Behaviors Associated with Impaired Communication

by Domino B. Puson

Categories of Cognitive Disorders

- Delirium
- Dementia
- Amnestic disorders

Organic Brain Syndrome

- Delirium

**Symptoms of Delirium**

- Difficulty with attention
- Easily distracted
- Disoriented
- May have sensory disturbances such as illusions, misinterpretations, or hallucinations
- Can have sleep—wake cycle disturbances
- Changes in psychomotor activity
- May experience anxiety, fear, irritability, euphoria, or apathy

**Most Common Causes of Delirium**

- Physiologic or metabolic: Hypoxemia, electrolyte disturbances, renal or hepatic failure, hypo- or hyperglycemia, dehydration, sepsis, or shock, heart failure, vitamin B deficiency, vitamin C, niacin, or protein deficiency, cardiovascular shock, brain tumor, head injury, or exposure to gasoline, paint solvents, insecticides, and related substances
- Infection: Systemic: sepsis, urinary tract infection, pneumonia
  - Central meningitis, encephalitis, HIV, syphilis
- Drug-related: Intoxication: alcohol, sedatives, and hypnotics
  - Withdrawal: alcohol, sedatives, and hypnotics
  - Reactions to anesthesia, prescription medication or illicit street drugs

Treatment

- Identify and treat any causal or contributing medical conditions
- Sedation to prevent inadvertent self-injury may be indicated
- Haloperidol (Haldol) may be used in doses of 0.5 to 1 mg to decrease agitation
Managing Confusion

“I know things are upsetting and confusing right now, but your confusion should clear as you get better.”

Organic Brain Syndrome

- Dementia

PROMOTING SLEEP AND PROPER NUTRITION

- Promoting client's safety
  - Teach client to request assistance for activities (getting out of bed, going to bathroom).
  - Provide close supervision to ensure safety during these activities.
  - Promptly respond to client's call for assistance.
  - Provide one-on-one care for client if necessary.
- Speaking in a calm, non-rushing manner
  - Speak to client in a calm, non-rushing manner; use simple sentences.
  - Allow adequate time for client to comprehend and respond.
  - Allow client to make decisions as much as possible.
- Providing care for special needs
  - Provide special needs care when making all clients safe.
  - Controlling environment to reduce sensory overload
  - Keep environment free of sensory overload.
  - Maintain minimal sensory overload.
  - Monitor client’s response to stimuli; explain to family and friends that client may need to visit quietly one on one.
  - Provide adequate lighting and noise, but do not reinforce misperceptions.
- Promoting sleep and proper nutrition
  - Monitor sleep and elimination patterns.
  - Monitor food and fluid intake; provide prompts or assistance to eat and drink adequate amounts of fluid and fluids.
  - Provide specific strategies to keep client from getting lost.
  - Document behavior and responses to keep records of behavior.
  - Encourage some exercise during day like walking in a chair, walking in hall, or other activities client can manage.
Apraxia

Agnosia

Executive Functioning

Organic Brain Syndrome

- Dementia

Symptoms of Dementia

- Loss of memory (initial stages, recent memory loss such as forgetting food cooking on the stove; later stages, remote memory loss such as forgetting names of children, occupation)
- Deterioration of language function (forgetting names of common objects such as chair or table, palilalia (echoing sounds), and echoing words that are heard (echolalia))
- Loss of ability to think abstractly and to plan, initiate, sequence, monitor, or stop complex behaviors (loss of executive function): the client loses the ability to perform self-care activities
### Etiology

- Metabolic activity is decreased in the brains
- Genetic component
- Other causes

### Stages of Dementia

- **Mild**
- **Moderate**
- **Severe**

### Creutzfeldt-Jakob disease
Treatment and Prognosis

The prognosis for the progressive types of dementia may vary but all prognoses involve progressive deterioration of physical and mental abilities until death.

NURSING CARE

- Risk for Injury
- Disturbed Sleep Pattern
- Risk for Deficient Fluid Volume
- Risk for Imbalanced Nutrition: Less Than Body Requirements
- Chronic Confusion
- Impaired Environmental Interpretation Syndrome
Nursing Diagnosis

- Impaired Memory
- Impaired Social Interaction
- Impaired Verbal Communication
- Ineffective Role Performance

Intervention

- Promoting client’s safety and preventing injury
  - Offer constructive assistance with or supervision of eating, bathing, or self-care activities. Identify environmental triggers to help client avoid them.
  - Promoting adequate sleep, proper nutrition, and hygiene, and activity
  - Prepare delicious meals and snacks. Give client self-care opportunities, such as eating in the kitchen and chatting. Invite staff and other clients to visit the client while she or she is eating. Ensure the room is quiet, free from noise and agitation. Address the client’s individual needs and concerns.
  - Encourage the client to eat and drink throughout the day, offering fluids and fiber or prompt.
  - Prevent client from eating or drinking if necessary. Maintain a healthy lifestyle, including regular exercise and physical activity, such as walking.

