

ALCOHOL: ACUTE WITHDRAWAL

Alcohol, a CNS depressant drug, is used socially in our society for many reasons: to enhance the flavor of food, to encourage relaxation and conviviality, for celebrations, and as a sacred ritual in some religious ceremonies. Therapeutically, it is a major ingredient in many OTC/prescription medications. It can be harmless, enjoyable, and sometimes beneficial when used responsibly and in moderation. Like other mind-altering drugs, however, it has the potential for misuse and, in fact, is the most widely abused drug in the United States (research suggests 5%–10% of the adult population) and is potentially fatal. Alcohol abuse often exists in combination with a psychiatric problem, commonly referred to as dual diagnosis.

CARE SETTING

May be inpatient on a behavioral unit or outpatient in community programs. Although patients are not generally admitted to the acute care setting with this diagnosis, withdrawal from alcohol may occur secondarily during hospitalization for other illnesses/conditions. A short hospital stay may be required during the acute phase because of severity of general condition, or a delayed discharge from acute care can be the result of alcohol withdrawal beginning within 6–48 hr of admission.

RELATED CONCERNS

Cirrhosis of the liver
Heart failure: chronic
Psychosocial aspects of care
Substance dependence/abuse rehabilitation
Upper gastrointestinal/esophageal bleeding

Patient Assessment Database

Data depend on the duration/extent of use of alcohol, concurrent use of other drugs, degree of organ involvement, and presence of other pathology, such as mental/physical illness.

ACTIVITY/REST

May report: Difficulty sleeping, not feeling well rested

CIRCULATION

May exhibit: Generalized tissue edema (due to protein deficiencies)
Peripheral pulses weak, irregular, or rapid
Hypertension common in early withdrawal stage but may become labile/progress to hypotension
Tachycardia common during acute withdrawal; numerous dysrhythmias may be identified

EGO INTEGRITY

May report: Feelings of guilt/shame; defensiveness about drinking
Denial, rationalization
Multiple stressors/losses (relationships, employment, finances)
Use of alcohol to deal with life stressors, boredom, depression

ELIMINATION

May report: Diarrhea
May exhibit: Bowel sounds varied (may reflect gastric complications, e.g., hemorrhage)

FOOD/FLUID

May report: Nausea/vomiting; food intolerance
May exhibit: Gastric distension; ascites, liver enlargement (seen in cirrhosis)
Muscle wasting, dry/dull hair, swollen salivary glands, inflamed buccal cavity, capillary fragility (malnutrition)

Bowel sounds varied (reflecting malnutrition, electrolyte imbalances, general bowel dysfunction)

NEUROSENSORY

- May report:** “Internal shakes”
Headache, dizziness, blurred vision; “blackouts”
- May exhibit:** Psychopathology, e.g., paranoid schizophrenia, major depression (may indicate dual diagnosis)
Level of consciousness/orientation varies, e.g., confusion, stupor, hyperactivity, distorted thought processes, slurred/incoherent speech
Memory loss/confabulation
Affect/mood/behavior: May be fearful, anxious, easily startled, inappropriate, silly, euphoric, irritable, physically/verbally abusive, depressed, and/or paranoid
Hallucinations: Visual, tactile, olfactory, and auditory, e.g., picking items out of air or responding verbally to unseen person/voices
Eye examination: Nystagmus (associated with cranial nerve palsy); pupil constriction (may indicate CNS depression); arcus senilis—ringlike opacity of the cornea (although normal in aging populations, suggests alcohol-related changes in younger individuals)
Fine motor tremors of face, tongue, and hands; seizures (commonly grand mal)
Gait unsteady (ataxia), may be caused by thiamine deficiency or cerebellar degeneration (Wernicke’s encephalopathy)

PAIN/DISCOMFORT

- May report:** Constant upper abdominal pain and tenderness radiating to the back (pancreatic inflammation)

