

HALLUCINOGEN-,PHENCYCLIDINE-, AND CANNABIS-RELATED DISORDERS

DSM-IV

HALLUCINOGEN-RELATED/INDUCED DISORDERS

- 292.89 Hallucinogen intoxication
- 292.81 Intoxication delirium
- 292.89 Hallucinogen persisting perception disorder (flashbacks)
- 292.89 Hallucinogen-induced anxiety disorder
- 292.84 Hallucinogen-induced mood disorder

PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)/INDUCED DISORDERS

- 292.89 Phencyclidine intoxication
- 292.81 Intoxication delirium
- 292.11 Induced psychotic disorder with delusions
- 292.12 Induced psychotic disorder with hallucinations

CANNABIS-RELATED/INDUCED DISORDERS

- 292.89 Cannabis intoxication
- 292.81 Intoxication delirium
- 292.89 Cannabis-induced anxiety disorder

Hallucinogenic substances can distort an individual's perception of reality, altering sensory perception, and inducing hallucinations. For this reason, these substances are referred to as "mind expanding." They are highly unpredictable in the effects they may induce each time they are used, and adverse reactions, including "flashbacks," can recur at any time, even without current use of the drug. Hallucinogens have been used as part of religious ceremonies and at social gatherings by Native Americans for more than 2000 years. Therapeutic uses for LSD have been proposed; however, more research is required. At this time, no real evidence speaks to the safety and efficacy of LSD in humans.

Of the drugs that produce mood and perceptual changes varying from sensory illusions to hallucinations, the most popular and well-known are ergot and related compounds (LSD, morning glory seeds), phenyl alkylamines (mescaline, "STP," and MDMA or "Ecstasy"), and indole alkaloids (DMT).

A separate classification of drugs includes phencyclidine (PCP, "angel dust," HOG) and similarly acting compounds such as ketamine (Ketalar) and the thiophene analogue of phencyclidine (TCP). Although these drugs have an entirely different chemical structure, they can have similar hallucinogenic effects and therefore are included here.

Additionally, cannabis (marijuana, hashish, synthetic THC) also produces an altered state of awareness accompanied by feelings of relaxation and mild euphoria and is often used in conjunction with other substances.

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 is thought to have 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 for behavior.

Certain personality traits may play an important part in the development and maintenance of dependence. Characteristics that have been identified include impulsivity, negative self-concept, weak ego, low social conformity, neuroticism, and introversion. Substance abuse has also been associated with antisocial personality and depressive response styles.

Biological

A genetic link is thought to be involved in the development of substance abuse disorders. Although statistics are currently inconclusive, hereditary factors are generally accepted to be a factor in the abuse of substances. Research is currently being done into the role biochemical factors play in the problems of substance abuse.

Family Dynamics

A predisposition to substance use disorders is found in the dysfunctional family system. Often one parent is absent or is an overpowering tyrant, and/or another parent is weak and ineffectual. Substance abuse may be evident as the primary method of relieving stress. The child has negative role models and learns to respond to stressful situations in like manner. However, parents may be average, normal individuals with children who succumb to overwhelming peer pressure and become involved with drugs.

In the family the effects of modeling, imitation, and identification on behavior can be observed from early childhood onward. Peer influence may exert a great deal of influence also. Cultural factors may help to establish patterns of substance use by attitudes of acceptance of such use as a part of daily or recreational life.

CLIENT ASSESSMENT DATA BASE

Factors that can affect the kind of reaction (positive or negative) experienced by the hallucinogen user include individual circadian rhythms (fatigue), previous drug-taking experience, personality, mood, and expectations. Concurrent use of alcohol/other drugs can compound symptoms/reactions. One's educational level can also cause different perceptions.

Activity/Rest

Insomnia, fatigue
Disturbances of sleep/wakefulness
Hyperactivity (LSD, mescaline, PCP)

Circulation

Diastolic BP decreased (cannabis, high-dose PCP)
Hypertension, hypertensive crisis (low- to moderate-dose PCP)
Tachycardia/palpitations; possible dysrhythmias (high-dose PCP)

Ego Integrity

Euphoria, anxiety, suspiciousness, paranoia (PCP psychosis)
Substance abuse as the primary method of coping
Highly dependent nature, with characteristics of poor impulse control, low frustration tolerance, low self-concept; depersonalization, weak superego, possibly resulting in absence of guilt feelings for behavior or self-reproach, excessive guilt, fearfulness
Moods reflect depression or anxiety
Preoccupation with the idea that brain is destroyed and/or will not return to a normal state
Food/Fluid
Increased appetite (cannabis)
Nausea/vomiting, increased salivation

