Behavioral

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I. INTRODUCTION

PCCN Test Plan

**Neurological, Multisystem & Behavioral: 15%**

a. Altered Mental Status
b. Delirium
c. Dementia
d. Psychological Disorders
   • Anxiety Disorders
   • Depression
e. Substance Abuse
   • Alcohol Withdrawal
   • Chronic Alcohol Abuse
   • Chronic Drug Abuse
   • Drug-Seeking Behavior

II. ASSESSMENT (PSYCHOSOCIAL)

a. Acute Care Hospitalization is a Potential Crisis for Pt and Family
b. Pre-Existing Mental Health Diagnosis
c. Undiagnosed Mental Health Problems
d. Pre Hospitalization Coping Skills
e. Anxiety Level
f. Scope of Control/Powerlessness
g. Sources of Support
h. Life Cycle Stage (Erikson)
i. Maslow’s Stage
j. Family Stress
k. Cognitive Level
l. Sleep Deprivation
m. Synergy: Resiliency, Vulnerability, Resource Availability
n. Pain Level
o. Grief and Loss
p. Fear Level
q. Attention Level
r. Ability to Retain Information
s. Physical Symptoms of Mental Stress
III. DELIRIUM

Definitions

Delirium
“Rapid onset and fluctuating course, the symptoms of delirium include disturbances in consciousness and attention and changes in cognition, such as memory deficits or perceptual disturbances.” American Psychiatric Association DSM-IV

Perceptual changes such as hallucination, illusions and delusions are not required for the diagnosis of delirium.

Dementia
Gradual onset of memory impairment and cognitive disturbances. Slow steady decline in cognitive function. Can be organic or metabolic in etiology but typically not reversible and often not treatable.

Incidence: (delirium)

a. 20% – 50% of All Hospitalized Patients
b. Undiagnosed in 66%-84% of Hospitalized Pts
c. 20-80% Rate in ICU Patients
d. 87% of Ventilated Patients
e. Associated with Increased Mortality, Morbidity, Hospital Stay and Over All Costs

Etiologies & Predisposing Factors

a. Cognitive Impairment
b. Electrolyte Imbalance
c. Dehydration
d. Hyperthermia
e. Sleep Deprivation
f. Restraint Use
g. Medications
h. Vision and/or Hearing Problems
i. Infection
j. Malnutrition
k. Age >65
l. Withdraw Syndromes
m. Acute CNS Problems
n. History of:
   • Depression
   • Dementia
   • Stroke
   • Seizures
   • ETOH Abuse

o. Medical History of
   • Renal Failure
   • Liver Failure
   • CHF
   • HIV
   • Endocrine Disorders

Clinical Presentation

a. Disorientation/Confusion
b. Decreased Attention Span and Ability to Focus
c. Hyperactive Type
   • Restlessness
   • Agitation
   • Does Not Follow Commands (leave catheter alone or in place)
   • Wide Mood Swings
   • Attempting to Get Out of Bed
d. Hypoactive Type (more common, worse outcome)
   • Lethargy
   • Withdrawal
   • Decreased Responsiveness

Treatment Options

a. Prevention!
b. Early Identification of Risk Factors
c. Accurate Assessment/Diagnosis (Delirium Scales)
d. Treatment/Modification of Risk Factors/Cause
e. Review all Medications as Possible Cause
f. Treat Electrolyte and Metabolic Derangements
g. Non-Pharmacological
   • Repeat Orientation
   • Sleep Protocol
   • Early Mobilization
   • Minimal Restraint Use
   • Pain Control
   • Cognitive Stimulation
h. Pharmacological (can cause and/or treat)
   - Benzodiazepines
   - Narcotics
   - Haloperidol (FDA approved for Delirium)
   - Antipsychotics
   - Neuroleptics

**IV. DEPRESSION**

**Definition**

An abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness that are inappropriate and out of proportion to reality. The overt manifestations, which are extremely variable, range from a slight lack of motivation and inability to concentrate to severe physiologic alterations of body functions and may represent symptoms of variety of mental and physical conditions, a syndrome of related symptoms associated with a particular disease, or a specific mental illness.  
* - *Mosby’s Medical Dictionary*

**Etiology and Predisposing Factors**

a. Fear & Anxiety Related to Current Events/Illness
b. Response to Loss and/or Grief and/or Deprivation
c. Diminished Self-Esteem
d. Guilt – Real or Perceived
e. Metabolic Causes
   - Electrolyte Imbalances
   - Endocrine Dysfunction
   - Neurotransmitter Imbalance
   - Medication Derived
   - Chronic Pain
f. Sleep Deprivation

**Clinical Presentation**

a. Agitation → Lethargy
b. Inability to Concentrate
c. Inability to Focus
d. Change in Sleep Patterns
e. Severe Fatigue
f. Signs of Sadness/Hopelessness
g. Thoughts of Death
h. Suicide Ideations
Treatment Options

a. Counseling  
b. Significant Other Support  
c. Rule Out Organic/Metabolic Causes  
d. Antidepressants

V. MENTAL ILLNESS

Mental illness might be a chronic comorbidity of the hospitalized adult. This adds an increase challenge to nursing care requirements for patients. Informed consent, adherence and patient education are more difficult if the patient does not have a full concept of reality.

