

Seminar three:

Flash Cards.



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Anorexia nervosa

- Low Body Mass Index (BMI); underweight
- Amenorrhea (absence of menstruation)
- Emaciation (abnormally thin with possible weakness)
- Bradycardia (low heart rate < 60 beats per minute [BPM] for an adult)
- Hypotension (low blood pressure)



Anorexic patients have an increased risk of re-polarization changes which can increase the risk of sudden death. What should the provider order?

The provider should order an electrocardiogram (ECG) to assess for inverted T-waves



How to calculate BMI:

Patient's weight (lb) /
([height (in)]² x 703



BMI

Below 18.5	Underweight
18.5 to 24.9	Normal
25 to 29.9	Overweight
30 and up	Obese



Medications for anorexia

No med for anorexia, but can give olanzapine (Zyprexa) to reduce delusional thinking associated with the need to lose weight



Psychotherapy for anorexia:

- CBT
- Cognitive Processing Therapy
- DBT
- Interpersonal Therapy
- Family Therapy
- Art Therapy



Care management for anorexia:

- Nutritional counseling
- Weight restoration
- Correcting any unstable electrolyte imbalances
- Vitamin supplementation
- Dental care (referral and continued monitoring)



Bulimia Nervosa

- BMI will usually be within the normal range
- Erosion of dental enamel will be present on physical examination
- Evidence of Russell's Sign



Russell's Sign

Scarring or calluses on the knuckles or back of the hand due to repeated episodes of self-induced vomiting



Rectal Prolapse

Rectum becomes stretched out and protrudes from the anus (caused by laxative use, constipation, extreme exercise, and vomiting)



Medication for bulimia:

- fluoxetine (Prozac)
- SSRIs and TCAs reduce the frequency of the patient's bingeing and purging



Psychotherapy for bulimia:

- CBT
- CPT
- Group Therapy
- Family Therapy
- Experiential Therapy



Care management for bulimia:

- Nutritional therapy
- Continued clinical assessment for physical complications



DO NOT GIVE bupropion
(Wellbutrin; NDRI) to...

A patient with an eating disorder due to increased risk for seizures (related to electrolyte imbalance)



Rett Syndrome

- Neurodevelopmental disorder with specific deficits following a marked period of normal functioning afterbirth
- Caused by a mutation in the methyl CpG binding protein 2, or MECP2 gene



Rett Syndrome is primarily seen in...

Females



Clinical signs of Rett Syndrome:

Starting 6 months after birth:

- Loss of purposeful hand skills
- Stereotypic hand movements
- Deceleration of head growth
- Decreased social engagement
- Development of scoliosis and a poor gate



Risk factor for Rett Syndrome:

Seizure disorder



Nonpharmacological for
Rett Syndrome:

- Speech Therapy
- Occupational Therapy
- Physical Therapy



Fetal Alcohol Syndrome

- Complications that arise when a person is exposed to alcohol before birth. The effects result in physical, behavioral, and/or cognitive complications
- Think: “underdeveloped”



Characteristics of Fetal Alcohol Syndrome:

- Low birth weight and height
- Short palpable fissures
- Epicanthal skinfolds
- Low nasal bridge
- Short nose
- Indistinct philtrum
- Small head circumference
- Small eye openings (microphthalmia)
- Wide-set eyes
- Thin upper lip



Fragile X Syndrome

- Genetic disorder that is caused by changes on the Ribonucleoprotein 1 (FMR1) gene (important for the development of an essential protein for brain development)
- Effects both males and females (however, females have milder symptoms)



Characteristics of Fragile X Syndrome:

- Large, long head and ears
- Short stature
- Hyperextendable joints
- Post pubertal macroorchidism (abnormally large testes)
- Developmental and learning delays (trouble learning new skills)
- Social and behavioral complications (poor eye contact, anxiety, and attention)



Management of Fragile X Syndrome:

- Currently, no cure for this condition
- Talk Therapy
- Behavioral Therapy
- Physical therapy



Autism Spectrum Disorder

- Social reciprocity (challenged by social exchanges)
- Nonverbal communication
- Have difficulties forming and/or maintaining relationships
- Perform repetitive motor movements (flapping, banging objects together, rocking back-and-forth...)
- Become hyper-focused or fixated on specific interests



In autistic patients, parents and/or teachers may report:

- Patient is unresponsive when called directly by name
- There is little or no eye contact
- The patient lines, stacks, organizes objects
- Have intense tantrums
- Perform self-injurious behaviors (head banging or self-biting)



Risk factors for ASD:

- Male gender
- History of intellectual disability
- Genetic predisposition



ASD screening:

- Modified Checklist for Autism in Toddlers (M-CHAT)
- Autism Diagnostic Observation Schedule – Generic (ADOS-G)
- Ages and Stages Questionnaire (ASQ)



Medication classes for ASD:

- SSRIs
- Stimulants
- Anxiolytics
- Anticonvulsants
- Antipsychotics: FDA approved antipsychotic treatment for irritability associated with ASD : risperidone (Risperdal)



If a patient is > 45 and is experiencing mania for the first time...