Neurosensory

Blurred vision, altered depth perception

Dizziness, headache (LSD)

Flashback (spontaneous transitory recurrence of a drug-induced experience [LSD] in a drug-free state) often associated with fatigue, emotional stress, and other drug use (especially alcohol, marijuana)

“Bad trips” (self-limiting and confined to period of intoxication)

LSD: Three kinds: (1) bad body trip (e.g., “my body is purple”), (2) bad environment trip (e.g., visual distortions so real the person thinks he or she is going crazy), (3) bad mind trip (e.g., unexpected subconscious material bursts forth into consciousness, as in, “I’m responsible for my mother’s death.”)

PCP: Aggravates any underlying psychopathology

Cannabis: Rare; however, when occurs, panic attacks are usually seen

Pupillary dilation, catatonic staring (LSD, PCP, mescaline); vertical and horizontal nystagmus, lack of convergence (PCP)

Muscle incoordination/tremors, spasms, or increased muscle strength may be noted with PCP (the anesthetic effect deadens pain perception), deep-tendon reflexes increased (low- to moderate-dose PCP) or depressed (high-dose PCP), opisthotonos (body-arching spasm)

Level of Consciousness: Usually responsive; coma may occur (especially if intracranial hemorrhage occurs with PCP); slurred speech, mutism

Mental Status: Perceptual changes, e.g., sensation of slowed time, perceptions enhanced (colors richer, music more profound, smells and tastes heightened), synesthesia (merging of senses, colors are “heard” or sounds are “seen”), changes in body image, hallucinations (usually visual), depersonalization

Delirium with clouded state of consciousness (sensory misperception, disorientation, memory impairment, difficulty in sustaining attention, disordered stream of thought, psychomotor activity); delusions, illusions, hallucinations (rare with cannabis intoxication); may occur within 24 hours after use or following recovery days after PCP taken

Delusions occurring in a normal state of consciousness; may persist beyond 24 hours after cessation of hallucinogen use (persecutory delusions can follow cannabis use immediately or may occur during the course of cannabis intoxication)

Mood: Euphoria/dysphoria; anxiety, emotional lability, apathy, grandiosity

Behavioral Findings: May include assaultiveness, bizarre behavior, impulsivity, unpredictability, belligerence, impaired judgment, paranoid ideation, panic attacks

Seizure activity (high-dose PCP)

Pain/Discomfort

Decreased awareness of pain

Sudden intense chest pain or persistent chest discomfort (if drug is smoked)

Respiration

Decreased rate/depth of respiration (PCP, heavy cannabis use)

Rhonchi, gurgling sounds

Safety

Participation in high-risk behaviors

History of accidental injuries

Diaphoresis

Conjunctival redness/infection (cannabis)

Assaultive behavior (PCP psychosis), risk to self (impaired judgment/acting on altered perceptions)

Temperature elevated

Social Interactions

Sense of “happy sociability,” friendliness (intoxication)

Dysfunctional family system—an overbearing, tyrannical, absent, or weak and ineffectual parent

Overwhelming peer pressure leading to drug involvement

Impaired social or occupational functioning may be seen with drug use/tolerance (fights, loss of friends, absence from work, loss of job, or legal difficulties)

Teaching/Learning

Concurrent use of other drugs, including alcohol

Family history of substance abuse

DIAGNOSTIC STUDIES

Drug Screen/Urinalysis: To identify drug(s) being used.

Other Screening Studies (e.g., Hepatitis, HIV, TB): Depend on general conditions, individual risk factors, and care setting.

Addictive Severity Index (ASI): To assess substance abuse and determine treatment needs.

NURSING PRIORITIES

1. Protect client/others from injury.
2. Promote physiological/psychological stability.
3. Provide appropriate referral and follow-up.
4. Support client/family in Intervention (confrontation) process for decision to stop using drugs.

