Psychiatric Skills for

Non-Psych Nurses

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INTRODUCTION

As with all areas of health care, the field of psychiatry has changed significantly in recent years. An informed public understands psychiatric problems and accesses psychiatric care more than ever before; general hospitals provide psychiatric services and frequently at various levels of care; significant advances have been made in psychopharmacology and psychobiology. These examples just begin to describe recent and on-going advances in the psychiatric field.

Both specialized psychiatric nurses and nurses in other practice areas are impacted by such changes as they deliver patient care. In clinical practice today nurses are expected to recognize and understand the traditional and non-traditional uses of antidepressant medications; or to assist in differentiating delirium from dementia through astute clinical observation and documentation; or to provide support to the grieving families who have just lost a loved one.

For many nurses, the psychiatric experience provided in their nursing school curriculum was a brief and confusing introduction to a strange and complex specialty area. For some ambitious practicians included experience in inpatient psychiatry day treatment or out-patient settings, psychosomatic nursing alcohol and drug treatment and enlarged upon the student's understanding of the psychosocial aspects of care. Often, stressed and anxious students felt lucky to locate all the practice settings never mind to begin to integrate the skills and techniques demonstrated in the nursing process utilized by psychiatric nurses in the same familiar process employed in all nursing care settings and the basic psychiatric nursing skills of clear communication, empathetic listening and appropriate limit setting for example can be valuable in most practice areas. In fact many nurses encounter a "blurring" phenomena in practice settings, Psychiatric units desire psychiatric nurses who can competently start and monitor IV's, provide wound care and offer diabetic teaching while concurrently providing quality psychiatric care for the primary psychiatric diagnosis. Today's psychiatric unit, care for patients with multiple health care needs. This parallel challenge is experienced by nurses who must be alert to detect early signs of alcohol withdrawal in the post-op patient or to understand the implications of a secondary diagnosis of bipolar illness in a new MI patient.

This course, then, is designed to provide the non-psychiatric nurse with a relevant update of psychiatric knowledge skills and current practice. As all areas of health care provide services to higher acuity and more complex patients, nurses recognize a need to feel skilled and competent in providing care once considered outside their area of expertise. In "dusting off" such skills the nurse may find both patient care and job satisfaction is enhanced.

COURSE OBJECTIVES

UPON COMPLETION OF THIS COURSE THE NURSE WILL BE ABLE TO:

1. Articulate two challenges which changes in health status pose to the average adult.
2. Describe two possible coping mechanisms adults employ to cope with the stress of physical illness.
3. Describe the Diagnostic and Statistical Manual, 3rd Edition, Revised.
4. Discuss how the DSM III R can be used.
5. List the first two axis of the DSM III R multiaxial system.
6. Describe two common psychiatric diagnoses.
7. Define a crisis.
8. Give three examples of psychosocial crisis in a general care setting.
9. Discuss the grief process.
10. List two crisis intervention techniques useful in a hospital setting.
11. Name two significant factors to assess in determining suicidality.
12. Describe a “No Harm” contract.
13. List two steps to insure safety in a suicidal patient.
14. Briefly discuss the evolution of psychopharmacology.
15. List 3 major classifications of psychiatric medications.
16. Name the major side effects associated with the three classifications of psychiatric drugs named in #15.
17. List two medications used to diminish side effects of psychiatric medications.
18. Differentiate between first and second generation antidepressants.
19. List two possible areas of concern re: use of lithium.
20. List three signs of alcohol withdrawal.
21. Name two symptoms associated with the onset of alcohol withdrawal.
22. Describe an ideal drug to treat alcohol withdrawal.
23. Discuss two adjustments seniors must make to the aging process.

COURSE OBJECTIVES (continued)

24. Name the major psychiatric illness of the senior population.
25. Discuss two dangers of polypharmacy in the aging population
26. Describe three signs of delirium.
27. Describe 3 signs of dementia.
28. Discuss three strategies for dealing with confusion in the elderly.
29. Name two community resources which can provide information re: psychiatric conditions.
30. Describe how support groups can help family members.

REACTIONS TO ILLNESS IN THE HOSPITALIZED ADULT

Our own responses to physical illness provide us with some basic insight into the typical responses of our patients to an episode of ill health. Generally, we react negatively to the signs of even a minor illness. We may feel resentful, angry, disappointed, or frustrated. An illness never occurs when we can afford the time off to care for and nurture ourselves as would be optimal. Often an illness develops concurrent with pre-existing instances when we respond initially with acceptance, after a day or so in bed we resort to impatience with our bodies' betrayal. An illness provides a reminder that we are not in complete and ultimate control of our lives. Ill health may generate thoughts or feelings about our vulnerability, the unpredictability of life our on-going aging process or other related psychological or philosophical issued we generally avoid. If all this can be provoked by a run in with this seasons' flu, what is the experience of a hospitalized adult patient?

The coping tasks of the ill adult are varied and significant. Although each patient will, hopefully, not confront all of them, there are 8 major tasks facing the ill adult. All of these relate to 4 areas of basic human need as identified by Maslow: basic physiological needs; safety; love and belonging; and the need for self-esteem.

THE EIGHT COPING TASKS OF ILL ADULTS ARE:

1. Change in body image
2. Reality of their own mortality
3. Coping with altered relationships with others
4. Dealing with an altered level of dependency
5. Adjusting to physiological changes
6. Grieving for their losses (self or life style)
7. Fear of recurrent problems
8. Illness occurs with other stressors

The term "coping" deserves some discussion before moving on to the description of the tasks. Although a common term, it implies many meanings. In the broadest of interpretations, one may define coping as meeting the challenges and demands of life in a physiologically successful manner, More specifically coping may mean problem solving on an emotional, cognitive or motor level, separately or concurrently. Psychologically, coping usually means an individual's response to perceived threats to their internal emotional well being. Coping is usually a learned

response pattern to stressful events which the individual has developed though a trial and error process over their life span, As such, coping is a process rather than an event.

As most illness challenge an individual both physically and emotionally, coping with illness involves multi-levels of physical emotional activity. Think for a moment of your own bout with the flu – you are called upon to manage your physical symptoms, deal with your absence from work, problem-solve the difficulties your illness may present to your family members, cope with your emotional response to being ill and so forth. How much more complex is the challenge of coping with hospitalization?

In today's health care climate, hospitalization implies a seriousness that recalls the fears of previous generations when hospitals were viewed as a place people go to die. Today, people are hospitalized for acute illnesses. During their usual brief stay, ill adults are often confronted with a change in body image. This is obvious in surgical patients who suffer an incision and often removal of a body part. Even in non-surgical situations, however, most patients experience a change in their self-image as it relates to body image. In many cases, people cannot perform basic bodily functions unassisted. IV's, for example, replace drinking liquids or a catheter may replace the customary trip to the bathroom. Cardiac patients may experience their illness as having "something wrong" with the core of their physical being,. These are concrete illustrations of alterations in perception of body image. On a more abstract level, changes in body image may cause an individual to feel "less than" their previous self or to wonder if others perceive them as less adequate than adequate than prior to their illness.

Illnesses which warrant hospitalization frequently serve to confront an individual with the reality of their own mortality. Symbolically illnesses are frequently characterized by a sense of vulnerability. The defenses, bravado, or façade that may effectively protect an individual from awareness of their own mortality is often stripped away when one relinquishes their "identity" and dons a hospital gown. Furthermore, a hospitalized patient today is surrounded by seriously ill individuals. The atmosphere may be tense, the staff very busy and professional, and the array of technology impressive if not frightening. In many instances such as critical care or step down units, an individual's typical defenses which usually protect them from serious thought about their own mortality and provoke the ill adult to think about spiritual, psychological or philosophical issues on a personal level. Often such concerns are on the minds of close family members or friends as well. A family communication system which supports verbalization of these feelings and concerns may provide the most helpful coping mechanism for dealing with this issue.

Another of the major tasks for the ill adult is coping with altered relationships with others in their social/support system. The illness of an adult often impacts their relationships with their significant others. The patient typically experiences greater needs for support and nurturance from others in reaction to their health impairment; they may feel more dependent, less in control, more anxious, or less decisive as they enter and attempt to negotiate the health care system. Their self-esteem and self-image may suffer in adjusting to the routine of assessment, diagnosis and on-going treatment.

Concurrent with these emotional events in the ill individual, significant others are experiencing their own emotional responses to their loved one's illness. Friends and family members may feel confused, over-whelmed, uncertain, uncomfortable, sad, upset, angry, disbelieving or other strong reactions,. Their responses may vary and fluctuate. Significant others may feel unable to comfort the ill individual or may over-react to the illness. Whatever their response, the initial situation is one of emotional instability just when the ill adult needs more stability and support than usual.

Illness in an adult can initiate significant alterations in family relationships. For example, the CVA of a parent can elevate an adult child to a parental role and cause the patient to be relegated to a more childlike position in the family constellation. Or the serious illness of a middle-aged adult can propel a comfortably retired grandparent into role of housekeeper/parent to young grandchildren. These are two possible upheavals that cause significant stress and pose major coping challenges in adult illness. Each scenario would require significant family adaptation on emotional, physical and financial levels at a time when all are severely stressed by the presenting problem of the illness.

Another significant issue involved is that of dealing with an alteration in dependence. Few of us are comfortable thinking of ourselves as dependent and needing the care of others yet a serious physical illness forces this reality upon an individual. Suddenly ones' usual predictable routine is completely altered. The illness interrupts and disrupts an individuals' lifestyle. In the hospital, the client's day is externally directed and he/she must relinquish all but minimal control of their time to MD, nurses, and other hospital personnel. In many situations, care and assistance may be required for the most basic daily functions – hygiene, eating, ambulation and elimination. This drastic change may have literally occurred overnight or evolved after a brief period of crisis. In serious illness this focus may be sustained for a long period as life at home becomes oriented around MD visits, lab tests, physical therapy, etc. These changes are a serious challenge to an individual's self-image and self-esteem.

Concurrent with this, is the task of adjusting to physiological changes. While the emotional tasks seem to predominate, adjustment to our bodies changed physiology is also a significant demand. This area includes the lifestyle and self care changes many adults must make to accommodate to illness. Typical changes include dietary, exercise, stress reduction, medication usage, alterations in libido, alteration in physical abilities such as after an amputation, alterations in sensory abilities or sensitivity. Often, because these needs are concrete, quantifiable and visible, these physiological changes become a focal point, even a battle ground. Non-compliance can be an enormous issue for the newly diagnosed diabetic or recovering cardiac patient, for example. The individual can use non-compliance as a way to express their anger and frustration, even their rejection of their altered life situation.

For many ill adults the emotional issues and challenges of altered health status combined with physiologic adjustments create a grieving for their former lifestyle. This grief may be expressed in an overt, direct manner or more indirectly through a sad or introspective mood.

The individual may verbalize wishes for the wholeness, vigor, strength or well-being they enjoyed prior to the onset of their condition. Also, they may experience guilt or regret that they did not adequately value their well being and took their health "for granted". These comments often dismay significant others who feel at a loss for a meaningful response. A sensitive care giver who can provide acceptance, empathy and understanding of the patients' perceived loss can offer needed support and role model an appropriate response for family members as well. The patient may experience themselves as a "new person" who is unfamiliar and practice with uncertainty their "new self" with nursing staff. In some individuals, staff may witness all the well-known stages of grieving as described by Kubler-Ross as the individual relinquishes their former self and self image.

This sense of loss coupled with uncertainty regarding their "new self" may contribute to another of the major coping tasks, fear of recurrent problems. The betrayal by the body which permeates so much of the emotional turmoil ill adults experience often takes on a life of its own as the individual begins to fear future possible health problems. These fears may be supported by ignorance, misunderstandings or deficits in the patients' knowledge regarding their illness. Additionally patient teaching proceeds slowly when an individual (and possibly significant others, as well) is impaired due to anxiety or depression. Many individuals will verbalize fears and a general pessimism regarding their health status and their future.

The final coping task in this list relates to a fact of contemporary life that we are all familiar with. Each of us has a life replete with stresses. Yet illnesses strike individuals concurrent with an array of other stressors. For example, financial stressors are prevalent in today's economic climate; these may be severely complicated by reduced income and increased health care costs. Marital and familial stressors exist in many families; these too, are complicated by the role changes and the physiologic/emotional changes that arise from serious illness. And then there are the everyday stressors, the car still breaks down, or the children are ill or the work schedule is inflexible,. The patient's illness typically takes precedence, at least for a time, over other concurrent stressors, This very shift can cause increased stress to other family members who must take on added coping and problem solving responsibilities, Additionally, the ill adult is often painfully aware of the stress caused by their absence from home, family, work and so on, The individual may experience guilt, depression or other emotional reactions both to their illness and to the inconvenience and disruption caused by their illness,. Obviously this can become very complex.

Stressors are not limited to an individual's personal situation. Just the act of hospitalization causes significant stress related to many issues previously discussed. Depression and anxiety are the two most common responses to serious illness and both diminish further the patient's self-esteem, and feelings of helplessness as well as impair cognitive ability to process and integrate new information,. In our very busy practice settings, it is sometimes difficult to remember very basic strategies which promote self-esteem. For example, ill adults often appreciate not being touched unannounced by caregivers. Verbalizing what you need to do prior to beginning your work on an IV or taking vital signs is quite basic yet our preoccupation with our goals can lead to such oversights. When procedures or treatments are required, don't forget

to give a simple step-by-step explanation and keep the individual posted as you proceed. When asked to assess their hospital experiences, ill adults sometimes complain about the absence or privacy in the setting. Caregivers can become insensitive to patient's needs for privacy particularly around checking body parts, wounds or apparatus, Pulling the curtains before throwing back the covers is a small act of respect that is much appreciated.

