MENTAL HEALTH NURSING · STUDY GUIDE

Final Exam Study Guide

This guide covers the whole course. Each chapter is shorter than in its exam guide: the core ideas, the points to lock in, one table, two worked cases, the common traps and six new self-test items. Use it after you have worked through the exam guides. If a chapter feels thin, go back to that chapter's exam guide or the textbook. The cram sheet at the end gathers every number and rule from all fourteen chapters.

WHAT THIS GUIDE COVERS

- Foundations · Chapters 1 to 4: mental health and stigma, the therapeutic relationship, legal and ethical practice, and assessment with the mental status exam and risk screening.
- Biology and disorders · Chapters 5 to 12: psychopharmacology, anxiety and trauma, mood disorders, psychosis, substance use, personality disorders, eating and somatic disorders, and delirium and dementia.
- Safety and settings · Chapters 13 and 14: crisis, suicide, aggression and restraint, and care across the lifespan and into the community.

CHAPTER 1

Mental Health, Mental Illness and Stigma

Read it in full: **Chapter 1 in the textbook**. Practice it in the lab: **Dual-Continuum Plotter: Distress or Disorder?** and **Red Flags and the SBAR Call**.

What to know

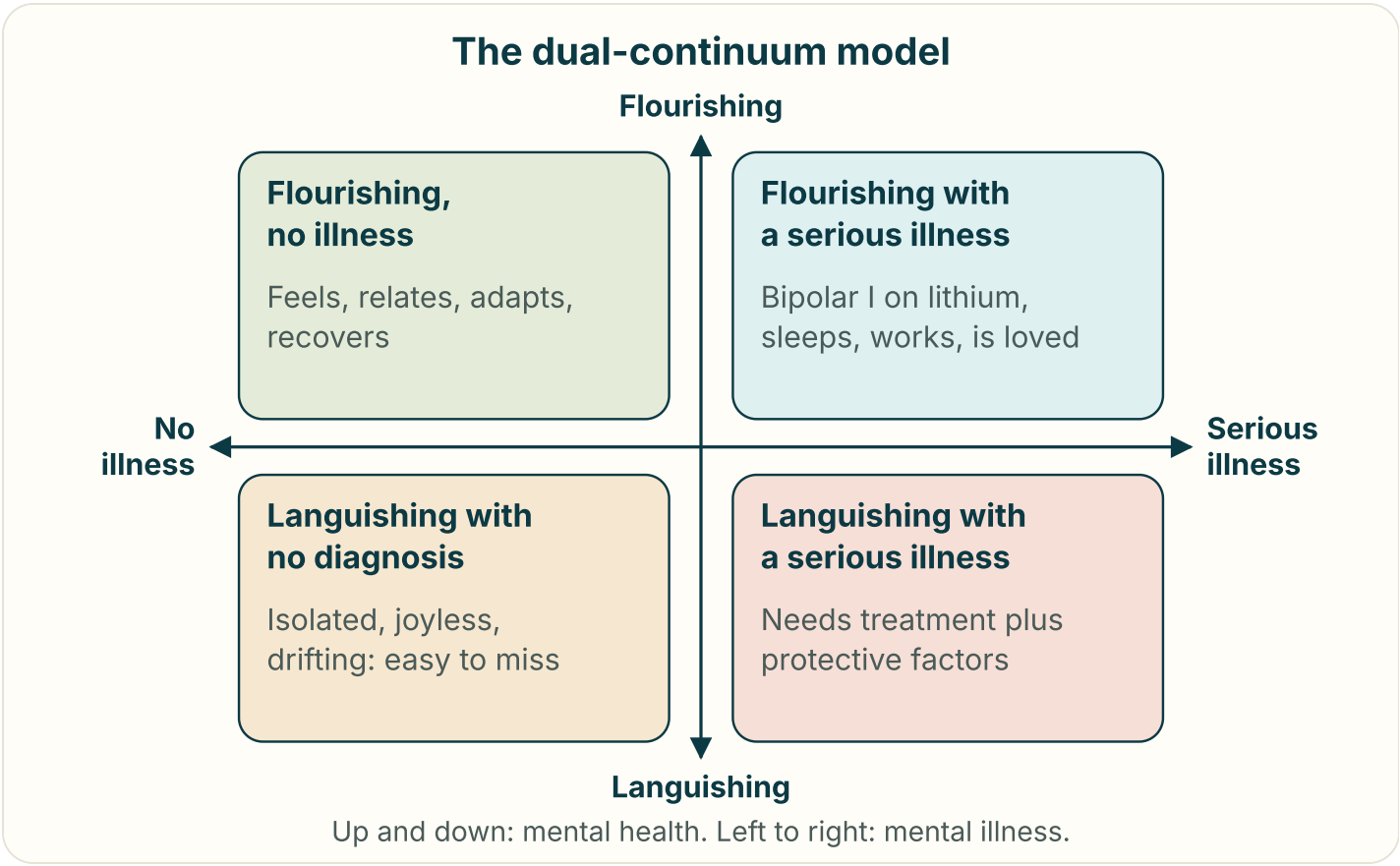
Mental health is a positive capacity, not the absence of a diagnosis. The **dual-continuum model** puts health (flourishing to languishing) and illness (none to serious) on separate axes, so a person can flourish with bipolar disorder or languish with no diagnosis. Distress becomes disorder through duration, impairment and departure from cultural expectation.

About one in five adults has a disorder in a year; half of lifetime disorders start by fourteen and three quarters by the mid twenties. More than half get no care in a given year (the treatment gap),

and people with serious mental illness die ten to twenty years early, mostly from physical disease (the mortality gap). Nursing names the **human response**, not the DSM-5-TR label.

Stigma runs as public, self, structural and courtesy stigma, plus label avoidance; contact beats information. **Diagnostic overshadowing** blames new physical symptoms on the psychiatric diagnosis. People with mental illness are far more often victims of violence. Use person-first, behavioral language and "died by suicide." Care is recovery-oriented (CHIME) and trauma-informed (four Rs, six principles).

> **LOCK THESE IN**
>
> - Two axes, not one line.
> - Duration, impairment, cultural departure.
> - Mortality gap 10 to 20 years, mostly physical disease.
> - Overshadowing: same workup as anyone.
> - Motive labels are not findings.
> - Assessment, teaching, evaluation and observation-level decisions are never delegated.



Two axes, not one line. Because health and illness are separate, a person can flourish with a diagnosis or languish without one. Treating them as one line hides the undiagnosed person who is quietly disappearing.

Chapter 1 terms

Term	Meaning
Dual continuum	Health and illness as separate axes
Treatment gap	Having a disorder versus getting adequate care
Self-stigma	Public beliefs turned inward: "why try"
Structural stigma	Unequal funding, boarding, network gaps
CHIME	Connectedness, Hope, Identity, Meaning, Empowerment
Four Rs	Realize, recognize, respond, resist re-traumatization

Worked cases

CASE 1.1 · LABELS INTO OBSERVATIONS

A note says "drug-seeking and manipulative." Rewrite it.

STEP 1 · FIND THE LABELS

Both are guesses about motive.

STEP 2 · DESCRIBE

"Requested pain medication four times in two hours; rates pain 8 of 10."

STEP 3 · ADD CONTEXT

"States last dose did not help; assessment findings and plan discussed with provider."

WHY

The next nurse can act on observations; labels travel and close thinking.

CASE 1.2 · RED FLAG, THEN SBAR

Mr. Ellis says he has saved his tablets and plans to take them tonight.

STEP 1 · ACT FIRST

Stay with him, start continuous observation, secure the tablets.

STEP 2 · S AND B

Who, where, what was said; diagnosis, history, recent changes.

STEP 3 · A

"He has a plan, means and strong intent; tablets secured."

STEP 4 · R

"Please see him within the hour and review the observation level."

TRAPS PEOPLE FALL INTO

- **No diagnosis means healthy.** The dual continuum says otherwise.
- **Suicide drives the mortality gap.** Physical disease does.
- **"Committed suicide."** Say "died by suicide."
- **Celebrating sudden calm.** Reassess suicide directly.

Chapter 1 self-test · six items

1. A woman with well-managed schizophrenia works, has friends and sleeps well. Where does she sit on the dual continuum?

A. Languishing because she has a diagnosis
B. Flourishing with a serious illness
C. At the midpoint of a single wellness line
D. Mentally healthy only once in remission

B. Flourishing with a serious illness Health and illness are separate axes, so flourishing with a diagnosis is possible.

2. Which form of stigma is a three-day emergency department wait for a psychiatric bed?

A. Structural stigma
B. Courtesy stigma
C. Label avoidance
D. Self-stigma

A. Structural stigma Stigma built into systems and funding is structural.

3. What does nursing diagnosis focus on, compared with a DSM-5-TR diagnosis?

A. The billing code that matches the disorder
B. The specific category of mental disorder
C. The person's human response to the illness
D. The family history of psychiatric illness

C. The person's human response to the illness The medical diagnosis names the disorder; nursing names the response, such as hopelessness or disrupted sleep.

4. A man with an intellectual disability has new agitation. What should the nurse do first?

A. Request a behavior plan from the team
B. Assume it is his usual baseline mood
C. Chart it as behavioral and give a PRN
D. Look for a medical cause such as infection

D. Look for a medical cause such as infection New behavior change is a medical event until proven otherwise; avoid diagnostic overshadowing.

5. Which statement about violence and mental illness is accurate?

A. People with mental illness are more often victims
B. Most violence comes from serious mental illness
C. A diagnosis alone predicts future violence
D. People with psychosis are usually dangerous

A. People with mental illness are more often victims The share of violence due to serious mental illness alone is small; victimization is far more common.

6. Which is a trauma-informed admission question?

A. "Nothing here will upset you, so do not worry."
B. "Is anything here likely to feel unsafe for you?"
C. "Were you abused? I need details for the chart."
D. "Tell me everything that happened in childhood."

B. "Is anything here likely to feel unsafe for you?" You can act on the answer without the story; asking for details can harm.

The Therapeutic Relationship and Communication

Read it in full: **Chapter 2 in the textbook**. Practice it in the lab: **The Therapeutic Frame: Phases and Boundaries** and **Hard Moments: Silence, Voices and a Disclosure**.

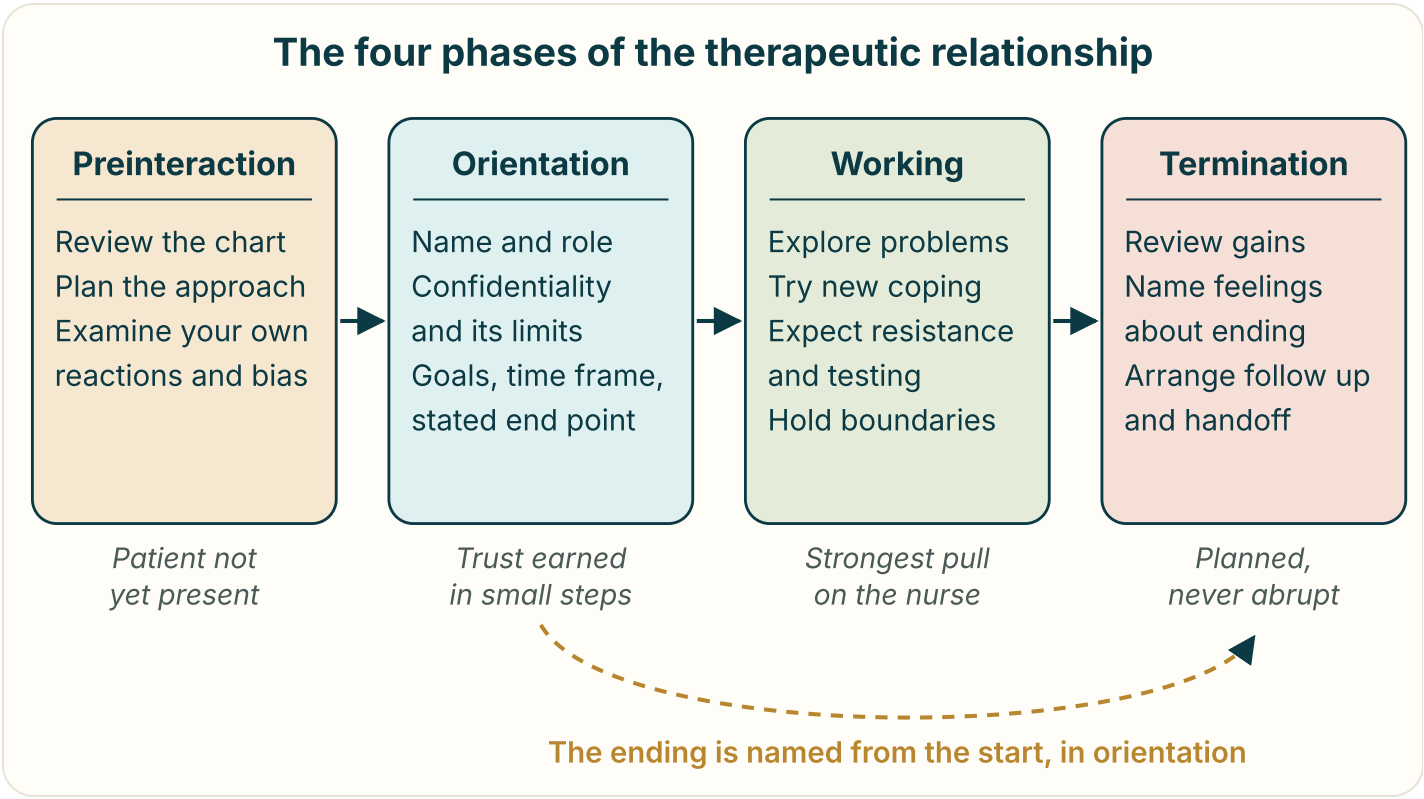
What to know

In mental health nursing the relationship is the treatment. **Therapeutic use of self** means every choice can be justified clinically, and self-awareness keeps the tool calibrated. The phases are **preinteraction** (including self-examination), **orientation** (role, confidentiality limits, goals, an end point), **working** (resistance appears) and **termination** (planned from the start).

