

# **ALCOHOL-RELATED DISORDERS**

## **DSM-IV**

### **ALCOHOL-INDUCED DISORDERS**

- 303.00 Alcohol intoxication
- 291.81 Alcohol withdrawal
- 291.89 Alcohol-induced mood disorder
- 291.89 Alcohol-induced anxiety disorder
- 292.81 Intoxication delirium

Alcohol is a CNS depressant drug that is used socially in our society for many reasons (e.g., to enhance the flavor of food, to encourage relaxation and conviviality, for feelings of celebration, and as a sacred ritual in some religious ceremonies). Therapeutically, it is the 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 abuse and, in fact, is the most widely abused drug in the United States (research suggests 5% to 10% of the adult population) and is potentially fatal. Frequently, the client in a residential care setting has been using alcohol in conjunction with other drugs. It is believed that alcohol is often used by clients who have other mental illnesses to assuage the pain they feel. The term “dual diagnosis” is used to mean an association between the use/abuse of drugs (including alcohol) and other psychiatric diagnoses. It may be difficult to determine cause and effect in any given situation to determine an accurate diagnosis. However, it is important to recognize when both conditions are present so that the often-overwhelming problems of treatment are instituted for both conditions.

This plan of care addresses acute intoxication/withdrawal and is to be used in conjunction with CP: Substance Dependence/Abuse Rehabilitation.

## **ETIOLOGICAL THEORIES**

### **Psychodynamics**

The individual remains fixed in a lower level of development, with retarded ego and weak superego. The person retains a highly dependent nature, with characteristics of poor impulse control, low frustration tolerance, and low self-esteem.

### **Biological**

Enzymes, genes, brain chemistry, and hormones create and contribute to an individual’s response to alcohol. The two types of alcohol-related disorders are (1) familial, which is largely inherited, and (2) acquired. A childhood history of attention-deficit disorder or conduct disorder also increases a child’s risk of becoming alcoholic. Certain physiological changes also may cause addiction to alcohol, or alcoholism.

### **Family Dynamics**

One in 12–15 persons has serious problems from drinking. In a dysfunctional family system, alcohol may be viewed as the primary method of relieving stress. Children of alcoholics are 4 times more likely to develop alcoholism than children of nonalcoholics. The child has negative role models and learns to respond to stressful situations in like manner. The use of alcohol is cultural, and many factors influence one’s decision to drink, how much, and how often. Denial of the illness can be a major barrier to identification and treatment of alcoholism and alcohol abuse.

## **CLIENT ASSESSMENT DATA BASE**

Data depend on the duration/extent of alcohol use, concurrent use of other drugs, degree of organ involvement, and presence of other psychiatric conditions.

## **Activity/Rest**

Difficulty sleeping, not feeling well rested

## **Circulation**

Peripheral pulses weak, irregular, or rapid

Hypertension common in early withdrawal stage but may become labile/progress to hypotension

Tachycardia common during acute withdrawal

## **Ego Integrity**

Feelings of guilt/shame; defensiveness about drinking

Denial, rationalization

Reports of multiple stressors; problems with relationships

Multiple stressors/losses (relationships, employment, financial)

Use of substances to deal with life stressors, boredom, etc.

## **Elimination**

Diarrhea

Bowel sounds varied (may reflect gastric complications [e.g., gastric hemorrhage])

## **Food/Fluid**

Nausea/vomiting, food tolerance

Muscle wasting, dry/dull hair, swollen salivary glands, inflamed buccal cavity, capillary fragility (malnutrition)

Generalized tissue edema may be noted (protein deficiencies)

Gastric distension; ascites, liver enlargement (seen in cirrhosis)

## **Neurosensory**

“Internal shakes”

Headache, dizziness, blurred vision, “blackouts”

Psychopathology such as paranoid schizophrenia, major depression (may indicate dual diagnosis)

**Level of Consciousness/Orientation:** 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)

Nystagmus (associated with cranial nerve palsy)

Pupil constriction (may indicate CNS depression)

Arcus senilis, a ringlike opacity of the cornea (normal in aging populations, suggests alcohol-related changes in younger clients)

Fine motor tremors of face, tongue, and hands; seizure activity (commonly grand mal)

Gait unsteady/ataxia (may be due to 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

History of tobacco use, recurrent/chronic respiratory problems

Tachypnea (hyperactive state of alcohol withdrawal)

Cheyne-Stokes respirations or respiratory depression

**Breath Sounds:** Diminished/adventitious sounds (suggests pulmonary complications [e.g., respiratory depression, pneumonia])

