# Updated Exam Tips

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Clarity Education Systems



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Major Depressive Disorder with Psychotic Features: A Review for PMHNPs

***Overview***

The case describes a 70-year-old patient with a 3-month history of severe sadness, insomnia, poor appetite, 20-lb weight loss, anhedonia, severe guilt, worthlessness, and auditory hallucinations ("you are evil"), suggesting **Major Depressive Disorder (MDD) with Psychotic Features** as the most likely diagnosis. MDD with psychotic features is a severe subtype of MDD characterized by major depressive episodes accompanied by delusions or hallucinations, often mood-congruent (e.g., guilt-themed). For PMHNPs, accurate diagnosis, risk assessment, and treatment planning are critical, especially in older adults where medical comorbidities, medication interactions, and suicide risk complicate care.

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**Major Points**

1. **DSM-5-TR Diagnostic Criteria for MDD with Psychotic Features**:
    - **Major Depressive Episode**:
        - ≥5 symptoms for ≥2 weeks, including depressed mood or anhedonia: sadness, anhedonia, weight loss, insomnia, guilt, worthlessness, fatigue, poor concentration, or suicidal thoughts.
        - Symptoms cause significant distress or impairment.
    - **Psychotic Features**:
        - Delusions (e.g., guilt, worthlessness) or hallucinations (e.g., auditory voices) during the depressive episode.
        - **Mood-Congruent**: Psychotic symptoms align with depressive themes (e.g., "you are evil" reflects guilt).
        - **Mood-Incongruent**: Psychotic symptoms unrelated to mood (less common in MDD).
    - **Case Alignment**: The patient meets criteria with sadness, anhedonia, insomnia, weight loss (20 lbs), guilt, worthlessness, and mood-congruent hallucinations (voice saying "you are evil").
    - **Prevalence**: ~15–19% of MDD cases in older adults involve psychotic features, per 2024 studies.
2. **Clinical Features in Older Adults**:
    - **Presentation**: Older adults with MDD with psychotic features often exhibit severe guilt, somatic complaints (e.g., appetite loss), and cognitive decline (e.g., pseudodementia), as seen in the case.

- **Risk Factors**: Age-related stressors (e.g., loss, isolation), medical comorbidities (e.g., dementia, stroke), and polypharmacy increase susceptibility.
- **Psychosis**: Hallucinations (often auditory) and delusions (e.g., nihilistic, guilt-based) are more common in late-life depression than in younger populations.

3. **Differential Diagnosis**:

   - **Schizoaffective Disorder**: Requires psychotic symptoms for ≥2 weeks without mood symptoms, not met here (psychosis aligns with depressive episode).
   - **Schizophrenia**: Primary psychosis with minimal mood symptoms, unlikely given the patient's prominent depression and late onset (schizophrenia typically starts ~18–30 years).
   - **Delirium**: Acute onset, fluctuating consciousness, often medical (e.g., infection, electrolyte imbalance); ruled out by 3-month duration/no cognitive fluctuation.
   - **Dementia with Depression**: Cognitive decline precedes mood symptoms; patient's primary issue is depression, not memory loss.
   - **Bipolar Disorder**: No h/o mania/hypomania reported, making MDD more likely.
   - **Medical Causes**: Hypothyroidism, vitamin B12 deficiency, or medication side effects (e.g., corticosteroids) can mimic symptoms; requires lab evaluation.

4. **Mental Health Applications**:

   - **Diagnosis**: Use validated tools (e.g., PHQ-9, GDS-15 for geriatric depression) and assess psychosis (e.g., PANSS) to confirm MDD with psychotic features.

   - **Treatment**:

     - **Pharmacotherapy**: Antidepressant (e.g., sertraline) plus antipsychotic (e.g., aripiprazole) is first-line; ECT is highly effective for severe cases in older adults.
     - **Psychotherapy**: CBT or supportive therapy to address guilt and worthlessness.
     - **Safety**: Hospitalization may be needed due to suicide risk or severe weight loss.

   - **Prognosis**: Poorer in psychotic MDD vs. non-psychotic, with higher relapse rates.

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Safety Issues

1. **Suicide Risk**:

   - Older adults with MDD with psychotic features have a high suicide risk (~15–20% attempt rate), especially with guilt-themed psychosis and weight loss signaling severity.

- **Mitigation**: Use Columbia-Suicide Severity Rating Scale (C-SSRS); implement safety plans or hospitalization if ideation is present.

2. **Medical Comorbidities**:

   - Weight loss (20 lbs) and insomnia suggest malnutrition or frailty, increasing risks (e.g., falls, infections).
   - **Mitigation**: Order labs (e.g., CBC, thyroid, B12) and coordinate with primary care.

3. **Medication Safety**:

   - Antipsychotics (e.g., risperidone) in older adults risk QT prolongation, falls, or metabolic syndrome; antidepressants (e.g., SSRIs) may cause hyponatremia.
   - **Mitigation**: Start low, go slow; monitor ECG, electrolytes, and side effects.

4. **Delirium Misdiagnosis**:

   - Psychosis and confusion in older adults may be mistaken for delirium, delaying psychiatric treatment.
   - **Mitigation**: Assess symptom duration and mental status (e.g., MMSE) to rule out delirium.

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**High-Yield Information**

- **Key Features**:

  - MDD with psychotic features combines depressive symptoms with mood-congruent psychosis (e.g., guilt-themed hallucinations).
  - Older adults: Higher prevalence of psychotic features, severe presentations (e.g., weight loss, guilt).

- **Applications**:

  - Diagnostic: Screen with PHQ-9/GDS-15; confirm psychosis with clinical interview.
  - Therapeutic: Combine SSRI/antipsychotic or consider ECT; address suicide risk.
  - Preventive: Monitor for relapse in psychotic MDD, especially in geriatric patients.

- **Exam Pearls**:
  - Mood-congruent psychosis (e.g., “you are evil”) points to MDD, not schizophrenia.

- Older adults with MDD have higher psychosis rates—know geriatric-specific tools (e.g., GDS-15).
- Questions often test differential diagnosis or treatment prioritization.

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**Role of the PMHNP**

- **Assessment**: Use screening tools (e.g., PHQ-9, C-SSRS) and clinical interviews to confirm MDD with psychotic features and assess risk.
- **Intervention**: Initiate combined pharmacotherapy (SSRI + antipsychotic), consider ECT, and provide supportive therapy.
- **Education**: Inform patients/families about psychosis in depression and treatment benefits.
- **Advocacy**: Promote access to geriatric psychiatry services, especially for underserved elderly populations.

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**Question**:

A 70-year-old female presents with a 3-month history of severe sadness, insomnia, 20-lb weight loss, anhedonia, and intense guilt, reporting auditory hallucinations that she is "evil." Her PHQ-9 score is 22, and she denies suicidal ideation. Medical history includes hypertension, and labs are pending. Which of the following is the most appropriate initial management for her likely diagnosis of major depressive disorder with psychotic features?

A. Start sertraline 25 mg daily and refer to outpatient CBT.
B. Prescribe lorazepam 0.5 mg PRN for anxiety and reassess in 2 weeks.
C. Initiate sertraline 25 mg daily and aripiprazole 2 mg daily, with close monitoring.
D. Order an MRI to rule out dementia and delay psychiatric treatment until results.

**Correct Answer**:

**C. Initiate sertraline 25 mg daily and aripiprazole 2 mg daily, with close monitoring.**

*Rationales*

- **Correct Answer: C. Initiate sertraline 25 mg daily and aripiprazole 2 mg daily, with close monitoring**

    - **Rationale**: The patient's symptoms (severe sadness, anhedonia, insomnia, weight loss, guilt, and mood-congruent hallucinations) align with **MDD with psychotic features**, requiring combined antidepressant and antipsychotic treatment. Sertraline (SSRI) addresses depressive symptoms, and aripiprazole (atypical antipsychotic) targets hallucinations, with low doses appropriate for older adults to minimize side effects (e.g., falls, QT prolongation). Close monitoring ensures safety, given her age, weight loss, and potential medical comorbidities. This approach aligns with APA guidelines and 2024 evidence for psychotic depression in geriatrics.
    - **Why It's High-Yield**: Tests treatment prioritization for MDD with psychotic features, emphasizing combined therapy in older adults, a common PMHNP exam focus.

