MENTAL HEALTH NURSING · STUDY GUIDE

Exam 4 Study Guide

This guide covers chapters 7 and 8. First the mood disorders: depression as a whole-body syndrome, the bipolar spectrum, the medications by mechanism and the four emergencies inside mood pharmacology. Then psychosis: the three symptom domains, the duration ladder, the conversation that neither confirms nor argues, the antipsychotics and their emergencies, and the recovery work after discharge. 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 in one place.

WHAT THIS GUIDE COVERS

- Chapter 7 · MDD criteria and SIGECAPS, grief versus depression, persistent depressive and adjustment disorders, medical mimics, the PHQ-9 and the MSE in severe depression, mania and hypomania, bipolar I and II, cyclothymia, mixed features, rapid cycling, postpartum psychosis, the antidepressant trap, nursing care in mania, antidepressants by mechanism, serotonin syndrome, the tyramine reaction, discontinuation syndrome, lithium, valproate, carbamazepine, lamotrigine, ECT, communication, milieu, delegation, suicide screening and safety planning.
- Chapter 8 · positive, negative and cognitive symptoms, catatonia, the duration ladder, schizoaffective and delusional disorder, medical mimics and anti-NMDA receptor encephalitis, cannabis, the violence myth, the MSE in psychosis, command hallucinations, water intoxication, neither confirm nor argue, disorganized speech, the four dopamine pathways, antipsychotic profiles, the four movement timelines, NMS, clozapine, monitoring schedules, de-escalation, restraint law, delegation and recovery-oriented care.

CHAPTER 7

Depressive and Bipolar Disorders

Read it in full: **Chapter 7 in the textbook**. Practice it in the lab: **The Depression Bench: Count It, Name It, Chart It** and **Mania or Hypomania? The Episode Classifier**.

What to know

Major depressive disorder needs five of nine symptoms most of the day, nearly every day, for at least **two weeks**, with depressed mood or **anhedonia** among them. **SIGECAPS** holds the rest: Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor change, Suicidality. Only two of the nine are about feeling; the rest are about how the body runs, which is why "cheer up" is clinically incoherent. Older adults often present with somatic complaints, memory problems and irritability; adolescents with irritability.

Grief comes in waves, keeps self-esteem, still allows pleasure between waves, and thoughts of death are about joining the person who died. Depression is constant, collapses self-esteem into worthlessness, and thoughts of death are about deserving to die. They can coexist. **Persistent depressive disorder** lasts two years in adults (one in youth). **Adjustment disorder** follows a stressor within three months. Rule out hypothyroidism, anemia, B12 and vitamin D deficiency, sleep apnea, Parkinson disease, stroke, pancreatic cancer, pain, and drugs such as steroids, interferon, isotretinoin and alcohol.

The **PHQ-9** is nine items scored 0 to 3; 5, 10, 15 and 20 mark mild, moderate, moderately severe and severe. A positive item 9 needs a direct interview, not a note. The MSE in severe depression shows self-care decline, psychomotor retardation, soft slow speech, flat affect, mood described as "empty," and themes of guilt and death. Chart behavior: "remained in bed four hours, ate two bites," not "unmotivated." Sudden brightness may be response, energy before hope, or a decision made: ask what changed.

Mania: abnormally elevated, expansive or irritable mood with increased energy for at least **7 days** (any duration if hospitalized), with three DIGFAST symptoms (four if only irritable) and marked impairment, hospitalization or psychosis. **Hypomania**: the same list for at least **4 days**, observable to others, without marked impairment, psychosis or hospitalization. Decreased need for sleep is not insomnia: rested on three hours. **Bipolar I** needs one lifetime manic episode. **Bipolar II** needs hypomania plus a major depressive episode and is not milder. **Cyclothymia** is two years of subthreshold swings. **Mixed features** carry the highest suicide risk. Rapid cycling is four or more episodes a year. **Postpartum psychosis**, usually within two weeks of delivery, is an emergency.

Most people with bipolar disorder first present depressed, and diagnosis is delayed by years. An antidepressant alone can trigger a switch to mania, a mixed state or faster cycling, so screen for past elevation first (the Mood Disorder Questionnaire; ask family). In acute mania: low stimulation, high-calorie finger foods and fluids, brief, firm limits that every staff member gives the same way, redirection instead of argument, protection from financial and sexual consequences, and close watch on sleep, hydration and exhaustion.

SSRIs take two to four weeks, sometimes six, for mood; sexual dysfunction, hyponatremia and bleeding risk are the cautions. Bupropion lowers the seizure threshold. Mirtazapine sedates and boosts appetite at low doses. Trazodone: an erection over four hours is an emergency. Tricyclics are lethal in overdose. MAOIs need a tyramine-free diet, no decongestants or dextromethorphan, and a fourteen-day washout (five weeks after fluoxetine). The four emergencies: **serotonin syndrome** (hours; clonus, hyperreflexia; cyproheptadine), **lithium toxicity**, **tyramine crisis** and **Stevens-Johnson syndrome** on lamotrigine. **Discontinuation syndrome** is FINISH: flu-like, insomnia, nausea, imbalance, sensory "zaps," hyperarousal; taper.

