***Psychiatric Assessment***

۞ A thorough assessment of a psychiatric patient consists of:

(1) Psychiatric history.

(2) Mental status examination

(3) Physical examination

(4) And certain relevant laboratory and psychological tests.

**A Comprehensive Psychiatric Assessment**

A thorough psychiatric assessment is crucial for accurately diagnosing and treating mental health conditions. It typically involves four key components:

**1. Psychiatric History**

* **Personal history:** Patient's childhood, adolescence, and adulthood experiences, including family relationships, education, and occupation.
* **Family history:** Mental health conditions in family members, particularly first-degree relatives.
* **Past psychiatric history:** Previous diagnoses, treatments, and outcomes.
* **Substance use history:** Alcohol, drugs, and medications.
* **Medical history:** General health conditions and medications.

**2. Mental Status Examination**

* **Appearance:** Grooming, posture, and eye contact.
* **Behavior:** Motor activity, speech, and cooperation.
* **Mood:** Subjective report of emotional state.
* **Affect:** Observable emotional expression.
* **Thought process:** Coherence, organization, and presence of delusions or hallucinations.
* **Thought content:** Preoccupations, obsessions, or suicidal ideation.
* **Orientation:** To person, place, and time.
* **Memory:** Immediate, short-term, and long-term recall.
* **Attention and concentration:** Ability to focus and sustain attention.
* **Intelligence:** Estimated level of cognitive functioning.
* **Insight:** Awareness of one's illness.
* **Judgment:** Ability to make sound decisions.

**3. Physical Examination**

* **General medical evaluation:** Vital signs, physical appearance, and any signs of illness.
* **Neurological examination:** Assess cognitive functions, motor skills, and reflexes.
* **Specific examinations:** Depending on the presenting symptoms, e.g., neurological exam for seizures, gynecological exam for hormonal issues.

**4. Laboratory and Psychological Tests**

* **Laboratory tests:** Blood tests to rule out medical conditions that can mimic psychiatric symptoms (e.g., thyroid function, electrolyte imbalance).
* **Psychological tests:** Standardized assessments to measure specific cognitive functions, personality traits, or psychiatric symptoms (e.g., IQ tests, personality inventories, depression scales).

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

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

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

the initial interview is a one-time event to establish a baseline, while informal interviews are ongoing interactions that help to maintain a therapeutic relationship and monitor the client's condition.

۞ **The purposes of interview are**:

1. To establish rapport with the patient.
2. Complete the nursing history within specific period of time.
3. To make nursing diagnosis.

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

1. Initial or beginning phase: in this phase you should begin to develop a rapport with the client and to engage the client in the meeting.
2. Middle phase: in this phase the necessary data are collected.
3. Termination phase: interview summarizes what has been accomplished during the meeting.

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

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

* Introduce yourself.
* Be calm: كونك مهذبًا ومحترمًا فإنك تظهر أنك مسيطر.

being polite and respectful you show that you are in control. This can be very comforting to someone who is afraid.

* Be gentle: كن لطيفاً: اقترب من الشخص بطريقة لطيفة. بسبب مرضهم والوصمة المرتبطة به، قد يكونون مشبوهين

Approach the person in a gentle manner. Due to their illness, and the related stigma, they may be suspicious.

* Do not laugh: Never laugh at anything strange a person says. This will stop them from trusting you and make them feel stigmatized.
* Do not correct: If the person says things that are strange or unbelievable do not try and correct them.
* Get the whole story: Always try and speak to the family or someone who knows what has been going on.
* Ensure privacy: Always try and speak to the person alone, a person may have things they wish to share with you that they wish to keep private, even from their own family.
* Make time: This is very important. Do not keep looking at your watch.