A **crossing** is a brief step outside the frame; a **violation** is exploitative, including secrets kept from the team. Transference is the patient's; countertransference is the nurse's and goes to supervision. Use SOLER with a slight angle and a clear exit, and sit down.

Techniques keep the focus on the person: open questions, reflecting, clarifying, silence, focusing, making observations, presenting reality, summarizing. Avoid false reassurance, advice, why questions, defending and arguing with delusions. Follow the feeling, not the content. Ask about suicide directly, never accept a secret in advance, use qualified interpreters, de-escalate at the prodrome, and chart quotations and interventions.

> **LOCK THESE IN**
>
> - Preinteraction, orientation, working, termination.
> - Secrets from the team are violations.
> - Countertransference goes to supervision.
> - Slight angle, clear exit, sit down.
> - Never promise secrecy.
> - Interpreter: never family, never children.



A relationship with a plan. Each phase has its own nursing task. The step students skip is the self examination in preinteraction, and the error that hurts most is an ending nobody planned.

Chapter 2 responses

Patient says	Therapeutic reply
"I cannot do this anymore."	"Tell me what you mean. Are you thinking about killing yourself?"
"Why bother? Nothing helps."	"It sounds exhausting to keep trying. What has felt most useless?"
"The voices say the food is poisoned."	"I do not hear them, and I believe you do. Are they telling you to do anything?"
"Promise you will not tell."	"I cannot promise that; safety information goes to the team."
Silence and tears	Stay seated: "Take your time. I am not going anywhere."

Worked cases

CASE 2.1 · A CROSSING BECOMING A DRIFT

A student has stayed late three times for one patient and accepted a small gift.

STEP 1 · NAME IT

Repeated crossings with one person: a chain that can end in a violation.

STEP 2 · CHECK THE SIGNS

Special status, disproportionate time, secrecy, defensiveness.

STEP 3 · ACT

Take it to supervision; restore the frame kindly.

RULE

If you would not do it for every patient and chart it, do not do it.

CASE 2.2 · ANSWERING THE FEELING

A patient says, "Nobody here listens to me."

STEP 1 · AVOID DEFENDING

"That is not true, we work hard for you" protects the team.

STEP 2 · REFLECT AND EXPLORE

"Tell me about a time today you felt unheard."

RESULT

The complaint becomes data and may reveal a real care gap.

TRAPS PEOPLE FALL INTO

- **Promising confidentiality without limits.** State limits in orientation.
- **Filling silence.** Count to ten.
- **Using family to interpret.** Use a qualified interpreter.
- **Charting "encouraged to verbalize feelings."** Chart what happened and the person's words.

Chapter 2 self-test · six items

1. In which phase does the nurse state the limits of confidentiality?

A. Orientation
B. Termination
C. Working
D. Preinteraction

A. Orientation Confidentiality and its limits are set at first contact, in orientation.

2. Where do resistance and testing most often appear?

A. The orientation phase
B. The working phase
C. The termination phase
D. Preinteraction

B. The working phase The working phase brings the real therapeutic labor and the strongest pull on the nurse.

3. A nurse wants to rescue one particular patient and feels flattered by him. What is this?

A. Consensual validation
B. Transference
C. Countertransference
D. Therapeutic use of self

C. Countertransference Intensity out of proportion in the nurse is countertransference, to take to supervision.

4. Which reply uses the technique of making observations?

A. "Everything will be fine after the call."
B. "Why are you pacing around like that again?"
C. "You should sit down and try to relax now."
D. "I notice you have paced since the phone call."

D. "I notice you have paced since the phone call." Making observations is objective and non-accusatory and can open a topic.

5. A client says, "You are the only nurse who cares." What is the best reply?

A. "That is not true; the others care too."
B. "I do care more than most of them, honestly."
C. "Everyone here is working on the same plan."
D. "Let us keep this just between the two of us."

C. "Everyone here is working on the same plan." Warm and non-rejecting, while keeping the team plan intact.

6. Which delegation is specific enough to be safe?

A. "Keep an eye on him for a while, please."
B. "Stay at arm's length; report any refusal."
C. "Watch him and decide if he seems okay."
D. "Check on him whenever you get a chance."

B. "Stay at arm's length; report any refusal." Direction must be specific about level, distance and what to report.

Legal and Ethical Issues in Mental Health Care

Read it in full: **Chapter 3 in the textbook**. Practice it in the lab: **The Ladder: Least Restrictive First** and **Say-It Bench: The Call You Cannot Answer**.

What to know

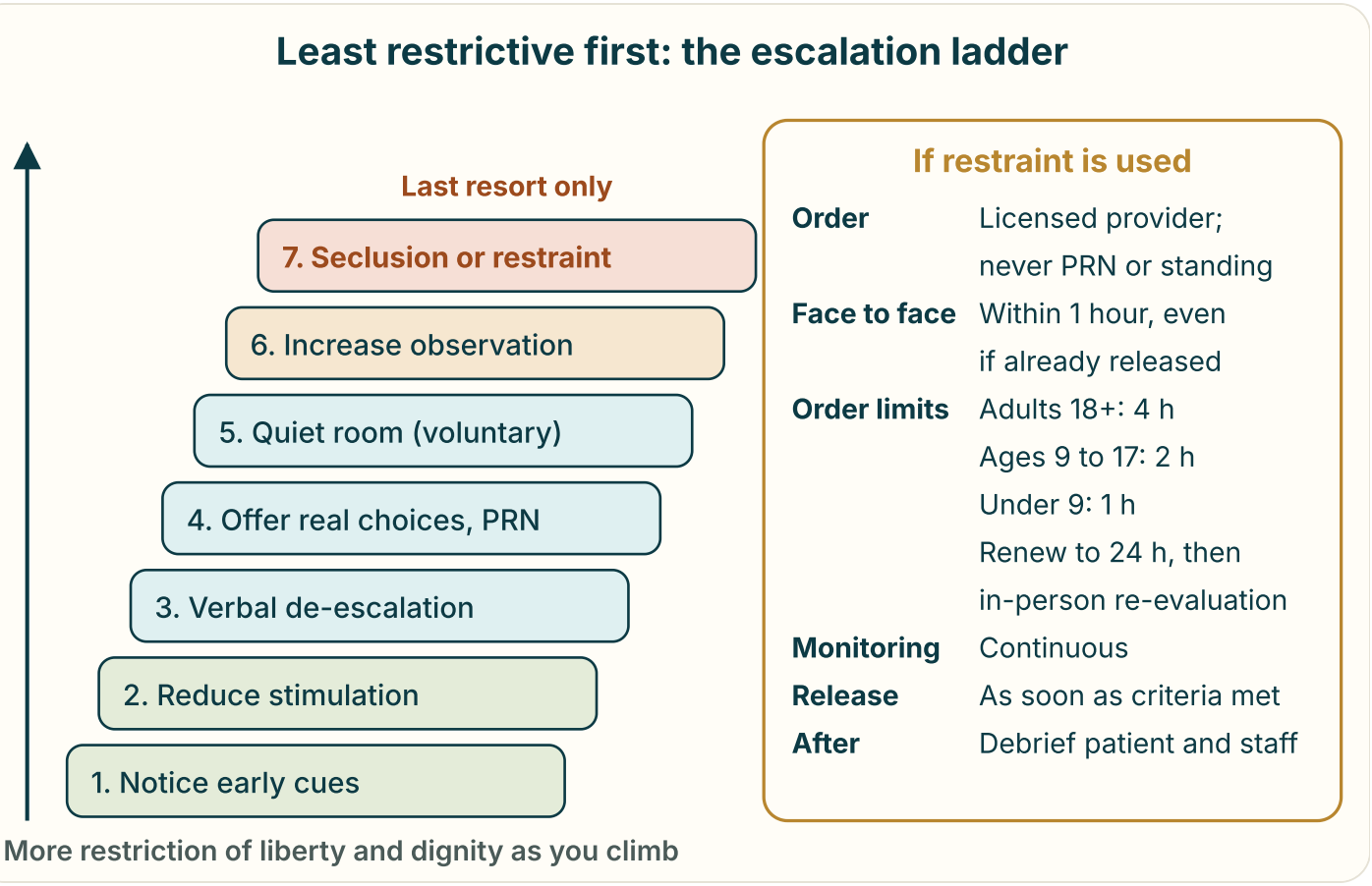
Principles: autonomy, beneficence, nonmaleficence, justice, veracity, fidelity. Resolve dilemmas by process: is the refusal informed, is capacity for this decision impaired, what is the least restrictive path, escalate, document the reasoning. Moral distress is real and should be named.

Voluntary patients may request discharge in writing, subject to a notice period of about 48 to 72 hours; notify the provider first. Emergency holds (often 72 hours) need danger to self, others or grave disability. Commitment needs clear and convincing evidence (Addington). Involuntary status removes the right to leave and almost nothing else. False imprisonment, battery and assault are the torts to avoid.

HIPAA: never confirm presence to a caller; you may always listen. Psychotherapy notes and 42 CFR Part 2 records have extra protection. Tarasoff: the nurse elicits, protects, notifies and documents verbatim. Capacity is decision-specific (understanding, appreciation, reasoning, choice); competence is a court's finding. Restraint: no PRN or standing orders, face-to-face within one hour, 4, 2 and 1 hour limits, continuous monitoring, never prone, release early, debrief.

LOCK THESE IN

- Voluntary: notify the provider first.
- Hold criteria: self, others, grave disability.
- Clear and convincing evidence.
- Capacity: four abilities, one decision.
- Unwise is not incapable.
- Restraint: 1 h face-to-face; 4, 2, 1 h.



Climb only as far as safety needs. Each rung must fail before the next is used. Restraint has strict federal limits on orders, timing, monitoring and debriefing, and it is never punishment or a staffing fix.

Chapter 3 at a glance

Item	Rule
Voluntary	Written request; notice about 48 to 72 h
Emergency hold	Often 72 h; detention and evaluation, not routine forced medication
Commitment	Hearing; clear and convincing evidence
Tarasoff	Serious threat, identifiable victim; escalate
Right to refuse	Survives detention; emergency exception only
Restraint	Order, never PRN; 1 h face-to-face; continuous monitoring

Worked cases

CASE 3.1 · WHICH ABILITY?

A man repeats every risk of stopping his medication but says, "None of this is about me."

STEP 1 · UNDERSTANDING

Intact.

STEP 2 · APPRECIATION

Impaired: he denies the facts apply to him.

NEXT

Report to the provider; capacity is judged for this decision only.

CASE 3.2 · THE FAMILY CALL

A caller asks if her son is on the unit.

STEP 1 · DO NOT CONFIRM

"I am not able to confirm whether anyone is a patient here."

STEP 2 · VALIDATE AND OFFER

"I can hear how worried you are. I can take information from you."

LISTENING IS ALLOWED

Receiving information is not a disclosure.

TRAPS PEOPLE FALL INTO

- **Treating involuntary as no rights.** Only the right to leave is removed.
- **Testing capacity only after refusal.** Agreement needs the same test.
- **PRN restraint orders.** Never permitted.
- **Calling the threatened person yourself.** Escalate; follow policy and the provider.

Chapter 3 self-test · six items

1. Which principle is tested when a nurse is tempted to say a hold ends tomorrow without knowing?

A. Veracity
B. Beneficence
C. Justice
D. Fidelity

A. Veracity Veracity is truthfulness; a discovered untruth can end the relationship.

2. A voluntary patient is told he cannot leave with no hold in place. Which tort is this?

A. Assault by threat
B. Battery by touching
C. Defamation of character
D. False imprisonment

D. False imprisonment Unlawfully restricting movement is false imprisonment.

3. Which records need consent stricter than baseline HIPAA?

A. Appointment reminder calls
B. Vital signs on a medical ward
C. Substance use program records
D. Routine laboratory results

C. Substance use program records 42 CFR Part 2 protects substance use treatment records.

4. Who determines legal competence?

A. The family
B. A court of law
C. The psychiatrist
D. The nurse

B. A court of law Competence is legal; capacity is a clinical judgment at the bedside.

5. When does the right to refuse psychotropic medication pause?

A. Whenever any hold is signed
B. Once a diagnosis has been made
C. For the whole of the admission
D. In a true behavioral emergency

D. In a true behavioral emergency Only an imminent danger justifies emergency medication, and the right returns afterward.

6. Which restraint practice is prohibited?

A. Debriefing the patient after
B. Restraining a person face-down
C. Releasing early once calm
D. Offering fluids and toileting

B. Restraining a person face-down Prone restraint risks positional asphyxia and is never used.

CHAPTER 4

Assessment: The Mental Status Exam and Risk Screening

Read it in full: **Chapter 4 in the textbook**. Practice it in the lab: **The First Ninety Seconds: Setting Up the Interview** and **The Mimic Desk: Ruling Out the Body First**.

