MENTAL HEALTH NURSING · STUDY GUIDE

Exam 7 Study Guide

This guide covers the last two chapters, where the whole book gets tested. First crisis, suicide and aggression: shrinking a crisis, asking about suicide directly, building a plan a person can use at three in the morning, reading the escalation curve, and the law and debrief around restraint. Then the lifespan and the community: children, perinatal care, older adults, recovery-oriented community care and the dangerous transition 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 13 · crisis as a gap, Caplan's phases, the four to six week window, maturational, situational and adventitious crisis, crisis intervention and psychological first aid, trauma-informed care, suicide epidemiology and language, static and dynamic risk, formulation over prediction, the C-SSRS and ASQ, the six-step safety plan, no-suicide contracts, lethal means counseling, admission status, capacity and confidentiality, ligature risk and observation, the escalation curve, verbal de-escalation, restraint law and monitoring, chemical restraint, the emergencies inside agitation, debriefing and postvention.
- Chapter 14 · development as the baseline, early-onset disorders, NSSI in adolescents, talking with children and teenagers, assent, stimulants, SSRIs and antipsychotics in young people, perinatal screening with the EPDS, blues, perinatal depression and postpartum psychosis, medications in pregnancy and lactation, adults, late-life depression, the three Ds, polypharmacy and hidden emergencies, elder mistreatment, the recovery model, levels of care, the discharge window, long-acting injectables and clozapine, telehealth, the milieu and delegation, language, and the nurse who lasts.

CHAPTER 13

Crisis, Suicide, Aggression and De-escalation

Read it in full: **Chapter 13 in the textbook**. Practice it in the lab: **Safety Plan Builder: Six Steps and a Safer Environment** and **The Escalation Curve and the Matched Response**.

What to know

A **crisis** is acute disequilibrium in which usual coping has failed. It is defined by the gap between the event and the person's coping and support, not by the size of the event, so never rank someone's distress. Caplan's phases: familiar coping, failure and rising anxiety, mobilizing emergency resources, then major disorganization, where suicidal thinking, substance use and aggression often appear. Crises are **time-limited, usually four to six weeks**, and resolve upward or downward. "What made today the day you came in?" finds the precipitant.

Three types stack: **maturational** (expected transitions, so support is often missing), **situational** (unexpected personal events) and **adventitious** (disasters affecting a community). Culture shapes what counts as a crisis. Crisis intervention is narrow: contact and safety, put the problem into words and shrink it, identify remaining coping, a few concrete next steps, and named follow-up. Give more structure to a disorganized person and hand decisions back as they reorganize. **Psychological first aid** offers safety, comfort, connection, information and linkage; forced single-session debriefing is not supported. Assume a trauma history may be present.

Older men, especially those living alone, have the highest suicide death rate; women attempt more, men die more, largely from method lethality. Firearms cause roughly half of US suicide deaths. Rates are raised in Indigenous people, veterans, LGBTQ youth in unsupportive settings, after psychiatric discharge and after release from incarceration. Say "died by suicide"; never "failed," "successful," "gesture" or "manipulative." Asking does not plant the idea.

Static risk factors are historical (a prior attempt is the strongest predictor; family history, abuse, illness, male sex, certain diagnoses). **Dynamic** factors can change today (ideation with plan and intent, access to means, intoxication, agitation, insomnia, hopelessness, recent loss, command hallucinations, recent discharge). Risk factors predict individual suicide barely better than chance, so no score decides disposition; write a **formulation**: chronic vulnerability, acute drivers, protective factors, what is modifiable, and the plan. Watch the antidepressant window (energy returns before mood; boxed warning under 25) and **sudden calm**.

Ask plainly, after a normalizing line, then climb: passive ideation, active ideation, method, plan, intent, preparatory behavior or rehearsal, access. Ask what has stopped them so far. Do not stop at

"no plan." Count to five in silence; respond to content, not your alarm. The **C-SSRS** structures the questions; the **ASQ** is a four-item youth screen; PHQ-9 item 9 is a prompt for full assessment, not an assessment. Record the person's words. Screen everywhere, because many people who die by suicide saw a health service in the prior month.

The **Stanley-Brown safety plan** has six steps built in one sitting in the patient's words: warning signs, internal coping, people and places for distraction, people to ask for help, professionals and crisis lines (988), and **making the environment safe**, the step with the strongest evidence. Test each step out loud and decide where the plan lives. **No-suicide contracts** have no evidence, shift responsibility, falsely reassure and give no legal protection. Lethal means counseling is matter-of-fact and temporary: off-site firearm storage, locks, smaller medication supplies. Ligature points cause most inpatient suicides; checks happen at irregular intervals and must see chest rise. The first week after discharge is the highest-risk period.

