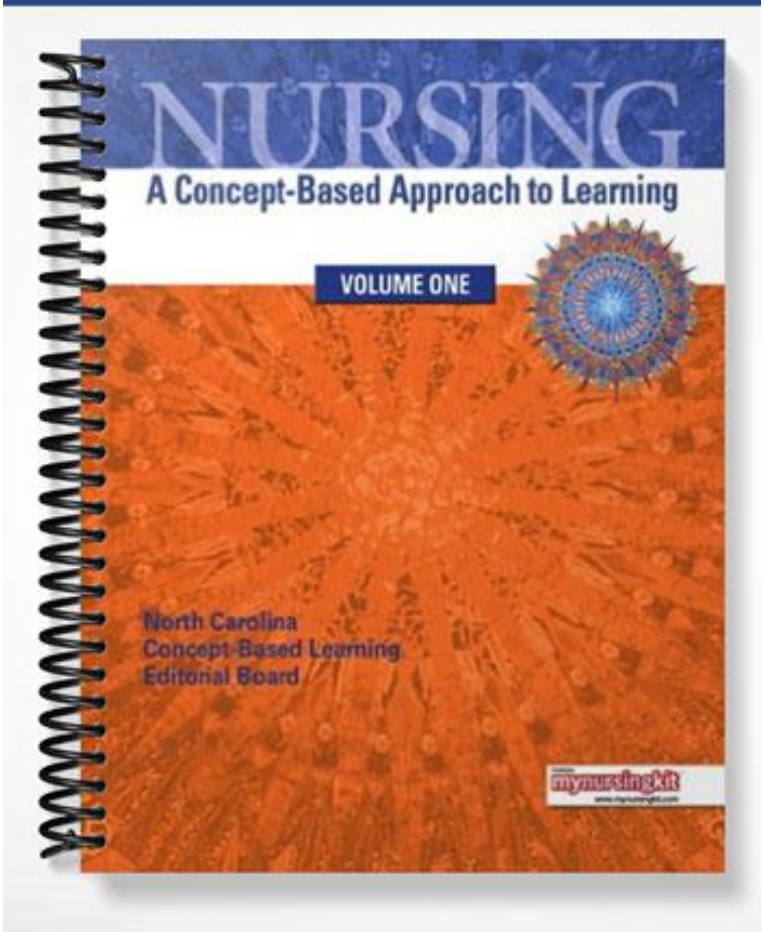
SOLUTIONS MANUAL



Concept 2: Addiction Behavior

I. About Addiction Behavior

A. Definition

1. **Psychologic or physical need for a substance (e.g., alcohol) or process (e.g., gambling)**
2. **Individual will risk negative consequences in an attempt to meet the need**
3. **Addiction behaviors**
   - ***a) Compulsive***
   - ***b) Problematic patterns of action resulting in psychologic and/or physiologic dependence***

B. Substance use

1. **Recreational modification of mood or behavior**
2. **Wide sociocultural variations in acceptability of chemical use**
3. **Narcotics, sedatives, stimulants, and hallucinogens**
   - ***a) Often used illegally***
   - ***b) General population considers recreational use socially unacceptable***
   - ***c) Abuse of these substances may lead to addiction***

C. Process addictions

1. **Other forms of addiction**
   - ***a) Workaholism***
   - ***b) Shopping***
   - ***c) Cutting***
   - ***d) Spending and Indebtedness***
   - ***e) Eating disorders***
2. **Involve compulsive behaviors**
   - ***a) Serve to reduce anxiety***
   - ***b) May be linked to obsessive-compulsive disorder***
   - ***c) May result from reward deficiency syndrome***
     - (1) Individuals with reward deficiency syndrome have decreased ability to experience pleasure
     - (2) Drives person to seek external forms of gratification

D. Personality characteristics of addicts

1. **Compulsive preoccupation with obtaining the substance**
2. **Loss of control over consumption**
3. **Development of tolerance, dependence**
4. **Impaired social and occupational functioning**
5. **Behaviors include (but not limited to)**
   - ***a) Tendency for addicts to indulge in impulsive risk-taking behaviors***
   - ***b) Low tolerance for frustration and pain***
   - ***c) Tendency of addicts to rebel against social norms and engage in antisocial and risky behaviors***
     - (1) Stealing
     - (2) Promiscuity
     - (3) Driving while intoxicated
     - (4) Committing violence against others
   - ***d) Often arises from anxieties***
6. **Pseudoaddiction**
   - ***a) Displays drug-seeking behaviors***
   - ***b) Differs in that they have true underlying pain***
   - ***c) Behaviors generally stop when adequate pain control achieved***

E. Normal presentation

1. **Addiction versus dependence**
   - ***a) Dependence is physiologic need for substance that client cannot control***
   - ***b) Addiction includes the physiologic process but also includes psychologic need***
     - (1) Causes addicts to seek out substances at any cost
     - (2) Addicts may neglect, children, work, other responsibilities
2. **Models and theories**
   - ***a) Biopsychosocial model***
     - (1) Links biologic, psychologic and social factors as contributing to development of addiction
   - ***b) Link between addiction and impulse control***

(1) Addiction linked to dopaminergic system of brain's reward system

(2) Speed of addiction

c) Disease model

(1) Disease that results from a neurochemical and/or behavioral process

(2) Treatment aimed at idea of changing behaviors

(3) Supporting positive responses

d) Pleasure model

(1) Addiction is emotional fixation acquired through learning → Aimed at obtaining pleasure and avoiding discomfort

(2) If pleasure that results is sufficiently strong,induces repetition

(3) Overcomes person's natural drive, resulting in addiction

(4) Model is basis of zero tolerance for drugs as a prevention strategy

e) Cultural model

(1) Cultures that do not permit use of a substance likely to have a lower incidence of addiction

(2) Increase in prevalence of gambling addiction from loosening legislation regarding casinos strengthens this position

f) Neurobiological

(1) Postulates that addiction the result of an increase in focus on addictive behavior

(2) Corresponding gradual loss of interest in other activities

(3) Mesolimbic dopaminergic system suspected of playing a role

(a) Reward learning process

(b) Plays role in seeking out of rewarding stimuli

(4) Areas in brain that define something as pleasant

(a) Stimulated as a result of addiction → substance or behavior takes on increased level of need

(b) End result is anhedonia: inability to feel pleasure

F. Alterations

1. Addiction takes many forms

a) Nicotine

(1) One of the most highly addictive substances

(2) May lead to multiple health problems

b) Impacts → user, family, society

c) Statistics

(1) One out of four Americans between 26 and 34 has used cocaine at some time

(2) Approximately 5.5% of 19–22-year-olds surveyed had used Ecstasy (MDMA) the previous year

(3) Two and a half percent of the world's population have used marijuana

(4) Six hundred thousand people are estimated to be addicted to heroin

(5) Only surface of statistics re: addiction

2. Alterations and treatments

a) See ALTERATIONS AND TREATMENTS, p.29

b) Other alterations include (but not limited to)

