**xtra**

**Practical Guide**

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**Psychiatric–Mental Health Nursing Departments**

**Psychiatric Assessment**

۞ A comprehensive assessment of a psychiatric patient consists of:

1. Physical assessment
* Physical examination
* Laboratory test
* Diagnostic test (MRI,EEG)
1. Psychological evaluation by ***(mental state examination, psychological test, rating scale)***
* Surveys childhood experience
* Personality
* Objective and subjective symptoms of the psychiatric illness
1. Intellectual
2. Social
3. Spiritual aspect of the individual

۞ The psychiatric history and mental status examination are usually obtained during the initial interview.

**۞ There are two types of interview:**

1. **Initial interview**: conducted when the client is first conducted in the treatment setting.
2. **Informal interview**: may casually take place at different times during each day during the course of giving nursing care.

**۞ The purposes of interview are:**

1. To gather the information necessary to understand and treat the client
2. To establish rapport with the patient.
3. Complete the nursing history within specific period of time.
4. To make nursing diagnosis.

**۞** **Phases of interview: an interview consists of three phases:**

1. **Preparatory phase:**  During this phase, it is important not to let one's stereotypes and prejudices affect the nurse–patient relationship. Nurses who are aware of their own prejudices can deal with them constructively. Professional nurses learn to approach patients with open minds and to be sensitive to the human needs that underlie diverse behaviors
2. **Introduction phase**: in this phase you should begin to develop a rapport with the client and to engage the client in the meeting.
3. **Working phase**: in this phase the necessary data are collected.
4. **Termination phase**: interview summarizes what has been accomplished during the meeting.

۞ **The student as interviewer**: the aim of the student interview is to discover the patient pattern of illness, exactly the nature of the symptoms.

**۞ Guide That to help you to approach interview:**

* Introduce yourself.
* Be calm: being polite and respectful you show that you are in control. This can be very comforting to someone who is afraid.
* Be gentle: Approach the person in a gentle manner. Due to their illness, and the related stigma, they may be suspicious.
* Do not laugh: Never laugh at anything strange a person says. This will stop them from trusting you and make them feel stigmatized.
* Do not correct: If the person says things that are strange or unbelievable do not try and correct them.
* Get the whole story: Always try and speak to the family or someone who knows what has been going on.
* Ensure privacy: Always try and speak to the person alone, a person may have things they wish to share with you that they wish to keep private, even from their own family.
* Make time: This is very important. Do not keep looking at your watch.

**Psychiatric History:**

1. **Identifying data**: collecting basic details about the patient, such as name, sex, age, educational status, occupation, and significant other.
2. **Chief complaint**: the reason for the patient’s presentation..
3. **History of present illness**: date of onset, duration and course of symptoms. Obtain the chronological description of recent events leading to this presentation, precipitating events, and any other psychosocial stressor.
4. **Psychiatric history**: psychiatric Illness may be a single event, chronic, or intermittent, and the course of the Illness may improve or deteriorate over time.
5. **Alcohol and Substance use history**:
* **Method** of use (oral, inhalation, injection, intranasal),
* **Amount** of use, frequency of use and
* **Time period** of use.
* Any substances **used in the past** should be recorded.
* **Common substances of abuse** include: alcohol, heroin, opiates, marijuana, cocaine, crack, methamphetamines, inhalants, stimulants, hallucinogens, caffeine and nicotine.
1. **Medical history**: illness, injuries, and treatment received, allergies, past and present side effects from medication
2. **Family history:** because many mental illnesses are hereditary. Record any history of mental illnesses in the patient's family. Commonly hereditary mental illnesses include: depression, bipolar disease, schizophrenia and attention deficit disorder
3. **Development history**: will provide insight into the origins of behavior, any psychological trauma past, present, family, social, and cultural.
4. **Social history**: this section should cover the major domains of patient's life.
5. **Occupational and educational history**: What is the highest grade that the patient completed? Where did the patient go to school? Were there any discipline problems at school? Assessing how the patient functions at work and school can provide helpful clues to the mental health picture.
6. **Culture**: should list any important issues regarding the patients ethnic and cultural background. The cultural assessment will help the nurse understand the patients cultural beliefs, values and practices
7. **Spirituality and values:** should note the patient's religious background. In addition, the degree of involvement within the religious community and any spiritual practices should be assessed. Nurses who have an understanding of the patient's spiritual views will be better able to empathically identify with them. It can also help the nurse determine if the patient has unresolved spiritual needs/concerns. Unresolved spiritual issues will inhibit recovery. When spiritual concerns are identified appropriate referrals (such as to the Chaplin) may help assure holistic wellness.
8. **The financial assessment**: financial situation is important for multiple reasons: Clients with lower socioeconomic class are at higher risk for many mental health conditions and may need help with money and would benefit from a consultation with a social worker.
9. **Determining coping skills**: is an important part of the psychosocial assessment. If the nurse understands the patient's current coping techniques, they will provide better care by helping patient's foster adaptive coping skills.
10. **Determining the patients abilities and interests**: helps get a full picture of the patient. Ask the patient: What are their hobbies? What are they good at? What gives the patient pleasure?