How, then, do adults cope with illness and all the challenges illness presents? Luckily, coping is not a skill one must develop after the onset of illness. Coping for each individual is a lifelong process. Learning or developing coping skills began in early childhood and progressed as the stresses and challenges of daily living became more complex and persistent. As individuals proceed through life, life experience, their belief system, their family and personal values and the various priorities and commitments they establish all impact on coping skills. In very broad terms, the ranges of coping styles cover a continuum from approach style at one end through avoidant style at the other. Approaching coping behaviors are ones which directly engage the problem and the concurrent emotions, Individuals with an approach coping style plunge into the recommended therapy and actively fight to regain their health, Such patients want very detailed information and education; they wish to be totally engaged in all information and education; they wish to be totally engaged in all aspects of evaluation and treatment; they set goals and follow through, Other approach strategies include an ability to regain a sense of control both through understanding, involvement and through self management (relaxation, seeks support and help, verbalizes feelings, etc). Additionally, diversion, involvement in social events, and maintenance of independence are approach style coping strategies.

At the other end of the spectrum are adults whose basic coping style is avoidance. These individuals utilize denial, repression, projection and other strategies to minimize their perception of threat from their illness. Non-compliance with or misunderstanding of treatment can be ways an individual denies or minimizes the seriousness of their illness. Passive behavior is an avoidance strategy as are delaying decisions, withdrawing from supports and significant others, manipulation, maintenance of unrealistic hope or abuse of substances including alcohol, drugs and nicotine. Between the two extremes are individuals who mix coping skills from both ends of the spectrum. The majority of people fall in the mid range on this continuum. It may be difficult initially to accurately assess which coping style predominates in an individual. However, it is important for the nurse to identify an individual's coping style, and when possible, specific individual strategies. Typically, ill adults cope as best they can given the circumstances. Caregivers must accept ad support a patients coping abilities even when they believe other strategies might before effective. It is more helpful to focus on the patient's best restructure coping skills during an acute illness. The stress of a major illness and hospitalization will generally not facilitate learning new coping skills although the nurse may refer the individual to resources which can assist them to expand their coping repertoire during their recovery.

The initial goals of coping strategies include minimizing uncomfortable emotional responses such as anxiety, fear, guilt, etc; enhancement of self-esteem; maintenance of positive/supportive relationships; and generation of hope.

There are many reactions that ill adults may have to illness. Three major categories of reaction are frequently seen in hospitalized individuals.

1. The angry individual – Anger is often a reaction to perceived powerlessness. When a patient feels powerless, they may relate in an angry manner with staff in an unconscious attempt to externalize their uncomfortable inner experience. Their angry style may also be an indirect expression that others are responsible for their internal discomfort. Such patients may be loud, demanding, rude, time consuming and very frustrating to staff. Successful interventions may include acknowledging the patient's individuality and unique situation; keeping them informed; responding to their realistic needs while setting firm limits re: amount of time the nurse has available. For example, a caregiver might review with the individual their care for the shift and negotiate with the individual when they want their bath or dressing changed. The caregiver might then say to the patient "I will be back in one hour to change your dressing. Is there anything you need before I leave? I'll be caring for other patients until I return at 10 o'clock," in a neutral, informational tone of voice. Be sure to return on time for the procedure or inform the patient that you will be delayed.

2. The agitated, hyper vigilant individual – This response presents its own set of challenges to the caregiver. The anxiety underlying the agitation is often a response to the individuals feeling of helpless or decreased control due to their illness. These uncomfortable perceptions cause anxiety and the anxiety, in turn, increases the uncomfortable feelings. The hyper vigilance represents an attempt to regain a sense of control by asking questions to obtain information but the anxiety may prevent the ill adult from adequately processing and integrating the information received. Some successful interventions might include consistency in staff assignment; suggesting relaxation interventions, such as deep breathing, hot shower, diversion (reading, sewing, etc.); providing patient teaching while a family member is present and encouraging the individual to make notes to review later; and providing the patient with adequate pain control.

3. The withdrawn individual – This type of reaction is serious for a number of reasons. A withdrawn patient can become "lost in the cracks." He/she may not receive the assessment and intervention this behavior requires and can be ignored emotionally and even physically in a busy practice setting. Some patients are naturally isolative and have only a minimal support system because of their personality style. In others, however, this reaction may be related to a clinical depression which needs further assessment. Some helpful interventions include identifying the behavior as a problem and interviewing the patient as well as significant others to establish a baseline – is this typical coping or an abnormal, unusual response to stress; monitor the behavior from day to day for increase or decrease in intensity; relay your concerns to other caregivers including the patients' physician, Finally, nurses need to have a basic knowledge of the process of assessing suicidality, and the ability to ask the appropriate questions when circumstances indicate this intervention is appropriate.

HOW PSYCHIATRIC DIAGNOSIS ARE MADE: THE DIAGNOSTIC AND STATISTICAL MANUAL (DSM IIR)

Since 1952 with the appearance of the first American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, clinicians have had access to an official manual containing symptomatic descriptions of psychiatric diagnostic categories. Prior to this original edition, there was little in the way of organized or uniform diagnosis of psychiatric disorders. Psychiatry may be one of the more subjective areas of medical science. Both patient presentation and interpretation of presenting symptoms through the individual clinicians' theoretical orientation have been factors which may account for variation in diagnosis of similar symptom clusters. The DSM I may be seen as an effort by the Americana Psychiatric Association to assist clinicians to view psychiatric symptom clusters more congruently. Also, psychiatry is a field where clinicians other than MD's apply diagnostic labels, Using a nationally approved and disseminated glossary of diagnostic categories allow allied mental health professionals such as psychologists, social workers, nurses and MFCC's the same access to psychiatric descriptions and diagnostic nomenclature.

In 1968 the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) appeared followed by the DSM-III in 1974. Continual review and updating of the SAM reflects the dynamic nature of psychiatry and the evolving knowledge base revealed through on-going research.

Currently in use since 1987 is the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-IIIR). The large, multidisciplinary work group who gathered to revise the DSM-III was charged with the task of increasing the sensitivity in certain diagnostic categories including sleep disorders, anxiety disorders, childhood psychiatric disorders and psychosis. Need for revision of diagnostic categories was based on research when well-conducted scientific studies were available; clinical experience, however, was a significant factor in diagnostic revisions. The APA recognizes that the DSM must support validity and reliability of diagnosis and that diagnosis is the foundation on which treatment and management decisions are made. Additionally, the DSM is used for educating a variety of health professionals and as a reference in many aspects of research; it must be accepted across a wide range of theoretical viewpoints and maintain compatibility with ICD-9-CM codes.

THE AXIS SYSTEM

The most current edition, the DSM-IIIR emphasizes that the text classifies mental disorders not people. A mental disorder is described as a "clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (DSM-IIIR p. XXII). The DSM-IIIR focuses on describing the

clinical features of psychiatric disorders and provides guidelines including specific criteria for establishing diagnosis. A multiaxial system is utilized in DSM-IIIR which incorporates mental disorders, physical illnesses or conditions, psychosocial stressors and global level of overall functioning. This system reflects a biopsychosocial assessment focus. The 5 axis of the system are:

Axis I **Clinical Psychiatric Syndromes**

Axis II **Developmental Disorders**

Axis III **Physical Disorders and Conditions**

Axis IV **Severity of Psychosocial Stressors**

Axis V **Global Assessment of Functioning (GAF)**

Multiple diagnoses are acceptable on Axis I and II when this accurately reflects an individual's conditions. Just as a person may have several medical diagnoses, it is possible to have co-existing mental disorders.

Axis I disorders are clinical syndromes. Some examples of these include Major Depression, Adjustment Disorder, Schizophrenia or Alcohol Dependence. Obviously an individual could conceivably have two or even more of these diagnoses concurrently on Axis I.

Axis II is used to list Developmental Disorders and Personality Disorders. Both of these are generally disorders which begin in early life and continue through adulthood. Developmental disorders involve a delay or a failure to progress in skill acquisition of a motor, social, cognitive or language nature. The term personality disorder is used to describe a constellation of rigid, maladaptive personality traits which cause the individual significant distress, relationship difficulties and functional impairment. Personality disorders are often recognized during adolescence and persist through adulthood.

Examples of Developmental Disorders which would appear on Axis II include: Autistic Disorder, Developmental Expressive Writing Disorders, or Attention Deficit Hyperactivity Disorder.

Personality Disorders which would also be listed on Axis II are Antisocial Personality Disorder, Histrionic Personality Disorder or Narcissistic Personality Disorder, to name a few.

On Axis III the clinician lists any physical disorders which are known to be current or, if pertinent, by history.

Axis IV is the severity of psychosocial stressors scale. Here the clinician codes the life stressors of the past year which may have contributed to the clients current diagnosis on a 1 – 6 scale – one being none through 6 being catastrophic. Clinical judgment is exercised in rating the stress an "average" individual in similar circumstances would experience from the psychosocial stressors in the clients' life over the preceding year.

The Global Assessment of Functioning scale allows the assessing clinician to indicate an overall impression of the client's level of functioning currently and within the past year. The numerical value given from 90 – 1 reflects the range of optimal mental health ---- severe illness. Psychological, social and occupational function are all assessed and integrated into a numerical GAF expressed as:

Axis V: **Current GAF**
Highest GAF, past year

The highest GAF, past year has prognostic value as it indicated the level of functioning available to the client prior to the onset of acute psychiatric illness and, for most individuals, indicates the level of function they can expect to resume after resolution of their current difficulty.

In summary, a complete multiaxial assessment based on the DSM-IIIR will result in a 5 axis diagnosis including:

DIAGNOSIS	EXAMPLE
Axis I (Clinical Psychiatric Syndrome)	Major Depression
Axis II (Developmental Disorders)	Narcissistic Personality
Axis III (Medical)	Status Post CVA
Axis IV (Psychosocial Stressors)	1. Financial stressors due to inability to return to work 2. Expressive aphasia 2° CVA severity 5 3. Locomotion difficulties 2° CVA 4. Interpersonal stressors due to change in independent level of functioning 2°CVA severity 5
Axis V	Current GAF: 35 Highest GAF in past year: 70

Most of the DSMIII-R is dedicated to describing psychiatric syndromes and developmental disorders. Consistent information is provided for each diagnostic label. Information includes essential features; associated features; typical age at onset; typical course of the illness; typical impairment; complications; predisposing factors; prevalence in the general population and sex ratio; familial pattern; and differential diagnosis.

COMMON PSYCHIATRIC DIAGNOSIS

Certain psychiatric diagnoses occur more frequently in the general population than others. Diagnoses that are prevalent in our culture include:

Axis I	Depression Disorder (Major depression)	3 – 9%
	Schizophrenia	.2 – 1%
	Bipolar Disorder	.4 – 1.2%
	Alcohol Abuse or Dependence	13%
	Adjustment Disorders	
Axis II	Personality Disorders of all types	

As the stigma associated with mental illness diminishes and general understanding of psychiatric problems increases, patients with psychiatric diagnosis utilizing psychiatric medications will be seen more frequently in the medical hospital, the physician's office, medical clinics and other health care settings. Nurses can frequently enhance patient care by assuring integration of care.

This section will conclude with two case examples of patients with current acute medical problems who also have secondary psychiatric diagnosis which require on-going attention.

CLINICAL PRESENTATIONS

EXAMPLE 1

Mrs. Drew is a 47 year old married woman who is admitted to 3 North post-op after orthopedic surgery. She was injured in a MVA and brought to surgery after assessment in the ERD. Her physical condition is stable – she is awake and alert but is quiet, rather withdrawn, has little variance in facial expression or tone of voice, and her eye contact with you is minimal. When you interact with her she answers questions rather abruptly and makes no attempt to converse or be social. You notice that you feel somewhat uncomfortable or anxious around her. Later in the shift, Mrs. Drew's husband comes in to visit. You observe their interaction and

notice that the quality of Mrs. Drew's interaction with her husband is quite similar to her interactional style with you. As Mr. Drew leaves, you ask if you can speak with him for a moment and question him about his wife's interpersonal style and subdued affect. In attempting to thoroughly assess your patient's emotional state you might ask: "Is this her usual personality style? Or "Is Mrs. Drew subdued as a consequence of the physical and emotional trauma associated with her accident?" or "Could her behavior be part of her reaction to pain medication?" These are some of the differentiating questions that occur to you. Mr. Drew is receptive to your inquiry and states, "My wife is schizophrenic. She was diagnosed many years ago. This information needs to be in her chart as she must be maintained on anti-psychotic medication. As a matter of fact, I plan to notify her psychiatrist of her hospitalization tomorrow and hope she can visit my wife soon." You request the name and phone number of Mrs. Drew's psychiatrist as well as the names and dosages of her psychiatric medication. You also ask Mr. Drew for any suggestions he has which could assist the nursing staff and Mrs. Drew cope with the stress of her hospitalization. Then you report the information you have gathered to the nurse manager and Mrs. Drew's primary care physician. You may suggest that Mr.. Drew contact Mrs. Drew's primary care physician with this information as well.

EXAMPLE 2

Mr. Johns, a 52 year old male is admitted to your med-surg unit after several days in CCU. His cardiac condition is stable and in reporting his treatment, the CCU nurse notes that he is on 20 mg of Prozac each morning. You ask why he's receiving Prozac and are told he's been on it for 5 months since being hospitalized for major depression. In interviewing Mr. Johns you inquire about his depression. He relates he was hospitalized at age 35 for depression after losing a young son in an accident. At that time, he was in the hospital for 5 ½ weeks after a suicide attempt. He took 2 different anti-depressants as the first one was ineffective. More recently, Mr. Johns' became depressed when he believed his job to be threatened by company downsizing and after the marriage of his youngest daughter who moved to Hawaii. Although Mr., Johns was not suicidal 5 months ago, he experienced early morning awakening; obsessive negative thoughts related to his fears of job loss; anorexia; lack of motivation and slowing of his speech. His wife insisted he seek psychiatric care after he refused to get out of bed for an entire weekend. He was hospitalized for 5 days. Prozac was begun immediately and he's continued at 20 mgs every AM. He is willing to discuss how his current illness has affected his depression, denies any suicidal ideas and agrees when you suggest that his psychiatrist should be notified of his current health problems. Mr. Johns thanks you for your interest and understanding. He feels somewhat embarrassed by his psychiatric illness but is relieved to have his "cards on the table".