(1) Anorexia nervosa and bulimia

(2) Cutting

(3) Exercise addiction

(4) Gambling

(5) Plastic surgery

(6) Sexual addiction

(7) Tattoo and piercing addictions

G. Language of addiction and recovery

1. See Table 2-1 TERMINOLOGY ASSOCIATED WITH SUBSTANCE ABUSE, p.30

H. Effects of addiction on families

1. Substance abuse is a family problem

a) Alters family problems

b) Alters behaviors of individual family members

2. Parental substance abuse

a) Devastating to family

b) Power struggles between abusing and nonabusing partners

c) Contributing factor to emotional neglect, physical or sexual abuse

d) ***Addict may abandon family and old friends for new relationships in drug subculture***

e) ***Addict may isolate***

3. **Ineffective communication patterns**

a) ***Contribute to anxiety and anger***

b) ***Substance abuse not discussed within or outside family system***

c) ***Family denial***

d) ***Nonabusing partners may remain in relationship***

(1) Emotional dependency

(2) Money

(3) Family cohesion

(4) Religious compliance

(5) Outward respectability

e) ***Nonabusing partner may leave relationship***

(1) May threaten to leave

(2) Abuser may promise to not drink

(3) Family reunited

(4) Abuser relapses

(5) Family in dysfunctional pattern

4. **Codependency**

a) ***Nonsubstance abusing partner remains with substance abusing partner***

b) ***Codependents operate dysfunctionally***

c) ***Driven to control user's behavior***

d) ***Caretakers***

(1) Often suffer from low self-esteem and fear of abandonment

(2) Caretaking may be compensation for feelings of inadequacy

(3) Women may be more vulnerable to codependent behavior

e) ***Nurses must remain professional***

5. **Enabling behavior**

a) ***Any action that consciously or unconsciously facilitates substance dependence***

b) ***Protect the substance abuser from the natural consequences of the problem***

c) ***Is a response to addiction***

d) ***Not a cause of addiction***

e) ***Purpose is family's desire to stay together***

f) ***Can continue***

g) ***Spouses and children need healing and treatment***

(1) As much or more than addicted family member

(2) Support networks → Adult Children of Alcoholics, Al-Anon

I. Effects of addiction behaviors on children

1. **Studies on children of alcoholics (COAs)**
   a) ***Information true for children of parents addicted to street or prescription drugs***
   b) ***Addiction behaviors exist regardless of substance being abused***
2. **Estimated 1 of every 8 Americans is a child of an alcoholic parent**
3. **COAs often suffer the effects their entire lives**
4. **Dysfunctional family roles develop**
5. **Often believe they are cause of addiction**
6. **Parent may jeopardize children's health and safety**
7. **Learn to "keep the secret"**
8. **Expected to be in control of their behavior and feelings at all times**
   a) ***Expected to be perfect and never make mistakes***
9. **COAs learn not to expect reliability in relationships**
   a) ***Trust no one = you will not be disappointed***
10. **Four patterns of COA behaviors**
    a) ***Hero***
    b) ***Scapegoat***
    c) ***Lost child***
    d) ***Mascot***
11. **Designated roles for dysfunctional families**
    a) ***Keep family balanced***
    b) ***Each role a way to handle the distress and shame***

c) ***Every family member has sense of some control***

d) ***Roles <u>do not</u> change family system's dysfunction***

12. Adult COAs

a) ***Grow up without mature adult role models***

b) ***Without experience of healthy family dynamics***

c) ***Expect all relationships to be based on power, violence, deceit, misinformation***

d) ***Difficulty expressing emotion***

e) ***Difficulty receiving expressions of feelings***

f) ***Some repeat pattern of family***

13. Need to change others

a) ***Feel need to control the environment for the good of others***

b) ***Typically deny powerlessness***

c) ***Try to solve problems alone***

d) ***Blame themselves for not being able to achieve what no one can achieve***

14. Often use obsessions

a) ***Defense mechanism***

b) ***Constant worrying***

c) ***Preoccupations with work***

d) ***Other activities that bring about good feelings***

e) ***Obsessive pattern covers feelings of helplessness***

(1) Blocks feelings of anxiety

(2) Inadequacy

(3) Fear of abandonment

J. Assessment

1. Nursing history

a) ***Clients***

b) ***Trusting nurse-client relationship***

c) ***Involve family members when gathering assessment data***

d) ***Recognize clues of addiction while complications still preventable***

2. Physical assessment findings dependent on nature of addiction

a) ***Clients with addiction to self inflicted wounding (cutting) may have unexplained lacerations***

b) ***Clients addicted to narcotics demonstrate symptoms in Exemplar 2.4***

c) ***Be alert for symptoms that are abnormal***

3. **Crisis assessment related to substance abuse**

   a) ***Individual assessment***

   b) ***Family assessment***

   c) ***Community assessment***

   d) ***See BOX 2-1 CRISIS ASSESSMENT RELATED TO SUBSTANCE ABUSE, p.32***

4. **Diagnostic tests**

   a) ***Based on type of addiction***

   b) ***May include***

      (1) Serum drug levels

      (2) Toxicology testing

      (3) Chest x-ray for inhaled substances

      (4) Organ biopsies related to damage caused by substance

      (5) Urine, saliva, and serum testing for substance metabolites

      (6) Hair testing to determine substance use within a period of 90 days

5. **Caring interventions**

   a) ***Goal of all interventions to move client toward treatment and recovery***

   b) ***Recovery a state of voluntary sobriety***

   c) ***No single intervention sufficient to ensure recovery***

   d) ***Requires substantial work on the part of the addict***

6. **Communication**

   a) ***Therapeutic communication***

      (1) Client at center of all communication

      (2) Many clients with addictions have poor communication skills

      (3) Clients with addictions/addictive behaviors

         (a) Need assistance with verbal and nonverbal communication

         (b) Nurse can give example

(c) Conversation

(i) Nurses should discuss volume, tone, rate of speech

(ii) Model taking turns in speaking and not interrupting

(iii)Have clients practice skills

(d) Assertiveness training

7. Family intervention

a) Addictive behavior in crisis stage → family and loved ones of addict may confront him with impact of addict's behavior on others

b) Another goal is to prevent addict from denying the problem

c) Family often plans intervention in advance

d) Desired result is addict begins to recognize impact of behavior

e) Becomes motivated to seek treatment

f) Family should make preparations in advance for immediate entrance to rehabilitation

8. Crisis intervention

a) Crisis is point at which usual resources and coping skills are no longer effective

b) People experience events to which they must respond

c) Expected life changes which may evoke maturational crises

d) Unexpected life changes may result in situational crises

e) Event needs to be perceived subjectively as a threat to need fulfillment, safety, or meaningful existence → maturational or situational crisis

f) Addicts have poor life management skills

g) During crisis situations addict is most likely to be motivated to seek help to treat their addiction and turn lives around

(1) State of disequilibrium usually lasts 4-6 weeks

(2) High level of anxiety forces individual to:

(a) Adapt and return to previous level of addiction

(b) Develop more constructive coping skills and seek help for the addiction

(c) Decompensate to a lower level of functioning

(3) At this time people most receptive to professional interventio

(4) See Box 2-1, CRISIS ASSESSMENT RELATED TO SUBSTANCE ABUSE, p.32

h) Useful with addictive behavior

9. Goal of crisis intervention

a) Assist client in resolving the immediate problem

b) Regaining emotional equilibrium

c) May lead to better use of coping mechanisms when dealing with future stressful life events

