



وزارة الصحة  
Ministry of Health

# دليل ممارسات تمريض الصحة النفسية

## Handbook of Mental Health Nursing Practices

الإصدار الأول  
1445 هـ - 2023 م

## HANDBOOK BY MOH 2023

In this Manual, the Ministry of Health maps a recommended nursing competent model for Psychiatric and Mental health nurses in dealing with the psychiatric or mental health disorders handbook contains a competent model as well as descriptions of mandatory safe nursing practice. The Psychiatric and Mental health nursing competent model is advisory in nature, informational in content, and are intended to assist new nurses in providing a safe nursing practice.

### Prepared By

General Department of Mental Health and Social Services in collaboration with General Department of Nursing Affairs, under Umbrella of Deputyship for Therapeutic Services.

### Ministry of Health

This is a living guidance that is subject to change as more evidence accumulates. A regular update will be considered whenever needed. The guidance should be used to assist nurses to the best available practice in regards to Psychiatric

and Mental health disorders according to the best available and current evidence.

### What is the current need?

Historically, nurses have been the backbone for health care influencing standards of care and public health policy. Managing psychiatric patients during acute stage and even in a cold case has challenged the psychiatric nurses' role within the therapeutic milieu fostering innovative practices to meet patient needs. Our Psychiatric and mental health Complex's met the challenges with resilience, creativity and commitment. The next challenge is to learn from experience. Building on innovative technology opens the window to new models of care.

### Why is this document important?

The mental health nurse's handbook is a resource for mental health nurses and their employers to guide their preceptorship and supervision conversations, helping to focus on some key areas of practice. It is intended as a brief practical guide and provides links to other important and helpful resources.

### **How the Psychiatric and Mental Health Manual will help?**

The Manual represented in this document will provide strategies to support Psychiatric and Mental Health capacity plans and provide a sustainable nursing competent with

a focus on patient safety, infection control and quality of care. Furthermore, it will provide guidance to the hospitals to keep delivering health care with required nursing staff to handle a significant increase in demand for Psychiatric and Mental ill patient.

## Handbook of Mental Health Nursing Practices

### Executive Summary:

change in health care and health care delivery demand that nurses have a sound knowledge base and be skillfully competent when providing care to clients, regardless to underlining condition. This fact assumes even greater importance for the area of psychiatric – mental health nursing. The nurses need to be able to assess, nursing Diagnose, plan and intervene quickly and appropriately as a part of an interdisciplinary team using Evidence –based knowledge, this manual provide the requirement.

**Handbook of mental health nursing practices** is an easy to be use, portable, clinical reference designed to provide practical nurses and nursing students with quick reference approach to essential need-to-know critical information for clinical practice. This manual provides a hands-on resource for the students and nurses working in any setting, for example emergency department, inpatient or outpatient areas, when working with client who may have a mental health issue or psychiatric disorder or a client who is prescribed some type of psychopharmacological agent. Nurses returning to the clinical psychiatric area will also find this handbook helpful as review and refresher resource.

(This is an official Ministry of Health and should not be edited in any way)

<b>Title:</b>	<b>Eradah and Mental Health Complex; A Nurse Staffing Model</b>
<b>Applied to:</b>	Handbook is directed to all nurses dealing with patients in mental health settings.
<b>Replaces</b> (if appropriate):	Nurses staff working in psychiatric and mental health Clinics in general hospitals.
<b>Recommended References:(attached with manual)</b>	
Foley, M. (2010). Lippincott's handbook for psychiatric nursing and care planning.	
<b>Version</b>	Version -1
<b>Issue Date:</b>	12 June 2023

## Acknowledgement

This Handbook reflects the work of dedicated individuals who worked hardly on the stressful and highly risk environment which would not be possible without their commitment and generous contributions. The General Department of Mental Health and Social Services in collaboration with General Department of Nursing would like to extend its sincere thanks and appreciation to the members who participate of preparing, reviewing, and approving this manual. Finally, we wish to recognize the leadership and foresight of the Deputy Minister of Therapeutic Services, in recognizing the importance of this work and continuous support for the completion of this project.

## Table of Contents

Title	Page
<b>Mental Health Nursing Ethics</b>	<b>9</b>
The profession of psychiatric nursing	10
Professional Ethical Practice	13
The Code of Ethics	15
<b>Standards of Psychiatric Nursing Practice</b>	<b>20</b>
The Standards of Psychiatric Nursing Practice	21
<b>Accountability and Responsibility in Nursing</b>	<b>31</b>
Introduction and Definition	32
Importance of Accountability	33
How Can Nurses Demonstrate Accountability in Psychiatric Nursing Practice?	35
4 Consequences of Lack Of Accountability In Nursing Practice	38
Professional Responsibility in Nursing	39
Essential Responsibilities of Nurses	41
<b>Mental Health Nursing Assessment Guidelines</b>	<b>47</b>
Mental Health Nursing Assessment Interview Guidelines	48
Mental Status Examination Guidelines	50
Extrapyramidal Symptom Nursing Assessment Guidelines	54
<b>Mental Health Nursing Care Guidelines</b>	<b>56</b>
Schizophrenia Nursing Care Guidelines	58
Active Hallucinations Nursing Care Guidelines	60
Delusional Nursing Care Guidelines	62
Major Depressive Nursing Care Guidelines	65
Manic Episode Nursing Care Guidelines	67

Personality Disorder Nursing Care Guidelines of Providing Guidelines for Personality Disorder Patient Care	70
Violent and Assaultive Nursing Care Guidelines of Providing Guidelines for Violent Patient Management	72
Alcohol Withdrawal Nursing Care Guidelines	74
Paranoid schizophrenia nursing care guidelines	77
Behavioral problems nursing care guidelines	78
Nursing care guidelines for patients with restraint	80
Substance intoxication nursing care guidelines	82
Drug withdrawal nursing care guidelines	84
<b>Mental Health Nursing Diagnosis</b>	<b>86</b>
Impaired Verbal Communication (A)	88
Impaired Verbal Communication (B)	90
Self-Care Deficit	92
Risk for Injury	93
Risk for Self-Directed or Other-Directed Violence	97
Impaired Social Interaction	100
Risk for Suicide	103
Ineffective Coping	106
Hopelessness	109
Powerlessness	113
Denial	115
Low Self-Esteem	118
Deficient Knowledge	121
Disturbed Sensory Perception: Auditory/Visual	124
Sensory-Perceptual Alterations	127

Anxiety	129
Fear	132
<b>Psychiatric and Addiction Disorder</b>	<b>136</b>
Schizophrenia	137
Bipolar Disorder	146
Cyclothemic Disorder	149
Anxiety, and Related Disorders	153
Dementia	168
Eating Disorder	181
Autism Spectrum Disorder	189
Substance- Related Disorders	194
Depression Disorder	203
Attention – Deficit / Hyperactivity Disorder (ADHD)	218
Social Communication Disorder (SCD)	228
<b>References</b>	<b>232</b>



# **Mental Health Nursing Ethics**

## The profession of psychiatric nursing:

The nursing profession is considered one of the distinguished professions that focuses on important characteristics of care, knowledge, and skill. Taking care of mental and physical health, full knowledge of the diseases and health offered to the client, and familiarity with the basic skills of nursing.

In the field of mental health, nursing is the basic core taken from the physiological, psychological, and biological health sciences, in which mental health nursing focuses on the external and internal influences of the human being.

Scientists and researchers knew psychiatric nursing is a specialized field of nursing that focuses on meeting the mental health needs of the consumer, in partnership with family, significant others, and the community in any setting. It is a specialized interpersonal process embodying the concept of caring.

Psychiatric nursing is one of the specialties that provide nursing care to clients of different ages, races, and religions with the same professionalism and quality at work for those who suffer from mental illnesses or psychological pressures. Mental health nurses can work with the therapeutic team to provide medical care to clients with personality disorders, addiction, psychosis, suicide, eating disorders, and other mental illnesses that have been approved by scientists and researchers.

The field of nursing in general is a thriving field in nature and in constant need. According to the statistics of the Bureau of Labor Statistics and the World

Health Organization 2020, by 2030, the world is expected to need nursing cadres to compensate for the shortage due to the increasing need for this profession.

In addition to raising health awareness and increasing education and health specialties. Our government paid attention to this need and increased job opportunities and science.

According to the latest nursing statistic from the Commission for Health Specialties, the total number of universities and colleges (public and private) in the Kingdom specializing in the field of nursing = is 39 colleges (25 government/14 private colleges). Education in nursing is provided at the degree (diploma, bachelor's, master's, and doctorate) in all nursing specializations.

According to the latest nursing statistic from the Commission for Health Specialties, the total number of universities and colleges (public and private) in the Kingdom specializing in the field of nursing = is 39 colleges (25 government/14 private colleges). Education in nursing is provided at the degree (diploma, bachelor's, master's, and doctorate) in all nursing specializations.

As for the nursing staff classified by the Saudi Commission for Health Specialties (both males and females), approximately (30.954). Therefore, the percentage of the need for nursing specialization and Saudi nursing in the Kingdom is approximately 45%, during the Corona virus crisis. On a professional level, our sane government has given health in general and the field of mental health in particular a lot of attention. It has continued its efforts to develop mental health to the present time by approving regulations and laws for mental health care for the practitioner and the client.

Our government started in 1952 with the opening of the first hospital specializing in psychiatric diseases and after the beginning of the development of psychiatry in the Kingdom. The first facility specialized in mental health was opened in the city of Taif. To this day, we have more than 21 hospitals specializing in mental health and addiction treatment, with a clinical capacity of 4,046, in addition to 14 hospitals under construction and 99 psychiatric clinics, in addition to the Ministry of Health match, which aims to create health facilities in its hospitals to establish and develop Mental health care and addiction treatment wards in public hospitals.

On a scientific level, our reasonable government paid attention to nursing, offering specialized diplomas in mental health nursing practices, which started with the opening of the first mental health hospital in Taif, to improve the standard of specialized healthcare in the mental health field and graduate top-notch nursing professionals to care for clients in mental health.

Nowadays, all colleges and universities are racing to raise the standards of education in the field of mental health, so they are looking forward to master's and doctoral degrees in mental health in general and in psychiatric nursing in particular. they affirmed the Ministry of Health's interest in psychiatric nursing in the continuous support of nursing for the goals of psychiatric nursing care and addiction treatment, including:

- Developing services and quality of psychiatric nursing practice.
- Increasing societal awareness of mental illnesses provided by specialized psychiatric nursing.

- Realizing the obstacles that may face psychiatric nursing and working to solve them.
- Working to bridge the gaps in the continuous need for psychiatric nursing.

### Professional Ethical Practice

Registered Psychiatric Nurses are aware of, promote, and uphold the profession's ethical values.

#### Indicators: A Psychiatric Nurse Professional:

- Practices and conducts oneself in a way that is commendable to the profession.
- Practices with honesty, integrity, and respect, upholding the profession's ethics, standards, principles, rules, and values.
- Supports and upholds the professional code of ethics.
- Recognizes possible issues and takes action to prevent or resolve them, based on their own values, beliefs, and experiences in interactions with clients.
- Guides psychiatric nursing practice with ethical values.
- In psychiatric nursing practice, uses the components of confidentiality and consent.
- Recognizes the therapeutic relationship's power imbalance and takes steps to avoid abusing that power.
- Supports clients' rights to make well-informed decisions.
- Keeps the lines between professional and personal interactions clear.

### **Fundamental View:**

For a person who needs assistance with their mental health, psychiatric nursing is concerned with helping them realize a complete and civilized life that fits their unique personalities. "With his or her personality" refers to a unique personality. We should cherish a person's sense of personal values and way of life.

Self-determination may be challenging for someone who needs mental health support. One can make moral decisions that are very different depending on the organization to which one belong (family, community, place of employment, or school). There are several reasons for this. The process of cognition known as understanding may occasionally be skewed. In other instances, if orientation (a recognition function) is impaired, one may also lack other cognitive abilities including memory, caution, thinking, and execution.

Low self-determination capability makes it difficult to gauge a patient's intentions, and there must be modest conflicts to encourage self-determination progress. It can be said that all psychiatric nursing assistance aims at the recovery of a patient's capacity for self-determination. "Self-identification" necessitates the sense of others they're relationship with them. The assistance "supports" the recovery of the patient's ability to make decisions on their own in the case where a patient is unable to do so on their own and their intention cannot be checked.

### **Code of Ethics and standers of psychiatric nursing Practice:**

The expected level of performance for all Registered Psychiatric Nurses is broadly outlined in the Standards of Psychiatric Nursing Practice. The standards

provide as a roadmap for learning the knowledge, abilities, attitudes, and values required to practice safely. They serve as a desirable and attainable benchmark for evaluating actual performance. Promoting, directing, and overseeing the practice of professional mental nursing is their main objective.

The Code of Ethics establishes the conduct that Registered Psychiatric Nurses are expected to engage in (RPNs). All members of the profession should adhere to the ethical principles and ideals outlined in the Psychiatric Nursing Code of Ethics. In addition to promoting high ethical standards in practice and acting as a self-evaluation tool for Registered Psychiatric Nurses, it creates a framework for professional responsibility and accountability.

## THE CODE OF ETHICS

Registered Psychiatric Nurses support the following principles through the Code of Ethics:

- Secure, efficient, and moral treatment to assure the safety of the public.
- Respect for people's inherent worth, freedom of choice, and dignity.
- Mental Health, Health and well-being.
- Quality practice.

### Secure, efficient, and moral treatment to assure the safety of the public

The Registered Psychiatric Nurse:

1. Recognizes the distinction between interpersonal and professional interactions and accepts responsibility for both.

2. Demonstrates a commitment to forming therapeutic alliances and conducts themselves in a way that upholds the dignity of such relationships.
3. Ensures that one does not use another person's weaknesses to further one's own objectives.
4. Seeks to obtain additional information or guidance from reliable sources to ensure practices at the individual's level of competence.
5. Aims to maintain continued competency throughout one's professional career while assuring evidence-based practice.
6. Aims to maintain a degree of physical, mental, and emotional stability in order to deliver competent, safe, and moral care.
7. Ensures that one does not initiate or take part in any behavior that is thought to be detrimental to the well-being of others.
8. Safeguards the privacy of all data obtained in the course of a professional interaction.
9. Practices covered by the laws that control access to, use of, and sharing of private data.
10. Demonstrates honesty, integrity, reliability, objectivity, and diligence in how they conduct themselves.
11. During the delegating responsibilities they Recognizes the expertise and limitations of co-workers/ colleagues or student.
12. Inform the proper authorities of a health care provider's inept or unethical actions.
13. accepts responsibilities for one's own actions and makes all necessary efforts to avoid or reduce harm.



14. conducts oneself in a way that enhances the profession's reputation at the local, communal, provincial, and governmental levels.
15. Recognizes, supports, and upholds the ethical standards of the field.

### **Respect for people's inherent worth, freedom of choice, and dignity**

The Registered Psychiatric Nurse:

1. Respects individuals' independence and the freedom to make their own decisions by including them as full decision-making partners.
2. Strives to ensure that a person's preferences are recognized, voiced, and supported.
3. Respects the individuality, decency, and intrinsic worth of every person and works to uphold their rights.
4. Embraces diversity and acknowledges that a person's culture can have an impact on their health habits and way of thinking.
5. Respects the individual's moral and legal right to refuse medical treatment and to decide to live in danger so long as those choices are legal.
6. Understands, respects, and uses the components of informed consent.
7. Ensures that mental nursing decisions are in line with the person's preferences or, if appropriate, the preferences of a replacement decision maker
8. Gives people the chance to make decisions even when their capacity for self-determination is compromised.

### **Mental Health, Health and well-being**

The Registered Psychiatric Nurse:

1. Respects all patient's needs and values in relation to their physical, mental, developmental, social, and spiritual demands.
2. Recognizes the relationship between physical and mental health as a dynamic process that varies over the course of a lifetime.
3. Acknowledges the intricate connections between emotional, developmental, physical, and mental health as well as the impact of social variables on physical, mental, and mental health as well as illness.
4. Recognizes how expectations, expectations, and lifestyle affect one's physical and mental health.
5. Acknowledges the importance of culture and spirituality in promoting health, preventing illness, and recovering from it.
6. To achieve equity in services for mental and physical health.

### Quality Practice

The Registered Psychiatric Nurse:

1. Recognizes that all facets of health are influenced by community, socioeconomic, and political systems.
2. Ensures that approaches to physical and mental health are collaborative, holistic, and dynamic and include promoting health, preventing illness, and ensuring interventions that promote rehabilitation and recovery.
3. Uses research to advance evidence-based practice, psychiatric nursing knowledge, and advancements in mental health care, and contributes to that research.
4. By encouraging a good, healthy, and ethical working environment, contributes to great practice.

5. Helps to maintain and promote safe practice environments.
6. Promotes the use of both human and material resources to make sure that safe and competent practice is a top priority.
7. Advocates for equal treatment and protection of all people as well as fair and equitable access to services and benefits.
8. Respect and values the efforts and knowledge of other healthcare professionals, and engage in cooperative manner with them.

# **Standards of Psychiatric Nursing Practice**

## THE STANDARDS OF PSYCHIATRIC NURSING PRACTICE

The expected level of performance for all Registered Psychiatric Nurses is broadly outlined in the Standards of Psychiatric Nursing Practice. There are five (5) psychiatric nursing practice standards. A standard is a measure of achievement based on a desired level of perfection. The standards provide as a roadmap for acquiring the necessary information, skills, values, judgment, and attitudes to practice safely. They represent a desirable and attainable standard against which actual performance can be measured. Their principal goal is to promote, guide, and direct the practice of professional psychiatric nursing. Each standard of practice has a number of indications that help specify how to comply with the standard of practice. A statement that helps explain how the requirements can be satisfied is referred to as an indication. For each norm, the indications are representative but not exhaustive.

### Therapeutic relations

**Description:** therapeutic relations entail expectations of how nurses in mental health settings are expected to interact with their patients and their families.

**Definitions:** **The therapeutic relationship** refers to the relationship between the nurse and patient that is characterized by respect for dignity, intentional presence, expression of respect, empathy, and mutual trust. When service users perceive a therapeutic relationship between them and the provider, they gain trust and open up which promotes positive outcomes (Moreno-Poyato et al., 2019).

The term "**emotional intelligence**" refers to the capacity to recognize, understand, and effectively express emotions. Emotional intelligence is exemplified by the appropriate regulation of emotions, objective communication of one's emotions, and reasoned action as opposed to emotive and impulsive action (Reshetnikov et al., 2020).

**Principles of therapeutic relations in mental health nursing:**

1. Forge therapeutic relationships with patients based on respect, empathy, mutual trust, effective communication, and ongoing interactions to create a positive experience of care and optimal health outcomes for the service user.
2. Demonstrate emotional intelligence and tolerance when working with patients in mental health settings.
3. Interact with service users whilst observing professional boundaries by avoiding behaviors that might be construed by others as favoritism or discriminatory in nature.
4. Be able to conduct sensitive and difficult conversations revolving around patient experience, management, and condition.
5. Model professional expectations for therapeutic relationships between the provider and service user.
6. Be able to engage various communication strategies to prevent and resolve crises and conflict, especially when dealing with aggressive or violent service users
7. Allocates enough time to attend to the needs of individual patients. Moreover, knows when there is not enough time to meet those demands and makes strategies to do so.

8. Works with the patient's family conducting a holistic assessment, planning care, and delivering of modalities such as family therapy.
9. Recognizes the patient's family as an integral element of care provision, understands that the condition of a service user might impact the well-being of family members and intervenes to facilitate family coping.
10. Recognize ethical and legal situations and issues that emerge in therapeutic relations in a mental health setting and respond to them appropriately drawing from the professional code of conduct, ethical principles, and local laws and regulations.

### **Competent, evidence-based practice**

**Description:** This standard highlights the principles that nurses are expected to follow in integrating the best available evidence to support care providers and encourage optimal outcomes for service users in the mental health setting.

**Definitions:** Evidence-based practice: refers to the conscientious approach to clinical issues drawing on the best available evidence to inform practice and decision making taking into account several factors such as competencies, patient values, and preferences (Chien., 2019).

#### **Principles of evidence-based practice in mental health nursing:**

1. Integrate the best available evidence in clinical judgment and clinical decision-making to provide a rationale for each intervention and to recognize implications and/or untoward outcomes from interventions.

2. Use evidence-based resources including symptom assessment scales such as suicide risk and depression assessment scales to conduct comprehensive patient assessment whilst recognizing.
3. Evaluates prevailing practice against the best available evidence, and identifies gaps, and work to revise and align practice in light of the best available evidence.
4. Recognize that individuals with mental health illnesses might be having other physical ailments whose diagnoses and management interact with each other and therefore draw on the best available evidence base to optimize the care provided.
5. Apply evidence-based practices to encourage and empower patients to undertake self-management by enabling them to identify and respond to their various health needs.
6. Draw on the evidence base to assess risks and potential hazards in mental health nursing and undertake interventions to mitigate any imminent risk.
7. Identifies areas for improvement in practice, followed by a search for evidence, an assessment of the information's quality, and a synthesis of the evidence.
8. Draw on the evidence base to assess and practice in a manner that promotes the safety of service providers and service users.
9. Commit to lifelong learning by taking advantage of formal and informal learning opportunities to keep tabs on the latest practice and also foster continuous professional development.



10. Consistently reflect on individual practice and aligns individual practice towards evidence-based practice.
11. Draws on evidence-based practice to design appropriate teaching materials and teaching strategies taking into account the literacy and communication needs.
12. Draws on the evidence base to integrate innovations into practice to improve outcomes and address gaps in healthcare delivery.

### **Professional responsibility and accountability**

**Professional responsibility and Accountability:** refer to a standard of psychiatric nursing practice that is built upon the core values of respect, honesty, integrity, and compassion. It also refers to professional boundaries, insurance and conscientious objection. This standard encompasses the commitment of a psychiatric nurse to provide quality care to all patients and adhere to ethical principles, practice standards, and legal requirements. The nurse must also take responsibility for their decisions and actions, and be held accountable for their performance in order to protect the patient's safety and well-being (Chesterton et al., 2020).

### **Principles of Professional responsibility and Accountability in mental health nursing:**

1. Advocate on behalf of patients who require you to ensure their rights and interests are protected.
2. Respect the dignity, autonomy, and rights of those receiving care and their families regardless of their mental health status or any other differences.

3. Be able to maintain the highest possible level of competence in the delivery of services to patients and their families.
4. responsible and accountable for the decisions and actions, including inactions and omissions, in nursing practice and must be willing to accept responsibility for any errors or omissions.
5. Abide by the ethical and professional values and the standards of conduct and practice in the Code
6. Be able to involve the patient and their family/caregivers in decision-making and strive to create a collaborative approach to care.
7. Ensure that any information shared between patient and nurse is held in strict confidentiality, unless there is a legal obligation to disclose
8. keep professional boundaries with patients. Professional boundaries set the limits of the therapeutic relationship including acceptable behavior between nurse and the patient.
9. Remain knowledgeable and informed about the latest advances in mental health care, and act in accordance with professional standards.
10. Ensure that all patients are treated fairly and justly, and that their care is provided in an equitable manner.
11. Duty to protect the health of your patient, your own health and safety and that of the wider community.

### Leadership and management

**Description: Leadership and management** in psychiatric nursing is an important standard of practice to ensure quality care for patients. Leadership and management involve setting clear expectations and providing direction to

nurses, while also making sure that the nurses are following professional standards and ethical guidelines. Leadership and management also involve providing administrative and clinical oversight, ensuring efficient operations, and coordinating resources. This includes developing and implementing policies and procedures that reflect best practices, as well as ensuring that the staff is properly trained and educated in the latest trends and standards of nursing practice. Leadership and management also involve setting goals and objectives for the organization, developing a vision for the organization, and monitoring progress towards these goals. Finally, it is important to foster a culture of respect, collaboration, and communication between staff members and patients.

**Definition:**

**Leadership and management:** Leadership and management are two distinct skills that are often used interchangeably but have different meanings. Leadership is the ability to inspire, motivate, and direct others to achieve a goal or accomplish a task. Management is the ability to organize, plan, and control resources to achieve a goal or accomplish a task. Leadership is about influencing people and inspiring them to do their best, while management is about overseeing the work of others and ensuring that it is done efficiently and effectively (Alilyyani et al., 2021). Leaders create a vision and inspire others to follow it, while managers provide the resources and structure needed to make the vision a reality.

**Principles of Leadership and management in mental health nursing:**

1. Provide leadership in mental health nursing practice by setting standards and expectations, and advocating for optimal care.
2. Utilize evidence-based strategies to promote recovery, resilience, and well-being.
3. Facilitate the development of therapeutic relationships and promote a culture of respect and dignity.
4. Utilize a collaborative approach to care and work in partnership with the interdisciplinary team.
5. Promote and facilitate effective communication between all stakeholders.
6. Lead, coordinate, and manage the care of individuals with mental health conditions across the lifespan.
7. Participates in quality improvement activities to initiate change in psychiatric nursing practice and in the health care system.
8. Support family members and caregivers in understanding and managing mental health issues.
9. Promote the use of health promotion strategies to improve outcomes.
10. Utilize professional, ethical, and legal standards to guide practice.

### Professional ethical practice

**Description:** Professional ethical practice in psychiatric nursing is the practice of nursing that is based on ethical principles, such as respect for autonomy, beneficence, non-maleficence, justice, and fidelity. In psychiatric nursing, it is essential to recognize, respect, and promote the rights of the client and to ensure the safety and well-being of the client (Manderius et al., 2023). It is also important to maintain confidentiality, to be honest and open with the client, and

to practice within the scope of the nurse's training and licensure. Professional ethical practice in psychiatric nursing also involves recognizing and advocating for the rights of the client, advocating for the client's best interests, and providing appropriate nursing care. In addition, it is important to maintain professional boundaries, to provide culturally competent care, and to maintain a safe and therapeutic environment.

**Definition: Professional ethical practice** refers to the adherence to a set of ethical principles and standards of behavior when providing psychiatric care to patients. This includes respecting patient autonomy, maintaining confidentiality, providing competent and compassionate care, and advocating for the best interests of patients (Manderius et al., 2023).

**Principles of professional ethical practice in mental health nursing:**

1. provide care aimed at promoting the wellbeing of their patients.
2. Should be able to strive to do no harm to their patients and should avoid causing harm or distress to their patients.
3. Provision of care that is fair, equitable, and unbiased.
4. Should be loyal to the profession and their patients, and they must strive to maintain a trusting relationship with their patients.
5. Be able to Act with honesty and integrity in all professional activities.
6. accountable for providing competent care to their clients, using their professional knowledge and skills to make decisions that are in the best interest of the client and taking responsibility for their actions.

7. Maintain their professional integrity by adhering to the ethical principles of the profession, remaining current in their knowledge and skills, and ensuring that their practice is evidence-based and non-biased.
8. Be able to have the appropriate knowledge, skills, and abilities to practice their profession safely and effectively.
9. Advocate for individuals to receive the highest quality of care in a safe and effective manner.
10. Be accountable for one's own professional actions.

Mental health nurses must adhere to this set of standards of practice that include therapeutic relationships, evidence-based practice, professional responsibility and accountability, leadership and management, and professional ethical practice. These standards are essential for the provision of quality care and the promotion of optimal health outcomes for individuals and families affected by mental health issues.

# **Accountability and Responsibility in Nursing**

## ACCOUNTABILITY AND RESPONSIBILITY IN NURSING

### INTRODUCTION

While responsibility refers to someone's duty to carry out a task to completion, accountability generally refers to what happens after something has happened. Accountability is therefore concerned with the consequences of someone's actions, rather than their initial duty to carry these actions out.

**DEFINITION:** Professional nursing accountability will be defined as taking responsibility for one's nursing judgments, actions, and omissions as they relate to life-long learning, maintaining competency, and upholding both quality patient care outcomes and standards of the profession while being answerable to those who are ...