What to know

Set up for safety and privacy, sit at an angle, keep exits clear, and assume a trauma history may be present. The MSE is a snapshot of now: appearance, behavior and motor, speech, mood (their words), affect (what you see), thought process (how), thought content (what), perception, cognition, insight and judgment. Keep observed and reported data apart.

Rule out the body: check glucose first; new psychosis after forty, visual hallucinations, fluctuating attention, focal signs or abnormal vital signs mean a medical workup. Know the mimics. MoCA is out of 30 with a cut-off about 26. The CAM needs acute onset or fluctuation and inattention, plus disorganized thinking or altered consciousness.

Ask about suicide directly and climb the ladder: ideation, plan, intent, access, preparatory acts, protective factors. Restrict means, build a six-step safety plan, never use a contract. Ask about intent after every self-injury. Close every risk finding with an observation level, a means action and an SBAR.

> **LOCK THESE IN**
>
> - Mood is said; affect is seen.
> - Process is how; content is what.
> - Glucose first.
> - CAM 1 and 2, plus 3 or 4.
> - Ladder: ideation, plan, intent, access.
> - No contracts.

The mental status exam, domain by domain

Observe	Ask and quote	Screen cognition
Appearance	Mood (what they say)	Level of consciousness
Behavior and motor	Thought content	Orientation x 4
Speech	Perception	Attention (serial 7s)
Affect (what you see)	Insight	Recall at 5 minutes
Thought process (flow)	Judgment (recent acts)	Abstraction

Incongruence is a finding

Mood: "I am fine," in quotation marks. Affect: tearful, dysphoric, restricted.
The mismatch gets a direct follow-up question, not just a note.

Describe, do not conclude. The MSE is a snapshot of right now. Chart mood in the person's words and affect in clinical adjectives, and quote every risk statement verbatim.

MSE quick reference

Domain	Example wording
Appearance	Three sweaters in warm weather
Speech	Pressured; increased latency
Mood	"Empty"
Affect	Flat, incongruent
Process	Tangential; flight of ideas
Content	Verbatim risk quotes
Perception	Command auditory hallucinations
Cognition	Inattentive on months backward

Worked cases

CASE 4.1 · PROCESS OR CONTENT?

A patient says, "They put a chip in my ear," then jumps from her son to the weather to a dog and never comes back.

STEP 1 · CONTENT

A persecutory delusion; quote it.

STEP 2 · PROCESS

Topic jumps that never return: tangential.

THEN

Ask what she plans to do about the belief; intent changes risk.

CASE 4.2 · THE DENIAL THAT IS NOT A CLEARANCE

After weeks of anguish, a man is calm and has written letters but denies suicidal thoughts.

STEP 1 · SEE THE SIGNS

Sudden calm and preparatory acts.

STEP 2 · ACT

Keep observation, ask about a decision made, escalate.

RULE

A denial is not a clearance.

TRAPS PEOPLE FALL INTO

- **Charting "patient is anxious."** Describe what you saw and heard.
- **Confusing circumstantial and tangential.** One returns; one never does.
- **Testing without glasses or hearing aids.** Scores fall for the wrong reason.
- **Letting assistive personnel screen.** They report; the nurse assesses.

Chapter 4 self-test · six items

1. A client giggles while describing her father's death. How is this charted?

A. Affect incongruent with content
B. Thought process tangential
C. Insight full and intact today
D. Mood euthymic and appropriate

A. Affect incongruent with content Affect that does not match the content is incongruent and is described, not interpreted.

2. Which hallucination type should most raise concern for alcohol withdrawal or stimulants?

A. Gustatory
B. Auditory
C. Tactile
D. Olfactory

C. Tactile Tactile hallucinations such as insects on the skin suggest stimulants or alcohol withdrawal.

3. Which client most needs a medical workup before a psychiatric label?

A. A 25-year-old with known panic attacks
B. A 22-year-old with a 2-year history of voices
C. A 30-year-old with stable bipolar disorder
D. A 67-year-old with new psychosis and fever

D. A 67-year-old with new psychosis and fever New psychosis after forty with fever points to a medical cause.

4. Which item is part of a six-step safety plan?

A. A written promise not to act
B. Making the environment safer
C. Agreeing to stop all medication
D. A rule against telling family

B. Making the environment safer The six steps end with environmental safety and means restriction.

5. What predicts suicide risk more reliably than sadness?

A. Hopelessness
B. Insomnia alone
C. Poor appetite
D. Tearfulness

A. Hopelessness Hopelessness carries more predictive weight than sadness.

6. A client with NSSI says, "I cut to feel real again." What does this describe?

A. A psychotic command from voices
B. Manipulation to gain staff attention
C. Ending dissociation through self-injury
D. A failed suicide attempt to document

C. Ending dissociation through self-injury NSSI often regulates emotion or ends dissociation; ask about intent separately.

CHAPTER 5

Neurobiology and Psychopharmacology

Read it in full: **Chapter 5 in the textbook**. Practice it in the lab: **Four Pathways and the Price of Blocking Them** and **The Lithium Level Bench**.

What to know

Drugs act on synthesis, release, receptors, reuptake or enzymes. Reuptake blockade is immediate, so side effects arrive in days; receptor downregulation and plasticity bring benefit over weeks. Sort findings by time: hours is pharmacology, weeks is therapeutic, months in movement is tardive. Anticholinergic blockade gives dry mouth, constipation, retention and delirium.

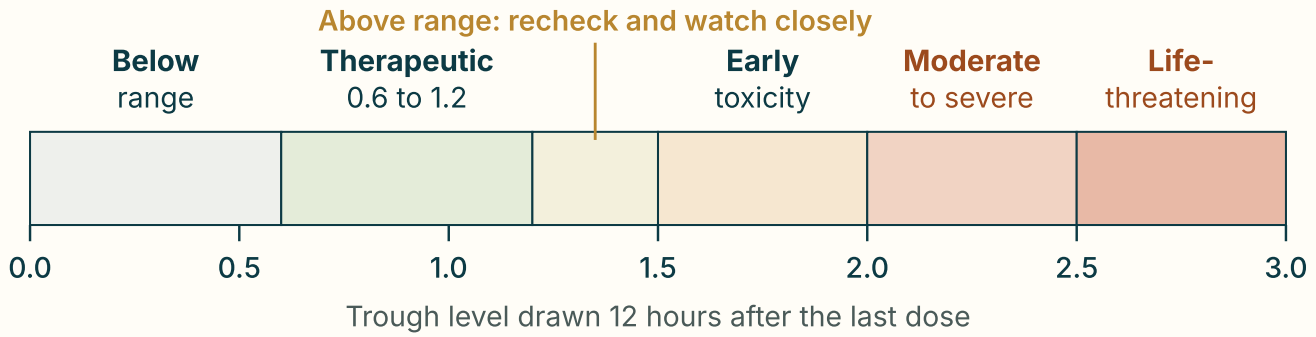
SSRIs first line; mood lifts at two to six weeks while energy returns first, so screen directly early. Tricyclics are lethal in overdose. MAOIs need a tyramine diet and washout (two weeks; five after fluoxetine). Bupropion lowers the seizure threshold. Lithium: 0.6 to 1.2 mEq/L trough, toxic above 1.5, raised by dehydration, NSAIDs, thiazides and ACE inhibitors; sick-day rule: hold and call.

Antipsychotics block D2 in four pathways (mesolimbic benefit, mesocortical blunting, nigrostriatal EPS, tuberoinfundibular prolactin). Dystonia hours, akathisia days to weeks, parkinsonism weeks, TD months to years. NMS: days, rigidity; serotonin syndrome: hours, clonus. Clozapine needs ANC checks and a bowel regimen. A forced PRN is a chemical restraint.

LOCK THESE IN

- Side effects in days, benefit in weeks.
- Lithium follows sodium.
- Fine tremor expected; coarse tremor toxic.
- Akathisia: do not add antipsychotic.
- NMS rigid; serotonin clonic.
- Clozapine fever: ANC today.

Serum lithium, drawn to scale (mEq/L)



Trough level drawn 12 hours after the last dose

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

Low sodium or low volume means high lithium.

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

Chapter 5 drug red flags

Finding	Think	Act
Coarse tremor, vomiting on lithium	Toxicity	Hold, stat level
Fever, sore throat on clozapine	Agranulocytosis	Hold, stat ANC
Rash on lamotrigine	SJS	Stop, escalate
Occipital headache on an MAOI	Tyramine crisis	Hold, urgent escalation
Clonus hours after a triptan plus SSRI	Serotonin syndrome	Stop serotonergic drugs
Rigidity and fever days after a dose rise	NMS	Hold antipsychotic, cool

Worked cases

CASE 5.1 · THE TWO CLOCKS

A man on day three of sertraline has nausea and says, "It makes me worse and does nothing."

STEP 1 · EXPLAIN THE TIMING

Side effects come in days; mood lifts in two to six weeks.

STEP 2 · PLAN

Continue, monitor, and screen for suicide as energy returns.

TEACH THE FAMILY

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

CASE 5.2 · LITHIUM SICK DAY

A woman on lithium has the flu with vomiting.

STEP 1 · RULE

Hold the dose and call.

STEP 2 · WHY

Low volume and sodium raise lithium.

ALSO

Acetaminophen, not ibuprofen.

TRAPS PEOPLE FALL INTO

- **"Chemical imbalance."** A retired oversimplification.
- **Ibuprofen with lithium.** Raises the level.
- **Anticholinergics for TD.** They worsen it.
- **Calling a depot injection punishment.** Frame it as a choice.

Chapter 5 self-test · six items

1. Which transmitter system do benzodiazepines and alcohol enhance?

A. GABA at GABA-A receptors
B. Dopamine at D2 receptors
C. Serotonin at 5-HT1A receptors
D. Glutamate at NMDA receptors

A. GABA at GABA-A receptors Benzodiazepines and alcohol potentiate GABA-A, the brain's main inhibitory brake.

2. Which antidepressant is most dangerous in overdose because of QRS widening?

A. Sertraline
B. Bupropion
C. Mirtazapine
D. Amitriptyline

D. Amitriptyline Tricyclics block cardiac sodium channels and can be lethal in overdose.

3. A client on lithium starts a thiazide diuretic. What is the risk?

A. A falling lithium level
B. Tyramine crisis
C. A rising lithium level
D. Serotonin syndrome

C. A rising lithium level Thiazides reduce lithium clearance and raise the level.

4. Which pathway's blockade raises prolactin?

A. Mesolimbic pathway
B. Tuberoinfundibular
C. Nigrostriatal pathway
D. Mesocortical pathway

B. Tuberoinfundibular Dopamine in the tuberoinfundibular pathway normally suppresses prolactin.

5. What is the AIMS used to screen for?

A. Tardive dyskinesia
B. Agranulocytosis
C. Lithium toxicity
D. Serotonin syndrome

A. Tardive dyskinesia The Abnormal Involuntary Movement Scale screens for tardive dyskinesia.

6. A client willingly accepts an offered PRN for anxiety. How is this classified?

A. Seclusion under federal rules
B. A physical restraint episode
C. Treatment, not chemical restraint
D. Chemical restraint needing an order

C. Treatment, not chemical restraint An accepted PRN is treatment; the same drug forced to control behavior is chemical restraint.

CHAPTER 6

Anxiety, Obsessive-Compulsive and Trauma-Related Disorders

Read it in full: **Chapter 6 in the textbook**. Practice it in the lab: **Redesign the Shift: Trauma-Informed Care** and **Red Flag Desk and the SBAR Call**.

What to know

The amygdala drives the alarm; the prefrontal cortex brakes it; the hippocampus stamps time and place. Grade anxiety with Peplau: mild (teach), moderate (short directions), severe (stay, reduce stimuli, do not teach), panic (safety, never alone). Disorder needs proportion, persistence and impairment; avoidance is the engine.

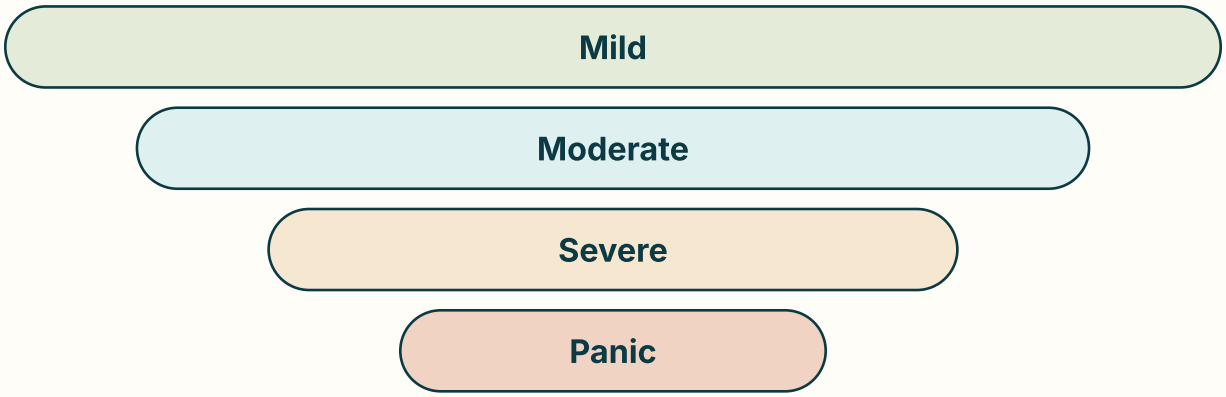
Panic attacks peak in minutes and pass in twenty to thirty; rule out cardiac and other mimics. GAD needs six months of worry with three of six symptoms. Blood-injection-injury phobia causes fainting: lay the person down. GAD-7: 0 to 21, cut points 5, 10, 15. Akathisia is the "anxiety" that worsens when treated as anxiety.