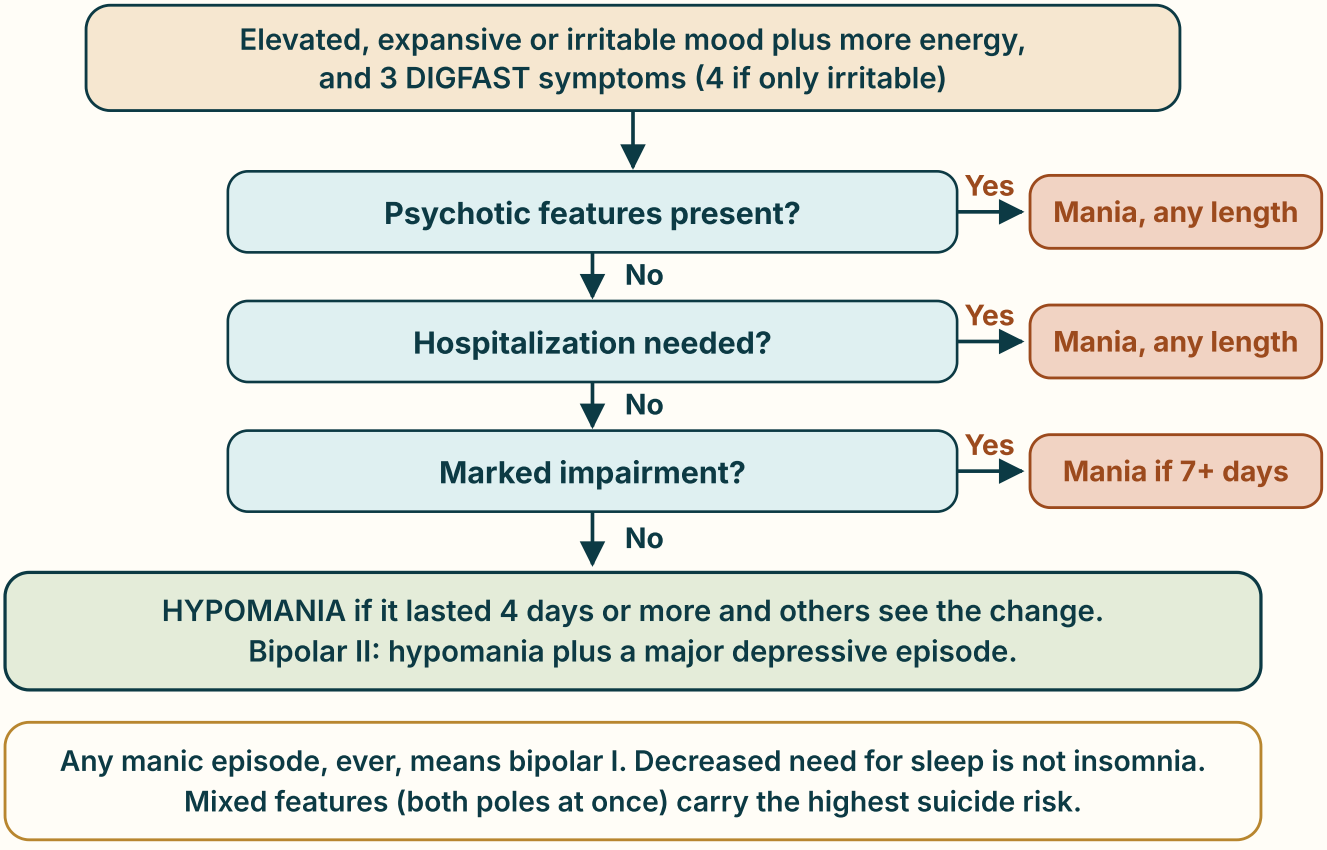
Lithium targets 0.8 to 1.2 mEq/L for acute mania and 0.6 to 1.0 for maintenance, with toxicity above 1.5, severe above 2.0, and dialysis above roughly 2.5. Draw a 12-hour trough. Baseline: renal, thyroid, electrolytes, pregnancy, ECG when indicated; Ebstein anomaly with first-trimester exposure. Valproate: liver, platelets, pancreatitis, ammonia, teratogen. Carbamazepine: blood counts, SIADH, enzyme induction, HLA-B*1502. Lamotrigine: slow titration, re-titrate after more than five missed days, halve the start with valproate, any rash means stop. **ECT** is the fastest treatment for severe, catatonic, psychotic or suicidal depression: NPO, hold benzodiazepines, anticonvulsants and lithium as ordered, expect brief confusion and memory disturbance.

