

TCHP

Education
Consortium

INTERVENTIONS IN PSYCHIATRY

PART OF THE FOUNDATIONS OF PSYCHIATRY
INDEPENDENT LEARNING PROGRAM

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THE FOUNDATIONS OF PSYCHIATRIC CARE: INTERVENTIONS

INTRODUCTION/PURPOSE STATEMENT

Staff who are entering into the psychiatric care setting need to have all kinds of information so that they can deliver optimal care without falling into the pitfalls that may loom before them. The Foundations of Psychiatric Care home study series was developed by expert staff from Hennepin County Medical Center, the Minneapolis VA Medical Center, and Regions Hospital to get this information out in an easy-to-read, practical, and relevant manner. This program is divided into four sections: I) Introduction; II) Patient Care; III) Safety; and IV) Interventions. The purpose of the *Interventions in Psychiatry* module (this home study) is to provide an overview of psychiatric medications, individual and group interventions, shock therapy, and education.

TARGET AUDIENCE

We developed this program to provide the information necessary to care for the psychiatric patient. The sections were written for the person who has not worked in psychiatry before; however, more experienced psychiatry staff may find the information useful and interesting.

CONTENT OBJECTIVES

1. Review the major classifications of medications in psychiatry.
2. Identify measures to ensure safe medication administration to psychiatric patients and improve medication compliance.
3. Explain the elements of therapeutic 1:1 interactions, including health teaching, crisis intervention, problem solving, and coping.
4. Explain the types of groups available, how to introduce and close a group and what identifies a group as working in the here-and-now.
5. Discuss the role of nursing staff as co-facilitator and what makes a therapist successful in a group.
6. Discuss the eleven curative factors.
7. Describe the purpose, preparation, follow-up and adverse effects of electroconvulsive therapy
8. List several complementary and alternative therapies used in mental health care.
9. Discuss the areas that psychoeducation for the mentally ill patient may address and state common deficits mental health patients may exhibit.

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CONTINUING EDUCATION INFORMATION

<p>For completing this Home Study and evaluation, you are eligible to receive:</p>	<p>2.5 MN Board of Nursing contact hours / 2.08 ANCC contact hours</p> <p><i>Criteria for successful completion:</i> You must read the home study packet, complete the post-test and evaluation, and submit them to TCHP for processing.</p> <p>The Twin Cities Health Professionals Education Consortium is an approved provider of continuing nursing education by the Wisconsin Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.</p>
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Please see the last page of the packet before the post-test for information on submitting your post-test and evaluation for contact hours.

OVERVIEW OF PSYCHOPHARMACOLOGY

A BRIEF REVIEW OF NEURO- ANATOMY AND PHYSIOLOGY

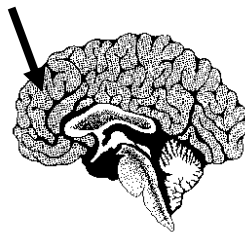
Everyone knows that the brain with its specialized chemistry is very complex. So why do we go through it? It is vital that you understand the functions of certain parts of the brain and its chemistry to know how some of the psychiatric medications work.

Neuroanatomy

The Pre-Frontal Cerebral Cortex

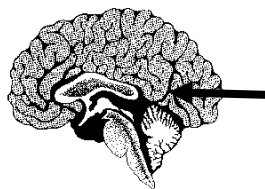
The pre-frontal cerebral cortex is the brain's "executive." It is in this part of the brain that planning occurs, based on information from all of the other parts of the brain. It:

- processes visual, auditory, and somatosensory impulses
- holds the short term memory
- controls specific and coordinated muscle movements
- controls speech
- regulates attention, perception, motility, temporal integration, affect, and emotion
- integrates the learning and memory association centers
- performs high-order abstract thought, creative problem solving, temporal sequencing of behavior.



Basal Ganglia and Limbic System

The other side of the brain contains two sections that are very important regarding the psychiatric patient. The basal ganglia primarily regulate and mediate motor activity and have a high concentration of dopamine receptors. The basal ganglia plays a key role in the brain's



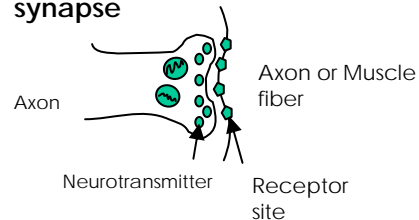
cognitive functioning.

The limbic system is involved in the experience and expression of emotions. It also may play a role in memory and in references to past experiences.

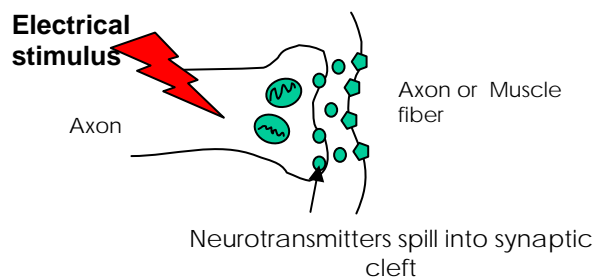
Neurophysiology

Information goes from one part of the body to another by electrical and chemical transmission through the nervous system. Think of a light in a room – turn on the switch (electrical stimulus) and the light bulb will light up. The light bulb is like the neurotransmitters -- the chemicals that either facilitate or inhibit the transmission of an impulse from one neuron to another. See the diagram below...

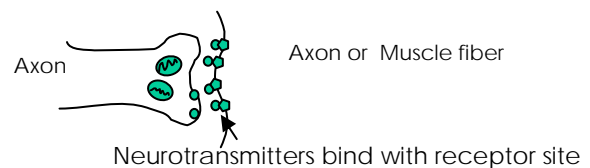
1. Inactive synapse



2. Activated



3. Transmission of impulse



4. Return of neurotransmitter



Neurotransmitters are split from receptor site and reabsorbed by the sending axon.

Why is this important to you? Many of the medications that are given in psychiatry work in this system:

1. To replace a deficient amount of neurotransmitter (increase the wattage of the light bulb)
2. To block the neurotransmitter from binding with a receptor site (unscrew the light bulb)
3. To stop or facilitate the splitting of the neurotransmitter from the binding site (tighten the light bulb)

Dopamine

One of the neurotransmitters of the most interest in psychiatry is dopamine. Receptor sites for dopamine are found in several areas of the pre-frontal cerebral cortex. Dopamine works with the *extrapyramidal system*, which controls:

- ◆ movement and stereotypy (which is a lack of variation in movement or patterns of speech.) This is why people with Parkinson's disease are on dopamine medications;
- ◆ the motor expression of emotion;
- ◆ the feelings and decision-making processes that precede choice;
- ◆ the regulation of heat loss, satiety, rage, and gastric acidity;
- ◆ working memory, which is needed for higher-level information processing tasks.

A lack of dopamine has been implicated in major depression. Too much dopamine may be related to the manic phase of bipolar disorder. Schizophrenia, particularly the psychotic symptoms, may be related to too much dopamine.

Norepinephrine

Norepinephrine (or noradrenaline) is a neurotransmitter that has receptor sites in the pons and medulla of the brain. It is one of the chemicals released in the "fight or flight" response. Attention,

perception, mood, locomotion, and cardiovascular changes are affected by norepinephrine.

Like dopamine, a lack of norepinephrine may cause depression; too much norepinephrine can cause stress, anxiety, panic, and aggression. Norepinephrine works closely with the limbic system – a link that may have something to do with schizophrenia.

Serotonin

Serotonin is active in the forebrain and the limbic system. It **inhibits** the transmission of certain impulses, such as arousal, sexual interest, aggression, and the ability to pursue goal directed behavior.

Stress causes an increase in serotonin; a lack of serotonin may cause anxiety. Depression may be related to either a lack of serotonin to modulate mood or a lack of receptor sites to which serotonin may bind.

Acetylcholine

The most common neurotransmitter, acetylcholine, works in the brain to affect sleep, arousal, nociception (position sense), the modulation and coordination of movement, and memory acquisition and retention.

A lack of acetylcholine is thought to be one of the causes of Alzheimer's disease, and may be a causative factor in the manic phase of bipolar disorder. Too much acetylcholine may be related to depression.

Gaba-gamma-aminobutyric acid (GABA)

Lastly, GABA is another inhibiting neurotransmitter. It inhibits the electrical stimulus that moves from neuron to neuron. GABA provides an anti-convulsant and calming effect, and possibly works in the basal ganglia to assist in coordinating motor movement.

GABA, in insufficient amounts, may cause severe separation anxiety in children and panic disorder in adults. It has also been implicated in the development of schizophrenia (in conjunction with an overabundance of dopamine).

Kindling

Kindling is a term that is used to describe a change in the neurophysiologic system. This change results from constant electrical stimulation of the brain in an area that will cause aggression. In time, this chronic stimulation will alter behavior even after the stimulus has stopped. What does this have to do with psychopharmacology? Well, some of the medications that are given decrease the kindling mechanism so that aggression is decreased at the neuronal level.



ADMINISTRATION OF MEDICATIONS

What You Need to Know

Side Effects

Many of the medications used in psychiatry have serious side effects that range from being uncomfortable to being life-threatening. Patients often have a difficult time staying on their medications because of the side effects. It is important for you to know the most common, and the most serious, side effects of medications that your patient is taking. You also need to know strategies for managing these side effects.

Time for Therapeutic Effect

There are some medications that will take effect within the first hour of administration, such as the benzodiazepines. Many long-term medications take a minimum of 1-2 weeks for the patient to see an effect, however, and the full therapeutic action does not occur for 4-6 weeks.

Half-Life

The term “half-life” indicates the amount of time that it takes for a given amount of medication in the body to decrease by half. Why is this important? The half-life determines how long it will take to reach a steady state: when the amount of medication that is going out (being metabolized) is equal to the amount of medication going in (being administered). When that point is found, the optimal dosage can be given to avoid peaks and valleys, as well as side effects from too much of the medication.

It takes about five half-lives for a medication to reach a steady state. So if a medication has a half-life of 10 hours, it would take about 50 hours to reach a steady state. Also, the longer the half-life, the longer it takes for the body to be free of the medication.

Dosing

Knowing the range of dosages for a medication is also very important. Errors in prescribing or pharmacy filling can be caught early if you know the usual dose of the medication. This same information should also be passed on to the patient so she knows what amount of medication she should be taking. Dosing will also be determined by the half-life. Dosing with children and older adults may be much lower than the usual dose of the medication.

Medication Interactions

It is really important to know the things that medications can interact with – other medications, foods, herbs, nicotine, caffeine, etc... Interactions can cause the medication to work less well (or not at all), may increase the strength of the medication (synergistic effect), or may cause serious side effects.

Principles of Medication Administration

1. Treat the primary illness and/or target behaviors.

Careful assessment and documentation of the symptoms and behaviors of the patient can help in monitoring the effectiveness of the medications prescribed. Medications should only be administered to help the patient – never to make things easier on the staff.

2. Use the most benign interventions when treating empirically.

In looking at the tables at the end of this section, you will see that most of the medications used in psychiatry have many uncomfortable, if not risky, side effects. Be vigilant to ensure that medications being prescribed are appropriate and correctly dosed for the patient's behaviors.

3. Institute medication trials systematically.

If a patient is given a variety of medications simultaneously to control a behavior, do you know which one worked? No. It's important to start one medication at a time to see what the therapeutic effect and the side effects are. Medication regimes should be as simple as possible to increase adherence and decrease medication-medication interactions.

4. Have a quantifiable means to assess efficacy.

If you don't state the behaviors that you want to control assessed and documented, how will you know if the medication worked? Having a flow sheet or care plan that defines the symptom or behavior and allows ongoing assessment and documentation will let you see if the medication is working properly.

5. The use of medication is only one part of the treatment.

Psychotherapy, patient education, group therapy, coping skills training, and many other therapies are available to help the patient get better – medications are only part of the treatment plan.

Tricks of the Trade for Safe Medication Administration

Administering medications safely is one of the most important things that you can do. Giving the wrong dosage, giving the medication to the wrong patient, or not ensuring that the patient actually consumes the medication can all have serious effects.

Administering the Right Medication and Dose

We all learned it in school – the five rights: the right patient, the right time, the right dose, the right route, and the right medication. Always double check to make sure that the medication and dosage are correct.

Check the medication names closely against the order. Check to see if the medication is a new one, or if the patient was on the medication previously. Listen to your patient – many patients know exactly what they are supposed to be taking – they may catch a medication error before it happens. If the medication does look different, let your patient know up-front. Some patients can become quite anxious if something that they are accustomed to taking is suddenly a different sized or colored pill.

Be sure to tell patients when dosages have been changed, or when substitutions have been made (i.e., 25 mg tablet instead of 10 mg tablet). This will help increase trust in you and compliance in taking the medication.

Administering to the Right Patient

Patients who have mental illnesses may not necessarily have a good grasp on reality. If you go to the patient with a medication and say, "Are you John Doe?" they might say "Yes," even if they are not. Check the name band of the patient if you are not absolutely sure of the patient's name. If giving a medication at night, be sure that you can see the patient clearly.

Ensuring the Patient Gets the Medication

Patients who do not want to take their medications can avoid doing so in a number of ways. The most straightforward way they can do that is by refusing. That's easy. Don't give them the medication until further discussion has been held, unless they are court ordered to take the medication.

Patients can also "pocket" the medication in their cheek or under their tongue (this is also called "cheeking"). You should always look in the patient's mouth for pocketed medications. In this situation, the patient might simply not want to take it, but may also want to "save up" the medication for a suicide attempt later.

There are also patients who might take the medication and then self-induce vomiting. If you suspect this, you should monitor the patient for about an hour after ingestion of the pill.

PSYCHOTROPIC MEDICATIONS

Medications used to treat the symptoms of psychiatric illnesses are called “psychotropic” agents. There are four categories of psychotropic medications:

- Antipsychotic (neuroleptic) medications
- Antidepressant medications
- Anti-Anxiety medications
- Mood Stabilizing (antimanic) medications

Antipsychotic Medications

Medications that reduce the symptoms of psychosis are called antipsychotic or neuroleptic agents. Psychosis is a condition in which the patient is out of touch with reality. The person may have visual, auditory, or other sensory hallucinations, or may have strange and untrue ideas. Psychosis can be found in schizophrenia, acute mania, and severe (psychotic) depression. It may also be seen in forms of dementia and delirium.

The action of antipsychotic medications is based on neurotransmitter physiology. Typical antipsychotic medications block the transmission of dopamine in an effort to decrease the psychotic symptoms, aggressiveness, affect, and impulsivity. The **atypical** antipsychotic medications act differently: these medications selectively block both dopamine and serotonin transmission. Antipsychotic medications are not addictive.

Antipsychotic Medications

Antipsychotic medications are divided into typical and atypical antipsychotics. Typical antipsychotics are used infrequently. Occasionally these medications are part of a patient’s medication profile.

The atypical antipsychotic medications are newer. They affect both dopamine and serotonin in the brain. They are commonly prescribed because there are fewer side effects. There is less risk of tardive dyskinesia and they work well for both positive and negative symptoms. Unfortunately, they are quite expensive.