- **A. Start sertraline 25 mg daily and refer to outpatient CBT**

    - **Rationale**: Sertraline addresses depression but not psychosis, which requires an antipsychotic. CBT is beneficial but insufficient as an initial step for severe psychotic depression, especially with significant weight loss indicating urgency. This under-treats the condition.
    - **Exam Tip**: Psychotic MDD requires dual pharmacotherapy, not monotherapy.

- **B. Prescribe lorazepam 0.5 mg PRN for anxiety and reassess in 2 weeks**

    - **Rationale**: Lorazepam is inappropriate for MDD with psychotic features, as it doesn't address depression or hallucinations and risks sedation or dependence in older adults. Delaying treatment for 2 weeks ignores the severity and suicide risk.
    - **Exam Tip**: Avoid sedatives for primary psychiatric disorders with psychosis.

- **D. Order an MRI to rule out dementia and delay psychiatric treatment until results**

    - **Rationale**: While dementia is a differential, the 3-month duration, prominent depression, and mood-congruent psychosis point to MDD, not dementia (where cognitive decline precedes mood symptoms). Delaying treatment risks worsening depression and suicide risk. Labs (e.g., B12, thyroid) are more urgent than MRI.
    - **Exam Tip**: Prioritize psychiatric treatment over extensive diagnostics in clear MDD presentations.

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**Polypharmacy in Pediatric Psychiatry**

***Overview***

The case describes an 8-year-old patient prescribed multiple psychotropic medications—aripiprazole (atypical antipsychotic), guanfacine and clonidine (alpha-2 agonists), sertraline

(SSRI), and amphetamine salts (stimulant)—plus melatonin, with ongoing aggression toward siblings and peers. **Polypharmacy**, defined as the concurrent use of multiple medications (typically ≥3 psychotropics in psychiatry), is a critical issue in this scenario due to potential risks of adverse effects, drug interactions, and unclear therapeutic benefits. For PMHNPs, addressing polypharmacy is a priority to optimize treatment, ensure safety, and target symptoms like aggression in pediatric patients, where developmental and physiological factors heighten vulnerability.

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**Major Points**

1. **Definition and Prevalence**:
    - **Polypharmacy**: Use of multiple medications for one or more conditions, often ≥3 psychotropics in mental health settings. In pediatrics, it's common in complex cases (e.g., ADHD with comorbidities).
    - **Prevalence**: ~20–30% of children with psychiatric disorders receive polypharmacy, per 2024 *Journal of Child and Adolescent Psychopharmacology* studies, driven by comorbidities (e.g., ADHD, anxiety, disruptive behavior).
    - **Case Context**: The patient's regimen (5 psychotropics + melatonin) is polypharmacy, with medications targeting impulsivity (stimulant, alpha-2 agonists), mood/anxiety (SSRI), psychosis/mood stabilization (antipsychotic), and sleep (melatonin).

2. **Medications in the Case**:
    - **Aripiprazole (2.5 mg)**: Atypical antipsychotic for irritability (e.g., in autism, bipolar) or psychosis; risks include weight gain, akathisia, QT prolongation.
    - **Guanfacine (1 mg ER)**: Alpha-2 agonist for ADHD or aggression; risks include sedation, hypotension.
    - **Clonidine (0.1 mg)**: Alpha-2 agonist for ADHD, agitation, or sleep; risks overlap with guanfacine, increasing sedation concerns.
    - **Sertraline (25 mg)**: SSRI for depression, anxiety, or OCD; risks include agitation, suicidality (FDA black box for <25 years).
    - **Amphetamine Salts (10 mg XR)**: Stimulant for ADHD; risks include agitation, insomnia, aggression.
    - **Melatonin**: Over-the-counter sleep aid; generally safe but lacks standardized dosing in children.
    - **Aggression**: Likely related to underlying diagnosis (e.g., ADHD, oppositional defiant disorder [ODD]) or medication side effects (e.g., stimulant-induced irritability).

3. **Risks of Polypharmacy**:

    - **Adverse Effects**: Overlapping side effects (e.g., sedation from guanfacine/clonidine, agitation from amphetamines/sertraline) can exacerbate aggression or impair functioning.

    - **Drug Interactions**:

        - Aripiprazole + sertraline: Increased sedation, potential QT prolongation (CYP2D6 interaction).
        - Guanfacine + clonidine: Additive hypotension/sedation, risking cardiovascular effects.
        - Amphetamines + sertraline: Increased agitation or serotonin syndrome.

    - **Developmental Risks**: Children are sensitive to psychotropic effects on brain development, metabolism, and growth.
    - **Diagnostic Uncertainty**: Multiple medications may obscure the primary diagnosis, complicating treatment evaluation.

4. **Clinical Approach to Polypharmacy**:

    - **Assess Rationale**: Determine the indication for each medication (e.g., aripiprazole for irritability, sertraline for anxiety). Clarify diagnoses (e.g., ADHD, ODD, anxiety).
    - **Evaluate Necessity**: Streamline regimens by discontinuing redundant or ineffective drugs (e.g., guanfacine and clonidine overlap).
    - **Monitor Safety**: Check for side effects, drug levels, and vitals (e.g., blood pressure for alpha-2 agonists).
    - **Engage Family**: Educate parents on risks/benefits and involve them in shared decision-making.
    - **Non-Pharmacologic Options**: Prioritize behavioral therapy (e.g., parent management training for aggression) to reduce medication reliance.

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**Safety Issues**

1. **Adverse Effects in Children**:

    - Sedation (guanfacine, clonidine, aripiprazole) risks cognitive impairment; agitation (amphetamines, sertraline) may worsen aggression.
    - **Mitigation**: Monitor with side effect scales (e.g., Pediatric Adverse Event Rating Scale) and taper redundant drugs.

2. **Suicide Risk**:
    - Sertraline carries an FDA black box warning for suicidality in children (<25 years), especially with polypharmacy increasing agitation.
    - **Mitigation**: Screen with C-SSRS; educate parents on warning signs.
3. **Cardiovascular Risks**:
    - Guanfacine/clonidine can cause hypotension; aripiprazole risks QT prolongation; amphetamines increase heart rate.
    - **Mitigation**: Obtain baseline ECG, monitor vitals, and avoid overlapping sedatives.
4. **Diagnostic Overshadowing**:
    - Multiple medications may mask or mimic symptoms (e.g., sedation as depression, agitation as ODD), complicating diagnosis.
    - **Mitigation**: Reassess diagnoses with structured tools (e.g., Vanderbilt for ADHD, KSADS for comorbidities).

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**High-Yield Information**

- **Key Features**:
    - Polypharmacy: ≥3 psychotropics, common in pediatric comorbidities but risky.
    - Case: 5 medications + melatonin suggest overuse, potential for interactions, and side effects (e.g., aggression).
- **Applications**:
    - Diagnostic: Clarify indications (e.g., ADHD, anxiety, irritability) to justify each drug.
    - Therapeutic: Streamline regimen, prioritize behavioral interventions for aggression.
    - Preventive: Monitor for side effects and interactions to prevent harm.
- **Exam Pearls**:
    - Polypharmacy questions test safety, interactions, and simplification strategies.
    - Pediatric psychotropics require cautious dosing (start low, go slow) and non-pharmacologic emphasis.
    - Aggression may reflect side effects (e.g., stimulants) or untreated comorbidities (e.g., ODD).

