. Promote patient's normal patterns for eating, sleeping, toileting.
   f. Provide sensory aids (glasses, hearing aids) to prevent misinterpretation of cues in the environment.

2. <u>Environmental</u>
   a. Move the patient closer to the nurse's station for increased supervision.
   b. Increase lighting to compensate for aging eyes, use night lights.
   c. Decrease extraneous noise to provide a more restful environment.
   d. Clip the call light to the patient's sleeve as a "warning system."
   e. Provide diversional activities (music, TV, reading, something to keep hands occupied).

3. <u>Psychosocial</u>
   a. Encourage family/friends to visit.
   b. Orient/reorient the patient.
   c. Use touch to calm and reassure the patient.
   d. Provide continuity of staff.

7/96 F:\WPWIN60\TYPING\ALTERRES.AB

Course Obj. 4
Theor. Obj. 4.1

UNIVERSAL SELF-CARE REQUISITE

1. Maintaining sufficient air, water & food.

2. Managing elimination & sanitary conditions.

3. Balancing activity & rest.

4. Balancing solitude & social interaction.

5. Controlling/preventing hazardous situations.

6. Promoting/fostering normal human and development (integrity of physical and emotional structure).

RAS / 5-11-94

DEVELOPMENTAL SELF-CARE REQUISITES

These are requirements that create and maintain proper development within the life cycle.

1/ **healthy individuation**

2/ **successful social adaptation**

3/ **security of family, friends**

4/ **education**

5/ **occupational security**

6/ **good health**

7/ **high standard of living**

HEALTH DEVIATION SELF CARE REQUISITES

Persons who are ill or injured or who have specific forms of pathology including disabilities and those who are under medical care ask these questions:

- What is wrong?
- Why is this happening?
- What should I do?

To restore normalcy, the following needs (requisites) must be met:

1/ seek and obtain medical assistance

2/ be aware of the effects & results of pathological conditions & states

3/ effectively carry out prescribed diagnostic, therapeutic and rehabilitation measures

4/ modify self-concept by accepting self as being in a particular state of health (instead of denial)

5/ learn to live with the effects of pathological conditions & states within a lifestyle that promotes continued self care potential

6/ regulate discomforting and deleterious effects of medical care.

MENTAL STATUS EXAM

Level of Awareness

Ranges on a continuum from unconsciousness and frank coma to drowsiness and hypersomnolence to alertness, hyperalertness, or suspiciousness to frank paranoia or mania.

Orientation

"Oriented X 3" means awareness of time, person and place.

Appearance and Behavior:

Any observable characteristics e.g. dress (neat, unkempt, eccentric), facies (animated, fixed, sad, angry, pale, reddened), posture (relaxed, tense, erect, sitting, lying); motor activity (agitated, tremors, slow or fast movements, abnormal movements (dystonias).

Also includes: any unusual physical characteristics of any part of the body reaction to interviewer (friendly, suspicious, hostile, indifferent, dependent, passive-this is subjective so must support with objective observations).

Speech and Communication: rate (fast or slow); volume (inaudible up to very loud); modulation and flow (dull monotone or lively and spirited); production (mute up to pressured speech, clear or slurred).

Nonverbal communication: eye contact, gestures and posture. Note whether nonverbal communication matches verbal communication.

Affect (Mood)

Affect is the way a person's mood appears to others; mood is the person's subjective feeling (happy, sad, nervous, etc.).

Inappropriate affect: emotions and verbal comments do not match.

Elevated affect: euphoria -- excessive feeling of well-being; exaltation -- intense elation accompanied by feelings of grandeur.

Depressed affect:

depression -- hopelessness; grief/mourning -- prolonged sadness associated with loss; anxiety -- feeling of apprehension caused by unconscious conflicts; fear -- excessive fright from consciously recognized danger; ambivalence -- alternating and opposite feelings about a person or situation; aggression -- rage, anger or hostility that is excessive; labile mood -- alternating periods of elation and depression or anxiety within a short time; lack of affect -- blunted or flat without the normal range of emotions; la belle indifference -- lack of worry when most people would feel worried.

Thinking Process: intellectual functioning -- also called cognition or cognitive ability -- how a person reasons and thinks through problems -- thoughts may be slowed or racing.

- loose associations -- thoughts are poorly connected
  - circumstantiality: after many digressions, a conclusion or "point" finally emerges.
  - tangentiality: after many digressions no conclusion is reached.
- neologisms -- inventing or "coining" words -- often sound bizarre.
- flight of ideas -- rapid speaking with quick shifting from one idea to another ideas do seem to have a logical connection.
- perseveration -- repetition of the same thought or word in response to different questions.
- blocking -- a stoppage in the train of thought or in the midst of a sentence word salad -- disconnected mixture of unrelated words.

Disturbances in Content of Thought:

- delusion -- a fixed false belief that cannot be corrected by reasoning delusion of grandeur -- exaggerated beliefs about one's importance.
- delusion of reference -- belief that one is the center of others attention and discussion
- delusion of persecution -- belief that others are seeking to hurt or damage on either physically or verbally.

Memory

- recent memory -- ability to recall events in the immediate past and up to two weeks previously
- long term memory -- ability to recall events from the distant past -- names of schools attended, birthdays, sequence of U.S. presidents etc.

Perception

- Derived from the senses of vision, hearing, touch and smell.
- Perceptual distortions are called hallucinations when they do not exist in reality.
- Illusions -- are distortions of perception that exist in reality but are distorted.
- Depersonalization -- a loss of sense of control over oneself and a feeling of detachment from one's surroundings.
- Derealization -- a sense of unreality about the environment or a distortion or frank loss of reality about the environment (may be experienced by persons without mental dysfunction during times of extreme stress or fatigue).

Mental Status Exam

* Abstract Thinking: ability to derive a conclusion from a logical reasoning process (the opposite of concrete thinking). Assess by proverb interpretation and similarities.
Judgment: ability to behave in a socially acceptable manner e.g. "What would you do if you found a wallet with a large sum of money in the street? What would you do if you discovered a fire burning in a building?

Poor judgment is also exhibited by lack of modest or bizarre dress.

Ref. Taken from: Barry, Patricia D., Psychosocial Nursing: Assessment and Intervention, 1984.

Rev. 1-18-96

* Proverbs:
- "People who live in glass houses shouldn't throw stones."
- "The grass is always greener on the other side of the street."
- "There's no use crying over spilled milk."
- "Every cloud has a silver lining."

Similarities:
- "In what way are painting and music alike?"
- "In what way are a rose and a tulip alike?

also:
- bicycle and train
- watch and ruler
- corkscrew and hammer

Appendix M

Mental Status Assessment

Psychiatric assessment, or determination of a person's mental status, is the psychologic counterpart of a physical examination. It is the basis for making diagnoses and understanding dynamic factors that contribute to the patients' maladaptive or dysfunctional coping. Data for mental status assessment include the following.

Appearance	Physical characteristics, apparent age, peculiarity of dress, cleanliness, use of cosmetics
Behavior	Strange, threatening, violent (describe), unusual mannerisms (grimacing, tics, gait, psychomotor agitation or retardation), friendly, embarrassed, fearful, purposeful, disorganized, stereotyped, withdrawn, aggressive
Attitude	Cooperative, facilitates or impairs interview, beliefs about the situation, sarcasm (ask about coping techniques fof problems or stress)
Ability to communicate	Coherent; *flow* of speech natural, vague, loose, disorganized; *rate* (rapid, slow); mute, delays, repetition of phrases or content, neologisms, obscene, flight of ideas (do personality traits interfere with communication?)
Affect	Flat, blunted, appropriate, inappropriate (congruence), abnormal emotional reactions (explore depth, persistence, and intensity of emotion)
Thought content	Delusions, obsessions, ideas of reference, thought broadcasting, insertion, withdrawal, concrete
Perceptions	Hallucinations, depersonalization, derealization, dissociation
Orientation	Grasp of significance of existing situations, environment, clearness of conscious process. Oriented to *person, place, time,* consciousness (confused, delirious, stuporous)
Memory	Ability to recall *remote* and *recent* experiences (time and place of birth, schools attended, dates of significant things, serial numbers, "remember a sentence")
Intellect	Fund of knowledge, comprehension, abstract or concrete reasoning, judgment ("What if you found a wallet in front of your house?")
Insight	Understands own condition, situation, reason for being in hospital

DO for week 2

STUDENT WORKSHEET Chapter 7 Exercise (Keep in your workbook, wk 1)

Interaction Analysis

Directions

Place the number of the communication technique you identify in the space to the right of the statement. Some techniques are used more than once; some are not demonstrated. As is true of many interactions, some comments by the nurse are therapeutic, some are not. Reword any responses that you consider nontherapeutic in the spaces provided.

1. accepting
2. advising
3. attempting to translate into feelings
4. broad opening
5. disapproving
6. encouraging description of perceptions or feelings
7. encouraging comparison
8. encouraging formation of a plan of action
9. exploring
10. focusing
11. general lead
12. giving information
13. giving recognition
14. introducing an unrelated topic
15. making an observation
16. offering self
17. placing events in time sequence
18. reflection
19. restating
20. seeking consensual validation
21. silence
22. stereotyped comment
23. suggesting collaboration
24. summarizing
25. verbalizing the implied
26. voicing doubt

Interaction Recording

N. "Good morning, Mr. Smith." _____

C. "Hello."

N. "My name is Ann North. We met in O.T. yesterday." _____

C. "Yeah, I remember. Call me Tim."

N. "Tim, I'd like to spend some time with you." _____

C. "I guess that would be OK."

N. "How are things going?" _____

C. "Oh, I guess OK."

N. "OK?" _____

C. "Well, really , not so good."

N. "Things always look worse before they get better." _____

C. "My sister always says things like that to me."

N. "I'm apt to remind people of their sisters." _____

C. "Yea, well maybe."

N. "You were saying that things really aren't going so well." _____

C. "No, I got a little insane at home."

N. "Tell me more about what you mean by 'a little insane.' " _____

C. "Well, I was raising my voice so my sister had the police come and take me to the hospital."

N. "It's hard to believe you'd be sent to the hospital for raising your voice." _____

C. "My sister's a bitch. She used to beat me when I was little."

N. "Oh?" _____

used w permission as text user

VIDEO *Mental Health Status Assessment*

Some Key Points to Look For

1. The primary purpose of the Mental Status Exam is to gather objective data to be used in determining: the etiology, diagnosis, prognosis, and treatment.

2. In what phase of the Nursing Process is the Mental Status Exam used?
   Answer: the _____ phase.

3. List at least 4 settings where the Mental Status Exam can be helpful.

   _____ _____

   _____ _____

4. What physical conditions can cause changes in Mental Status? (List 5 or more.)

   _____ _____

   _____ _____

   _____ _____

   _____ _____

   _____ _____

5. When should you perform the Mental Status Exam?

   _____

6. As regards general behavior and appearance, what might you look for?

   _____

7. Name 3 aspects of speech that are assessed.

   _____ _____ _____

8. How are "mood" and "affect" different?

   _____

   _____

9. Give a brief definition of the following "misinterpretations of reality":
   a/ Ideas of reference: _____
   b/ Grandiose delusion: _____
   c/ Paranoid delusion: _____
   d/ Hallucination (See quest. # 10 !!): _____
   e/ Thought insertion: _____
   f/ Loose associations: _____

10. List 5 types of false sensory perceptions (i.e., hallucinations).

    _____ _____ _____

    _____ _____

11. What is "confabulation"?

    _____

12. What 3 things are assessed for suicidal and homicidal ideation?

    _____ _____ _____

13. What things are typically assessed in the "Mini-Mental Exam"? (List them.)

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

14. Define and contrast "delirium" and "dementia".

    _____

    _____

~~CLASS~~ EXERCISE

Individual

refer to Varcarolis' Text Legal Chapter

Matching Terms & Meanings
Legal & Ethical Issues

1.	_____	confidentiality	A. The fundamental principle underlying the ANA code on confidentiality.
2.	_____	Tarasoff ruling	B. A doctrine which mandates that the least drastic means be taken for achieving a specific purspose.
3.	_____	involuntary admission	C. An act with intent to confine a person to a specific area, that is not defensible as being necessary in the patient's best interest.
4.	_____	false imprisonment	D. An intentional act designed to make the victim fearful and apprehensive of harm.
5.	_____	battery	E. Act or failure to act that breeches duty of due care and results in a person's injuries.
6.	_____	ethics	F. Psychotherapist's duty to warn his or her client's potential vicitm of potential harm.
7.	_____	negligence	G. Civil wrongs for which the wrongdoer pays damages to the injured party.
8.	_____	torts	H. A California court decision that imposes on the therapist a duty to warn the appropriate person when he learns his client may present a risk of harm to a specific person.
9.	_____	right to privacy	I. The ethical responsibility of a health care professional that prohibits the disclosure of privileged information without the patient's informed consent.
10.	_____	least restrictive alternative	J. Admission to a hospital without the patient's consent, e.g. when the person is a danger to himself or others.
11.	_____	assault	K. The harmful or offensive touching of another's person.
12.	_____	duty to warn	L. The discipline concerned with standards of values, behaviors, or beliefs adhered to by individuals or groups.

Located in "Video Lab" run by Marge Sen

	Quarter 5 - PSYCH - Video Listings
1	ANXIETY DISORDERS
2	UNCERTAIN JOURNEY-FAMILIES COPING W/ SERIOUS MENTAL ILLNESS
3	MENTAL HEALTH STATUS ASSESSMENT
4	SCHIZOPHRENIA - CAUSATION
5	SCHIZOPHRENIA - SYMPTOMATOLOGY
6	SCHIZOPHRENIA - THE COMMUNITY'S RESPONSE
7	RECOGNIZING EXTRAPYRAMIDAL SYMPTOMS (1)
8	RECOGNIZING EXTRAPYRAMIDAL SYMPTOMS (2)
9	SUBSTANCE ABUSE - INTERVIEW & ASSESSMENT
10	SUBSTANCE ABUSE - COPING MECHANISMS
11	SUBSTANCE ABUSE - TREATMENT MODALITIES
12	SUBSTANCE ABUSE - RECOVERY & PREVENTION OF RELAPSE
13	SOUNDS OF SILENCE - CLAUDIA BLACK
14	SOUND OF SILENCE
15	AGGRESSION
16	DELUSIONS
17	HALLUCINATING
18	SUICIDE PREVENTION PART 1 (Adult)
19	SUICIDE PREVENTION PART 2 (COPY 1) (Child)
20	SUICIDE PREVENTION PART 2 (COPY 2)
21	IF YOU LOVED ME
22	OCD
23	HOW TO SABOTAGE TREATMENT
24	RECOVERY - CLAUDIA BLACK
25	ONE VOICE, DOMESTIC VIOLENCE - A SOCIAL REALITY
26	ONE VOICE, DOMESTIC VIOLENCE - IDENTIFYING VICTIMS & BATTERERS
27	ONE VOICE, DOMESTIC VIOLENCE - INSTITUTIONALIZED INTERVENTIONS
28	PHYSICIANS PERSPECTIVES ON DOMESTIC VIOLENCE
29	DYING TO BE THIN
30	PSYCHOTROPIC MEDICATIONS
31	PSYCHOTROPIC NURSING - DUAL DIAGNOSIS
32	OUT OF THE DARKNESS - WOMEN AND DEPRESSION
33	MENTAL HEALTH ISSUES IN THE ACUTE CARE SETTING - CD
34	MOOD DISORDERS - DVD

35	ANXIETY DISORDER - DVD
36	CAUSES, ASSESSMENT, AND TREATMENT (PERSONALITY DISORDERS)
37	PARANOID, SCHIZOID, AND SCHIZOTYPAL (PERSONALITY DISORDERS)
38	ANTISOCIAL, BORDERLINE, HISTRIONIC, AND NARCISSISTIC (PERSONALITY DISORDERS)
39	AVOIDANT, DEPENDENT, AND OBSESSTIVE-COMPULSIVE (PERSONALITY DISORDERS)
40	SIGNS AND SYMPTOMS OF DEPRESSION
42	RECOGNIZING THE RISKS FOR SUICIDE

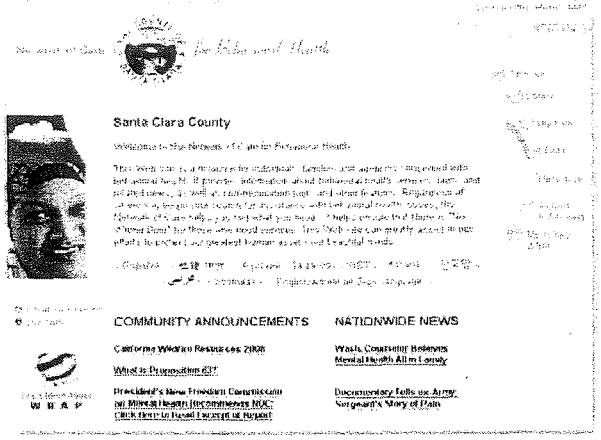
Santa Clara Network of Care: a Web site for people with behavioral health issues.

Network of Care
recommended by the President's New Freedom Commission on Mental Health

It's all about behavioral health.

"I never thought that the Internet could improve our lives...

...but it did."



It's easy, even for beginners, to use Network of Care.

The Santa Clara Network of Care for Behavioral Health is a comprehensive, Internet-based community resource for people with behavioral health issues, as well as their caregivers and service providers. This easy-to-use Web site provides an extensive directory to put people in touch with the right services at the right time. It also offers vital information about diagnoses, insurance and advocacy, as well as daily news from around the world concerning behavioral health. This unique, one-stop information tool enables you to find pertinent behavioral health Web sites, keep personal records, and communicate directly with elected officials to make your voice heard in the legislative halls.

http://santaclara.networkofcare.org/mh

HARVARD MEDICAL SCHOOL

Harvard Mental Health Letter

VOLUME 25 • NUMBER 7 | JANUARY 2009

Options for treatment-resistant depression

Why electroconvulsive therapy may be the best alternative to medication.

Although medications and psychotherapy are usually the first treatments offered to patients with major depression, they don't work for everyone. As we reported in August 2008, the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study found that about one-third of patients were unable to achieve full relief of symptoms (remission) even after trying four different strategies.

But the STAR*D data on relapse rates suggest that treatment-resistant depression may be even more common than remission rates might indicate. Relapse was a significant problem at each treatment level. By the end of the study, 50% of the patients who were able to achieve remission after trying a fourth treatment ended up relapsing within an average of 2.5 months.

By taking both relapse and remission rates into account for the entire study, Dr. J. Craig Nelson, an expert in treatment-resistant depression at the University of California, San Francisco, estimated that only 43% of patients enrolled in STAR*D were able to sustain their recovery. Other commentators have estimated that recovery rates may be even lower.

Thus, for treatment-resistant depression, clinicians remain interested in nonpharmacological ways to change brain function. Two FDA-approved options now exist: electroconvulsive therapy (ECT) and vagus nerve stimulation (VNS). In October 2008 the FDA also approved transcranial magnetic stimulation (TMS) for patients with depression who have not benefited from one antidepressant, but not for those who haven't responded to multiple drugs.

Insurers have balked at paying for VNS because it has not proven any more effective than ECT—and they may also refuse to pay for TMS. Therefore, ECT remains the most practical alternative because it is effective, covered by health insurance, and readily available.

ECT at a glance

Although ECT is often regarded as a treatment of last resort, it is probably the most powerful tool available to treat depression. Misconceptions and stigma about ECT may explain why it is not used more often. Here's a brief review of current ECT practice and several remaining challenges.

Who might benefit. ECT is an option for any patient whose depression has not been relieved after trying three or more distinct drugs; for patients at risk for suicide (ECT works faster and more reliably than drugs); for women who are pregnant or have just given birth who don't want to take antidepressants; and for elderly patients who either don't respond to drugs as well as they used to, or who, with age, have become more sensitive to side effects.

Although ECT has been used in children and adolescents, the technique has not been well studied in this population. The American Academy of Child and Adolescent Psychiatry has produced guidelines for ECT treatment of adolescents, recommending that it be considered after a patient does not respond to two or more medications, or when symptoms are so severe that fast treatment is necessary.

How it works. Before each treatment, the patient receives a short-acting anesthetic to prevent awareness of the procedure and to reduce discomfort. Other drugs are given to relax the muscles. While the patient is sleeping, the psychiatrist uses a special device to deliver an electrical impulse that stimulates the brain and causes a seizure. ▸▸

INSIDE

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There are no outward signs of this seizure, but the doctor can watch it on a monitor (similar to an electroencephalogram) that measures electrical activity of the brain.

The mechanism of ECT action is not understood, but the seizure seems to restore the brain's ability to regulate mood. It may enhance the transmission of chemical signals or improve blood flow to the brain; animal studies suggest it may stimulate the creation of new brain cells. It is the seizure (not the electrical stimulus) that generates improvement.

Duration. Therapy usually consists of three ECT sessions a week, for a total of six to 12 treatments.

Side effects. The most bothersome side effects are memory problems and difficulty concentrating, although certain ECT techniques may help reduce risk. Other side effects—partly from the anesthetic—include headache and nausea.

Challenges in remission and relapse

The Consortium for Research in ECT (CORE) and the Columbia University Consortium (CUC) concluded that ECT produced remission rates of 86% and 55%, respectively—higher than those achieved with medication in the STAR*D trial. (The CUC study had stringent remission criteria.) An analysis of 18 studies also found that ECT was more effective than drug therapy—although some studies may not have used optimal drug doses. Remission usually occurs relatively quickly with ECT, in an average of one to three weeks, compared with four to 12 weeks or longer with drug treatment.

In some medical centers, however, remission rates may not be as high as those achieved in university-based research studies, where the selection criteria for participation are carefully applied. A study of seven community hospitals, for example, reported that only 30% to 47% of patients achieve remission after ECT.

A persistent challenge is relapse after successful ECT treatment. Several options help reduce this risk. First, ECT can be tapered gradually once remission is achieved, by decreasing sessions from three times a week to once or twice a week, and then to once a month, rather than stopping abruptly. Other options include maintenance ECT therapy, maintenance drug treatment, or some combination of the two.

Although maintenance ECT is usually delivered on a fixed calendar basis (such as once or twice a month), researchers are now trying to find ways to better tailor the treatment schedule to each patient's symptoms.

Memory and thinking problems

ECT can cause three types of memory and thinking problems: retrograde amnesia (problems recalling events in the past), anterograde amnesia (reduced ability to retain new information), and postictal delirium (confusion following ECT). Studies have consistently found such deficits tend to be temporary, and many patients either don't find them bothersome or find ways to cope. But others find them wrenching. Indeed, ECT-related memory problems are the main reason that patients refuse to consider ECT or decide to end treatment early. Several strategies may help reduce risk of ECT-related memory problems.

Electrode placement. During an ECT session, electrodes can be placed on one side of the skull (unilateral placement) or on each temple (bilateral placement). Studies have found that unilateral ECT is less likely to cause cognitive problems than bilateral ECT, yet may be just as effective. For this reason, patients usually initially undergo unilateral ECT, and then progress to bilateral ECT only if they don't receive sufficient benefit from the unilateral treatments.

But unilateral treatments may not be appropriate for all patients. In order to work, ECT must overcome a patient's "seizure threshold," an individualized set point that determines what amount of electrical stimulation is necessary to induce a seizure. Unilateral ECT requires a stronger electrical stimulus to overcome a patient's seizure threshold than bilateral

ECT does. The ECT devices approved for use in the United States may not produce the energy levels necessary for unilateral placement of electrodes, especially in older patients, because seizure threshold increases with age.

