P 815-818: Mental Health Assessment  (know this)

Role of Psyche Nurse

1. Create a climate of
   a. Healing
   b. Growth Promotion
   c. Caring

2. Therapeutic, professional relationship:
   a. Caregiver, advocate, teacher.

3. Know psyche meds
   a. Know the categories

DSM IV –TR

1. Axis 1 – clinical disorders
2. Axis 2 - Personality disorders
3. Axis 3 - Medical conditions (like COPD, asthma)
4. Axis 4 - Psychosocial; environmental problems (unemployed, homeless, no support, what kind of help do they need)
5. Axis 5 – Global functioning (0-100) – below 30 is seriously impaired. (Usually below 30 if hospitalized – doctor decides)

Mental Illness: does not develop overnight.

1. Mental illness - - - - - Mental health: most are somewhere in-between.

Therapeutic Milieu (structured group therapy)

1. Environment structure- improve mental health
2. Basic needs met- safety, sleep, nutrition, meds
   a. Important to provide that patients sleep
3. Need private and physical space: use limit setting on personal space.
4. Structural programs for social activities
5. Inclusion of family and significant others (list family involved with patient)

Therapeutic Communication

1. Broad opening
2. Presenting reality is important
   a. “I’m sorry, I don’t see that bug”

Non Therapeutic Behavior

1. Don’t ignore any patient
2. Don’t sympathize with their disorder
3. Don’t encourage dependence : teach them to be independent

Types of admissions

1. Voluntary
2. Involuntary: they think their fine
3. Patient’s rights
   a. Refusal of treatment
   b. Confidentiality and privacy
   c. Least restrictive alternative
d. Can go against the patient’s wishes only with a court order.

**Nutrition and disease processes**

1. Diarrhea : low residue diet
   a. Meat, fish, poultry, eggs, milk (up to 2 c/day), vegetable juices without pulp, Fruit juices without pulp (but not prune), breads, cereals, fruit ices, sherbet, gelatin

2. Constipation
   a. High fiber diet substitutes: “FiberCon”, “Metamucil”
   b. Exercise and water
   c. Encourage breads and cereals (6-11 servings daily), dried peas or beans, fresh fruits and vegetables.

3. Colostomy and ileostomy concerns
   a. Gas producing foods: apples, asparagus, beans, beer, bran, broccoli, cabbage, carbonated bev’s, cauliflower, celery, coconut, cream sauces, cucumber, eggs, fish, fried food, garlic, honey, melon, milk, nuts, onions, prunes, radishes, wheat, yeast
   b. Foods that increase risk for blockage

**Personality disorders**

**DMS IV TR Categories**

*Personality: Pattern of behavior of how someone relates to self, others, and environment*

**Paranoid personality disorder**

a. Axis 2

b. Assessment
   a. Pervasive mistrust and suspiciousness of other
   b. Aloof and withdrawn
   c. Guarded and hypervigilant
   d. Limited affect
   e. Labile mood – mood changes quickly
   f. Examine and analyze other’s behaviors
   g. Remain physical distance from staff and others
   h. Projection – main defense mechanism

c. Nursing interventions
   i. Approach in formal, business like manner
   j. Avoid jokes or social chitchat
   k. Involve them in formation of care plans
   l. Work w/patient to establish trust- be hones and straightforward, keep commitments
   m. Help patient validate ideas (refrain from acting on paranoid ideas)

**Schizoid personality disorder**

a. Assessment
   n. Detached from social relationships – do not desire friends or family
   o. Restricted range of emotions and marked difficulty expressing emotions
   p. Aloof and indifferent – appear emotionally cold, uncaring and unfeeling
   q. No leisure activities
   r. Extensive fantasy life – reluctant to reveal
   s. Can distinguish fantasy from reality – **no disordered or delusional thoughts**

b. Nursing interventions
t. Assist patient to function in community
u. Refer to case manager for housing (room and board with meals and laundry services best)
v. If needed and for employment
w. Case manager can find health care service and manage finances.

**Schizotypal personality disorder**

a. Assessment
   a. Similar to schizophrenia – not as decompensating
   b. Appear odd, aloof, isolated, peculiar
   c. Unkempt and disheveled, clothes don’t fit or match
   d. Ideas of reference, magical thinking, and odd beliefs
   e. Believe in ESP, clairvoyance and “sixth sense”
   f. **Limited social contact except first degree relatives**
   g. Social anxiety – does not decrease with familiarity
   h. May be suspicious and paranoid, can’t trust strangers.

b. Nursing interventions
   a. Help patient develop self care and daily routine for hygiene bathing (same nurse daily)
   b. Help patient develop social skills to function in the community with minimal discomfort. (role play interactions, practice clear and logical requests)
   c. If uncomfortable with face to face interactions, phone or written requests may help
   d. Help patient identify one person who they can trust and turn to. (social worker or family member)
   e. May be put on antipsychotic meds.

**Antisocial personality disorder**

a. Assessment
   a. Lack of remorse for behavior
   b. Violates rights of others – exploitation of others
   c. Lying, impulsivity, poor judgment, irresponsible, thrill seeking behaviors
   d. Rationalizes own behavior, lack of insight
   e. Irritable and aggressive, shallow emotions
   f. Poor work history
   g. Can be very engaging and charming
   h. Often displays false emotion depending on the situation: pretend
   i. Can not feel empathy – exploit others without guilt
   j. Does not consider the legal, moral, or ethical issues when making decisions
   k. Behavior is determined by what they want- immediate gratification.

b. Nursing interventions
   a. Limit setting – state the limit and the consequences
   b. Identify expected, acceptable behavior
   c. Consistent adherence to rules and treatment plan
   d. Confrontation – immediately with problem behavior
   e. Teach patient appropriate social skills
   f. Teach effective problem solving skills- have patient attend groups
   g. Teach patient ways to decrease impulsivity
   h. Teach proper outlet to express anger or frustration
   i. Time out to avoid stressful
   j. Avoid the use of drugs and or alcohol
Borderline personality disorder (people are on the border of neurosis and psychosis)

a. Assessment
   a. Fear of abandonment – real or perceived
   b. Intense, unstable, chaotic relationships
   c. Chronic feelings of loneliness, emptiness, boredom, frustration
   d. Unstable self image
   e. Recurrent self mutilating behavior
   f. Recurrent suicidal threats and gestures.
   g. Labile mood (changes rapidly)
   h. Pervasive mood – dysphoric (unhappiness, restlessness, malaise)
   i. Impulsivity (very impulsive)
   j. Irritability
   k. Lack of insight
   l. Impaired judgments (gambling, money, sex)
   m. “Splitting” – polarized thinking about self & others
      1. Example: “all good or all bad” no in-between,
      2. Like to manipulate staff. Good to change staff.
   n. Transient psychotic symptoms – auditory hallucinations demanding self-harm or delusions (only those that are psychotic, not all of them)
   o. Obsessive rumination. (same thoughts over and over again.)
   p. Dissociative episodes – awake but unaware of actions
   q. Flashbacks to previous abuse or trauma (PSD)

b. Nursing interventions
   a. Provide safe environment – no harm “contract”
      3. (Cutting, burning, punching self)
   b. Ask about suicidal ideation or plan
   c. Help patient express feelings and emotions properly; identify feelings and decreased impulsivity.
   d. Help patient cope and control emotions
   e. Journals – express emotion and gain insight
   f. Teach social and communication skills. “I understand why your upset, but you can’t . . . “
   g. Teach realistic expectations in relationships. They are easy to exploit.
   h. Help patient to set schedule = plan activities to manage time in hospital and after discharge
   i. Nurse must use calm, matter of fact manner when treating wounds or injuries. (Not punitive lecturing)
   j. Nurse must care and show genuine interest but use caution: patient may misinterpret relationship as friendship – keep professional boundaries
   k. Rotate staff members – patient may attach to one staff member and be flattering and manipulative

Histrionic Personality disorder

a. Assessment
   a. Very dramatic
   b. Excessive emotions – rapid shift in moods
   c. Has to be the center of attention
   d. Speech is colorful and theatrical
   e. Seeks to impress others – overdress and exaggerates intimacy of relationships
f. Display of emotion may seem phony or forced
h. Uncomfortable when not the center of attention
i. May fish for compliments, create unbelievable stories, or create a public scene for attention
j. May embarrass family members and friends with flamboyant and inappropriate public behavior
k. Friends may feel used, manipulated or exploited
l. Often seek treatment for a variety of vague physical or psychological complaints.