Need to explore medical causes, it could be a stroke or other underlying cause



Nonpharmacological care for ASD:

- Individual and Family Therapy
- Establishing supportive affirmations for appropriate behaviors
- Role-playing to teach social and personal interactions
- Importance of communicating the diagnosis with the patient's school



Attention Deficit Hyper-Activity Disorder (ADHD)

- Persistent pattern of inattention and/or hyperactivity, impulsivity (or both). The pattern(s) interfere with functioning and development
- There are two types of ADHD: Inattentive and Hyperactive/Impulsive



Inattentive Vs. Hyperactive/Impulsive

Inattentive	Vs.	Hyperactive/Impulsive
Lack of attention to details		Fidgety or squirmy
Careless mistakes		Unable to remain seated
Cannot sustain attention		Restlessness
Does not listen		Loud and noisy
Easily distracted, does not follow instructions		Always "on the go"
Difficulty organizing tasks		Excessive talking
Loses or miss places objects		Not able to take turns; blurts out answers
Forgetful in daily activities		Acts or reacts without thinking



ADHD screening:

- Adult Self-Report Scale (ASRS)
- Vanderbilt ADHD Diagnostic Parent and Teacher Rating Scales (VADRS)
- Conners' Parent Rating Scale – Revised (CPRS-R:L)/Conners' Teacher Rating Scale – Revised (CTRS-R:L)



Risk factors for ADHD:

- Abnormalities of the frontal-subcortical pathway:
- Frontal cortex
 - Basal ganglia
 - Reticular activating system



ADHD neurotransmitter abnormalities:

- Decreased dopamine
- Decreased norepinephrine
- Decreased serotonin



Pharmacological management for ADHD:

- Stimulants: Adderall and Ritalin
- Non-stimulants: Guanfacine (Intuniv), Clonidine (Catapres), and Atomoxetine (Strattera)



Amphetamines

Approved in children 3 and older



Methylphenidate

Approved in children 6 and older



Guanfacine (Intuniv)

Approved for ages 6 to 17



Clonidine (Catapres)

Approved for ages 6 and older



Atomoxetine (Strattera)

Approved for ages 6 and older



Signs of stimulant abuse:

Insomnia, tremors, increased blood pressure and heart rate, heart palpitations, agitation, anxiety, irritability, mood swings, and/or elevated mood



Prior to starting a patient on a stimulant...

Assess for any cardiac history



Nonpharmacological management of ADHD:

- Behavioral Therapy
- Combined parent/child CBT
- Education (coping skills, redirection, focusing techniques...)
- Treatment for co-occurring learning disorders
- Family Therapy
- Monitor clinical progress over time
- Monitor growth and developmental milestones



Borderline Personality Disorder (BPD)

- Impulsivity, often with self-damaging behaviors
- Recurrent suicidal behavior
- Avoid abandonment
- Patterns of unstable interpersonal relationships
- Identity disturbances
- Chronic feelings of emptiness and/or doubt
- Inappropriate anger responses



Risk factors for BPD:

- Abandonment in early life (childhood or adolescence)
- Disrupted family life balance
- Poor family/relationship communication skills
- Sexual, physical or emotional abuse



Pharmacological management of BPD

- Impulsiveness – SSRIs and mood stabilizers
- Affective instability – SSRIs and mood stabilizers
- Anxiety – SSRIs, non-benzodiazepine anxiolytics, and benzodiazepines (with extreme caution)



Nonpharmacological management of BPD

- Primary – DBT (address and decrease thoughts of suicide/self-harming behaviors)
- CBT
- Anger management



Anti-social Personality Disorder (ASPD)

- Reckless regard for the welfare of others
- Lack of remorse
- Failure to conform or adhere to societal norms
- Must be at least 18 years of age
- Impulsive and deceitful
- Commits acts of crime
- Violence towards other and animals
- Consistently irresponsible



Risk factors for ASPD:

- May have genetic and environmental causes; mostly unknown
- Sexual, physical, or emotional child abuse
- Antisocial or alcoholic parent(s)



Pharmacological management of ASPD

- Aggressiveness – first-line: second-gen antipsychotics (risperidone, quetiapine). Second and third-line: SSRIs (sertraline, fluoxetine), and mood stabilizers (lithium and carbamazepine)
- Impulsivity – anticonvulsants (oxcarbazepine and carbamazepine)
- ADHD behaviors – bupropion and atomoxetine (non-addictive)



Nonpharmacological management of ASPD

- Early identification/treatment in childhood (Conduct Disorder) may be most effective
- Behavioral Therapy
- Individual Psychotherapy
- Family Therapy (to include family supportive measures)



Disruptive Mood Dysregulation Disorder (DMDD)

- Childhood depressive disorder diagnosed in children older than 6 but younger than 18
- Chronic dysregulate “moodiness”
- Temper outbursts
- Severe irritability



Risk factors for DMDD:

- Male
- School-aged
- Family history of anxiety, depression, and/or substance use
- Comorbid ADHD



DMDD screening:

- Clinical observation
- Parent, caregiver, school reports of behavioral challenges, moodiness, and temper outburst
- Personal and family history of BD
- The DMDD Questionnaire



Pharmacological management of DMDD

- SSRIs and mood stabilizers for irritability/mood dysregulation
- Stimulants for energizing symptoms
- Antipsychotics for aggressive-type behaviors



Nonpharmacological management of DMDD

- Individual Psychotherapy
- Group Therapy
- Family Therapy (to include family supportive measures)



Intermittent Explosive Disorder (IED)

- Repeated and sudden (lasting no longer than 30 minutes)
- Impulsive, aggressive, and violent behavior which involve angry verbal outbursts
- Grossly disproportionate to the situation
- Poor communication skills
- “Mad crazy” for NO reason



Risk factors for IED:

- Male
- Family history of IED
- Exposure to violence at an early age
- Recipient of psychological, emotional or sexual violence
- History of anxiety, personality or substance abuse disorders



Pharmacological management of IED

- Antidepressants – fluoxetine (Prozac; SSRI) most studied SSRI for IED
- Mood stabilizers and regulators
- Antipsychotics



Nonpharmacological management of IED

- Individual Psychotherapy
- CBT (cognitive restructuring, relaxation training, coping skills training, relapse prevention)



Oppositional Defiant Disorder (ODD)

- Enduring pattern of angry and irritable mood
- Argumentative, defiant, and vindictive
- Lasting at least six months with greater than four signs or symptoms
- Bad temper, angry, blaming patterns, annoys others, spiteful



Risk factors for ODD:

- Child abuse or neglect; harsh and inconsistent parenting with discipline extremes and/or lack of supervision
- Family history of mental health or substance use disorder
- Inconsistent discipline from outside sources such as in teachers or daycare supervisors



Pharmacological management of ODD

Aggression and agitation can be treated with SSRIs, alpha agonists, mood stabilizers, and antipsychotics



Nonpharmacological management of ODD

- Individual Psychotherapy
- Family Therapy; child management skills
- CBT
- Parent training
- Parent-child Interaction Therapy (PCIT)
- Social skill training



Conduct Disorder (CD)

- Aggression towards people or animals
- Violate societal norms
- Known bully
- Destructive
- Sets fires
- Breaks the law
- Complete lack of remorse



Criminal behavior and under 18, think...

- Conduct Disorder
- If > 18 years of age = Antisocial Personality Disorder



Risk factors for CD:

- Childhood brain trauma
- Significant traumatic events
- Genetic predisposition
- History of child abuse
- Social or situational (school) problems



Pharmacological management of CD

Mood and aggression: SSRIs, mood stabilizers, alpha agonists (clonidine and guanfacine), and antipsychotics



Nonpharmacological management of CD

- Individual and Family Therapy
- Behavioral Therapy



Major Depressive Disorder (MDD)

- **S**leep disorder
- **I**nterests reduced
- **G**uilt or self-blame

- **E**nergy loss or fatigue

- **C**oncentration problems
- **A**ppetite changes
- **P**sychemotor changes
- **S**uicidal thoughts



MDD is caused by dysregulation of...

Dopamine, norepinephrine,
and serotonin



When considering MDD, you also need to rule out...

Bipolar Disorder



MDD can cause what in the older population?

Cognitive and memory symptoms – referred to as pseudodementia



Pseudodementia

Treatable and common in depressed older patients with signs of reduced motivation, impaired concentration, and mental slowing



Patients with dementia usually have a premorbid history of...

- Slowly declining cognition
- MDD patients see relatively acute onset and are significant when compared to premorbid functioning



Dementia vs. Pseudodementia (MDD)

Dementia (related disorders)	Vs.	Pseudodementia (MDD)
Surreptitious onset		Sudden onset
Slow progression		Rapid progression
Lack of insight		Perceptive
Confabulations		Memory disorders
Tendency to diminish the disability		Tendency to emphasize the disability
Behaviors are in line with the severity of the illness		Behavior does not correspond to the severity of the illness
Does not respond with answers		Can generally make a coherent response
Is worse at night		No changes at night
Inconsistency of affect		Depressed mood
Few vegetative symptoms		Frequent vegetative symptoms
Rare psychiatric history		Psychiatric history
Lower suicide risk		Higher suicide risk



Risk factors for MDD:

- Can happen at any age
- Can occur in comorbid cases (diabetes, cancer, heart disease...)
- Personal or family history of depression
- Result of major life changes, trauma or stress



MDD screening:

- Patient Health Questionnaire-9 (PHQ-9)
- Beck's Depression Inventory (BDI)
- Hamilton Depression Rating Scale (HAM-D)



Pharmacological management of MDD

- SSRIs – first-line option
- SNRIs
- TCAs
- MAOIs
- Atypical (bupropion [Wellbutrin], mirtazapine [Remeron], nefazodone, trazodone, vortioxetine [Trintellix])



Antidepressant rebound:

Re-emergence of the primary disorder often to a greater extent than before treatment. This is common when medications are stopped abruptly (especially with medications that have a short half-life)