RESPIRATION

- May report:** History of smoking, recurrent/chronic respiratory problems
- May exhibit:** Tachypnea (hyperactive state of alcohol withdrawal)
Cheyne-Stokes respirations or respiratory depression
Breath sounds diminished, adventitious sounds (suggest pulmonary complications, e.g., respiratory depression, pneumonia)

SAFETY

- May report:** History of recurrent trauma such as falls, fractures, lacerations, burns, blackouts, or motor vehicle crashes
- May exhibit:** Skin: Flushed face/palms of hands; scars, ecchymotic areas; cigarette burns on fingers, spider nevus (impaired portal circulation), fissures at corners of mouth (vitamin deficiency)
Fractures healed or new (signs of recent/recurrent trauma)
Temperature elevation (dehydration and sympathetic stimulation); flushing/diaphoresis (suggests presence of infection)
Suicidal ideation/suicide attempts (some research suggests alcoholic suicide attempts are 30% higher than national average for general population)

SOCIAL INTERACTION

- May report:** Frequent sick days off from work/school; fighting with others, arrests (disorderly conduct, motor vehicle violations/driving under the influence [DUI])
Denial that alcohol intake has any significant effect on present condition
Dysfunctional family system of origin (generational involvement); problems in current relationships
Mood changes affecting interactions with others

TEACHING/LEARNING

- May report:** Family history of alcoholism
History of alcohol and/or other drug use/abuse

Ignorance and/or denial of addiction to alcohol, or inability to cut down or stop drinking despite repeated efforts; previous periods of abstinence/withdrawal
Large amount of alcohol consumed in last 24–48 hr
Previous hospitalizations for alcoholism/alcohol-related diseases, e.g., cirrhosis, esophageal varices

Discharge plan considerations: **DRG projected mean length of inpatient stay: 4.9 days**
May require assistance to maintain abstinence and begin to participate in rehabilitation program
Refer to section at end of plan for postdischarge considerations.

DIAGNOSTIC STUDIES

Blood alcohol/drug levels: Alcohol level may/may not be severely elevated, depending on amount consumed, time between consumption and testing, and the degree of tolerance, which varies widely. In the absence of elevated alcohol tolerance, blood levels in excess of 100 mg/dL are associated with ataxia; at 200 mg/dL, patient is drowsy and confused; respiratory depression occurs with blood levels of 400 mg/dL, and death is possible. In addition to alcohol, numerous controlled substances may be identified in a poly-drug screen, e.g., amphetamine, cocaine, morphine, oxycodone (Percodan), methaqualone (Quaalude).

CBC: Decreased Hb/Hct may reflect such problems as iron-deficiency anemia or acute/chronic GI bleeding. WBC count may be increased with infection or decreased if immunosuppressed.

Glucose/ketones: Hyperglycemia/hypoglycemia may be present, related to pancreatitis, malnutrition, or depletion of liver glycogen stores. Ketoacidosis may be present with/without metabolic acidosis.

Electrolytes: Hypokalemia and hypomagnesemia are common.

Liver function tests: LDH, AST, ALT, and amylase levels may be elevated, reflecting liver or pancreatic damage.

Nutritional tests: Albumin is low and total protein may be decreased. Vitamin deficiencies are usually present, reflecting malnutrition/malabsorption.

Other screening studies (e.g., hepatitis, HIV, TB): Depends on general condition, individual risk factors, and care setting.

Urinalysis: Infection may be identified; ketones may be present, related to breakdown of fatty acids in malnutrition (pseudodiabetic condition).

Chest x-ray: May reveal right lower lobe pneumonia (malnutrition, depressed immune system, aspiration) or chronic lung disorders associated with tobacco use.

ECG: Dysrhythmias, cardiomyopathies, and/or ischemia may be present because of direct effect of alcohol on the cardiac muscle and/or conduction system, as well as effects of electrolyte imbalance.

Addiction Severity Index (ASI): An assessment tool that produces a “problem severity profile” of patient, including chemical, medical, psychological, legal, family/social, and employment/support aspects, indicating areas of treatment needs.