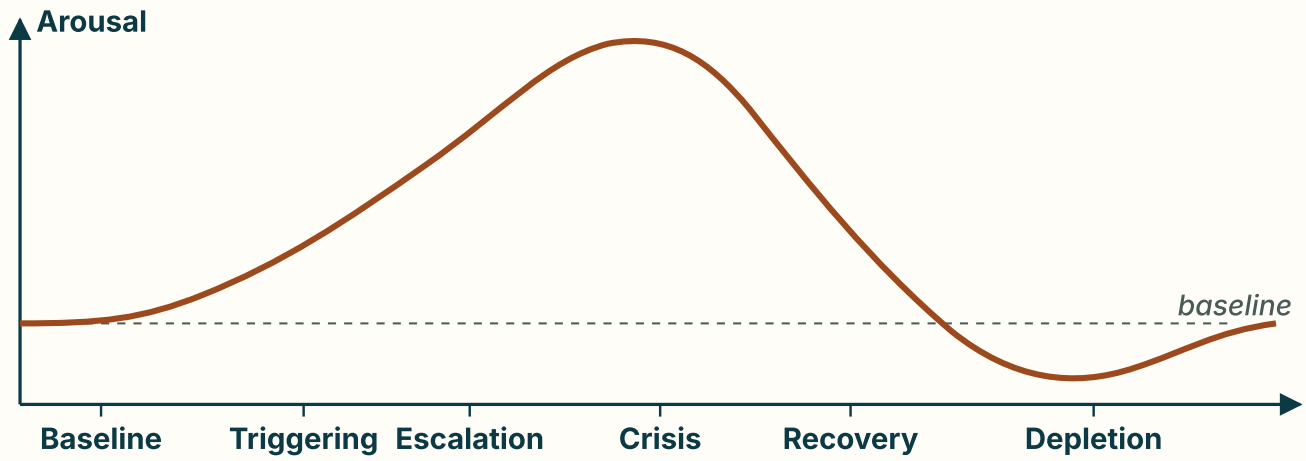
Aggression climbs a curve: **baseline** (learn triggers), **triggering** (approach, ask, solve the practical problem), **escalation** (short sentences, two acceptable choices, less stimulation, a second staff member early), **crisis** (protect people, least restrictive effective step), **recovery** (minimal demands), **post-crisis depletion** (repair). Tools such as the Brøset Violence Checklist prompt action. Project BETA: two arm lengths, angle, exits clear for both, hands visible, one spokesperson, concise, name wants and feelings, agree where you can, limits as information, choices and optimism, debrief. People with mental illness are far more often victims.

Restraint and seclusion are last-resort emergency measures: a specific order (never PRN or standing), limits of 4 hours for adults, 2 for ages 9 to 17 and 1 under 9, renewable to 24 hours before an in-person re-evaluation, a face-to-face evaluation within one hour, continuous monitoring with assessment about every fifteen minutes and limb release at least every two hours, and release as soon as the danger resolves. The order is a maximum, not a duration. **Prone restraint** risks positional asphyxia; sudden quiet in a hold is a respiratory emergency. Rule out delirium, hypoglycemia, hypoxia, withdrawal and **akathisia** first. Chemical restraint carries the same rules; offer oral medication first; no IM olanzapine within one hour of a parenteral benzodiazepine. Debrief the patient and the staff, and plan postvention.

LOCK THESE IN

- Crisis is the gap between event and coping; it resolves within 4 to 6 weeks.
- Maturational, situational, adventitious; ask about all layers.
- A prior attempt is the strongest predictor, yet no score predicts one person; write a formulation.
- Ladder: passive, active, method, plan, intent, rehearsal, access.
- Safety plan step six (means restriction) has the strongest evidence; no contracts.
- First week after discharge is the most dangerous period.
- Match the response to the stage of the escalation curve; one spokesperson.
- Order is a maximum; release early; never prone; debrief both patient and staff.

The escalation curve and the matched response



Baseline	Learn triggers and what calms them; write it in the plan
Triggering	Approach early, ask, listen, solve the practical problem
Escalation	One speaker, short sentences, two real choices, less stimulation
Crisis	Protect people; least restrictive effective step; clear the area
Recovery	Minimal demands, low stimulation, fluids, one person present
Depletion	Repair and debrief when ready; update the care plan

Early moves are cheap; late moves are costly. Interventions that work at the triggering stage are useless once control is lost. The curve dips below baseline afterward, the time for repair, not a lecture.