DISCHARGE GOALS

1. Homeostasis achieved.
2. Complications prevented/resolved.
3. Abstinence from drug(s) maintained on a day-to-day basis.
4. Participation in drug rehabilitation program.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

Risk Factors May Include:

[Possible Indicators:]

VIOLENCE, risk for, directed at self/others

Chemical alteration, exogenous (CNS stimulants/mind-altering drug), toxic reactions to drug(s)

Organic brain syndrome (drug anesthetizes mind and body)

Psychological state (narrowed perceptual field)

Synesthesias, hallucinations, illusions, visual/auditory distortions; panic state; suspiciousness of others, paranoid ideation, delusions

Hostile, threatening verbalizations; exaggerated emotional response; increased motor activity, pacing, excitement, irritability, agitation

Change in behavior pattern; unpredictable behavior; increasing anxiety, fear, and feelings of loss of control

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

Overt and aggressive acts; self-destructive behavior

Decreased response to pain

Demonstrate self-control, as evidenced by relaxed posture, free of violent behavior.

Acknowledge reality of situation and understanding of relationship of behavior to drug use.

Participate in treatment program.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Place in darkened, quiet, nonthreatening environment with a nonintrusive observer.

Lowered stimulation decreases the likelihood of confusion and fear; thus, there is less chance of violent behavior. Use of an observer promotes safety. **Note:** PCP users seek help only after the situation has gotten out of hand, and it is therefore important to take safe action immediately.

Speak in a soft, nonthreatening voice. Use “Talk-downs” when LSD has been taken. If technique is tried with other drugs (particularly PCP) and agitation increases, stop immediately.

Nonthreatening communication may have a calming effect. However, “Talk-downs” (the use of orientation, support, and reassuring words/touch) may be deleterious in the presence of PCP intoxication, resulting in an increase in the client’s agitation level.

Observe for escalating anxiety, fear, irritability, and agitation.

May indicate potential for progression to violent behavior. **Note:** Client is not in complete control of self because of drug use.

Accept and deal with client’s anger without reacting on an emotional basis.

Responding emotionally on a personal level is not constructive and may escalate reactions.

Provide protection within the environment via constant observation and removal of objects that may be used to hurt self or others.

Reduces risk of injury to client and/or staff. Client may not feel pain and may not be able to follow directions because of use of the drug.

Observe behavior without administering medications.

A period of drug-free observation should precede any decision to administer medications (e.g., antianxiety agents), so that a clear clinical picture can develop. In addition, because it is not known what other drugs may also have been taken, it is not generally advisable to add another drug.

Collaborative

Administer medications as necessary, e.g.:
diazepam (Valium);

Used to reduce muscle spasms and/or restlessness in PCP user.

haloperidol (Haldol).

Preferred to control psychosis and assaultive behavior.

Avoid use of phenothiazine neuroleptics.

Drugs such as chlorpromazine (Thorazine) are generally avoided because of the possibility of potentiating PCP anticholinergic effects.

Apply restraints, if needed, and document reason(s) for use.

Restraints should be avoided in a frightened, hallucinating client but may be necessary because of potential injury to self or others, or when other dangerous drugs have been taken. PCP users are unpredictable, so it is best to err on the side of safety (using restraints with sufficient documentation) rather than to risk injury.

NURSING DIAGNOSIS

**TRAUMA/SUFFOCATION/POISONING,
risk for**

Risk Factors May Include:

Internal factors, host: psychological perception (hallucinations); clouded sensorium and impaired judgment; fear

Muscle incoordination; reduced hand/eye coordination

Decreased response to/perception of pain, reduced temperature/tactile sensation

Clonic movements, muscle rigidity (may precede or occur with generalized seizure activity)

Interactive conditions between individual and environment that impose a risk to the defensive and adaptive resources of the individual (e.g., placing hand in open flame, “flying out of window”); unfamiliar environment

Possibly Evidenced by:

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

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

Verbalize understanding of factors (e.g., drug use) that contribute to possibility of injury and take steps to correct situation.

Initiate behaviors and lifestyle changes necessary to minimize and/or prevent injury.

Maintain/achieve physiological stability as evidenced by patent airway and adequate respiratory/cardiac function.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Ascertain what drugs have been taken.

Necessary for appropriate intervention/anticipation of needs. Lethal overdoses of hallucinogenic drugs (except for MDA, PCP) are rare; however, caution must be taken because adulterants such as sedatives, hypnotics, anticholinergics, and strychnine are often used for “cutting” the drug. **Note:** Two reasons one might not know what drug was taken are (1) the individual lies for legal concerns or may feel embarrassed and (2) the person who sold the drugs to the client either did not know what was in them or lied to the client. In either case, the nurse needs to listen to the client but be aware that the information the client gives may not be accurate.

Anticipate some form of unpredictability and be prepared for the unexpected, including physiological as well as psychological emergencies.