10. Role of nurses

a) Active participation in solving the problem

b) They do not take over and make decisions for clients

c) Unless clients are suicidal or homicidal

(1) Primary focus of nurse→ Assist client in developing skills that enable client to adapt to or move beyond crisis state

d) Behavioral skills

(1) Assist clients in identifying alternative ways of resolving crisis

(2) Learn steps/alternative behaviors

(3) Client more receptive to trying alternative behaviors while in crisis state

(4) Nurse continually reinforces clients strengths

(5) Provides client opportunity to vent feelings

e) Spiritual skills

(1) Help client find meaning in/understand the personal significance of unexpected event

(2) Ongoing issue during and after crisis period

(3) Result of search depends on individuals spirituality or philosophy of life

f) Cognitive skills

(1) Thought processes

(2) Denial common to addicted clients and family

(3) Goal of adaptive cognitive skills is to maintain a satisfactory self-image and a sense of competence and mastery

g) Psychosocial skills

(1) Enable person in crisis to maintain relationships with family and friends

(2) Crucial skill is to accept comfort and support from others

(3) (3) Friends and family may be sources of information

(4) (4) Community resources

h) Demographic and personal factors

i) Factors specific to the event influence the outcome of crisis event more

(1) Biologic

(2) Psychologic

(3) Environmental

(4) Social

(5) Tasks and coping skills vary among these events

(6) The more control over factors, the more adaptive the individual is likely to be

j) Successful resolution of crisis leads to growth

11. Behavioral therapy

a) Clients learn techniques to modify or change addictive behaviors

(1) Based on principle that all behavior has specific consequences

(2) Behavior is changed by conditioning

(3) Reinforcement

(a) Consequences that lead to increase in particular behavior

(i) Positive reinforcement provides reward for desired behavior

(ii) Negative reinforcement removes negative stimulus to increase chances that the desired behavior will occur

(4) Punishment

(a) Consequences that lead to decrease in undesirable behavior → Positive, negative punishment

(5) Extinction

(a) Progressive weakening of an undesirable behavior through repeated non-reinforcement of the behavior, e.g., family ignores negative attention seeking behaviors

(6) Reinforcement more desirable than punishment

(a) Punishment effective and sometimes necessary

(b) *Behavior changed through reinforcement more desirable clinical outcome*

(7) Contingency contracts

(a) *If the client performs a targeted response → then client receives desired reinforcers*

(b) *Only as effective as the rewards chosen*

(c) *Client first learning behavior → rewards given immediately*

(8) Token economies

(9) Well suited to treating addiction behavior

b) Nurses in position to evaluate client response to treatment → time spent with clients enables nurses to see developing patterns of behavioral change

12. Milieu therapy

a) Successful recovery environment

b) Basic goals no matter the setting (group home, community center, day program or inpatient unit):

(1) Clients as responsible

(2) Group and social interaction

(3) Client right to choose and participate in a variety of treatments

(4) Informality or relationships with health care professionals

c) Includes:

(1) Clear communication

(2) Safe environment

(3) Activity schedule with therapeutic goals

(4) Support network

d) Overall goal → support changes in client's behavior necessary to free client from addiction

(1) Nurses model and teach desirable behaviors

(2) Nurse member of client's psychiatric team

(3) Spends most time with and around client

(4) Observations and interactions with client

13. Group therapy

a) ***Beneficial experience in which the group members help each other through process of change aided by professional group therapist***

b) ***Groups can be held in a variety or settings***

c) ***Mechanisms or change within a group***

(1) See Table 2-2 CURATIVE FACTORS OF GROUP THERAPY, p.36

d) ***Two concepts basic to group therapy***

(1) Group as social microcosm

(2) Here and now concept

e) ***Nurses function as group therapists in many settings***

(1) Establishing type of group appropriate for outcome

(2) Single nurse or cotherapists

f) ***Leader helps members relate to one another***

(1) Initially members are strangers

(2) Encourage members to remain in the group

(3) Helping the group develop a sense of cohesiveness

(4) Establishing a code of behavior and norms with the group

g) ***Two roles***

(1) Technical expert

(2) Model setting participant

h) ***Effective with children and adolescents***

(1) Addicts of children of addicts

(2) With young children usually 5 in group

(3) Adolescents

(4) Often parallel group for parents

14. Support groups

a) ***Members share thoughts and feelings and help one another examine issues and concerns***

b) ***Characteristics of support groups***

(1) Clients define their own needs

(2) Members have equal power

(3) Groups may or may not be autonomous from mental health professionals

(4) Attendance is voluntary

(5) Groups may be responsive to a specific population

c) Function

(1) Educate community members

(2) Help family and friends support the individual;

(3) Act as crisis support

(4) Referral source

(5) Advocate to help people get their needs meth

(6) Helps clients form healthier base of support helps prevent recidivism into addictive behavior

(7) Interpersonal contact of support group vital

(8) Contribute to increased self esteem

(9) Sense of identity

(10) Increased dignity

(11) Improved self responsibility

15. Step programs

a) Spiritual plan for recovery

(1) Alcoholics Anonymous (AA)

(2) Others followed

(a) Narcotics Anonymous (NA)

(b) Al-Anon

(c) Cocaine Anonymous

(d) Adult Children of Alcoholics (ACoA)

(e) Emotions Anonymous

(f) Gamblers Anonymous

b) Prescribed beliefs, values, and behaviors

c) Sequential plan for recovery stated in 12 steps

(1) See BOX 2-2 THE 12 STEPS OF ALCOHOLICS ANONYMOUS, p. 37

(2) Step work is considered to be a lifelong process

(3) Usually with the aid of a sponsor

(4) Twelve-step fellowship includes the activities of the organization

d) Only requirement is sincere desire to change the target behavior

e) Four common meeting formats

(1) Open discussion—individuals asked to share thoughts and feelings regarding a general topic introduced at the beginning of the meeting

(2) Speaker meetings—one to three members talk for the entire meeting

(3) Big Book or 12 and 12

(4) Birthday meetings

16. Family therapy

a) Family system treated as a unit

b) Focus on family dynamics

c) Goals

(1) Help families cope

(2) Improve their communication and interpersonal skills

(3) Establish boundaries

(4) Moderate family cohesion and flexibility

d) Families strive to maintain balance and harmony

(1) Addicted member causes balance to shift

(2) Use internal and external resources to adapt

(3) Competent families adapt more efficiently than dysfunctional families

e) Change is frightening to families

(1) Invest energies in maintaining status quo

(2) Results in enabling the addiction rather than supporting changes that will improve health

f) Family therapy "norms"