Nurses have a professional responsibility to demonstrate knowledge and judgment and be accountable for their actions and decisions. Nurses must also be aware of how their actions and decisions reflect on their reputation, their employer's/organization's reputation, and the nursing profession in general.

### ACCOUNTABILITY IN NURSING

Accountability is about maintaining competency and safeguarding quality patient care outcomes and standards of the profession while being answerable to those who are affected by one's nursing or midwifery practice.

### NURSING PROFESSIONAL RESPONSIBILITY

Includes professional, legal, and ethical responsibilities and cultural safety. Nurses have a professional responsibility to demonstrate knowledge and judgment and be accountable for their actions and decisions.



## Importance of Accountability

When nurses understand and appreciate the importance of professional accountability in nursing, that awareness is naturally carried over into every aspect of practice. Nursing accountability is essential for the delivery of safe, effective patient care. The following are four reasons explaining why all nurses should strive to practice accountability.

1. Accountability in nursing helps foster trusting relationships between patients and nurses, which can positively influence patient outcomes.
2. Nurses who hold themselves accountable set themselves up for success.
3. A culture of accountability in nursing reduces the misuse of valuable healthcare resources. Costs, making healthcare services more affordable for all patients.
4. Nurses whom practice accountability can promote a positive reputation for the facilities where they are employed.
5. Four core components of accountability in nursing practice:
6. Accountability in nursing can be demonstrated in all aspects of patient care. There are several characteristics associated with accountability, including dependability, confidentiality, acting as a patient advocate, and ensuring best practices are followed. Accountability in nursing practice can be classified under one of four core components, as defined below.

### 1. Professional Accountability:

The Code of Ethics established by the American Nursing Association defines professional accountability as being answerable to oneself and others for one's

own actions. Nurses have a formal obligation of accountability placed on them by their Nurse Regulatory Board and must be willing to accept professional responsibility for the care they provide.

## **2. Legal Accountability:**

All nurses should be mindful of their legal responsibilities related to the role of patient care. Nurses are personally accountable by law for their actions and/or omissions and have a legal obligation to provide care within their Scope of Practice. Further, legal accountability in nursing includes the responsibility of nurses to know what tasks or duties may be delegated to others and the care with which they make decisions regarding delegation.

## **3. Ethical Accountability:**

This component of accountability in nursing practice relates to the nurse's responsibility to provide for patients and to maintain the patient's best interest as a priority. Ethical responsibilities in nursing include beneficence, respect, non-maleficence, fairness, and honesty.

## **4. Employment Accountability:**

Nurses should practice accountability to their employers. While there is usually an assumption that employer and employee goals are the same, if opinions differ, nurses must choose how to respond. It is imperative that nurses understand accountability to employers should not require them to conduct themselves in a manner that is against legal or ethical guidelines for nursing practice. Likewise, employers should strive to create an atmosphere that fosters professional, legal, and ethical accountability in all nurses.

## HOW CAN NURSES DEMONSTRATE ACCOUNTABILITY IN NURSING PRACTICE?

There are endless opportunities to demonstrate accountability in nursing practice. The following is a list of the 10 best ways nurses can demonstrate accountability in nursing practice.

### 1. Work within your Scope of Practice.

The nurse's Scope of Practice is in place to help maximize patient health outcomes and safeguard patient experiences. When nurses work outside their Scope of Practice, patients, coworkers, healthcare facilities, and society are at risk. Working within the Scope of Practice is one of the best ways to demonstrate accountability in nursing practice.

### 2. Accept responsibility for yourself and your actions.

You cannot make other people act responsibly, but you can accept responsibility for your own behavior and work ethic. Practicing accountability in nursing requires a willingness to acknowledge your role in situations, good or bad. When you demonstrate personal accountability, it becomes easy to build strong relationships with employers and peers, which can positively impact patient outcomes.

### 3. Follow policies and procedures as established by your employer.

Nurses demonstrate accountability to employers by following policies and procedures. It is vital for nurses to understand that policies and procedures are not meant to replace legal limitations in nursing practice as set forth in the Nurse Practice Act. Any nurse with questions about a policy or procedure's legality or

legal limits should verify any facility policies they believe conflict with Nurse Practice Act regulations.

#### **4. Accept correction or instruction from supervisors when needed.**

Everyone likes to be complimented or told they are doing a good job. It is not always easy, though, to accept correction. Being accountable in nursing means being willing to listen to team leaders or managers and learning from them. While no one has a right to demean you or make you feel embarrassed, supervisors who approach you with your and your patient's best interest in mind and who treat you with respect will appreciate any effort from you to improve.

#### **5. Stay up to date with professional nursing standards.**

Any nurse can work a 12-hour shift and go home. Nurses who genuinely care about patients and their careers understand the importance of accountability in nursing practice. A vital step in practicing nursing accountability is to be aware of changes related to professional nursing practices. A few ways nurses can stay up to date are joining a nursing association, reading nursing journals or magazines, joining social media platforms, subscribing to podcasts, taking continuing education courses, and attending nursing conventions.

#### **6. Use evidence-based practices when providing patient care.**

Evidence-based practice (EBP) is described as the judicious and conscientious use of current best evidence combined with clinical expertise and patient values to guide health care decisions. Evidence-based practices use scientific research necessary to make crucial decisions for patient care. Using evidence-based practices, nurses can understand the effectiveness or potential risks associated

with patient care. Using EBP is an excellent way to demonstrate accountability in nursing practice. To effectively apply evidence-based practices, nurses are encouraged to formulate care-relevant questions, identify knowledge gaps, research literature when needed, and involve the patient in clinical decision-making when appropriate.

### **7. Implement accountability safeguards.**

All nurses should strive to implement accountability safeguards within their professional roles. Accountability safeguards include utilizing quality improvement, peer review, and research to help ensure safe, high-quality patient care.

### **8. Complete tasks assigned to you before leaving work.**

We all have days that seem to run out of hours before our work is finished. When you are tired or stressed, you may be tempted to clock out at the end of your shift and let someone else take up the slack from your unfinished work. Can you imagine what would happen if one nurse on each shift did this each day? Eventually, it could lead to significant problems. Accountability in nursing practice means acknowledging that everyone has a job to do and not shirking your responsibilities onto someone else. Granted, some employers may have rules restricting overtime, but before you leave a job undone, talk to your supervisor and ask how they want the situation handled.

### **9. Set personal and professional goals.**

When you set goals and follow through with them, you create a habit of personal accountability. The more goal-oriented you become, the greater the level of

accountability you will demonstrate. Those habits will become more natural with time, and you will experience the benefits in both your personal and professional life.

### **10. Provide safe, quality care to all patients.**

Nurses are accountable to patients by fulfilling obligations set forth in the Code of Ethics and Scope and Standards of Practice. These documents outline the requirement of nurses to provide exemplary care to all patients in need of healthcare services.

## **4 Consequences of Lack of Accountability in Nursing Practice**

A lack of accountability in nursing practice can have significant, far-reaching consequences. Nurses should strive to demonstrate accountability in all aspects of practice. The following are examples of consequences of lack of accountability in nursing.

### **1. Increased risk to patient safety:**

In 2020, more than 750,000 cases of nursing error occurred in the U.S. Of those cases, nearly 90,000 resulted in patient death or serious injury. Nurses who practice professional accountability strive to provide safe, high-quality care to patients, reducing risks to patient safety.

### **2. Increased healthcare costs:**

Nurses who practice irresponsibly contribute to the high cost of healthcare. These costs may be the result of lawsuits against the nurse or healthcare facility, or expenses related to an increased need for patient care directly related to nursing errors.

### 3. Poor nurse-patient and interprofessional relationships:

Patients want to be cared for by nurses who are professionally responsible. Healthcare providers want to work with peers who take their jobs seriously, and they can count on when they need a hand. Accountability in nursing means being dependable, and when nurses are not, relationships become strained.

### 4. Loss of job and/or nursing license:

Employers and the nursing profession demand accountability from all nurses. Unfortunately, when nurses lack accountability in professional practice, it can result in the loss of jobs or the loss of their nursing license.

## Professional Responsibility in Nursing

Professional responsibility as applied to nurses refers to the ethical and moral obligations permeating the nursing profession. These standards relate to patient care, collaboration with other medical professionals, integrity, morals and the responsibility to effectuate social change. Nurses must learn these rules during their schooling, whether they are becoming a registered nurse or certified nurse practitioner. Ethical violations could result in a loss of license or discipline by the state nursing board.

### Patient's Interests:

The best interests of the patient are pre-eminent above any other concern or bias held by the nurse. She is to espouse compassion and respect for the patient's self-determination, regardless of the patient's sex, age, nationality, race or medical condition. Nurses must always resolve conflicts of interest in ways to ensure patient safety and guard professional integrity. Part of this

responsibility is the nurse's duty to collaborate fully with the entire treatment team, including doctors, other nurses and specialists.

### **Advocacy and Responsibility:**

The nurse has a duty to advocate for her patients. She must work to advance the patient's legal rights, privacy protections and right to choose whether or not to participate in medical research. As an advocate, the nurse must ensure that she meets all qualification and state licensure regulations prior to participating in nursing activities and must be vigilant against other colleagues with impairments. At all times, nurses have the professional duty to accept personal responsibility for their actions and are accountable for nursing judgment and action or inaction. This accountability extends to situations in which the nurse delegates duties to a colleague or subordinate.

### **Values and Morals:**

The nurse has a duty of self-respect and morality to herself as well as those around her, including patients. Nurses must maintain constant professional growth and commitment to lifelong learning. Ethics rules dictate that a nurse must manifest a positive wholeness of character, meaning her virtuous character extends beyond the workplace and into her personal life. Nurses are expected to be moral and express wisdom, courage and honesty. Nurses in a leadership role must provide employees an opportunity to express grievances in a positive way and create environments that foster ethical nursing practices.



### **Community Education:**

Nurses have an ethical duty to spread knowledge and information about health, wellness and the avoidance of disease. Nurses should advance the profession by participating in community outreach programs and civic activities related to health care. Nurses have a duty to stay abreast of national and global health concerns, outbreaks, epidemics and infectious diseases. A nurse must also stay educated about vaccines, world hunger, pollution, lack of access to health care, violations of human rights and the equitable distribution of nursing services.

### **Perpetuation of Ethical Standards:**

Nurses have a responsibility to maintain open and constant discourse with colleagues about ethical issues. Nurses must affirm the values of the profession to other members and carry out collective adherence through enrollment in professional associations. Nurses must stay actively involved in discussions and debate related to social change and reform, particularly pertaining to access to health care, homelessness and the stigma of illness.

## **ESSENTIAL RESPONSIBILITIES FOR NURSES**

A nurse's responsibilities may vary depending on where they work, what licenses they have obtained and how experienced they are. Here are 13 of the most common tasks nurses are responsible for:

### **1. Recording medical history and symptoms**

Nurses record and maintain accurate documentation of their patients' health to ensure they receive the proper treatment. Most nurses begin this process by

asking patients questions about their medical history to gather information about previous diagnoses and surgeries, current medications, allergies and relevant family medical information. They may also ask the patient questions about any symptoms they are currently experiencing and record their vitals.

If the patient receives a new diagnosis, medication or treatment plan during their visit, a nurse may be responsible for updating their medical record with this information. Maintaining detailed and accurate medical records is critical for ensuring patients receive the best possible care.

## **2. Administering medications and treatments**

Most nurses can administer medications and treatments to their patients with a physician's order. They can also help develop a treatment plan for their patients. Specialized nurses, such as nurse practitioners, may be able to prescribe medications without a doctor's approval. Some treatments nurses may help with include cleaning and dressing wounds, changing bandages and inserting catheters. Nurses may also assist doctors with more advanced procedures or administer emergency care to patients in critical condition.

## **3. Collaborating with teams for patient care**

Nurses play a vital role in collecting information from patients and sharing it with the rest of their medical team. Because this is such a key responsibility for those in the nursing profession, nurses must have excellent verbal and written communication skills to effectively collaborate with physicians and other healthcare providers. Clear, concise communication can also ensure that

patients and their family members understand all of the information they receive.

Related: Communication Skills in Nursing: Definition and Examples.

#### **4. Performing diagnostic tests**

Nurses may perform a wide variety of diagnostic tests, including checking vitals and collecting tissue, blood, stool or urine samples for analysis. It is important for nurses to pay close attention to detail to ensure these tests are administered properly because they need this information to diagnose patients and develop treatment plans. Nurses may also be responsible for analyzing the results and sharing what they find with the rest of their medical team.

#### **5. Conducting physical examinations**

Nurses often conduct a physical examination of patients at the beginning of their visit to assess their overall health. This may involve taking the patient's temperature, recording their weight, monitoring their heartbeat and checking their blood pressure. This examination may also include testing the patient's reflexes, checking their lymph nodes and examining their eyes, ears, nose and throat. The physical examination provides nurses and the rest of the medical team with a current update on the patient's health and an opportunity to talk to patients about their health goals and concerns.

#### **6. Monitoring patients' health**

Nurses must carefully monitor and observe their patients to record any symptoms or relevant information that could lead to a diagnosis or a change in their treatment plan. This may involve carefully checking patient records to

ensure the correct medications and dosages are listed, maintaining intravenous (IV) lines to ensure they are changed regularly and monitoring the patient's vital signs. Nurses must also pay close attention to nonverbal cues from their patients to help them identify underlying causes for their health-related issues.

### **7. Providing support and advice to patients**

It is important to make sure patients feel cared for, listened to and understood, especially when nurses need to deliver challenging medical news. Patients often look to nurses for support and advice to help them process their diagnoses and determine what steps they should take next. Nurses who are empathetic toward patients and their family members can provide comfort and guidance during these situations. They may also equip their patients with effective coping strategies or provide them with inpatient and outpatient resources.

### **8. Operating medical equipment**

Nurses use a wide variety of diagnostic tools to care for their patients, including stethoscopes, glucometers, pulse oximeters, thermometers and blood pressure machines. Depending on where they work and what licenses they hold, nurses may also be trained to operate more specialized machinery, such as intravenous infusion pumps, ventilation equipment and wound drainage systems. Having a strong background in technology and mathematics can help nurses properly operate medical equipment and analyze the results.

### **9. Educating patients about how to manage an illness**

Part of a nurse's role is to educate their patients about various medical conditions and provide clear instructions on how they can manage their

symptoms. This could include explaining what medications the patient needs to take, when the patient should schedule a follow-up appointment and instructions for rehabilitative exercises or practices. Nurses may also be responsible for explaining additional post-treatment home care needs to a patient's family or caregiver. This can include recommendations for the patient's diet and nutrition, exercise routine and physical therapy.

Some nurses may also proactively educate people about common diseases by speaking at seminars, helping with blood drives or offering their services at health screening and immunization clinics.

Related: A Day in the Life of a Nurse: Typical Daily Activities and Duties

## **10. Advocating for the health and well-being of patients**

In order to properly care for their patients and ensure their safety, nurses may often act as advocates for their health and overall well-being. This can involve translating the medical information or diagnosis a doctor provides to ensure the patient understands the important details, encouraging patients to ask questions or connecting patients with resources at another facility that's better suited for their needs. Nurses can also advocate for their patients by taking the time to actively listen to their concerns, respecting their wishes and communicating what the patient wants with their family or other staff members.

## **11. Providing basic bedside care**

Nurses may be responsible for a wide range of basic bedside care tasks, depending on their particular working environment. These tasks can include helping patients bathe, use the bathroom and perform other hygiene-related

activities. Bedside nurses also offer their patients emotional support, administer medications and track their vitals.

## **12. Training and educating staff**

In addition to the clinical work they do to take care of patients, qualified nurses with an appropriate amount of experience may help train and supervise newer members of their medical team, including practical nurses and nurses' aides. Some nurses may even work with nursing students by offering training courses through a local college or providing continuing education programs for nurses looking to advance in their careers.

Related: 7 Leadership Styles in Nursing

## **13. Maintaining inventory**

Experienced nurses may take on extra job roles, such as maintaining inventory and ordering supplies. This is often a shared responsibility, but tenured nurses may supervise entire departments. Making sure supplies are properly organized, accounted for and restocked on time can help ensure the medical team has all of the resources they need to provide quality care for their patients.

# **Mental Health Nursing Assessment Guidelines**

## Mental health nursing assessment interview guidelines

### Purpose:

- Provide guidelines for psychiatric nursing assessment.
- To provide safety and sense of belongingness to the patient.
- To establish good working relationship between patient and staff.

### Definitions:

Psychiatric nursing assessment - is the scientific process of identifying a patient's psychosocial problems, strengths, and concerns regarding psychological stability. In addition to serving as the basis for treating psychiatric patients, the psychiatric nursing assessment has broad clinical applications because a patient's psychological problems can have an impact on overall health.

### Nursing guidelines:

1. Perform a rapid review of the patient's medical record.
2. Perform hand hygiene.
3. Be aware of your safety environment at all times.
4. Confirm the patient's identity using at least two patient identifiers.
5. Provide privacy.
6. Choose a quiet setting, and easy access to an exit if needed.
7. Sit a comfortable distance from the patient at an angle allows eye contact while appearing less threatening.
8. Introduce yourself, and address the patient by surname.
9. Explain the procedure to the patient and family (if appropriate).



10. Use an assessment tool according to type of assessment to guide you with collecting your assessment data.
11. Use statements that encourage verbalization by the patient.
12. Listen carefully to the patient and respond with sensitivity. Adopt a professional but friendly attitude and maintain eye contact.
13. Use a calm, nonthreatening tone of voice. Doing so encourages the patient to talk more openly. Employ therapeutic communication techniques to assist with forming a trusting relationship.
14. Building a therapeutic relationship based on trust takes time.
15. Allow the patient to carry the conversation. Redirect the patient as necessary.
16. Pay attention to unspoken signals.
17. Take note of any coping mechanisms the patient may be using.
18. Be alert for signs that the patient's behavior is escalating or that the patient is becoming agitated because you may suddenly find yourself in an unsafe situation.
19. Screen the patient for suicidal ideation using a brief, standardized, evidence-based screening tool.
20. Special Considerations
21. Keep in mind that a patient's background, culture, beliefs, and values can affect the response to illness and adaptation to care.
22. Deal effectively with communication barriers.
23. If the patient becomes agitated or upset, stop the assessment and call for additional staff support.

## 24. Documentation.

### **Mental status examination guidelines**

#### **Purpose:**

- Provide guidelines for mental status examination.
- Obtain a complete cross-sectional assessment of the patient's mental condition.
- In combination with biographical and historical information from the mental history, help in making an accurate diagnosis.
- Use to get a knowledge of the patient's psychological functioning at a specific time point in order to provide appropriate care.

#### **Definitions:**

The mental state examination (MSE) is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behaviour, mood, affect, speech, thought process, thought content, perception, cognition, insight and judgement.

#### **Nursing care guidelines:**

1. Wash your hands and done PPE if appropriate.
2. The mental state examination (MSE) is a structured method for evaluating and describing a patient's current mental state across the domain of appearance, attitude, behavior, mood, affect, speech, thought process, thought content, perception, cognition, insight, and judgement.
3. Provide privacy.
4. Introduce yourself to the patient including your name and role.

5. Explain the procedure to the patient and family (if appropriate).
6. Confirm the patient's identity using at least two patient identifiers.
7. Use therapeutic communication techniques.
8. Ask the patient if they would be happy to talk with you about their current issues.
9. Assess the patient's condition according to components of MSE (table1) and ways to assess every component.
10. Before you finish the interview, you should thank the patient for his cooperation.
11. Perform hand hygiene.

**Table 1.1: Mental status examination components**

Component		What to assess
Appearance & Behavior	Physical appearance	Gender; ethnicity; body habitus; apparent age; cleanliness and grooming, hair/clothing style, cosmetics, and jewelry; syndromic features.
	Manner of relating to clinician and parents	Ease of separation from each parent; reactions to meeting the clinician (eg eagerness to please, defiance, overfamiliar); eye contact; facial expression. Note <b>presence of hallucinatory behaviors</b> (e.g., talking to self; laughing incongruently).
	Activity level	<b>Psychomotor slowing or agitation</b> , sustained or episodic, goal-oriented, or erratic; coordination, unusual postures, or motor patterns (e.g., tics, stereotypies, odd mannerisms, tremors).

<b>Speech</b>		Spontaneous and talkative to <b>mute</b> . Fluency, rate, volume, tone.
<b>Mood</b>		Predominant emotion over days/weeks (eg euthymic, apathetic, angry, dysphoric, apprehensive, euphoric). Use 0-10 scale (0: extremely sad & wishing to end life immediately, 10: extremely happy).
<b>Affect</b>		Current observed emotional state. Describe type, range (constricted to labile), reactivity ( <b>blunted</b> or <b>flat</b> to reactive), & appropriateness.
<b>Thought</b>	Stream (i.e., speed)	Poverty of thought ( <b>thought blocking</b> ), poverty of content ( <b>perseveration</b> ), racing thoughts, <b>flight of ideas</b> .
	Form	Logical & goal-directed or <b>disordered</b> (e.g., circumstantial, tangential, derailment, looseness of associations, word salad).
	Content	Obsessions, <b>delusions</b> (e.g., persecutory, referential, grandiose, somatic, bizarre), phobias, magical thinking, <b>thoughts of harm to self or others</b> .

<b>Perception</b>		Altered bodily experiences (e.g., depersonalization, derealization), <b>passivity phenomenon</b> , illusion, <b>hallucination</b> (e.g., auditory, visual, olfactory, tactile).
<b>Cognition</b>	Level of consciousness	Alert, drowsy, <b>delirium</b> , <b>stupor</b> .
	Orientation	Awareness to <b>confusion</b> of self, current setting, date & familiar people.
	Attention	Need for redirection/repeating, sustained activity, distractibility.

	Memory	Immediate (e.g., repeat numbers, names back), short-term (e.g., recall three objects at 2 and 5 minutes), long-term (e.g., recall events of past week).
	Ability	Impression of current abilities; concrete to abstract thinking.
<b>Insight &amp; Judgment</b>	Insight	Intact, partial, or <b>poor insight</b> . Ability to identify potentially pathological events (e.g., hallucinations, suicidal impulses); acknowledgement of a possible mental health problem; locus of control (internal v external).
	Judgment	Intact to <b>impaired judgment</b> . Problem solving ability in context of current psychological state (can be explored by recent decision making).

## Extrapyramidal symptom nursing assessment guidelines

### Purpose:

- To provide guidelines for extrapyramidal symptom nursing assessment.
- To provide safety and sense of belongingness to the patient.
- To identify and reduce extrapyramidal side effects.

### Definitions:

Extrapyramidal symptoms (EPS), are drug-induced movement disorders, which include acute and long-term symptoms.

**Dystonia:** continuous spasms and muscle contractions,

**Akathisia:** may manifest as motor restlessness,

**Parkinsonism:** characteristic symptoms such as rigidity,

**Bradykinesia:** slowness of movement, tremor,

**Tardive dyskinesia:** irregular, jerky movements.

### Nursing care guidelines:

1. Review the patient's medical record for past and current medication use. Antipsychotics, decongestants, antihistamines, anticonvulsants, and SSRIs can produce extrapyramidal symptoms.
2. Determine the length of time the patient has been on the drug that's likely causing extrapyramidal symptoms.
3. Gather and prepare the necessary equipment and supplies.
4. Perform hand hygiene.
5. Confirm the patient's identity using at least two patient identifiers.

6. Provide privacy.
7. Explain the procedure to the patient and family (if appropriate).
8. Ask whether the patient has ever experienced extrapyramidal symptoms.
9. Explain the risk factors for extrapyramidal symptoms to the patient, and ask whether any of those factors apply.
10. Assess extrapyramidal side effects, and extrapyramidal signs and symptoms.
11. Contact the physician for additional request based on the patient's condition.
12. Provide immediate interventions to treat symptoms as indicated and medical request.
13. Remain with the patient, and offer support and reassurance.
14. Perform hand hygiene.
15. Documentation.

# **Mental Health Nursing Care Guidelines**



## Mental Health Nursing Care Guidelines

1. Schizophrenia nursing care guidelines
2. Active hallucinations nursing care guidelines
3. Delusional nursing care guidelines
4. Major depressive nursing care guidelines
5. Manic episode nursing care guidelines
6. Personality disorder nursing care guidelines of Provide guidelines for personality disorder patient care
7. Violent and assaultive nursing care guidelines of Provide guidelines for Violent patient management
8. Alcohol withdrawal nursing care guidelines
9. Paranoid schizophrenia nursing care guidelines
10. Behavioral problems nursing care guidelines
11. Nursing care guidelines for patients with restraint
12. Substance intoxication nursing care guidelines
13. Drug withdrawal nursing care guidelines

## 1. Schizophrenia nursing care guidelines

### Purpose:

- Provide nursing care guidelines for schizophrenia patient.
- To provide safety and sense of belongingness to the patient.
- To establish good working relationship between patient and staff.

### Definitions:

Schizophrenia - Characterized as disturbances of language and communication, thought, perception, affect, and behavior. Usually of psychotic proportion, it is a disturbance that lasts for at least 6 months. Thought disturbances are marked by alterations of concept formation that may lead to misinterpretation of reality, misconceptions, and sometimes to delusions and hallucinations. Mood changes include ambivalence, blunting, inappropriateness, and loss of empathy with others. Behavior may be withdrawn, regressive, and bizarre.

Negative symptoms - Include reduced range of expression of emotion (flat or blunted affect), markedly reduced amount or fluency of speech, and loss of the will to do things \ They are called negative because they give the impression that something has been taken away from the individual, not added, as is the case with hallucinations and delusions. Negative symptoms reduce the apparent textural richness of an individual's personality.

Positive symptoms - Hallucinations, delusions, positive formal thought disorder and bizarre behavior. Positive symptoms predict better response to medication and less permanent disability.

### Nursing care guidelines:

1. Provide a safe environment.
2. Perform a rapid assessment of the patient's behavior (violence risk, substance use, risk of self-injury, suicide, and homicidal ideation).
3. Provide privacy.
4. Perform hand hygiene.
5. Use therapeutic communication.
6. Confirm the patient's identity using at least two patient identifiers.
7. Make a nursing care plan that includes assessment, diagnosis, planning, implementation and evaluation.
8. Assess the patient using a Mental Status Examination (MSE).
9. Assess the patient's functional strengths and capacity to do daily activities.
10. Monitor the patient's nutritional status and body weight.
11. Administer medications, as ordered, following safe medication administration practices.
12. Assess the patient's response to psychotropic medications, including adverse reactions.
13. Provide patient and family psychoeducation.
14. If the patient is having hallucinations or delusions, don't encourage them. Instead, promote reality.
15. If the patient is experiencing disorganized or paranoid thoughts, negotiate with the patient (if needed) to reduce fear and provide reassurance about safety.

## 2. Active hallucinations nursing care guidelines

### Purpose:

- To provide guidelines FOR Active hallucinations patient care
- To provide safety and sense of belongingness to the patient.
- To establish good working relationship between patient and staff.

### Definitions:

Hallucinations – are perception-like experiences that occur in the absence of external stimulus. They may be auditory, visual, olfactory, gustatory, or tactile; however, they're most commonly auditory or visual. In certain cultural contexts, hallucinations may be a normal part of a religious experience.

### Nursing care guidelines:

1. Make sure that you have a way to leave the area when you enter the patient's location and that you have sufficient staff available to keep you safe.
2. Perform hand hygiene.
3. Confirm the patient's identity using at least two patient identifiers.
4. Approach the patient in a nonthreatening, calm, caring manner.
5. Introduce yourself to the patient and family (if applicable) to build rapport, gain trust, and help develop the nurse-patient relationship.
6. Assess the patient's behaviors during active hallucinations. Be alert for such behaviors as the patient pausing in conversation and seeming preoccupied, looking toward a perceived source of a voice, or responding to a perceived voice in some manner.

