

DEPRESSANTS (BARBITURATES, NONBARBITURATES, HYPNOTICS AND ANXIOLYTICS, OPIOIDS)

DSM-IV

SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-INDUCED DISORDERS

292.89 Sedative, hypnotic, or anxiolytic intoxication

292.0 Sedative, hypnotic, or anxiolytic withdrawal

292.81 Intoxication delirium

292.84 Induced mood disorder

OPIOID-RELATED DISORDERS

292.89 Opioid intoxication

292.81 Intoxication delirium

292.0 Opioid withdrawal

(For further listings, consult *DSM-IV*.)

CNS depressants are drugs that slow down the central nervous system. They are usually divided into four types: barbiturates, antianxiety agents, sedative-hypnotics, and narcotics (opiooids such as morphine, heroin).

CNS depressants prescribed for symptoms of anxiety, depression, and sleep disturbances are among the most widely used and abused drugs. These drugs are very likely to be abused when the underlying conditions remain untreated. Sometimes these drugs are used in conjunction with stimulants, with the user developing a pattern of taking a stimulant to be “up,” then needing the depressant drug to “come down.”

Several principles apply to all CNS depressants: (1) The effects are interactive and cumulative with one another and with the behavioral state of the user; (2) there is no specific antagonist that will block the action of these drugs; (3) low doses produce an initial excitatory response; (4) they are capable of producing physiological and psychological dependency; and (5) cross-tolerance and cross-dependence may exist between various CNS depressants. Although the margin of safety of these drugs is great, they have a characteristic syndrome of withdrawal that can be very severe.

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

ETIOLOGICAL THEORIES

Psychodynamics

Individuals who abuse substances fail to complete tasks of separation-individuation, resulting in underdeveloped egos. The person has a highly dependent nature, with characteristics of poor impulse control, low frustration tolerance, and low self-esteem. The superego is weak, resulting in absence of guilt feelings. Underlying psychiatric status must be assessed, as these individuals may use stimulants for varying self-medication reasons.

Psychostructural factors (e.g., personality) are seen as significant. The defect is believed to precede the addiction, with the ego structure breaking down and the substance being used as a maladaptive coping mechanism. Characteristics that have been identified include impulsivity, negative self-concept, weak ego, low social conformity, neuroticism, and introversion.

Biological

A genetic link is thought to be involved in the development of substance use disorders. Although statistics are currently inconclusive, hereditary factors are generally accepted to be a factor in the abuse of substances.

Family Dynamics

There is an apparent predisposition to substance abuse disorders in the dysfunctional family system. Factors such as the absence of a parent or a parent who is an overpowering tyrant or weak and ineffectual, and the use of substances as the primary method of relieving stress, appear to contribute to this dysfunction. These role models have a negative influence, and the child learns to handle stress in like manner. However, parents may be average, normal individuals with children who succumb to overwhelming peer pressure and become involved with drugs. Cultural factors such as acceptance of the use of alcohol and other drugs may also influence the individual's choice.

CLIENT ASSESSMENT DATA BASE

Data depend on stage of withdrawal and concurrent use of alcohol/other drugs.

Activity/Rest

General malaise
Interference with sleep pattern, insomnia (withdrawal)
Lethargy, drowsiness, somnolence
Yawning

Circulation

Pulse usually slowed; tachycardia (suggests withdrawal syndrome); irregular pulse (atrial fibrillation, ventricular dysrhythmias)
Hypotension

Ego Integrity

Substance use for stress management
Feelings of helplessness, hopelessness, powerlessness
Underdeveloped ego; highly dependent nature, with characteristics of poor impulse control, low frustration tolerance, and low self-esteem
Weak superego, with absence of guilt feelings
Psychostructural factors (e.g., personality) are seen as significant with substance use/abuse (maladaptive coping mechanisms)

Elimination

Diarrhea, occasionally constipation

Food/Fluid

Nausea/vomiting

Neurosensory

Twitching

Mental Status: Confusion, concentration, and memory problems; impaired judgment with some affective change; alterations in consciousness may exist, from extreme agitation to coma; slurred speech

Behavior: Mood swings, lack of motivation, aggression, combativeness (related to general “disinhibiting” effect of the drug, loss of impulse control), dysphoric mood (withdrawal)

Temporary psychosis with acute onset of auditory hallucinations and paranoid delusions (unexplained neuropsychiatric presentation may be indicative of drug use)

Psychomotor activity may be increased

Hypersensitivity (e.g., anxiety, tremors, hypotension, irritability, restlessness, and seizure activity)