Caregiver Education: Dementia

- To help clients cope with memory loss and confusion, encourage them to follow their usual routine and habits of bathing, and dressing rather than imposing new ones.
- Because safety from injury is a risk for clients with dementia, caregivers should encourage as much independence as possible for the client in performing self-care responsibilities but should provide support when client engages in potentially dangerous activities such as cooking or bathing. For example, sit in the kitchen and chat with the client while he or she is cooking or sit outside the door while the client is bathing rather than doing it for him or her.
- Clients who are bored, alone, or not engaged in any activities tend to become more agitated and irritable. Try to encourage clients to participate in activities of interest.
- Clients with dementia frequently believe their physical safety is jeopardized and may feel threatened or suspicious and paranoid. These feelings can lead to agitation or erratic behavior and compromise the client’s safety. Avoid direct confrontation of the client’s fears or paranoia, but try to anticipate and eliminate the environmental triggers that cause them as the presence of strangers, changes in the daily routine, or impaired memory.

1. The nurse is working in a long-term care setting with clients with dementia. One of the ancillary staff makes a joke about a client in the client’s presence. The nurse tells the staff person that is unacceptable behavior. The staff person replies, “Oh, he can’t understand what I’m saying, and besides, he was laughing too. What’s the big deal?” How should this nurse respond?

2. A client is newly diagnosed with dementia in the early stages. Can the client make decisions about advance medical directives? Why or why not? At what point in the progression of dementia can the client no longer make quality-of-life decisions?

Schizophrenia
RELATED DISORDERS

- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder:
- Brief psychotic disorder
- Shared psychotic disorder (folie à deux)

POSITIVE AND NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

<table>
<thead>
<tr>
<th>Positive or Hard Symptoms</th>
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<tbody>
<tr>
<td>Ambivalence: Holding seemingly contradictory beliefs or feelings about the same person, event, or situation</td>
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<tr>
<td>Auditory hallucinations: Fragmented or poorly related thoughts and ideas</td>
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<tr>
<td>Delusions: Fixed false beliefs that have no basis in reality</td>
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<td>Echopraxis: Imitation of the movements and gestures of another person whom the client is observing</td>
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<tr>
<td>Flight of ideas: Continuous flow of verbalization in which the person jumps rapidly from one topic to another</td>
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<tr>
<td>Hallucinations: False sensory perceptions or perceptual experiences that do not exist in reality</td>
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<td>Ideas of reference: False impressions that external events have special meaning for the person</td>
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<tr>
<td>Perseveration: Persistent adherence to a single idea or topic; verbal repetition of a sentence, word, or phrase, resisting attempts to change the topic</td>
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<th>Negative or Soft Symptoms</th>
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<tr>
<td>Alogia: Tendency to speak very little or to convey little substance of meaning (poverty of content)</td>
</tr>
<tr>
<td>Anergia: Feeling no joy or pleasure from life or any activities or relationships</td>
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<tr>
<td>Apathy: Feelings of indifference toward people, activities, and events</td>
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<td>Blunted affect: Restricted range of emotional feeling, tone, or mood</td>
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<td>Catatonia: Psychologically induced immobility occasionally marked by periods of agitation or excitement; the client seems motionless, as if in a trance</td>
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<td>Flat affect: Absence of any facial expression that would indicate emotions or mood</td>
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<td>Lack of volition: Absence of will, ambition, or drive to take action or accomplish tasks</td>
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types of schizophrenia

- Schizophrenia, paranoid type
- Schizophrenia, disorganized type
- Schizophrenia, catatonic type
- Schizophrenia, undifferentiated type
- Schizophrenia, residual type

Biologic Theories

- Genetic Factors
Biologic Theories

- Neuroanatomic and Neurochemical Factors

Treatment

- Psychopharmacology
  - Maintenance Therapy
    - fluphenazine (Prolixin) in decanoate and enanthate preparations
    - haloperidol (Haldol) in decanoate

Side Effect

- Extrapyramidal Side Effects
  - Dystonic reactions
  - Pseudoparkinsonism
  - Akathisia
- Tardive Dyskinesia
Psychosocial Treatment

- Individual and group therapy
- Family therapy
- Family education
- Social skills training

Assessment

- 4 A’s of Schizophrenia
  - Associative looseness
  - Affective disturbance
  - Ambivalence
  - Autism