(1) Euro-American middle class heterosexual family has been yardstick

(2) Ignored other cultures, social classes, family structures

(3) Now therapy taking multicultural, investigative approach

g) Recommended when nurse or family determines family system is impaired

h) All family members must believe that they are part of process

i) APRNs

j) Help families look at a number of issues

k) Overall goals of family therapy

(1) Teach parents better parenting and nurturing skills

(2) Reinstate generational boundaries in the family hierarchy

(3) Improve family communication

(4) Teach the family how to problem solve

l) Informal nursing assessment of families

(1) Relationships between individual members of the family

(2) Roles that various members of the family assume

(3) Family communication patterns

(4) Achievement of the family's developmental tasks

(5) Normal coping strategies that the family uses

(6) Past and current efforts to cope with addiction

(7) Family support systems

(8) Sociocultural norms and values of the family

(9) Personal goals for each family member

m) Families with addictive member

(1) Disagreements and conflicts normal

(2) May become so involved in dysfunctional behavior that they see dysfunctional behavior as normal

n) Teaching families general principles for resolving conflict helpful nursing intervention

o) See BOX 2-3 EIGHT STEPS USED TO RESOLVE FAMILY DISAGREEMENTS, p. 38

17. Pharmacologic therapies

a) Treat and prevent symptoms of withdrawal and treat overdose

b) May have multiple drug interactions

(1) See MEDICATIONS, p.39

II. Exemplar 2.1 Alcohol Abuse

A. Overview

1. **Most commonly used and abused substance in the U.S.**
2. **Alcoholism**
   a) ***Primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations***
   b) ***Characterized by inability to control primary addictive behavior (drinking) fixation***
   c) ***Continued use regardless of consequences and impaired thought processes***
3. **Alcohol**
   a) ***Includes liquor, beer, wine***
   b) ***Still socially acceptable, often encouraged***
   c) ***Wide availability may be primary reason widely abused***
   d) ***Alcohol abuse costs in 1998 $184.6 billion***
   e) ***Estimated nearly 25% of all people admitted to a general hospital have alcohol problems***
4. **Pattern of dependence varies**
   a) ***Regular daily intake of large amounts of alcohol***
   b) ***Binge drinking → heavy drinking on weekends of days off from work***
   c) ***May abstain for long periods of time, the begin drinking patterns again***
   d) ***Sometimes can drink with control, other time cannot control drinking behavior***
   e) ***Addiction behaviors appear with increasing frequency***
5. **Two groups**
   a) ***Type 1***
   b) ***Type 2***

B. Pathophysiology and etiology

1. **CNS depressant**
2. **Absorbed in the mouth, stomach, and digestive tract**
3. **Dual diagnosis and dual disorder**
   a) ***Co-occurring disorders***
   b) ***One disorder can be an indication of another***

*c) **Relationship between alcoholism and depression***

4. Etiology

*a) **Major health problem***

(1) 100,000 deaths annually in the U.S.

(2) 2/3 of nation's adult population consumes alcohol regularly

(3) Estimated 14 million Americans (1 in every 13 adults) abuse alcohol or are alcoholics

(4) Estimated 25–40% of all clients in U.S. general hospital beds are being treated for complications of alcohol-related problems

(5) Many underage people obtain and use alcohol

(6) Demographics for underage drinking

(a) Lowest among Asians

(b) Highest among whites

(7) Alcohol and other drugs found in ED visits

(a) See Table 2-3 TOP 10 COMBINATION DRUGS FOUND IN ALCOHOL-RELATED EMERGENCY DEPARTMENT VISITS, p. 41

5. Risk factors

*a) **Genetic factors***

*b) **Biologic factors***

*c) **Sociocultural factors***

(1) Ethnic differences in way alcohol metabolized

(2) Caucasians, Hispanics, and African Americans have sufficient ADH for metabolizing alcohol

(3) Religious backgrounds

*d) **Developmental considerations: alcoholic fathers and their sons***

(1) Genetic research → children of alcoholics higher risk

(2) Primarily true with male relatives

(3) Sons of alcoholic fathers

*e) **Critical thinking in client care***

6. Clinical manifestations

*a) **Positive effects***

b) Consumed in excess

(1) Diminish ability to function and can ultimately lead to life threatening conditions

(2) Chronic use of alcohol can cause severe neurologic and psychiatric disorders

(3) Severe liver damage occurs with chronic alcohol abuse

(4) Chronic abuse of alcohol can damage many other systems

(5) Malnutrition

(a) Thiamine (B1) deficiency

(i) Thiamine depletion thought to cause Wernicke-Korsakoff syndrome

(a) Severe cognitive impairment

(b) Warnock's encephalopathy

(c) Korsakoff's psychosis → 80% of people with Wernicke's encephalopathy

(6) Altered sleep cycle

(a)

(7) Accidents

(a) Blood alcohol levels (BALs) highly predictive of CNS effects

(b) Legal level of intoxication 0.08% in US

(8) Tolerance

(a) Cross tolerance to general anesthetics, barbiturates, benzodiazepines and other CNS depressants

(b) If alcohol withdrawn abruptly → becomes overly excited

(c) See CLINICAL MANIFESTATIONS AND THERAPIES, p. 42

(9) Multisystem effects

(a) Blackouts

(b) Wernicke-Korsakoff (described previously)

(c) See Table 2-4 PYHSIOLOGIC COMPLICATIONS FROM ALCOHOL DEPENDENCE, p. 43

(10) Withdrawal

(a) 6–8 hours after the alcoholic's last drink

(b) Early symptoms include

(i) Irritability

(ii) Anxiety

(iii) Insomnia

(iv) Tremors

(v) Sweating

(vi) Mild tachycardia

(vii) Rare cases: seizures or visual, tactile, or auditory hallucinations

(c) Symptoms usually peak during the second day of abstinence

(d) Likely to show significant improvement by fourth or fifth day

(e) Symptoms worse for individuals who repeatedly withdraw from alcohol

(f) Alcohol withdrawal delirium: delirium tremens (DTs)

(i) Usually on days 2 and 3, may appear as late as 14 days after last drink

(ii) Confusion, disorientation, hallucinations, tachycardia, hypertension or hypotension, extreme tremors, agitation, diaphoresis and fever

(iii) Death may result from cardiovascular collapse of hyperthermia

(iv) Improved diagnosis and medical treatment has dropped mortality rate from 20% to 1%

(11) Overdose

(a) Signs of intoxication

(b) Results of intoxication

(i) Accidents

(ii) Falls

(iii) Alcohol poisoning

(iv) Large amounts of alcohol consumed within very short period of time

7. Collaboration

a) Team shares collaborative goal of helping the client achieve sobriety

8. Diagnostic tests

a) Breathalyzer is simplest BAL assessment

b) ***Symptoms (See Table 2-5, BLOOD ALCOHOL LEVELS AND SYMPTOMS, p. 44) at BALs***

c) ***Withdrawal assessment with high BAL***

(1) Medications started after BAL below a set norm

9. Treatment of withdrawal – Pharmacologic therapies

a) ***Symptomatic***

(1) Minimize adverse outcomes of withdrawal

(2) Avoid adverse effects of withdrawal medications

(3) Close monitoring

b) ***Symptom triggered approach***

(1) Less total medication

(2) Shorter duration of treatment

(3) Clinical Institute Withdrawal Assessment for Alcohol – medicate when score higher than 8

c) ***Medications for alcoholism***

(1) Disulfiram (Antabuse) – aversion therapy → intense vomiting if alcohol consumed

(2) Naltrexone (ReVia, Depade) – blocks pathway to brain that triggers feeling of pleasure with alcohol and other narcotics

d) ***Complementary and alternative medicine – calming effects***

(1) EEG biofeedback (neurotherapy)

(2) Yoga

C. Nursing process

1. Overview

a) ***Variety of settings***

b) ***Impaired senses and increased risk taking behaviors***

c) ***Intoxicated client***

d) ***Challenging for nurses***

(1) Nonjudgmental atmosphere

(2) Educate clients

(3) Support and encourage abstinence while assisting clients to make lifestyle changes

2. Assessment

a) Past alcohol use

(1) Polysubstance abuse

b) Medical history

(1) Concomitant physical or mental condition

(2) Current medications

(3) Allergies

(4) Overview of current mental status

(5) Psychosocial concerns

(6) Screening tools

(a) Michigan Alcohol Screening Test Brief Version—10 questions, self-administered