Obsessions are ego-dystonic; compulsions buy brief relief. Never rip a ritual away; schedule, measure and reduce it while ERP teaches the brain. Reassurance-seeking is a compulsion. PTSD: Criterion A event plus intrusion, avoidance, negative cognition and mood, and arousal for more than a month; acute stress disorder is three days to a month. Ground flashbacks; do not ask for the story.

LOCK THESE IN

- Mild teach; severe do not teach.
- Avoidance keeps fear alive.
- GAD-7 10 or more: evaluate.
- Never block a ritual abruptly.
- PTSD over 1 month.
- Grounding, not narrative.

Peplau's levels of anxiety: the perceptual field narrows



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

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

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

Chapter 6 durations and tools

Item	Value
GAD, social anxiety, specific phobia	6 months
Panic disorder	Attacks plus 1 month of worry or change
Separation anxiety	6 months adults; 4 weeks children
PTSD	More than 1 month
Acute stress disorder	3 days to 1 month
Adjustment disorder	Within 3 months; resolves within 6 after
Prolonged grief	12 months in adults
OCD	More than 1 hour a day or major distress

Worked cases

CASE 6.1 · PANIC IN THE ED

A 55-year-old with no history has chest pain and doom.

STEP 1 · RULE OUT FIRST

ECG, troponin, glucose, oxygen: possible MI or PE.

STEP 2 · THEN SUPPORT

If cleared, stay, pace the breath, predict that it passes.

NEVER

Diagnose panic by reassurance alone.

CASE 6.2 · THE REASSURANCE LOOP

A man with OCD asks, "Did I lock it?" for the sixth time.

STEP 1 · DECLINE KINDLY

"Answering feeds the doubt. Let us sit with it together."

STEP 2 · STAY PRESENT

Presence is the care.

WHY

Reassurance is a compulsion.

TRAPS PEOPLE FALL INTO

- **Teaching in panic.** Wait for mild or moderate anxiety.
- **Calling OCPD OCD.** OCPD is ego-syntonic.
- **Single-session debriefing.** Not supported.
- **Buspirone as PRN.** It takes 2 to 4 weeks.

Chapter 6 self-test · six items

1. Which level of anxiety fixes attention on one detail and blocks problem-solving?

A. Mild
B. Low
C. Severe
D. Moderate

C. Severe In severe anxiety the field collapses to a fragment and teaching does not work.

2. Which feature defines agoraphobia?

A. Fear of places where escape is hard
B. Fear of being judged in public
C. Fear of one specific animal
D. Fear of losing an attachment figure

A. Fear of places where escape is hard Agoraphobia involves two or more situations where escape or help would be difficult.

3. Which medication reduces trauma-related nightmares?

A. Haloperidol
B. Prazosin
C. Buspirone
D. Bupropion

B. Prazosin Prazosin, an alpha-1 antagonist, quiets norepinephrine-driven nightmares.

4. What is the gold-standard psychotherapy for OCD?

A. Single-session psychological debriefing
B. Supportive reassurance on request
C. Free association psychoanalysis
D. Exposure and response prevention

D. Exposure and response prevention ERP pairs graded exposure with withholding the ritual.

5. Hair loss from repeated pulling, with failed efforts to stop, responds best to what?

A. Habit reversal training
B. Shaving the scalp
C. Willpower and reminders
D. Reassurance from staff

A. Habit reversal training Habit reversal uses awareness and a competing response.

6. A client freezes and stares during a flashback. What does the nurse do?

A. Ask her to tell the whole story now
B. Touch her shoulder firmly from behind
C. Leave her alone until it ends
D. Name the place and date and ground her

D. Name the place and date and ground her Orient and ground without unannounced touch; do not seek the narrative.

CHAPTER 7

Depressive and Bipolar Disorders

Read it in full: **Chapter 7 in the textbook**. Practice it in the lab: **Say-It Bench: Hopelessness, Guilt and Grandiosity** and **Ask Directly, Then Build the Plan**.

What to know

MDD: five of nine for two weeks with depressed mood or anhedonia (SIGECAPS). Grief comes in waves with intact self-esteem; depression brings worthlessness; they can coexist. PHQ-9 cut points 5, 10, 15, 20; a positive item 9 means a direct interview. Rule out thyroid, anemia, B12, sleep apnea, drugs and alcohol.

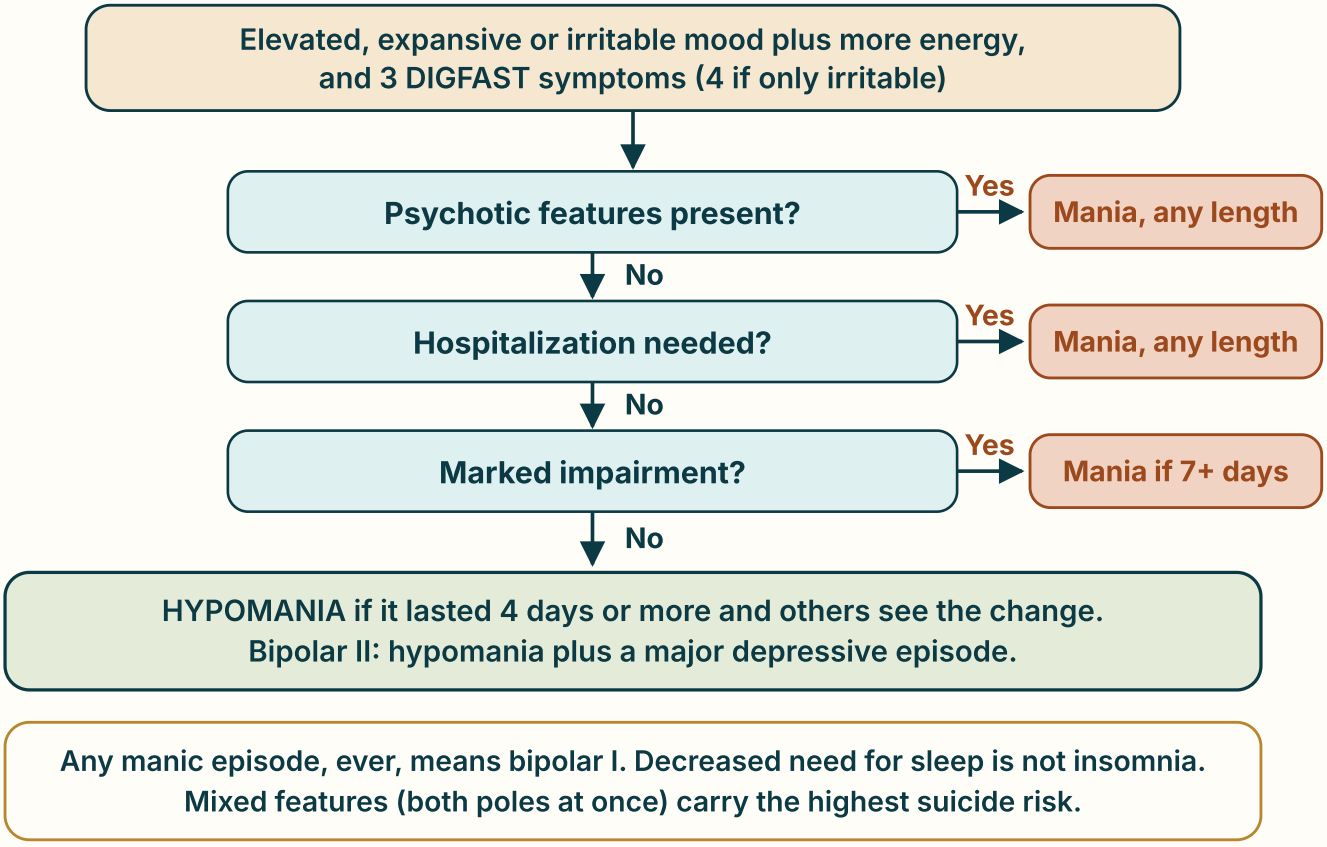
Mania: seven days (any length if hospitalized) with marked impairment, hospitalization or psychosis; hypomania: four days, observable, without those. One manic episode means bipolar I; bipolar II is hypomania plus major depression and is not milder. Mixed features carry the highest suicide risk; postpartum psychosis is an emergency. Screen for past highs before an antidepressant.

The four emergencies: serotonin syndrome, lithium toxicity, tyramine crisis and lamotrigine rash. Discontinuation is FINISH; taper. Lithium targets 0.8 to 1.2 for mania and 0.6 to 1.0 for maintenance. ECT is fastest for severe, psychotic or suicidal depression. Stay with the feeling; never argue with hopelessness or grandiosity; means restriction and a written safety plan.

LOCK THESE IN

- 5 of 9 for 2 weeks.
- Mania 7 days; hypomania 4.
- One mania means bipolar I.
- Mixed features: highest risk.
- Screen for highs first.
- Any lamotrigine rash: stop.

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.

Chapter 7 drugs

Drug	Key point
SSRIs	2 to 4 weeks, sometimes 6; sexual dysfunction; hyponatremia
Bupropion	Seizure threshold; no sexual dysfunction
Mirtazapine	Sedation and appetite at low dose
Trazodone	Priapism over 4 hours is an emergency
MAOIs	Tyramine diet; 14-day washout
Lithium	Trough; sodium and volume rules
Lamotrigine	Slow titration; rash means stop
ECT	NPO; hold benzodiazepines, anticonvulsants, lithium as ordered

Worked cases

CASE 7.1 · GRIEF OR DEPRESSION?

A widow cries in waves, laughs at memories and wishes to be with her husband. Another feels worthless every day for a month and believes she deserves to die.

STEP 1 · FIRST WOMAN

Grief pattern.

STEP 2 · SECOND WOMAN

Depression pattern; screen for suicide directly.

BOTH CAN COEXIST

Grief never rules out treatment.

CASE 7.2 · MIXED FEATURES

A man with depression has racing thoughts, little sleep and agitation.

STEP 1 · NAME IT

Depressive episode with mixed features.

STEP 2 · ACT

Treat as elevated suicide risk; assess directly; review any antidepressant with the provider.

TRAPS PEOPLE FALL INTO

- **Requiring sadness.** Anhedonia counts.
- **Insomnia equals mania.** Mania is rested on little sleep.
- **Bipolar II is mild.** Risk is at least equal.
- **Discontinuation equals relapse.** Think FINISH after a missed refill.

Chapter 7 self-test · six items

1. Which mnemonic lists the depression criteria?

A. CHIME
B. SIGECAPS
C. FINISH
D. DIGFAST

B. SIGECAPS SIGECAPS: sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicidality.

2. Which mnemonic lists the symptoms of mania?

A. DIGFAST
B. SIGECAPS
C. OARS
D. SBAR

A. DIGFAST DIGFAST covers distractibility, impulsivity, grandiosity, flight of ideas, activity, sleep deficit, talkativeness.

3. Which client needs a direct interview because of the PHQ-9 alone?

A. Item 3 scored as 2 points
B. A total score of 9 points
C. A total score of 6 points
D. Item 9 scored above zero

D. Item 9 scored above zero A positive item 9 on self-harm needs a direct follow-up interview.

4. A client on paroxetine ran out of pills two days ago and has dizziness and "zaps." What is this?

A. Early serotonin syndrome
B. Benzodiazepine withdrawal
C. Discontinuation syndrome
D. A switch into mania

C. Discontinuation syndrome Abrupt stopping of a short half-life SSRI causes FINISH symptoms.

5. Which teaching belongs with trazodone?

A. Expect a fast mood change within 2 days
B. Avoid aged cheese and tap beer at all times
C. Have a lithium level drawn every week
D. An erection over 4 hours is an emergency

D. An erection over 4 hours is an emergency Priapism is a rare urological emergency with trazodone.

6. Before ECT, which medication is usually held as ordered?

A. Vitamin D
B. Docusate
C. Lithium
D. Omeprazole

C. Lithium Lithium is held because of delirium risk; benzodiazepines and anticonvulsants also raise the seizure threshold.

CHAPTER 8

Schizophrenia Spectrum and Other Psychotic Disorders

Read it in full: **Chapter 8 in the textbook**. Practice it in the lab: **Four Pathways, Four Consequences, and the Movement Clock** and **The Least Restrictive Ladder**.

What to know

Positive symptoms add (hallucinations, delusions, disorganization); negative symptoms subtract (blunting, alogia, anhedonia, avolition, asociality); cognitive symptoms best predict function. Catatonia is an emergency treated with benzodiazepines or ECT. The ladder: brief under one month, schizophreniform one to six, schizophrenia six or more; schizoaffective needs two weeks of psychosis without mood symptoms.

Visual hallucinations or new psychosis after forty mean a medical workup; anti-NMDA receptor encephalitis is treatable. Neither confirm nor argue: "I believe you hear it; I do not; it sounds frightening." Use short concrete sentences. Ask about command content and intent. Daily weights catch water intoxication.

