MENTAL HEALTH NURSING · STUDY GUIDE

Exam 5 Study Guide

This guide covers chapters 9 and 10. First substance use: the circuit every substance hijacks, how the disorder is graded, how to screen everyone, how to talk without confronting, the withdrawal emergencies that kill, and the medications that halve mortality. Then personality disorders: what makes a pattern a disorder, the three clusters, chronic versus acute-on-chronic risk, boundaries, splitting and the team, and the therapies that work. 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 9 · the mesolimbic pathway and the three-stage cycle, tolerance versus addiction, the eleven criteria and severity, person-first language, SBIRT and the screening tools, the substance history and toxicology limits, motivational interviewing and OARS, alcohol withdrawal and CIWA-Ar, Wernicke and Korsakoff, opioid overdose and naloxone, COWS and precipitated withdrawal, stimulants, sedatives and other classes, MOUD, alcohol and nicotine medications, harm reduction, co-occurring disorders, the milieu, 42 CFR Part 2, pregnancy, NOWS, adolescents, older adults and impaired nurses.
- Chapter 10 · traits versus disorders and the general criteria, the biosocial theory, prevalence and the hopeful outcome data, language, Clusters A, B and C, borderline versus bipolar, complex PTSD, the MSE and the interpersonal field, self-injury and suicide, chronic versus acute-on-chronic risk, boundaries and limit setting, splitting, the milieu and delegation, DBT and other therapies, medication as adjunct, drug emergencies, de-escalation, restraint law and SBAR.

CHAPTER 9

Substance Use and Addictive Disorders

Read it in full: **Chapter 9 in the textbook**. Practice it in the lab: **The Withdrawal Clock** and **Say-It Bench: The Conversation That Does Not Argue**.

What to know

A substance use disorder is a chronic, relapsing, treatable brain condition, not a moral failure. Every addictive substance converges on the **mesolimbic pathway** (ventral tegmental area to nucleus accumbens to prefrontal cortex). Repeated surges down-regulate D2 receptors, recruit stress systems in the extended amygdala and weaken the prefrontal brakes. The three-stage cycle is **binge and intoxication**, **withdrawal and negative affect**, and **preoccupation and anticipation**. Cues keep their power for years (incentive sensitization), and the reward set point drops (allostasis), so the person is chasing normal, not euphoria.

Tolerance and withdrawal are not addiction. A person on scheduled morphine for cancer pain has neuroadaptation; DSM-5-TR does not count tolerance and withdrawal when a medication is taken as prescribed. Eleven criteria over twelve months in four clusters: **impaired control**, **social impairment**, **risky use** and **pharmacological**. Two to three is mild, four to five moderate, six or more severe. Quantity, frequency and legality are not criteria.

Language changes treatment: clinicians reading "substance abuser" choose more punitive responses. Say a person with a substance use disorder; positive or negative toxicology screen; recurrence of use or return to use; an infant with neonatal opioid withdrawal syndrome; MOUD is treatment. Chart behavior, never "drug-seeking": requests, ratings and the current MOUD dose, which raises baseline opioid needs.

SBIRT: screen everyone, give a brief motivational intervention to low and moderate risk, refer high risk. Suspicion is biased; screen the retired teacher like everyone else. Tools: NIAAA single question (one or more heavy days positive), **AUDIT-C** (4 or more men, 3 or more women), CAGE or CAGE-AID (2 or more yes), DAST-10 (3 or more), **CRAFFT** for ages 12 to 21 (2 or more), T-ACE and TWEAK in pregnancy. Take the history by substance: agent, route, amount, frequency, and above all **time and amount of last use**, which sets the withdrawal clock. A urine drug screen is an immunoassay, misses fentanyl and others, and is not a lie detector.

Motivational interviewing replaces confrontation, which increases sustain talk. Use OARS: Open questions, Affirmations, Reflections, Summaries. Roll with resistance and ask permission

before informing. Screen for suicide directly: risk rises in intoxication, withdrawal and after a return to use.