Crisis types

Type	Trigger	What the nurse looks for
Maturational	Normative transition: parenthood, retirement, leaving home	Isolation; loss of identity; little support because it is "expected"
Situational	Unexpected personal event: job loss, divorce, diagnosis, eviction	Sudden change in functioning; money and housing threat; shame
Adventitious	Disaster affecting a community	Bereavement plus resource loss; anniversary reactions

Safety plan versus no-suicide contract

Element	Contract	Safety plan
Asks the patient to	Promise not to act on a feeling	Do a specific list of behaviors
Responsibility	Patient alone	Shared; the team owns follow-up and means
Evidence	None; possible harm	Less suicidal behavior; better engagement
Disclosure	Suppressed	Increased: names, numbers, locations
Legal standing	No protection	Documents evidence-based mitigation

The escalation curve

Stage	What you see	Matched response
Baseline	Settled, engaged	Rapport; learn triggers and calming strategies
Triggering	Pacing, louder speech, repeated requests	Approach early, ask, listen, solve the problem
Escalation	Arguing, refusing, swearing, invading space	Short sentences; two choices; less stimulation; call a second staff member
Crisis	Throwing, striking, self-injury, flight	Protect people; one spokesperson; least restrictive effective step
Recovery	Settling but aroused	Minimal demands; fluids; one person present
Depletion	Exhaustion, remorse, shame	Repair; debrief when ready; update the plan

Worked cases

WORKED CASE 1 · SHRINKING A CRISIS

Ms. Vale, 42, lost her job four days ago, was served an eviction notice yesterday, and has not eaten or answered the phone since. She came in after her sister found her crying in the car.

STEP 1 · CLASSIFY

Two situational stressors stacked; phase four disorganization (not eating, withdrawal).

STEP 2 · FIND THE PRECIPITANT

"What made today the day you came in?" She says the eviction notice "was the last thing."

STEP 3 · SCREEN FOR SUICIDE

Ask directly; she reports passive thoughts of not waking, no plan.

STEP 4 · SHRINK AND MOBILIZE

Name the problems one at a time; she identifies her sister and a tenant legal aid office she has heard of.

STEP 5 · CONCRETE STEPS AND FOLLOW-UP

Two steps she chooses (call legal aid, stay with her sister tonight) and a named follow-up call tomorrow at 10.

WHY HANDING BACK MATTERS

Each decision she makes is evidence she is still an agent in her own life.

WORKED CASE 2 · WRITING A FORMULATION

Mr. Grant, 50, has a prior overdose, alcohol use disorder, lost his job four days ago, and has a firearm at home. He has custody of two children and is willing to engage.

STEP 1 · CHRONIC VULNERABILITY

Prior attempt, alcohol use disorder.

STEP 2 · ACUTE DRIVERS

Job loss four days ago; access to a firearm.

STEP 3 · PROTECTIVE FACTORS

Custody of two children; willingness to engage.

STEP 4 · MODIFIABLE NOW

The firearm and the plan for tonight.

STEP 5 · WRITE IT

"Chronic elevated risk from prior attempt and alcohol use disorder; acutely elevated by job loss and firearm access; protective factors are custody of two children and engagement; plan: firearm to his sister tonight, safety plan completed, contact in 24 hours."

NOT A NUMBER

A low score never justifies discharge; the formulation is defensible care.

WORKED CASE 3 · THE CANCELLED PASS

A man has just been told his weekend pass is cancelled. He stands close to the station, voice raised, fists clenched; other patients are watching.

STEP 1 · PLACE HIM ON THE CURVE

Escalation: defensive, still verbal.

STEP 2 · SET THE GEOMETRY

One nurse steps forward at two arm lengths, at an angle; others stay back; exits clear for both.

STEP 3 · VALIDATE

"You have every right to be angry about this. Tell me what you were told."

STEP 4 · OFFER CHOICES AND AN HONEST LIMIT

"I cannot change the pass tonight. I can get Dr. Iyer's reasoning and call your sister with you now. Here, or in the quiet room?"

AVOID

"Calm down," threats of seclusion, "that is the policy," and a semicircle of staff.

WORKED CASE 4 · AGITATION OR AKATHISIA?

Mr. Delgado, 34, three days into haloperidol with a dose increase yesterday, paces constantly, cannot sit thirty seconds, says his legs "feel like they are crawling," and asks for help. Temperature 36.9 °C, glucose normal.

STEP 1 · RULE OUT THE EMERGENCIES

Normal temperature and glucose, no rigidity: not NMS, not hypoglycemia.

STEP 2 · NAME IT

Inner restlessness after an antipsychotic increase, asking for help rather than threatening: **akathisia**.

STEP 3 · AVOID THE ERROR

Do not give more antipsychotic, and do not restrain.

STEP 4 · SBAR RECOMMENDATION

"Please review him now for akathisia; I would like an order for propranolol or lorazepam and to consider reducing the haloperidol. No further antipsychotic dose until you see him."

WHY IT MATTERS

Akathisia is linked to suicidal thinking.

