(Mental Health Nursing)
(GNM - 2 years)
(Unit - 4, 5, 6)

What to Know on the Exam :-

Mania - 7 Questions

Assess the clinical picture :- behaviour on the Unit
what are the Nursing priorities?
Limit setting - How to Handle the pt with Mania
Safety & Physiologically
How do you Manage & prioritize, safety & take care of Psych & Physio Needs.

Mania

Several theories :- Hereditary, possible excess of Norepinephrine & dopamine, electrolytes, possible cholinergic or acetylcholine link is also Noted with an inadequate amount accounting for Mania.

Signs & Symptoms of Mania

Listed for children But probably in adults too)

Euphoric / expansive Mood :- extremely Happy, silly or giddy

Irritable Mood :- Hostility & Rage, often over trivial Matters.

Grandiosity :- Believes abilities to be better than everyone else's

Decreased Need for sleep :- May only sleep 4-5 Hours per Night & wake up feeling Rested.

Pressured Speech:- loud, intrusive, & difficult to interrupt

Racing thoughts:- Rapid change of topics.

Distractibility:- unable to focus on anything for very long.

Increase in goal-directed activity / Psychomotor agitation:- activities become obsessive, increased psychomotor agitation.

Excessive involvement in pleasurable or Risky activities:- Exhibits behaviour that has an erotic / pleasure seeking quality about it

Psychosis:- May experience Hallucinations & delusions

Suicidality:- May exhibit suicidal behaviour during a depressed or mixed episode or when psychotic.

Signs and Symptoms can be described according to three stages:-

Stage I:- Hypomania

(Pt enjoys this phase, Not a cause for social or occupational impairment, does Not Require Hospitalization)

Mood:- Cheerful and expansive, underlying irritability that surfaces Rapidly when wishes & desires go unfulfilled / Nature is volatile & fluctuating.

Cognition and Perception:- idea of self being of great worth & ability, thinking flighty, Rapid flow of ideas, easily distracted By irrelevant stimulation so that goal-directed activities are difficult.

Activity and Behaviour:- increased Motor activity, very extroverted & sociable - therefore many acquaintances But Not many close friendships, talk & laugh a lot loudly & inappropriately, Horny, some anorexic, may phone the Prudent or over spend on credit cards.

Stage II - Acute Mania

Marked impairment in functioning, Requires Hospitalization May get so Hyper will die from sleep deprivation)

Mood:- euphoria & elation, on continuous 'High" but subject to frequent variation, can go to Irritable & Angry to sad & crying.

Cognition & Perception:- Racing & Disjointed thinking, flight of ideas (if severe may be incoherent). Pressured speech, Distractibility is all-pervasive, Hallucinations & delusions (usually of grandeur & paranoia)

Activity & Behaviour:- Psychomotor activity is excessive, increased Horniness, poor impulse control, Maybe sexually uninhibited, excessive spending, ability to Manipulate others to carry out wishes skillfully projects Responsibility of failure to others, energy is inexhaustible, Need for sleep

is diminished, Hygiene May be Neglected, dress May be Neglected, flamboyant, or bizarre, excessive use of Make-up & jewelry.

Stage III Delirious Mania

(grave form of disorder)

Mood:- euphoria, very labile, despair then quickly to unRestrained Merriment & ecstasy, then irritable, or totally indifferent May Have panic anxiety.

Cognition & Perception:- clouding of consciousness, confusion, disorientation & sometime stupor, Religiosity, delusions of grandeur or persecution, auditory & visual Hallucination, extremly Distractible incoherent.

Activity & Behaviour:- Frenzied Psychomotor activity, agitated purposeless Movt. exhaustion injury to self or death without intervation.

Prioritize these diagnoses By Navowls Hierachy of Needs

Another Big part of the intervention For Manic patients is to educate them about Meds → see ti.

& Also teach about cause & symptoms of Mania to pt. & family, along with assertiveness & anger Management, crisis Hotline, support groups, psychotherapy & financial assistance.