**Mental Status Assessment**

Gathering the correct information about the client’s mental status is essential to the development of an appropriate plan of care. The mental status examination is a description of all the areas of the client’s mental functioning. The following are the components that are considered critical in the assessment of a client’s mental status. Examples of interview questions and criteria for assessment are included.

* **Identifying Data**

**1. Name**

**2. Gender**

**3. Age**

* How old are you?
* When were you born?

**4. Race/culture**

* What country did you (your ancestors) come from?

**5. Occupational/financial status**

* How do you make your living?
* How do you obtain money for your needs?

**6. Educational level**

* What was the highest grade level you completed in school?

**7. Significant other**

* Are you married?
* Do you have a significant relationship with another person?

**8.** **Living arrangements**

* Do you live alone?
* With whom do you share your home?

**9. Religious preference**

* Do you have a religious preference?

**10. Allergies**

* Are you allergic to anything?
* Foods? Medications?

**11. Special diet considerations**

* Do you have any special diet requirements?
* Diabetic? Low sodium?

**12.** **Chief complaint**

* For what reason did you come for help today?
* What seems to be the problem?

**13. Medical diagnosis**

* **General Description**
* **Appearance**

**1.** **Grooming and dress**

* Note unusual modes of dress.
* Evidence of soiled clothing?
* Use of makeup?
* Neat; unkempt?

**2. Hygiene**

* Note evidence of body or breath odor.
* Note condition of skin, fingernails.

**3. Posture**

* Note if standing upright, rigid, slumped over.

**4. Height and weight**

* Perform accurate measurements.

**5.** **Level of eye contact**

* Intermittent?
* Occasional and fleeting?
* Sustained and intense?
* No eye contact?

**6. Hair color and texture**

* Is hair clean and healthy-looking?
* Greasy, matted, tangled?

**7.** **Evidence of scars, tattoos, or other distinguishing skin marks**

* Note any evidence of swelling or bruises.
* Birth marks?
* Rashes?

**8. Evaluation of client’s appearance compared with chronological age**

* **Motor Activity**

**1. Tremors**

* Do hands or legs tremble?
* Continuously?
* At specific times?

**2. Tics or other stereotypical movements**

* Any evidence of facial tics?
* Jerking or spastic movements?

**3.** **Mannerisms and gestures**

* Specific facial or body movements during conversation?
* Nail biting?
* Covering face with hands?
* Grimacing?

**4. Hyperactivity**

* Gets up and down out of chair.
* Paces.
* c. Unable to sit still.

**5. Restlessness or agitation**

* Lots of fidgeting.
* Clenching hands.

**6. Aggressiveness**

* Overtly angry and hostile.
* Threatening.
* Uses sarcasm.

**7. Rigidity**

* Sits or stands in a rigid position.
* Arms and legs appear stiff and unyielding.

**8.** **Gait patterns**

* Any evidence of limping?
* Limitation of range of motion?
* Ataxia?
* Shuffling?

**9. Echopraxia**

* Evidence of mimicking the actions of others?

**10.** **Psychomotor retardation**

* Movements are very slow.
* Thinking and speech are very slow.
* Posture is drooping.

**11. Freedom of movement (range of motion)**

* Note any limitation in ability to move.
* **Speech Patterns**

**1. Slowness or rapidity of speech**

* Note whether speech seems very rapid or slower than normal.

**2. Pressure of speech**

* Note whether speech seems hyperactive.
* Unable to be episodic?

**3. Intonation**

* Are words spoken with appropriate emphasis?
* Are words spoken in monotone, without emphasis?

**4.** **Volume**

* Is speech very loud? Soft?
* Is speech low-pitched? High-pitched?

**5. Stuttering or other speech impairments**

* Hoarseness?
* Slurred speech?

**6.** **Aphasia**

* Difficulty forming words.
* Use of incorrect words.
* Difficulty thinking of specific words.
* Making up words (neologisms).
* General Attitude

**1.** **Cooperative/uncooperative.**

* Answers questions willingly.
* Refuses to answer questions.

**2.** **Friendly/hostile/defensive**

* Is sociable and responsive.
* Is sarcastic and irritable.

**3. Uninterested/apathetic**

* Refuses to participate in interview process.

**4.** **Attentive/interested**

* Actively participates in interview process.

