MENTAL HEALTH NURSING · STUDY GUIDE

Exam 3 Study Guide

This guide covers chapters 5 and 6. First the neurobiology and the medications: why side effects come in days and relief in weeks, how lithium follows sodium, what dopamine blockade costs, and the emergencies that kill quickly. Then the anxious core of three diagnostic families: the anxiety disorders, obsessive-compulsive and related disorders, and the trauma- and stressor-related disorders. Work one chapter at a time. Read the "what to know" paragraphs, study the tables, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts the numbers and red flags in one place.

WHAT THIS GUIDE COVERS

- Chapter 5 · the synapse and reuptake, receptor downregulation and the two clocks, six neurotransmitters, the HPA axis, SSRIs, SNRIs, tricyclics, MAOIs and the outliers, the energy-before-mood window, lithium and its levels, valproate, carbamazepine and lamotrigine, the four dopamine pathways, EPS and tardive dyskinesia, metabolic monitoring, clozapine, long-acting injectables, NMS, serotonin syndrome, benzodiazepines, buspirone, chemical restraint and delegation.
- Chapter 6 · the threat circuit, Peplau's levels of anxiety, when anxiety becomes disorder, panic disorder, agoraphobia, GAD, social anxiety, phobias and separation anxiety, the GAD-7 and medical mimics, OCD and the relief trap, related disorders, exposure and response prevention, PTSD and acute stress disorder, adjustment and prolonged grief, trauma-informed care and grounding, the medications and the red flags.

CHAPTER 5

Neurobiology and Psychopharmacology

Read it in full: **Chapter 5 in the textbook**. Practice it in the lab: **The Synapse and the Two Clocks** and **The Lithium Level Bench**.

What to know

Neurons release transmitter into the **synaptic cleft**, receptors read it, and it is cleared by **reuptake** into the presynaptic neuron or by enzymes (monoamine oxidase and COMT). Every drug in this

chapter changes synthesis, release, receptor binding, reuptake or enzyme activity. Blocking reuptake raises transmitter within hours, so side effects come fast. Benefit comes from slower **receptor downregulation** and plasticity over weeks. Side effects run on pharmacokinetic time; benefit runs on neuroplastic time. Sort a finding by when it started: hours is pharmacology, three to four weeks is therapeutic effect, months in movement is tardive.

Six transmitters explain most of what you see. **Dopamine**: reward, movement, salience. **Serotonin**: mood, anxiety, sleep, appetite, sex, gut. **Norepinephrine**: arousal and sympathetic drive. **GABA**: the brake (benzodiazepines, alcohol). **Glutamate**: excitation and learning (ketamine, esketamine). **Acetylcholine**: memory and parasympathetic tone, so blocking it gives dry mouth, blurred vision, constipation, retention, tachycardia and delirium in older adults. No disorder is one chemical; the "chemical imbalance" story is retired. The HPA axis (CRH, ACTH, cortisol) links chronic stress and trauma to illness, and neuroplasticity means the brain can learn new patterns.

SSRIs are first line because they are safest in overdose and easiest to tolerate. SNRIs add norepinephrine effects (pain benefit, blood pressure rise with venlafaxine). Early effects such as nausea and jitteriness settle in one to two weeks; sexual dysfunction persists in a minority, so ask. Watch hyponatremia in older adults and bleeding with NSAIDs or anticoagulants. Sleep and appetite improve first, then energy, and **mood last at two to six weeks**. Energy before hope is the raised-risk window behind the boxed warning for people under 25: increase contact and screen directly in weeks one to four.

Tricyclics are lethal in overdose (sodium channel block, QRS widening). **MAOIs** need a tyramine-restricted diet (aged cheese, cured meats, soy sauce, tap beer, sauerkraut, yeast extract) and a two week washout before a serotonergic drug, five weeks after fluoxetine. **Bupropion** has no sexual dysfunction or weight gain, helps smoking cessation and lowers the seizure threshold, so avoid it in seizure and eating disorders. **Mirtazapine** sedates and boosts appetite, more so at lower doses. **Trazodone** can cause priapism. **Esketamine** needs a certified setting and two hours of monitoring. Abrupt stopping of paroxetine or venlafaxine causes discontinuation syndrome: taper.

Lithium is an ion cleared by the kidney alongside sodium. Range **0.6 to 1.2 mEq/L**, drawn as a 12-hour trough; anything above 1.5 is toxicity. Dehydration, vomiting, diarrhea, fever, heavy sweating, low-salt diets, NSAIDs, thiazides, ACE inhibitors and ARBs raise the level. Teach steady salt, two to three liters of fluid unless contraindicated, acetaminophen instead of ibuprofen, and the **sick-day rule: hold and call**. Monitor kidney and thyroid function, calcium and pregnancy status. **Valproate**: liver, pancreas, ammonia, teratogen. **Carbamazepine**: blood counts, hyponatremia, makes oral contraceptives fail, HLA-B*1502 screen. **Lamotrigine**: titrate slowly; any rash means stop and escalate.