In both of these situations, adverse consequences could result from the discontinuation of psychiatric medications or the avoidance of the psychosocial component of the patients total health picture. Each patient's medical condition, length of stay, and response to treatment could be negatively impacted if the psychiatric history were ignored or undiscovered.

ASSESSMENT SKILLS IN A CRISIS SITUATION

WHAT CONSTITUTES A CRISIS

What is a crisis? Although objective definitions can easily be found, a crisis is a very subjective experience. One person's crisis is another individual's daily event and after a stressful week at work, running out of milk on Friday evening at Dinner can feel like a major crisis. We cannot define what another person will experience as an emotional crisis, nor do we have the right to judge their experience or apply our standards to determine if they are really experiencing a crisis. Factors influencing which life events are perceived as a crisis are many and may include: pre-existing stress level; family and/or cultural standards for experiencing and coping with stressful life events; reactions of significant others to the event; feelings about the event such as guilt, shame, blame, betrayal, etc.; violence associated with the event; if the event was anticipated or not; and previous coping skills for dealing with crisis. Basically, a crisis state exists when an individual's usual coping abilities are inadequate to deal with a current stress.

In the health care settings crisis events are numerous. We as care providers may react to situations in our work as a crisis. We routinely encounter traumas, violence, deaths, human error, and human suffering in our day to day work. These meet the most vigorous crisis standards yet we are expected to remain detached, provide competent, effective interventions and then move along to the next patient and situation. Additionally we are often called upon to assist our patients and their family members deal with their crisis on an emotional level. And for many of us, this is just what we may feel least prepared to do.

WHEN DO NURSES NEED TO RESPOND TO EMOTIONAL CRISIS?

This section will discuss skills and techniques for response to the emotional crises, which health care providers are likely to encounter. But first, a few comments about our needs in the crisis laden health care environment. Not only must we be able to care for our patients, but we must be able to care for ourselves. We must develop awareness of our reactions to work related stressors; develop the ability to articulate our feelings; develop stress reduction skills which we practice routinely; choose work settings which are supportive and which care for the caregiver. We must also know which situations are most difficult for us and avoid them when possible. Nurses in trauma and critical care areas, in particular, are repeatedly exposed to sights, sounds, and smells that are intensely disturbing and stressful. Self care in these situations is essential to insure optimal performance and job satisfaction as well as to prevent burn-out. Very few people can care for others in crisis while they are experiencing crisis level stress themselves.

What are some of the crisis situations which health care providers encounter? Clearly we provide direct care to patients whose lives are threatened by trauma or disease. Some of these situations are acute, intense, traumatic, and rapid – others are slow, chronic, painful and exhausting. Some patients recover from life threatening crisis and others do not. We expect to care for our patients and usually feel prepared to care for the physical needs. However, we may

feel less confident about dealing with the family member – at the bedside, with the ambulance, or in the surgical waiting room. Often, we are expected to comfort a grieving parent, spouse or child, for example, when we ourselves feel stressed or upset.

Another crisis situation nurses may encounter is the development of acute psychiatric symptoms in a medical patient. How do you cope with a patient who becomes depressed and suicidal or bizarre and psychotic? And again, how do you deal with this patients' spouse or children?

How nurses are called upon to handle emotional crises varies not only from institution to institution, but from shift to shift as well. Obviously, every nurse needs to be familiar with the policies and resources of their particular setting. As the "round the clock" health care provider the ED night nurse may need to develop greater skills in assisting grieving family members than the day shift, ambulatory surgery staff nurse. It is essential that staff be aware of the support services their institution has available, when these services are available and how to access them. Armed with this information the nurse can begin to intervene in a crisis situation.

Grief is a universal life experience all but the most emotionally isolated individuals inevitably experience in their lifetime. Nurses are frequently confronted with grieving family members in the acute or extended care settings. Grief is the most immediate reaction to the death of a loved one and is comprised of sadness and emotional pain. When confronted with a grief stricken individual, may of us feel uncertain o f how to respond and inadequate to meet their needs. Both these uncomfortable feelings uncertainty and inadequacy may stem from an assumption that we need to "fix" the grieving person. In reality, offering empathy and support are all we need to do.

Grief presents in many guises. It is a reaction to a very particular intense stress and an individual's personal grief will reflect their personality style, coping abilities and cultural influences. A few typical grief reactions are:

1. ***DENIAL*** – the individual is detached matter-of fact, distant, and maintains the stiff-upper-lip.

2. ***HYSTERIA*** – the individual cries profusely, may wail, call out to the deceased, moan or lose control of their behavior. In some cultures people will hit themselves, pull out their hair, or rip their clothes. This can make hospital staff that is unaccustomed to such grief very uncomfortable but it is often culturally appropriate. We should try to provide the family with privacy for their grief but it is also appropriate to insist they keep their voices and behavior within bounds that will respect the rights of other patients.

3. ***WITHDRAWAL*** – the individual may shield their face, stop interacting, speak in monosyllables only when spoken to, and avoid eye contact.

4. ***ANGER*** – this individual may project gilt and blame for the death onto the caregivers; they may be loud, rude and provocative. This person may criticize the MD or the ambulance team and attempt to get the nurse to agree with them.. They need to ventilate and be accepted but the care giver must not take sides or get in the middle and must resist taking the anger personally.

Typically, grieving individuals have decreased concentration. They may seem scattered and dazed; often they are unable to focus. They feel numb, thoughts may become blocked and interactions may be interrupted or incomplete. We can help with this by refocusing, redirecting, and prompting individuals to finish thoughts. The characteristic liability of grief can be frightening for people. They cry then recover, begin to speak or make a phone call and are then struck by another wave of grief just when they were beginning to feel a bit of control. Describing this process and explaining this a normal grief can be quite reassuring.

Merely remaining with a grief stricken individual is very supportive and helpful. Small comforts such as a cup of tea, a pat on the arm or hand, or a call to a neighbor are very helpful and often appreciated. Support the person to do as much as they are able for themselves but also ask them what they wish you to do. When you cannot stay with the person, check on them frequently or call on other hospital resources to assist them. Another empathetic offer is to see if the person wants the company of a priest, rabbi or minister. After a time, do ask if they wish to view the body. In some cultures the family will wish to prepare the body and even have a bedside service before the body goes to the morgue. It is a great kindness when our busy settings can be flexible enough to grant such comfort to a grieving family. Do prepare the family members for the appearance of the deceased by describing tubes in place, etc. and accompany them to the bedside. Stay with them until you feel confident they can be safely left alone. Finally, see that the person does not leave the hospital alone unless they insist. Offer to call them a cab if needed.

These very simple gestures are all that needs to be done in a grief crisis. When social service staff is available they may wish to provide resource information regarding bereavement or grief support groups, or information on other resources to families who have sustained special loses. These basic suggestions are empathetic and supportive to anyone attempting to cope with grief.

When a caregiver has taken these supportive and empathetic steps they have utilized the first 2 of 3 techniques of crisis intervention. These are:

1. Develop an alliance
2. Gather information
3. Problem solving

By reaching out to the bereaved, spending time with them and offering a few caring gestures, you are usually able to develop an alliance. This allows the person to feel slightly less alone and isolated with their grief. Next, by gathering some simple information - “Would you

like me to call your minister? … Tell me how I can help you?" – you help them to help themselves by articulating their needs. The final stage can begin when resources are offered but it may be premature to begin this until a few weeks after the death. (Literature or phone numbers may be provided to another family member or friend to offer to the bereaved after the immediate period of grief elapses.)

These basic steps can be used to intervene with other crisis situations which nurses may deal with in an acute care setting such as a change of mental status. Change of mental status may appear as confusion, suspiciousness, misperceptions, etc. Whatever is occurring, developing an alliance and gathering information are key to accurate assessment and, therefore, to effective intervention. These phases often overlap and, in fact, in gathering data you may actually develop your alliance with the patient. Often, caring, sensitive and perceptive questions convey sincere concern to a patient while indirect investigation of a situation can arouse suspiciousness and paranoia. These same techniques are used with a patient or a family member. Many crises in an inpatient setting affect your patient and their significant others as well. What information needs to be gathered in these circumstances? Some helpful questions include:

1. Is there a precipitating event? Why is this change occurring now? What has recently occurred that feels threatening to the patient's coping abilities and emotional equilibrium?? Have there been changes in meds or in laboratory values?
2. Has the patient experienced similar changes in the past? You may ask – "Have you felt like this before?" and explore what was the precipitant then.
3. What helped the patient in the past? Is there something the patient can do to help themselves? "What may I do to help?", you may wish to ask.
4. Why is this patient susceptible to this change just now?
5. What resource does the patient have available? How can she/he access these resources? How can you assist the patient to get support?

You may have other questions that will be pertinent to the specific situation. Once information is gathered, it is essential the nurse know how to access the most helpful resources. Is there a psychiatric crisis nurse or a psychiatric liaison nurse who can be called in to consult, for example? Often with changes in mental status, intervention needs to be rapid to be effective as deterioration can occur all too quickly.

Again, nurses are often not in a position to proceed with the problem solving steps of intervening in a crisis. In situations where problem solving is appropriate, here are some techniques.

1. <u>Keep problem solving simple</u>. Often as care providers we can get caught up in elaborate solutions – ones that actually go beyond the confines of the crisis as the patient perceives it. We need to take our lead from the patient and allow them as much action and control as possible. We assist them to act and do, not do for them.

2. Set realistic goals. This means goals that are realistic for the patient given their abilities, previous level of function, their vision of the crisis, etc.

3. Identify and focus on the patient's strengths and abilities. This is not a time for the patient to develop new coping skills. We can help enhance their self-esteem by supporting their capabilities.

4. Avoid advice. This can increase the patient's feelings of helplessness or inadequacy. Explore options; help the client walk step-by-step through possible solutions; encourage them to "try out" alternatives but allow the patient to choose their solution.

5. Know when to stop intervening. And refer to mental health professional. Know your limits and how to access other resources in your institution.

Another situation of crisis proportion is when a patient becomes violent while hospitalized. The combative or assaultive patient presents a frightening dilemma to nursing staff. There are a variety of underlying causes for this type of behavior, but regardless of its origin, care providers have an immediate responsibility to protect themselves, the assaultive individual and other patients. Although many assaultive patients are associated with psychiatric services, the nursing literature reflects a growing concern with violence in all areas of the hospital setting. While psychotic or psychiatrically impaired individuals may account for the majority of patient assaults, other patients on non-psychiatric services do become combative. Examples may include individuals who are under the influence of alcohol or other drugs of abuse; patients withdrawing from alcohol; patients who develop an ICU psychosis; and unusual drug reaction; or who are demented. Such situations can develop in the emergency department, critical care areas, med-surg and skilled nursing areas – in other words, just about any setting is occasionally at risk.

Assault is defined as any verbal or physical threat with the power at hand to commit harm. A patient who threatens verbally to hit at staff and raises a clenched fist is assaultive. Battery occurs when actual physical contact with the intended victim is made.

The problem of care givers being assaulted by patients is thought to be grossly under-reported nationally. Often staff doesn't wish to deal with the paperwork involved in reporting such incidents or are unwilling to leave their unit to go to the appropriate area for an assessment especially when their unit is experiencing turmoil. While these sentiments can be understood, we are unfair to ourselves when we minimize or dismiss such a stressful event and do not care for ourselves appropriately.

There may be attitudinal reasons as well for the under-reporting of patient assaults. Often victims feel responsible when they are injured. They may blame themselves believing their

assessment skills were inadequate or they waited too long to medicate the patient or that occasional situations of this nature are "part of the job" or even question if their heavy workload caused them to provoke the assault in some way. Such thinking represents classic "blame the victim" reasoning and can serve to compound the stress reaction which staff ay experience subsequent to the event.

Being assaulted by a patient is an experience which defies our expectations for our role as a care provider. In addition to causing emotional and often physical harm, assaults ma have significant symbolic meaning, Responses to such an event will vary depending on the level of threat perceived during the event and the extent of injury to the staff. Responses will also be influenced by the interpretation the nurse attaches to the event,. Do they view themselves as less competent because of this event; feel concern that peers will think less of them; or continue to feel unsafe at work? Any of these are normal early reactions that can cause lingering effects.

Later reactions occurring from several hours till days or even weeks later may include: decreased concentration, sleep disturbance including dreams of the event, intrusive thoughts about the assault, hyper vigilance, avoiding patient contact, decreased self-esteem, or changes in relationships with peers or family reactions of supervisors or administration; may experience concerns about their feelings toward the patient who injured them and wonder if it is professional to feel or verbalize negative responses. They may also experience a dilemma about pressing legal charges against the patient.

Combative or assaultive patients clearly pose two concurrent problems. One is that a safe environment is essential. Immediate interventions must occur to contain the combative patient and prevent them from harming themselves or others. The other problem is that any staff member who is assaulted at work must be cared for immediately as well. Both these problems must be handled as outlined in institutional guidelines and here again staff needs to be familiar with the policies related to such events.

Institutions generally have some method of gathering sufficient staff to safely contain an agitated, combative patient. There are however, general guidelines that can assist in these stressful and difficult situations.

1. Always use the least restrictive interventions necessary to reestablish safety. This is a basic tenet of patients' rights and a legal concept known as reasonable force. We must try firm voice commands first then proceed to a "show of force" before physically restraining a patient when at all feasible. A "show of force" can be quite effective with an out of control individual. When an agitated, combative person is confronted by a significant number of staff (4 - 6) and directed to stop a behavior or suffer certain specific consequences (such as application of wrist restraints): they may choose to cooperate. It is necessary to keep staff available for follow through however,

until you are certain that this patient has reestablished self control. Often this can be assisted by administration of prescribed meds to decrease agitation or cause sedation.

2. When a number of staff gather to physically contain, it is essential that one person lead and direct the intervention. Only this person should talk to the patient as well as to the intervention team. The leader should assign staff to restrain specific limbs and set up a "go-ahead" command for the team. To prevent injury, it is important that the team act in unison. Only the leader should speak to the patient. A patient who is confused or agitated enough to become combative cannot process multiple inputs.

3. Keep direction to the patient and the team simple, specific and concrete. Think before you speak. Use short words and short sentences. Everyone in this type of situation is anxious and stressed; simple clear communications are essential.