7. Ask the patient about the hallucinatory experience and help the patient shift toward reality. You might seek clarification by saying, "I don't hear any voices. What are you hearing?" Keep in mind that these experiences are real to the patient and that discounting them blocks communication. Focus on how the patient feels so that you can understand how to relieve the patient's fears.
8. Offer to help the patient feel safe in the present environment.
9. Assess the patient's risk of self-injury, suicide, and homicidal ideations. Address the patient's immediate safety needs.
10. When the active hallucinations cease, provide teaching to the patient and family (if appropriate) according to their individual communication and learning needs to increase their understanding, allay their fears, and enhance cooperation.
11. Explain that hallucinations are a symptom of the disorder. Suggest the use of a diary to monitor the hallucinations. Help to identify triggers that may precede hallucinations and to develop strategies to manage these symptoms when they occur.
12. Teach a patient who has auditory hallucinations to talk back forcefully to the voices to help control the hallucinations. Encourage the patient to do so in a private area rather than in public to avoid ridicule and perceived stigma. Also teach the patient such distraction techniques as watching TV, talking to someone, or keeping busy, and such strategies as taking prescribed medications, avoiding drugs and alcohol use, and managing anxiety to help control auditory hallucinations.

13. Assist the patient to develop positive coping skills so that the patient can cope with personal, social, and environmental stresses that can trigger hallucinations.
14. Assess the patient for deficits in cognitive functioning. If the patient has difficulty focusing, encourage participation in activities that improve attention. If the patient has memory problems, encourage making lists and writing down important information.
15. Monitor the patient's anxiety level and administer antianxiety medication as ordered, following safe medication administration practices. The intensity of hallucinations is typically related to the patient's anxiety level.
16. If the patient takes antipsychotic medication to manage hallucinations, monitor for extrapyramidal effects.
17. Never force a patient to discuss thoughts or feelings if it seems that doing so will increase the patient's anxiety level.
18. Documentation.

### 3. Delusional nursing care guidelines

#### Purpose:

- Provide guidelines for delusional disorder patient care
- To provide safety and sense of belongingness to the patient.
- To establish good working relationship between patient and staff.

#### Definitions:

Delusions: are fixed, false beliefs with no basis in reality.

#### Nursing care guidelines:

1. Perform hand hygiene.
2. Confirm the patient's identity using at least two patient identifiers.
3. Approach the patient with a calm, accepting demeanor.
4. Actively listen to the patient.
5. Observe for behavioral clues, and decrease environmental stimuli as needed.
6. Determine the need for external control, including seclusion or restraint. Communicate the decision to the patient and put a plan into action, as ordered.
7. If appropriate, interact with the patient one-on-one. A patient who's distrustful is better able to handle one-on-one interaction than a group situation.
8. Ask the patient to describe the delusion. If asked, point out that you aren't experiencing the same stimuli, but don't argue. These actions help identify the type of delusion so that you can implement the correct intervention while establishing trust.
9. Keep the patient engaged, and keep communication open and non-judgmental.
10. Observe the patient's speech for symptoms of a thought disorder.
11. Assess the patient's ability to recognize a cause-and-effect relationship.
12. Help the patient identify what might have triggered the delusion, if possible. Place the delusion in a time-frame. Helping the patient recognize symptom triggers and management strategies is integral to effective treatment.

13. Assess the intensity, frequency, and duration of the delusion.
14. Encourage the patient to express feelings related to the delusion to ascertain the feelings that the delusion generates.
15. Identify, respect, and respond to the emotional components of the delusion.
16. Teach the patient positive coping strategies, and provide feedback on the use of those strategies.
17. Don't feed into the patient's delusional system. Acknowledge the patient's frustration and possible fear, but keep the focus of the conversation based in reality.
18. Set firm limits if the delusion is obsessive to lessen the amount of time talking about the delusion.
19. Validate the parts of the delusion that are real if the delusional system is intertwined with elements of reality.
20. Create a distraction to divert the patient's focus from the delusion. For example, ask permission to accompany the patient on a walk.
21. Promote physical activity.
22. Recognize and reinforce healthy, positive aspects of the patient's personality.
23. Encourage personal responsibility in wellness and recovery.
24. Collaborate with the patient, practitioner, and occupational and physical therapy specialists to assess the patient's ability to perform activities of daily living.



25. Collaborate with the patient to establish a daily, achievable routine. Focus on maintaining social function and quality of life.
26. Work with the patient to develop an effective symptom management program and social support network. Refer the patient to outside resources, as needed.
27. Perform hand hygiene.
28. Documentation.

#### 4. Major depressive nursing care guidelines

##### Purpose:

- Provide guidelines for major depressive disorder patient care.
- To provide safety and sense of belongingness to the patient.
- To uplift patient's self-esteem.
- To render physical care to the patient.

##### Definitions:

Major depressive disorder: are depressed mood and loss of interest or pleasure. Changes in eating, sleeping, and activity typically occur in people with depression; however, they may also occur with other physical disorders.

##### Nursing care guidelines:

1. Review the patient's medical and behavioral health history. Review the patient's personal, family history and suicide risk factors.
2. Gather and prepare the necessary equipment and supplies.
3. Perform hand hygiene.
4. Introduce yourself to the patient and explain why you're in the room.

5. Confirm the patient's identity using at least two patient identifiers.
6. Provide privacy.
7. Before initiating physical contact, explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs to increase their understanding, allay their fears, and enhance cooperation. Employ therapeutic communication techniques to help form a trusting relationship. Early therapeutic alliances between staff members and patients reduce the risk of violent behavior during psychiatric hospitalizations.
8. Perform a complete psychiatric assessment (including screening for suicidal ideation) using a facility-approved assessment tool.
9. Solicit information from the patient's family when possible.
10. Monitor the patient's vital signs at an interval determined by the patient's condition to ensure physiologic stability.
11. Monitor the patient's eating patterns, keeping records of intake and output if necessary.
12. Encourage frequent, small meals.
13. Request a physician's order for medication to help aid sleep if the patient's sleep is impaired.
14. Work to gradually engage the patient in unit activities to prevent isolation and immobility.
15. Spend time with the patient, even if the patient is nonverbal.
16. Assist the patient with showering and toileting if necessary.

17. Administer medications, as prescribed, following safe medication administration practices, and be alert for adverse effects.
18. Monitor for changes in sleeping patterns or activity that might signal mania in a patient who's taking antidepressants.
19. Allow reasonable time and space for visitation with family members or other support services, unless contraindicated.
20. Be alert for suicidal ideation, especially as the patient begins to have more energy. Institute suicide precautions, as needed.
21. Special Considerations: If the practitioner has ordered ECT, make sure that the patient or parent, as appropriate, has signed the informed consent form and that it's in the patient's medical record. If the patient is to receive ECT in the morning, maintain nothing-by-mouth status, as indicated. When the patient returns from ECT, obtain vital signs and provide reorientation, because the patient's memory might be impaired.
22. Documentation.

## 5. Manic Episode nursing care guidelines

### Purpose:

- Provide guidelines FOR Manic episode patient care.
- To provide safety and sense of belongingness to the patient...
- To uplift patient's self-esteem.
- To render physical care to the patient.

### Definitions:

**Bipolar - disorder** is an illness that leads to extreme and erratic shifts in an individual's mood, thinking, and behavior.

**Mania** - is one of the primary symptoms of bipolar I disorder. A patient with mania is likely to experience feelings of extreme happiness and elation, increased energy, and decreased need for sleep and food. The speech and thoughts of a manic patient are described commonly as "racing." A manic patient typically has a short attention span and can be easily distracted, which can cause the patient to become impulsive, intrusive, irritable, argumentative, and potentially violent.

#### **Nursing care guidelines:**

1. Don't leave the patient unattended before you have the opportunity to perform your initial assessment because a patient with bipolar disorder is at higher risk for suicide than the general patient population.
2. Review the patient's medical record for a history of psychiatric illness, medication use, and other medical disorders.
3. Perform hand hygiene.
4. Confirm the patient's identity using at least two patient identifiers.
5. Introduce yourself to the patient to begin the process of building a therapeutic relationship.
6. Assess the stage of the patient's mania by observing mood, cognition and perception levels, and activity and behaviour to determine necessary interventions.
7. Assess the patient's risk factors for suicide using a suicide assessment tool appropriate for the patient's age and characteristics. Implement suicide

precautions, as necessary. A patient experiencing a manic episode is at high risk for suicide because of increased energy and the potential for hallucinations and delusions.

8. Assess the physiologic effects of the patient's mania, which include dehydration, inadequate nutrition, alterations in sleep patterns, and weight loss.
9. Praise the patient for alternative behaviors that encourage socialization.
10. Monitor the patient's intake and output.
11. Weigh the patient daily, as necessary, if manic episodes are precipitating excessive caloric expenditures.
12. Assist the patient in identifying negative, self-defeating thoughts.
13. Provide a safe environment for the patient. Note that a patient in a manic phase requires a calm and highly structured environment to decrease stimuli that may agitate or excite the patient.
14. Administer routine medications to the patient, as ordered, following safe medication administration practices.
15. Administer as-needed/ as-order medications judiciously.
16. Monitor the patient routinely for medication adverse effects that may affect treatment.
17. Provide a consistent schedule for the patient that includes sleeping, eating, physical activity, and social and emotional stimulation.
18. Provide simple and direct explanations to the patient because a patient in a manic episode may not be able to follow lengthy discussions.
19. Encourage the patient to verbalize feelings.

20. Encourage the patient to participate in supervised physical activities to provide a positive outlet for excess energy.
21. Allow or limit the patient's participation in group activities, depending on the patient's tolerance.
22. Help the patient plan activities that are capable of being achieved.
23. Evaluate the degree to which the patient can tolerate stimuli because a patient experiencing mania has little tolerance for excess stimulation.
24. Notify the physician of any changes in the patient's behavior or indications of suicidal ideation.
25. Be aware that some medications, such as lithium, require frequent blood level monitoring to ensure that they remain within the therapeutic range.
26. Be aware that schizophrenia, anxiety disorders, borderline personality disorder, histrionic personality disorder, substance abuse involving stimulants, and adolescent conduct disorders produce symptoms that may mimic a manic episode.
27. Perform hand hygiene.
28. Documentation.

## **6. Personality Disorder Nursing Care Guidelines of Providing Guidelines for Personality Disorder Patient Care**

### **Purpose:**

- To provide safety and sense of belongingness to the patient.
- To uplift patient's self-esteem.
- To render physical care to the patient.

### Definitions:

Personality disorder-is a persistent pattern of inner experience and conduct that deviates significantly from the cultural norms of the individual, is widespread and inflexible, has an onset in adolescence or early adulthood, is stable over time, and causes distress or impairment.

### Nursing care guidelines:

1. Review the patient's medical history, psychiatric diagnosis, and therapeutic regimen.
2. Perform hand hygiene.
3. Confirm the patient's identity using at least two patient identifiers.
4. Explain facility procedures to the patient and family (if appropriate),
5. Observe the patient for mood instability, impulsivity, hypersensitivity, self-destructive behavior, profound mood shifts, and unstable and intense interpersonal relationships.
6. Perform a suicide risk assessment using a facility-approved assessment tool.
7. Monitor the patient for suicide ideation.
8. Assess the nature of the disorder and the range of behaviors presented.
9. Monitor for maladaptive social responses, such as anxiety, defensiveness, interrupted family processes, ineffective role performance, chronic low self-esteem, self-mutilation, impaired social interaction, and self- or other-directed violence.
10. Develop a patient education plan for modifying impulsive behavior, and make a contract with the patient for this behavior modification.

11. Schedule dialectical behavior therapy, as ordered, to help the patient control intense emotions, decrease the number and severity of self-harm episodes, and improve relationships.
12. Administer medications, as needed and ordered, following safe medication administration practices:
13. Perform hand hygiene.
14. Documentation.

## 7. Violent and Assaultive Nursing Care Guidelines of Providing Guidelines for Violent Patient Management

### Purpose:

- To provide safety and a sense of belongingness to the patient.
- To uplift patient, self-esteem.
- To render physical care to the patient.

### Definitions:

Violent/aggressive behavior is usually episodic and is means of expressing feelings of anger, fear, or hopelessness about a situation.

### Nursing care guidelines:

1. If the patient exhibits signs of violent or aggressive behavior, use de-escalation strategies or provide crisis intervention. Report violence or a credible threat to leadership and following the channels designated by facility.



2. Encourage the patient to vent any hostility verbally. Divert the patient's attention, or help the patient redirect energy to appropriate activities or exercise.
3. Provide a private, nonstimulating environment that can help make it easier for the patient to relax or talk.
4. Be honest with the patient, answer questions truthfully, and don't make false promises.
5. Encourage the patient to lie down in a comfort room; remain with or continuously observe the patient.
6. Assess the patient's need for medication and offer the medication, if prescribed, before initiating the use of physical restraint or seclusion.
7. Administer medication to the patient, as needed and ordered, following safe medication administration practices.
8. Using restraint or seclusion
9. If less restrictive interventions fail to help the patient regain or maintain self-control, initiate the use of physical restraint or seclusion.
10. Obtain a physician's order for the use of physical restraint or seclusion.
11. When planning a strategy for approaching the patient, be sure to do so in an area away from the patient because the patient might perceive an oncoming battle to control behavior and, therefore, may feel challenged rather than reassured.
12. Recruit a sufficient number of trained staff members to provide assistance, but have them remain on the periphery and be visible to the patient.

13. Explain to the patient quietly and calmly what you're going to do, and keep repeating this information as you approach the patient.
14. Use firm but humane physical holds to place the patient in physical restraint or seclusion.
15. If the patient responds inappropriately to seclusion by becoming harmful to self, remove the patient from seclusion and instead apply physical restraints and place the patient in an appropriate room. When a patient is in physical restraints, administer prescribed medications following safe medication administration practices, as ordered, to help the patient control behavior and decrease the time spent in physical restraints.
16. Assess the patient for injuries; if you find any, notify the physician.
17. Continue to reassess the patient's need for physical restraint or seclusion, and discontinue use as soon as the patient's condition permits according to the physician 's order.
18. Debrief the patient after discontinuation of physical restraint or seclusion to identify what the patient could have done differently, and counsel the patient about any physical or psychological trauma that might have resulted from the use of physical restraint or seclusion.
19. Perform hand hygiene.
20. Documentation.

## 8. Alcohol withdrawal nursing care guidelines

### Purpose:

- Provide guidelines for alcohol withdrawal management.
- To provide safety and sense of belongingness to the patient.

- Managing a patient with alcohol withdrawal to maintain airway, circulation, breathing, and patient safety.

### Definitions:

Alcohol withdrawal - is the changes the body goes through when a person suddenly stops drinking after prolonged and heavy alcohol use. Symptoms include trembling (shakes), insomnia, anxiety, and other physical and mental symptoms.

Alcohol withdrawal delirium- is marked by acute distress following abrupt withdrawal after prolonged or massive use.

### Nursing care guidelines:

1. Gather and prepare the necessary equipment and supplies.
2. Review the patient's medical record for a history of alcohol use, previous withdrawal episodes, and other existing conditions.
3. Provide nonjudgmental, supportive, empathetic, and comprehensive emotional care.
4. Perform hand hygiene.
5. Put on personal protective equipment as necessary of infection control precaution standards.
6. Confirm the patient's identity using at least two patient identifiers.
7. Provide privacy.
8. Quickly assess circulation, airway, and breathing.
9. Notify the emergency response team and intervene appropriately if the patient's condition warrants.
10. Explain the procedure to the patient and family (if appropriate).

11. Perform a complete admission assessment.
12. If the patient is at high risk for complications, attach a continuous cardiac monitor and pulse oximeter to monitor closely for changes in condition
13. Decrease environmental stimuli by placing the patient in a quiet room with controlled lighting.
14. Provide one-on-one supervision, if necessary, to ensure the patient's safety. If less-restrictive measures fail, restrain the patient, as ordered, to protect the patient and staff from injury.
15. Reassess the patient's vital signs and condition frequently, as indicated by the withdrawal process. (Patients with severe symptoms may require reassessment every 10 to 15 minutes.)
16. Administer prescribed medications.
17. Institute fall and seizure precautions to promote patient safety.
18. Elevate the head of the patient's bed 30 to 45 degrees, unless contraindicated, to prevent aspiration.
19. During the early stages of withdrawal, maintain the patient on nothing-by-mouth status, if necessary, to prevent aspiration.
20. Provide frequent oral care, as necessary.
21. Suction the patient's airway, as necessary.
22. Assess the patient for signs of inadequate nutrition and dehydration.
23. Monitor the patient's laboratory test results for electrolyte imbalances, such as hypomagnesemia, hypokalemia, and hypophosphatemia.
24. Monitor liver function test results, such as aspartate aminotransferase and gamma-glutamyl aminotransferase levels.
25. Notify the Physician of critical test results within facility's established time frame to prevent detrimental treatment delays.
26. Monitor the patient's intake and output.

27. Administer IV fluids, as prescribed.
28. Remove and discard your personal protective equipment.
29. Perform hand hygiene.
30. Documentation.

## 9. Paranoid schizophrenia nursing care guidelines

### Purpose:

- Provide nursing care guidelines for patients with paranoid schizophrenia.
- To provide security and a sense of belonging to the patient.
- To demonstrate effective working relationships between patients and personnel.

### Definitions:

Schizophrenia with paranoid features more bizarre behavior and intense feelings of mistrust or fear. These clients will not confide in others and may be challenging to communicate with, as they frequently misinterpret innocent conversations or behavior..

### Nursing care guidelines:

1. Assess the client's neurological condition.
2. Observe client interactions with staff and other customers.
3. Openly discuss the client's beliefs and thoughts, demonstrating empathy and support.
4. Before beginning, explain each procedure and its purpose in detail and with precision.
5. Maintain sensitivity to the client's personal space. Avoid startling the client with sudden movements or unnecessary contact.

6. Discuss emotions and help the client in identifying behaviors that result in conflict or alienate others.
7. Discuss and have the client demonstrate (through the use of role-playing, if applicable) more appropriate responses and reactions to behaviors and stressors.
8. Minimize environmental stimuli.
9. Encourage social interaction, but do not compel participation in activities.
10. Set behavioral boundaries and enforce them with medication or restraints, as per facility protocol.
11. Administer medications properly and observe for adverse reactions.
12. Offer commendation and encouragement for accomplishments.
13. Consider any cultural concerns or impacts of treatment.
14. Provide reorientation as appropriate, but avoid confrontation of the delusions.
15. Provide education, resources, and support to the family and loved ones of the client.
16. As appropriate, include the patient's family or loved ones in the treatment plan.

## 10. Behavioral problems nursing care guidelines

### Purpose:

- Provide nursing care guidelines for patients with behavioral problems.
- To provide security and a sense of belonging to the patient.
- To demonstrate effective working relationships between patients and staff.

### Definitions:

Behavioral Problems refer to manifestations of a Pet exhibiting abnormal responses to stimuli that are not caused by an underlying medical condition, such as aggression, anxiety, destructive, and/or compulsive behavior.

### **Nursing care guidelines:**

1. Assess the client's current level of functioning and communication and commence therapy at that level.
2. Attend regularly scheduled meetings with the client.
3. Introduce yourself to the client and state that you are there to assist him or her.
4. Remain at ease during periods of silence; do not overwhelm the client with words.
5. As tolerated, employ physical contact with the client (e.g., holding the client's hand). Remove your hand if the client reacts negatively to touch but continue your attempts to establish physical contact.
6. Communicate with the client in a low voice. If the client remains unresponsive, continue with the expectation that they will eventually respond.
7. Request that the client open his or her eyes and look you in the eye when you speak with him or her.
8. Provide positive feedback to the client for any response to you or the external environment. Encourage him or her to continue responding and connecting with others.
9. As tolerated, use a radio, tape player, or television to provide stimulation in the client's room.
10. Assess the client's stimuli tolerance; do not force too much stimulation too quickly.

11. Avoid allowing the client to isolate himself or herself in a room alone for long periods.
12. Initially, encourage the client to spend brief periods with a single other person; for example, have the client sit with a single person for 15 minutes per hour.
13. Interact with the client briefly on a one-to-one basis initially; gradually increase the amount of time and the number of people with whom the client interacts.
14. Communicate with the client as if he or she will respond, and refrain from rapidly babbling at the client. Allow the client sufficient time to respond either verbally or physically.
15. Mention other people and objects in the client's immediate environment when interacting with them.
16. Encourage the client to express himself or herself nonverbally initially (e.g., by writing or drawing).
17. Encourage the client to discuss these nonverbal communications and, as tolerated, advance to more direct verbal communication. Encourage the client to express emotions to the greatest extent possible.
18. Walk slowly with the client at first. Transition gradually from gross motor activity (walking, hand gestures) to activities requiring fine motor skills (writing, drawing) (jigsaw puzzles, writing).
19. See “Key Considerations in Mental Health Nursing: Nurse-Client Interactions” and other care plans as indicated.
20. If indicated, educate the client, family, and significant others about withdrawn behavior, safe medication use, and other disease processes.

## 11. Nursing care guidelines for patients with restraint

### Purpose:

- Provide nursing care guidelines for patients with restraint.



- To provide security and a sense of belonging to the patient.
- To demonstrate effective working relationships between patients and personnel.

### Definitions:

Restraint is an intervention or device that prevents the patient from moving freely or restricts normal access to the patient's own body.

### Nursing care guidelines:

1. The patient in restraints or equipped with safety devices will have access to a call light or other means of requesting assistance or communicating needs.
2. All devices and restraints must be applied to a body part without impeding circulation or applying pressure to a nerve. Every two hours, restraint must be released and reapplied, as necessary.
3. With each assessment, hygiene and toileting needs are assessed and met, as necessary.
4. If both the upper and lower extremities require restraint, if possible apply it to the upper extremity and the opposite lower extremity.
5. Attach restraints securely and out of the patient's reach. For bedridden patients, restraints should be secured under the bed, to the bed frame only, and not to the side rails, and tied for easy release by medical personnel.
6. If a patient is in a Posey bed, the zipper must always be closed, unless a one-to-one attendant is present or a physician orders otherwise.
7. If a patient is positioned in a Safekeeper bed, the door must remain locked at all times, unless a one-to-one attendant is present or a physician orders otherwise.

8. The progression of a patient out of a restraint device will be discussed and implemented by an interdisciplinary team, and not by a shift or discipline independently.
9. When restraint is no longer indicated, a LIP will document in the medical record an order to discontinue restraint.

## 12. Substance intoxication nursing care guidelines

### Purpose:

- Provide nursing care guidelines for patients with substance intoxication.
- To provide security and a sense of belonging to the patient.
- To demonstrate effective working relationships between patients and personnel.

### Definitions:

Substance intoxication a reversible syndrome due to the recent ingestion of a specific substance, including clinically significant behavioral or psychological changes as well as one or more signs of physiological involvement

### Nursing care guidelines:

#### Immediate physical care:

1. Treat as having a head injury until proven otherwise any patient who presents as incoherent, disoriented, or drowsy.
2. Perform baseline measurements of blood pressure, respiratory rate, temperature, and heart rate.
3. Maintain observations every 30 minutes during the acute phase, then every 60 minutes until symptoms stabilize.
4. Monitoring fluid intake and maintaining hydration
5. Perform a complete physical and mental examination.

6. Any patient who presents with seizures must be evaluated for alcohol withdrawal, benzodiazepine withdrawal, and stimulant intoxication, in addition to other potential causes.
7. The patient must be observed for at least four hours using the Glasgow Coma Scale (GCS) or the Alert, Verbal, Pain, Unconscious (AVPU) scale following a seizure.
8. Follow a medical officer's prescribed medication regimen.

#### Physical care on stabilization:

1. Maintain observations every four hours.
2. Assess further the possibility of withdrawal. Early identification and intervention in withdrawal management can prevent potentially life-threatening complications.
3. Identify and observe the effects of multiple substances on the intoxicated individual.
4. Maintain the prescribed medication schedule as directed by a medical officer.

#### Environment:

1. Treat in a quiet or low stimulus environment if possible
2. Protect from injury or accidents.

#### Supportive care:

1. Friendly and respectful interaction with the patient
2. Introduce yourself and ask the patient's name with courtesy.
3. Orient the patient to their surroundings and develop rapport.
4. Whenever possible, postpone disturbing questions or procedures.
5. Provide clear, specific instructions and, if necessary, accompany the patient to and from their destination.

## 13. Drug withdrawal nursing care guidelines

### Purpose:

- Provide nursing care guidelines for patients with Drug withdrawal.
- To provide security and a sense of belonging to the patient.
- To demonstrate effective working relationships between patients and personnel.

### Definitions:

Drug withdrawal a syndrome that develops after cessation of prolonged, heavy consumption of a substance.

### Nursing care guidelines:

#### Immediate physical care:

1. Obtain a complete history of recent drug use.
2. Select the proper withdrawal scale according to the protocol indicated by the recent AOD use history of the patient.
3. Continue observing:
4. Half-hourly during the acute phase, and then every two hours until symptoms stabilize.
5. Maintain hydration by monitoring fluid and nutrient intake (2-2.5 liters/day is suggested).
6. Maintain consistent observation until symptoms stabilize.
7. Engage a specialist clinician to ensure proper medication prescribing and dispensing.

#### ON STABILISATION

1. Maintain observations every four hours.

2. Assess further for the possibility of withdrawal; early recognition and intervention of withdrawal management can prevent complications that may be life-threatening.
3. Identify and observe the effects of multiple substances on the intoxicated individual.
4. Maintain the prescribed medication schedule as directed by a medical officer.

Environment:

1. Treat in a quiet or low stimulus environment if possible
2. Protect from injury or accidents.

Supportive care:

1. Anxiety management is essential for effective management of all withdrawal states
2. Frequent non-judgmental reassurance of the patient may reduce the severity of withdrawal syndrome.
3. Orient the patient to their surroundings and develop rapport.
4. Whenever possible, postpone disturbing questions or procedures.
5. Provide clear, specific instructions and, if necessary, accompany the patient to and from their destination.

# **Mental Health Nursing Diagnosis**

## Mental Health Nursing Diagnosis

1. Impaired Verbal Communication (A)
2. Impaired Verbal Communication (B)
3. Self-Care Deficit
4. Risk for Injury
5. Risk for Self-Directed Violence
6. Impaired Social Interaction
7. Risk For Suicide
8. Ineffective Coping
9. Hopelessness
10. Powerlessness
11. Denial
12. Low Self-Esteem
13. Deficient Knowledge
14. Disturbed Sensory Perception: Auditory/Visual
15. Sensory-Perceptual Alterations
16. Anxiety.
17. Fear.

## 1. IMPAIRED VERBAL COMMUNICATION: (A)

### Definition

Decreased, delayed, or absent capacity to receive, process, transmit, and/or use symbols. [to communicate] (NANDA-I, 2018, p. 263).

### Possible Contributing Factors (“related to”)

- Unfulfilled trust versus mistrust obligations.
- Neurological alterations.
- Inadequate
- Sensory stimulation.

### Defining Characteristics (“evidenced by”)

- Inability to distinguish between one's own physiological and emotional needs and those of others.
- Increased levels of anxiety caused by social interaction.
- Incapability to distinguish between one's own and another's bodily boundaries.
- Repetition of what he or she hears others say or imitation of their movements.
- Unable to differentiate internal from external stimuli.

### Goals/Objectives

- **Short-term Goal:**
  - The client will distinguish their own body parts from those of others (within specified time, depending on severity and chronicity of disorder).



- **Long-term Goal:**

- By the time of discharge from treatment, the client will have developed ego identity (as evidenced by the ability to recognize physical and emotional self as distinct from others).