Antipsychotics reach all four dopamine pathways. Blocking **mesolimbic** is the benefit (fewer positive symptoms). Blocking **mesocortical** can worsen negative and cognitive symptoms. Blocking **nigrostriatal** gives movement effects. Blocking **tuberoinfundibular** raises prolactin. Movement effects follow a clock: **acute dystonia** in hours to days (IM benztropine or diphenhydramine; laryngospasm is an airway emergency), **akathisia** in days to weeks (do not give more antipsychotic), **parkinsonism** in weeks, **tardive dyskinesia** in months to years (AIMS every six months on first-generation and every twelve on second-generation agents; anticholinergics make it worse).

Second-generation agents carry a metabolic bill, worst with olanzapine and clozapine. Monitor weight, waist, blood pressure, glucose and lipids. **Clozapine** is best for treatment-resistant schizophrenia and reduces suicide, but needs ANC monitoring (weekly for six months, every two weeks for six months, then monthly), a bowel regimen, and teaching that fever or sore throat means call now. **NMS** builds over days with lead-pipe rigidity, hyperthermia, unstable vital signs, confusion and high CK. **Serotonin syndrome** builds over hours with clonus and hyperreflexia. Long-acting injectables are a choice, never a punishment.

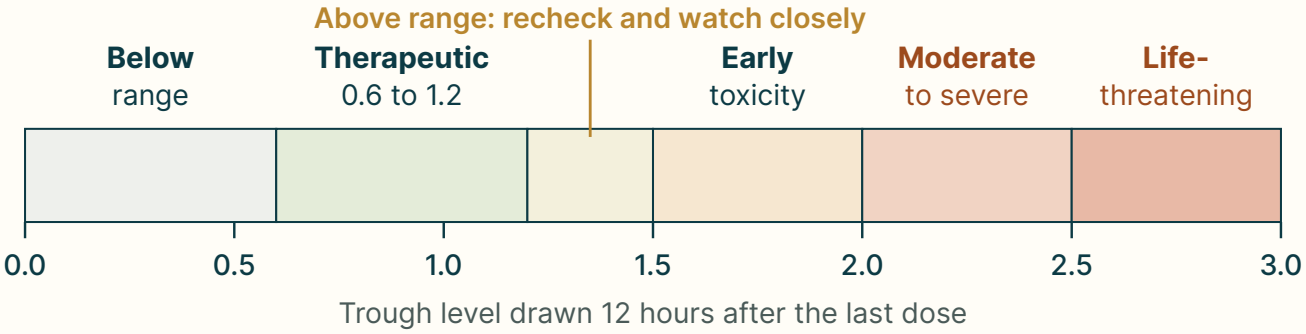
Benzodiazepines work in minutes and suit crisis, catatonia and alcohol withdrawal, but tolerance and dependence follow and abrupt stopping can cause seizures. Avoid with opioids and alcohol; watch falls in older adults. **Buspirone** takes two to four weeks and is not a PRN. **Hydroxyzine** is a non-habit-forming PRN; **propranolol** treats performance anxiety and akathisia. A PRN the person accepts is treatment; the same drug forced to control behavior is a **chemical restraint** with

all the legal rules of physical restraint. Assistive personnel never give medications, do the AIMS or teach. Charting is behavior, never "non-compliant" or "drug-seeking."

LOCK THESE IN

- Side effects in days, benefit in weeks: sort findings by time of onset.
- Antidepressants: mood at 2 to 6 weeks; energy returns first; screen directly in weeks 1 to 4.
- Lithium 0.6 to 1.2 mEq/L trough; above 1.5 is toxic; low sodium or volume means high lithium.
- Sick-day rule for lithium: vomiting, diarrhea or fever means hold and call.
- Dystonia hours, akathisia days to weeks, parkinsonism weeks, TD months to years.
- NMS: days, rigidity, low reflexes. Serotonin syndrome: hours, clonus, hyperreflexia.
- Clozapine: ANC schedule, bowel regimen, fever or sore throat means check the ANC.
- MAOI: tyramine diet; 2 week washout, 5 weeks after fluoxetine.

Serum lithium, drawn to scale (mEq/L)



Trough level drawn 12 hours after the last dose

0.6 to 1.2	Fine tremor, polyuria, thirst, metallic taste: expected
1.5 to 2.0	Coarse tremor, vomiting, diarrhea, ataxia, slurred speech: hold, stat level
2.0 to 2.5	Marked ataxia, nystagmus, tinnitus, confusion: urgent escalation
Above 2.5	Seizures, dysrhythmia, coma, renal failure: prepare for dialysis

Low sodium or low volume means high lithium.

A narrow window. The therapeutic band is barely wider than the gap to toxicity. Dehydration, vomiting, fever, NSAIDs, thiazides and ACE inhibitors all push the level to the right.