## Safety

History of recurrent accidents, such as falls, fractures, lacerations, burns, blackouts, or automobile accidents

**Skin:** Flushed face/palms of hands, scars, ecchymotic areas, cigarette burns on fingers, spider nevi (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/attempts (some research suggests alcoholic suicide attempts are 30% higher than national average for general population)

## Social Interactions

Frequent sick days off work/school, fighting with others, arrests (disorderly conduct, motor vehicle violations [DUIs])

Denial that alcohol intake has any significant effect on the present condition/situation

Dysfunctional family system of origin; problems in current relationships

Mood changes affecting interactions with others

## Teaching/Learning

History of alcohol and/or other drug use/abuse (including tobacco)

Ignorance and/or denial of addiction to alcohol or inability to cut down or stop drinking despite repeated efforts

Large amount of alcohol consumed in last 24–48 hours, previous periods of abstinence/withdrawal

Previous hospitalizations for alcoholism/alcohol-related diseases (e.g., cirrhosis, esophageal varices)

Family history of alcoholism/substance use

## DIAGNOSTIC STUDIES

**Blood Alcohol/Drug Levels:** Alcohol level may/may not be severely elevated depending on amount consumed and length of time between consumption and testing. In addition to alcohol, numerous controlled/illicit substances may be identified in a polydrug screen (e.g., amphetamine, cocaine, morphine, Percodan, Quaalude).

**CBC:** Decreased (Hb/Hct) may reflect such problems as iron-deficiency anemia or acute/chronic GI bleeding. White blood cell count may be increased with infection or decreased, if immunosuppressed.

**Glucose:** Hyperglycemia/hypoglycemia may be present, related to pancreatitis, malnutrition, or depletion of liver glycogen stores.

**Electrolytes:** Hypokalemia and hypomagnesemia are common.

**Liver Function Tests:** CPK, LDH, AST, ALT, and amylase may be elevated, reflecting liver or pancreatic damage.

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

**Other Screening Studies (e.g., Hepatitis, HIV, TB):** Dependent 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 owing to 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 the client, including chemical, medical, psychological, legal, family/social, and employment/support aspects, indicating areas of treatment needs.

## **NURSING PRIORITIES**

1. Maintain physiological stability during withdrawal phase.
2. Promote client safety.
3. Provide appropriate referral and follow-up.
4. Encourage/support SO involvement in Intervention (confrontation) process.

## **DISCHARGE GOALS**

1. Homeostasis achieved.
  2. Complications prevented/resolved.
  3. Sobriety being maintained on a day-to-day basis.
  4. Ongoing participation in a rehabilitation program/attendance at group therapy (e.g., Alcoholics Anonymous).
  5. Plan in place to meet needs after discharge.
- This plan of care is to be used in conjunction with CP: Substance Dependence/Abuse Rehabilitation.

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### **NURSING DIAGNOSIS**

#### **Risk Factors May Include:**

### **BREATHING PATTERN, risk for ineffective**

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— Client Will:**

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

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Monitor respiratory rate/depth and pattern as indicated. Note periods of apnea, Cheyne-Stokes respirations.

Frequent assessment is important because toxicity levels may change rapidly. Hyperventilation is common during acute withdrawal phase. Kussmaul 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. This may be compounded by drugs used to control alcohol withdrawal symptoms.

Elevate head of bed.

Decreases possibility of aspiration; lowers diaphragm, enhancing lung inflation.

Encourage cough/deep breathing exercises and frequent position changes.

Facilitates lung expansion and mobilization of secretions to reduce risk of atelectasis/pneumonia.

Auscultate breath sounds. Note presence of adventitious sounds (e.g., rhonchi, wheezes).

Client is at risk for atelectasis related to hypoventilation and pneumonia. Right lower lobe pneumonia is common in alcohol-debilitated clients and is often due to aspiration. Chronic lung diseases are also common (e.g., emphysema, chronic bronchitis).

Have suction equipment, airway adjuncts available.

Sedative effects of alcohol/drugs potentiate risk of aspiration, relaxation of oropharyngeal muscles, and respiratory depression, requiring intervention to prevent respiratory arrest.

### **Collaborative**

Administer supplemental oxygen if necessary.

Hypoxia may occur with CNS/respiratory depression.

Review chest x-rays, pulse oximetry as available/indicated.

Monitors presence of secondary complications such as atelectasis/pneumonia; evaluates effectiveness of respiratory effort, identifies therapy needs.