NURSING PRIORITIES

1. Maintain physiological stability during acute withdrawal phase.
2. Promote patient safety.
3. Provide appropriate referral and follow-up.
4. Encourage/support SO involvement in “Intervention” (confrontation) process.
5. Provide information about condition/prognosis and treatment needs.

DISCHARGE GOALS

1. Homeostasis achieved.
2. Complications prevented/resolved.
3. Sobriety being maintained on a day-to-day basis.
4. Ongoing participation in rehabilitation program/attending group therapy, e.g., Alcoholics Anonymous.
5. Condition, prognosis, and therapeutic regimen understood.
6. Plan in place to meet needs after discharge.

This plan of care is to be used in conjunction with CP: Substance Dependence/Abuse Rehabilitation.

NURSING DIAGNOSIS: Breathing Pattern, risk for ineffective

Risk factors may include

Direct effect of alcohol toxicity on respiratory center and/or sedative drugs given to decrease alcohol withdrawal symptoms

Tracheobronchial obstruction

Presence of chronic respiratory problems, inflammatory process

Decreased energy/fatigue

Possibly evidenced by

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Respiratory Status: Ventilation (NOC)

Maintain effective breathing pattern with respiratory rate within normal range, lungs clear; be free of cyanosis and other signs/symptoms of hypoxia.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Respiratory Monitoring (NIC)</p> <p>Independent</p> <p>Monitor respiratory rate/depth and pattern as indicated. Note periods of apnea, Cheyne-Stokes respirations.</p> <p>Auscultate breath sounds. Note presence of adventitious sounds, e.g., rhonchi, wheezes.</p>	<p>Frequent assessment is important because toxicity levels may change rapidly. Hyperventilation is common during acute withdrawal phase. Kussmaul's respirations are sometimes present because of acidotic state associated with vomiting and malnutrition. However, marked respiratory depression can occur because of CNS depressant effects of alcohol if acute intoxication is present. This may be compounded by drugs used to control alcohol withdrawal symptoms (AWS).</p> <p>Patient is at risk for atelectasis related to hypoventilation and pneumonia. Right lower lobe pneumonia is common in alcohol-debilitated patients and is often due to chronic aspiration. Chronic lung diseases are also common, e.g., emphysema, bronchitis.</p>
<p>Airway Management (NIC)</p> <p>Elevate head of bed.</p> <p>Encourage cough/deep-breathing exercises and frequent position changes.</p> <p>Have suction equipment, airway adjuncts available.</p>	<p>Decreases potential for aspiration; lowers diaphragm, enhancing lung inflation.</p> <p>Facilitates lung expansion and mobilization of secretions to reduce risk of atelectasis/pneumonia.</p> <p>Sedative effects of alcohol/drugs potentiate risk of aspiration, relaxation of oropharyngeal muscles, and respiratory depression, requiring intervention to prevent respiratory arrest.</p>