Current atypical antipsychotics

- Aripiprazole (Abilify)
- Clozapine (Clozaril)
- Olanzapine (Zyprexa)

- Olanzapine/Fluvoxamin Combination (Symbyax)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Ziprasidone (Geodon)

Typical antipsychotic medications have been around for 50 years. They affect dopamine in the brain. Although they cost less, they are not commonly used because they have a risk of tardive dyskinesia. They don’t work well for negative symptoms.

Current Typical Antipsychotic Medications

- Acetophenazine (Tindal)
- Chlorpromazine (Thorazine)
- Chlorprothixene (Taractan)
- Fluphenazine (Permitil, Prolixin)
- Haloperidol (Haldol)
- Loxapine (Loxitane)
- Mesoridazine (Serentil)
- Molindone (Moban)
- Perphenazine (Trilafon)
- Pimozide (Orap)
- Promazine (Sparine)
- Thioridazine (Mellaril)
- Thiothixene (Navane)
- Triflupromazine (Vesprin)
- Trifluoperazine (Stelazine)

Benefits of Antipsychotic Medications

- Thoughts are clearer
- Improved concentration
- Improved emotional drive
- Reduced illness symptoms
- Newer medications have fewer side effects
- Not addictive
- Used for a variety of illnesses such as:
 - Schizophrenia and other Psychotic Disorders,
 - Bipolar Affective Disorder,
 - Major Depression,
 - Borderline Personality Disorder,
 - Anxiety Disorders,
 - Illnesses with abnormal thoughts
- Start to work fast

Routes of Administration

Most patients who are on antipsychotic medications take them daily in an oral form. Tablets and elixirs are available for many medications. A few oral medications such as Zyprexa are available in a quick dissolve tablet. There are also medications that can be injected for a faster response (i.e., for the patient who is acutely psychotic). Finally, there are some medications that can be given at longer intervals – days to weeks. This type of medication is known as a “depot” medication. (See Table 1).

Side Effects of Typical Antipsychotic Medications

Patients who take typical medications are at risk for many side effects (see Table 2), some of which can be severe. The most significant side effects are as follows.

Acute Dystonias

Antipsychotic medications affect the whole brain, not just the piece of the brain that causes the psychosis. When the medications affect the *extrapyramidal* part of the brain, the person is said to have *extrapyramidal side effects (EPS)*. The abnormally turning movement of the limbs, trunk, and neck is called a dystonia. The person may have very rigid muscles and be uncoordinated. These may be painful and frightening to a patient.

Akathisia

Akathisia is another extrapyramidal side effect in which the patient has a feeling of restlessness. This restlessness may be an inner feeling of disquiet, or may be as severe as an inability to sit still or lie quietly.

Tardive Dyskinesia

Usually seen with long-term antipsychotic agent use, tardive dyskinesia (TD) is a result of chronic blockade of the dopamine receptor sites. Tardive dyskinesia is a permanent disorder in about 50% of patients; early detection is the only chance for preventing TD. TD causes involuntary movements throughout different areas of the body.

Symptoms of TD

- tongue protrusion
- lip smacking
- puckering
- blinking

- lateral jaw movements
- choreiform (wormlike) movements of the limbs and trunk
- shoulder shrugging
- pelvis thrusting
- wrist and ankle flexion or rotation
- foot tapping, toe movements
- sucking
- chewing
- other involuntary movements

Abnormal Involuntary Movement Scale (AIMS)

The Abnormal Involuntary Movement Scale (AIMS) examination has been widely recommended for periodic screening for tardive dyskinesia (TD) and follow-up for patients already diagnosed with TD. However, it is not limited to assessing for TD, but can be used for assessing any abnormal movements associated with patients who have been on maintenance (usually for at least three months) neuroleptic medications. A trained clinician conducts the exam and scores the patient.

The 12-item instrument evaluates patient’s severity of movements in three main anatomic areas: (facial/oral, extremities, and trunk), based on a five-point scale (0 = none, 4 = severe).

The AIMS ideally takes five – to – ten minutes to assess for dyskinetic movements. It is strongly suggested that a baseline should be done before starting neuroleptic medication and then repeated every three to six months thereafter during an outpatient visit or in the patient’s room while hospitalized. Monitoring for any changes is the key. Patients, their families and the doctor should work as a team in understanding the risks, benefits and possible side effects associated with taking these medications.

Orthostatic Hypotension

People who are on antipsychotic medications can experience a low blood pressure, or orthostatic hypotension. Orthostatic hypotension occurs when the person goes from a lying or sitting to a standing position and feels faint, light-headed, or dizzy. The neurological signs are from decreased blood flow to the brain because of the decreased blood pressure.

Neuroleptic Malignant Syndrome (NMS)

Although the exact mechanism is not known, neuroleptic malignant syndrome is thought to occur because of extreme dopamine receptor blockade from

the use of antipsychotic medications. This is a **life-threatening** condition. Once manifested, signs of NMS can develop explosively in 24-72 hours. NMS can occur from hours to months after initiation of the medication, and mortality can be as high as 20-30%.

Indicators of imminent or possible NMS:

- elevated temperature
- severe extrapyramidal rigidity
- elevated BP (especially DBP)
- autonomic instability: diaphoresis, tachycardia, dyspnea, increased heart rate)
- altered level of consciousness (confusion, disorientation)
- increased CPK as a result of breakdown of striated muscles (rhabdomyolysis)

Other Side Effects to Watch For

- Dry mouth
- Sedation
- Constipation
- Slower thoughts
- Rash
- Caution the patient about time spent in the sun, because these medications make you sunburn more easily.
- Caution the patient not to use illegal drugs or alcohol. This combination can cause harm to the body, especially the brain and liver, and it can counteract the benefits of the medication.

Antidepressant Medications

Antidepressants may be prescribed for people who meet the DSM-IV criteria for depression. Antidepressants reduce the symptoms of depression, and may also be used for certain types of anxiety disorders.

Antidepressant medications may also be used in conjunction with other classes of psychotic medications for other disorders (bipolar disorder, schizoaffective disorder, attention deficit/hyperactivity disorder). Like the antipsychotic medications, antidepressants are not addictive.

Antidepressants are used to treat major depression, generalized anxiety disorder, panic disorder, social phobia and obsessive compulsive disorder.

Antidepressant Medications

1. Selective Serotonin Reuptake Inhibitors (SSRI's)

- Action: don't allow the serotonin to be reabsorbed into the cell as quickly, causing the serotonin to work longer.
- Medications: fluvoxamine (Luvox), paroxetine (Paxil), fluoxetine (Prozac), sertraline (Zoloft), citalopram (Celexa), and escitalopram (Lexapro).

2. Serotonin/norepinephrine Reuptake Inhibitors (SNRI's)

- Action: blocks the reuptake of norepinephrine and serotonin.
- Medications: venlafaxine (Effexor) and duloxetine (Cymbalta)

3. Monoamine Oxidase Inhibitors (MAOI)

- Action: don't allow serotonin or norepinephrine to be reabsorbed, which makes them available for the next electrical impulse.
- Medications: phenelzine (Nardil) and tranylcypromine (Parnate).
- People who are on MAO inhibitors cannot eat a wide variety of foods due to interactions.
- *Currently not often prescribed because of the number and severity of side effects and the necessity of maintaining diet restrictions.*

4. Tricyclic Antidepressants (TCA)

- Action: brings norepinephrine levels to normal
- Medications: clomipramine (Anafranil), amitriptyline (Elavil), nortriptyline (Pamelor), desipramine (Pertofrane), and imipramine (Tofranil).
- *Currently not prescribed often because of number and severity of side effects.*

5. Other Medications

- Trazadone (Desyrel): increases availability of serotonin; called a heterocyclic antidepressant
- Bupropion (Wellbutrin): increases dopamine and norepinephrine levels; called

a heterocyclic antidepressant. Bupropion is also used for smoking cessation (Zyban®)

- Mirtazepine (Remeron): don't allow the serotonin to be reabsorbed into the cell as quickly, causing the serotonin to work longer.
- Citalopram (Celexa): restores levels of serotonin

Benefits of Antidepressant Medications

- Reduces symptoms of depression
- Newer medications have fewer side effects
- Some medications can be used for multiple conditions
- Some medications only need to be taken once a day
- Usually there is some improvement initially
- Because each medication works differently in each person, another medication can be tried

Routes of Administration

All antidepressant medications come in a pill. Some medications come in a quick dissolve tablet. (See Table 1).

Onset of Action for Antidepressant Medications

Side effects tend to occur right away, and most resolve within a week. Some improvement is seen within two weeks, with maximum improvement in four to six weeks. Improvement takes some time because medication enters the brain slowly, then the medication alters the brain chemicals, and finally brain cells respond to the changes in brain chemistry.

Side Effects of Antidepressant Medications

The side effects of these medications are listed in Tables 3 and 4.

Cautions

People who are on MAO inhibitors need to be very cautious about their diet. They should avoid cheese, fermented or aged protein, pickled or smoked fish, beer, red wine, sherry, liqueurs, cognac, yeast, bean pods, beef/chicken liver, spoiled or overripe fruit, banana peel, and yogurt. These foods contain tyramine, and may cause a hypertensive crisis if taken with MAOI's.

Antidepressant medications are prescribed carefully to people who may be at risk for suicide. A suicide attempt or completion by overdosing on antidepressant medications is not uncommon. Many physicians will prescribe only enough medication for 2-3 days, requiring that the patient come back for evaluation. While a person is acutely depressed, they may not have the energy to commit suicide. Treatment may provide enough energy to commit suicide.

Lomipramine (Anafranil), fluvoxamine (Luvox), fluoxetine (Prozac), and sertraline (Zoloft) are all FDA indicated for Obsessive Compulsive Disorder (OCD).

Antianxiety Medications

Anti-anxiety medications are thought to create changes in the levels of the neurotransmitters (dopamine, norepinephrine, and serotonin). Some of the medications also enable the GABA receptors to work better by inhibiting impulses that would cause anxiety and insomnia. Anti-anxiety medications may be given to a wide variety of patients in the inpatient and outpatient setting. In the psychiatry setting, anti-anxiety medications are used to help the patient with anxiety that is disrupting his/her quality of life, or as an adjunct to other medications.

The benzodiazepines can cause physical dependence and psychological addiction. Because of this, the use of these medications are monitored closely for risks and benefits.

Medications

The majority of medications that help with anxiety are called "*benzodiazepines*." The names of the benzodiazepine medications used for anxiety are:

- Diazepam (Valium)
- Lorazepam (Ativan)
- Clonazepam (Klonopin)
- Chlordiazepoxide (Librium)
- Oxazepam (Serax)
- Chlorazepate (Tranxene)
- Alprazolam (Xanax)

There is also a medication called buspirone (BuSpar) that is used to treat anxiety. It is similar to the action

of the benzodiazepines except that it does not cause sleepiness/drowsiness.

These medications are prescribed with caution by psychiatric health care providers because of their addictive nature.

Beta-blockers (atenolol and propranolol) may be used for anxiety. Hydroxyzine (Vistaril, Atarax) may also be used because it has relaxing properties and is non-addicting.



Routes of Administration

Some of the benzodiazepines (lorazepam, Librium, and Valium) can be given to the patient through an injection for faster relief of anxiety symptoms. Normally, however, the benzodiazepines and buspirone are given orally (See Table 1).

Side Effects

Please see Tables 5 and 6 for the side effects related to the antianxiety medications.

Mood Stabilizing Medications

Patients with “mania” may benefit from mood stabilizing medications. The most common form of mania comes with the bipolar disorder; however, patients with schizoaffective disorder or schizophrenia may also benefit from one of these medications. The medication most often used for bipolar disorder to control manic episodes is lithium. There are several other medications that may be used either alone or in conjunction with lithium to help decrease the severity or limit the symptoms of mania.

1. Lithobid and Eskalith (Lithium Carbonate)
 - ◆ Corrects abnormalities in the electrolyte balance and transport, as well as neurotransmitter action in nerve cells.
 - ◆ This naturally occurring salt has been used for more than 50 years.
2. Anticonvulsants:
 - ◆ Tegretol (carbamazepine)
 - ◆ Neurontin (gabapentin)
 - ◆ Depakote (divalproex sodium)
 - ◆ Topamax (topiramate)
 - ◆ Lamictal (lamotrigine)

Anticonvulsants are usually used to treat people with seizures. These medications stabilize the brain and help prevent mood swings.

Route of Administration

These medications are available in a variety of forms including tablets, quick dissolving tablets and sustained released tablets.

Please see Table 1 for more complete information.

Side Effects

The most common side effects of lithium are diarrhea, dizziness, increased thirst and urine volume, increased WBC count, nausea, tremors, weight gain, abnormal heart rate changes.

Please see Table 7 for additional side effects of lithium and the other mood stabilizing medications.

ENHANCING ADHERENCE TO MEDICATION REGIME

Patients with mental illnesses sometimes have a very difficult time adhering to their medication therapy. This may be because they are ashamed of their illness, or that they deny that they have an illness, or that they are too ill to take their medications. Uncomfortable or serious side effects may also cause

the patient to stop taking his/her medications. Medications can also be very costly and not all patients have insurance. As health care providers, we can do some things to encourage the patient to stay on the medication plan:

1. Listen to what the patient wants for his own life.
2. Be concrete about what the medication will do for the person. For example, say "You won't hear the voices," or "You will be able to go back to work."
3. Be specific about the side effects of the medication and how to manage them (e.g., when to call the physician, etc...)
4. Have the patient describe exactly how many and at what times she takes the medication.
5. Have the patient state who he will call if he has questions.
6. Have the patient describe how she will remember to take the medication and what she will do if a dose is missed.
7. Do anticipatory guidance related to what to do when they begin to think about stopping the medications. Not taking medications can lead to relapse and rehospitalization.
8. Follow-up with the patient and show concern that he is continuing to take the medications. During follow-ups, phrase questions to show the person that you assume he is taking the medication; for example, say "How many pills do you have left?"
9. Use the patient's support systems to encourage the patient to continue taking the medications.
10. If the patient is defensive about the medications, start with "safe" topics and develop trust.
11. Understand and accept that some people will refuse treatment. Try to help the patient make a truly informed decision.

SUMMARY

Understanding the mechanism of action, the desired effect, side effects, half-life, and dosages of the medications we give to psychiatric patients can help us to give the best care possible to patients. We can identify and prevent side-effects, assess for the effectiveness of the medication, and give the least

amount of medication possible to get the maximal effect. This section has provided an overview of some of the important aspects of psychiatric medications and their administration.

LOOK AT THE FOLLOWING PAGES FOR TABLES RELATED TO PSYCHOPHARMACOLOGY!

