

# NCLEX MASTERS



## Test Taking Strategies Psych Basics to Pass the Nclex

English Version e2

**Psychiatric Nursing**

**Nclex Masters 2008**

# Psychiatric Nursing

## Intervention of Psychiatric Patients

The ***Diagnostic and Statistical Manual of Mental Disorders (DSM)*** is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. It is used in the United States and in varying degrees around the world, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies and policy makers.

The DSM has attracted controversy and criticism as well as praise. There have been five revisions since it was first published in 1952, gradually including more disorders. It initially evolved out of systems for collecting census and psychiatric hospital statistics, and from a manual developed by the US Army.

The last major revision was the DSM-IV published in 1994, although a "text revision" was produced in 2000.

The DSM-V is currently in consultation, planning and preparation, due for publication in May 2012.<sup>[1]</sup> An early draft will be released for comment in 2009. The mental disorders section of the International Statistical Classification of Diseases and Related Health Problems (ICD) is another commonly-used guide, used more often in some parts of the world. The two classifications have developed alongside each other and use the same diagnostic codes.

### ***The current DSM***

#### **Categorization**

The DSM-IV is a categorical classification system. The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder. DSM-IV states that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries..." but isolated, low-grade and noncriterion (unlisted for a given disorder) symptoms are not given importance.

Qualifiers are sometimes used, for example mild, moderate or severe forms of a disorder.

For nearly half the disorders, symptoms must be sufficient to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning", although DSM-IV-TR removed the distress criterion from tic disorders and several of the paraphilias.

Each category of disorder has a numeric code taken from the ICD coding system, used for health service (including insurance) administrative purposes.

**The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:**

- **Axis I:** clinical disorders, including major mental disorders, as well as developmental and learning disorders
- **Axis II:** underlying pervasive or personality conditions, as well as mental retardation
- **Axis III:** Acute medical conditions and physical disorders.
- **Axis IV:** psychosocial and environmental factors contributing to the disorder
- **Axis V:** Global Assessment of Functioning or Children's Global Assessment Scale for children under the age of 18. (on a scale from 100 to 1)

## The Multiplex Axis System

**Common Axis I disorders** include depression, anxiety disorders, bipolar disorder, ADHD, phobias, and schizophrenia.

**Common Axis II disorders** include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and mental retardation.

**Common Axis III disorders** include brain injuries and other medical/physical disorders which may aggravate existing diseases or present symptoms similar to other disorders.

### Cautions

The DSM-IV-TR states that, because it is produced for the completion of Federal legislative mandates, its use by people without clinical training can lead to inappropriate application of its contents.

Appropriate use of the diagnostic criteria is said to require extensive clinical training, and its contents "cannot simply be applied in a cookbook fashion".<sup>[15]</sup> **The APA notes that diagnostic labels are primarily for use as a "convenient shorthand" among professionals.** The DSM advises that laypersons should consult the DSM only to obtain information, not to make diagnoses, and that people who may have a mental disorder should be referred to psychiatric counseling or treatment.

Further, a shared diagnosis/label may have different etiologies (causes) or require different treatments; the DSM contains no information regarding treatment or cause for this reason. The range of the DSM represents an extensive scope of psychiatric and psychological issues or conditions, and it is not exclusive to what may be considered "illnesses".

### DSM-IV sourcebooks

The DSM-IV doesn't specifically cite its sources, but there are four volumes of "sourcebooks" intended to be APA's documentation of the guideline development process and supporting evidence, including literature reviews, data analyses and field trials.

The Sourcebooks have been said to provide important insights into the character and quality of the decisions that led to the production of DSM-IV, and hence the scientific credibility of contemporary psychiatric classification.<sup>[20][21]</sup>

### DSM-V planning

The DSM-V is tentatively scheduled for publication in 2012.<sup>[22]</sup> In 1999, a DSM-V Research Planning Conference, sponsored jointly by APA and the National Institute of Mental Health (NIMH), was held to set the research priorities.

Research Planning Work Groups produced "white papers" on the research needed to inform and shape the DSM-IV,<sup>[23]</sup> and the resulting work and recommendations were reported in an APA monograph<sup>[24]</sup> and peer-reviewed literature.<sup>[25]</sup>

There were six workgroups, each focusing on a broad topic: Nomenclature, Neuroscience and Genetics, Developmental Issues and Diagnosis, Personality and Relational Disorders, Mental Disorders and Disability, and Cross-Cultural Issues.

Three additional white papers were also due by 2004 concerning gender issues, diagnostic issues in the geriatric population, and mental disorders in infants and young children.<sup>1</sup>

The white papers have been followed by a series of conferences to produce recommendations relating to specific disorders and issues, with attendance limited to 25 invited researchers.

[DSM-IV-TR Official Site](#) - American Psychiatric Association.

## **Mental Assessment**

The **mental status examination** (or **mental state examination** in the UK and Australia) abbreviated **MSE**, is an important part of the clinical [assessment](#) process in [psychiatric](#) practice. It is a structured way of observing and describing a [patient's](#) current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgement.<sup>[1]</sup> There are some minor variations in the subdivision of the MSE and the sequence and names of MSE domains.

The purpose of the MSE is to obtain a comprehensive cross-sectional description of the patient's mental state, which when combined with the biographical and historical information of the [psychiatric history](#), allows the clinician to make an accurate [diagnosis](#) and [formulation](#), which are required for coherent treatment planning.

The data are collected through a combination of direct and indirect means: unstructured observation while obtaining the biographical and social information, focused questions about current symptoms, and formalized [psychological tests](#).<sup>[2]</sup>

The MSE is not to be confused with the [mini-mental state examination](#) (MMSE) which is a brief neuro-psychological [screening test](#) for [dementia](#).

### **Theoretical foundations**

The MSE derives from an approach to psychiatry known as descriptive psychopathology<sup>[3]</sup> or descriptive [phenomenology](#)<sup>[4]</sup> which developed from the work of the philosopher and psychiatrist [Karl Jaspers](#).<sup>[5]</sup> From Jaspers' perspective it was assumed that the only way to comprehend a patient's experience is through his or her own description (through an approach of [empathic](#) and non-theoretical enquiry), as distinct from an interpretive or [psychoanalytic](#) approach which assumes the analyst might understand experiences or processes of which the patient is unaware, such as defense mechanisms or unconscious drives.