Pupils small/pinpoint constriction (opiates), dilated (barbiturates); reaction to light slowed; horizontal gaze, nystagmus, lack of convergence

Gait unsteady/staggering, loss of coordination, positive Romberg’s sign

Pain/Discomfort

Headache, abdominal pain/severe cramping

Muscle aches

Deep muscle/bone pain (methadone abusers)

Respiration

Continuous rhinorrhea, excessive lacrimation, sneezing

Respiratory depression (overdose)

Increased respiratory rate (withdrawal syndrome)

Safety

Hot/cold flashes; diaphoresis

Thermoregulation instability with hyperpyrexia, hypothermia possible

Skin: Piloerection (“gooseflesh”); puncture wounds on arms, hands, legs, under tongue, indicating injection drug use

Social Interactions

Dysfunctional family of origin system

Dysfunctional patterns of interaction with family/others

Teaching/Learning

Preexisting physical/psychological conditions

Family history of substance use/abuse

History of chronic condition/disease process

Concurrent use of other drugs, including alcohol

DIAGNOSTIC STUDIES

Drug Screen: Identifies drug(s) being used.

STD Screening: To determine presence of HIV, hepatitis B, etc.

Other Screening Studies: Depend on general condition, individual risk factors, and care setting.

Addiction Severity Index (ASI): Produces a problem-severity profile, which indicates areas of treatment needs.

NURSING PRIORITIES

1. Achieve physiological stability.
2. Protect client from injury.
3. Provide appropriate referral and follow-up.
4. Promote family involvement in the withdrawal/rehabilitation process.

DISCHARGE GOALS

1. Homeostasis achieved.
2. Complications prevented/resolved.
3. Abstinence from drug(s) initiated/maintained on a day-to-day basis.
4. Attends rehabilitation program, group therapy (e.g., Narcotics Anonymous).
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

Risk Factors May Include:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria—

Client Will:

TRAUMA/SUFFOCATION/POISONING, risk for

CNS depression (effect of overdose)

CNS agitation (effect of abrupt withdrawal)

Hypersensitivity to the drug(s)

Psychological stress (narrowed perceptual fields seen with anxiety)

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

Verbalize understanding of risks of taking drugs.

Refrain from acting on hallucinations/impaired judgment.

Complete withdrawal without injury to self/development of complications.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Talk with client/SO regarding when person was last seen well; noting history/duration of health problems, sleep patterns, and prescriptions used.

Determines degree and approximate time frame for impairment, with sleep disruption often the first observable sign of problem. Ongoing health problems (e.g., chronic pain conditions) potentiate substance use. Prescription information provides clues to identify drug(s) and amount taken.

Identify drug(s) taken, when taken, and route used, if possible.

Assess level of consciousness (e.g., agitated, stuporous, lethargic, confused, or comatose).
Note pinpoint pupils.

Evaluate for evidence of head trauma.

Determine when food was last eaten.
Note reports of nausea.

Monitor temperature as indicated.
Observe for signs of dehydration.

Monitor BP, pulse, respirations.

Provide quiet, lighted room (e.g., an isolation room with simple furniture).

Observe client at all times; use staff or family members as available.

Reorient to surroundings and circumstances as needed.

Note presence of tremors.

Provide seizure precautions (e.g., padded side rails, bed in low position, airway adjunct/suction at bedside).

Note changes in behavior indicative of psychosis (e.g., distorted reality, altered mood, impaired language and memory).

Assess emotional state, noting psychiatric history and suicide gestures/attempts. Note use/abuse of other substances.

Helpful to identify interventions for specific drug. Determining drug(s) taken may be difficult without blood/urine testing as the client may not feel free to tell because of embarrassment or for legal reasons, or may not know what has been ingested.

May indicate degree of intoxication and level of intervention required. Constricted pupils are a classic sign of opioid (heroin) use.

This is important to note for differential diagnosis, to prevent inappropriate treatment/interventions.

Presence of food in stomach may slow absorption of drug(s) into the bloodstream; however, if level of consciousness is depressed, presence of food in stomach increases the risk of vomiting and aspiration.

Hypothermia may be seen in intoxication, whereas hyperpyrexia may occur with withdrawal or indicate infectious process. **Note:** Dehydration often accompanies hyperpyrexia, requiring additional intervention/fluid replacement.

Changes in these signs depend on drug taken (e.g., Valium may be evidenced by hypotension, tachycardia).

Reduces internal or external stimuli, which may lead to injury as depressant effect lessens.

Client with varying levels of consciousness should not be left alone because of the danger of accidental injury.