Antidepressant Black Box Warning:

Children, adolescence, and young adults (up to age 24): increased suicidal thoughts. Monitor for suicidal thoughts, behavior, agitation, and aggression when taking an antidepressant



Nonpharmacological management of MDD

- CBT
- Electroconvulsive therapy (ECT)



Clinical management of suicidality

- Always assume the client is serious
- Consider hospitalization
- Consider mobilizing all available patient social resources
- Note: DO NOT select answers with "complete a no-harm contract"



Bipolar Disorder (BD)

- **D**istractibility
- **I**mpulsive (poor judgment, increased spending, reckless driving...)
- **G**randiosity (increased self-esteem)

- **F**light of ideas
- **A**ctivity (increased)
- **S**leep (stays awake)
- **T**alkativeness



Neurotransmitters involved in mood disorders

γ -Aminobutyric acid (GABA), glutamate, dopamine, serotonin, and norepinephrine



Risk factors for BD:

- First-degree relatives (parent or sibling)
- Periods of high stress
- Substance abuse



Pharmacological management of BD

- Gold standard: Lithium
- Carbamazepine manic episodes)
- Divalproex sodium (Depakote) – acute manic and depressive episodes and preventing a relapse
- Lamotrigine (Lamictal) – bipolar depression (watch for SJS)
- Lurasidone (Latuda) – bipolar depression
- Olanzapine (Zyprexa) + fluoxetine (Prozac; Symbyax) FDA approved for bipolar depression



Nonpharmacological management for BD

- CBT
- Behavioral Therapy
- Interpersonal Therapy
- Supportive groups
- Milieu Therapy



It is important to rule out what conditions when considering depression and Bipolar Disorders?

hypo and hyperthyroidism



Conversion Disorder

Stressful experience, then suddenly have symptoms such as blindness, mutism, paralysis, paresthesia or another neurologic dysfunction that cannot be explained by a medical condition



Management of conversion disorder:

- Individual Therapy
- Stress Reduction Therapy
- Involves an interdisciplinary team approach to address needs of the patient: neurology; psychiatry; speech, physical, and occupational therapy



Adjustment Disorder

- Emotional or behavioral reaction to a stressful event within three months
- Can be classified as an Adjustment Disorder with a specifier (depressive, anxious, conduct issues or a combo one or more)



Risk factors for Adjustment Disorder:

- Divorce or marital problems
- Relationship or interpersonal problems
- Retirement
- Having a child
- Going to school or college
- Difficulties at work or school
- Physical assault
- Natural disaster



Pharmacological management of Adjustment Disorder:

Depends on the specifier:
SSRIs, SNRIs, NDRIs, and Atypical antidepressants



Nonpharmacological management of Adjustment Disorder:

- CBT
- Behavioral Therapy
- Individual Therapy



Post-traumatic Stress Disorder (PTSD)

- Reexperiencing an extremely traumatic event
- Increased arousal
- Avoidance of stimuli associated with the trauma



Pharmacological management of PTSD:

- SSRIs and TCAs
- Prazosin (Minipress; alpha blocker) for nightmares



Nonpharmacological management of PTSD:

- CBT
- Eye movement desensitization and reprocessing (EMDR) Therapy (desensitization, installation, body scan, closure, reevaluation)
- Exposure Therapy
- Relaxation Therapy
- Supportive Group Therapy



Desensitization

Visualize the trauma – feel it – block it: the patient focuses on the memory and reports any emerging thoughts that occur during eye-movement or other rhythmic, bilateral stimulation (taps or tones). Desensitization continues until the patient reports that the memory is no longer distressing



Installation

Replace negative thoughts with positive thoughts: the patient associates and strengthens a positive belief with the traumatic event until it feels completely true



Body scan

Visualize the trauma with the new positive thoughts, while scanning the body to identify any tension: the patient observes for any physical response while thinking of the traumatic event and the new positive cognition, and identify any residual somatic distress



Closure

Used to end the session; if the targeted memory was not fully processed in the session, the patient is given specific instructions and techniques to provide preservation of skills and ensure safety until the next session



Reevaluation

The clinician evaluates the patient's current psychological state, whether treatment effects have maintained, emergence of any memories since the last session, and to identify targets for the current session



Obsessive-Compulsive Disorder (OCD)

- Obsessions: recurrent and persistent thoughts, impulses or images that cause anxiety and/or distress
- Compulsions: repetitive behaviors or mental actions that a patient feels driven to perform in response to an obsession



Risk factors for OCD:

- First degree relatives (parent or sibling)
- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)



Pharmacological management for OCD:

- SSRIs (may need higher doses)
- TCAs (clomipramine; Anafranil)



Nonpharmacological management for OCD:

- CBT
- Exposure Therapy



Tourette Syndrome

- Must have had at least two motor tics and one vocal tic (do not have to be occurring at the same time)
- Cannot be caused by substance or medication use
- Must have appeared before the age of 18
- Must not wax and wane



Neurotransmitters involved in Tourette Syndrome:

Hyperactive dopamine, norepinephrine, and serotonin



Pharmacological management of Tourette Syndrome:

- SSRIs – fluoxetine (Prozac); sadness, anxiety, and OCD
- Alpha agonists – guanfacine (Intuniv) and clonidine (Catapres); obsessive behavioral symptoms (impulse control and rage attacks)
- Atypical antipsychotics – haloperidol (Haldol), pimozide (Orap), and aripiprazole (Abilify) are FDA approved for treatment



Nonpharmacological management of Tourette Syndrome:

- CBT
- Behavioral Therapy
- Deep brain stimulation (DBS)



Deep brain stimulation (DBS)

The use of electrodes implanted within certain areas of the brain to produce an electrical impulse and regulate abnormal electrical activity



Persistent (Chronic) Motor or Vocal Tic Disorder

- A single or multiple motor or vocal tic, but the two variations must not be present at the same time
- Quick and uncontrollable movements, or vocal outbursts – but not both!
- An example is excessive blinking



Schizophrenia

- Unable to distinguish reality from falsehood
- Divided into positive symptoms and negative symptoms
- 18 – 25 years old for males
- 25 – 35 years old for females



Schizophrenia abnormal structures as evidenced by functional studies:

- Enlarged lateral ventricles
- Diffuse alterations in gray and white matter
- Widened cortical sulci
- Decreased cerebral blood flow
- Reduction in size of the hippocampus, amygdala, and thalamus



Suspected alterations in neuronal signal transmission involved in Schizophrenia:

- Increased dopamine in the mesolimbic pathway
- Increased glutamate
- Decreased GABA
- Decreased serotonin



Risk factors for Schizophrenia:

- Inadequate synapse formation
- Excessive pruning of synapses
- Excitotoxic death of neurons (apoptosis)
- Prenatal exposure to toxins or viral agents



Positive schizophrenia symptoms:

- Hallucinations
- Delusions
- Referential thinking
- Suspiciousness
- Disorganized behavior
- Hostility
- Grandiosity
- Mania



Negative schizophrenia symptoms:

- Affective flattening
- Poverty of speech (alogia)
- Avolition
- Apathy
- Abstract thinking
- Anhedonia
- Attention deficits



Pharmacological management of schizophrenia:

- Atypical psychotics: first-line treatment and have fewer significant neurological side effects via blockage of both dopamine (D2) and 5HT2A
- Most patient will require lifelong treatment
- Adjunctive medications may be helpful in achieving full symptom control



Nonpharmacological management of schizophrenia:

- Individualized Therapy to assist with activities of daily living, setting and meeting life goals, and reality testing
- Group Therapy for problem-solving, medication management, and life skills
- Crisis management planning to mitigate potential relapse needs
- Assertive community treatment



Preventative care for Schizophrenia:

- Serum glucose and lipid panels
- Liver and kidney function tests
- CBC
- Weight, BMI, and waist to hip ratio
- Annual eye exam if the patient is taking a typical antipsychotic or on quetiapine (Seroquel)



Dementia vs. Delirium

Dementia (related disorders)	Vs.	Delirium
Slow progression = months to years		Sudden onset = hours to days
Normal speech		Slurred speech
Conscious/attentive		In and out of consciousness; distracted
Memory loss		Memory loss
Language difficulties		Language difficulties
Hallucinations are possible		Hallucinations are common
Listless or apathetic mood with possible agitation		Anxious, fearful, suspicious, agitated, disengaged or disinterested
Often no other signs of illness		Often have signs of medical illnesses, such as fever, chills, pain, when urinating...



Delirium

- Acute onset
- Altered level of consciousness
- Inattention
- Changes in concentration
- Present a poor prognosis with elevated mortality rates



Pharmacological management of delirium:

- Haloperidol (Haldol; typical antipsychotic); the preferred treatment for agitated and delirious patients
- Avoid benzodiazepines unless the patient is at risk and has not responded to Haldol; due to the possibility of prolonged delirium. An exception to this is alcohol or substance abuse



Nonpharmacological management of delirium:

- Close monitoring due to safety needs
- Ensure that the patient has an appropriate support system to attend to the basic needs of the patient
- Surround the patient with familiar things/people
- Provide a clock or Calendar to help orient the patient as often as possible



Dementia

- Gradual development resulting in:
 - Impaired executive function
 - Altered memory
 - Impaired global intellect with preservation of level of consciousness
 - Impaired problem-solving
 - Impaired organizational skills



Cortical vs. Subcortical dementia

Cortical Dementia	Vs.	Subcortical Dementia
Deficits in language		Depression
Deficits in memory		Irritability
		Apathy
		Motor symptoms
		End stages are same as cortical dementia
Examples: Alzheimer's Disease Creutzfeldt-Jakob Disease		Examples: Huntington's Disease, Parkinson's Disease, and AIDS dementia



Cognitive screening:

- Mental status exam as part of the general assessment
- Mini Mental Status Examination (MMSE)
- St. Louis University Mental Status Exam (SLUMS)
- The Clock Drawing Test