(b) CAGE—questionnaire is self report

(c) Nonthreatening questions

(d) Clinical Institute Withdrawal Assessment for Alcohol, Revised—10-item assessment tool

3. Diagnosis

a) Risk for Injury

b) Risk for violence

c) Ineffective denial

d) Ineffective coping

e) Imbalanced nutrition: less than body requirements

f) Chronic or situational low self-esteem

g) Deficient knowledge

h) Disturbed sensory perception

i) Disturbed thought processes

4. Plan

a) Goals depend on client needs

b) Client will admit alcohol is controlling his or her life

c) ***Client will agree to enter an alcohol treatment facility***

d) ***Client will experience no complications (or no further complications) as a result of alcohol abuse or alcohol withdrawal***

e) ***Client will obtain optimal nutritional status***

f) ***Client will remain sober***

g) ***Client will participate in support groups such as AA after discharge from treatment facility***

5. Implementation

a) ***Risk for Injury and Risk for Violence***

(1) Assess client's level of disorientation to determine specific risks to safety

(2) Knowledge of client's level of cognitive functioning necessary to develop appropriate plan of care

(3) Obtain drug history, urine and blood samples

(4) Place client in quiet private room → decrease excessive stimuli

(a) Not alone if excessive hyperactivity or suicidal ideation

(5) Frequently orient client to reality and environment

(a)

(6) Monitor vital signs every 15 minutes until stable

(7) Assess blood alcohol level

(8) Assess for signs of intoxication or withdrawal

b) ***Ineffective denial***

(1) Develop nonjudgmental, therapeutic nurse-client relationship

(2) Identify maladaptive behaviors or situations

c) ***Ineffective coping***

(1) Establish trusting nurse–client relationship

(2) Set limits on manipulative behavior, maintain consistency in responses

(3) Encourage client to verbalize feelings, fears, anxieties

(4) Explore methods of dealing with stressful situations other than resorting to alcohol use

d) ***Imbalanced nutrition: less than body requirements***

(1) Administer vitamins and dietary supplements as ordered – Vitamin B1

(2) Monitor lab work, report significant changes

(3) Collaborate with a dietitian to determine number of calories needed and realistic weight

(4) Document intake and output, calorie count

(5) Daily weights if necessary

(6) Teach importance of adequate nutrition

e) Chronic low or situational low self-esteem

(1) Spend time with client and convey attitude of acceptance

(2) Encourage client to accept responsibility for his/her behaviors and feelings

(3) Encourage client to focus on strengths and accomplishments

(4) Encourage participation in therapeutic group activities

(5) Offer recognition and positive feedback for actual achievements

(6) Teach assertiveness techniques and effective communication techniques

f) Deficient knowledge

(1) Assess client's level of knowledge and readiness to learn the effects of alcohol on the body

(2) Develop a teaching plan that includes measurable objectives

(3) Include significant others if possible

(4) Begin teaching with simple concepts and progress to more complex issues

(5) Interactive teaching strategies and written material

(6) Include

(a) Physiologic effects of alcohol

(b) Propensity for dependence

(c) Risks to fetus if client pregnant

g) Disturbed sensory perceptions

(1) Observe client for withdrawal symptoms, seizure precautions

(2) Monitor vital signs

(3) Provide supportive physical care during detoxification

(4) Assess level of orientation frequently; orient and reassure client

(5) Explain all interventions before approaching client

(6) Decrease external stimuli-dim lights, quiet environment

(7) Administer medications according to detoxification process

h) Disturbed thought processes

(1) Give positive reinforcement when thinking and behavior appropriate

(2) Use simple step-by-step instructions

(3) Express reasonable doubt if client relays suspicious or paranoid beliefs; reinforce accurate perceptions

(4) Do not argue with client experiencing delusions or hallucinations; convey acceptance that client believes situation but you do not see or hear what is not there

(5) Talk to the client about real events and real people

(6) Respond to feelings; reassure client

(7) Risk for relapse highest within first few months

(8) Assist clients in recognizing behaviors that lead to relapse:

(a) HALT acronym--Hungry, Angry, Lonely, Tired

6. Evaluation

a) Potential expected outcomes include

(1) Client controls anxiety to a tolerable level

(2) Client displays new coping mechanisms

(3) Client experiences no complications or new complications as a result of alcohol use or withdrawal

(4) Client accepts responsibility or how his behavior impacts the family unit

7. See NURSING CARE PLAN: A Client Experiencing Withdrawal from Alcohol, p. 49

D. Review

1. Relate: Link the Concepts

2. Refer: Go to MyNursingKit

3. Reflect: Case Study

Activities: Exemplar 2.1 Alcohol Abuse

1. **Individual**
   Assign students to review the Alcoholics Anonymous website. Have each student explore a specific area on the website (Information for professionals, About AA – Newsletter for professionals, AA as a resource for the health care professional, a message to correctional professionals, etc.). Students will share what they learned at their assigned site with the class. Discuss the value of Alcoholics Anonymous as a resource for nurses when caring for clients who abuse alcohol.

2. **Small Group Activity**
   Assign each group a common health problem related to chronic alcohol use or allow them to pick one of their choice (Wernicke's encephalopathy, cirrhosis of the liver, esophageal varices, peptic ulcer, etc.). The group will develop a visual presentation for the class explaining the link between alcohol use and the disease, the pathophysiology, etiology, and clinical manifestations along with a nursing plan of care for the client with this disease process.

3. **Large Group Activity**
   Invite a spokesperson from Alcoholics Anonymous or a local alcohol treatment facility to talk with the class about the needs of the alcoholic and how they can be most effective when providing nursing care. If possible, arrange for students to visit an Alcoholics Anonymous meeting or visit an alcohol treatment facility after hearing the speaker's lecture.

III. Exemplar 2.2 Nicotine Abuse

A. Overview

1. **Cigarette smoking single most preventable cause of death and disease in the US**
   a) ***443,000 deaths each year attributable to cigarette smoking***
   b) ***Does not count second hand smoke or chewing tobacco***
2. **Nicotine**
   a) ***Highly addictive***
   b) ***Enters body via lungs, oral mucous membranes***
   c) ***Legal, increasingly socially unacceptable***
3. **Commercial tobacco contains over 4000 chemicals**
   a) ***Cancer causing agents***
   b) ***Affects every organ system***
   c) ***See Table 2-6 COMMON CHEMICALS FOUND IN TOBACCO AND THEIR EFFECTS, p. 52***