**5.** **Guarded/suspicious**

* Continuously scans the environment.
* Questions motives of interviewer.
* Refuses to answer questions.
* **Emotions**
* **Mood(Subjectively experience and reported by person Response to question)**

**1. Depressed; despairing**

* An overwhelming feeling of sadness.
* Loss of interest in regular activities.

**2. Irritable**

* Easily annoyed and provoked to anger.

**3. Anxious**

* Demonstrates or verbalizes feeling of apprehension.

**4.** **Elated**

* Expresses feelings of joy and intense pleasure.
* Is intensely optimistic.

**5. Euphoric**

* Demonstrates a heightened sense of elation.
* Expresses feelings of grandeur (“Everything is wonderful!”).

**6. Fearful**

* Demonstrates or verbalizes feeling of apprehension associated with real or perceived danger.

**7. Guilty**

* Expresses a feeling of discomfort associated with real or perceived wrongdoing.
* May be associated with feelings of sadness and despair.

**8. Labile**

* Exhibits mood swings that range from euphoria to depression or anxiety.
* **Affect(objectively expression of emotion observed or defined by the interviewer)**

**1. Congruence with mood**

* Outward emotional expression is consistent with mood (e.g., if depressed, emotional expression is sadness, eyes downcast, may be crying).

**2. Constricted or blunted**

* Minimal outward emotional expression is observed.

**3. Flat**

* There is an absence of outward emotional expression.

**4. Appropriate**

* The outward emotional expression is what would be expected in a certain situation (e.g., crying upon hearing of a death).

**5. Inappropriate**

* The outward emotional expression is incompatible with the situation (e.g., laughing upon hearing of a death).
* **Thought Processes**
* Form of Thought

**1. Flight of ideas**

* Verbalizations are continuous and rapid and flow from one to another.

**2. Associative looseness**

* Verbalizations shift from one unrelated topic to another.

**3.** **Circumstantiality**

* Verbalizations are lengthy and tedious and because of numerous details, are delayed reaching the intended point.

**4.** **Tangentiality**

* Verbalizations that are lengthy and tedious and never reach an intended point.

**5. Neologisms**

* New words that an individual invents that are meaningless to others, but have symbolic meaning to the psychotic person.

 **6.** **Concrete thinking**

* Absence of ability to think abstractly.
* Unable to translate simple proverbs.

**7.** **Clang associations**

* Speaking in puns or rhymes; using words that sound alike but have different meanings.

**8. Word salad**

* Using a mixture of words that have no meaning together; sounding incoherent.

**9. Perseveration**

* Persistently repeating the last word of a sentence spoken to the client (e.g., Nurse: “George, it’s time to go to lunch.” George: “lunch, lunch, lunch, lunch”).

**10.** **Echolalia**

* Persistently repeating what another person says.

**11. Mutism**

* Does not speak (either cannot or will not).

**12****. Poverty of speech**

* Speaks very little; may respond in mono-syllables.

**13. Ability to concentrate and disturbance of attention**

* Does the person hold attention to the topic at hand?
* Is the person easily distractible?
* Is there selective attention (e.g., blocks out topics that create anxiety)?
* **Content of Thought**

**1.** **Delusions (Does the person have unrealistic ideas or beliefs?)**

1. **Persecutory**: A belief that someone is out to get him or her is some way (e.g., “The FBI will be here at any time to take me away.”).
2. **Grandiose**: An idea that he or she is all-powerful or of great importance (e.g., “I am the king, and this is my kingdom! I can do anything!”).
3. **Reference**: An idea that whatever is happening in the environment is about him or her (e.g., “Just watch the movie on TV tonight. It is about my life”).
4. **Control or influence**: A belief that his or her behavior and thoughts are being controlled by external forces (e.g., “I get my orders from Channel 27. I do only what the forces dictate”).
5. **Somatic**: A belief that he or she has a dysfunctional body part (e.g., “My heart is at a standstill. It is no longer beating”).
6. **Nihilistic**: A belief that he or she, a part of the body, or even the world does not exist or has been destroyed (e.g., “I am no longer alive”).

**2. Suicidal or homicidal ideas**

* Is the individual expressing ideas of harming self or others?

 **Risk factors for suicide include:**

* Previous suicide attempt
* Family history of suicide
* Those who feel hopeless
* Those who abuse drugs and alcohol
* History of depression/bipolar disorder
* Feeling isolated
* Physical illness
* History of aggressiveness/impulsivity
* Those who are unwilling to seek help or those with barriers to mental health treatment

**Risk factors for homicidal behavior include**:

* Male gender
* Those with gang affiliations
* Unemployment status
* Drug/alcohol use
* Active psychotic symptoms
* And lower socioeconomic status

**3.** **Obsessions**

* Is the person verbalizing about a persistent thought or feeling that he or she is unable to eliminate from their consciousness?
* ***Common Obsessional Contents:***
	+ Dirt/ contamination/cleaning
	+ Orderliness/ symmetry
	+ Doubts/ checking/ counting
	+ Aggressive impulses/ inappropriate acts
	+ Religion (blasphemous thoughts)
	+ Ruminations: obsessional thoughts.
	+ Rituals: certain repeated compulsions

**4.** **Suspiciousness**

* Continuously scans the environment.
* Questions motives of interviewer.
* Refuses to answer questions.