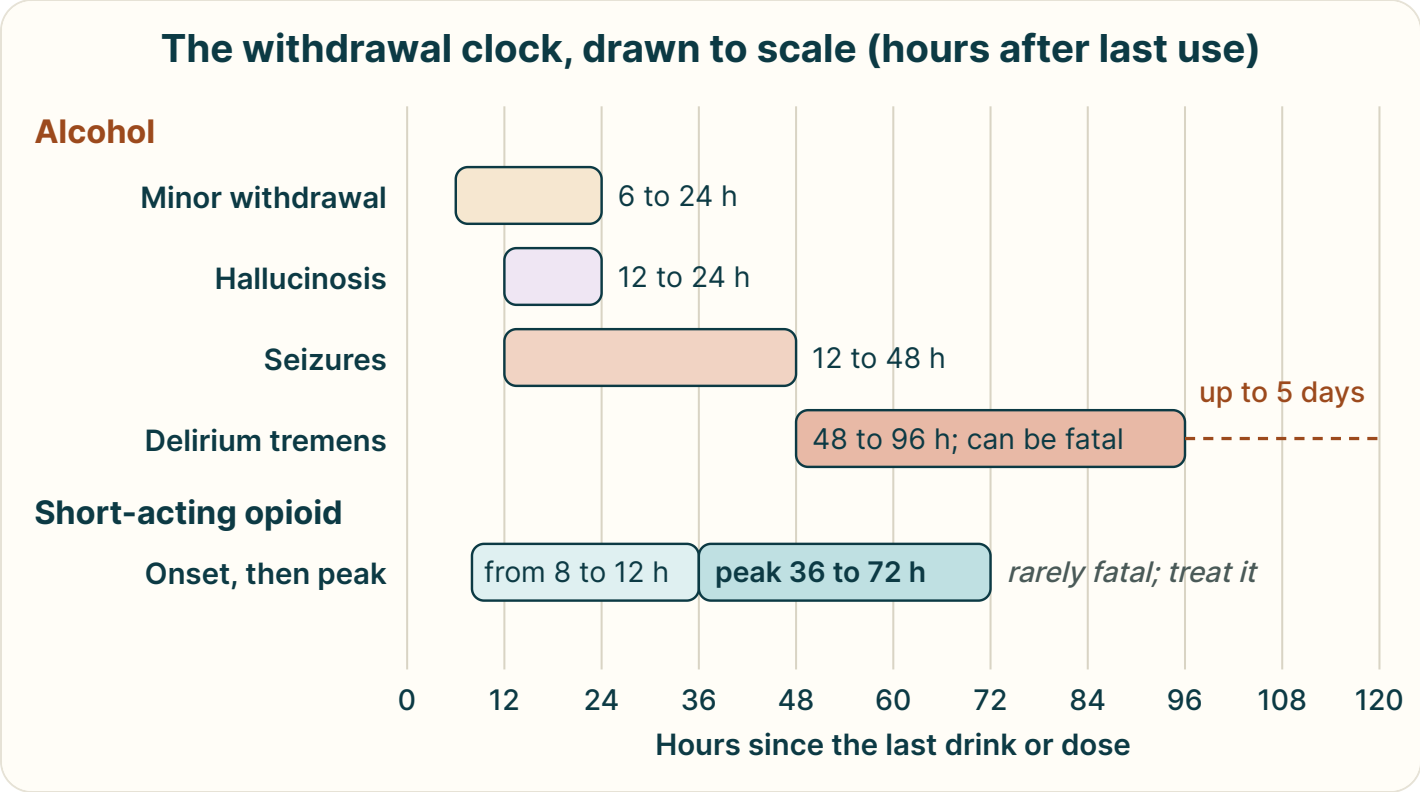
Alcohol withdrawal can kill: chronic alcohol enhances GABA and blocks NMDA, so stopping unmasks a hyperexcitable brain. The clock: minor withdrawal 6 to 24 hours, hallucinosis 12 to 24 hours (sensorium intact), seizures 12 to 48 hours, **delirium tremens 48 to 96 hours** and up to five days. CIWA-Ar has ten items, max 67; dose at about 8 to 10 or more, flag 15 or more, and only in a patient who can communicate. Symptom-triggered benzodiazepines; lorazepam in liver disease or older adults. **Thiamine before glucose**. Wernicke (confusion, eye findings, ataxia; treat on suspicion) can become Korsakoff with confabulation.

Opioid overdose: miosis, respiratory depression, depressed consciousness. **Naloxone** lasts about 30 to 90 minutes, shorter than many opioids, so re-sedation is expected; titrate to breathing (about 12 a minute), not to full alertness. Opioid withdrawal (COWS, eleven items) starts 8 to 12 hours after a short-acting opioid and peaks at 36 to 72; it is rarely lethal but is treated. **Buprenorphine** given too early causes **precipitated withdrawal**; wait for a COWS of about 8 to 12 or use low-dose induction. Stimulants: cool the hyperthermia, benzodiazepines first, no unopposed beta-blockade; screen for suicide in the crash. Never stop benzodiazepines abruptly; flumazenil is not routine. Xylazine sedation is not reversed by naloxone, but give naloxone anyway.