Antidepressant classes

Class	Examples	Watch for
SSRI	Sertraline, escitalopram, fluoxetine, paroxetine	Nausea, sexual dysfunction, hyponatremia, bleeding risk; paroxetine worst discontinuation
SNRI	Venlafaxine, duloxetine	Raised blood pressure, sweating; pain benefit
Tricyclic	Amitriptyline, nortriptyline, clomipramine	Anticholinergic load, orthostasis, lethal overdose with QRS widening
MAOI	Phenelzine, tranylcypromine, selegiline patch	Tyramine crisis, serotonin syndrome, washout rules
NDRI	Bupropion	Lowers seizure threshold; no sexual dysfunction; smoking cessation
Tetracyclic	Mirtazapine	Sedation and appetite gain, more sedating at lower doses
Glutamatergic	Esketamine, ketamine	Fast effect on suicidal ideation; dissociation; monitored setting

Movement effects and emergencies

Effect	Onset	What you see	Response
Acute dystonia	Hours to days	Torticollis, oculogyric crisis, laryngospasm	IM benztropine or diphenhydramine; airway first
Akathisia	Days to weeks	Inner restlessness, pacing; called "anxiety"	Lower dose or switch; propranolol
Parkinsonism	Weeks	Bradykinesia, cogwheel rigidity, shuffling	Dose cut, anticholinergic or amantadine
Tardive dyskinesia	Months to years	Lip smacking, tongue protrusion, grimacing	AIMS; VMAT2 inhibitor; stop anticholinergics
NMS	Days, often after a dose increase	Lead-pipe rigidity, hyperthermia, high CK	Stop the antipsychotic, cool, fluids, escalate
Serotonin syndrome	Hours	Agitation, clonus, hyperreflexia, diarrhea	Stop serotonergic drugs, cool, benzodiazepine
Agranulocytosis	Clozapine, carbamazepine	Fever, sore throat	Hold, stat ANC
Tyramine crisis	After tyramine on an MAOI	Occipital headache, stiff neck, high BP	Hold, urgent escalation

Worked cases

WORKED CASE 1 · LITHIUM AFTER THE FLU

Mr. Bell, 46, takes lithium for bipolar I disorder. His last level was 0.9 mEq/L. He has had vomiting and diarrhea for two days and took ibuprofen for aches. Today he has a coarse tremor, slurred speech and an unsteady gait.

STEP 1 · LINK THE CAUSE

Vomiting and diarrhea lower volume and sodium; ibuprofen (an NSAID) reduces lithium clearance. Both push the level up.

STEP 2 · READ THE SIGNS

Coarse tremor, slurred speech and ataxia fit early toxicity, about 1.5 to 2.0 mEq/L. A fine tremor would have been expected; a coarse one is not.

STEP 3 · ACT

Hold the dose, notify the prescriber, request a stat level, assess hydration.

STEP 4 · SBAR HEADLINE

"Coarse tremor, vomiting and ataxia after two days of gastroenteritis and ibuprofen use: requesting a stat lithium level."

TEACH FOR NEXT TIME

Sick-day rule: with vomiting, diarrhea or fever, hold and call. Use acetaminophen, not ibuprofen.

WORKED CASE 2 · RESTLESS, OR ANXIOUS?

Ms. Nguyen, 24, started haloperidol five days ago. She paces, cannot sit through lunch and says, "I have to keep moving." A note reads "increasingly anxious and agitated; give PRN haloperidol."

STEP 1 · CHECK THE CLOCK

Days after starting a high-potency antipsychotic is the akathisia window.

STEP 2 · ASK THE SEPARATING QUESTION

"Is the restlessness on the inside, like you cannot make your legs be still, or is it worry in your thoughts?" She says it is in her legs.

STEP 3 · AVOID THE ERROR

More antipsychotic makes akathisia worse.

STEP 4 · REPORT

"This looks like akathisia, not anxiety." Anticipate a dose reduction, a switch or propranolol.

WHY IT MATTERS

Akathisia distress can be severe enough to raise suicide risk.

WORKED CASE 3 · NMS OR SEROTONIN SYNDROME?

Two clients. Client A: haloperidol increased two days ago; temperature 39.4 °C, rigid arms, low reflexes, confused. Client B: sertraline plus tramadol given six hours ago; agitated, sweating, ankle clonus, brisk reflexes.

STEP 1 · COMPARE ONSET

A developed over days; B over hours.

STEP 2 · COMPARE TONE

A has lead-pipe rigidity with low reflexes; B has clonus and hyperreflexia.

STEP 3 · NAME THEM

A: **neuroleptic malignant syndrome**. B: **serotonin syndrome**.

STEP 4 · ACT ON EACH

A: hold the antipsychotic, cool, fluids, stat CK, escalate. B: stop the serotonergic drugs, cool, escalate; expect a benzodiazepine and possibly cyproheptadine.

ONE LINE TO REMEMBER

Rigid and lead-pipe points neuroleptic; jerky and clonic points serotonergic.

WORKED CASE 4 · THE ANTIDEPRESSANT WINDOW

Mr. Ross, 22, started sertraline ten days ago. His mother says he is up and showering again but still says "nothing will ever change." She asks if this means it is working.