Patients may also need to undergo more sessions of unilateral than bilateral ECT to achieve remission. In the CUC study, patients received an average of seven unilateral treatments followed by an average of three bilateral treatments—or a total of 10 treatments on average—to achieve remission. In contrast, the CORE study, which involved only bilateral treatment, found that patients required an average of seven sessions to achieve remission. For this reason, some clinicians advise starting with bilateral treatments.

Pulse width. Electricity is produced in waves. In ECT, the longer the pulse width (the space between peaks in the wave), the greater the chance of cognitive side effects. In the past, ECT devices used relatively long "sine wave" pulses. Today, most devices use shorter pulse widths that may also help prevent memory loss and other cognitive problems.

Under investigation. Researchers are investigating whether particular drugs or dietary supplements might help protect memory during ECT treatments. Researchers at Massachusetts General Hospital and McLean Hospital, for example, have conducted pilot studies with galantamine (Razadyne, Reminyl), a medication that modestly improves cognitive deficits in patients with Alzheimer's disease. But the research is still in the early stages.

Although ECT is not a perfect treatment (and none is, after all), it remains the best alternative for patients who continue to struggle with disabling symptoms of depression even after taking several different medications. It works relatively quickly, it's effective for most patients, and for some it may be life-saving.

ECT remission and relapse rates

Study	Patients achieving remission with ECT	Relapse rates at 6 months, with various maintenance therapies	
Consortium for Research in ECT (CORE)	86%	Nortriptyline (Aventyl, Pamelor) and lithium	32%
		ECT	37%
Columbia University Consortium (CUC)	55%	Placebo	84%
		Nortriptyline	60%
		Nortriptyline and lithium	39%

Sources: Sackeim HA, et al., *Journal of the American Medical Association* (March 14, 2001), Vol. 285, No. 10, pp. 1,299–307; and Kellner CH, et al., *Archives of General Psychiatry* (Dec. 2006), Vol. 63, No. 12, pp. 1,337–44.

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Matthews JD, et al. "The Impact of Galantamine on Cognition and Mood During Electroconvulsive Therapy: A Pilot Study," *Journal of Psychiatric Research* (June 2008): Vol. 42, No. 7, pp. 526–31.

For more references, please see www.health.harvard.edu/mentalextra.

Remission, relapse, and recovery

STAR*D investigators collected data about both remission rates (those listed below are based upon self-report after 14 weeks of treatment) and relapses that occurred at some point during follow-up. If patients did not adequately respond at one level, they progressed to the next.

Study arm	Treatment options		Achieved remission	Relapsed after remission	Average time to relapse
Level 1 (initial treatment)	Citalopram (Celexa)		37%	34%	4.4 months
Level 2: Patients could choose to switch or augment, but were then randomized to a new option	Switch to bupropion (Wellbutrin), sertraline (Zoloft), venlafaxine (Effexor), or cognitive therapy	Augment citalopram with bupropion, buspirone (BuSpar), or cognitive therapy	31%	47%	4.5 months
Level 3: Patients could choose to switch or augment, but were then randomized to a new option	Stop current therapy and switch to mirtazapine (Remeron) or nortriptyline (Pamelor)	Augment current therapy with lithium or T_3 thyroid hormone (Cytomel)	14%	43%	3.9 months
Level 4: Patients were randomized to one of the two treatments	Stop current therapy and receive tranylcypromine (Parnate) or mirtazapine plus venlafaxine		13%	50%	2.5 months

Source: Rush AJ, et al. *American Journal of Psychiatry* (Nov. 2006), Vol. 163, No. 11, pp. 1,905–17.

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Electroconvulsive Therapy (ECT) for Nursing Students

Evan Garner MD

Indications:

There are several indications for ECT. At El Camino about 95% of the patients are being treated for a major depressive episode. They may have unipolar depression or bipolar depression. Pts may have other comorbid psychiatric conditions.

Procedure:

The patient is placed under general anesthesia for about 5 minutes. After going to sleep, patients are given a paralytic agent ("muscle relaxant" is a euphuism), succinylcholine.

A stimulus is delivered to cause a seizure. The seizure should last between 20 seconds and 2 minutes to be effective.

The electroencephalogram (EEG) is monitored to observe the seizure.

The motor seizure if observed by watching the patient's hand. A blood pressure cuff is placed on the forearm, so the succinylcholine dose does not reach the patients hand. The motor seizure should occur only in the hand/ wrist.

Treatments

An acute series is 12-15 ECT procedures. Procedures are done 3 times a week (Monday, Wednesday and Friday)

Maintenance ECT is often done. This may be once a week for a month, then once every two weeks for a 2months, and then once a month. Maintenance treatment can be tailored for each patient situation.

Monitoring:

QIDS: The patient fills out a depression questionnaire prior to each treatment

MADRS: the physician completes a depression questionnaire once a week

Side effects: Nausea, confusion, muscle aches, headaches and memory are all possible. Pt are monitored for these each visits.

Legal:

Most ECT treatment done at El Camino is for voluntary pts who are able to understand the risks, benefits and alternatives to treatments. Capacity is examined each month by a non-ECT physician (psychiatrist or neurologist). If the patient lacks capacity to consent to treatment, then a court order is needed to proceed with treatment.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Welcome to the El Camino Hospital ECT Program

A few notes about procedures…

1) We will need you to make every effort to come to all of your treatments. If you are ill we would still like you to arrive for your treatment to be assessed. If you feel unable to make it to your treatment, please call the following numbers as soon as possible: 650-988-7180
(There will be pre op staff there to take your call at 5AM)

2) You are to be "NPO after midnight" the night before your treatment. This means no food, fluids, mints or gum after 12 midnight. Smoking is not prohibited, but it can increase gastric secretions, thus increasing risks of anesthesia

3) You will need a responsible adult to stay with you for 24 hours after the treatment.

4) You will not be allowed to drive until 14 days have passed since completing the acute treatment series. At that time, you can get clearance to drive again from your regular psychiatrist or medical doctor. Even once you can drive again, you need to allow 24 hours to pass after subsequent ECTs. Never drive when you are feeling unsafe to drive.

5) You will need to attend two ECT clinics a month to sign consent forms that are required by the State of California. The consent clinics are on Tuesdays at 1:30pm and Thursdays at 10:30am. You will be notified Thursday the week prior to the week your clinics occur. The clinics take place in the Behavioral Health outpatient area.

6) You will be asked for your list of medications before every treatment by the pre-operative Nurses. Please have your current medication list prepared in advance to reflect any changes. Make sure to note any changes in medical, psychiatric, herbal and over-the-counter medications. Please do not take any medications that you have not previously discussed with your doctor in order to prevent using medications that might interfere with ECT or anesthesia.

7) Treatment times are scheduled in advance and are often not possible to reschedule. The afternoon before your treatment, you will be called by the Surgery Center or the OR to confirm your treatment and arrival times. Your treatment times are subject to change.

8) You will need to continue seeing your community psychiatrist for medication management while undergoing ECT. Reports of clinic visits are sent to your outpatient psychiatrist.

9) If you feel you would like to have further discussions with the treatment team outside of the procedure itself, please feel free to contact Tamara Malcolm RN to schedule an appointment. 650-962-5795

Date_____ Patient signature_____

Significant Other signature_____

Please write a paragraph on how your depression is currently impacting your life:

DO NOT SIGN THIS FORM UNTIL YOU HAVE ALL THE INFORMATION YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT (ECT).

The nature and seriousness of my mental condition, for which ECT is being recommended, is

severe depression

RECOMMENDATION: I understand that ECT involves passage of an electrical stimulus across my brain for a few seconds, sufficient to induce a seizure. In my case the treatments will probably be given _____ times per week for _____ weeks, not to exceed a total of _____ treatments and not to exceed 30 days from the first treatment. Additional treatments cannot be given without my written consent.

Reasonable alternative treatments (such as psychotherapy and/or medication) have been considered and are not presently recommended by my doctor because medications have been ineffective

IMPROVEMENT: I understand that ECT may end or reduce depression, agitation and disturbing thoughts. In my case there may be permanent improvement, no improvement, or the improvement may last only a few months. Without this treatment my condition may improve, worsen or continue with little or no change.

SIDE EFFECTS AND RISKS: I understand there is a division of opinion as to the effectiveness of this treatment as well as uncertainty as to how this procedure works.

I also understand this treatment may have brief side effects: headaches, muscle soreness and confusion.

There may be some memory loss which could last less than an hour or there may be a permanent spotty memory loss. Memory loss and confusion may be lessened by the use of unilateral (one-sided) electrical brain stimulation rather than bilateral (two-sided) stimulation.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

My physician states I have the following medical condition(s) which increase the risk in my case, as follows:

I HAVE THE RIGHT TO ACCEPT OR REFUSE THIS TREATMENT. IF I CONSENT, I HAVE THE RIGHT TO REVOKE MY CONSENT FOR ANY REASON AT ANY TIME PRIOR TO OR BETWEEN TREATMENTS.

Dr. _____ has explained the above information to my satisfaction. At least 24 hours have elapsed since the above information was explained to me. I have carefully read this form or had it read to me and understand it and the information given to me.

I HEREBY CONSENT TO ECT _____
Signature Date and Time

_____
Witness Signature

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Patient Label

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR$_{16}$)

Name or ID _____ Date: _____

Check the one response to each item that best describes you for the past seven days.

During the past seven days...

1. Falling Asleep:

- ☐ 0 I never take longer than 30 minutes to fall asleep
- ☐ 1 I take at least 30 minutes to fall asleep, less than half the time
- ☐ 2 I take at least 30 minutes to fall asleep, more than half the time
- ☐ 3 I take at least 60 minutes to fall asleep, more than half the time

2. Sleep During the Night:

- ☐ 0 I do not wake up at night
- ☐ 1 I have a restless, light sleep with a few brief awakenings each night
- ☐ 2 I wake up at least once a night, but I go back to sleep easily
- ☐ 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking Up Too Early:

- ☐ 0 Most of the time, I awaken no more than 30 minutes before I need to get up
- ☐ 1 More than half the time, I awaken more than 30 minutes before I need to get up
- ☐ 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually
- ☐ 3 I awaken at least one hour before I need to, and can't go back to sleep

4. Sleeping Too Much:

- ☐ 0 I sleep no longer than 7-8 hours/night, without napping during the day
- 1 I sleep no longer than 10 hours in a 24 hour period including naps
- ☐ 2 I sleep no longer than 12 hours in a 24-hour period including naps
- ☐ 3 I sleep longer than 12 hours in a 24-hour period including naps

5. Feeling Sad:

- ○ 0 I do not feel sad
- ○ 1 I feel sad less than half the time
- ○ 2 I feel sad more than half the time
- ○ 3 I feel sad nearly all the time

6. Decreased Appetite:

- ☐ 0 My usual appetite has not decreased
- ☐ 1 I eat somewhat less often or lesser amounts of food than usual
- ☐ 2 I eat much less than usual and only with personal effort
- ☐ 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat

7. Increased Appetite:

- ☐ 0 My usual appetite has not increased
- ☐ 1 I feel a need to eat more frequently than usual
- ☐ 2 I regularly eat more often and/or greater amounts of food than usual
- ☐ 3 I feel driven to overeat both at mealtime and between meals

8. Decreased Weight (Within the Last Two Weeks):

- ☐ 0 My weight has not decreased
- ☐ 1 I feel as if I've had a slight weight loss
- ☐ 2 I have lost 2 pounds or more
- ☐ 3 I have lost 5 pounds or more

9. Increased Weight (Within the Last Two Weeks):

- ☐ 0 My weight has not increased

Directions to treatments:

1) Turn onto North drive from Grant road.
2) Park in visitor parking by the main entrance to the hospital.
3) Enter through main entrance door and walk straight ahead until you see Elevators A/B to your left.
4) Go up to the second floor.
5) Make a right at the main hall. Go to the end of the hall and enter the last door on the left.
6) Tell the nurses you are students there to observe ECT.
7) Ask Questions!!
8) If you still have questions after seeing a treatment contact ECT coordinator at 5795

Week-2

Rebecca Sherwood, DNSc, APRN, BC
Instructor

Student's Name: _____
Nursing 85A

INDIVIDUAL ACTIVITY REPORT

Name of Activity: _____

Date Attended: _____ **Time:** _____ **Place:** _____

OBJECTIVE DATA (e.g. format of meeting, number and characteristics of attendees, main points discussed, etc. REMEMBER CONFIDENTIALITY !!)

SUBJECTIVE DATA (your own personal feelings / response)

PROFESSIONAL IMPLICATIONS (How might you use this experience with future patients? What questions came up for you?)

54K/KL

Tips For Termination

SAYING "GOOD-BYE" TO CLIENTS IS NEVER EASY, BUT ABSOLUTELY NECESSARY

Why is saying "Good-bye" difficult?

- Emotional pain associated with ending a relationship into which one has invested a great deal
- Worker and client can both feel guilty for not having invested even more time in the working relationship, and for not having accomplished more
- There are fears associated with ending a relationship if previous endings have gone badly
- There are time pressures associated with closing cases; staff can feel that they don't have the time to say "Good-bye"
- The worker may feel that the client will be "too angry" or "too sad", or "feel rejected" and want to avoid this

Both client and worker need an opportunity to talk about what was and was not accomplished during their work together.

- Negative feelings that a client has can be transferred to the next worker if the negative feelings are not resolved
- Clients need an opportunity to say "Thank-you" and to give value to work that was accomplished
- Clients can carry feelings about what was not spoken which impacts future relationships
- What happens at the end of a working relationship can cloud and distort everything that was accomplished up to that point

STRATEGIES FOR MANAGING TERMINATION

- Let the client know even before a planned ending that termination is inevitable due to job changes, internal case transfers, or time-limited program stays (e.g., PHP)

- Expect that clients will have strong feelings about ending the working relationship

- Validate whatever feelings arise, and accept them as a normal part of saying "Good-bye"

- Identify with the client what was accomplished together, i.e., What skills and abilities has the client learned in the course of his/her work with you? What is the client taking away from the experience of working with you?

- Identify what the client valued in his/her relationship with you, and describe how you think this type of support will continue (If you have reason to believe that there will be significant changes with the next worker, be honest and direct about this)

- Communicate to the client that he/she will continue work with a new worker (if this is the plan); reassure the client that he/she can and will continue to make progress

- Identify with the client what will be worked on with the next worker

- Identify who else the client can turn to for support during the period of transition to a new worker, e.g., a support group, family, friends, community resources

- Share your feelings of loss about ending the working relationship if this feels appropriate at the time

- Don't overlook the option of having a meeting with the terminating worker, the new worker, and the client in which previous accomplishments and future goals are identified

- Remind the client (and yourself!) that endings and transitions are a normal part of life

Mini-Review
SCHIZOPHRENIA: 22
A Disorder of Thinking (CH-~~19~~)

Theory	o neurochemical o genetic o anatomical o developmental
Medical Diagnoses	o Paranoid o Disorganized o Catatonic o Residual o Undifferentiated (Mixed)
OR Em **Assessment**	
o **Universal**	o flat, blunted affect o confused, jumbled thinking → fearful, terrified o delusions & hallucinations → o ambivalence o poor judgment o altered nutrition o poor grooming and self care o isolation & withdrawal o bizarre behaviors o increased suicide risk
o **Developmental**	o poor cognitive ability o family dysfunction o double-bind messages o structured living (e.g., board & care home) o scapegoating o disturbance in developmental tasks o poor self-esteem
o **Health Deviation**	o frequent or long-term hospitalization o difficulty expressing signs & symptoms of illness o medication noncompliance o symptom management o side effects of antipsychotic meds

Mini-Review
SCHIZOPHRENIA:
A Disorder of Thinking (CH-~~19~~ 22)
(Continued)

Nurse's Process Level	o fear of harm to self o frustration with slow progress o helplessness	
Nursing Diagnoses	o Altered Thought Process o Impaired Verbal Communication o Self-Care Deficit Dressing/Grooming	
Goals	o decrease level of anxiety and fear o improve ADL ability	
Interventions	o establish a trusting relationship o assure patient he is in a safe place o focus on the feeling behind the hallucination or delusion o engage in "here-and-now" activities & conversation o assist with grooming o provide continuity of care	
Medications	antipsychotics "old" Thorazine Prolixin Haldol Clozaril "new" Risperadone Olanzapine	antiparkinsonians Cogentin Artane Benadryl
Evaluation	o Are goals realistic? o Are interventions effective? o What is the client's evaluation?	

~~CLASS~~ EXERCISE
Individual

Matching Terms & Meanings in Schizophrenia (Exercise-1)

1.	_____	Neologisms	A. Thinking disturbance in which ideas shift from one subject to another in an unrelated manner.
2.	_____	Hallucination	B. A state of psychologically induced immobilization at times interrupted by episodes of extreme agitation.
3.	_____	Anhedonia	C. Mimicking or imitating the speech of another person.
4.	_____	Waxy Flexibility	D. Not being able to sense where oneself (one's body) leaves off and others begin.
5.	_____	Autism	E. Holding two opposing emotions or attitudes simultaneously.
6.	_____	Echolalia	F. A mixture of phrases meaningless to both the listener and the speaker.
7.	_____	Loss of Ego Boundaries	G. Inability to experience pleasure.
8.	_____	Word Salad	H. Made-up words that only have meaning for the person who made them up.
9.	_____	Associative Looseness	I. Condition in which thinking reflects the individual's private perceptual world rather than reality.
10.	_____	Catatonia	J. Keeping one's arms or legs placed in a certain position for hours.
11.	_____	Affect	K. A sense perception for which no external stimulus exists.
12.	_____	Ambivalence	L. Outward appearance of experiencing an emotion.

~~CLASS~~ EXERCISE Individual

Matching Terms & Meanings in Schizophrenia
(Exercise-2)

1.	_____ Akathisia	A.	Beliefs that one's body or mind is controlled by an outside agency.
2.	_____ Thought Broadcasting	B.	False impressions that outside events have a special meaning for oneself.
3.	_____ Extrapyramidal Side Effects	C.	Regular, rhythmic movements, usually of legs associated with taking antipsychotic drugs.
4.	_____ Paranoia	D.	A false belief held to be true in spite of evidence to the contrary.
5.	_____ Neuroleptic Malignant Syndrome	E.	Stiffening of muscular activity in face, body, and limbs as a side effect caused by neuroleptics.
6.	_____ Tardive Dyskinesia	F.	Muscle spasms / side-effect of antipsychotic meds.
7.	_____ Delusions of Being Controlled	G.	An error in the perception of a sensory stimulus.
8.	_____ Pseudoparkinsonism	H.	Involuntary muscular spasms as an irreversible result of the use of phenothizine-like drugs.
9.	_____ Ideas of Reference	I.	Intense, strongly defended irrational suspicion.
10.	_____ Delusion	J.	Examples include acute dystonia, akathisia, pseudoparkinsonism, and tardive dyskinesia.
11.	_____ Acute Dystonia	K.	Rare, sometimes fatal reaction to high-potency neuroleptic drugs.
12.	_____ Illusion	L.	Belief that one's thoughts can be heard by others.

VIDEO *SCHIZOPHRENIA: Symptomatology*

Preview Question: **If you have ever encountered a person with schizophrenia, how did you feel?**

Some Key Points to Look For

1. Briefly (2-3 words each) describe how 3 different people at beginning of video felt about encountering people with schizophrenia.
   a. _____
   b. _____
   c. _____
2. Define "**delusion**": _____
   _____
3. List 6 examples of common delusions.

   _____ _____
   _____ _____
   _____ _____
4. Define "**hallucination**": _____
   _____
5. What kind of hallucination is the most common? _____

Some Guidelines for Interacting

6. Give 2 reasons why it is not a good idea to try to use logic and reasoning to dispel the delusion of someone with schizophrenia. *(Hints: Effective? Possible danger?)*
   _____
   _____
7. When a person with schizophrenia is expressing "mild" delusions and/or hallucinations, how does the video recommend you respond? *(Hint: Two things you should do.)*
   _____
   _____
8. On the other hand, if the delusion/hallucination is "strongly held", what technique is suggested to counter the delusion/hallucination: _____
9. What might you do to help a person with schizophrenia who is exhibiting the symptom of "social withdrawal"?
   _____
10. Give some techniques for communicating with a person with "disordered thinking".
    _____
    _____

VIDEO *Schizophrenia: Causation*

Some Key Points to Look For

1. List 3 basic characteristics of schizophrenia mentioned at start of the video.

   _____

   _____

   _____

2. The name "schizophrenia" comes from the German word "schizein" meaning: _____ .
3. Is schizophrenia the same thing as split (or multiple) personality disorder? _____ .
4. What percent of the U.S. population has been, is or will be affected by schizophrenia? ____
5. Onset of schizophrenia frequently occurs in late adolescence or early adulthood with about _____ percent in the age group from _____ to _____ years old.
6. Compare epidemiology of schizophrenia in men and women -- in terms of frequency, onset, relapse rate and adaptation.

   _____

   _____

   _____

7. Schizophrenia is ___ times more prevalent in the _____ socioeconomic group.
8. Schizophrenia is more common in individuals raised in _____ areas.
9. What ratio of people with schizophrenia attempt suicide? _____
   Of those who attempt suicide, what ratio succeed? _____
10. What percentage of people with schizophrenia have drug or alcohol dependencies? ____
11. Is schizophrenia a psychological disease caused by dysfunctional family life? _____
12. Does stress from overwork cause schizophrenia?
13. How does stress affect a person who already has schizophrenia? (*Hint:* relapse)
14. List 3 biological factors that are associated with schizophrenia.

    _____

    _____

    _____

15. The fact that some schizophrenics have an abnormally high pain threshold has what implications for caregivers? _____

    _____

16. What is the percent occurrence of schizophrenia when neither parent has the disease? _____ When one parent does? _____ When both parents do? _____

17. Briefly state what adoption studies show about schizophrenia.

_____

_____

18. Briefly state what studies of identical twins show about schizophrenia.

_____

_____

19. Do adoption studies and studies of identical twins support the psychological basis of schizophrenia or the biological basis? _____

20. People raised in urban areas are 8 times more likely to develop schizophrenia. This is an example of an _____ factor that could be a cause of schizophrenia.

21. People with schizophrenia are 2-3 times more likely to be born to women who had problems in pregnancy (e.g., bleeding or difficult birth). This is another example of an _____ factor that could be a cause of schizophrenia.

23. What aspect of the brain's biochemistry has been the focus of more recent research into schizophrenia? _____

24. Briefly describe how emotions and attention are affected by neurotransmitters and by schizophrenia.

_____

_____

25. Why is it that people who overdose on amphetamines exhibit similar symptoms to people who have schizophrenia?

_____

_____

26. The brains of identical twins should be identical. However, what do MRI studies show about the brains when one of the twins has schizophrenia?

_____

27. Give 2 examples of how people with schizophrenia have difficulty processing information.

_____

_____

28. Based on modern research, is schizophrenia a psychological illness caused by dysfunctional families and poor parenting -- or is it a biologically-based illness, a brain disease like Alzheimer's?

_____

Week-3

Nursing 54K / Psychiatric

Instructor: Rebecca Sherwood

Name: _____

Date: _____

Critical Thinking Exercise
SUICIDE

PROPOSITION

"If someone really wants to kill himself, he will find a way and there is nothing I can do about it."