TABLE 1: ROUTES OF ADMINISTRATION

<i>Class</i>	<i>Medication</i>	<i>PO</i>	<i>Liquid</i>	<i>Sustained release</i>	<i>Injectable</i>	<i>Intra-muscular</i>
Atypical Anti-Psychotics	Clozapine (Clozaril)	X				
	Risperidone (Risperdal)	X	X & quick dissolve tablet			Long acting
	Quetiapine (Seroquel)	X				
	Olanzapine (Zyprexa)	X				Fast acting, prn use
	Ziprasidone (Geodon)	X				Fast acting, prn use
	Aripizole (Abilify)	X	X			
	Olanzapine/Fluvoxamin Combination (Symbyax)	X				
Antipsychotics	Mesoridazine (Serentil)	X			X	
	Chlorpromazine (Thorazine)	X	X	X	X	
	Thioridazine (Mellaril)	X	X			
	Promazine (Sparine)	X				
	Chlorprothixene (Taractan)	X				
	Triflupromazine (Vesprin)	X				
	Loxapine (Loxitane)	X	X		X	
	Molindone (Moban)	X				
	Perphenazine (Trilafon)	X	X		X	
	Acetophenazine (Tindal)	X				
	Haloperidol (Haldol)	X	X		X	Long acting
	Thiothixene (Navane)	X	X		X	
	Pimozide (Orap)	X				
	Fluphenazine (Permitil, Prolixin)	X	X		X	Long acting
Trifluoperazine (Stelazine)	X	X		X		
MAOI	MAO Inhibitors	X				
TCA	Tricyclic Antidepressants (TCA)	X			Amitriptyline Imipramine	
Selective Serotonin Reuptake Inhibitors (SSRI's)	Fluvoxamine (Luvox)	X				
	Paroxetine (Paxil)	X	X			
	Fluoxetine (Prozac)	X		X		
	Sertraline (Zoloft)	X	X			
	Citalopram (Celexa)	X	X			
	Escitalopram (Lexapro)	X				

<i>Class</i>	<i>Medication</i>	<i>PO</i>	<i>Liquid</i>	<i>Sustained release</i>	<i>Injectable</i>	<i>Intra-muscular</i>
Serotonin/norepinephrine Reuptake Inhibitors (SNRI's)	Venlafaxine (Effexor)	X		X		
	Duloxetine (Cymbalta)	X				
Anti-Anxiety (Anxiolytics)	Lorazepam (Ativan)	X			X	
	Clonazepam (Klonopin)	X				
	Chlordiazepoxide (Librium)	X			X	
	Oxazepam (Serax)	X				
	Chlorazepate (Tranxene)	X		X		
	Alprazolam (Xanax)	X				
	Buspirone (BuSpar)	X				
Mood-Stabilizers	Lithium	X	X	X		
	Carbamazepine (Tegretol)	X	X	X		
	Sodium divalproex (Depakote)			X		
	Gabapentin (Neurontin)	X				
	Topiramate (Topamax)	X				
	Lamotrigine (Lamictal)	X	Can chew or dissolve tablet			

TABLE 2: SELECTED ANTIPSYCHOTIC MEDICATIONS SIDE EFFECTS

	Increased HR	Decreased BP	Dizziness/fainting	Drowsiness	Constipation	Headache	Tremor	Sleep disturbances	Confusion	Increased BP	Indigestion	Anxiety/agitation	Uncontrolled movements	Chest pain/MI	NMS (Neuroleptic Malignant Syndrome)	Dysrhythmia	Weight gain	Decreased libido/impotence	Tardive dyskinesia	Other	
Clozaril (Clozapine)	X	X	X	X	X	X	X	X	X	X	X	X									Agranulocytosis Fever
Risperidone (Risperdal)	X		X		X	X		X			X		X	X	X						
Quetiapine (Seroquel)		X	X	X	X						X										
Olanzapine (Zyprexa)	X	X	X	X	X	X		X					X	X		X		X			
Haloperidol (Haldol)		X	X	X	X					X			X	X		X		X			Seizures Liver toxicity Agranulocytosis
Loxapine (Loxitane)			X	X				X	X		X				X				X		Jaundice
Molindone (Moban)	X	X	X	X	X	X		X		X	X		X		X		X				Jaundice
Thiothixene (Navane)		X	X	X						X				X		X					Jaundice Anemia
Pimozide (Orap)					X		X				X	X	X		X						Dyskinesia
Fluphenazine (Prolixin)					X		X				X	X	X		X	X					Dyskinesia Sexual difficulties Liver toxicity
Chlorpromazine (Thorazine)	X	X	X	X						X			X	X							Choking Jaundice
Perphenazine (Trilafon)	X	X	X	X	X	X		X		X			X		X		X				Jaundice Seizures
Mesoridazine (Serentil)		X	X	X						X			X	X		X					Choking Jaundice
Trifluoperazine (Stelazine)			X	X				X				X	X		X				X		
Aripiprazole (Abilify)		X	X	X	X	X		X				X		X	X		X				Inc. Blood Sugar Seizures
Olanzapine/Fluvoxamin Combination (Symbyax)				X			X								X	X			X		Inc. Blood Sugar Abnormal thinking Water retention

TABLE 3: SSRI, MAOI AND OTHER ANTIDEPRESSANT MEDICATION SIDE EFFECTS

Medication	M = Most Common I = Infrequent R = Rare														
	Nausea, diarrhea, constipation	Drowsiness	Hypotension	Hypertension	Weight gain	Sexual difficulties	Dizziness	Headache	Weight loss	Anxiety/nervousness	Hypomania	Weakness	Seizures	Sleep disturbances	Other
Citalopram (Celexa)	M	M	M	I	M	R									Hyponatremia (R)
Trazadone (Desyrel)	M	M	I		M		M	M			R				Priapism (R) Tinnitus Dysrhythmias (R) Leukopenia (R)
Venlafaxine (Effexor)	M			R		I	I	M	M	I	R		R		
Mirtazepine (Remeron)	M	M			M		M				R				Abnormal dreams/thinking (M) Agranulocytosis (R)
Nefazodone (Serzone)	M	M					I			I	R	I	R	M	
Bupropion (Wellbutrin)	I							I	M	M	R		R	M	Tinnitus (R) Leukopenia (R)
Fluvoxamine (Luvox)	M	M				I	I	I			R	I		M	Liver toxicity (R)
Paroxetine (Paxil)	M	M	M			I	I	M		I	R		R	I	Sweating (M)
Fluoxetine (Prozac)	M	I				I	M	M	M	I	R		R	M	Sweating (I)
Sertraline (Zoloft)	M	M		R		R			M		R		R	I	
Escitalopram (Lexapro)	M	M				M	M	M	M					M	Sweating
Phenelzine (Nardil)	M	M		M	M	M	M	M		I	R				Sweating (I) Euphoria (I) Urinary retention (I) Toxic delirium (R) Acute anxiety (R)
Tranlycypromine (Parnate)	M	M		M		I	M	I				I			Agranulocytosis (R) Thrombocytopenia (R)
Duloxetine (Cymbalta)	M					I	M			I				M	Decreased appetite (I) Sweating (I) Fatigue (M)

TABLE 4: TRICYCLIC ANTIDEPRESSANT (TCA) MEDICATION SIDE EFFECTS

Most Common	Infrequent
<ul style="list-style-type: none"> • Drowsiness • Dizziness • Insomnia • Blurred vision • Rash • Dry mouth 	<ul style="list-style-type: none"> • Photosensitivity • Agitation • Diarrhea • Hypertension • Hair loss • Increased/decreased libido • Nausea • Sweating • Weight gain or loss • Worsening of paranoid psychosis in schizophrenic people

TABLE 5: ANTI-ANXIETY MEDICATION: BUSPIRONE (BUSPAR) SIDE EFFECTS

Most Common	Infrequent
<ul style="list-style-type: none"> ▪ mild drowsiness ▪ dizziness ▪ insomnia/dream disturbances 	<ul style="list-style-type: none"> ▪ headache ▪ nausea ▪ faintness ▪ excitement

TABLE 6: BENZODIAZEPINES USED TO TREAT ANXIETY: SIDE EFFECTS

Alprazolam (Xanax)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • light-headedness • depression • dry mouth • diarrhea/constipation 	<ul style="list-style-type: none"> • headache • confusion • tremor • dizziness • nervousness

Clonazepam (Klonopin)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • ataxia (shaky movements) • behavioral disturbances 	<ul style="list-style-type: none"> • tremor • confusion • abnl eye movements • constipation/diarrhea • rash • nausea

Clorazepate (Tranxene)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness 	<ul style="list-style-type: none"> • headache • confusion • depression • dizziness • nervousness • irritability • hypotension • blurred vision • nausea/vomiting • incontinence • rash

Chlordiazepoxide (Librium)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • sedation • dizziness • weakness • nausea 	<ul style="list-style-type: none"> • confusion • constipation • increased/decreased libido • menstrual irregularities • jaundice • edema

Diazepam (Valium)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness 	<ul style="list-style-type: none"> • slurred speech • tremor • fatigue • headache • insomnia • hypotension • blurred vision • nausea • incontinence • rash • respiratory depression

Lorazepam (Ativan)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • sedation • dizziness 	<ul style="list-style-type: none"> • amnesia • insomnia • agitation • disorientation • depression • headache • visual problems • nausea • abdominal discomfort • weakness

Oxazepam (Serax)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • lethargy 	<ul style="list-style-type: none"> • headache • tremor • dizziness • slurred speech • edema • nausea • rash

Carbamazepine (Tegretol)

Most Common	Infrequent
<ul style="list-style-type: none"> • dry mouth and throat • constipation • impaired urination • decreased sense of taste • dizziness • drowsiness • unsteadiness • loss of appetite • nausea/vomiting 	<ul style="list-style-type: none"> • decreased WBC count • fatigue • blurred vision • confusion • male infertility • photosensitivity

TABLE 7: MOOD STABILIZING MEDICATION SIDE EFFECTS

Lithium

Most Common	Infrequent
<ul style="list-style-type: none"> • diarrhea • dizziness • increased thirst and urine volume • increased WBC count • nausea • tremors • weight gain • abnormal heart rate changes 	<ul style="list-style-type: none"> • blurry vision • skin problems • metallic taste • joint pain • ringing in ears • unsteadiness • loss of bladder control • abnormal thyroid function • hypokalemia • inhibited erection • edema
Risks <ul style="list-style-type: none"> • Parkinsonism • hair loss • abnormal movements • elevated blood calcium and glucose • "black-out" spells • seizures 	

Gabapentin (Neurontin)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • dizziness • fatigue • ataxia • nystagmus • tremor • nausea • rhinitis 	<ul style="list-style-type: none"> • skin rash • weight gain • vision changes • vomiting • constipation • hypotension

Topiramate (Topamax)

Most Common	Infrequent
<ul style="list-style-type: none"> • anxiety • depression • sedation • double vision • decreased appetite • weight loss • nausea • vision abnormalities 	<ul style="list-style-type: none"> • weight gain

Divalproex Sodium (Depakote)

Most Common	Infrequent
<ul style="list-style-type: none"> • drowsiness • diarrhea • nausea/vomiting • fatigue/weakness • tremor • headache • asthenia 	<ul style="list-style-type: none"> • indigestion • stomach cramps • slurred speech • insomnia • nervousness • resp. infection • blurred vision

Lamotrigine (Lamictal)

Most Common	Infrequent
<ul style="list-style-type: none"> • dizziness • headache • blurred or double vision • lack of coordination • insomnia • rash • nausea/vomiting 	<ul style="list-style-type: none"> • Stevens-Johnson Syndrome: a serious skin condition characterized by inflammation of the skin and mucous membranes

INDIVIDUAL INTERVENTIONS

Communication and Interaction

- **Communication** includes everything that people convey to each other verbally and non-verbally.
- **Interactions** are actions between persons.

There are **four different types of interactions** involving communication.

Communication between Strangers

Two people exchange and receive information within role expectations until a goal is reached and the purposes of the communication/interaction have been achieved.

Communication between Friends

Two people exchange and receive information so that communication is directed towards sharing each others concerns, own experiences and attitudes until goal(s) are reached and the purposes of the communication/interaction have been achieved.

Communication between Health Care Providers (HCP)

Two providers focus on the patient where the communication is directed towards the problems and goals of the patient; the purpose of the interaction is clear and achievable.

Communication between Health Care Providers (HCP) and Patient

The provider focuses attention on the patient and directs communication so that goals can be reached and the purposes of the interaction can be achieved.

Communication between strangers, friends, or HCPs can be meaningful, purposeful, and goal-directed, but interactions between the HCP and patient **are always meaningful.**

Interpersonal relationships are essential for bringing about change and growth. To accomplish change and growth one needs to participate (interact) at some level. Patients agree to interact with the HCP

because they want to benefit from services of an HCP who has special qualifications and competence.



What is an Individual Intervention?

An individual intervention – also called a 1:1 -- is the communication and interaction between the HCP and the patient on a 1:1 basis.

Any 1:1 interaction between the HCP and patient has three components:

- A focus on the patient
- Goals at which communication is directed
- Defined purpose of the individual intervention

The HCP applies knowledge and interacts with the patient to accomplish specific goals and actions.

Specific actions are aimed at:

- Obtaining information
- Giving or sharing information

- Allowing for the expression of feelings
- Identifying and clarifying patient needs and goals
- Providing education

1. Obtaining information

Purpose: *To collect admission data and assess patient's ability to share information.*

- Physical symptoms
- Allergies
- Medications patient is currently taking
- What led up to admission
- Patient's feelings about illness/hospitalization – why are they here?

2. Giving or sharing information

Purpose: *To assess and encourage patient's attitude/readiness to be involved, follow direction, and participate.*

- Orient patient to unit surroundings
- Discuss routines and unit policies
- Introduce staff
- Discuss the limits of the HCP-patient relationship
- Discuss the expectations of and for the patient

3. Allowing for the expression of feelings

Purpose: *To create a climate for the patient to make a difference in expressing feelings openly.*

- Provide appropriate and sufficient time to talk
- Demonstrate interest, and avoid being rushed
- Provide a setting that is free from interruptions
- Ensure private and confidential environment
- Plan for flexibility; allow the professional or the patient to reschedule
- Display a professional attitude that includes warmth, acceptance, objectivity, and compassion

4. Identifying and clarifying needs and goals

Purpose: *To provide for the continuity of care through specific actions of the HCP.*

- Make observations
- Listen
- Make verbal and non-verbal responses
- Interpret data
- Record data

If the HCP shows knowledge and self-confidence, the patient feels that the interaction is directed towards understanding and helping the patient problem solve. The patient is allowed to work on increasing coping skills through meaningful contacts in which interest and concern are shown.

5. Providing teaching

- Restore, maintain, and promote health of patient
- Help patient move towards goal(s)
- Provide information so patient can formulate solutions that will work for them
- Assess patients' level of understanding, acceptance, knowledge, and learning ability

The Psychiatric Setting

People come to a psychiatric setting in a crisis that can't be managed in their current surroundings.

There are a variety of mental health units that can provide services based on needs of each patient. Units can be specialized according to type of illness, to age groups, or to safety issues. Whatever the crisis, each unit is designed to be ready to provide the proper interventions necessary to help each individual.

Some patients have a long history of mental illness; others come for their first admission anxious regarding the locked doors, loss of control, and unfamiliar surroundings. Each patient has her own perceptions, issues, expectations, and needs. Hospitalization, in itself, is stressful as a person finds herself having to comply with unit rules and unit schedules or treatment programs.

All psychiatric settings consist of a multidisciplinary team. Nurses, psychiatrists, social workers, nursing assistants, occupational therapists and other staff may be involved in the patients care at any given time. Each staff member needs to create opportunities to developing therapeutic relationships with their patients.