Methadone and buprenorphine roughly halve mortality; never demand a taper to prove commitment. Methadone: full agonist, certified programs, start low and go slow, QTc and CYP3A4 interactions. Buprenorphine: partial agonist with a ceiling on respiratory depression; let the film dissolve fully. Naltrexone: blocks; needs 7 to 14 opioid-free days, opioid analgesics will not work, and tolerance falls. Acamprosate: renal, fine in liver disease. Disulfiram: aversive, hidden alcohol, effect up to 14 days. Offer nicotine replacement on admission. Harm reduction keeps people alive. Integrated care treats co-occurring disorders together. 42 CFR Part 2 tightly protects records. In pregnancy, agonist treatment is standard. NOWS is treated first with rooming-in and Eat, Sleep, Console. Impaired colleagues are reported to alternative-to-discipline programs.

LOCK THESE IN

- Tolerance and withdrawal alone are not addiction.
- 11 criteria: 2 to 3 mild, 4 to 5 moderate, 6+ severe. Quantity is not a criterion.
- Screen everyone; time and amount of last use sets the clock.
- Alcohol: minor 6 to 24 h, hallucinosis 12 to 24 h, seizures 12 to 48 h, DTs 48 to 96 h.
- Thiamine before glucose. Confusion in a person who drinks is Wernicke until proven otherwise.
- Naloxone: titrate to breathing; expect re-sedation.
- Buprenorphine too early causes precipitated withdrawal.
- MOUD halves mortality; patients on MOUD still need full pain treatment.



The last use sets the clock. Time and amount of the last use tell you which danger comes next. Alcohol withdrawal can kill; opioid withdrawal is brutal but rarely lethal, and both are treated.

Screening and severity tools

Tool	Population and target	Positive
NIAAA single question	Adults, unhealthy alcohol use	1 or more heavy days in a year
AUDIT-C	Adults, risky drinking	4+ men; 3+ women (scored 0 to 12)
CAGE / CAGE-AID	Adults, likely dependence	2 or more yes
DAST-10	Adults, drugs other than alcohol	3 or more
CRAFFT	Ages 12 to 21	2 or more
T-ACE / TWEAK	Pregnancy	2 or more
CIWA-Ar	Alcohol withdrawal severity	8 to 10 treat; 15 or more severe
COWS	Opioid withdrawal severity	5 to 12 mild; 13 to 24 moderate; 25 to 36 moderately severe; 37+ severe

Medications for substance use disorders

Medication	Mechanism	Key teaching
Methadone	Full mu agonist, long half-life	Certified program; QTc; no added sedatives
Buprenorphine	Partial agonist, high affinity, ceiling effect	COWS before induction; let the film dissolve; rinse for teeth
Naltrexone	Opioid antagonist; cuts alcohol reward	7 to 14 opioid-free days first; analgesics will not work; overdose risk if use resumes
Acamprosate	Glutamate and GABA balance	Three times daily; renal; diarrhea
Disulfiram	Aldehyde dehydrogenase inhibition	Avoid hidden alcohol; effect lasts up to 14 days
Varenicline	Partial nicotinic agonist	Start before quit date; vivid dreams, nausea
Thiamine	Cofactor replacement	Before or with glucose; prevents Wernicke

Worked cases

WORKED CASE 1 · GRADING THE DISORDER

Mr. Ruiz, 44, says, "I only meant to have two, but it is always the whole bottle. I quit every Monday. My sister will not let me see the kids. I drive after. It takes a fifth now to feel it." Grade it.

STEP 1 · IMPAIRED CONTROL

More than intended; failed efforts to cut down: 2.

STEP 2 · SOCIAL IMPAIRMENT

Continued use despite family problems: 1.

STEP 3 · RISKY USE

Driving after drinking (hazardous use): 1.

STEP 4 · PHARMACOLOGICAL

Tolerance: 1. Total 5 criteria.

STEP 5 · GRADE

Four to five is **moderate** alcohol use disorder. Ask about other criteria (withdrawal, time spent, role failure) before finalizing.

LANGUAGE

"A person with a moderate alcohol use disorder," not "an alcoholic."

WORKED CASE 2 · CIWA-AR TRENDING UP

Mr. Ellery, 58, two days after surgery, last drink Sunday evening, prior withdrawal seizure. His CIWA-Ar rose from 9 to 19 in two hours; HR 128, BP 178/96, T 38.4 °C, visual hallucinations, disoriented to place.

STEP 1 · READ THE TREND

A score of 15 or more and a rise of 5 or more between checks are both escalation triggers.

STEP 2 · PLACE HIM ON THE CLOCK

About 48 hours after the last drink with disorientation and autonomic instability: progressing toward **delirium tremens**.

STEP 3 · ACT

Seizure precautions, symptom-triggered benzodiazepine per protocol, IV thiamine, check magnesium and potassium.

STEP 4 · SBAR

"His CIWA-Ar went from 9 to 19 in two hours and he is disoriented to place. I think he is progressing to DTs. Please see him now; I am requesting front-loaded benzodiazepines, IV thiamine, magnesium and potassium levels and a higher level of care."