4. Keep patient safety a priority. Grab patients' limbs above or below joints. Never sit on a patient. Use your weight to contain; lean into the restraining move. Always monitor the patients' a airway. Allow time for agitation to diminish and for medication to work before moving the patient. Be sure restraints are applied securely but without compromising the patient in any way. Check the patient in restraints frequently – many institutions specify frequency in their policies on restraints.

If the injured nurse was not removed from the area before the physical containment of the patient, they must be attended to now. It is important that they report the incident and seek medical attention. A verbal debriefing is very helpful and peers or charge staff who was there for the incident need to insure this occurs. Assaults really challenge a staff's cohesiveness and ability to deal with stress. Everyone on the unit reacts and it is important for management to support a non-evaluatory debriefing after such an incident. The injured nurse and all staff need an opportunity to discuss what happened, how they became aware of the incident, how it affected them and their responses. This is an opportunity to correct misinformation and clarify the actual incident as well as to discuss emotional responses. It can be a time to educate staff about normal responses to stressful events and how to manage stress. Often a psychiatric liaison nurse or other resource person can be used in this role. Although it is appropriate to use such events as a learning opportunity, it is never appropriate to blame the injured staff member for the inci threats or verbal abuse are serious events. As our culture becomes increasingly stressful and individuals utilize threats and violence more frequently to express their low self-esteem, despair and hopelessness, it is inevitable that health care settings will be disrupted by such events more frequently than in the past. Such stress, in addition to the routine but challenging stressors inherent in health care, will increase the incidence of burn-out among nurses. The phenomena of

burn-out is generally regarded as the result of cumulative stress and is often discussed as a corollary of the co-dependency are processes more than events, the moment or situation which facilitates a nurse to self-identify oneself as either burned-out or co-dependent would quality as a crisis based on the earlier definition of usual coping abilities being inadequate in a current situation.

The literature on burn-out and co-dependency in health care professionals is voluminous and even a summary of it is beyond the scope of this section. However, prevention of these conditions or early awareness of the development of either phenomenon will be assisted by some of the recommendations on page 17, such as: self-knowledge about our reactions to job stress: routine practice of stress reduction techniques including regular exercise, and seeking and insisting upon support in the work place. Many nurses find support groups at their work site or in their community invaluable to their self-care and management of work related stress.

SUICIDALLITY IN THE HOSPITALIZED PATIENT

WHAT IS KNOWN ABOUT SUICIDE

Suicide has been described throughout recorded history. In early times, it was considered an appropriate alternative to certain types of victimization such as rape or defeat in battle. Certain cultures prescribed suicide in specific circumstances or even forced embers to commit suicide as a part of ritualistic ceremonies. Today, many religions specifically prohibit or denounce suicide. Some states consider suicide a felony and individuals who attempt suicide can be prosecuted. In our society, many people have strong feelings and judgmental opinions regarding the act of suicide.

In spite of a strong cultural bias against suicide today, it is the 8th leading cause of death nationwide. This statistic takes into account only obvious and identifiable suicides. Many coroners, for example, refuse to classify a death as suicide unless a note is found. Among young people aged 15 to 24, suicide is the 3rd leading cause of death. The rate of adolescent/young adult suicide doubles in the 20 year period from 1965 to `985.

Perhaps because suicide is such a puzzling and distressing behavior, many myths have developed about it. Belief in suicide myths could actually deter a caregiver from assessing a patient for suicidal thoughts. Here are some typical examples.

Myth #1 **Suicidal people are always depressed.** Although this is often the case, some people who attempt suicide do not appear depressed at all but appear agitated, may be psychotic or organically impaired.

Myth #2 **If you ask questions about suicide, you will give a patient the idea.** Belief in this myth could prevent a caregiver from asking some difficult but essential questions. Accurate assessment requires investigation regarding the existence of a suicide plan and its' potential lethality.

Myth #3 **People with families who come from "good homes" do not commit suicide.** Suicide attempts occur across the social and economic spectrum. Mot suicides are committed by non-psychotic individuals who have recently experienced a life disruption such as a significant loss.

Myth #4 **Suicide is unrelated to alcohol or other drug abuse**. In fact, suicidal thoughts and suicide attempts often are closely related to use of alcohol or other drugs. Patients may feel depressed and hopeless about their addiction and the negative consequences addiction has engendered in their life or may become impulsive while under the influence of alcohol or other drugs.

Myth #5 **People who verbalize suicidal thoughts are manipulative and don't need to be taken seriously**. All suicidal threats are serious and must be responded to in a timely and appropriate manner. Most people who commit suicide have directly or indirectly verbalized intent prior to their action.

Such myths reflect our societies' discomfort with and negative feelings about suicidal thoughts, impulses and plans. Obviously, if caregivers were to hold any of these myths as accurate information about suicide, their ability to evaluate a patient for suicidal risk could be impaired.

THE SUICIDAL RISK ASSESSMENT

How does a concerned health care provider make a suicide evaluation? As with any type of evaluation, the basic task is to gather, and then logically order, factual data. First, what behaviors and/or verbalizations alert the caregiver to the possibility that suicidal thoughts are present? Are there recent life events that challenge the patients; **self-identity** or cause a **real or anticipated loss**? Either of these two issues are highly correlated with suicidal thoughts and behavior. Significant changes in health status such as diagnosis of a terminal illness, relapse of a terminal illness, physical alterations (such as amputation or colostomy), or development of a disability affect identify and involve loss. Any of these are events to which individuals might react by experiencing suicidal thoughts or impulses. Other hospitalized individuals may have less obvious precipitating factors for their suicidal thoughts. In these cases, concern may arise because the patient presents with evidence of significant depression. Symptoms of depression include:

1. Decreased appetite; weight loss
2. Sleeplessness, especially early morning awakening
3. Change in social patterns
4. Psychomotor retardation – slow speech, thoughts, gait and movement
5. Preoccupation with inner thoughts/conflicts
6. Easily moved to tears
7. Withdrawn, apathetic, apprehensive, anxious behavior
8. Anhedonia (inability to experience pleasure)

It is helpful to consider some demographic parameters regarding suicide risk this early stage of evaluation.

1. **What is the patients' age?**

As mentioned earlier, adolescents have one of the highest rates of suicide. Often saddled with adult sized problems, adolescents do not possess adult coping skills. They to be rather concrete in their thinking and problem solving abilities, and are emotionally labile. Also at increased age-related suicide risk are the elderly who have often sustained multiple losses prior to the recent crisis and may harbor yearnings to be reunited in death with loved ones.

2. **What is the patient's gender**?

Statistically men are at greater risk of completed suicide across the life span. Although more women attempt suicide, men choose more lethal means and more often complete suicide attempts.

3. **What is the patient's marital status**?

Married persons with children attempt suicide less frequently than married individuals who are not parents. Married persons without children attempt suicide less often than single individuals. Single persons are at greatest risk.

4. **What is the patient's socio-economic status**?

Not surprisingly, lower income people are at greater risk for suicide. Their hopelessness about their options especially in a crisis situation influences their liability to use suicide as a problem solving tactic.

5. **Is the patient affiliated with a religious group**?

Persons with religious affiliations are less likely to attempt suicide. Several prominent religious specifically prohibit or denounce suicide and this factor deters many individuals with strong religious connections.

Once the demographic predictor and the precipitating factors or event are noted, the remaining assessment is based on interviewing the patient for specific precise information. Probably the most significant information to be fathered is whether the individual has a plan to harm themselves. Eliciting this information requires making direct and specific inquiries. Questions such as:

- **"Have you ever thought about hurting or killing yourself?"**
- **"Do you have a plan?"**
- **"How would you take your life?"**

must be posed. Often caregivers feel extremely uncomfortable asking such direct questions. Each of us has our own beliefs and values regarding privacy, personal rights, freedom of action, suicide, etc. Asking these questions can cause a caregiver to experience internal conflicts, embarrassment or concern about overstepping our bounds. However, presence of a plan is rarely detected unless direct questions are asked and having a plan is the most significant predictor of suicidal behavior. Also, many people who harbor a suicide plan feel very ambivalent, guilty or depressed about keeping this secret. Often they feel extremely relieved when they are offered an opportunity to unburden themselves of these thoughts. They may also feel grateful that someone was adequately sensitive to recognize the signs and bring the topic out in the open. Another

reaction is that the individual may have believed themselves to be **"going crazy"** to have developed these ideas and can be reassured that suicidal thoughts are not uncommon responses to a crisis.

If the individual admits to any type of suicidal thoughts or urges, then 3 parameters of any suicide plan must be evaluated:

1. How specific is the plan?
2. How lethal is the plan?
3. Do the persons have the means available to carry out the plan?

At times these parameters appear to merge or overlap, but each one is an important and distinct factor.

Specificity refers to how definitely the details of the plan have evolved. Lethality refers to the likelihood of fatality if the plan is acted upon. And availability refers to the access the individual has to implement the plan.

A specific plan is detailed as to method, timing and availability of means. For example, a plan to overdose could be considered vague if a patient says, "Well, if I ever felt bad enough I'd go to a store and buy some pills." verses a more specific plan such as, "I've been saving up many codeine and tranquilizers and I'm going to take them next Tuesday when my spouse is out of town and I'll be home alone."

Lethality is a major factor in predicting outcome of suicide attempts. Earlier in this section, it was noted that men more often complete suicide; this is because they choose methods of greater lethality. Gunshot wounds, for example, are highly lethal and are more often utilized in male attempts. Overdoses are less lethal related to type of medication; amount of medication ingested; if the overdose victim is found by someone; and the health of the victim. Women more frequently overdose in attempting suicide. (See Lethality Assessment Scale page 30.)

ASSESSMENT

LETHALITY ASSESSMENT SCALE

Danger of Self	Typical Indicators
1. No predictable risk of immediate suicide	Has no notion of suicide or history of attempts, has satisfactory social support network, and is in close contact with significant others
2. Low risk of immediate suicide	Person has considered suicide with low lethal method; no history of attempts or recent serious loss; has satisfactory support network; no alcohol problems; basically wants to live
3. Moderate risk of immediate suicide	Has considered suicide with high lethal method but no specific plan or threats; or, has plan with low lethal method history of low lethal attempts, with tumultuous family history and reliance on Valium or other drugs for stress relief; is weighing the odds between life and death.
4. High risk of immediate suicide	Has current high lethal plan, obtainable means, history of previous attempts, has a close friend but is unable to communicate with him or her; has a drinking problem; is depressed and wants to die.
5. Very high risk of immediate suicide	Has current high lethal plan with available means, history of high lethal suicide attempts, is cut off from resources; is depressed and uses alcohol to excess, and is threatened with a serious loss, such as unemployment or divorce or failure in school

Source: Hoff LA: People in Crisis, ed Addison-Wesley, 1989, page 209.

Availability of means is the third aspect of a plan. If an individual plans a suicide by gunshot wound, for example, it is essential to determine their access to gun and ammunition. Do they own a gun? Is the weapon loaded or is ammunition available? Is there a gun in their home or at work? Or, would they have to purchase of a gun in order to carry out this plan? Whatever the plan, it is important to determine if the means is at hand or how detailed is the plan to access the means necessary for completion.

There are a few other pieces of information an inquirer would gather in completing a suicide assessment. The first is to determine if a history of previous attempts exist. Once an individual attempts to commit suicide they break the societal taboo against such behavior and no longer have the protection this invisible barrier affords. Most People who successfully complete suicide attempts have contemplated ad/or attempted suicide previously.

Another avenue of inquiry involves recent changes in behavior especially behaviors that may signify or accompany life closure. An obvious example would be writing or updating ones' will. Some less obvious examples are giving away treasured personal items or having serious conversations with family members, friends or even caregivers which express appreciation and have an overt or covert good-bye theme. Such behaviors may be observed or overheard by the caregiver or reported by the family. In some instances, recognition of such behavior as a closure gesture may be the tip-off which alerts a sensitive health care provider to the patients; state of mind.

COPING WITH A SUICIDAL PATIENT

Once a care provider establishes that a risk for suicidal behavior exists it is imperative that this information is communicated to the other members of the health care team. Immediate response is essential to protect the patient as well as those who are responsible for the patients care and well-being. Usually, the information is communicated to the clinical manager of the department and/or the hospital supervisor in addition to the primary physician on the case. Hospitals typically have policies which address the care of suicidal patients. Often a patient who has suicidal thoughts or impulses may not be left alone and arrangements must be made for a "sitter" to remain in the patient's room at all times. In some institutions, family members may act in this role while at others the hospital requires staff to function in this capacity. Another typical response is that an assessment by a psychiatrist is required as soon as possible to evaluate for transfer to a psychiatric service.

When making inquiries to determine suicidal risk, it is essential not to promise confidentiality or convey in any way that your conversation with the patient will remain confidential. While individuals may feel guilty or ashamed of such thoughts, and therefore desire they be kept secret, it is obvious that the patient's safety require communication with the health care team. If a patient asks for promises of confidentiality the nurse can empathize with this desire or explore the feelings which motivate the need for secrecy. This may be an opportunity to assure the individual that such feelings are experienced by many people in response to devastating changes in health status or other life crisis. The nurse might say, for example, "I can understand your desire to keep your suicidal feelings confidential, but I must act in the best interest of your safety and well-being. You know I'm not surprised that you feel this way because I know that suicidal feelings are not uncommon for people who are confronted with situations like yours. Our staff is prepared to help you deal with your feelings as well as your physical health." This kind of reaction could begin to normalize a response that feels frightening, shameful or crazy to the patient and offer the non-judgmental support.

A no-harm contract may be implemented once a determination is made that suicide risk is evident. This is a written statement in which the patient makes a commitment not to act upon suicidal feelings or impulses and to verbalize such thoughts when they occur. A staff member, often the caregiver who interviewed the patient regarding their suicidality, will develop with the patient a mutually agreed upon statement and sign the statement as a witness to the patient's

commitment to avoid suicidal actions. This simple intervention is often highly effective in preventing suicidal behavior. Some reasons for its effectiveness include:

1. It conveys a powerful message about the seriousness of suicidal thoughts and impulses.

2. It conveys the health care team's concern for the patient.

3. It facilitates the patient making a formal commitment not to act upon their feelings. In fact, the nurse may state, "It is alright to have such feelings but it is not alright to act upon them."