Symptoms

Positive
- Abnormal thought form
- Agitation
- Association disturbance
- Bizarre disorganized behavior
- Conceptual disorganization
- Delusion
- Pathologic or extreme excitement

Negative
- Attention impairment
- Anergia
- Alogia
- Poor eye contact
- Anhedonia
- Asocial behavior
- Attention deficit
- Avolition
- Blunted flat affect

Symptoms

Positive
- Feelings of persecutions
- Grandiosity
- Hallucination
- Hostility
- Ideas of reference
- Illusion
- Insomnia
- Pressured speech
- Suspiciousness

Negative
- Communication difficulties
- Passive social withdrawal
- Poor hygiene
- Poor rapport
- Poverty of speech
Disorganized Symptoms

- Confused thinking
- Incoherent and inorganized speech and behavior
- Others

Types of Hallucinations

- Auditory hallucinations
- Visual hallucinations
- Olfactory hallucinations
- Tactile hallucinations
- Gustatory hallucinations
- Cenesthetic hallucinations
- Kinesthetic hallucinations

Goals

- Build trust
- Provide for basic needs of nutrition, fluids, as well as safety
- Clarify and reinforce reality
- Promote and build self-esteem
- Encourage independence
- Assist in medical intervention
Nursing Diagnoses

- Self-Care Deficits
- Social Isolation
- Deficient Diversional Activity
- Ineffective Health Maintenance
- Ineffective Therapeutic Regimen Management

Interventions for Agitation

**Do**
- Remove cause of agitation
- Eliminate stimulants
- Set limits
- Monitor physical discomforts
- Administer drugs as ordered

**Don’t**
- Display anger, frustration, discouragement
- Criticize
- Argue

Interventions for Delusions

**Do**
- Explain all procedures
- Provide personal space
- Maintain eye contact
- Provide consistency (Cornerstone of trust)
- Set realistic goals

**Don’t**
- Touch without warning
- Whisper or laugh in the presence of the client
- Argue and disprove delusions
- Reinforce delusions
- Present logical argument

Interventions for Hallucination

**Do**
- Decrease environmental stimuli
- Identify contributory factors
- Argue and disprove hallucination
- Be alert to nonverbal stimulation
- Present reality

**Don’t**
- Participate in the hallucination process

Patient Teaching

- Hallucinations are very powerful and their influence should not be taken lightly
- Teach side effects, especially EPS
- Teach purpose of therapy
- Teach significant others how to be supportive of patient at times with contact with reality is poor
- Teach patient action of antipsychotic medications

**CLIENT AND FAMILY TEACHING: SCHIZOPHRENIA**

- How to manage illness and prevent relapse
- Importance of maintaining prescribed medication regimen and regular follow-up
- Avoiding alcohol and other drugs
- Self-care and proper nutrition
- Teaching social skills through education, role modeling, and practice
- Counseling and education of family/significant others about the biological causes and clinical course of schizophrenia and the need for ongoing support
- Importance of maintaining contact with community and participating in supportive organizations and care
Mood or Affective Disorders

Etiology

- Psychodynamic, Existential, Cognitive-Behavioral, Developmental Theories
- Biological Theories
  - Neurochemical and neuroendocrine
  - Neuroanatomical Factors

Types of Bipolar

- Bipolar I disorder
- Bipolar II disorder

Onset and Clinical Course

- early 20s; others start older than 50 years
- mania requires at least 1 week of unusual bipolar behavior
Treatment

- PSYCHOPHARMACOLOGY
  - antimanic agent
  - Anticonvulsant Drugs
- PSYCHOTHERAPY

Assessment

- Impaired judgement
- Flight of ideas
- Level of agitation
- Inflated Self esteem
- Delusions of grandeur
- Short attention span (easily distracted)
- Emotional labile (from euphoria to rage in seconds)

Assessment

- Restlessness, impulsiveness
- Flamboyant, eccentric dress
- Disturbed sleep patterns
- Delusions of perceptions
- Risk of suicide (may be impulsive)
- Lack of insight and judgement
- Pressured, very rapid speech
Diagnosis

- Risk for Other-Directed Violence
- Risk for Injury
- Imbalanced Nutrition: Less Than Body Requirements
- Ineffective Coping
- Noncompliance
- Ineffective Role Performance
- Self-Care Deficit
- Chronic Low Self-Esteem
- Disturbed Sleep Pattern

Interventions

- Provide quiet, non-stimulating environment
- Provide finger foods to eat while pacing around
- Monitor for injuries (may be too hyperactive to note injury)
- Encourage compliance with medications, especially if lithium.
- Provide for short periods of sleep if unable to sleep at night