CAVEAT

CIWA-Ar needs a patient who can communicate; pain, sepsis or PE can also raise the score.

WORKED CASE 3 · NALOXONE DONE RIGHT

Ms. Park, 31, is found with pinpoint pupils, breathing 4 times a minute and barely rousable. She has an opioid use disorder.

STEP 1 · SUPPORT BREATHING

Open the airway and ventilate.

STEP 2 · GIVE NALOXONE

Titrate to a respiratory rate of about 12 and adequate oxygenation, not to full alertness.

STEP 3 · EXPECT RE-SEDATION

Naloxone lasts about 30 to 90 minutes; fentanyl often needs repeat doses. Keep observing.

STEP 4 · AVOID THE TRAP

Waking her fully precipitates withdrawal and makes leaving to use again more likely.

NEXT

Offer buprenorphine or methadone and send her home with naloxone for her and her family.

WORKED CASE 4 · THE REFLECTION THAT WORKS

Mr. Allen, 50, admitted with pancreatitis, says, "I can stop any time I want. I just do not want to."

STEP 1 · AVOID CONFRONTATION

"If that were true you would not be here" forces him to defend his position and strengthens it.

STEP 2 · REFLECT

"So stopping feels like something in your control, and right now it is not what you want."

STEP 3 · EVOKE CHANGE TALK

"What would have to be different for you to want to?"

STEP 4 · ASK PERMISSION BEFORE INFORMING

"Would it be okay if I shared what we usually see with drinking at that level?"

OARS

Open questions, Affirmations, Reflections, Summaries.

TRAPS PEOPLE FALL INTO

- **Calling tolerance addiction.** A person on prescribed opioids for cancer pain has neuroadaptation, not a use disorder.
- **Asking "how much is too much?"** The diagnosis is functional, not a quantity threshold.
- **Screening only people who "look like" they use.** Suspicion under-detects in women, older adults and professionals.
- **Hanging dextrose before thiamine.** A glucose load can precipitate Wernicke encephalopathy.
- **Naloxone to full alertness.** Titrate to breathing; full reversal precipitates withdrawal.
- **Giving buprenorphine to a comfortable patient who just used.** It precipitates sudden severe withdrawal.
- **"You are already on an opioid."** MOUD raises analgesic needs. Treat the pain.
- **Letting people "detox" untreated.** Opioid withdrawal is treated; admission is a chance to start MOUD.

Chapter 9 self-test · ten items

1. A patient on scheduled morphine for cancer pain develops tolerance and withdrawal when doses are missed. What is true?

A. He meets criteria for a severe use disorder
B. He has a mild disorder based on these two
C. These alone do not count toward a use disorder
D. He should be tapered off to prevent addiction

C. These alone do not count toward a use disorder DSM-5-TR does not count tolerance and withdrawal when a medication is taken as prescribed.

2. How many criteria in 12 months make a substance use disorder moderate?

A. 2 to 3
B. 1 only
C. 6 or more
D. 4 to 5

D. 4 to 5 Two to three is mild, four to five moderate, six or more severe.

3. Which chart entry follows the chapter's language rules?

A. "Toxicology screen positive for opioids."
B. "Patient relapsed and fell off the wagon."
C. "Urine came back dirty for opioids."
D. "Known addict; drug-seeking again."

A. "Toxicology screen positive for opioids." Toxicology is positive or negative. Labels like dirty, addict and drug-seeking are judgments.

4. A 16-year-old is seen in clinic. Which screen fits this age?

A. AUDIT-C
B. CRAFFT
C. CIWA-Ar
D. T-ACE

B. CRAFFT CRAFFT is the adolescent screen for ages 12 to 21; T-ACE is for pregnancy; CIWA-Ar is a severity scale.

5. Which history item most directly sets the withdrawal clock?

A. Longest period of abstinence so far
B. Age at first use of the substance
C. Number of prior treatment episodes
D. Time and amount of the last use

D. Time and amount of the last use Last use tells you when withdrawal will start and which danger comes next.

6. A malnourished client with alcohol use disorder needs IV fluids with dextrose. What comes first?

A. Thiamine
B. Magnesium
C. Folate
D. Glucose

A. Thiamine Give thiamine before or with glucose to prevent Wernicke encephalopathy.

7. When does delirium tremens usually appear after the last drink?

A. 24 to 48 hours
B. 6 to 24 hours
C. 48 to 96 hours
D. 12 to 24 hours

C. 48 to 96 hours Minor withdrawal 6 to 24, hallucinosis 12 to 24, seizures 12 to 48, and DTs 48 to 96 hours.

8. After naloxone, a client is breathing 12 times a minute but sleepy. What is the goal?

A. Discharge once she opens her eyes to voice
B. Adequate breathing, then watch for re-sedation
C. Repeat doses until she is fully awake now
D. Stop monitoring once the first dose works

B. Adequate breathing, then watch for re-sedation Titrate to respiratory adequacy. Naloxone wears off before many opioids, so observe closely.