ACTIONS/INTERVENTIONS	RATIONALE
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<p>Airway Management (NIC)</p> <p>Collaborative</p> <p>Administer supplemental oxygen if necessary.</p> <p>Review serial chest x-rays, ABGs/pulse oximetry as available/indicated.</p>	<p>Hypoxia may occur with CNS/respiratory depression.</p> <p>Monitors presence of secondary complications such as atelectasis/pneumonia; evaluates effectiveness of respiratory effort, identifies therapy needs.</p>
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<p>NURSING DIAGNOSIS: Cardiac Output, risk for decreased</p> <p>Risk factors may include</p> <p>Direct effect of alcohol on the heart muscle</p> <p>Altered systemic vascular resistance</p> <p>Electrical alterations in rate, rhythm, conduction</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Circulation Status (NOC)</p> <p>Display vital signs within patient’s normal range; absence of/reduced frequency of dysrhythmias.</p> <p>Demonstrate an increase in activity tolerance.</p>
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<p>ACTIONS/INTERVENTIONS</p> <p>Hemodynamic Regulation (NIC)</p> <p>Independent</p> <p>Monitor vital signs frequently during acute withdrawal.</p> <p>Monitor cardiac rate/rhythm. Document irregularities/dysrhythmias.</p> <p>Monitor body temperature.</p>	<p>RATIONALE</p> <p>Hypertension frequently occurs in acute withdrawal phase. Extreme hyperexcitability, accompanied by catecholamine release and increased peripheral vascular resistance, raises BP and heart rate; however, BP may become labile/progress to hypotension. <i>Note:</i> Patient may have underlying cardiovascular disease, which is compounded by alcohol withdrawal.</p> <p>Long-term alcohol abuse may result in cardiomyopathy/HF. Tachycardia is common because of sympathetic response to increased circulating catecholamines. Irregularities/dysrhythmias may develop with electrolyte shifts/imbalance. All these may have an adverse effect on cardiac function/output.</p> <p>Elevation may occur because of sympathetic stimulation, dehydration, and/or infections, causing vasodilation and compromising venous return/cardiac output.</p>
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<p>ACTIONS/INTERVENTIONS</p> <p>Hemodynamic Regulation (NIC)</p>	<p>RATIONALE</p>
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<p>Independent</p> <p>Monitor I&O. Note 24-hr fluid balance.</p> <p>Be prepared for/assist in cardiopulmonary resuscitation.</p> <p>Collaborative</p> <p>Monitor laboratory studies, e.g., serum electrolyte levels.</p> <p>Administer fluids and electrolytes, as indicated.</p> <p>Administer medications as indicated, e.g.: Clonidine (Catapres), atenolol (Tenormin);</p> <p>Potassium.</p>	<p>Preexisting dehydration, vomiting, fever, and diaphoresis may result in decreased circulating volume that can compromise cardiovascular function. <i>Note:</i> Hydration is difficult to assess in the alcoholic patient because the usual indicators are not reliable, and overhydration is a risk in the presence of compromised cardiac function.</p> <p>Causes of death during acute withdrawal stages include cardiac dysrhythmias, respiratory depression/arrest, oversedation, excessive psychomotor activity, severe dehydration or overhydration, and massive infections. Mortality for unrecognized/untreated delirium tremens (DTs) may be as high as 25%.</p> <p>Electrolyte imbalance, e.g., potassium/magnesium, potentiate risk of cardiac dysrhythmias and CNS excitability.</p> <p>Severe alcohol withdrawal causes patient to be susceptible to fluid losses (associated with fever, diaphoresis, and vomiting) and electrolyte imbalances, especially potassium and magnesium, and glucose.</p> <p>Although the use of benzodiazepines is often sufficient to control hypertension during initial withdrawal from alcohol, some patients may require more specific therapy. <i>Note:</i> Atenolol and other [beta]-adrenergic blockers may speed up the withdrawal process and eliminate tremors, as well as lower the heart rate, blood pressure, and body temperature.</p> <p>Corrects deficits that can result in life-threatening dysrhythmias.</p>