Nursing Diagnosis	outcomes	Interventions
◦ Risk for injury r/t Hyperactivity	Pt exhibits No injury	◦ Reduce Stimuli, Private Room, Noise low, Remove Hazards, Stay with pt, provide phys. activities, admin tranquilizers
◦ Risk For violence - self & others R/t Manic excitment, delusions, Hallucinations	Pt Has Not Haumedanyone Pt exhibits No agitation	◦ Reduce Stimuli, CK q 15 Min, Remove Hazards, physical activity / Maintain Calm attitude, Have enough Staff to show strength
◦ Imbalance Nutrition - less than Req r/t Refusal to sit still & eat	◦ Pt eats well balanced diet	◦ Provide High-protein & calorie snacks for eating on the Run (fingerfood), snacks & Record I & O's.
◦ Disturb. thought process r/t Biochem alt in Brain AEB delusions	◦ Pt verbalizes accurate interpretation of environment	◦ Assist client to define & test Reality.
◦ Disturbed Sensory Preception R/t biochem. Alt in brain AEB Hallucinations.	Pt verbalizes Hallu. Have Stopped	Assist Client to define & test Reality
◦ Impaired social interaction R/t ego centric, Narcissistic behaviour AEB No friends	◦ Pt accepts responsible Behaviour ◦ Pt interacts appropriately	◦ Ignore charm or arguments, set limits or violations.

Lithium- 4 Questions

Toxic levels & their side effects

Patient teaching

NID- Potential For injury - what is the Nurses Responsibility in terms of injury?

Lithium - Antimanic Mood stabilizers

Used for :- prevention & treatment of Manic episodes of Biopolar Disorders. Also used for Bipolar Depression.

unlabeled use :- Major Depression, Neutropenia (abnormally small amt of Neutrophils in the blood), cluster or Migraine Headache Prophyloxis, alchol Dependence.

How does it work :-

May enHance Reuptake of Norepinephrine & Serotonin - May take 1-3 weeks to decrease symptoms.

Contraindications :-

Hypertension, Cardiac or Renal diseases, dehydration, Sodium depletion, Brain damage, Preg & lact. caution w/ thyroid disorders, diabetes, Urinary Retention History of seizures, & elderly.

Dose

For acute Mania 1800-2400 mg/daily. For Maintenance 900-1200 Mg/daily

Therapeutic Plasma Range

For acute Mania - 1.0 - 1.5 mEq/L. For Maintenance 0.6-1.2 Eq/L

Nursing Diagnosis With any patient on Lithium is Risk For Injury R/t Lithium toxicity

Because?

The therapeutic Range is very Narrow! therefore, Serum Lithium levels s/b checked once or twice a week until Serum level are stable, then Monthly during Maintenace therapy. Blood draws s/b drawn 12 Hours after last dose.

Teach Pt & family about follow up blood checks!!!

Because?

Lithium is chemically Similar to Sodium in the body If you loose Sodium (by vomiting, diarrhea, Sodium Restriction due to diet), dehydration, sweating, fever. diuresis) the Lithium will Replace Sodium in the Blood increasing Serum Lithium levels causing toxicity.

Teach Pt & family about Sodium & to avoid excess or Strenuous exercise, Notify Dr. w/ vomiting or diarrhea. Eat Right!!!

Recognize Lithium Toxicity:-

- **Mild toxicity** - level 1.5 - 2.0 mEq/L
  - Blurred vision, ataxia (loss of muscle coordination), tinnitus, persistent Nausea & vomiting, severe diarrhea.
- **Moderate toxicity** - levels of 2.0 - 3.5 mEq/L
  - Excessive dilute urine, increasing tremors, Muscular irritability, Psychomotor, Retardation Mental confusion, giddiness.
- **Severe toxcity** - level above 3.5 mEq/L
  - Impaired consciouness, Nystagmus, seizure, coma, oliguria, anuria, arrhythmias, Myocardial infarction, cardiovascular collapse.

So, Recognize these - Teach patient to Recognize these. Teach family to Recognize these!. If you see them, If patient says He/She Has them HOLD one Med. Check Lithium levels & Notify Physician if level are above 1.5 mEq/L.

MED (20 questions)

How Do you treat :-

Anxiety :- antianxiety drugs or anxiolitics (aka Minor Tranquilizers)

What are the anxiolitics?

Antarax, Vistaril

Xanax
Librium
Klonopin
Tranxene
Valium
Ativan
Serax

Benzodiazepines

Miltown

Buspar

What should we Rember about this Anxiolitics?

Takes 2.5 - 3.5 Half Lives or weeks to be effective.

- So NOT a PRN
- Does Not depress CNS
- Must be traped off this Med

What should we Rember about these anxiolitics?

They are CNS depressants
- So Makes Pt drowsy confused, lethargic
- Alcohol is CNS depressant to o
- work By GABA potentiating
- They act immediately
  - So May be ordered as PRN Meds.
- They are very addictive

So don't give drug addicts, just be New addiction.