B. Pathophysiology and etiology

1. **Stimulant**
   a) ***Low dose stimulates nicotinic receptors in brain to release dopamine and epinephrine - > vasoconstriction***
   b) ***Initially***
      (1) Increases respiration, mental alertness, cognitive ability → eventually depresses those responses
      (2) Moderate doses can cause tremors
      (3) High doses (acute poisoning) can cause convulsions and death
   c) ***Tolerance to nausea and dizziness, not to cardiovascular effects***
   d) ***Difficulty sleeping***
   e) ***Dependence results from chronic use***
      (1) Withdrawal symptoms
   f) ***Chronic health problems from smoking***
   g) ***Quitting difficult → release of dopamine reinforces the addictive craving for more***
2. **Etiology**

a) Most common form of recreational drug use—more than 1 billion people

b) Number one cause of preventable death and disease for both women and men

c) Related to low birth weight and premature births in pregnant smokers

d) Secondhand smoke

3. Risk factors

a) Most common

(1) Emotions

(2) Social pressure

(3) Alcohol use

(4) Lack of education

(5) Age

(6) Lower socioeconomic status

b) Heart disease leading risk

c) Increases risk for

(1) Lung, stomach, pancreas, colon, kidney and bladder cancers

(2) COPD

(3) Hypertension, stroke

(4) Macular degeneration, cataracts

(5) Peripheral vascular disease

(6) Graves disease, infertility, earlier menopause, dysmenorrheal, impotence

(7) Osteoporosis, degenerative disc disease

(8) Discolored teeth, fingernails

(9) Premature aging and wrinkling

(10) Bad breath, reduced sense of smell and taste,

(11) Gum disease

(12) Preterm labor, spontaneous abortion, low birth weight, SIDS and learning disorders

d) Clinical manifestations

(1) See CLINICAL MANIFESTATIONS AND THERAPIES, NICOTINE ABUSE, p. 53

4. **Collaboration**
   a) ***Support***
   b) ***Nicotine replacement therapy***
   c) ***Smoking cessation program***
   d) ***Complementary therapies***

C. Nursing process

1. **Nurses interact with nicotine addicted clients in wide range of settings**
   a) ***Acute care***
   b) ***Outpatient centers***
   c) ***Psychiatric facilities***
   d) ***Nonjudgmental approach***
      (1) See Box 2-4 EXAMPLES OF OPEN-ENDED QUESTIONS FOR ASSESSMENT, p.54
2. **Assessment**
   a) ***Smoking history***
   b) ***Substance use history***
   c) ***Medical history***
   d) ***Psychiatric history***
3. **Diagnosis—client specific (e.g., client with lung cancer vs. adolescent)**
   a) ***Risk for injury***
   b) ***Ineffective denial***
   c) ***Ineffective coping***
   d) ***Ineffective airway clearance***
   e) ***Anxiety***
4. **Plan—goals may include**
   a) ***Client will verbalize the negative effects, both short-term and cumulative, associated with smoking***
   b) ***Client will voice strategies for support with quitting if/when the client is ready to stop smoking***
   c) ***Client will identify three activities that can aid in avoiding nicotine use***
   d) ***Client will not experience complications as a result of nicotine use***

5. **Implementation**
   a) ***Serve as role model by not smoking***
   b) ***Provide educational information regarding dangers of smoking***
   c) ***Help make smoking socially unacceptable***
   d) ***Suggest resources such as hypnosis, lifestyle, and behavior modification to clients who want to stop smoking***
   e) ***Suggest resources to clients who want to quit smoking***
   f) ***Help young adults recognize and resist marketing efforts of tobacco companies***
6. **Evaluation—expected outcomes may include**
   a) ***Client describes feelings regarding nicotine use, abstinence, and methods of coping without use of nicotine***
   b) ***Client verbalizes negative effects on his life and lives of loved ones as a result of nicotine use***
   c) ***Client is free from injury or complications resulting from nicotine use***
   d) ***Client describes strategies that will or can be useful when beginning a program to quit smoking***
7. **Critical thinking in client care**
8. **See NURSING CARE PLAN: A CLIENT ABUSING NICOTINE, p. 55**
9. **Review**
10. **Relate: Link the Concepts**
11. **Refer: Go to MyNursingKit**
12. **Reflect: Case Study**

Activities: Exemplar 2.2 Nicotine Abuse

1. **Individual**
   Collect a nursing history and data assessment from a known smoker. You may choose a family member, friend, or client (if the client gives permission). Determine the person's interest in quitting, details regarding the person's smoking history, and a description of any failed attempt the person may have made to quit smoking. Using the data you collect, prepare a nursing care plan and submit for grading.

2. **Small Group**
   Each group will create a scenario demonstrating how they would help a client quit smoking or stop chewing tobacco. The group will then act out the scenario in front of the class. One member will play the role of the client, another the role of the nurse, and other members may play the roles of family or friends or whatever characters are required to support the scenario. The group will hand in a written teaching plan based on the scenario they enacted for the class. Encourage class participation regarding other approaches or comments that could have been useful in helping the client in the scenario.

3. **Large Group**
   Invite a former smoker to speak to the class about why the person started smoking, what motivated him or her to stop, assistive devices used when quitting, and how the person feels about his or her history of smoking. A question and answer period should be held after the discussion, followed by a class debate about how the smoking industry encourages people to start smoking.

IV. Exemplar 2.3 Prenatal Substance Exposure

A. Overview

1. **Fetus exposed to most of what mother consumes, uses, or inhales**
2. **First trimester**
   a) ***See Table 2-7 POSSIBLE EFFECTS OF SELECTED DRUGS OF ABUSE/ADDITION ON FETUS AND NEWBORN, p. 58***

B. Pathophysiology and etiology

1. **First trimester**
   a) ***Greatest potential for gross abnormalities → fetal organs first developing***
   b) ***Teratogenesis: 31 days after LMP to day 71***
2. **Substances commonly abused during pregnancy**
   a) ***Caffeine***
   b) ***Alcohol***
      (1) Fetal alcohol exposure
      (2) Fetal alcohol spectrum disorders => fetal alcohol syndrome
      (3) Maternal health undermined
      (4) Intrapartum
      (5) Breastfeeding
   c) ***Cocaine and crack***
      (1) Acts on nerve terminals to prevent reuptake of dopamine and norepinephrine
      (2) Taken IV or snorting powder form
      (3) Crack can be smoked → quicker, more intense high
      (4) Risks during pregnancy
         (a) Maternal
         (b) Pregnancy
         (c) Infant/toddler
         (d) Breastfeeding
   d) ***Marijuana***
      (1) Most widely used illicit drug among women

(2) Complicated to research

(3) No evidence that teratogenic

(4) Some infants exposed in utero appear to have withdrawal symptoms—trembling, excessive crying

e) Phencyclidine (PCP)

f) MDMA (Ecstasy)

g) Heroin

h) Methadone

i) Tobacco

(1) Most significant, modifiable cause of poor pregnancy outcome

(2) Strong association with LBW infants

(3) Increased risk of preterm birth, premature rupture of membranes, fetal demise, placenta previa, abruptio placentae

(4) Pregnant smoker may also participate in other unhealthy behaviors

(5) Smoking, prenatal and after birth, associated with increased risk of SIDS

(6) Risks of secondhand smoke

(7) Mechanism unknown

(8) More women quitting during pregnancy, though many restart within first year after birth

(9) Recommend any decrease in smoking

3. Etiology

a) Drug use

(1) 4% of pregnant women aged 15–44 report using illicit drug in last month, compared to 10% of nonpregnant women (2007)