In practice, the MSE is a blend of empathic descriptive phenomenology and [empirical](#) clinical observation. It has been argued that the term *phenomenology* has become corrupted in clinical psychiatry: current usage, as a set of supposedly [objective](#) descriptions of a psychiatric patient (a synonym for [signs](#) and [symptoms](#)), is incompatible with the original meaning which was concerned with comprehending a patient's [subjective](#) experience.<sup>[6][7]</sup>

### **Application**

The mental status examination is a core skill of psychiatrists and nurses and is a key part of the initial psychiatric assessment in an [out-patient](#) or [psychiatric hospital](#) setting. It is a systematic collection of data based on observation of the patient's behavior while the patient is in the clinician's view during the interview.

The purpose is to obtain evidence of symptoms and signs of mental disorders, including danger to self and others, that are present at the time of the interview. Further, information on the patient's insight, judgment, and capacity for abstract reasoning is used to inform decisions about treatment strategy and the choice of an appropriate treatment setting.<sup>[8]</sup> It is carried out in the manner of an informal enquiry, using a combination of open and closed questions, supplemented by structured tests to assess cognition.<sup>[9]</sup>

The MSE can also be considered part of the comprehensive [physical examination](#) performed by [physicians](#) and nurses although it may be performed in a cursory and abbreviated way in non-mental-health settings.<sup>[10]</sup> Information is usually recorded as free-form text using the standard headings,<sup>[11]</sup> but brief MSE checklists are available for use in emergency situations, for example by [paramedics](#) or [emergency department](#) staff. The information obtained in the MSE is used, together with the biographical and social information of the psychiatric history, to generate a diagnosis, a psychiatric formulation and a treatment plan.

## Appearance

Clinicians assess the physical aspects such as the appearance of a patient, including apparent age, height, weight, and manner of dress and grooming. Colorful or bizarre clothing might suggest [mania](#), while unkempt, dirty clothes might suggest [schizophrenia](#) or [depression](#). If the patient appears much older than his or her chronological age this can suggest chronic poor self-care or ill-health. Clothing and accessories of a particular subculture, [body modifications](#), or clothing not typical of the patient's gender, might give clues to [personality](#). Observations of physical appearance might include the physical features of [alcoholism](#) or [drug abuse](#), such as signs of [malnutrition](#), nicotine stains, dental erosion, a rash around the mouth from [inhalant abuse](#), or needle track marks from intravenous drug abuse. Observations can also include any odor which might suggest poor personal [hygiene](#) due to extreme self-neglect, or intoxication with alcohol.<sup>[14]</sup>

## Attitude

Attitude, also known as [rapport](#),<sup>[15]</sup> refers to the patient's approach to the interview process and the interaction with the examiner. The patient's attitude may be described for example as cooperative, uncooperative, hostile, guarded, suspicious or [regressed](#). The most subjective element of the mental status examination, attitude depends on the interview situation, the skill and behaviour of the clinician, and the pre-existing relationship between the clinician and the patient. However, attitude is important for the clinician's evaluation of the quality of information obtained during the assessment.<sup>[16]</sup>

## Behavior

Abnormalities of behavior, also called abnormalities of activity,<sup>[17]</sup> include observations of specific abnormal movements, as well as more general observations of the patient's level of activity and arousal, and observations of the patient's [eye contact](#) and [gait](#). Abnormal movements, for example [choreiform](#), [athetoid](#) or [choreoathetoid](#) movements may indicate a [neurological](#) disorder. A [tremor](#) or [dystonia](#) may indicate a neurological condition or the side effects of [antipsychotic](#) medication. The patient may have [tics](#) (involuntary but quasi-purposeful movements or vocalizations) which may be a symptom of [Tourette's syndrome](#). There are a range of abnormalities of movement which are typical of [catatonia](#), such as [echopraxia](#), [catalepsy](#), [waxy flexibility](#) and [paratonia](#) (or *gegenhalten*<sup>[18]</sup>). Stereotypies (repetitive purposeless movements such as a rocking or head banging) or mannerisms (repetitive quasi-purposeful abnormal movements such as a gesture or abnormal gait) may be a feature of chronic schizophrenia or [autism](#). More global behavioral abnormalities may be noted, such as an increase in arousal and movement (described as [psychomotor agitation](#) or [hyperactivity](#)) which might reflect [mania](#) or [delirium](#). An inability to sit still might represent [akathisia](#), a side effect of antipsychotic medication.

Similarly a global decrease in arousal and movement (described as [psychomotor retardation](#), [akinesia](#) or [stupor](#)) might indicate depression or a medical condition such as [Parkinson's disease](#), [dementia](#) or delirium. The examiner would also comment on eye movements (repeatedly glancing to one side can suggest that the patient is experiencing hallucinations), and the quality of eye contact (which can provide clues to the patient's emotional state).<sup>[19][20][21]</sup>

## Mood and affect

The distinction between [mood](#) and [affect](#) in the MSE is subject to some disagreement, for example Trzepacz and Baker (1993)<sup>[22]</sup> describe affect as "the external and dynamic manifestations of a person's internal emotional state" and mood as "a person's predominant internal state at any one time", whereas Sims (1995)<sup>[23]</sup> refers to affect as "differentiated specific feelings" and mood as "a more prolonged state or disposition". This article will use the Trzepacz and Baker (1993) definitions, with mood regarded as a current subjective state as described by the patient, and affect as the examiner's inferences of the quality of the patient's emotional state based on objective observation.

Mood is described using the patient's own words, and can also be described in summary terms such as neutral, [euthymic](#), [dysphoric](#), [euphoric](#), [angry](#), [anxious](#) or [apathetic](#). [Alexithymic](#) individuals may be unable to describe their subjective mood state. An individual who is unable to experience any pleasure may be suffering from [anhedonia](#).

Affect is described by labelling the apparent emotion conveyed by the person's nonverbal behavior (anxious, sad etc.), and also by using the parameters of appropriateness, intensity, range, reactivity and mobility. Affect may be described as appropriate or inappropriate to the current situation, and as [congruent](#) or [incongruent](#) with their thought content.

For example, someone who shows a bland affect when describing a very distressing experience would be described as showing incongruent affect, which might suggest schizophrenia. The intensity of the affect may be described as normal, blunted, exaggerated, flat, heightened or overly dramatic.

A flat or [blunted affect](#) is associated with schizophrenia, depression or [post-traumatic stress disorder](#); heightened affect might suggest mania, and an overly dramatic or exaggerated affect might suggest certain [personality disorders](#).

Mobility refers to the extent to which affect changes during the interview: the affect may be described as mobile, constricted, fixed, immobile or [labile](#). The person may show a full range of affect, in other words a wide range of emotional expression during the assessment, or may be described as having restricted affect.