Maintaining contact provides reassurance, reduces anxiety when sensorium clears.

Involuntary movements of one or more parts of the body may result from abrupt removal of drug.

These precautions can prevent injury if convulsions occur during withdrawal.

Drug intoxication can precipitate an alteration in perceptions/psychotic behavior.

Patterns of drug use will indicate likelihood of intentional or accidental overdose. Substance abuse/suicidal attempts may be symptom of, or response to, underlying psychiatric illness or to hallucinations caused by sensitivity to drug.

Determine history/characteristics of hallucinations.

May be auditory, visual, or tactile and be very frightening. May also trigger suicidal/homicidal behavior.

Institute suicide precautions, as indicated.

May need environmental restraints to protect client until own coping abilities improve and internal locus of control is attained/regained.

Collaborative

Administer medication per current treatment/protocol, e.g.:

Phenobarbital;

Prolonged effect provides smoother sedation with “high” of more rapidly acting drugs. Also has an anticonvulsant effect.

Methadone;

Replaces heroin or other narcotic analgesics in detoxification program, reducing/minimizing withdrawal symptoms.

Clonidine (Catapres);

Can suppress/reverse symptoms of opioid withdrawal and has lesser likelihood of abuse than methadone. Drug may be used instead of or in combination with methadone during detoxification. **Note:** May be contraindicated for some clients because of high degree of sedation and hypotension.

Buprenorphine (Buprenex).

Current research suggests low doses of this drug may block opioid-withdrawal symptoms.

Assist with barbiturate detoxification program.

Reintoxication should be done before drug withdrawal is attempted. This establishes an independent estimate of prior drug use and provides a baseline on which to begin the detox schedule. Reintoxication is done so the drug can be withdrawn on a strict schedule and should begin as soon as there are signs of intoxication (e.g., nystagmus, slurred speech, ataxia on backward and forward tandem gait).

Involve in Intervention (confrontation) and/or therapy as indicated.

Client will need ongoing assistance to acknowledge and maintain drug-free existence.

Transfer to medical setting as indicated.

Severe CNS depression/deterioration of condition (physiological instability) requires more aggressive intervention than that generally provided in psychiatric setting.

NURSING DIAGNOSIS**BREATHING PATTERN, risk for ineffective/GAS EXCHANGE, risk for impaired****Risk Factors May Include:**

Neuromuscular impairment
Decreased energy/fatigue
Inflammatory process
Decreased lung expansion

Possibly Evidenced by:

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

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

Maintain normal/effective breathing pattern with absence of cyanosis or other symptoms of respiratory distress

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Monitor respiratory rate/depth/rhythm and breath sounds.

Sedative/depressant effects on CNS may result in loss of airway patency and/or respiratory depression. Prompt treatment is necessary to prevent respiratory arrest. **Note:** Acute pulmonary edema is a common complication in heroin overdose/intoxication.

Have suction equipment/airway adjuncts available.

Sedative effects of drugs, increased salivation, and vomiting potentiate risk of aspiration. Relaxation of oropharyngeal muscles and respiratory depression requires prompt intervention to prevent respiratory compromise/arrest.

Collaborative

Review chest x-ray.

Common complications of depressant (opiate) abuse include pneumonia, aspiration pneumonitis, lung abscess, and atelectasis, which will require specific treatment.

Monitor pulse oximetry, when indicated.

Chronic addiction may result in decreased vital capacity and pulmonary diffusion affecting gas exchange. Presence of septic pulmonary emboli or pulmonary fibrosis (from talc granulomatosis occurring in injection drug abuse) may further compromise respiratory function.

Provide supplemental oxygen.

May be necessary to improve oxygen intake in presence of respiratory depression.

Administer medications, as indicated, e.g.,

Naloxone (Narcan), nalmeferne (Revex);
and transfer to medical setting

Narcotic antagonists can reverse the effects of respiratory depression in opioid intoxication.
Note: Narcan may trigger acute withdrawal syndrome, requiring more aggressive intervention. Revex has a longer half-life (approximately 11 hours) and is less likely to cause reemergence effects.

NURSING DIAGNOSIS**INFECTION, risk for****Risk Factors May Include:**

Injection drug use techniques, impurities in injected drugs

Localized trauma

Malnutrition; altered immune state

Possibly Evidenced by:

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

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

Verbalize understanding of and demonstrate lifestyle changes to reduce risk factor(s).

Achieve timely healing of infectious process, if present, and be afebrile.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Refer to CP: Stimulants, ND: Infection, risk for, for interventions specific to this nursing diagnosis.