**5. Magical thinking**

* Is the person speaking in a way that indicates his or her words or actions have power? (e.g., “If you step on a crack, you break your mother’s back!”)

**6. Religiosity**

* Is the individual demonstrating obsession with religious ideas and behavior?

**7. Phobias**

* Is there evidence of irrational fears (of a specific object or a social situation)?

**8. Poverty of content**

* Is little information conveyed by the client because of vagueness or stereotypical statements or clichés?
* **Perceptual Disturbances**

**1. Hallucinations (Is the person experiencing unrealistic sensory perceptions?)**

* Auditory (Is the individual hearing voices or other sounds that do not exist?)
* Visual (Is the individual seeing images that do not exist?)
* Tactile (Does the individual feel unrealistic sensations on the skin?)
* Olfactory (Does the individual smell odors that do not exist?)
* Gustatory (Does the individual have a false perception of an unpleasant taste?)

**2. Illusions**

* Does the individual misperceive or misinterpret real stimuli within the environment (e.g., sees something and thinks it is something else)?

**3. Depersonalization (altered perception of the self)**

* The individual verbalizes feeling “outside the body;” visualizing him- or herself from afar.

**4. Derealization (altered perception of the environment)**

* The individual verbalizes that the environment feels “strange or unreal.” A feeling that the surroundings have changed.
* **Sensorium and Cognitive Ability**

**1.** **Level of alertness/consciousness**

* Is the individual clear-minded and attentive to the environment?
* Or is there disturbance in perception and awareness of the surroundings?

**2. Orientation. Is the person oriented to the following?**

* Time
* Place
* Person
* Circumstances

**3. Memory**

* Recent (Is the individual able to remember occurrences of the past few days?)
* Remote (Is the individual able to remember occurrences of the distant past?)
* Confabulation (Does the individual fill in memory gaps with experiences that have no basis in fact?)

**4. Capacity for abstract thought**

* Can the individual interpret proverbs correctly?
	+ *“What does ‘no use crying over spilled milk’ mean?”*
* **Impulse Control**

**1. Ability to control impulses (Does psychosocial history reveal problems with any of the following?)**

* Aggression
* Hostility
* Fear
* Guilt
* Affection
* Sexual feelings
* **Judgment and Insight**

**1.** **Ability to solve problems and make decisions**

* What are your plans for the future?
* What do you plan to do to reach your goals?

**2. Knowledge about self**

* Awareness of limitations
* Awareness of consequences of actions
* Awareness of illness
	+ “*Do you think you have a problem?”*
	+ *“Do you think you need treatment?”*

**3. Adaptive/maladaptive use of coping strategies and ego defense mechanisms (e.g., rationalizing maladaptive behaviors, projection of blame, displacement of anger)**

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***Therapeutic communication Techniques***

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| **Therapeutic Techniques** | **Examples** |
| 1- Offering self | My name is ………..Visiting hours are ……My purpose in being here is….. |
| 2- Giving Information. | I’ll sit with you a while.I’ll stay here with you.I’m interested in your comfort.  |
| 3- Using silence. |  |
| 4-Accepting. | Yes.Uh Hmm.I follow what you said.Nodding |
| 5-Giving Recognition  | Good morning Mr. S. You’ve tooled a leather wallet.I notice that you’ve combed your hair. |
| 6-Giving Broad Openings  | Is there something you’d like to talk about? What are you thinking about? |
| 7-Offering General leads.  | Go on And then? Tell me about it?What seemed to lead up to…? |
| 8-Placing the event in time Or in sequence. | Was this before or after…..?When did this happen? |
| 9-Making observations. | You appear tense.I notice that you’re biting your lips. |
| 10-Encouraging Description Of Perceptions. | Tell me when you feel anxious what is happening? |
| 11-Encouraging comparison  | Was this something like…? Have you had similar experiences? |
| 12-Re stating. | Pt. I can’t sleep. I stay awake all night.Nurse you have difficulty sleeping.Pt. The fellow that is my mate died at war and is rending me yet to marry. Nurse you were going to marry him but he died during the war. |
| 13-Reflecting. | Pt, Do you think I should tell the doctor.…? Nurse, Do you think you should? |
| 14-Focusing. | This point seems worth looking at more closely. |
| 15-Exploring. | Tell me more about that would you describe it more fully. |
| 16-Seeking clarification | I’m not sure that I follow.What would you say is the main Point of what you said?  |
| 17-Presenting Reality.  | I see no one else in the room.That sound was a car back-firing.Your mother is not here, I’m nurse |
| 18-Voicing Doubt.  | Isn’t that un usual? Really? That’s hard to believe |
| 19-Seeking consensual Validation. | Tell me whether my understanding of it agrees with yours.Are you using this word to convey the idea? |
| 20-Verbalizing the implied. | Pt, I can’t talk to you or to anyone it’s a waste of time.Nurse, Is it your feeling that no one understands?Pt, My wife pushes me around just like my mother and sister did. Nurse, Is it your impression that women are domineering?  |
| 21-Encouraging evaluation. | What are your feelings in regard to….? Does this contribute to your discomfort.….?  |
| 22- Attempting to translate  Into feelings. | Pt, I’m dead Nurse, Are you suggesting that you feel lifeless?Or is it that life seems without meaning |
| 23-Suggesting collaboration  | Perhaps you and I can discuss and discover what produces your anxiety. |
| 24-Summarizing. | Have I got this straight?You’ve said that …….During the past hour you and I have discussed … |
| 25-Encouraging formulation of a plan of Action.  | What could you do to let your anger out harmlessly? Next time this comes up, what might you do to handle it  |