TRAPS PEOPLE FALL INTO

- **Judging a crisis by the size of the event.** The gap between event and coping defines it.
- **Forcing a trauma survivor to narrate.** Single-session debriefing is not supported; psychological first aid is.
- **Using a risk score to discharge.** Scores predict poorly; write a formulation.
- **Stopping at "no plan."** Ask about intent, rehearsal and access.
- **Skipping step six.** Means restriction has the strongest evidence.
- **Keeping someone restrained until the order ends.** The order is a maximum; release when safe.
- **Reading sudden quiet in a hold as compliance.** It is a respiratory emergency until proven otherwise.
- **Treating akathisia as aggression.** More antipsychotic or restraint makes it worse.

Chapter 13 self-test · ten items

1. Two people lose the same job; one plans a budget, the other stops eating. What explains the difference?

A. How long each person worked in that job
B. Whether the person has a psychiatric diagnosis
C. The objective severity of the job loss itself
D. The balance of threat, coping and support

D. The balance of threat, coping and support Crisis is defined by the gap between the event and current coping and support, not the event size.

2. A first-time parent struggling after the birth of a healthy baby is in which type of crisis?

A. Situational
B. Adventitious
C. Maturational
D. Chronic

C. Maturational Normative transitions such as parenthood are maturational crises.

3. How long does acute crisis disequilibrium usually last?

A. About 24 to 48 hours
B. About 4 to 6 weeks
C. Until medication works
D. About 6 to 12 months

B. About 4 to 6 weeks Crises are time-limited, and that window is the clinical opportunity.

4. Among these histories, which most raises a person's chance of eventually dying by suicide?

A. A previous suicide attempt
B. Living in a rural area
C. A recent move to a new city
D. A family history of depression

A. A previous suicide attempt A prior attempt is the strongest static risk factor.

5. A client says "no" when asked if he has a plan. What should the nurse ask next?

A. Whether he will sign a no-suicide contract
B. Why he would ever think about dying at all
C. About intent, rehearsal and access to means
D. Nothing more; a "no" means the risk is low

C. About intent, rehearsal and access to means A "no" to plan is falsely reassuring; preparatory behavior and access change tonight's plan.

6. Ms. Rowe and her nurse are writing her plan. Which part does research support most strongly?

A. Making the environment safe
B. Writing internal coping skills
C. Listing personal warning signs
D. Naming people for distraction

A. Making the environment safe Means restriction, step six, has the strongest evidence base.

7. When is suicide risk highest across an episode of inpatient care?

A. The first hour after admission
B. The first week after discharge
C. The day the diagnosis is given
D. The night before a family visit

B. The first week after discharge Post-discharge suicide rates are many times the general rate, highest in the first week.

8. A patient is pacing, swearing and refusing, but not yet striking. Which response matches this stage?

A. A team hold and an IM injection right now
B. No demands, just a blanket and quiet rest
C. A full debrief about what went wrong today
D. Short sentences, two acceptable choices

D. Short sentences, two acceptable choices This is the escalation stage: reduce stimulation, set limits as choices, call a second staff member early.

9. An adult was placed in restraint 40 minutes ago and is now calm and following directions. What should happen?

A. Keep them on until the next shift comes
B. Release now, since criteria are met
C. Keep restraints on until the order ends
D. Wait for the four-hour order renewal

B. Release now, since criteria are met The order is a maximum, not a duration; release at the earliest safe moment.

10. During a hold, a struggling patient suddenly goes quiet and limp. What is the priority?

A. Release, open the airway, check a pulse
B. Give a second sedating dose right away
C. Document that the patient became compliant
D. Continue the hold until the device is on

A. Release, open the airway, check a pulse Sudden quiet in a hold may be positional asphyxia or arrest.

CHAPTER 14

Across the Lifespan and Into the Community

Read it in full: **Chapter 14 in the textbook**. Practice it in the lab: **Four Days Postpartum: Separate the Three Pictures, Then Escalate** and **It Is 2 a.m. Saturday: Building a Discharge That Holds**.

What to know

Half of lifetime mental illness begins by fourteen and three quarters by the mid twenties, with close to a decade between first symptom and treatment. The question is whether behavior is expected for the developmental stage and whether it impairs: look at intensity, duration, pervasiveness and impairment. Children show distress through behavior and the body: depression as irritability, stomach aches and school refusal; anxiety as clinginess; trauma as regression or "hyperactivity." Ask what the behavior communicates before calling a child oppositional.

ADHD needs symptoms before twelve in two or more settings. Autism brings sensory sensitivity that matters during every procedure. Anxiety disorders are the most common and most treatable pediatric conditions; depression rises after puberty, especially in girls, while suicide deaths rise in adolescent boys. Early psychosis responds to coordinated specialty care in the first year. Adolescent **NSSI** usually regulates affect, is never "attention-seeking," and raises future suicide risk: ask intent separately ("hoping to feel better, or hoping to die? Sometimes it is both").