9. A client who used fentanyl two hours ago is comfortable and asks to start buprenorphine now. What is the risk?

A. Serotonin syndrome
B. Respiratory arrest at once
C. Precipitated withdrawal
D. A tyramine reaction

C. Precipitated withdrawal High-affinity buprenorphine displaces the full agonist and drops receptor activity abruptly.

10. Which teaching belongs with naltrexone?

A. Avoid mouthwash because of a severe reaction
B. Opioid pain medicine will not work while on it
C. Let the film dissolve fully under the tongue
D. Take it three times daily even after drinking

B. Opioid pain medicine will not work while on it Naltrexone blocks opioid receptors, so analgesics fail and tolerance falls. The others describe disulfiram, buprenorphine and acamprosate.

CHAPTER 10

Personality Disorders

Read it in full: **Chapter 10 in the textbook**. Practice it in the lab: **Cluster Console: What Each Pattern Needs From You** and **Say-It Bench: Boundaries, Splitting and the Team**.

What to know

Personality is a person's stable way of perceiving, feeling, relating and controlling impulses. Traits become a **disorder** only when the pattern is **inflexible** and **pervasive**, deviates markedly from cultural expectation in at least two of four domains (cognition, affectivity, interpersonal functioning, impulse control), is stable from adolescence or early adulthood, causes distress or impairment, and is not better explained by another disorder, a substance or a medical condition. Assess at baseline, over time, with collateral, never on hospital day one in withdrawal, mania or grief. ICD-11 now rates severity with trait qualifiers.

These patterns grow where temperament meets environment. Childhood adversity is common, especially in borderline personality disorder. Linehan's **biosocial theory**: an emotionally sensitive child in a chronically invalidating environment never learns to name or regulate emotion. Each frustrating behavior was once an intelligent solution. About one in ten adults meets criteria for a personality disorder; borderline affects about 1.4 to nearly 6 percent and about 20 percent of inpatients; 8 to 10 percent die by suicide. The hopeful data: most people with borderline personality disorder reach sustained remission over ten to sixteen years.

"Difficult" is how you feel, not what you found. Replace adjectives with a verb and a quotation: "asked four times in one hour for the nurse to sit with her; tearful when told the nurse would return after med pass; stated 'everyone leaves'." "Psychopath" and "sociopath" are not diagnoses. People with these diagnoses are far more likely to be harmed than to harm.

Cluster A (odd or eccentric): paranoid (distrust, not delusional; be transparent and literal, no whispering, keep time promises), schizoid (genuinely prefers solitude, not lonely; brief task-focused contact), schizotypal (odd beliefs, ideas of reference, magical thinking; neither argue nor endorse). **Cluster B** (dramatic, emotional, erratic): borderline (instability of affect, identity, relationships; impulsivity; self-injury; abandonment fear; validate then structure), antisocial (since 15, diagnosed at 18 or older with conduct disorder before 15; written, uniform limits), histrionic and narcissistic (do not compete or deflate; name the hurt). **Cluster C** (anxious or fearful): avoidant (wants closeness but fears rejection), dependent, obsessive-compulsive PD (ego-syntonic, no true obsessions); build competence, not dependence.

Borderline versus bipolar: borderline mood shifts are reactive and last hours to a day or two, with emptiness between; bipolar episodes last days to weeks with decreased need for sleep and more energy. Ask how long the mood lasts and what starts it. Complex PTSD (ICD-11) adds re-experiencing, avoidance and hypervigilance. Screen for substance use, ADHD, autism and medical mimics. In the MSE, the interpersonal field is data; countertransference goes to supervision, never into action. Transient stress-related paranoia or dissociation resolves with the stressor; impaired orientation means look for delirium.

Ask about self-injury and suicide directly and **separately**. NSSI usually regulates affect and is not "for attention," but it strongly predicts later suicide attempt and death. Use behavior chain analysis: prompting event, thought, feeling, what it did, what followed. Many people carry **chronic risk**; what warrants acute action is **acute-on-chronic** escalation: a new or more lethal method, new means, rehearsal, a recent loss, ambivalence turning to resolve, giving things away, sudden calm, more substance use, loss of a therapist. Document the baseline so "worse" means something. Examine the body; overshadowing kills.

Boundaries are the therapy. State them early and keep them exactly. If you would not do it for every patient and could not chart it, do not do it. Limits have three parts: acknowledge the feeling,

state the limit, offer what you can do, then come back when you said. **Splitting** is a trauma-derived defense, not a tactic, and the split lives in the team: one written plan, limits agreed in team meetings, one communicator. When told "you are the only one who cares," neither agree nor dismiss. Validate, then structure: in that order.