### *Non-therapeutic communication Techniques*

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| --- | --- |
| **Non therapeutic techniques** | **Examples** |
| 1-Reassuring  | I wouldn’t worry about ……..Everything will be all right You’re coming along fine …… |
| 2-Giving Approval  | That’s good ……I’m glad that you….. |
| 3-Rejecting  | Let’s not discuss ……..I don’t want to hear about…..  |
| 4-Disapproving | That’s bad………..I’d rather you wouldn’t  |
| 5-Agreeing  | That’s right…….I agree……… |
| 6-Disagreeing  | That’s wrong …..I definitely disagree with ……..I don’t believe that ……… |
| 7-Advising  | I think you should …….Why don’t you……. |
| 8-Probing | Now tell me about……Tell me your life history….. |
| 9-Challenging  | But how can you be president of the united states?If you’re dead why is your heart beating.  |
| 10-Testing  | What day is this? Do you know what kind of a hospital is this? Do you still have the idea that? |
| 11-Defending  | This hospital has a fine reputationNo one here would lie to you But Dr. B. is a very able psychiatrist.  |
| 12-Requesting an Explanation | Why do you think that?Why do you feel this way?Why did you do that?  |
| 13-Indicating the Existence of an External source | What makes you say that who toldYou that you were Jesus?What made you do that? |
| 14-Belittling feelings Expressed | Pt. I have nothing to live for …….I wish I was dead.Nurse everybody gets down in the dumps.Or. I’ve felt that way some times |
| 15-Making stereotyped  Comments | Nice weather we’re having.I’m fine and how are you?It’s for your own good.Keep your chin up Just listen to your doctor and take part in activities-you’ll be home in no time. |
| 16-Giving Literal responses  | Pt. They’re looking in my head With television.Nurse. Try not to watch Television or with what channel? |
| 17-Using Denial  | Pt. I’m nothing Nurse of course you’re something.Every body is something |
| 18- Interpreting | What you really mean is……… Unconsciously you’re saying… |
| 19- Introducing an Unrelated topic  | Pt. I’d like to die Nurse did you have visitors this weeks end? |

***Major Classifications of Drugs Used in the Treatment of Mental Illness***

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| --- |
| 1. Anti-psychotic agents /Major tranquilizers. / Phenothiazine./ Neuroleptics. /Ataractic agents.
2. Anti-anxiety agents/ Minor tranquilizers.
3. Antidepressant agents/ Mood elevators/ Energizers.
4. Anti-mania agents
5. Anti-Parkinson Agents/ Anti extra pyramidal effect agents
6. Anticonvulsant agents
 |

1. ***Anti-psychotic Drugs***

|  |  |
| --- | --- |
| 1- Phenothiazines:* Chropromazine (Thorazine).
* Thioridazine (Mellaril).
* Trifluoperazine (Stelazine).

2- Thioxathene:* Thioxathene (Navane)

3- Butrophenone:* Halopridol (Halodol)
 | 4- Dibenzoxaepine:* Loxapine (Loxitane).

5- Dihydroindolone:* Molindone (Moban).

6- Atypical:* Clozapine.
* Respridone (Resperdal).
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***Indications****:*

* Schizophrenia.
* Manic phase of manic-depressive illness.
* Occasionally can be used in the in severe depression with or in sever anxiety, particularly when patient may have the tendency toward drug or alcohol dependency.