Sit at eye level with children. See adolescents alone for part of every visit and say so to everyone. Explain confidentiality and its limits before risky questions. Guardians consent; children give **assent**. Some care can be consented to by minors depending on the state. Stimulants: track height, weight, appetite, BP, HR, sleep, cardiac history and diversion. SSRIs carry a boxed warning to age 24; watch for **activation syndrome** and monitor closely in the first weeks, since energy can return before hope. Antipsychotics in children cause more weight gain, lipid and prolactin change; akathisia is often misread as "worse ADHD."

Perinatal mood and anxiety disorders affect about one in five childbearing people; suicide and overdose are leading causes of death in the year after birth. Screen everyone in pregnancy and postpartum with the **EPDS** (no somatic items). Any positive item 10 means a same-visit suicide assessment. Ask about frightening thoughts of harm to the baby. **Ego-dystonic** intrusive thoughts (the parent is frightened and avoids) fit anxiety or OCD; ego-syntonic beliefs inside psychosis are an emergency. **Blues**: up to 80 percent, day 2 to 5, gone by 14. **Perinatal depression and anxiety**: about 10 to 20 percent, any time in pregnancy to 12 months. **Postpartum psychosis**: 1 to 2 per 1000, usually first two weeks, strongly linked to bipolar disorder; never leave the parent alone with the infant.

In pregnancy, weigh drug risk against untreated-illness risk; stopping a mood stabilizer at the positive test invites relapse. Sertraline is commonly preferred, with transient neonatal adaptation symptoms possible. **Lithium**: small Ebstein risk; clearance rises in pregnancy and falls at delivery, so check levels more often late and right after birth. **Valproate**: the clearest teratogen; avoid in anyone who could become pregnant unless no alternative. Benzodiazepines near term: floppy infant. **Clozapine**: breastfeeding contraindicated. Brexanolone and zuranolone: sedation and sudden loss of consciousness, no driving for the set window. Adults, especially men, often present with irritability, overwork and alcohol; ask about hopelessness and firearms.

Late-life depression is not normal aging; it shows somatic complaints, anhedonia and slowed thinking. Use the Geriatric Depression Scale. Pseudodementia: abrupt onset, loud memory complaints, "I do not know," improves with treatment, but needs follow-up. Older men over 75 have the highest suicide rate, with high lethality and little warning. Any acute mental status change is **delirium until proven otherwise**: check medications, infection and retention first.

Older bodies clear drugs less; strip anticholinergic burden (Beers). Hidden emergencies: serotonin syndrome (clonus, hyperreflexia), NMS (rigidity, hyporeflexia), lithium toxicity, **SSRI hyponatremia**, tardive dyskinesia (metoclopramide is a hidden cause). Interview older adults alone routinely to screen for mistreatment; nurses are mandatory reporters.

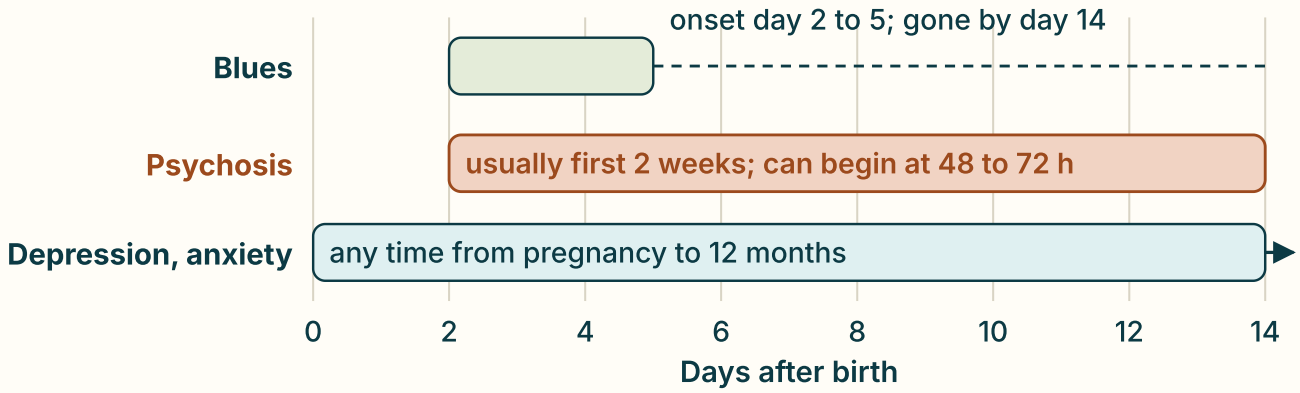
Recovery means a self-directed life with meaning, not the absence of symptoms (connectedness, hope, identity, meaning, empowerment). Goals belong to the person ("return to welding by spring"); nobody is "non-compliant." Levels of care run from inpatient to PHP, IOP, **ACT** (small caseload, team goes to the person, 24/7), outpatient and peer services. The days after discharge are the highest-risk window: a follow-up within **seven days**, a safety plan in the patient's words, means counseling, medication supply and **caring contacts**. Test the plan: "It is Saturday at 2 a.m." Long-acting injectables reduce relapse and make lapses visible. Clozapine ANC: weekly six months, every two weeks six months, then monthly; interrupt below 1000, stop below 500. Housing First outperforms staircase models. In telehealth, confirm location and a call-back number and ask who else is in the room.