- pt gets dependence, Builds tolerance therefore Must be tapered off.
  - do not stop abruptly
  - Orthostatic Hypotension dangle.

How do you treat :-

Depression :- Antidepression drugs or antidrepressants

- SSRI's, MAOI's, Tricyclics, Others

What are things to Remember about antidepressants in general (applied to all)?

- A patient with bad or vegetative depression with NOT Have energy to carry out suicide, but as these antidepressants starts to do their job but Have Not quite Brought the patient to Happy Mod, they will Have enough of an energy increase to carry out suicide. Therefore, a Nursing Diagnosis For Any Patient Starting antidepressants is Risk For suicide.
- All antidepressent Cause dry Month, Sedation, Nausea, Discontinuation Syndrome.

Teaching For all antidepressents

- Don't think with antidepressents
- Don't Stop taking Meds abruptly
- Don't stop because your symptoms went away
- usally takes 4 weeks for drug to take effect.

- Always carry a card with your drug information on it.

Ethnopharmacology:

Exit For Blacks & Asians :- They will probably get started on a lower than typical dose

What are SSRI's?

These ~~drug~~ drugs inhibit the Reuptake of excess serotonin in the synaptic cleft. Serotonin is thought to be Needed for a Happy & well Mood. Therefore, the SSRI or Selective Serotonin Reuptake inhibitor leaves More Serotonin in the body to do its job.

What are the SSRI's?

Celexa

Prozac, Sarafem

Luvox

Lexapro

Paxil

Zoloft

Symptoms of Serotonin Syndrome:-

- Mental Status changes, Restlessness, Myoclonus, Hyperreflexia
- tachycardia, labile blood pressure, diaphoresis.
- Shivering, tremors.

What teaching goes with SSRI's?

- Serotonin syndrome is a possibility if concurrent w/ other serotonin increasing antidepressants.
- Taper off these Meds or Pt May get discontinuation syndrome which presents with flu-like symptoms
- Insomnia is fairly common.
  - Also Headache, weight loss, Sexual Dysfunction GI Distress ^ BP, ^HR

What are the MAOI's?
Marplan
Nardil
Parnate

→ WHat are MAOI's?

Monoamine oxidase is an enzyme that destroys or inactivates unused Monoamine Neurotransmitters Histamine, Serotonin, Melatonin & More.
Therefore, a MAOI or Monomine Oxidase inhibitor stops this enzyme leaving More of these amines available in the Brain to do their job.

What Has tyramine?

Aged cheese, Raisin, wines
Smoked or Processed Meat,
Caviar, corned beef, livers
Soy sauce, Brewers yeast.
Yogurt, Sour cream, beer
Coffee, tea, Chocolate Bouillon
Figs, all alcohol.

What teaching that goes with MAOI's?

- can't take them with other antidepressants
  - If switch, Must be 2-3 wk period between.
- will Have a Hypertensive crisis with Food with tyramine

What are the Tricyclic's?

Elavil, Endep
Asendin
Anafranil
Norpramin
Tofranil
Aventyl, Pamelor
Vivactil
Sumontil

alpha, function

Smooth Muscle Contraction, includes vasoconstriction - so you get orthostatic Hypotension

What are Tricyclics TCA?

→ These are the bad guys. They do many things, inhibit the Reuptake of serotonin, & Norepinephrine, Block alpha Receptors, Ach Receptors, Histamine Receptors.

Histamine function

- Ileum contractions
- Modulate circadian cycle
- Systemic vasodilation
- Bronchoconstriction

Blocking the Ach Receptor causes Anticholinergic side effects

Ach - side Effects

"Mad as a Hatter"	Delirium
"Blind as a bat"	Mydriasis
"Red as a beet"	Flushed
"Dry as a bone"	Dry Skin
Hot as a Hare	Hyperthermia

Confusion, drowsiness, Hallucinations, dry Mouth, Constipation, palpitations, tachyarrhythmia, urinary Retention, dry eyes, blurred vision, falls.

Asendin
Has High
Risk for
EPS

→ Patients only get one weeks worth of these prescribed at one time because they are so dangerous & goods to use for suicide

What are the others?"

Zyban, wellbutrin
Ludiomil
Remeron
Desyrel
Serzone
Effexor
cymbalta

Ludiomil (Maprotiline) & Remeron (Mirtazapine)

Have anticholinergic side effects.