DBT (individual therapy, skills group, phone coaching, consultation team; mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness) has the strongest evidence. Nurses coach skills: TIPP (cold water, intense exercise, paced breathing, paired muscle relaxation), radical acceptance, opposite action, DEAR MAN. MBT, TFP, schema therapy, STEPPS and good psychiatric management also work. No medication treats the disorder; drugs target comorbidity or a symptom, each with a target and a stopping rule. Avoid standing benzodiazepines. Know NMS, serotonin syndrome, EPS and TD; AIMS every 6 months on first-generation and 12 months on second-generation agents. De-escalate first; never "calm down." Restraint rules: provider order, never PRN, face-to-face within one hour, 4, 2 and 1 hour limits, continuous monitoring, debrief.

LOCK THESE IN

- Disorder needs pervasive, inflexible, early onset, impairing, and not better explained.
- Most people with borderline personality disorder remit over 10 to 16 years.
- Cluster A transparency; Cluster B validate then structure; Cluster C build competence.
- Hours after a trigger: borderline. Days to weeks with less sleep: bipolar.
- Ask about self-injury and suicide separately, every time.
- Act on acute-on-chronic escalation above the person's documented baseline.
- Splitting is a defense; the fix is one team plan.
- Medication is adjunctive only; avoid standing benzodiazepines.

Three clusters, three nursing stances

Cluster A

Odd or eccentric

- Paranoid
- Schizoid
- Schizotypal

The nurse:

Be transparent and literal; keep time promises; respect distance

Cluster B

Dramatic, emotional, erratic

- Borderline
- Antisocial
- Histrionic
- Narcissistic

The nurse:

Validate first, then structure; identical limits from every nurse

Cluster C

Anxious or fearful

- Avoidant
- Dependent
- Obsessive-compulsive PD

The nurse:

Build competence, not dependence; ask for their options first

Borderline or bipolar? Mood that lasts hours after a trigger points to borderline; days to weeks with less sleep and more energy points to bipolar.

Know the cluster, know the first move. The cluster predicts what the person needs at the door: transparency and distance, validation plus structure, or graded independence.

The ten personality disorders

Cluster and disorder	Core pattern	What the nurse does
A · Paranoid	Pervasive distrust; reads malice into neutral events	Transparent and literal; announce actions; no whispering
A · Schizoid	Detached; prefers solitude; indifferent to praise	Brief task-focused contact; do not force groups
A · Schizotypal	Odd beliefs, ideas of reference, magical thinking	Neither argue nor endorse; stay concrete
B · Borderline	Instability of affect, identity, relationships; self-injury	Validate then structure; identical limits; skills coaching
B · Antisocial	Disregard for others since 15; age 18+	Written uniform limits; no bedside renegotiation
B · Histrionic	Excess emotionality; needs to be central	Steady tone; attend to content, not theater
B · Narcissistic	Grandiosity, need for admiration, brittle shame	Do not compete or deflate; name the hurt
C · Avoidant	Wants closeness; fears rejection	Graded social exposure; praise effort
C · Dependent	Needs to be cared for; cannot decide alone	Ask for their options first; small independent tasks
C · Obsessive-compulsive PD	Perfectionism, rigidity; ego-syntonic	Schedules and rationale; small flexibility steps

Limits and boundaries in practice

Situation	Avoid	Say instead
Idealizing: "You are the only one who cares."	"I do try harder than some people."	Validate, refuse special status, bring it to the team
Boundary test: "Give me your cell number."	"I am not allowed; it is policy."	Own the limit; add crisis line and therapist to the safety plan
Anger: "Nobody told me anything all day!"	"Calm down or I will call security."	Agree with the grievance; quieter space; give back control
Dependence: "Just tell me what to do."	"Here is what I would do."	"What are the two options you have been weighing?"
Secret: "I scratched my arm. Do not tell."	"Okay, this stays between us."	"I cannot keep it from the team; I will tell them with you."

Worked cases

WORKED CASE 1 · TRAIT OR DISORDER?

Two clients. Ms. Lane, 24, has been tearful, impulsive and furious with her partner for six days since starting to drink heavily after a breakup. Mr. Voss, 35, has, since his teens, believed coworkers, neighbors and partners are plotting against him, tests everyone's loyalty and holds grudges for years, but can consider other explanations.

STEP 1 · APPLY THE GENERAL CRITERIA

Pervasive, inflexible, early onset, impairing, not better explained.

STEP 2 · MS. LANE

New, situational, and better explained by alcohol and acute stress: **not** a personality disorder. Reassess at baseline.

STEP 3 · MR. VOSS

Long-standing since adolescence, across settings, impairing: consistent with **paranoid personality disorder**; not delusional because he can consider alternatives.