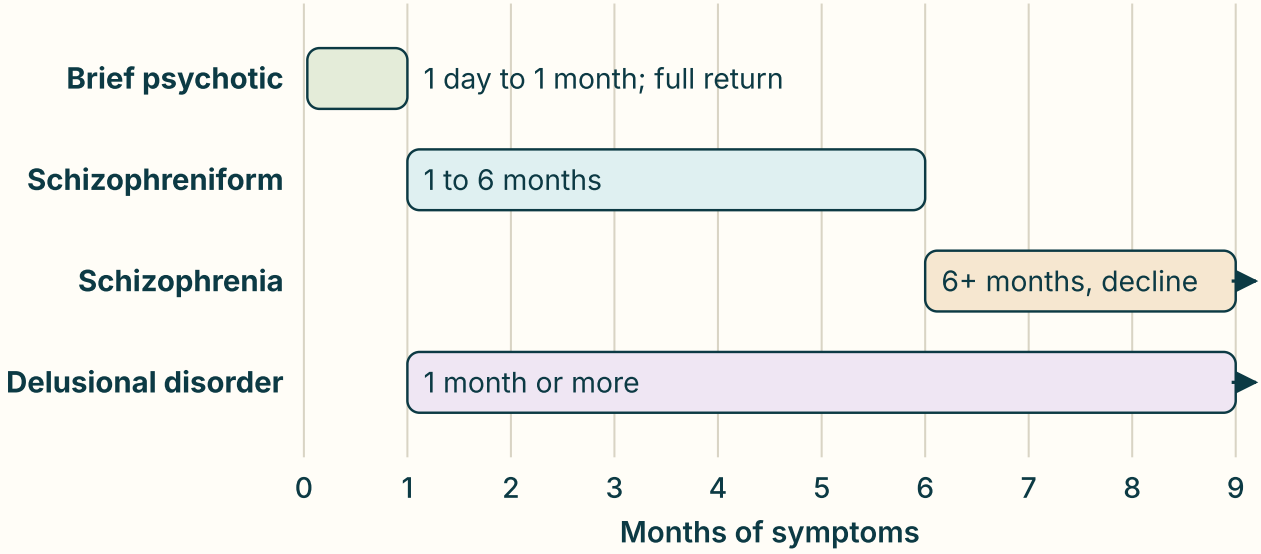
Antipsychotics: mesolimbic benefit, nigrostriatal EPS, tuberoinfundibular prolactin, mesocortical blunting. Akathisia is not agitation. NMS: rigidity, fever above 38 °C twice, unstable vital signs, high CK: hold and escalate. Clozapine: ANC schedule, myocarditis in the first two months, constipation and ileus. Involuntary admission is not involuntary medication; anosognosia is not

incapacity. Coordinated specialty care and family psychoeducation do the real work after discharge.

LOCK THESE IN

- Negative and cognitive symptoms decide function.
- Under 1, 1 to 6, 6+ months.
- Neither confirm nor argue.
- Akathisia: no more antipsychotic.
- NMS: hold, cool, CK.
- Sleep loss: first relapse sign.

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.

Chapter 8 movement timelines

Effect	Onset	Response
Acute dystonia	Hours to days	IM benztropine or diphenhydramine; airway
Akathisia	Days to weeks	Lower dose, switch, propranolol
Parkinsonism	Weeks	Dose cut, anticholinergic, amantadine
Tardive dyskinesia	Months to years	AIMS; VMAT2 inhibitor; no anticholinergics
NMS	Usually first 2 weeks of a start or rise	Hold every antipsychotic; ICU care

Worked cases

CASE 8.1 · MOOD WITH PSYCHOSIS

A woman has had hallucinations only during manic episodes.

STEP 1 · APPLY THE HINGE

No two weeks of psychosis without mood symptoms.

STEP 2 · NAME IT

Bipolar disorder with psychotic features, not schizoaffective.

CASE 8.2 · THE FRIGHTENED TRAY

A man inspects and refuses his tray, saying it is poisoned.

STEP 1 · RESPOND

"That would be terrifying. I do not see it that way. Would a sealed carton help?"

STEP 2 · RECORD

His words, the refusal and what he accepted.

TRAPS PEOPLE FALL INTO

- **Calling catatonia refusal.** It is an emergency.
- **Arguing with a delusion.** You join the delusion as an opponent.
- **More antipsychotic for akathisia.** Makes it worse.
- **"No insight" means incapacity.** Anosognosia is not incapacity.

Chapter 8 self-test · six items

1. Which finding most suggests a medical cause of new psychosis?

A. Withdrawal from friends over many months
B. Auditory voices commenting on actions
C. Persecutory beliefs about the neighbors
D. Visual hallucinations, fluctuating attention

D. Visual hallucinations, fluctuating attention Visual hallucinations and fluctuating attention point toward delirium or another medical cause.

2. Psychosis has lasted three months with no mood episodes. Which diagnosis fits?

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

B. Schizophreniform disorder One to six months is schizophreniform.

3. Which risk factor raises the chance of acting on command hallucinations?

A. The voice is believed to be powerful
B. The voice is unfamiliar and faint
C. The person has never obeyed before
D. The person is sober and well rested

A. The voice is believed to be powerful Identified, powerful or delusion-congruent voices, past obedience and substances raise risk.

4. Which antipsychotic must be taken with a meal of about 500 calories?

A. Haloperidol
B. Clozapine
C. Ziprasidone
D. Olanzapine

C. Ziprasidone Ziprasidone needs food for absorption and prolongs the QT interval.

5. A client on clozapine reports no bowel movement for five days. Why does this matter?

A. It is expected and needs no action
B. It can progress to fatal ileus
C. It signals the drug is working well
D. It means the dose is too low for now

B. It can progress to fatal ileus Clozapine constipation and ileus are a real cause of death; a bowel regimen is part of the drug.

6. Which family pattern predicts relapse and falls with psychoeducation?

A. High expressed emotion
B. Infrequent family visits
C. Shared evening meals
D. Firm medication routines

A. High expressed emotion Criticism, hostility and over-involvement predict return to hospital.

CHAPTER 9

Substance Use and Addictive Disorders

Read it in full: **Chapter 9 in the textbook**. Practice it in the lab: **Pharmacotherapy Bench: The Medication That Fits This Patient** and **The Unit Board: Delegation, Milieu and Keeping People Alive**.

What to know

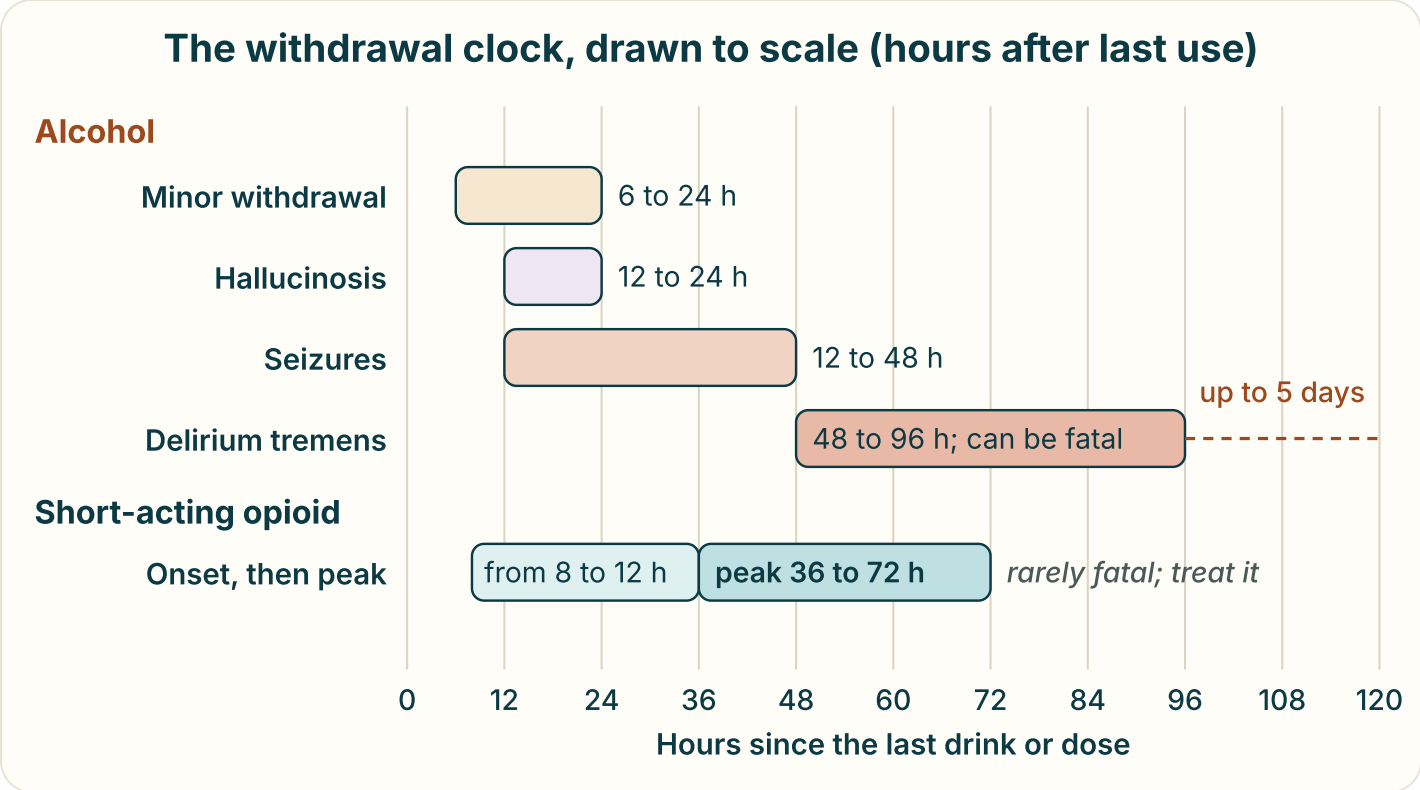
Addiction hijacks the mesolimbic pathway through binge, withdrawal and preoccupation stages. Tolerance and withdrawal alone are not a disorder. Eleven criteria in four clusters: 2 to 3 mild, 4 to 5 moderate, 6 or more severe. Screen everyone (AUDIT-C, CAGE-AID, DAST-10, CRAFFT for 12 to 21). Time and amount of last use set the clock. Toxicology is a limited immunoassay. Use OARS, not confrontation.

Alcohol withdrawal can kill. The clock: minor 6 to 24 h, hallucinosis 12 to 24, seizures 12 to 48, DTs 48 to 96 h. CIWA-Ar drives symptom-triggered benzodiazepines; thiamine before glucose; Wernicke can become Korsakoff. Naloxone is titrated to breathing; re-sedation is expected. Opioid withdrawal (COWS) is rarely lethal but treated; buprenorphine too early precipitates withdrawal.

MOUD (methadone, buprenorphine) halves mortality; never demand a taper. Naltrexone blocks and needs 7 to 14 opioid-free days. Acamprosate is renal; disulfiram is aversive. Patients on MOUD still need full pain treatment. Harm reduction keeps people alive; integrated care treats co-occurring disorders together; NOWS is treated first with Eat, Sleep, Console.

LOCK THESE IN

- Tolerance is not addiction.
- 2 to 3, 4 to 5, 6+.
- Thiamine before glucose.
- DTs 48 to 96 h.
- Naloxone to breathing.
- MOUD halves mortality.



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.

Chapter 9 classes

Class	Intoxication	Withdrawal
Alcohol	Slurred speech, ataxia	Can kill: seizures, DTs
Opioids	Miosis, slow breathing	Mydriasis, aches, GI upset; rarely fatal
Sedatives	Sedation, ataxia	Like alcohol; may be delayed days
Stimulants	Mydriasis, hyperthermia, paranoia	Crash; suicidal ideation
PCP	Violence, vertical nystagmus	Minimal

Worked cases

CASE 9.1 · A HIDDEN WITHDRAWAL

Day two after hip surgery, a 60-year-old who drinks daily is tremulous, sweaty and seeing insects on the wall but knows they are not real.

STEP 1 · PLACE IT

About 24 to 48 hours; hallucinosis with intact sensorium.

STEP 2 · ACT

CIWA-Ar, symptom-triggered benzodiazepine, thiamine, seizure precautions.

WATCH

DTs from about 48 hours.

CASE 9.2 · PAIN ON BUPRENORPHINE

A woman on buprenorphine rates post-operative pain 9 of 10.

STEP 1 · AVOID THE MYTH

"You are already on an opioid" is wrong.

STEP 2 · ACT

Continue MOUD, page for a multimodal pain plan.

TRAPS PEOPLE FALL INTO

- **"Clean" urine.** Negative toxicology screen.
- **Waking fully with naloxone.** Precipitates withdrawal.
- **Abrupt benzodiazepine stop.** Seizure risk.
- **Groups that ban MOUD.** Do not refer there.

Chapter 9 self-test · six items

1. Which history item best predicts when withdrawal will begin?

A. Time of the last use
B. Age at first use
C. Family history of use
D. Number of past treatments

A. Time of the last use Last use sets the withdrawal clock.

2. A client is confused, has nystagmus and an unsteady gait and drinks heavily. What is suspected?

A. Cannabis hyperemesis
B. Opioid intoxication
C. Wernicke encephalopathy
D. Korsakoff syndrome alone

C. Wernicke encephalopathy Confusion, eye findings and ataxia: treat on suspicion with thiamine.

3. Which reply reflects motivational interviewing?

A. "Everyone can see you are an alcoholic by now."
B. "You must stop now or you will lose your liver."
C. "If you really cared you would quit today."
D. "Part of you wants to cut back, and part does not."