Alzheimer's Dementia

- Most common dementia
- Cortical area of the brain
- Caused by cerebral atrophy and enlarged ventricles
- Decrease in acetylcholine and norepinephrine
- Gradual onset with progressive neuro-deficits



Risk factors for Alzheimer's Disease:

- Age
- Family history
- Latinos and African Americans



Creutzfeldt-Jakob Disease

- Human prion disease
- Rapidly progressive and always fatal (within one year)
- Early: fatigue, flu-like symptoms, and cognitive impairment. Late-stage: aphasia, apraxia, emotional lability, depression, mania, psychosis, personality changes, and dementia



Dementia due to HIV

- Subcortical dementia
- Early signs = cognitive decline, motor abnormalities, behavioral abnormalities
- Patients have complications related to guilt, self-esteem, and fear of dying
- Parenchymal abnormalities visualized on magnetic resonance imaging (MRI)



HIV/AIDS medication management:

- Must use caution when prescribing antipsychotic medications: antiretrovirals and protease inhibitors can interact with psychotropic medications
- Make sure to continue treating with antiretrovirals



Late signs of HIV/AIDS:

- Global cognitive impairment
- Mutism
- Seizures
- Hallucinations
- Delusions
- Mania
- Apathy



Lewy Body Dementia

- Abnormal deposits of a protein
- Presents with recurrent visual hallucinations
- Parkinsonian-like features = bradykinesia, cogwheel rigidity, and tremors
- These patients adversely react to antipsychotics (due to anticholinergic properties)



Vascular Neurocognitive Disorder

- Second most common dementia
- Caused by cardiovascular disease
- Presents in a sudden and stepwise decline (symptoms stay the same for a while and then suddenly get worse)



Risk factors for Vascular Dementia:

- Most common in men with hypertension and cardiovascular risk factors
- Hallmark presentation = carotid bruits, fundoscopic abnormalities (ocular fundus photography), and enlarged cardiac chambers



Pick's Disease (Frontotemporal Dementia)

- Damaged neurons in the frontal and temporal lobes of the brain
- Slow and steady progression
- Leads to personality, behavioral, and language changes (slurred speech) in the early stages with late-stage cognitive changes



Huntington's Disease (Subcortical-type Dementia)

- Mostly associated with motor abnormalities (choreoathetosis movements)
- Memory, language, and insight usually stay intact until the later stages
- Marked by cycle motor slowing with difficulty completing complex tasks
- High incidence of depression and psychosis



Pharmacological management of dementia:

Cholinesterase inhibitors: donepezil (Aricept), rivastigmine (Exelon), and galantamine (Razadyne)



Cholinesterase inhibitors side effects:

- Nausea, vomiting, diarrhea
- Tachycardia
- Sleep disturbances



For medications given to older adults...

- Lowest effective dose and attempt to wean when appropriate “go low and go slow”
- Benzodiazepines should be avoided; dementia patients are vulnerable to sedation, falls, and delirium



Nonpharmacological management of dementia:

- Memory training
- Reminiscence Therapy
- Sensory stimulation
- Behavioral Management
- Animal-assisted Therapy
- Exercise



The Therapeutic Relationship

- Patient and nurse practitioner enter a mutual, interactive, and interpersonal relationship
- Focused on the patient's needs and our goal-directed



Characteristics of a therapeutic relationship:

- Authentic
- Genuine
- Empathetic
- Respectful
- Clear and established professional boundaries
- Ironclad confidentiality
- Mutual acceptance



Erickson's 8 Stages of
Psychosocial Development
Stage 1

- Infancy; birth – 1: Trust vs. Mistrust
- Virtue: **H**ope, Maldevelopment: Withdrawal



Erickson's 8 Stages of
Psychosocial Development
Stage 2

- Early Childhood; 1 – 3: Autonomy vs. Shame and Doubt
- Virtue: **W**ill, Maldevelopment: Compulsion



Erickson's 8 Stages of
Psychosocial Development
Stage 3

- Late Childhood; 3 – 6: Initiative vs. Guilt
- Virtue: **P**urpose, Maldevelopment: Inhibition



Erickson's 8 Stages of
Psychosocial Development
Stage 4

- Stage 4 – School-Age; 6 – 12: Industry vs. Inferiority
- Virtue: **C**ompetence, Maldevelopment: Inertia (passivity)



Erickson's 8 Stages of
Psychosocial Development
Stage 5

- Adolescence; 12 – 20: Identity vs. Role confusion
- Virtue: **F**idelity, Maldevelopment: Repudiation



Erickson's 8 Stages of
Psychosocial Development
Stage 6

- Early Adulthood; 20 – 35: Intimacy vs. Isolation
- Virtue: **L**ove, Maldevelopment: Distantiation



Erickson's 8 Stages of
Psychosocial Development
Stage 7

- Middle Adulthood; 35 – 65: Generativity vs. Stagnation
- Virtue: **C**are, Maldevelopment: Rejectivity



Erickson's 8 Stages of
Psychosocial Development
Stage 8

- Late Adulthood; >65: Integrity vs. Despair
- Virtue: **W**isdom, Maldevelopment: Disdain