- They all have sedative effects. exception Zyban, wellbutrin (bupropion)

Desyrel (trazodone) can give you priapism - prolonged or inappropriate erection (Hold Med & contact physician immediately)

- serzone (Nefazodone)

May cause life-threatening liver failure (Report jaundice anorexia, GI complaints, or Malaise immediately)

FDA Has put a black box warning on this drug for that Reason.

- Remeron (Mirtazapine) cause patient to gain weight

How do you treat:-

Mood Disorders:- Mood stabilizing drugs or antipsychotic Mood stabilizers.

What are they?

There are 4 different Kinds of Mood stabilizing drugs:-

Antimanic-
Lithium.

Calcium Channel Blockers.
Calan, Isoptin
Verapamil

Antipsychotic

Zyprexa
Abilify
Thorazine
seroquel

Risperdal
Geodon

Anticonvulsant.
Klonopin
Tegretol
Depakene, Depakote
Lamictal
Neurontin
Topomax

What to Remember about Mood stabilizing drugs?

Lithium is the oldest & Most often used Mood stabilizers. Is often used with other Mood stabilizing drugs.

Lamictal (lamotrigene):- Causes an increased risk of Stevens Johnson Syndrome.

What is Stevens Johnson syndrome?

- Another kind of SJS is Toxic Epidermal Necrolysis (TEN)
- It is a severe adverse Reaction to drugs which is a Rash on the Mucous Membranes.
  - Starts out with
    - Flu Symptoms
    - Blisters in Mouth, eye, ears, Nose
    - Burning during urination
  - stop the Med immediate at first signs of blisters
- Literature as links to NSAIDS & carbamazepine (tegretol)

How to Treat :-

Schizophrenia

what are the antipsycotic drugs (aka Neuroleptic)

↓

1st generation :- targeted the positive symptoms.

Phenothazines – chemical class.

Thoroxine (Chloropromazine)
Prolixin (fluphenazine)
Trilafon (perphenazine)
Compazine
Mellaril (thioridazine)
Stelazine (trifluoperazine)

2nd generation - targeted the Negative symptoms

Thioxanthene - chemical class.

Navane (thiothixene)

Butyrophenone - chemical class

Haldol (Haloperidol)

↓

Atypical - targeted both positive & Negative symptoms. various chemical classes:-

↓

Risperdal (Risperidone)

Loxitane (loxapine)

Moban (Molindone)

Orap (pimozide)

Zyprexa (olanzapine)

Seroquel quetiapine)

Geodon (ziprasidone)

Abilify (aripiprazole)

What do we Need to Remember in general with anti psychotic drugs (applies to all)!

- Most work by Blocking dopamine Receptors with

and adrenergic blocking also.

- Even with just 80% of the dopamine Receptors blocked, Extrapyramidal symptoms EPS

  → Clients Have to decide whether the want altered thought or altered body control.

- with the Muscarinic blocking Anticholinergic symptoms occur.
- with long-term use Tardive dykinesia is a Risk (can be irreversible)
- Orthostatic Hypertension :- occurs but will usually go away after-3-4 weeks
- Hormonal effect occur including :- Retrograde ejaculation ejaculation into the bladder.
  gynecomastic (large & lactating breast on men)
  amenorrhea :- (No menstrual period For women).
- Agranulocytosis can occur.
- It a diabetic takes antipsychotic drugs their Risk of is increased.
- These drugs lower the Threshold for seizures

  So ~~to~~ watch pt w/ seizure history closely.

- Skin Rash, GI upset, Sedation, Photosensitivity.

Extrapyramidal Symptoms (EPS) includes:-

- Pseudoparkinsonism
- Akinesia
- Akathesia
- Dystonia
- Oculagyrics crisis

↓

EPS' are fixed with ABCs

- Antane (anticolinergic)
- Benadryl (antihistamine)
- congentic (antcholinergic)
- Symmetrel

Tradive dyskinesia

- Face (Tic, blinking, grimacing)
- Tongue (chewing, protrusion, tremor)
- Lips (smacking)
- Respiratory (irregular breathing, grunting)

↓

Important to known about TDIs.

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Don't panic with Mild Sumptoms & drug because patient's chance of Committing suicide is great

TD's are potentially irreversible:

They can be acutely suppressed with a increased dose (Ms Mellon)

Drug should be stopped immediately at first signs to stop chance of permance (book)

Non