4. It conveys the staff's awareness that the patient is ultimately in control and the staff's confidence that the patient can and will control their behavior.

When a not-harm contract is used it may be reviewed and signed again at regular intervals such as every shift or every day until the acute suicidality of the patient is resolved. (See Self-Harm/No Suicide Contract Suggestions page 33.)

INTERVENTION

Do's and Don'ts of No Self-Harm/No-Suicide Contracts

No self-harm/no-suicide contracts are effective in many situations, and they work well with certain groups of clients. They can be used in hospital or outpatient settings as a means of providing additional support to people who are likely to harm themselves. It is imperative to establish a trusting relationship with the person prior to making a contract.

Do's

- Do fully assess a client to decide if a contract will be a helpful aid to treatment.
- Do include possible alternatives in the contract such as "If I'm feeling like hurting myself, I'll call _____, or I'll ask for _____."

Don'ts'

- Don't use a no-suicide contract before performing a full nursing assessment.
- Don't place more trust in a contract or emphasis on it than in clinical judgment. The contract is a helpful therapeutic tool but does not replace good clinical judgment. Clients who are acutely suicidal may agree to the contract even though they have no intention of adhering to it.

- Do establish a relationship with the client prior to initialing the contract.
- Do use the contract as a way of connecting with and staying connected with the client.
- Do specify in the contract the intervals for re-evaluation. In outpatient work the interval may be one week; the inpatient interval may range from every shift to every one to three days.
- Do have both nurse and client sign the contract and date it.
- Do have the client write out the contract if at all possible. Be creative if a client is unable or unwilling to write it out; the contract could be audiotaped, or client and nurse might each write half.

Sample No Self-Harm/No Suicide Contract

- I, Cathy Smith, will not harm myself in any way. If I feel I am going to lose control, I will tell the staff (call the crisis unit, call my therapist, etc.)
- I will not bring nor will I ask others to bring harmful articles or substances on the unit.
- This contract lasts until 1/10/92 and is renewable at that time.

Signed
Cathy Smith 1/3/92
Nancy Jones, RN 1/3/92

Psychiatric Nursing, 4th Edition, Wilson and Kneisl, Addison/'Wesley, 1992.

Dealing with a suicidal patient is another circumstance which a caregiver may encounter infrequently. Yet it is one that must be handled immediately and appropriately. N order to respond quickly and decisively it is important to be aware of the relevant policies that provide direction for staff action in your institution. When this circumstance arises it usually is experienced by staff as a crisis and may provoke feelings of anxiety and inadequacy. Having a knowledge base which includes an understanding of the institutions' expectations for staff response will help diminish discomfort and increase effectiveness.

Unfortunately, despite awareness, assessment and interventions, suicides do occur even in hospital settings. Perhaps no other type of death affects the survivors in quite the same way. Family members, significant others and caregivers all respond in like manner to a completed suicide – guilt, anger, feelings of inadequacy and self blame often predominate. Everyone seems to feel there must have been something left undone – something which could have prevented this act.

Social work services may be prepared in a hospital setting to give appropriate referrals to family members for support group or counseling services. However, the staff on a hospital unit where a patient commits suicide need support and an opportunity to verbalize their responses to this event, as well. In this circumstance resources for staff might come from the psychiatric unit or crisis service if the suicide occurred on a non-psychiatric setting,. Other resources might be a hospital based or community based critical stress debriefing team, a psychiatric-clinical liaison nurse or staff from a near-by-psychiatric service or mental health clinic, or hospitals' EAP service.

In addition to their own feelings, unit staff may be called upon to answer questions or assist family members or other patients in the unit deal with their own reactions and feelings. Such tasks can be extremely stressful for the nurse who is already experiencing his or her own emotional pain due to this traumatic event. It is essential that support be provided for the staff as a group to process their reactions, memories, feelings and concerns after a patient suicide.

PSYCHOPHARMACOLOGY

USE OF MEDICATION IN PSYCHIATRIC ILLNESS

Medications for the treatment of psychiatric illnesses are a relatively recent development in effective psychiatric care. For many years biological therapies such as diet or hydrotherapy were utilized. In 1938 electroconvulsive therapy came into use as a therapeutic intervention and later, insulin shock therapy. The earliest phase of psychopharmacological intervention began about 55 years ago when barbiturates and amphetamines were synthesized. In 1949, John Cade, an Australian physician, noted that lithium work to subdue wild behavior in animals. Another decade elapsed before use of lithium became an accepted psychopharmacological intervention for manic=depressive illnesses. Other psychotherapeutic agents came into use in indirect was as well. Chlorpromazine (Thorazine) which is now regarded as the original major tranquilizer was developed as an antihistamine. When its effects on thought patterns behavior, affect and perceptions were noted, it was introduced as a tranquilizer to treat schizophrenia. First used as an antipsychotic medication in 1952, Thorazine became widely used to treat schizophrenia by the mid 1950's. The push to develop better antipsychotic medications lead to the discovery of the tricyclic antidepressive agents. Another type of anti-depressant drugs, the MAO (mono amine oxidase) inhibitors was accidentally discovered also. These drugs were used in the treatment of TB and researchers noted the improved mood and affect in TB patients taking MAAO inhibitors.

The development and se of psychopharmacological agents has resulted in a veritable revolution in the treatment of psychiatric disorders. Emphasis in psychiatric research and treatment has evolved to a focus today which is strongly biological and the effective use of medications which act primarily on the neurochemistry of the brain can be viewed as one of the driving forces in this evolution. While the majority of psychiatrists utilize various forms of psychotherapeutic interventions, expertise in psychopharmacology is an essential skill in modern effective psychiatric care. Before discussing the various classes of drugs, their uses and side effects, here are some principles which underlie effective psychopharmacological intervention:

PRINCIPLES OF PSYCHOPHARMACOLOGICAL INTERVENTION

1. All psychiatric illnesses should receive careful assessment for psychopharmacological intervention.

2. A clear diagnosis is the best basis for effective psychopharmacological intervention. When diagnosis is still in question, parameters should be established to clarify the diagnosis.

3. Awareness of co-existing medical problems, current use of medication and potential for drug interactions is essential for optimal outcomes.

4. The caregivers involved in treatment must be knowledgeable about drug side effects, provide adequate patient education about side effects and co-monitor with the patient all responses to medications.

5. In the majority of situations use of only one agent from a given class of psychiatric medications is best.

6. Patients must be adequately screened for drug and alcohol abuse or dependency prior to beginning treatment with psychopharmacological agents. When appropriate, detox should be completed and the patient reassessed for psychiatric disorder rather than superimposed psychopharmacological intervention during on-going alcohol or other drug abuse.

MAJOR CLASSIFICATIONS OF PSYCHIATRIC DRUGS AND THEIR SIDE EFFECTS

There are relatively few major classifications of medications used specifically to treat psychiatric disorders. These include:

ANTIPSYCHOTICS	These agents are also referred to as major tranquilizers or neuroleptics and are utilized to treat a wide range of disorders which produce psychotic symptomatology.
ANTIDEPRESSANTS	These agents are utilized to treat symptoms of depression. There are currently three sub-groups of antidepressants: 1. The TCA's (tricyclic anti-depressants) and related cyclic antidepressants. 2. The MAOI's (monoamine oxidase inhibitors) 3. The atypical antidepressants.
LITHUM	This naturally occurring element is used to treat manic depressive disorders. In recent years a small number of anticonvulsants have been noted to be effective for treatment of manic depressive disorder in individuals who cannot tolerate lithium.
ANXIOLYTIC	Currently the major anti-anxiety agents are various members of the benzodiazepine family.

One of the problems or challenges of psychopharmacology is that some of the most effective drugs have serious side effects – side effects which can promote non-compliance with the medication regimen or even mimic symptoms of a psychiatric disorder. Therefore, a discussion of psychopharmacology would be incomplete if it did not include the major medications used to intervene with severe side effects – the ANTICHOLINERGIC AGENTS.

ANTIPSYCHOTIC AGENTS

Psychosis, per se, is not a psychiatric illness, rather it is a symptom associated with a wide range of disorders. The hallmark of psychosis is considered by many as loss of contact with reality. This may take various forms including delusions, severe confusion, hallucinations, or sever impairment in judgment or ability to reason. For many people, the disorder most often associated with psychosis is schizophrenia. However, psychosis sometimes compounds severe depression, and may be noted in various neurological conditions including acute metabolic and toxic states, head injury, M.S., delirium, dementias, and CNS infections or neoplasm. Treating an individual with antipsychotic medications may relieve the psychotic symptoms but does not treat the underlying process.

Often the admission of a patient to the general hospital with an established diagnosis of schizophrenia can cause alarm or concern among the health care team. Many factors may influence an individuals' reaction to this diagnostic label – education, previous professional or personal experience, input from our culture including the media and so on. The DSMIII-R discusses 5 subtypes of schizophrenia in detail. However, for a very brief overview, it may be helpful to think of 2 basic types of schizophrenia each with specific biological findings and clinical pictures. Type one schizophrenia is recognized by positive symptoms: hallucinations, delusions, and disturbed thought patterns. Positive symptom schizophrenia is currently believed to be associated with a hyperactive dopamine systems and it responds very well to antipsychotic medication. Type two or negative symptom schizophrenia is characterized by anhedonia (inability to experience pleasure), flat affect, diminished motivation, social isolation, and the absence of hallucinations or delusions. These symptoms are less responsive to antipsychotic medications. While schizophrenia is a chronic condition, it is characterized by periods of exacerbation and periods (often lengthy) or remission. Many individuals who are schizophrenic are maintained on anti-psychotic medication and may be admitted with a history of on-going antipsychotic use. This important information should be relayed to the primary care physician.

Some individuals become psychotic during a hospitalization and require intervention to decrease the alarming and unpleasant symptoms of psychosis. Antipsychotic agents are most effective in treating:

- Hallucinations
- Delusional thinking including paranoia
- Severe confusion including impaired judgment
- Psychomotor agitation
- Bizarre behavior
- Belligerence or aggression

The drug of choice in a given situation will be one which will effectively treat the psychotic symptoms while causing the least side effects. It is important to be aware of and consider side

effects when prescribing and administering these agents,. At times a certain antipsychotic may be chosen to use the expected side effects to benefit the patient in addition to the primary effect of the drug. An example of this might be to choose an agent with a sedative side effect when treating psychotic symptoms in a person who is agitated as well.

Table one lists the antipsychotic medications in current use. It illustrated the pharmacological principles of efficacy and potency. Efficacy of a drug refers to its maximal therapeutic effect while potency refers to the amount of medication required to achieve maximal effect.

TABLE I

From Handbook of Psychiatric Drug Therapy
S. Hyman & G. Arans, Little Brown, 1987

Antipsychotic drugs: potencies and side effect profiles

Drug	Approximate dose equivalent	Sedative Effect	Hypotensive Effect	Anticholinergic Effect	Extra pyramidal Effect
Phenothiazines					
Aliphatic	100	High	High	Medium	Low
Chlorpromazine (Thorazine)					
Triflupromazine (Vesprin)	30	High	High	Medium	Medium
Piperidines					
Mesoridazine (Serentil)	50	Medium	Medium	Medium	Medium
Thioridazine (Mellaril)	95	High	High	High	Low
Piperazines					
Acetopphenazine (Tindal)	15	Low	Low	Low	Medium
Fluphenazine (Prolixim, Perrmitil)	2	Medium	Low	Low	High
Perphenazine (Trilafon)	8	Low	Low	Low	High
Trifuoperazine (Stelazine)	5	Medium	Low	Low	High
Thiozanthenes					
Aliphatic					
Chlorprethizene (Taractan)	75	High	High	High	Low
Piperazine					
Thiothizene (Navane)	5	Low	Low	Low	High
Dibenzoxazepine					
Lozapine (Loxitane, Daxolin)	10	Medium	Medium	Medium	High
Butyrohenones					
Droperidol (Inapsine-injection only)	1	Low	Low	Low	High
Haloperidol (Haldol)	2	Low	Low	Low	High
Indoine					
Molindone (Moban)	10	Medium	Low	Medium	High
Diphenylbutyipiperidines					
Pimozide (Orap)	1	Low	Low	Low	High

Antipsychotic medications have the potential to cause a wide range of side effects including sedation, hypotension, anticholinergic effects and extra pyramidal symptoms. Sedation and hypotension (usually postural) require no elaboration as they are common drug side effects which can be easily monitored and/or self reported b the patient. Precautions and patient teaching are the same for these side effects when caused by any other drug. The typical anticholinergic effects noted include dry mouth blurred vision, constipation and urinary hesitancy or retention. These effects often diminish as the individual becomes accustomed to the medication. Anticholinergic side effects are best treated symptomatically with fluids, diet, etc.

Extrapyramidal side effects include several different types of CNS reactions which can be both severe and frightening in nature. The Parkinson-lie side effects include a mask-like facial expression, muscular rigidity, tremor, slower motor responses or shuffling gait. Such side effects typically become evident about one week or so after the initiation of antipsychotic therapy. Another extra pyramidal side effect (EPS) is an acute dystonia. Acute dystonia can occur even after one dose of medication and usually occur early in the course of antipsychotic therapy. Patients often complain of a stiff neck or jaw when experiencing a dystonic reaction. However, these bizarre and painful muscle contractions can affect the tongue, face, neck and back.

Both of these EPS respond well to IM or PO anticholinergic agents. Typically, Cogentin, Benadryl, or Artane are used to counteract these EPS.

Another EPS is akathesia. The nurse may observe this as restlessness or an inability to be still. The patient's motor restlessness is visible and is subjectively experienced as anxiety, or agitation. Akathesia may develop weeks or months after the onset of drug therapy. Unfortunately, this side effect can present as an increase in symptoms and may be addressed by increasing the antipsychotic dose which intensifies the akathesia. While akathesia may partially respond to anticholinergic medications the most effective remedy may be low dose benzodiazepines in conjunction with lowering the dose of antipsychotic medication to the minimum effective dose. Low potency antipsychotic agents usually cause less akathesia.