STEP 1 · PLACE HIM ON THE TIMELINE

Energy usually returns before mood, which lifts at two to six weeks.

STEP 2 · SEE THE HAZARD

More energy with ongoing hopelessness is the raised-risk window, especially under 25.

STEP 3 · ACT

Screen directly: "Are you having thoughts of killing yourself?" Increase contact and review the safety plan.

STEP 4 · TEACH THE FAMILY

"If the energy comes back before the hope does, call us that day."

ALSO WATCH

Less sleep with more energy and goal-directed activity in week two may be a switch into hypomania, not a good response.

TRAPS PEOPLE FALL INTO

- **Expecting mood to lift in week one.** Side effects come first; mood takes two to six weeks.
- **Calling a fine lithium tremor toxicity.** Fine tremor is expected. Coarse tremor with vomiting or ataxia is not.
- **Giving ibuprofen to a client on lithium.** NSAIDs raise the level. Use acetaminophen.
- **Treating akathisia as agitation.** More antipsychotic makes it worse.
- **Using anticholinergics for tardive dyskinesia.** They worsen it. Screen with AIMS and report.
- **Mixing up NMS and serotonin syndrome.** Onset and muscle tone separate them.
- **Calling a depot injection a punishment.** It is a choice that removes the daily decision.

- **Charting "drug-seeking."** Chart what the person said and did, and assess the need.

Chapter 5 self-test · ten items

1. Why do SSRIs cause nausea in days but lift mood only after weeks?

A. The liver blocks the drug for the first few weeks
B. Nausea must pass before any mood effect can start
C. Benefit depends on slow receptor and plasticity changes
D. The drug needs weeks to reach the bloodstream at all

C. Benefit depends on slow receptor and plasticity changes Reuptake blockade is immediate, so side effects come fast. Mood improves through downregulation and plasticity over weeks.

2. Which effect follows from blocking acetylcholine?

A. Tremor, rigidity and a slow, shuffling gait
B. Raised prolactin with galactorrhea and amenorrhea
C. Clonus and hyperreflexia, most marked in the legs
D. Dry mouth, constipation and urinary retention

D. Dry mouth, constipation and urinary retention Anticholinergic effects include dry mouth, blurred vision, constipation, retention, tachycardia and delirium in older adults.

3. A client on phenelzine reports a pounding occipital headache after a salami and aged cheese sandwich. What does the nurse suspect?

A. Tyramine hypertensive crisis
B. An acute dystonic reaction
C. Serotonin syndrome from the MAOI
D. Early lithium toxicity

A. Tyramine hypertensive crisis MAOIs block the enzyme that destroys dietary tyramine, which then drives a hypertensive crisis.

4. Which drug most raises a lithium level?

A. Sertraline at a stable dose
B. Ibuprofen taken for aches
C. Acetaminophen taken for fever
D. Lorazepam given for anxiety

B. Ibuprofen taken for aches NSAIDs, thiazides, ACE inhibitors and ARBs raise lithium. Acetaminophen is the safer choice.

5. A client's lithium trough is 1.0 mEq/L and he has a fine hand tremor and thirst. What is the best action?

A. Call a rapid response for early toxicity
B. Restrict his fluids to bring the level down
C. Hold the dose and request a stat repeat level
D. Treat it as expected; keep routine monitoring

D. Treat it as expected; keep routine monitoring The level is therapeutic and fine tremor and polydipsia are expected effects.

6. Which teaching belongs with lamotrigine?

A. Any new rash means stop and call right away
B. Avoid aged cheese and cured meats
C. Draw a trough level 12 hours after each dose
D. Report fever or sore throat for an ANC

A. Any new rash means stop and call right away Rapid titration raises the risk of Stevens-Johnson syndrome, so any rash is escalated at once.

7. Months into antipsychotic therapy, a client has lip smacking and tongue protrusion. What is this?

A. Akathisia with pacing
B. Pseudoparkinsonism
C. Tardive dyskinesia
D. Acute dystonic reaction

C. Tardive dyskinesia Tardive dyskinesia is the late effect, months to years, screened with the AIMS.

8. A client on clozapine has a fever of 38.6 °C and a sore throat. What is the priority?

A. Give acetaminophen and recheck tomorrow
B. Hold the dose and request a stat ANC
C. Start a bowel regimen right away
D. Encourage fluids and rest overnight

B. Hold the dose and request a stat ANC Fever or sore throat on clozapine is agranulocytosis until an absolute neutrophil count proves otherwise.

9. Which finding best separates serotonin syndrome from NMS?

A. A rapid heart rate with heavy sweating
B. Confusion and altered mental status
C. Inducible ankle clonus, brisk reflexes
D. A temperature above 38 °C and rising

C. Inducible ankle clonus, brisk reflexes Both can cause fever, tachycardia and confusion. Clonus and hyperreflexia point to serotonin; lead-pipe rigidity points to NMS.