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<p>NURSING DIAGNOSIS: Injury, risk for [specify]</p> <p>Risk factors may include</p> <p>Cessation of alcohol intake with varied autonomic nervous system responses to the system's suddenly altered state</p> <p>Involuntary clonic/tonic muscle activity (seizures)</p> <p>Equilibrium/balancing difficulties, reduced muscle and hand/eye coordination</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Risk Control (NOC)</p> <p>Demonstrate absence of untoward effects of withdrawal.</p> <p>Experience no physical injury.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Substance Use Treatment: Alcohol Withdrawal (NIC)</p> <p>Independent</p> <p>Identify stage of AWS (alcohol withdrawal syndrome): Stage I is associated with signs/symptoms of hyperactivity(e.g., tremors, sleeplessness, nausea/vomiting, diaphoresis, tachycardia, hypertension). Stage II is manifested by increased hyperactivity plus hallucinations and/or seizure activity. Stage III symptoms include DTs and extreme autonomic hyperactivity with profound confusion, anxiety, insomnia, fever.</p> <p>Monitor/document seizure activity. Maintain patent airway. Provide environmental safety, e.g., padded side rails, bed in low position.</p> <p>Check deep-tendon reflexes. Assess gait, if possible.</p> <p>Assist with ambulation and self-care activities as needed.</p> <p>Provide for environmental safety when indicated. [Refer to ND: Sensory Perception, disturbed, (specify) following.]</p> <p>Collaborative</p> <p>Administer medications as indicated e.g.:</p> <ul style="list-style-type: none"> Benzodiazepines (BZDs), e.g., oxazepam (Serax), chlordiazepoxide (Librium), lorazepam (Ativan), diazepam (Valium), clonazepam (Klonopin), clorazepate (Tranxene); 	<p>Alcohol withdrawal usually begins 3–36 hr after the last drink. Prompt recognition and intervention may halt progression of symptoms and enhance recovery/improve prognosis. In addition, recurrence/progression of symptoms indicates need for changes in drug therapy/more intense treatment to prevent death. DTs may not present until 2–3 days after last alcohol intake, usually lasting 1–5 days, but may persist for up to 10 days.</p> <p>Grand mal seizures are most common and may be related to decreased magnesium levels, hypoglycemia, elevated blood alcohol, or history of head trauma/preexisting seizure disorder. <i>Note:</i> Seizures generally occur between 12 and 48 hr following cessation of alcohol intake, and in the absence of history of/other pathology causing seizures, they usually stop spontaneously, requiring only symptomatic treatment.</p> <p>Reflexes may be depressed, absent, or hyperactive. Peripheral neuropathies are common, especially in malnourished patient. Ataxia (gait disturbance) is associated with Wernicke’s syndrome (thiamine deficiency) and cerebellar degeneration.</p> <p>Prevents falls with resultant injury.</p> <p>May be required when equilibrium, hand/eye coordination problems exist.</p> <p>BZDs are commonly used to control neuronal hyperactivity because of their minimal respiratory and cardiac depression and anticonvulsant properties. Studies have also shown that these drugs can prevent progression to more severe states of withdrawal. IV/PO administration is preferred route because IM absorption is unpredictable. Muscle-relaxant qualities are particularly helpful to patient in controlling “the shakes,” trembling, and ataxic quality of movements. BZDs are usually given around the clock, and some patients may initially require large doses to achieve desired effect, and then drugs may be tapered and discontinued, usually within 96 hr. <i>Note:</i> These agents are used cautiously in patients with known hepatic disease because they are metabolized by the liver, and therefore Serax may be preferred because it has a shorter half-life.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Substance Use Treatment: Alcohol Withdrawal (NIC)</p> <p>Collaborative</p> <p>Anticonvulsants, e.g., carbamazepine (Tegretol);</p> <p>Haloperidol (Haldol);</p> <p>Thiamine;</p> <p>Magnesium sulfate.</p>	<p>Anticonvulsant drugs may be used to prevent seizure activity.</p> <p>May be used in conjunction with BZDs for patients experiencing hallucinations.</p> <p>Thiamine deficiency (common in alcohol abuse) may lead to neuritis or polyneuropathy, Wernicke's encephalopathy, and/or Wernicke-Korsakoff syndrome.</p> <p>Reduces tremors and seizure activity by decreasing neuromuscular excitability.</p>