To remember Erickson's:

TRUST AUTONOMY to INITIATE the
INDUSTRY, IDENTIFY INTIMACY,
and GENERATE INTEGRITY



To remember Erickson's:

HoW PoCo Fool CoW

The age of the patient in the
question is more than likely the
right answer



Piaget

S ensory motor	0 – 2	Experience in the world through senses and actions <ul style="list-style-type: none"> • Object permanence and stranger anxiety
P re-operational	2 – 7	Representing things with words and images; using intuitive rather than logical reasoning <ul style="list-style-type: none"> • Pretend play • Egocentrism
C oncrete	7 – 11	Thinking logically about concrete events; grasping concrete analogies and performing arithmetical operations <ul style="list-style-type: none"> • Conservation • Mathematical transformations
F ormal	12 and up	Abstract reasoning <ul style="list-style-type: none"> • Potential for mature moral reasoning



Object permanence

A child's ability to know that objects
continue to exist even though they
can no longer be seen or heard



Object consistency

- Understanding that a relationship is still present even or when the person is not physically present
- Absence does not equal disappearance or abandonment, only temporary distance



Freud

Freud's Psychosocial Stages

Oral Stage
0-18 months



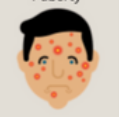
Anal Stage
18-36 months



Phallic Stage 3-6



Latent Stage 6-Puberty



Genital Stage
Puberty to Death

Note: Johnson, K. & Sandberg, S. (2020). Psychiatry: mental health. Nurse Practitioner Review and Resource Manual (5th ed.). American Nurses Association.



Freud normal occurrences:

- Oral stage – sucking, biting, and chewing
- Anal stage – bowel/bladder control
- Phallic stage – genitals/masturbation



Idealization

A way of coping with anxiety in which an object or person of ambivalence is viewed as perfect = “exaggerated positive qualities”



Devaluation

Used when a person attributes themselves, an object, or another person as completely flawed, worthless, or as having exaggerated negative qualities



Variance

Any event that alters patient progress towards their expected outcomes



Sources of variance

- Provider competency
- Severity of illness
- Practice patterns that inhibit or expedite care



Motivational Interviewing

- Goal focused
- Non-confrontational and focused
- Patient-centered with an empathetic approach
- Designed to empower the patient (he or she is in control; he or she can do it)
- Affirmations of positive traits
- Reflective listening = connecting the dots



Transtheoretical Change Model
Precontemplation

Not aware of the problem;
not ready to change =
provide feedback and make
the patient aware



Transtheoretical Change Model
Contemplation

"Thinking about change" and is
aware, but not committed to
change = help the patient to see
the benefits and consequences



Transtheoretical Change Model
Preparation

"Aware" and making steps towards
changing = help to make a realistic
plan; it must be effective and
appropriate



Transtheoretical Change Model
Action

Patient is engaged in a specific
action = support and be an
advocate; help with change



Transtheoretical Change Model Maintenance

Engaged in behaviors to prevent relapse = help to prevent relapse; help to identify behaviors that lead to relapse and how to prevent it



Transtheoretical Change Model Relapse

Conduct an assessment: when, what, where, why, how to stop



Cognitive Therapy – Beck

Goal: the goal is to change the client's irrational thinking or negative thoughts and replace them with positive thoughts



Behavioral Therapy

Focuses on changing maladaptive behaviors by participating in active behavioral techniques such as

- Exposure
- Relaxation
- Skills training
- Problem solving
- Role-playing
- Modeling



Cognitive and Behavioral Therapy

- Designed to change thought patterns, conscious and unconscious beliefs, attitudes, and behaviors = to facilitate and achieve goals
- The therapist and the patient are a team; together, they clarify problems, brainstorm strategies for addressing the problems, and create solutions



Activities in CBT

- Journaling – write it out
- Cognitive restructuring – replacing negative with positive thoughts



Dialectical Behavioral Therapy – Linehan

Think BPD

- The main goal is to decrease self-harming and suicidal behaviors
- Decrease interfering behaviors
- Decrease emotional reactivity
- Decrease self-invalidation
- Decrease crisis-generating behaviors
- Decrease passivity
- Increase realistic decision making
- Increase accurate communication of emotions and competencies



Existential Therapy

Emphasizes accepting freedom and making responsible choices

- Helps the patient identify a reason to live
- **Helps the patient understand subjective experiences**
- Focuses on the present with personal responsibility
- **Encourages life reflection**

Extremely well suited for those with terminal illnesses, contemplating suicide or going through a major life transition



Humanistic Theory – Rogers

- Person centered
- Self-directed therapy with self-actualization
 - Helps the patient understand that each person has the potential to become fulfilled and find meaning



Interpersonal Therapy

- The goal is to help the patient identify **interpersonal problems and manage relationship problems**
 - It is focused on interpersonal issues causing distress



Family Systems Therapy "Systemic"

- Focuses on chronic anxiety within families
- Increases the awareness of each member and how they function within the family
- Increases levels of self-differentiation
- Identifies the need to **recognize and overcome triangles**. Triangles within a family relationship produce stress
- Can use genograms