EXERCISE

What do you think about the above proposition? Do you agree or disagree with it? Write down your feelings and thoughts (without stopping or putting your pen down) for the next ten minutes.

******* For more room, continue on back *******

SUICIDE

TERMS

- suicidal ideation
- no-suicide contract
- SAD person's scale
- lethality of method
- nurses' process level
  (anxiety, irritation, avoidance, and denial)

CONCEPTS

- most people who contemplate suicide are highly ambivalent about dying
- openly talking about suicide is a relief for the suicidal person
- talking can decrease the risk of suicide
- when depression is lifting, there is more energy to carry out a suicide plan
- about 75% of people who attempt to commit suicide give definite clues
- all threats of suicide should be taken seriously
- even if a threat is "manipulative", the person may still actually go on to commit suicide

Mini-Review
MAJOR DEPRESSION

Theory	Biological: Genetic, Biochemical, Neuroendocrine Psychoanalytic: Loss / Aggression Social: Learned Helplessness / Cognitive
OREM **Assessment**	
o **Universal**	o poor grooming o anhedonia o anergia o psychomotor agitation or retardation o decreased appetite o constipation o sleep disturbance o decreased libido o risk of suicide o sadness, guilt, hopelessness o anger, irritability
o **Developmental**	o unworthiness and sense of failure in family and occupational roles or schooling
o **Health Deviation**	o reluctant to seek help o undeserving
Nurses' Process Level	o unrealistic expectations (expect negative response) o annoyance o sense of rejection by client o reluctance to "invade space"
Nursing Diagnosis	o risk for self-directed violence o self-esteem disturbance o altered nutrition, elimination patterns, sleep patterns

Mini-Review
MAJOR DEPRESSION
(Continued)

Goals	o will remain free of self-directed injury o will name positive attributes of self o will return to normalcy in food, fluid, elimination, sleep patterns
Intervention	o implement suicide precautions o spend short periods of time sitting with client through the day o use silence effectively o avoid platitudes and superficial compliments o assist with ADL's and universal self-care requisites, e.g. food, fluid, elimination, sleep <u>Somatic Therapies</u> o Medications: SSRI's, MAOI's, Tricyclics, antianxiety o Electroconvulsive Therapy
Evaluation	o safety from harm o nutritional status and hydration o hopelessness o grooming and appearance o S/E medications

Postpartum Depression

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Overview

Patients and their caregivers frequently overlook postpartum depression, despite the fact that effective nonpharmacologic and pharmacologic treatments are available for this condition.[1]Untreated postpartum affective illness places the mother and infant at risk and is associated with significant long-term effects on child development and behavior.[2, 3, 4]Therefore, appropriate screening for and prompt recognition and treatment of depression are essential for maternal and infant well-being and can improve outcomes.[5] The American Academy of Pediatrics (AAP) has encouraged pediatric practices to create a system to better identify postpartum depression to ensure a healthier parent-child relationship.[6]Postpartum psychiatric illness was initially conceptualized as a group of disorders specifically linked to pregnancy and childbirth and thus was considered diagnostically distinct from other types of psychiatric illness. Evidence now suggests, however, that postpartum psychiatric illness is virtually indistinguishable from psychiatric disorders that occur at other times during a woman's life.[2, 1, 3]

Statistics

During the postpartum period, up to 85% of women experience some type of mood disturbance;the AAP estimates that more than 400,000 infants are born each year to mothers who are depressed.[6] Although for most women, symptoms of mood disturbance are transient and relatively mild (ie, postpartum blues), 10-15% of women experience a more disabling and persistent form of depression, and 0.1-0.2% of women experience postpartum psychosis.[7, 8, 9,10]

Further information

For patient education information, see the Depression Center, as well as Depression and Postpartum Depression. Additional information is available at: http://mededppd.org/default2.asp.

Risk Factors for Postpartum Mood Disorders

Although predicting who is at risk for postpartum psychiatric illness is difficult, hormonal, psychosocial, and biologic factors are considered to be risk factors for postpartum mood disorders.[2, 5, 11, 12, 13]

Hormonal factors

Although levels of estrogen, progesterone, and cortisol fall dramatically within 48 hours after delivery,[6, 14] women with postpartum depression do not differ significantly from nondepressed women with regard to levels of estrogen,progesterone, prolactin, and cortisol or in the degree to which these hormone levels change. However, affected individuals may be abnormally sensitive to changes in the hormonal milieu and may develop depressive symptoms when treated with exogenous estrogen or progesterone.[14]

Psychosocial factors

Women who report inadequate social supports, marital discord or dissatisfaction, or recent negative life events, such as a death in the family, financial difficulties, or loss of employment, are more likely to experience postpartum depression.[11] However, there has been no apparent,consistent association between obstetric factors and risk for postpartum depression. Woolhouse et al found intimate partner violence to be common among women reporting postnatal depressive symptoms, which may be an important factor to consider in the management of these patients.[15, 16]

Biologic vulnerability

Women with a previous history of depression, a family history of a mood disorder, or depression during the current pregnancy are at increased risk for postpartum depression.[11] Furthermore, women with a previous history of postpartum depression or psychosis have a risk of recurrence of up to 90%.[17, 18]

Screening for Postpartum Mood Disorders

Despite multiple contacts with medical professionals during the postpartum period, patients and their caregivers often overlook postpartum affective illness. Too often,postpartum depression is dismissed as a normal or natural consequence of childbirth.[2, 19, 20] In fact, women commonly report the persistence of depressive symptoms for many months before the initiation of treatment. Although symptoms of depression may remit spontaneously, many women are still depressed 1 year after childbirth.[1, 3, 21, 22]Screening of all mothers during the antepartum and postpartum period is indicated.[5, 9, 21, 23,24, 25] Screening women for depressive symptoms during pregnancy may also help to identify those women at higher risk for postpartum depression.[2]

Screening tools

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item, self-rated questionnaire used extensively for detection of postpartum depression. A score of 10 or more on the EPDS or an affirmative answer on question 10 (presence of suicidal thoughts) requires more thorough evaluation. The EPDS may be included in routine well-baby and pediatric visits.[26] A 3-question version of the EPDS was tested in a pediatric emergency department, and the results showed that the abbreviated version of the EPDS was similar to the full version in screening for postpartum depressive symptoms. Further studies are needed in order to confirm these findings.[27]

No increased benefit to using one screening tool over another has been shown. Using the following 2 questions may be as effective as employing more lengthy tools, although they have not been validated in different cultural settings[5] :

- Over the past 2 weeks have you felt down, depressed, or hopeless?
- Over the past 2 weeks have you felt little interest or pleasure in doing things?

Depression screening should include systems in place to follow up positive results with subsequent diagnosis and treatment.[2, 10, 19] In a study of postpartum depression among urban, low-income mothers, Chaudron et al found

that, although the EPDS, Beck Depression Inventory II (BDI-II), and Postpartum Depression Screening Scale (PDSS) have high accuracy in identifying depression, cutoff scores may need to be altered in this population to identify depression more accurately.[28]

In the study, which included 198 mothers of infants up to age 14 months, the sensitivities and specificities of each screening tool were calculated in comparison with diagnoses of major depressive disorder (MDD) or minor depressive disorder (MnDD) made on the basis of a psychiatric diagnostic interview. Optimal cutoff scores for the BDI-II (≥14 for MDD and ≥11 for MDD/MnDD) and EPDS (≥9 for MDD and ≥7 for MDD/MnDD) were lower than currently recommended.[28] For the PDSS, the optimal cutoff score was consistent with current guidelines for MDD (≥80) but higher than recommended for MDD/MnDD (≥77).

Postpartum Blues

Up to 85% of women experience postpartum affective instability. Rapidly fluctuating mood, tearfulness, irritability, and anxiety are common symptoms.[29, 30, 31, 32]

Symptoms peak on the fourth or fifth day after delivery and last for several days, but they are generally time-limited and spontaneously remit within the first 2 postpartum weeks.[29]

Symptoms do not interfere with a mother's ability to function and to care for her child. Women with more severe symptoms or symptoms persisting longer than 2 weeks should be screened for postpartum depression.[2, 3]

Management

Postpartum blues are typically mild in severity and resolves spontaneously. No specific treatment is required, other than support and reassurance. However, further evaluation is necessary if symptoms persist longer than 2 weeks.[3, 29, 30]

Postpregnancy Depression

Postpartum depression is more persistent and debilitating than postpartum blues, often interfering with the mother's ability to care for herself or her child.[2] Untreated depression is associated with poor maternal health and intrauterine growth restriction.[2, 33] The postpartum period is the most vulnerable time for a woman to develop psychiatric illness with postpartum depression occurring in 10-15% of women in the general population. Postpartum depression develops most frequently in the first 4 months following delivery but can occur anytime in the first year. Postpartum depression is no different from depression that can occur at any other time in a woman's life.[2, 34] Women who have suffered 1 episode of major depression following childbirth have a risk of recurrence of about 25%.[35]

Risk factors

Women at highest risk for postpartum depression are those with a personal history of depression, who have suffered a previous episode of postpartum depression, or who have experienced depression during pregnancy.[9, 11] In addition to a history of depression, recent stressful life events and daily stressors, such as childcare, lack of social support (especially from the partner), unintended pregnancy, and insurance status, have been validated as risk factors.[2, 11, 23]

Presentation

Signs and symptoms of postpartum depression are clinically indistinguishable from major depression that occurs in women at other times.[36] Typically, the disorder develops insidiously over the first 3 postpartum months,[2] although postpartum depression may have a more acute onset.

Symptoms of major depression may include depressed mood, tearfulness, anhedonia, insomnia, fatigue, appetite disturbance, suicidal thoughts, and recurrent thoughts of death.[37] In the postpartum period, depression is characterized as intense sadness, anxiety, or despair. This interferes with the mother's ability to function, causing risk of harm to the mother or infant.[2] Anxiety is prominent, including worries or obsessions about the infant's health and wellbeing.[11] The mother may have ambivalent or negative feelings toward the infant. She may also have intrusive and unpleasant fears or thoughts about harming the infant.[38]

Management overview

Postpartum depression manifests along a continuum; some patients may experience relatively mild or moderate symptoms, while others may present with a more severe form of depression, characterized by prominent neurovegetative symptoms and marked impairment offunctioning.[1, 35] Exclude medical causes for mood disturbance (eg, thyroid dysfunction, anemia). The initial evaluation includes a thorough medical history, physical examination, and routine laboratory tests.[21, 35]

Earlier initiation of treatment is associated with a better prognosis,[39] and the severity of the illness should guide treatment.[22, 35] Failure to treat or inadequate treatment may result in deterioration of the relationship between the mother and the baby or the partner. It can also increase the risk of morbidity in both mother and infant, as well as compromise the infant's social and educational development.[40, 41, 42] Nonpharmacologic treatment strategies are useful for women with mild to moderate depressive symptoms. Individual or group psychotherapy (cognitive-behavioral and interpersonal therapy) are effective.[8, 36, 43, 44] Psychoeducational or support groups may also be helpful. These modalities may be especially attractive to mothers who are nursing and who wish to avoid taking medications.[45] Pharmacologic strategies are indicated for moderate to severe depressive symptoms or when a woman's condition does not respond to nonpharmacologic treatment.

Medication may also be used in conjunction with nonpharmacologic therapies. Inpatient hospitalization may be necessary for severe postpartum depression.[46, 47, 48] A consideration is electroconvulsive therapy (ECT), which is rapid, safe, and effective for women with severe postpartum depression, especially those with active suicidal ideation.[49]

Pharmacotherapy considerations

Antidepressants remain the first line of treatment.[4, 22, 28] However, there are preliminary data to suggest that estrogen, alone or in combination with an antidepressant, may be beneficial. Typically, symptoms start to diminish in 2-4 weeks. A full remission may take several months. If this is the first episode of depression, 6-12 months of treatment is recommended. In partial responders, increasing the medication dosage may be helpful. For women with recurrent major depression, long-term maintenance treatment with an antidepressant is indicated.[22]

Anxiolytic agents such as lorazepam and clonazepam may be useful as adjunctive treatment in patients with anxiety and sleep disturbance.

SSRIs

Selective serotonin reuptake inhibitors (SSRIs) are first-line agents and are effective in women with postpartum depression. Use standard antidepressant dosages (eg, fluoxetine [Prozac] 10-60mg/day, sertraline [Zoloft] 50-200mg/day, paroxetine [Paxil] 20-60mg/day, citalopram [Celexa] 20-60mg/day, or escitalopram [Lexapro] 10-20mg/day). Adverse effects of this drug category include insomnia, jitteriness, nausea, appetite suppression, headache, and sexual dysfunction.

SNRIs

Serotonin/norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine (Effexor) 75-300mg/day or duloxetine (Cymbalta) 40-60mg/day are also highly effective for managing depression and anxiety.

Adverse effects of SNRIs include those of the SSRIs as well as sleep disturbances, constipation, and abnormal vision.

TCAs

Tricyclic antidepressants (TCAs) (eg, nortriptyline 50-150mg/day) may be useful for women withsleep disturbance, although some studies suggest that women respond better to the SSRI drug category. Adverse effects of the TCAs include sedation, weight gain, dry mouth, constipation, and sexual dysfunction.

Postpartum Psychosis

Postpartum psychosis is the most severe form of postpartum psychiatric illness.[50] The condition is rare, occurring in approximately 1-2 per 1000 women after childbirth.[7] At highest risk are women with a personal history of bipolar disorder or a previous episode of postpartum psychosis.[51, 52]

Presentation

Postpartum psychosis has a dramatic onset, emerging as early as the first 48-72 hours after delivery. In most women, symptoms develop within the first 2 postpartum weeks.[50, 52] The condition resembles a rapidly evolving manic or mixed episode, with symptoms such as restlessness and insomnia, irritability, rapidly shifting depressed or elated mood, and disorganized behavior.[50, 52]

The mother may have delusional beliefs that relate to the infant (eg, the baby is defective or dying, the infant is Satan or God), or she may have auditory hallucinations that instruct her to harm herself or her infant.[3, 31, 38, 50, 52]

The risks for infanticide and suicide are high among women with untreated postpartum psychosis.[31, 38] Rates of infanticide in this population are as high as 4%.[38]

Management

Puerperal psychosis is a psychiatric emergency that typically requires inpatient treatment.[17,49, 52] Most patients with postpartum psychosis have bipolar disorder. Acute treatment includes a

mood stabilizer (eg, lithium, valproic acid, carbamazepine) in combination with antipsychotic medications and benzodiazepines.[17]

Electroconvulsive therapy (ECT) (often bilateral) is well tolerated and rapidly effective.[48]

Breastfeeding and Psychotropic Medications

Women who plan to breastfeed must be informed that all psychotropic medications, including antidepressants, are secreted into breast milk. Concentrations in breast milk vary widely.[53] Infant serum blood levels of antidepressants are not typically obtained unless the question of toxicity in the infant arises.Data on the use of tricyclic antidepressants, fluoxetine, sertraline, and paroxetine during

breastfeeding are encouraging, and serum antidepressant levels in the breastfed infant are either low or undetectable. Reports of toxicity in breastfed infants are rare, although the long term effects of exposure to trace amounts of medication are not known.[4] Women treated with valproic acid and carbamazepine should avoid breastfeeding, because these agents have been associated with hepatotoxicity in the infant.[4] In addition, avoid breastfeeding in premature infants or in those with hepatic insufficiency who may have difficulty metabolizing medications present in breast milk.[4] Breastfeeding in women treated with lithium should be pursued with caution because lithium is secreted at high levels in breast milk and may cause significant toxicity in the nursing infant. If the breastfed infant is exposed to lithium in the breast milk, periodic monitoring of lithium levels and thyroid function is indicated.[4, 53]

Prevention of Postpartum Psychiatric Illness

Women at high risk for postpartum illness should be identified before delivery. This includes women with a previous episode of postpartum illness and women with a history of either unipolar or bipolar depression. Women who experience depression during pregnancy should also be considered at high risk for postpartum illness.[11]

In addition to monitoring, women with a history of recurrent depression or a history of postpartum depression may benefit from prophylactic treatment with an antidepressant medication. If antidepressants are not used during pregnancy, they may be initiated shortly before or immediately after delivery to reduce the risk of recurrent illness.[22] Women with bipolar disorder or a history of postpartum psychosis may benefit from prophylactic treatment with lithium, initiated either before or within 24 hours of delivery.[17, 18] The prophylactic efficacy of nonpharmacologic interventions in this setting has not been fully assessed, although one study reported lower rates of postpartum depression in a group of women receiving interpersonal therapy for depression during pregnancy.[45]

Impact of Postpartum Depression on Child Development

A large body of literature suggests that a mother's attitude and behavior toward her infant significantly affects mother-infant bonding and infant well-being and development. Postpartum depression may negatively affect these mother-infant interactions.[2, 54] Mothers with postpartum depression are more likely to express negative attitudes about their infant and to view their infant as more demanding or difficult. Depressed mothers exhibit difficulties engaging the infant, either being more withdrawn or inappropriately intrusive, and more commonly exhibit negative facial interactions. These early disruptions in mother-infant bonding may have a profound impact on child development.[55] Children of mothers with postpartum depression are more likely than children of nondepressed mothers to exhibit behavioral problems (eg, sleep and eating difficulties, temper tantrums,

hyperactivity), delays in cognitive development, emotional and social dysregulation, and early onset of depressive illness.[40] As previously stated, the American Academy of Pediatrics (AAP) has stated that more than 400,000 infants are born each year to depressed mothers. Due to the potential negative effects of postpartum depression on mother-infant bonding and infant well-being and development, the AAP has encouraged pediatric practices to create a system to better identify postpartum depression in order to ensure a healthier parent-child relationship.[56]

Key Considerations

Postpartum psychiatric illness consists of a highly prevalent group of disorders that affect women during their childbearing years. Although postpartum blues is typically benign and self-limited, postpartum depression and postpartum psychosis cause significant distress and dysfunction. Despite multiple contacts with medical professionals during the postpartum period, puerperal mood disorders are frequently missed, and many women go without treatment. Untreated mood disorders place the mother at risk for recurrent disease. Furthermore, maternal depression is associated with long-term cognitive, emotional, and behavioral problems in the child. One of the most important objectives is to increase awareness across the spectrum of health-care professionals who care for women during pregnancy and the puerperium so that postpartum mood disorders may be identified early and treated appropriately. Effective pharmacologic and nonpharmacologic therapies are available.

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HOW TO RECOGNIZE DEPRESSION

QUESTION: *Could someone you know be suffering from depression?*

YES	NO	
☐	☐	1. Does that person feel a deep sense of depression, sadness, or hopelessness most of the day?
☐	☐	2. Has that person experienced diminished interest in most or all activities?
☐	☐	3. Has that person experienced significant appetite or weight change when not dieting?
☐	☐	4. Has that person experienced a significant change in sleeping patterns?
☐	☐	5. Does that person feel unusually restless . . . or unusually sluggish?
☐	☐	6. Does that person feel unduly fatigued?
☐	☐	7. Does that person experience persistent feelings of hopelessness or inappropriate feelings of guilt?
☐	☐	8. Has that person experienced a diminished ability to think or concentrate?
☐	☐	9. Does that person have recurrent thoughts of death or suicide?

Note: Other explanations for these symptoms may need to be considered.

Source: Adapted from *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, D.C.: American Psychiatric Association; 1994.

If you answered yes to five or more of these questions (including questions # 1 or # 2) . . . and if the symptoms described have been present nearly every day for 2 weeks or more, the person should consider speaking with a health care professional about different treatment options for depression.

DEFINITIONS OF COMMON UNHELPFUL OR INACCURATE THINKING PATTERNS

CBT

1. ALL OR NOTHING THINKING. You see things in black and white categories. If your performance falls short of perfect, you see yourself as a total failure. "I really screwed up that time, that makes me a total failure."

2. OVERGENERALIZATION. You see a single negative event as a never ending pattern. You don't get the job you were applying for, "I'm never going to get a job."

3. MENTAL FILTER. You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the glass that is discolored by a single drop of ink. "I failed this morning, the rest of my day is ruined."

4. DISQUALIFYING THE POSITIVE. You reject positive experiences by insisting they "don't count". This enables you to maintain a negative belief that is contradicted by your everyday reality. "His/her opinion doesn't really know me."

5. JUMPING TO CONCLUSIONS. You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.
   a. *Mind reading*. You arbitrarily conclude that someone is reacting negatively to you, and you don't bother to check this out. "This person is trying to get something from me."
   b. *Fortune teller error*. You anticipate that things will turn out badly, and you feel convinced that your prediction is an already established fact. "I know I'm going to get the run-around."

6. MAGNIFICATION (CATASTROPHIZING) and MINIMIZATION. You exaggerate the importance of things (such as your goof-up or someone else's achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities at the other's imperfections). "I made a mistake, I'm ruined." (catastrophizing), or "I won't get this job because my skills aren't good enough." (minimizing)

7. EMOTIONAL REASONING. You assume that your negative emotions necessarily reflect the way things really are. "I feel it, therefore it must be true."

8. SHOULD STATEMENTS. You try to motivate yourself with "shoulds" and "shouldn'ts", as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also should statements. The emotional consequence is guilt. When you direct should statements towards others you feel anger, frustration, and resentment. "S/he should help me."

9. IMPLIED SHOULD STATEMENTS. You ask someone for a behavior change or action without actually saying so. You imply that he/she "should" be doing something else. "Don't you have something thing better to do?" ("You should leave me alone.")

10. LABELING AND MISLABELING. This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself, "I'm a failure", or to someone else, "S/he's a jerk". Mislabeling involves describing an event with language that is highly colored ando. emotionally loaded. "S/he is a stupid S.O.B.

11. PERSONALIZATION. You feel that someone is directing their actions or words at you. "S/he did that to irritate me," or you feel you are responsible for something bad happening. A co-worker gets fired, "It's my fault because I didn't show him/her the ropes."

TEN WAYS TO UNTWIST YOUR THINKING*

CBT

1. **Identify the Distortion.** Write down your negative thoughts so you can see which of the ten cognitive distortions you're involved in. This will make it easier to think about the problem in a more positive and realistic way.

2. **Examine the Evidence.** Instead of assuming that your negative thought is true, examine the actual evidence for it. For example, if you feel that you never do anything right, you could list several things you have done successfully.

3. **The Double-Standard Method:** Instead of putting yourself down in a harsh, condemning way, talk to yourself in the same compassionate way you would talk to a friend with a similar problem.

4. THE EXPERIMENTAL TECHNIQUE. Do an experiment to test the validity of your negative thought. For example, if, during an episode of panic, you become terrified that you're about to die of a heart attack, you could jog or run up and down several flights of stairs. This will prove that your heart is healthy and strong.

5. **Thinking in Shades of Gray.** Although this method might sound drab, the effects can be illuminating. Instead of thinking about your problems in all-or-nothing extremes, evaluate things on a range from 0 to 100. When things don't work out as well as you hoped, think about the experience as a partial success rather than a complete failure. See what you can learn from the situation.

6. **The Survey Method.** Ask people questions to find out if your thoughts and attitudes are realistic. For example, if you believe that public speaking anxiety is abnormal and shameful, ask several friends if they ever felt nervous before they gave a talk.

7. **Define Terms.** When you label yourself "inferior" or "a fool" or "a loser," ask, "What is the definition of 'a fool'? You will feel better when you see that there is no such thing as "a fool" or "a loser".