Each patient is assessed and placed in the type of environment they need to help them regain control and begin resolving their crisis. Decisions about the type of unit the patient may be admitted to rests with a Psychiatrist, Social Worker, or Charge Nurse.

The Therapeutic Relationship (1:1) in the Inpatient Setting

The HCPs goals are to provide 1:1 crisis intervention, including:

- **Creating** a safe and predictable environment
- **Helping** the patient regain self-control
- **Reducing** anxiety and or psychotic symptoms
- **Identifying** maladaptive coping vs. positive coping so that the patient can gain insight.

Therapeutic Outcomes:

- The patient expresses feelings.
- Patient needs and goals are identified.
- The patient is assisted to find solutions to problems or begin to process them.
- Information relative to the patient's readiness, needs, and feelings is identified and provided.
- The patient attains the highest possible level of health.

The Transition between Outpatient and Inpatient Therapy

Some patients who require inpatient treatment are also in outpatient therapy. In outpatient therapy, the patient may have long term goals related to personality restructuring. In the inpatient setting, however, the HCP's role is to listen and redirect goals towards current crisis intervention. Patients should be encouraged to record (journal) or share this information with their outpatient therapist on discharge or with the inpatient psychiatrist. Patients may be instructed by the psychiatrist to follow certain

techniques which the psychiatrist will communicate to the team. It is important to educate the patient about the goal of the hospitalization; that is, to help them regain their self-control; not replace their current outpatient therapy.

Different Types of Environments -- Different Types of Patients

The HCP-patient 1:1 or intervention focus will depend on the type of environment (milieu) in which one works and the patient's ability to participate.

In one type of milieu, the HCP provides 1:1 interventions for the immediate crisis and focuses interactions on working through problems using learning experiences with peers on the unit. Group therapy, occupational therapy, medication groups and educational groups are a few examples of these experiences. The HCP:

- ◆ Observes the patient on the unit
- ◆ Provides a safe environment
- ◆ Gives the patient opportunities to increase socialization, interact, discuss issues, gain insight
- ◆ Encourages the patient to adopt accepted behavior on the unit.

Individual interventions provide time for discussion and problem solving of issues, as well as to process situations that the patient experiences.

The following is an example of a patient who is in touch with reality, but in a crisis that has greatly impaired his mental health.

This is Bob's first hospitalization. He states that he has been depressed for the last two months. He is neatly dressed, states he has a wife and two children. He admits to feelings of hopelessness, lack of energy, and thoughts of suicide. Yesterday his wife left him, stating he's become increasingly difficult to live with. He decided to get his hunting rifle and "do himself in." Instead, he called his friend and came to the hospital. He appears sad, but able to give direct eye contact and able to verbalize his concerns.

During the first few days, Bob is able to say he feels safe on the unit, but still has no reason to live. The HCP involves him in the unit programs. He shares in

1:1's, group and communication with his peers, his frustrations of trying to deal with his depression and relationship issues with his wife. Medication is started and the patient learns about his illness and antidepressant therapy from the HCP.

On discharge Bob is feeling more hopeful. On 1:1, he discusses getting back to work, going to marital counseling with his wife and continuing his antidepressants. He's able to talk about how his depression has affected his life and the people around him.

In another type of milieu, the emphasis is on providing structure for the patient. This type of patient may be impaired enough that they need 1:1 interactions to keep them in touch with familiar patterns of daily living. Activities and unit routines are structured to provide safety, consistency, firm limit setting, medication management, and to improve disturbed thinking and restore or stabilize coping skills. Patients may be easily over-stimulated, requiring modifications to their environment.

The following case demonstrates this type of milieu. The HCP to patient 1:1 interaction involves redirection, reality orientation, reassessing medication management, building trust and providing avenues for the patient to express concerns more appropriately.

Mr. Williams, a 62 year old man, had been hospitalized many times. This admission he was preoccupied, showed little interest in his surroundings or in other people, smiled inappropriately, and was indifferent to his personal appearance. He required continuous supervision. He did not know the day, month, or year, and was unable to tell who he was, where he was, or who the people were around him. He wandered aimlessly around the unit, or paced back and forth.

The HCP assigned to Mr. Williams makes short, frequent 1:1's to reorient him. His name is put on his door in large print. He is guided through his daily living tasks and brought consistently to unit activities. The HCP assesses on 1:1 that Mr. Williams is hearing voices and his thoughts are racing. Medication management begins. The patient is given support and reassurance throughout the day. The patient is allowed to wander and pace to

alleviate his anxiety but redirected if intrusive to others on the unit.

In the next few weeks, Mr. Williams is oriented and able to follow the structure of the daily unit schedule with some encouragement and reminders. He can sit for periods of time and, if needed, walk the halls to decrease periods of anxiety. If he can't get relaxed he has learned to ask for medication as needed. HCPs on 1:1 provide direction with daily living tasks, support, reassurance, and encourage him to seek out assistance when he feels anxious. Mr. Williams at times talks about his illness and the HCP listens. Mr. Williams is later discharged to a long-term treatment facility.

Some units have a combination of patients, making it a challenge for staff to provide a therapeutic environment for all. Activities are provided during the day to facilitate opportunities for patients to interact with others. This also provides observation time for the HCP. Individual interactions allow the patient and the staff to assess, identify, and express concerns fully in order to work towards therapeutic outcomes. Whatever the environment, 1:1 interactions are a main tool used by the psychiatric HCP to assess and provide meaningful care to the patient.

Elements of the Nursing Process

The HCP uses the **nursing process** in all 1:1's to reach therapeutic goals.

The three basic elements are:

1. **The patient's behavior**
2. **Reaction of the HCP**
3. **Actions for the patient's benefit**

These basic elements relate to the process of helping the patient and to the HCP's effective functioning. We need to continually increase our knowledge, skills and abilities so that we can assess our patients accurately and provide the appropriate interaction. The effectiveness of the 1:1 interaction between HCP and patient is dependent upon the HCP's knowledge and assessment tools.

Sometimes our actions are ineffective because we take automatic actions that we think the patient will

benefit from. In retrospect, we find that we didn't assess the patient's immediate needs correctly. This can happen for a number of reasons. The HCP may determine later that the patient is unable to communicate well, perceives his environment inaccurately, or has poor coping skills. The patient may allow the HCP to act in a way that is not helpful. Basic objectives, actions, goals and therapeutic outcomes need to be reviewed again and again to establish and maintain the helpful nature of the therapeutic interaction.

Therapeutic Interventions for Specific Patient Behaviors

Depressed or Withdrawn Patient

- Be firm and consistent that the patient be involved in activities of daily living (ADL's) and unit activities despite low energy, poor concentration or hopeless feelings.
- Talk about suicidal thoughts and have plan for safety.
- Assess need for medication management for insomnia, anxiety, constipation or other somatic concerns.
- Educate regarding antidepressant therapy.

Out of Control/Intrusive/Hostile-demanding Patient

- Provide firm and consistent limits and or structure.
- Plan with the patient appropriate ways to deal with impulsive thoughts – behavioral plan (time-outs, use of staff to help de-escalate aggressive behavior).
- Assess need for medication management and help the patient to recognize when he/she needs to seek out assistance before behavior is out-of-control.

Psychotic/Paranoid/Delusional Patient

- Provide firm and consistent limits and/or structure.
- Don't over stimulate! Make short, frequent visits, keeping 1:1 focused on support and allowing patient to address concerns.
- Reorient as needed- never agree with false perceptions or participate in irrational beliefs.

- Assess medication management: stay with patient to make sure medications are taken. Never mask medications – be honest with patient regarding medication and how it will help.
- Assess and help with ADL's.

Dependent/Demanding Patients

- Provide firm and consistent limits -- repeat limits as necessary; be respectful.
- Don't meet hostility with hostility -- accept behavior initially; then use 1:1 time to allow patient to ventilate concerns and make a realistic plan of action with them.
- Anticipate needs. Empathy and concern will gain trust and the patient will feel less threatened and will function more independently.

Personality Disorder Patients (borderline, antisocial, narcissistic)

- Provide firm and consistent limits -- restate rules in factual manner.
- Maintain a neutral stance -- don't overreact to positive or negative behaviors.
- Support – develop trust.
- Empathize, don't sympathize – focus on patient's feelings.
- Restate goals and focus behavior. Emphasize that consequences are part of life.
- Maintain good communication with staff to avoid splitting.
- Faulty communication may cause problems with unit milieu.

An Individual Intervention Case Example

Mary, a 19-year-old college student, arrived to the MHU last night. Admission data show this is Mary's third admission for depression. Mary reports no energy and has been spending days in bed and missing her classes at college. In the a.m. recorded report, the evening HCP states Mary had chosen to lie in bed all evening in her room curled up in a ball on her bed. On approach, she offers little. She told the HCP she wishes she could fall asleep and never wake up.

After introductions, the day HCP encourages Mary to be involved in unit activities. The HCP acknowledges Mary's lack of energy as a symptom of her depression. Mary is reassured and supported to attend groups, get her scheduled medications and eat her meals on the unit with the other patients. The HCP allows time for Mary to ask questions and express her concerns. The HCP asks Mary if she feels safe on the unit. The HCP schedules a 1:1 with Mary during the day when they both have free time. Mary is encouraged to seek out the HCP if she has any concerns. Mary agrees to do this.

During that day the HCP observes Mary on the unit and in groups. Mary sits quietly by herself and offers little in groups. Later, during their scheduled 1:1, Mary is able to share with the HCP that she has difficulty in groups due to her poor concentration and low energy. "I feel stupid. I can't remember what people ask me or say." Mary also shares that she can't sleep at night. The HCP reassures her that as her depression gets better she will gradually get her concentration and energy back. The HCP listens as Mary expresses how difficult school has been. Mary agrees to continue to be out on the unit and go to activities. She also agrees not to take naps during the day. They talk about insomnia and depression. The 1:1 ends. Mary agrees to seek out the HCP if needed. The HCP observes Mary talking to another patient during the noon meal.

In nursing report that day, the HCP shares with the evening staff that Mary remains depressed, but with encouragement has been out on the unit. On 1:1 she has verbalized that she has been isolating due to poor concentration and low energy. She states she feels safe on the unit. The HCP reports that the psychiatrist has started Mary on mild sleep medication along with her antidepressant.

Common blocks to HCP-Patient Relationship

The HCP may engage in any of the following activities due to own anxieties, attitudes about the patient or preconceived notions of how the patient should behave.

Communication

1. **Changing the subject-** HCP shifts focus of 1:1.
2. **Giving own opinions-** HCP states her own opinions and ideas about the patient and concerns that hinder exploration of patients own problems.
3. **Inappropriate reassurance-** false or inappropriate comments made by the HCP can keep the patient from expressing worry.
4. **Jumping to conclusion-** offering solutions prematurely without fully letting the patient explore problem(s) themselves.
5. **Inappropriate use of facts-** use of medical or nursing knowledge to teach or tell patient before exploring how the patient actually feels about the topic.

Sharing of Information

It is the responsibility of the HCP to maintain a trusting relationship with the patient.

1. **Confidentiality-** between professional staff and patient. Releases are signed if patient agrees to share information with others. Information sharing about other patients to patients is never allowed.
2. **Staff splitting-** refer problems the patient has with other staff back to the patient to resolve. (Patient can take issue to HCP manager or hospital advocate-don't get in the middle!)

Serious Boundary Issues

Focus is not on the patient- goals cannot be reached and purpose achieved. Professional relationship is jeopardized.

1. **Role reversal/inappropriate self-disclosure** - HCP looks to the patient for satisfaction and gratification.
2. **Secrecy**- HCP keeps critical knowledge or behavior about the patient from the staff or selectively shares information.
3. **Giving or receiving gifts.**
4. **Spending time** together with patient away from work.
5. **Inappropriate touch/sexual intimacy**

Because of the many comprehensive services available in any psychiatric setting, it may be that we need to consult another discipline. Guided (therapeutic) verbal exchange, 1:1 therapy, is a shared activity among all psychiatric disciplines. It is the challenge of the multidiscipline team to create opportunities for therapeutic relationships to occur. In any given setting, a psychiatrist, social worker, RN, occupational therapist, human technologist and a wealth of community professionals may be involved. Team meetings, end of shift reports and treatment plans help to provide consistency and agreed upon goals.

Forty-Nine Tips for Interacting with Difficult Patients

1. Find out what works and what doesn't. Remember, a strategy may not work every time.
2. Clearly communicate what works and what doesn't to other staff.
3. Open communication enables the staff to receive a complete view of the patient.
4. Have brief, daily discussions about the patient.
5. Try to have the same staff care for the patient.
6. Reinforce to the patient that he deserves the best care possible, and you will continue to offer the prescribed treatment.
7. Determine if the patient can be helped. Status-quo may be all that is possible.
8. Avoid over-helping.
9. Work towards prevention when possible.
10. Listen completely to the patient. Don't interrupt unless the patient has become repetitive.
11. Let the patient know that you hear what he is saying. Seek first to understand.
12. Match your facial expression, degree of animation, body posture, voice volume and speed of verbalizations.
13. Don't match so much that the person feels mocked.
14. Don't match hostility.
15. Establish rapport if possible.
16. Don't take it personally. Be impartial and dispassionate.
17. Staff should seek to understand themselves, the patient, and how the patient and staff affect each other.
18. Set firm limits on dependency, manipulateness, rage and self-destructive behaviors.
19. Reflect on why the situation bothers you and what you can do so the situation doesn't bother you.
20. Be aware that you may feel guilty because you aren't giving the patient what he wants.
21. Control your attitude. Stay clam. Change your reaction and perspective if needed.
22. Show caring, not pity.
23. Focus on the positive, not the negative.
24. Accept the fact that you cannot make someone change his or her behavior.
25. Manage your emotions. Avoid being emotional.
26. Acknowledge that difficult patients can create negative emotions in even the most experienced caregivers.
27. Don't angrily confront the patient.
28. Acknowledge the real stresses in the patient's situation.
29. Avoid breaking down needed defenses.
30. Avoid over stimulation of rage.
31. Don't get drawn into arguments with the patient.
32. Repetition is key. It may take 2-3 attempts to get cooperation.
33. Reinforce the patient's strengths.
34. Deal with entitlement without confronting the patient's defenses.
35. Increase the level of awareness of your behavior.
36. Carefully document. Leave emotion out of documentation.
37. Make boundaries and consequences clear.

38. Set firm, clear, consistent limits.
39. Accept the patient as he is. Accept the situation as it is.
40. Look for opportunities in the experience.
41. Reflect on what you are learning from the situation.
42. Be flexible.
43. Learn to say “Oh well”.
44. Remember that this too shall pass.
45. Engage in healthy ways to relieve stress. Practice stress management techniques.
46. You will get along better with people when the emphasis is on similarities.
47. Focus on effective communication with the patient.
48. Success in communication depends on establishing common ground.
49. No one cooperates with someone who appears to be against them.

