CHAPTER 37 MENTAL DISORDERS

LPNs/LVNs and Clients with Mental Health Disorders:
° Nurses will encounter people with mental health disorders in the health care setting, so basic understanding is important.
° Definition of mental health and illness varies over time and with culture [corresponds to Box 37-1]

Important Aspects of Mental Health [corresponds to Box 37-2]
° Accurate understanding of reality
° Healthy self-concept
  o Term: insight
° Ability to relate well to others
° Sense of meaning in life
° Creativity/productivity
° Control over one’s own behavior
° Adaptability to change and conflict

American Psychiatric Association
° Mental illnesses caused by a combination of factors including genetics, biological, social, chemical, and psychological influences.
° Classification by Diagnostic and Statistical Manual of Mental Disorders, 4th ed, text revision
° Classify disorders, not people
° Facts about mental illness in the US (National Institute of Mental Health statistics) [corresponds to Box 37-3]

5 Most Common Mental Illnesses:
° Major depressive disorder
° Alcohol abuse
° Schizophrenia
° Self-inflicted injuries
° Bipolar disorder

Stigma of Mental Illness
° Culture has different, more negative attitude toward people with mental illness than toward people with physical illness.
° Stigma, demeaning labels, social isolation
° Common terms referring to people with mental illness (crazy, nuts) are negative, insulting, and demeaning. Having a mental illness can make a person feel labeled or marked for ridicule and judgment.
° Some inequalities between mental and physical illness:
  o People must often report mental illness when they apply for jobs or licenses.
  o Insurance companies reimburse less for mental than for physical illness.
  o Diagnosis of depression might not be recorded by physician because of employment consequences to client.

Nurse’s Role in Mental Health Promotion:
° Help client recognize the risk factors and prevent them [corresponds to Figure 37-1]
° Provide 3 levels of care:
Prevention – as in drug abuse education and prevention
Treatment – as in depression screening to treat condition early
Rehabilitation – as in walk-in clinic for clients with schizophrenia to learn to socialize

National Alliance for the Mentally Ill (NAMI) recommendations:
  ° Refuse to stigmatize people.
  ° Provide excellent care.
  ° Tell legislators to change unfair laws and health policies and to fund mental health.
  ° Contribute to NAMI.
  ° Speak out for people with mental disorders.

Causes of 3 Major Disorders (schizophrenia, major depressive disorder, bipolar disorder):
  ° Combination of nature and nurture
    ° Genetic, structural, and neurotransmitter changes [corresponds to Table 37-1]
    ° Social and environmental factors
  ° Treated with psychotropic medications
    ° Groups of medications target specific symptoms [corresponds to Figure 37-2]

Schizophrenia
  ° Complex brain disorder affecting about 10% of population characterized by psychosis, decreased ability to relate to self and others; decreased ability to function; disorganized thoughts and behaviors
  ° Term: schizoaffective disorders, prototype
  ° Disease can make people unable to understand that they are mentally ill (lack of insight); this affects compliance with treatment.
  ° Cause of schizophrenia -10 major findings:
    ° Familial
    ° Neurochemical changes
    ° Changes in brain structure and function
    ° Cognitive impairments
      • Term: executive function
    ° Neurologic abnormalities
    ° Brain electrical abnormalities
    ° Immunologic and inflammatory abnormalities
    ° Season of birth – primarily winter and spring
    ° Urban living
    ° Other – pregnancy and birth complications, minor physical anomalies, absence of rheumatoid arthritis
  ° DSM IV criteria for diagnosis of schizophrenia
    ° Two or more of:
      • Delusions
      • Hallucinations
      • Disorganized speech
      • Catatonic behavior (decreased response to environment)
• Social/occupational dysfunction
• Duration of disturbance for at least 6 months