With depression, avoid reassurance, early problem-solving and false cheer; stay with the feeling and screen directly. With mania, avoid arguing, laughing along and long explanations; use short sentences, one message, redirection and a limit stated once. The milieu supplies structure; deliver it trauma-informed. Delegate observation, never interpretation, and insist on verbatim reports. Ask "Are you having thoughts of killing yourself?" then plan, means, timing, intent, prior attempts and protective factors. Build a written safety plan with **means restriction**, not a contract. Risk peaks in the early treatment window and just after discharge or a lowered observation level.

LOCK THESE IN

- MDD: 5 of 9 for 2 weeks, including depressed mood or anhedonia. SIGECAPS.
- PHQ-9 cut points 5, 10, 15, 20; positive item 9 means a direct interview now.
- Mania 7 days or any hospitalization; hypomania 4 days with no psychosis, no hospitalization, no marked impairment.
- One lifetime manic episode means bipolar I. Bipolar II is not milder.
- Mixed features: highest suicide risk. Postpartum psychosis: emergency.
- Screen for past elevation before any antidepressant.
- Serotonin syndrome hours and clonus; NMS days and rigidity.
- Lamotrigine rash: stop and call. MAOI: tyramine diet and 14-day washout.

Mania or hypomania? Three questions decide it



Severity, not the symptom list, decides it. Both use the same symptoms. Psychosis or hospitalization makes it mania at any length; marked impairment for a week makes it mania; otherwise four observable days is hypomania.

Grief, depression and adjustment

Feature	Grief	Major depression	Adjustment disorder
Course	Waves with reminders; eases over months	Most of the day, nearly every day, 2 weeks+	Within 3 months of a stressor; resolves within 6 months after
Self-esteem	Preserved	Worthlessness, guilt	Usually preserved
Pleasure	Present between waves	Pervasive anhedonia	Reduced but present
Death thoughts	Wish to be with the deceased	Others better off; plan may exist	Uncommon; screen anyway

Mania versus hypomania

Dimension	Mania	Hypomania
Duration	7 days, or any length if hospitalized	4 consecutive days
Symptoms	3 (4 if only irritable)	3 (4 if only irritable)
Impairment	Marked	Observable change; function preserved
Psychosis	May be present	Never; psychosis makes it mania
Hospitalization	Often	Not required; if needed, it is mania
Diagnosis	Bipolar I	Bipolar II, with a major depressive episode

Lithium levels in this chapter

Serum lithium	Findings	Nursing action
0.6 to 1.2 mEq/L	Fine tremor, thirst, polyuria, metallic taste	Continue; salt and fluid consistency; sick-day rules
1.5 to 2.0	Nausea, vomiting, diarrhea, coarse tremor, drowsiness	Hold, notify, stat level, assess hydration
2.0 to 2.5	Ataxia, slurred speech, confusion, tinnitus, nystagmus	Urgent notification, IV fluids, monitoring
Above 2.5	Seizures, coma, dysrhythmia, oliguria	Emergency; prepare for hemodialysis

Worked cases

WORKED CASE 1 · COUNTING THE CRITERIA

Ms. Banks, 34, says for three weeks she has slept four hours a night, lost interest in painting, feels worthless, cannot concentrate at work, has lost 4 kg and moves slowly. She denies feeling sad. PHQ-9 is 17 with item 9 scored 1.

STEP 1 · FIND THE GATEWAY

No sadness, but **anhedonia** (lost interest in painting) counts as the required core symptom.

STEP 2 · COUNT SIGECAPS

Sleep, Interest, Guilt or worthlessness, Concentration, Appetite or weight, Psychomotor: six of nine.

STEP 3 · CHECK DURATION

Three weeks: more than two. Criteria for major depression are met, pending medical mimics.

STEP 4 · READ THE PHQ-9

17 falls in the moderately severe band (15 to 19).

STEP 5 · ACT ON ITEM 9

Ask directly now: "Are you having thoughts of killing yourself?" A positive item 9 needs an interview, not a note.

WORKED CASE 2 · BEFORE THE ANTIDEPRESSANT

Mr. Cho, 26, is depressed and about to start sertraline. His sister mentions that last spring he slept three hours a night for a week, felt fantastic, and spent $9,000 on a business idea.

STEP 1 · RECOGNIZE THE HISTORY

Decreased need for sleep with energy, plus risky spending: a past elevated episode.

STEP 2 · DECIDE WHAT IT MEANS

If it lasted a week or caused marked impairment, it was mania (bipolar I); if four days without impairment, hypomania.

STEP 3 · SEE THE DANGER

An antidepressant alone in bipolar depression can trigger a switch, a mixed state or faster cycling.

STEP 4 · ESCALATE

Report the collateral history to the provider before the first dose.

WHY ASK FAMILY

Insight into past hypomania is often poor; the sister supplied what he did not.

WORKED CASE 3 · MANIA ON THE UNIT

Mr. Diaz, 41, in acute mania, has slept two hours, is shouting that he "solved cardiology" and demands a phone now. He has not eaten today.

STEP 1 · REDUCE STIMULATION

Move him to a low-traffic area, dim the lights, turn the television off.

STEP 2 · ANSWER WITHOUT ARGUING

"I can hear how urgent this feels. Phones are open at four. Walk with me to the quiet room."