***Psychiatric History***

* **Identifying data**: collecting basic details about the patient, such as name, sex, age, educational status, occupation, and significant other.
* **Chief complaint**: the reason for the patient’s presentation..
* **History of present illness**: date of onset, duration and course of symptoms. Obtain the chronological(**Chronological Description**
* **Definition:** A systematic account of events, experiences, or symptoms in the order in which they occurred over time.
* **Purpose:** Provides a clear timeline of a person's life, highlighting significant milestones, challenges, and changes.
* **Example:** "The patient reported experiencing increased anxiety symptoms following a job loss in 2022.")

description of recent events leading to this presentation, precipitating events(**Precipitating Events**

* **Definition:** Specific events or situations that trigger or worsen a mental health condition.
* **Purpose:** Helps identify potential causes or contributing factors to a person's symptoms.
* **Example:** "A recent breakup الانفصال with a significant other is believed to be a precipitating factor for the patient's depressive episode.")

, and any other psychosocial stressor.

* **Past medical history**: past and current medical problem, treatment, and allergies.( **Thyroid disorders:** Hypothyroidism and hyperthyroidism can cause mood swings and depression.
*  **Neurological disorders:** Conditions like Parkinson's disease and multiple sclerosis can lead to depression and anxiety.
*  **Cardiovascular disease:** Heart disease and stroke can increase the risk of depression and anxiety.)
* **Past psychiatric history**: past and current diagnosis, hospitalization, treatment and past problem with suicidal thoughts and attempts.
* **Family history**: presence of psychiatric illness in family members.
* (**Genetic:**
* **Refers to the study of genes and heredity.**
* **Involves the transmission of traits from parent to offspring through DNA.**

Hereditary:

Relates to the passing of traits from one generation to the next.

Can be influenced by both genetic and environmental factors.

* **Social history**: this section should cover the major domains of patient's life.
* **Development history**: past, present, family, social, and cultural.
* **Substance abuse history**: if any substance abuse is present ask about the amount used and the method of use.

***Mental Status Exam***

* + ***Appearance*:** Dress, grooming, hygiene, cosmetics, apparent age, posture, facial expression.
  + ***Behavior*/ activity:** Hyperactivity or hypoactivity, rigid, relaxed, restless, or agitated motor movements, gait and coordination, facial grimacing, gestures, mannerisms(**Mannerisms** in psychiatry refer to **unusual or exaggerated behaviors** that individuals exhibit, often without being aware of them,,  **Echopraxia:** Imitating the movements of others.
  +  **Echolalia:** Repeating words or phrases.
  +  **Stereotypies:** Repetitive, meaningless movements.
  +  **Grimacing:** Making unusual facial expressions.
  +  **Posturing:** Holding unusual or rigid postures.
  +  **Catatonic behavior:** Remaining motionless or exhibiting resistance to movement.), passive, combative قتالية, bizarre.
  + ***Attitude/rapport***: attitude toward the examiner. For example, is the patient friendly, cooperative, bored, or defensive?
  + ***Mood* and affect:**
* **Mood** (Subjectively experience and reported by person Response to question):- sad, fearful, depressed, angry, anxious, ambivalent شخص يشرب ومسمتع وبنفس الوقت يعتقد بضرر الكحول, happy, ecstatic ( great raptureفرحة كبيرة or delight نشوة ), grandiose.
* **Affect** (objectively expression of emotion observed or defined by the interviewer):- appropriate, apathetic, constricted, blunted reduce emotional responses , flat, labile, and euphoric intense excitement and happiness .
  + ***Speech*:** quality, quantity, rate, and volume.
  + ***Thought process***: the organization of the patient’s thoughts. (Logical or illogical).
  + ***Thought content*:** Major preoccupations**,** Suicidal ideation, Obsessions and compulsions.
  + ***Perception*:** Hallucination, illusions, depersonalization, derealization,.
  + ***Cognitive Functions and Consciousness****:* oriented (time, place & person), alert, concentrated...
  + ***Insight*:** ability of the patient to understand of his or her illness.
  + ***Judgment***: The ability to assess the situation correctly and act appropriately with the situation (decision making).