8. **The Semantic Method.** Simply substitute language that is less colorful and emotionally loaded. This method is helpful for "should statements". Instead of telling yourself "I *shouldn't* have made that mistake," you can say, "It would be better *if* I hadn't made that mistake".

9. **Re-attribution.** Instead of automatically assuming that you are "bad" and blaming yourself entirely for a problem, think about the many factors that may have contributed to it. Focus on solving the problem instead of using up all your energy blaming yourself and feeling guilty.

10. **Cost-Benefit Analysis.** List the advantages and disadvantages of a feeling (like getting angry when your plane is late), a negative thought (like "No matter how hard I try, I always screw up"), or a behavior pattern (like overeating and lying around in bed when you're depressed). *You can also use the Cost-Benefit Analysis to modify a self-defeating belief such as, "I must always try to be perfect."*

11. Self-affirmation, positive self-statements

Week-4

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NURSING 85A & 85AL
REBECCA SHERWOOD
DE ANZA COLLEGE

Nursing Management of Alcohol Withdrawal

Self-Learning Module
Nursing Education Department

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Nursing Management of Alcohol Withdrawal
Table of Contents

Nursing Management of Alcohol Withdrawal

Directions:

- √ Completing this module will take approximately one hour.
- √ Read the contents of this module.
- √ Complete the post-test.
- √ Send the post-test to Education at mailstop ECH323.
- √ After all requirements are met, you will earn 1hour of CE credit.

Introduction:

This self-learning module is to be used as a guideline by the health care professional in identifying and caring for the hospitalized adult experiencing alcohol withdrawal. You will learn how to identify and assess patients at risk for alcohol withdrawal, identify symptoms consistent with withdrawal, and describe treatment options.

Learning Objectives:

Upon completion of this module, the learner will:

1. Recognize the signs, symptoms, and diagnoses suggestive of alcohol withdrawal.
2. Indicate the areas to assess in documenting a patient history related to chemical dependency.
3. List the basic principles of alcohol withdrawal and detoxification.
4. Identify treatment options for alcohol withdrawal.
5. Use the Alcohol Withdrawal Scale (AWS) to identify, assess, and score symptoms of alcohol withdrawal.

Pathophysiology of Alcohol Withdrawal

Ethanol (ETOH) is rapidly absorbed by the gastric and intestinal mucosa and enters the bloodstream. It is eliminated in small quantities by the lungs and kidneys but is primarily metabolized by the liver. The quantity of alcohol present in one shot of spirits, one 4 oz glass of wine, or one 12 oz can of beer will raise the blood alcohol level by approximately 25 mg/dL in the average adult, who will metabolize ETOH at the rate of about 15-25 mg/dL/h, assuming normal liver function.

Long-term exposure to ethanol modifies certain neurotransmission sites in the central nervous system (CNS). Withdrawal from alcohol results in rebound hyperstimulation and some degree of neuronal death. The repeated cycle of addiction and withdrawal can produce a phenomenon known as "kindling", whereby a patient can predictably reach his previous level of withdrawal severity on each subsequent episode.

Because alcohol is a depressant, alcohol withdrawal is characterized by symptoms that are opposite to the effects of alcohol ingestion. During withdrawal, CNS arousal ensues due to increased levels of catacholamines, in part due to the down-regulation of GABA (gamma-aminobutyric acid) receptors; GABA is an inhibitory CNS transmitter. GABA receptors are the site of action for benzodiazepines and may partly explain their benefit in alcohol withdrawal. Alcohol's affect on GABA may contribute to alcohol's anxiolytic, sedative, and motor impairment actions. Hyperexcitability and seizures may develop in alcohol withdrawal from a compensatory change in the number or function of GABA receptors following chronic alcohol exposure.

The severity of the withdrawal syndrome is related to the dose and duration of ethanol consumption. Risk factors include being over 40 years of age, daily consumption, heavy binge drinking, and previous history of withdrawal symptoms.

Identification and Assessment of Patients at Risk for Withdrawal

Identification, diagnosis, and treatment of patients experiencing or at risk of alcohol withdrawal can be challenging and problematic. The patient's admitting diagnosis may be for another medical condition, illness, or injury. Alcohol is the most commonly abused drug in the world. The incidence of alcohol dependence and/or abuse in patients of a general hospital facility is 35-50%.

Personal and Family History

When completing the comprehensive patient assessment and history, questions about substance use should begin with the least threatening subjects. Start with questions about substances that are culturally acceptable, such as number of cups of coffee per day, progress to the number of cigarettes per day and then to the daily intake of alcohol and other drugs. How questions are asked is the key to accurate responses. Patients are sensitive to any negative attitude or judgment

from the interviewer. Frame questions in a way that normalizes patients' responses. **Examples include:**

> **"When you drink alcohol, what do you like to drink?"**
> **"How much do you drink a day?"(As though everyone drinks alcohol every day.)**
> **"How old were you when you first had a drink?"**

A change in style of response by the patient can be a clue. A patient will freely tell you how many cups of coffee he drinks a day or how many cigarettes he smokes but, when asked about alcohol or other drugs, the chemically dependent person often switches from precise answers to vague one such as "I drink a few beers now and then," "I drink socially," or "I've tried cocaine once or twice." Anger, evasive or glib conversation during taking of the substance use history should alert you to the potential for substance abuse or dependence.

Alcohol Use History

Use of a **non-judgmental** style will encourage honest communication from the patient. Assess for:

- The type, amount, and frequency of alcohol consumption by the patient.
- Last drink (date, time, amount)
  **Alcohol withdrawal symptoms appear as early as two hours after the last drink. Early intervention prevents detox complications.*
- The pattern of drinking throughout the day or night
- How long patient has been drinking. (In weeks, months, years)
  **More severe withdrawal symptoms are noted in patients who have a history of long-term alcohol abuse.*
- History of withdrawal symptoms in the past with the cessation of alcohol consumption including, drinking to get back to sleep, tremors, diaphoresis, nausea/vomiting, diarrhea, seizures, or DT's.
- The CAGE questionnaire may illicit additional helpful information.

CAGE Questionnaire

- Have you ever felt you ought to Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning (Eye opener) to steady your nerves or get rid of a hangover?

Two or more affirmative answers indicate probable alcoholism.

Any single affirmative answer deserves further evaluation.

Medical History

Signs, Symptoms and Diagnoses Suggestive of Alcohol Use and Withdrawal

Signs and Symptoms Suggestive of Chronic Substance Use or Abuse

- Jaundice
- Ecchymoses
- Palmar erythema
- Spider nevi
- Edema
- Cigarette burns of hands
- Feelings of Worthlessness
- Social withdrawal
- Self-Neglect
- Loss of appetite
- History of psychiatric or emotional problems
- History of violent behavior
- Interpersonal relationship difficulties
- Loneliness

Common Diagnoses Associated with Alcohol Abuse

Gastro Intestinal
- Liver disease
  - Esophageal Varices
  - Hepatic Encephalopathy
- Pancreatitis
- Ulcers
- GI bleeding
- Recurrent peptic ulcer

Cardiovascular
- Cardiomyopathy
- Refractory hypertension

Neurological
- Seizures
- Peripheral neuropathy disease

Psychiatric
- Sleep disorders
- Depression
- Delirium
- Dementia
- Drug and / or tobacco addiction

Other
- Trauma
- Gout
- Wernicke-Korsakoff Syndrome

Laboratory Finding Suggestive of Chronic Alcohol Use

B.A.L. $\geq$ .150 w/o intoxication

CBC:
↓ Hg/Hct.
↑ MCV
↓ plat

Chemistries:
↑amylase
↑HDL
↓K+
↓Mg
↓Ca++
↑trig
↑uric acid
↓ or ↑glucose

Liver Function Tests (LFTs):
↑ SGOT (AST)
↑SGPT (ALT)
↑GGT
↑alk phos
↑bilirubin
↓albumin
↑PT

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Patient Label

AUDIT- C ALCOHOL SCREENING TOOL
(alcohol use disorders identification test?)

QUESTIONS:	N/A= 0	A= 0	B= 1	C= 2	D= 3	E= 4	score
1. How often do you have a drink containing Alcohol?		Never	Monthly or less	2-4 x per month	2-3 x per week	4 or more x per week	
2. How many standard drinks containing alcohol do you have on a typical day?		1 or 2	3 or 4	5 or 6	7 to 9	More than 10	
3 How often do you have 6 or more drinks on one occasion?		Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Sub score for n/a:						**TOTAL:**	

SCORING:

The AUDIT- C is scored on a 0-12 point scale.

Each AUDIT-C question has 5 answer choices. Points allotted are:

A: = 0, B: = 1, C: = 2, D: =3, E: = 4

- In **men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or alcohol use disorders
- In **women**, a score of 3 or more is considered positive, optimal for identifying hazardous drinking or alcohol use disorders
- However, when points are all from question 1 and "0" for questions 2 and 3, it is considered that drinking currently is in excess and requires more assessment over the past few months to confirm accuracy.

Print Staff Name _____ Staff Signature _____ Date _____ Time _____

Nursing Management of Alcohol Withdrawal

Research has shown that use of a standardized symptom scale to identify and monitor patients' withdrawal symptoms, as well as use of symptom driven dosing of medication is more effective at controlling withdrawal symptoms. This individualized regimen as opposed to the traditional approach of having a routine regime of set medication doses that are tapered each day reduces the number of hospital days for detox. The El Camino Hospital protocol for managing a patient with alcohol withdrawal is based on this research.

Signs and Symptoms of Alcohol Withdrawal

The signs and symptoms of withdrawal are opposite of the drug alcohol's effects. Since alcohol is a short-acting depressant/sedative drug, withdrawal symptoms are similar to stimulant-like effects or symptoms of activation of the sympathetic nervous system. Symptoms usually occur within the first 6 to 24 hours after cessation of drinking alcohol

Early	Later	Late
◆ Anxiety ◆ Mild diaphoresis ◆ Mild hand tremor ◆ Restlessness ◆ Nausea ◆ Vomiting	◆ Tachycardia ◆ Hypertension ◆ Gross tremor (even at rest) ◆ Abdominal cramps ◆ Moderate diaphoresis ◆ Psychomotor agitation ◆ Increased temperature ◆ Dehydration	◆ Extreme agitation & restlessness ◆ Grand mal seizures (onset usually <48 hrs after last drink) ◆ Hallucinations can be visual, tactile and/or auditory (onset usually 48-96 hours after alcohol cessation) ◆ Delusions (usually 48-96 hrs after last drink) ◆ Confusion

Using the Alcohol Withdrawal Scale (AWS)

The goal of alcohol withdrawal is to calm the CNS and potentiate the effects of the inhibitory neurotransmitter GABA (gamma-aminobutyric acid). Uncomplicated alcohol withdrawal using the AWS usually lasts approximately three days. This timeframe may be shorter if the patient does not drink large amounts of alcohol or if they do not drink daily. The amounts of medication given should be less by days two and three.

Please, refer to the included Patient Management Protocol, Alcohol Withdrawal Scale, and the Detox Clinical Pathway orders.

An assessment of the patient's somatic and mental symptoms using the Alcohol Withdrawal Scale is done on initiation of the clinical pathway. Repeat assessments are done **prior** to any medication administration, **1 hour** following medication administration, and **no less than every four hours.**

Benzodiazepene dosage and frequency is dependent upon these scores.

- **Somatic symptoms**, especially pulse, diaphoresis, and tremors, are key indicators. Keep in mind that scores in this section need to be due to symptoms of alcohol withdrawal, rather than other medical problems. These can include: an elevated diastolic blood pressure as a symptom of untreated hypertension, fever related to an infection, or rapid respirations due to underlying cardiac or pulmonary disease. Tremors that continue after other somatic symptoms have abated may be a sign of hypomagnesemia. Use critical thinking and the AWS score sheet to detect patterns.

- **Mental symptoms** are assessed in the second section of the AWS. When assessing for orientation and contact make sure that symptoms are due to withdrawal, not as a result of sedation from previously administered medications. Hallucinations refer to symptoms that occur when the patient is awake and are not to be confused with nightmares, which are common.

- There is **flexibility and room for the nurse's subjective input** in the scoring process. The total AWS score drives the clinical interventions. Specific medication dosages have been determined for **mild** (score <5), **moderate** (5-9) and **severe** (>10) withdrawal symptoms.

Long acting benzodiazepines such as Valium or Librium are preferable for their longer duration. This provides a smoother withdrawal, fewer breakthrough symptoms, and the prevention of seizures. Both are metabolized by the liver, and broken down into active metabolites, which have longer half-lives than their parent drug. These drugs can accumulate and cause toxicity in the presence of liver injury or liver damage. Give with caution if the LFTs are elevated.

Shorter acting benzodiazepines such as Oxazepam (Serax) or Ativan, can be used with patients who have liver disease in general and hepatic encephalopathy in particular. These medications are metabolized directly to inactive glucuronides, and are excreted through the kidneys. These can also be used for elderly and post-operative patients to avoid oversedation. In addition, sublingual Ativan can be used for patients who are NPO, such as those with pancreatitis. When using Ativan, monitor for possible paradoxical response of increased agitation and restlessness, especially when used for elderly patients.

EL CAMINO HOSPITAL

PROTOCOL: ALCOHOL WITHDRAWAL, MANAGEMENT OF THE PATIENT WITH USING ORAL MEDICATION

OUTCOME:

1. Patients experiencing alcohol withdrawal will be managed in a clinically appropriate manner.
2. Adequate nutritional status will be maintained.
3. Injury to patient and staff will be avoided.
4. Assessment and referral for chemical dependency treatment services will be completed.

SUPPORTIVE DATA:

1. This alcohol withdrawal treatment pathway is for PO medications. If the physician chooses to order IV medications, then the patient is to be monitored in accordance with safe clinical practice and hospital procedures, NOT by this protocol.
2. Alcohol is a central nervous system depressant to which the body adapts by increasing neuronal activity to maintain normal function. The signs and symptoms of this increased activity remain when alcohol is withdrawn, and are known as Alcohol Withdrawal Syndrome (AWS). These signs and symptoms can begin 6-12 hours after the last drink and last 2-4 days. Delirium Tremens (DT's) can begin 48-96 hours after the last drink and last for days.
3. Drugs for treating AWS commonly are benzodiazepines because of their cross tolerance with alcohol. Essentially, one drug is traded for another similar one. Only one should be used for each patient because of the cumulative effects of combining the drugs.
    a. *Diazepam (Valium) PO is the drug of choice for patients with no known liver disease. Valium IV is the drug of choice during a seizure.*
    b. Oxazepam (Serax) PO is recommended for patients with severe liver disease, or elderly patients with compromised liver function because it has a much shorter half life, and is metabolized faster by the liver.
    c. Lorazepam (Ativan) IV, IM, or SL is for patients unable to take medications by mouth.
4. Chronic or habitual abusers may develop a tolerance to alcohol which can be assessed by obtaining a Blood Alcohol Level (BAL). A BAL that is greater than 0.15 in a patient who does not appear intoxicated reveals a greater tolerance and suggests a greater chance of developing AWS.
5. **Thiamine** is given routinely to prevent Wernicke-Korsakoff Syndrome. This syndrome is a mixture of nerve and memory deficits such as confusion, ataxia, oculomotor problems, hypothermia and bradycardia. Thiamine should be given prior to IV glucose for best effect.
6. **IV glucose** may be given because these patients suffer from hypoglycemia from poor nutrition and decreased hepatic glucose stores, which can result in agitation, confusion and seizures.
7. Seizures are a potential complication especially for those with a history of previous withdrawal seizures, multiple detoxifications, or low magnesium.
8. Low serum **magnesium** is associated with neuromuscular irritability, seizures and increased incidence of DT's. Therefore magnesium may also be ordered for continued tremors and to prevent seizures.
9. Anesthesia and opiates may mask alcohol dependency and withdrawal symptoms.
10. Routine use of antihypertensives should be avoided as they mask blood pressure and pulse changes which are important factors in assessing withdrawal symptoms.
11. DT's are most common when drinking is suddenly stopped after a period of heavy use (more

than 4-5 drinks per day). It is rare in persons less than 30 years old. 4-5% of those with AWS will get DT's.

12. Alcohol decreases the release of Anti-Diuretic Hormone (ADH). As the BAL drops in the early stages of AWS, the patient may be over hydrated secondary to this increased ADH. Severe AWS patients may need fluids because of diaphoresis, hyperthermia, tachycardia, and emesis. The fluid loss with DT's may be as much as 6 liters in 24 hours.
13. **Hallucinosis** is a condition characterized by auditory and visual hallucinations and delusions occurring early in withdrawal. The patient maintains a clear sensorium, but may need reassurance. Up to 25% of withdrawing patients experience this without progressing to DT's.
14. * Asterisk below indicates MD order required.

ASSESSMENT:

1. Systems review and history:
    a. How long has the patient been drinking? Describe patterns of use including amounts (least, average, most), and when was the last drink. Include other abused substances.
    b. Is there a history of previous withdrawal symptoms? Did it include seizures or DT's?
    c. Is there concomitant medical history – especially conditions exacerbated by alcohol like pancreatitis, GI bleeding, seizures, gout, significant liver disease.
    d. Patients with compromised respiratory function require closer monitoring and may need less benzodiazepines.
    e. What is the patient's age?
2. Begin Alcohol Withdrawal Flowsheet.

INTERVENTIONS:

1. Take vital signs and do flowsheet assessment scale every 4 hours, PRN, before and one hour after administration of medications. Record scores on flowsheet.
2. *Medicate per withdrawal scale order set, and record. Obtain additional medication dosage orders as needed.
3. Place patient on oximetry if respiratory distress is noted, or if there is a history of lung disease.
4. *Monitor BAL, CBC, chemistries, magnesium, protime, blood ammonia level.
5. Report any unexpected changes in level of consciousness, seizures, temperature greater than 101 degrees, or respiratory distress.
6. If the patient is confused, provide a calming environment, leave the light on, allow family to visit.
    a. *Obtain an order for a sitter, if needed.
    b. *Consider antipsychotic drugs or anticholinergics for symptoms of Hallucinosis.
    c. *Use restraints as a last resort as then tend to increase agitation.
7. Monitor nutritional status, encourage fluids, record intake and output.
8. *Give vitamins as ordered.
9. *Order Chemical Dependency consult, and leave phone message at ext. 7763.
10. *In the presence of continued tachycardia and hypertension in a patient who has no other obvious withdrawal symptoms, and who has been medicated appropriately for withdrawal, consult the physician regarding ordering a **beta blocker** such as Atenolol. Caution for patients with COPD as beta blockers may cause bronchospasm.
11. If symptoms persist beyond a few days, despite adequate treatment, consider other causes.

DOCUMENTATION:

1. On Alcohol Withdrawal Scale flowsheet assessments and total intervention scores.
2. Per unit standards vital signs, medications given and responses.

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8. Yost, D. (1996). Alcohol withdrawal syndrome. *American Family Physician*, 54, 657-664.

CROSS REFERENCE:

Procedure: Restraints, Soft, Application of
Procedure: Seizures, Management of the Patient with

AUTHORS: C. Trowbridge, RN, BC, BSN, A. Wilcox, RN, MS, NP
REVISED BY: C. Trowbridge, RN, BC, BSN, and Michael Fitzgerald, MS, RNCS

APPROVAL: Clinical Practice Council: 4/00
REVIEW/REVISION: CPC: 06/03, 4/04
DISTRIBUTION: Generic except Nursery, NICU, L&D, OR, Outpatient Dialysis

Medication reference list for use with Alcohol Withdrawal Scale and specific MD orders:

Mild withdrawal symptoms score 1-4, medicate q6 hours with:

a. Valium 10mg #1 PO, or
b. Serax 10mg #1 PO, or
c. Ativan 1mg #1, PO, IM, or SL

Moderate withdrawal symptoms, score 5-9, medicate q1-2 hours with:

a. Valium 10mg #1 PO, or
b. Serax 10mg #1 PO, or
c. Ativan 1mg #1 PO, IM, or SL

Severe withdrawal symptoms, score 10 or greater, medicate q1 hour with:

a. Valium 10mg #2 PO, or
b. Serax 10mg #2 PO, or
c. Ativan 2mg PO, IM or SL

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

Name:

ID:

Physician:

ALCOHOL WITHDRAWAL SCALE

SOMATIC SYMPTOMS	0	1	2	3	4	SCORE
					DATE:	
					TIME:	
					INITIAL:	
1. Pulse	<100	101-110	111-120	>120		
2. Diastolic BP	<95	96-100	101-105	>105		
3. Temperature	<98.6	98.7-99.5	99.6-100.4	>100.4		
4. Respirations	<20	20-24	>24			
5. Diaphoresis*	None	Mild	Moderate	Severe		
6. Tremor*	None	Mild	Moderate	Severe		
MENTAL SYMPTOMS *(If asleep, score zero for mental symptoms)*						
1. Agitation*	none	mild	rolling in bed	tries to leave bed	enraged	
2. Contact* *(not due to sedation)*	able to converse	distractible	drifting contact	cannot dialogue		
3. Orientation *(not due to sedation)*	x4	x3	x2/x1	none		
4. Hallucinations*	none	suggestive	x1	x2	Scenic	
5. Anxiety*	none	mild	severe			
					TOTAL SCORE:	
					**Clinical Interventions Score	