The milieu is treatment: posted schedule, meals on time, protected sleep, a daily community meeting. Assistive personnel may do 1:1 observation (the RN sets the level), vital signs, escorting and contraband searches with a second staff member, and must report things like given-away belongings; they may not change observation levels, do the MSE or risk screen, initiate restraint or teach. De-escalation stays ahead of restraint everywhere. Use person-first language throughout. Protect yourself from compassion fatigue, vicarious trauma, moral distress and burnout with supervision, debriefing, boundaries and your own care. After a suicide, postvention supports families and staff; a nurse who loses a patient is a second victim.

LOCK THESE IN

- Measure behavior against development: intensity, duration, pervasiveness, impairment.
- See adolescents alone; explain confidentiality limits first; get assent.
- SSRI boxed warning to age 24; activation syndrome means call the prescriber.
- EPDS item 10 positive means same-visit suicide assessment.
- Blues day 2 to 5; psychosis usually first 2 weeks; never alone with the infant.
- Older adult acute change: delirium until proven otherwise; check drugs, infection, retention.
- Discharge: follow-up within 7 days, safety plan, means counseling, caring contacts.
- Delegate observation, never assessment, teaching or evaluation.

Three postpartum pictures that must never be confused



Blues	Depression / anxiety	Psychosis
Up to 80%	About 10 to 20%	1 to 2 per 1000
Tearful, labile	Low mood, dread, intrusive thoughts	Delusions about the infant; confusion
Still bonding	Therapy, medication, safety plan	Emergency: never alone with infant
Support, sleep, re-screen		

Frightened BY the thought (ego-dystonic): anxiety or OCD. Convinced by it: psychosis.

Same calendar, different illnesses. Only postpartum psychosis is an emergency in which hesitation is dangerous. The key question is whether the parent is frightened by the thought or convinced by it.

Three postpartum pictures

Feature	Blues	Depression / anxiety	Psychosis
Frequency	Up to 80%	About 10 to 20%	1 to 2 per 1000 births
Onset	Day 2 to 5; gone by day 14	Pregnancy to 12 months	Usually first 2 weeks; can be 48 to 72 h
Picture	Tearful, labile, functioning	Low mood, dread, guilt, intrusive thoughts	Confusion, delusions about the infant, no fatigue
Link	Hormones, sleep loss	Prior mood or anxiety disorder, trauma, low support	Bipolar disorder; recurs
Response	Support, sleep, re-screen	Therapy, medication, safety plan	Emergency; never alone with infant

Pregnancy and lactation

Agent	Issue	Nurse monitors and teaches
SSRIs (sertraline often preferred)	Neonatal adaptation syndrome	Prepare parents; do not stop abruptly
Lithium	Small Ebstein risk; clearance changes	More frequent levels late and postpartum; hydration in labor
Valproate	Neural tube defects; neurodevelopmental harm	Avoid unless no alternative; contraception; folate
Benzodiazepines	Neonatal sedation, floppy infant	Lowest dose, shortest course; watch the newborn
Clozapine	Infant neutropenia	No breastfeeding; maternal ANC continues
Brexanolone, zuranolone	Sedation, sudden loss of consciousness	Supervised infant care; no driving for the window

Levels of care

Level	What it provides	Fits when
Inpatient	24-hour containment	Imminent risk or cannot care for self
Partial hospitalization	Most of the day; sleeps at home	Step-down or step-up
Intensive outpatient	Hours, several days a week	Needs structure; can work or study
ACT	Team goes to the person; 24/7; small caseload	SMI with repeated admissions or homelessness
Outpatient, collaborative care	Scheduled therapy and prescribing	Stable illness
Peer, clubhouse, supported work and housing	Role, income, community	Always, alongside the others

Worked cases

WORKED CASE 1 · THE FRIGHTENING THOUGHT

Two mothers, both two weeks postpartum. Ms. Lin says, "I keep picturing dropping her down the stairs. It horrifies me, so I will not carry her near the stairs." Ms. Ruiz, who has not slept in three nights and feels fine, says calmly, "This is not really my baby. I have to save her from what is inside."

STEP 1 · ASK BOTH

"A lot of new parents have frightening thoughts about the baby being harmed. Have you had thoughts like that?"

STEP 2 · MS. LIN

Frightened by the thought and avoiding: **ego-dystonic intrusive thoughts**, typical of perinatal anxiety or OCD. Naming it as an anxiety symptom is relieving. Screen and refer.

