Psychosocial and Behavioral
CCRN/PCCN
Certification Review

Note
- Relatively new chapter for the CCRN and PCCN exam
- CCRN: 4% of total exam (about 6 questions)
- PCCN: part of the Neurology/Multisystem/Behavioral content which is 15%
- This review is very brief; not comprehensive; help to understand key components

The Test Plan

CCRN
- Delirium and dementia
- Mood disorders and depression
- Substance dependence
- Suicidal behavior
- Abuse/neglect
- Antisocial behaviors, aggression, violence
- Developmental delays
- Failure to thrive

PCCN
- Altered mental status
- Delirium
- Dementia
- Anxiety disorders
- Depression
- Substance abuse
  - Alcohol withdrawal
  - Chronic alcohol abuse
  - Chronic drug abuse
  - Drug-seeking behavior

Objectives
- Identify behavioral characteristics of mood disorders as presented in critically ill patients.
- Identify behavioral characteristics of substance abuse as presented in critically ill patients.

Psychosocial Issues
- Many of the psychosocial issues and concerns of the acutely ill patient are interdependent. For example, inadequately managed pain may lead to feelings of powerlessness, anxiety, and depression that, in turn, heighten the patient’s perception of pain.

AACN Core Curriculum, 2010, p. 561

Psychosocial Issues
- Powerlessness
  - Promote communication, involve patient in care planning process, encourage spiritual support, prepare patient for procedures
- Sleep deprivation
  - Environmental control, relaxation techniques, administer pharmacologic agents
- Grief and loss
- Sensory overload or deprivation
Delirium (Acute Confusional State)

- Clinical state associated with a disturbance of consciousness that is accompanied by a change in cognition that cannot be accounted for by a preexisting or evolving dementia
  (AACN Core Curriculum, p. 570)
  - Develops over hours to days
  - Fluctuates
  - Often temporary
- Neurological organ dysfunction!

Delirium

- 50% of critically ill experience delirium
- 80% of terminally ill develop delirium near death
- Due to general medical condition (hypoxia, metabolic acidosis, CVA/TIA, electrolyte imbalance, hyper-/hypoglycemia, infection, pain, etc.) or substance-induced (medication, toxin, drug abuse)

Delirium

- Cognitive
  - Diminished attention span
  - Reduced ability to focus
  - Disorientation
  - Confusion
  - Hallucinations
  - Abnormal Mental Status Examination
- Behavioral
  - Excessive restlessness
  - Lethargy
  - Inappropriate behavior
  - Picking at bed linens, gown
  - Attempting to get OOB
  - Crying out, moaning
- Physiologic
  - Tremors, seizures (ETOH withdrawal)

Delirium

- Three categories
  - Hyperactive
    - AKA “ICU psychosis”
    - Restless and agitated
  - Hypoactive
    - AKA “acute encephalopathy”
    - Present in stupor and barely responsive
  - Mixed
    - Exhibit both hyperactive and hypoactive symptoms

Delirium

- Assess for factors that could contribute
- Decrease use of medications that could contribute
- Assess for delirium (e.g., Confusion Assessment Method-ICU)
- Provide adequate rest & sleep
- Restraints only as necessary for patient safety
- Consult psychiatrist if standard management does not resolve delirium
- Reassure family that the patient is not in control of their behaviors

Delirium

- Pharmacologic
  - Avoid additional drugs unless needed for patient, family, or staff safety
  - Currently no FDA approved drugs for treatment of delirium
    - Antipsychotic (e.g., haloperidol) is recommended by APA, SCCM
    - Benzodiazepine (in combination with antipsychotic); BZD may worsen delirium, especially in elderly
  - Few EBP protocols available
    - See www.icudelirium.org
Dementia

- Insidiously gradual onset with progressive cognitive decline
- Months or years
- Alzheimer’s disease is the most common type
- Incidence increases with age
- Patient is alert
- Tx: supportive with pharmacologic and non-pharmacologic
  - Cholinesterase inhibitors (Aricept, Exelon, Reminyl)

Alcohol Withdrawal

- Syndrome that develops after the cessation of (or reduction in) heavy and prolonged alcohol use
- Signs and symptoms occur 12 to 48 hours after cessation of alcohol intake
  - Two or more symptoms of autonomic hyperactivity

Alcohol Withdrawal

- Many tools for assessment
  - Have you ever felt you should cut down on your drinking?
  - Have people annoyed you by criticizing your drinking?
  - Have you ever felt bad or guilty about your drinking?
  - Eye opener: Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
  - The CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted.