<p>NURSING DIAGNOSIS: Sensory Perception, disturbed (specify)</p> <p>May be related to</p> <p>Chemical alteration: exogenous (e.g., alcohol consumption/sudden cessation) and endogenous (e.g., electrolyte imbalance, elevated ammonia and BUN)</p> <p>Sleep deprivation</p> <p>Psychological stress (anxiety/fear)</p> <p>Possibly evidenced by</p> <p>Disorientation to time, place, person, or situation</p> <p>Changes in usual response to stimuli; exaggerated emotional responses, change in behavior</p> <p>Bizarre thinking</p> <p>Listlessness, irritability, apprehension, activity associated with visual/auditory hallucinations</p> <p>Fear/anxiety</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Cognitive Ability (NOC)</p> <p>Regain/maintain usual level of consciousness.</p> <p>Distorted Thought Control (NOC)</p> <p>Report absence of/reduced hallucinations.</p> <p>Identify external factors that affect sensory-perceptual abilities.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Substance Use Treatment: Alcohol Withdrawal (NIC)</p> <p>Independent</p> <p>Assess level of consciousness; ability to speak, response to stimuli/commands.</p> <p>Observe behavioral responses, e.g., hyperactivity, disorientation, confusion, sleeplessness, irritability.</p> <p>Note onset of hallucinations. Document as auditory, visual, and/or tactile.</p> <p>Provide quiet environment. Speak in calm, quiet voice. Regulate lighting as indicated. Turn off radio/TV during sleep.</p> <p>Provide care by same personnel whenever possible.</p> <p>Encourage SO to stay with patient whenever possible.</p> <p>Reorient frequently to person, place, time, and surrounding environment as indicated.</p> <p>Avoid bedside discussion about patient or topics unrelated to patient that do not include patient.</p> <p>Provide environmental safety, e.g., place bed in low position, leave doors in full open or closed position, observe frequently, place call light/bell within reach, remove articles that can harm patient.</p> <p>Collaborative</p> <p>Provide seclusion, restraints as necessary.</p>	<p>Speech may be garbled, confused, or slurred. Response to commands may reveal inability to concentrate, impaired judgment, or muscle coordination deficits.</p> <p>Hyperactivity related to CNS disturbances may escalate rapidly. Sleeplessness is common as a result of loss of sedative effect gained from alcohol usually consumed before bedtime. Sleep deprivation may aggravate disorientation/confusion. Progression of symptoms may indicate impending hallucinations (stage II) or DTs (stage III).</p> <p>Auditory hallucinations are reported to be more frightening/threatening to patient. Visual hallucinations occur more at night and often include insects, animals, or faces of friends/enemies. Patients are frequently observed “picking the air.” Yelling may occur if patient is calling for help from perceived threat (usually seen in stage III AWS).</p> <p>Reduces external stimuli during hyperactive stage. Patient may become more delirious when surroundings cannot be seen, but some respond better to quiet, darkened room.</p> <p>Promotes recognition of caregivers and a sense of consistency, which may reduce fear.</p> <p>May have a calming effect, and may provide a reorienting influence.</p> <p>May reduce confusion, prevent/limit misinterpretation of external stimuli.</p> <p>Patient may hear and misinterpret conversation, which can aggravate hallucinations.</p> <p>Patient may have distorted sense of reality or be fearful or suicidal, requiring protection from self.</p> <p>Patients with excessive psychomotor activity, severe hallucinations, violent behavior, and/or suicidal gestures may respond better to seclusion. Restraints are usually ineffective and add to patient’s agitation, but occasionally may be required to prevent self-harm.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Substance Use Treatment: Alcohol Withdrawal (NIC)</p> <p>Collaborative</p> <p>Monitor laboratory studies, e.g., electrolytes, magnesium levels, liver function studies, ammonia, BUN, glucose, ABGs.</p> <p>Administer medications as indicated, e.g.: Antianxiety agents as indicated. (Refer to ND: Anxiety [severe/panic]/Fear, following);</p> <p>Thiamine, vitamins C and B complex, multivitamins, Stresstabs.</p>	<p>Changes in organ function may precipitate or potentiate sensory-perceptual deficits. Electrolyte imbalance is common. Liver function is often impaired in the chronic alcoholic, and ammonia intoxication can occur if the liver is unable to convert ammonia to urea. Ketoacidosis is sometimes present without glycosuria; however, hyperglycemia or hypoglycemia may occur, suggesting pancreatitis or impaired gluconeogenesis in the liver. Hypoxemia and hypercapnia are common manifestations in chronic alcoholics who are also heavy smokers.</p> <p>Reduces hyperactivity, promoting relaxation/sleep. Drugs that have little effect on dreaming may be desired to allow dream recovery (REM rebound) to occur, which has previously been suppressed by alcohol use.</p> <p>Vitamins may be depleted because of insufficient intake and malabsorption. Vitamin deficiency (especially thiamine) is associated with ataxia, loss of eye movement and pupillary response, palpitations, postural hypotension, and exertional dyspnea.</p>