LEGEND

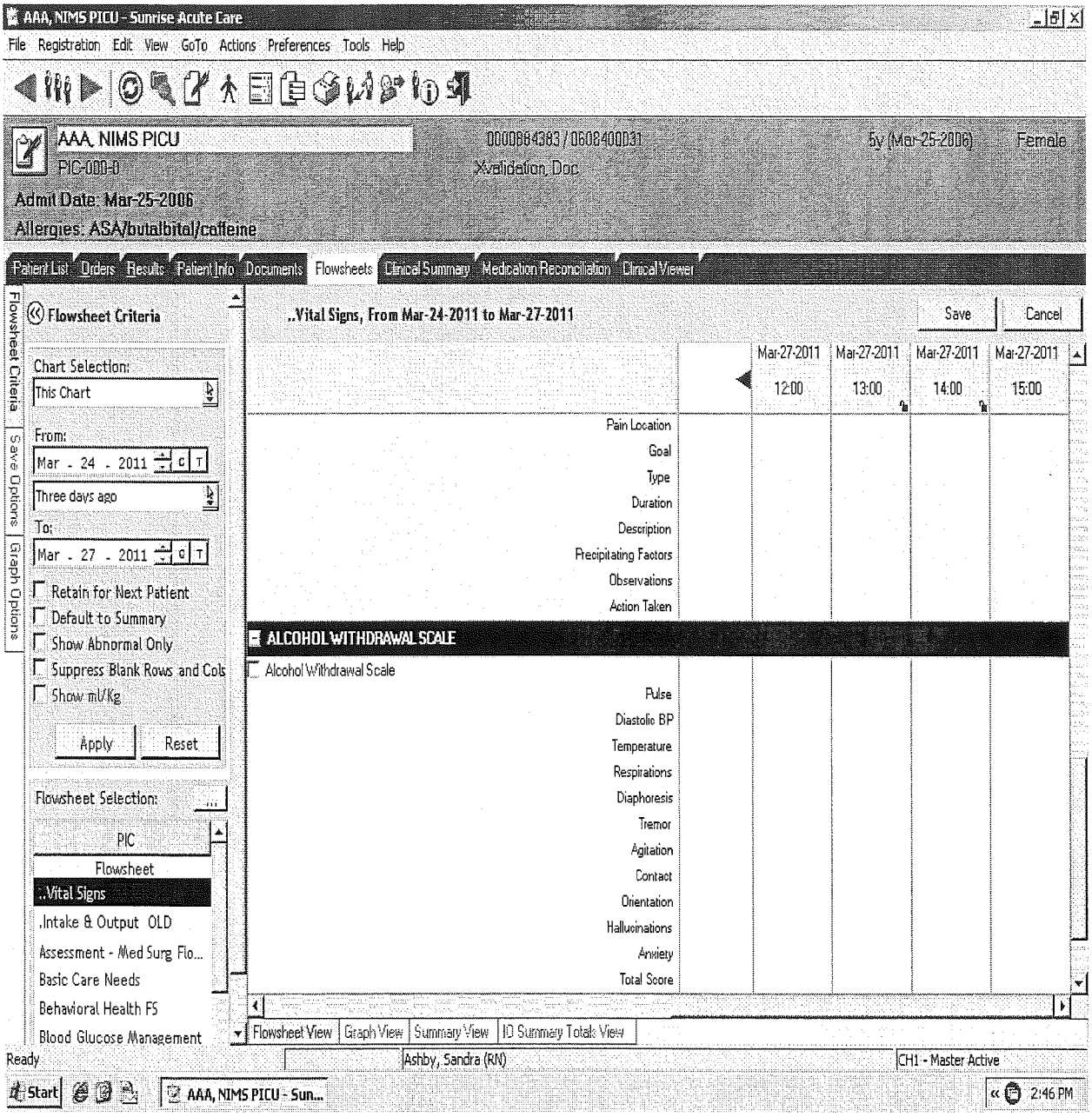
SYMPTOMS	SCORE	DEFINITION	SYMPTOMS	SCORE	DEFINITION
*Diaphoresis	*Mild*	Wet Hands	*Contact	*Distractible*	e.g. noise
	Moderate	Forehead	*Hallucinations	*Suggestive*	Misinterprets environment
	Severe	Profuse (body sweats, bed damp)		*x1*	One kind, e.g., visual
*Tremor	*Mild*	Arms raised & fingers spread		*x2*	Two kinds, e.g. visual & tactile
	Moderate	Fingers spread		*Scenic*	As in a film
	Severe	Spontaneous	*Anxiety	*Mild*	Only if asked
*Agitation	*Mild*	Uneasy		*Severe*	Spontaneous complaint

**Clinical Interventions	*1*	Med given per protocol	*2*	No medication administered	*3*	Comfort/Supportive measures given

Nurse's Initial's and Signature:								

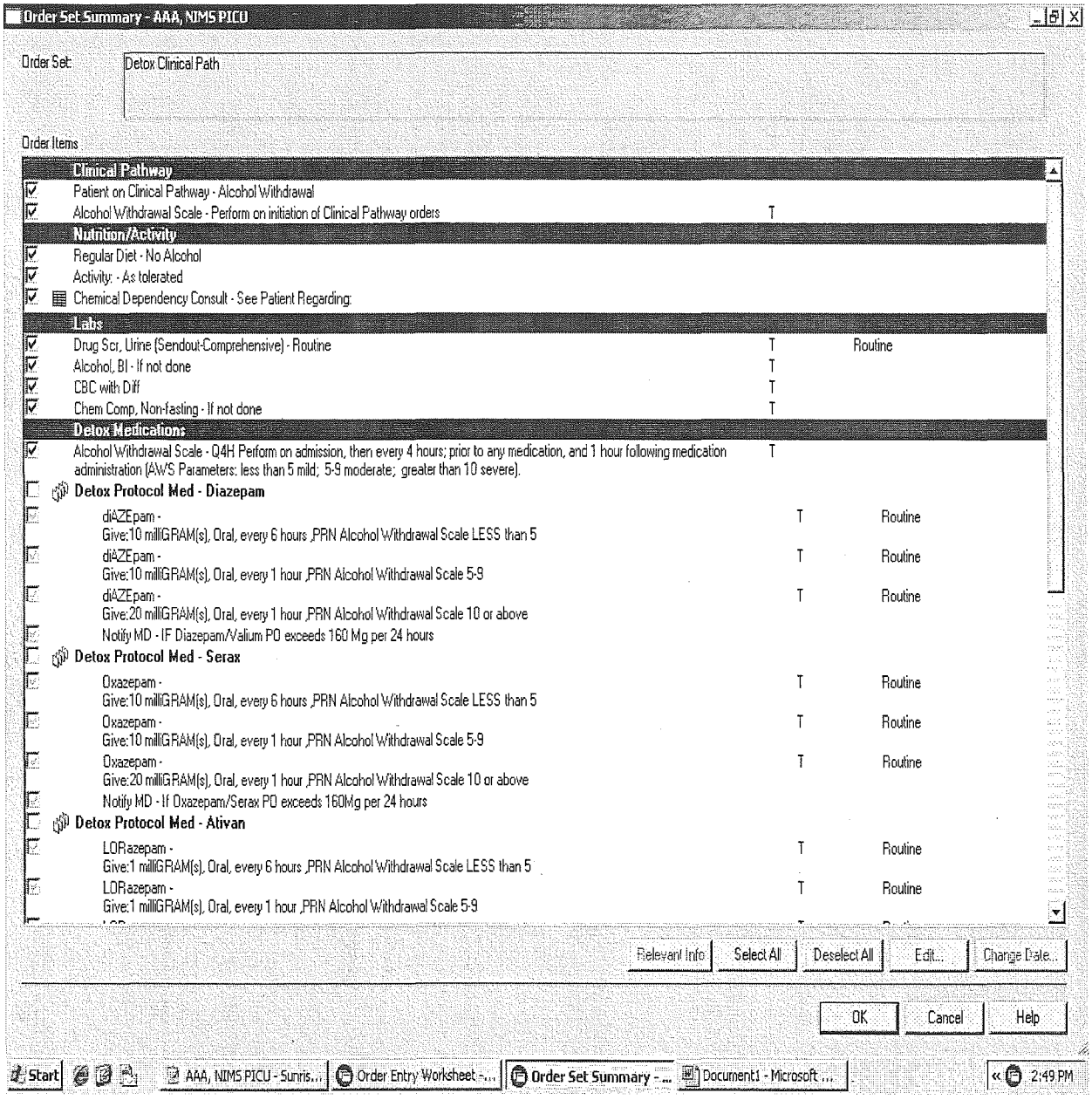
ECHO FLOWSHEET

FOR ALCOHOL WITHDRAWAL



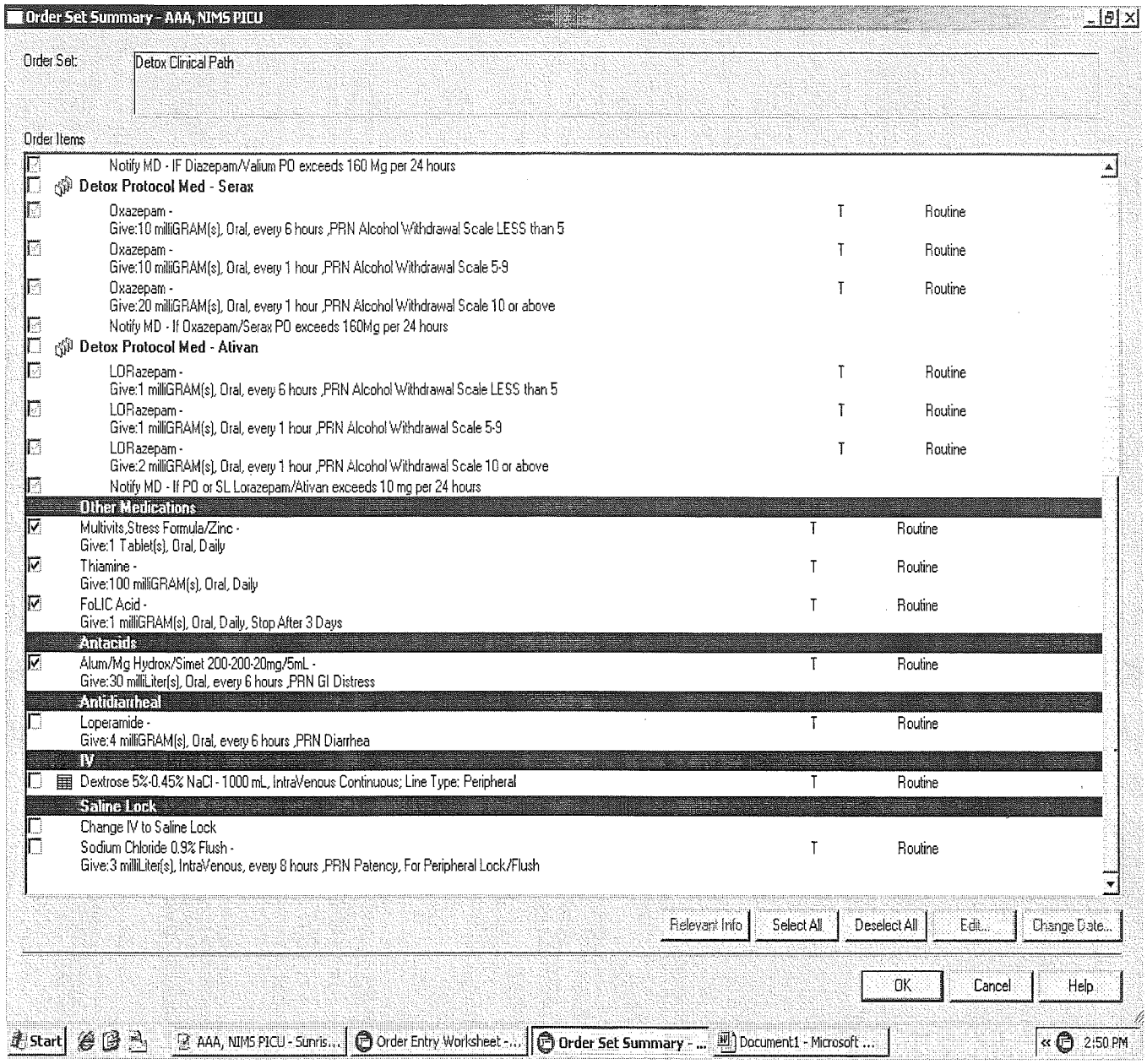
ECHO DETOX CLINICAL PATH

FOR ALCOHOL WITHDRAWAL



ECHO DETOX CLINICAL PATH

FOR ALCOHOL WITHDRAWAL



Oral versus Intravenous

Oral administration is the route of choice for the administration of benzodiazepines in the management of alcohol withdrawal symptoms. They are easier to administer and have a longer duration. For example: the duration of effect for IV Diazepam (Valium) is 15-60 minutes as compared to 3 to 8 hours for oral Diazepam.

> There is a high risk of respiratory depression with IV benzodiazepines. When IV Valium is used, the tendency is to sedate the patient to point of respiratory depression, potentially necessitating intubation. With the short duration of affect, the patient awakens (as with post anesthesia) with agitation and confusion, and may even become combative. This can result in more IV Valium being given and the patient may even need to be restrained. This is preventable if oral benzodiazepines are used. If a patient is on IV benzodiazepines, they are no longer following the Detox Clinical Path.

Other considerations

Frequent reassurance, checking in with the patient, providing comfort measures, and using a non-judgmental, supportive approach is key to a successful detox process.

If the patient is not in Delirium Tremens (DTs) and continues to have mild withdrawal symptoms or anxiety after 3 days, **stop using the detox pathway and AWS** and switch to low dose of benzodiazepine every 4 hours prn for another day. The patient can also be discharged with a low dose of benzodiazepine every 4 hours prn for 1 to 2 more days.

At least 50% of patients with mental illnesses also have substance dependence problems, and also comorbid medical problems (often untreated). Assess whether the patient may have an underlying psychiatric problem, such as depression, anxiety, symptoms of bipolar disorder (manic symptoms.), or schizophrenia, that may be factors in presenting symptoms, especially if somatic (objective) withdrawal symptoms (i.e. elevated vital signs and tremors).

Safe Detox Principles

- Use Alcohol Withdrawal Scale (AWS)
- Monitor Labs:
  - Blood Alcohol Level
  - CBC
  - Liver Panel
  - Serum Magnesium
  - Electrolytes
- Based on AWS score administer appropriate comfort/supportive measures and medications per clinical pathway or MD orders.
- Replace thiamine
  - Thiamine is given routinely to prevent Wernicke-Korsakoff Syndrome. This syndrome is a mixture of nerve and memory deficits such as confusion, ataxia, oculomotor problems, hypothermia and bradycardia. It should be given prior to infusion of IV glucose for best effect.

- Monitor for GI disturbances, tremors, seizures, depression, and electrolyte imbalances.
- In a patient who has no other obvious withdrawal symptoms obtain an order for Beta Blockers for continued tachycardia and /or hypertension.
- Obtain an order for Chemical Dependency (CD) consultation upon admission.

Things to keep in mind

1. It is helpful to determine if a patient has a **tolerance** to alcohol. We do this by a) inquiring about amounts of alcohol consumed; b) inquiring about patient's experience with cessation of alcohol and related withdrawal symptoms; c) referring to current blood alcohol level; d) interviewing family members; e) review of the chart

2. Refer to **Detox Clinical Pathway.**

3. Always remember to assess the **WHOLE** patient. Make interventions based on assessments of withdrawal including: vital signs, mentation, level of anxiety, tremors, diaphoresis, etc. Don't use just one piece of data.

4. Use the **Alcohol Withdrawal Scale (AWS)** to determine clinical intervention(s).

5. **Don't be afraid to medicate!** If a patient has a tolerance to alcohol he/she will require large amounts of benzodiazepines (BZDPs) to treat the withdrawal. If a patient is under medicated, withdrawal can progresses to DT's. DT's are associated with a 10-25% mortality rate.

6. Also keep in mind that **BZDPs can cause over sedation, agitation, and violence** when given intravenously. BZDPs, like alcohol can also cause disinhibition. All benzodiazepines may cause confusion in elderly patients.

7. Remember that alcohol withdrawal is a process. Early withdrawal symptoms are seen as early as 2 HOURS after the last drink. **Rather than "observing for DTs" observe for symptoms of withdrawal and intervene early.**

Glossary of Terms

Alcoholism:	Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortion in thinking, most notably denial.
Delirium Tremens (DT's)	Life threatening syndrome, characterized by extreme autonomic nervous system hyper-excitability, resulting from abrupt cessation of the drug alcohol.
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. 1. tolerance 2. withdrawal 3. the substance is often taken in larger amounts or over a longer period than was intended 4. there is a persistent desire or unsuccessful efforts to cutdown or control substance use 5. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects 6. important social, occupational, or recreational activities are given up or reduced because of substance use. 7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
Detox	Detoxification is the process of eliminating a drug from the body.
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: 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 3. recurrent substance related legal problems 4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
Tolerance:	Defined by either of the following: 1. a need for markedly increased amounts of the substance to achieve intoxication or desired effect 2. markedly diminished effect with continued use of the same amount of the substance.
Withdrawal:	Withdrawal is the constellation of symptoms that occur with the abrupt cessation of a drug.

Metabolism of Alcohol

Liver enzymes detoxify alcohol, oxidizing and eliminating approximately 1 standard drink* an hour, if the liver is healthy. The rate is constant regardless of the amount of alcohol ingested.

Metabolism of alcohol through oxidation:
Alcohol ⇒ Alcohol Dehydrogenase ⇒ Acetaldehyde ⇒ Acetaldehyde Dehydrogenase ⇒ Acetate

Blood Alcohol Level	Effects	Amount
0.05 (or BAL 50)	Changes in behavior, mood and judgment	2-3 standard drinks in an hour
0.10 (or BAL100)	Impaired voluntary motor activity, ataxic gait	4-5 standard drinks in an hour, the legal limit in most states- in CA 0.08 or 80
0.20 (or BAL 200)	The areas of the brain that govern intellect, reason, judgment and motor functioning are depressed, resulting in extreme motor impairment, loss of control of emotions, often leading to outbursts of emotions, such as anger, weeping, and impulsive behavior, which can include violent acts.	8-10 standard drinks an hour
0.30 (or BAL 300)	Stupor begins	Amounts vary depending on individual tolerance
0.40 (or BAL 400)+	Coma, respiratory arrest, possible death	Amounts vary depending on individual tolerance

*1 standard drink =12 oz. of beer = 5 oz. of wine = 1.5 oz. of hard alcohol

Establishing a Therapeutic Alliance
Use of Motivational Interviewing & Stages of Change Theory

Dilemma: How to engage patients in order to encourage them to talk about a subject-alcohol/drug use history that most people do not want to talk about?

Step into patients' shoes. Why might patients not be forthcoming regarding their history? What might they be afraid could happen if they were honest?
-Medical personnel could:
Report them to the police, probation, parole officers
Contact CPS, take their children
Treat them poorly while in the hospital, look down on them
Not medicate them adequately, especially with pain medications
Inform their family member/significant others of their use history
Others:

-Cultural stigma, and negative attitude, assumptions of moral and character defect
-Patient's own sense of shame, guilt, anger with self for not being able to control ETOH consumption

Motivational Interviewing (Miller & Rollnick):
Motivational interviewing is a non-confrontational communication technique that uses and empathetic and reflective listening style that ultimately results in the client (rather than the clinician) identifying concerns about their alcohol and drug use and expressing a desire to change their behavior. The techniques are conducive to brief interventions, which can be utilized effectively during an assessment interview and throughout the treatment process:
Principles:
-Readiness to change fluctuates based on motivation
-Incorporate Prochaska & DiClemente's Transtheoretical Model of **Stages of Change** integrated with Miller & Rollnick's **Motivational Interviewing** in order to help motivate people for change.
-People pass through predictable stages when changing an established behavior:

1) **Pre-contemplation**: Not thinking about changing behavior. May not even be aware that there is a problem or need to change their behavior. Traditionally referred to in chemical dependency treatment programs as "in denial". May be aware that there is a problem, but not interested in changing the behavior.
   Goal for clinician: Engage the patient in a therapeutic alliance and provide information/education. Raise doubt: increase the client's perception of risks and problems with current behavior. Help the patient to make informed decisions about behavior choices.
2) **Contemplation:** Acknowledges problem, and concerns about their behavior. Is considering the possibility of change, but is **ambivalent** and uncertain.
   Goal for clinician: Assist patient to look at pros and cons of behavior (It is important to acknowledge that there are pros and demonstrate an understanding of their ambivalence.) Tip the balance: elicit reasons to change, risks of not changing. Support patients sense of self-efficacy, that they can change their behavior.
3) **Determination and Preparation:** The patient is committed to and planning to make a change in their behavior in the near future, but is still considering what to do and how to go about change.

Goal for clinician: Assist the patient to determine the best plan of action to facilitate change. Help to create an Action Plan. Identify barriers to change, and develop strategies to address/overcome barriers.

4) **Action**: The client is actively changing their behavior, but has not reached a stable state. (Approx. 6 mos. of changed behavior)
   Goal for clinician: Assist patient in maintaining behavior change and address problems as they arise.
5) **Maintenance/Relapse Management**: The client has achieved initial goals, such as abstinence and is working to maintain behavior changes. If the patient experiences a reoccurrence of previous behavior symptoms or relapses, they reassess current action plan, make adjustments, determine what to do differently to maintain change.
   Goal for clinician: Assist the patient to renew the processes of contemplation, determination, and action, without becoming discouraged due to relapse. Renew sense of self-efficacy. Emphasize that relapse is an opportunity for learning, a time to make adjustments, rather than viewing it as failure.

Five Principles of Motivational Interviewing:

1) **Express empathy**. Key initial phase is engagement, establishment of a collaborative, therapeutic alliance. Enhance motivation for change through **empathetic non-judgmental** history gathering interwoven with education regarding effects of substance use linked with their symptoms, assessment findings, and medical complications. Explore pros and cons of use. Examine discrepancies between the patient's and others' perceptions of the problem behavior. Express concern and keep the door open. **Acceptance facilitates change**. Skillful reflective listening is a crucial part of expressing empathy. (Demonstrate that you understand things from their perspective. Example: It sounds like you really enjoy having a few drinks with friends after work, and if you did decide to stop drinking, that would be a big loss for you.) Remember that ambivalence regarding changing behavior is normal.
2) **Develop discrepancy between the patient's goals or values and their current behavior.** The "Columbo Approach" The client should present arguments for change. Acknowledge the pros or benefits of behavior (in this case drinking ETOH), as well as the cons or risks.
3) **Avoid arguments and direct confrontation.** "You can wrestle or you can dance." If the patient feels that they have to defend their behavior- defending breeds defensiveness. Resistance from the patient is a signal to the clinician to change the approach or dance step! Labeling, such as "alcoholic" is unnecessary.
4) **Adjust to client resistance rather than opposing it directly.** "Roll with resistance."
5) **Support self-efficacy.** Belief in the possibility of change is a powerful motivator. Reinforce positives in past behaviors/choices. The client is responsible for choosing to and for carrying out change. The clinician is a facilitator and guide.

Nursing Management of Alcohol Withdrawal
Self-Learning Module
POST TEST

NAME:_____ UNIT:_____ DATE:_____

1. Which of the following are suggestive of chronic alcohol use? (p. 5)
   a. Jaundice
   b. Interpersonal relationship difficulties
   c. Self-neglect
   d. Ecchymosis
   e. All of the above

2. Which of the following are the most critical questions to ask in the initial determination of alcohol withdrawal symptoms? *Choose all that apply.* (p. 4)
   a. When was your last drink?
   b. Do you have a family history of alcoholism?
   c. What is your drink of choice; liquor, beer, or wine?
   d. How long have you been drinking?
   e. Have you ever been arrested because of your alcohol use?

3. Select the lab values suggestive of chronic alcohol use: (p. 5)
   a. Elevated SGOT (AST)
   b. BAL ≥ 0.150 without intoxication
   c. Hypokalemia
   d. A & C
   e. All of the above

4. **TRUE OR FALSE:** because alcohol is a depressant, alcohol withdrawal is characterized by symptoms that are opposite to the effects of alcohol ingestion. (p. 3)

5. Which words correspond with the letters in the CAGE acronym? (p. 4)
   a. **C**ontoured use, **A**bsenteeism, **G**astritis, **E**levated B/P
   b. **C**ontrol, **A**lcoholics Anonymous, **G**ait Disturbance, **E**cchymosis
   c. **C**ut Down, **A**nnoyed, **G**uilty, **E**ye Opener

6. In patients with a history of chronic alcohol use, tolerance is defined as: (p. 18)
   a. The patient's acceptance of their dependency on alcohol
   b. The BAL at which the patient begins to show signs of intoxication
   c. A markedly diminished effect with continued use of the same amount of alcohol
   d. The number of hours the nurse can care for the patient
   e. None of the above

7. **TRUE OR FALSE:** symptoms of alcohol withdrawal may include grand mal seizures 12 to 24 hours after the patients last drink. (p. 6)

8. Based on the El Camino Hospital protocol, which of the following interventions **REQUIRE** a physician order? (p. 9)
    a. A chemical dependency consult
    b. Beta blockers for hypertension
    c. Oximetry if patient in respiratory distress or history of lung disease
    d. Administer vitamins
    e. All of the above

Case Scenario:

John Jones is a 36-year-old male with a 22-year history of heavy alcohol use. He has previously been through alcohol withdrawal and until very recently has been participating in Alcoholics Anonymous. During a recent trip to see his father, he experienced a traumatic event that precipitated a resumption of alcohol consumption. He has been admitted for alcohol withdrawal. On assessment you note his vital signs are: T=98.6 F, Respirations 18, Pulse 180, Blood Pressure 128/84. He is complaining of nausea and has a refused his breakfast tray. He is diaphoretic (forehead) and has hand and arm tremor both at rest and while reaching for his TV remote control. He appears uneasy, but is oriented X 4 and denies being anxious. He is not misinterpreting the environment and does not report seeing or hearing anything that is not in the environment.