### Interventions with Selected Rationales

- Maintain an individual relationship with the child. The consistency of staff-client interactions helps the formation of trust.
- Assist the child in recognizing his or her independence during self-care activities, such as dressing and feeding. These activities heighten the child's awareness of his or her uniqueness from others.
- Identify the child's body parts and assist him or her in naming them. This activity may heighten the child's awareness of his or her own uniqueness in relation to others.
- Gradually increase physical contact while using touch to highlight client and nurse differences. Touch should be avoided until trust has been established, as the client may perceive it as threatening.

### Outcome Criteria

- The client can distinguish between their own and others' body parts.
- The client demonstrates the ability to differentiate between self and environment by discontinuing the use of echolalia (repeating words heard) and echopraxia (imitating movements seen).

## 2. IMPAIRED VERBAL COMMUNICATION: (B)

### Possible Contributing Factors (“related to”)

- Alteration of perceptions
- Lack of confidence.
- Panic level of anxiety.
- Regression to a previous stage of development.
- Withdrawal within oneself.
- Disordered, unrealistic thought processes.

### Defining Characteristics (“evidenced by”)

- Ideas loosely connected.
- Utilization of words with personal significance (neologisms).
- Use of incoherent, meaningless language (word salad).
- Use of rhyming words in a nonsensical manner (clang association).
- The repetition of audible words (echolalia).
- Does not speak (mutiesm).
- Expressions reflect concrete reasoning (inability to think in abstract terms).
- Inadequate eye contact (no eye contact or prolonged staring into the other person's eyes).

### Goals/Objectives

- **Short-term Goal:**
  - Inadequate eye contact (no eye contact or prolonged staring into the other person's eyes).

- **Long-term Goal:**

- At the time of discharge from treatment, the client will be able to engage in socially acceptable verbal communication with healthcare providers and peers.

### Interventions with Selected Rationales

- At the time of discharge from treatment, the client will be able to engage in socially acceptable verbal communication with healthcare providers and peers.
- At the time of discharge from treatment, the client will be able to engage in socially acceptable verbal communication with healthcare providers and peers.
- As required, orient the client to reality. Utilize the client's name. Validate those aspects of communication that aid in determining what is real and what is not. These techniques may facilitate the restoration of the client's functional communication patterns.
- Abstract phrases and clichés must be avoided, and explanations must be tailored to the level of comprehension of the client. Due to the prevalence of concrete thinking, misinterpretations are more likely to occur.

### Outcome Criteria

- Client can communicate in a manner that is understood by others.
- The client's nonverbal and verbal communications are congruent.

- Client can recognize that disorganized thinking and impaired verbal communication occur during times of heightened anxiety and to intervene to correct these behaviors.

### 3. Self-Care Deficit

#### Definition

Inability to independently perform task associated with [activities of daily living] (NANDA-I, 2018, pp. 243–246).

#### Possible Contributing Factors (“related to”)

- Musculoskeletal impairment.
- Cognitive impairment.
- Regression to an earlier developmental stage
- Panic level of anxiety.

#### Defining Characteristics (“evidenced by”)

- Lack of ability to bathe.
- Inability to dress oneself
- Incapability to transfer food from a container to the mouth.
- Inability to use the toilet independently.

#### Goals/Objectives

- **Short-term Goal:**
  - The client will develop a relationship of trust with the caregiver and a method for communicating needs.

- **Long-term Goals:**

- The client's needs are being met through established means of communication.
- If the client is unable to speak or communicate through other means, the caregiver expects the client's needs to meet those needs.

### Interventions with Selected Rationales

- Maintain staff assignment consistency over time. This enhances confidence and the ability to comprehend the client's actions and communication.
- Anticipate and satisfy the client's requirements until satisfactory communication patterns are established. Learn (from the client's family, if possible) any unusual words the client uses.
- Identify nonverbal gestures or signals that the client may use to communicate needs in the absence of verbal communication. Repeatedly practice these communication skills. Some children with severe intellectual disability can only learn through systematic habit training.

### Outcome Criteria

- Client helps with activities of self-care to the best of his or her ability.
- Client's self-care needs are being met.

## 4. RISK FOR INJURY

### Definition

Physically vulnerable to [internal or external] environmental conditions that interact with an individual's adaptive and defensive resources, thereby compromising health. (NANDA International [NANDA-I].

## Risk Factors (“related to”)

- substance intoxication
- substance withdrawal
- disorientation.
- Seizures.
- Hallucinations
- Psychomotor agitation
- Unstable vital signs
- Delirium
- Flashback
- Panic level of anxiety

## Goals/Objectives

- **Short-term Goal:**
  - The condition of the client will stabilize within 72 hours.
- **Long-term Goal:**
  - Client will not experience physical injury.

## Interventions with Selected Rationales

- Assess client’s level of disorientation to determine specific requirements for safety. Knowledge of client’s level of functioning is necessary to formulate appropriate plan of care.
- If possible, obtain a drug history to determine the following:
  - Substance(s) used.
  - The time and amount of the last consumption.

- Duration and frequency of usage.
- The quantity consumed daily.
- Collect a urine sample for laboratory analysis of drug content. Subjective history is frequently unreliable. For an accurate assessment of a client's condition, it is crucial to be aware of the substances ingested.
- Place client in quiet, private room. Excessive stimuli increase client agitation.
- Implement necessary safety precautions (client safety is a nursing priority):
  - Frequently observe client behavior's; assign staff one-to-one if condition warrants; accompany and assist client when ambulating; use wheelchair for long-distance transport.
  - When the client is in bed, ensure that the side rails are raised.
  - To protect the client in case of a seizure, pad the headboard and side rails of the bed with thick towels.
  - Use mechanical restraints as needed to protect the client if disorientation is accompanied by excessive hyperactivity (e.g., as may occur in stimulant intoxication).
- Ensure smoking materials and other potentially hazardous objects are stored out of reach of the client. In a confused and disoriented state, the client may harm himself or others.
- Frequently orient client to reality and surrounding environment. If a client becomes disoriented and inadvertently leaves a secure environment, the client's safety may be at risk.
- Initially, monitor the client's vital signs every 15 minutes, and then less frequently as symptoms subside. During acute intoxication and

detoxification, vital signs provide the most reliable information regarding the client's condition and need for medication.

- \* Adhere to medication regimen as prescribed by physician. Typical medical interventions for intoxication with the following substances are as follows:
  - **Alcohol:** Alcohol intoxication and alcohol poisoning require primarily supportive care, such as close monitoring, assessment for breathing or choking difficulties, oxygen therapy, vitamins, and fluids to prevent dehydration (Mayo Clinic, 2017).
  - **Narcotics:** Opioid antagonists such as naloxone (Narcan) can be administered intravenously, intramuscularly, subcutaneously, or intranasally to reverse the CNS and respiratory depression caused by opioid overdose.
  - **Stimulants:** The treatment of stimulant overdose typically begins with minor tranquilizers like chlordiazepoxide (Librium) and progresses to major tranquilizers like haloperidol (Haldol). Due to their propensity to lower seizure threshold, antipsychotics should be administered with caution. Intravenous diazepam is used to treat multiple seizures.
  - **Hallucinogens and Cannabinoids:** These substances do not require substitution therapy. Benzodiazepines (e.g., diazepam or chlordiazepoxide) may be prescribed to prevent harm to the client or others in the event of adverse reactions, such as anxiety or panic. Antipsychotic medications can be used to treat psychotic reactions.



## Outcome Criteria

- The client exhibits no signs or symptoms of substance intoxication or withdrawal.
- The client demonstrates no signs of physical injury sustained during intoxication or withdrawal.

## 5. RISK FOR SELF-DIRECTED OR OTHER-DIRECTED VIOLENCE

### Definition

Susceptible to behaviors in which a person demonstrates he or she can be physically, emotionally, or sexually harmful [to self or others]. (NANDA International [NANDA-I], 2018, pp. 416–417).

### Risk Factors (“related to”)

- Lack of trust (suspiciousness of others).
- Panic level of anxiety.
- Negative role modeling.
- Rage reactions.
- Command hallucinations.
- Delusional thinking.
- Negative body language includes stiff posture, clenched fists and jaw, hyperactivity, pacing, shortness of breath, and threatening stances.
- Histories or threats of violence against self or others, or destruction of others' property.
- Impulsivity.

- Suicidal ideation, plan, available means.
- Perception that the environment is dangerous.
- Receiving threatening auditory or visual instructions.

### Goals/Objectives

- **Short-term Goals:**
  - Within [a given timeframe], the client will recognize signs of increasing anxiety and agitation and seek assistance from staff (or another care provider) in order to intervene.
  - The client will not cause harm to self or others.
- **Long-term Goal:**
  - The client will not cause harm to self or others.

### Interventions with Selected Rationales

- Maintain a low level of environmental stimuli for the client (low lighting, few people, simple decor, low noise level). The level of anxiety increases in a stimulating environment. A suspicious or agitated customer may perceive individuals as dangerous.
- Frequently observe client's behavior (every 15 minutes). Do this when performing routine tasks so as to avoid arousing the individual's suspicion. In order to intervene if necessary to ensure the safety of the client (and others), close observation is required.
- Remove all potentially harmful objects from the client's environment, so that in his or her agitated and confused state, the client cannot use them to cause harm to themselves or others.

- Try to redirect the client's aggressive behavior with physical outlets for his or her anxiety (e.g., physical exercise). Physical activity is a healthy and efficient method for relieving stress.
- The staff should maintain and convey composure towards the client. Anxiety is contagious and can spread from staff members to clients.
- Have sufficient staff available to demonstrate strength to the client if necessary. This demonstrates the client's control over the situation and provides staff with physical security.
- Administer tranquilizers as prescribed by the physician. Monitor a medication's efficacy and possible adverse side effects. When planning interventions for a psychiatric client, the path of the "least restrictive alternative" must be selected. If the client cannot be calmed through "talking down" or medication, mechanical restraints may be required. Restraints should only be used as a last resort, after all other interventions have failed and the client poses a clear danger to himself or others. Ensure that sufficient personnel is available to assist. Follow institution-established protocol. Assess the client at least every 15 minutes to ensure that circulation to the extremities is not compromised (check temperature, color, and pulses); to assist the client with nutritional, hygienic, and elimination needs; and to position the client so that comfort is enhanced and aspiration is prevented. Continuous one-on-one monitoring may be required for clients with a high risk of self- or accidental injury who are also highly agitated. The safety of patients is a nursing priority.

- Assess the client's readiness for restraint removal or reduction as agitation decreases. Remove one restraint at a time, while evaluating the client's reaction. This reduces the risk of injury to clients and employees.
- Interact with the client to gain a better understanding of his or her thought content, thought processes, and perceptions, paying special attention to any content that may indicate a risk for violence against self or others. The expression of suicidal or homicidal thoughts or command hallucinations instructing the client to harm self or others increases the risk for violence and indicates the need for additional safety measures.

### Outcome Criteria

- Anxiety is maintained at a level that eliminates the need for aggression in the client.
- The client exhibits trust in his or her environment.
- The client maintains a realistic perspective.
- The client does not cause harm to self or others.

## 6. IMPAIRED SOCIAL INTERACTION

### Definition

Inadequate or excessive quantity or ineffectiveness of social interaction (NANDA-I, 2018, p. 301).

### Possible Contributing Factors (“related to”)

- Self-concept disturbance
- Lack of readily available significant others
- Unfulfilled responsibilities of trust versus mistrust

- Neurological alterations.
- Dysfunctional family system.
- Environments that are disorganized or chaotic

### Defining Characteristics (“evidenced by”)

- A lack of responsiveness or interest in individuals.
- Communicated or exhibited discomfort in social situations.
- Verbalized or observed incapacity to receive or convey a satisfying sense of belonging, caring, interest, or shared history.
- Unsuccessful social interaction behaviors observed.
- Dysfunctional interpersonal interactions
- Behavior deemed inappropriate for age by the dominant cultural group.
- Absence of eye contact and facial reactivity.
- Apathy or repulsion toward affection and physical contact.
- Inability to develop cooperative play and friendships with peers.

### Goals/Objectives

- **Short-term Goal:**
  - Within one week, the client will engage in age-appropriate interactions with the nurse in a one-on-one setting.
- **Long-term Goal:**
  - At the time of treatment discharge, the client will be able to interact with staff and peers using age-appropriate and acceptable behaviors.

## Interventions with Selected Rationales

- Develop a trustworthy relationship with the client. Acceptance of the client boosts his or her self-esteem.
- Offer to remain present during the client's initial interactions with others. The presence of a trustworthy individual provides a sense of safety.
- Provide the client with constructive criticism and positive reinforcement for their efforts. Positive feedback increases self-esteem and promotes behavior repetition.
- When interactions with other people are manipulative or exploitative, confront the client and withdraw attention. Attention to the inappropriate behavior may serve to reinforce it.
- Serve as a model for the client by interacting appropriately with other clients and staff.
- Provide group situations for client. The client will learn socially acceptable behavior through these group interactions, with both positive and negative feedback from his or her peers.

## Outcome Criteria

- The client seeks out staff member for therapeutic and social interaction.
- Client has developed and maintained a positive interpersonal relationship with another client.
- Participates in group activities willingly and in an appropriate manner.
- The client articulates the reasons for his or her historical incapacity to form close interpersonal relationships.

## 7. RISK FOR SUICIDE

### Definition

Self-inflicted, life-threatening injury susceptibility (NANDA International [NANDA-I], 2018, p. 422).

### Risk Factors (“related to”)

- Depressed mood.
- Males over 65 years of age, adolescents.
- Grief; hopelessness; social isolation
- Alienation from others; real or perceived.
- Purposelessness.
- Feeling trapped.
- History of prior suicide attempt.
- Widowed or divorced.
- Chronic or terminal illness.
- Psychiatric illness or substance abuse.
- Threats of killing self.
- States desire to die.
- Has a suicide plan and means to carry it out.
- Giving away possessions.

### Goals/Objectives

- **Short-term Goals:**
  - Client will seek out staff when he or she feels the urge to self-harm.
  - The client will work with a reliable staff member to develop a safety plan.

- The client will refrain from self-harm.
- **Long-term Goal:**
  - The client will implement his or her personal safety plan.

### Interventions with Selected Rationales

- Create a secure atmosphere for the client. Remove all potentially hazardous items from the client's reach (sharp objects, straps, belts, ties, glass items). Maintain close supervision during mealtime and medication administration. As deemed necessary, conduct room searches. The safety of patients is a nursing priority.
- Conduct a thorough, collaborative, and ongoing assessment of the client's suicide risk factors and warning signs within the context of a therapeutic relationship. Transmitting an attitude of acceptance and a willingness to collaborate with clients in maintaining their safety increases the likelihood that they will share their thoughts and feelings openly and honestly. Suicide risk fluctuates over time; therefore, periodic evaluation is necessary to ensure patient safety.
- Encourage the client to reach out to a staff member or support person if suicidal thoughts emerge or intensify. Frequently, suicidal clients are ambivalent about their emotions. A client may benefit from discussing their emotions with a trusted individual prior to experiencing a crisis situation.
- Maintain close observation of client. Provide one-on-one contact, constant visual observation, or 15-minute checks in accordance with the level of suicide precautions (at irregular intervals). Place the patient in a room near the nurse's station; avoid assigning a private room. Accompany the individual



to off-base activities if attendance is indicated. May require accompaniment to the bathroom. Intensive observation is required to ensure that the client does not self-injure in any way. Being vigilant for suicidal and elopement attempts enhances the capacity to prevent or interrupt harmful behavior.

- Maintain extreme caution when administering medications (e.g., assure that client has swallowed pills). Prevents the client from accumulating an overdose or discarding medication. Antidepressant medication, along with other medications, can be fatal if taken in excess.
- Make rounds at frequent, irregular intervals (especially at night, toward early morning, at change of shift, or during other predictably busy times for staff) (especially at night, toward early morning, at change of shift, or during other predictably busy times for staff). Prevents staff monitoring from becoming routine. It is essential to be aware of the location of the client, especially when the staff is busy, unavailable, or less observant.
- Encourage expressions of sincere emotions. Through exploration and conversation, assist the client in identifying signs of hope in his or her life.
- Encourage client to express anger within acceptable parameters. Provide a method for the safe release of hostility. Assist the client in identifying the true cause of his or her anger and in developing adaptive coping skills for use outside of the treatment setting. Depression and suicidal behavior may be viewed as inwardly directed rage. If this anger can be expressed in a safe environment, the client may eventually be able to overcome these feelings.

- Determine community resources and other support systems that the client can utilize to maintain his or her safety plan. Having a concrete plan for seeking help during a crisis can deter or prevent self-destructive behavior.
- As required, orient the client to reality. Identify misperceptions or misinterpretations of the environment based on the senses. Take care not to minimize the client's apprehensions or disapprove of their verbal expressions.
- Most important, spend time with client. This provides a sense of safety and security while also communicating, "I want to spend time with you because I believe you are a valuable individual."

### Outcome Criteria

- Client expresses no suicidal ideation.
- Client does not engage in acts of self-harm.
- If feeling suicidal, the client is able to verbalize the names of resources outside the hospital from which he or she can request assistance.

## 8. INEFFECTIVE COPING

### Definition

A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being (NANDA-I, 2018, p. 327).

### Possible Contributing Factors (“related to”)

- Situational crises
- Maturational crises

- Inadequate support systems.
- Low self-esteem.
- Unresolved grief.
- Inadequate coping strategies.

### Defining Characteristics (“evidenced by”)

- Inability to meet role expectations
- Alteration in societal participation.
- Inadequate problem solving
- Increased dependency.
- Manipulation of others in the environment for purposes of fulfilling own desires.
- Refusal to follow rules.

### Goals/Objectives

- **Short-term Goal:**
  - By the end of 1 week, client will comply with behavioral expectations and refrain from manipulating others to fulfill own desires.
- **Long-term Goal:**
  - By time of discharge from treatment, client will identify, develop, and use socially acceptable coping skills.

### Interventions with Selected Rationales

- Establish trusting relationship with client (be honest, keep appointments, be available to spend time). The therapeutic nurse client relationship is built on trust.

- Set limits on manipulative behavior. Be sure the client knows what is acceptable, what is not, and the consequences for violating the limits set. Ensure that all staff maintains consistency with this intervention. Client is unable to establish own limits, so limits must be set for him or her. Unless administration of consequences for violation of limits is consistent, manipulative behavior will not be eliminated.
- Encourage client to verbalize feelings, fears, and anxieties. Answer any questions he or she may have regarding the disorder. Verbalization of feelings in a nonthreatening environment may help client come to terms with long-unresolved issues.
- Explain the effects of substance abuse on the body. Emphasize that prognosis is closely related to abstinence. Many clients lack knowledge regarding the deleterious effects of substance abuse on the body.
- Explore with client the options available to assist with stressful situations rather than resorting to gambling or use of substances (e.g., contacting various members of Alcoholics Anonymous, Narcotics Anonymous, or Gamblers Anonymous; physical exercise; relaxation techniques; or meditation). Client may have persistently resorted to addictive behaviors and thus may possess little or no knowledge of adaptive responses to stress.
- Provide positive reinforcement for evidence of gratification delayed appropriately. Positive reinforcement enhances self-esteem and encourages client to repeat acceptable behaviors.

- Encourage client to be as independent as possible in own self-care. Provide positive feedback for independent decision making and effective use of problem-solving skills.

### Outcome Criteria

- Client is able to verbalize adaptive coping strategies as alternatives to use of addictive behaviors in response to stress.
- Client is able to verbalize the names of support people from whom he or she may seek help when the desire to gamble or use substances is intense.

## 9. HOPELESSNES

### Definition

Subjective state in which an individual sees limited or no available personal choices or alternatives and is unable to mobilize energy on their own (NANDA-I, 2018, p. 124).

### Possible Contributing Factors (“related to”)

- Voluntary restriction of activity.
- Decreased or impaired physiological state.
- Long-term stress.
- Abandonment.
- Loss of belief in transcendental values (God). 9.3. Defining Characteristics (“evidenced by”)
- Passivity decreased verbalization.
- Decreased affection.
- Verbal cues that indicate discouragement.

- Lack of initiative.
- Decreased response to stimuli.
- Decreased appetite.
- Lack of involvement in your care.
- Look to a different side of the interlocutor.

### Goals/Objectives

- **Short-term Goals:**
  - Patient will incorporate coping mechanisms to counteract feelings of hopelessness.
  - Patient will recognize and verbalize thoughts and feelings with a trusted individual.
  - Patient will participate in care that is within their control (ADLs, making small decisions).
- **Long-term Goal:**
  - By time of discharge from treatment, client will develop long-term goals to foster a positive outlook.

### Interventions with Selected Rationales

- Encourage a positive mental perspective, discourage negative thoughts, and brace patient for negative results. Accurate information is generally favored by families; surprise information concerning a shift in status may cause the family to worry that information is being withheld from them.

- Provide openings for the patient to verbalize feelings of hopelessness. The nurse promotes a supportive environment by taking time to listen to the patient in a nonjudgmental way.
- Manage to have consistency in staff appointed to care for the patient. This approach establishes trust, reduces the patient's feeling of isolation, and may promote coping and restore hope.
- Assist patient with looking at options and establishing goals that are relevant to him or her. Mutual goal setting guarantees that goals are achievable and helps to restore a cognitive-temporal sense of hope.
- Encourage the patient to recognize his or her own strengths and abilities. Promoting awareness can facilitate the use of these strengths.
- Work with the patient to set small, attainable goals. Mutual goal setting guarantees that goals are achievable and helps to restore a cognitive-temporal sense of hope.
- Render physical care that the patient is unable to achieve and respect patient's abilities. This approach overcomes weakness, guilt, and other negative perceptions.
- Stay and spend time with the patient. Use empathy; try to understand what the patient is saying and communicate this understanding to the patient. These approaches can inspire hope. Experiencing warmth, empathy, genuineness, and unconditional positive regard can greatly reduce feelings of hopelessness.
- Assist the patient in establishing realistic goals by recognizing short-term goals and revising them as needed. Supervising the patient little by little

makes the problem more manageable. Setting realistic goals is important so as not to be frustrated with the chance of not to accomplish them.

- Help the patient in developing a realistic appraisal of the situation. Patients may not be aware of all the available resources and support groups that can help them move through this stressful life situation.
- Acknowledge acceptance of expression of feelings. Active listening may help patients express themselves.
- Promote an attitude of realistic hope. Stressing the patient's intrinsic worth and seeing the immediate problem as manageable in time may provide support. Giving unrealistic hopes will not help the patient and might worsen the situation.
- Send feelings of acceptance and understanding. Avoid false reassurances. An honest relationship facilitates problem-solving. False reassurances are never helpful to patients.
- Provide time for patient to initiate interactions. Patients who have feelings of hopelessness require special moment to initiate relationships and sometimes are not able to.

### Outcome Criteria

- Client is able to verbalize desire to live and have hopeful outlook to the future.
- Client is able to verbalize meaningful expression of life.



## 10. POWERLESSNESS

### Definition

The lived experience of lack of control over a situation, including a perception that one's actions do not significantly affect an outcome (NANDA-I, 2018, p. 343).

### Possible Contributing Factors (“related to”)

- Lifestyle of helplessness.
- Healthcare environment.
- Complicated grieving process.
- Lack of positive feedback.
- Consistent negative feedback.

### Defining Characteristics (“evidenced by”)

- Reports lack of control [e.g., over self-care, situation, outcome].
- Nonparticipation in care.
- Reports doubt regarding role performance.
- Reluctance to express true feelings.
- Apathy.
- Dependence on others.
- Passivity.

### Goals/Objectives

- **Short-term Goal:**
  - Within 5 days, the client will actively engage in care decision-making.

- **Long-term Goal:**

- By the time the client is discharged from treatment, he or she will be able to successfully address difficulties and take care of his or her living circumstances, reducing emotions of helplessness.

### Interventions with Selected Rationales

- Encourage the client to assume maximum responsibility for self-care activities (examples follow). Providing options to the customer will boost his or her sense of control.
  - Include the client in the goal-setting process for his or her treatment.
  - Permit the client to determine his or her own timetable for self-care activities.
  - Determine the client's privacy needs and provide them accordingly.
  - Offer constructive comments on decision-making. Respect the client's freedom to make these decisions independently, and desist from attempting to sway him or her toward more reasonable options.
- Assist the customer in setting realistic goals. Unrealistic goals position the client for failure and perpetuate emotions of helplessness.
- Assist the client in identifying controllable aspects of his or her living condition. The client's emotional state hinders his or her problem-solving abilities. To fully grasp the benefits and implications of accessible solutions, assistance is necessary.
- Assist the client in identifying parts of his or her life that are beyond his or her control. Encourage verbalization of sentiments associated with this

disability in order to address unresolved issues and accept what cannot be altered.

- Determine how the customer may attain success. Encourage involvement in these activities and encourage both participation and success with positive reinforcement. Positive reinforcement boosts self-esteem and promotes behavior repetition.

### Outcome Criteria

- The client verbalizes the decisions taken in a strategy to keep control of his or her living condition.
- The client expresses his or her sincere sentiments concerning life circumstances over which he or she has no control.
- The client is able to verbalize a problem-solving system as necessary for satisfactory role performance.

## 11. DENIAL

### Definition

A conscious or unconscious effort to deny the awareness or significance of an incident in order to lessen anxiety/fear, to the expense of health [or other elements of the individual's life]. (NANDA-I, 2018, p. 336).

### Possible Contributing Factors (“related to”)

- Weak, undeveloped ego.
- Fears and worries lying dormant.
- Low self-esteem.
- Fixation in the earliest stages of development.

## Defining Characteristics (“evidenced by”)

- Denies drug abuse or other dependencies.
- Denies that substance abuse or gambling causes issues in life.
- Continues to use substances or gamble while knowing it impairs function, exacerbates bodily problems, or disrupts interpersonal relationships.
- Utilizes dangerous substances in physically perilous conditions.
- Rationalization and projection are utilized to explain maladaptive behaviour.
- Unable to acknowledge [the disorder's] influence on life pattern.

## Goals/Objectives

- **Short-term Goal:**
  - The client will focus on behavioral results connected with substance-related or addicted disorder, rather than external difficulties.
- **Long-term Goal:**
  - The client will verbally accept responsibility for his or her actions and recognize the relationship between substance abuse or gambling and personal difficulties.

## Interventions with Selected Rationales

- Begin by establishing a relationship of trust between the nurse and the patient. Be honest. Keep all promises. The foundation of a therapeutic partnership is trust.
- Communicate an accepting attitude to the client. Ensure that he or she realizes, "It is not you, but your action, that is contributing to the undesirable

outcomes and inability to perform." An accepting attitude fosters sentiments of dignity and self-worth.

- Utilize techniques of motivational interviewing to analyze the client's motivation to change. Motivational interviewing is a patient-centered approach that incorporates open-ended questions, reflection, and a variety of other therapeutic communication techniques that may reduce defensive responses by accepting the client and initiating intervention based on where the client is in recognizing the need for change.
- Provide facts to dispel myths around substance abuse and gambling. The client may justify his or her behavior by claiming, "I'm not addicted. I can quit drinking (or gambling) whenever I choose, or I simply use marijuana before class to calm. Then what? I know several others that do. Moreover, you cannot become addicted to marijuana." There are several fallacies around addictions. The client may be able to recognize his or her own conduct as a disease requiring treatment if he or she is provided with factual, nonjudgmental knowledge about the behaviors that characterize substance-related and addictive illnesses.
- Identify current maladaptive behaviors or events in the client's life and explain how drug abuse or gambling may have contributed. The first step in reducing denial is for the client to see the connection between drug abuse (or gambling) and personal issues.
- Carefully employ confrontation. Do not permit the customer to engage in lifestyle fantasies. Confrontation impedes the client's capacity to utilize

denial; a sympathetic approach maintains the client's self-esteem and avoids putting him or her on the defensive.