Doctor Shop!

b. Nursing interventions
   a. Provide feedback about their social interactions with others – including manner of dress and nonverbal behavior.
   b. Teach appropriate social skills.
   c. Help patient gain insight into behavior.

Narcissistic Personality disorder

a. Assessment
   a. Requires excessive admiration
   b. Grandiose sense of self importance
c. Believe they are special or unique
d. Have arrogant or haughty attitude
e. Envious of others or believe others are envious of them
f. Lack of empathy.
   g. Preoccupied with fantasies of unlimited success, power, beauty, or ideal love
   h. Begrudge when others are recognized or material success (believe it should be theirs)
i. Sense of entitlement – want favorable treatment

b. Nursing Interventions
   a. Challenge to care for!
   b. Avoid becoming angry when they are rude or arrogant or unwilling to wait.
   c. Do not take criticism personality
d. Set limits on rude or verbally abusive behavior
e. Help patient to gain insight.

Obsessive compulsive personality disorder (OCD)

a. Assessment
   a. Preoccupied with perfectionism, orderliness and mental and interpersonal control
   b. Preoccupied with details, lists, order, organizing and schedules
c. Over conscientious, scrupulous, and inflexible
d. Formal and serious demeanor
e. Difficulty expressing emotions, display it in their actions.
f. Affect is restricted
g. Anxious or fretful to reveal emotions
h. Lacks spontaneity: must tell them the plans as early as possible to prepare.
i. Rigid, stubborn and unbending. Rituals are their safe heaven
j. Have low self esteem
k. Harsh, critical and judgmental of themselves
l. Have difficulty working collaboratively with people. Do well alone.
m. Tend to be autocratic with peers – appearing pompous and self-righteous
n. Miserly and hoards possessions
   o. Excessively devoted to work and productivity
p. Few friends, little social life.
q. Underlying feelings of ambivalence, conflict and hostility
r. Use reaction formation – not daring to expose defiance & anger

b. Nursing Interventions
   a. Help patient accept or tolerate less than perfect work – takes a long time.
s. Help patient to gain insight into their behavior – “what happened to make you anxious at this time?”
t. Patients may benefit from cognitive restructuring – Therapist can ask: What is the worst thing that can happen if . . “ to challenge rigid and inflexible thinking.
u. Encourage patients to take risks and try new ways.

**Dependent Personality Disorder**

a. Assessment
   a. Excessive need to be taken care of.
b. Clinging and submissive behavior
c. Fear of separation and being alone
d. Difficulty making decisions
e. Difficulty expressing disagreement with others.
f. Have low self esteem
g. Commonly feel unhappy or depressed, pessimistic
h. Will remain in abusive relationships
   i. Willing to do wrong or illegal activities to sustain even poor quality relationships.

b. Nursing interventions.
   a. Assist patient in daily functioning – plan menus, shop for groceries, budget money, pay bills. **Foster independence the minute they get to the unit.**
b. Refrain from making decisions or giving advice help patient make decisions
c. Provide support and positive feedback
d. Help patient to identify strengths.

**Avoidant personality disorder**

a. Assessment
   a. Very low self esteem
b. Hypersensitive to criticism. They withdrawal from people.
c. Socially inhibited (fear rejection & humiliation)
d. Want closeness and intimacy but fear rejection
e. They need excessive reassurance before risking a relationship.
f. Extreme shyness, timid, withdrawn
g. Fearful of making a mistake or being humiliated
h. Fearful of rejection or embarrassing themselves
   i. Lonely

b. Nursing interventions
   a. Require much support and reassurance
b. Help patient identify positive self-aspects
c. Provide opportunities for positive self esteem
d. Provide positive feedback
e. Assist patient to develop social skills in small groups.

**Depressive Personality**

a. Assessment
   a. Similar to major depression but less severe
b. Sad, gloomy, dejected affect
c. Persistent unhappiness and hopelessness
d. Negative and pessimistic thinking
e. Low self esteem feel worthless

**Passive Aggressive Personality disorder**

a. Passive resistance to demands
b. Retaliate in very subtle way
c. Believe life has been unkind to them or someone has wronged them – seek retribution in subtle and passive ways
d. Demonstrates passive resistance by procrastinating, being forgetful, stubborn, intentional inefficiency.

**Mood Disorders**

**Major Depression (the following are diagnoses)**

a. Etiology: genetic?, physical?, Psychosocial?
b. Focus on Assessments, Interventions, What you should talk about
c. Affective: total despair – hopelessness, apathy, anhedonia (cannot experience pleasure), loneliness, sadness (will tell you)
d. Behavioral: dependent behavior, social withdrawal, neglected hygiene and grooming, slowed movements, slumped posture, little eye contact, little communication.
   i. New admits vs already in (making sure hygiene ADLs are done)
e. Cognitive: self deprivation, impaired decision making
f. Obsessional thinking
g. Delusional thinking: not making any sense
h. Somatic delusion: some feeling that cannot be seen by others
i. SI – suicidal ideation
j. Lack of concentration: can’t do things like games that require memory
k. Social despair: feel like know one wants them
l. Psychological: slowdown in entire body
   i. Lethargy, psychomotor retardation, anorexia, wt. loss, sleep disturbances.
m. Risk for Suicide SAFETY is #1
   i. Assess risk – ask directly if plan made.
   ii. Maintain safe environment: your responsibility
   iii. Initiate suicide precautions (SP)
   iv. Contract for safety: patient to sign
   v. Make rounds at irregular intervals
   vi. Beware of med hoarding: check mouth and use a clear cup
   vii. Assist with problem solving- explore feelings – convey hope
n. Low self esteem
   i. Be accepting: offer self and spend time with patient
   ii. Encourage independence and decision making when ready
   iii. Teach assertiveness and communication skills
   iv. Involve in-group activities – sense of mastery, avoid groups that require concentration.
o. Self care deficit
   i. Assist initially with grooming and hygiene
   ii. Gradual independence with grooming
   iii. Monitor calorie intake – monitor weight
iv. Monitor sleep: don’t allow them to stay in bed all the time.
   1. Encourage regular bedtime and rituals.
   2. Meds are a last resort.

p. Social isolation
   i. Spend time with pt. this conveys acceptance
   ii. If pt mute – therapeutic communication
   iii. Involve in appropriate groups
   iv. Encourage them to be out of bed for activities
   v. Allow visitors and phone calls.

q. Dysfunctional grieving
   i. Assess stage of pt’s grief (stage – anger, bargaining, acceptance, etc.)
   ii. Explain to pt. guild and anger is part of grief
   iii. Provide physical outlet for anger
   iv. Tell them crying is ok – part of grieving
   v. Support groups, spiritual support
   vi. Journal writing – feelings
   vii. Help pt set goals for future

Dysthymic Disorders: no major depression or mania or psychosis

r. Not a long term progressive illness
s. Usually treated as outpatients
t. Depressive mood for most of the day, more days then not for at least 2 years (1 year for children and adolescents – difficult to diagnose in adolescents)
u. Extremely sad, tell you that their very anxious, loneliness, hopelessness, inappropriate anger.