STEP 3 · FEED THE PERSON WHO CANNOT SIT

High-calorie finger foods and fluids he can carry.

STEP 4 · KEEP LIMITS CONSISTENT

Every staff member states the same brief limit the same way.

MONITOR

Sleep, hydration, weight and exhaustion; unrelieved mania can deplete the body dangerously.

WORKED CASE 4 · THE RASH

Ms. Gold, 30, had her lamotrigine dose increased six days ago. She now has a rash on her trunk, two mouth sores and a temperature of 38.2 °C.

STEP 1 · NAME THE RISK

Stevens-Johnson syndrome or toxic epidermal necrolysis, driven by rapid titration.

STEP 2 · ACT

Hold the drug and escalate immediately; do not wait to see if it spreads.

STEP 3 · SBAR

"New rash on lamotrigine, dose increased six days ago, two oral lesions and temperature 38.2. Drug held. I need immediate evaluation."

RELATED RULES

More than five missed days means re-titrating from the start; valproate doubles lamotrigine levels.

TRAPS PEOPLE FALL INTO

- **Requiring sadness for depression.** Anhedonia alone can be the gateway symptom.
- **Calling grief depression, or ruling out depression because of grief.** Shapes differ, and the two can coexist.
- **Treating decreased need for sleep as insomnia.** The person in mania feels rested; it is an early warning sign.
- **Calling bipolar II "mild."** More time depressed and suicide risk at least equal to bipolar I.
- **Starting an antidepressant without asking about past highs.** Monotherapy can trigger a switch.
- **Arguing with grandiosity.** It reliably escalates. State the limit once and redirect.
- **Celebrating sudden brightness.** Ask what changed; it may be a decision made.
- **Mistaking discontinuation for relapse.** FINISH symptoms after a missed weekend of paroxetine or venlafaxine.

Chapter 7 self-test · ten items

1. A client reports no sadness but has lost all interest in music and friends for three weeks. Which is true?

A. Two weeks is too short to count at all
B. Depression is ruled out without sadness
C. Only grief explains this kind of change
D. Anhedonia can meet the core criterion

D. Anhedonia can meet the core criterion MDD requires depressed mood or anhedonia. Loss of interest can be the gateway symptom.

2. Which feature points to depression rather than uncomplicated grief?

A. Wishing to be with the one who died
B. Constant worthlessness and self-blame
C. Waves of sadness set off by reminders
D. Laughing at a memory of the person

B. Constant worthlessness and self-blame In grief self-esteem is usually preserved. Worthlessness points to depression.

3. What PHQ-9 score marks the start of the moderately severe range?

A. 15
B. 10
C. 5
D. 20

A. 15 Cut points are 5, 10, 15 and 20 for mild, moderate, moderately severe and severe.

4. A client had five days of elevated mood, little sleep and fast speech, then was admitted for safety. What episode is this?

A. Cyclothymia, because it was brief
B. A mixed episode, because of speech
C. Mania, because she was hospitalized
D. Hypomania, because it lasted 5 days

C. Mania, because she was hospitalized Hospitalization makes it mania regardless of duration.

5. Which diagnosis requires at least one lifetime manic episode?

A. Major depressive disorder
B. Cyclothymic disorder
C. Bipolar I disorder
D. Bipolar II disorder

C. Bipolar I disorder Bipolar I needs only one manic episode. Bipolar II has hypomania and major depression but never mania.

6. A new mother, Dana, delivered 10 days ago. She is up all night, confused at times, and says her infant is an impostor. What comes first?

A. Reassure her that this is common baby blues
B. Encourage her to rest while she holds the baby
C. Book an outpatient visit with her for next week
D. Emergency psychiatric evaluation, infant kept safe

D. Emergency psychiatric evaluation, infant kept safe Postpartum psychosis is an emergency with risk to parent and infant.

7. Six hours after a dose change, a client on escitalopram plus tramadol has fever, sweating and lower-limb clonus. What is suspected?

A. Serotonin syndrome
B. Lithium toxicity
C. Tyramine crisis
D. Neuroleptic malignant syndrome

A. Serotonin syndrome Hours after serotonergic changes, with clonus and hyperreflexia, points to serotonin syndrome.

8. A client on lithium wants something for a headache. What should the nurse suggest?

A. Ibuprofen
B. Acetaminophen
C. Ketorolac IM
D. Naproxen

B. Acetaminophen NSAIDs raise lithium levels. Acetaminophen is the safer choice.

9. A man in a manic episode shouts that he has cured cancer and must call the news station this minute. Which reply is best?

A. "Let me explain every one of the unit phone rules."
B. "That is not true, and you know that is not true."
C. "Wow, that is amazing, tell the whole group about it!"
D. "That feels urgent. The phones open at four; walk with me."

D. "That feels urgent. The phones open at four; walk with me." Acknowledge, state the limit once and redirect. Arguing, joining in and long explanations escalate.