D. "Part of you wants to cut back, and part does not." A double-sided reflection rolls with ambivalence instead of confronting.

4. Which medication has a ceiling effect on respiratory depression?

A. Hydromorphone
B. Buprenorphine
C. Methadone
D. Fentanyl

B. Buprenorphine Partial agonism limits respiratory depression, improving overdose safety.

5. Which alcohol medication suits a client with significant liver disease?

A. Naltrexone
B. Lorazepam
C. Disulfiram
D. Acamprosate

D. Acamprosate Acamprosate is renally cleared; naltrexone and disulfiram need liver monitoring.

6. A newborn exposed to opioids has a high-pitched cry and tremor. What is first-line care?

A. Formula only and minimal handling by parents
B. Rooming-in, skin-to-skin, low stimulation
C. Nursery isolation with bright lights
D. Morphine before any comfort steps

B. Rooming-in, skin-to-skin, low stimulation Non-drug nursing care first, the Eat, Sleep, Console approach.

CHAPTER 10

Personality Disorders

Read it in full: **Chapter 10 in the textbook**. Practice it in the lab: **Trait, State or Disorder, and the Words You Chart** and **The De-escalation Ladder and the Drug Emergencies**.

What to know

A personality disorder is pervasive, inflexible, early in onset, impairing and not better explained by another condition; assess at baseline with collateral. The biosocial theory joins emotional sensitivity with invalidation. Most people with borderline personality disorder reach sustained remission over ten to sixteen years.

Cluster A (paranoid, schizoid, schizotypal): transparency and distance. Cluster B (borderline, antisocial, histrionic, narcissistic): validate then structure, identical limits. Cluster C (avoidant, dependent, OCPD): build competence. Borderline mood shifts last hours after a trigger; bipolar episodes last days to weeks with less sleep.

Ask about self-injury and suicide separately. Act on acute-on-chronic escalation above a documented baseline. Boundaries are the therapy; splitting is a defense and the fix is one team plan. DBT has the strongest evidence; medication is adjunct only; avoid standing benzodiazepines. De-escalate before restraint; never say "calm down."

LOCK THESE IN

- Pervasive, inflexible, early, impairing.
- Most remit over 10 to 16 years.
- A transparency; B validate then structure; C competence.
- Separate questions: NSSI and suicide.
- Escalation above baseline.
- One team plan.

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.

Chapter 10 clusters

Cluster	Disorders	Stance
A: odd or eccentric	Paranoid, schizoid, schizotypal	Transparent, literal, respect distance
B: dramatic, emotional, erratic	Borderline, antisocial, histrionic, narcissistic	Validate then structure; uniform limits
C: anxious or fearful	Avoidant, dependent, OCPD	Graded independence; their options first

Worked cases

CASE 10.1 · A LIMIT WITH WARMTH

A client asks you to stay past your med pass.

STEP 1 · ACKNOWLEDGE

"Tonight feels unbearable."

STEP 2 · LIMIT

"I cannot stay past eight."

STEP 3 · OFFER

"Fifteen minutes now, and I will be back at nine." Then return at nine.

CASE 10.2 · DEPENDENT ASKS FOR AN ANSWER

"Just tell me what to do about my mother."

STEP 1 · DO NOT DECIDE FOR HER

It removes the rehearsal she needs.

STEP 2 · ASK

"What are the two options you have been weighing? What does each cost?"

TRAPS PEOPLE FALL INTO

- **Diagnosing in a crisis.** Assess at baseline.

- **"Attention-seeking."** Describe the behavior and need.
- **Agreeing to be the favorite.** Refuse special status warmly.
- **Medicating the disorder.** Psychotherapy is the treatment.

Chapter 10 self-test · six items

1. A man distrusts coworkers and tests loyalty but can consider other explanations. Which disorder fits?

A. Schizoid personality disorder
B. Paranoid personality disorder
C. Avoidant personality disorder
D. Delusional disorder

B. Paranoid personality disorder Distrust without fixed delusion; he can weigh alternatives.

2. Which is required for antisocial personality disorder?

A. Age 18+ with conduct disorder before 15
B. Onset of symptoms only after age 40
C. A family history of the same disorder
D. A history of psychosis in childhood

A. Age 18+ with conduct disorder before 15 The diagnosis needs age 18 or older and evidence of conduct disorder before 15.

3. Which DBT skill uses cold water to the face to calm the body fast?

A. Opposite action
B. Radical acceptance
C. DEAR MAN
D. TIPP skills

D. TIPP skills TIPP down-regulates physiology: temperature, intense exercise, paced breathing, paired muscle relaxation.

4. How does the nurse best respond to splitting on a unit?

A. Side with the staff the client praises
B. Transfer the client to a new unit now
C. Unify the team around one written plan
D. Confront the client in front of peers

C. Unify the team around one written plan The split lives in the team; one plan agreed in a meeting repairs it.

5. Which finding means a borderline client's risk has escalated above baseline?

A. Ongoing passive thoughts of dying
B. Old scars on both forearms
C. Regular attendance at DBT group
D. A new, more lethal method obtained

D. A new, more lethal method obtained New or more lethal means is an acute-on-chronic marker.

6. Why are standing benzodiazepines avoided in borderline personality disorder?

A. They cure the disorder far too quickly
B. They can disinhibit and worsen self-harm
C. They are banned on all inpatient units
D. They are useless for any kind of anxiety

B. They can disinhibit and worsen self-harm Disinhibition, dependence and blunted distress tolerance make them harmful.

CHAPTER 11

Eating Disorders and Somatic Symptom Disorders

Read it in full: **Chapter 11 in the textbook**. Practice it in the lab: **At the Table: Seven Things to Say** and **The Reassurance Loop and the New Symptom**.

What to know

Eating disorders are diagnosed by behavior, cognition and physiology, not size; atypical anorexia is just as dangerous. SCOFF two or more warrants assessment; ask about suicide. Blind weights. Restriction slows and weakens the heart; vomiting gives hypokalemic metabolic alkalosis, laxatives non-anion-gap acidosis. Admission thresholds include HR under 40, SBP under 90, K under 3.0, phosphate under 2.5, temperature under 35.5 °C.

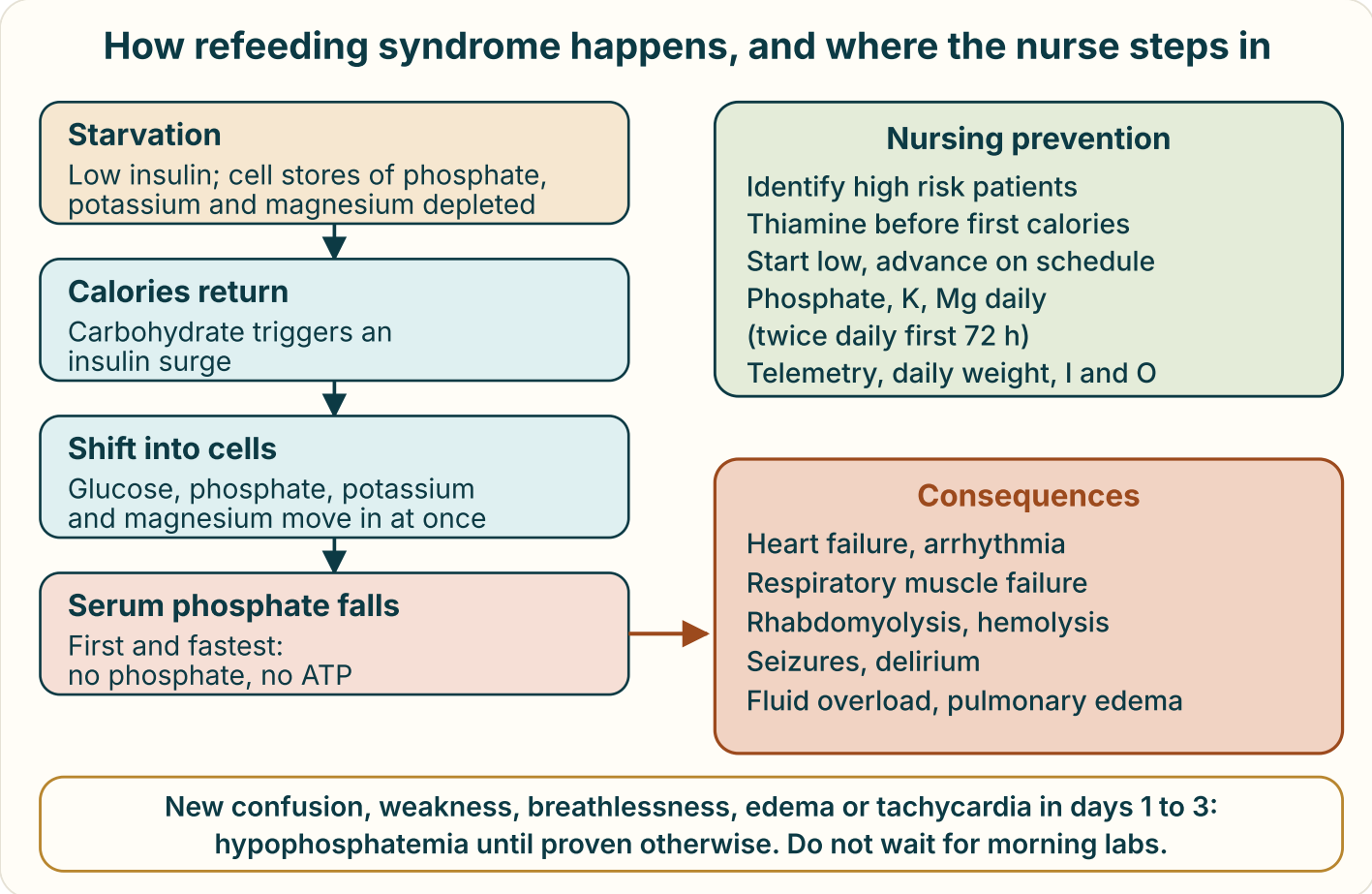
Refeeding drives phosphate into cells: phosphate falls first. Thiamine before calories, start low, labs daily (twice daily first 72 hours), telemetry. Meal support: fixed times, no food talk, the supplement rule set before the meal, no negotiation at the table, post-meal observation 30 to 60 minutes.

Somatic symptom disorder is defined by disproportionate thoughts, anxiety or time; the symptom can be medically explained. Functional neurological disorder shows positive signs like Hoover's sign. Factitious disorder is intentional without external reward; on another it is abuse. Malingering

is not a disorder. Use scheduled visits and functional goals, never say "nothing is wrong," and assess every new symptom fully.

LOCK THESE IN

- Never judge by size.
- Vomiting alkalosis; laxatives acidosis.
- Phosphate falls first.
- Thiamine before calories.
- No negotiation at the table.
- Every new symptom gets a full assessment.



Phosphate before calories. Refeeding kills through the insulin-driven shift of phosphate into cells. The second or third day of refeeding is often the most dangerous.

Chapter 11 quick reference

Item	Rule
SCOFF	2 or more yes
Admission	HR under 40; SBP under 90; K under 3.0; phosphate under 2.5
Refeeding labs	Daily; twice daily first 72 h
Meal window	30 min meal; 15 min snack
Post-meal	30 to 60 min observed
Bupropion	Contraindicated with eating disorders and purging

Worked cases

CASE 11.1 · BRADYCARDIA IS NOT FITNESS

A runner with HR 42, amenorrhea and 8 kg weight loss.

STEP 1 · RECOGNIZE

Relative energy deficiency, not conditioning.

STEP 2 · ACT

ECG, electrolytes, assess for an eating disorder.

CASE 11.2 · "CAN I HAVE ANOTHER SCAN?"

A man with illness anxiety asks for a third head scan.

STEP 1 · NAME THE FEAR

"That fear sounds exhausting."

STEP 2 · EXPLAIN

"Nothing on today's exam would change with a scan, and scans find harmless things that lead to more tests."

STEP 3 · REDIRECT

Look at what happens when the fear arrives.

TRAPS PEOPLE FALL INTO

- **Congratulating weight loss.** Can feed a life-threatening illness.
- **Relaxing on refeeding day two.** Often the most dangerous.
- **Calling a symptom "faking."** Describe the exam.
- **Ordering tests to soothe anxiety.** Order on objective findings.

Chapter 11 self-test · six items

1. Which client with type 1 diabetes and recurrent DKA should be asked about an eating disorder?

A. A teen who exercises after school daily
B. A teen who checks glucose four times a day
C. A teen who counts carbohydrates with care
D. A teen omitting insulin to lose weight

D. A teen omitting insulin to lose weight Insulin omission for weight loss causes recurrent DKA and should be asked about directly.