Bipolar Disorder (mania)

v. I-manic or mixed symptoms, II – major depression and or hypomania
w. Cyclothymic disorder: numerous episodes of hypomania and depression
x. Characterized by mood swings: Ranges from profound depression to extreme euphoria
y. Hypomania (mild to moderate mania)
   i. Cheerful, but irritable if wishes not met
   ii. Thinking is flighty (rapid flow of ideas)
   iii. Heightened awareness of environment
   iv. Easily distracted: cannot get them to focus.
   v. Talks to everyone but can’t form friends
z. Mania
   i. Euphoria and elation: everything is wonderful “high”
   ii. Mood changes – irritable
      1. Anger to sadness to crying to laughing
   iii. Flight of ideas, rapid thinking
   iv. Pressured speech (may be disorganized and incoherent)
   v. Hallucinations and delusions of grandeur
   vi. Often the only thing that helps them is medication.
   vii. Impaired judgment – often involve money and sexuality
   viii. Poor concentration, easily distracted
   ix. Inability to sleep
   x. Anorexia and weight loss
   xi. Intrusive, overbearing behavior
   xii. Manipulation of others:

aa. Nursing Planning and interventions
i. Risk for injury
   1. Provide safe environment
   2. 1:1 when manic and delirious
   3. Reduce stimuli
   4. Solitary physical activities that use large muscle groups. (art therapy – drawing)

ii. Risk for violence towards others
   1. Safe environments
   2. 1:1 until calm
   3. Staff to be on alert for safety with other patients
   4. Keep other agitated pts. Separate.

iii. Imbalance Nutrition
   1. High calorie, high protein food (finger foods to eat on the run)
   2. Monitor diet, calorie count, weight

iv. Impaired social interaction
   1. Set limits on intrusive behavior
   2. Use pleasant but firm and calm approach
   3. Avoid power struggles, bargaining, charm
   4. Reinforce non-manipulative behavior
   5. Help pt identify positive self aspects
   6. Avoid group activities when manic gradually introduce nto small groups.
   7. Protect from giving away belongings

v. Disturbed thought process
   1. Orient to reality
   2. Only allow appropriate TV shows or movies
   3. Do not reinforce delusions of grandeur
   4. Use distraction to refocus patient

Suicide: A behavior

vi. 95% have a diagnosed mental disorder
vii. Bipolar and Major depression more likely to have a successful suicide and most had prior attempts.

viii. Assessment:
   1. Consider: Demographics, Presenting symptoms / medical diagnosis, Psychiatric diagnosis, Suicidal Ideas, Support System, Crisis, Psych/medical family history, coping strategy.
   2. Over 50 and Adolescents highest risk
   3. Male
   5. Single, divorced and widowed
   6. Other suicides in family.
   7. Presenting Symptoms: Mood disorder, Substance abuse, Anxiety disorder, Schizophrenia, chronic or terminal illness.

ix. Prevention: Effective clinical care, Easy access to clinical interventions, Restrictive access to highly lethal methods, Family and Community support, Support from ongoing medical and mental health services, Learned skills in problem solving, cultural and religious beliefs.

x.

bb. Anti-manic medications

i. **Lithium carbonate** – Monitor serum levels
1. 1.0 – 1.5 mEq/1 maintenance
2. 1.5 or higher toxic symptoms begin
   a. Early toxic signs (1.5 – 2.0) blurred vision, tinnitus, nausea and vomiting, diarrhea
   b. Late toxic signs (2.0-3.5) increased urinary output of diluted urine, increased tremors, muscle irritability, Psychomotor retardation, mental confusion
   c. Above 3.5: impaired consciousness, nystagmus, seizures, coma, oliguria/anuria, dysrhythmias, myocardial infarction, cardio-vascular collapse.
3. May take 1-2 weeks for therapeutic level
4. Need adequate renal function
   a. Increased excretion occurs with: Acetazolamide, Osmotic diuretics, and Theophylline
   b. Decreased excretion occurs with: Non steroid anti-inflammatory drugs, thiazide diuretics (increases risk of toxicity)
5. Increased risk of neurotoxicity when used with carbamazepine, haloperidol, methylidopa
6. Effect of tricyclics or neuromuscular blockers will increase with concurrent use of lithium
7. Maintain fluid and electrolyte balance: use with loop diuretics or Fluoxetine causes increased levels
8. Tell them that they will have frequent blood drawings, teach them not to take the lithium before blood is drawn.
ii. Clonazepam (Klonopin) – a benzodiazepine (addictive)
iii. Carbamazepine (Tegretol) – maintain in therapeutic range
   1. KNOW BLOOD LEVEL (6-12 mg/l)
iv. Valproic acid (Depakote) maintain in therapeutic range
   1. KNOW BLOOD LEVEL (50-100 mg/l)
   2. Check hepatic function
v. Other anticonvulsants used
   1. Gabapentin (Neurontin)
   2. Topiramate (Topamax)
   3. Lamotrigine (Lamictal)
   4. Oxcarbazepine (Trileptal)

**Antidepressant medications**

cc. Selective Serotonin Reuptake Inhibitors (SSRI) – fewer side effects
   i. Watch for serotonin syndrome – occurs when these meds are taken with other meds that increase serotonin levels
      1. Hypertension, tachycardia, fever, change in mood and behavior
      2. Must call doctor right away – cannot stop med cold turkey
   ii. Teach pt about discontinuation syndrome
      1. Any antidepressant med: cannot stop taking med immediately. Must be weaned off.
   iii. Adolescents increase risk for suicide
   iv. Meds
      1. Citalopram (Celexa)
      2. Escitalopram (Lexapro)
      3. Fluoxetine (Prozac): Neuroleptic Malignant Syndrome with MAOIs (muscle rigidity, fever – similar to serotonin syndrome)
4. Fluvoxamine (Luvox)
5. Paroxetine (Paxil)
6. Sertraline (Zoloft)

**dd. Tricyclics (older group of antidepressants)** Dangerous

i. Must be cautious: risk factors with heart disease, liver problems
ii. Side effects: include **increased heart rate**
   1. May cause angina (must report immediately)
iii. Inhibit reuptake of norepinephrine and serotonin
iv. Takes 10-14 days for effective
v. Drugs
   1. Amitriptyline (Elavil)
   2. Doxepin (Sinequan)
   3. Clomipramine (Anafranil)
   4. Amoxapine (Asendin)
   5. Desipramine (Norpramin)
   6. Imipramine (Tofranil)

vi. Serious side effects
   1. Cardiovascular toxicity, Seizures, dysrhythmias, renal failure, hepatitis
   2. Caution in geriatric population
   3. **Overdose: hyperpyrexia, confusion, hallucinations, increased reflexes**
   4. Assess liver status (ALT and AST) – no tricyclics if hepatic problems.
   5. **DO NOT GIVE if hepatic impairment, MI, seizures or glaucoma**

**ee. Monamine Oxidase Inhibitors (MAOIs)**

i. Phenelzine (Nardil)
ii. Tranylcypromine (Parnate)
iii. Isocarboxazid (Marplan)
iv. Patients are on a VERY restrictive diet (**no tyramine** (Hypertensive crisis))
   1. Foods to avoid
      a. Cheese, pickled foods, chocolates
      b. Certain meat (caviar, herring, liver, smoked sausages, luncheon meat)
      c. Alcoholic beverages (sherry, vermouth, red wines)
      d. Certain vegetables (Fava beans, Italian green beans, snow peas, sauerkraut)
      e. Soups packaged with yeast products.
   v. Therapeutic levels reached in 2-4 weeks
   vi. **Need to D/C MAOIs for 5-6 weeks before another antidepressant.**
   vii. **Side Effects:** Drowsiness, insomnia, orthostatic hypotension, blurred vision, nausea, constipation, dry mouth, anorexia, sexual dysfunction,
   viii. **SERIOUS SIDE EFFECTS:** Hypertensive crisis, circulatory collapse, dysrhythmias

**ff. Atypical Antidepressants**

i. Venlafaxine (Effexor)
ii. Duloxetine (Cymbalta)
iii. Bupropion (Wellbutrin) (– obsessive compulsive disorder)
iv. Nefazodone (Serzone)
v. Mirtazapine (Remeron)
vi. Serious side effects: Stevens-Johnson syndrome (SJS), seizures, vaginal, uterine, or anal hemorrhage, suicidal ideation, Parkinsonism, bone marrow suppression, liver failure

**Electroconvulsive therapy (ECT)**

**gg.** Used for patients not improving with medications

**hh.** Used for severe depression, mania, catatonic schizophrenia, schizoaffective disorder
ii. Need informed consent
jj. 6-12 treatments given 2-3 times a week
kk. Medications used:
   i. Short acting barbiturate: methohexital (Brevital)
   ii. Muscle relaxant succinylcholine (Anectine)
ll. Memory loss: re-orient them when they come out.
mm. Monitor vital signs

Schizophrenias

Etiology: Not homogeneous, results from genetic predisposition, biochemical dysfunction, physiological factors, and psychosocial stress.