° Symptoms as described by clients with schizophrenia [corresponds to Box 37-4]
° Manifestations of schizophrenia fall into one of three major categories.
  o Positive:
    • Hallucinations
    • Delusions [corresponds to Table 37-2 Types of Delusions]
    • Disorganized:
      • Disorganized thinking
      • Disorganized behavior
  o Negative symptoms:
    • Flat affect
    • Alogia (poverty of speech)
    • Avolition (lack of motivation)
    • Anhedonia (inability to feel pleasure)
    • Prodromal phase – warning phase, usually with negative symptoms
  o Acute phase – positive and negative symptoms
° Treatment for schizophrenia:
  o Medication improves long-term prognosis and reduces incidence of suicide.
  o Because of lack of insight, medication compliance is a major problem for clients with schizophrenia.
  o Continuum of care
    • Hospitalization for acute episodes
    • Case management to ensure community services
    • Resources for housing, food, etc.
    • Housing and care options (subacute care, day hospitalization, supervised living, group homes, foster care homes
    • Outpatient treatment in client’s community
    • Support for families; referrals
  o Milieu therapy – for clients in institutional setting
    • Environment pleasant, simple, safe, no background noise.
    • Consistent nursing staff to promote trust.
    • Nurse models normal behavior and interactions.
    • Clients encouraged to participate in social activity.
  o Psychosocial rehabilitation
    • Goal is to adjust to living in the community.
    • Learning strategies for preventing relapse of mental illness [corresponds to Box 37-5]
  o Psychopharmacology – cornerstone of therapy for schizophrenia
    • Medication is basic part of therapy (antipsychotics or neuroleptics) [corresponds to Box 37-6]; may take 3-6 weeks to have desired effect
  o Goals of treatment:
• Relief of psychosis symptoms.
• Safety
• Improved function and quality of life
• Compliance with medication regimen

Categories of Medications for Schizophrenia:
° Typical antipsychotics (first generation)
° Atypical antipsychotics (second generation)
° New-generation antipsychotics
° Depot injection

Typical Antipsychotics
° More effective in treating positive symptoms, especially acute psychosis with agitation; not very effective on negative symptoms.
° After 12-24 months of stable maintenance, drug can slowly be tapered. Some clients require lifelong treatment.
° Antipsychotics target dopamine-2 receptors; they reduce dopamine activity in the brain; have several side effects
° Side effects of typical antipsychotics
  o Extrapyramidal side (EPS) effects very uncomfortable [corresponds to Box 37-7]
    • Dystonia – abnormal muscle contraction
      ↑ Mild, such as jaw tightening
      ↑ Severe, such as torticollis (stiff neck)
    • Abnormal movement (pseudoparkinsonism or dyskinesia)
    • Akathisia (restlessness)
    • Tardive dyskinesia (cogwheel rigidity, involuntary movement) may develop after long-term therapy
    • Drugs to treat EPS [corresponds to Table 37-3]
  o Neuroleptic malignant syndrome
    • Idiopathic reaction, potentially fatal
    • High fever, muscle pain and rigidity, unstable BP, diaphoresis, pale skin, delirium, inability to speak, tremors, elevated creatinine phosphokinase (CPK) indicating muscle damage.
    • Usually occurs early in therapy.
    • Nurse must monitor for signs and report immediately!
  o Other side effects:
    • Breast enlargement (gynecomastia) and milk production (galactorrhea)
    • Weight gain
  o Additive effects of antipsychotic medications with CNS depressants, antacids
    ° Anticholinergic drugs [corresponds to Table 37-3]
      o Restore dopaminergic and cholinergic activity balance. Dopamine-acetylcholine balance is goal.
      o Anticholinergics can also have side effects; manifestations [corresponds to Box 37-8]
        • Weight gain
• Orthostatic hypotension
• Cardiac side effects
• Seizures
• Photosensitivity

Atypical Antipsychotics
  ° Effective with negative symptoms and have fewer side effects
  ° Effective for people who don’t respond to typical agents
  ° Side effects
    o Most serious side effect of atypical antipsychotic clozapine is agranulocytosis; can be life threatening; clients receiving clozapine must have weekly WBC count for first 6 months and biweekly WBC after that
    o Other major side effect diabetes

New-Generation Antipsychotic aripiprazole (Abilify, Abilitat)
  ° Stabilizes dopamine levels in brain

Depot injection
  ° Slow release; haloperidol (Haldol) and fluphenazine (Prolixin);
  ° Relieves compliance issues because only given once every 1 to 4 weeks