10. A client is started on buspirone for generalized anxiety. What should the nurse teach?

A. It takes 2 to 4 weeks and is not for rescue
B. Take it whenever a panic attack begins
C. It works in minutes like lorazepam does
D. It is habit forming and must be tapered

A. It takes 2 to 4 weeks and is not for rescue Buspirone is non-sedating and non-addictive but slow, so it is useless as a PRN.

CHAPTER 6

Anxiety, Obsessive-Compulsive and Trauma-Related Disorders

Read it in full: **Chapter 6 in the textbook**. Practice it in the lab: **The Anxiety Level Dial** and **The Relief Trap**.

What to know

Anxiety is the body's alarm. Sensory input reaches the thalamus and takes a fast route to the **amygdala**, which drives the sympathetic surge and the HPA axis (CRH, ACTH, cortisol). The **prefrontal cortex** appraises and brakes it, and the **hippocampus** stamps memory with place and time. In anxiety and trauma disorders the amygdala is loud and the braking is weak, so reasoning with a person in severe anxiety fails and breathing and grounding work. GABA (benzodiazepines), serotonin (SSRIs over weeks) and norepinephrine (hyperarousal; prazosin for nightmares) carry most of the clinical weight. Explain the physiology: "That is epinephrine. It is unpleasant and it is not dangerous."

Peplau's levels are the bedside tool. Mild: the field widens and learning is enhanced, so teach. Moderate: the field narrows; give short directions and paced breathing. Severe: fixed on one detail, cannot problem-solve; stay, reduce stimuli, short simple sentences, do not teach. Panic: disorganized, may dissociate, risk of injury; ensure safety, minimal words, quiet space, PRN per

order, never leave alone. As anxiety rises, your sentences get shorter and your voice lower and slower.

Anxiety becomes a disorder through **proportion** (judged against culture and context), **persistence** (six months for GAD, phobia and social anxiety; more than one month for PTSD) and **impairment**, usually through avoidance. Avoidance works in the short term, which is why it is hard to give up, and it keeps the fear from ever being disconfirmed. About one in five adults has an anxiety disorder in a year, often starting in childhood, with heavy overlap with depression and substance use, so screen for suicide too.

A **panic attack** peaks within minutes with at least four symptoms and usually resolves in twenty to thirty minutes; it is a specifier, not a diagnosis. **Panic disorder** adds at least a month of worry about more attacks or avoidance: the fear of the fear. Panic mimics MI, PE, arrhythmia, hypoglycemia and thyrotoxicosis, so a first attack after forty, syncope, hypoxia or an abnormal ECG means a medical workup. **Agoraphobia** needs two or more of five situations. **GAD** is six months of hard-to-control worry with three of six physical symptoms. Blood-injection-injury phobia causes a vasovagal faint, so lay the person supine. Separation anxiety can occur in adults.

The **GAD-7** is scored 0 to 21 with cut points at 5, 10 and 15; 10 or more warrants evaluation. Pair it with a depression screen and a direct suicide question. Subtract the mimics: hyperthyroidism, hypoglycemia, arrhythmia, asthma, PE, caffeine, stimulants, decongestants, albuterol, steroids and withdrawal. **Akathisia** is the "anxiety" that gets worse every time you treat it as anxiety. Avoid false reassurance, "why" questions, "I know exactly how you feel," advice and minimizing.

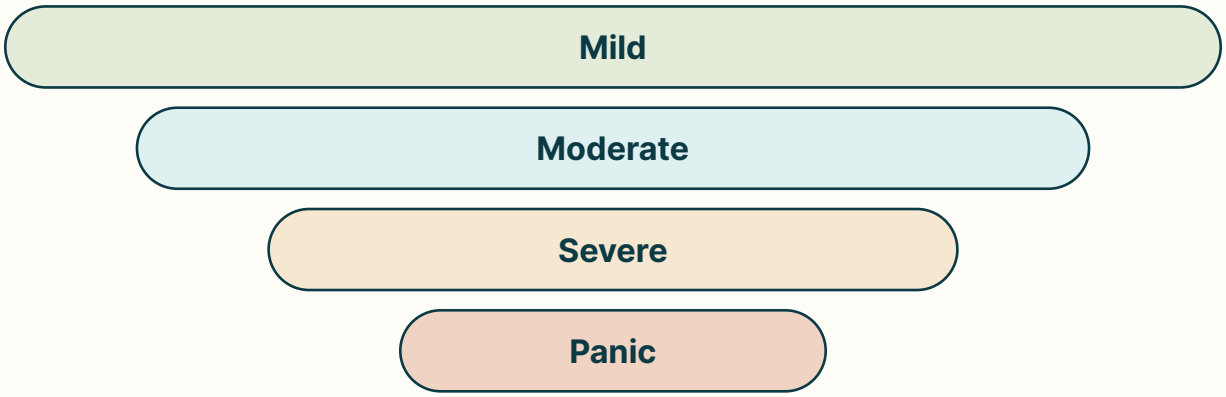
Obsessions are intrusive, unwanted and ego-dystonic; **compulsions** are rituals that briefly reduce distress. The relief reinforces the ritual: the relief trap. OCD requires more than an hour a day or significant distress or impairment, with an insight specifier; severity is measured with the Y-BOCS. A parent with intrusive images of harming an infant is describing an obsession, not an intention. Do not confuse OCD with obsessive-compulsive personality disorder, which is ego-syntonic. Related disorders: body dysmorphic disorder (high suicidal ideation), hoarding (never force a clear-out), trichotillomania and excoriation (habit reversal training).