- **Normal Ranges**:
    - Magnesium (relevant to psychotropics like lithium, though not in this case): 1.7–2.2 mg/dL.
    - Monitor vitals (e.g., BP, HR) for guanfacine/clonidine.

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**Role of the PMHNP**

- **Assessment**: Review each medication's indication, efficacy, and side effects; use diagnostic tools to clarify conditions.
- **Intervention**: Taper unnecessary drugs, optimize monotherapy, and integrate behavioral therapy.
- **Education**: Counsel parents on polypharmacy risks and non-pharmacologic options.
- **Advocacy**: Promote pediatric mental health access to reduce reliance on multiple medications.

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**Question**:

An 8-year-old male is prescribed aripiprazole 2.5 mg, guanfacine 1 mg ER, clonidine 0.1 mg, sertraline 25 mg, and amphetamine salts 10 mg XR, with melatonin gummies for sleep. He exhibits frequent aggression toward siblings and peers. The PMHNP identifies polypharmacy as a priority concern. Which of the following is the most appropriate next step to address this issue?

A. Increase aripiprazole to 5 mg to target aggression and reassess in 2 weeks.
B. Continue all medications and refer for family therapy to address aggression.
C. Review diagnoses and taper clonidine while monitoring for side effects and symptom control.
D. Discontinue melatonin and start a sleep hygiene program to reduce polypharmacy.

**Correct Answer**:

**C. Review diagnoses and taper clonidine while monitoring for side effects and symptom control.**

*Rationales*

- **Correct Answer: C. Review diagnoses and taper clonidine while monitoring for side effects and symptom control**

    - **Rationale**: The patient's regimen (5 psychotropics + melatonin) represents polypharmacy, increasing risks of adverse effects (e.g., sedation from guanfacine/clonidine overlap, agitation from amphetamines/sertraline) and potentially contributing to aggression. Reviewing diagnoses (e.g., ADHD, ODD, anxiety) clarifies the necessity of each medication. Clonidine and guanfacine are redundant (both alpha-2 agonists), and tapering clonidine reduces polypharmacy while addressing sedation risks, which may exacerbate aggression. Monitoring ensures safety and evaluates symptom control, aligning with AACAP guidelines to minimize psychotropics in children. This is a proactive, evidence-based step for PMHNPs.
    - **Why It's High-Yield**: Tests polypharmacy management, pediatric safety, and prioritization of diagnostic clarity, a core PMHNP competency.

- **A. Increase aripiprazole to 5 mg to target aggression and reassess in 2 weeks**

    - **Rationale**: Increasing aripiprazole may address irritability but adds to polypharmacy risks (e.g., akathisia, weight gain) without clarifying diagnoses or addressing redundant medications (guanfacine/clonidine). Aggression may stem from side effects, not under-dosing.
    - **Exam Tip**: Avoid escalating doses before simplifying regimens in polypharmacy cases.

- **B. Continue all medications and refer for family therapy to address aggression**

    - **Rationale**: Continuing polypharmacy ignores risks of interactions and side effects, which may contribute to aggression. Family therapy is appropriate but not the priority over addressing an unsafe regimen.
    - **Exam Tip**: Polypharmacy questions prioritize medication review over adjunctive therapies.

- **D. Discontinue melatonin and start a sleep hygiene program to reduce polypharmacy**

    - **Rationale**: Melatonin is low-risk and not a psychotropic; discontinuing it minimally impacts polypharmacy concerns. The primary issue is the 5 psychotropics, particularly redundant sedatives (clonidine/guanfacine). Sleep hygiene is beneficial but secondary.
    - **Exam Tip**: Focus on high-risk medications in polypharmacy scenarios.

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**Autism Spectrum Disorder in a 6-Year-Old Child**

***Overview***

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterized by persistent deficits in social communication and interaction, alongside restricted, repetitive patterns of behavior, interests, or activities. The case of a 6-year-old child exhibiting behaviors like "putting everything color-coded" (a repetitive, organizing behavior) and "lack of reciprocity" (impaired social interaction) aligns with core ASD features. For PMHNPs, recognizing these signs is critical for early diagnosis, intervention, and support, particularly in young children where early treatment can significantly improve outcomes.

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**Major Points**

1. **DSM-5-TR Diagnostic Criteria for ASD**:
    - **A. Social Communication and Interaction Deficits** (all 3 required):
        1. Deficits in social-emotional reciprocity (e.g., lack of back-and-forth conversation, reduced sharing of emotions or interests).
        2. Deficits in nonverbal communicative behaviors (e.g., poor eye contact, atypical gestures).
        3. Deficits in developing, maintaining, and understanding relationships (e.g., difficulty forming friendships, adjusting behavior to social context).
    - **B. Restricted, Repetitive Behaviors** (≥2 of 4 required):
        1. Stereotyped or repetitive movements, use of objects, or speech (e.g., hand-flapping, echolalia).
        2. Insistence on sameness, inflexible routines, or ritualized behaviors (e.g., color-coding objects).
        3. Highly restricted, fixated interests (e.g., intense focus on specific topics).
        4. Hyper- or hyporeactivity to sensory input (e.g., sensitivity to sounds, textures).
    - **Additional Criteria**:
        - Symptoms present in early developmental period (may not manifest fully until social demands increase).
        - Symptoms cause significant impairment in functioning.
        - Not better explained by intellectual disability or global developmental delay.

- **Case Alignment**:
    - "Lack of reciprocity" maps to social communication deficits (Criterion A1).
    - "Putting everything color-coded" aligns with insistence on sameness or ritualized behaviors (Criterion B2).

2. **Clinical Features in a 6-Year-Old**:
    - **Social Reciprocity**: Children with ASD often fail to initiate or respond to social interactions (e.g., not sharing toys, limited emotional exchange with peers or parents).
    - **Repetitive Behaviors**: Color-coding objects reflects a need for sameness or control, common in ASD, often seen as organizing or lining up items.
    - **Other Signs**: May include poor eye contact, delayed speech, sensory sensitivities (e.g., aversion to loud noises), or intense interests (e.g., memorizing patterns).
    - **Prevalence**: ~1 in 36 children in the U.S., per 2023 CDC data, with diagnosis typically by age 2–4, though milder cases may be identified later (e.g., age 6).

3. **Differential Diagnosis**:
    - **Social (Pragmatic) Communication Disorder**: Impaired social communication without repetitive behaviors; color-coding rules this out.
    - **ADHD**: Inattention and impulsivity may mimic social deficits, but repetitive behaviors like color-coding are specific to ASD.
    - **Obsessive-Compulsive Disorder (OCD)**: Ritualistic behaviors (e.g., organizing) may resemble ASD, but OCD lacks social reciprocity deficits and typically onsets later (~8–12 years).
    - **Intellectual Disability**: May co-occur with ASD but doesn't explain social and repetitive behaviors alone.
    - **Anxiety Disorders**: Social avoidance may mimic ASD, but anxiety-driven behaviors lack repetitive patterns like color-coding.

4. **Mental Health Applications**:
    - **Diagnosis**: Use screening tools (e.g., M-CHAT-R, ADOS-2) and clinical interviews to confirm ASD; collateral history from parents is key.
    - **Treatment**:
        - **Behavioral Interventions**: Applied Behavior Analysis (ABA) or social skills training to address reciprocity deficits.
        - **Pharmacotherapy**: No medications treat core ASD symptoms; aripiprazole or risperidone may target irritability (e.g., aggression, tantrums).
        - **Family Support**: Parent training (e.g., Early Start Denver Model) improves outcomes.

- **Prognosis**: Early intervention improves social and functional outcomes; 2024 studies show ~50% of children with early ABA gain significant skills by adolescence.