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**NURSING DIAGNOSIS****Risk Factors May Include:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:****CARDIAC OUTPUT, risk for decreased**

Direct effect of alcohol on the heart muscle

Altered systemic vascular resistance

Electrical alterations in rate, rhythm, conduction

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]Display vital signs within client's normal range;  
absence of/reduced frequency of dysrhythmias.

Demonstrate an increase in activity tolerance.

Verbalize understanding of the effect of alcohol on the heart.

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**ACTION/INTERVENTIONS**

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**RATIONALE****Independent**

Monitor vital signs frequently during acute withdrawal.

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. **Note:** Client may have underlying cardiovascular disease that is compounded by substance withdrawal.

Monitor cardiac rate/rhythm. Document irregularities/dysrhythmias.

Long-term alcohol abuse may result in cardiomyopathy/congestive heart failure. Tachycardia is common owing to sympathetic response to increased circulating catecholamines. Irregularities/dysrhythmias may develop with electrolyte shifts/imbalance. All of these may have an adverse effect on cardiac function/output.

Monitor body temperature.

Elevation may occur because of sympathetic stimulation, dehydration, and/or infections, causing vasodilation and compromising venous return/cardiac output.

Monitor intake/output. Note 24-hour fluid balance.

Be prepared for/assist in cardiopulmonary resuscitation.

### Collaborative

Monitor laboratory studies (e.g., serum electrolyte levels).

Administer medications as indicated: e.g., clonidine (Catapres), atenolol (Tenormin);

Potassium.

Preexisting dehydration, vomiting, fever, and diaphoresis may result in decreased circulating volume, which can compromise cardiovascular function. **Note:** Hydration is difficult to assess in the alcoholic because the usual indicators are not reliable, and overhydration is a risk in the presence of compromised cardiac function.

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 15%–25%.

Electrolyte imbalance (e.g., potassium/magnesium) potentiates risk of cardiac dysrhythmias and CNS excitability.

Although the use of benzodiazepines is often sufficient to control hypertension during initial withdrawal from alcohol, some clients may require more specific therapy. **Note:** Atenolol and other beta-adrenergic blockers may speed up the withdrawal process and eliminate tremors, as well as lower heart rate, BP, and body temperature, reducing the need for benzodiazepines.

Corrects deficits that can result in life-threatening dysrhythmias.

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### NURSING DIAGNOSIS

#### Risk Factors May Include:

#### Possibly Evidenced by:

#### Desired Outcomes/Evaluation Criteria— Client Will:

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### INJURY, risk for (specify)

Cessation of alcohol intake with varied autonomic nervous system responses to the suddenly altered state

Involuntary clonic/tonic muscle activity (convulsions)

Equilibrium/balancing difficulties, reduced muscle and hand/eye coordination

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

Demonstrate absence of untoward effects of withdrawal.

Experience no physical injury.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Identify stage of alcohol withdrawal, symptoms:  
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 delirium tremens (DTs) and extreme autonomic hyperactivity with profound confusion, anxiety, insomnia, fever.

Monitor/document seizure activity. Maintain patent airway. Provide environmental safety (e.g., padded side rails, bed in low position).

Check deep-tendon reflexes. Assess gait, if possible.

Assist with ambulation and self-care activities as needed.

Provide for environmental safety when indicated. (Refer to ND: Sensory/Perceptual alteration [specify].)

### **Collaborative**

Administer IV/PO fluids with caution, as indicated. clearance of toxins while reducing risk of overhydration.

Administer medications as indicated:

Benzodiazepines such as: chlordiazepoxide (Librium), diazepam (Valium), clonazepam (Klonopin);

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.

Grand mal seizures are most common and may be related to decreased magnesium levels, hypoglycemia, elevated blood alcohol, history of head trauma/preexisting seizure disorder. **Note:** In absence of previous history of other pathology causing seizure activity, seizures usually stop spontaneously, requiring only symptomatic treatment.

Reflexes may be depressed, absent, or hyperactive. Peripheral neuropathies are common, especially in malnourished clients. Ataxia (gait disturbance) is associated with Wernicke's syndrome (thiamine deficiency) and cerebellar degeneration.

Prevents falls with resultant injury.

May be required when equilibrium, hand/eye coordination problems exist.