These drugs are dangerous and lead to bizarre thinking/harmful behavior.

Maintain client under close observation. Note precursors that might indicate increasing agitation (e.g., body tension, rising voice tone, quickening of movements). (Refer to ND: Violence, risk for.)

These drugs alter thinking, and many are anesthetic; therefore, the client may hurt self because of bizarre thinking (e.g., attempt to jump out window or escape from restraints).

Remove objects that may be used to hurt self or others.

Provides protection within the environment.

Provide a hockey/bicycle helmet as indicated.

If client is banging head against hard objects, a helmet can decrease the potential for/severity of injury.

Monitor vital signs, respiratory rate/depth and rhythm.

Decreased diastolic BP (cannabis) or hypertensive crisis (PCP) may develop. Bradypnea/respiratory arrest may also occur, especially with PCP or heavy cannabis use.

Assess gag/swallow response and character of respirations.

Hypersalivation and vomiting, especially in the presence of ineffective cough and/or loss of muscle tone, may result in occlusion of airway, crowing/gurgling/choked respirations, leading to respiratory arrest.

Position client on side, or with head to the side, as indicated.

Facilitates drainage of vomitus and buildup of saliva and prevents aspiration in sedated/comatose client.

Encourage fluid intake frequently, if client can swallow safely.

Increased hydration keeps secretions loose and easier to expectorate and enhances renal clearance of drugs.

Have emergency equipment (including airway adjunct/suction) and medications available.

Toxic effects of several of these drugs on the heart and respiratory system may result in cardiac/respiratory arrest, requiring prompt intervention to prevent death.

Collaborative

Administer medications, e.g., diazepam (Valium) as indicated.

May be useful to reduce agitation and hyperactivity once drug(s) used is identified.

Apply restraints with caution when used.

May prevent injury to self or others. However, restraints should be avoided, if possible, in a frightened, hallucinating client, as they can increase agitation.

Transfer to acute medical setting as indicated.

Provides closer monitoring and more aggressive therapy (e.g., IV fluids with ammonium chloride or ascorbic acid for forced diuresis and acidifying of urine to enhance renal clearance of PCP). **Note:** Drug effects are dose related: .5 mg = low dose; .10 mg = high dose; .20 mg can lead to hypertensive crisis, coma, and death because of respiratory/cardiac failure.

NURSING DIAGNOSIS

TISSUE PERFUSION, risk for altered cerebral

Risk Factors May Include:

Alterations in blood flow (hypertensive crisis)

Possibly Evidenced by:

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

Desired Outcomes/Evaluation Criteria—Client Will:

Regain/maintain usual level of consciousness free of adverse neurological symptoms/complications.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Elevate head of bed; keep client's head in midline position.

Enhances venous drainage, thereby reducing risk of vascular congestion that increases intracranial pressure, with possibility of hemorrhage in PCP intoxication.

Observe for pupillary or vital sign changes, decreased level of consciousness and/or motor function.

Provides for early detection and intervention to minimize intracranial pressure/injury.

Encourage rest and quiet. Reduce environmental stimuli.

Promotes relaxation and may help lower blood pressure.

Monitor BP.

Evaluates need for/effectiveness of interventions.

Collaborative

Administer antihypertensive medications, e.g., diazoxide (Hyperstat), hydralazine (Apresoline).

Effective in lowering blood pressure to prevent hypertensive crisis, which can be associated with PCP intoxication.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

THOUGHT PROCESSES, altered

Physiological changes (use of hallucinogenic substance)

Impaired judgment with loss of memory

Inaccurate interpretation of environment, memory impairment, bizarre thinking, disorientation

Inability to make decisions; unpredictable behavior

Cognitive dissonance; distractibility

Inappropriate/nonreality-based thinking

Sleep deprivation

Inability to communicate needs/desires effectively (mutism or confusion)

Exhibit return of cognition/memory and ability to function.

Communicate effectively.

Report absence of visual/auditory distortions.

Verbalize understanding that the drug is the cause of/contributes to alteration in perception.

ACTIONS/INTERVENTIONS

Independent

Observe the client closely; do not leave him or her unattended; make sure restraints are secure when used. Remove objects from the environment that client could use to harm self and/or others. (Refer to ND: Violence, risk for.)

Anticipate some form of unpredictable behavior and be prepared for the unexpected.

Tell client that current thoughts and feelings are a result of the drug, when appropriate.

Allow client to sleep whenever possible.