STEP 3 · MS. RUIZ

Convinced by the belief, sleepless without fatigue: **possible postpartum psychosis**, an emergency.

STEP 4 · ACT FOR MS. RUIZ

One-to-one observation, never alone with the infant, urgent psychiatric evaluation at the bedside, infant safety orders.

THE HINGE

Is the parent frightened of the thought or convinced by it?

WORKED CASE 2 · THE BROWN BAG

Mr. E, 81, is brought in with "worsening dementia" over three weeks. His daughter empties a bag: diphenhydramine for sleep, oxybutynin, a newly started SSRI, and a tricyclic for nerve pain. His sodium is 126 mEq/L.

STEP 1 · TREAT IT AS DELIRIUM FIRST

Acute change in an older adult is delirium until proven otherwise.

STEP 2 · COUNT THE ANTICHOLINERGIC BURDEN

Diphenhydramine, oxybutynin and the tricyclic add up to confusion, retention and falls.

STEP 3 · NAME THE HIDDEN EMERGENCY

A new SSRI with sodium 126: **SSRI-associated hyponatremia**, a classic cause of "sudden dementia."

STEP 4 · ESCALATE

Report the sodium and the drug list; request review of the anticholinergics and the SSRI.

THEN REASSESS

Re-test cognition after the cause is treated; consider late-life depression if mood is low.

WORKED CASE 3 · A DISCHARGE THAT HOLDS

Mr. Bell, 29, is being discharged after a suicide attempt. His first clinic appointment is in three weeks, his phone is broken, and his medications are in a cabinet at home.

STEP 1 · SEE THE WINDOW

The first week after discharge is the highest-risk period.

STEP 2 · BOOK FOLLOW-UP

Appointment within seven days, written on something he carries.

STEP 3 · BUILD AND TEST THE PLAN

"It is Saturday at 2 a.m. and the thoughts come back. Walk me through what you do." The broken phone shows the gap: arrange a working number.

STEP 4 · RESTRICT MEANS

Agree with his brother to hold the medications; confirm who holds what.

STEP 5 · CARING CONTACTS

Brief follow-up messages in the first days.

WHY

Discharge planning is an intervention, not paperwork.

WORKED CASE 4 · DELEGATING ON THE UNIT

You have one experienced assistive staff member. Tasks: 1:1 observation of a patient at suicide risk, lowering another patient's observation level, vital signs, a contraband search, and teaching about a new medication.

STEP 1 · DELEGATE

1:1 observation (you set the level and brief them), vital signs, and the contraband search with a second staff member.

STEP 2 · KEEP

Lowering an observation level, the risk reassessment behind it, and medication teaching.

STEP 3 · BRIEF SPECIFICALLY

"Stay within arm's reach, including the bathroom with the door ajar; tell me right away if she gives anything away, stops eating, or talks about dying."

STEP 4 · EXPECT REPORTS

Reports of given-away belongings or missed meals are exactly what you want.

RULE

Delegate observation, never assessment, teaching or evaluation.

TRAPS PEOPLE FALL INTO

- **Holding a child to adult norms.** Measure against the developmental stage.
- **Promising a teenager total secrecy.** Explain the limits first; a broken promise ends the relationship.
- **Waiting out activation syndrome.** Report it to the prescriber.
- **Treating postpartum psychosis as severe blues.** It is an emergency; the presentation fluctuates.
- **Stopping a mood stabilizer at the positive test.** Weigh drug risk against untreated illness risk.
- **Calling "sundowning" a diagnosis.** It describes timing; it never stops a workup.
- **Booking the first appointment three weeks out.** Follow-up within seven days.
- **Ignoring your own warning signs.** Compassion fatigue and vicarious trauma are expected; build in supervision.

Chapter 14 self-test · ten items

1. A 7-year-old cries on the first day of school and settles by mid-morning. What is the best interpretation?

A. Oppositional behavior needing a firm limit
B. Early sign of a major depressive disorder
C. Expected separation worry for this age
D. Separation anxiety disorder needing treatment

C. Expected separation worry for this age Expected behavior for the stage, without impairment, is not a disorder.

2. Which approach to an adolescent interview is correct?

A. Always keep a parent present for safety
B. Promise that everything stays secret
C. See the teen alone only if abuse is suspected
D. See the teen alone for part of every visit

D. See the teen alone for part of every visit Seeing adolescents alone routinely, and saying so to everyone, avoids making it look like an accusation.