***Observation Guide***

* ***General appearance:***
* Body built: Height and weight, proportions of the different parts of the body to each other.
* Posture: How the person holds himself/herself, this might reflect mood and personality.
* Grooming: how the person dress, tidiness, colors, make up, hair.
  + ***General Behavior:***
* With staff: e.g. likes to talk to nurses, wouldn’t talk to nurses or do what they ask for, expresses dislike of the staff.
* With others: e.g. likes to talk to others (whom?), prefer to sit on his/her own, attacks others in words or with objects.
* Activity: general level of activity and its forms e.g. moves all the time, prefers to sit, repeats the same movements, etc.How does the person feel about activity e.g. welcomes it, needs to be encouraged to participate etc…
  + ***Eating and drinking***: state of appetite, way of eating or drinking, rituals attached to eating or drinking, diet restrictions e.g. eats quickly, in a certain sequence, messing with food.
  + ***Sleeping:*** state of sleep during the night, onset, duration, and continuity e.g. takes a long time to settle, sleeps easily wakes early etc… state of sleep during the day, usual pattern, illness pattern. e.g. sleep and drowsy, alert etc…
  + ***Speaking:*** rate e.g. quick, slow, stops in the middle of a sentence fluency e.g. finds difficulties in finding his words content e.g. apparently meaningless sentences, always talks about the same thing, talks about things the listener cannot see, carries a usual conversation etc…
  + ***Mood:*** form e.g. irritable, preoccupied, disinterested etc… stability, e.g. change quickly, always the same regardless of any thing, keeps being different etc…
  + ***Memory:*** e.g. easily forgets, needs reminding, forgets a recent event only remembers past events only etc…
  + ***Attention***: e.g. most be sustained for a period of time on the same subject or activity, appropriate concentration, disoriented i.e. cannot recognize parson place or time e.g. cannot tell the difference between morning and artificial light at night.
  + ***Judgment:*** e.g. grasp meaning of what is said, releases the fact he/she ill, denies being in hospital when he is.
  + ***Facial expression***: e.g. fixed expression, an expression of tension or relaxation expresses the appropriate emotions in relation to content of speech e.g. looks sad when he talks about something painful or unpleasant.
  + ***Perception:*** factors influencing his perception in a given situation form of perception distortion e.g. hallucination e.g. hearing things other cannot hear, seeing things other cannot see. Or illusion e.g. seeing or hearing things present in his own way disturbed perception relates to any of the five senses (hearing, seeing, smelling, touching, and tasting).
  + ***Self concept:*** How does the person see himself, how does he estimate himself, the degree of dignity he has e. g. he thinks he is nothing or that he is the most important person in a group, he allows himself to be ill-treated and be the fun of the group or does he respect himself.

**Note:** It is important to note that the different items of this observation guide are related to each other e.g. an inability to pay attention will influence the facial expression and the communication ability of the pt. as well as his behavior in many ways, like his activity.

Observation is not only a description of the present symptoms; it is also what one interferes from what is present and from the relatedness between and among the different items observed.

* ***Communication:***
  + Identifying elements of difference between usual pattern and illness pattern of communicating with others.
  + Ability to listen e.g. pays attention and interprets correctly, cannot talk in anything due to his preoccupation.
  + Ability to send a message as intended e.g. always says the wrong thing and makes others feel angry when he does not mean it.
  + Ability to receive a message e.g. degree of attention paid, answer before the speaker has finished saying what he has.

***Common signs and symptoms in psychiatry***

***(1) Abnormalities of behavior and movements***

* **Negativism**: Doing opposite of what is required. An uncooperative attitude.
* **Psychomotor Retardation:** Slowed mental and motor activities.
* **Hyperactivity**: Excessive motor activity.
* **Stupor**: A state in which the person does not move, speak or response to stimuli, but he is conscious.
* **Catatonia**: motor anomalies non-organic disorders (as opposed to disturbances of consciousness and motor activity secondary to organic pathology).
* **Waxy Flexibility:** Retention of the same posture for a long time in which the person has been placed.
* **Psychomotor Agitation**: Restlessness with psychological tension.
* **Aggression**: A method of showing anger which may be verbal or physical or both. May be directed toward another person, object or self.
* **Bizarre**: differing from usual, meaningless and purposeless behavior, action or thought.
* **Regression**: Reversion to an earlier or primitive mode of behavior. Less matured behavior to deal with stressful event , Infantile or child like mode of behavior.
* **Dyskinesia:** Restless movement of group of muscles (face, neck, hands).
* **Dystonia**: Painful severe muscle spasm.
* **Akathisia**: subjective feeling of muscular tension secondary to antipsychotic or other medication, which can cause restlessness, repeated sitting and standing.
* **Tics:** Sudden repeated involuntary muscle twisting. e.g. repeated blinking, grimacing.
* **Compulsion**: uncontrollable impulse to perform an act repetitively .e.g. Dipsomania (compulsion to drink alcohol), kleptomania (compulsion to steal), Trichotillomania (compulsion to pull one’s hair).
* **Echopraxia**: Imitative repetition of movement of somebody.
* **Stereotype:** repetition of same actions, postures or gestures for a long time a Monotonous way.
* **Mannerism**: habitual involuntary movements.