Alcohol Withdrawal

- Mild to moderate dependency
  - Agitation
  - Anxiety
  - Tremors
  - Nausea and vomiting
  - Weakness
  - Diaphoresis
  - Hallucinations

Alcohol Withdrawal

- Delirium tremens (48 to 72 hours after cessation)
  - Anxiety attacks - Delirium
  - Sleeplessness - Tachycardia
  - Disorientation - Fever
  - Confusion - Grand mal seizure
  - Cognitive impairment

Alcohol Withdrawal

- Diagnostics
  - Blood alcohol level
  - Liver function studies
  - Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) to quantify the severity of withdrawal and guide collaborative diagnoses of patient needs
Alcohol Withdrawal

Nonpharmacologic Treatment
- Protect the patient, family, and staff from harm
- Use a nonthreatening, supportive manner
- Engage the patient in short, directed conversations
- Decrease stimulation that could precipitate aggressive or violent behaviors

Pharmacologic Treatment
- Administer medications to a patient who is at risk for withdrawal or who demonstrates withdrawal behaviors
- Benzodiazepines
- Adjunctive treatment
  - Thiamine, folate, multivitamins
  - Hydration; correct electrolyte imbalances
- Meta-analysis showed sedative-hypnotic agents are more effective than neuroleptic agents in reducing duration of delirium and mortality

Discharge Planning
- Referral to Alcoholics Anonymous

Ethical issues
- Staff conflict in caring for patients whose health problems are perceived to be "self-inflicted"

Substance Abuse/Dependence
- Arrive to ICU/PCU with conditions directly or indirectly related to substance use/dependence
- Affects brain functioning and therefore behavior
- Alcohol (EtOH) is most common abused substance

Opioids and morphine derivatives
- Naloxone (Narcan) will reverse excessive sedation
- Opioid withdrawal is seldom life-threatening
  - Short-acting (heroin) withdrawal Sx begin 8-12 hrs after last use and peak at 48-72 hrs
  - Long-acting (methadone) begins 24-36 hrs after last use and peaks 72-96 hrs
- Sx: autonomic instability (↑HR and BP, sweating, chills, hot/cold flashes, ↑temp); others
- Tx: methadone, clonidine with or without benzodiazepines, or buprenorphine
Substance Abuse/Dependence

- Depressants
  - Sx/s of withdrawal similar to EtOH
  - Seizures can occur
- Dissociative anesthetics and hallucinogens
  - Provide safety; treat altered VS
- Stimulants
  - Profound dysphoria: assess for suicidal ideations, provide safety
- Inhalants/Solvents
  - Symptomatic tx of neurotoxic effects on cognition, motor, and sensory involvement
- Marijuana
  - Irritability, sleep disturbances, anxiety, restlessness

Antisocial Personality Disorder (ASPD)

- Ongoing pattern of maladaptive personality traits that are both persistent and rigid
  - 10% of population
  - 80-85% of incarcerated criminals have ASPD
- Deceit, manipulation are central features; also:
  - Failure to conform to social norms
  - Repeated physical fights
  - Consistent irresponsibility
  - Lack of remorse
- Many suffer from prolonged abuse and/or neglect
  - Increased risk of dying prematurely by violent means

Antisocial Personality Disorder (ASPD)

- Earliest indicators of patient’s having ASPD is nursing staff’s disagreeing on how to address patient’s problematic behaviors
  - Break or bend hospital policies and rules -> can become verbally or physically aggressive
- Nursing interventions
  - Communicate frequently as a care team
  - Maintain demeanor or respect, concern, professionalism
  - Avoid power struggles
  - Maintain own safety