3. Ten days after starting an SSRI, a 15-year-old is jittery, sleepless and impulsive. What does the nurse do?

A. Reassure the family that it will pass
B. Report possible activation syndrome
C. Stop the drug at home starting today
D. Double the dose so it reaches effect

B. Report possible activation syndrome Activation syndrome is a reason to call the prescriber, not to wait it out.

4. A new mother marks "hardly ever" on EPDS item 10 about self-harm. What is required?

A. A direct suicide assessment this visit
B. Refer her to a support group only
C. Repeat the EPDS at the 6-week checkup
D. No action, since the answer was rare

A. A direct suicide assessment this visit Any positive item 10 requires same-visit risk assessment.

5. On day 4 postpartum, a mother who has not slept in three nights says the baby has been switched. What comes first?

A. Ask her partner to watch her overnight at home
B. Reassure her that this is common baby blues
C. Encourage rest and recheck in the morning
D. Never leave her alone with the infant; escalate

D. Never leave her alone with the infant; escalate Possible postpartum psychosis is an emergency requiring immediate evaluation and infant safety.

6. Which medication most clearly carries neural tube defect risk?

A. Lorazepam
B. Valproate
C. Lithium
D. Sertraline

B. Valproate Valproate is the clearest teratogen in psychiatry and is avoided in anyone who could become pregnant unless no alternative exists.

7. An 82-year-old becomes confused over two days after starting tramadol with his SSRI and has clonus in both ankles. What is suspected?

A. Alzheimer progression
B. Hydrocephalus
C. Serotonin syndrome
D. Malignant hyperthermia

C. Serotonin syndrome Clonus and hyperreflexia after adding a serotonergic drug point to serotonin syndrome.

8. Which element of a discharge plan most reduces post-discharge risk?

A. Follow-up booked within 7 days
B. A signed no-harm agreement
C. First visit in about 3 weeks
D. A pamphlet on local services

A. Follow-up booked within 7 days A follow-up within a week, plus safety plan, means counseling and caring contacts, reduce post-discharge deaths.

9. Which client best fits assertive community treatment?

A. A man with stable depression seen once a year
B. A teen with ADHD who is doing well at school
C. A woman with mild anxiety who works full time
D. A homeless man with schizophrenia, 5 admissions

D. A homeless man with schizophrenia, 5 admissions ACT serves people with serious mental illness and repeated admissions, homelessness or criminal-legal contact.

10. Which task may be delegated to trained assistive personnel?

A. One-to-one observation set by the RN
B. Teaching about a new antidepressant
C. Performing the suicide risk screen
D. Lowering a client's observation level

A. One-to-one observation set by the RN Observation is a monitoring task; the RN keeps assessment, the level decision and teaching.

ONE PAGE

Cram sheet

Everything from chapters 13 and 14 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
Crisis duration	About 4 to 6 weeks	Resolves upward or downward
Firearms	About half of US suicide deaths	Most lethal common method
Safety plan	6 steps; 15 to 45 minutes	988 crisis line
Restraint orders	4 h adult; 2 h ages 9 to 17; 1 h under 9	Renew to 24 h, then in-person re-evaluation
Restraint monitoring	Assess about every 15 min; limbs released at least every 2 h	Face-to-face within 1 h
IM olanzapine	Not within 1 h of a parenteral benzodiazepine	Cardiorespiratory deaths reported
Early onset	Half by 14; three quarters by mid twenties	About a decade to first treatment
ADHD	Symptoms before 12, two settings	School report matters
SSRI boxed warning	Under 25 (to age 24)	Activation syndrome
Perinatal disorders	About 1 in 5	Universal screening
Postpartum	Blues up to 80%; depression 10 to 20%; psychosis 1 to 2 per 1000	Blues day 2 to 5, gone by 14
Discharge follow-up	Within 7 days	Caring contacts
Clozapine ANC	Interrupt below 1000; stop below 500	Weekly, then every 2 weeks, then monthly
Lithium (Ch 14)	0.6 to 1.2; toxic above about 1.5; severe above 2.0	Thiazides, ACE inhibitors, NSAIDs, dehydration

Models and tools

Name	The parts
Caplan phases	Familiar coping, failure, emergency resources, disorganization
Crisis intervention	Contact and safety, shrink the problem, mobilize coping, steps, named follow-up
Suicide ladder	Passive, active, method, plan, intent, rehearsal, access
Safety plan	Warning signs, internal coping, distraction, people to ask, professionals, safer environment
Escalation curve	Baseline, triggering, escalation, crisis, recovery, depletion
Project BETA	Space, not provocative, one voice, concise, wants and feelings, listen, agree, limits, choices, debrief
Recovery	Connectedness, hope, identity, meaning, empowerment

Rules that keep people safe

Topic	The rule
Asking	Plain words; asking does not plant the idea.
Contracts	Never a substitute for a safety plan.
Release	The order is a maximum; release when criteria are met.
Holds	Never prone; sudden quiet is an emergency.
Agitation	Rule out delirium, hypoglycemia, hypoxia, withdrawal and akathisia first.
Postpartum psychosis	Never alone with the infant; escalate by SBAR.
Older adults	Acute change is delirium; strip anticholinergics.
Language	Person-first; behavior, not verdicts; "died by suicide."

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