The affect may also be described as reactive, in other words changing flexibly and appropriately with the flow of conversation, or as unreactive. A bland lack of concern for one's disability may be described as showing *belle indifférence*,<sup>[25]</sup> a feature of [hysteria](#) in older texts.<sup>[26][27][28]</sup>

## Speech

The patient's [speech](#) is assessed by observing the patient's spontaneous speech, and also by using structured tests of specific language functions. This heading is concerned with the production of speech rather than the *content* of speech, which is addressed under thought form and thought content (see below).

When observing the patient's spontaneous speech, the interviewer will note and comment on [paralinguistic](#) features such as the loudness, rhythm, [prosody](#), [intonation](#), pitch, [phonation](#), [articulation](#), quantity, rate, spontaneity and latency of speech. A structured assessment of speech includes an assessment of expressive language by asking the patient to name objects, repeat short sentences, or produce as many words as possible from a certain category in a set time.

Simple language tests form part of the [mini-mental state examination](#). In practice, the structured assessment of receptive and expressive language is often reported under Cognition (see [below](#)).<sup>[29]</sup>

Language assessment will allow the recognition of medical conditions presenting with [aphonia](#) or [dysarthria](#), neurological conditions such as [stroke](#) or [dementia](#) presenting with [aphasia](#), and specific language disorders such as [stuttering](#), [cluttering](#) or [mutism](#).

People with autism or [Asperger's syndrome](#) may have abnormalities in paralinguistic and [pragmatic](#) aspects of their speech. [Echolalia](#) (repetition of another person's words) and [palilalia](#) (repetition of the subject's own words) can be heard with patients with [autism](#), schizophrenia or [Alzheimer's disease](#).

A person with schizophrenia might use [neologisms](#), which are made-up words which have a specific meaning to the person using them. Speech assessment also contributes to assessment of mood, for example people with mania or [anxiety](#) may have rapid, loud and [pressured speech](#); on the other hand [depressed](#) patients will typically have a prolonged speech latency and speak in a slow, quiet and hesitant manner.

## Thought process

[Thought](#) process in the MSE refers to the quantity, tempo (rate of flow) and form (or logical coherence) of thought. Thought process cannot be directly observed but can only be described by the patient, or inferred from a patient's speech. Regarding the tempo of thought, some people may experience flight of ideas, when their thoughts are so rapid that their speech seems incoherent, although a careful observer can discern a chain of poetic associations in the patient's speech.

Alternatively an individual may be described as having retarded or inhibited thinking, in which thoughts seem or progress slowly with few associations. Poverty of thought is a global reduction in the quantity of thought and thought [perseveration](#) refers a pattern where a person keeps returning to the same limited set of ideas.

A pattern of interruption or disorganization of thought processes is broadly referred to as [formal thought disorder](#), and might be described more specifically as thought blocking, fusion, loosening of associations, tangential thinking, derailment of thought, or knight's move thinking. Thought may be described as circumstantial when a patient includes a great deal of irrelevant detail and makes frequent diversions, but remains focused on the broad topic.

Flight of ideas is typical of mania. Conversely, patients with depression may have retarded or inhibited thinking. Poverty of thought is one of the [negative symptoms](#) of schizophrenia, and might also be a feature of severe depression or [dementia](#). A patient with dementia might also experience thought perseveration. Formal thought disorder is a common feature of schizophrenia. Circumstantial thinking might be observed in [anxiety disorders](#) or certain kinds of [personality disorders](#).<sup>[33][34][35]</sup>

## Thought content

A description of thought content would describe a patient's [delusions](#), overvalued ideas, obsessions, [phobias](#) and preoccupations. Abnormalities of thought content are established by exploring individual's thoughts in an open-ended conversational manner with regard to their intensity, salience, the emotions associated with the thoughts, the extent to which the thoughts are experienced as one's own and under one's control, and the degree of belief or conviction associated with the thoughts.<sup>[36][37][38]</sup>

A delusion can be defined as "a false, unshakeable idea or belief which is out of keeping with the patient's educational, cultural and social background ... held with extraordinary conviction and subjective certainty",<sup>[39]</sup> and is a core feature of [psychotic](#) disorders. The patient's delusions may be described as persecutory or [paranoid delusions](#), [delusions of reference](#), [grandiose delusions](#), [erotomanic](#) delusions, [delusional jealousy](#) or [delusional misidentification](#).

Delusions may be described as mood-[congruent](#) (the delusional content in keeping with the mood), typical of manic or [depressive psychoses](#), or mood-incongruent (delusional content not in keeping with the mood) which are more typical of schizophrenia.

Delusions of control, or passivity experiences (in which the individual has the experience of the mind or body being under the influence or control of some kind of external force or agency), are typical of schizophrenia. Examples of this include experiences of [thought withdrawal](#), [thought insertion](#), [thought broadcasting](#), and somatic passivity. [Schneiderian first rank symptoms](#) are a set of delusions and hallucinations which have been said to be highly suggestive of a diagnosis of schizophrenia.

Delusions of guilt, delusions of poverty, and nihilistic delusions (belief that one has no mind or is already dead) are typical of [depressive psychoses](#).

An overvalued idea is a false belief that is held with conviction but not with delusional intensity. [Hypochondriasis](#) is an overvalued idea that one is suffering from an illness, [dysmorphophobia](#) is an overvalued idea that a part of one's body is abnormal, and people with [anorexia nervosa](#) may have an overvalued idea of being overweight.

An obsession is an "undesired, unpleasant, intrusive thought that cannot be suppressed through the patient's volition",<sup>[40]</sup> but unlike passivity experiences described above, they are not experienced as imposed from outside the patient's mind.

Obsessions are typically intrusive thoughts of violence, injury, dirt or sex, or obsessive [ruminations](#) on intellectual themes. A person can also describe obsessional doubt, with intrusive worries about whether they have made the wrong decision, or forgotten to do something, for example turn off the gas or lock the house. In [obsessive-compulsive disorder](#), the individual experiences obsessions with or without compulsions (a sense of having to carry out certain ritualized and senseless actions against their wishes).

A phobia is "a dread of an object or situation that does not in reality pose any threat",<sup>[41]</sup> and is distinct from a delusion in that the patient is aware that the fear is irrational. A phobia is usually highly specific to certain situations and will usually be reported by the patient rather than being observed by the clinician in the assessment interview.