Summary

Individual interventions can be used effectively with all types of psychiatric patients. The HCP needs to assess each patient's needs carefully and use the maximum of knowledge and expertise to facilitate the patient's return to his optimal level of functioning. There are various barriers that can interfere with the therapeutic effect of the 1:1, so the professional needs to be constantly in tune to the focus, goals, and purpose of the intervention.

Applying What You've Learned...

We recommend that you do one or more of the following activities to apply what you've learned in this section:

1. Observe experienced staff member in a 1:1 interaction with a patient.
2. Discuss elements of productive and non-productive individual interventions.
3. Identify appropriate candidates for individual interventions.

GROUP INTERVENTIONS: THE ROLE OF THE CO-THERAPIST

Other professionals saw the benefits of group sessions and offered their own theories. Many different theories of group therapy have been developed.

INTRODUCTION

This section is designed for mental health staff of an inpatient psychiatry unit who will be co-leading group therapy. It will give an overview of the theories and philosophies of group therapy with a focus on Interpersonal Skills Group (IPS), a psychotherapy group.

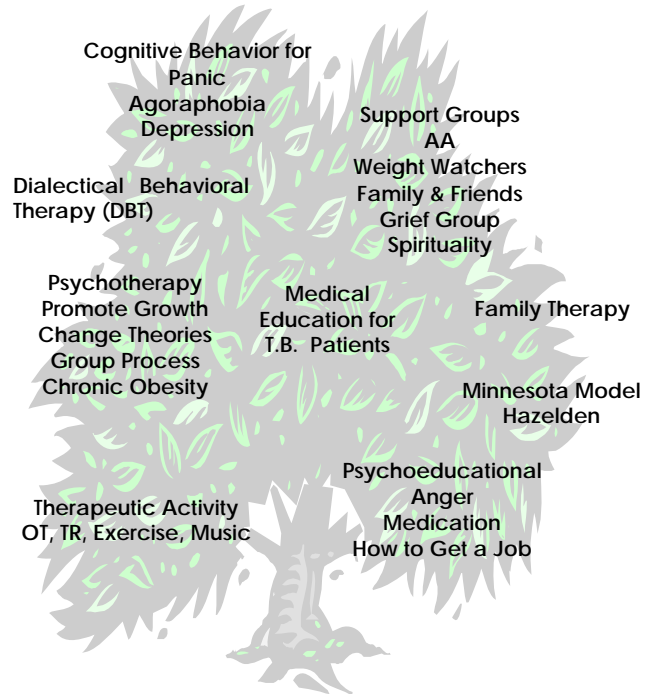
Today psychiatric settings have a multidisciplinary staff involved in facilitating different types of groups. From the morning unit meeting, run by the nursing assistant to encourage the patient to set daily goals, to the nurse facilitating a medication education group. Other examples include the occupational therapist leading a communication skills group, or the social worker and psychologist facilitating a group on social support or understanding psychiatric illness. The main goal is to engage the patient in recovery and management of their illness.

The purpose of group therapy is to identify problem areas in patient's lives and build a sense of belonging among members in order to facilitate change. Symptoms of mental illness frequently keep people isolated. For people with mental illness, one of the rewards of meeting people and sharing in a group is gaining the knowledge that they are not alone. The group can help people identify what it is that they would like to change in their relationships with others and learn more about their own control in the outcome of relationships. Groups can help patients come to terms with their mental illness.

Historical Perspective

Group therapy began in the early 20th century (1906), when Dr. Joseph Pratt gathered his patients who had tuberculosis and gave them a lecture about hygiene, diet, and rest. He noted that the patients who took this time to share health tips and offer encouragement and support to other patients did better overall. Dr. Pratt shared this observation with his colleagues who then gathered their own patients for educative sessions. This was the beginning of the medical educative model.

Types of Groups



GROUP THERAPY IN THE CLINICAL SETTING

Types of Group Therapies

1. The *Medical-Educative Model* outlined by Dr. Joseph Pratt helped start the movement to group therapy in the 20th century. In psychiatry we have psycho-educational groups such as Medication Group, group teaching about a specific diagnosis and groups about a specific topic such as discharge.
2. *Psychodynamic Therapies* are based on the exploration of thoughts and behaviors and their effects on relationships. The group helps to identify maladaptive patterns and provide a safe environment in which to practice changes. This therapy encourages insight.
3. *Humanist Therapies* help people feel better about themselves and have goals of “self-actualization” and increased insight. Humanistic therapists include Carl Rogers, Ph.D., who coined the term “patient-centered therapy,” and Frederick S. Perls with his Gestalt Therapy and Existential Therapy.
4. *Cognitive Behavioral Therapy* directs the patient to change irrational thoughts involved in negative emotions and self-destructing actions. Panic attacks, agoraphobia, and depression are examples of problems that are treated in these groups.
5. *Family Therapy* is based on the premise that an individual’s problems arise in and are solved in the context of the family.
6. *Therapeutic Activity Groups* such as occupational therapy and recreational therapy are focused on teaching people how to work and live independently and examine themselves in different situations.
7. *Self-Help or Support Groups* unite people with common problems. The benefit of these groups is that members do not feel they are the only one with the problem. Members hear that others have gone through the same things and have found solutions they are willing to share. Examples of support groups are: Family and Friends Group, Grief Group, Spirituality Group, Alcoholics Anonymous, Overeaters Anonymous, and Emotions Anonymous.

8. *The Minnesota Model for Treating Addictions* is used by the Hazelden Foundation.
9. *Dialectical Behavioral Therapy (DBT)* was pioneered by Marsha Linehan based on the idea that psychosocial treatment of people with borderline personality disorder is as important as psychotherapy and pharmacotherapy. It can also benefit patients with anxiety, mood, impulse, control, addictive and personality disorders. DBT is based on the belief that some people raised in an invalidating environment and due to unknown biological factors, react abnormally to emotional situations. Their level of arousal rises quicker, peaks at higher levels and takes more time to return to baseline. This explains constant crises and extreme emotional lability in patients with borderline personality disorder. Past invalidation has prevented effective coping with the sudden, intense surges of emotion. DBT teaches skills to cope with emotions and targets suicidal behavior, behaviors that interfere with treatment and other dangerous, destabilizing behavior.

Types of Groups on Inpatient Psychiatry

There are a wide variety of groups on inpatient psychiatry. Occupational Therapy Groups, Therapeutic Recreation Groups, and Psychotherapy Groups. Groups will have titles such as:

Self-esteem Group	Nutrition Group
Cooking Group	Mid-life Group
Leisure Skills Group	Family Group
Sex Education Group	Medication Group
Anger Group	Grief Group
Body Movement Group	Chemical Dependency Group
Good Grooming Group	Budgeting Money Group
Women’s Group	Life Choices Group
How-to-Get-a-Job Group	Alcoholics Anonymous Group
Men’s Group	Interpersonal Skills Group
Exercise Group	Current Events Group
Senior Group	Narcotics Anonymous Group
Relationship Group	
Adolescent Group	

How Nursing Staff can Support Groups

Staff on psychiatry are instrumental in getting the right information to the patients. The goals of every

group are complementary to and in accordance with the goals of the unit, and the care plans of each patient. Nursing staff are in a prime position to recommend groups to their patients, to select groups in the care plans for their patients, and to assist them in getting to the various groups selected. This involves sharing assignments that allow time to help patients be ready for group.

Assisting patients to get to group is important. Patients often need reminders about the time. They will want to clean up and have breakfast before the group program starts. Staff will need to help patients who have trouble with organization, or have physical handicaps to get ready for the group. Reminding patients about the next group on the schedule helps them keep their commitments. Staff can talk to patients while making rounds. In talk therapy groups, sit in the circle of the group and offer comments of encouragement as appropriate.



What Makes an Effective Psychotherapy Group?

The atmosphere of the group is important. The atmosphere needs to be informal and relaxed, with people in the group demonstrating interest in the process. The purpose of the group must be clear, with the goals of the group outlined. The rules of

expected behavior must be stated clearly. An outline of the sequence of events in the group is helpful so that members know what to expect throughout the session.

There must be a sense of cohesion in the group. Building cohesion starts with making members feel they are included in the group. Group members need to feel they can depend on the support of the group and can trust the group. A feeling of belonging emerges with the group members wanting to be together. If the therapist makes the group personally rewarding for each member, there will be a cohesive feeling in the group. This involves clarifying observations to help members understand themselves better. There are times when a member is very unpopular. It is helpful to point out the good qualities of this member and show the group how they can learn more about themselves and about working out conflict when they take time to understand and tolerate differences. Group members need to develop the ability to accept conflict within the group and either resolve the conflict or decide within the group process that each person can live with the differences. The goal is to understand, tolerate, and support differences in a respectful manner.

In effective groups, power is discussed. Each person in the group is encouraged to feel their own personal power and control. A group leader should never do for the group what the group can do for itself. An example of what the group can do is the introduction at the beginning of the group. If there are members of the group who can give the introduction to the group, they should be the ones to do so. The message to the members is that it is their group; that they have responsibility for what happens in the group.

Active participation involves members giving each other feedback. Sharing perceptions, feelings, and experiences in a constructive, respectful manner encourages members to look at how they are viewed in relation to others.

What Makes a Successful Therapist?

To be successful, the therapist must show empathy, warmth, genuineness, and imagination. The therapist is responsible for the patient to feel respected, accepted, and understood. The therapist must demonstrate a presence with the patients. The therapeutic alliance involves the patient and therapist

understanding one another. It does not mean they must like each other. There must be a willingness to learn from each other. This is especially important when there are many different cultures to assimilate. True cohesion comes when both positive and negative expressions of feelings may be stated. It takes time to develop this trust. On an inpatient unit there are many interactions available for patients to discuss. This is a positive point for the inpatient group.

Realities of an Inpatient Setting

Just getting the patient to group is sometimes difficult. The patient must juggle time, and there is a lot of competition for the patient's time on the inpatient unit. The patient needs to be in groups, but she also may want to smoke a cigarette, go on a pass, spend time with a visitor, or watch TV. The patient also must see the doctor, eat meals, take care of ADLs, and attend various clinic or consult appointments. There is a lot of competition for the patient's time.

One of the realities of the inpatient setting is the rapid patient turnover. Rarely do groups on the same unit have the same members two days in a row. New members start every day. The therapist needs to take time to introduce the group and some time to terminate with people who are leaving. That allows little time to address the issues for patients that day. Frequently when a patient is ready to engage in the group process, they are also ready for discharge.

There is a variety of psychopathology in each group on the inpatient unit. On a unit dedicated to one focus, such as eating disorders or addictions, the issues are the same. On a general psychiatry unit, the group is first looking for similarities or for what they have in common. Unfortunately, participants are always uncomfortable. They are caught up in what is wrong with them. They may not want to take medication. They may not be interested in learning more about themselves. They may be unmotivated. Most do not want to be in the hospital, and may, for example, be angry about revoked privileges. Some do not want to change, feel it is all a conspiracy, and/or are resistant to "getting fixed".

On an inpatient unit, the therapists are not able to screen the patient as well as would be ideal. Nursing staff may be too busy to sit down and share

information about the patient before group starts, and inappropriate patients may not be identified.

The inpatient group may have different co-therapists each day. This emphasizes again that there is no carry-over from one day to the next. For the rotating co-therapist it is harder to reorganize patterns of behavior in the group. By co-leading Interpersonal Skills Group (IPS), the staff may see the patient in a totally different light. Patients are interacting with other patients and come out of themselves when they are reaching out to others. For nursing staff, the difficulty may be that on Tuesday and Wednesday, staff had to restrain the patient and on Thursday, find themselves co-facilitating IPS group with that patient. This has an impact on the group. There cannot be cohesion without trust.

How to Create and Maintain a Psychotherapy Group

Group structure is important. A group feels safe when everyone knows what to expect. Let patients know what is expected of them. External structure helps develop internal structure. It is useful to have a consistent introduction to group to review the rules, goals, and purpose every day. Patients can take responsibility for doing the introduction. The introduction should be clear to answer many questions: What is the purpose of the group? What time does it start and end? What happens if I have to leave early? What if I am late to group? What are the goals of the group? What is expected of me while I am in the group? What happens with the information I give the group? A person with manic symptoms or a person with organic symptoms may screen themselves out. Sometimes patients get to group and realize they cannot follow the group task and will leave. Patients are encouraged to stay if the leader thinks they might make it with some extra help. If a patient decides to leave, it is always proper for the therapist to thank them for trying to be part of the group.

After the introduction, and when everyone has introduced themselves, it is useful to ask the group who wants time to talk about their issues that day. It is not staff's role to confront or criticize. A group that focuses on anger can fall apart or escalate. Patients come into the hospital out of control. The idea is to help them get their defenses together so they can talk about their emotions rather than act out. Psychotic patients may attend group if they are not disruptive to the process.

Safety Factors

When gathering a group, the staff needs to pay attention to the issue of safety. Each person in the group needs to feel safe, both physically and emotionally. It is the group leaders' responsibility to assure the safety of each person.

In order to assure safety in the group, the leaders need to look at who they are inviting to the group. An assessment must be made about each person. This is a brief screening period made while leaders are in the process of inviting patients to group. Group leaders will rely on nursing staff for judgment of inviting patients to the group. The invitation implies a contract between the leader and the patient. The basic contract is "As leader, I will do all I can to make the group experience a safe and useful place for you. I will do all I can to offer support and make every effort to understand you, while assisting you in getting to know group members." The patient's acceptance of the invitation says, "I agree to follow the group rules and do all I can to trust the process of the group for the single session I attend."

Patients need to know they do not have to share anything in group that they do not want to share. Reassure them that part of the group leaders' responsibilities is to keep them from sharing too much. A talk therapy group meets daily. Patients are expected to come daily. They can take time to get to know peers and share a little each day.

Curative Factors

Engaging the patient that is hospitalized for short periods of time in the therapeutic process can be quite difficult.

Irvin Yalom, M.D. has identified curative factors which are the effective elements of groups. The curative factors were identified in research Yalom did when he was studying the potential to do psychotherapy on an inpatient unit as well as outpatient clinics. Yalom found these elements are present in both inpatient and outpatient groups. Not all curative factors are present in every group session.

1. ***Instillation of Hope.*** Patients are demoralized and hopeless on admission. They are disconnected, withdrawn, and isolated. They

observe others with similar problems getting better. The group offers support and acceptance; a way to connect with others in an honest way. The group offers support for where they are at functionally and emotionally. They can begin to cope with others in an honest way.