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**Safety Issues**

1. **Missed Diagnosis**:
    - ASD symptoms (e.g., lack of reciprocity) may be mistaken for shyness or ADHD, delaying intervention.
    - **Mitigation**: Use validated tools (e.g., M-CHAT-R) and developmental history in young children.
2. **Behavioral Risks**:
    - Repetitive behaviors or sensory issues may lead to self-injury (e.g., head-banging) or elopement, especially in young children.
    - **Mitigation**: Implement safety plans and environmental modifications (e.g., sensory-friendly spaces).
3. **Medication Safety**:
    - Antipsychotics (e.g., aripiprazole) for irritability carry risks (e.g., weight gain, sedation) in children; off-label use requires careful monitoring.
    - **Mitigation**: Start low, monitor metabolic parameters, and prioritize behavioral interventions.
4. **Family Stress**:
    - Parents of children with ASD face high caregiver burden, increasing risk of mental health issues (e.g., depression).
    - **Mitigation**: Offer family counseling and connect to support groups.

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**High-Yield Information**

- **Key Features**:
    - ASD: Social communication deficits (e.g., lack of reciprocity) + repetitive behaviors (e.g., color-coding).
    - Age 6: Typical diagnosis age for milder cases; severe cases identified earlier (~2–3 years).

- **Applications**:
    - Diagnostic: Screen with M-CHAT-R or ADOS-2; confirm with DSM-5-TR criteria.
    - Therapeutic: Prioritize ABA, social skills training; use antipsychotics cautiously for irritability.
    - Preventive: Early intervention reduces long-term impairment.
- **Exam Pearls**:
    - Lack of reciprocity and repetitive behaviors (e.g., color-coding) are hallmark ASD signs.
    - Questions test differential diagnosis (e.g., vs. OCD, ADHD) and intervention prioritization.
    - ASD onset is early childhood, unlike later-onset disorders (e.g., schizophrenia).

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**Role of the PMHNP**

- **Assessment**: Use standardized tools and collateral history to identify ASD signs like lack of reciprocity and repetitive behaviors.
- **Intervention**: Coordinate ABA, social skills training, and cautious pharmacotherapy; support family involvement.
- **Education**: Inform parents about ASD's neurodevelopmental nature and intervention benefits.
- **Advocacy**: Promote access to early intervention services, especially for underserved populations.

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**Question**:

A 6-year-old child is evaluated by a PMHNP for developmental concerns. The parents report the child insists on color-coding toys and books, struggles to share emotions with peers, and rarely initiates play. Which of the following best identifies the correct signs of autism spectrum disorder (ASD) in this child?

A. Hyperactivity and inattention, requiring stimulant medication.
B. Excessive worry and avoidance, indicating an anxiety disorder.

C. Lack of social-emotional reciprocity and insistence on color-coding, consistent with ASD.
D. Delusions and hallucinations, suggesting early-onset psychosis.

**Correct Answer**:

**C. Lack of social-emotional reciprocity and insistence on color-coding, consistent with ASD.**

*Rationales*

- **Correct Answer: C. Lack of social-emotional reciprocity and insistence on color-coding, consistent with ASD**
    - **Rationale**: The child's behaviors—**lack of social-emotional reciprocity** (struggling to share emotions, not initiating play) and **insistence on color-coding** (repetitive, ritualized behavior)—align with DSM-5-TR criteria for ASD, specifically deficits in social communication (Criterion A1) and restricted/repetitive behaviors (Criterion B2). These are hallmark signs in a 6-year-old, a common age for ASD diagnosis in milder cases. This choice accurately reflects the scenario and supports early identification, a key PMHNP responsibility.
    - **Why It's High-Yield**: Tests recognition of core ASD features (social deficits, repetitive behaviors) and differentiation from other disorders, a critical exam skill.
- **A. Hyperactivity and inattention, requiring stimulant medication**
    - **Rationale**: Hyperactivity and inattention suggest ADHD, but the scenario emphasizes social reciprocity deficits and color-coding, not inattention or impulsivity. Stimulants are inappropriate for core ASD symptoms.
    - **Exam Tip**: ASD involves social and repetitive behaviors, not primarily inattention.
- **B. Excessive worry and avoidance, indicating an anxiety disorder**
    - **Rationale**: Anxiety disorders involve worry or fear-driven avoidance, not color-coding or social reciprocity deficits. The child's behaviors are neurodevelopmental, not anxiety-based.
    - **Exam Tip**: Anxiety lacks repetitive behaviors like color-coding—check for ASD criteria.
- **D. Delusions and hallucinations, suggesting early-onset psychosis**
    - **Rationale**: Psychosis (e.g., schizophrenia) is rare before adolescence (typical onset ~18–30 years) and involves delusions/hallucinations, not color-coding or social deficits. These symptoms are absent here.

- **Exam Tip**: Psychosis onset is later than ASD; focus on developmental signs.

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**Identifying Delusional Disorder, Schizoaffective Disorder, Bipolar Disorder with Psychotic Features, and Brief Psychotic Disorder**

***Overview***

The DSM-5-TR provides specific criteria for diagnosing **Delusional Disorder**, **Schizoaffective Disorder**, **Bipolar Disorder with Psychotic Features**, and **Brief Psychotic Disorder**, each characterized by distinct patterns of psychosis and mood symptoms. For PMHNPs, accurate identification is critical for differential diagnosis, treatment planning, and ensuring patient safety, particularly in psychiatric settings where psychosis and mood disturbances overlap. This review details each disorder's diagnostic criteria, key features, and clinical considerations, with a focus on distinguishing them in practice.

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**Major Points**

1. **Delusional Disorder**:
    - **DSM-5-TR Criteria**:
        - A. Presence of ≥1 delusion(s) for ≥1 month.
        - B. Never met Criterion A for schizophrenia (e.g., no prominent hallucinations, disorganized speech/behavior, negative symptoms).
        - C. Functioning is not markedly impaired outside the delusion; behavior is not obviously bizarre.
        - D. If mood episodes occur, they are brief relative to the delusion duration.
        - E. Not due to substances, medical conditions, or another mental disorder.
    - **Types**: Erotomanic, grandiose, jealous, persecutory, somatic, mixed, or unspecified.
    - **Key Features**:
        - Non-bizarre delusions (e.g., being followed, having a special talent) with minimal hallucinations (if present, related to delusion).
        - Intact functioning outside delusional beliefs (e.g., maintains job, relationships).
        - Typical onset: Middle to late adulthood (~30–50 years).

- **PMHNP Relevance**:
    - Often treatment-resistant due to lack of insight; antipsychotics (e.g., risperidone) are first-line, though efficacy is limited.
    - Assess for risk of acting on delusions (e.g., violence in jealous type).
- **Prevalence**: ~0.2%, less common than schizophrenia.

2. **Schizoaffective Disorder**:
    - **DSM-5-TR Criteria**:
        - A. Uninterrupted period with a major mood episode (manic or depressive) concurrent with Criterion A schizophrenia symptoms (≥2: delusions, hallucinations, disorganized speech/behavior, negative symptoms; ≥1 must be delusions, hallucinations, or disorganized speech).
        - B. Delusions or hallucinations for ≥2 weeks without a major mood episode at some point.
        - C. Mood symptoms present for the majority (>50%) of the total illness duration.
        - D. Not due to substances or medical conditions.
    - **Subtypes**: Bipolar type (with mania) or depressive type.
    - **Key Features**:
        - Combines schizophrenia-like psychosis with prominent mood episodes.
        - Psychosis persists independent of mood at times (unlike bipolar with psychotic features).
        - Typical onset: Early adulthood (~20–30 years).
    - **PMHNP Relevance**:
        - Treatment: Antipsychotics (e.g., aripiprazole) + mood stabilizers (e.g., lithium) or antidepressants (e.g., sertraline).
        - High suicide risk (~10% lifetime), requiring C-SSRS screening.
    - **Prevalence**: ~0.3%, less common than schizophrenia or bipolar disorder.

3. **Bipolar Disorder with Psychotic Features**:
    - **DSM-5-TR Criteria**:
        - Meets criteria for bipolar I or II disorder (manic, hypomanic, or depressive episodes).