Preoccupations are thoughts which are not fixed, false or intrusive, but have an undue prominence in the person's mind. Clinically significant preoccupations would include [thoughts of suicide](#), homicidal thoughts, suspicious or fearful beliefs associated with certain personality disorders, depressive beliefs (for example that one is unloved or a failure), or the [cognitive distortions](#) of anxiety and depression.

The MSE contributes to clinical risk assessment by including a thorough exploration of any suicidal or hostile thought content. Assessment of suicide risk includes detailed questioning about the nature of the person's suicidal thoughts, belief about death, reasons for living, and whether the person has made any specific plans to end his or her life.<sup>[42]</sup>

## Perceptions

A [perception](#) in this context is any sensory experience, and the three broad types of perceptual disturbance are [hallucinations](#), pseudohallucinations and [illusions](#). A hallucination is defined as a sensory perception in the absence of any external stimulus, and is experienced in external or objective space (i.e. experienced by the subject as real).

An illusion is defined as a false sensory perception in the presence of an external stimulus, in other words a distortion of a sensory experience, and may be recognized as such by the subject.

A pseudohallucination is experienced in internal or subjective space (for example as "voices in my head") and is regarded as akin to fantasy. Other sensory abnormalities include a distortion of the patient's sense of time, for example [déjà vu](#), or a distortion of the sense of self ([depersonalization](#)) or sense of reality ([derealization](#)).

Hallucinations can occur in any of the five senses, although [auditory](#) and [visual](#) hallucinations are encountered more frequently than [tactile](#) (touch), [olfactory](#) (smell) or [gustatory](#) (taste) hallucinations.

Auditory hallucinations are typical of [psychoses](#): third-person hallucinations (i.e. voices taking about the patient) and hearing one's thoughts spoken aloud (*gedankenlautwerden* or *écho de la pensée*) are among the [Schneiderian first rank symptoms](#) indicative of schizophrenia, whereas second-person hallucinations (voices talking to the patient) threatening or insulting or telling them to commit suicide, may be a feature of [psychotic depression](#) or schizophrenia.

Visual hallucinations are generally suggestive of organic conditions such as [epilepsy](#), drug intoxication or drug withdrawal.

Many of the visual effects of [hallucinogenic drugs](#) are more correctly described as visual illusions or visual pseudohallucinations, as they are distortions of sensory experiences, and are not experienced as existing in objective reality.

Auditory pseudohallucinations are suggestive of [dissociative disorders](#). Déjà vu, derealization and depersonalization are associated with [temporal lobe epilepsy](#) and dissociative disorders.<sup>[43][44]</sup>



## Cognition

This section of the MSE covers the patient's level of [alertness](#), [orientation](#), [attention](#), [memory](#), visuospatial functioning, [language](#) functions and [executive](#) functions.

Unlike other sections of the MSE, use is made of structured tests in addition to unstructured observation. Alertness is a global observation of [level of consciousness](#) i.e. awareness of, and responsiveness to the environment, and this might be described as alert, clouded, drowsy, or stuporose.

Orientation is assessed by asking the patient where he or she is (for example what building, town and state) and what time it is (time, day, date). Attention and concentration are assessed by the [serial sevens](#) test (or alternatively by spelling a five-letter word backwards), and by testing [digit span](#).

Memory is assessed in terms of immediate registration (repeating a set of words), short-term memory (recalling the set of words after an interval, or recalling a short paragraph), and long-term memory (recollection of well known historical or geographical facts). Visuospatial functioning can be assessed by the ability to copy a diagram, draw a clock face, or draw a map of the consulting room.

Language is assessed through the ability to name objects, repeat phrases, and by observing the individual's spontaneous speech and response to instructions. Executive functioning can be screened for by asking the "similarities" questions ("what do x and y have in common?") and by means of a verbal fluency task (e.g. "list as many words as you can starting with the letter F, in one minute").

The mini-mental state examination is a simple structured cognitive assessment which is in widespread use as a component of the MSE.

Mild impairment of attention and concentration may occur in any [mental illness](#) where people are anxious and distractible (including psychotic states), but more extensive cognitive abnormalities are likely to indicate a gross disturbance of [brain](#) functioning such as delirium, dementia or [intoxication](#).

Specific language abnormalities may be associated with pathology in [Wernicke's area](#) or [Broca's area](#) of the brain. In [Korsakoff's syndrome](#) there is dramatic memory impairment with relative preservation of other cognitive functions.

Visuospatial or constructional abnormalities here may be associated with [parietal lobe](#) pathology, and abnormalities in executive functioning tests may indicate [frontal lobe](#) pathology. This kind of brief cognitive testing is regarded as a screening process only, and any abnormalities are more carefully assessed using formal [neuropsychological testing](#).<sup>[45]</sup>

The MSE may include a brief neuropsychiatric examination in some situations. Frontal lobe pathology is suggested if the person cannot repetitively execute a motor sequence (e.g. "paper-scissors-stone"). The [posterior columns](#) are assessed by the person's ability to feel the vibrations of a tuning fork on the wrists and ankles.

The parietal lobe can be assessed by the person's ability to identify objects by touch alone and with eyes closed. A [cerebellar](#) disorder may be present if the person cannot stand with arms extended, feet touching and eyes closed without swaying (Romberg's sign); if there is a tremor when the person reaches for an object; or if he or she is unable to touch a fixed point, close the eyes and touch the same point again.

Pathology in the [basal ganglia](#) may be indicated by rigidity and resistance to movement of the limbs, and by the presence of characteristic involuntary movements. A lesion in the [posterior fossa](#) can be detected by asking the patient to roll his or her eyes upwards (Perinaud's sign).

Focal neurological signs such as these might reflect the effects of some prescribed psychiatric medications, chronic drug or alcohol use, [head injuries](#), [tumors](#) or other brain disorders.<sup>[46][47][48][49][50]</sup>

## Insight

The person's understanding of his or her mental illness is evaluated by exploring his or her explanatory account of the problem, and understanding of the treatment options.

In this context, [insight](#) can be said to have three components: recognition that one has a mental illness, [compliance](#) with treatment, and the ability to re-label unusual mental events (such as delusions and hallucinations) as pathological.<sup>[51]</sup> As insight is on a continuum, the clinician should not describe it as simply present or absent, but should report the patient's explanatory account descriptively.<sup>[52]</sup>

Impaired insight is characteristic of [psychosis](#) and dementia, and is an important consideration in treatment planning and in assessing the capacity to [consent](#) to treatment.<sup>[53]</sup>

## Judgment

Judgment refers to the patient's capacity to make sound, reasoned and responsible decisions. Traditionally, the MSE included the use of standard hypothetical questions such as "what would you do if you found a stamped, addressed envelope lying in the street?"; however contemporary practice is to inquire about how the patient has responded or would respond to real-life challenges and contingencies. Assessment would take into account the individual's [executive system](#) capacity in terms of impulsiveness, [social cognition](#), self-awareness and planning ability.