- Examine the client's use of rationalization or projection when attempting to justify or assign responsibility for his or her actions to others or circumstances. Rationalization and projection prolong the denial stage that the client has difficulties due to substance abuse or gambling.
- Encourage involvement in group activities. Peer input is frequently more acceptable than authority figure feedback. Peer pressure and affiliation with persons who are experiencing or have encountered similar difficulties can be significant factors.
- Offer prompt positive acknowledgment of the client's statements of illness-related understanding and acceptance of personal responsibility. Positive reinforcement boosts self-esteem and promotes behavior repetition.

### Outcome Criteria

- The client verbally demonstrates an awareness of the link between personal issues and substance abuse or gambling.
- The client verbally accepts responsibility for his or her behavior.
- The client verbalizes a knowledge of drug addiction (or gambling addiction) as a disease requiring continuing treatment and care.

## 12. LOW SELF-ESTEEM

### Definition

Negative judgments and/or emotions regarding one's own abilities.

### Possible Contributing Factors (“related to”)

- Refusal by peers.
- Lacking of acceptance and/or affection
- Negative reinforcement repeated
- Personal dissatisfaction with one's ascribed gender. Refusal by peers.
- Lacking of acceptance and/or affection
- Negative reinforcement repeated
- Personal dissatisfaction with one's ascribed gender.

### Defining Characteristics (“evidenced by”)

- Incapable of forming intimate personal connections.
- Negative self-image
- Negative expressions of value.
- Isolation from peers
- Heightened sensitivity to slights and criticisms.
- Reports having feelings of remorse or humiliation
- Negative assertions in speech
- Eye contact is missing.

### Goals/Objectives

- **Short-term Goal:**
  - The client will express positive self-statements, emphasizing past successes and future aspirations.

- **Long-term Goal:**

- The client will express and display actions that suggest self-satisfaction with gender identity, the capacity to engage with others, and a sense of self-worth.

### Interventions with Selected Rationales

- To improve the client's sense of self-worth:
  - Encourage the client to participate in activities that are likely to result in success.
  - Assist the client in focusing on areas of his or her life that elicit good emotions. Discourage ruminating over perceived failures or events over which the client has no control. Provide positive reinforcement for these behaviors.
- Assist the client in identifying the habits or parts of life he or she want to alter. If feasible, aid the client in developing problem-solving strategies for effecting the transformation. Having some influence over one's life can reduce emotions of helplessness and boost sentiments of self-worth and self-satisfaction.
- Offer to provide assistance to the client if he or she is experiencing peer rejection. Investigate options for boosting peer acceptability. Having a support person accessible who does not condemn the client's conduct and offers unconditional acceptance helps the client move toward self-acceptance as a valuable person.
- Assess suicide risk factors and warning signs and collaborate with the client to establish a personal safety plan. The safety of patients is a nursing priority.



## Outcome Criteria

- The client verbalizes a favorable self-perception.
- The client expresses satisfaction with his or her accomplishments and exhibits actions that reflect self-worth.
- The client no longer engages in self-harm.

## 13. DEFICIENT KNOWLEDGE

### Definition

Absence of cognitive knowledge relevant to a particular subject, or the acquisition of such information (NANDA-I, 2018, p. 259).

### Possible Contributing Factors (“related to”)

- Lack of motivation to study.
- Severe anxiety levels.
- Low self-esteem.
- Regression to an earlier developmental level.
- Cognitive impairment.
- Misinterpretation of information.

### Defining Characteristics (“evidenced by”)

- Denial of emotional difficulties
- Statements like "I don't know why the doctor placed me in the mental unit."  
"I have a physical ailment."
- Manifestation of a general medical disease triggered by psychological or behavioral factors.
- Exacerbations of physical sickness in the past.

- Failure to comply with mental therapy.
- Behaviors that are inappropriate or excessive (e.g., hysterical, hostile, agitated, apathetic).

### Goals/Objectives

- **Short-term Goal:**
  - The client will comply with the instruction plan supplied by the nurse.
- **Long-term Goal:**
  - The client will be able to express psychosocial aspects impacting his or her medical condition by the time of discharge.

### Interventions with Selected Rationales

- Determine the client's level of understanding on the physical effects of psychiatric disorders. A sufficient database is required for the creation of an effective lesson plan.
- Determine the client's degree of anxiety and learning readiness. Above a reasonable degree of worry, learning does not occur.
- Discuss the physical examinations and laboratory testing performed. Describe the aim and outcomes of each. Fear of the unknown may contribute to a higher anxiety level. The customer has the right to be informed of all medical treatments and to accept or refuse them.
- Explore the feelings and worries of the client. Move slowly These emotions may have been suppressed or repressed for such a long time that their expression might be quite unpleasant. Be supportive. Expression of emotions

in a safe atmosphere and with a trustworthy individual may assist a person to tackle unsolved concerns.

- Encourage that the client keep a diary of the onset, duration, and severity of physical symptoms. A separate record should also be made of instances that the client finds particularly upsetting. This comparison may yield objective data from which to examine the association between physical symptoms and stress.
- Assist the client in determining which of their requirements are being satisfied by the sick role. Develop together more adaptable ways to meet these requirements. Role-playing provides practice. Repetition via practice assists to alleviate distress in the real circumstance.
- Provide teaching in assertiveness skills, including the capacity to distinguish between passive, assertive, and aggressive conduct, and the significance of respecting the human rights of others while preserving one's own fundamental human rights. These abilities will maintain the client's sense of self-worth while enhancing his or her capacity to develop satisfying interpersonal interactions.
- Discuss stress management approaches such as relaxation techniques, physical activity, meditation, breathing exercises, and autogenic. Utilizing these adaptive approaches may reduce the manifestation or aggravation of physical symptoms caused by stress.

### Outcome Criteria

- The client expresses a knowledge of the relationship between psychological stress and the worsening (or maintenance) of physical sickness.

- The client is able to apply adaptive coping strategies to manage stress.

## 14. DISTURBED SENSORY PERCEPTION: AUDITORY/VISUAL

### Definition

Change in the amount or patterning of incoming stimuli [either internally or externally initiated] accompanied by a diminished, exaggerated, distorted, or impaired response to such stimuli.

### Possible Contributing Factors (“related to”)

- Anxiety at the panic level
- Internalized withdrawal
- Stress severe enough to pose a threat to a fragile ego.

### Defining Characteristics (“evidenced by”)

- Talking and laughing to self.
- Listening pose (tilting head to one side as if listening).
- Pauses in the middle of a statement to listen.
- Rapid mood fluctuations.
- Disorganized mental processing.
- Inappropriate replies.
- Disorientation.
- Lack of concentration
- Perceptual distortions

## Goals/Objectives

- **Short-term Goal:**

- Within one week, the client will review hallucination content with a nurse or therapist.

- **Long-term Goal:**

- The client will be able to define and test reality, hence avoiding hallucinations. (This objective may not be achievable for the individual with a chronic condition who has suffered auditory hallucinations for a number of years.) A more attainable objective may be that the client would verbally acknowledge that the sensory abnormalities are a result of his or her condition and exhibit techniques to stop hallucinations.

## Interventions with Selected Rationales

- Observe the client for hallucinations (listening pose, laughing or talking to self, stopping in midsentence). Intervention at an early stage may avoid violent reactions to command hallucinations.
- Avoid touching the customer without first informing him or her of your intention to do so. The client may view contact as dangerous and respond with hostility.
- Acceptance encourages the client to discuss the hallucination's content. What do the voices sound like they are saying to you? This is essential in order to avoid command hallucinations from causing the client or others harm.

- Do not contribute to the hallucination. Instead of specific language that support the hallucination, such as "the aliens" or "the spacecraft," use impersonal terms such as "the voices" or "the image you see" when referring to the hallucination. The veracity of the hallucination is confirmed by reiterating the client's account.
- Assist the client in comprehending the relationship between elevated anxiety and hallucinations. If the client can learn to halt anxiety's escalation, hallucinations may be avoided.
- Try to divert the client's attention away from the hallucination. Some individuals continue to have auditory hallucinations after the initial psychotic episode has faded. Some customers find that listening to the radio or watching television helps them tune out the voices. Others have benefitted from the voice dismissal intervention. The client is instructed to shout loudly, "Go away!" or "Leave me alone!" in order to exert conscious control over the conduct. Participating in activities, particularly intellectual pursuits or listening to music, is useful for reducing anxiety and accompanying perceptual abnormalities by serving as a diversion from them.

### Outcome Criteria

- The client is able to understand that hallucinations occur at times of severe anxiety.
- The client is able to notice symptoms of rising anxiety and use measures to prevent the reaction.

## 15. SENSORY-PERCEPTUAL ALTERATION

### Definition

Change in the quantity or patterns of incoming stimuli [whether internally or externally generated] followed with a modified or impaired reaction to such stimuli.

### Possible Contributing Factors (“related to”)

- Alteration in the structure/function of brain tissue as a result of the following conditions:
  - Advanced age
  - Vascular disease
  - Hypertension
  - Cerebral hypoxia
  - Abuse of mood- or behavior-altering substances
  - Exposure to environmental toxins
  - Various other physical conditions that increase the risk of brain abnormalities.

### Defining Characteristics (“evidenced by”)

- Poor concentration.
- Sensory distortions.
- Hallucinations.
- Disorientation to time, place, person, or circumstances.
- Inappropriate responses.
- Talking and laughing to self.

- Suspiciousness.

## Goals/Objectives

- **Short-term Goal:**

- The client will maintain orientation to time, place, person, and circumstances for a predetermined amount of time with the aid of a caregiver.

- **Long-term Goal:**

- The client will exhibit accurate environmental perception by responding properly to environmental stimuli.

## Interventions with Selected Rationales

- Reduce the number of external stimuli in the client's surroundings (e.g., low noise level, few people, simple decor). This reduces the likelihood of the client developing incorrect sensory impressions.
- Do not contribute to the hallucination. Inform the customer that you disagree with their view. Maintain realism by reorienting and concentrating on actual circumstances and people. Reality orientation improves cognitive performance and the client's sense of self-respect.
- If the client responds with panic to erroneous sensory perception, provide reassurance of safety. Safety and security of patients are nursing objectives.
- Address the client's unrealistic view and present the issue as it actually occurs. Explanation of genuine circumstances and engagement in real activities inhibit the capacity to respond to hallucinations.



- If feasible, ensure that the client is cared for by the same staff members on a consistent basis, so as to foster a sense of security and stability.
- Instruct prospective caregivers on how to identify indications and symptoms of a client's faulty sensory perceptions. Describe the methods they can employ to restore realism to the situation.

### Outcome Criteria

- With guidance from the caregiver, the client is able to identify false views of the environment.
- Prospective caregivers are able to communicate solutions to rectify inaccurate perceptions and restore reality to the situation.

## 16. ANXIETY

### Definition

Anxiety is a vague, disagreeable sense of discomfort or fear accompanied by an autonomic reaction (the source is frequently unknown to the individual); a feeling of worry brought on by the prospect of danger. It is a warning signal that alerts the individual to approaching danger and enables them to take appropriate action (NANDA International [NANDA-I], 2018, p. 324).

### Possible Contributing Factors (“related to”)

- Unconscious conflict about essential values and goals of life
- Situational and maturational crises
- Real or perceived] threat to self-concept
- Real or perceived] threat of death
- Unmet needs

- Being exposed to a phobic stimulus.
- Attempts at interference with ritualistic behaviors.

### Defining Characteristics (“evidenced by”)

- Increased respiration
- Increased pulse
- Decreased or increased blood pressure
- Nausea
- Confusion
- Increased perspiration
- Faintness
- Trembling or shaking
- Restlessness
- Insomnia
- Fear of dying, going insane, or acting irrationally during an assault.

### Goals/Objectives

- **Short-term Goal:**
  - In one week, the client will articulate intervention strategies for rising anxiety.
- **Long-term Goal:**
  - Upon completion of therapy, the client will be able to detect symptoms of anxiety beginning and intervene before to the development of panic.

## Interventions with Selected Rationales

- Maintain a calm and nonthreatening attitude while interacting with the customer. Anxiety is infectious and may spread from employees to clients or vice versa. The client develops a sense of safety in the presence of a calm service member.
- Assure the client of his or her protection and safety. This can be communicated via the nurse's actual presence. Do not abandon the customer at this time. The client may worry for their lives. A client's sense of security and assurance of safety are enhanced by the presence of a reliable individual.
- Explain medical experiences to the customer using simple language and succinct instructions delivered in a calm and audible manner. In a moment of extreme anxiety, the client is incapable of comprehending anything other than the most basic communication.
- During episodes of intense anxiety, hyperventilation may develop. Hyperventilation decreases the concentration of carbon dioxide (CO<sub>2</sub>) in the blood, which may result in dizziness, high heart rate, shortness of breath, numbness or tingling in the hands or feet, and syncope. Assist the client in breathing into a tiny paper bag held over the mouth and nose if hyperventilation ensues. The client should alternate between 6 and 12 natural breaths and brief diaphragmatic breaths. This approach should not be utilized with individuals suffering from cardiovascular or respiratory conditions, such as coronary artery disease, asthma, or chronic obstructive pulmonary disease.

- Keep the immediate environment as stimuli-free as possible (dim lighting, few people, simple decor). A stimulating atmosphere may heighten anxiety levels.
- Administer tranquilizers as directed by the physician. Evaluate medications for their efficacy and undesirable side effects.
- When the client's degree of worry has decreased, discuss probable causes with them. The first step in training the client to stop the increase of anxiety is to identify the triggering factor(s).
- Teach the client the signs and symptoms of growing anxiety, as well as methods for preventing its escalation (e.g., relaxation techniques, deep-breathing exercises, physical exercises, brisk walks, jogging, meditation). The customer will pick the most suitable strategy for him or her. Relaxation techniques provide a physiological reaction opposite to that of worry, and physical activity is a healthy way to release extra energy.

### Outcome Criteria

- The client can maintain adequate anxiety levels for problem-solving.
- The client may articulate indications and symptoms of increasing anxiety.
- The client is able to demonstrate ways for preventing anxiety from progressing to panic.

## 17. FEAR

### Definition

Response to a perceivable threat that is consciously acknowledged as dangerous (NANDA-I, 2018, p. 337).

### Possible Contributing Factors (“related to”)

- Phobic stimulus.
- Being in a location or circumstance from which it may be difficult to escape.
- Causing embarrassment to self in front of others.

### Defining Characteristics (“evidenced by”)

- Refuses to leave own home alone.
- Refuses to eat in public.
- Refuses to speak or perform in public.
- Will not expose self to (specify phobic object or situation).
- Identifies object of fear.
- Symptoms of fear or sympathetic activation in the presence of a phobic object or circumstance.

### Goals/Objectives

- **Short-term Goal:**
  - Within thirty minutes, the client will address the phobic object or circumstance with the healthcare professional (time specified).
- **Long-term Goal:**
  - By the time of treatment discharge, the client will be able to function in the presence of the phobic object or circumstance without suffering panic anxiety.

### Interventions with Selected Rationales

- Assure the client of his or her protection and safety. At the panic level, the client may worry for his or her life.

- Investigate the client's impression of bodily integrity or self-perception threats. To aid in the desensitization process, it is crucial to comprehend the client's perspective on the phobic object or circumstance.
- Discuss the facts of the problem with the client in order to assist the client in identifying the aspects that can and cannot be altered. Before progress may be made in lessening the client's dread, the client must acknowledge the unchangeable components of the issue.
- Participate with the client in the identification of alternative coping techniques (e.g., client may choose either to avoid the phobic stimulus or attempt to eliminate the fear associated with it). Encouraging the client to make decisions fosters sentiments of autonomy and increases feelings of self-worth.
- If the client chooses to work on eliminating the fear, desensitization approaches may be used. This is a behavior modification approach aimed to progressively expose the individual to the feared scenario or item (either in fact or through fantasy) until the fear is no longer experienced. This is occasionally done using implosion treatment, in which the subject is "flooded" with stimuli linked to the phobic scenario or item (rather than gradually) until anxiety is no longer experienced in regard to the situation or object. Repetitive exposure to the phobic stimuli under nonthreatening situations diminishes the physical and psychological symptoms associated with fear.
- Encourage the client to explore the underlying emotions that may be contributing to their illogical worries. Assist the client in comprehending how

addressing these emotions, as opposed to repressing them, might result in more adaptive coping skills. The expression of sentiments in a safe atmosphere may aid the client in resolving unsolved concerns.

### Outcome Criteria

- When exposed to the phobic object or scenario, the client does not suffer crippling dread.
- The client verbalizes strategies for avoiding the phobic object or event with minimum lifestyle modification.
- The client can display adaptive coping strategies that can be employed to maintain an acceptable level of anxiety.

# **Psychiatric and Addiction Disorder**



## Schizophrenia

### Definition

Schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders and negative symptoms.

### Schizophrenia classification according to ICD10

- **Paranoid schizophrenia**

Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of effect, volition and speech, and catatonic symptoms, are either absent or relatively inconspicuous.

- **Hebephrenic schizophrenia**

A form of schizophrenia in which affective changes are prominent, delusions and hallucinations are fleeting and fragmentary, behavior irresponsible and unpredictable, and mannerisms common. The mood is shallow and inappropriate, thought is disorganized, and speech is incoherent. There is a tendency to social isolation. Usually the prognosis is poor because of the rapid

development of "negative" symptoms, particularly flattening of affect and loss of volition. Hebephrenia should normally be diagnosed only in adolescents or young adults.

- **Catatonic schizophrenia**

Catatonic schizophrenia is dominated by prominent psychomotor disturbances that may alternate between extremes such as hyperkinesia and stupor, or automatic obedience and negativism. Constrained attitudes and postures may be maintained for long periods. Episodes of violent excitement may be a striking feature of the condition. The catatonic phenomena may be combined with a dream-like (oneiroid) state with vivid scenic hallucinations.

- **Undifferentiated schizophrenia**

Psychotic conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the subtypes, or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics.

- **Post-schizophrenic depression**

A depressive episode, which may be prolonged, arising in the aftermath of a schizophrenic illness. Some schizophrenic symptoms, either "positive" or "negative", must still be present but they no longer dominate the clinical picture. These depressive states are associated with an increased risk of suicide.

- **Residual schizophrenia**

A chronic stage in the development of a schizophrenic illness in which there has been a clear progression from an early stage to a later stage characterized

by long- term, though not necessarily irreversible, "negative" symptoms, e.g. psychomotor slowing; underactivity; blunting of affect; passivity and lack of initiative; poverty of quantity or content of speech; poor nonverbal communication by facial expression, eye contact, voice modulation and posture; poor self-care and social performance.

- **Simple schizophrenia**

A disorder in which there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance. The characteristic negative features of residual schizophrenia (e.g. blunting of affect and loss of volition) develop without being preceded by any overt psychotic symptoms.

- **Schizophrenia, unspecified**

**Risk factors, Table 2.1:**

Physiological	<ul style="list-style-type: none"> <li>a. Genetics</li> <li>b. Histological Changes</li> <li>c. Biochemical</li> <li>d. Anatomical Abnormalities</li> </ul>
Environmental	<ul style="list-style-type: none"> <li>a. Stressful Life Events</li> <li>b. Sociocultural</li> </ul>

## Criteria for Schizophrenia Diagnosis in DSM-5

Mental health professionals use the *DSM-5* when determining what someone is experiencing. Doctors use the information and analyze:

- diagnostic features and symptoms
- level of impairment
- duration of symptoms
- other conditions that share symptoms

Diagnosing Schizophrenia Using Symptoms and Features:

- Professionals use specific diagnostic features in the *DSM-5* to help determine whether someone meets the criteria for schizophrenia. The *DSM-5* delineates five main criteria. Paraphrased:

A. Two or more of:

- 1- Delusions
- 2- Hallucinations
- 3- Disorganized speech (such as speaking incoherently, losing track of thoughts)
- 4- Disorganized or catatonic behavior
- 5- Negative symptoms

B. Level of functioning has declined.

C. The symptoms in Criterion A have persisted for at least 6 months

D. Schizoaffective disorder, major depression, and bipolar disorder have been ruled out.

E. Substance use/abuse has been ruled out as a cause.

- In order for someone to be diagnosed with schizophrenia, he must experience a group of these symptoms and features. One or two are not enough.
- To receive a schizophrenia diagnosis, someone can have any of the symptoms and features, but he must have the following:
  - At least two symptoms from Criteria A.
  - One of those two must be delusions, hallucinations, or disorganized speech.
  - These must have been present for at least one month.

### Possible signs and symptoms; Table 2.2:

<p><b>Symptomatology—Positive Symptoms</b></p>	<p>Content of Thought</p>	<p><i>a. Delusions:</i></p> <ol style="list-style-type: none"> <li>1- Delusion of Persecution.</li> <li>2- Delusion of Grandeur.</li> <li>3- Delusion of Reference.</li> <li>4- Delusion of Control or Influence.</li> <li>5- Somatic Delusion</li> <li>6- Nihilistic Delusion.</li> </ol> <p><i>b. Religiosity</i></p> <p><i>c. Paranoia</i></p> <p><i>d. Magical Thinking</i></p>
	<p>Form of Thought</p>	<ol style="list-style-type: none"> <li>a. Associative Looseness.</li> <li>b. Neologisms.</li> <li>c. Concrete Thinking</li> <li>d. Clang Associations</li> <li>e. Word Salad</li> </ol>

		<ul style="list-style-type: none"> <li>f. Circumstantiality</li> <li>g. Tangentially</li> <li>h. Mutism</li> <li>i. Perseveration</li> </ul>
	Perception	<ul style="list-style-type: none"> <li>1. Hallucinations: (Auditory, Visual, Tactile, Gustatory, Olfactory).</li> <li>2. Illusions.</li> <li>3. Sense of Self: (Echolalia, Echopraxia, Identification and Imitation, Depersonalization).</li> </ul>
<b>Symptomatology—Negative Symptoms</b>	Affect	<ul style="list-style-type: none"> <li>1. Inappropriate Affect.</li> <li>2. Bland or Flat Affect</li> <li>3. Apathy</li> </ul>
	Volition  Interpersonal Functioning and Relationship to the External World	<ul style="list-style-type: none"> <li>1. Emotional Ambivalence</li> <li>2. Deteriorated Appearance</li> <li>1. Impaired Social Interaction.</li> <li>2. Social Isolation.</li> </ul>
	Psychomotor Behavior	<ul style="list-style-type: none"> <li>1. Anergia</li> <li>2. Waxy Flexibility</li> <li>3. Posturing</li> <li>4. Pacing and Rocking</li> </ul>

	Associated Features	<ol style="list-style-type: none"> <li>1. Anhedonia</li> <li>2. Regression</li> </ol>
--	---------------------	---

### Treatment modalities:

Schizophrenia requires lifelong treatment, even when symptoms have subsided. Treatment with medications and psychosocial therapy can help manage the condition. In some cases, hospitalization may be needed.

- **Medications**

Antipsychotic medications are the most commonly prescribed drugs. They're thought to control symptoms by affecting the brain neurotransmitter dopamine. The goal of treatment with antipsychotic medications is to effectively manage signs and symptoms at the lowest possible dose. The psychiatrist may try different drugs, different doses or combinations over time to achieve the desired result. Other medications also may help, such as antidepressants or anti-anxiety drugs.

#### Second-generation antipsychotics

These newer, second-generation medications are generally preferred because they pose a lower risk of serious side effects than do first-generation antipsychotics. Second-generation antipsychotics include:

- Aripiprazole (Abilify)
- Asenapine (Saphris)
- Brexpiprazole (Rexulti)

- Cariprazine (Vraylar)
- Clozapine (Clozaril, Versacloz)
- Iloperidone (Fanapt)
- Lurasidone (Latuda)
- Olanzapine (Zyprexa)
- Paliperidone (Invega)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Ziprasidone (Geodon)

### **First-generation antipsychotics**

These first-generation antipsychotics have frequent and potentially significant neurological side effects, including the possibility of developing a movement disorder (tardive dyskinesia) that may or may not be reversible. First-generation antipsychotics include:

- Chlorpromazine
- Fluphenazine
- Haloperidol
- Perphenazine

These antipsychotics are often cheaper than second-generation antipsychotics, especially the generic versions, which can be an important consideration when long-term treatment is necessary.



## Long-acting injectable antipsychotics

Some antipsychotics may be given as an intramuscular or subcutaneous injection. They are usually given every two to four weeks, depending on the medication. Ask your doctor about more information on injectable medications. This may be an option if someone has a preference for fewer pills and may help with adherence.

Common medications that are available as an injection include:

- Aripiprazole (Abilify Maintena, Aristada)
- Fluphenazine decanoate
- Haloperidol decanoate
- Paliperidone (Invega Sustenna, Invega Trinza)
- Risperidone (Risperdal Consta, Perseris)

### • **Psychosocial interventions**

Once psychosis recedes, in addition to continuing on medication, psychological and social (psychosocial) interventions are important. These may include:

- **Individual therapy.** Psychotherapy may help to normalize thought patterns. Also, learning to cope with stress and identify early warning signs of relapse can help people with schizophrenia manage their illness.
- **Social skills training.** This focuses on improving communication and social interactions and improving the ability to participate in daily activities.
- **Family therapy.** This provides support and education to families dealing with schizophrenia.

- **Vocational rehabilitation and supported employment.** This focuses on helping people with schizophrenia prepare for, find and keep jobs.

Most individuals with schizophrenia require some form of daily living support. Many communities have programs to help people with schizophrenia with jobs, housing, self-help groups and crisis situations. A case manager or someone on the treatment team can help find resources. With appropriate treatment, most people with schizophrenia can manage their illness.

- **Hospitalization**

During crisis periods or times of severe symptoms, hospitalization may be necessary to ensure safety, proper nutrition, adequate sleep and basic hygiene.

- **Electroconvulsive therapy**

For adults with schizophrenia who do not respond to drug therapy, electroconvulsive therapy (ECT) may be considered. ECT may be helpful for someone who also has depression.

## **Bipolar Disorder**

### **Definition**

Bipolar disorder is a mental illness that is characterized by extreme mood swings. These mood swings can range from manic episodes (a period of abnormally high energy and activity) to depressive episodes (a period of low energy and activity). Bipolar disorder can also cause changes in sleep, appetite, and energy levels. People with bipolar disorder may also experience psychotic symptoms, such as hallucinations or delusions.

## Risk factors

- **Genetics**

Bipolar disorder tends to run in families. Children with a parent or sibling with the disorder have a higher chance Source of developing it than those without affected family members. Identical twins don't have the same risk of developing the illness. It's likely that genes and environment work together in the development of bipolar disorder.

- **Environment**

Sometimes a stressful event or major life change triggers a person's bipolar disorder. Examples of possible triggers include the onset of a medical problem or the loss of a loved one. Drug abuse might trigger bipolar disorder.

- **Brain structure**

Functional Magnetic Resonance Imaging (fMRI) and Positron Emission Technology (PET) are two types of scans that can provide images of the brain.

## DSM-5 Criteria for Bipolar Disorder:

The DSM-IV defined two types of bipolar disorder: bipolar I and bipolar II. However, the DSM-V now includes a third category: cyclothymic disorder. In addition, the criteria for diagnosing bipolar disorder have been changed in the DSM-V. As mentioned above, there are three major types or categories or types of bipolar disorder.

- **Bipolar I**

Bipolar I is characterized by manic episodes that last for at least seven days, or manic episodes that are so severe that they require hospitalization. In order to get a diagnosis for bipolar 1, the manic episode should last for at least one week. The person should also have three or more of the following symptoms:

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or under pressure to keep talking
- Flight of ideas or racing thoughts
- Distractibility
- Increased goal-directed activity (e.g., work, school, social, sexual) or psychomotor agitation.

These represent a change from the person's normal functioning and they should be severe enough to cause impairment in work, school, or social life.