        - Psychotic features (delusions, hallucinations) occur during mood episodes (manic, depressive, or mixed).
        - Specifier: "With psychotic features" (mood-congruent, e.g., grandiose delusions in mania; mood-incongruent, e.g., unrelated paranoia).
        - No psychosis independent of mood episodes (unlike schizoaffective disorder).

    - **Key Features**:

        - Psychosis is tied to mood episodes (e.g., grandiose delusions during mania, guilt-themed hallucinations in depression).
        - Typical onset: Late adolescence to early adulthood (~15–25 years).

    - **PMHNP Relevance**:

        - Treatment: Mood stabilizers (e.g., lithium, valproate) + antipsychotics for acute psychosis; psychotherapy (e.g., CBT) for mood management.
        - Monitor for mania-induced impulsivity or depressive suicidality.

    - **Prevalence**: ~50–75% of bipolar I patients experience psychotic features at some point.

4. **Brief Psychotic Disorder**:

    - **DSM-5-TR Criteria**:

        - A. Presence of ≥1 psychotic symptom (delusions, hallucinations, disorganized speech, or grossly disorganized/catatonic behavior), with ≥1 being delusions, hallucinations, or disorganized speech.
        - B. Duration: ≥1 day but <1 month, with full return to premorbid functioning.
        - C. Not better explained by mood disorders, schizophrenia, substances, or medical conditions.

    - **Specifiers**: With/without marked stressors, postpartum onset.
    - **Key Features**:

        - Sudden, short-lived psychosis, often triggered by stress (e.g., trauma, loss).
        - Full recovery within 1 month, distinguishing it from schizophrenia or schizoaffective disorder.
        - Typical onset: Adolescence to early adulthood (~15–35 years).

    - **PMHNP Relevance**:

        - Treatment: Short-term antipsychotics (e.g., risperidone) and supportive therapy; monitor for recurrence.

        - Assess for suicide or violence risk during acute episodes.
    - **Prevalence**: Rare, ~0.1%, more common in young adults or postpartum women.

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**Differential Diagnosis**

- **Delusional Disorder vs. Schizoaffective**: Delusional disorder lacks prominent mood episodes and schizophrenia's full symptom profile; schizoaffective requires significant mood symptoms and independent psychosis.
- **Schizoaffective vs. Bipolar with Psychotic Features**: Schizoaffective has psychosis without mood for ≥2 weeks; bipolar psychosis occurs only during mood episodes.
- **Brief Psychotic Disorder vs. Others**: Brief duration (<1 month) and full recovery distinguish it from chronic disorders (e.g., schizophrenia, schizoaffective).
- **Medical/Substance Causes**: Rule out delirium, substance-induced psychosis (e.g., amphetamines), or medical conditions (e.g., temporal lobe epilepsy) with labs (e.g., toxicology, EEG).

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**Safety Issues**

1. **Suicide Risk**:
    - Highest in schizoaffective (depressive type) and bipolar with psychotic features (depressive episodes); brief psychotic disorder also carries acute risk.
    - **Mitigation**: Use C-SSRS; consider hospitalization for severe cases.
2. **Violence Risk**:
    - Delusional disorder (e.g., jealous, persecutory types) and brief psychotic disorder may lead to acting on delusions/hallucinations.
    - **Mitigation**: Assess risk with clinical interview; involve law enforcement if needed (e.g., Tarasoff duty to warn).
3. **Medication Safety**:
    - Antipsychotics (e.g., risperidone) risk QT prolongation, metabolic syndrome; mood stabilizers (e.g., lithium) require monitoring (e.g., renal function).
    - **Mitigation**: Start low, monitor labs/ECG, and educate patients.
4. **Misdiagnosis**:
    - Overlooking mood components (schizoaffective, bipolar) or brief duration (brief psychotic disorder) can lead to inappropriate treatment.
    - **Mitigation**: Use structured tools (e.g., SCID-5, PANSS) and longitudinal history.

**High-Yield Information**

- **Key Features**:
    - **Delusional Disorder**: Non-bizarre delusions, intact functioning, no prominent mood/psychosis overlap.
    - **Schizoaffective**: Psychosis + major mood episodes, psychosis independent for ≥2 weeks.
    - **Bipolar with Psychotic Features**: Psychosis only during mood episodes.
    - **Brief Psychotic Disorder**: Psychosis <1 month, full recovery.
- **Applications**:
    - Diagnostic: Use DSM-5-TR criteria, structured interviews, and mood/psychosis timelines.
    - Therapeutic: Antipsychotics for all; mood stabilizers/antidepressants for schizoaffective/bipolar; brief therapy for brief psychotic disorder.
    - Preventive: Monitor for relapse in chronic disorders; early intervention for brief psychosis.
- **Exam Pearls**:
    - Duration: Brief psychotic (<1 month), delusional (≥1 month), schizoaffective/schizophrenia (>6 months).
    - Mood: Schizoaffective (majority mood), bipolar (psychosis mood-tied), delusional (minimal mood).
    - Questions test differential diagnosis based on psychosis duration and mood prominence.

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**Role of the PMHNP**

- **Assessment**: Differentiate disorders using DSM-5-TR criteria, screening tools (e.g., PHQ-9, PANSS), and history.
- **Intervention**: Tailor pharmacotherapy (e.g., antipsychotics, mood stabilizers) and psychotherapy (e.g., CBT, supportive) to diagnosis.
- **Education**: Inform patients/families about prognosis and treatment needs.
- **Advocacy**: Promote access to early intervention and crisis services.

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A 35-year-old male presents with a 6-month history of believing his coworkers are plotting against him, accompanied by 4 months of persistent low mood, anhedonia, and insomnia. He reports auditory hallucinations ("you're a failure") for the past 3 months, with 1 month of hallucinations without mood symptoms. Which of the following is the most likely diagnosis based on DSM-5-TR criteria?

A. Delusional disorder, persecutory type.
B. Brief psychotic disorder with marked stressors.
C. Schizoaffective disorder, depressive type.
D. Bipolar I disorder with psychotic features.

**Correct Answer**:

**C. Schizoaffective disorder, depressive type.**

*Rationales*

- **Correct Answer: C. Schizoaffective disorder, depressive type**
    - **Rationale**: The patient meets DSM-5-TR criteria for **schizoaffective disorder, depressive type**: a 6-month period with a major depressive episode (low mood, anhedonia, insomnia for 4 months) concurrent with Criterion A schizophrenia symptoms (delusions, hallucinations). The 1-month period of hallucinations without mood symptoms satisfies the requirement for psychosis independent of mood for ≥2 weeks. Mood symptoms dominate most of the illness (4/6 months), and the duration exceeds 6 months, ruling out briefer disorders. This aligns with PMHNP diagnostic precision for complex psychosis-mood presentations.
    - **Why It's High-Yield**: Tests differentiation of schizoaffective disorder by mood duration and independent psychosis, a core PMHNP exam skill.
- **A. Delusional disorder, persecutory type**
    - **Rationale**: Delusional disorder involves non-bizarre delusions (e.g., being plotted against) without prominent mood symptoms or hallucinations. The patient's significant depression (4 months) and hallucinations exclude this diagnosis.
    - **Exam Tip**: Delusional disorder lacks major mood episodes or prominent hallucinations.

- **B. Brief psychotic disorder with marked stressors**
    - **Rationale**: Brief psychotic disorder requires psychosis lasting <1 month with full recovery. The 6-month duration and persistent mood symptoms rule this out, and no clear stressor is noted.
    - **Exam Tip**: Duration is key—brief psychotic disorder is <1 month.
- **D. Bipolar I disorder with psychotic features**
    - **Rationale**: Bipolar I requires manic or mixed episodes, but the patient has only depressive symptoms. Psychosis occurs independently of mood for 1 month, which is inconsistent with bipolar's mood-tied psychosis.
    - **Exam Tip**: Bipolar psychosis occurs only during mood episodes, unlike schizoaffective.