DSM IV criteria to confirm diagnosis

Characteristic symptoms (2 or more in 1 month)

i. Delusions, Hallucinations, Disorganized speech, Grossly disorganized or catatonic behavior, Negative symptoms (affective flattening, alogia (lack of speech), avolition (zero motivation))

ii. Social, Occupational dysfunction: work, self care, academic

iii. Duration: continuous disturbances for 6 months with 1 month of symptoms.

iv. Schizoaffective and Mood disorder exclusions: if these have been ruled out because no major depressive, manic or mixed episodes have occurred concurrently with active-phase symptoms.

v. Substance/General medical condition exclusion: disturbance not due to physiological effect of substance, or medical condition.

vi. Relationship to a pervasive developmental disorder: Additional diagnosis of schizophrenia is only made if prominent delusions or hallucinations are also present for at least 1 month.

vii. Residual phase: there are periods of remission and exacerbation.

Stressful life events: No evidence that stress causes schizophrenia, but stress may contribute the severity of the disease.

Current theory: biological based disease influenced by environmental factors.

Types of Schizophrenia:

viii. Disorganized Schizophrenia (hebephrenic schizophrenia)
   1. Withdrawal from society, inappropriate behaviors very bizarre (poor hygiene, muttering)
   2. Onset before age 25, extreme social impairment, communication incoherent, commonly chronic, affect is flat or grossly inappropriate.

ix. Catatonic Schizophrenia
   1. Abnormalities in motor behavior: may be manifested by stupor or excitement (severe)
   2. Extreme psychomotor retardation (Catatonic stupor). Low spontaneous movements and activity. Mutism is common, and resistance to instructions or movement. Waxy flexibility may be exhibited (posturing or voluntary assumption of bizarre positions).
   3. Catatonic excitement: extreme psychomotor agitation. Movements are frenzied and purposeless. May also have incoherent speaking or shouting.
a. Require physical and medical control: often destructive, violent to others.

x. Paranoid Schizophrenia
   1. Suspicion toward others
   2. Presence of delusions or persecution or grandeur and auditory hallucinations related to a single theme. (Tense, suspicious and guarded.) May be argumentative, hostile and aggressive.
   3. Onset is usually later (mid 20s). Less regression of mental faculties, emotional response and behavior than other subtypes.
   4. Occupational functioning and independent living is promising.
   5. Appear normal while on meds.

xi. Undifferentiated schizophrenia
   1. Clients that don’t meet criteria for other subtypes, or meet criteria for more than one.
      Behavior is psychotic with evidence of delusions, hallucinations, incoherence and bizarre behavior.
   2. Usually seen when off their meds.

xii. Residual schizophrenia
    1. Active symptoms are no longer present, but client has two or more residual symptoms. (Odd behaviors, withdrawal, speech problems, etc.)
   2. Individual has at least one previous episode of schizophrenia with symptoms. Residual occurs in a stage following an acute episode. There is continuing evidence of the illness, but no prominent psychotic symptoms.
   3. Symptoms include social isolation, poor personal hygiene, blunt or inappropriate affect, poverty of or overly elaborate speech, and illogical thinking or apathy.

xiii. Schizoaffective disorder
    1. Disorder meets both criteria for schizophrenia AND one of the affective disorders (depression, mania, or a mixed disorder)
    2. Schizophrenic behaviors with strong element of mood disorder symptoms (depression or mania). Client may appear depressed with psychomotor retardation and suicidal ideation, or symptoms may include euphoria, grandiosity, and hyperactivity.
    3. Decisive factor: presence of characteristic schizophrenic symptoms.
       a. Example: dysfunctional mood AND bizarre delusions, prominent hallucinations, incoherent speech, catatonic behavior, or blunted or inappropriate affect.
    4. Better prognosis than other forms, but worse than just a mood disorder.

xiv. Brief Psychotic Disorder
    1. Psychotic symptoms that last longer than 1 day, but less than 1 month.
    2. Sudden onset of psychotic symptoms that may or may not follow a severe stressor.
    3. Presence of emotional turmoil or overwhelming or overwhelming confusion.
    4. May have incoherent speech, delusions, hallucinations, bizarre behavior, and disorientation.
    5. Individuals with preexisting disorders are susceptible to this disorder.

xv. Schizophreniform Disorder.
    1. Schizophrenic symptoms but only for 1 to 6 months
    2. Rarely used diagnosis
    3. Schizophrenia but duration more than 1 and less than 6 months
    4. Sometimes a “provisional” diagnosis

xvi. Delusional disorder
    1. Presence of 1 or more non-bizarre delusions for at least 1 month, hallucinations are not prominent, and apart from delusions, behavior is non-bizarre.
a. Erotomania – in love W/famous person  
b. Grandiose – special relationship with famous person or believe they are that person  
c. Jealous – believe sexual partner is cheating, may become violent  
d. Persecutory – feeling cheated, spied on, followed, harassed or poisoned, may become violent. [most common type]  
e. Somatic – physical defect, disorder, or illness.  
i. Delusions may include: emit foul odor, have infestation of insects, have internal parasites, have misshapen or ugly body parts, have dysfunctional body parts.  

xvii. Shared psychotic disorder (Folie a Deux)  
1. One person begins to share delusional beliefs of another person with psychosis.  
2. 2 people in close relationship: dominant person with delusional thinking imposes thinking onto passive person.  
3. Couple usually socially isolated.  
4. More common in women  

Positive Symptoms of Schizophrenia (think about excess)  

xviii. Hallucinations:  
1. Auditory, visual, olfactory, gustatory, tactile “can you tell me what the voices are saying?”  

xix. Delusions  
1. Persecution, Grandeur, Reference, control/influence, somatic (physical complaint), Nihilistic (belief that part of their body is missing or not functioning).  

xx. Disorganized Thinking  
1. Religiosity – obsessed to disfunction with religious ideas and behaviors  
2. Paranoia – Extreme suspiciousness  
3. Magical thinking – thoughts and behaviors control others  
4. Illusions – misinterpret real external stimulus  
5. Associative looseness – thought process shifts  
6. Circumstantiality – very detailed before reaching point  
7. Clang associations – word rhyme  
8. Concrete thinking – literal interpretation  
9. Echolalia – repeat words  
10. Echopraxia – mimic actions  
11. Mutism – refuse to speak (exception to excess)  
12. Neologisms – invents new words – only have meaning to them  
13. Perseveration – same word response to questions  
14. Tangentiality – never get to point – unrelated topics  
15. Word salad – toss words together randomly  
16. Identification/imitation – unconsciously imitate other person, confusion in their self identity  
17. Depersonalization – losing one’s sense of self – become psychotic  

Negative symptoms of schizophrenia (Loss)  

xxi. Affect – flat – void of emotional tone, Inappropriate, Apathy  
xxii. Avolition – No direction or motivation for goal directed activity
1. Interferes with their ability to make decisions

xxiii. Anergia – lack of energy for ADLs or social interaction

xxiv. Anhedonia – Inability to experience to experience pleasure

xxv. Psychomotor symptoms
   1. Posturing
   2. Pacing and rocking
   3. Waxy flexibility – remain in bizarre and uncomfortable positions for long periods of time.
   4. Autism – focus inward of fantasy world, distorts or excludes external word.
   5. Alogia – poverty of speech
   6. Impaired grooming
   7. Diminished sexual/intimacy of relationships
   8. Social isolation
   9. Regression