Impaired judgment is not specific to any diagnosis but may be a prominent feature of disorders affecting the [frontal lobe](#) of the brain. If a person's judgment is impaired due to mental illness, there might be implications for the person's safety or the safety of others.<sup>[54]</sup>

## Cultural considerations

There are potential problems when the MSE is applied in a [cross-cultural](#) context, when the clinician and patient are from different cultural backgrounds. For example, the patient's culture might have different norms for appearance, behavior and display of emotions. Culturally normative spiritual and religious beliefs need to be distinguished from delusions and hallucinations, and cognitive assessment would take the patient's language and educational background into account. Another confounding element is the clinician's own possible racist bias.<sup>[55][56]</sup>

## Children

There are particular challenges in carrying out an MSE with young children, and others with limited language such as people with [intellectual impairment](#). The examiner would explore and clarify the individual's use of words to describe mood, thought content or perceptions, as words may be used [idiosyncratically](#) with a different meaning from that assumed by the examiner. In this group, tools such as play materials, puppets, art materials or diagrams (for instance with multiple choices of facial expressions depicting emotions) may be used to facilitate recall and explanation of experiences.<sup>[57]</sup>

## Psychiatric Nursing Intervention

Like any other interventions where the nurse looks after the physical integrity of the patient, psychiatric intervention follow the same principles of **safe and effective intervention**.

Remember to identify the central idea of the question, determining which of the process of nursing intervention is being described in the question and how it relates to answers on one of the nursing processes.

The intervention of psychiatric patients does not differ from the intervention of non-psychiatric patients on the application of the principles of safety and effective intervention. The difference is mainly in the identification of symptoms and signs which can be seen as less objective by lack of quantification processes, etc.

Exact degrees of depression or other conditions do not exist; however, psychiatrists and psychologists use other parameters to establish the intensity of conditions by incorporating a medical language and terminology standards to this practice.

Become familiar with the language use to describe conditions; know the symptom and signs. Treatments, and drug administration and commonly used drugs, and common language used to assess, diagnose and/or evaluate patients.

Refer to guidelines by the American Psychiatric Associations or to the Diagnostic and Statistical Manual of Mental Disorders IV –fourth .ion- presenting diagnostic criteria widely used in psychiatry medicine evidence based. Your best source to get ready for psychiatric nursing. Can you identify a psychiatric assessment from a psychiatric diagnostic, plan, implement and evaluate the outcome?

The psychiatric nursing questions on the NCLEX exam range between 9 and a .3% of the 75 or 80 questions, or roughly between .0 and .2 nursing psychiatric questions. Most psychiatric conditions are idiopathic and practitioners in most cases only do inferences about the patho-physiology of the same; however, we know now that most mental disorders are classed are neurobiological, psychological or phsycho-social dysfunctions where one syndrome may have several etiologies.

A depressive syndrome may be due to an idiopathic major depressive disorder, and conversely, a neurobiological disorder may present a depressive syndrome, including dementia, delirium, or maniac behavior.

Reminder:

To fail 5 of .0 means to fail 50% of the psychiatric questions and the NCLEX algorithm is programmed to find about your interventions skills in all areas, including psychiatry nursing.

Like any other skills being tested for, the NCLEX software will present the examinee with several questions at several levels of difficulty; if you passed a question the algorithm of the program will increase its difficulty until it proves your skills level. Psychiatry nursing is considered the Achille's heel of examinees; a great number of examinees do not pass this area of testing simply because didn't prepare for psychiatric nursing questions, nor have been expose to psychiatric nursing prior to the NCLEX exam.

The nursing process applies to all patients, including of course psychiatric clients. Become familiar with the application of all nursing processes as you know now from a psycho-social view. Assessing the psycho-social integrity of a patient takes training a conscious effort to recognize symptoms and signal, etc.

### **Personality Disorders**

Pervasive, inflexible, and stable personality traits that deviate from cultural norms and cause distress or functional impairment.

Personality disorders occur when these traits are so rigid and maladaptive that they impair interpersonal or vocational functioning. Personality traits and their potential maladaptive significance are usually evident from early adulthood and persist throughout much of life.

**Mental coping mechanisms** (defenses) are used unconsciously at times by everyone.

But in persons with personality disorders, coping mechanisms tend to be immature and maladaptive .

Repetitious confrontation in prolonged psychotherapy or by peer encounters is usually required to make such persons aware of these mechanisms. They may seek help because of symptoms (eg, anxiety, depression) or maladaptive behavior (eg, substance abuse, vengefulness) that results from their personality disorder.

Often they do not see a need for therapy, and they are referred by their peers, their families, or a social agency because their maladaptive behavior causes difficulties for others

### **Diagnosis and Classification**

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, divides personality disorders into three clusters:

#### **A) odd/eccentric, B) dramatic/erratic, and C) anxious/inhibited.**

**Paranoid personality:** Persons with this personality disorder are generally cold and distant in interpersonal relationships or are controlling and jealous if they become attached.

They tend to react with suspicion to changes in situations and to find hostile and malevolent motives behind other people's trivial, innocent, or even positive acts. Often these hostile motives represent projections of their own hostilities onto others.

**Schizoid personality:** Persons with this personality disorder are introverted, withdrawn, solitary, emotionally cold, and distant. They are most often absorbed in their own thoughts and feelings and fear closeness and intimacy with others.

**Schizotypal personality:** Like schizoid persons, persons with this personality disorder are socially isolated and emotionally detached, but in addition, they express oddities of thinking, perception, and communication, such as magical thinking, clairvoyance, ideas of reference, or paranoid ideation.

**Borderline personality:** Persons with this personality disorder--predominantly women--are unstable in their self-image, mood, behavior, and interpersonal relationships. This personality disorder becomes evident in early adult years, but it tends to become milder or to stabilize with age.

**Antisocial personality** (previously called **psychopathic** or **sociopathic**): Persons with this personality disorder callously disregard the rights and feelings of others.

They exploit others for materialistic gain or personal gratification (unlike narcissistic persons, who exploit others because they think their superiority justifies it).