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**Six Medications for Pediatric Patients: Clonidine, Guanfacine, Adderall, Vyvanse, Strattera, and Ritalin**

***Overview***

In pediatric psychiatry, **clonidine**, **guanfacine**, **Adderall**, **Vyvanse**, **Strattera**, and **Ritalin** are commonly used to manage conditions like attention-deficit/hyperactivity disorder (ADHD), disruptive behavior disorders, and related symptoms (e.g., aggression, impulsivity). PMHNPs must understand each medication's indications, optimal administration timing, and key teaching points to ensure safe use, minimize side effects, and promote adherence in children. This review provides a structured guide for what each medication is, when to give it, and what to teach parents and patients, emphasizing pediatric-specific considerations.

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**Major Points**

1. **Clonidine (Catapres)**:
    - **What**:
        - **Class**: Alpha-2 adrenergic agonist.
        - **Indications**: ADHD (FDA-approved for ages ≥6), aggression, tics, or sleep disturbances (off-label in pediatrics).
        - **Mechanism**: Stimulates alpha-2 receptors, reducing norepinephrine release, calming hyperactivity and agitation.
        - **Forms/Dosing**: Tablets (0.1–0.3 mg/day, divided 2–3 times daily); transdermal patch (0.1–0.3 mg/day, weekly). Typical starting dose: 0.05 mg at bedtime, titrated slowly.

- **When to Give**:
    - **Tablets**: Evening or bedtime to leverage sedative effects; may divide doses (e.g., morning and evening) for daytime ADHD control.
    - **Patch**: Apply weekly to hairless skin (e.g., upper arm), rotating sites to avoid irritation.
    - **Rationale**: Evening dosing minimizes daytime sedation; consistent timing prevents rebound hypertension.
- **What to Teach**:
    - **Parents**: Monitor for sedation, hypotension (e.g., dizziness), or bradycardia; avoid abrupt discontinuation to prevent rebound hypertension. Report mood changes or irritability.
    - **Patients**: Take at bedtime to help with sleep; avoid removing the patch without guidance.
    - **Safety**: Check blood pressure regularly; taper off slowly if stopping (e.g., reduce by 0.05 mg every 3–7 days).

2. **Guanfacine (Intuniv, Tenex)**:
    - **What**:
        - **Class**: Alpha-2 adrenergic agonist.
        - **Indications**: ADHD (FDA-approved for ages 6–17, Intuniv ER); off-label for aggression, tics.
        - **Mechanism**: Similar to clonidine, reduces norepinephrine, improving attention and impulse control.
        - **Forms/Dosing**: Extended-release (Intuniv, 1–4 mg/day, once daily); immediate-release (Tenex, 0.5–2 mg/day, divided). Start at 1 mg daily, titrate weekly.
    - **When to Give**:
        - **Extended-Release**: Morning or evening (consistent time); evening preferred if sedation is prominent.
        - **Immediate-Release**: Divided doses (morning/evening) to minimize peak sedation.
        - **Rationale**: Once-daily ER dosing improves adherence; timing adjusts for sedation tolerance.
    - **What to Teach**:
        - **Parents**: Watch for sedation, hypotension, or fatigue; avoid abrupt cessation to prevent rebound symptoms. Report mood worsening or fainting.

        - **Patients**: Take with a small snack to reduce stomach upset; don't skip doses.
        - **Safety**: Monitor BP and heart rate; avoid dehydration, which exacerbates hypotension.

3. **Adderall (Amphetamine Salts)**:
    - **What**:
        - **Class**: CNS stimulant (Schedule II).
        - **Indications**: ADHD (FDA-approved for ages ≥3); narcolepsy (less common).
        - **Mechanism**: Increases dopamine and norepinephrine, improving focus and reducing impulsivity.
        - **Forms/Dosing**: Immediate-release (5–40 mg/day, divided 1–3 times); extended-release (Adderall XR, 5–30 mg/day, once daily). Start at 5 mg daily for ages 3–5, 10 mg for ≥6.
    - **When to Give**:
        - **Immediate-Release**: Morning and early afternoon to avoid insomnia; avoid evening doses.
        - **Extended-Release**: Morning for all-day coverage.
        - **Rationale**: Stimulants peak quickly; evening doses disrupt sleep.
    - **What to Teach**:
        - **Parents**: Monitor for appetite suppression, weight loss, insomnia, or increased irritability/aggression. Report signs of abuse (e.g., euphoria) or cardiovascular issues (e.g., palpitations).
        - **Patients**: Take in the morning; eat breakfast to maintain appetite.
        - **Safety**: Baseline ECG for cardiac risk; monitor growth curves; avoid in anxiety or tic disorders if symptoms worsen.

4. **Vyvanse (Lisdexamfetamine)**:
    - **What**:
        - **Class**: CNS stimulant (Schedule II).
        - **Indications**: ADHD (FDA-approved for ages ≥6); binge-eating disorder (adolescents ≥12, less common).
        - **Mechanism**: Prodrug of dextroamphetamine, increasing dopamine/norepinephrine with smoother onset, reducing abuse potential.
        - **Forms/Dosing**: Capsules (10–70 mg/day, once daily). Start at 20–30 mg daily, titrate by 10–20 mg weekly.

- **When to Give**:
    - Morning, with or without food, to provide all-day symptom control and avoid insomnia.
    - **Rationale**: Long-acting (10–12 hours), minimizing need for multiple doses.
- **What to Teach**:
    - **Parents**: Monitor for appetite loss, insomnia, or mood changes; report cardiovascular symptoms (e.g., chest pain). Store securely due to abuse potential.
    - **Patients**: Swallow capsule whole or mix contents in water; take early to avoid sleep issues.
    - **Safety**: Screen for cardiac history; monitor weight/growth; taper if stopping to avoid withdrawal.

5. **Strattera (Atomoxetine)**:
    - **What**:
        - **Class**: Selective norepinephrine reuptake inhibitor (non-stimulant).
        - **Indications**: ADHD (FDA-approved for ages ≥6).
        - **Mechanism**: Increases norepinephrine, enhancing attention and impulse control; less effect on dopamine, reducing abuse potential.
        - **Forms/Dosing**: Capsules (10–100 mg/day, once or twice daily). Start at 0.5 mg/kg/day, target 1.2 mg/kg/day, max 100 mg.
    - **When to Give**:
        - Morning or split morning/evening; evening dosing may help with daytime sedation.
        - **Rationale**: Steady-state effect (2–4 weeks) allows flexible timing; split dosing reduces side effects.
    - **What to Teach**:
        - **Parents**: Expect 2–4 weeks for full effect; monitor for suicidal ideation (FDA black box warning), liver issues, or mood changes. Report fatigue or jaundice.
        - **Patients**: Take consistently; report stomach upset or dark urine.
        - **Safety**: Monitor for suicidality (C-SSRS); check liver function if symptoms arise.

6. **Ritalin (Methylphenidate)**:

    - **What**:

        - **Class**: CNS stimulant (Schedule II).
        - **Indications**: ADHD (FDA-approved for ages ≥6); narcolepsy.
        - **Mechanism**: Blocks dopamine/norepinephrine reuptake, improving focus and reducing hyperactivity.
        - **Forms/Dosing**: Immediate-release (5–60 mg/day, divided 2–3 times); extended-release (e.g., Concerta, 18–54 mg/day, once daily). Start at 5 mg twice daily.

    - **When to Give**:

        - **Immediate-Release**: Morning and early afternoon to avoid insomnia.
        - **Extended-Release**: Morning for sustained coverage.
        - **Rationale**: Avoid evening doses to prevent sleep disruption.

    - **What to Teach**:

        - **Parents**: Monitor for appetite suppression, weight loss, or tics; report palpitations or agitation. Secure storage to prevent misuse.
        - **Patients**: Take with breakfast; avoid late doses to sleep well.
        - **Safety**: Baseline ECG; monitor growth; avoid in patients with severe anxiety or tics.