**Nursing Diagnosis**

xxvi. Disturbed Thought Process
   1. Establish relationship – use same staff with client
   2. Respond to feeling – tone
   3. Express reasonable doubt – do NOT argue
   4. Involve patient in talk about reality
   5. Explain all procedures and routines
   6. Avoid physical contact, laughing, or whispering
   7. Avoid competitive activities
   8. If patient becomes suspicious: provide food in closed or sealed containers, keep meds in closed containers and bring to patients, let patient get own water in clear cup, be sure patient swallows pills.

xxvii. Impaired Verbal Communication
   1. Assign same staff members
   2. Do not pretend to understand
   3. Listen for themes, attempt to decode (do they have pain?, did someone else do something?)
   4. Validate and clarify your understanding “this is what I think your telling me . . . “
   5. Explain in simple, direct terms

xxviii. Disturbed sensory perception
   1. Establish relationship
   2. Assess for cues of hallucinations (what are they doing? Like shutting doors, looking around). “I understand you hear voices, but I can’t hear them”
   3. Assess for auditory commands
   4. Present reality
   5. Acknowledge voices do exist FOR patient
   6. Avoid touch, but remain with patient
   7. Help patient relate how feelings of anxiety lead to disturbed sensory perception “did something upset you today”
   8. Try to identify triggers
9. Involve patient in appropriate activities
10. Focus conversations on reality

xxix. Risk for violence (self/others)
1. Assess for signs of increased agitation, aggression, or anxiety
2. Provide safe environment, decrease stimuli
   a. Quiet place with low lights, less stimuli
3. Remain calm when interacting with patient
4. Use therapeutic communication: “you seem angry”, offer self
5. Encourage appropriate behavior to channel energy
6. Have sufficient staff present for show of strength
7. If unable to talk to patient and deescalate then may to give PRN meds
8. If all else fails – restraints and seclusion

xxx. Social isolation
1. Brief but frequent contact with patient
2. Use activities to help establish rapport and promote relationships
3. Talk with patient about “safe” topics (weather, how did your day go, did you meet with your doctor today?)
4. Do NOT force contact with any paranoid or hostile patient

xxxi. Noncompliance
1. Teach patient about disease, medications, and treatment
2. Help patient understand how meds decrease symptoms
3. Include family and friends when teaching
4. Teach family how to respond to patient’s behavior
5. Provide info on community resources and local support groups

Antipsychotic Medications (neuroleptics)

1. Traditional meds – Block dopamine receptors in brain (lots of side effects)
   a. Thorazine (most side effects – liver, skin, & blood) 40 – 800 mg. Used a lot as a PRN
      i. Hypersensitivity to sun.
      ii. Tardive dyskinesia – major side effect.
   b. Prolixin (very valuable) given IM 6.25mg – 50mg every week to 10 days
   c. Mellaril 150 -800 mg
   d. Stelazine 2 – 40 mg

2. New meds (antipsychotics) affect both dopamine and serotonin (atypical antipsychotics)
   a. Clozaril (clozapine) – Weekly WBC to detect agranulocytosis (higher incidence of toxic effects) 300-900 mg
   b. Risperidone (Risperdal) 4 – 8 mg: increased appetite – watch for hyperglycemia, weight gain
   c. Zyprexa 10 – 15 mg: increased appetite – watch for hyperglycemia, weight gain
   d. Seroquel 150 – 170 mg: increased appetite – watch for hyperglycemia, weight gain
   e. Geodon 40n-60 mg: prolongs QT, need baseline EKG – watch for changes. Elderly at risk for MI.
   f. Abilify 2 – 10 mg:
   g. Invega 3 – 12 mg
h. Effects
   i. Relief of psychosis, Relief of anxiety, Relief of acute mania

i. **Side effects.** Non Pleasant and Critical needs reporting
   i. Anticholinergic effects: dry mouth, blurred vision, urinary retention, constipation, sedation, orthostatic hypotension, tachycardia, nausea and GI upset, skin rash.
   ii. Hormonal effects (decreased libido, amenorrhea (serious depending on age), weight gain)
   iii. Decreased seizure threshold (get a neuro console with a seizure disorder)
   iv. Hypersalivation, usually temporary
   v. Neuroleptic, agranulocytosis, photosynthesis
   vi. Older patients at risk for CVA or MI

i. **Extrapyramidal Side Effects (EPS)**
   a. Pseudo parkinsonism – symptoms of Parkinson’s
      i. Treat with Cogen
tin, Artane, Akineton, Kemadrin
   b. Akathisia (Can’t sit still, restless)
   c. Dystonia (pain in face, arms, legs, neck)
   d. Oculogyric Crisis: eyes roll back in head.
   e. Can treat side effects with IM Benadryl, Cogentin (usually ordered PRN), Symmetrel, Artane, Akineton, Kemadrin.

3. Serious Antipsychotic side effects
   a. Tardive dyskinesia (involuntary movement of tongue and facial muscles)
      i. Potentially irreversible unless caught early
      ii. Assess for first sign – vermiform movements of tongue

4. Antipsychotic medications **Neuroleptic malignant Syndrome** – MEDICAL EMERGENCY rare
   a. Hyperpyrexia (rapid very high fever – check temp often), muscle rigidity, increased pulse and respirations, fluctuating BP, Mental status changes (stupor – coma), Diaphoresis, Elevated CPK, WBC
   b. NOTIFY MD stat of any symptoms
   c. Discontinue neuroleptic med
      i. They can never take another antipsychotic again.
   d. Recheck often
   e. Treatment:
      i. Dantrolene (Dantrium)
   f. Bromocriptine (Parlodel)
   g. Transfer to intensive care
   h. Rare, but potentially fatal.

5. MAOIs
   a. WARNING: Can be fatal when used within 2 weeks of other antidepressants, carbamazepine, bupropion, SSRIs, SARI, buspirone, sympathomimetics, tryptophan, dextromethorphan, anesthetic agents, CNS depressants, and amphetamines. (5 weeks after therapy with fluoxetine).
   b. Fluid intake 2 – 3 liters per day
   c. Tyramine Content foods to avoid
      i. Aged Cheeses, Raisins, smoked meats, chocolate, liver, cured fish, wine
Somatoform & Dissociative Disorders

-Somatoform disorders are characterized by physical symptoms suggesting medical disease, but no seen organic pathology or pathophysiological mechanism. MENTAL DISORDER

1. An expression of feelings and anxiety through physical symptoms
   a. Many of these patients do not perceive themselves as having a mental disorder.
   b. Symptoms cannot be explained by medical tests
   c. Precipitated by stress
   d. Dependency needs are unmet. Interferes with function
2. More common in poorly educated, lower socioeconomic groups, rural population, women
3. Drug abuse and depression are common
4. Primary and Secondary gain play a major role
   a. Primary gain: Real or perceived threat shifted to biological integrity to avoid dealing with stressor.
   b. Secondary gain: Obtain attention or support that might not otherwise be fourth coming.
5. Pain is most common, associated with affective and anxiety disorder.
6. Contributing factors
   a. Genetic: high incidence in first-degree relatives: inherited or environment?
   b. Biochemical: decreased levels of serotonin and endorphins may play a role in pain disorder. High levels may cause the patient to feel pain more.
   c. Psychodynamic: Ego defense mechanism (hypochondriasis) Physical complaints are an expression of low self-esteem. It is easier to feel that something is wrong with the body than with self.
      i. Views self as “BAD”, physical suffering as deserved.
      ii. Unacceptable emotions repressed and converted to somatic hysterical symptoms that are symbolic to original emotional trauma
   d. Family dynamics: Some families have difficulty expressing emotions and resolving conflicts verbally. The child may become ill and the focus is shifted from conflict to child’s illness. A type of harmony replaces discord and the child receives positive reinforcement for the illness.
   e. Learning theory: similar to family: sick role relieves the need to deal with stress. Shift in focus from the stress to the physical sickness (primary gain). Conflict is relieved within the family as concern is shifted toward the illness and away from the real issue (tertiary gain). This will cause repetition of the response.
   f. Culture: type and frequency vary across cultures. They may not be able to exhibit emotions.
7. Somatization disorder: Check textbook for diagnostic criteria
   a. History of multiple vague symptoms usually GI, Sexual, pseudo neurologic
   b. Must complain of at least 4 sites of pain.
   c. Something small is made large.
   d. Period of remission / exacerbation
   e. Multiple doctors – drugs - Substance abuse HX
   f. Typically chronic and begins at about 30. Suicidal attempts no uncommon.
8. Body Dysmorphic disorder
   a. Preoccupation with some imagined defect in their appearance. If some defect is present, it is grossly exaggerated. (Facial flaws, thinning hair, acne, wrinkles, scars, facial swelling, asymmetry)
   b. Numerous visits to plastic surgeon. – Often associated with delusional thinking
   c. Depression and OCD common with this group
   d. Treatment: Individual, group, behavior therapy. Medications, but not addictive meds.
   e. Pain management programs
   f. Diagnosis: Delusional disorder – Somatic type.
   g. Also defined as the fear of some physical defect.
   h. Appear in late teens, early twenties, usually female.
9. Pain Disorder
a. Pain at one or more anatomical sites is the predominant focus of the clinical presentation, warrants clinical attention
b. Associated with dependency needs/stress 