***Side Effects:***

 Blurred vision, Dry mouth and lips, Constipation, Nasal congestion, Decreased libido and inhibition of ejaculation, Postural hypotension, Photosensitivity, Dermatitis, Impaired psychomotor functions, Drowsiness, Weight gain, Edema, irregular menstruation and decreased sex drive, Amenorrhea, and sedation and Extra pyramidal side effects or parknisonian - like symptoms.

***Extra pyramidal side effects***

1. Pseudo Parkinsonism Symptoms include; tremor, shuffling gait, Drooling, rigidity, and looseness of arm movements.
2. Akathisia, is a continuous restlessness, fidgeting and pacing beyond the conscious control of the client, clients will say things Such as, “I didn’t realize I was so active, “or I can’t stop, I have To keep going,
3. Akinesia: Muscular weakness and fatigue like symptoms.
4. Dystonia; include involuntary muscular movement, of the face, Arms, legs, and neck.
5. Oculogyric crisis: is a syndrome characterized by sudden onset of uncontrolled rolling back of the eyes.
6. Tardive dyskinesia: is characterized by bizarre facial and tongue movements, a stiff neck, and difficulty swallowing.

***Contraindications****:*

 Antipsychotic drugs are generally not prescribed for clients with narrow – angle, glaucoma, prostate problems, or cardiac problems which may result in circulatory collapse. The client with a pacemaker, convulsive disorder, bone marrow depression, or liver disease or hypersensitivity to the drug or CNS depression or sub cortical damage.

***Patient Teaching:***

* Warn pt. To avoid activities that require alertness until CNS effects of the drug are known.
* Tell pt. to avoid alcohol.
* Have pt report urine retention or constipation.
* Tell pt. to use sun block and to wear protective clothing outdoors.
* Tell pt. to relieve dry mouth with sugarless gum or hard candy.
1. ***Anti-anxiety Drugs***

|  |  |
| --- | --- |
| **Benzodiazepines**:* Anti-anxiety
* Alprazolam (Xanax).
* Chlordiazepoxide (Librium).
* Diazepam (Valium).
* Lorazepam (Ativan).
* Oxazepam (serax).
* Prazepam (Centrax).
 | * Sedative Hypnotic:
* Estazolam (ProSom).
* Triazolam (Halcion).
 |

***Indications****:*

 Treatment of choice in the management of:

* Anxiety.
* Insomnia.
* Stress related conditions.

***Contraindications:***

 In patient with a history of hypersensitivity to the drugs, a history of alcoholic or addiction.

***Side Effects:***

Dizziness, dry mouth, headaches, urticaria, nervousness, blurred vision, and mental confusion, rashes, fatigue, ataxia, genitourinary complaints, diplopia, palpitations, irritability, slurred speech, depression, and decreased blood pressure.

***Patient Teaching***

* Warn pt. To avoid hazardous activities that require alertness or good psychomotor coordination until CNS effects of drug are known.
* Tell pt. to avoid alcohol while taking this drug.
* As a pre-medication before surgery, lorazepam provides substantial preoperative amnesia.
1. ***Anti-depressant Drugs***

|  |
| --- |
| * Tricyclic.
* Non-tricyclic.
* Selective Serotonin Reuptake inhibitors “SSRI”.
* Nonselective Uptake Inhibitor.
* Mono-Amine Oxidase Inhibitors (MAOI).
 |

***(M.A.O.I.) Mono-Amino-Oxidase-Inhibitors***

|  |
| --- |
| * + Tranylcypromine sulfate (Parnate)
	+ phenelzine sulfate (Nardil)
 |

***Indications:***

 Used for the treatment of a typical depression, depression with a hysterical component, or in severe loss situations (Maximum effect is reached in 3 to 4 weeks).

***Side Effects:***

Hypertensive crisis is produced when the medication is taken in combination with tyramin rich foods. Which is signaled by the presence? Of a generalized or occipital headache, diaphoresis, increased restlessness, palpitations, pallor, chills, stiff neck, nausea, vomiting, muscle twitching, and chest pains*.*

 ***Contraindications:***

For clients who are unable to conform to the restrictive diet required and those who have cerebrovascular defects, or cardiovascular disorders, liver disease, over 60 years of ages.

***Patient Teaching:***

* Warn pt. to avoid foods high in tyramine or tryptophan and Large amounts of caffeine.
* Tell pt. to avoid alcohol while taking drug.
* To prevent dizziness resulting from orthostatic hypotension; tell pt. to get out of bed slowly, sitting up for 1 minute first.
* Because MAOI may suppress angina pain, warn pt. to moderate activities and to avoid overexertion.
* Advice pt. to consult his doctor before taking any other prescription or OTC medications.
* Warn pt. not to stop drug suddenly.