- **Bipolar II**

Bipolar II is characterized by depressive episodes that alternate with periods of hypomania (a less severe form of mania). In order to get a diagnosis for bipolar II, the person must have had at least one major depressive episode that lasted for two weeks or more. In addition, the person must have experienced at least one hypomanic episode (a less severe form of mania). The symptoms of a hypomanic episode include:

- Feeling unusually happy or optimistic
- Being more talkative than usual

- Having a decreased need for sleep
- Feeling like you're "on top of the world"
- Being easily distracted
- Having an increased sex drive
- Engaging in risky behaviors (e.g., spending sprees, impulsive decisions)

Additionally, the symptoms should not be severe enough to cause a break from reality (psychosis).

### Cyclothymic disorder

Cyclothymic is a milder form of bipolar disorder that is characterized by shorter and less severe mood swings. The symptoms of cyclothymic are similar to the symptoms of bipolar disorder, but they are not as severe. In order to be diagnosed with cyclothymic, a person must have had periods of hypomania and depression for at least two years (one year in children and adolescents).

There is also another additional criterion that must be met in order for a person to be diagnosed with bipolar disorder. These include:

- The symptoms are not due to the effects of drugs, alcohol, or another medical condition.
- Symptoms are not better explained by another mental disorder, such as schizophrenia or schizoaffective disorder.
- The symptoms cause significant distress or impairment in work, school, or other important areas of functioning.
- Symptoms are not due to the normal ups and downs of life.

## Possible signs and symptoms:

- **Symptoms of mania include:**
  - rapid speech.
  - lack of concentration.
  - high sex drive.
  - decreased need for sleep yet increased energy.
  - increase in impulsivity.
  - drug or alcohol abuse.
- **Symptoms of depression include:**
  - loss of energy.
  - feeling hopeless.
  - trouble concentrating.
  - Irritability.
  - trouble sleeping or sleeping too much.
  - appetite changes.
  - thoughts of death or suicide.
  - attempting suicide.

## Treatment modalities:

Research has shown that the treatments listed here are effective for people with bipolar disorder and are considered to be evidence-based. Evidence-based treatments for bipolar disorder include:

- **Medications**

Mood stabilizing medications, antipsychotic and antidepressant medications.

- **Psychoeducation**

Psychoeducation educates patients about their illness and the most effective ways of treating symptoms and preventing relapse. Psychoeducation covers topics such as the nature and course of bipolar disorder, the importance of active involvement in treatment, the potential benefits and adverse effects of various treatment options, identification of early signs of relapse, and behavior changes that reduce the likelihood of relapse.

- **Cognitive Behavioral Therapy**

Cognitive behavioral therapy (CBT) aims to change a person's way of thinking to be more adaptive and healthier. CBT is a blend of two therapies: cognitive therapy and behavioral therapy.

- **Interpersonal and Social Rhythm Therapy**

In Interpersonal and Social Rhythm Therapy (IPSRT), patients first learn to recognize the relationship between their circadian rhythms and daily routines, as well as their mental health symptoms. IPSRT then focuses on stabilizing sleep/wake cycles, maintaining regular patterns of daily activities (i.e., sleeping, eating, exercise, and other stimulating activities), and addressing potential problems that may disrupt these routines.

- **Family-Based Services**

Mental illness affects the whole family. Family services teach families to work together towards recovery. In family-based services, the family and clinician meet to discuss problems the family is experiencing. Families then attend

educational sessions where they will learn basic facts about mental illness, coping skills, communication skills, problem-solving skills, and ways to work with one another toward recovery.

- **Social Skills Training**

Many people with bipolar disorder have difficulties with social skills. Social skills training (SST) aims to correct these deficits by teaching skills to help express emotion and communicate more effectively so individuals are more likely to achieve their goals, develop relationships, and live independently. Social skills are taught in a very systematic way using behavioral techniques, such as modeling, role playing, positive reinforcement, and shaping.

- **Illness Self-Management**

Components of illness self-management include psychoeducation, coping skills training, relapse prevention, and social skills training.

- **Assertive Community Treatment (ACT)**

Services provided in ACT include: case management, comprehensive treatment planning, crisis intervention, medication management, individual supportive therapy, substance abuse treatment, rehabilitation services (e.g., supported employment), and peer support.

- **Psychosocial Interventions for Alcohol and Substance Use Disorders**

Integrated treatment includes motivational enhancement and cognitive-behavioral interventions.

- **Supported Employment**



Supported Employment is a program designed to help people with severe mental illness find and keep competitive employment. The approach is characterized by a focus on competitive work, a rapid job searches without prevocational training, and continued support once a job is obtained.

- **Psychosocial Interventions for Weight Management**

Resources to support weight loss are available. Weight programs generally last 3 months or longer and include education about nutrition and portion control. Participants learn skills to monitor their daily food intake and activity levels, have regular weigh-ins, and set realistic and attainable personal wellness goals.

## **Anxiety, and Related Disorders**

### **Definition**

**Anxiety** is a vague feeling of dread or apprehension that occur in response to internal or external stimuli and can result in physical, emotional, cognitive, and behavioral symptoms.

**Anxiety disorders** is group of condition in which the affected person experiences persistent anxiety that the patient cannot dismiss and interferes with his or her daily activities.

**Anxiety as a response to stress:** Stress is the wear and tear that life causes on the body. It occurs when a person has difficulty dealing with life situation, problems, and goals. Each person handles stress differently.

**Prevalence of anxiety disorders:**

Approximately 13% of children and adolescents, 16% of adults aged 18 to 54 years, and 20% of adults aged 55 years or older have an anxiety disorder.

### Risk factors

- Sex: women are twice as likely than are men to have an anxiety disorder.
- Being separated or divorced.
- Having experienced childhood physical or sexual abuse.
- Low socioeconomic status.
- Family history of similar disorders.
- Substance or stimulant abuse.

### Hans Selye determined three stage of reaction to stress:

**1- Alarm reaction stage:** stress stimulates the body to send messages from the hypothalamus to the glands such as adrenal gland to send out adrenaline and norepinephrine to prepare for potential defense needs.

**2-Resistance stage:** the digestive system reduces function to shunt blood to areas needed for defense. The lung Take more air, heart beat faster to defend the body by fight, flight. If the person adapts to stress, the body responses relax.

**3-Exhaustion stage:** occurs when the person has responded negatively to anxiety and stress: body stores are depleted or the emotional components are not resolved.

### Levels of anxiety:

- **Mild anxiety:** Is a sensation that something is different and warrants special attention.

- **Moderate anxiety:** is disturbing feeling that something is definitely wrong, the person become nervous or agitated.
- **Severe anxiety:** cognitive skills decrease, person has trouble thinking. Cannot solve problems or learn effectively, doesn't respond to redirection. The person pace, restless, irritable and angry.
- **Panic anxiety:** perceptual field reduced to focus on self, cannot process any environmental stimuli, distorted perception, doesn't recognize potential danger, cannot communicate verbally, may be suicide.

### Etiology of anxiety disorders:

#### 1- Genetic theory:

Genes play important part in development of anxiety disorders:

- Individuals with positive family history more common than others.
- Monozygotic twins more common than dizygotic twins.

#### 2- Neurobiologic theory:

- studies have shown that variation in the autonomic nervous system or noradrenergic system may cause some people to experience anxiety disorder.
- other studies revealed that are certain structure such as (hippocampus, locus ceruleuse) which is responsible for processing stimuli and plays a role in encoding information into memories may be over active in some people making them more vulnerable to anxiety disorder especially post traumatic stress disorder.

### **3- Neurochemical theory:**

- studies revealed abnormalities in the regulation of gamma- aminobutyric acid(GABA) an inhibitory neurotransmitter function as the body natural anti-anxiety agent by reducing cell excitability.
- serotonin((5-HT), has many subtypes.(5-HT1a)play role in anxiety as well as affecting aggression and mood. Serotonin play a distinct role in OCD, panic disorder, GAD.
- an excess norepineprine is suspected in panic disorder, post traumatic disorder.

### **4- Psychodynamic theories:**

- Psychoanalytic theory: according to psychoanalytic theory Freud saw that anxiety arises from intrapsychic conflict when the ego is overwhelmed by excitation from any of three sources:
  - The outside world (realistic anxiety).
  - The instinctual level of id, including love, anger, and sex (neurotic anxiety).
  - The superego (moral anxiety).
- Interpersonal theory: Sullivan viewed anxiety as being generated from problems in interpersonal relationships. Caregivers can communicate anxiety to infants or children through inadequate nurturing, agitation when holding or handling the child. In adults, anxiety arises from the person need to conform the norms and values of his or her cultural group, the higher level of anxiety, the lower ability to communicate and to solve problems and greater chance for anxiety disorder to develop.

## 5- **Behavioral theory:**

Behavioral theorists view anxiety as being learned through experiences. People can change or unlearn behaviors through new experiences. Behaviorists believe that people can modify maladaptive behaviors without gaining insight into the causes for them.

## **Classification of Anxiety Disorders:**

### 1- **Generalized Anxiety Disorder (GAD):**

Generalized anxiety disorder is an anxiety disorder that is characterized by excessive, uncontrollable and often irrational worry about everyday things, which is disproportionate to the actual source of worry. This excessive worry often interferes with daily functioning.

#### **Characteristics of GAD:**

- Anxiety that's persistent over whelming, uncountable, and out proportion to the stimulus.
- Usually emerges slowly and tends to be chronic.
- Effects range from mild to severe.
- Up to 25% of patients with GAD develop panic disorder

#### **Signs and symptoms:**

- Manifestation of excessive physiologic arousal:
  - Shortness of breath, tachycardia, sweating, frequent urination, nausea, fatigue, headache, cold- clammy skin, insomnia, muscle tension, dry mouth.

- Evidence of distorted cognitive processes:
  - Poor concentration, unrealistic assessment of problems, excessive anxiety and worry over minor matters, fear of grave or death.
- Evidence of poor coping:
  - Avoidance, poor problem solving skills.

### **Treatment:**

- For mild anxiety: (Relaxation techniques to decrease arousal, Psychotherapy to help the patient identify and deal with the cause of anxiety and plan effective responses to anxiety).
- Cognitive therapy to reduce cognitive distortions by teaching the patient how to view her or his worry realistically.
- Pharmacological therapy if anxiety impair patients daily functioning:
  - Antianxiety agents such as benzodiazepines.
  - Tricyclic antidepressant such as imipramine.

### **Nursing diagnosis:**

*Anxiety:* related to biologic factor as evidenced by feeling of discomfort apprehension or helplessness.

*Goal:* The client will exhibit decrease anxiety level.

### *Nursing intervention:*

- Stay with the patient when anxious and encourage her to discuss her feeling.
  - Remain calm, nonjudgmental.
  - Suggest activities that distract from anxiety.

- Reduce environmental stimuli.
- Provide environmental counseling to reduce stress such as avoid caffeine and alcohol)
- When the patient is more receptive teach appropriate ways to ease and manage anxiety.
- Encourage the client's participation in relaxation exercise as deep breathing.
- Help the client see that mild anxiety can be positive for change.
- Administer prescribed antianxiety medication as order.
- Inform the patient and her family that these drug may cause adverse reactions (drowsiness, fatigue, ataxia, blurred vision, slurred speech, tremors).
- Advise the patient not to discontinue medications with the physician approval, abrupt withdrawal cause severe symptoms.

## **2- Panic Disorder:**

Panic disorder is discreet episodes of panic attacks, that is 15 to 30 minutes of rapid, intense anxiety in which the person experiences great emotional fear as well as physiologic discomfort.

### **Characteristics of panic disorder:**

- Anxiety in its most severe form.
- Recurrent, unexpected panic attacks that cause intense apprehension and feeling of impending doom.
- Between attacks, marked by persistent worrying that another attack may occur.

- Panic attack occur suddenly, with no warning,
- During attack, patient may fear he's dying or losing control of his emotion.
- If chest pain or shortness of breath occurs, may go to hospital emergency department.

**Signs and symptoms:**

- may mimic Heart attack: (Palpitation and rapid heartbeat, sweating, generalized weakness, shortness of breath, chest pain or pressure, sensation of choking, abdominal pain, pallor or flushing).
- Diminished ability to focus or to think clearly.
- Rapid speech, pacing.

**Treatment:**

- Behavioral therapy involving desensitization.
- Relaxation techniques to help patient cope with panic attack.

**Nursing diagnosis:**

Anxiety related to increasingly frequent panic attack as evidenced by tension, apprehension.

*Goal:* The patient will develop an awareness of his own anxiety.

***Nursing intervention:***

- During panic attack:
  - Stay with the patient until attack subsides.
  - Avoid touching the patient until you've established rapport (patient may be stimulated or frightened)



- Maintained calm approach.
- Speak in short, simple sentences.
- Reduce external stimuli including exposure to groups of people.
- Provide safe environment and prevent harm to the patient and others.
- Encourage the patient to express his feeling.
- Allow her to pace around the room.
- Between attacks:
  - Encourage the patient to discuss her fears, help her to identify situation that trigger the attack.
  - Discuss alternative coping mechanism.
  - Monitor therapeutic and adverse effects of drugs.

### 3- Post traumatic stress disorder (PTSD):

Persistent, recurrent images and memories of a serious traumatic event that the person has either experienced or witness, impairing her ability to function.

#### **Characteristics of post-traumatic stress disorder:**

- PTSD includes traumatic events as wartime, accidents, rapes, and acts of violence.
- May involve flashback, nightmares about events along with avoidance of reminders.
- PTSD can be acute or chronic:
  - Acute PTSD diagnosed if symptoms appear within 6 of trauma.
  - Chronic if symptoms begin later than 6 months after incident.

- Signs and symptoms may occur up to several years after the traumatic events.

**Specific cause:**

- Triggering traumatic event.

**Signs and symptoms:**

Anger, poor impulse control, chronic anxiety, avoidance of people, places, and things associated with traumatic experience, emotional detachment, depersonalization, difficulty concentrating, difficulty falling asleep, inability to recall details of traumatic events, social withdrawal, hopelessness, relationship problems, labile affect.

**Treatment:**

- Individual psychotherapy: give the patient chance to talk through the traumatic experience.
- Group therapy: help the patient realize she isn't alone.
- Pharmacological drugs: benzodiazepines & antidepressant.

**Nursing diagnosis:**

Post-traumatic stress syndrome related to disaster as evidenced by flashbacks, nightmares and verbalization of guilt.

*Goal:* Patient will verbalize an understanding of post-traumatic stress disorder.

*Nursing intervention:*

- Establishing trust by accepting the patient current level of functioning and assuming positive, nonjudgmental attitude.
- Provide information regarding post traumatic response, relationship among his fear, sleeplessness, and anxiety.
- Encourage the patient to express her grief and gain coping skills to relieve anxiety.
- Use crises intervention techniques.
- Deal constructively with the patient displays of anger:
  - Encourage the patient to assess angry outbursts.
  - Assist in regaining control over angry impulses.
- Help the patient relive shame and guilt precipitated by real action.
- Administer prescribed medication as ordered.

#### 4- **Phobias:**

Is an irrational, intense, persistent fear of certain situations, activities, things, or persons that does not pose significant danger.

#### **Characteristics of phobia:**

- Onset in childhood to early adulthood.
- More persistent seen in adult phobia.

#### **Classification of phobia:**

##### **Agoraphobia:**

Agoraphobia is the intense fear of being alone or in public place from which escape would be difficult or help would be unavailable in the event of becoming disabled.

### **Characteristics of agoraphobia:**

- Usually occur in patients with history of panic disorder.
- Most common fears include crowds, large public spaces and places where person feel trapped.
- Nearly 6% of adults develop agoraphobia at some point in their lives.
- Agoraphobic patients have higher depression and suicide rate and may prone to alcohol and sedative abuse.

### **Signs and symptoms:**

- Overriding fear of open or public spaces.
- Avoidance of public places and confinement to home.
- When accompanied by panic disorder, fear that having panic attack in public will lead to (signs of panic disorder)
- depressive symptoms, depersonalization.

### **Treatment:**

- Behavioral therapy.
- Pharmacological therapy: including benzodiazepines, TCAs & SSRIs.
- Desensitization, which gradually exposes the patient to the situation that triggers fear and avoidance.
- Relaxation techniques as well as psychotherapy, in which the patient discuss underlying emotional conflicts with the therapist or support group.

## **Social phobias:**

Persistent, irrational fear and compelling desire to avoid situations in which the person may be exposed to unfamiliar people.

### **Characteristics of social phobias:**

- Recognize that fear is excessive or unreasonable.
- Interferes with functioning cause marked distress.
- No secondary or another disorder.
- Duration at least 6 months if the person is under 18 years of age.
- Sufferer avoid these situations whenever possible.

### **Signs and symptoms:**

- Fear or avoidance of eating, writing or speaking in public.
- Low self-esteem, difficulty talking, nausea or stomach upset, profuse sweating.

### **Treatment:**

- Desensitization therapy.
- Modeling behaviors, patient observe someone modeling or demonstrating appropriate behaviors when confronted with feared situation.
- Assertive training to help the patient become assertive in her interpersonal interaction.

### **Nursing interventions:**

- Avoid urge the patient fears.

- Teach the patient progressive muscle relaxation, or thought stopping techniques.
- Suggest ways to channel energy and relieve stress such as running and creative activities.
- Don't let the patient withdraw completely.

### **Specific phobia:**

Intense, irrational anxiety when anticipating a specific feared entity or places.

### **Characteristics of specific phobia:**

- Natural environment
- (water, heights).
- Animal
- Blood- injection.
- Situational phobia: fear of being in specific situation such as (hospital, elevator).
- Other types as (fear of getting lost while driving).

### **Predisposing factors:**

- Experiencing or observing trauma.

### **Signs and symptoms:**

- Sever anxiety with exposure or even threat of exposure.
- Low self-esteem.
- Depression.
- Feeling of weakness, ineffectiveness due to routine avoidance.

### **Nursing diagnosis:**

Anxiety related to phobia as evidenced by sufficient discomfort to seek treatment.

*Goal:* Client will verbalize feeling of fear and discomfort.

### *Nursing intervention:*

- Encourage the patient to discuss feared object or situation.
- Collaborate with the patient and multidisciplinary team to develop and implement systematic desensitization program.
- Administer antianxiety and antidepressant as ordered.
- Avoid urge the patient fears.
- Teach the patient progressive muscle relaxation, or thought stopping techniques.
- Suggest ways to channel energy and relieve stress such as running and creative activities.
- Don't let the patient withdraw completely.

### *Other nursing diagnosis:*

- Ineffective individual coping.
- Risk for directed violence toward others.
- Social isolation.

## Dementia

### Definition

Dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities.

### Dementia classification

#### 1- Alzheimer's Disease:

This condition is the most common type of dementia. It accounts for about 60-80% of cases. The most distinguishing feature of this disease is the buildup of tau tangles and amyloid plaques in the brain. It is believed that brain changes are a cause of the disease. Some symptoms of this condition are difficulty remembering recent names, events, and conversations. Apathy and depression are also Alzheimer's disease's early symptoms. Some later symptoms are poor judgment, impaired communication, confusion, depression, disorientation, difficulty speaking, walking and swallowing, and behavior changes.

#### 2- Vascular Dementia

Known as post-stroke or multi-infarct dementia, vascular dementia is less common than Alzheimer's disease, accounting for 10% of cases of dementia. Some symptoms are impaired judgment, loss of motivation, strokes or bleeding in the brain. The number, location and size of the brain injuries will determine how the patient's physical functioning and thinking are affected.



Vascular dementia cannot be treated, but people can prevent further brain injuries from the cause of the ailment. There are numerous therapies and medication you can use to manage its symptoms.

### **3- Lewy Body Dementia**

Patients with dementia with Lewy bodies have thinking problems and memory loss common in Alzheimer's disease. However, this type of dementia has other early symptoms such as well-formed visual hallucinations, sleep disturbances, gait imbalance, slowness, and other parkinsonian movement features.

The brain changes in this type of dementia alone can cause dementia, or they can occur as the brain changes of Alzheimer's and/or vascular dementia. When this occurs, the patient is said to suffer from 'mixed dementia'.

### **4- Creutzfeldt-Jakob Disease**

Creutzfeldt-Jakob Disease is the most common kind of fatal brain disorders. This disorder occurs in cattle, and it has been transferred to people under some certain cases. Rapidly fatal disorder affects memory and coordination and thus causing behavior changes. Symptoms include speech impairment, memory loss, confusion, muscle twitching, and stiffness. Occasionally, hallucinations and blurred vision are also gone with this condition. There is no cure for this type of dementia.

### **5- Huntington's Disease**

This disease is a progressive brain disorder that is caused by a defective gene. The gene defect may cause abnormalities in a brain protein, which result in

worsening symptoms. This disease tends to occur in people aged between 30 & 50 years old.

It is an inherited progressive dementia and it may affect the patient's behavior, cognition, and movement. The common symptoms of dementia caused by Huntington's disease are impaired judgment, memory problems, mood swings, speech problems, frequent urination, and depression. Also, hallucinations and delusions may occur. Additionally, people with Huntington's disease may experience uncontrollable jerking movements and difficulty ambulating.

There is no treatment to stop the development of this disease, but you can take medication to control movement disorders as well as psychiatric symptoms.

## **6- Mixed Dementia**

In mixed dementia, abnormalities associated with more than one cause of dementia such as Alzheimer's and vascular dementia, occurring simultaneously in the brain. Some studies show that mixed dementia is more popular than previously thought.

## **7- Frontotemporal Dementia**

Some common symptoms are changes in behavior and personality and difficulty with language, Nerve cells in the side regions and front of the brain are affected. People with frontotemporal dementia develop symptoms at about age 60 and survive for fewer years than patients with Alzheimer's disease.

Some main symptoms of frontotemporal dementia are decreased inhibition, often resulting in inappropriate behavior, decreased empathy, apathy, loss of motivation, anxiety, depression, repetitive or compulsive behaviors. This type of

dementia cannot be treated, but patients can use medicines to deal with uncomfortable symptoms.

### **8- Normal Pressure Hydrocephalus**

Some symptoms of this type of dementia are difficulty walking, inability to control balance and urination and memory loss, in addition to impairments involving in speech and problem-solving abilities. This condition is caused by the build-up of fluid in the brain. Impaired fluid drainage causes the added pressure on the brain, involving in the brain's ability to normally function.

### **9- Parkinson's Disease**

When Parkinson's disease develops, it will lead to a progressive dementia that is similar to Alzheimer's or dementia with Lewy bodies. Problems with movement are common signs of the disease. If dementia develops, these symptoms are similar to dementia with Lewy bodies.

Parkinson's disease dementia may affect social judgment, memory language or reasoning. Most people with Parkinson develop dementia, but the time from the onset of Parkinson's symptoms to the onset of dementia's symptoms varies from person to person. Some risk factors for getting Parkinson's disease are the onset of movement symptoms followed by cognitive impairment as well as REM sleep behavior disorder, which describes to have frequent nightmares as well as visual hallucinations.

## **10- Wernicke-Korsakoff Syndrome**

It is a chronic memory disorder that is caused by the deficiency of vitamin B1, which helps brain cells to produce energy from sugar. When the level of thiamine falls too low, brain cells will not be able to generate enough energy to work properly. The most common cause of this disorder is alcohol misuse. People suffering from this disorder may have strikingly severe memory problems while other social and thinking skills are unaffected.

## **11- Progressive Supranuclear Palsy**

It is not a common brain disorder that may damage the upper brain stem. This region is also affected in Parkinson's, which may explain motor problems. Eye movements are especially affected, leading to limited mobility of the eye. Some other common early symptoms of this type of dementia are the loss of balance, general body stiffness, unexplained falls, apathy, as well as depression. A patient who suffers from this type of dementia may suddenly cry or laugh easily. When the disorder develops, people will experience blurred vision and loss of facial expression. Besides, they may experience slurred speech and difficulty in swallowing liquids or solid foods.

This type of dementia gets progressively worse, but patients can live 10 years or more after the onset of common signs.

## **12- Mild Cognitive Impairment**

Dementia can be a result of medical illnesses, medications, and other treatable causes. An individual with mild cognitive impairment will experience memory loss and impaired speech and judgment. These conditions do not affect the

normal activities of patients' daily living. They may experience behavioral changes involving in anxiety, depression, aggression, as well as emotional apathy.

### **13- Multi-Infarct Dementia**

This type of dementia turns up when a person has experienced many small strokes that may damage brain cells. As one side of the body can be disproportionately affected, patients may experience impaired language and other functions, depending on the brain area that is affected. Doctors call them "local" symptoms, as they are opposed to the "global" symptoms found in Alzheimer' disease that is likely to affect some functions as well as both body sides. When the strokes turn up on both brain sides, this type of dementia is more likely than when stroke turns up on one brain side. Sometimes, a single stroke can impair the brain enough to lead to dementia.

People with multi-infarct dementia will have trouble communicating and concentrating. They may experience memory problems; however, this may not be the earliest symptom of this type of dementia. Depression is also a common symptom in patients with multi-infarct dementia.

### **14- Subcortical Vascular Dementia**

This is known as a rare type of dementia that involves microscopic damages to the nerve fibers as well as small blood vessels. The symptoms of this type of dementia are related to the subcortical neural circuit disruption involving in short-term memory, mood, organization, attention, decision-making, as well as appropriate behavior. A common symptom of this condition is psychomotor

slowness. Some other symptoms are urinary incontinence, trouble walking, slowness, clumsiness, lack of facial expression, as well as speech difficulties. These symptoms begin to occur after age 60, and they develop in a stepwise way. Patients who suffer from subcortical vascular disease often experience a history of stroke, high blood pressure, or evidence of disease of large blood vessels in the heart or neck valves. The treatment for this type of dementia is aimed at preventing strokes and controlling blood pressure.

#### **15- Alcohol-Related Dementia**

Drinking too much alcohol especially if combined with a diet that lacks vitamin B1, can result in brain damage. This type of dementia can be prevented. Experts recommend that people who drink no more than 2 standard drinks a day can lower the risk of developing health problems related to alcohol.

#### **16- Human Immunodeficiency Virus-Associated Dementia**

It is a complication that affects some individuals with HIV and acquired AIDS, an immune deficiency syndrome. This type of dementia is associated with severe motor, cognitive and behavioral problems that affect day-to-day functioning, and lower the quality of life. It is not common in patients in the early stages, but it may increase when the disease HIV/AIDS develops. Additionally, this type of dementia is the most severe type of HIV-associated neurocognitive disorder. Milder forms affect thinking skills.

#### **17- Younger-Onset Dementia**

The younger-onset dementia describes any form of dementia found in people above 65 years old. This type of dementia is less common than that occurring

after 65 years old. Younger-onset dementia can be hard to diagnose. People who are diagnosed with this type of dementia may have a family history of dementia. Some particular types of dementia may be found in younger people are frontotemporal dementia and Alzheimer's disease. There are a plenty of other conditions, which can lead to dementia. Therefore, it is important for the patients to get diagnosing of dementia early to find out proper treatment. The doctor will need to know the symptoms the individual is experiencing, their frequency, duration and rate of progression. Diagnosing dementia needs a review of the individual's health care, medication history and family history. This also includes evaluating the depression, nutrition, and substance abuse and other conditions that may result in memory loss. Some of them are vitamin deficiency, anemia, kidney or liver disease, diabetes, infections, thyroid disease, cardiovascular, and pulmonary problems. People who suspect to have dementia must undergo blood tests and physical exam to determine which kinds of dementia they may be suffering from

### **Risk factors**

- Age
- Genetics/family history.
- Smoking and alcohol use.
- Atherosclerosis.
- Cholesterol.
- Plasma homocysteine.
- Diabetes.

- Mild cognitive impairment.

### Criteria for dementia Diagnosis in DSM-5

In the DSM-5, the term "dementia" is replaced with "major neurocognitive disorder" and "mild neurocognitive disorder".