c. Primary and secondary gain, play a role. 
d. Most common somatoform disorder, more common in women, peaks at about 40 years old. 
e. Pain disorder associated with physiological factors: 
   i. Duration of less than 6 months
   ii. CHRONIC: Duration of 6 months or longer
f. Associated with affective and anxiety disorders
g. A medical condition has a major role in the onset, severity, exacerbation or maintenance of pain. But level of pain is excessive to the condition.

10. Conversion Disorder: loss or change in body function resulting from psychological conflict.
   a. Affect voluntary muscles or sensory functions. (Paralysis, aphony, seizures, coordination disturbances, difficulty swallowing, urinary retention, akinesia, blindness, deafness, double vision, anosmia, loss of pain sensation, pseudocyesis (false pregnancy – a conversion symptom that may represent a strong desire to be pregnant).
   b. The symptoms occur suddenly and often the person has an inappropriate lack of concern (severity of illness). This is called the la belle indifference and is a clue.
   c. Most symptoms resolve spontaneously within a few weeks.
   d. Secondary gain plays a role.

11. Hypochondriasis
   a. Non delusional preoccupation with having a serious disease or the fear of having a serious disease based upon misinterpretation of bodily symptoms
   b. Excessive preoccupation with body and sensations
   c. Past experience with physical illness; a little truth to the way they describe it, but excessive.
   d. Six months or longer in duration, no short term episodes.
   e. Psychosomatic families: equal between men and women. Early onset.
   f. Fear of disease is very disabling.
   g. Anxiety, depression and OCD traits.

12. Treatment Modalities
   a. Individual psychotherapy after physical is ruled out.
   b. Group and behavior therapy
   c. Psychopharmacology – drugs resulting in dependence are to be avoided: anti depressants (pain independent of mood) Tricyclics, and anti convulsants are used for pain.
   d. Pain management programs.

**Dissociative Disorders:**

*Dissociative disorders are defined by a disruption in the usually integrated functions of consciousness, memory, identity, or perception.*

1. Occurs with extreme stress (disasters), more common in woman and young adults.
   a. It is an alteration in memory/identity to protect from anxiety.
      i. Effort to preserve identity by splitting off for self preservation
   b. Interferes with function

2. Dissociative Amnesia **TEST ALERT**
   a. Pathological loss of memory:
      i. Localized: inability to recall an incident or traumatic event for a specific time.
      ii. Selective: Inability to recall only certain incidents associated with a traumatic event for a specific period after the event. They select
iii. Continuous: Inability to recall events occurring after a specific time up to and including the present. (Cannot form new memories)

iv. Generalized: [rare] Not being able to recall anything during their entire life.

v. Systematized Amnesia: cannot remember events related to a specific category of information, or to one particular person or event.

b. Usually follows onset of an extreme psychosocial stress. Termination is typically abrupt and followed by complete remission.

3. Dissociative Fugue
   a. Sudden travel away with inability to recall some or all of one’s past
   b. Cannot recall personal identity and often assumes a new identity.
   c. Duration is usually brief (hours to days or rarely months)
   d. Recovery is rapid.
   e. Usually precipitated by severe psychological stressor, or excessive alcohol.

4. Dissociative Identity Disorder
   a. Existence of two or more personalities in a single individual.
   b. One is dominant over the other most of the time.
   c. Transition is usually sudden and precipitated by stress.
   d. Diagnostic criteria
      i. Two or more distinct personality states
      ii. At least two recurrently take control of persons behavior
      iii. Inability to recall important personal identification.
      iv. Not due to physiological effects of substance abuse.
   e. Can be misdiagnosed with depression, borderline and antisocial personality disorder, schizophrenia, epilepsy, or bipolar.
   f. Severe trauma (abuse) in childhood contributes to this disease.
   g. No specific treatment: Milieu management (environment)

5. Dissociative Depersonalization Disorder
   a. Persistent experience of feeling detached from and outside one’s body or mental processes
   b. Reality testing is intact
   c. Perception of themselves and their environment is altered.
   d. Causes anxiety, depression, and fear of going insane. Disturbance in their perception of time

6. Treatment Modalities for Dissociative disorders
   a. No specific medications but anti depressants or anti-anxiety medications given for comorbid condition.
   b. Milieu Management (environment-structured, quiet, simple, group meetings)

7. Nursing diagnosis
   a. Disturbed thought process (memory loss)
   b. Ineffective coping
   c. Disturbed personal identity
   d. Disturbed sensory-perception (visual/kinesthetic)

**Delirium, Dementia and Amnestic Disorders**

Cognitive disorders include those in which a clinically significant deficit in cognition or memory exists, representing a significant change from a previous level of functioning.

1. Delirium: A disturbance of consciousness and a change in cognition that develop rapidly over a short period
   a. Characteristics
      1. Rapid abrupt onset/duration brief (1 week to 2 weeks)
      2. Clouded state of consciousness, difficulty maintaining and shifting attention
      3. Disorganized thinking
4. Rambling, incoherent speech
5. Disorientation to time and place
6. Illusions (misinterpretation of surroundings), hallucinations
7. Fluctuating level of awareness
8. Difficulty with short term memory
9. Altered wake/sleep cycle
10. Emotional instability
11. Autonomic: tachy, flushed face, sweating, dilated pupils, elevated BP
12. Age and duration effects duration. May become dementia

b. Diagnostic Categories
1. Due to medical condition – systemic infection, hypoxic, hypoglycemia, Hypercarbia, acid base imbalance, thiamine deficiency
2. Substance induced: analgesics, anesthesia, antihistamines
3. Substance intoxication: cannabis, cocaine, hallucinogens, etc.
4. Substance withdrawal – alcohol, sedatives, anxiolytics (sedatives), hypnotics; d/t half-life of substance.
5. Multiple etiologies

2. Dementia: most are progressive and irreversible
   a. Progressive, Aphasia, Apraxia, personality changes
   b. Stages
1. No apparent decline
2. Loss of things or forgetting names of people or other things they should know; awareness of decline; anxiety/depression may occur
3. Mild cognitive decline- notice taken by others as individual gets lost; has declining ability to concentrate; difficulty names or words (aphasia); inability to plan or organize.
4. Mild to moderate cognitive decline – confusion; failure to remember major events such as family member’s birthday; inability to perform tasks (Apraxia); deny by confabulating; become depressed; or withdraw socially.
5. Moderate cognitive decline – early dementia; loss of ability to perform some ADLs; forget names, addresses, phone numbers of relatives; become disoriented to time, place; frustration, withdrawal, self absorption occur.
6. Moderate to Severe – middle dementia; inability to recall recent major events; disorientation to time – day/month/year; unable to manage ADLs without help; incontinence; sleep problems; loss of language skills; psychomotor sx (wandering, agitation, aggression, etc); Sundowning: institutionalization takes place
7. Severe Cognitive Decline – Late dementia – inability to recognize family members; bedfast with problems of immobility; death due to infection, sepsis, or aspiration

c. Categories of Dementia Look at table 26:1
1. Primary – Alzheimer’s Type (50% of all dementia)
2. Secondary
   1. Vascular Dementia
   2. HIV
   3. Head Trauma
   4. Parkinson’s
   5. Huntington’s
6. Pick’s
7. Creutzfeldt-Jakob – similar to mad cow disease
8. Other medical conditions
9. Substance induced persisting
10. Multiple etiologies