Nursing care for clients with schizophrenia:
  ° Use mental status assessment to describe client:
    o Appearance
    o Orientation
    o Mood and affect
    o Speech characteristics
    o Thought disorder
    o Hallucinations
    o Behavior
    o Memory
    o Judgment/insight
  ° Be sensitive to cultural variations in what is considered normal behavior.
  ° Physical assessment:
    o Confine physical data to what is essential.
    o Keep physical touch minimal; may be threatening to client.
    o Provide prn medications for EPS to encourage compliance.
  ° Focus on promoting self-care coping skills, safety.
  ° Encourage clients to perform ADLs and participate in activities.
  ° Give positive reinforcement for appropriate behavior and insight.
  ° Reinforce reality.
  ° Encourage client to express feelings of fear or anxiety. Validate feelings.
  ° Observe actively hallucinating or delusional clients closely.
  ° Communicate with family to increase understanding of client.
  ° Intervene at early sign of escalating behavior. Avoid triggers of client behavior.
  ° Be aware of your own body language with an agitated client. Turn body slightly to side; talk calmly and confidently. Start with least restrictive intervention first. Order of interventions for inappropriate behavior:
    o Talk to client.
- Redirect client’s attention.
- Offer medications in confident manner.
- Isolate or medicate client.
- Use restraints only as last resort.
  - Instruct client and family about strategies to prevent relapse. [corresponds to Box 37-5]
  - Teach client ways to prevent weight gain.

Mood Disorders

- Major depressive disorder
  - Diagnostic criteria
    - Depressed mood most of time for prolonged time
    - Diminished ability to feel pleasure
    - Weight and sleep pattern change
    - Insomnia or hypersomnia
    - Psychomotor agitation or retardation
    - Fatigue
    - Feelings of worthlessness or inappropriate guilt
    - Diminished ability to think or concentrate
    - Recurrent thoughts of death
  - Cause and incidence
    - Genetic, brain physiology, and psychosocial components
  - Course of the disease
    - May begin at any age in susceptible person
    - Postpartum depression
      - Postpartum psychosis – usually within 3 weeks of birth
    - Seasonal affective disorder
      - Cause: reaction to reduced sunlight
      - Treatment: phototherapy
  - Clinical features
    - Client’s descriptions of feeling of depression [corresponds to Box 37-10]
  - Manifestations of a major depressive episode [corresponds to Figure 37-4]
    - Psychotic depression more severe and usually more prolonged
    - Risk factors for suicide [corresponds to Box 37-11]
      - Highest among older adults
      - Geriatric depression scale [corresponds to Box 37-12]
    - Ask clients about suicidal thoughts; allow them to talk about their feelings.
  - Treatment to decrease depressive symptoms, improve client’s functional level, and prevent recurrence
    - Four groups of antidepressants [corresponds to Box 37-13]:
      - Tricyclic and related agents
        - Take 2-4 weeks to show effect
        - Can be fatal in overdose
- Anticholinergic effects in older adults [corresponds to Box 37-14]
- Watch for glaucoma in clients

↑ Selective serotonin reuptake inhibitors
- Usually first choice for treating depression; fewer side effects than antidepressants
- Low potential for abuse or for harm with overdose
- Side effects: GI effects (nausea, loose stools, weight loss); sexual side effects: decreased libido, ejaculatory/orgasmic dysfunction headache, anxiety, nausea, diarrhea, insomnia
- Drug interactions: can increase circulating levels of other protein-bound drugs like TCA drugs or lithium
- Serotonin syndrome:
  Cause: combination of SSRIs and MAOIs (including St. John’s wort or tryptophan)
  Manifestations: changes in mental status, agitation or restlessness, muscle spasms, hyperreflexia, diaphoresis, shivering, tremor, diarrhea, abdominal cramps, nausea, lack of coordination, headache
  Prevention: 2-week “wash-out” period to clear body between drugs

↑ Novel antidepressants
- Norepinephrine and dopamine reuptake inhibitor (bupropion; Wellbutrin, Zyban)
- Serotonin and norepinephrine reuptake inhibitor (venlafaxine; Effexor)
- Nonadrenergic-specific serotonergic antidepressants (mirtazapine; Remeron)
- Serotonin antagonists and reuptake inhibitors (trazodone [Desyrel] and nefazodone [Serzone])
  - Trazodone – potentially serious side effect priapism
- Norepinephrine reuptake inhibitor reboxetine (Vestra)