A final EPS is Tardive Dyskinesia. This serious and often irreversible side effect usually begins late in the course of antipsychotic drug therapy. Clinically, the presentation of TD includes involuntary sucking and smacking movements of the mouth, involuntary tongue thrusting, and other facial grimacing. Chorea of the trunk and extremities is typical as well. There is no cure for TD and the only treatment is to discontinue the antipsychotic medication. When discontinuation occurs, there is usually an increase in the face and body movements because the medication had been masking as well as causing this side effect. Over time the TD symptoms may diminish.

In addition to these major and fairly frequent side effects, antipsychotic can cause agranulocytosis, photosensivity, eye problems, hormonal problems, and cardiac side effects in rare instances.

Aside from these side effects, antipsychotic drugs can cause a rare idiosyncratic reaction known as Neuroleptic Malignant Syndrome (NMS). This extremely serious condition has a mortality rate of about 20% and even acutely psychotic patients who develop NMS may require transfer for treatment in an ICU.

NMS usually begins with muscle rigidity and fever. These symptoms precede autonomic instability and encephalopathy. A full blown NMS takes from 24 to 72 hours to develop. Fevers as high as 41 C or more are usual. Muscle tone can be so rigid as to lead to myonecrosis with secondary renal failure from myoglobinuria. Autonomic instability including unstable blood pressure, tachycardia, diaphoresis and pallor is common. Levels of consciousness may vary; however, stupor and even coma are not uncommon. Lab values reveal C PK 3 up to 15,000; leucocytosis of 15,000 to 30,000' creatine phosphokinase up to 5.1 mg/dl; increased liver enzymes and generalized slowing of EEF.

TABLE II

Medications commonly used to treat Neuroleptic Malignant Syndrome (NMS)
From Nurseweek – Northern California edition – March 9, 1952
Article Authors L. Pellitier, D. Daily & D,. Bennett

NAME GENERIC/TRADE	ACTION	USUAL DOSAGE
Bromocriptine mesylate (Pariodel)	Direct dopamine agonist; relieves akathesia and rigidity	2.5-5mg/TID
Amantadine (Symmetrel)	Anti-cholinergic agent; reversed Extrapyramidal symptoms and Catatonia	200-300 mg/day
Lorazepam (Ativan)	Restoration of dopamine-y-Aminobutyric acid balance, Relieving catatonia	3mg/day
Diphenhydramine Hydrochloride	Antihistamine; also provides Local anesthesia by preventing Initiation and transmission of Nerve impulses	50mg/IM
Benztropine mesylate (Cogentin)	(Same as amantadine)	2-4mg/day
Dantrolene sodium (Dantrium)	Direct acting skeletal muscle Relaxant; drug of choice for Treating malignant hyperthermia	1-10mg/kg/day (IV,po)
Lavodopa (Dopar, Larodopa, Levopa, Parda, Rio-Dopa)	Counters the presumed central dopamine blockade of NM: reduces profound parkinsonism (not first choice treatment)	100 mg/BID for suspected NM; up to 1mg/day for NM

Table II suggests the appropriate pharmacologic interventions to reverse NMS. However, excellent supportive care is essential including hydration, management of high fever, preventive skin care, cardiac monitoring and careful monitoring of output and renal function. When respiratory functions have been impaired due to muscle rigidity, pneumonias can complicate recovery.

Risk factors for NMS are:

- Physical agitation
- Physical exhaustion
- High doses of antipsychotics
- Dehydration
- A diagnosis of schizophrenia
- Hypernatremi
- Concomitant lithium therapy

Males develop NMS twice as frequently as women and 80% of those affected are under 40 years of age.

In the past two years, a new antipsychotic medication has been approved for use in the United States. Clozapine (brand name Clozaril) is targeted toward negative symptom of type 2 schizophrenia which has traditionally been more difficult to treat effectively with medications. While Clozaril has a very low side effect profile and does not appear to cause EPS, it has been associated with life threatening blood dycrasias which develops very rapidly. At present all patients who use Clozaril must have weekly blood tests.

ANTIDEPRESSANTS

Antidepressants are another major class of psychopharmalogical agents. Major depression, bipolar depression and depression with psychotic features are the disorders which are treated with antidepressants. These drugs have been found to be effective in panic disorders, neuropathic pain, and bulimia, as well, and to a lesser extent may be helpful in adjustment disorder with depressed mood, obsessive compulsive disorder, and PTSD (post traumatic stress disorder).

There are three types of antidepressants to review:

- Tricyclic related cyclic antidepressants
- Mono-anime oxidase inhibitors (MAOIS)
- Atypical antidepressants

The action of all these agents occurs at the level of receptor sites in the brain where the drugs alter the regulation of the neurotransmitter receptor systems.

Major depression is one of the more common psychiatric diagnosis in the U.S. Therefore, health care providers can expect to care for patients who have an established diagnosis of major depression. Symptoms include:

- Pervasive and continuous depressed mood which may be experienced as sadness, emptiness, hopelessness and helplessness.
- Increasing impairment in normal functioning in all areas of one's life.
- Ahedonia
- Disturbed sleep pattern – insomnia or hypersomnia
- Psychomotor retardation or agitation (speech, gait, movements)
- Exaggerated diminution of self esteem which may be experienced as worthlessness or guilt.
- Suicidal ideas, plans or recurrent thoughts of death.
- Indecisiveness and/or impaired concentration

In addition to psychiatric origins for depression, there are many physical disorders that can cause depression. Some of these are:

- AIDS
- Addison's Disease
- Cushing Disease
- CHF
- Diabetes
- Hyperthyroidism
- Malignancies
- MS
- Rheumatoid Arthritis
- Lupus

And depression is often associated with the use of certain drugs listed on Table 3

TABLE III

J. Preston and J. Johnson
Clinical Psychopharmacology Made Ridiculously Simple
1990 Med Master

TYPE	GENERIC NAME	BRAND NAME
Antihypertensives (for high blood pressure)	Reserpine Propranolo hydrochloride Methyldopa Guanethidine sulfate Clonidine hydrochloride Hydralazine hydrochloride	Serpasil, Ser-Ap-Es, Sandri Inderall
Corticosteroidsand Other Hormones	Cortisone acetate Estrogen Progesterone	Cortone Evex, Menrium, femest, lipo-Lutin, Progestasert, Proputon
Antiparkinson Drugs	Levodopa and carbidopa Levodopa Amantadine hydrochloride	Sinemet Dopar, Larodopa Symmetrel
Antianxiety Drugs	Diazepam Chlordiazepoxide	Valium Librium
Birth Control Pills	Progesterone estrogen	Various Brands
Alcohol	Wine, beer, spirits	Various Brands

Sedation or anticholinergic side effects are the two major types of side effects associated with antidepressant drugs. Just as with the antipsychotic drugs, in some cases side effects can be utilized to benefit the patient in addition to the primary action of the drug. For example, an agitated, restless patient with disturbed sleep ay benefit from an antidepressant with greater sedation as a side effect while a fatigued individual with psychomotor retardation may benefit from an antidepressant with enervating side effects.

Table IV lists the antidepressants in current use and compares their side effect profiles.

TABLE IV

J. Preston and J. Johnson
Clinical Psychopharmacology Made Ridiculously Simple
1990 Med Master

NAMES		USUAL DAILY DOSAGE		ACH
GENERIC	BRAND	RANGE	SEDATION	EFFECTS[1]
TRYCYCLIC and LIKE COMPOUNDS				
Imipramine	Tofanil	150-300 mg	Mid	Mid
Desipramine	Norpramin	150-300 mg	Low	Low
Amitriptyline	Elavil	150-300 mg	High	High
Nortriptyline	Aventyl, Pamelor	75-125 mg	Mid	Mid
Protriptyline	Vivactil	15-40 mg	Low	Mid
Trimipramine	Surmontil	100-300 mg	High	Mid
Doxepin	Sinequan, Adapin	150-300	High	Mid
Maprotiline	Ludiomil	150-225mg	Mid	Low
Amoxapine	Asendin	150-400 mg	Mid	low
Trazodone	Desyrel[2]	150-400 mg	Mid	None
Fluoxetine	Prozac	20-80mg	Low	None
Bupropion	Wellbutrin[3]	200-450 mg	Low	None
MAO INHIBITORS[4]				
Phenelzine	Nardil	30-90mg	Low	None
Tranycypromine	Parnate	20-60 mg	Low	None

[1]Ach Effects (anticholinergic side effects) include dry mouth, constipation, difficulty in urinating, and blurry vision. Can cause confusion and memory disturbances in the elderly or brain damaged patient.[1]
[2] Due to short half-life, requires divided dosing.
[3] Due to short half-life, requires divided dosing.
[4] Require strict adherence to dietary and medication regimen.

Note: prescribed maprotilline and bupropion to patients with history of seizures only with great caution.

The anticholinergic side effects of antidepressant medications can provoke non-compliance with medication regimens, Thorough patient education including what side effects are possible and suggestions for dealing with them is essential. Mild anticholinergic effects are more serious; examine all the drugs the patient is receiving to determine if other therapeutic agents could be causing anticholinergic effects as well.

Postural hypotension can occur with any of the antidepressants.

Cardiac toxicity is another concern with antidepressant medications because they exert a guanidine like effect and cause intra-cardiac conduction to slow. Patients at greater risk, therefore, are those with pre-existing cardiac conduction system disease. Benign EKG changes are sometimes noted in patients with normal cardiac status.

The MAOI groups of antidepressants are often reserved for use in individuals who have not responded to tricyclic or related cyclic anti-depressants. Successful use of MAOI's does require inactivate mono amine oxidase in both the liver and the intestine. When foods containing tyramine or vasoactive amines or medications which are sympathomimetic are ingested, life threatening side effects which require emergency medical attention can result. Symptoms of a hyperdrenergic crisis include severe headache, diaphoresis, mydriasis, neuromuscular irritability, hypertension, cardiac arrhythmias and CVAs.

When a patient is admitted for inpatient care who is on MAOI's it is essential to notify the dietary department. Typically a dietician will wish to consult with the patient and provide a copy of patient instruction re: MAOI's for staff. Table 4 is a sample of patient instructions for safe use of MAOI's.

In addition to hyperdrenergic crisis precipitated by non-compliance with dietary restrictions, the noted drugs can cause serious reactions when ingested with MAOI's.

TABLE V

Dr. Hyman and G, Arana
Handbook of Psychiatric Drug Therapy
1987 Little, Brown & Co.

Sample instructions for patients taking monoamine oxidase inhibitors

1. Certain foods and beverages must be avoided:
   All cheese except for fresh cottage cheese or cream cheese
   Meat
   - Beef liver
   - Chicken liver
   - Fermented sausages
     - Pepperoni
     - Salami
     - Bologna
     - Other fermented sausages
   - Other cured, unrefrigerated meats

   Fish
   - Caviar
   - Cured unrefrigerated fish
   - Herring (dried or pickled)
   - Dried fish

   Vegetables
   - Overripe avocados
   - Fava beans

   Fruit
   - Overripe fruits, canned figs

   Other foods
   - Yeast extracts (e.g., Marmite, Bovril)

   Beverages
   - Chianti wine
   - Some imported beers

   Some foods and beverages should be used only in moderation
   - Chocolate
   - Coffee
2. If you visit other physicians or dentists, inform them that you are taking an MAOI. This precaution is especially important if other medications are to be prescribed of if you are to have dental work or surgery.
3. Take no medications without a doctor's approval.
   Avoid all over-the-counter pain medications except:
   - Plain aspirin, acetaminophen (Tylenol) or ibuprofen

   Avoid all cold or allergy medication **except**:
   - Plain chlorpheniramine (Chlortrimeton) or brompheniramine (Dimetane)

   Avoid all nasal decongestants and inhalers

Avoid all cough medications **except**:
Lain quaifenisin elixir, (Robitussin)
Avoid all stimulants and diet pills.

4. Please report promptly any severe headache, nausea, vomiting, chest pain, or other unusual symptoms; if I am not available go directly to an emergency room.

Any symptoms occurring after ingesting these drugs concurrently with MAOI's require immediate assessment in an emergency room.

Other side effects which may occur with MAOI therapy include: hypotension which is dose related and may interfere with increasing the MAOI dosage; insomnia and agitation; weight gain; anticholinergic effects such as dry mouth, constipation or urinary retention; and impotence or anorgasmia.

Despite the effectiveness of the tricyclic antidepressants and mono-amine oxidase inhibitors in treating depression, both groups have several drawbacks which encourage research for additional antidepressant agents. This overall efficacy rate seems to be 75-80%. While this is significant, it still leaves a considerable percentage of depressed individuals unassisted, Secondly, both these groups of antidepressants take 2-4 weeks before maximum therapeutic effect is experienced. This can lead to frustration with subsequent non-compliance and create very complicated clinical situations when more than one therapeutic trial is required. Finally, both these groups of drugs can be highly lethal when used in overdose attempts.

The third group of drugs in the antidepressant category is the atypical antidepressants'. These newer antidepressants are noteworthy for having more specific neurochemical action than the tricyclics. While researchers are hopeful of developing an antidepressant with rapid onset of therapeutic effectiveness, the atypical antidepressants have not realized this goal. Although some may affect improvement more quickly than many f the original antidepressants, none seem to have a lag time shorter than 10 days.

The atypical antidepressants in current usage are:

Trazadone (Desyrel) This drug features no anticholinergic side effects, however, its sedating properties often cause it to be prescribed at bedtime. Usual dose is 500 – 600 mg/day. Trazadone is less toxic when used for overdose purposes

Buproprion (Wellbutrim) While without anticholinergic or cardiac side effects, Buproprion is associated with higher than expected incidence of seizures. It is slow in onset of therapeutic action and has a narrow therapeutic window. Usual dose is 200-400 mg/day.

Fluoxetine (Prozac) Probably the most well known of the *new antidepressants, Prozac has a more rapid onset of therapeutic effects and has relatively low lethality if used in a suicide attempt. Prozac is often given in one AM dose due to side effects of anxiety and insomnia. Other effects include GI distress, headache or increased perspiration. Usual dose is 20mg each am.