***(2) Abnormalities of speech pattern***

* **Irrelevant**: Speech which is not to the point. Unrelated.
* **Incoherent**: a mixture of phrases that have no meaning with any logical connection.
* **Pressure of speech**: increased in volume and contents. Difficult to slow down or stop.
* **Echolalia**: imitation of words or phrases made by other.
* **Mutism:** inability to speak.
* **Poverty of speech**: restricted amount of speech.
* **Stuttering**: frequent repetition or prolongation of a sound or syllable leading markedly impaired speech fluency.

***(3) Abnormalities of mood and affect***

***A. Mood***

* **Depression**: A feeling of sadness and despair.
* **Anxiety**: a state of feeling of apprehension and tension and anticipation of danger.
* **Euphoria**: An exaggerated feeling of well being (moderate in degree).b
* **Elation**: bexaggerated feeling of well being accompanied with physical over activity and excitement (heightened mood).
* **Ambivalence**: holding two opposing emotions or attitude toward a person, object or situation.
* **Anhedonia**: inability to experience pleasure.

***B. Affect***

* **Incongruous**: Emotion expressed inappropriately.
* **Blunt** (constricted): Lack of feeling or emotional response.
* **Flat affect**: absence of facial expression.
* **Indifference**: absence of emotional expression but experience is present.

***(4) Abnormalities of thought***

**A. Form of thought**

* **Flight of ideas**: rapid jumping from one idea to another.
* **Looseness of association**: illogical and haphazard connection between ideas.
* **Tangentially**: an association disturbance in which the speaker goes off the topic around the subject or inability to get the point of the story.
* **Circumstantialities**: the patient give unnecessary details but get the point.
* **Neologism**: making new meaningless words.
* **Concrete thinking**: inability to use abstract thinking.
* **Clang association**: the choice of wards is often take the form of rhyming.
* **Word salad**: incoherent mixture of words and phrases.
* **Perseveration**: Repeating the same sequence of thoughts persistently and inappropriately.

**B. Content of Thought**

* **Delusion**: It is a false, firmly held despite obvious proof against it and which can not be changed by reasoning.
  1. Persecutory/ paranoid delusion: involve the client's belief that "others" planning to harm him or are spying.
  2. Grandiose delusion: the client claim to association with a famous people or celebrities.
  3. Religious delusion.
  4. Somatic delusion: are generally vague and unrealistic belief about client's health & bodily function.
  5. Referential delusion: Ideas of Reference: An in correct interpretation of external events as having direct reference to self (TV, newspaper…..etc)
  6. Nihilistic delusion: the individual has a false idea that the self, a part of the self is none exist.
* **Obsession**: Recurring of an unwanted thought which the person can not resist or eliminate.
* **Phobia**: an intense irrational fear. E.g.

- Agoraphobia: Fear of open places.

- Claustrophobia: Fear of closed spaces.

* **Hypochondriacal**: A false believes of having one of the physical illnesses.
* **Thought Block**: sudden cessation of flow of thought or speech.
* **Thought withdrawal**: delusion that one’s thought are being removed from one’s mind by other people or forces.
* **Thought insertion**: delusion that thoughts are being implanted in one’s mind by other peoples or forces.
* **Thought broadcasting**: delusion that one’s thought can be heard by others, as thought they were being broadcast in the air.