Types of Disorders (DSM IV)

a. Psychotic – ex. Schizophrenia  
b. Personality Disorders – ex. Antisocial, borderline, narcissistic  
c. Anxiety – ex panic attacks, phobias, obsessive compulsive  
d. Developmental/Learning – ex autism, ADHA, retardation  
e. Cognitive – ex dementia & delirium  
f. Mood – ex depression

Nursing Priorities

a. Identify and seek appropriate and timely psychiatric assistance  
b. Safe Environment  
c. Identify and treat cause (if possible)  
d. Determine if There is a Risk of Injury  
e. Orientation  
f. Assist with  
  • Crisis Management  
  • Stress Management  
  • Coping Skills  
  • Social Support  
g. Pharmacological Management- antidepressants, antipsychotics, antianxiety agents  
h. Patient/Family/Support System Education  
i. Discharge Planning
VI. SUBSTANCE ABUSE

Commonly Abused Substances

a. Alcohol
b. Nicotine
c. Narcotics
d. Marijuana
e. Amphetamines
f. Benzodiazepine
g. Cocaine

Nursing Care Concerns/Priorities

a. Physical and/or Mental Dependence
b. Physical and or Mental Withdraw Symptoms
c. Assessment of Cause (recreational vs medical vs pain management)
d. Current State of Health
e. Current Nutritional State
f. Pharmacological Considerations ie tolerance and cross tolerance
g. Diagnosed or Undiagnosed Mental Health Issues
h. Ability for Self Care Post Discharge
i. Patient Education and Adherence
j. Appropriate Addiction Referral
k. Community and Social Support

Alcohol Withdrawal

Autonomic hyperactivity symptoms such as tachycardia, anxiety/agitation, dysphoric mood, diaphoresis, hypertension, sleeplessness and fine tremor are common physical findings when alcohol is abruptly stopped and typically will present within 2 days of cessation. Nausea, vomiting and hallucination may also occur.

Clinical Presentation for Delirium Tremors (72-96 hr Post drink)

a. Anxiety and/or Panic Attacks
b. Disorientation/Confusion
c. Insomnia
d. Disorganized Thought Processes
e. Visual and/or Auditory Hallucinations or Illusions
f. Tactile Hallucinations
g. Delirium
h. Tachycardia
i. Tachypnea
j. Fever
k. Seizure Activity

**Treatment Options**

a. Anticipate/Prevent – Prophylactic Withdraw Regimen
b. Safety Measures for Patient, Family, Staff and Therapeutic Devices
c. Decrease Stimulation
d. Utilize Short Directed Conversations
e. Nonthreatening and Supportive Approach
f. Hydration
g. Monitor Vital Signs and LOC
h. Medications
   - Benzodiazepines (Lorazepam, Diazepam, Chlordiazepoxide, Oxazepam)
   - Nutrition Support (MVI, Thiamine, Folate)
   - Neuroleptic (Haloperidol) (lacking research but used)
   - IV Ethanol
   - Propofol (lacking research but used)

**Sedative Withdrawal**

Physical withdraw signs and symptoms similar to ETOH. Treatment is different and will typically have to continue post discharge from the critical care setting. The patient is slowly “weaned” off the drug or transitioned to a longer acting agent like Chlordiazepoxide (Librium) or Diazepam (Valium) and then tapered off drug.

**Chronic Opiate Use: Clinical Presentation (withdrawal)**

a. Yawning
b. Extra Fluid Production (Tearing, Rhinorrhea, Diaphoresis)
c. Mydriasis & Myalgia
d. Tremors
e. Abd Cramps, Nausea, Vomiting, Diarrhea
f. Involuntary Leg Movements (kicking)
g. Piloerection
h. Muscle Cramping
i. Vital Sign Changes: Fever, Hypertension, Tachycardia

**Treatment Options**

a. Methadone – switch to longer acting agent → wean
b. Clonidine – block sympathetic hyperactivity
c. Buprenorphine – alpha opiate receptor partial agonist