Interventions

- Limit interpersonal interactions and competitive activities with others
- Encourage exercise, such as walking, jogging, as an outlet for energy.
- Monitor fluid and electrolyte imbalances, especially hyponatremia
- Monitor Lithium blood levels
- Sexually uninhibited
- Administer medications, if prescribed

Interventions

- Listen attentively, being alert not to feed into grandiosity and enhance manic behavior
- Limit foods and drinks that contain caffeine
- Provide activities that will keep patient busy but not overstimulate him
- Encourage salt intake of 3-6 g per day (Lithium is a salt, and reduced sodium intake can cause retention of Lithium and subsequent toxicity)

MYTHS AND FACTS ABOUT SUICIDE

- People who talk about suicide never commit suicide.
- Suicidal people only want to hurt themselves, not others.
- There is no way to help someone who wants to kill himself or herself.
- Do not mention the word suicide to a person you suspect to be suicidal, because this could give him or her the idea to commit suicide.

MYTHS AND FACTS ABOUT SUICIDE

- Ignoring verbal threats of suicide or challenging a person to carry out his or her suicide plans will reduce the individual's use of these behaviors
- Once a suicide risk, always a suicide risk.
SUICIDAL IDEATION

CLIENT STATEMENT
• “It will just be the end of the story.”
• “You have been a good friend.”
• “I can’t stand the pain anymore.”
• “Everyone would be better off without me.”

NURSE RESPONSES
• “Are you planning to end your life?”
• “You sound as if you are saying good-bye. Are you?”
• “How do you plan to end the pain?”
• “How do you plan to eliminate yourself, if you think everyone would be better off without you?”

Patient Teaching
• Instruct patient that adequate salt intake is essential to prevent fluid and electrolyte imbalances
• Instruct patient the importance of taking Lithium as prescribed
• Instruct patient that Lithium may cause weight gain and recommend exercise that will offset the additional weight
• Teach patient the importance of taking Lithium for life

Etiology
• GENETIC THEORIES
• NEUROCHEMICAL THEORIES
• NEUROENDOCRINE INFLUENCES
• Psychodynamic Theories

MAJOR DEPRESSION

Persistent sad or depressed mood, loss of interest in things that were once pleasurable with disturbance in sleep, Appetite (and weight), energy and concentration

MAJOR SYMPTOMS OF DEPRESSIVE DISORDER
• Depressed mood
• Anhedonism (decreased attention to and enjoyment from previously pleasurable activities)
• Unintentional weight change of 5% or more in a month
• Change in sleep pattern
• Agitation or psychomotor retardation
• Tiredness
• Worthlessness or guilt inappropriate to the situation (possibly delusional)
• Difficulty thinking, focusing, or making decisions
• Hopelessness, helplessness, and/or suicidal ideation
### PSYCHOPHARMACOLOGY
- **SSRIs.**
- **Cyclic Antidepressants**
- **Tetracyclic Antidepressants**
- **Atypical Antidepressants**
- **MAOIs**

### Treatment and Prognosis

#### Tetracyclic Antidepressant Medications

<table>
<thead>
<tr>
<th>Generic (Trade) Name</th>
<th>Side Effects</th>
<th>Nursing Implications</th>
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</thead>
<tbody>
<tr>
<td>amoxapine (Asendin)</td>
<td>Dizziness, orthostatic hypotension, sedation, insomnia, constipation, dry mouth and throat, rashes</td>
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<tr>
<td>doxepin (Sinequan)</td>
<td>Dizziness, orthostatic hypotension, tachycardia, sedation, blurred vision, constipation, dry mouth and throat, weight gain, sweating</td>
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#### Atypical Antidepressants

<table>
<thead>
<tr>
<th>Generic (Trade) Name</th>
<th>Side Effects</th>
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</thead>
<tbody>
<tr>
<td>venlafaxine (Effexor)</td>
<td>Increased blood pressure and pulse; nausea; vomiting; headache; dizziness; dryness; dry mouth sweating; congesitve symptoms; insomnia; urinary hesitancy; anorexia; constipation, dry mouth and throat, weight gain, headache</td>
<td>Administrator with food. Encourage adequate fluids. Give in PM. Encourage use of sugar-free beverages or hard candy. Ensure adequate fluids and balanced nutrition.</td>
</tr>
<tr>
<td>bupropion (Wellbutrin)</td>
<td>Nausea, vomiting, tremor, sedation, weight gain, headache, dizziness, drowsiness, hyperactivity, insomnia, urinary retention, cardiac arrhythmias, vomiting, diarrhea, constipation, dry mouth</td>
<td>Give with food. Administer dose in AM. Encourage use of sugar-free beverages or hard candy. Ensure adequate fluids and balanced nutrition. Report rash to physician.</td>
</tr>
<tr>
<td>nefazodone (Serzone)</td>
<td>Headache; dizziness; drowsiness; agitation; insomnia, urinary retention, constipation, dry mouth and throat, weight gain, sexual dysfunction, constipation</td>
<td>Administrator prior to meals. Monitor liver and kidney functions. Encourage use of sugar-free beverages and hard candy. Ensure adequate fluids and balanced nutrition. Report rash to physician.</td>
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<tr>
<td>mirtazapine (Remeron)</td>
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#### Monoamine Oxidase Inhibitor (MAOI) Antidepressants