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**Safety Issues**

1. **Polypharmacy Risks**:

    - Combining clonidine/guanfacine (sedation, hypotension) with stimulants (agitation, insomnia) increases adverse effects, as seen in polypharmacy cases.
    - **Mitigation**: Review necessity of each medication; taper redundant drugs (e.g., clonidine if guanfacine suffices).

2. **Suicide Risk**:

    - Strattera and stimulants carry FDA black box warnings for suicidality in children; monitor closely, especially with aggression or mood changes.
    - **Mitigation**: Use C-SSRS; educate parents on warning signs.

3. **Cardiovascular Risks**:
    - Stimulants (Adderall, Vyvanse, Ritalin) increase heart rate/BP; clonidine/guanfacine lower BP/HR, risking additive effects.
    - **Mitigation**: Obtain baseline ECG, monitor vitals, and avoid in high-risk cardiac cases.
4. **Growth and Development**:
    - Stimulants suppress appetite, risking weight loss and growth delay in children.
    - **Mitigation**: Track growth curves; consider drug holidays if appropriate.

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**High-Yield Information**

- **Key Features**:
    - **Clonidine/Guanfacine**: Non-stimulants for ADHD/aggression; sedating, given evening/morning.
    - **Adderall/Vyvanse/Ritalin**: Stimulants for ADHD; morning dosing to avoid insomnia.
    - **Strattera**: Non-stimulant for ADHD; slower onset, flexible timing.
- **Applications**:
    - Diagnostic: Confirm ADHD or comorbidity (e.g., ODD) before prescribing.
    - Therapeutic: Prioritize non-stimulants for stimulant-intolerant patients; combine with behavioral therapy.
    - Teaching: Emphasize adherence, side effect monitoring, and secure storage.
- **Exam Pearls**:
    - Know FDA approvals: Clonidine/guanfacine (≥6), Adderall (≥3), Vyvanse/Ritalin/Strattera (≥6).
    - Questions test dosing timing, side effects, and parent education.
    - Stimulants carry abuse potential; non-stimulants are safer for substance risk.

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**Role of the PMHNP**

- **Assessment**: Confirm diagnoses (e.g., ADHD, ODD) with tools (e.g., Vanderbilt); review medication necessity.
- **Intervention**: Optimize dosing, monitor side effects, and integrate behavioral therapy.

- **Education**: Teach parents/patients about timing, side effects, and safety (e.g., secure storage).
- **Advocacy**: Promote access to pediatric mental health services, reducing reliance on medications.

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**Question**:

A 7-year-old male with ADHD is prescribed guanfacine 1 mg ER daily, Adderall 10 mg XR daily, and melatonin 3 mg at bedtime. The parents report difficulty remembering dosing schedules and are concerned about daytime sleepiness. Which of the following is the most appropriate action to optimize treatment and provide education for this pediatric patient?

A. Increase Adderall to 15 mg XR to improve focus and reduce sleepiness.
B. Switch guanfacine to immediate-release and administer twice daily.
C. Educate parents to give guanfacine and melatonin at bedtime and Adderall in the morning, monitoring for sedation.
D. Discontinue melatonin and replace with clonidine 0.1 mg at bedtime for sleep.

**Correct Answer**:

**C. Educate parents to give guanfacine and melatonin at bedtime and Adderall in the morning, monitoring for sedation.**

*Rationales*

- **Correct Answer: C. Educate parents to give guanfacine and melatonin at bedtime and Adderall in the morning, monitoring for sedation**
    - **Rationale**: Guanfacine (sedating, used for ADHD) and melatonin (sleep aid) are best given at bedtime to leverage their sedative effects and address the parents' concern about daytime sleepiness. Adderall (stimulant) should be given in the morning to improve focus without disrupting sleep. Educating parents on this schedule optimizes efficacy, minimizes sedation during school hours, and ensures adherence. Monitoring for sedation addresses guanfacine's side effects, aligning with PMHNP roles in pediatric psychopharmacology and parent education.
    - **Why It's High-Yield**: Tests knowledge of medication timing, side effect management, and parent education, key PMHNP competencies.

- **A. Increase Adderall to 15 mg XR to improve focus and reduce sleepiness**
    - **Rationale**: Increasing Adderall may worsen insomnia or agitation without addressing guanfacine's sedative contribution to sleepiness. It ignores the need for proper timing and education, which is the priority.
    - **Exam Tip**: Avoid dose escalation before optimizing administration and assessing side effects.
- **B. Switch guanfacine to immediate-release and administer twice daily**
    - **Rationale**: Switching to immediate-release guanfacine increases dosing frequency, complicating adherence for parents already struggling with schedules. It may also worsen daytime sedation, as ER forms are designed for once-daily use.
    - **Exam Tip**: Extended-release forms improve adherence in pediatrics—consider timing first.
- **D. Discontinue melatonin and replace with clonidine 0.1 mg at bedtime for sleep**
    - **Rationale**: Adding clonidine introduces polypharmacy risks (redundant with guanfacine, increasing sedation/hypotension) without addressing the current regimen's timing issues. Melatonin is safer for sleep in children.
    - **Exam Tip**: Avoid adding medications when optimizing existing ones suffices.

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**Anxiety Disorders in the DSM-5-TR**

The DSM-5-TR categorizes anxiety disorders as conditions characterized by excessive fear or anxiety, often leading to avoidance behaviors and significant distress or impairment. These disorders are highly prevalent in psychiatric practice, and PMHNPs must master their identification, differential diagnosis, and management to provide effective care. This review details the diagnostic criteria, clinical features, and PMHNP considerations for all anxiety disorders listed in the DSM-5-TR, with a focus on pediatric and adult presentations relevant to certification exams.

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**Major Points**

1. **Separation Anxiety Disorder**:
    - **DSM-5-TR Criteria**:
        - A. Excessive fear/anxiety about separation from attachment figures (e.g., parents, caregivers), with ≥3 of 8 symptoms: distress when separated,

worry about losing attachment figures, fear of being alone, refusal to sleep away, nightmares about separation, somatic complaints (e.g., headaches), reluctance to leave home, or fear of harm to attachment figures.
    - B. Symptoms last ≥4 weeks in children/adolescents or ≥6 months in adults.
    - C. Causes significant distress or impairment.
    - D. Not better explained by another disorder (e.g., autism, psychosis).

- **Key Features**:

    - Common in children (onset ~7–12 years) but can occur in adults.
    - Symptoms: Clinging to parents, school refusal, somatic complaints (e.g., stomachaches).
    - Prevalence: ~4% in children, ~1–2% in adults.

- **PMHNP Relevance**:

    - Screen with tools like SCARED (Screen for Child Anxiety Related Disorders).
    - Treatment: CBT (first-line), SSRIs (e.g., fluoxetine) for severe cases.
    - Assess for school avoidance or family dynamics exacerbating symptoms.

2. **Selective Mutism**:

- **DSM-5-TR Criteria**:

    - A. Consistent failure to speak in specific social situations (e.g., school) despite speaking in others (e.g., home).
    - B. Interferes with educational/occupational achievement or social communication.
    - C. Duration ≥1 month (not limited to first month of school).
    - D. Not due to language barriers, communication disorders, or other mental disorders (e.g., autism).

- **Key Features**:

    - Onset typically in early childhood (~2–5 years), often noticed in school settings.
    - Not shyness but anxiety-driven; children may use nonverbal communication.
    - Prevalence: ~0.5–1%, more common in girls.

- **PMHNP Relevance**:

    - Screen with parent/teacher reports; assess for social anxiety overlap.

        - Treatment: Behavioral therapy (e.g., gradual exposure), SSRIs for severe cases.
        - Collaborate with schools for accommodations (e.g., nonverbal responses).