- **Major Neurocognitive Disorder**

*Diagnostic Criteria:*

- Evidence of a significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:
  - Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
  - A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.
- The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).
- The cognitive deficits do not occur exclusively in the context of delirium.
- The cognitive deficits are not better explained by another mental disorder



- **Mild Neurocognitive Disorder**

*Diagnostic Criteria:*

- Evidence of a modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:
  - Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and
  - A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.
- The cognitive deficits do not interfere with capacity for independence in everyday activities (i.e. complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).
- The cognitive deficits do not occur exclusively in the context of a delirium.
- The cognitive deficits are not better explained by another mental disorder.

### **Possible signs and symptoms**

- **Common early symptoms of dementia:**

- Memory loss
- Difficulty concentrating

- Finding it hard to carry out familiar daily tasks, such as getting confused over the correct change when shopping
- Struggling to follow a conversation or find the right word
- Being confused about time and place
- Mood changes
- **Symptoms specific to Alzheimer's disease:**
  - Memory problems, such as regularly forgetting recent events, names and faces
  - Asking questions repetitively
  - Increasing difficulties with tasks and activities that require organization and planning
  - Becoming confused in unfamiliar environments
  - Difficulty finding the right words
  - Difficulty with numbers and/or handling money in shops
  - Becoming more withdrawn or anxious
- **Symptoms specific to vascular dementia:**
  - Stroke-like symptoms: including muscle weakness or temporary paralysis on one side of the body (these symptoms require urgent medical attention)
  - Movement problems – difficulty walking or a change in the way a person walks
  - Thinking problems – having difficulty with attention, planning and reasoning
  - Mood changes – depression and a tendency to become more emotional

- **Symptoms specific to dementia with Lewy bodies:**
  - Periods of being alert or drowsy, or fluctuating levels of confusion
  - Visual hallucinations (seeing things that are not there)
  - Becoming slower in their physical movements
  - Repeated falls and fainting
  - Sleep disturbances
- **Symptoms specific to frontotemporal dementia:**
  - Personality changes – reduced sensitivity to others' feelings, making people seem cold and unfeeling
  - Lack of social awareness – making inappropriate jokes or showing a lack of tact, though some people may become very withdrawn and apathetic
  - Language problems – difficulty finding the right words or understanding them
  - Becoming obsessive – such as developing fads for unusual foods, overeating and drinking
- **Symptoms in the later stages of dementia:**
  - Memory problems – people may not recognize close family and friends, or remember where they live or where they are.
  - Communication problems – some people may eventually lose the ability to speak altogether. Using non-verbal means of communication, such as facial expressions, touch and gestures, can help.
  - Mobility problems – many people become less able to move about unaided. Some may eventually become unable to walk and require a wheelchair or be confined to bed.

- Behavioral problems – a significant number of people will develop what are known as "behavioral and psychological symptoms of dementia". These may include increased agitation, depressive symptoms, anxiety, wandering, aggression, or sometimes hallucinations.
- Bladder incontinence is common in the later stages of dementia, and some people will also experience bowel incontinence.
- Appetite and weight loss problems are both common in advanced dementia. Many people have trouble eating or swallowing, and this can lead to choking, chest infections and other problems. Alzheimer's Society has a useful factsheet on eating and drinking.

### Treatment modalities:

- Pharmacological management
  - Acetylcholinesterase (AChE) Inhibitors
  - N-methyl-D-aspartate (NMDA) Receptor Antagonist
  - Vitamins and Supplements
- Non-pharmacological management
  - Lifestyle Modification:
    - A healthy way of life is critical. Interventions that promote healthy and nutritious eating habits improve the overall health of AD patients
  - Exercise:
    - Physical activity can be an effective non-pharmacological treatment for dementia prevention and management.

## Eating disorder

### Definition

Eating disorders are characterized by “a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning”

### Main Categories of Eating Disorders

#### 1- Anorexia Nervosa

Anorexia Nervosa is a clinical syndrome in which the person has a morbid fear of obesity. It is characterized by the individual’s gross distortion of body image, preoccupation with food, and refusal to eat. The disorder occurs predominantly in females 12 to 30 years of age. Without intervention, death from starvation can occur.

#### 2- Bulimia Nervosa

Bulimia Nervosa is (commonly called “the binge-and-purge syndrome”) characterized by extreme overeating, followed by self-induced vomiting and abuse of laxatives and diuretics. The disorder occurs predominantly in females and begins in adolescence or early adult life.

#### 3- Binge-Eating Disorder

Binge-Eating Disorder is characterized by recurrent episodes of binge eating; that is, eating in a discrete period of time an excessive amount of food and feeling a sense that the episode of eating is beyond the individual’s control. The eating usually takes place in isolation, and the individual feels disgusted with himself or herself, depressed, or very guilty afterward. Binge-eating disorder differs from

bulimia nervosa in that the individual does not engage in compensatory behaviors (e.g., self-induced vomiting, laxatives, diuretics). Binge eating disorder frequently affects people over age 35, and it occurs more often in men than does any other eating disorder. Individuals are more likely to be overweight or obese, overweight as children, and teased about their weight at an early age.

#### **4- Related Disorders**

Eating or feeding disorders in childhood include pica, which is persistent ingestion of nonfood substances, and rumination, or repeated regurgitation of food that is then rechewed, re-swallowed, or spit out. Both of these disorders are more common in persons with intellectual disability.

#### **DSM5 Diagnostic Criteria / Anorexia Nervosa**

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

## DSM5 Diagnostic Criteria / Bulimia Nervosa

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
  - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

## DSM5 Diagnostic Criteria / Binge-Eating Disorder

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
  - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

- The binge-eating episodes are associated with three (or more) of the following:
  - Eating much more rapidly than normal.
  - Eating until feeling uncomfortably full.
  - Eating large amounts of food when not feeling physically hungry.
  - Eating alone because of feeling embarrassed by how much one is eating.
  - Feeling disgusted with oneself, depressed, or very guilty afterward.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

### Symptomatology— (Subjective and Objective Data)

- **Anorexia Nervosa**
  - Morbid fear of obesity. Preoccupied with body size. Reports feeling fat” even when in an emaciated condition.
  - Refusal to eat. Reports “not being hungry,” although it is thought that the actual feelings of hunger do not cease until late in the disorder.
  - Preoccupation with food. Thinks and talks about food at great length. Prepares enormous amounts of food for friends and family members but refuses to eat any of it:
    - Delayed psychosexual development.
    - Behavior, such as excessive hand washing, may be present
    - Extensive exercising is common.



- Feelings of depression and anxiety often accompany this disorder.
- May engage in the binge-and-purge syndrome from time to time.

- **Bulimia Nervosa**

- Binges are usually solitary and secret, and the individual may consume thousands of calories in one episode.
- After the binge has begun, there is often a feeling of loss of control or inability to stop eating.
- Following the binge, the individual engages in inappropriate compensatory measures to avoid gaining weight (e.g., self-induced vomiting; excessive use of laxatives, diuretics, or enemas; fasting; and extreme exercising)
- Eating binges may be viewed as pleasurable but are followed by intense self-criticism and depressed mood.
- Individuals with bulimia are usually within normal weight range—some a few pounds underweight, some a few pounds' overweight.
- Obsession with body image and appearance is a predominant feature of this disorder. Individuals with bulimia display undue concern with sexual attractiveness and how they will appear to others.
- Binges usually alternate with periods of normal eating and fasting.
- Excessive vomiting may lead to problems with dehydration and electrolyte imbalance.
- Gastric acid in the vomitus may contribute to the erosion of tooth enamel.

**Predisposing Factors to Eating Disorders : table 2.3**

<b>1- Physiological</b>	A. Genetic:	A hereditary predisposition to eating disorders has been hypothesized on the basis of family histories. Eating disorders are common among sisters and mothers of those with the disorders than among the general population.
	B. Neuroendocrine Abnormalities:	Studies have revealed elevated cerebrospinal fluid cortisol levels and a possible impairment of dopaminergic regulation and hypothalamic dysfunction in individuals with anorexia.
	C. Neurochemical Influences.	Neurochemical influences in eating disorders may be associated with the neurotransmitters serotonin and norepinephrine.
<b>2-Psychosocial</b>	A. Psychodynamic Theory:	The psychodynamic theory suggests that behaviors associated with eating disorders reflect a developmental arrest in the very early years of childhood caused by disturbances in mother-infant interactions. The tasks of trust, autonomy, and separation-individuation go unfulfilled, and the individual remains in the dependent position.
	B. Family Dynamics:	This theory proposes that the issue of control becomes the overriding factor in the family of the individual with an eating disorder. These families often consist of a passive father, a domineering mother, and an overly dependent child.

## Treatment modalities:

- Medical Management

Medical management focuses on weight restoration, nutritional rehabilitation, rehydration, and correction of electrolyte imbalances. Clients receive nutritionally balanced meals and snacks that gradually increase caloric intake to a normal level for size, age, and activity.

- Psychopharmacology

- Anorexia Nervosa

- Amitriptyline (Elavil) and the antihistamine cyproheptadine (Periactin) in high can promote weight gain in inpatients with anorexia nervosa.
- Olanzapine (Zyprexa) has been used with success because of its antipsychotic effect (on bizarre body image distortions) and associated weight gain.
- Fluoxetine (Prozac) has some effectiveness in preventing relapse in clients whose weight has been partially or completely restored.

- Bulimia Nervosa

- Antidepressants such as desipramine (Norpramin), imipramine (Tofranil), amitriptyline (Elavil), nortriptyline (Pamelor), phenelzine (Nardil), and fluoxetine (Prozac), were prescribed in the same dosages used to treat depression. The antidepressants are effective in reducing binge eating. They also improved mood and reduced preoccupation with shape and weight.

- Psychotherapy

- Family therapy: is useful to help members be effective participants in the client's treatment. Family-based early intervention can prevent future exacerbation of anorexia when families are able to participate in an effective manner.
- Individual therapy: Therapy that focuses on the client's particular issues and circumstances, such as coping skills, self-esteem, self-acceptance, interpersonal relationships, and assertiveness, can improve overall functioning and life satisfaction.
- Cognitive-behavioral therapy CBT: It has been found to be the most effective treatment for bulimia. Strategies designed to change the client's thinking (cognition) and actions (behavior) about food focus on interrupting the cycle of dieting, bingeing, and purging and altering dysfunctional thoughts and beliefs about food, weight, body image, and overall self-concept. Also, it has been adapted for adolescents with anorexia nervosa and used successfully for initial treatment as well as relapse prevention. Enhanced cognitive-behavioral therapy (CBT-E) has been even more successful than CBT. In addition to addressing the body image disturbance and dissatisfaction, CBT-E addresses perfectionism, mood intolerance, low self-esteem, and interpersonal difficulties.

## Autism Spectrum Disorder

### Definition

- Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history
  - Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
  - Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of.
  - Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
- Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
  - Stereotyped or repetitive motor movements, use of objects, or speech motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic.
  - Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small

- changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take the same route or eat the same food every day
- Highly restricted, fixated interests that are abnormal in intensity or focus  
strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests.
  - Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects.
- Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities.
  - Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
  - These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

### Signs and symptoms

The first symptoms of autism spectrum disorder frequently involve delayed language development, often accompanied by lack of social interest or unusual social interactions (e.g., pulling individuals by the hand without any attempt to look at them), odd play patterns (e.g., carrying toys around but never playing

with them), and unusual communication patterns (e.g., knowing the alphabet but not responding to own name). Deafness may be suspected but is typically ruled out. During the second year, odd and repetitive behaviors and the absence of typical play become more apparent. Since many typically developing young children have strong preferences and enjoy repetition (e.g., eating the same foods, watching the same video multiple times), distinguishing restricted and repetitive behaviors that are diagnostic of autism spectrum disorder can be difficult in preschoolers. The clinical distinction is based on the type, frequency, and intensity of the behavior (e.g., a child who daily lines up objects for hours and is very distressed if any item is moved). Autism spectrum disorder is not a degenerative disorder, and it is typical for learning and compensation to continue throughout life. Symptoms are often most marked in early childhood and early school years, with developmental gains typical in later childhood in at least some areas (e.g., increased interest in social interaction). A small proportion of individuals deteriorate behaviorally during adolescence, whereas most others improve. Only a minority of individuals with autism spectrum disorder live and work independently in adulthood; those who do tend to have superior language and intellectual abilities and are able to find a niche that matches their special interests and skills. In general, individuals with lower levels of impairment may be better able to function independently. However, even these individuals may remain socially naive and vulnerable, have difficulties organizing practical demands without aid, and are prone to anxiety and depression. Many adults report using compensation strategies and coping mechanisms to mask their difficulties in public but suffer from the stress and

effort of maintaining a socially acceptable facade. Scarcely anything is known about old age in autism spectrum disorder. Some individuals come for first diagnosis in adulthood, perhaps prompted by the diagnosis of autism in a child in the family or a breakdown of relations at work or home. Obtaining detailed developmental history in such cases may be difficult, and it is important to consider self-reported difficulties. Where clinical observation suggests criteria are currently met, autism spectrum disorder may be diagnosed, provided there is no evidence of good social and communication skills in childhood. For example, the report (by parents or another relative) that the individual had ordinary and sustained reciprocal friendships and good nonverbal communication skills throughout childhood would rule out a diagnosis of autism spectrum disorder; however, the absence of developmental information in itself should not do so. Manifestations of the social and communication impairments and restricted/repetitive behaviors that define autism spectrum disorder are clear in the developmental period. In later life, intervention or compensation, as well as current supports, may mask these difficulties in at least some contexts. However, symptoms remain sufficient to cause current impairment in social, occupational, or other important areas of functioning.

### **Risk factors**

**Environmental.** A variety of nonspecific risk factors, such as advanced parental age, low birth weight, or fetal exposure to valproate, may contribute to risk of autism spectrum disorder.

**Genetic and physiological.** Heritability estimates for autism spectrum disorder have ranged from 37% to higher than 90%, based on twin concordance rates.



Currently, as many as 15% of cases of autism spectrum disorder appear to be associated with a known genetic mutation, with different de novo copy number variants or de novo mutations in specific genes associated with the disorder in different families.

### Treatment modalities:

- **Behavior and communication therapies.** Many programs address the range of social, language and behavioral difficulties associated with autism spectrum disorder. Some programs focus on reducing problem behaviors and teaching new skills. Other programs focus on teaching children how to act in social situations or communicate better with others. Applied behavior analysis (ABA) can help children learn new skills and generalize these skills to multiple situations through a reward-based motivation system.
- **Educational therapies.** Children with autism spectrum disorder often respond well to highly structured educational programs. Successful programs typically include a team of specialists and a variety of activities to improve social skills, communication and behavior. Preschool children who receive intensive, individualized behavioral interventions often show good progress.
- **Family therapies.** Parents and other family members can learn how to play and interact with their children in ways that promote social interaction skills, manage problem behaviors, and teach daily living skills and communication.
- **Other therapies.** Depending on your child's needs, speech therapy to improve communication skills, occupational therapy to teach activities of

daily living, and physical therapy to improve movement and balance may be beneficial. A psychologist can recommend ways to address problem behavior.

- **Medications.** No medication can improve the core signs of autism spectrum disorder, but specific medications can help control symptoms. For example, certain medications may be prescribed if your child is hyperactive; antipsychotic drugs are sometimes used to treat severe behavioral problems; and antidepressants may be prescribed for anxiety. Keep all health care providers updated on any medications or supplements your child is taking. Some medications and supplements can interact, causing dangerous side effects.

## SUBSTANCE-RELATED DISORDERS

- Results from the abuse of drugs, side effects of medications or exposure to toxic substances.
- Many mental health professionals regard these disorders as behavioral or addictive disorders rather than as mental illnesses.
- Drug use can contribute to symptoms of other mental disorders such as depression, anxiety & psychosis.

### 1- ALCOHOLISM

A chronic & usually progressive illness involving the excessive consumption of alcoholic beverages. It is thought to arise from a combination of physiological, psychological, social & genetic factors. It is characterized by an emotional &

often physical drug dependence on alcohol & may lead to brain damage or early death.

### **Signs and symptoms**

- Placing excessive importance on the availability of alcohol.
- Ensuring this availability strongly influences the person's choice of associates or activities.
- Alcohol comes to be used more as a mood-changing drug than as a foodstuff or beverage served as a part of social custom or religious ritual.
- Initially, the alcoholic may demonstrate a high tolerance to alcohol, consuming more & showing less adverse effects than others.
- The person begins to drink against his or her own best interests, as alcohol comes to assume more importance than personal relationships, work, reputation or even physical health.

### **Alcoholism (treatment)**

- **Detoxification** is the medical management of delirium tremens (severe alcohol withdrawal symptoms).
  - The primary goal is sobriety which is to safely rid the patient's body of alcohol.
  - Patients undergoing detoxification which requires less than a week, usually stay in a specialized residential treatment facility or a separate unit within a general or psychiatric hospital.

- **Individual counseling & group therapy** which is aimed at complete & comfortable abstinence from alcohol & other mood-changing drugs of addiction.
  - Addiction to other drugs, particularly to tranquilizers & sedatives, poses a major hazard to alcoholics.
- **Alcoholics Anonymous (AA)**, a support group commonly used for those undergoing other treatment, in many cases helps alcoholics recover without the need to return to formal medical treatment.
  - While AA is generally recognized as an effective program for recovering alcoholics, not everyone responds to AA's style & message & other recovery approaches are available.
- **Drugs/Medications** may help some alcoholics remain alcohol-free.
  - When combined with alcohol, the drug disulfiram (Antabuse) causes unpleasant effects such as nausea, vomiting & throbbing headaches.
  - Naltrexone (ReVia) helps some alcoholics by lessening their cravings for alcohol.
  - Acamprosate also reduces an alcoholic's urge to drink.

## 2- DRUG DEPENDENCE

Psychological & physical state characterized by a compulsion to use a drug to experience psychological or physical effects.

### FORMS OF DRUG DEPENDENCE

- **Tolerance** occurs when the body becomes accustomed to a drug & requires ever-increasing amounts of it to achieve the same pharmacological effects.

This is worsened when certain drugs are used at high doses for long periods (weeks or months) & may lead to more frequent use of the drug.

- **Habituation** is a form of psychological dependence which is characterized by the continued desire for a drug, even after physical dependence is gone.
  - A drug often produces an elated emotional state & a person abusing drugs soon believes the drug is needed to function at work or home.
- **Addiction** is a severe craving for the substance & interferes with a person's ability to function normally.

### **CATEGORIES OF DRUGS OF ABUSE:**

- **Opiates** (heroin, dihydro-codeine, methadone, codeine)
- **Depressants** (barbiturates, alcohol)
- **Stimulants** (amphetamine, cocaine, ecstasy)
- **Hallucinogens** (LSD, PCP, mushrooms, ketamine)
- **Others** (cannabis, volatile substances, anabolic steroids)

#### **A. OPIATES/OPIOIDS**

Heroin is a preparation synthesized from morphine, which was introduced as a cough suppressant & non-addictive substitute for morphine.

#### **Signs & Symptoms of Abuse**

- Heroin produces a “rush” or “high” immediately after being taken.
- It produces a state of profound indifference & may increase energy.
- Opioids produce different effects under different circumstances.
- The drug user's past experience & expectations have some influence as to the administration of the drug (injection, ingestion or inhalation).

## **Withdrawal Symptoms from Opioids**

- Kicking movements in the legs
- Anxiety
- Insomnia
- Nausea & vomiting
- Sweating & fever
- Cramps
- Diarrhea

## **B. DEPRESSANTS OR SEDATIVE-HYPNOTICS**

- The drugs most commonly abused in this class are the barbiturates, which has been used to relieve anxiety & induce sleep.
- They are used medically in the treatment of epilepsy.
- Some people who abuse barbiturates ingest large amounts daily but never appear intoxicated.

## **Signs & Symptoms of Abuse**

- Barbiturates produce severe physical dependence, closely resembling the dependence & effects produced by alcohol.

## **Withdrawal Symptoms from Barbiturates**

- Shaking
- Insomnia
- Anxiety
- Convulsions & delirium

- Death can occur when use of barbiturates is suddenly discontinued.

### **DEPRESSANTS OR SEDATIVE HYPNOTICS**

- Barbiturates are particularly lethal when combined with alcohol.
- Toxic doses, which may be little more than what is required to produce intoxication, are often taken accidentally.

### **C. STIMULANTS**

#### **COCAINE**

- A white, crystalline powder with a bitter taste, is extracted from the leaves of the South American coca bush.
- It is used medically to produce anesthesia for surgery of the nose & throat & to constrict blood vessels & reduce bleeding during surgery.
- Abuse of cocaine can lead to severe physiological & psychological problems.
- A highly addictive, smokable form of cocaine called “crack” appeared in the 1980s.

#### **AMPHETAMINES**

Initially introduced for the treatment of colds & hay fever, were later found to affect the nervous system. People trying to lose weight commonly used them as appetite suppressants.

#### **Signs & Symptoms from Abuse**

- Heighten alertness
- Elevate mood

- Decrease fatigue & the need for sleep
- Make users irritable & talkative
- After prolonged daily use, can produce psychosis similar to schizophrenia.

#### **D. HALLUCINOGENS**

These drugs are not used medically in the United States except occasionally in the treatment of dying patients, the mentally ill, drug abusers & alcoholics.

##### **LSD (LYSERGIC ACID DIETHYLAMIDE):**

- Widely abused during the 1960s which is derived from peyote cactus.
- Tolerance to these drugs develops rapidly but no withdrawal syndrome is apparent when they are discontinued.

##### **PCP (PHENCYCLIDINE):**

- Known popularly as “angel dust” & “rocket fuel”, has no medical purpose for humans but is occasionally used by veterinarians as an anesthetic & sedative for animals.
- It became a common drug of abuse in the late 1970s & is considered a menace because it can easily be synthesized.

##### **Signs & Symptoms from Abuse**

- Produces detachment & euphoria
- Intensifies vision
- Crossing of senses (colors are heard, sounds are seen)
- Reduction in pain sensitivity



## Signs & Symptoms from Abuse

- May trigger or produce symptoms so like those of acute schizophrenia that professionals confuse the two states.
- Bizarre thinking
- Violently destructive behavior

### E. Others

#### 1. CANNABIS

- The plant Cannabis sativa is the source of both marijuana & hashish.
- The leaves, flowers & twigs of the plant are crushed to produce marijuana, its concentrated resin is hashish.
- Both drugs are usually smoked.

## Signs & Symptoms from Abuse

- State of relaxation
- Accelerated heart rate
- Perceived slowing of time
- Sense of heightened hearing, taste, touch & smell.
- Alters thinking & interferes with learning.
- Interferes with psychological & physical maturation.

#### 2. INHALANTS

This class includes substances that are usually not considered drugs such as glue, gasoline & aerosols like nasal sprays. Most of these substances are sniffed for their psychological effects, depress the CNS.

### **Signs & Symptoms from Abuse**

- Headache
- Nausea
- Drowsiness
- Impairs vision, judgment, muscle & reflex control.
- Permanent damage & death can result from sniffing highly concentrated aerosol sprays.

### **3. CAFFEINE**

An alkaloid found in coffee, tea, cacao & some other plants. It is also present in.

#### **NICOTINE:**

- An oily, liquid substance found in tobacco leaves that acts as stimulant & also contributes to smoking addiction.
- When extracted from the leaves, nicotine is colorless, but quickly turns brown when exposed to air.
- It has an acrid, burning taste. Most cola beverages.

### **Signs & Symptoms from Abuse**

- Promotes the flow of adrenaline
- Speeds up heartbeat & causes it to become irregular.
- Increases blood pressure
- Reduces appetite
- Causes nausea & vomiting

## PLANNING TREATMENT IN DRUG MISUSE

- **Make diagnosis.** Confirm drug use & assess presence & extent of dependence.
- **Consider need for emergency treatment.** Where there is evidence of psychotic illness or severe depressive illness the patient may require in-patient assessment.
- **Engage in service.** Treatment of drug misuse cannot be carried out through “one-off” interventions.
- **Address other needs.** The drug treatment service should consider part of its role as being a gateway to other services which the drug user may require but reluctant or unable to approach independently.

## Depression Disorder

### Definition

Depression is defined as an alteration in mood that is expressed by feelings of sadness, despair, and pessimism. There is a loss of interest in usual activities, and somatic symptoms may be evident. Changes in appetite and sleep patterns are common. Depression is likely the oldest and still one of the most frequently diagnosed psychiatric illnesses. It is so common in our society as to sometimes be called “the common cold of psychiatric disorders.”

### Onset and Clinical Course

An untreated episode of depression can last from a few weeks to months or even years, though most episodes clear in about 6 months. Some people have a single episode of depression, while 50% to 60% will have a recurrence of

depression. Approximately 20% will develop a chronic form of depression. Depressive symptoms can vary from mild to severe. The degree of depression is comparable with the person's sense of helplessness and hopelessness. Some people with severe depression (about 20%) have psychotic features .

## Types Of Depressive Disorders

### 1- Disruptive Mood Dysregulation Disorder

This disorder is characterized by chronic, severe, and persistent irritability. Clinical manifestations include frequent, developmentally inappropriate temper outbursts and persistently angry mood that is present between the severe temper outbursts. The behavior has been present for 12 or more months and occurs in more than one setting. The onset of the disorder occurs before age 10 years, but the diagnosis is not applied to children younger than 6 years.

### 2- Major Depressive Disorder

Described as a disturbance of mood involving depression or loss of interest or pleasure in usual activities and pastimes. There is evidence of interference in social and occupational functioning for at least 2 weeks. The diagnosis of MDD is specified according to whether it is a single episode or. The diagnosis will also identify the degree of severity of symptoms (mild, moderate, or severe) and whether the disorder is in partial or full remission.

Additionally, the following specifiers may be used to further describe the depressive episode:

- **With Anxious Distress:** Feelings of restlessness, anxiety, and worry accompany the depressed mood.

- **With Mixed Features:** The depression is accompanied by intermittent symptoms of mania or hypomania.
- **With Melancholic Features:** The depressed mood is characterized by profound despondency and despair. There is an absence of the ability to experience pleasure and expression of feelings of excessive or inappropriate guilt. Psychomotor agitation or retardation and anorexia or weight loss are evident.
- **With Atypical Features:** Includes the ability for cheerful mood when presented with positive events. There may be increased appetite or weight gain and hypersomnia. Additional symptoms include long-standing sensitivity to interpersonal rejection and heavy, leaden feelings in the arms or legs.
- **With Psychotic Features:** Depressive symptoms include the presence of delusions and/or hallucinations.
- **With Catatonia:** Depressive symptoms are accompanied by additional symptoms associated with catatonia (e.g., stupor, waxy flexibility, mutism, posturing) .
- **With Peripartum Onset:** This specifier is used when symptoms of major depressive disorder occur during pregnancy or in the 4 weeks following delivery.
- **With Seasonal Pattern:** This diagnosis indicates the presence of depressive episodes that occur at characteristic times of the year. Commonly, the episodes occur during the fall or winter months, and remit in the spring. Less commonly, there may be recurrent summer depressive episodes.

### **3- Persistent Depressive Disorder (Dysthymia)**

Is a mood disturbance with characteristics similar to, if somewhat milder than, those ascribed to major depressive disorder. There is no evidence of psychotic symptoms. The essential feature of the disorder is “a depressed mood that occurs for most of the day, for more days than not, for at least 2 years, or at least 1 year in children and adolescents” .Intermittent symptoms of MDD may or may not occur with this disorder. The same diagnostic specifiers described for MDD may also apply to persistent depressive disorder.

### **4- Premenstrual Dysphoric Disorder**

The essential features of premenstrual dysphoric disorder include markedly depressed mood, excessive anxiety, mood swings, and decreased interest in activities during the week prior to menses, improving shortly after the onset of menstruation, and becoming minimal or absent in the week post menses.