9. What is his Alcohol Withdrawal Scale (AWS) score?_____ (p. 11)

10. His physician has initiated the Detox Clinical Pathway and selected Diazepam to manage the patient's alcohol withdrawal. Which of these selections is appropriate for his AWS score? (p. 10 or 13)
    a. Diazepam 10 mg tab, #1, PO Q6hr, prn Alcohol Withdrawal Scale <5
    b. Diazepam 10 mg tab, #1, PO, Q1hr, to q2h, prn Alcohol Withdrawal Scale 5-9
    c. Diazepam 10 mg, #2, PO, Q1hr, prn withdrawal scale 10 or above.
    d. Diazepam 10 mg, #1 PO, prn signs and symptoms of withdrawal
    e. Diazepam 10 mg, #1 PO, Q4hr, prn Alcohol Withdrawal Scale <5

11. List at least 4 potential signs or symptoms of alcohol withdrawal: (p. 6)
    a. _____
    b. _____
    c. _____
    d. _____

12. **TRUE OR FALSE:** A score of 10 or more on the AWS, shows that the patient's symptoms of alcohol withdrawal are well controlled and the patient does not to be medicated at this time. (p. 7)

13. **TRUE OR FALSE:** Somatic symptoms such as tachycardia, diaphoresis, and tremors are key indicators of alcohol withdrawal. (p. 7)

14. **TRUE OR FALSE:** Valium is a short-acting benzodiazepine, which is a good choice to patients with cirrhosis, due to it's lack of active metabolites, the liver does not metabolize it. It is also a good choice, if necessary to be administered IM, because it is lipophilic. (p. 7)

15. **TRUE OR FALSE:** Use of IV Valium is a good choice for use with alcohol withdrawal because of its long duration, providing a smoother withdrawal and consistent blood levels of benzodiazepine. (p. 16)

16. **TRUE OR FALSE:** Risk of respiratory depression and arrest is high when using IV benzodiazepines, such as Valium and Ativan. (p. 16)

17. The nurse caring for a patient who is withdrawing from alcohol should monitor the patient using the AWS at least every _____ hour(s), prior to administering a benzodiazepine and _____ hour(s) after administering a benzodiazepine. The dose of benzodiazepine given is based on the total _____. (p. 7)

18. Two potential medical complications of chronic alcohol use are: (p. 5)
    a. _____
    b. _____

19. **TRUE OR FALSE:** Thiamine should be administered 100 mg IV or IM prior to giving glucose-containing fluids or given as a prophylaxis to prevent development of Wernicke's encephalopathy. (p. 8)

20. **TRUE OR FALSE:** It is important to confront the patient with their obvious behavior problem in order to help break through denial regarding being an alcoholic (p. 21)

☺ Congratulations you have completed this module.

KEEP YOUR POST TEST FOR FUTURE REFERENCE

CNS DEPRESSANTS
SEDATIVE-HYPNOTICS

USED TO TREAT ANXIETY AND INSOMNIA HISTORICALLY

MAJOR AND MINOR TRANQUILIZERS

1. PHENOTHIAZINES
2. BENZODIAZEPINES
   LIBRIUM, VALIUM,
   XANAX, ATIVAN

ALCOHOL

BARBITURATES

1. PHENOBARBITAL, SECONAL, NEMBUTAL, AMYTAL
2. QUAALUDES (SYNTHETIC SUBSTITUTE FOR BARBITAL)

OPIATES

NARCOTICS/ANALGESICS

ANY DRUG THAT PRODUCES SLEEP, LETHARGY AND THE RELIEF OF PAIN

OPIATES =OPIUM AND ITS PRODUCTS
(Morphine, Codeine)
OPIOIDS = SYNTHETIC DERIVATIVES
(Dilaudid, heroin, metopon, hycodan)
SYNTHETIC OPIATE-LIKE DRUGS
(Demerol, Nisentil, Leritine, Alvodine, Lomotil, Dolophine, Levo-dromoran)
SYNTHETIC LOW POTENCY
(Darvon, Zactone, Talwin)
FENTANYL

CNS STIMULANTS

PSYCHOMOTOR STIMULANTS

1. COCAINE, AMPHETAMINE, NICOTINE, CAFFEINE, METHAMPHETAMINE, DEXTROAMPHETAMINE, METHYL-PHENIDATE

CONVULSANTS, & RESPIRATORY STIM.

1. DOXIPAN, NIKETHAMIDE

PSYCHOTOMIMETIC STIMULANTS

1. MARIJUANA, LSD, PCP

METHAMPHETAMINE ANALOGS

1. MDA, MDMA

PSYCHEDELICS
PSYCHOTOMIMETICS
HALLUCINOGENS

PSYCHEDELIC (MIND REVEALING)

PSYCHOTOMIMETIC (PRODUCING ALTERED REALITY PERCEPTION SIMILAR TO PSYCHOTIC SYMPTOMS)

RELATED TO:

SEROTONIN

1. LSD AND PSILOCYBIN

DOPAMINE/AMPHETAMINE

1. PEYOTE, MESCALINE, NUTMEG MDMA

PCP

MARIJUANA

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Disease Concept of Addiction

I. History of drug/alcohol use
- A. Use of drugs by early man and animals
- B. Types of drugs used
- C. Treatment of chemical dependency
  1. moral, legal, medical treatment
  2. 1955--AMA "votes" alcoholism a disease

II. Medical definition of addiction -- DSM IV criteria
- A. Continued, compulsive use of a chemical in spite of adverse consequences in any area of the person's life
- B. Characteristics of addiction
  1. preoccupation with the chemical
  2. loss of control
  3. increased tolerance
  4. progression of symptoms--life deterioration
  5. tendency to relapse
- C. Elements of the disease
  1. progression
  2. chronic
  3. potentially fatal
  4. identifiable symptoms
  5. life deterioration
- D. Signs and Symptoms of Alcoholism (Jellinick Curve)

III. Research Regarding Addiction
- A. Brain Chemistry
- B. Tolerance versus dependence
- C. Adoption studies (Cloniger)
- D. Adult-children-of-alcoholics studies (Marc Schuckit, MD)

IV. Theories of addiction

A. Stanley Gitlow 1-2-3 model

B. THIQ (Virginia Davis, MD)

C. Cascade theory (Kenneth Blum)

D. Neurotransmitter deficiency (Avrum Goldstein, MD)

V. Use of neurotransmitter information in treatment options

A. See handout

B. 12-step groups

Diagnotic criteria used to distinguish between non pathological substance use and substance abuse include:

1. a pattern of pathological drug abuse manifested by intoxication throughout the day

2. inability to reduce intake or stop use

3. repeated attempts to control use w/ periods of abstinence or restriction of use to certain times of the day

4. continuation of substance abuse despite a serious physical disorder aggravated by the use of the substance

5. the need for regular use of the substance for adequate functioning .

6. an episode of complication as a result of intoxication (such as alcoholic blackout or opiate overdose)

The inability and reluctance to accept chemical dependency as a disease stems principally from the uniqueness, lack of information and ignorance concerning the illness.

ALCOHOLISM

* PROGRESSIVE
* CHRONIC
* POTENTIALLY FATAL
* IDENTIFIABLE SYMPTOMS
* LIFE DETERIORATION
* UNKNOWN CAUSE

* PREOCCUPATION WITH THE CHEMICAL
* LOSS OF CONTROL
* INCREASED TOLERANCE
* PROGRESSION OF SYMPTOMS
* TENDENCY TO RELAPSE

ALCOHOLISM

One of the first things we want you to understand is that alcoholism is a disease. What we mean by that is that it is:

1. **Progressive:** It is a disease which is not going to magically disappear. It is a disease which has a known and predictable course. The disease will continue to worsen unless the addicted person is intervened with and given professional help.

2. **Chronic:** It cannot be cured. It can be successfully treated and arrested. This person can live a very happy, healthy life as long as he does not return to alcohol use.

3. **Potentially fatal:** An alcoholic will die 12 to 15 years sooner than a non-alcoholic person. The suicide and accident rates of those addicted to alcohol are very high. The medical and mental deterioration also reduces the life span and quality of life for the alcoholic.

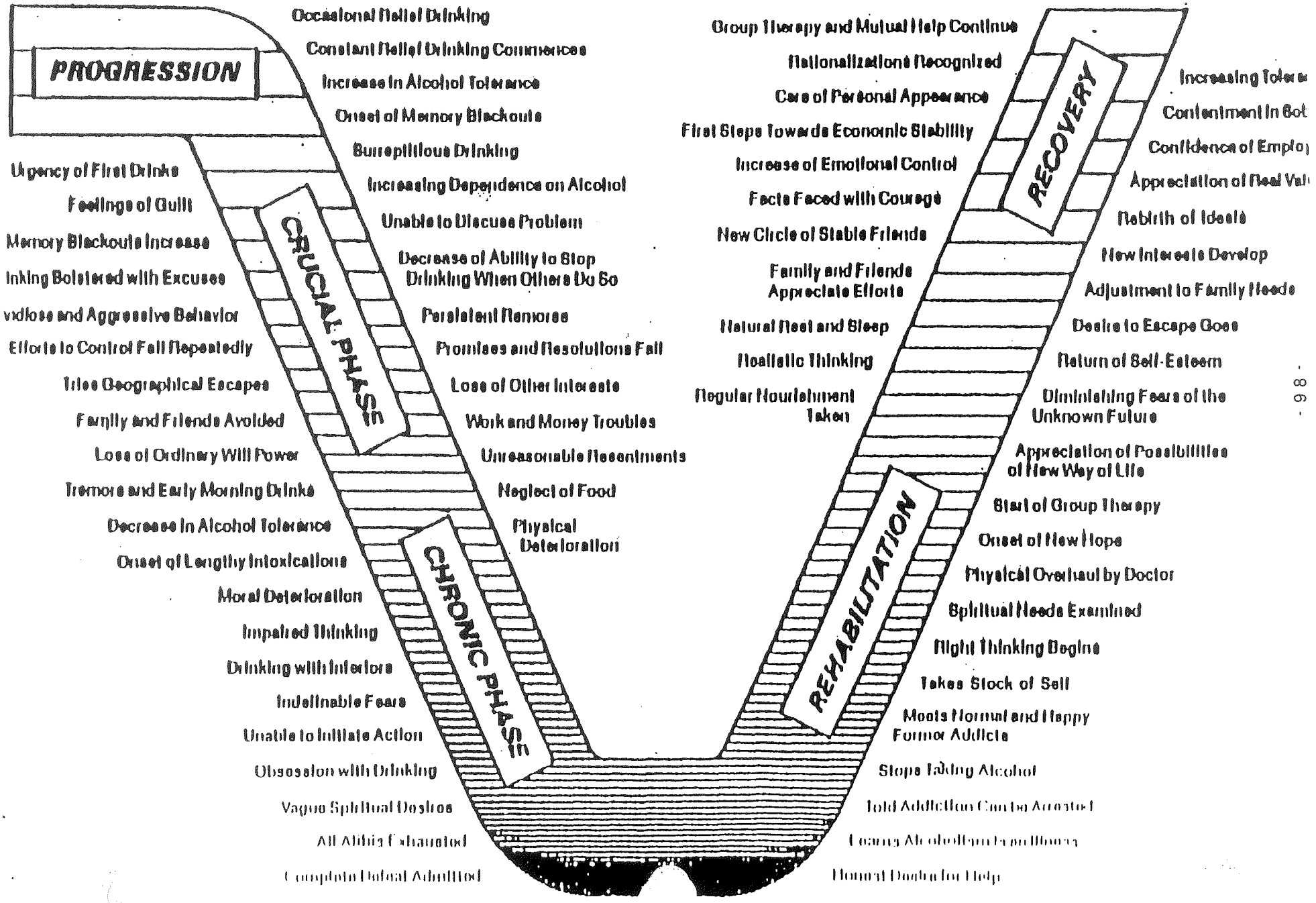
4. **Identifiable symptoms:** Alcoholics exhibit symptoms which are part of the disease. These symptoms include blackouts (chemically-induced memory losses), changes in alcohol/drug tolerance, loss of control (inability to stop and/or limit chemical consumption), denial (refusal to admit that alcohol use is a problem), preoccupation with alcohol (alcohol becomes the most important part of life), withdrawal symptoms (tremors, hallucinations, sweating), mood swings, behavior changes and poor eating and sleeping habits.

5. **Life deterioration:** Alcohol injures the person economically, socially, physically, psychologically and spiritually. His relationships break down, work performance is impaired, depression occurs often and his behavior goes against his values.

6. **Unknown cause:** Alcoholism has no known cause, but is probably a combination of a number of factors. Some people seem to be physically allergic to alcohol or genetically endowed with a tendency to become chemically addicted. Some people seem to learn to become addicted by using alcohol to reduce stress, handle emotions or to simply escape from reality. The cause is not important. What is important, is that the disease can be successfully treated.

THE PROGRESSION AND RECOVERY OF THE CHEMICALLY DEPENDENT

To be read from left to right.

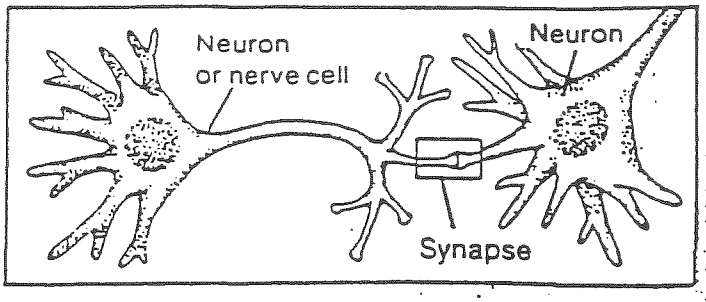


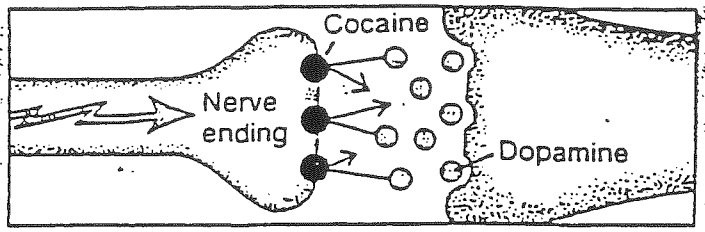
BLOCKING NORMAL RESTRAINTS

Cocaine, in effect, prevents the brain from calming itself down.

Normally, in response to certain external stimuli, specific neurons release a chemical called dopamine that helps trigger good feelings, or euphoria. The dopamine enters the junction, or synapse, between the first neuron and its neighbor. It stimulates the neighboring cells and thereby acts as a messenger (or neurotransmitter), sending information along so-called dopamine pathways.

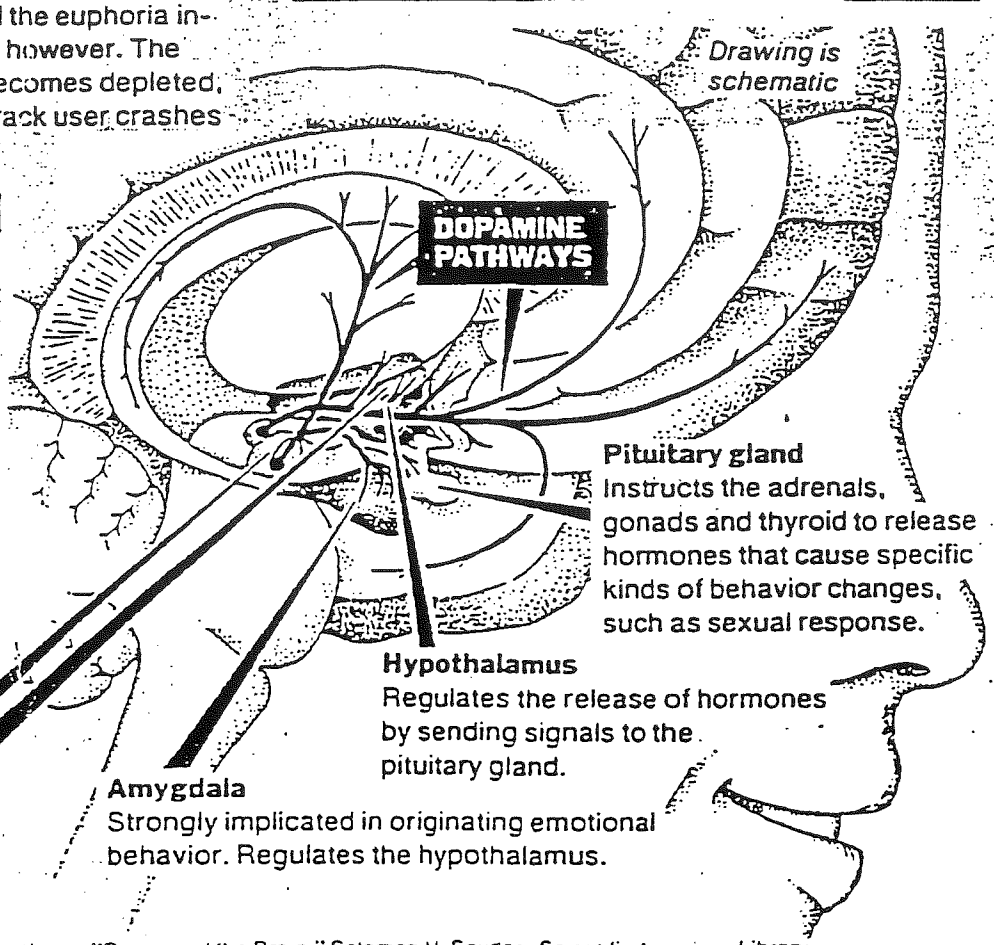
Normally, the dopamine is then reabsorbed by the sending neuron. But cocaine somehow blocks the reabsorption. The neighboring nerves thus become overexcited and the euphoria intensifies greatly. Not for long, however. The brain's supply of dopamine becomes depleted, and once that happens, the crack user crashes into profound depression.





PATHWAY TO EUPHORIA

One dopamine pathway goes through the major emotional centers of the brain, in the limbic system. When crack brings about an oversupply of dopamine, these centers are rapidly overstimulated and many changes occur: Heartbeat quickens, the stomach churns, sexual desire is enhanced, mood is greatly elevated.



CENTERS OF STIMULATION

Ventral tegmental area
Nucleus accumbens
Thought to be learning and reinforcing centers. An animal will repeat an activity that stimulates these areas.

Pituitary gland
Instructs the adrenals, gonads and thyroid to release hormones that cause specific kinds of behavior changes, such as sexual response.

Hypothalamus
Regulates the release of hormones by sending signals to the pituitary gland.

Amygdala
Strongly implicated in originating emotional behavior. Regulates the hypothalamus.

Sources: National Institute of Drug Abuse; "Drugs and the Brain," Solomon H. Snyder, Scientific American Library.

The New York Times/Patricia J. Wynne/Aug. 24, 1989

POST-TEST

1. Symptoms of chemical dependency include:

   a. preoccupation with the drug
   b. increasing tolerance
   c. tendency towards relapse
   d. all of the above

2. Blackouts are an early sign of alcoholism True or False

EVALUATION

	POOR				EXCELL
To what extent did this course meet your expectations?	1	2	3	4	5
Were the course objectives met?	1	2	3	4	5
Your overall impression of the speaker	1	2	3	4	5
How was the environment?	1	2	3	4	5

Comments appreciated

CHEMICAL DEPENDENCY SEMINARS

OBJECTIVES

At the completion of this seminar, the participant will be able to:

1. Discuss the signs and symptoms of the addict and alcoholic health professiona
2. Describe the components of the Johnsonian intervention
3. Discuss their personal attitudes towards addicted health professionals

WE CARE

For Chemical Dependent Health Professionals

Sharon Lutman, RN, Facilitator

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(408) 235-1178

We Care

for

Chemically Dependent Health Professionals

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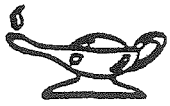

WE CARE

for

Chemically Dependent Health Professionals

Christ The Good Shepherd Church
Meridian and Alma Sts
San Jose, CA

Meetings:
Mon. 10:00-11:30
Thurs. 5:30-7:30

CHEMICAL DEPENDENCY IN THE HEALTH PROFESSIONAL

A. SCOPE OF THE PROBLEM

1. Physicians have a rate of addiction to prescription narcotics that is 4-35 times higher than the general population (depending on survey)
2. An estimated ten percent of California nurses are alcoholic, and two to three percent are addicted to another substance
3. The National Council of State Boards of Nursing Inc.: Of 971 disciplinary proceedings from 9/80-8/81, 649 (67%) were related to use of chemicals
4. Survey by Bay Area Task Force of San Francisco Coroner's Office in 1982: One nurse a month was dying from drug/alcohol related causes
5. The rate of addiction among anesthesiologists is so high that addiction is considered an occupational hazard:
   - Of 137 anesthesiologists identified with a problem, 37 had died as a result of addiction
   - Although they make up only four percent of all physicians, anesthesiologists represent thirteen percent of physicians treated for addiction
   - Of 125 anesthesiologists treated for addiction, 105 were addicted to fentanyl
6. The age at which physicians become addicted has dropped from 54 years in 1976 to 38 years in 1985 and is still falling

B. FACTORS IN HEALTH CARE WHICH INCREASE THE RISK OF CHEMICAL DEPENDENCY

1. Needing caretakers
2. Sacrifice of family time
3. Abnormal working hours
4. Hard physical work
5. Difficult mental work
6. Illusion of being in control
7. Little emotional support
8. High stress levels
9. A need for constant updating of skills
10. Little recognition given
11. Working with difficult patients

C. FACTORS WHICH THE HEALTH PROFESSIONAL BRINGS INTO THE PROFESSION THAT INCREASE THE RISK OF CHEMICAL DEPENDENCY

1. Many of us are children of alcoholics
2. Type of person who places others' needs before his/her own
3. Eighteen percent of health professionals are heavy drinkers
4. Spouse commonly alcoholic
5. Employed women as a group have a higher rate of alcoholism

Addiction is a disease with a genetic predisposition that manifests itself in a conducive environment

D. ATTITUDES WITHIN OUR PROFESSION THAT ARE BARRIERS TO RECOGNIZING A PROBLEM

1. Health professionals are givers of care, not receivers
2. Health professionals as proper health role model
3. Health professions are perfectionists
4. Florence Nightingale/fallen angel syndrome
5. Knowledge of pharmacology
6. Acceptance on some level with the profession of self-diagnosis, self-prescribing and self-medicating
7. Double standard in attitudes toward alcohol abuse vs. drug abuse

E. DENIAL AND THE PROBLEM

1. All health professionals must learn to employ denial or self-deception in order to work with the sick and dying
   - They learn to tell themselves they're not tired when they haven't slept enough
   - They harden themselves against the cries of patients undergoing painful procedures
   - They put aside personal problems when they walk into the hospital and they try to put aside the hospital problems when they go home
2. The same technique, used unconsciously, allows them to deny their own painful addiction
3. The denial is also compounded by the denial of family, friends, and co-workers who are fearful or ashamed of the problem
4. Even after allowance is made for denial and enabling behavior, reactions like ignoring or "helping" the addicted professional at work speaks volumes about the profession's ignorance of addiction