10. Which item belongs in a safety plan?

A. Steps to lock away or remove lethal means
B. A signed promise not to harm oneself
C. A pledge to call only the primary nurse
D. A rule that staff will keep it secret

A. Steps to lock away or remove lethal means Safety plans include warning signs, coping, supports, crisis contacts and means restriction. No-suicide contracts lack evidence.

Schizophrenia Spectrum and Other Psychotic Disorders

Read it in full: **Chapter 8 in the textbook**. Practice it in the lab: **The Spectrum Ladder: Domains, Duration and Cause** and **Say-It Bench: Neither Confirm Nor Argue**.

What to know

Psychosis is a change in perception, belief and the organization of thought. **Positive symptoms** are added: hallucinations (auditory most common; visual ones should make you think of delirium, withdrawal or neurological causes), delusions (persecutory most common), disorganized speech and disorganized or catatonic behavior. **Negative symptoms** are the five A's: affective blunting, alogia, anhedonia, avolition, asociality; they are easy to mislabel as laziness. **Cognitive symptoms** (processing speed, working memory, attention, executive function, social cues) best predict work, housing and friendships. Positive symptoms bring people in; negative and cognitive symptoms decide the next ten years.

Catatonia (stupor, mutism, negativism, posturing, waxy flexibility, echolalia, echopraxia, or excitement) is a medical emergency. It responds to benzodiazepines (a lorazepam challenge) and ECT; antipsychotics can worsen it into malignant catatonia, which looks like NMS. A person who stops moving, eating and speaking is not "refusing."

Schizophrenia needs two of five features, at least one of them delusions, hallucinations or disorganized speech, with **six months** of disturbance including one month of active symptoms and a fall in function. Learn the duration ladder: **brief psychotic disorder** one day to one month with full return; **schizophreniform** one to six months; **schizophrenia** six months or more; **delusional disorder** one month or more with function largely preserved. **Schizoaffective** needs a mood episode with psychosis plus two weeks of psychosis without prominent mood symptoms; psychosis only during mood episodes is a mood disorder with psychotic features.

A first episode after forty, or with visual hallucinations, fluctuating attention, fever, headache, seizure, autonomic instability or new neurological signs, is a medical workup. Anti-NMDA receptor encephalitis presents as psychosis with dyskinesias, seizures and autonomic instability in a young adult and is treatable. High-potency cannabis in adolescence is a strong modifiable risk factor. Lifetime prevalence is about 0.3 to 0.7 percent; onset is late teens to mid twenties in men

and late twenties in women. People with schizophrenia are victimized at several times the general rate. About one in twenty dies by suicide, highest early and with preserved insight, and the 10 to 20 year mortality gap is mostly cardiometabolic.

In the MSE, describe affect as blunted, flat, constricted or incongruent, not "inappropriate." Impaired insight is often **anosognosia**, not denial. Document observation and quotes: "stated, 'They put something in the vent,' inspected and declined the meal tray, sat facing the door." Ask about voices and their content directly. Command hallucination risk rises when the voice is identified, believed powerful or benevolent, congruent with a delusion, has been obeyed before, or when substances are involved. Daily weights catch **water intoxication**: a gain of more than three to four percent in a day with confusion means a sodium check now.

The rule: **neither confirm nor argue**. "I believe that you hear that. I do not hear it. It sounds frightening. Tell me what that is like." Move to the feeling, which is always real. For disorganized speech: short sentences, one question at a time, wait through long latency, concrete words, no idioms, less noise. If you cannot follow, say so; if speech is unintelligible, respond to the affect. Do not decode the delusion. Never whisper within sight of a person with persecutory beliefs. Build trust by doing exactly what you said.

Every antipsychotic blocks D2 everywhere. **Mesolimbic**: fewer positive symptoms. **Mesocortical**: can worsen negative and cognitive symptoms. **Nigrostriatal**: EPS and tardive dyskinesia. **Tuberoinfundibular**: high prolactin. Agitation and sleep improve in days, positive symptoms shift in one to two weeks, full response takes four to six weeks or more. Profiles: haloperidol (EPS), chlorpromazine (sedation, orthostasis), risperidone (prolactin), olanzapine (weight), ziprasidone (QT, take with about 500 calories), lurasidone (with at least 350 calories), partial agonists (akathisia). AIMS is every six months on first-generation and every twelve on second-generation agents. Smoking cessation raises clozapine and olanzapine levels.