Never abruptly block a ritual. Early on, allow and schedule it (wake the person earlier), record its frequency and duration, then reduce it collaboratively. **Exposure and response prevention** is the gold standard: graded exposure while the ritual is withheld, so the brain learns the catastrophe does not come. Reassurance-seeking is a compulsion, so kindly decline to answer the fifth "are you sure?" SSRIs for OCD need higher doses and eight to twelve weeks; clomipramine needs a baseline ECG. Watch skin breakdown, dehydration and poor sleep.

PTSD needs a Criterion A event (actual or threatened death, serious injury or sexual violence, directly, witnessed, learned about a close person, or repeated work exposure) plus four clusters for **more than one month**: intrusion, avoidance, negative changes in thinking and mood, and arousal and reactivity. **Acute stress disorder** runs from three days to one month. Single-session debriefing is not supported; psychological first aid is. **Adjustment disorder** starts within three months of a stressor and resolves within six months after it ends. **Prolonged grief disorder** lasts at least twelve months in adults. For flashbacks use **grounding** (5-4-3-2-1, feet on the floor, cold water), no unannounced touch, and do not ask for the trauma story. Prazosin helps nightmares; watch first-dose orthostasis.

> **LOCK THESE IN**
>
> - Mild: teach. Moderate: short directions. Severe: stay and do not teach. Panic: safety, never alone.
> - Disorder needs proportion, persistence and impairment; avoidance is the engine.
> - Panic attack peaks in minutes and passes in 20 to 30; rule out MI and other mimics first.
> - GAD-7: 0 to 21; cut points 5, 10, 15; 10 or more needs evaluation.
> - Never rip a ritual away; schedule it, measure it, reduce it together.
> - Reassurance-seeking is a compulsion; presence is the care.
> - PTSD: event plus intrusion, avoidance, negative cognition and mood, arousal, for over a month.
> - Flashback: grounding and orientation, not the trauma narrative.

Peplau's levels of anxiety: the perceptual field narrows



Level	Perception	What the nurse does
Mild	Field widens; learning enhanced	Teach now
Moderate	Field narrows to the task at hand	Short directions, paced breathing
Severe	Fixed on one detail; cannot problem-solve	Stay, cut stimuli, do not teach
Panic	Disorganized; may dissociate; injury risk	Safety, presence, never alone

As anxiety rises: shorter sentences, lower voice, fewer choices, steadier presence.

Grade it before you act. The level decides whether the person can be taught, redirected or only accompanied. Teaching belongs to mild and moderate anxiety, never to severe or panic.

The anxiety disorders

Disorder	Core fear	Duration	Nursing focus
Panic disorder	The next attack and what it means	Attacks plus 1 month of worry or change	Rule out mimics; stay during attacks
Agoraphobia	Being unable to escape or get help	6 months; 2 or more situations	Graded exposure; avoid companion dependence
GAD	Uncontrollable worry in many areas	6 months, most days	Sleep, caffeine, muscle tension, worry time
Social anxiety	Negative evaluation, humiliation	6 months	Role-play and rehearsal; not alcohol
Specific phobia	One object or situation	6 months	Desensitization; supine for blood-injection-injury
Separation anxiety	Loss of an attachment figure	6 months adults; 4 weeks children	Predictable routine; rehearsed separations

Anxiety medications at a glance

Drug	Onset	Nurse monitors and teaches
SSRIs	4 to 6 weeks (8 to 12 for OCD)	Early jitteriness; start low; no abrupt stop; suicidality under 25
SNRIs	4 to 6 weeks	Blood pressure; venlafaxine discontinuation
Buspirone	2 to 4 weeks	Not a PRN; not sedating; no dependence
Benzodiazepines	Minutes	Falls, amnesia; never with opioids or alcohol; taper
Hydroxyzine	15 to 60 minutes	Anticholinergic effects, falls
Prazosin	Days to weeks	Bedtime; first-dose orthostasis and syncope
Propranolol	Within an hour	Hold for low HR or BP; avoid in asthma
Clomipramine	Weeks	Baseline ECG; lethal in overdose

Worked cases

WORKED CASE 1 · MATCHING WORDS TO THE LEVEL

Ms. Adeyemi, 38, is in the ED. She is hyperventilating, says her head is pounding, keeps staring at the monitor and cannot follow your questions. Her ECG and glucose are normal.

STEP 1 · GRADE IT

Fixed on one detail, unable to problem-solve, headache and hyperventilation: **severe** anxiety.