RATIONALE

PCP is an anesthetic that alters thinking, and client may hurt self by attempting to jump out window, jump in front of cars, escape from restraints, etc. Removal of potentially harmful objects provides for protection and safety.

Use of hallucinogens can lead to bizarre thinking/harmful responses.

This information may be helpful to the client who can accept it; however, it may cause agitation.

Sleep cycle is disturbed, and client will need sleep after being agitated and expending excessive amounts of energy. Sleeping also provides time for drug(s) to clear system.

Observe for behavioral indicators of psychosis (e.g., delusions, hallucinations).

Note altered speech ability/patterns. Refer to loss of speech as temporary.

Anticipate client's needs and allow more time for client to respond to any necessary questions and/or comments.

Collaborative

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

Overdose may precipitate a psychotic episode that will clear within hours to days. If psychosis remains, this may indicate precipitation of preexisting condition (e.g., schizophrenia).

Mutism and confusion may occur, and information may reassure client that problem is drug-induced and that it will improve with time. **Note:** "Talk-down" approach may agitate the client and should be used with caution.

This may reduce need to communicate in presence of confusion/interference with memory. Adequate time allows full expression. **Note:** Be aware that touching and/or physical closeness may increase anxiety and agitation.

Chronic PCP users in whom psychiatric conditions develop/coexist may require further treatment for the thought disorder or depressive illness. The response may be very slow because of the persistence of PCP in the body tissues, sometimes for a period of several months or more.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

ANXIETY [specify level]/FEAR

Situational crisis; threat to/change in health status; perceived threat of death

Inexperience or unfamiliarity with the effect of drug(s) (e.g., PCP, LSD)

Impaired thought processes; sensory impairment

Assumptions of "losing my mind, losing control"; verbalized concern about unknown consequences/outcomes

Sympathetic stimulation (e.g., cardiovascular excitation, superficial vasoconstriction, pupil dilation, vomiting/diarrhea, restlessness, trembling)

Preoccupation with feelings of impending doom; apprehension

Attack behavior

Verbalize awareness/cause of feelings of anxiety.
Report anxiety reduced to a manageable level.

Appear relaxed, resting/sleeping appropriately.

Identify the fear and verbalize feelings of control of self and situation.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess level of anxiety on an ongoing basis.

Increased anxiety may lead to agitation and violent behavior, as client is not in complete control of actions/responses.

Place in darkened, quiet, nonthreatening environment with a nonintrusive observer.

Lowered stimulation decreases the likelihood of confusion and fear. Observer is used for safety (with other personnel available to help if needed).

Orient client to surroundings, time, and who is with him or her. Speak in soft voice, in a nonthreatening manner.

Knowing where one is can increase the feeling of security when experiencing a “bad trip.”

Use “Talk-down” with caution, telling the client that the ingested drug is the cause of feelings of anxiety, the effects are only temporary, and permanent damage should not occur.

Information that provides reassurance can be the single most important therapeutic intervention. “Talk-downs” are effective with persons who have taken LSD or similar substances. If the client can realize that the perceptions are drug-related, then an increase in control can take place. However, in some situations (e.g., PCP), “Talk-downs” can result in an increase in fear and agitation.

Encourage verbal expression of changes in perception that are occurring.

Can be used for assessment and provides guidance on direction for support.

Collaborative

Administer sedatives if necessary, e.g., diazepam (Valium), chlordiazepoxide (Librium).

These are drugs of choice to be used in extreme cases to calm client. **Note:** Medications are often discouraged because bad trips are usually self-limiting, and time is the best remedy for treating the negative effects.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

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

SELF CARE deficit

Perceptual/cognitive impairment

Therapeutic management (restraints)

Inability to meet own physical needs

Resume/perform self-care activities within level of own ability.

Verbalize commitment to lifestyle changes to meet self-care needs.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Provide care as needed.

Client may be agitated and care will need to be postponed until control is regained.

Involve client in formulation of plan of care, as possible.

Enables client to participate at level of ability and enhances sense of control. **Note:** PCP user often cannot interact without becoming agitated.

Work with client's present abilities. Do not pressure to perform beyond capabilities.

Failure can produce discouragement, depression, and agitation.

Provide and promote privacy within limits of safety needs.

Acknowledges human need, important to enhance self-esteem.

Collaborative

Include client in team meeting/staffing as indicated. Problem-solve particulars of self-care needs.

Multidisciplinary approach with involvement of everyone who is caring for the client, along with the client, increases probability of plan being effective/successful.