(2) Varies with age and race

b) Alcohol use

4. Risk factors

a) Psychosocial

(1) See Box 2-5 RISK FACTORS FOR SUBSTANCE ABUSE, p. 62

b) FDA Categories for prenatal substance exposure risks

5. Collaboration

a) ***Care most effective***

b) ***Team shares information during all phases of treatment***

6. **Complementary therapies**

C. Nursing process

1. **Assessment**

   a) ***May be difficult to identify → women may be reluctant to volunteer information***

   b) ***Subtle signs of drug use***

   c) ***Nonjudgmental approach using open-ended questions***

   d) ***Known substance abuse***

2. **Diagnosis**

   a) ***Imbalanced nutrition: less than body requirements***

   b) ***Risk for infections***

   c) ***Risk for ineffective health maintenance***

3. **Plan**

   a) ***Ideal is prevention of substance abuse***

   b) ***Client immediately reduces number of cigarettes smoked to ____and develops plan to quit smoking within 2 weeks***

   c) ***Client attends counseling sessions and/or drug treatment program within 48 hours***

   d) ***Client explains effects of substance being abused on fetal health***

4. **Implementation**

   a) ***Counsel all women about effects of alcohol in pregnancy***

   b) ***Prenatal care focuses on ongoing assessment and client teaching***

   c) ***Establish relationship of trust and support***

   d) ***Preparation for labor and birth***

      (1) Discuss pain medication

      (2) Immediate care for newborn

5. **Evaluation**

   a) ***Woman avoids substances and situations that pose risk to her or that of child***

   b) ***Woman seeks regular prenatal care***

   c) ***Woman describes impact of substance abuse on herself and unborn child***

d) Woman gives birth to healthy infant

e) Woman agrees to accept a referral

D. Review

1. **Relate: Link the Concepts**
2. **Ready: Go to Companion Skills Manual**
3. **Refer: Go to MyNursingKit**
4. **Reflect: Case Study**

Activities: Exemplar 2.3 Prenatal Substance Exposure

5. **Individual**
   Students will be assigned a specific substance commonly abused by pregnant women in the United States and develop a paper outlining etiology, pathophysiology of the effects of the drug on both the mother and the fetus throughout the stages of development, and a nursing plan of care to include specific assessments, diagnoses, goals, implementations, and evaluating outcomes for the pregnant client abusing this specific drug.

6. **Small Group**
   Divide students into small groups and assign each group a case study of a pregnant woman at a specific gestational age that abuses a specific drug or group of drugs (e.g., one client may be 12 weeks pregnant abusing nicotine, alcohol, and marijuana). Have them develop a teaching plan to promote abstinence and help the client to make healthier choices throughout her pregnancy. The students will then present their teaching plan to the class and lead a question and answer period about their assigned client.

7. **Large Group**
   Request permission for students to attend a 12-step program meeting, ideally one that supports pregnant women, and observe the information shared by attendees. Meet with the students in advance to inform them of their role, the importance of confidentiality of members attending the meeting, and whether they will be allowed to ask questions of the participants.

V. Exemplar 2.4 Substance Abuse

A. Overview

1. **Use of any chemical inconsistent with norms despite adverse effects**
   a) ***Anxiety and depressive disorders frequently occur with substance abuse***
   b) ***<90% of people who commit suicide have depressive or substance abuse disorder***
   c) ***9.4% of American population aged 12 or older reported problems with substance dependence or abuse***
   d) ***Pathologic use of chemical classified as psychoactive substance related disorder (See Box 2-7 DSM-IV-TR: DIAGNOSTIC CRITERIA FOR SUBSTANCE ABUSE VERSUS SUBSTANCE DEPENDENCE, p. 67)***
   e) ***Recurrent use that results in a failure to manage work, school, or home roles***
   f) ***Use in hazardous situations such as driving a car***
   g) ***Use resulting in substance-related legal problems or related interpersonal problems***
2. **Substance dependence:**
   a) ***Occurs when the client can no longer control use of the substance***
   b) ***Continues to use despite adverse effects and experiences withdrawal symptoms without continued use of the substance***
   c) ***Substance dependent individuals experience tolerance requiring increasing quantities of the substance to meet same level of need***
   d) ***Spend great deal of time obtaining drugs and limit their usual social, occupational, recreational activities***
   e) ***Need for drug is so powerful that it drives the addict to neglect children, responsibilities and law in effort to obtain drugs***
3. **Substance withdrawal symptoms**
   a) ***Physiologic, behavioral, cognitive, affective***
   b) ***After reduction or discontinuance of a drug that has been used heavily over a long period of time***
   c) ***Withdrawal lasts several days, may put client in medical danger***
   d) ***Tolerance is cumulative state in which a particular dose of the chemical elicits a smaller response than before***
   e) ***Individual needs higher and higher doses to obtain the desired effect***
4. **Chemical dependence is a complex, chronic progressive disease that can be fatal**
   a) ***Composed of several biochemical processes that are subject to voluntary control***

b) Psychologic, sociologic and spiritual aspects to chemical dependence

c) Most people chemically dependent are engaged in polysubstance abuse

B. Pathophysiology and etiology

1. Humans tend to seek pleasure and avoid stress and pain

a) Endogenous opioid system may be involved in development and maintenance of addictive behaviors

2. Etiology

a) Statistics

(1) In U.S. costs $414 billion a year

(2) Treatment, health-related problems

(3) Absenteeism, lost productivity

(4) Drug-related crime and incarceration

(5) Education and prevention

(6) 16,000 annual deaths

(7) 50% of motor vehicle fatalities

(8) 50% of all violent deaths

(9) 40–60% seeking treatment are court ordered

(10) Relapse rate in first year is 90%

(11) 46–50% of all Americans 12 and older have tried an illegal drug at least once in their life

b) Impaired Nurse

(1) Identified as high risk

(2) Leads to impaired practice

(a) See Table 2-8 WARNING SIGNS OF IMPAIRED NURSES IN THE WORKPLACE, p. 69

(3) Increased shame, guilt in impaired nurse

(4) Requirements for impaired nurses

3. Risk factors

a) Genetic factors—DRD2 A1 allele identified

b) Biologic factors-dopamine and dopamine receptor sites

c) Psychologic factors

d) Sociocultural factors

4. Clinical manifestations

a) Caffeine

b) Cannabis —marijuana

(1) Physiologic effects

(2) Subjective effects

c) CNS depressants

(1) Barbiturates, benzodiazepines, paraldehyde, meprobamate, chloral hydrate subject to abuse

(2) Cross dependence exists

(3) Cross tolerance to alcohol and general anesthetics

(4) Chronic use → tolerance of subjective effects but not respiratory depression

(5) Physiologic effects

(6) Benzodiazepines drugs of choice for anxiety

d) Psychostimulants: cocaine, amphetamines

(1) High abuse potential

(2) Subjective effect: euphoria → leading to addiction

(3) Cocaine

(4) Amphetamines

(a) Physiologic effects

(b) Subjective/behavioral

(c) Dependence more psychologic than physical

(d) Withdrawal

(e) Treatment for addiction

(i) Cognitive-behavioral therapy (CBT)

(ii) Culturally tailored CBT most effective

(5) Opiates

(a) Heroin

(b) Methadone → synthetic opiate to treat chronic pain, addiction to opiates

(6) Hallucinogens

(a) *Psychedelics → PCP, MDMA, LSD, mescaline, dimethyltryptamine (DMT), psilocin*

(b) *PCP initially used as anesthetic → severe side effects discontinued in humans*