STEP 2 · CHOOSE THE APPROACH

Stay with her, reduce stimuli, short simple sentences, calm repetition. Do not teach now.

STEP 3 · SAY IT

"I am staying right here. Breathe out with me, in for four, out for six. This will pass."

STEP 4 · PLAN TEACHING FOR LATER

When she drops to mild or moderate, explain the physiology and the plan.

WHY THE MIMICS CAME FIRST

Chest symptoms and doom can be MI or PE; a normal ECG and glucose came before calling this anxiety.

WORKED CASE 2 · THE MORNING RITUAL

Mr. Haas, 31, with OCD, washes for two hours every morning and misses breakfast and group. A staff member wants to lock the bathroom at 0730 to "break the habit."

STEP 1 · SPOT THE RISK

Abruptly blocking a ritual pushes anxiety to severe or panic and damages the alliance.

STEP 2 · ALLOW AND SCHEDULE

Wake him earlier so the ritual does not cost breakfast and group.

STEP 3 · MEASURE

Record baseline frequency and duration, and check his hands for fissures and dermatitis.

STEP 4 · REDUCE TOGETHER

As ERP progresses, set collaboratively agreed limits with the team and reduce gradually.

WHEN HE ASKS "ARE MY HANDS CLEAN?"

"I am not going to answer that one, because answering feeds the doubt. Let us sit with it together for ten minutes."

WORKED CASE 3 · A FLASHBACK ON NIGHT ROUNDS

At 0200 you shine a light into Ms. Salcedo's room. She screams, presses herself into the corner and says, "Not again, not again." She has a trauma history.

STEP 1 · STOP THE TRIGGER

Lower the light, step back, stay in sight, no touch.

STEP 2 · ORIENT

"Ms. Salcedo, this is Jordan, your nurse. You are in the hospital. It is Tuesday night and you are safe."

STEP 3 · GROUND

"Can you feel your feet on the floor? Tell me five things you can see."

STEP 4 · DO NOT ASK FOR THE STORY

The goal is safety and orientation, not disclosure.

FIX THE SYSTEM

Change the plan: knock, say your name softly, use indirect light, and explain night rounds at bedtime.

WORKED CASE 4 · SCREENING AND SCORING

Mr. Lopez, 45, scores 14 on the GAD-7. He also says he sleeps four hours, drinks five coffees a day and takes a decongestant.

STEP 1 · READ THE SCORE

0 to 21 scale with cut points 5, 10 and 15: 14 is **moderate**, and 10 or more warrants further evaluation.

STEP 2 · SUBTRACT MIMICS

Caffeine and the decongestant can drive anxiety; ask about thyroid symptoms and other substances.

STEP 3 · SCREEN FURTHER

Add a depression screen and ask directly about suicide, because anxiety, depression and insomnia together raise risk.

STEP 4 · DOCUMENT

Score, date and the plan. A screen with no action is worse than no screen.

REMINDER

The GAD-7 screens; it does not diagnose.

TRAPS PEOPLE FALL INTO

- **Teaching during severe anxiety.** The structure you are appealing to is offline. Teach at mild or moderate.
- **Calling a vigilant immigrant's fear irrational.** Proportion is judged against culture and context.
- **Diagnosing panic by reassurance alone.** A first attack after forty, syncope or an abnormal ECG means a medical workup.

- **Answering "are you sure?" again and again.** Reassurance feeds the compulsion.
- **Locking away a ritual on day one.** Allow, schedule, measure, then reduce collaboratively.
- **Confusing OCD with OCPD.** OCD is ego-dystonic; OCPD is an ego-syntonic lifelong style.
- **Debriefing everyone right after a disaster.** Single-session debriefing can harm. Psychological first aid is supported.
- **Asking for the trauma story during a flashback.** Ground and orient first.

Chapter 6 self-test · ten items

1. A student says, "I am nervous about the exam, so I am reviewing everything." Which level is this?

A. Mild anxiety
B. Severe anxiety
C. Panic level
D. Moderate anxiety

A. Mild anxiety Mild anxiety widens the perceptual field and enhances learning.

2. A client in severe anxiety asks about her new medication. What should the nurse do?

A. Leave her alone so she can read the leaflet herself
B. Stay calm and brief, and teach once anxiety falls
C. Give the full teaching sheet now while she is focused
D. Explain the drug mechanism in detail to reassure her

B. Stay calm and brief, and teach once anxiety falls At severe anxiety the field collapses and learning fails. Reduce stimuli, use short sentences and teach later.

3. Which client's first panic attack most needs a medical workup before anxiety is assumed?

A. A 25-year-old with a long history of panic attacks
B. A 19-year-old after a stressful exam week
C. A 52-year-old with chest pain and an abnormal ECG
D. A 30-year-old who calms within twenty minutes

C. A 52-year-old with chest pain and an abnormal ECG A first attack after forty, chest pain and an abnormal ECG point to a possible cardiac cause.