Aggression and Violence

- Aggression - physical or verbal behavior that may or may not cause harm to others
- Violence – acting out of aggression that results in injury to others or destruction of property
  - May be triggered by accumulation of stress in patients or family members who have feelings of desperation and who lack coping skills and/or resources to resolve a situation by other means

Aggression and Violence

- Signs & symptoms
  - Cognitive: inability to think clearly and rationally
  - Behavioral: anger, yelling, use of profanity; agitation; verbal threats; striking, pushing, kicking of staff; family member pacing
  - Physiologic: tachycardia, tachypnea, ↑BP, ↑muscle tension

Aggression and Violence

- Diagnostics – r/o organic brain disease, metabolic problem, drug or alcohol levels
- Goals –
  - Protect patient, family, and staff from injury
  - Provide support and information
  - Attend to aggressive behavior rapidly
  - Be proactive in using appropriate resources (e.g., social services, security)
Aggression and Violence

- Pharmacologic management
  - Anxiolytics, neuroleptics (i.e., haloperidol)

- Nonpharmacologic management
  - Involve social services, psychiatric consultation
  - Verbal, chemical, and physical restraints may be required to maintain safety
  - Requires plan and explanation to patient and family, daily renewal of order, close monitoring, alternatives PRN

  - Speak in calm, noncondescending manner
  - Allow patient or family member to ventilate without interruption
  - Place clear limits

Decision Making

Depression

- Feelings of sadness, lowered self-esteem, and pessimistic thinking and guilt
- Causes include psychodynamic, cognitive, biochemical, social and others (i.e., lack of sleep, unmanaged pain)

- Signs and symptoms –
  - Cognitive: ↓ ability to concentrate
  - Behavioral: agitation, sadness, fatigue, abnormal sleep patterns, recurrent thoughts of death

- Nonpharmacologic:
  - Treat manageable symptoms that contribute
  - Engage patient in care planning as appropriate
  - Provide mechanism to ↑ social support
  - Attend to any suicidal ideations
  - Psychiatric referral

  - Pharmacologic: antidepressants (e.g., tricyclics, SSRI)

Suicide

- Cognitive and behavioral signs and symptoms
  - Altered level of consciousness and orientation
  - Severe anxiety
  - Severe depression
  - Marked disorientation or confusion

- Physiologic signs and symptoms
  - Drug overdose
    - Tachycardia (amphetamine)
    - Bradycardia (digitalis)
    - Tachypnea (salicylates)
    - Bradyptene (barbiturates, opiates)
    - Dilated pupils (amphetamine)
    - Constricted pupils (opiates)
  - Trauma (GSW, stabbing, auto "accident")
    - Hypotension, shock
    - Pneumothorax, lung contusions
Suicide

- Diagnostics are related to method
  - Elevated liver enzymes: acetaminophen OD
  - Abnormal ABGs
    - Metabolic acidosis: salicylate, methanol OD
    - Respiratory acidosis: barbiturate, BZD, opiate OD
  - Drug screens: urine and blood

Suicide

- Treatment specific to mechanism of injury
  - Toxic ingestion: gastric lavage, consult poison control center
  - Protection from injury: constant observation
  - Discuss attempted suicide and patient’s feelings when stable
  - Mental health consultation
  - Facilitate visits from patient support system

Suicide

- Directly asking a person about suicidal intent will NOT cause suicide
- Does not mean person is mentally ill; viewed as logical last step by someone who is overwhelmed by stress
- May or may not have talked about it
- No racial, social, religious, cultural, or economic boundaries

Suicide

- Discharge planning
  - Provide information on a 24-hour suicide prevention hotline
- Ethical issues: attempted suicide by patient and family in cases of terminal disease or unbearable chronic condition

Abuse and Neglect

- Estimated one-half of Americans have experienced violence in their families
- Found in all religious, cultural, educational, and socioeconomic backgrounds
- Categories: physical, sexual, emotional, neglect, economic

Abuse and Neglect

- Establish trust
- Approach from the front
- Plan care with consideration to type of violence
- Refer to psychiatry
- Know your state’s reporting requirements
Any Questions?

References