**Amnestic Disorders**

An inability to learn new information (short-term memory deficit) despite normal attention, and an inability to recall previously learned information (long-term memory deficit)

1. **Characteristics**
   a. Unable to learn new information
   b. Inability to recall previously learned information despite normal attention
   c. No impairment of abstract thinking or judgment
   d. No personality change
   e. May confabulate

2. **Types**
   a. Due to general medical condition – head trauma, CVA, cerebral neoplastic disease, cerebral anoxia, herpes simplex encephalitis, poorly controlled DM type 2, brain surgery
   b. Substance induced persisting – eg. A drug of abuse, a medication, or toxin exposure: alcohol, sedatives, anticonvulsants, intrathecal methotrexate, toxins such as lead, mercury, carbon monoxide, organophosphate insecticides, industrial solvents

3. **Pseudodementia (Depression)**
   a. Cognitive symptoms of depression mimic dementia
   b. Rapid onset (normal dementia is slow onset)
   c. Oriented to time/place; no wandering
   d. Communicates distress (normal dementia does not)

4. **Treatment**: table 26-4 Pharmacology On Exam
   a. Treat medical problems – physical needs have priority
   b. Medications – improve memory
      i. Tracine (Cognex)
      ii. Donepezil (Aricept)
      iii. Rivastigmine (Exelon)
      iv. Memantine (Namenda)
      v. Physostigmine (Antilirium)
   c. Medications – antipsychotic
      i. Risperidone (Risperdal)
      ii. Olanzapine (Zyprexa)
      iii. Quetiapine (Seroquel)
      iv. Haloperidol (Haldol)
      v. Use benzodiazepines with caution

5. **Nursing diagnosis**
   a. Risk for Trauma

**Disorders of Infancy, childhood, and adolescence**

**Mental Retardation:**

*deficits in general intellectual functioning and adaptive functioning. IQ <70*

1. **Etiology**: 30-40% cannot be determined
   a. Heredity Factors: 5% of cases
i. Inborn metabolism errors: Tay Sachs, phenylketonuria, hyperglycinemia, Chromosomal disorders (down syndrome, Klinefelter syndrome)

b. Early Alterations in Embryonic Development 30% of cases
i. Injection of alcohol, or other drugs
ii. Maternal illness such as rubella, cytomegalovirus

c. Pregnancy and Perinatal Factors 10%
   i. Fetal malnutrition, viral and other infections, prematurity
   ii. Latter: trauma to head incurred during birth, placenta previa, prolapse of cord.

d. General Medical condition 5%
   i. Meningitis and encephalitis
   ii. Poisonings (lead, insecticides, medications)
   iii. Head injuries, asphyxiation, hyperpyrexia

e. Environmental 15-20%
   i. Deprivation of nurturance and social linguistics.

2. Four levels have been delineated.
   a. Mild: 50-70
      i. Capable of independent living with assistance during times of stress
      ii. Capable of 6th grade level skills
      iii. Need vocational skills
      iv. May have coordination deficit
   b. Moderate 35-49
      i. Can perform some activities but needs supervision
      ii. Capable of 2nd grade level skills
      iii. Some limitations in speech communication
      iv. Motor development is fare
   c. Severe 20-34
      i. May be trained in elementary hygiene skills
      ii. Requires complete supervision
      iii. Unable to benefit from academic or vocal skills
      iv. Needs systematic habit training, only able to perform simple tasks
      v. Wants and needs communicated by acting out
   d. Profound <20
      i. No capacity for independent functioning
      ii. Requires constant aid and supervision
      iii. Little if any speech development, no social skills
      iv. Lack of fine and gross motor movements

**Pervasive Developmental Disorders**

A group of disorders that are characterized by impairment in several areas of development, including social interaction skills and interpersonal communication

1. **Autistic Disorder**: withdrawal of child into self
   a. Occur about 6 in 1000, four times more in boys.
   b. Onset before age 3, usually runs a chronic course
   c. Caused by abnormalities in brain structure or function
   d. Profound social isolation.
   e. Causes
      i. Defuse neurobiological dysfunction with no clear primary deficit
      ii. Genetic: evidence of genetic factors: increased risk of a second child with autism
      iii. Perinatal: asthma/allergies during pregnancy increase risk.
   f. Social
      i. Cannot form relationships with parents or peers – lack of organized play
ii. No eye contact and may be non verbal or have limited speech and imagination
g. Restricted interests: resistive to even minor changes in the environment, routine may become an obsession.
h. Object attachment: especially those that move or spin
i. Nursing implications:
   i. Protect from self harm/injury: determine the cause of increased anxiety
   ii. Reward social contact, ie eye contact
   iii. Assist with self identity.
j. Other autism related disorders
   i. Rett’s, Asperger’s, Child disintegrative disorder.

2. Attention Deficit/Hyperactivity Disorder: A persistent pattern of inattention and or hyperactivity impulsivity that is more frequent and severe than is typically observed in individuals at a similar level of development.
   a. Types:
      i. Combined Type: At least six symptoms of inattention and six symptoms of hyperactivity for at least 6 months. MOST children and adolescents have the combined type.
      ii. Predominantly Inattentive Type: Persistence of at least six symptoms of inattention, but fewer than six hyperactivity-impulsivity, for at least 6 months.
      iii. Predominantly Hyperactivity type: Persistence of at least six symptoms of hyperactivity-impulsivity but less inattention for at least 6 months.
   b. Etiology
      i. Genetics: Large number of ADHD children come from parents who had similar problems as a child.
      ii. Biochemical: Possible that it involves dopamine, norepinephrine, and serotonin.
      iii. Anatomical: alterations in frontal lobes, basal ganglia, caudate nucleus, cerebellum
   iv. Prenatal, perinatal, and post natal
      1. Linked to smoking during pregnancy
      2. Intrauterine exposure to toxic substances including alcohol.
      3. Low birth weight, signs of fetal distress, precipitated or prolonged labor, perinatal asphyxia, and low Apgar scores.
   v. Environmental:
      1. Lead
      2. Diet factors: link with food dyes, additives, artificial flavorings and preservatives was introduced in the 70s but studies remain controversial.
   c. Treatment: Pharmacological: the exact mechanism of these meds is unknown
      i. Ritalin
      ii. Aderholt
      iii. Wellbutrin
   iv. Strattera: specific side effects – headache, nausea, dry mouth, decreased appetite
   v. SIDE EFFECTS: insomnia, anorexia, weight loss, tachycardia, temporary increase in growth and development

3. Conduct Disorder: Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. Physical aggression is common.
   a. Childhood onset: onset before age 10. Usually boys, frequently display physical aggression, and have disturbed peer relationships.
      i. Likely to develop antisocial personality disorder in adulthood.
   b. Adolescent- onset type: absence of any criteria characteristics before age 10. Less likely to display aggressive behaviors and tend to have more normal peer relationships.
   c. Contributing factors
      i. Genetic: may be linked to same gene associated with alcoholism
      ii. Temperament: difficult temperament by age 3 correlates with conduct disorder.
iii. Biochemical: Possible alterations in norepinephrine and serotonin. High levels of testosterone.
iv. Psychosocial factors: peer group rejection (result of aggression), influence by delinquent subgroup, poor family function: inconsistent harsh discipline, parents with substance abuse, antisocial personality, psych problems.
d. Nursing Process
   i. Protect others from violence
   ii. Improve social function
   iii. Assist to accept social responsibility
   iv. Improve self esteem
4. Oppositional Defiant Disorder: a pattern of negatism, defiant, disobedient, and hostile behavior toward authority figures that occurs more frequently than is usually observed in individuals of comparable age.
   a. Typically begins at 8 years old, and not later than early adolescence. More boys than girls
   b. Similar to conduct disorder except violating the rights of others.
   c. Biological influences: genes for metabolism of dopamine, serotonin, ad norepinephrine may be contributing factors.
   d. Family influences: Some opposition during childhood is normal and healthy. This normally begins at about 10 or 11 months, again during toddlerhood, and again in adolescence.
      i. Development of ODD may be influenced by:
         1. Parental problems in disciplining, structuring and limit setting
         2. Identification by the child with an impulse disordered parent who sets a role model for oppositional and defiant interactions with other people.
         3. Parent unavailability
   c. Nursing Process
      i. ODD is characterized by passive aggressive behavior (stubborn, procrastination, disobedience, carelessness, negativism, limit testing, deliberately ignoring communication of others.