↑ Monoamine oxidase inhibitors (MAOIs)
- Effective but seldom prescribed; serious side effects, potentially fatal interactions, hypertensive crisis, death in overdose
- Foods to avoid (high in tyramine) [corresponds to Box 37-15]
- Moclobemide (Manerix) is reversible selective inhibitor of MAO-A; shorter acting, lacks serious hypertensive side effects; does not require low tyramine diet
- Should not be given with older MAOIs or with narcotics

• Psychotherapy [correspond to Figure 37-6]
  ↑ Cognitive - learning to live with chronic condition
  ↑ Behavioral – targets and replaces dysfunctional behaviors
  ↑ Exercise – moderate physical exercise relieves depressive symptoms
• Electroconvulsive (ECT) therapy – done under general anesthesia; response often quicker than with medication
  ↑ May have side effect of transient memory loss and mental confusion
  
  o Priorities in nursing care:
  • Focus is client safety and promoting social interactions
  • Intervene if client report suicidal thoughts; report them.
  • Work to build trust with clients.
  • Encourage participation in structured group activities
  • Encourage hope; teach about disorders and treatment plan

  o Bipolar disorder (manic-depressive disorder) – first appearance usually in 20s; equally men and women; usually follows psychosocial stressor.

  o Diagnostic criteria:
    • Inflated self-esteem or grandiosity
    • Decreased need for sleep
    • More talkative
    • Distractibility
    • Excessive involvement in pleasurable activities
    • If abusing substances, may have more rapid cycling between mania and depression, more dysphoric feelings in manic phase
    • If accompanied by psychosis, more serious and more likely to involve aggression or suicide

  o Common symptoms (manic episode)
    • Agitated, euphoric, irritable
    • Pressured speech, rhyming speech
    • Hypersexual
    • Bright flashy clothing, outrageous jewelry
    • Rapid, disorganized and incoherent thinking [corresponds to Box 37-16]
    • Characteristics of a manic episode [corresponds to Figure 37-9]

  o Treatment of bipolar disorder
    • Medication is the mainstay of treatment
    • Lithium is primary drug; [corresponds to Box 37-17]
    ↑ Can have a toxic effect of renal function
    ↑ Sodium/fluid balance is important
    • Anticonvulsant mood stabilizers
    ↑ Valproate – Depakene, Depacon, Depakote
      - Can cause fetal anomalies; do not combine with CNS depressants
    ↑ Carbamazepine – Tegretol; thought to stabilize kindling process (small seizure building to big one); can cause bone marrow suppression
    ↑ Lamotrigine (Lamictal); can cause skin reactions, especially in children < 16 years
    • Treatment compliance is issue with any medication.
    • Client teaching is important.
• Mood stabilizer is used.
• Psychotherapy is helpful.
• Group therapy is helpful.

○ Priorities in nursing care:
  • Encourage and praise appropriate behavior.
  • Encourage medication compliance.
  • Establish acceptable guidelines for behavior.
  • Intervene quickly with least restrictive environment to help client regain control.
  • Encourage moderate exercise to release energy.
  • Have client pay attention to mood.
  • Keep hope alive.

○ Nursing Process Care Plan: Client with Depression

Personality Disorders

° Terms: personality and personality disorder
° Personality disorders divided in three clusters [correspond to Table 37-4]
° Diagnostic criteria for personality disorders:
  o Deviates significantly from normal expectations
  o Pervasive and inflexible
  o Begins in adolescence or young adulthood
  o Stable over time
  o Leads to distress or impaired functioning
° Common clinical features of personality disorders.
  o Impaired self-identity
  o Thinking patterns distorted
  o Emotions distorted
  o Impulsive behavior
  o Self-defeating cycle of behavior [corresponds to Figure 37-11]
  o Manipulative, socially inappropriate, difficult
° Priorities in nursing care:
  o Be aware of your own responses to manipulation and respond professionally. (Vent among staff, not with client.)
  o Enlist aid of family in understanding client.
  o Be matter of fact. Do not ignore client’s suspicions, but do not support irrational fears.
  o Ask about any signs of self-harm [corresponds to Figure 37-12]
  o Tell clients who may harm themselves to tell staff when they feel like doing so.
  o Help clients keep positive direction.

Critical Thinking Care Map: Caring for a Client Who Is Experiencing Psychosis#