Antisocial personality disorder is often associated with alcoholism, drug addiction, infidelity, promiscuity, failure in one's occupation, frequent relocation, and imprisonment.

**Narcissistic personality:** Persons with this personality disorder are grandiose; ie, they have an exaggerated sense of superiority.

Their relationships with others are characterized by their need to be admired, and they are extremely sensitive to criticism, failure, or defeat.

**Histrionic (hysterical) personality:** *Persons with this personality disorder conspicuously seek attention, are conscious of appearance, and are dramatic.*

*Their expression of emotions often seems exaggerated, childish, and superficial and, like other dramatic behaviors, often evokes sympathetic or erotic attention from others. Thus relationships are often easily established but tend to be superficial and transient*

**Dependent personality:** Persons with this disorder surrender responsibility for major areas of their lives to others and allow the needs of those they depend on to supersede their own needs.

They lack self-confidence and feel intensely insecure about their ability to take care of themselves.

**Avoidant personality:** Persons with this personality disorder are hypersensitive to rejection and fear starting relationships or anything new because they may fail or be disappointed.

This personality disorder is a spectrum variant of generalized social phobia. Persons with an avoidant personality disorder tend to have an incomplete or a weak response to anxiolytic drugs.

**Obsessive-compulsive personality:** Persons with this personality disorder are conscientious, orderly, and reliable, but their inflexibility often makes them unable to adapt to change. Because they are cautious and weigh all aspects of a problem, they may have difficulty making decisions.

### **Other Personality Types**

**Passive-aggressive (negativistic) personality:** Persons with this personality disorder typically appear inept or passive, but these behaviors are covertly designed to avoid responsibility or to control or punish others.

### **Cyclothymic personality**

In persons with this personality disorder, high-spirited buoyancy alternates with gloom and pessimism; each mood lasts weeks or longer.

Cyclothymic personality is considered a temperament, present in many gifted and creative people.

**Depressive (masochistic) personality:** Persons with depressive personality disorder are chronically morose, worried, and self-conscious.

Their pessimistic outlook impairs their initiative and disheartens persons who spend much time with them.

### **Treatment**

Treating a personality disorder takes a long time. Personality traits such as coping mechanisms, beliefs, and behavior patterns take many years to develop, and they change slowly. Changes usually occur in a predictable sequence, and different treatment modalities are needed to facilitate them

For some patients with personality disorders that involve how attitudes, expectations, and beliefs are mentally organized (eg, narcissistic or obsessive-compulsive types), psychoanalysis is recommended, usually for  $\geq 3$  years.

**General principles:** Although treatment differs according to the type of personality disorder, some general principles apply to all.

Drugs have limited effects. They can be misused or used in suicide attempts. When anxiety and depression result from a personality disorder, drugs are only moderately effective

Because personality disorders are particularly difficult to treat, therapists with experience, enthusiasm, and an understanding of the patient's expected areas of emotional sensitivity and usual ways of coping are important.

### **Fear and anxiety.**

Fear is an emotional, physiologic, and behavioral response to a recognized external threat (eg, an intruder, a runaway car).

Anxiety is an unpleasant emotional state; its causes are less clear. Anxiety is often accompanied by physiologic changes and behaviors similar to those caused by fear.

### **Maladaptive anxiety causes distress and dysfunction.**

The Yerkes-Dodson curve shows the relationship between emotional arousal (anxiety) and performance. As anxiety increases, performance efficiency increases proportionately but only to an optimal level, beyond which performance efficiency decreases with further increases in anxiety.

### **Etiology**

The causes of anxiety disorders are not fully known, but both physiologic and psychologic factors are involved. Physiologically, all thoughts and feelings may be understood as resulting from electrochemical processes in the brain, but this fact tells little about the complex interactions among the > 200 neurotransmitters and neuromodulators of the brain and about normal vs. abnormal arousal and anxiety.

### **Symptoms and Diagnosis**

Anxiety can arise suddenly, as in panic, or gradually over many minutes, hours, or even days. Anxiety may last from a few seconds to years; longer duration is often associated with anxiety disorders.

Anxiety ranges in intensity from barely noticeable qualms to complete panic, its most extreme form. Diagnosis of a specific anxiety disorder is based largely on its characteristic symptoms and signs. A family history of anxiety disorders (except posttraumatic stress disorder) is helpful, because many patients appear to have inherited a predisposition to the same anxiety disorders their relatives have as well as a general susceptibility to other anxiety disorders.

### **Panic Attacks And Panic Disorder**

Panic attacks are common, affecting > .3 of the population in a single year. Most persons recover without treatment; a few develop panic disorder. Panic disorder is uncommon, affecting < .% of the population in a 6-mo period. Panic disorder usually begins in late adolescence or early adulthood and affects women two to three times more often than men.

### **Symptoms, Signs, and Diagnosis**

A panic attack involves the sudden onset of at least 4 of the .3 symptoms. Symptoms must peak within .0 min and usually dissipate within minutes, leaving little for a physician to observe except the person's fear of another terrifying panic attack.

### **Treatment**

Patients should be told that their disorder results from both biologic and psychological dysfunction and that pharmacotherapy and behavior therapy usually help control symptoms. In addition to information about the disorder and its treatment, a physician can provide realistic hope for improvement and support based on a trusting physician-patient relationship.

**Attempted suicide** is a suicidal act that is not fatal, possibly because the self-destructive intention was slight, vague, or ambiguous or the action taken had a low lethal potential. Most persons who attempt suicide are ambivalent about their wish to die, and the attempt may be a plea for help and may fail because of a strong wish to live.

**Completed suicide** results in death. The distinction between completed and attempted suicides is not absolute, because attempted suicides also include acts by persons whose determination to die is thwarted only because they are discovered early and resuscitated effectively and because a suicide attempt may be unintentionally fatal by miscalculation.

### **Incidence**

Statistics on suicidal behavior are based mainly on death certificates and inquest reports, and they underestimate the true incidence. Even so, suicide is one of the top .0 causes of death among adults in urban communities. In Europe, the urban rate is higher than the rural; in the USA, they are about the same. In the USA, about 75 persons commit suicide every day. More than 70% of persons who complete suicide are > 40 yr old, and the incidence rises sharply among those > 60 yr old, particularly men. About 65% of those who attempt suicide are < 40 yr old.

Of about 200,000 suicide attempts in the USA each year, .0% are completed. Attempted suicides account for about 20% of emergency medical admissions and for .0% of all medical admissions. Women attempt suicide 2 to 3 times more often than men, but men are generally more apt to die in their attempts. Several studies have found a higher incidence of suicide among family members of patients who have attempted suicide.