F. PARADOX OF OPIATES

1. Accounts for the high functioning of addicted professionals as compared to alcohol abusers
2. Unlike alcohol, narcotics can leave the addict apparently clear-headed and steady and generally cause no organic damage (most narcotic-related diseases and deaths are caused by overdose, or secondary problems like malnutrition, of infectious from "dirty" drugs or needles)
3. "Taking narcotics would be physiologically harmless as eating bran if it weren't for the user's rising tolerance - the steady increase in the amount he needs to get high." - C.F.Ward, Chairman, Society of Anesthesiologists, Committee for Impaired Physicians.
4. Not to say they are functioning at their best, but health professionals are overcome not by the drugs, but by the effort to get the ever-increasing amount of drugs they need

G. PROFILE OF NURSES WHO ARE CHEMICALLY DEPENDENT

1. Study by LeClair Bissell, M.D. of 100 alcoholic nurses
   - Most were in top third of their graduating class
   - Most held advanced degrees
   - They held demanding and responsible jobs
   - They were highly respected for excellent work
   - They were ambitious and achievement-oriented
   - Normally started using drugs legally - usually as some form of self-medication
   - Used drugs in private
   - Tended to use legal medication rather than street drugs - obtained from legitimate sources as long as possible
2. Study by Bay Area Task Force of addicted nurses
   - Age disease manifested - 40 years
   - Had been using five years before identification
   - 75% smoked
   - 100% had previous surgery with subsequent use of pain medication
   - 65% were addicted to alcohol alone
   - 17% were addicted to narcotics AND alcohol
   - 21% were addicted to non-narcotics and alcohol
   - 13% were addicted to all three
   - 53% had sought psyciatric help
   - 34% had sought clergical help
   - 13% had sought help from physicians
   - None had turned to other nurses for help
   - 73% had not used drugs until they became nurses

H. ATTITUDES WITH THE HEALTH PROFESSION THAT ARE BARRIERS TO REACHING FOR HELP

1. Health profession as a whole very judgmental
2. Health profession has the idea that knowledge can "fix" the problem
3. Fear of problems with the license
4. Acknowledging the problem is admitting loss of control

I. IDENTIFICATION

1. Signs and symptoms of alcoholic nurse - see handout
2. Signs and symptoms of drug-dependent nurse - see handout

J. PROGRAMS DESIGNED TO RETURN THE IMPAIRED PROFESSIONAL TO HEALTHY RECOVERY

1. Diversion Program, in California (nurses, physicians)
2. Nurse and physician support groups

K. RECOVERY OF THE HEALTH PROFESSIONAL

1. First year stress-filled; physically, emotionally, financially
2. Half have legal problems or problems with their license
3. Healing occurs around professional identify
4. Begin to learn tools of recovery to handle stress previously handled with drugs
5. Financial stability returns
6. Health improves with knowledge of proper diet, rest, exercise, etc.
7. Acknowledge reality of possibility of relapse and need for ongoing recovery program
8. Return to work
   - Six months off recommended
   - Return-to-work contract
   - Recognition that functioning well at work may actually be a danger sign, in that it sets the stage for denial again
9. Objectives of recovery groups
   - Decrease physical and mental impairment due to chemical dependency
   - Promote understanding of the disease
   - Peer support and appropriate confrontation of old patterns
   - Refer the impaired professional to appropriate recovery facilities
   - Promote and develop other support groups
   - Educate and train professions in recognition of chemical dependency
10. Statistically health professionals in recovery with access to support groups have a greater than fifty percent success rate

The health profession should no longer be an army that shoots its wounded

WE CARE
FOR CHEMICALLY DEPENDENT HEALTH PROFESSIONALS
A NON-PROFIT CORPORATION

SIGNS AND SYMPTOMS OF THE DRUG ADDICTED NURSE

1. Suspicious behavior concerning controlled drugs:

   a. Consistently signs out more controlled drugs than anyone else.
   b. Consistently volunteers to be Med nurse.
   c. Purposely waits until alone to open narcotics cabinet.
   d. Frequently breaks or spills drugs.
   e. Discrepancies between her patients' reports and other patients' reports on effective pain medications.
   f. Vials appear altered.
   g. Incorrect narcotic count involving this nurse.
   h. Disappears into bathroom directly after being in narcotics cabinet.
   i. Defensive when questioned about medical errors.

2. Wears long sleeves all the time.

3. Too many medication errors.

4. Too many controlled drugs broken or spilled.

5. Extreme and rapid mood swings: irritable with patients, then calm after taking drugs.

6. Illogical or sloppy charting.

7. Comes to work early and stays late for no reason; hangs around unit.

8. Frequently absent from unit during shift.

9. Uses sick leave lavishly.

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FOR CHEMICALLY DEPENDENT HEALTH PROFESSIONALS
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SIGNS AND SYMPTOMS OF THE ALCOHOLIC NURSE

1. Isolated; wants to work night shifts; lunches alone; avoids informal staff get-togethers.

2. More irritable with patients and colleagues; withdrawn; mood swings.

3. Difficulty meeting schedules and deadlines.

4. Elaborate excuses for behavior such as being late for work.

5. Increasingly absent from duty with inadequate explanations; long lunch hours; sick leave after days off.

6. Calls in to request compensatory time at the beginning of shift.

7. Job shrinkage; does minimal work necessary.

8. Illogical or sloppy charting.

9. Black-outs; complete memory loss for events, conversations, phone calls to colleagues; euphoric recall of events on the unit.

CLASSROOM ASSESSMENT
Chemically Dependent Health Professionals

(Please turn in today at end of class.)

The most surprising things I learned were . . .

What I still want to know is . . .

Rev. 3/23/11

Exam-2 Mini-Review
ALCOHOLISM

Theory	biological-medical model of disease
Definition	W.H.O.
(use Orem's Model) **Assessment**	
o **Universal**	o affects all physical systems (G.I., G.U., neuro, etc.) o poor self care o nutritional deficiencies o depression o suicide risk o potentially fatal D.T.'s
o **Developmental**	o low self-esteem o family role dysfunction
o **Health Deviation**	o Denial, Denial, Denial o relapse common
Nurses' Process Level	o Judgmental, Judgmental, Judgmental
Interventions	o intervention for treatment programs o protect from injury o nutritional support -- thiamin ????? o Detox protocol (please refer to handout)
Evaluation	o safe detox o long-term Rx program

Rev. 3/23/11

Exam-2 Mini-Review
OTHER DRUGS

Commonly-Abused Drug Categories	
o **Sedative-Hypnotic**	o benzodiazepines, barbiturates
o **Psychostimulants**	o amphetamines, cocaine, nicotine, caffeine
o **Psychotomimetics**	o PCP, LSD, cannabis
o **Narcotics**	o opium, heroin, morphine, codeine, demerol
Theory	o deficiency in neurotransmitters o disturbance in pituitary endorphins o socioeconomic
Assessment	
o **Universal**	o coma, seizures o respiratory arrest (narcotics) o cardiac arrest o cardiovascular collapse (cocaine) o respiratory arrest (PCP) o poor grooming / self care o danger to self / others o suicide risk
o **Developmental**	o family dysfunction o loss of job o educational deprivation
o **Health Deviation**	o relapse common o self-image grandiose
Nurses' Process Level	o judgmental o negative attitudes
Interventions	o education o treatment of physical complications o referral information o nutritional intervention
Evaluation	o long-term treatment program o ability to accept responsibility

RecoveryPath

Understanding Your Illness

Alcoholism and Drug Abuse

Over the last twenty years, there has been an increasing awareness in the public of the significance of alcohol and drug abuse and dependence in our society. Just about everyone knows someone whose life has been affected by the problem; some by his or her own uncontrolled use, others by the impact of the illness on a family member or friend. About 13 in 100 Americans become alcohol dependent during their lifetimes. For other drugs, including marijuana, cocaine, stimulants, PCP and others, the rate is 6 out of 100. Together, about 1 in 5 people become dependent at some point on alcohol or illicit drugs (these figures do not include caffeine and nicotine, two other highly addictive substances). The risks of medical illness, injury, and early death skyrocket in those who are affected. Clearly, addictive substances play a powerful, destructive role in our nation's life and health.

Symptoms

While there is some disagreement in the public about what is "abuse" or "dependence" versus "safe" use, the medical profession generally defines dependence on alcohol or drugs as:

- *A pattern of pathological, out-of-control use*, which may include: frequent intoxication; regularly using more than one planned; unsuccessful attempts to quit or cut down; lots of time spent in the preparation, use, and after-effects of use; and use in order to relieve the withdrawal effects of prior use

- *Physical signs and symptoms*, including *tolerance* (need for increasing amounts of the substance to achieve an effect), *withdrawal* symptoms as the effect of the substance wears off (a wide range of symptoms, specific to each substance), and long-term health effects

- *Continued use even in the setting of obvious negative effects on his or her health, relationships, and work functioning* - in effect, the drug being in control of the person's life.

RecoveryPath

Alcoholism and Drug Abuse

There is detailed, important information about each kind of drug available from our staff; just ask.

Causes

Like other psychiatric disorders, substance dependence tends to be impacted by multiple factors, best grouped into three areas:

- BIOLOGICAL: There is a powerful genetic influence on the development of Alcohol Dependence, with children of alcoholic parents being about FOUR times more likely to become alcoholic themselves (sons' risk being even higher than daughters'). Just how this genetic vulnerability translates into the behavior of uncontrolled alcohol use is not well defined, but likely involves altered sensitivity of nerve cells to the effects of alcohol at a neurochemical level. The evidence for genetic factors in other kinds of substance dependence is less solid.

- PSYCHOLOGICAL: Alcohol, cocaine and other psychoactive substances (that is, substances having an impact on mood, thought, and/or behavior) are often used to "self-medicate" uncomfortable emotions. For example, an anxious person may use alcohol to alleviate anxiety in social situations, and even come to believe that his or her "personality" in social situation is more acceptable to others under the influence than not. Fatigued, overworked, and/or depressed people may turn to cocaine or stimulants in an attempt to get a "jump start". The short-term relief from these maneuvers can lure the user into avoidance of dealing with the inevitable longer-term destructive effects of abuse. Sometimes the psychological issues involved are more complex, with substance abuse being one of many signs of the person's sense of dependency, inadequacy, or distorted need to punish himself or herself. Growing up in a childhood environment where one was exposed to substance abuse as a regular part of family life can have the distorted effect of "modeling" the destructive behavior as normal.

ENVIRONMENTAL: Stress in one's daily life will usually act as a trigger to an amplified emotional response, which can put pressure on the chemically dependent person's vulnerability to use and

relapse. Job stress, relationship or family conflict, and threatened losses of finanical or medical health are common triggers. Learning one's relapse "triggers" is an essential part of recovery.

The Effects of Substance Abuse on the Body

It is important to understand the potential damage that can be done to one's health, both short and long-term, by abuse of alcohol and drugs. Here's a partial list:

- General: Reduced life span; chronic poor sleep; poor judgment and impulse control, with higher risk of fatality and injury due to auto accident, weapons, assault, homicide

- Brain/Nervous System: Blackouts (periods of memory loss for events while under the influence); chronic depression; hallucinations; seizures; anxiety disorders; dementia (permanent, progressive loss of memory and reasoning ability); peripheral neuropathy (exquisitely intense pain of arms and/or legs, poorly relieved by medication)

- Heart and Lungs: Cardiomyopathy (enlarged, poorly functioning heart muscle); congestive heart failure

- Digestive: Gastritis, peptic ulcers, cirrhosis (irreversible scarring of the liver); *much higher* risk of cancers of the mouth, stomach, liver, and bowel; poor nutrition (poor diet as well as direct "poisoning" of the intestinal absorptive cells)

- Skin/Muscle/Bone: Muscle weakness; poor wound healing; poor clotting

Treatment

The first step in getting help is recognizing there is a problem. Sometimes the chemically dependent person sees it for him- or herself; in other cases loving family and friends intervene. Often it

only happens when the consequences of alcohol or drug use make daily living unmanageable. Losing one's job due to missed days or poor performance, legal problems like arrest for driving under the influence, and breakups of relationships are examples.

Once a need for treatment is clear, the treatment always begins with a crucial first step: getting "off" the alcohol or drug, known as *detoxification*. For chemically dependent people, "detox" is a medical procedure that should only be done under a doctor's supervision to limit or avoid the symptoms of withdrawal - some of which are serious and life-threatening. Psychiatric assessment is often neccessary to check for symptoms of underlying depression or other emotional problems.

Once the detox is complete, the next step in treatment is reinforcing *abstinence* - the complete stopping of use. For those who are chemically dependent, evidence shows that in the overwhelming majority of cases, attempts at "social" or recreational use of drugs or alcohol result in relapse. Clearly, the most effective part of treatment is going regularly to Alcoholics Anonymous (AA), or other "12-step" support group. Please ask our staff for more information specifically about AA, NA, CA, and other 12-step groups.

For those with significant dependency or a history of relapse, a period of intensive group therapy treatment is essential to help the patient through the critical first few months of learning to live without alcohol and/or drugs. This often starts with a full-day program (Chemical Dependency Partial Hospital Program, or "CD-PHP"), then graduation to a less intensive half-day program (Intensive Outpatient Program, or "CD-IOP"). In these programs, the treatment is focused specifically on learning how to stay "clean and sober". For those for whom abstinence is improbable at home, a period of treatment at a residential program may be most effective, or living for a time at a supervised sober living environment while getting intensive outpatient treatment.

Lastly: addiction is a life-long problem, and so its treatment should be ongoing, through full abstinence and support groups such as AA.

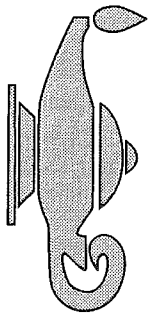
Our Mission

WE CARE For Chemically Dependent Health Professionals is a non-profit corporation established in 1981. Our mission is to provide group support for licensed health care professionals who are aspiring toward a dignified recovery from chemical dependency.

WE CARE

- Believes that chemical dependency is a treatable disease and that recovering professionals can return to a safe and competent level of practice.
- Is not an AA/NA group, however the cornerstone of WE CARE is the twelve-step program as a model of recovery.
- Provides weekly peer support groups facilitated by individuals experienced and knowledgeable in the treatment of chemical dependency, as it relates to the special needs of health care providers.
- Is not a therapy group, but we can offer support and referrals for vocational, legal, financial, medical and/or psychological issues as needed, as well as educational services to the health care community.

WE CARE



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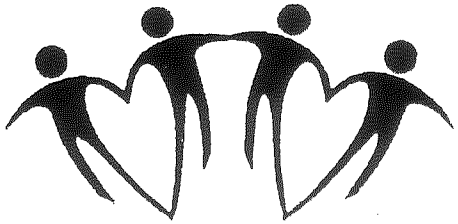


FOR CHEMICALLY DEPENDENT HEALTH PROFESSIONALS

A SUPPORT GROUP FOR RECOVERING HEALTH CARE PROFESSIONALS

WWW.WECARESUPPORTGROUP.ORG

Sarah's Story

The following story represents a typical health care professional who utilizes WE CARE. "Sarah" was fired from her job at a local hospital for diverting narcotics for her own use. She is not sure if the police are looking for her or whether she will lose her nursing license.

After joining the group it's clear that her level of shame is severe. She may even be at risk of suicide as the full implication of what has happened begins to sink in. Sarah sees the welcoming faces of others who understand what she is feeling and is surprised to hear each member tell of their own firings, arrests, fear and shame.

The group helps her put her life back together with referrals for medical, legal, or psychological treatment. They educate her about the nature of her disease. Over time Sarah begins to have hope as she watches others return to a safe, healthy practice as nurses, pharmacists, dental assistant, etc.

Eventually she can join the "alumni" of WE CARE who now work safely in the Bay Area and share their recovery with others in the health care community. Sarah returns not only to health, but to a level of healthy living that she may never have experienced before.

WWW.WECARESUPPORTGROUP.ORG

List of Services

- Answering service for individuals in crisis (408) 235-1178.
- Weekly peer support groups facilitated by individuals knowledgeable in chemical dependency.
- Educational programs and training.
- Consultation services.
- Assessment of needs and development of treatment plans for recovery.
- Assistance in planned interventions.
- Monitoring services for those State agencies that provide licensing of health care professionals.
- Development of re-entry contracts.
- Act as a resource to the State of California for the development of programs pertaining to the issues of the chemically dependent health professional.

WE CARE

Who We Are

WE CARE serves any health care professional licensed by the Board of Consumer Affairs (licenses need not be active) who wishes to pursue a sober lifestyle.

Support Groups
A safe supportive environment that meets on a weekly basis facilitated by health care professionals who have experience in chemical dependency recovery.

Meeting in San Jose.
Call for meeting times
and location.

No charge for group or assessments

Referrals
If you are referred to WE CARE, call 408-235-1178 for telephone assessment prior to your first group meeting.
www.wecaresupportgroup.org

Monitoring
W.C.C.D.H.P. is a confidential group. No person's attendance will be acknowledged without express written consent.

Non Profit Tax ID #77-0283887

408-2[illegible]1178

Exam-2 Mini-Review
ALCOHOLISM (CH-[redacted])

Theory	biological-medical model of disease
Definition	W.H.O.
Assessment (OREM)	
o **Universal**	o affects all physical systems (G.I., G.U., neuro, etc.) o poor self care o nutritional deficiencies o depression o suicide risk o potentially fatal D.T.'s
o **Developmental**	o low self-esteem o family role dysfunction
o **Health Deviation**	o Denial, Denial, Denial o relapse common
Nurses' Process Level	o Judgmental, Judgmental, Judgmental
Interventions	o intervention for treatment programs o protect from injury o nutritional support -- thiamin ????? o Detox protocol (please refer to handout)
Evaluation	o safe detox o long-term Rx program

Exam-2 Mini-Review
OTHER DRUGS (CH-)

Commonly-Abused Drug Categories	
o **Sedative-Hypnotic**	o benzodiazepines, barbiturates
o **Psychostimulants**	o amphetamines, cocaine, nicotine, caffeine
o **Psychotomimetics**	o PCP, LSD, cannabis
o **Narcotics**	o opium, heroin, morphine, codeine, demerol
Theory	o deficiency in neurotransmitters o disturbance in pituitary endorphins o socioeconomic
Assessment	
o **Universal**	o coma, seizures o respiratory arrest (narcotics) o cardiac arrest o cardiovascular collapse (cocaine) o respiratory arrest (PCP) o poor grooming / self care o danger to self / others o suicide risk
o **Developmental**	o family dysfunction o loss of job o educational deprivation
o **Health Deviation**	o relapse common o self-image grandiose
Nurses' Process Level	o judgmental o negative attitudes
Interventions	o education o treatment of physical complications o referral information o nutritional intervention
Evaluation	o long-term treatment program o ability to accept responsibility

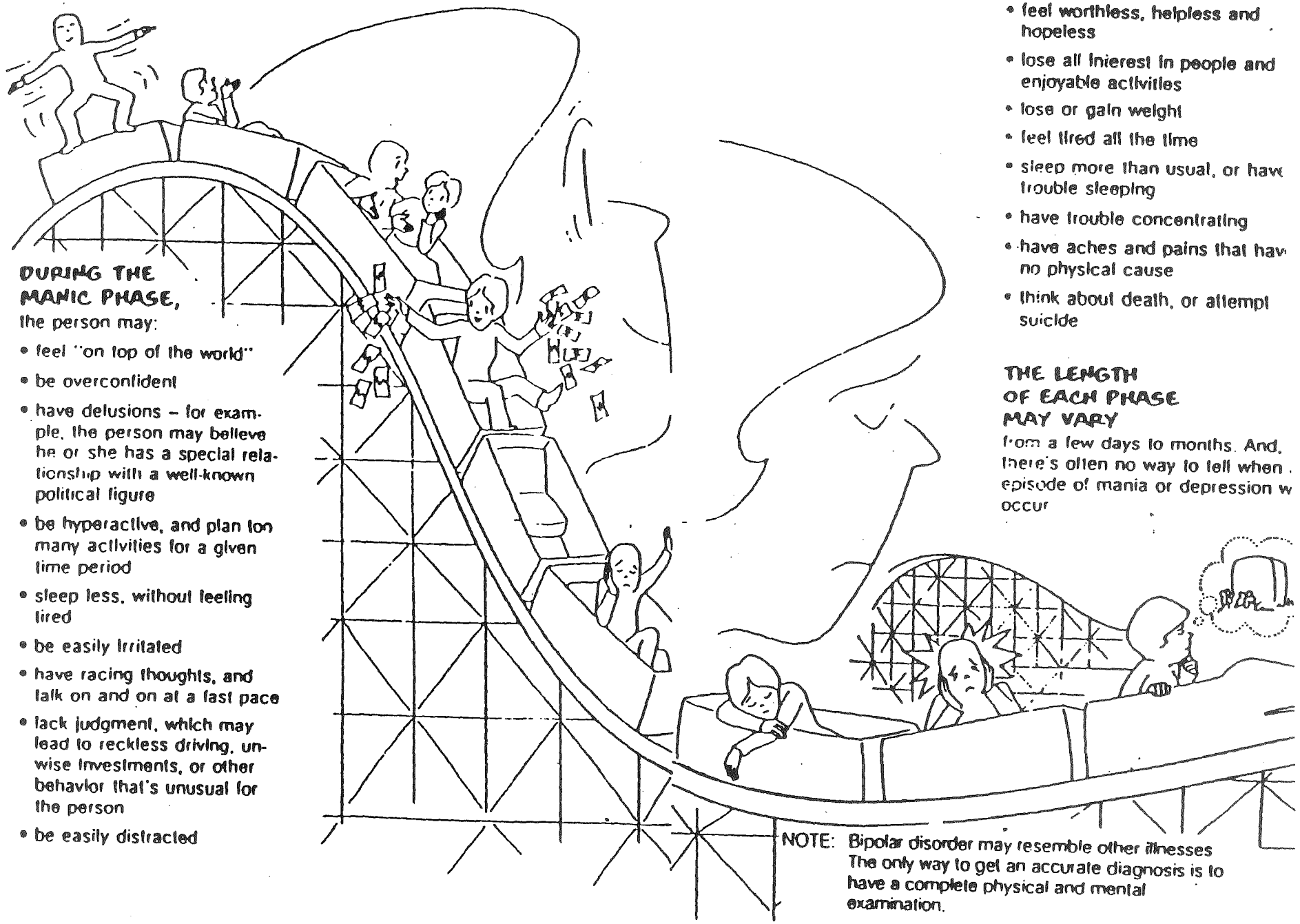
Mini-Review
BIPOLAR-AFFECTIVE DISORDER
MANIC STATE

Theory	o genetic predisposition o pathology of limbic system o definitions – mania, flight-of-ideas, etc.
Assessment (OREM) o **Universal**	o poor judgment o abnormally elevated mood with easily aroused irritability o possibly hallucinations & delusions o speech pressured & rapid o flight-of-ideas o dangerous level of physical activity o doesn't sleep o suicide risk
o **Developmental**	o family unable to cope o occupation at risk
o **Health Deviation**	o may enjoy elevated mood and not seek help o goes off medication
Nursing Diagnosis	o risk for injury o risk for violence to self or others o self care deficit o fluid volume deficit / altered nutrition o altered sleep patterns
Goals	o remains free from injury o will display nonviolent / nonprovoking behavior o will bathe and be well groomed o will wear appropriate clothing o will maintain good skin turpor o will sleep 6 hours within 24 hours

BIPOLAR-AFFECTIVE DISORDER
MANIC STATE (Continued)

Nurses' Process Level	o may get "caught up" in elevated mood o defensiveness against demands / criticism o helplessness o exasperation
Interventions	o decrease stimuli o protect patient from others o protect patient from embarrassment o protect patient from injury o monitor food / fluid o provide food to eat "on the run"
Medications	
o **Mood Stabilizers (Lithium Carbonate)**	o evens out highs and lows of mood o narrow window of therapeutic blood level (0.8 - 1.4 mEq/liter) o monitor for signs of toxicity (Varc. Table 21-5) (expected, early, advanced, late) o maintenance blood level = 0.4 - 1.0 o hold dose if level > 1.5 mEq/liter
o **Anticonvulsants**	o Tegretol (carbamezepine) o Valproic Acid
o **Antianxiety (Benzodiazepine)**	o Klonopin
o **Antipsychotic (Phenothiazine)**	o Thorazine (emergency use)
Evaluation	o mood o hydration / nutrition o bath & a.m. care o rest / sleep o understanding of illness & need for medication o knowledge of resources (e.g. support group)

People with bipolar disorder are on AN EMOTIONAL ROLLER COASTER.