2. ***Universality.*** Patients feel unique, alone, isolated in their experiences, fantasies, problems. In psychotherapy groups they begin to see that they are not so alone, not so unacceptable, and that their problems are not unique to them. They do this through sharing similar experiences. An articulate, high-functioning person can relate to a psychotic or schizophrenic person. They learn from each other. There are universal experiences.
3. ***Imparting Information.*** Information is given directly and indirectly about various possible ways to get better, about symptoms of mental illness, and about social skills. It is not helpful for people to give advice, but to share similar experiences. Experiences do end up being given. Advice does end up being given. There is a lot of indirect teaching that goes on. There are patients at different levels of recovery. For instance, some patients will have insight that the medications have helped them. They may be sitting next to the paranoid person who is refusing medications, resisting. The paranoid patient may start thinking about medications working because it is a peer who is telling him/her that the meds work.
4. ***Altruism.*** Patients learn in the process of the group that they have something to give. This increases self worth, decreases self-absorption, and enhances hope. Patients come in with a very low self-esteem and feel hopeless and worthless. During the course of the group they feel acceptance and support of others and they begin to empathize and realize that they have something to give and offer others. This starts to enhance their self-esteem.
5. ***Development of Socializing Techniques.*** Through feedback, patients learn about maladaptive behavior that keeps others away, and keeps the patient feeling lonely. It is very important that the group stay in the "here and now". Group provides an opportunity to try new behavior, to listen, to empathize, and to learn how to express feelings verbally. To experience these changes feelingly and cognitively and to obtain support for making changes develops socializing techniques. What this often means is

that instead of focusing on why someone has come into the hospital, and other problems that cannot be solved in the group context, patients begin to interact with each other. They begin to learn that some of their behavior patterns are maladaptive. They can learn other ways to interact. They begin to think there are changes they can make. It is a long-term process. There are skills that patients can go and practice on the unit. Say to the patient, "Do you think you can go and practice this assertive behavior with your own doctor? Try it on the unit and report back to us tomorrow."

6. **Imitative Behavior.** The patient can use the therapist or another patient as a role model of behavior. Yalom says this can assist in breaking the ice for someone who has been blocked in a pattern of rigid behavior. Even quiet, inactive group members can observe the therapeutic process.
7. **Catharsis.** Catharsis is used carefully in leading Interpersonal Skills Group (IPS). Expression and release of strong feelings is not enough to assist the learning process and must be accompanied by cognitive understanding which is facilitated during process analysis. Expression of strong anger is not encouraged because that can really fragment the group. People have not had time to know and trust each other in a safe way. Patients are encouraged to say what they like and do not like and what they might be irritated by. That is a safer way of encouraging expression of negative feelings.
8. **Existential Factors.** People come into the hospital feeling that they have no control over their lives. They may not have any direction. They may feel dumped. They may feel like failures. Finding meaning in life is an ongoing process. In the here and now of group, patients can practice making the moment meaningful with meaningful contact. Meaning is possible in the context of honest sharing and contact. These experiences demonstrate that there is a way to fill the emptiness and to find strength in oneself.
9. **Cohesiveness.** This is a universal factor of all therapy groups. Cohesiveness means valuing the group. It is the leaders' job to foster cohesiveness among members. This is achieved through sharing, support, empathy, and mutual respect. Many patients have never had a healthy group experience, including family lives, so this can be a powerful therapeutic experience.

Cohesiveness is demonstrated by patients looking forward to group.

10. **Interpersonal Learning.** Psychopathology is either caused by or leads to disordered relationships. Yalom said, "The patient suffers from disordered interpersonal relationships and therapy consists of helping the individual develop adaptive, more gratifying relationships." The group is a social microcosm and eventually the person will exhibit behavior that he/she would use in the larger environment. Patients can try out healthier behavior in the group and then apply it to their social environment outside group.

Responsibilities and Expectations of Co-Therapist

Once in the group, staff will best co-facilitate by helping the patients stay focused on the purpose of the group. In a psychotherapy group, encourage interaction between patients at appropriate times. Remind the group to slow down if members are presenting ideas in succession without allowing anyone to respond. As a part of providing a safe group, never divulge information about a patient to the group which he has not divulged on his own. What a staff person knows and what the patient is comfortable discussing may be very different.

The task of a co-therapist is to listen, listen, listen. The role of a co-therapist is to allow the members to express their feelings and for members to learn how they affect the other members of the group.

Co-therapists must consider the compatibility of his/her orientation and style of leadership. If there are rotating co-therapists with a single permanent therapist, the rotating co-therapist must follow the lead of the permanent therapist. There may be room for disagreement, as a model for patients of how to disagree respectfully, but it certainly is not to take up a major part of the group session.

The co-therapist offers a second set of eyes, and helps keep track of loose ends. If the therapist gets involved in one interaction, the co-therapist can remind the group that there were others who wanted time. The co-therapist permits greater objectivity by offering another point of view. The co-therapist can notice the facial expressions of members who may

need some encouragement to talk about what is happening in the group and how it affects them.

Self-Disclosure

Self-disclosure in a psychotherapy group is always an area requiring decisions by staff as to how much personal information they want to share with patients. There are some guidelines in the literature. It is good to remember that in a group the most powerful interactions occur between the patients. This means that patient to patient sharing is the most important event in the group, and the event that co-therapists are working toward. It does not make any difference if one co-therapist has had a similar experience as the patients and found a good resolution for him/herself. It does not equate with the importance of patients sharing their experiences with each other. The staff role here is to listen and encourage patients to share their experiences. Time in a group is limited – the less said by the co-therapists, the more time is available for patients to interact with one another. Appropriate self-disclosure focuses on here and now feelings rather than past events, (i.e., “When I talk to you I feel uneasy because you do not respond. Am I pushing you too hard?”). This encourages members to talk more openly.

Here-And-Now Model of Therapy

The here-and-now approach uses the interactional methods so that it focuses on the patient and what is happening in the session. This approach de-emphasizes historical events. The here-and-now is what patients and therapists observe in the session as they interact.

There is an activating stage for the here-and-now process. Patients may give some history but it is not the focus of the discussion. The focus for the activating stage is when members tell each other how they feel about each other. Asking questions that relate to what is observed in the group as peers interact with each other will facilitate the focus. Yalom said that the psychotherapy of the patient will come to light in the interactions of the group. The task for the therapist and co-therapist is to make all the data that happens in the group available to the patients. Questions like, “How do you feel when you hear ____ say that?” or, “What could you share with ____ today in this group?” are useful. Again, this interaction between patients is the important event. It is the therapists’ task to hear those subtle messages

communicated by members. Therapists need to look at the verbal and non-verbal communication and encourage feedback among the members.

Yalom’s model states that the maladaptive behaviors such as aggression, passivity, irritability, narcissism, and arrogance are all observable in the small group. When observations are made about these behaviors in a group, it is the therapists who will be instrumental in determining the outcome. Remind patients that one of the benefits of coming to the group is to learn more about themselves in relation to others. They may need help if they feel attacked. If this is the case, then the therapists must work through the intent of the sender and the awareness of the sender.

The second stage of the here-and-now is helpful at this point because the participants are asked to look at what is happening in the group and understand it. This is the understanding stage when the group tries to examine itself. Yalom’s model calls this the “illumination stage.” Members become self-reflective and examine what has just occurred in the group session. The therapist must help each group member learn as much as possible about the way s/he relates to the other members of the group. This way the group members can learn what makes others avoid them and what draws people to them. It facilitates the learning of social skills.

The therapist must know how to guide the group into the here-and-now. In the second stage, the therapist must clarify something about the relationships in the group. The therapist helps members look at each other and talk to each other using proper names and direct comments to each other. The therapist teaches how to give constructive feedback. It is the therapist’s responsibility to discuss only that area over which the patient has personal power to change – otherwise the process is too frustrating. The feedback given will be more powerful if it is describing a person’s feelings.

The second stage makes the group a therapy session. The illuminative stage reflects on what has happened in the group. The task is to help each member learn how s/he interacts with other members of the group. What makes people avoid them? The feedback from group members will help them see why they feel isolated or why they have been isolative. These topics require a greater need for support from therapists. It is important to remember that all group events are grist for the mill and if worked in a

supportive, constructive manner, will be therapeutic for the patient.

The Importance of Initiating and Closing Group

Just as it is important to start on time, it is equally important to end on time. The external structure will aid the patient's reorganization for internal structure. A consistent form of closure to the groups is a frame for the group discussion. The structure of the introduction, the body or work, and the conclusion aid in the development of internal structure for the patient.

The secondary anxiety due to expectations can gradually be alleviated as patients see how others contribute to the conclusion of the group. There are fewer questions of, "Are we done?" when patients know that they are expected to make a brief comment about how the group went for them or what they will take with them from the group. Frequently, the easiest way to conclude is for the therapist to summarize what he saw happening in the group and then to circle the group and have each person comment for themselves. It is important to stay on task while circling the group and getting comments. A few patients may want to take the time to make more points that they did not get to make during the group. Occasionally, a therapist may want to do the same. It is important to tend to what was an important point for each patient in the group. If one of the group rules is not to force members to talk, the concluding comment from each person may be the only other thing a new patient says in the group, besides introducing him/herself at the beginning of the group.

Posting: Leadership Processing

The posting sessions after group therapy provide time for some discussion regarding the differences in philosophy or style. Therapists may discuss their interactions with each other and the effect this has on the group. This also affords the therapists time to talk about personal and professional needs met by co-leading a group.

Posting provides a time to discuss the ease of communication and degree of defensiveness that each facilitator felt. Mutual respect will facilitate communication between the facilitators. The posting

session or supervision sessions can encourage an appreciation and acceptance of the different skills so the relationship is complementary. It takes a significant amount of work to have each facilitator feel equally responsible for the outcome of the group. A level of trust that signifies cooperation and the absence of competition enhances the climate of the group and combats the splitting that may be the way some patients operate in a group setting.

The posting session and the supervision sessions provide avenues to keep the lines of communication open so each therapist can feel a closeness without feeling like s/he is losing parts of themselves in the process. Boundaries are often an issue in the psychotherapy group, especially with the possibility of psychotic patients attending. It is important that co-therapists have worked on their relationship issues so they can be clear with their patients as a co-therapy team.

ELECTROCONVULSIVE THERAPY

Introduction

Electroconvulsive therapy (ECT) is a treatment for depression in which a brief application of electric stimulus is used to produce a generalized seizure.

In the United States in the 1940's and 1950's, ECT was often administered to the most severely disturbed patients who resided in large mental institutions. As often occurs with new therapies, ECT was used for a variety of disorders, even if not always appropriate. ECT became popular, and by 1942 was used extensively. In some instances, it proved quite helpful. Its use as a means of managing unruly patients, for whom other treatments were not then available, however, contributed to the perception that ECT was an abusive instrument of behavioral control for patients in institutions for the chronically mentally ill. With the introduction of effective psychopharmacologic medications and the development of judicial and regulatory restrictions, the use of ECT waned.

How effective is ECT?

Published controlled studies of ECT permit evaluation of its short-term efficacy in severe major depressions (delusional and endogenous), in acute mania, and in certain schizophrenic syndromes. Few controlled clinical trials extend beyond the treatment of the acute episode (i.e., about four weeks). These studies are difficult to compare because they have used differing diagnostic systems and research designs. Further, they have measured outcome only in terms of symptom reduction, not the quality of life and social functioning.

The success rate of ECT, when used appropriately for indicated conditions, has been well established. Some studies have found ECT to be at least as effective as medication treatments, while others have found ECT to be superior to medication. It may have also a more rapid onset than do many medications. Medication-resistant patients also respond less well to ECT. Twenty-50% percent of those who respond well to ECT relapse within six months and need antidepressant treatment, continuation of ECT for 4-6 weeks, or maintenance ECT (no end point).

The number of treatments in a course of therapy varies. Six to ten treatments are usually effective. In the United States, the usual frequency is three times weekly.

Indications for Use

ECT has a greater success rate for severe depression than any other treatment. It is also effective in the treatment of delusional depression and mania, especially intractable mania.

Given a diagnosis for which the efficiency of ECT has been established, the following indications for ECT use are:

- When the patient is at immediate risk for suicide and is not manageable by other means
- Acute manic episodes – especially when characterized by clouded sensorium, extreme psychomotor agitation, high risk for serious medical complications, or death through exhaustion and dehydration, and non-response to pharmacological interventions
- The severe and unremitting nature of the patient's emotional suffering, or extreme incapacitation, is also important.

- It can be safely used to treat depressed women who are pregnant up to the third trimester.
- Patients who are non-responsive to antidepressants, or who cannot tolerate their use because of physical conditions or severity of side effects.
- Schizophrenic patients with shorter duration of illness, a more acute onset, and, debatably, the presence of affective symptoms.

Who Won't Benefit from ECT?

ECT is not useful with chronically ill schizophrenics. ECT is not effective for patients with milder depressions (i.e., dysthymic disorders, adjustment disorder with depressed mood) and may not be successful in long-standing depression.

Medical Indications and Contraindications

The patient's medical status is often the determining consideration in the use of ECT. ECT may be necessary when the patient has medical conditions that preclude the use of tricyclic antidepressants (TCA), MAO inhibitors, lithium, and neuroleptics (antipsychotic medications). ECT should be considered in the patient who has severe depression or psychosis while the patient is in the first trimester of pregnancy.

ECT should be considered when alternative pharmacological and/or psychotherapeutic treatments have been given an adequate trial without adequate response. When a patient is non-responsive to other treatments, factors such as severity of illness, its natural course, and the risk of other treatments worsening the course (as, for example, antidepressant medications precipitating a manic episode) need to be taken into account.

Conversely, ECT is contraindicated for increased intracranial pressure. Space-occupying lesions in the brain, a recent history of myocardial infarction, and large aneurysms are relative contraindications for ECT. If the patient is not responsive to ECT, or if they suffer from debilitating side effects (medical or psychological), ECT probably would not be considered.

Maintenance ECT

There are few controlled studies on the periodic use of ECT after remission of the acute episode or as a maintenance regimen to prevent recurrence of new episodes. Following ECT, standard practice dictates that most depressed patients should be continued on antidepressant medications or lithium to reduce relapse. However, continuation and maintenance of ECT has been found to be effective, safe, well-tolerated, and cost effective. It has been shown to reduce relapse and re-hospitalization, including management of recurrent mood disorders in the elderly.

What are the Risks and Adverse Effects of ECT?

To maximize the benefits of ECT and minimize the risks, it is essential that the patient's illness be correctly diagnosed, that ECT be administered only for appropriate indications, and that the risks and adverse effects be weighed against the risks of alternative treatments. Risks and adverse effects of ECT can be divided into two categories:

- (1) Those medical complications that can be substantially reduced by the use of appropriately trained staff, best equipment and best methods of administration and
- (2) Side effects, such as spotty but persistent memory loss and transient post treatment confusion that can be expected even when an optimal treatment approach is used.

Present mortality is very low. Overall, the risk is not different from that associated with the use of short acting barbiturate anesthetics. The risk of death from anesthesia, although very small, is present and should be considered when evaluating the setting for performing ECT. In the past, up to 40% of patients suffered various complications, the most common being vertebral compression fractures. With present techniques, these risks have been virtually eliminated.

Cardiovascular Adverse Effects

During the few minutes following the stimulus, profound and potentially dangerous systemic changes may occur. First, there may be transient hypotension from bradycardia caused by central vagal stimulation. This may be followed by sinus tachycardia and also sympathetic hyperactivity that leads to a rise in blood pressure, a response that may be more severe in

patients with essential hypertension. Intracranial pressure also rises during the seizure. Additionally, cardiac arrhythmias during this time are not uncommon (but usually subside without sequelae). Thus, certain patient groups that would be adversely affected by these manifestations are at increased risk.