### **Etiology**

Psychological mechanisms leading to suicidal behavior resemble those frequently implicated in other forms of self-destructive behavior, such as alcoholism, reckless driving, self-mutilation, and violent antisocial acts. Suicide is often the final act in a course of such behavior. Suicidal acts usually result from multiple and complex motivations. The principal causative factors include mental disorders (primarily depression), social factors (disappointment and loss), personality abnormalities (impulsivity and aggression), and physical disorders.

**Depression** is involved in over half of all attempted suicides. Depression may be precipitated by social factors, such as marital discord, broken and unhappy love affairs, disputes with parents (among the young), and recent bereavements (particularly among the elderly)

**Alcohol** predisposes to suicidal acts by intensifying a depressive mood swing and by reducing self-control. About 30% of persons who attempt suicide have consumed alcohol before the attempt, and about half of them were intoxicated at the time.

Some patients with **schizophrenia** commit suicide. In chronic schizophrenia, suicide may result from the episodes of depression to which these patients are prone. The suicide method is usually bizarre and often violent.

Persons with **personality disorders** are prone to attempted suicide--especially emotionally immature persons who have a borderline or an antisocial personality disorder, tolerate frustration poorly, and react to stress impetuously with violence and aggression.

**Aggression** toward others is often evident in suicidal behavior--particularly in homicide followed by suicide and in the high incidence of suicide among prisoners serving terms for violent crimes. When the distressing impact is considered, suicide appears to be directed at other, significant persons.

**Organic brain disease**--as in delirium (eg, due to drugs, infection, or heart failure) or dementia--may be accompanied by emotional lability. Serious violent acts of self-injury may occur during a deep but transient depressive mood swing.

### **Methods**

The choice of methods is determined by cultural factors and availability and may reflect the seriousness of intent, since some (eg, jumping from heights) make survival virtually impossible, whereas others (eg, drug ingestion) make rescue possible

Two or more methods or a combination of drugs is used in about 20% of attempted suicides,

increasing the risk of death, particularly when drugs with serious interactions are combined. When multiple drugs are ingested, blood levels of all possible drugs should be obtained.

### **Prevention**

Any suicidal act or threat must be taken seriously. Although some attempted or completed suicides are a surprise and shock, even to close relatives and associates, clear warnings are given in most cases, generally to relatives, friends, medical personnel, or trained volunteers in emergency suicide prevention centers offering a 24-h service to persons in distress. On average, physicians will encounter six or more potentially suicidal persons in their practice each year. More than half of persons who commit suicide have consulted their physician within the previous few months, and at least 20% have been under psychiatric care during the preceding year.

Emergency psychological aid includes establishing a relationship and open communication with the person; reminding him of his identity (ie, using his name repeatedly); helping him sort out the problem that has caused the crisis; offering constructive help with the problem; encouraging him to take positive action; and reminding him that his family and friends care for him and want to help.

### **Management of Attempted Suicide**

Many persons who attempt suicide are admitted to a hospital emergency department in a comatose state. After an overdose of a potentially lethal drug has been confirmed, the drug should be removed from the patient, attempting to prevent absorption and expedite excretion; symptomatic treatment to keep the patient alive should be started.

**Psychiatric assessment** should be performed as soon as possible for all patients who attempt suicide. After the attempt, the patient may deny any problems, because the severe depression that led to the suicidal act may be followed by a short-lived mood elevation, a cathartic effect probably accounting for the rarity of repeated suicide attempts immediately after the initial one. relatives, or friends; and contacting the family physician.

The initial assessment should be made by a psychiatrist, although nonmedical personnel trained in the management of suicidal behavior can deal with suicidal patients satisfactorily.

Duration of hospital stay and the kind of treatment required vary. Patients with a psychotic disorder, organic brain disease, or epilepsy and some with severe depression and an unresolved crisis should be admitted to a psychiatric unit until they resolve underlying problems or can cope with them. If the patient's family physician is not in charge, he should be kept fully informed and given specific suggestions for follow-up care.

### **Effect of Suicide**

Any suicidal act has a marked emotional effect on all involved. The physician, family, and friends may feel guilt, shame, and remorse at not having prevented a completed suicide as well as anger toward the deceased or others.

### **Emergencies Requiring a General Medical Evaluation**

**Panic attacks** must be evaluated to rule out other disorders associated with anxiety, including psychosis, delusional disorders, phobias, substance abuse or withdrawal, thyrotoxicosis, MI, mitral valve prolapse, pheochromocytoma, hyperventilation, and cardiac arrhythmia. Panic attacks may be treated with propranolol .0 to 30 mg/day po to decrease the peripheral manifestations of anxiety or clonazepam 0.5 to 2 mg bid (a long-acting benzodiazepine) or



alprazolam 0.5 to .5 mg bid to tid for short-term treatment.

**Mania** can be a manifestation of a primary psychiatric disorder (bipolar disorder) or a primary physical disorder affecting the CNS (eg, Cushing's disease, closed head injury, cerebrovascular accidents, hyperthyroidism)

**Psychosis** occurs in schizophrenia, bipolar disorder, delusional disorders, and major depression. For a first episode or acute onset of psychosis, the same physical disorders and drugs associated with mania must be excluded, but extensive diagnostic reevaluation is generally not needed when relapse occurs in a patient known to have a chronic psychotic disorder.

**Delirium** is caused by a wide variety of toxic and metabolic conditions, and diagnosis requires a known or presumed identifiable etiology.

**Dissociative episodes** are noted only after other causes of altered memory (eg, head injury, cerebrovascular accident, seizure disorder) have been excluded.

**Catatonia** is diagnosed only after other causes of psychomotor excitement or stupor are excluded, including drug intoxication causing psychomotor excitement; antipsychotic drugs or antidepressants (eg, selective serotonin reuptake inhibitors) causing akathisia; mania; neurologic insult (eg, cerebrovascular accident) or severe Parkinson's disease causing psychomotor stupor; neuroleptic malignant syndrome; serotonin syndrome; and benzodiazepine overdose.

**Conversion disorders** have a psychological component and mimic patho-physiological disorders, such as blindness or paralysis; however, the anatomic distribution of symptoms usually reflects a layman's view of structure. Physical disorders must be ruled out before diagnosing conversion disorder.

**Seizures** that are not generalized tonic-clonic seizures can be difficult to differentiate from other psychiatric and physical disorders. Temporal lobe and absence seizures can cause dissociation of consciousness.