***Antidepressant Non MAOI Tricyclic Drugs***

|  |
| --- |
| * Clomipramin HCI(Anafranil)
* Imipramin HCL (Tofranil)
* Amitriptylin HCL (Tryptanol)
* Maprotiline HCI (Ludiomil)
 |

***Indications:***

 Used in patient with obsessive-compulsive disorders, and depression, Anxiety phobic anxiety (Maximum effect occurs in 14 to 21 days after the onset of administration)*.*

***Side Effects:***

Dry mouth, blurred vision, tachycardia, palpitations, constipation, urinary retention, drowsiness, decreased libido, weight gain, abnormal EEG.

*Contraindications:*

For pt.s with known cardiac disease, hypersensitivity to Tricyclic. Clients taking MAOI require a detoxification period of 24 to 21 days before beginning use of Tricyclic.

***Patient Teaching:***

* Warn pt. to avoid hazardous activities requires alertness and good psychomotor coordination especially during titration. Day time sedation and dizziness may occur.
* Tell pt. to avoid alcohol while taking this drug.
* Warn pt. not to withdraw drug suddenly.
* To prevent photosensitivity reactions, advice pt. to use sun block, wear protective clothing, and avoid prolonged exposure to strong sunlight.
* Tell pt. that dry mouth may be relived with sugarless hard candy or gum.
* Advice pt. to consult his doctor before taking any other prescription, or OTC medications.

***Anti-mania drugs***

|  |
| --- |
| * Lithium carbonate: Tab.250mg, 300mg
 |

***Indication and Dosage:***

 Prevent or control of mania. Adults: 300 to 600 mg p.o up to q.i.d, increasing on the basis of blood levels to achieve optimal dosage.

***Side Effects:***

 Pulse irregularities, fall in blood pressure, ECG changes, Dizziness, blurring of vision, slurred speech, anorexia, nausea, vomiting, diarrhea, thirst, dryness of mouth, weight loss.

Other: transient hyperglycemia, goiter, hypothyroidism (lowered T3, T4, and protein-bound. iodine)

***Contraindications****:* Contraindicated if therapy cannot be closely monitored.

***Nurse role:***

* Patient assessment.
* Coordination of treatment modalities.
* Psychopharmacological drug administration.
* Monitoring drug effects.
* Medication education.
* Design and participation in drug maintenance programs.
* Participation in interdisciplinary clinical research drug trials.
* When appropriate, perspective authority.

***Patient and family Teaching:***

* Lithium can treat your current emotional problems and will also help prevent relapse. So it’s important to continue with the drug after the current episode is resolved.
* Because therapeutic and toxic dosage ranges are so close, your lithium blood levels must be monitored. More frequent at first, the once every several month after that.
* Lithium is not addictive.
* Maintain a normal diet and normal salt and fluid intake. Lithium decrease sodium re-absorption by the renal tubules, which could cause sodium depletion. A low sodium intake causes a relative increase in lithium retention, which could lead to toxicity.
* Withhold the drug if excessive diarrhea, vomiting, or diaphoresis occurs. Dehydration can raise lithium level in the blood to toxic levels. Inform your physician if you have any of these symptoms.
* Diuretics are contraindicated with lithium.
* Lithium is irritating the gastric mucosa. Therefore take your lithium with meals.
* Periodic monitoring of renal functioning and thyroid function is indicated with long term use.
* Avoid using any over-counter medication without checking first with your doctor.
* If weight gain is significant, you may need to see a physician or nutritionist.
* Periodic blood test must be carried on.

***Pre Lithium Work Up***

* Renal: urinalysis. BUN, Createnine, 24 hrs Createnine clearance; history of renal disease in self or family; diabetes mellitus, hypertension, diuretic use, analgesic abuse.
* Thyroid: TSH, T4 “Thyroxin”, T3; history of thyroid disease in self & family.
* Other: complete physical, history; ECG, fasting blood sugar, CBC.

***Stabilizing Lithium level***

Common for an Increase in Lithium Levels:

* Decreased sodium intake.
* Diuretic therapy.
* Decreased renal functioning.
* Fluid & electrolyte loss: sweating, diarrhea, dehydration.
* Medical illness.
* Overdose.

***Ways to Maintain Stable Lithium Level***

* Stable dosing schedule by dividing doses or use of sustained release capsules.
* Adequate dietary sodium & fluid intake.
* Replace fluid and electrolyte during exercise or GI illness.
* Monitor S/S of lithium side effects & toxicity.
* If pt forgets a dose, he may take it if he missed dosing time by 2 hrs; if longer than 2 hrs, skip that dose & take the next dose; never double up on doses.