2. Which sign suggests repeated self-induced vomiting?

A. Lanugo on the back
B. Knuckle calluses
C. Yellowed palms only
D. Cold intolerance alone

B. Knuckle calluses Russell's sign is a callus from the teeth during induced vomiting.

3. Why is blind weighing used?

A. To make weight gain go faster
B. To hide weight from the team
C. To remove a restriction trigger
D. To shorten the hospital stay

C. To remove a restriction trigger Not seeing the number removes a reliable trigger; disclosure is a team decision.

4. During refeeding, which finding most needs urgent action?

A. New confusion and edema on day 3
B. Bloating after the first meals
C. Mild constipation on day 1
D. Fear of weight gain at meals

A. New confusion and edema on day 3 Confusion and edema early in refeeding suggest hypophosphatemia and fluid overload.

5. Which sign supports a functional neurological disorder diagnosis?

A. Babinski reflex
B. Hoover's sign
C. Papilledema
D. Absent ankle jerk

B. Hoover's sign Hoover's sign shows preserved automatic movement with impaired voluntary movement.

6. A client has had 30 normal tests and reports new chest pain unlike her usual pain. What does the nurse do?

A. Skip vitals because it is her pattern
B. Remind her that tests are always normal
C. Assess it fully, as for any patient
D. Tell her it is anxiety and redirect her

C. Assess it fully, as for any patient A new or different symptom gets a full assessment; overshadowing kills.

CHAPTER 12

Neurocognitive Disorders: Delirium and Dementia

Read it in full: **Chapter 12 in the textbook**. Practice it in the lab: **Subtype and Staging Console: Naming the Dementia Changes the Nursing** and **Psychopharm Bench: Give or Hold, and Which Emergency Is This?**.

What to know

Six domains; major disorder costs independence, mild does not. The three Ds: delirium (hours to days, fluctuating, inattention, altered consciousness), dementia (months to years, attention preserved early), depression (weeks, "I do not know," magnifies deficits). Any acute change in dementia is delirium until proven otherwise. Hypoactive delirium is most common and most missed.

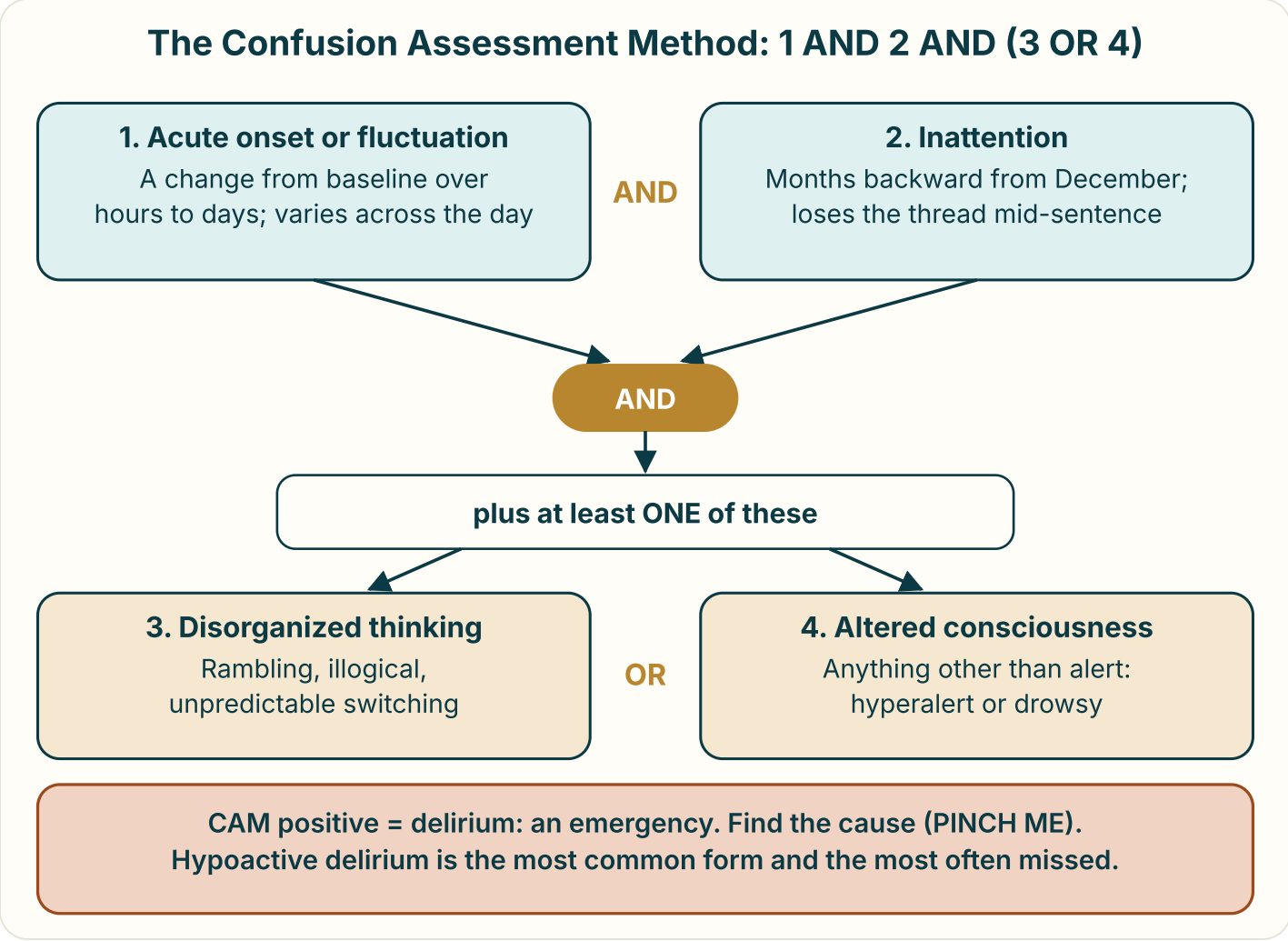
Screen with CAM (1 and 2 plus 3 or 4), 4AT or CAM-ICU. Sweep PINCH ME: pain, infection, nutrition, constipation, hydration, medication, environment; check bladder, bowels, SpO2, glucose, glasses and hearing aids. Anticholinergics and benzodiazepines are frequent culprits. HELP prevents about a third. Treat the cause; no restraint.

Subtypes: Alzheimer (memory first), vascular (stepwise), Lewy body (fluctuation, visual hallucinations, neuroleptic sensitivity: no haloperidol), frontotemporal (45 to 65, disinhibition). Exclude reversible contributors. Behavior is communication: DICE, pain first, validate the

emotion. Donepezil: hold if pulse under 60. Antipsychotics in dementia carry a mortality boxed warning.

LOCK THESE IN

- Acute change in dementia is delirium.
- Hypoactive is most missed.
- CAM 1 and 2, plus 3 or 4.
- Lewy body: no haloperidol.
- Pain first.
- Donepezil: pulse under 60, hold.



Inattention is mandatory. Both features 1 and 2 must be present, plus 3 or 4. Test attention with months backward; orientation questions fail much later.

Chapter 12 tools

Tool	Use
CAM	Delirium: 1 and 2, plus 3 or 4
4AT	4 or more suggests delirium
CAM-ICU with RASS	Ventilated or non-verbal patients
Mini-Cog	3 words plus clock
MoCA	Out of 30; +1 for 12 or fewer years of school
PAINAD	Observed pain when the person cannot report
GDS (Reisberg)	Stages 1 to 7

Worked cases

CASE 12.1 · THE FIVE-MINUTE SWEEP

An 85-year-old is newly drowsy and inattentive on day two after surgery.

STEP 1 · SCREEN

CAM positive.

STEP 2 · SWEEP

Bladder scan, bowels, pain, SpO2, glucose, temperature, glasses and hearing aids, new drugs.

THEN

Escalate with what you found.

CASE 12.2 · REPEATED QUESTIONS

A woman with dementia asks when her daughter is coming for the tenth time.

STEP 1 · ANSWER FRESH

"Your daughter comes at four."

STEP 2 · ADDRESS THE WORRY

"I will sit with you until then." Add a note by her chair.

TRAPS PEOPLE FALL INTO

- **"She is old and gets like this."** Ageism hides delirium.
- **Restraining delirium.** It worsens outcomes.
- **Correcting a bereavement.** Validate and redirect.
- **Feeding tubes in advanced dementia.** Hand feeding is the standard.

Chapter 12 self-test · six items

1. Which feature is the cardinal sign of delirium?

A. Word finding
B. Inattention
C. Memory loss
D. Low mood

B. Inattention Inattention is mandatory for delirium and is tested, for example with months backward.

2. A depressed older adult says, "I do not know," and complains loudly about memory. What does this suggest?

A. Early Alzheimer disease
B. Hyperactive delirium
C. Late-life depression
D. Frontotemporal dementia

C. Late-life depression Pseudodementia: the person magnifies deficits and answers "I do not know."

3. Which reversible cause fits urinary incontinence, gait change and cognitive slowing?

A. Early Alzheimer disease
B. Vascular neurocognitive disorder
C. Dementia with Lewy bodies
D. Normal pressure hydrocephalus

D. Normal pressure hydrocephalus Wet, wobbly and wacky: escalate for imaging.

4. A resident resists a shower and shouts "stop." What should the nurse do?

A. Stop, step back and look for a cause
B. Tell her firmly that it must be done
C. Call for help to complete the shower
D. Finish quickly while holding her arm

A. Stop, step back and look for a cause Stop, investigate pain or fear, and offer an alternative later; forced care can re-enact trauma.

5. What monitoring is required with lecanemab or donanemab?

A. Serial AIMS exams
B. Scheduled MRI for ARIA
C. Weekly ANC blood counts
D. Daily lithium trough levels

B. Scheduled MRI for ARIA Lecanemab and donanemab need MRI surveillance for amyloid-related imaging abnormalities.

6. A care partner says, "I have not slept properly in months." What is the best response?

A. Focus only on the patient's needs
B. Tell her this is normal for spouses
C. Suggest she work harder at routines
D. Assess burden and connect to respite

D. Assess burden and connect to respite Care partners have high rates of depression and illness; assess and connect to support.

CHAPTER 13

Crisis, Suicide, Aggression and De-escalation

Read it in full: **Chapter 13 in the textbook**. Practice it in the lab: **Crisis Console: Type, Phase and the First Move** and **Restraint Order Console: The Clock, the Law and the Debrief**.

What to know

Crisis is the gap between event and coping, resolves in four to six weeks, and comes in maturational, situational and adventitious types. Intervene narrowly: safety, shrink the problem, mobilize coping, concrete steps, named follow-up. Psychological first aid, not forced debriefing.

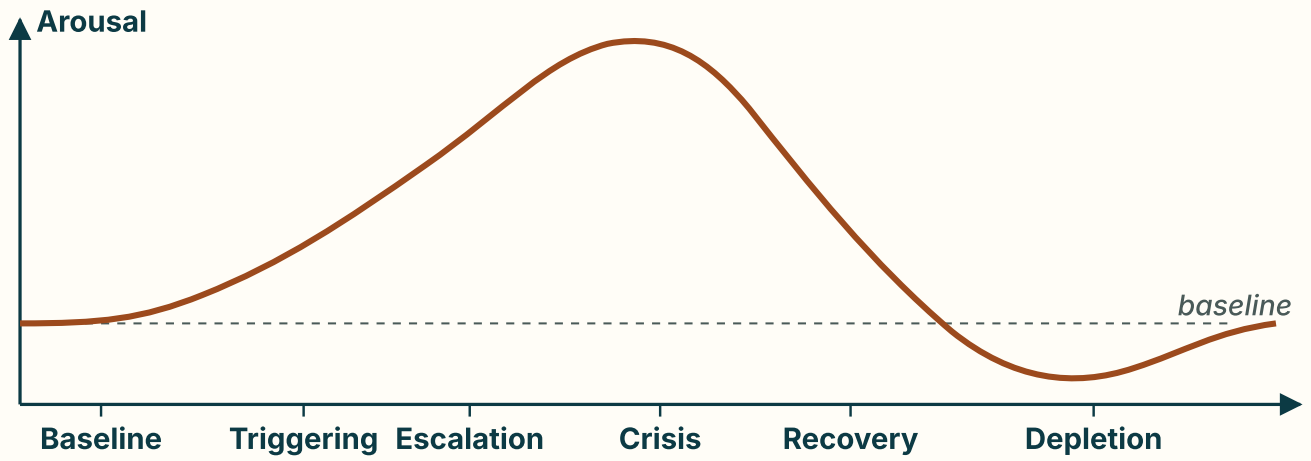
Ask plainly and climb the ladder to rehearsal and access. A prior attempt is the strongest predictor, yet no score predicts one person, so write a formulation. Build the six-step safety plan; step six (means) has the strongest evidence; no contracts. The first week after discharge is the most dangerous.

Match the response to the curve: approach at triggering, short sentences and two choices at escalation, protection at crisis, minimal demands in recovery, repair in depletion. Restraint: order is a maximum, 4, 2 and 1 hour limits to 24, one hour face-to-face, never prone, release early, rule out medical causes and akathisia, debrief patient and staff.

LOCK THESE IN

- Crisis 4 to 6 weeks.
- Formulation, not a score.
- Step six saves lives.
- First week after discharge.
- Match the curve.
- Release when safe.

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.

Chapter 13 suicide ladder

Step	Ask
Passive ideation	"Do you wish you would not wake up?"
Active ideation	"Are you having thoughts of killing yourself?"
Method and plan	"Have you worked out how?"
Intent	"How close have you come?"
Rehearsal	"Have you taken any steps or practiced?"
Access	"What do you have at home?"

Worked cases

CASE 13.1 · TESTING THE PLAN

A patient lists "call my brother" as step four.

STEP 1 · REHEARSE

"It is eleven at night. What is step four? Say it back."

STEP 2 · CHECK

Is the number in the phone? Does the brother answer at night?

WHERE IT LIVES

Photo on the phone, card in the wallet.

CASE 13.2 · QUIET IN A HOLD

During a hold, a man stops struggling and goes limp.