### **Emergencies Requiring Hospitalization or Other Institutional Support**

A patient with a psychiatric disorder who is a danger to himself or to others or who is so disabled that he cannot protect himself requires hospitalization. Persons who are dangerous but do not have a psychiatric disorder should be referred to law enforcement.

**Psychosocial crises** may be the reason that patients with severe, long-standing psychiatric disorders and no other support system seek help in the emergency department. Such patients often have a reduced capacity to manage psychosocial stresses of all types. Crises include conflicts with family, landlord, or roommate; financial problems; and loneliness.

### **Emergencies Requiring Minimal Pharmacologic Intervention**

Patients who are having a crisis but who do not have a major psychiatric disorder may need minimal or no pharmacologic treatment.

**Adjustment disorder** may require short-term outpatient treatment. Depending on the predominant symptoms, anxiolytic or antidepressant drugs may be used briefly. Antidepressants generally require 2 to 4 wk to reduce symptoms and therefore cannot be used without a coordinated short-term treatment plan.

**Rape or physical assault victims** frequently benefit from psychological assessment and treatment, including an anxiolytic used briefly.

**Borderline or other personality disorders** can produce transient psychotic symptoms, suicidal impulses, or impulsive aggressive behavior, including self-mutilation and suicide attempts in response to psychosocial stressors.

## **Emergencies Requiring More Comprehensive Pharmacologic Intervention**

Drugs prescribed in an emergency setting should be administered judiciously and target specific symptoms.

The etiology of altered mental status should be determined, when possible, before drugs are given because psychoactive drugs suppress psychiatric symptoms secondary to underlying physical disorders. Nonetheless, drugs are often required immediately to control disturbed behavior that poses a danger to the patient or others.

**Assaultive behavior** in patients must be controlled so that others are not harmed. Physical restraints should be applied only by staff who are adequately trained to protect patient rights and safety. Drugs can be given to control dangerous behavior without the psychiatric patient's consent.

**Acute (agitated) psychosis**, with aggressive or violent behavior, is a common emergency. Symptomatic treatment must often precede definitive diagnosis. Patients with acute psychosis require hospitalization or treatment in a crisis group home or other hospital alternative if judged to be a danger to self or others.

**Bipolar I disorder** occurs as mania or major depression. An antipsychotic drug is often needed to control acute manic symptoms. Mood stabilizers, such as lithium, carbamazepine, and valproate, require several weeks to normalize mood and are effective as prophylaxis.

When an antidepressant is prescribed for patients with bipolar disorder, a mood stabilizer should be prescribed concurrently to attempt to prevent antidepressant-induced mania.

**Schizophrenia** can occur with acute exacerbations or relapses. Noncompliance with prescribed maintenance treatment accounts for about 50% of relapses among patients with schizophrenia.

**Brief psychotic disorder** is treated similarly to an acute exacerbation of schizophrenia, although lower drug doses are typically required.

**Substance intoxication and withdrawal** may occur with a psychiatric disorder or as a primary presenting complaint. Phencyclidine (PCP), cocaine, and alcohol are the substances that most commonly lead to violent behavior. PCP users can present with almost any psychiatric symptom. Physical restraints or sedation may be necessary for violent patients..

**Overdose of prescribed psychoactive drugs** can also cause intoxication. If the patient has taken a toxic dose and is awake, treatment consists of inducing emesis followed by administering activated charcoal. Overdose with tricyclic antidepressants or carbamazepine requires cardiac monitoring.

Overdose with barbiturates or benzodiazepines and alcohol may cause respiratory arrest. Acetaminophen overdose requires monitoring of blood levels, and if the blood level of acetaminophen indicates probable liver damage, acetylcysteine must be given according to protocol.

Akathisia is a common adverse effect of high-potency antipsychotics; when severe, it is accompanied by extreme anxiety or terror.

## **Psychiatric Meds to Remember by Association**

### **ANTI PARKINSON'S**

**C**- cogentin  
**A**- artane  
**P**- parlodel  
**A**- akineton  
**B**- benadryl  
**L**- larodopa  
**E**- Eldepryl  
**S**- symmetril

Increase protein and give B6  
Akathisia  
Dystonia  
Tardive Dysinesia  
Neuroleptic Malignant Syndrome

## **ANTI-ANXIETY**

**V**-valium  
**L**-librium  
**A**-ativan  
**S**-serax  
**T**-tranxene

**M**-miltown  
**E**- equanil  
**V**-vistaril  
**A**-taxene  
**I**-Inderal  
**B**-buspar

Tolerance develop until seven days

A- void abrupt discontinuation after prolonged use  
N- Not give if BP is up, hepatic/renal dysfunction or history of drug abuse  
X-xanax, ativan, serax is also an anti-anxiety meds  
I-increase in 3D's- drowsiness, dizziness, decreased BP  
Enhances action of GABA  
T-teach client to rise slowly from supine position  
Y-es alcohol should also be avoided.

## **MAOI Drugs**

**M**-marplan  
**N**-nardil

## **P**-parnate

Hypertensive crisis within several hours of ingestion of tyramine containing foods  
Tyramine foods:  
aged cheese, beer, ale, red wine, pickled foods, smoked or pickled fish, beef or  
chopped liver, avocado of figs.

## **ANTI-DEPRSSION**

**A**- asendin

**N**-norpramin

**T**- tofranil

**S**-sinequan

**A**-anafranil

- aventyl

**V**-vivactil

**E**-Elavil

**P**-paxil

**Z**-zoloft

D-riving is contraindicated

E-ffect has a delayed onset of 7-2. days

P-regnancy consult with your physician

R-elieves symptoms but never cure

E- valuate vital sign

S-toppind drug abruptly is Out!

S-afety measures

I-nstruct to report undesirable side effect

O-bserve for suicidal tendencies

N-o alcohol or CNS depressants

## **ANTI-MANIC DRUGS**

Lithium- Eskalith

Increase risk of toxicity when given with: thiazide diuretics, methyldopa, and NSAIDs

Decrease lithium levels with excess sodium and antacids. Increase CNS toxicity with

Haloperidol: 0.6-..2 -meq/l Therapeutic Effect, > ..5 meq/l Toxic, 2.0 meq/l lethal

L- evel - **therapeutic 0.6-..2 meq/l**

I-ncreased Urination

T-hirst Increased

H-eadaches and Tremors

I-ncreased fluids

U-nsteady

M-orton's Salt -adequate intake