**Tourette’s Disorder**

*Presence of multiple motor tics and one or more vocal tics.*

1. Disorder causes marked distress or interferes with social, occupational, and other areas of functioning.
2. More common in boys, usually appears at about 6-7 and is life-long, although symptoms usually diminish during adolescence and adulthood, and in some cases, disappear by early adulthood.
3. Biological Factors
   a. Genetics: inheritable component.
   b. Biochemical: abnormal levels of dopamine, serotonin, dynorphin, gamma-aminobutyric acid (GABA), acetylcholine, and norepinephrine associated with Tourette’s
4. Environmental:
   a. Complications of pregnancy (severe nausea and vomiting or excessive stress.
   b. Low birthweight, head trauma, carbon monoxide poisoning, and encephalitis.
   c. Environmental issues may influence the genetic disposition.
5. Nursing Process
   a. Assessment: can involve the head, torso, and upper and lower limbs.
   b. Initial symptoms may begin with a single motor tic, commonly eye blinking, or with multiple symptoms.
   c. Vocal tics include various words or sounds.
      i. Palilalia: repeating certain words or phrases out of context, repeating own words or sounds.
ii. Echolalia: repeating what others say.

6. Psychopharmacological intervention: most effective when combined with psychosocial therapy
   a. Haldol (drug of choice) 0.05 – 0.075 mg/kg per day in two or three divided doses.
   b. Pimozide (Orap): A neuroleptic with a response rate and side effect similar to Haldol.
      i. Used to treat severe motor tics that don’t respond to conventional treatment.
   c. Clonidine: Used due to low side effects and relative safety
      i. Side effects: dry mouth, sedation, dizziness, hypotension
   d. Atypical Antipsychotics: Risperidone – most studied atypical antipsychotic for Tourette’s
      i. Risperidone shown to reduce symptoms in 21 – 61% when compared to placebo.

1. Weight gain and abnormal glucose tolerance side effects.

Separation Anxiety Disorder

Excessive anxiety concerning separation from the home or from those to whom the person is attached.

1. Affects girls 18 years old and younger.
2. Refusal to attend school, fearful of being away from home, Follows caregivers, nightmares, physically sick
3. Temperamental, parental over protection, stressful life event.
4. Often diagnosed at age 5 or 6 when child goes to school.

Eating Disorders

EATING DISORDERS REFER TO A GROUP OF CONDITIONS CHARACTERIZED BY ABNORMAL EATING HABITS
THAT MAY INVOLVE EITHER INSUFFICIENT OR EXCESSIVE FOOD INTAKE TO THE DETRIMENT OF AN
INDIVIDUAL’S PHYSICAL AND EMOTIONAL HEALTH

1. Anorexia Nervosa: morbid fear of obesity
   a. Gross distortion of body image, preoccupation of food, and refusal to eat.
   b. Onset is early to late adolescence and occurs in about 1% of females
   c. Feelings of anxiety and depression often present
   d. Can cause amenorrhea (absence of three consecutive menstrual cycles)

2. Bulimia Nervosa: episodic, uncontrolled, compulsive rapid food ingestion followed by inappropriate
   behaviors to rid the body of excess calories.
   a. Purging behaviors: either self induced vomiting, or misuse of laxatives, diuretics, or enemas
      i. Also may use fasting or excessive exercise.
   b. Persistent concern with personal appearance.
   c. Excessive vomiting or laxative or diuretic use may lead to dehydration and electrolyte imbalance.
   d. Gastric acid in the vomitus can cause erosion of tooth enamel, or even tears in the gastric or
      esophageal mucosa.

3. Predisposing factors to Anorexia and Bulimia Nervosa:
   a. Genetic: 56% of the risk for developing anorexia nervosa. More common among sisters and
      mothers than the general population. (shared psychosis?)
   b. Neuroendocrine Abnormalities: primary hypothalamic dysfunction in anorexia nervosa
   c. Neurochemical: serotonin, dopamine, high levels of endogenous opioids in spinal fluid, cortisol
      i. Many experience amenorrhea before the onset of starvation and weight loss.
      ii. Some have gained weight with the administration of Narcan
   d. Psychodynamic influences: eating disorder result from early and profound disturbances in mother-
      infant interactions. Retarded ego development in the child and unfulfilled sense of separation-
      individualization.
      i. Compounded when mother responds to physical and emotional needs with food.
   e. Family Influences: conflict avoidance – psychosomatic symptoms; anorexia nervosa reinforced in an
      effort to avoid spousal conflict. Deny marital problem by defying the sick child as the family
problem. (Similar to a primary gain – somatic disorder). Power and control – family appears cohesive.

4. Anorexia Assessment:
   a. Weight loss to 85% of desired body weight.
   b. Intense fear of gaining weight or becoming fat, even though underweight.
   c. Distorted body image
   d. Amenorrhea—three consecutive menstrual cycles.
   e. Overachievers
   f. Preoccupation with food.
   g. Hypotension, hypothermia, bradycardia

5. Bulimia Assessment
   a. Recurrent episodes of binge eating
      i. Eating in a discrete period of time (2hr) an amount of food that is definitely larger than most people would eat.
      ii. A sense of a lack of control over eating the period
   b. Recurrent inappropriate compensatory behavior in order to prevent weight gain.
   c. Binge eating and compensatory behavior occur twice weekly for at least 3 months
   d. Self evaluation is unduly influenced by body shape and weight
   e. Does not occur exclusively during episodes of anorexia nervosa
   f. Self worth dependent on body image and appearance.
   g. Secretive eating/purging pleasure in eating followed by shame and depression
   h. Electrolyte imbalance, teeth enamel erosion, dehydration

6. Obesity (NOT in DSM IV)
   a. BMI greater than 30; Normal BMI is 20-24.9; Overweight 25-29.9
   b. 80% offspring of obese parents are obese
   c. 65% of population in America are obese (2002)
   d. Less educated are more obese (inverse proportion)
      i. 6 times more likely in lower socioeconomic class
   e. BMI of 40 and over=morbid obesity
   f. Depression personality qualities
   g. Dependency issue, seeking nurture and care

7. Predisposing factors
   a. Genetics: implicated in 80% of offspring of two obese parents.
   b. Physiological: lesions in appetite and satiety (gratification) centers, hypothyroidism, decreased insulin production, increased cortisone production
   c. Lifestyle Factors: Sedentary lifestyle
   d. Psychological: unresolved dependency needs

8. TREATMENT:
   a. Behavior modification: cognitive therapy and restructuring
      i. Insure that the treatment does not “control” them, the client must perceive that they are in control of the treatment. (contract)
      ii. Individual psychotherapy is not the first choice.
   b. Family therapy
      i. Support family as they deal with feelings of guilt associated with the perception they may have contributed.
      ii. Focus on the function operation of the family and help them resolve the conflict that causes them to keep the member in the “sick role”. These families may be non-compliant.
      iii. Refer them to local support groups for families with individuals with eating disorders
   c. Pharmacology
      i. No specific medications, but various medications are prescribed for anxiety and depression.
         1. SSRI – Prozac
2. Appetite stimulants: clorpromazine (Thorazine), cyproheptadine (Periactin); olanzapine (Zyprexa)
3. Mood stabilizers: imipramine (Tofranil), amitriptyline (Elavil), topiramate (Topamax)