Structural Family Therapy

- Assesses **sub-systems within a family and any boundaries or hierarchies that exist**
- Focuses on **direct interactions between family members** as the primary method of inducing positive change
- Can use genograms



Strategic Therapy

- **Problem-focused** or symptom-focused
- **Paradoxical directives** - reverse psychology
- **Straightforward directives**
- **Reframing belief systems**



Solution-focused Therapy

- Focuses on reworking the present situation and identify solutions that have previously worked in the past
- Primary goal = effective resolution of problems through cognitive problem-solving with the use of personal resources and strengths
- Uses **miracle solutions, exception-finding questions, and scaling questions**



Projection

When a patient attributes their own unacceptable thoughts, feelings, and motives onto another person



Displacement

Redirection of an impulse (usually aggression) onto a powerless substitute target. The target can be a person or an object that can serve as a symbolic substitute



Sublimation

Displacement of unacceptable emotions into behaviors which are constructive and socially acceptable rather than destructive



Intellectualization

Concentrating on intellectual aspects to avoid emotional aspects of a difficult situation



Rationalization

An attempt to logically justify generally unacceptable behavior



Adverse Childhood Experiences (ACEs)

- Potentially traumatizing or traumatic events that occur in childhood. That can include all types of abuse and neglect
- Can have lasting impacts on their mental health, physical health, and general well-being



Biopsychosocial Framework of Care The Recovery Model

- Looking beyond just surviving and actually existing or thriving
- Treatment approach which does not focus on full-system resolution but emphasizes resilience and control over problems found in life



The Recovery Model

It is not just about "getting rid of problems," but seeing beyond mental health complications to recognize and foster their abilities, interest, and dreams

- Seeing beyond the problems
- Self-direction, autonomy
- It is non-linear; patients learn from experience
- Individualized and person-centered
- Supports getting on with life and doing things, developing relationships, and gaining true meaning



The Four Dimensions of Recovery

- Looking to beyond the illness:
 - Health
 - Home
 - Purpose
 - Community



Assertive Community Treatment (ACT)

- A case management approach
 - A type of rehabilitation that occurs after inpatient hospitalization. It is less restrictive
 - Design to help people become independent
 - Primary goal = reduce reliance on the hospitals by providing round the clock services to those who need it the most (e.g., poorly functioning schizophrenia, autism, substance abuse...)



ACT treatment plan =

Centered around the patient's personal strengths, needs and desires for the future. This is the epitome of holistic care



Stage 1. Forming

The orientation phase. The leader is most active in this stage. Universal norms are discussed such as confidentiality, attendance, and rules of communication and participation are addressed. This is the stage that discusses the time frame/termination of the group



Stage 2. Storming

The transition phase. Anxiety, ambiguity, and conflict become prevalent as group members test and act-out behaviors to define themselves and the group norms. This stage creates an interpersonal climate where members should feel free to disagree with each other



Stage 3. Norming

The cohesiveness phase. Members develop group-specific standards (cohesiveness) and therapeutic alliance forms such as disapproving late-arriving members, or the level of anger/conflict that will be tolerated



Stage 4. Working

The performing phase. During this stage, individual growth and team productivity, and effectiveness occur. Members experiment with new ideas or behaviors and egalitarianism develops



Stage 5. Adjourning

The termination phase. The closure for the group as a whole or the individual that left. The primary task is to discuss and review actual outcomes and achievements, explore feelings of what worked (and what didn't), and any feelings of loss. Introducing new concerns or initiatives is not appropriate



Yalom's Therapeutic Forces in Groups

Instillation of Hope

Encouragement that recovery is possible by sharing stories and information



Yalom's Therapeutic Forces in Groups

Universality

Recognition of a shared experience and knowing a person's problems are not unique



Yalom's Therapeutic Forces in Groups

Altruism

Helping and supporting others by experiencing the ability to help another person can build self-esteem. It helps to develop adaptive coping mechanisms



Yalom's Therapeutic Forces in Groups

Development of social skills

Learning new ways to talk about feelings, observations, and concerns



Yalom's Therapeutic Forces in Groups

Imitative Behavior

Modeling another's manners & recovery skills



Yalom's Therapeutic Forces in Groups

Interpersonal Learning

Finding out about themselves & others from the group (interpersonal relationships, corrective emotional experience, and social microcosm)



Yalom's Therapeutic Forces in Groups

Group Cohesiveness

The feeling of belonging to the group, and valuing the group



Yalom's Therapeutic Forces in Groups

Catharsis

The release of emotional tension (i.e., a burst of crying. Express emotions in a safe environment)



Yalom's Therapeutic Forces in Groups

Existential Factors

Learning to take responsibility for one's own actions



Yalom's Therapeutic Forces in Groups

Corrective Refocusing

Re-experience conflicts in the group allowing for the recognition and change of behaviors that may be problematic



Transference

Displacement of feelings for significant people in the patient's past onto the provider in the present situation



Countertransference

The providers emotional reaction to the client, based on his or her past experiences