STEP 4 · NURSING APPROACH FOR MR. VOSS

Be transparent and literal, explain before acting, never whisper, keep every time promise.

RULE

Personality is assessed over time, not on day one in a crisis.

WORKED CASE 2 · CHRONIC OR ACUTE-ON-CHRONIC?

Ms. R, 27, with borderline personality disorder, has had daily passive thoughts of dying for four years and two prior overdoses. Tonight, after her therapist ended their work on Friday, she says she intends to die tonight and has hoarded tablets in her room.

STEP 1 · STATE THE BASELINE

Chronic passive ideation for years.

STEP 2 · FIND THE ESCALATION

New intent, a specific plan, hoarded means, loss of a protective relationship: **acute-on-chronic** risk.

STEP 3 · ACT FIRST

Start 1:1 observation and remove the tablets.

STEP 4 · SBAR

"This is above her baseline: intent, a plan with hoarded medication. I have started 1:1 and removed the tablets. I need you to evaluate her within the hour and review the observation level and safety plan."

DOCUMENT

The baseline in words, so the next clinician knows what "worse" means.

WORKED CASE 3 · SPLITTING ON THE UNIT

Day staff say Mr. Hartigan is "being mistreated by nights." Night staff say he is "playing everyone." He tells you, "You are the only one who gets me."

STEP 1 · NAME THE PATTERN

Splitting: people experienced as all-good or all-bad, showing up as a divided team.

STEP 2 · REFRAME IT

A trauma-derived defense, not a strategy.

STEP 3 · RESPOND AT THE BEDSIDE

"I am glad talking helps. I am part of the same team, and I would like us to bring what happened on nights to the group."

STEP 4 · FIX THE STRUCTURE

Team meeting, one written plan everyone can quote, limits agreed in the meeting, one communicator.

AVOID

Agreeing with him, or dismissing him; both deepen the split.

WORKED CASE 4 · A LIMIT IN THREE PARTS

At 1945 Ms. Tate, 30, says, "Please stay with me. Tonight is unbearable." You have the 2000 medication pass.

STEP 1 · ACKNOWLEDGE THE FEELING

"I can hear that tonight feels unbearable."

STEP 2 · STATE THE LIMIT CONCRETELY

"I cannot stay past eight because I have the medication pass."

STEP 3 · OFFER WHAT YOU CAN

"I can give you fifteen minutes right now, and I will come back at nine."

STEP 4 · KEEP IT EXACTLY

Come back at nine. The returning is the intervention.

COACH A SKILL

Offer TIPP: cold water to the face and paced breathing with a longer exhale while you are there.

TRAPS PEOPLE FALL INTO

- **Diagnosing a personality disorder during withdrawal or mania.** Assess at baseline, over time, with collateral.
- **Calling schizoid and avoidant the same.** Schizoid prefers solitude; avoidant wants closeness but fears rejection.
- **Confusing OCPD with OCD.** OCPD is ego-syntonic with no true obsessions or compulsions.
- **Calling NSSI "just for attention."** It predicts later suicide attempts. Assess intent separately.
- **Admitting for chronic risk alone.** It can reinforce crisis as the route to care. Act on escalation above baseline.
- **Becoming "the one nurse who gets it."** Boundary drift ends in one more abandonment.
- **Blaming the patient for splitting.** The split is in the team; repair it with one plan.
- **Treating the disorder with medication.** No drug treats it; psychotherapy does.

Chapter 10 self-test · ten items

1. Which feature is required for a personality disorder?

A. A pattern seen only with one relative at home on weekends
B. A pattern that began only within the past six weeks
C. A pattern that appears only during acute intoxication
D. A pattern traced back to adolescence or early adulthood

D. A pattern traced back to adolescence or early adulthood The pattern must be long-standing with early onset, pervasive and not better explained by a substance.

2. Which pairing sits at the center of the biosocial account of how borderline personality disorder develops?

A. Emotional sensitivity plus chronic invalidation
B. A purely genetic defect present from birth
C. A single traumatic event in late adulthood
D. A deliberate choice to manipulate caregivers

A. Emotional sensitivity plus chronic invalidation The theory joins biological emotional sensitivity with chronic invalidation.

3. What do the long-term studies show for most people with borderline personality disorder?

A. Remission only with lifelong medication
B. Steady worsening throughout adult life
C. Sustained remission over 10 to 16 years
D. No change in symptoms after age 30

C. Sustained remission over 10 to 16 years The McLean and collaborative longitudinal studies show most people remit and stay remitted.

4. A man genuinely prefers solitude, is indifferent to praise and is not lonely. Which disorder fits?

A. Schizotypal personality disorder
B. Schizoid personality disorder
C. Dependent personality disorder
D. Avoidant personality disorder

B. Schizoid personality disorder Schizoid is detachment without loneliness. Avoidant wants connection but fears rejection.