***Maintenance Lithium Level***

* Every 3 months: Lithium level “for the first 6 months”
* Every 6 months: reassess renal status, Lithium level, TSH.
* Every 12 months: reassess thyroid function, ECG.

Assess more often if pt is symptomatic or if toxicity is suspected.

***4. Anti-Parkinson Agent***

|  |
| --- |
| * Procyclidine HCL (Kemadrin)
* Trihexyphenidyl HCL (Artane)
* Amantadine HCL (Symmetrel)
* Carbidopa-levodopa (Sinemet)
 |

***Indications:***

Used to control the parknisonian-like symptoms the side effects of antipsychotic drugs.

***Side Effects:***

Blurred vision, mental confusion, dry mouth, constipation, urinary retention.

***Patient Teaching:***

* If insomnia occurs; tell the pt. to take the drug several hours before bedtime.
* If orthostatic hypotension occurs, instruct the pt. not to stand or change position too quickly.
* Instruct the pt. to report adverse reactions to the doctor, especially dizziness, depression, anxiety, nausea, and urine retention.
* In the pt. with parkinsonisim, warn against discontinuing the drug abruptly to prevent precipitating a Parkinson crisis.
* Tell pt. to take the drug with food to minimize GI upset.
* Warn the pt. and his caregivers not to increase dosage without doctor’s orders.
* Warn the pt. of possible dizziness and orthostatic hypotension, especially at start of therapy.
* Inform the pt. that pyridoxine (vit. B6) doesn’t reverse the beneficial effects of carbidopa-levadopa; multivitamins can be taken without losing control of symptoms.

***5. Anti-convalsants Drugs***

|  |
| --- |
| * valproate sodium (Depakine)
* carbamazepine (Tegretol)
 |

***Indications:***

 Used alone or with other drugs to treat seizure disorders, to manage acute isolated seizures not caused by seizure disorders, and to prevent seizures after trauma or a craniotomy. Some Anticonvulsants are used to treat status epileptics.

***Side Effects:***

 Anticonvulsant agents may cause adverse CNS effects, such as confusion somnolence, tremor, and ataxia. Many anticonvulsants also may cause GI effects such as vomiting, CV disorders, such as arrhythmia and hypotension, and hematologic disorders, such as leucopenia and thrombocytopenia.

***Patient Teaching***

* Warn pt. to avoid activities requiring alertness and good psychomotor coordination until CNS response to drug is determined.
* Instruct pt. to take drug with food or milk to reduce adverse GI effects.
* Warn pt. not stop drug therapy abruptly.
* Tell pt. to keep tablets in original container tightly closed, and away from moistures
* Tell pt. to notify the doctor immediately if fever, sore throat, mouth ulcers, or easy bruising or bleeding occurs.
* Tell pt. that drug may cause mild to moderate dizziness and drowsiness when first taken
* Advise pt. that periodic eye examinations are recommended

### *Side Effects of the psychotropic drugs*

|  |  |
| --- | --- |
| ***Side Effect*** | ***Nursing intervention*** |
| Blurred vision | * Reassurance ( generally subsides in 2-6 weeks)
 |
| Dry mouth and lips  | * Frequent rinsing of mouth
* Lozenges
* Lip balm
 |
| Constipation  | * + Mild laxative
	+ Roughage in diet
	+ Exercises
	+ Fluids
 |
| Nasal congestion | * + Nose drops / Moisturizer
 |
| Decreased libido and inhibition of ejaculation | * + Prepare client for effect.
	+ Reassurance ( reversible )
	+ Ask physician about change to less anti adrenergic drug.
 |
| Postural hypertension.  | * + Frequent monitor of blood pressure during dosage adjustment period.
	+ Advise client to get up slowly.
	+ Elastic stocking if necessary
 |
| Photosensitivity | * + Protective clothing.
	+ Dark glasses use of sunscreen
 |
| Dermatitis | * + Stop indication.
	+ Request physician to change order and prescribe systemic antihistamine.
	+ Initiate comfort measures.
 |
| Impaired psychomotor function. | * + Advise client to avoid dangerous tasks.
 |
| Drowsiness | * + Give single daily dose at bedtime.
 |
| Weight gain. | * + Caloric control, exercise-diet teaching
 |
| Edema | * + Request physician to prescribe diuretic.
	+ Reassurance
 |
| Irregular menstruation and decreased sex drive | * + Reassurance (reversible)
	+ Have physician change class of drugs
 |
| Amenorrhea | * + Reassurance and counseling (does not indicate lack of ovulation).
	+ Instruct client to continue birth control.
 |
| Sedation | * + Instruct client not to drive or operate potentially dangerous equipment.
	+ Ask physician about charge to less sedating drug.
	+ Provide quiet and decrease stimulation when sedation is desired effect
 |