***(5) Abnormalities of perception***

* **Hallucination**: A false perception in the absence of an actual stimulus. It may be in any of the five senses.
  + - Auditory: involve hearing sounds, most often voices talking to or about the client.
    - Visual: can involve seeing images that do not exist at all such as light or dead person.
    - Tactile: refers to sensation such as electricity running through the body.
    - Olfactory: involve smells odor where none exist, it may be a specific scent such as urine or feces.
    - Gustatory: involve taste in the mouth or sense that food taste like something .
    - Cenesthetic: involve the client's report that he or she feels bodily function that is usually undetectable.
    - Kinesthetic: occur when the client is motionless but report the sensation of bodily movement.
* **Illusion**: Misinterpretation of an environmental stimulus.
* **Depersonalization** (altered perception of the self): a subjective sense of being unreal, strange, and unfamiliar to oneself. OR, A false belief of experiencing change in the body image or personality.
* **Derealization** (altered perception of the environment): a false of experiencing change in the surrounding or a feeling of changed reality.

***(6) Abnormalities of consciousness and awareness***

* **Disorientation**: Unawareness of a person in regard to time, place and person.
* **Confusion**: A clouding of consciousness with impaired capacity to think, perceive, remember and respond appropriately.
* **Drowsiness**: Diminished awareness with inclination to sleep.

***(7) Abnormalities of insight***

* **Impaired of insight**: unawareness of a person in regard to his current mental status, its origin and maladaptive behavior.

***(8) Abnormalities of memory***

* **Impaired Memory**: Inability to remember events correctly which may be about immediate, recent or past events.
  + Immediate: recall of perceived material within seconds to minutes.
  + Recent: recall of events over past few days.
  + Recent Past: recall of events over past few months.
  + Remote: recall of events in distant past.
* **Amnesia**: partial or total inability to recall past experiences; may be organic or emotional in origin.
* Retrograde: amnesia prior to a point in time.
* Anterograde: amnesia for events occurring after a point in time.

***(9) Abnormalities of sleep***

* + **Insomnia:** diminished or lack of sleep.
  + **Hypersomnia:** excessive prolonged sleep.
  + **Parasomnia:** disturbed behavior during sleep.

***Therapeutic communication Techniques***

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

### *Non-therapeutic communication Techniques*

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

***Major Classifications of Drugs Used in the***

***Treatment of Mental Illness***

|  |  |
| --- | --- |
| Class | Other Nomenclature |
| 1-Anti-psychotic agents  2-Anti anxiety agents  3-Antidepressant agents  I/M.A.O.I  II/tricycles T.C.  4-Anti mania agents  5-Anti- parknisonian Agents.  6-Anti convulsing agents. | Major tranquilizers. / Phenothiazines.  Neuroleptics. /Ataractic agents.  Minor tranquilizers.  Mood elevators.  Energizers.  Anti extra pyramidal effect agents. |

***Antipsychotic Drugs***

|  |  |
| --- | --- |
| 1- Phenothiazines:   * Chropromazine (Thorazine). * Thioridazine (Mellaril). * Trifluoperazine (Stelazine).   2- Thioxathene:   * Thioxathene (Navane)   3- Butrophenone:   * Halopridol (Halodol) | 4- Dibenzoxaepine:   * Loxapine (Loxitane).   5- Dihydroindolone:   * Molindone (Moban).   6- Atypical:   * Clozapine. * Respridone (Resperdal). |

***Indications:***

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

***Side Effects:***

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

***Extra pyramidal side effects***

1- Pseudo Parkinsonism Symptoms include; tremor, shuffling gait, Drooling, rigidity, and looseness of arm movements.

2- Akathisia, is a continuous restlessness, fidgeting and pacing beyond the conscious control of the client, clients will say things Such as, “I didn’t realize I was so active, “or I can’t stop, I have To keep going,

3- Akinesia: Muscular weakness and fatigue like symptoms.

4- Dystonia; include involuntary muscular movement, of the face, Arms, legs, and neck.

5- Oculogyric crisis: is a syndrome characterized by sudden onset of uncontrolled rolling back of the eyes.

6- Tardive dyskinesia: is characterized by bizarre facial and tongue movements, a stiff neck, and difficulty swallowing.