Cautious replacement corrects dehydration and promotes renal

Commonly used to control neuronal hyperactivity that occurs as alcohol is detoxified. IV/PO administration is the route preferred, as intramuscular absorption is unpredictable. Muscle-relaxant qualities are particularly helpful to the client in controlling the "shakes," trembling, and ataxic quality of movements. Clients may initially require large doses to achieve desired effect, and then the drug(s) may be tapered and discontinued, usually within 96 hours. **Note:** These agents must be used cautiously in clients

Oxazepam (Serax);	with hepatic disease, as the agents are metabolized by the liver. Although less dramatic for control of withdrawal symptoms, this may be the drug of choice in a client with liver disease because of its shorter half-life.
Phenobarbital;	Useful in suppressing withdrawal symptoms and is an effective anticonvulsant. Use must be monitored to prevent exacerbation of respiratory depression.
Magnesium sulfate;	Reduces tremors and seizure activity by decreasing neuromuscular excitability.
Thiamine.	Thiamine deficiency (common in alcohol abuse) may lead to neuritis, Wernicke's syndrome, and/or Korsakoff's psychosis.

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**Nursing Diagnosis**

**May Be Related to:**

**Possibly Evidenced by:**

**Desired Outcomes/Evaluation Criteria—**

**Client Will:**

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**Sensory/Perceptual alterations (specify)**

Chemical alteration: Exogenous (e.g., alcohol consumption/sudden cessation) and endogenous (e.g., electrolyte imbalance, elevated ammonia and BUN)

Sleep deprivation

Psychological stress (anxiety/fear)

Disorientation in time, place, person, or situation

Changes in usual response to stimuli; exaggerated emotional responses, change in behavior

Bizarre thinking

Restlessness, irritability, apprehension

Regain/maintain usual level of cognition.

Report absence of auditory/visual hallucinations.

Identify external factors that affect sensory-perceptual abilities.

## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Assess level of consciousness, ability to speak, response to stimuli/commands.

Speech may be garbled, confused, or slurred. Response to commands may reveal inability to concentrate, impaired judgment, or muscle coordination deficits.

Observe behavioral responses (e.g., hyperactivity, disorientation, confusion, sleeplessness, irritability).

Hyperactivity related to CNS disturbances may escalate rapidly. Sleeplessness is common because of loss of sedative effect gained from alcohol usually consumed prior to bedtime. Sleep deprivation may aggravate disorientation/confusion. Progression of symptoms may indicate impending hallucinations (Stage II) or DTs (Stage III).

Note onset of hallucinations. Document as auditory, visual, and/or tactile.

Auditory hallucinations are reported to be more frightening/threatening to client. Visual hallucinations occur more at night and often include insects, animals, or faces of friends/enemies. Clients are frequently observed picking the air; yelling may occur if client is calling for help from perceived threat (usually seen in Stage III).

Provide quiet environment. Speak in calm, quiet voice. Regulate lighting as indicated. Turn off radio/TV during sleep.

Reduces external stimuli during hyperactive stage. Client may become more delirious when surroundings cannot be seen, although some respond better to quiet, darkened room.

Provide care by same personnel whenever possible.

Promotes recognition of caregivers and a sense of consistency that may reduce fear.

Reorient frequently to person, place, time, and surrounding environment as indicated.

May reduce confusion/misinterpretation of external stimuli.

Avoid bedside discussion about client or topics unrelated to the client that do not include the client.

Client may hear and misinterpret conversation, which can aggravate hallucinations.

Provide environment 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 client).

Client may have distorted sense of reality, be fearful, or be suicidal, requiring protection from self-harm.

## Collaborative

Provide seclusion, restraints as necessary.

Monitor laboratory studies (e.g., electrolytes, magnesium levels, liver function studies, ammonia, BUN, glucose, ABGs).

Administer medications as indicated, e.g.:

Antianxiety agents (Refer to ND: Anxiety [severe/panic]/Fear);

Thiamine; vitamins C & B complex, multivitamins; Stresstabs.

Clients with excessive psychomotor activity, severe hallucinations, violent behavior, and/or suicidal gestures may respond better to seclusion. Restraints are usually ineffective and add to client's agitation but occasionally may be required for short periods to prevent self-harm.

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 hypercarbia are common manifestations in chronic alcoholics who are also heavy smokers.

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 been suppressed by alcohol use.

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.

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### NURSING DIAGNOSIS

#### May Be Related to:

#### Possibly Evidenced by:

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### NUTRITION: altered, less than body requirements

Poor dietary intake (replaced by alcohol consumption)

Effects of alcohol on organs involved in digestion (e.g., stomach, pancreas, liver); interference with absorption and metabolism of nutrients and amino acids; and increased loss of vitamins in the urine

Reports of inadequate food intake, altered taste sensation, lack of interest in food, abdominal pain

Body weight 20% or more under ideal

Pale conjunctiva and mucous membranes; sore, inflamed buccal cavity/cheilosis

Poor muscle tone, skin turgor

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Hyperactive bowel sounds, diarrhea

Third spacing of circulating blood volume (e.g., edema of extremities, ascites)

Presence of neuropathies

Laboratory evidence of decreased red cell count (anemias), vitamin deficiencies, reduced serum albumin level, or electrolyte imbalance

Verbalize understanding of effects of alcohol ingestion and reduced dietary intake on nutritional status and general well-being.