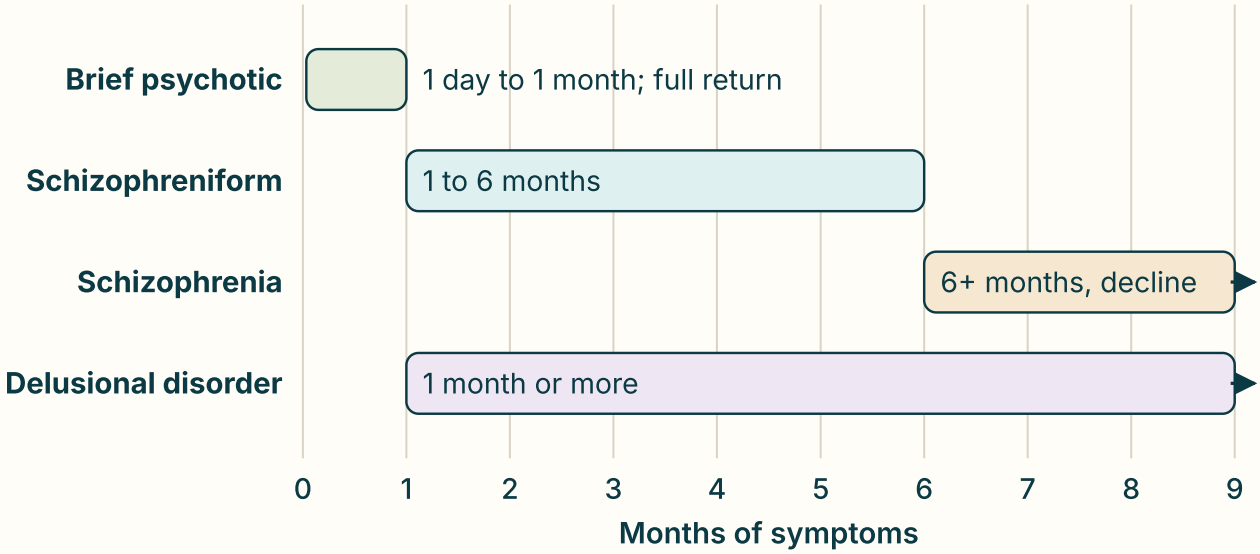
NMS: rigidity, temperature above 38 °C on two occasions, autonomic instability, altered mental status, high CK, usually within two weeks of starting or raising a dose. Hold every antipsychotic, call for help, cool, IV fluids, watch urine output. **Clozapine**: ANC weekly for six months, every two weeks for six months, then monthly; fever or sore throat means an ANC today; myocarditis mostly in the first two months; seizures; constipation and ileus can kill; sialorrhea. De-escalate

early with one speaker, two arm lengths, an angle, choices and an oral PRN offered as a choice. Involuntary admission is not involuntary medication, and anosognosia is not incapacity. Never restrain prone. After discharge, coordinated specialty care, family psychoeducation (lower expressed emotion), assertive community treatment and Individual Placement and Support do the real work. Sleep loss is the earliest relapse signal.

LOCK THESE IN

- Positive symptoms admit; negative and cognitive symptoms decide function.
- Brief under 1 month; schizophreniform 1 to 6; schizophrenia 6 months or more.
- Schizoaffective needs 2 weeks of psychosis without mood symptoms.
- Visual hallucinations or new psychosis after 40: medical workup first.
- Neither confirm nor argue; acknowledge, state your view, move to the feeling.
- Mesolimbic benefit; nigrostriatal movement; tuberoinfundibular prolactin; mesocortical blunting.
- Akathisia on day four is not agitation; do not give more antipsychotic.
- Clozapine fever means ANC today; constipation can kill.

The psychotic spectrum by duration, drawn to scale



Schizoaffective: a mood episode with psychosis PLUS 2 weeks of psychosis without prominent mood symptoms.
Psychosis only during mood episodes: a mood disorder with psychotic features.
Substance-induced: begins with the exposure and resolves with it.

Time sorts the spectrum. The same symptoms get a different name at one month and at six months. Memorize the ladder rather than a list of adjectives.

Antipsychotic profiles

Agent	Class	Watch especially for
Haloperidol, fluphenazine	First generation, high potency	Dystonia, akathisia, parkinsonism, TD, prolactin
Chlorpromazine	First generation, low potency	Sedation, orthostasis, anticholinergic load, photosensitivity
Risperidone, paliperidone	Second generation	Highest prolactin of the group; dose-related EPS
Olanzapine	Second generation	Greatest weight gain and metabolic burden
Quetiapine	Second generation	Sedation, orthostasis, weight; low movement risk
Ziprasidone	Second generation	QT prolongation; take with about 500 calories
Lurasidone	Second generation	Akathisia; take with at least 350 calories
Aripiprazole, brexpiprazole, cariprazine	D2 partial agonists	Akathisia, activation, insomnia; least metabolic
Clozapine	Treatment resistance	Agranulocytosis, myocarditis, seizures, ileus, sialorrhea

Monitoring schedule in this chapter

Monitoring	Baseline	Then
Weight, BMI, waist	Yes	Every visit for 6 months, then quarterly
Blood pressure, glucose or A1c	Yes	At 12 weeks, then yearly
Fasting lipids	Yes	At 12 weeks, then yearly
AIMS	Yes	Every 6 months (first generation) or 12 months (second generation)
ANC on clozapine	Yes	Weekly 6 months, every 2 weeks 6 months, then monthly
ECG	If cardiac risk, ziprasidone, IV haloperidol or clozapine	With dose changes and added QT drugs

Worked cases

WORKED CASE 1 · NAMING IT BY THE CLOCK

Mr. Ali, 22, has heard voices and believed his phone is monitored for three months. He stopped attending classes. There are no mood episodes and no substance use.