**Which are also referred to as second generation antidepressants.*

Sertraline (Zoloft) The newest atypical antidepressant, Zoloft has less severe side effects and is associated with GI disturbances, headache agitation and insomnia or fatigue, Usual dose is 50-200 mg given in one AM dose. Therapeutic effect occurs in about two weeks.

In concluding a discussion of antidepressant drugs, there are a few common points relevant to all. Clinical action is slow. Antidepressant response includes improved sleep, less emotional lability, decreased fatigue and decreased psychomotor retardation. These are objective symptoms and patients using antidepressants must be made aware that these medications do not raise self esteem or eradicate the sadness, loneliness, or emptiness that often characterizes depression. (Concurrent psychotherapy is most useful for these subjective aspects of depression.) Antidepressant medications are not addictive. Depressions are recurrent illnesses and the discontinuation of antidepressants should be supervised by a psychiatrist. Finally, alcohol use is strongly discouraged while using antidepressants.

In recent years, various antidepressant drugs have been noted to be helpful in clinical situations other than major depression. Antidepressants are frequently used to treat phobias, panic attacks and obsessive-compulsive disorders. They may be used alone or in conjunction with other psychopharmacologic agents. Childhood enuresis and hyperactivity also may respond positively to antidepressant therapy. Chronic pain is often improved through use of antidepressant drugs, as well.

LITHIUM AND ANTICONVULSIVE AGENTS

Lithium is the drug of choice for bipolar disorder. This psychiatric disorder is characterized by episodes of manic behavior alternating with periods of serious depression. Between these acute episodes are periods of stable behavior and normal mood.

Symptoms of mania include:

- Euphoria or irritability which is persistent
- Grandiosity
- Racing thoughts
- Rapid and pressured speech
- Decreased sleep
- Distractibility
- Increased activity or agitation
- Poor judgment
- Excessive emotionality

Lithium is a naturally occurring salt which is highly effective in stabilizing the mood in manic-depressive illness. On-going use of lithium may prevent relapse or diminish the intensity of future manic episodes. Lithium is immediately available in the body, however, 10-14 days are usually required before a therapeutic level is reached in the blood and manic behavior subsides. Initially, a blood level in the range of 1.0 to 1.5 may be needed o effect symptomatic relief. Once mood stabilization is achieved, therapeutic levels are typically in the 0.8 to 1.2 range. In the initial stages of lithium therapy blood levels will be drawn frequently;; as progress occurs and is maintained blood samples are decreased to weekly, then monthly and ultimately, every few months.

One of the drawbacks to effective treatment with lithium is that the therapeutic level and the toxic level are quite close. Toxicity is quite unpleasant and experience with lithium toxicity can provoke non-compliance. This is one reason why blood levels are monitored so closely. Sings of toxicity include lethargy, ataxia, slurred speech, severe nausea and vomiting, tremor, tinnitus, arrhythmias and hypotension. This can proceed if unrecognized to seizures, shock, delirium, coma and death.

While 70-80% of manic patients improve with lithium, the remainder cannot tolerate the drug or do not respond therapeutically. In recent years considerable attention has been paid to other drugs which may be effective in treating bi-polar disorder. The most promising drugs for this use are anticonvulsants including carbamazepine and valporic acid. Both of these drugs have been effective in some individuals who did not respond to lithium. These two drugs have also been used with lithium and in some cases augment the effectiveness of lithium. This augmentation may be useful for someone who experiences lithium side effects at doses below the therapeutic level, for example. In such a situation, the anticonvulsant drug essentially boosts the action of the lithium without requiring and increase in the dose of lithium.

Side effects of lithium include G.I. distress, polyuria, lethargy, fatigue, mild tremor, memory disturbances and benign EKG changes. Many of these side effects are transient. Common side effects of carbamazepine include dizziness, ataxia, sedation, dysarthis, diplopia and G.I. distress. Even these are infrequent and generally mild. Side effects may be further minimized by increasing dosage in small increments. Valporic acid has few side effects: notably nausea and sedation.

ANTI-ANXIETY AGENTS

The final class of psychoactive drugs is the anti-anxiety agents also known as tranquilizers.

Anxiety is a familiar phenomena which is part of the human experience. Minor anxiety has positive value and increases alertness, awareness and concentration. Severe anxiety, however, can interfere with day-to-day functioning.

Anxiety may be a component of a major psychiatric disorder such as schizophrenia or depression or anxiety may be a reaction to stressful event or life situation. Additionally there are several discreet anxiety disorders seen in psychiatric practice. Anti-anxiety medications may be effective treatment for anxiety arising from any of these origins.

Symptoms of anxiety include:

Tachycardia
Shortness of breath
Dizziness/light-headaches
Diarrhea or urinary frequency
Initial insomnia
Parethesias
Muscle tension or trembling
Restlessness/agitation
Impaired concentration or attention
Tension, nervousness
Feelings of unreality

Some medications can cause a feeling of anxiety such as caffeine, nasal decongestant sprays asthma medications, steroids, allergy preparations, amphetamines and cocaine. Such drugs should be discontinued if possible rather than using anti-anxiety agents in addition.

Anti-anxiety agents can be quite effective in treating stress related anxiety. In such situations, drug treatment for a week to a month is optimal as dependence on anti-anxiety agents is well known.

In generalized anxiety disorder, Buspar is the drug of choice. Unlike traditional anti-anxiety agents, Buspar requires 2 – 6 weeks usage before optimal therapeutic effects is experienced,. This medication is used on a routine not a PRN basis. Buspar is not a benzodiazepine.

Panic disorder is serious and debilitating anxiety disorder. Effective treatment of this biochemical illness is usually an antidepressant agent often in combination with an anti-anxiety agent. Treatment of panic disorders requires careful monitoring and can be a lengthy process.

Concurrent psychotherapy is suggested for optimal outcomes in stress related anxiety, generalized anxiety disorder and panic disorders.

Other than Buspar, all the anti-anxiety agents in concurrent use are benzodiazepines. All the members of this drug family are associated with risk for drug dependency, addiction and withdrawal.

Sudden discontinuation or too rapid decrease in dosage can result in withdrawal symptoms that mimic the symptoms for which the drug was originally prescribed. Convulsions are seen in benzodiazepine withdrawal and may occur up to a few weeks after the last dose. Benzodiazepine withdrawal requires competent medical oversight to be brought to a safe conclusion.

TABLE VI

Dr. Hyman and G. Arana
Handbook of Psychiatric Drug Therapy
1987 Little, Brown & Co.

			Elimination
Compound	**Active substances in Blood**	**Distribution**	**Half-life (hr)***
Alprazolam	Alprazolam	Intermediate	6 - 20
Chlordiazepoxide	Chlordiazepoxide	Slow	5 – 100
	Desmethychlordiazepoxide		
	Demoxepam, desmethyldiazepa		
Clonazepam	Clonazepam		34
Clorazepate	Desmethyldiazepam	Rapid	30 – 100
Diazepam	Diazepam, desmethyldiazepam	Rapid	30 – 100
Flurazepam	Hydroxyethyl flurazepam	Rapid	50 – 100
	Desalkyldiazepam		
Halazepam	Desmethyldiazzepam		30 – 100
Lorazepam	Lorazepam	Intermediate	10 – 20
Oxazepam	Oxazepam		5 – 21
Prazepam	Desmethyldiazepam		30 – 100
Tamazepam	Tamazepam		10 – 12
Triazolam	Triazolam		1.7 – 3

The half-life represents the total for all active metabolites; the elderly tend to have the longer half-lives in the ranges reported.
*The parent compound is a prodrug for desmethyldiazepam, which is the active compound in the blood. These drugs differ in the rates at which they are metabolized to the active substance (e.g., clorazepate has a very rapid onset, prazepam a very slow one).

Benzodiazepines are the drug of choice for alcohol withdrawal which will be discussed in depth a bit later.

Side effects of benzodiazepines include fatigue, drowsiness, sedation, impaired memory and diminished motor coordination. When alcohol is co-ingested with benzodiazepines, CNS depression is intensified. Alcohol and benzodiazepines can be lethal when used together in an overdose attempt.

As psychiatric disorders become more recognized and psychopharmacological interventions become more specific and effective, care providers will see more patients utilizing psychiatric medications, A few simple guidelines to enhance patient care are:

1. Obtain a thorough history of prescription drug use.
2. When a person is using a psychopharmacologic agent inquire: "Why is (name of drug) prescribed for you?" "Who prescribes _____for you?" and "How long have you been on _____?" All this information should be recorded and relayed to the primary M.D.
3. Suggest that the patient's psychiatrist be notified of the patient's admission.
4. Suggest the patient's psychiatrist be consulted re: alterations in psychopharmacology.
5. Psychopharmacologic agents should not be discontinued abruptly.

PSYCHOPHARMACOLOGIC MANAGEMENT OF THE PATIENT IN ACUTE ALCOHOL WITHDRAWAL

One of the more difficult aspects of managing alcohol withdrawal is that the withdrawal syndrome often surprises care givers. Some patients who experience alcohol withdrawal in a hospital setting are themselves surprised at this turn of events due to ignorance denial or other cognitive impairment. Often the admitting physician is unaware of the patient's alcohol history or has colluded with the patient in the denial process. Patients, families and physicians all are known to minimize alcohol usage.

These are formidable obstacles to overcome and very careful nursing assessment is critical if we are to minimize events of unexpected alcohol withdrawal, Whenever evidence exists to suggest recent alcohol ingestion these clues should be validated if possible and communicated to the healthcare team.

Six to eight hours after drinking is typically when the first signs of alcohol withdrawal are experienced. Earliest withdrawal symptoms are subjective and may present as complaints of nervousness or anxiety. Shortly after this, there may be a mild but noticeable increase in autonomic nervous system activity. Blood pressure and heart rate may begin to increase. Other signs include restlessness, inattentiveness, irritability, increased startle response and onset of a fine postural tremor. Ideally, this is the point at which intervention with benzodiazepines would begin.

At about 24 hours after the last drink, symptoms of alcohol withdrawal become more pronounced. Transient confusion and inappropriate verbal responses may be noted. Nausea and vomiting may occur. Disturbed sleep often including nightmares is typical. If benzodiazepines have not been offered earlier, now is the time to begin frequent dosage based on subjective and objective data.

Withdrawal seizures are not uncommon between 8 and 48 hours after the last drink. Patients may experience u to several grand mal type seizures in a short period of time within this window (8 – 48 hours). Alcohol withdrawal seizures are not usually focal seizures, therefore, are not typically treated with anti-convulsants.

The benzodiazepines are the drug of choice to provide a safe alcohol withdrawal. Their rapid onset permits quick intervention and they can be given in high doses when needed to prevent delirium tremens. I/V administration of Valium is appropriate for seizure control, as well. It is not unusual to use Valium 10-20 mg or more every hour in the early hours of acute alcohol withdrawal. Once benzodiazepines are used significantly during withdrawal as adequate detoxification through daily dosage, reduction must be instituted to prevent further withdrawal from the benzodiazepine. In hospitals where an alcohol and drug recovery unit exists, calls to the medical director and nursing staff for consultation in the management of acute alcohol withdrawal is highly recommended.

While Valium is widely used for alcohol withdrawal, other benzodiazepines may be substituted. The half-life of the drug should be considered in choosing a drug to treat alcohol withdrawal in addition to onset of action. Benzodiazepines with a lengthy half-life provide a more stable blood level and less severe withdrawal problems.

SPECIAL PROBLEMS OF THE ELDERLY

BIOPSYCHOSOCIAL ADJUSTMENTS AND PSYCHIATRIC ILLNESSES

The elderly segment of our population is currently growing at a faster rate than any other age group. Census projections are that by 2000 there will be almost 35 million people in our country over 65 years of age. This large group can be subdivided into older citizens (71-80), the "old-old" (81-90) and the "very old-old" (91-100). Currently, the greatest amount of depression, organic mental disorders and chronic disabling illnesses occurs in the 81-90 year olds. But before we explore these issues let's review some of the usual and typical challenges of aging.

Because of the post WWII baby boom, our country is experiencing a huge block of adults who will approach old age simultaneously and with ore social awareness, political power and expectations of the health care system than ever before. Traditionally, several impediments including ageism, myths about the aging process, stigma and access issues have disabled the elderly in their pursuit of services. These blocks stand to be severely challenged by the baby boomer block.

Ageism refers to negative and hostile attitudes toward the elderly who are viewed with disrespect or as a burden on society as a whole. Subtle ageism may be experienced in caring or interacting with the elderly and impair the quality of services provided to aging adults. Some views which reflect age bias include:

- Beliefs that the elderly are too rigid or unable to change and therefore rationalizing that certain services or interventions are a waste of time.

- An attitude of "why bother" because the elderly are going to die anyway.

- Avoidance of the elderly because of personal fears of aging or unresolved conflicts in our relationships with parents or other older significant others. Such views may impair or even prevent health care providers from objective assessment and intervention.

Our culture has supported a variety of myths about aging which are negative and unfounded. Loneliness, depression or senility are not aspects of "normal" aging, for example. Many elderly have internalized such myths and may not seek treatment for eminently treatable problems such as depression. Care providers must assess their own buy-in to such negative stereotypes and participate in debunking such myths.

As the current generation ages we can expect the stigma associated with mental illness to diminish. However, the current older generation still subscribes to many fears or shameful feelings regarding mental illness. In their youth, psychiatric problems were less understood treatment was both less effective and less available, and families tended to ignore or hide psychiatric problems. Care givers much examine their own attitudes as well as make consistent efforts to destigmatize mental illness for the elderly.

Access to service is a problem that exists on several levels. Financial problems are often a deterrent for the elderly in accessing needed services. In our current economy, services are being cut back routinely, and the remaining services become accessible to less and less clients. Physical barriers such as inaccessible buildings and rest rooms may limit access to some elderly from connecting with needed services. Disabling illness which diminish mobility also limit access and the limited availability of home-care, long-term care, attendant care, etc, present access problems to some segments of the elderly. Care providers must advocate for the needs of our older citizens.