Central Nervous System Adverse Effects

There are two categories of central nervous system effects: the immediate consequences of the ECT seizure and the more enduring effects, both of which are affected by the treatment course. Immediately after awakening from the treatment, the patient experiences confusion, transient memory loss, and headache. The time it takes to recover clear consciousness, which may be from minutes to several hours, varies depending on individual differences in response, the type of ECT administered, the spacing and number of treatments given, and the age of the patient.

Memory Loss

Depressive disorders are characterized by cognitive deficits that may be difficult to differentiate from those due to ECT. It is, however, well established that ECT produces memory deficits. Deficits in memory function persist after the termination of a normal course of ECT. Severity of the deficit is related to the number and spacing of treatments, type of electrode placement, and nature of the electric stimulus. Greater deficit occurs from bilateral than from unilateral placement.

Learning and Retaining New Information Problems

The ability to learn and retain new information is adversely affected for a time following administration of ECT. Within several weeks after its termination, however, this ability typically returns to normal. There is objective evidence, based on neuropsychological testing, on loss of memory for a few weeks surrounding the treatment; however, such objective tests have not firmly established persistent or permanent deficits for a more extensive period, particularly for unilateral ECT. Deficits for the period immediately surrounding the course of treatment may persist. Research conducted as long as three years after treatment has found that many patients report that their memory was not as good as it was prior to the treatment. They report particular difficulties for events that occurred on average six

months before ECT (retrograde amnesia) and on average 2 months after the treatment (anterograde amnesia). Because there is also a wide difference in individual perception of the memory deficit, the subjective loss can be extremely distressing to some and of little concern to others.

Other Adverse Effects

There are other possible adverse effects from ECT. Some patients perceive ECT as a terrifying experience; some regard it as an abusive invasion of personal autonomy; some experience a sense of shame because of the social stigma they associate with ECT; and some report extreme distress from persistent memory deficits. However, many other patients have viewed this treatment as life-saving. In an article entitled "Are Patients Shocked by ECT?," 54% said going to the dentist was more distressing than having ECT; 81% said they would do it again.

What Needs to Happen When ECT is a Treatment Option?

Shared Decision Making

When the physician has determined that clinical indications justify the administration of ECT, the law requires, and medical ethics demand, that the patients' freedom to accept or refuse the treatment be fully honored. An ongoing consultative process should take place. The physician must make the nature of options available clear to the patient, as well as the fact that the patient is entitled to choose among those options. The physician should involve the patient's family and other support systems in the decision making process.

Informed Consent and Patient Education

Information regarding ECT should be presented before the decision has been made to fully ensure understanding and compliance. This information should be provided using a variety of approaches. An excellent video to use to both provide information and to demonstrate the treatment is called "Shock Therapy", which is a segment from the TV show "20/20." It is about 15 minutes in length and gives a balanced view of ECT. Print materials written in understandable language should be provided for patients/families to review. Opportunities must be provided for them to ask questions.

A discussion with the physician to discuss the character of the procedure, its possible risks and benefits (including full acknowledgment of post treatment confusion, memory dysfunction, and other attendant uncertainties), and the alternative treatment options (including the option of no treatment at all). Special individual needs may also be relevant to some patients; for example, a personal situation that requires rapid remission to facilitate return to work and to reduce family disruption. In all matters, the patient should not be inundated with technical detail; the technical issues should be translated into terms meaningful and accessible to the patient.

The consent given by the patient at the outset of treatment should not be the final exchange on this issue, but should be re-examined with the patient repeatedly throughout the course of the treatment. These periodic reviews should be initiated by the physician and not depend on patient initiative to "rescind." In a small minority of cases, a patient will lack adequate legal capacity to consent to the proposed procedure. In such cases, timely court proceedings are necessary if treatment is to be provided. In Minnesota, this court proceeding is called a "Price-Shepherd" hearing. In this event, the court decides if ECT can be administered against the will of the patient. In the VA, a Treatment Review Panel can be convened to make a similar determination.

It is not easy to achieve this ideal of "informed consent" in any aspect of medical practice; and there are special difficulties that arise regarding the administration of ECT. In particular, the patients for whom this procedure is medically appropriate may be suffering from a severe psychiatric illness that, although not impairing their legal competency to consent, may nonetheless cloud judgment in fully weighing all of the available options. Such judgmental distortion does not justify disregarding the patient's choices; rather, it makes it all the more important that the physician strive to identify and clarify the options that the patient alone is entitled to exercise.

How Should ECT be Administered to Maximize Benefits and Minimize Risks?

Once a patient and the physician have decided that ECT may be indicated, the patient should undergo a pretreatment medical examination that includes a history, physical, neurological examination, EKG, and laboratory tests. Medications that affect the

seizure threshold should be noted and decreased or discontinued when clinically feasible. MAO inhibitors should be discontinued two weeks before treatment, and patients should be lithium-free. Severe hypertension should be controlled before beginning treatment. Because some patients with compromised cardiovascular status will be receiving ECT, cardiac conditions should be evaluated and monitored closely.



Nursing Responsibilities

Pre-Treatment

These interventions should mirror those for any procedure requiring general anesthetic. These include*:

- Assurance of presence of required forms/consents
- NPO status per hospital protocol
- Emptying of bladder
- Removal of all prosthetic devices (eyes, limbs, dentures) and other items (rings, hearing aids) as per protocol.
- Monitor the BP, T, P, R
- Administration of pre-ECT medication

*Refer to your hospitals' protocol

Treatment

Hospitals vary regarding nursing involvement during the actual treatment. You may be asked to assist the physician and anesthesiology personnel in the monitoring of vital signs and administration of adjunctive medications. At no time should the nursing staff substitute for a duly recognized anesthesia staff person. Refer to your hospital's protocol.

Description of an ECT Treatment

Typically, the ECT treatment is given in the early morning after an 8 to 12 hour period of fasting. The typical procedure is as follows:

1. Atropine or another anticholinergic agent is given prior to the treatment.
2. An intravenous line is placed in a peripheral vein, and access to this vein is maintained until the patient is fully recovered.
3. The EKG, blood pressure, and pulse rate are monitored through the procedure. Seizure monitoring is necessary to ensure the elicitation and adequacy of the seizure. Seizure monitoring may be accomplished by an EEG or by the "cuff" technique. In the cuff technique, a blood pressure cuff is placed on an arm or leg and is inflated above systolic pressure prior to the injection of a muscle relaxant. The cuff blocks the distribution of muscle relaxant to the cuffed limb.
4. Stimulus electrodes are placed either bifrontotemporally (bilateral) or with one electrode placed on the vertex and the second electrode placed on the ipsilateral side (unilateral).
5. Bilateral ECT may be more effective in certain patients or conditions. It has been established, however, that unilateral ECT, particularly on the nondominant side, is associated with a shorter confusional period and fewer memory deficits.
6. The anesthetic *methohexital* is given first, followed by succinylcholine for muscle relaxation.
7. Ventilatory assistance is provided with a positive pressure bag using 100% oxygen.
8. The electrical current is initiated and usually lasts 2 seconds or less. A brief pulse stimulus is associated with fewer cognitive defects than the traditional sine wave stimulus. Seizure threshold varies greatly among patients and may be difficult to determine; in bilateral ECT, the lowest amount of electrical energy to induce an adequate seizure should be used. Unilateral ECT requires at least 100% over the required threshold. An average seizure lasts 30-60 seconds.
9. The patient is also usually monitored with EKG readings throughout and after the procedure. Continuous oxygen is administered prior to and immediately following the treatment until the patient is at least somewhat responsive.

Recovery from Treatment

Hospitals will also vary with regard to protocols for the recovery period. However, post-ECT patients should be recovered similarly to any post-general anesthetic patient with consistent monitoring and access to emergency resources. Refer to your hospital's protocol.

Post-Treatment

Upon return to the unit/ward, the nursing actions are, again, the same as for any other post-anesthesia patient❖:

- Monitor the BP, T, P, R
 - Assessment of confusion and appropriate reality orientation
 - Assessment of presence of headaches or stiffness and intervention per MD orders/protocol
 - Provision of meal, when appropriate
 - Provision of required assistance for dressing and return of items removed prior to treatment
 - If maintenance ECT, assurance of transportation home and supervision for at least 12 hours
- ❖Refer to your hospitals' protocol

Summary

For many years, ECT was thought of as a barbaric and inhumane treatment. ECT can, however, be an extremely effective treatment if administered to the appropriate patient. The professional should know what types of patients would benefit from ECT, the risks, the benefits, and the care given before, during, and after the treatment.

Applying What You've Learned...

We recommend that you do one or more of the following activities to apply what you've learned in this section:

1. Review the policies and procedures regarding ECT.
2. Observe the preparation, procedure, and post-procedure care of the ECT patient.
3. Practice preparing the patient for ECT and performing post-procedure care.

VAGUS NERVE STIMULATION (VNS)

In 1986, researchers discovered that intermittently stimulating the vagus nerve terminated seizures in dogs. When VNS was used in humans, it was found to have an antidepressant and mood stabilizing effect. VNS is thought to cause changes in serotonin, norepinephrine, GABA and glutamates which are neurotransmitters involved in major depression. VNS is done with an implanted, multi-programmable pulse generator.

COMPLEMENTARY AND ALTERNATIVE MEDICINE

Today many people feel empowered to make many choices when it comes to prevention and treatment of illness. Complementary and alternative medicine are a part of this new trend.

Complementary medicine is used **together with** conventional medicine. An example of a complementary therapy is using aromatherapy to help lessen a person's discomfort following surgery.

Alternative medicine is used **in place of** conventional medicine. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, or receiving chemotherapy which was recommended by a conventional physician.



What are some complementary and alternative therapies to mental health care?

Animal Assisted Therapies

Working with animals under the guidance of a health care professional may benefit some people with symptoms by facilitating positive changes such as increasing socialization, encouraging communication in groups, developing self esteem and decreasing anxiety.

Self-help Groups

Many people with mental illnesses find that self-help groups are an invaluable resource for recovery and for empowerment.

Diet and Nutrition

Adjusting both the diet and nutrition may help some people with mental illness manage their symptoms and promote recovery.

Pastoral Counseling

Counselors working within the traditional faith communities increasingly are recognizing the need to incorporate psychotherapy and/or medication, along with prayer and spirituality, to effectively help some people with their symptoms.

Art Therapy

Some mental health providers use art therapy as both a diagnostic tool and as a way to treat disorders such as depression, abuse-related trauma, and schizophrenia.

Dance/Movement Therapy

The premise is that this therapy helps a person integrate the emotional, physical and cognitive facets of "self".

Music/Sound Therapy

Research suggests that music stimulates the body's natural "feel good" chemicals (opiates and endorphins).

Culturally Based Healing Arts

Traditional Oriental medicine (such as acupuncture, shiatsu and reiki), Indian systems of health care (such as Ayurveda and yoga) and Native American healing

practices (such as the Sweat Lodge and Talking Circles) all incorporate the beliefs that:

- Wellness is a state of balance between the spiritual, physical, and mental/emotional "selves"
- An imbalance of forces within the body is the cause of illness
- Herbal/natural remedies, combined with sound nutrition, and meditation/prayer, will correct this imbalance.

Remember, educating each patient regarding the importance of communicating all methods of therapies they are engaged in with their health care team will lead to the most effective management of their mental illness.

PSYCHOEDUCATION

Please note that this section is not intended to cover all elements of patient health education. It should be used as an adjunct to other educational programs designed to teach clinicians how to do quality Patient Health Education.

Definitions

Psychoeducation is the education or training of a person with a psychiatric disorder in areas that serve the goals of treatment and rehabilitation.

Psychoeducation:

- Enhances acceptance of illness, promotes active cooperation in treatment, and strengthens coping skills
- Includes cognitive, affective, and behavioral components
- Involves purposeful use of educational techniques and teaching-learning theory along with psychotherapeutic concepts
- May have an ameliorating effect on some symptoms of mental illness. In other words, just knowing more about the illness can reduce anxiety, and therefore, perhaps reduce symptoms.
- Focuses on strengths
- Is an integral part of the treatment plan
- Extends to the family/significant others

Principles

The principles of psychoeducation are the same as those for other adult education, with some additional special considerations due to the person's mental illness.

Characteristics of the Adult Learner

1. **Internal motivation** – adults learn because they want to learn, not because someone tells them they need to learn.
2. **Problem-centered orientation to learning** – for adults, it is always the “bottom-line” – they want to know how what you are teaching them relates to what they are feeling or experiencing, both physically and emotionally and what impact it will have on them.
3. **Life experiences** – adult learners bring life experiences with them. We must recognize this, solicit these experiences, and build on them.
4. **Self-direction** – adult learners will be self-directed if we utilize appropriate techniques and if they have the confidence that they can do what we are asking. We have to be willing to assess what they are and are not willing to do.

Andragogical Approach to Learning

Mutual (between the staff and the patient) diagnosis of need:

- There must be active involvement between patient and staff about the patient's learning needs
- Identify the patients' priorities and concerns and start there
- Do not overwhelm with technical talk. You can address this in the context of their concerns and priorities

Identify critical factors which support or hinder the ability to make changes in health behaviors:

What helps the patient do something (e.g., someone to exercise with him, a pill box to help him check his meds) or gets in the way of doing something (lives in a bad neighborhood, so can't walk for exercise; can't afford the medication)?

Appropriate Assessment Techniques

It is important to recognize that needs assessment is an ongoing process. Needs change based on the timing of the assessment (is it a new diagnosis? Is the person ready to hear it? Are they too psychotic? Depressed? Sedated?)

Salient belief model: this technique is useful on a 1:1 basis or in small groups. It helps identify very quickly the foremost concern of the patient(s).

Examples:

“If I say _____ (schizophrenia, depression, bipolar, etc...) to you, what do you think of?”

OR

“Have you ever known anyone who has had _____? Tell me about that.”

Matrix Assessment

Matrix assessment (see example): this technique is useful in a small group. With this technique, you draw a grid on a black board, white board, or flip chart. Go around the room and ask each person to give his/her name and answer the question “What I really want to know about _____ is _____.” Write their name at the top of the grid and their question along the side. Use their own words as much as possible. Put an X in the appropriate box. Some people may have the same question. Put an X in the appropriate box.

It is okay if someone doesn't want to give an answer. If someone says they have nothing to learn here, invite them to stay and perhaps help others learn, or invite them to leave. However, be sure to document in the patient record that they were invited and their response. Do not use this technique if you are not willing to adapt your class to their interests. You will find, however, that most people have the same questions, and you will develop your education according to the frequently asked questions. From the example below, think about how you would start the class, given what the patient indicated.

Example:

	Nancy	Karen	Bill	
--	-------	-------	------	--

Why did I get this illness?	X	X		2
How can I keep it from coming back?	X	X		2
Does ECT cause memory loss?		X		1
What are the side effects of medications?	X			1

For example, you might say:

“This is a great list. Bill, I noticed you didn’t identify anything specific. It’s okay for you to stay if you wish, or to leave. I see most of you are interested in keeping the depression from coming back. There are a number of ways to do this. In order to prevent a recurrence, it helps to know some of the causes (your beginning point).” Now you can frame your teaching focusing on their priorities: how to prevent relapse.