STEP 1 · CHECK SYMPTOMS

Hallucinations plus delusions: two of five, including at least one core symptom.

STEP 2 · CHECK DURATION

Three months: more than one, less than six.

STEP 3 · NAME IT

Schizophreniform disorder. If it continues past six months with decline, the diagnosis becomes schizophrenia.

STEP 4 · RULE OUT MIMICS

Vital signs, glucose, neurological check, substances, collateral history.

WHY IT MATTERS

Duration of untreated psychosis is one of the few modifiable predictors of outcome.

WORKED CASE 2 · THE POISONED FOOD

Ms. Okoye, 29, says, "The staff are poisoning my food," and has refused two trays.

STEP 1 · AVOID BOTH ERRORS

Do not say "No one is poisoning you, look, I will eat some." Do not agree.

STEP 2 · NAME THE FEAR

"That would be terrifying to believe."

STEP 3 · STATE YOUR VIEW HONESTLY

"I do not see it that way, and I do not want you to go hungry."

STEP 4 · SOLVE THE PRACTICAL PROBLEM

"Would a sealed carton be easier?" Record intake.

DOCUMENT

Her words in quotation marks, the refusals, and what she accepted.

WORKED CASE 3 · A COMMAND WITH A TARGET

Mr. Ford, 35, tells you, "A voice is telling me to hit that man by the window."

STEP 1 · REINFORCE DISCLOSURE

"Thank you for telling me. That took trust."

STEP 2 · ASSESS RESISTANCE

"Are you able to not do what it says right now? Have you done what it said before?"

STEP 3 · REDUCE STIMULATION

Move somewhere quieter and stay with him; increase observation.

STEP 4 · ESCALATE

Immediate provider evaluation, a named target changes the observation level, and the team builds a safety plan.

NEVER

"Just try to ignore it." A command hallucination is never left unassessed.

WORKED CASE 4 · FEVER ON DAY THREE

Mr. Cole, 27, started haloperidol three days ago with a dose increase yesterday. Temperature 39.4 °C, generalized rigidity, blood pressure swinging 90/50 to 160/95, confused.

STEP 1 · RECOGNIZE

Rigidity, hyperthermia, autonomic instability and altered mentation soon after a dose increase: **NMS**.

STEP 2 · ACT

Hold every antipsychotic dose, call rapid response and the prescriber, core temperature, cooling, IV access for fluids, urine output.

STEP 3 · SBAR

"Possible NMS. Haloperidol started three days ago, raised yesterday. Temperature 39.4, lead-pipe rigidity, labile BP, confused. Drug held. Need you now; requesting CK, CMP, CBC and ICU evaluation."

CONTRAST

Serotonin syndrome would come on in hours with clonus and brisk reflexes.

TRAPS PEOPLE FALL INTO

- **Over-weighting positive symptoms.** Negative and cognitive symptoms predict long-term function.
- **Calling catatonia refusal.** It is a medical emergency; antipsychotics may worsen it.
- **Diagnosing schizoaffective when psychosis only occurs with mood episodes.** That is a mood disorder with psychotic features.
- **Assuming people with schizophrenia are dangerous.** They are victimized several times more often.
- **Saying "yes, I believe you" to end the argument.** Lying costs the relationship. Separate "real to you" from "real."
- **Asking "why" about a delusion.** It demands justification and feels like mockery.
- **Treating akathisia with more haloperidol.** The most common medication error on inpatient units.
- **Treating "no insight" as incapacity.** Anosognosia is not incapacity; involuntary admission is not consent to medication.

Chapter 8 self-test · ten items

1. Which finding is a negative symptom?

A. Persecutory delusions

B. Command auditory hallucinations

C. Loose associations in speech

D. Alogia, or poverty of speech

D. Alogia, or poverty of speech Negative symptoms are losses: blunting, alogia, anhedonia, avolition, asociality.

2. Which symptom domain best predicts whether a person will keep a job and housing?

A. Cognitive symptoms
B. Grandiose delusions
C. Positive symptoms
D. Visual hallucinations

A. Cognitive symptoms Cognitive symptoms are the strongest single predictor of long-term function.

3. Psychosis began suddenly after a house fire and fully resolved in two weeks. What is the likely diagnosis?

A. Schizophreniform disorder
B. Brief psychotic disorder
C. Delusional disorder
D. Schizophrenia

B. Brief psychotic disorder One day to one month with full return to baseline is brief psychotic disorder.

4. A client has had psychosis during manic episodes only. Which diagnosis fits?

A. Delusional disorder, grandiose type
B. Schizoaffective disorder, bipolar type
C. Bipolar disorder with psychotic features
D. Schizophrenia with mood features

C. Bipolar disorder with psychotic features Schizoaffective needs two weeks of psychosis without prominent mood symptoms.