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<tr>
<td>moclobemide (Maproli)</td>
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<tr>
<td>phenelzine (Nardil)</td>
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<tr>
<td>tranylcypromine (Parnate)</td>
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#### Selective Serotonin Reuptake Inhibitor (SSRI) Antidepressants

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<tr>
<td>sertraline (Zoloft)</td>
<td>Dizziness, sedation, headache, insomnia, tremor, sexual dysfunction, dry mouth and throat, nausea, vomiting, constipation, diarrhea</td>
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</tr>
<tr>
<td>paroxetine (Paxil)</td>
<td>Dizziness, sedation, headache, insomnia, weakness, fatigue, constipation, dry mouth and throat, nausea, vomiting, diarrhea, sweating</td>
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</tr>
<tr>
<td>citalopram (Celexa)</td>
<td>Dizziness, sedation, insomnia, nausea, vomiting, weight gain, constipation, diarrhea</td>
<td></td>
</tr>
<tr>
<td>escitalopram (Lexapro)</td>
<td>Dizziness, dizziness, weight gain, sexual dysfunction, restlessness, dry mouth, headache, nausea, diarrhea</td>
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OTHER MEDICAL TREATMENTS AND PSYCHOTHERAPY

- Electroconvulsive Therapy
- Psychotherapy

Diagnostic Criteria

- Depressed mood
- Diminished interest or pleasure in activities of the day
- Significant weight loss or weight gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feeling of worthlessness or inappropriate guilt
- Diminished ability to think or concentrate
- Suicidal ideation

Nursing Diagnosis

- Mood Disturbance
- Dysfunctional Grieving
- Risk for Self-Directed Violence
- Social Isolation
- Self-esteem disturbance
- Self-Care Deficit
- Imbalanced Nutrition: Less than body requirements

Patient Teaching

- Inform the patient that it may take two weeks for antidepressants to take effect
- Teach side effects of medication
- Teach that depression may be related to certain physiological or chemical imbalances and that medications may fill the gap
- Teach patient that depression is often related to loss

Sexual Disorders

PARAPHILIAS

Are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving nonhuman objects, the suffering of or humiliation of oneself or one's partner, or children or other nonconsenting persons, that occur over a period of at least 6 months.
Treatment of Paraphilias

- Relapse prevention
- Medications used: cyproterone or spironolactone or gonadotropin hormone realising agonist to effect a chemical castration. SSRI (fluvoxamine and proxetine)

Assessment

- Sexual Health Status
- Sexual history

Nursing Diagnosis

- Anxiety and Fear
- Spiritual Distress
- Compromised Family Coping
- Disturbed Personal Identity
- Ineffective Role Performance
- Ineffective Sexuality Patterns
- Risk for violence: Self Directed or other-directed
- Pain
- Deficient Knowledge
- Sexual Dysfunction
Nursing Interventions

- Reducing Anxiety
- Reducing Violence
- Promoting Comfort with Gender Identity
- Reducing Pain
- Educating About Noncoercive Sex Patterns
- Reinforcing Sexual Health
- Managing Compulsive Sexual Behavior
- Addressing Sexual Dysfunction
- Enhancing communication
- Reducing Spiritual Distress
- Increasing Knowledge

Gender Identity Disorder

Commonly referred to as transexualism, is a complex condition in which a person feels that their inner nature is more like that of the opposite gender.

Etiology

- No identified cause
- Neuroanatomical differences

Treatment

- Psychotherapy
- Hormones
- Sexual Reassignment surgery

Education for Clients and Families

- Education is an important component of the nurse's role with all clients.
- Provide information so that the client can understand their experience and encourage mastery of the situation.
- The nurse needs not to be an expert, but should have an awareness of the behavioral approaches that are part of the treatment.

...FOR GOD BOUGHT YOU WITH A PRICE. SO YOU MUST HONOR GOD WITH YOUR BODY.

I Corinthians 6:20