<p>NURSING DIAGNOSIS: Anxiety [severe/panic]/Fear</p> <p>May be related to</p> <ul style="list-style-type: none"> Cessation of alcohol intake/physiological withdrawal Situational crisis (hospitalization) Threat to self-concept, perceived threat of death <p>Possibly evidenced by</p> <ul style="list-style-type: none"> Feelings of inadequacy, shame, self-disgust, and remorse Increased helplessness/hopelessness with loss of control of own life Increased tension, apprehension Fear of unspecified consequences; identifies object of fear <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Anxiety [or] Fear Control (NOC)</p> <ul style="list-style-type: none"> Verbalize reduction of fear and anxiety to an acceptable and manageable level. Express sense of regaining some control of situation/life. Demonstrate problem-solving skills and use resources effectively.
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Anxiety Reduction (NIC)</p> <p>Independent</p> <p>Identify cause of anxiety, involving patient in the process. Explain that alcohol withdrawal increases anxiety and uneasiness. Reassess level of anxiety on an ongoing basis.</p> <p>Develop a trusting relationship through frequent contact, being honest and nonjudgmental. Project an accepting attitude about alcoholism.</p> <p>Inform patient about what you plan to do and why. Include patient in planning process and provide choices when possible.</p> <p>Reorient frequently. [Refer to ND: Sensory Perception, disturbed, (specify).]</p> <p>Collaborative</p> <p>Administer medications as indicated, e.g.:</p> <ul style="list-style-type: none"> Benzodiazepines, e.g., oxazepam (Serax), chlordiazepoxide (Librium), diazepam (Valium); Barbiturates, e.g., phenobarbital, or possibly secobarbital(Seconal), pentobarbital (Nembutal). <p>Arrange “Intervention” (confrontation) in controlled setting.</p> <p>Provide consultation for referral to detoxification/crisis center for ongoing treatment program as soon as medically stable (e.g., oriented to reality).</p>	<p>Person in acute phase of withdrawal may be unable to identify and/or accept what is happening. Anxiety may be physiologically or environmentally caused. Continued alcohol toxicity will be manifested by increased anxiety and agitation as effects of medication wear off.</p> <p>Provides patient with a sense of humanness, helping to decrease paranoia and distrust. Patient will be able to detect biased or condescending attitude of caregivers.</p> <p>Enhances sense of trust, and explanation may increase cooperation/reduce anxiety. Provides sense of control over self in circumstance where loss of control is a significant factor. <i>Note:</i> Feelings of self-worth are intensified when one is treated as a worthwhile person.</p> <p>Patient may experience periods of confusion, resulting in increased anxiety.</p> <p>Antianxiety agents are given during acute withdrawal to help patient relax, be less hyperactive, and feel more in control.</p> <p>These drugs suppress alcohol withdrawal but need to be used with caution because they are respiratory depressants and REM sleep cycle inhibitors.</p> <p>Process wherein SO/family members, supported by staff, provide information about how patient’s drinking and behavior have affected each one of them, helps patient acknowledge that drinking is a problem and has resulted in current situational crisis.</p> <p>Patient is more likely to contract for treatment while still hurting and experiencing fear and anxiety from last drinking episode. Motivation decreases as well-being increases and person again feels able to control the problem. Direct contact with available treatment resources provides realistic picture of help. Decreases time for patient to “think about it”/change mind or restructure and strengthen denial systems.</p>

POTENTIAL CONSIDERATIONS following acute care (dependent on patient’s age, physical condition/presence of complications, personal resources, and life responsibilities)

Refer to: Substance Dependence/Abuse Rehabilitation plan of care, and plans of care for any specific underlying medical/psychiatric condition(s).