Demonstrate behaviors, lifestyle changes to regain/maintain appropriate weight.

Maintain stable weight or progressive weight gain toward goal with normalization of laboratory values and absence of signs of malnutrition.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Evaluate presence/quality of bowel sounds. Note abdominal distension, tenderness.

Irritation of gastric mucosa is common and may result in epigastric pain, nausea, and hyperactive bowel sounds. More serious effects of GI system may occur secondary to cirrhosis and hepatitis.

Note presence of nausea/vomiting, diarrhea.

Nausea and vomiting are often among the first signs of alcohol withdrawal and may interfere with achieving adequate nutritional intake.

Assess ability to feed self.

Tremors, altered mentation, or hallucinations may interfere with ingestion of nutrients and indicate need for assistance.

Provide small, easily digested, frequent meals/snacks, and advance as tolerated.

May limit gastric distress and enhance intake and toleration of nutrients. As appetite and ability to tolerate food increase, diet should be adjusted to provide the necessary calories and nutrition for cellular repair and restoration of energy.

**Collaborative**

Review laboratory tests (e.g., AST, ALT, LDH, serum albumin/prealbumin, transferrin).

Assesses liver function, adequacy of nutritional intake; influences choice of diet and need for effectiveness of supplemental therapy.

Refer to dietitian/nutritional support team.

Useful in establishing and coordinating individual nutritional regimen.

Provide diet high in protein with at least half of calories obtained from carbohydrates.

Administer medications as indicated, e.g.:

Antacids, antiemetics, antidiarrheal;

Vitamins, thiamine.

Institute/maintain NPO status as indicated.

Stabilizes blood sugar, thereby reducing risk of hypoglycemia, while providing for energy needs and cellular regeneration.

Reduces gastric irritation and limits effects of sympathetic stimulation.

Replace losses. **Note:** All clients should receive thiamine and vitamins, because deficiencies (clinical or subclinical) exist in most, if not all, clients with chronic alcoholism.

Provides gastrointestinal rest to reduce harmful effects of gastric/pancreatic stimulation in presence of GI bleeding or excessive vomiting.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:**

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**ANXIETY [severe/panic]/FEAR**

Cessation of alcohol intake/physiological withdrawal

Situational crisis (hospitalization)

Threat to self-concept, perceived threat of death

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; identifying object of fear

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**

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**RATIONALE****Independent**

Identify cause of anxiety, involving client in the process. Explain that alcohol withdrawal increases anxiety and uneasiness. Reassess level of anxiety on an ongoing basis.

Clients 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 medications wear off.

Develop a trusting relationship through frequent contact, being honest and nonjudgmental. Project an accepting attitude about alcoholism.

Inform client what you plan to do and why. Include client in planning process and provide choices when possible.

Reorient frequently. (Refer to ND: Sensory/ Perceptual alterations [specify].)

### **Collaborative**

Administer medications as indicated, e.g.:  
Benzodiazepines: chlordiazepoxide (Librium), diazepam (Valium);

Barbiturates: phenobarbital, or possibly secobarbital (Seconal), pentobarbital (Nembutal).

Arrange Intervention (confrontation) in controlled group setting.

Provide consultation for referral to recovery/ rehabilitation program for ongoing treatment as soon as medically stable (e.g., oriented to reality).

Provides client with a sense of humanness, helping to decrease paranoia and distrust. Client will be able to detect biased or condescending attitude of caregivers.

Enhances sense of trust, and explanation may increase cooperation/reduce anxiety. Provides sense of control over self in circumstances where loss of control is a significant factor. **Note:** Feelings of self-worth are intensified when one is treated as a worthwhile person.

Client may experience periods of confusion, resulting in increased anxiety.

Antianxiety agents are given during acute withdrawal to help client relax, be less hyperactive, and feel more in control.

These drugs suppress alcohol withdrawal but need to be used with caution as they are respiratory depressants and REM sleep cycle inhibitors.

The process of Intervention, wherein SOs/family members, supported by staff, provide information about how the client's drinking and behavior have affected each one of them, helps the client to acknowledge that drinking is a problem and has resulted in current situational crisis.

Client 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 client to "think about it"/change mind or restructure and strengthen denial systems.