5. A client asks, "Just say you believe me about the voices." Which reply is best?

A. "Why would anyone be talking to you that way?"
B. "Yes, I believe you completely, I really do."
C. "The voices are not real; they are your illness."
D. "I believe it is real to you; I see it differently."

D. "I believe it is real to you; I see it differently." Distinguishing "real to you" from "real" is honest and keeps the alliance.

6. Which side effect follows from tuberoinfundibular dopamine blockade?

A. Lip smacking and tongue thrusting
B. Restlessness and constant pacing
C. Galactorrhea and amenorrhea
D. Apathy and blunted expression

C. Galactorrhea and amenorrhea That pathway normally suppresses prolactin, so blockade raises it.

7. Four days into a new antipsychotic, Mr. Lee rocks in his chair and says his legs will not stay still. What is the best action?

A. Report likely akathisia to the prescriber
B. Encourage him to sit through group anyway
C. Apply restraints for everyone's safety
D. Give the PRN haloperidol for agitation

A. Report likely akathisia to the prescriber Akathisia worsens with more antipsychotic. A dose change or propranolol is anticipated.

8. Which finding is most consistent with NMS rather than serotonin syndrome?

A. Diarrhea and hyperactive bowel sounds
B. Lead-pipe rigidity, reduced reflexes
C. Ankle clonus with brisk tendon reflexes
D. Onset within hours of starting a new drug

B. Lead-pipe rigidity, reduced reflexes NMS develops over days with generalized rigidity and normal or reduced reflexes.

9. A client on clozapine for seven weeks reports chest pain and shortness of breath. What does the nurse request?

A. A lithium level and electrolytes now
B. Troponin, CRP, ECG and an echocardiogram
C. A stat absolute neutrophil count alone
D. A bowel regimen and stool softener

B. Troponin, CRP, ECG and an echocardiogram Myocarditis occurs most often in the first two months of clozapine.

10. A client held involuntarily refuses a routine evening antipsychotic dose. What is true?

A. Involuntary status means he must take it
B. His refusal proves he lacks capacity
C. Staff may give it IM to keep the schedule
D. He may decline it outside an emergency

D. He may decline it outside an emergency Involuntary admission is not involuntary medication. Treatment over objection needs separate review or a true emergency.

Cram sheet

Everything from chapters 7 and 8 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
MDD	5 of 9 symptoms for 2 weeks	Depressed mood or anhedonia required
Persistent depressive disorder	2 years adults; 1 year youth	Often no remembered baseline
PHQ-9	5, 10, 15, 20	Item 9 positive: interview now
Mania / hypomania	7 days (or hospitalized) / 4 days	3 DIGFAST, 4 if only irritable
Rapid cycling	4 or more episodes in 12 months	Poorer lithium response
Postpartum psychosis	Usually within 2 weeks of delivery	Emergency
SSRI onset (Ch 7)	2 to 4 weeks, sometimes 6	Physical side effects in days
MAOI washout	14 days; 5 weeks after fluoxetine	No decongestants or dextromethorphan
Lithium (Ch 7)	Mania 0.8 to 1.2; maintenance 0.6 to 1.0	Toxic above 1.5; dialysis above about 2.5
Lamotrigine	Re-titrate after more than 5 missed days	Halve the start with valproate
Psychosis ladder	Brief under 1 month; schizophreniform 1 to 6; schizophrenia 6+	Delusional disorder 1 month+
Prevalence	0.3 to 0.7% lifetime	About 1 in 20 die by suicide
NMS fever	Above 38 °C on two occasions	Usually within 2 weeks of a start or increase
Water intoxication	Weight gain over 3 to 4% in a day	Check sodium now

Pairs people mix up

Pair	How to tell them apart
Grief vs depression	Waves and intact self-esteem vs constant mood and worthlessness
Decreased need for sleep vs insomnia	Rested on 3 hours vs exhausted on 3 hours
Bipolar I vs II	Any mania vs hypomania plus major depression
Schizoaffective vs mood disorder with psychosis	2 weeks of psychosis without mood symptoms vs psychosis only in episodes
Akathisia vs agitation	Inner restlessness after a new antipsychotic vs escalation from a trigger
NMS vs serotonin syndrome	Days, rigidity, low reflexes vs hours, clonus, brisk reflexes
Anosognosia vs incapacity	Unaware of illness vs unable to weigh this decision

Rules that keep people safe

Topic	The rule
Before antidepressants	Screen for past mania or hypomania; ask family.
Early treatment window	Energy before hope: more contact, direct screening.
ECT	NPO, remove dentures and jewelry, void, hold benzodiazepines, anticonvulsants and lithium as ordered.
Psychosis talk	Neither confirm nor argue; move to the feeling.
De-escalation	One speaker, two arm lengths, an angle, choices, oral PRN offered.
Restraint	Never prone, never alone, never PRN; 1 hour face-to-face; 4, 2, 1 hour limits.
Discharge	Sleep loss is the first relapse signal; family psychoeducation lowers expressed emotion.

Dr. Garg Learning · CC BY-SA 4.0