(c) *MDMA (Ecstasy) club drug*

(d) *LSD*

(7) Inhalants

(a) *Anesthetics - Nitrous oxide, laughing gas*

(b) *Volatile nitrites—amyl nitrite, butyl nitrite, isobutyl nitrite*

(c) *Organic solvents*

e) Withdrawal

(1) Symptoms from opiates/stimulants unpleasant not life-threatening

(2) Acute cocaine withdrawal by cause client to become suicidal

(3) See Table 2-10 DRUGS USED IN THE TREATMENT OF SUBSTANCE WITHDRAWAL/ABUSE, p. 75

C. Collaboration

1. Interdisciplinary team

a) Specializing in psychiatric and substance abuse disorders

2. Therapies

a) Detoxification

b) Aversion therapy

c) Group and/or individual psychotherapy

d) Psychotropic medications

e) Cognitive-behavioral strategies

f) Family counseling

g) Self-help groups

3. Inpatient or out patient

4. Overdose is life threatening → stabilize medically prior to addiction treatment

D. Diagnostic testing

1. Body fluid testing

a) ***Blood, urine most common***

b) ***Saliva, perspiration, hair***

c) ***Serum drug levels in ED***

2. **Urine drug screening (UDS)**

a) ***Noninvasive***

b) ***Most common***

c) ***Prospective employees, athletes***

d) ***Used in court***

e) ***Time in blood/urine dose and metabolite dependent***

3. **Emergency care for overdose**

a) ***See Table 2-11 SIGNS AND TREATMENT OF OVERDOSE AND WITHDRAWAL, p. 76***

E. Nursing process

1. **Variety of settings**

a) ***Alcohol/drug treatment programs***

b) ***Hospital emergency departments***

c) ***Occupational health/Community health nurses***

d) ***Urgent care, pain clinics, ambulatory care centers***

e) ***Nonjudgmental approach***

f) ***Educate client***

2. **Assessment**

a) ***Comprehensive approach***

b) ***History of past substance use***

c) ***Medical and psychiatric history***

(1) All meds, OTC and R_x

(2) Allergies

(3) Mental status

(4) Psychosocial issues

(5) Screening tools

(a) Brief Drug Abuse Screening Test (B-DAST)

(b) Clinical Opiate Withdrawal Scale (COWS)

3. **Diagnosis**
   - ***a) Risk for injury***
   - ***b) Risk for violence***
   - ***c) Ineffective denial***
   - ***d) Ineffective coping***
   - ***e) Imbalanced nutrition: less than body requirements***
   - ***f) Chronic or situational low self-esteem***
   - ***g) Deficient knowledge***
   - ***h) Disturbed sensory perceptions***
   - ***i) Disturbed thought processes***
4. **Plan**
   - ***a) Short term goals***
     - (1) Client will admit having a substance abuse problem and that the client has lost control of his/her life as result
     - (2) Client will seek help to stop using the substance
     - (3) Client will suffer no complications of drug withdrawal symptoms
     - (4) Client will enter drug rehabilitation program to change behavior
   - ***b) Long-term goals***
     - (1) Client will explore impact of addiction on family/job/friends
     - (2) Client will describe and recognize use of denial in avoiding problems related to substance abuse
     - (3) Client will change thinking and behavior as result of understanding negative consequences of substance abuse
     - (4) Client will regularly attend support group to maintain sobriety
     - (5) Client will remain free of substance/maintain sobriety
5. **Implementation**
   - ***a) Risk for injury and Risk for violence***
     - (1) Assess level of disorientation to determine specific risks to safety of client and others
     - (2) Obtain drug history, urine and blood samples

(3) Place client in quiet, private room → decrease excessive stimulation

(4) Do not leave client alone if excessive hyperactivity/suicidal ideation present

(5) If disoriented → frequently orient to reality and environment

(6) Ensure client has no access to potentially harmful objects

(7) Monitor VS every 15 minutes until stable

(8) Reevaluate as instructed by treating physician

(9) Ineffective denial

(10) Be genuine, respectful, honest, convey attitude of acceptance → develop nonjudgmental, therapeutic nurse-client relationship

(11) Identify maladaptive behaviors/siltation's with client and discuss how substance use may have been a contributing factor to personal problems

(12) Encourage client participation in therapeutic group activities such as Narcotics Anonymous

b) Ineffective coping

(1) Set limits on manipulative behavior → maintain consistency in responses

(2) Encourage client to verbalize feelings, fears, anxieties

(3) Explore methods of dealing with stressful situations

(4) Teach healthy coping mechanisms → help client adapt to stress without resorting to drug use

c) Imbalanced nutrition: less than body requirements

(1) Administer vitamins/dietary supplements as ordered

(2) Monitor lab work → report significant changes to physician

(3) Collaborate with dietitian to determine calories needed, realistic weight

d) Chronic low or situational low self-esteem

(1) Spend time with client and convey attitude of acceptance

(2) Encourage to accept responsibility for own behaviors and feelings

(3) Encourage to focus on strengths and accomplishments; minimize attention to negative ruminations

(4) Encourage participation in therapeutic group activities

(5) Teach assertiveness and effective communication techniques

e) Deficient knowledge

(1) Assess level of knowledge and readiness to learn

(2) Develop teaching plan that includes measurable objectives

(a) Short-term goals → success at early stage

(b) Include significant others if possible

(3) Begin with simple concepts → progress to more complex

(4) Interactive teaching strategies, written materials appropriate to educational level

(5) Include effects of substances: physiologic, psychologic, risks to fetus

f) Disturbed sensory perceptions

(1) Observe for withdrawal symptoms

(2) Monitor VS

(3) Provide adequate nutrition and hydration

(4) Assess level of orientation frequently

(5) Orient and reassure client of safety in presence of hallucinations, delusions, illusions

(6) Explain all interventions before approaching client

(7) Avoid loud noises, talk softly, decrease external stimuli

(8) Administer meds according to detoxification schedule

g) Disturbed thought processes

(1) Give positive reinforcement when thinking and behavior appropriate

(2) Use simple, step by step instructions, face to face interaction when communicating with client

(3) Express reasonable doubt if client relays suspicious/paranoid beliefs

(4) Reinforce accurate perception of people/situations

(5) Do not argue with delusions/hallucinations → convey acceptance that client believes it to be true

(6) Talk to client about real events, people

(7) Respond to feelings, reassure client of his safety

h) Community resources

(1) Individual, group, family therapy

(2) Detoxification settings

(3) Less restrictive structured environments → maintain presence in community

(4) Self help groups—AA, NA

6. **Evaluation**

   a) ***Client suffers no complication from withdrawal***

   b) ***Admits problem with substance and seeks help***

   c) ***Enters substance abuse program***

   d) ***Can describe choices that contributed to substance abuse***

   e) ***Attends support group meetings daily after leaving rehab***

   f) ***Remains substance free***

F. Review: Substance Abuse

G. Relate: Link the Concepts

H. Refer: Go to MyNursingKit

I. Reflect: Case Study

Activities: Exemplar 2.4 Substance Abuse

1. **Individual:**
   Assign students to investigate the State Board of Nursing website to determine options available to help nurses with a substance abuse issue and the impact on the nurse's license. Have them write a short paper explaining their interpretation of their findings

2. **Small Group**
   Assign each group to explore one treatment alternative available in your community for the client with a substance abuse problem and develop a presentation for the class on their findings. Students should include treatment modalities offered, length of program, cost, type of follow-up care provided, and recidivism rate for those who complete the program.

3. **Large Group**
   Hold a discussion with the class regarding their feelings about those who abuse drugs—both health care professionals and clients—with the goal of helping students to recognize their bias and create a nonjudgmental approach to caring for clients with addiction behaviors.