### **5- Substance/Medication-Induced Depressive Disorder**

The depressed mood associated with this disorder is considered to be the direct result of the physiological effects of a substance (e.g., a drug of abuse, a medication, or toxin exposure) and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

### **6- Depressive Disorder Due to Another Medical Condition**

This disorder is characterized by symptoms associated with a major depressive episode that are the direct physiological consequence of another medical condition. The depression causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

## DSM5 Diagnostic Criteria / Major Depression Disorder

- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- Note: Do not include symptoms that are clearly attributable to another medical condition.
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents can be irritable mood).
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
  - Significant weight loss when not dieting or weight gain (e.g., a change of > 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain)
  - Insomnia or hypersomnia nearly every day.
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
  - Fatigue or loss of energy nearly every day.

- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - The episode is not attributable to the physiological effects of a substance or to another medical condition.
  - Note: Criteria A to C represent a major depressive episode.
  - Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.



- The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- There has never been a manic episode or a hypomanic episode.
- Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition.

### Symptomatology (Subjective and Objective Data)

- The effect of a depressed person is one of sadness, dejection, helplessness, and hopelessness. The outlook is gloomy and pessimistic. A feeling of worthlessness prevails.
- Thoughts are slowed and concentration is difficult. Obsessive ideas and rumination of negative thoughts are common. In severe depression, psychotic features such as hallucinations and delusions may be evident
- Physically, there is evidence of weakness and fatigue—very little energy to carry on activities of daily living (ADLs). The individual may express an exaggerated concern over bodily functioning, seemingly experiencing heightened sensitivity to somatic sensations.
- Some individuals may be inclined toward excessive eating and drinking, whereas others may experience anorexia and weight loss.
- Sleep disturbances are common, either insomnia or hypersomnia.

- At the less severe level (dysthymia), individuals tend to feel their best early in the morning, then continually feel worse as the day progresses. The opposite is true of persons experiencing severe depression.
- A general slowdown of motor activity commonly accompanies depression (called psychomotor retardation). At the severe level, energy is depleted, movements are lethargic, and performance of daily activities is extremely difficult. Conversely, severely depressed persons may manifest psychomotor activity through symptoms of agitation.
- Verbalizations are limited. When depressed persons do speak, the content may be either ruminations regarding their own life regrets or, in psychotic clients, a reflection of their delusional thinking.
- Social participation is diminished. The depressed client has an inclination toward egocentrism and narcissism—an intense focus on the self. This discourages others from pursuing a relationship with the individual, which increases his or her feelings of worthlessness and penchant for isolation.

#### Predisposing Factors to Depressive Disorders: Table 2.4.

<p><b>Physiological Factor</b></p>	<p><b>Genetics</b></p>	<p>Numerous studies have been conducted that support the involvement of heredity in depressive illness. First-degree relatives of individuals with MDD have a two to fourfold higher risk for the disorder than that of the general population.</p>
------------------------------------	------------------------	---

	<b>Biochemical</b>	A biochemical theory implicates the biogenic amines norepinephrine, dopamine, and serotonin. The levels of these chemicals have been found to be deficient in individuals with depressive illness.
	<b>Neuroendocrine Disturbances</b>	Elevated levels of serum cortisol and decreased levels of thyroid stimulating hormone have been associated with depressed mood in some individuals.
	<b>Substance Intoxication and Withdrawal</b>	Depressed mood may be associated with intoxication or withdrawal from substances such as alcohol, amphetamines, cocaine, hallucinogens, opioids, phencyclidine-like substances, sedatives, hypnotics, or anxiolytics.
	<b>Medication Side Effects</b>	A number of drugs can produce a depressive syndrome as a side effect. Common ones include anxiolytics, antipsychotics, and sedative-hypnotics. Anti hypertensive medications such as propranolol and reserpine have been known

		to produce depressive symptoms.
	<b>Other Physiological Conditions</b>	Depressive symptoms may occur in the presence of electrolyte disturbances, hormonal disturbances, nutritional deficiencies, and with certain physical disorders, such as cardiovascular accident, hepatitis, and diabetes mellitus.
<b>Psychosocial</b>	<b>Psychoanalytical Theory</b>	Freud observed that melancholia occurs after the loss of a loved object, either actually by death or emotionally by rejection, or the loss of some other abstraction of value to the individual. Freud indicated that in clients with melancholia, the depressed person's rage is internally directed because of identification with the lost object.
	<b>Cognitive Theory</b>	Beck and colleagues (1979) proposed that depressive illness occurs as a result of impaired cognition. Disturbed thought processes foster a negative

		evaluation of self by the individual. The perceptions are of inadequacy and worthlessness. Outlook for the future is one of pessimism and hopelessness.
	<b>Learning Theory</b>	The learning theory proposes that depressive illness is predisposed by the individual's belief that there is a lack of control over his or her life situation. It is thought that this belief arises out of experiences that result in failure (either perceived or real). Following numerous failures, the individual feels helpless to succeed at any endeavor and therefore gives up trying. This "learned helplessness" is viewed as a predisposition to depressive illness.
	<b>Object Loss Theory</b>	The theory of object loss suggests that depressive illness occurs as a result of having been abandoned by, or otherwise separated from, a significant other during the first 6 months of

		<p>life. Because during this period the mother represents the child's main source of security, she is the "object." The response occurs not only with a physical loss. This absence of attachment, which may be either physical or emotional, leads to feelings of helplessness and despair that contribute to lifelong patterns of depression in response to loss.</p>
--	--	---

## Treatment Modalities

- **Psychopharmacology**

- Selective Serotonin Reuptake Inhibitors (SSRI):
  - The most frequently prescribed category of antidepressants, are effective for most clients. Their action is specific to serotonin reuptake inhibition; these drugs produce few sedating, anticholinergic, and cardiovascular side effects, which make them safer for use in older adults.
- Atypical Antidepressants:
  - Atypical antidepressants are used when the client has an inadequate response to or side effects from SSRIs. Atypical antidepressants include venlafaxine (Effexor), duloxetine (Cymbalta), bupropion

- (Wellbutrin), nefazodone (Serzone), mirtazapine (Remeron), and vilazodone (Viibryd).
- Tricyclic Antidepressants,
    - Tricyclics are the oldest antidepressants. They relieve symptoms of hopelessness, helplessness, anhedonia, inappropriate guilt, suicidal ideation, and daily mood variations. Each drug has a different degree of efficacy in blocking the activity of norepinephrine and serotonin or increasing the sensitivity of postsynaptic receptor sites. Tricyclic (and also heterocyclic) antidepressants have a lag period of 10 to 14 days before reaching a serum level that begins to alter symptoms; they take 6 weeks to reach full effect. Because they have a long serum half-life, there is a lag period of 1 to 4 weeks before steady plasma levels are reached and the client's symptoms begin to decrease. Tricyclic antidepressants are contraindicated in severe impairment of liver function and in myocardial infarction (acute recovery phase). They cannot be given concurrently with MAOIs. Because of their anticholinergic side effects, tricyclic antidepressants must be used cautiously in clients who have glaucoma, benign prostatic hypertrophy, urinary retention or obstruction, diabetes mellitus, hyperthyroidism, cardiovascular disease, renal impairment, or respiratory disorders.
  - Monoamine Oxidase Inhibitors (MAOIs):
    - MAOIs have been used infrequently because of potentially fatal side effects and interactions with numerous drugs, both prescription and

over-the-counter preparations. However, they may be superior to typical medications for treatment of typical and treatment-resistant depression. The most serious side effect is hypertensive crisis, a life-threatening condition that can result when a client taking MAOIs ingests tyramine containing foods and fluids or other medications. The MAOI–tyramine interaction produces symptoms within 20 to 60 minutes after ingestion. For hypertensive crisis, transient antihypertensive agents, such as phentolamine mesylate, are given to dilate blood vessels and decrease vascular resistance.

- **Other Medical Treatments and Psychotherapy**

- Electroconvulsive Therapy:

- Psychiatrists may use electroconvulsive therapy (ECT) to treat depression in select groups, such as clients who do not respond to antidepressants or those who experience intolerable side effects at therapeutic doses (particularly true for older adults). In addition, pregnant women can safely have ECT while many medications are not safe for use during pregnancy. Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication. It has also shown a high degree of efficacy for patients with psychotic features and marked psychomotor disturbances. Clients usually receive a series of six to 15 treatments scheduled three times a week. Generally, a minimum of six treatments are needed to see sustained improvement in depressive symptoms. Maximum benefit is achieved in 12 to 15 treatment.



- Psychotherapy:
  - A combination of psychotherapy and medications is considered the most effective treatment for depressive disorders in both children and adults . There is no one specific type of therapy that is better for the treatment of depression. The goals of combined therapy are symptom remission, psychosocial restoration, prevention of relapse or recurrence, reduced secondary consequences such as marital discord or occupational difficulties, and increasing treatment compliance . Interpersonal therapy focuses on difficulties in relationships, such as grief reactions, role disputes, and role transitions , Interpersonal therapy help the person find ways to accomplish this developmental task .Behavior therapy seeks to increase the frequency of the client’s positively reinforcing interactions with the environment and to decrease negative interactions. It may also focus on improving social skills. Cognitive therapy focuses on how the person thinks about the self, others, and the future and interprets his or her experiences. This model focuses on the person’s distorted thinking, which, in turn, influences feelings, behavior, and functional abilities .
- New and Investigational Treatments:
  - These include transcranial magnetic stimulation (TMS), magnetic seizure therapy, deep brain stimulation, and vagal nerve stimulation. TMS is a U.S. Food and Drug Administration–approved treatment for major depression in treatment-resistant clients. When used as an adjunct to antidepressant medications, TMS was found to be safe and

effective. When used alone, TMS is most effective for mild or moderate depression .

## Attention-Deficit/Hyperactivity Disorder (ADHD)

### Definition

Attention-Deficit/Hyperactivity Disorder (ADHD) is a chronic neurobehavioral disorder and often associated with serious areas of impairment and comorbidities over a life span.

### Classification according to ICD10

ICD-10-CM classification for ADHD include:

- Attention-deficit hyperactivity disorder, predominantly inattentive type
- Attention-deficit hyperactivity disorder, predominantly hyperactive type
- Attention-deficit hyperactivity disorder, combined type
- Attention-deficit hyperactivity disorder, other type
- Attention-deficit hyperactivity disorder, unspecified type

### Risk factors

- Blood relatives, such as a parent or sibling, with ADHD or another mental health disorder.
- Exposure to environmental toxins — such as lead, found mainly in paint and pipes in older buildings.
- Maternal drug use, alcohol use or smoking during pregnancy.
- Premature birth.

## Diagnostic criteria according to DCM5

- There are three possible types of ADHD with their own specific symptoms. To receive any diagnosis of ADHD, you must have:
  - Persistent symptoms for  $\geq 6$  months in  $\geq 2$  settings (e.g., school, home, church)
  - Several symptoms of ADHD present prior to age 12
  - Symptoms that are not better accounted for by a different psychiatric disorder (e.g., anxiety) and do not occur exclusively during a psychotic disorder (e.g., schizophrenia)
  - Several symptoms that significantly disrupt your functioning at work/school, with family, or socially
- The three different types of ADHD include:
  - Predominantly inattentive type
  - Hyperactive-impulsive type; and
  - Combined type
- Your type of ADHD is then determined based on your most predominant symptoms.

## Criteria for predominantly inattentive ADHD

In order to be diagnosed with ADHD predominantly inattentive type you must meet five or more of the following symptoms if you are an adult ( $\geq 17$  years) and six or more symptoms if you are a child ( $< 17$  years):

- **Carelessness/poor attention to detail:** Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate)
- **Diminished attention span:** Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading)
- **Poor listening skills:** Often does not seem to listen when spoken to directly (e.g., the mind seems elsewhere, even in the absence of any obvious distraction)
- **Lacks follow-through:** Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)
- **Disorganized:** Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines)
- **Avoids tasks requiring concentration:** Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., preparing reports, completing forms, reviewing lengthy papers)
- **Loses things:** Often loses things necessary for tasks or activities (e.g., wallets, keys, paperwork, eyeglasses, phones)
- **Easily distracted:** Is often easily distracted by things in the environment or unrelated thoughts.

- **Forgetful:** Is often forgetful in daily activities (e.g., doing chores, running errands, returning calls, paying bills, keeping appointments)

### Criteria for hyperactive-impulsive ADHD

In order to be diagnosed with ADHD predominately hyperactive-impulsive type you must meet five or more of the following symptoms if you are an adult ( $\geq 17$  years) and six or more symptoms if you are a child ( $< 17$  years):

- **Fidgets a lot:** Often fidgets with or taps hands or feet, may squirm when seated.
- **Trouble staying still:** Often leaves seat in situations when remaining seated is expected (e.g., in the office, or during movies)
- **Restlessness:** Desire to move about when it's inappropriate or consistent feelings of restlessness that are difficult to control
- **Trouble keeping quiet:** Often unable to engage in leisure activities quietly. May engage in self-talk or struggle to keep from interjecting or pivoting to more "exciting" activities
- **Very much "on the go":** Acting as if "driven by a motor." Uncomfortable being still for an extended time, as in restaurants or meetings and people may find it hard to keep up with you
- **Often talks excessively:** Excessively chatty, sometimes unaware of the effect it has on others.
- **Impulsively blurting things out:** Often blurts out an answer before a question has been completed, completes people's sentences, or cannot wait to speak in a conversation

- **Trouble waiting your turn:** Often has difficulty waiting your turn, such as waiting in line.
- **Interrupts/Intrudes:** Often interrupts or intrudes on others. You may take over activities without being invited, butt into conversations, or start using other people's things without asking or receiving permission.

### Criteria for ADHD combined type

When a person meets the criteria for both types of ADHD they are diagnosed with a combined type. In many cases, a person may have symptoms from both categories but only meet the criteria for one type. This is a pretty normal presentation and doesn't impact your treatment plan.

### Other considerations when getting diagnosed with ADHD

In addition to determining the type of ADHD, clinician may also give a rating based on the status of the condition (is it active or in remission) and the severity.

### Status of ADHD

If the person previously met the criteria for ADHD but are currently experiencing fewer symptoms, he/she may get labeled as in partial remission. In this case, he/she still has impairments but don't meet enough symptoms to have a full diagnosis. Oftentimes, people who are receiving effective treatment may fall into this category.

### Severity of ADHD

Clinician may also give a rating of severity based on the symptoms, may be rated as:

- **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in only minor functional impairments.
- **Moderate:** Symptoms or functional impairment between “mild” and “severe” are present.
- **Severe:** Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

### Potential signs and symptoms

Inattentiveness (difficulty concentrating and focusing)

The main signs of inattentiveness are:

- having a short attention span and being easily distracted
- making careless mistakes – for example, in schoolwork
- appearing forgetful or losing things
- being unable to stick to tasks that are tedious or time-consuming
- appearing to be unable to listen to or carry out instructions
- constantly changing activity or task
- having difficulty organizing tasks
- Hyperactivity and impulsiveness

The main signs of hyperactivity and impulsiveness are:

- being unable to sit still, especially in calm or quiet surroundings
- constantly fidgeting

- being unable to concentrate on tasks
- excessive physical movement
- excessive talking
- being unable to wait their turn
- acting without thinking
- interrupting conversations
- little or no sense of danger

### Treatment modalities

ADHD includes a multifaceted treatment and the focus is on reducing ADHD symptoms and improving functioning. Effective treatment examples include long-term medication therapy, academic intervention, and cognitive behavioral therapy. Medication (stimulant and non-stimulant) often provides the first line of treatment for many individuals with ADHD, but not all.

### ADHD Therapy #1: Behavioral Therapy for Children

Behavioral therapy addresses problem behaviors common among children with ADHD by structuring time at home, establishing predictability and routines, and increasing positive attention. A good behavioral therapy plan begins with common-sense parenting.

ADHD behavioral therapy plans should do the following:

- Reinforce good behavior with a reward system.
- Discourage negative behavior by ignoring it.
- Take away a privilege if the negative behavior is too serious to ignore.
- Remove common triggers of bad behavior.



## ADHD Therapy #2: Cognitive Behavioral Therapy for Adults

An effective CBT program will help adults with ADHD correct the following distorted thought processes and more:

- **All-or-nothing thinking** — **viewing** everything as entirely good or entirely bad: If you don't do something perfectly, you've failed.
- **Overgeneralization** — **seeing** a single negative event as part of a pattern: For example, you always forget to pay your bills.
- **Mind reading** — thinking you know what people think about you or something you've done — and it's bad.
- **Fortune telling** — forecasting that things will turn out badly.
- **Magnification and minimization** — exaggerating the significance of minor problems while trivializing your accomplishments.
- **"Should" statements** — focusing on how things should be, leading to severe self-criticism as well as feelings of resentment toward others.
- **Comparative thinking** — measuring yourself against others and feeling inferior, even though the comparison may be unrealistic.

## ADHD Therapy #3: Dialectical Behavior Therapy for Adults

Dialectical Behavioral Therapy (DBT), like CBT, focuses on the social and emotional challenges associated with ADHD and other neuro-psychological disorders. DBT was initially designed to treat the harmful behaviors of patients diagnosed with borderline personality disorder (BPD). It is now one of the most successful treatments for improving emotional regulation skills. DBT is taught in a series of skill-based modules in weekly group sessions — each one focused on

a particular skill. Individual therapists provide additional support to personalize the use of these skills in life situations.

#### **ADHD Therapy #4: ADHD Coaching**

ADHD coaches help children, teens, and adults with ADHD organize and take charge of their lives. More specifically, coaches can help their clients achieve emotional/intellectual growth, strong social skills, effective learning strategies, compelling career and business exploration, and thoughtful financial planning.

A professionally trained ADHD coach can realistically assist his or her ADHD clients in building skills like:

- Time, task, and space management
- Motivation and follow-through
- Developing systems for success
- Healthy communications and relationships
- Strategic planning and perspective
- Making conscious & wise choices
- A simplified and more orderly life
- Achieving a balanced, healthy lifestyle

#### **ADHD Therapy #5: Brain Training or Neurofeedback**

Neurofeedback uses brain exercises to reduce impulsivity and increase attentiveness in children and adults with ADHD. By training the brain to emit brain-wave patterns associated with focus.

### **ADHD Therapy #6: Play Therapy**

Play therapy is used to help children with ADHD connect, learn, provide reassurance, calm anxiety, and improve self-esteem. Play is an indirect way for therapists to recast children's perceptions, cognitions, and behaviors.

### **ADHD Therapy #7: Music Therapy**

For patients with ADHD, music therapy bolsters attention and focus, reduces hyperactivity, and strengthens social skills.

### **ADHD Therapy #8: Art Therapy**

Art therapy helps children and adults with ADHD and other neuropsychological disorders who communicate their thoughts more easily through visual images and art making than they do with written or spoken words. Art therapy can be especially effective for active, busy children with ADHD, as it keeps their hands moving and triggers an acute mental and emotional focus not always achieved in talk therapy.

Children with ADHD use art therapy because the processes of drawing, painting, and sculpting can help address emotional problems, develop interpersonal skills, manage behavior, reduce stress, and increase self-awareness. Through art therapy, children with ADHD can build mental flexibility, problem-solving skills, and communication skills as they explain what they made to a parent or friend. Art also allows for organic moments of positive social interactions, like sharing materials, making compliments, or even making suggestions.

## Social communication disorder (SCD)

### Definition

Social communication disorder (SCD) is a neurodevelopmental condition that leads to difficulty speaking in social settings. SCD typically appears during early child development.

It is listed under the rubric of communication disorders within the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) and it is reported to be characterized **by impairment in use of verbal and nonverbal communication for social aims.**

It is often confused with autism spectrum disorder (ASD) because of similar traits, making diagnoses tricky. To get an accurate diagnosis, doctors must eliminate the possibility of ASD and vice versa.

### Classification according to ICD10

Social (pragmatic) communication disorder is part of a cluster of diagnoses called communication disorders. Communication disorders are a group of psychiatric conditions that include:

- Language Disorder
- Speech Sound Disorder
- Childhood-onset Fluency Disorder (Stuttering)
- Social (Pragmatic) Communication Disorder

### Risk factors

Although the cause of social communication disorder is currently unknown, the risk is higher if there is a family history of autism, other communication

disorders, or specific learning disabilities. SCD can occur alone or along with conditions including:

- Language disorders
- Speech sound disorders
- Childhood-onset fluency disorders (stuttering)
- Unspecified communication disorders

### Diagnostic criteria according to DSM5

The DSM-5 lists the diagnostic criteria Trusted Source for SCD, noting that a person must have all of the following symptoms:

- Difficulties in social contexts with verbal and nonspeaking communication: These difficulties include:
  - Trouble matching communication to the context
  - Issues with understanding the rules of conversation
  - Difficulty understanding communication that is not literal and explicit
- Limitations in communication: A person's communication and social skills challenges affect their life in meaningful ways, such as by undermining communication, social relationships, or academic performance.
- Symptoms must appear early in development: However, they might not become evident until the child reaches an age where the expected level of social communication exceeds their abilities.
- No other diagnosis: Another diagnosis, such as autism or an intellectual disability, does not better explain the symptoms.

A person will also only receive a diagnosis of SCD if they have the ability to speak and understand language. Children who never do either may need a different diagnosis. Consequently, most children get their diagnosis close to the age of 4 or 5 years Trusted Source rather than as an infant or a toddler.

### Potential signs and symptoms

Social communication disorder causes individuals to struggle with changing their communication style to fit different scenarios. They may develop a vocabulary, understand grammar and individual words but aren't aware of pragmatic language.

SCD can impact speaking, writing, gestures and sign language. Signs of SCD include:

- Difficulty recognizing when and how to change tone or communication styles. For example, speaking differently on the playground versus the classroom.
- Trouble sharing information, initiating conversations, greeting people and engaging in conversation.
- Constantly interrupting and struggling to adhere to conversation etiquette such as providing more details or interpreting verbal and nonverbal cues.
- Issues understanding implied communication such as humor, sarcasm or metaphors.
- Poor eye contact
- Difficult expressing and understanding the feelings of others

## Treatment modalities

There are a variety of treatments that parents, teachers, and doctors can do, but speech-language therapy is the primary treatment. Experts use various methods that work on conversation skills through one-on-one or small group activities.

Treatment methods for SCD:

- Organize structured playdates: Invite a friend over and monitor the interaction while your child does a structured activity. As the skills in this area grow, you can try new locations.
- Read books: While reading, hypothesize what the characters may be thinking and why, and ask open-ended questions about the book.
- Play games: Playing teaches boundaries and how to wait your turn. During the game, ask open-ended questions and promote conversation.
- Speech pragmatic training: This practice teaches the meaning of idioms and the appropriate use of greetings.
- Create social scripts: These scripted prompts show people how to use language during certain social situations.
- Stories: Media like books and anecdotal stories can play a key role in explaining social situations, promoting problem-solving and teaching responses that fit social situations
- Have visual aids: At times when they may not be able to verbalize how they feel, those with SCD may be able to communicate using pictures, toys or props.

## References:

1. Alilyyani, B., Kerr, M. S., Wong, C., & Wazqar, D. Y. (2021). An integrative review of nursing leadership in Saudi Arabia. *Nursing Open*, 9(1), 140–155. <https://doi.org/10.1002/nop2.1117>
2. Chesterton, L., Tetley, J., Cox, N., & Jack, K. (2020). A hermeneutical study of professional accountability in nursing. *Journal of Clinical Nursing*, 30(1-2), 188–199. <https://doi.org/10.1111/jocn.15539>
3. Chien L. Y. (2019). Evidence-Based Practice and Nursing Research. *The journal of nursing research: JNR*, 27(4), e29. <https://doi.org/10.1097/jnr.0000000000000346>
4. Manderius, C., Clintståhl, K., Sjöström, K., & Örmon, K. (2023). The Psychiatric Mental Health Nurse's ethical considerations regarding the use of coercive measures – a qualitative interview study. *BMC Nursing*, 22(1). <https://doi.org/10.1186/s12912-023-01186-z>
5. Moreno-Poyato, A. R., Delgado-Hito, P., Leyva-Moral, J. M., Casanova-Garrigós, G., & Montesó-Curto, P. (2019). Implementing evidence-based practices on the therapeutic relationship in inpatient psychiatric care: A participatory action research. *Journal of clinical nursing*, 28(9-10), 1614–1622. <https://doi.org/10.1111/jocn.14759>
6. Ministry of Health,(2023). Procedure Manual for Psychological Service Departments, Kingdome of Saudi Arabia. <https://www.moh.gov.sa/Ministry/MediaCenter/Publications/Pages/Policies-Procedures-Psychological-Service.pdf>
7. Reshetnikov, V. A., Tvorogova, N. D., Hersonskiy, I. I., Sokolov, N. A., Petrunin, A. D., & Drobyshev, D. A. (2020). Leadership and Emotional Intelligence: Current Trends in Public Health Professionals Training. *Frontiers in public health*, 7, 413. <https://doi.org/10.3389/fpubh.2019.00413>
8. American Psychiatric Nurses Association. (2014). Standards of practice: seclusion and restraint.



9. Ackley, B. J., Ladwig, G. B., Makic, M. B. F., Martinez-Kratz, M. R., & Zanotti, M. (2019). Nursing diagnosis handbook E-book: An evidence-based guide to planning care. Elsevier Health Sciences.
10. Herdman, T. H., Kamitsuru, S., & Lopes, C. (Eds.). (2021). NANDA International nursing diagnoses: Definitions & classification, 2021-2023. Georg Thieme Verlag.
11. Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2016). Nursing diagnosis manual: Planning, individualizing, and documenting client care. FA Davis.
12. Townsend, M. C., & Morgan, K. I. (2017). Psychiatric mental health nursing: Concepts of care in evidence-based practice. FA Davis.
13. Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2019). Nurse's pocket guide: Diagnoses, prioritized interventions, and rationales. Philadelphia: F.A. Davis.
14. American Nurses Association. (2019). Nursing care of schizophrenia patients. Silver Spring, MD: Author.
15. International Society of Psychiatric-Mental Health Nurses. (2018). Schizophrenia nursing care guidelines. Journal of the American Psychiatric Nurses Association, 24(1), 65-71.
16. American Psychiatric Association. (2020). Guideline for the treatment of schizophrenia. Arlington, VA: Author.
17. Alzheimer's Association. (2018). Managing behavioral symptoms in dementia. Chicago, IL: Author.
18. American Nurses Association. (2018). Nursing guidelines for managing agitation in older adults with dementia. Silver Spring, MD: Author.
19. British Geriatrics Society. (2018). Guidelines for the care of patients with behavioral and psychological symptoms of dementia. London, UK: Author.
20. American Nurses Association. (2019). Restraint and seclusion: Resource document. Silver Spring, MD: Author.
21. Mental Health Commission of Canada. (2018). Guideline for the prevention and management of the use of restraint and seclusion in mental health settings. Ottawa, ON: Author.

22. National Alliance on Mental Illness. (2017). Restraint and seclusion: A guide for mental health professionals. Arlington, VA: Author.
23. American Nurses Association. (2018). Nursing care of patients with substance use disorders. Silver Spring, MD: Author.
24. International Nurses Society on Addictions. (2019). Substance abuse nursing care guidelines. *Journal of Addictions Nursing*, 30(2), 77-83.
25. American College of Emergency Physicians. (2018). Guidelines for the management of intoxicated patients in the emergency department. Dallas, TX: Author.
26. American Nurses Association. (2018). Nursing management of patients with alcohol withdrawal syndrome. Silver Spring, MD: Author.
27. Substance Abuse and Mental Health Services Administration. (2015). Withdrawal management guidelines. Rockville, MD: Author.
28. American Society of Addiction Medicine. (2015). Guidelines for the management of opioid withdrawal. Chevy Chase, MD: Author.

يسعدنا استقبال ملاحظاتكم ومقترحاتكم  
لتحسين الخدمات العلاجية والتأهيلية من قبل  
تمريض الصحة النفسية عبر الإيميل

[dms@mo.gov.sa](mailto:dms@mo.gov.sa)