In addition to social, political and cultural issues pertinent to the elderly, the later years have their own set of specific biopsychosocial factors which present challenges to aging adults. Biological aging is expected and to varying degrees to accepted part of growing old. Yet individuals of the same chronological age may, in fact, age quite differently. Many factors impact biological aging such as stress experienced in life and coping skills, heredity, nutrition, exercise, cultural influences, presence or absence of illness and relationships.

There are a number of theorists who have focused on the aging process. Among them seems to be some consensus that an adequate adjustment to older age includes finding meaning in the pursuits of older adulthood, an ability to review one's life and reminisce positively about life events and an ability to integrate the past into the present achieving some sense of accomplishment and wholeness. These abilities will allow the older adult a sense of satisfaction and assist them in coping with the changes and challenges of the later years.

One of the hallmarks of the aging process is a generalized slowing of thought processes and motor activities. Although this slowing is certainly individualized, it is universal. With aging comes some sensory losses – vision, hearing, smell, etc. become less acute causing input to less sharply defined and processed. This does not mean, however, that intelligence diminishes. Researchers do not agree on the supposed decline in intelligence associated with aging and many suspect reported declines have more to do with artifacts of testing older adults. Some studies even report an increase in IQ in older adults.

Memory deficits have long been associated with aging. In fact, people may begin identifying memory impairment in early or mid-adulthood and presume they are on a downhill slide. A variety of factors influence memory such as attention span, fatigue, boredom and rate of input to name a few. Such factors can be adjusted to facilitate enhanced memory. The memory process involves three steps:

1. Receiving the information
2. Storing the information
3. Retrieving the information

Impairment can be related to problems at any stage of this process. Inputting too much information at once can interfere with reception. This is often the problem when young adults who juggle careers, family, and households note memory problems. Storage of information can be enhanced when information is meaningful and relevant. Retrieval of information can be facilitated by use of mediators – associations or gimmicks such as acronyms. Also memory can be boosted by pacing oneself and, or course, repetition.

Undeniably the older years have a certain set of stressors associated with them – retirement, losses of loved ones, physical health problems, and limited financial resources are serious challenges. Coping skills learned over the life style are not lost in later years, however, and acquiring new coping skills is quite realistic. Many older adults cope and adjust to the psychobiological challenges of later years quite well. Among those who do not fare as well depression is the most prevalent psychiatric disorder of these years. Fortunately it is also the most treatable.

When depression occurs in the elderly, symptoms are similar to those experienced in depression occurring at earlier points in the life cycle. Some misleading symptoms may characterize depression in the later years including memory loss, disorientation and agitation. These symptoms can cause clinicians to misdiagnose depression as an organic, irreversible impairment. Additionally, older adults often romanticize their depression. Distressing emotional responses may be embarrassing and frightening to older adults who may exaggerate the stigma associated with mental illness. The depressed elderly may unconsciously focus on physical complaints as a way of expressing their distress. Chronic complaints of G.I. distress, constipation, headaches, dyspnea, chest or musculoskeletal pain which do not respond to treatment or seem to have no basis may, in fact, represent a clinical depression. This is important to be mindful of since depressed older adults have a higher rate of suicide attempts than any other age group and a higher lethality rate, too.

Other psychiatric disorders which present with some frequency in older adults include other mood disorders, adjustment disorders and substance abuse. Chemical dependency can and does develop in later life. Chronic pain, inadequate coping mechanisms, losses of significant others and support systems, inadequate adjustments to changes in life style and identity, increased use of prescription and over-the-counter medications are a few of the factors that may predispose older adults to develop chemical dependency.

PSYCHOPHARMACOLOGY

Effective psychopharmalogical intervention with older adults is difficult to achieve. Some reasons for this include aspects of normal aging. As one grows older, kidney function diminishes due to nephron loss, liver function diminishes and lung function diminishes. These changes cause drugs to be detoxified at a slower rate and the half-life of drugs to be longer. Another complicating factor is that many older adults are on various prescription medicines. The average older patient takes 12 medications daily. Prescriptions may be written by several

different physicians. Pill sharing commonly occurs among groups of friends, as well. All these factors create a very complicated baseline on to which psychopharmacologic agents may be added.

Many prescribing clinicians are well aware of the hypersensitivity older adults may experience to anti-depressant drugs, anxielytic agents and anti-psychotic medications, Low doses are the rule with slow incremental dosage increases. Careful monitoring for therapeutic effectiveness is essential to arrive at the correct, therapeutic dosage.

When low-dose psychopharmacology is initiated, the prescribing clinician must carefully review all the other drugs the patient takes. This is necessary to evaluate for potential complications including complications from side effects. Many psychotherapeutic agents have considerable side effects or may increase the side effect potential of drugs the patient was on previously. Older adults use significant amounts of over-the-counter medications particularly sleep aides and laxatives. Careful patient teaching is essential to avoid side effects such as drowsiness or lethargy which could be enhanced by over-the-counter drugs as well as other prescriptive agents.. Patient teaching should be concise, meaningful and repeated.

DELIRIUM AND DEMENTIA

Delirium and dementia are not problems exclusively found in older adults but these two conditions are associated with the later years when they may occur more often. These are two distinct processes which may overlap in some individuals. This picture is further complicated by inaccurate use of the terminology. Both these conditions produce some confusion – a term which is often used if it were a separate condition.

To begin this discussion here are some definitions of major terms:

Delirium a physically based disorder which is characterized by rapid onset without a history of cognitive problems. Although delirium is typically of a short duration, it is a difficult and challenging condition. It is characterized by intermittent memory loss, confusion, disturbed sleep patterns and appetite, difficult maintaining or shifting attention, fluctuating levels of consciousness and incoherent or disordered speech. Underlying organic causes are usually found for an episode of delirium. Such causes may include drug toxicity, head trauma, a systemic infection, alcohol withdrawal, hypoxia, fluid and electrolyte imbalance or TIA's. Delirium often worsens at night as in sundowner syndrome, This may be related to the hearing or vision impairments of the older years beginning exaggerated a low-light environment. Delirium is 99% reversible.

Dementia dementia is a progressive, primary degenerative condition. Its onset is insidious evidenced by a slow, steady decline. Alzheimer's' disease is the most common dementia. In the early stages of dementia, individuals are often aware of their decline, This awareness can trigger a clinical depression. Gradually, the demented adult looses perception of language, situations, identities, etc. Dementia is not normal aging. In addition to Alzheimer's disease, dementia may be caused by metabolic disorders, Huntington Chorea, multi-infarct dementia, Binsewangers disease, carbon monoxide poisoning, cardiac arrest, head injuries, various infections, space occupying lesions, auto-immune disorders, alcoholism and some cases of epilepsy. Although the dementia associated with psychiatric disorders, drug toxicity, nutritional disorders and some metabolic disorders are treatable and may improve most dementias have a poor prognosis.

Depression a separate clinical entity can compound either of these disorders and complicate the clinical pictures.

Remember that depression is very amenable to appropriate treatment.

Confusion too, may compound these disorders. Confusion can be caused by organic, sensory or emotionally based problems and has a good prognosis.

In assessing for delirium and dementia, be a keen observer. The patient's appearance and presentation may offer you some excellent clues. Observe and assess for:

Grooming a change in grooming or performance of ADL's (not related to disability), may suggest a sudden onset of behavioral change as seen in delirium.

Affect and activity Level stable or fluctuating moods, agitated or hypoactive lability of affect is consistent with delirium while a flat, withdrawn mood may suggest depression.

Orientation check to see if the person is oriented to person, time, place and situation. Anxiety can impair memory so you may wish to repeat these questions later in the interview after you re-orient the patience once. Demented individuals may provide non-sensical replies if they are disoriented or their orientation may fluctuate.

Memory Assess both recent and remote memory. Demented individuals may respond irritably, or perseverate, or confabulate when questioned. Depressed persons may have difficulty concentrating and may not respond.

Identification Ask your patient to identify a couple of common articles such as your pen or watch. In dementia, agnosia (the inability to identify familiar objects) is often present.

Explore the patient's medical history searching for physical problems which could affect cognitive functioning. Explore social history for recent losses or other stressors, explore alcohol and drug use patterns for clues regarding drug toxicity or alcoholism; explore prescription and over-the-counter drug use for toxicity issues or side effects, Always interview family members or friends who are present regarding medical history, patient's self-care abilities, recent stressors, onset of cognitive changes, and family history of psychiatric disorders, alcoholism and dementia. Be sure to explore with both the patient and their significant others the onset and course of the symptoms.

There are proven interventions for working with older adults who suffer from confusion secondary to delirium or dementia. First, it is important the sudden or slow changes in cognition be noted and attended to. Ascertaining the underlying cause is essential and many underlying causes are highly responsive to appropriate treatment.

Secondly, pay attention to the physical aspects of the patient's situation. Does the patient need pain relief? Pain can cause confusion. Remember that as we age, we need 3 X more light – this includes increased nighttime lighting to diminish misperceptions of unfamiliar surroundings. Background noise can add to confusion by distracting a person from focusing on the care giver attempting to communicate or by obscuring a direct communication. Another face of aging is that the urinary bladder shrinks requiring more frequent urination. Nocturia is normal in the elderly but nighttime wake-ups in strange rooms in a bed with side rails can be quite confusing and frightening, In regard to nighttime problems, also be aware the older adults require less sleep than young and middle aged folks., Many seniors do fine with five hours sleep. Use of sleeping pills to lengthen sleep that is adequate and age appropriate, is asking for problems. Schedules need to be adjusted to meet the needs of our patients not vice versa.

Attention to the familiar in the environment can significantly cut down on problems with confusion. Allowing patients to use their own clothes, a blanket from home or other personal objects can assist them to be more in touch with reality. Use family to be with patients during difficult times as much as possible.

Physical activity can be helpful, too. If your patient has a sitter, prepare a care plan which focuses on keeping the patient as active as possible. Motion can decrease agitation – if you have a rocking chair handy try it for an agitated older adult, Find simple chores for the

patient – one gerontologist suggests allowing a patient to fold and refold the unit's washcloths. Such an activity can decrease tension, smoothes through repetition and provide an opportunity to do a familiar task.

When interacting with confused older adults use short simple sentences, Be patient – cognitive impairment significantly slows information reception and processing, Responses will take about three times as long, too. Minimize any decision making during periods of confusion., Another communication strategy is to focus your verbal interaction on calming and reassuring the individual. Clarifications of reality can be offered but do not argue or insist with a confused patient. This can provoke agitation. When circumstances in the environment are agitating, use the patient's deficits to their advantage. Try and distract them from the present by engaging them in a conversation about their past life.

A final reminder about restraints – they almost uniformly increase confusion. Although patient safety is undeniably a major priority, alternatives to restraints such as use of a geri-chair are important solutions to these problems.

In our concurrent health-care environment, many acute care facilities include a skilled nursing facility or an extended care unit as part of the physical plant. If this is the case in your practice setting, utilize this resource for assistance in planning care and interventions when caring for confused elder adults. Phoning a colleague for suggestions and avoid "reinventing the wheel". Also many SNF's have a geriatric clinical nurse specialists who may be willing to consult to your service.

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RESOURCES

Lithium Information Center, University of Wisconsin,

National Alliance for the Mentally Ill. (See phone book for local chapters.)

National Self Help Clearing House, Graduate University Center, City University of New York, 33 W 42nd St., N.Y., 10036.

Self Help Center, 1600 Dodge Ave., Evanston, Ill. 60204 – Phone: (312) 328-0470.

Co-Dependents Anonymous, P.O. Box 3357, Phoenix, AZ 85067-3577.

POST TEST

1. Which of the following are major classifications of psychiatric drugs?

   a. Antipsychotics
   b. Antidepressants
   c. Auxiolytics
   d. All of the above

2. Antipsychotics are used to treat:

   a. Hallucinations
   b. Severe Agitation
   c. Severe distortion of judgment
   d. All of the above

True or False

T F 3. Antipsychotic drugs are selected based on drug effect and side effect profile.

T F 4. Anticholinergic type side effects are immediately treated by using other medications.

T F 5. There are several types of EPS (Extrapyramidal side effects).

T F 6. Acute Dystonia and Parkinsonian-like side effects usually respond to anticholinergic agents.

T F 7. Akathesia can easily be mistaken for increased psychiatric symptoms.

T F 8. NMS (Neuroleptic Malignant Syndrome) is untreatable.

T F 9. Antidepressant drugs work by regulating neurochemical processes in the brain

T F 10. Antidepressants are known for their rapid onset of action.

T F 11. There are no known drugs which cause depression as a side effect.

T F 12. When a patient is on MADI's, it is important to notify dietary department.

T F 13. The atypical antidepressants have fewer side effects.

T F 14. Lithium is used to treat major depression.

T F 15. When a patient is on Lithium, blood levels need to be drawn to monitor lithium levels.

T F 16. The therapeutic level of lithium varies widely from the toxic level.

T F 17. Some anticonvulsant drugs may be effective in bi-polar individuals who are lithium resistant.

T F 18. Today's psychiatric unit cares for patients with multiple health care needs.

T F 19. Coping skills development is a lifelong process.

T F 20. Coping strategies are intended to enhance self-esteem.

T F 21. Anger is often a reaction to feeling powerful.

22. Choose the correct statement regarding the DSM III R (The Diagnostic and Statistical Manual)

a. Is the product of a multidisciplinary task force within the field of mental health.

b. Two psychiatric diagnoses which are prevalent in our culture are: Depressive Disorder and alcohol abuse or dependence.

c. The DSM III R utilizes a multiaxial system which reflects a biopsychosocial focus.

d. Axis #1 and #2 reflect psychiatric diagnosis, axis #3 reflects physical disorders and axis #4 and #5 reflect levels of stressors and global functioning.

e. All of the above.

True or False

T F 23. A crisis is a situation which overwhelms an individual's usual, adequate coping abilities.

T F 24. Grief reactions are predictable and regimented in appearance; therefore they are easy to identify and fix.

T F 25. In a crisis situation, it is irrelevant to determine a precipitating event or if the patient has previously had any similar experiences.