STEP 1 · ACT

Release, turn supine or lateral, open the airway, check a pulse, call the team.

NEVER

Read it as compliance.

TRAPS PEOPLE FALL INTO

- **Ranking distress.** Crisis is personal.
- **"Promise me."** Write a plan instead.
- **Three staff approach at once.** One spokesperson.
- **"The order is still valid."** Not a reason to keep restraint.

Chapter 13 self-test · six items

1. A hurricane destroys a town and many families lose homes. Which crisis type is this?

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

C. Adventitious Disasters affecting a community are adventitious crises.

2. What does psychological first aid avoid?

A. Pushing survivors to recount details
B. Offering food, water and shelter
C. Connecting people with supports
D. Giving accurate practical information

A. Pushing survivors to recount details Forced narration is not supported; safety, comfort and connection are.

3. Which statement about suicide risk scores is accurate?

A. They replace the clinical interview
B. They cannot predict one person's death
C. SAD PERSONS is a reliable triage tool
D. A low score supports safe discharge

B. They cannot predict one person's death Risk factors predict barely better than chance for individuals; write a formulation.

4. What is the best way to counsel about a firearm at home?

A. Lecture him on the danger of guns
B. Ask him to promise not to use it
C. Leave it if he denies having a plan
D. Temporary storage away from home

D. Temporary storage away from home Matter-of-fact, temporary means restriction such as off-site storage with a trusted person.

5. Which de-escalation move is part of Project BETA?

A. Stand directly face-on, close by
B. Several staff explain the rules at once
C. One person speaks to the patient
D. Use a firm "calm down" early on

C. One person speaks to the patient A single spokesperson, safe geometry and choices de-escalate.

6. Within what time must a face-to-face evaluation occur after restraint for violent behavior?

A. 4 hours
B. 8 hours
C. 24 hours
D. 1 hour

D. 1 hour The face-to-face evaluation is required within one hour of initiation.

CHAPTER 14

Across the Lifespan and Into the Community

Read it in full: **Chapter 14 in the textbook**. Practice it in the lab: **Eye Level: What to Say to a Child or a Teenager** and **The Brown Bag: Anticholinergic Burden and the Emergencies That Hide**.

What to know

Measure child behavior against development (intensity, duration, pervasiveness, impairment) and ask what it communicates. See adolescents alone and explain confidentiality limits first; get assent. Stimulants: growth, BP, sleep, diversion. SSRIs: boxed warning to 24, activation syndrome. Antipsychotics in children: metabolic effects; akathisia misread as "worse ADHD."

Screen every pregnancy and postpartum period with the EPDS; any positive item 10 means same-visit suicide assessment. Blues (up to 80 percent, day 2 to 5), perinatal depression and anxiety (10 to 20 percent, pregnancy to 12 months), postpartum psychosis (1 to 2 per 1000, first two weeks, emergency). Weigh drug risk against untreated illness; valproate is the clearest teratogen; clozapine bars breastfeeding.

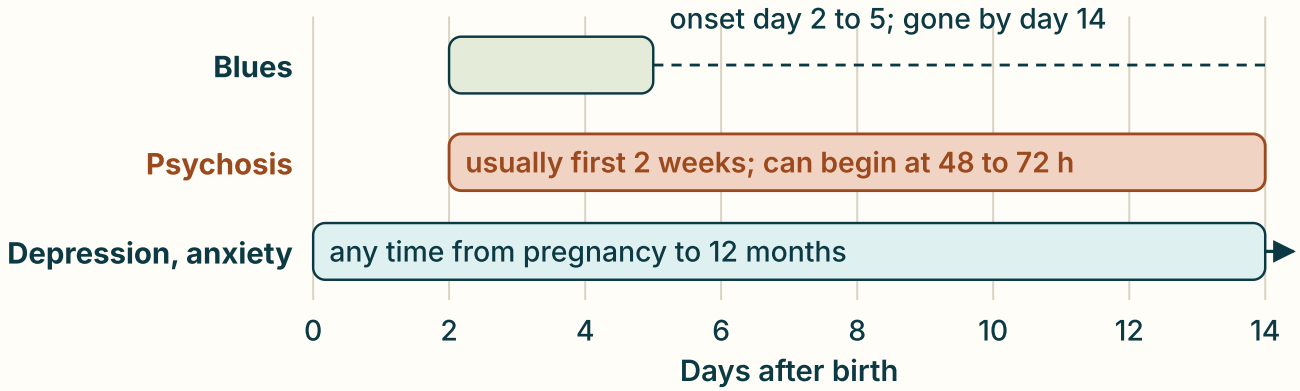
Older adults: acute change is delirium until proven otherwise; strip anticholinergic burden; watch serotonin syndrome, NMS, lithium toxicity, SSRI hyponatremia and TD. Community care is recovery-oriented; the first week after discharge is the highest-risk window: follow-up within

seven days, safety plan, means counseling, caring contacts. ACT serves people with repeated admissions. Delegate observation, never assessment. Protect yourself from compassion fatigue.

LOCK THESE IN

- Development is the baseline.
- Assent plus consent.
- EPDS item 10 means assess now.
- Postpartum psychosis is an emergency.
- Older adult change is delirium.
- Follow-up within 7 days.

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.

Chapter 14 lifespan rules

Group	Key rule
Children	Behavior against development; play and drawing are assessment
Adolescents	Seen alone part of each visit; limits stated first
Perinatal	Universal EPDS; ask about frightening thoughts
Pregnancy drugs	Risk versus untreated illness
Older adults	Delirium first; Beers; elder abuse screening
Community	Recovery goals; ACT; caring contacts

Worked cases

CASE 14.1 · A CHILD AT EYE LEVEL

A 7-year-old has stomach aches every school morning and has missed three weeks.

STEP 1 · MEASURE IMPAIRMENT

Three weeks missed is impairment, not expected worry.

STEP 2 · ASK

Sit on the floor with paper; ask about the hardest part of the day.

CONSIDER

Anxiety and what has happened to this child.

CASE 14.2 · LITHIUM AT DELIVERY

A woman with bipolar disorder on lithium is in labor.

STEP 1 · KNOW THE SHIFT

Clearance falls abruptly after delivery.

STEP 2 · ACT

Hydration, levels per protocol, hold as ordered, watch the newborn.

TRAPS PEOPLE FALL INTO

- **"Defiant" without assessment.** Ask what the behavior communicates.
- **"Severe blues" for psychosis.** Escalate now.
- **Sundowning as a diagnosis.** Keep working it up.
- **A three-week follow-up.** Within seven days.

Chapter 14 self-test · six items

1. A teen asks, "Will you tell my parents?" What is the best reply?

A. "It depends on what kind of mood I happen to be in."
B. "Yes, I tell your parents everything that you say."
C. "Of course not, everything stays just between us two."
D. "Most stays private; if you are in danger, I get help."

D. "Most stays private; if you are in danger, I get help." State the limits honestly before any disclosure.

2. Which monitoring belongs with stimulants in a child?

A. Height, weight, BP and sleep
B. Monthly lithium trough levels
C. Tyramine diet teaching
D. Weekly absolute neutrophil counts

A. Height, weight, BP and sleep Stimulants can affect growth, appetite, BP, heart rate and sleep.

3. Which EPDS feature makes it suited to the perinatal period?

A. It focuses mainly on sleep hours
B. It is scored only by the partner
C. It avoids somatic items like fatigue
D. It measures infant weight gain

C. It avoids somatic items like fatigue Fatigue and poor sleep are expected in new parents and would inflate scores.

4. Which antipsychotic makes breastfeeding contraindicated because of infant neutropenia?

A. Haloperidol
B. Clozapine
C. Quetiapine
D. Aripiprazole

B. Clozapine Clozapine agranulocytosis risk transfers to the infant.

5. An 80-year-old on a new SSRI is falling and confused with sodium 124 mEq/L. What is suspected?

A. SSRI-associated hyponatremia
B. Normal aging of the brain
C. Early Alzheimer disease
D. Benign sundowning pattern

A. SSRI-associated hyponatremia SIADH from SSRIs is a classic cause of "sudden dementia" in frail adults.

6. What are caring contacts?

A. Daily visits by the inpatient psychiatrist
B. Brief follow-up messages after discharge
C. Family members who hold all medications
D. A contract signed before discharge

B. Brief follow-up messages after discharge Short, non-demanding contacts after discharge reduce suicide risk by showing someone remembered.

ONE PAGE

Cram sheet

Every number and rule in the course, sorted by topic. Cover the right column and rebuild each row. If a row will not come back, go to that chapter's exam guide.

Foundations and law

Item	Value or rule	Chapter
Adults with a disorder per year	About 1 in 5; half of lifetime disorders start by 14	1
Mortality gap	10 to 20 years; mostly physical disease	1, 3, 8
Distress to disorder	Duration, impairment, departure from cultural expectation	1
Relationship phases	Preinteraction, orientation, working, termination	2
Voluntary discharge request	Notice about 48 to 72 h; notify the provider first	3
Emergency hold	Often 72 h; self, others, grave disability	3
Commitment standard	Clear and convincing evidence (Addington, 1979)	3
Capacity	Understanding, appreciation, reasoning, choice	3
Restraint orders	4 h adults; 2 h ages 9 to 17; 1 h under 9; renew to 24 h	3, 8, 10, 12, 13
Face-to-face	Within 1 h, even if released	3, 13
Restraint care	Assess about every 15 min; release limbs at least every 2 h; never prone	3, 13

Assessment and screening tools

Tool	Cut-off or rule	Chapter
MoCA	Out of 30; about 26; +1 for 12 or fewer years of school	4, 12
CAM	1 and 2, plus 3 or 4	4, 12
4AT	4 or more suggests delirium	12
MMSE	20 to 24 mild; 13 to 19 moderate; 12 or below severe	12
PHQ-9	5, 10, 15, 20; item 9 positive means interview now	7
GAD-7	0 to 21; 5, 10, 15; 10 or more evaluate	6
AUDIT-C	4+ men; 3+ women	9
CRAFFT	2 or more; ages 12 to 21	9
CIWA-Ar	Treat about 8 to 10; severe 15+; rise of 5 escalates	9
COWS	Buprenorphine start about 8 to 12+	9
SCOFF	2 or more yes	11
EPDS	Any positive item 10: same-visit suicide assessment	14
Suicide ladder	Ideation, plan, intent, access, rehearsal, protective factors	4, 13

Medications

Drug or class	Key numbers and rules	Chapter
SSRIs	Mood 2 to 6 weeks (2 to 4 in Ch 7); boxed warning under 25; energy before hope	5, 7, 14
MAOIs	Tyramine diet; washout 2 weeks, 5 weeks after fluoxetine	5, 7
Lithium	0.6 to 1.2 trough; toxic above 1.5; Ch 7: mania 0.8 to 1.2, maintenance 0.6 to 1.0	5, 7, 14
Lithium raisers	Dehydration, vomiting, low salt, NSAIDs, thiazides, ACE inhibitors, ARBs	5
Valproate	50 to 125 mcg/mL; liver, pancreas, ammonia; teratogen	5, 7, 14
Lamotrigine	Slow titration; any rash stop; re-titrate after 5+ missed days	5, 7
Clozapine ANC	Weekly 6 months, every 2 weeks 6 months, monthly; interrupt under 1000, stop under 500	5, 8, 14
AIMS	Every 6 months (first generation) or 12 months (second generation)	5, 8
Buprenorphine	Partial agonist; too early precipitates withdrawal	9
Naltrexone	7 to 14 opioid-free days first	9
Donepezil	Hold if pulse under 60	12
Antipsychotics in dementia	Mortality boxed warning, about 1.6 to 1.7 times	12

Time courses

Condition	Timing	Chapter
Alcohol withdrawal	Minor 6 to 24 h; hallucinosis 12 to 24; seizures 12 to 48; DTs 48 to 96	1, 4, 9
Opioid withdrawal	Starts 8 to 12 h; peaks 36 to 72 h	9
Movement effects	Dystonia hours to days; akathisia days to weeks; parkinsonism weeks; TD months to years	5, 8
Serotonin syndrome vs NMS	Hours, clonus, hyperreflexia vs days, rigidity, low reflexes	5 to 14
Mania / hypomania	7 days or hospitalized / 4 days	7
Psychosis ladder	Brief under 1 month; schizophreniform 1 to 6; schizophrenia 6+	8
PTSD / ASD	Over 1 month / 3 days to 1 month	6
Crisis	About 4 to 6 weeks	13
Postpartum	Blues day 2 to 5, gone by 14; psychosis usually first 2 weeks	7, 14
Refeeding	Labs twice daily first 72 h; days 2 to 3 most dangerous	11
After discharge	Highest risk first week; follow-up within 7 days	13, 14

Rules that keep people safe

Topic	The rule
Language	Person-first; behavior, not motive; "died by suicide"; positive or negative toxicology.
Suicide	Ask directly; safety plan with means restriction; never a contract.
Secrets	Never accept one in advance; tell the team with the patient.
Psychosis	Neither confirm nor argue; move to the feeling.
New symptoms	Same workup as anyone; delirium until proven otherwise in older adults.
Delegation	Observation and tasks yes; assessment, teaching, evaluation, observation levels never.
De-escalation	One speaker, two arm lengths, an angle, exits clear, two real choices; never "calm down."
Thiamine	Before glucose, in alcohol use and refeeding.
Lewy body dementia	No haloperidol.
Postpartum psychosis	Never alone with the infant; escalate by SBAR.

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