***Contraindications:***

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

***Patient Teaching:***

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

***Anti-anxiety Drugs***

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

***Indications:***

Treatment of choice in the management of:

* Anxiety.
* Insomnia.
* Stress related conditions.

***Contraindications:***

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

***Side Effects:***

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

***Patient Teaching***

1-Warn pt. To avoid hazardous activities that require alertness or good psychomotor coordination until CNS effects of drug are known.

2-Tell pt. to avoid alcohol while taking this drug.

3-As a pre-medication before surgery, lorazepam provides substantial preoperative amnesia.

***Anti-depressant Drugs***

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

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

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

***Indications:***

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

***Side Effects:***

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

***Contraindications:***

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

***Patient Teaching:***

1- Warn pt. to avoid foods high in tyramine or tryptophan and Large amounts of caffeine.

2- Tell pt. to avoid alcohol wile taking drug.

3- To prevent dizziness resulting from orthostatic hypotension; tell pt. to get out of bed slowly, sitting up for 1 minute first.

4-Because MAOI may suppress angina pain, warn pt. to moderate activities and to avoid overexertion.

5- Advice pt. to consult his doctor before taking any other prescription or OTC medications.

6-Warn pt. not to stop drug suddenly.

***Antidepressant Non MAOI Tricyclic Drugs***

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

***Indications:***

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

***Side Effects:***

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

***Contraindications:***

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

***Patient Teaching:***

1-Warn pt. to avoid hazardous activities requires alertness and good psychomotor coordination especially during titration. Day time sedation and dizziness may occur.

2-Tell pt. to avoid alcohol while taking this drug.

3-Warn pt. not to withdraw drug suddenly.

4-To prevent photosensitivity reactions, advice pt. to use sun block, wear protective clothing, and avoid prolonged exposure to strong sunlight.

5-Tell pt. that dry mouth may be relived with sugarless hard candy or gum.

6- Advice pt. to consult his doctor before taking any other prescription, or OTC medications.

***Anti mania drugs***

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

***Indication and Dosage:***

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

***Side Effects:***

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

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

***Contraindications:*** Contraindicated if therapy can not be closely monitored.

***Nurse role:***

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

***Patient and family Teaching:***

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

***Pre Lithium Work Up***

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

***Stabilizing Lithium level***

Common for an Increase in Lithium Levels:

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

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

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

***Maintenance Lithium Level***

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

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

***Anti-Parkinson Agents***

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

***Indications:***

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

***Side Effects:***

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

***Patient Teaching:***

1-If insomnia occurs; tell the pt. to take the drug several hours before bedtime.

2-If orthostatic hypotension occurs, instruct the pt. not to stand or change position too quickly.

3-Instruct the pt. to report adverse reactions to the doctor, especially dizziness, depression, anxiety, nausea, and urine retention.

4- In the pt. with parkinsonisim, warn against discontinuing the drug abruptly to prevent precipitating a Parkinson crisis.

5-Tell pt. to take the drug with food to minimize GI upset.

6- Warn the pt. and his caregivers not to increase dosage with out doctor’s orders.

7-Warn the pt. of possible dizziness and orthostatic hypotension, especially at start of therapy.

8-Inform the pt. that pyridoxine (vit. B6) doesn’t reverse the beneficial effects of carbidopa-levadopa; multivitamins can be taken without losing control of symptoms.

***Anti-Convulsants Drugs***

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

***Indications:***

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

***Side Effects:***

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

***Patient Teaching***

1-Warn pt. to avoid activities requiring alertness and good psychomotor coordination until CNS response to drug is determined.

2-Instruct pt. to take drug with food or milk to reduce adverse GI effects.

3-Warn pt. not stop drug therapy abruptly.

4-Tell pt. to keep tablets in original container tightly closed, and away from moistures5-Tell pt. to notify the doctor immediately if fever, sore throat, mouth ulcers, or easy bruising or bleeding occurs.

6- Tell pt. that drug may cause mild to moderate dizziness and drowsiness when first taken.

7-Advise pt that periodic eye examinations are recommended.

### *Side Effects of the psychotropic drugs*

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