5. A client's mood swings last a few hours after texts from her partner, with emptiness between. What does this suggest?

A. Borderline personality disorder
B. Cyclothymic disorder
C. Major depressive disorder
D. Bipolar II disorder, rapid cycling

A. Borderline personality disorder Reactive shifts lasting hours point to borderline. Bipolar episodes last days to weeks with less sleep and more energy.

6. Which is the best response after a client discloses new cuts?

A. "You know that is just for attention."
B. "Promise me you will not do it tonight."
C. "What was going on right before you cut?"
D. "Why would you do that to yourself again?"

C. "What was going on right before you cut?" Ask about the function and the antecedent. Why questions, labels and contracts fail.

7. Which finding signals acute-on-chronic risk in a client with years of passive ideation?

A. Old, healed forearm scars
B. A newly bought, stored means
C. A long history of weekly therapy
D. Daily passive thoughts of dying

B. A newly bought, stored means New means, new plan, rehearsal or recent loss are escalations above baseline.

8. A client says, "Give me your cell number for after discharge." Which reply is best?

A. "I am not allowed; it is against unit policy."
B. "Ask the night nurse, she might give hers."
C. "Sure, but only call if it is an emergency."
D. "No, but let us add the crisis line to your plan."

D. "No, but let us add the crisis line to your plan." Own the limit as care and substitute something durable.

9. Which statement about splitting is accurate?

A. It is best handled by the most skilled nurse
B. It is a defense, and the fix lies in the team
C. It is a deliberate tactic to control the staff
D. It means the client should be discharged now

B. It is a defense, and the fix lies in the team Splitting is a trauma-derived defense. One written plan and team agreement repair it.

10. What is the role of medication in borderline personality disorder?

A. First-line treatment for the disorder itself
B. Standing benzodiazepines for daily distress
C. Adjunct for comorbidity or a target symptom
D. A replacement for DBT once the client is stable

C. Adjunct for comorbidity or a target symptom No drug treats the disorder. Psychotherapy is the treatment; avoid standing benzodiazepines.

ONE PAGE

Cram sheet

Everything from chapters 9 and 10 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
SUD severity	2 to 3 mild; 4 to 5 moderate; 6+ severe	11 criteria over 12 months
AUDIT-C	4+ men; 3+ women	Scored 0 to 12
CRAFFT	2 or more	Ages 12 to 21
CIWA-Ar	Treat at about 8 to 10; severe 15+	Escalate if it rises by 5 or more
Alcohol clock (Ch 9)	6 to 24; 12 to 24; 12 to 48; 48 to 96 h	DT mortality about 1 to 4% treated
Opioid withdrawal	Starts 8 to 12 h; peaks 36 to 72 h	Methadone: starts 24 to 48 h
Naloxone	Lasts about 30 to 90 min	Titrate to RR about 12
Buprenorphine start	COWS about 8 to 12+	12 to 24 h after short-acting; 24 to 48 after methadone
Naltrexone	7 to 10 days off short-acting; 10 to 14 off methadone	Then the first dose
Disulfiram	Reaction within 10 min; effect up to 14 days	Hidden alcohol list
NOWS	24 to 72 h after birth	Eat, Sleep, Console
Return to use	About 40 to 60%	Like asthma and hypertension
Borderline PD	About 1.4 to nearly 6% of adults; 8 to 10% die by suicide	Most remit over 10 to 16 years
Antisocial PD	Diagnosed at 18+, conduct disorder before 15	Disregard since 15

Pairs people mix up

Pair	How to tell them apart
Tolerance vs addiction	Neuroadaptation vs the behavioral cluster of lost control
Alcohol vs opioid withdrawal	Can kill vs rarely lethal (both treated)
Hallucinosis vs DTs	Sensorium intact vs clouded, fluctuating consciousness
Wernicke vs Korsakoff	Reversible triad vs irreversible amnesia with confabulation
Methadone vs buprenorphine vs naltrexone	Full agonist vs partial agonist with ceiling vs antagonist
Schizoid vs avoidant	Prefers solitude vs wants closeness but fears it
Borderline vs bipolar	Hours after a trigger vs days to weeks with less sleep
Chronic vs acute-on-chronic risk	The person's baseline vs escalation above it

Rules that keep people safe

Topic	The rule
Screening	Everyone, with a validated tool, not suspicion.
Glucose	Thiamine first.
Benzodiazepines	Never stop abruptly in a dependent person; flumazenil is not routine.
Pain on MOUD	Continue the MOUD dose and add full analgesia.
Secrets	Never promise; tell the team with the patient.
Limits	Feeling, limit, offer; then keep it exactly.
De-escalation	Never say "calm down"; feeling plus a choice.

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