DURING THE MANIC PHASE,

the person may:

- feel "on top of the world"
- be overconfident
- have delusions – for example, the person may believe he or she has a special relationship with a well-known political figure
- be hyperactive, and plan too many activities for a given time period
- sleep less, without feeling tired
- be easily irritated
- have racing thoughts, and talk on and on at a fast pace
- lack judgment, which may lead to reckless driving, unwise investments, or other behavior that's unusual for the person
- be easily distracted

DURING THE DEPRESSIVE PHASE,

the person may:

- feel worthless, helpless and hopeless
- lose all interest in people and enjoyable activities
- lose or gain weight
- feel tired all the time
- sleep more than usual, or have trouble sleeping
- have trouble concentrating
- have aches and pains that have no physical cause
- think about death, or attempt suicide

THE LENGTH OF EACH PHASE MAY VARY

from a few days to months. And, there's often no way to tell when an episode of mania or depression will occur

NOTE: Bipolar disorder may resemble other illnesses. The only way to get an accurate diagnosis is to have a complete physical and mental examination.

Week-5

Nursing 54K / Psychiatric
Instructor: Rebecca Sherwood

Name: _____
Date: _____

Critical Thinking Exercise
SPOUSAL ABUSE CLIENT

SCENARIO

During the morning report, you learn that a woman was admitted during the night with injuries from spousal abuse. Upon hearing this information, another staff member states "she's just going to go right back to him no matter what we say or do, so what's the point?"

EXERCISE

In response to the above scenario, write down your feelings and thoughts (without stopping or putting your pen down) for the next five minutes.

***** For more room, continue on back *****

SO WHY DO THEY STAY

Slapping, hair pulling, kicking, biting...battered women relate a litany of abuse experienced at the hand of our intimate partners. The results are bruises, broken bones, black eyes, internal injuries, sometimes death. Always broken hearts.

Yet, most battered women really do not want to leave their abusive partners. Many of the women who call shelter crisis lines tell the staff and volunteers that they just want the abuse to end. We hope for the fantasy TV endings like the lives of Claire and Heathcliff Huxtable or Ward and June Cleaver.

So why do we stay? When we are beaten by the person who has promised to love and cherish us, what makes us stay for the second and third beating? When I speak to community groups about domestic violence, I am nearly always asked the question. Often women in the audience would exclaim, "If my partner laid a hand on me, I would be out the door."

Imagine, for a moment, your own family. Would you really be able to walk out the door? Could you leave your home, neighborhood, and friends? Where would you go? Could you, your lively children, plus dog, stay at your brother's apartment, on his couch, for an indefinite period of time? What would his two roommates have to say about that? Could you stay with your parents who live in one of those adults-only condos?

I would not be surprised if the first time it happened you would help your partner rationalize why it happened. Your partner was (tired, stressed, angry, drinking, jealous, upset about losing a job or worried about expenses). Any excuse will fill the blank! YOU (made a mistake, came home late, disagreed with your partner, bought lunch at the mall...). Fill this blank with the reason your partner says you caused the abuse.

But abuse is not about reason. It is about power. It is about control of one's partner. And it works. The physical abuse is only the most obvious. It is reinforced by a whole spectrum of other kinds of abuse. We've already mentioned the excuses, the minimizing and blaming, saying it was her fault or it really wasn't that serious. Abuser isolate their victims and keep them from having friends or family around. They control what we do, who we see, what we read and where we go. Abusers abuse our psyche and emotions by calling us unprintable names, humiliating us, constantly criticizing us.

Abusers are intimidating. I know an abuser who left a single bullet on the kitchen counter! It takes only a look, a threat, to instill fear. Abusers are coercive, threatening to leave, forcing us to participate in illegal activities. Abusers make sure we have no money, keep us from getting a job, making us put our check into their account. Abusers treat their partners like servants, acting like "master of the castle", making all the important decisions.

Finally, abusers use the children by making us feel guilty about them, threatening to take children, using the children to relay messages to their mother.

Abuse works because many of us continue to pretend it does not happen to "good" women. So anyone who is abused must be "bad"! We blame the victim for her own abuse by calling her co-dependent. We expect her to prevent the abuse instead of asking why the abuser chooses to abuse. In short, we collude with the abuser.

Abusers succeed because they are not abusive all the time. In fact, sometimes they are fun and charming. They are almost always charming around other people.

Battered women stay because we are afraid. We are afraid no one will believe the truth. We fear we will lose our children. We are afraid we will have no where to go. We are fearful we will not be able to support the children. We are afraid we will be condemned by our church or family. We are terrified the abuser will hurt out friends or family. Ultimately, we fear we will be killed trying to leave.

All these fears are legitimate. Most battered women, killed by their abusers, have tried to leave. Some die in the process of leaving and many are killed trying to start over. The blood of millions of battered women is on the hands of friends and families, social workers, clergy, doctors, police, attorneys, judges and anyone else who has failed to believe them, failed to heed their pleas for help.

Maybe we should reverse the question, "so why does she stay" and ask, "so why does the abuser abuse?" With all the obstacles in our path the real question is, "How can we possibly leave?"

By L.O.

Effects of Domestic Violence

Effect of abuse on physical health

- A recent article in a medical journal found that **"the stress of being in an abusive relationship may cause the women to be more susceptible to disease** (Leibschultz, 2000)."
- Battered female victims identified depression, feelings of low self-esteem, helplessness, and **generally severe stress reactions coupled with somatic complaints** (Walker, 1979).
- **"The stress of being in an abusive relationship often has a physiological impact, as well as the obvious physical and psychological impact: it often increases one's vulnerability to illness** (Hagion-Rzepka, 2000)."

Effect of abuse on mental health

- **"Chronic abuse causes serious psychological harm. The tendency to blame the victim, however, has interfered with the psychological understanding and diagnosis of a post-traumatic syndrome.** Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology (Herman, 1992, p. 116)."
- **Panic disorders, phobias, anxieties and depression of abuse survivors is markedly different than ordinary phobias, anxieties and panic disorders** which are not based in fact or traumatic experience, as they are in abuse survivors (Herman, 1992).

Evidence of long-term effects

- A study comparing children of battered women and refugees of war found significant similarities including sadness, anger, confusion, and PTSD. The study concluded, **"these studies provide convincing evidence that the effects of violence exposure are not transient or temporary but may endure over many years** (Berman, 1999, p. 60)."
- These same effects have been observed in adult abuse victims as well as children (Raphael, 1998; Walker, 1979).
- Normal **recoveries may take months for victims** of crime (Bard & Sangrey, 1986).
- Some **survivors may develop extreme symptoms years later** in response to major life stressors (van der Kolk, 1987).
- One study found that rape victims experienced **consistently higher levels of fear and anxiety ...for as long as 16 years after the rape occurred.** (Ellis, Atkeson & Calhoun, 1981).

Specific long-term effects of domestic violence

- Long-term effects observed in adult victims of domestic violence include: **intense startle reactions, tension, nightmares, chronic fatigue, disturbed sleeping and eating patterns and medical symptoms** (van der Kolk, 1987; Davidson & Foa, 1991; Herman, 1992; Goodman, Koss, & Russo, 1993a; Koss, Goodman, Browne, Fitzgerald, Keita & Russo, 1994.)

- Some survivors remain passive, withdrawn, and continue to display apathy and symptoms of depression (Chapman, 1962; Peterson & Seligman, 1983).

- A survivor's ability to trust and to form emotional attachments is severely impacted by domestic violence (Dehart, 1996).

- A recent study of women who had been **victims of long-term emotional abuse identified PTSD symptoms, along with depression** and dissociative forms of coping (Raphael, 1998).

- **Domestic violence is strongly associated with depression, anxiety, somatization, attempted suicide**, and chemical abuse (Jaffe, Wolfe, Wilson, & Zak, 1986; Kemp, Rawlings, & Green, 1991). These mental health problems are directly attributable to the abuse (Roberts, Williams, Lawrence, & Raphael, 1998).

Effect on employability

- **Abuse frequently leads to self-doubt, depression, and confusion**, and may take several years to uncover and heal (Sackett & Saunders, 1999).

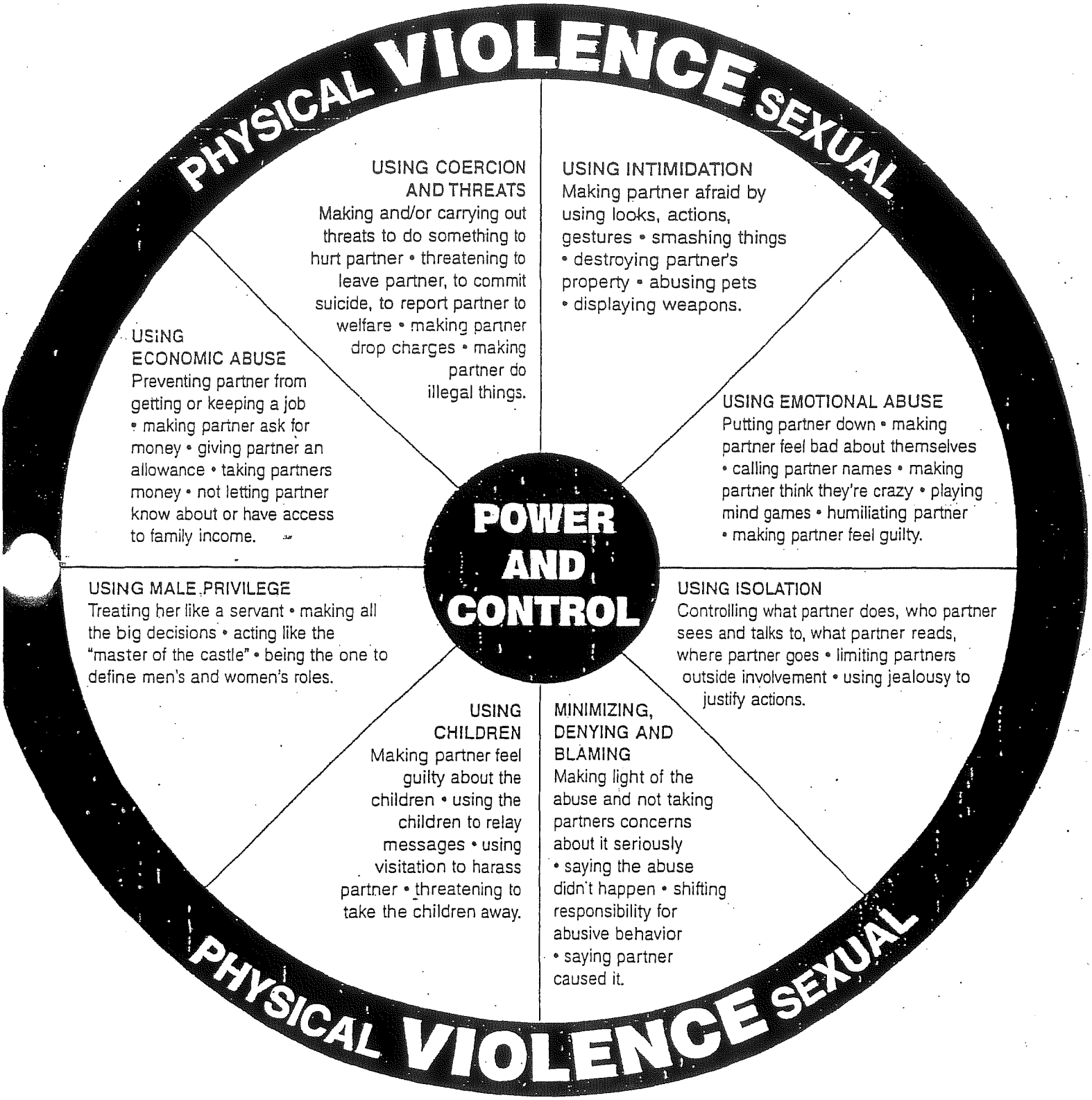
- "**Survivors of family violence often experience** difficulty in future relationships, which affects not only the stability of home and family, but also **professional relationships in the course of employment.**" (Hagion-Rzepka, 2000).

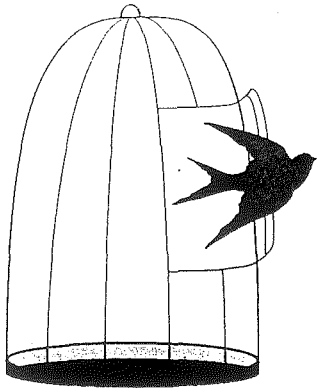
- The percentage of abused women reporting interference from their abusers with their efforts to obtain employment, education or training ranges from 15% to 50%. (LaViolette & Barnett, 2000).

Other economic consequences of abuse

- **Domestic violence is a major cause of homelessness**: a recent study in Santa Clara County found that 50% of homeless women and children were fleeing their abusive homes (Burstein & Woodsmall, 1987).

- The **majority of welfare recipients have experienced domestic violence** in their adult lives, and a high percentage are currently abused. (Taylor Institute, 1997).


PHYSICAL VIOLENCE SEXUAL
USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt partner • threatening to leave partner, to commit suicide, to report partner to welfare • making partner drop charges • making partner do illegal things.
USING INTIMIDATION
Making partner afraid by using looks, actions, gestures • smashing things • destroying partner's property • abusing pets • displaying weapons.
USING ECONOMIC ABUSE
Preventing partner from getting or keeping a job • making partner ask for money • giving partner an allowance • taking partners money • not letting partner know about or have access to family income.
USING EMOTIONAL ABUSE
Putting partner down • making partner feel bad about themselves • calling partner names • making partner think they're crazy • playing mind games • humiliating partner • making partner feel guilty.
POWER AND CONTROL
USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles.
USING ISOLATION
Controlling what partner does, who partner sees and talks to, what partner reads, where partner goes • limiting partners outside involvement • using jealousy to justify actions.
USING CHILDREN
Making partner feel guilty about the children • using the children to relay messages • using visitation to harass partner • threatening to take the children away.
MINIMIZING, DENYING AND BLAMING
Making light of the abuse and not taking partners concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behavior • saying partner caused it.
PHYSICAL VIOLENCE SEXUAL



WOMEN/SV

Women-of-Means Escape Network
Silicon Valley

www.womensv.org
womensv@losaltoscf.org
650.996.2200

Are you afraid of your partner?

Does he try to control you?

Are you afraid of losing everything if you leave?

Unhealthy relationships happen even in nice neighborhoods.

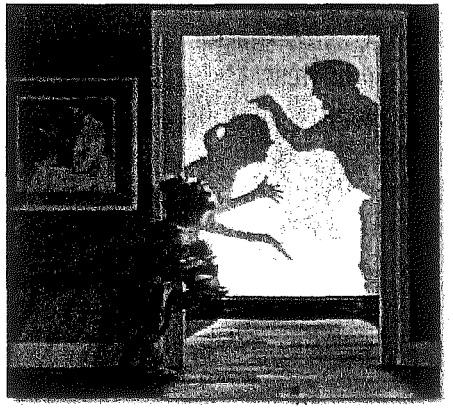
There is help.

All communication is confidential.

Abuse doesn't always leave bruises:

- ✓ Does your partner criticize you, isolate you, threaten you, humiliate you, call you names, swear at you, or undermine your self-esteem?
- ✓ Does your partner make you feel like everything is always your fault?
- ✓ Does your partner control all the assets?
- ✓ Does your partner have a "Jekyll and Hyde" personality: one face in public, another very different & threatening one behind closed doors?
- ✓ Does your partner threaten to "destroy you" or take everything, including the children, if you leave?
- ✓ Is your partner damaging your relationship with your children?
- ✓ Are you losing your confidence, self-esteem & joy in life?
- ✓ Are you worried about what your friends & neighbors would think if they knew the truth?

The scars left by emotional abuse can last a lifetime—for you and your children.



Safety first!

- If you plan to leave, **do <u>not</u> tell your partner**. Women are at more risk for harm when they decide to leave.
- Your phone and computer use can be monitored. Use a trusted friend's phone or disposable phone.

You are the best judge of when to leave.

Whatever your decision, with enough guidance and support, you can create a healthier life for yourself--and for your children.

LOS ALTOS COMMUNITY FOUNDATION est. 1991

A Program of the Los Altos Community Foundation

WOMEN/*SV* is a non-profit program sponsored by the Los Altos Community Foundation and by individual donations.

We offer information and resources to raise awareness about all forms of intimate partner abuse, including emotional and financial. And we build a strong network of support to help women deal with it more safely and effectively.

You don't have to suffer in silence anymore. You are entitled to safety, peace, and freedom in your home.
You don't deserve abuse.
It's not your fault.
There is a way out.
We can help you find it.

Contact WOMEN/*SV* today.

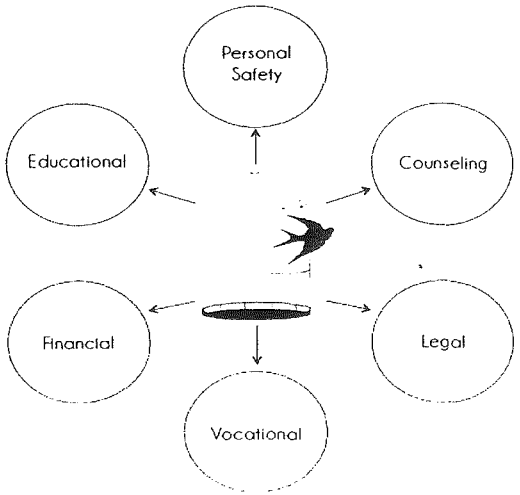
All communication is confidential.

Wherever you are in your journey to freedom—from dawning awareness to wanting to leave but not knowing who to ask or where to go—

WOMEN/*SV* can help.

An affluent abuser's power, money, influence, and technical expertise can make it hard to leave safely, get a fair settlement, keep custody of your children, and maintain your standard of living. We can connect you with resources related to:

- individual safety planning
- personal counseling for you & your children
- legal support to find an attorney familiar with all forms of domestic violence
- educational consults for children struggling in school
- vocational training & support
- financial counseling to help determine & manage your fair share of the assets



WOMEN/*SV* is the 2013 winner of the Santa Clara County Psychological Association's annual service award for its "dedication to improving the well-being of the community."

Congresswoman Anna Eshoo praises WOMEN/*SV*'s "dedication to this important issue," and says our "powerful work" is "bringing about positive change" and "making a positive impact in our community."

Sarah M., physician & survivor:

"I felt validated for the first time. I learned what healthy love looks like. It wasn't what I had. I realized I wasn't going crazy. I was being abused. Because of WOMEN/*SV*, I found the help I needed. I got my life back."

Your donations help women like Sarah--and their children--build safer, healthier lives.

You can donate online at **www.womensv.org** or by sending a check to:

Los Altos Community Foundation,
183 Hillview Ave.,
Los Altos, CA, 94022

*Note WOMEN/*SV* in the memo line.

ANXIETY DISORDERS
Mini-Review

Theory	<u>Biochemical</u> • high norepinephrine, low serotonin • low GABA activity, lactic acid <u>Neuroanatomical</u> • abnormalities in limbic system <u>Genetic</u> • familial inheritance <u>Psychosocial</u> • unconscious childhood conflicts • breakthrough of repressed thoughts • unmet needs in early childhood • learned from parents' anxiety • distortions in thinkings <u>Sociocultural</u> • values conflicts after immigration
Medical Diagnoses	• Panic Disorder (with or without agorophobia) • Phobias (Agorophobia, Social phobia, Specific phobia) • Obsessive Compulsive Disorder (OCD) • Generalized Anxiety Disorder (GAD) • Post Traumatic Stress Disorder (PTSD)
<u>Assessment</u> (OREM) o **Universal** o **Developmental**	 • sympathetic nervous system response • poor sleep • tiredness • depression • poor appetite due to fear of germs • constipation • suicide risk • poor coping ability • use of defense mechanisms • inability to complete ADL's • strain in relationships • role changes and reversals • interruption of developmental stages • poor job performance or unable to work • unable to leave house

Mini-Review
ANXIETY DISORDERS (Cont'd)

Assessment (cont'd) o **Health Deviation**	• seeks help for physical symptoms (e.g., tachycardia) • feel embarrassment or shame for phobias, compulsions, etc. (ego-dystonic) • low self-esteem
Nurse's Process Level (Nurses Feelings)	• feels the client's anxiety • frustration and irritation with client's rituals and slowness and extreme attention to detail • impatience due to the unrealistic nature of client's fears • may withdraw physically and emotionally from client • fatigue from necessity to repeat interventions over and over
Nursing Diagnoses	• Disturbance in self-esteem • Ineffective individual coping • Anxiety or Fear • Altered Family Process
Goals	• decrease anxiety to lower levels • use new, more effective coping mechanisms • decrease obsessive-compulsive behaviors • decrease in self-deprecatory statements
Interventions	• stay with client • maintain calm demeanor • walk with pacing client • encourage description of feelings • teach new coping strategies
Medications	• anxiolytics (benzodiazipines, BuSpar) • antidepressants (Anafranil, Luvox)
Evaluation	• Is anxiety level lower? • Does client recognize physical symptoms as anxiety related? • Have obsessions, compulsions, worry, etc. decreased? • Has self-care ability improved? • Have interpersonal relationships improved?

Exam-2 Mini-Review
EATING DISORDERS (CH-25)

Theory	Disturbance of separation-individuation stage of development, poorly developed defense mechanisms (self-deprecating), denial of basic needs and obsessive control over hunger -- results in biological disturbances.
Assessment OREM	
o **Universal**	o nutrition severely altered o electrolyte imbalances o impulsive behaviors o possible depression o isolate from others o suicide risk
o **Developmental**	o family dysfunction o interruptions in education
o **Health Deviation**	o low self-esteem o reluctant to seek help (shame or denial)
Nurses' Process Level	o emotional responses o counter transference
Interventions	o physiological stability with nutrition o antidepressants o group therapy o family therapy
Evaluation	o weight stability o more adaptive coping ability