4. A client with blood-injection-injury phobia is due for a blood draw. What does the nurse do?

A. Distract the client while seated upright
B. Give caffeine to raise the heart rate
C. Have the client stand to stay alert
D. Have the client lie down for the draw

D. Have the client lie down for the draw This phobia causes a vasovagal response with bradycardia and fainting, so position supine.

5. What GAD-7 score is the usual threshold for further evaluation?

A. 15
B. 3
C. 10
D. 21

C. 10 Cut points are 5, 10 and 15 for mild, moderate and severe; 10 or more warrants evaluation.

6. A client with OCD asks, for the fifth time, "Are you sure my hands are clean?" Which reply is best?

A. "Why do you keep asking me that very same question?"
B. "Answering feeds the doubt; let us sit with it together."
C. "Go wash them once more and then you will feel better."
D. "Yes, they are perfectly clean, I promise you that."

B. "Answering feeds the doubt; let us sit with it together." Reassurance-seeking is a compulsion. Decline kindly and stay present with the uncertainty.

7. Which feature separates OCD from obsessive-compulsive personality disorder?

A. In OCD the thoughts feel unwanted and alien
B. In OCD the traits are lifelong and valued
C. In OCD there are no repetitive behaviors
D. In OCD the person wants no change at all

A. In OCD the thoughts feel unwanted and alien Obsessions are ego-dystonic. OCPD is an ego-syntonic style the person generally does not want changed.

8. A firefighter has nightmares and avoids work six weeks after a fatal fire. Which diagnosis fits the timing?

A. Adjustment disorder, anxious
B. Prolonged grief disorder
C. Acute stress disorder (ASD)
D. Post-traumatic stress disorder

D. Post-traumatic stress disorder Symptoms beyond one month after a Criterion A event fit PTSD. Acute stress disorder covers three days to one month.

9. During a flashback, which nursing action is correct?

A. Orient her to the present and use grounding
B. Hold her arms firmly to snap her out of it
C. Ask her to describe exactly what she sees
D. Leave her alone until the episode passes

A. Orient her to the present and use grounding Grounding and orientation without unannounced touch. Do not ask for the trauma narrative.

10. A client is starting prazosin for trauma nightmares. What does the nurse teach?

A. Take it each morning along with your breakfast
B. It works within minutes, so use it as a PRN
C. Rise slowly; the first dose can cause fainting
D. It is safe to stop it all at once at any time

C. Rise slowly; the first dose can cause fainting Prazosin is given at bedtime and can cause first-dose orthostatic hypotension and syncope.

ONE PAGE

Cram sheet

Everything from chapters 5 and 6 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
Antidepressant onset	Mood 2 to 6 weeks; full response up to 8	Sleep and appetite first, then energy
Boxed warning	Under 25	Screen directly in weeks 1 to 4
MAOI washout	2 weeks; 5 weeks after fluoxetine	Before a serotonergic drug
Lithium	0.6 to 1.2 mEq/L trough; toxic above 1.5	Levels every 5 to 7 days until stable, then every 3 to 6 months
Lithium fluids	2 to 3 L a day unless contraindicated	Steady salt intake
Valproate range	50 to 125 mcg/mL	Liver, platelets, ammonia
Clozapine ANC	Weekly 6 months, every 2 weeks 6 months, then monthly	Interrupt below 1000; stop below 500
AIMS	Baseline, then every 6 months (first generation) or 12 months (second generation)	Tardive dyskinesia screen
Panic attack	Peaks in minutes; passes in 20 to 30	At least 4 symptoms
GAD-7	0 to 21; cut points 5, 10, 15	10 or more: evaluate
Durations	GAD, phobia, social anxiety 6 months; PTSD over 1 month; ASD 3 days to 1 month	Prolonged grief 12 months
OCD threshold	More than 1 hour a day or major distress	SSRI trial 8 to 12 weeks

Pairs people mix up

Pair	How to tell them apart
NMS vs serotonin syndrome	Days, rigidity, low reflexes, high CK vs hours, clonus, hyperreflexia, diarrhea
Akathisia vs anxiety	Restlessness in the legs after an antipsychotic vs worry in the thoughts
Dystonia vs tardive dyskinesia	Hours to days, spasm vs months to years, choreoathetoid movements
Fine vs coarse lithium tremor	Expected vs toxicity sign
OCD vs OCPD	Ego-dystonic intrusions vs ego-syntonic style
ASD vs PTSD	3 days to 1 month vs more than 1 month
PRN vs chemical restraint	Accepted treatment vs forced control of behavior

Rules that keep people safe

Topic	The rule
Lithium sick day	Vomiting, diarrhea or fever: hold and call.
Lamotrigine	Any rash: stop and escalate.
Clozapine	Fever or sore throat: stat ANC; bowel regimen always.
Benzodiazepines	Taper; never stop abruptly; never with opioids or alcohol.
Rituals	Allow, schedule, measure, reduce collaboratively.
Trauma-informed	Explain before touching; offer choices; same-gender staff for intimate care.
De-escalation	Two real choices beat one command.

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