Needs assessment checklist This technique requires some preparation. As you work with patients with similar problems, you have probably become aware of the questions they ask. Write these down, or ask groups of patients to write down their most pressing questions. Have these typed up. On the left hand side of the list put a space for the patient to check which questions he/she would like to have answered. On the right hand side, have the patient initial and date that item when he/she feels the question has been answered satisfactorily. Some patients will have trouble with this as they are not used to being asked what they want to learn. The patient can keep the list for reference as appropriate. A copy should be kept on the chart, however, for documentation. Factors to include:

1. The illness or condition and its management
2. Information and skills a patient will need to assume responsibility for self-care
3. Psychosocial, emotional, and environmental supports needed to cope over time
4. Circumstances or life-style issues that require modification of the treatment plan to enhance compliance
5. Medication actions, side effects, food interactions, when to call health care provider
6. Additional tests/monitoring
7. When to resume normal activities

8. Relationship of this illness to other illness/functions/systems of the body

Appropriate Teaching Methods

Most people don’t want to be lectured to. Be sure to use a variety of media for your education. Give them handouts (always prepared at appropriate grade level and in proper format, of course) that they can review repeatedly. Supplement with videos and other audiovisuals. Many patients are now computer literate, so you can refer them to appropriate web sites on the Internet. The use of materials should ALWAYS be in tandem with discussion with a clinician. Materials in and of themselves are not sufficient.

Conducive Climate for Learning

Many psychiatric patients cannot tolerate long periods of time. Adjust your class/intervention to what the patient can tolerate. In some instances, especially with patients with schizophrenia and those with some hypomania, this may be only 10-15 minutes at a time. Make sure the room is large enough but not too large. It often helps to have some snacks and drinks available, especially for longer classes. **Always** allow time for questions and discussion.

Self-Efficacy

This term refers to a person’s belief that he or she can perform a specific behavior. It is the person’s confidence in their ability to perform an action. It is a good predictor of actual future performance. All people can enhance their self-efficacy.

Whether or not people change health behaviors is determined by:

- Readiness for change – timing. Just because a person is not ready or able RIGHT NOW doesn’t mean he or she will never be able to do so
- The number of behavioral choices available
- How much effort will be required to perform the behavior
- How much anxiety is involved in changing behaviors and learning the new behavior

Elements of self-efficacy:

1. **Skills mastery** is the most effective way of increasing self-efficacy. Patients can be taught how to do the thing we want them to do. This is even true when we are working with them to complete self-monitoring charts, filling medication boxes, doing exercise, monitoring pulse, etc... In teaching interpersonal skills to psychiatry patients, this can include role playing and using videotaping to allow them to see their successes.
2. **Modeling** is the second most effective way of increasing self-efficacy. In mental health we can do this by showing videos using real patients who have succeeded, bringing in recovered patients to talk with them and referring them to community resources that serve people with shared experiences. Resources for mental health modeling may include the Minnesota Depression and Manic Depressive Association (MDMDA) or the Alliance for the Mentally Ill (AMI) to provide recovering patients to speak with and assist patients.
3. **Reinterpretation of health beliefs** is another way to enhance self-efficacy. Most patients have some explanation for why they are feeling/behaving the way they do. We must find out what that explanation is. Often, by assisting them in reinterpreting these beliefs, we can break it down into more manageable, realistic parts that make sense. For instance, some psychiatric patients believe that they have done something wrong in the past that has “caused” their illness. Helping them to understand the biological basis of psychiatric illness is often a great help.
4. **Persuasion** is effective, but the least effective of the four elements to enhance self-efficacy. We provide the patient with lots of information; we plead, cajole, and insist that they change behaviors. We are sure that if we just gave them enough information they would “see the light” and be able to do it. For some people this works. Unfortunately, for many of us (not just mental health patients), this is not sufficient. We may intellectually “know” something and still not change behaviors.

Special Learning Needs of Mental Health Patients

Denial of Illness – psychiatric patients, not unlike patients with chronic medical illnesses, often deny the existence of an illness. This may be due to a lack of information and understanding about the illness, or shame about the illness. Research demonstrates that those who believe they have an illness have better outcomes.

Impaired Cognitive Functioning – some patients with chronic psychiatric illness show a decline in intellectual functioning as their illness progresses. This decline necessitates the adaptation of teaching materials to an appropriate level and format.

Difficulty with Abstraction – patients with severe thought disorders, as well as some other disorders, often have difficulty with abstraction, making it difficult for them to grasp much of what we are saying. Therefore, your teaching must be simple, direct, and concrete.

Feelings of Dependency – again, not unlike patients with chronic medical conditions, psychiatric patients often fear becoming dependent on the health care provider, and therefore refuse appropriate treatment. Health care providers then tend to label the patient as non-compliant or “gamey.”

Strategies

- Keep instructions short and simple (KISS).
- Information will need to be repeated frequently and in different ways over time.
- Use various media to present the material.
- Use skills mastery and modeling to achieve the best outcome.
- If patient is not receptive, try at another point in time – don’t assume lack of willingness is forever.
- Don’t try to teach when the patient is acutely psychotic, delirious, demented, manic, or so depressed he/she can’t get out of bed. Look for the “teachable moment.”

Self-Management (Lorig, 1994, Living with Chronic Illness)

Definition: the patient is able to learn the skills necessary to “negotiate the path of their illness.” In order to negotiate this path, patients need:

- Skills to deal with their illness, including taking medications, dealing with agencies, learning new ways to cope with hallucinations, anxiety, etc...
- Skills to continue with a normal life, such as learning how to maintain a healthy lifestyle, including good eating habits, exercise, maintaining an apartment, work, and social life.
- Skills to deal with emotions to help patients deal with the impact of the illness on their lives. Normal emotions experienced may include:
 - Anger
 - Depression
 - Frustration
 - Fear and uncertainty
 - Isolation
 - Changes in relationships with friends and family

Self monitoring: patients can be taught to identify and monitor their own symptoms and improvement. For many patients, this will be a new concept. They may need help in identifying their most troublesome symptoms. Assist them in utilizing charts for daily monitoring of appropriate symptoms and behaviors and to develop plans for managing difficult times (see Liberman articles and modules referenced at the end).

Facilitating Behavior Change

Patients should not be **told** what behaviors they need to change or what their goals **ought** to be. Our responsibility is to assist patients in identifying realistic goals and behaviors that will move them toward those goals. It is important to differentiate between an outcome and a behavior. For example, “I don’t want to be depressed anymore” is an outcome. We help the patient try to identify factors that will help avoid the depression. These behaviors may include:

- Taking medications
- Exercising
- Keeping appointments
- Keeping busy (at what? Help them to be **very** specific)

Contracting for behavior change is very different than the contracting we have been used to. In the past, we usually tell the patient what behaviors are acceptable and what will happen if they don’t comply. We are suggesting a very different approach. In appropriate behavioral contracting there are a number of steps:

What is the behavior the PATIENT wants to do THIS WEEK? You want short-term goals. This is less overwhelming for patients. This may include (pick just one at a time!):

- Taking medications
- Walking
- Going to the drop-in center
- Listening to music when hallucinations get bad
- Getting up at the same time every day
- How much will it be done (walking around the block, going to the drop-in center)? It is important to start realistically. Find out how much the patient has done in the past and build on that.

When will this be done? Before lunch? After the drop-in center? Maybe walk to the drop-in center? Connect the new activity with an old habit if possible. Another approach is to do the new activity before an old activity – the old activity is your reward for doing the new activity.

How often will it be done? It is usually best to try something 3-4 times/week, not every day. It is unlikely that every day plans will meet with success. If someone does better than 3-4 times/week, so much the better; but the patient will not feel like a failure if she/he does not do it every day. Taking medications is an exception. This should be done **AS SCHEDULED**.

Teach the patient to ask “**How confident** (0=totally unsure and 10=totally sure) am I that I can do this contract?” If the answer is less than a 7, or 70%, go back and look at what problems keep the patient from being more confident. See if you can assist them in problem-solving.

Patients can be taught these self-management strategies and contracting. If they don’t work right away, explore with them the barriers and facilitating factors!

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1. Symptom management
2. Recreation for leisure

3. Medication management
4. Basic conversation skills
5. Taking long acting medications by injection
6. Community re-entry

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DIRECTIONS FOR SUBMITTING YOUR POST TEST FOR CONTACT HOURS

To obtain a certificate of completion for this home study program, please complete the post-test and evaluation on the next few pages. The date on your certificate of completion will be the date that your home study is received. **Any materials received with a postmark after the expiration will be discarded.**

HealthEast, HCMC, & MVAMC Employees

If you are an employee of HealthEast, HCMC, or MVAMC, you may send the post-test and evaluation to TCHP for processing. Your post-test will be returned to you through your hospital. It cannot be mailed to your home.

Paid Participants

If you are not an employee of one of the TCHP hospitals, please send the post-test and evaluation to TCHP with a check for \$15.00. Please make check payable to **TCHP Education Consortium** and mail to:

**TCHP Education Consortium
Capitol Office Building
525 Park Street, Suite 120
St. Paul, MN 55103**

Your post-test will be returned to you with the certificate of completion.

Interventions Post Test

Please print all information clearly and sign the verification statement:

Name _____
(please print legal name above)

Birth date (required)

Format: 01/03/1999

M	M	D	D	Y	Y	Y	Y

For HealthEast, HCMC, or MVAMC, employees only:

Hospital _____ Unit _____

Personal verification of successful completion of this educational activity (required):

I verify that I have read this home study and have completed the post-test and evaluation.

Signature

- 1) Many medications in psychiatry work to:
 - a) replace a deficient amount of neurotransmitter
 - b) block the neurotransmitter from binding with a receptor site
 - c) stop or facilitate splitting of the neurotransmitter from the binding site
 - d) all of the above
- 2) Most antipsychotic medications block the transmission of what neurotransmitter?
 - a) serotonin
 - b) acetylcholine
 - c) dopamine
 - d) GABA
- 3) The **atypical** antipsychotic medications block the transmission of:
 - a) acetylcholine and serotonin
 - b) GABA and dopamine
 - c) acetylcholine and GABA
 - d) dopamine and serotonin
- 4) Which type of antidepressant doesn't allow serotonin to be reabsorbed into the axon as quickly?
 - a) MAO inhibitors
 - b) SSRI's
 - c) Tricyclic antidepressants
- 5) Which type of antidepressant has interactions with a wide variety of foods?
 - a) MAO inhibitors
 - b) SSRI's
 - c) Tricyclic antidepressants
- 6) Which of the following does NOT allow for the expression of feelings?
 - a) a private and confidential environment
 - b) a set time limit
 - c) a professional attitude of warmth, acceptance, and objectivity
 - d) a setting that is free from interruptions
- 7) Outpatient therapy, such as personality restructuring, should be continued in the inpatient setting.
 - a) True
 - b) False
- 8) An individual intervention for the psychotic patient might include:
 - a) setting firm and consistent limits
 - b) minimizing stimulation
 - c) assessing medication administration
 - d) all of the above
- 9) Which of the following elements can make a psychotherapy group effective?
 - a) an informal and relaxed atmosphere
 - b) clear purpose with clear goals
 - c) sense of cohesion in the group
 - d) all of the above
- 10) Is it all right for a patient to leave group if he chooses?
 - a) Yes
 - b) No
- 11) Your parent had schizophrenia and was hospitalized many times. Should you bring this up in group?
 - a) Yes, your experience with your parent can help others understand their own relationships.
 - b) No, the most important interactions occur within the group.

Continued on next page / reverse side...

- 12) Which of the following patients would NOT have an indication for ECT?
- a) A 38-year-old woman with acute mania, exhibiting extreme psychomotor agitation
 - b) A 67-year-old man who is unable to take anti-depressant medications because of a physical condition
 - c) A 24-year-old man, non-suicidal, diagnosed within the last week with depression
 - d) A 25-year-old woman with suicidal depression in her 3rd month of pregnancy
- 13) ECT is not useful with chronically ill schizophrenics.
- a) True
 - b) False
- 14) Which of the following may be a side effect of ECT that is administered under optimal conditions?
- a) vertebral compression fractures
 - b) spotty but persistent memory loss
 - c) epilepsy
 - d) none of the above
- 15) Is the severely depressed patient allowed to refuse ECT as a treatment?
- a) Yes
 - b) No
- 16) Which of the following will **not** help the psychiatric patient to learn?
- a) tailoring the class to meet the needs of the individuals in the class
 - b) a variety of education methods, including demonstration, handouts, videos
 - c) two to four hour classes to get all of the information across at once
 - d) a room that is large enough to have personal space, but not too large
- 17) Pet therapy can be a beneficial complementary because it facilitates positive changes such as:
- a) Increasing socialization
 - b) Developing self esteem
 - c) Decreasing anxiety
 - d) All of the above
- 18) Your patient has four goals that he wants to accomplish this week. Which of these goals does he absolutely need to accomplish?
- a) Walking to the drop-in center three times/week
 - b) Getting up at 8:30 a.m. every day
 - c) Going to the grocery store once this week
 - d) Taking medications on time every day

Expiration date: The last day that post tests will be accepted for this edition is **December 31, 2017**—your envelope must be postmarked on or before that day.

EVALUATION: INTERVENTIONS IN PSYCHIATRY

Please complete the evaluation form below by placing an "X" in the box that best fits your evaluation of this educational activity. Completion of this form is required to successfully complete the activity and be awarded contact hours.

At the end of this home study program, I am able to:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Review the major classifications of medications in psychiatry.					
2. Identify measures to ensure safe medication administration to psychiatric patients and improve medication compliance.					
3. Explain the elements of therapeutic 1:1 interactions, including health teaching, crisis intervention, problem solving, and coping.					
4. Explain the types of groups available, how to introduce and close a group and what identifies a group as working in the here-and-now.					
5. Discuss the role of nursing staff as co-facilitator and what makes a therapist successful in a group.					
6. Discuss the eleven curative factors.					
7. Describe the purpose, preparation, follow-up and adverse effects of electroconvulsive therapy					
8. List several complementary and alternative therapies used in mental health care.					
9. Discuss the areas that psychoeducation for the mentally ill patient may address and state common deficits mental health patients may exhibit.					
10. The teaching / learning resources were effective. <i>If not, please comment:</i>					

Continued on next page / reverse side...

The following were disclosed in writing prior to, or at the start of, this educational activity (please refer to the first 2 pages of the booklet).

	Yes	No
11. Notice of requirements for successful completion, including purpose and objectives		
12. Conflict of interest		
13. Disclosure of relevant financial relationships and mechanism to identify and resolve conflicts of interest		
14. Sponsorship or commercial support		
15. Non-endorsement of products		
16. Off-label use		
17. Expiration Date for Awarding Contact Hours		
18. Did you, as a participant, notice any bias in this educational activity that was not previously disclosed? <i>If yes, please describe the nature of the bias:</i>		

19. How long did it take you to read this home study and complete the post test and evaluation:

_____hours and _____minutes.

20. Did you feel that the number of contact hours offered for this educational activity was appropriate for the amount of time you spent on it?

___ Yes

___ No, more contact hours should have been offered

___ No, fewer contact hours should have been offered.

Expiration date: December 31, 2017