3. **Specific Phobia**:
    - **DSM-5-TR Criteria**:
        - A. Marked fear/anxiety about a specific object or situation (e.g., heights, animals, needles).
        - B. Object/situation almost always provokes immediate fear/anxiety.
        - C. Fear is out of proportion to actual danger.
        - D. Fear leads to avoidance or is endured with intense distress.
        - E. Symptoms last ≥6 months.
        - F. Causes significant distress or impairment.
        - G. Not better explained by other disorders.
    - **Key Features**:
        - Types: Animal, natural environment, blood-injection-injury, situational, other.
        - Onset: Childhood (~7–11 years) or early adulthood; persists if untreated.
        - Prevalence: ~12% lifetime, higher in females.
    - **PMHNP Relevance**:
        - Treatment: Exposure-based CBT (first-line); short-term benzodiazepines rarely used in children.
        - Assess for functional impairment (e.g., avoiding medical procedures).
4. **Social Anxiety Disorder (Social Phobia)**:
    - **DSM-5-TR Criteria**:
        - A. Marked fear/anxiety about social situations involving scrutiny (e.g., speaking, socializing).
        - B. Fear of negative evaluation (e.g., embarrassment, rejection).
        - C. Social situations provoke fear/anxiety and are avoided or endured with distress.
        - D. Fear is disproportionate to threat.
        - E. Symptoms last ≥6 months.
        - F. Causes significant distress or impairment.
        - G. Not due to substances, medical conditions, or other disorders.

- **Key Features**:
    - Onset: Adolescence (~10–15 years), often persists into adulthood.
    - Symptoms: Blushing, trembling, avoidance of social settings (e.g., school presentations).
    - Prevalence: ~13% lifetime.
- **PMHNP Relevance**:
    - Screen with GAD-7 or Liebowitz Social Anxiety Scale.
    - Treatment: CBT (social skills training), SSRIs (e.g., sertraline) for moderate-severe cases.
    - Assess for bullying or social stressors.

5. **Panic Disorder**:
    - **DSM-5-TR Criteria**:
        - A. Recurrent unexpected panic attacks (sudden surge of intense fear with ≥4 symptoms: palpitations, sweating, trembling, shortness of breath, chest pain, nausea, dizziness, chills/heat, paresthesias, derealization, fear of losing control, fear of dying).
        - B. ≥1 attack followed by ≥1 month of persistent worry about additional attacks or maladaptive behavior (e.g., avoidance).
        - C. Not due to substances, medical conditions, or other disorders.
    - **Key Features**:
        - Onset: Late adolescence to early adulthood (~15–25 years), rare in young children.
        - Symptoms: Sudden panic, anticipatory anxiety, agoraphobia (fear of situations where escape is difficult).
        - Prevalence: ~2–3% lifetime.
    - **PMHNP Relevance**:
        - Treatment: CBT (exposure, cognitive restructuring), SSRIs (e.g., escitalopram); avoid long-term benzodiazepines.
        - Rule out medical causes (e.g., thyroid, cardiac) with labs.

6. **Agoraphobia**:
    - **DSM-5-TR Criteria**:
        - A. Marked fear/anxiety about ≥2 situations: public transportation, open spaces, enclosed places, lines/crowds, being outside alone.

        - B. Fear of inability to escape or get help in case of panic or embarrassment.
        - C. Situations provoke fear/anxiety, are avoided or endured with distress.
        - D. Fear is disproportionate to danger.
        - E. Symptoms last ≥6 months.
        - F. Causes significant distress or impairment.
        - G. Not due to other disorders or conditions.

    - **Key Features**:
        - Onset: Late adolescence to early adulthood (~20–30 years).
        - Often co-occurs with panic disorder; can be standalone.
        - Prevalence: ~1–2% lifetime.

    - **PMHNP Relevance**:

        - Treatment: CBT (exposure-based), SSRIs for severe cases.
        - Assess for functional impairment (e.g., inability to leave home).

7. **Generalized Anxiety Disorder (GAD)**:

    - **DSM-5-TR Criteria**:

        - A. Excessive anxiety/worry about multiple events/activities, occurring more days than not for ≥6 months.
        - B. Worry is difficult to control.
        - C. Associated with ≥3 (adults) or ≥1 (children) symptoms: restlessness, fatigue, poor concentration, irritability, muscle tension, sleep disturbance.
        - D. Causes significant distress or impairment.
        - E. Not due to substances, medical conditions, or other disorders.

    - **Key Features**:

        - Onset: Childhood to adulthood (~11–30 years), often chronic.
        - Symptoms: Persistent worry, somatic complaints (e.g., tension headaches).
        - Prevalence: ~6% lifetime.

    - **PMHNP Relevance**:

        - Screen with GAD-7; assess for comorbidities (e.g., depression).
        - Treatment: CBT (first-line), SSRIs (e.g., sertraline), buspirone for adults.

8. **Substance/Medication-Induced Anxiety Disorder**:

    - **DSM-5-TR Criteria**:

        - A. Prominent anxiety or panic attacks predominant in clinical picture.

        - B. Evidence of substance intoxication/withdrawal or medication use temporally related to symptoms.
        - C. Not better explained by another anxiety disorder.
        - D. Does not occur only during delirium.

    - **Key Features**:

        - Onset: Any age, tied to substance use (e.g., caffeine, amphetamines, cannabis withdrawal).
        - Symptoms: Mimic other anxiety disorders but resolve with substance cessation.
        - Prevalence: Varies by substance; common in substance use populations.

    - **PMHNP Relevance**:

        - Screen with toxicology; assess medication history (e.g., corticosteroids).
        - Treatment: Address substance use (e.g., detox, CBT); avoid anxiolytics long-term.

9. **Anxiety Disorder Due to Another Medical Condition**:

    - **DSM-5-TR Criteria**:

        - A. Prominent anxiety or panic attacks.
        - B. Evidence that symptoms are direct consequence of a medical condition (e.g., hyperthyroidism, pheochromocytoma).
        - C. Not better explained by another mental disorder.
        - D. Does not occur only during delirium.

    - **Key Features**:

        - Onset: Any age, tied to medical condition onset.
        - Symptoms: Mimic GAD or panic disorder; resolve with medical treatment.
        - Prevalence: Rare, depends on condition.

    - **PMHNP Relevance**:

        - Order labs (e.g., TSH, cortisol) to rule out medical causes.
        - Treatment: Address underlying condition; temporary SSRIs or therapy if needed.

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**Safety Issues**

1. **Suicide Risk**:
    - Anxiety disorders, especially GAD and social anxiety, increase suicidality risk (~5–10% ideation in adolescents).
    - **Mitigation**: Screen with C-SSRS; implement safety plans.
2. **Medication Safety**:
    - SSRIs (e.g., sertraline) carry FDA black box warnings for suicidality in children/adolescents (<25 years).
    - Benzodiazepines risk dependence, cognitive impairment; contraindicated long-term in pediatrics.
    - **Mitigation**: Start SSRIs low, monitor closely; avoid benzodiazepines except in acute crises.
3. **Medical Misdiagnosis**:
    - Anxiety symptoms (e.g., palpitations, shortness of breath) may mimic medical conditions (e.g., cardiac, thyroid).
    - **Mitigation**: Order labs (e.g., CBC, TSH) and rule out substance/medical causes.
4. **Functional Impairment**:
    - School refusal (separation anxiety, social anxiety) or avoidance (agoraphobia) disrupts development.
    - **Mitigation**: Collaborate with schools for accommodations; prioritize CBT.

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**High-Yield Information**

- **Key Features**:
    - **Separation Anxiety**: Fear of separation, common in children (~7–12 years).
    - **Selective Mutism**: Anxiety-driven silence in specific settings (~2–5 years).
    - **Specific Phobia**: Fear of specific objects/situations (~7–11 years).
    - **Social Anxiety**: Fear of scrutiny (~10–15 years).
    - **Panic Disorder**: Unexpected panic attacks (~15–25 years).
    - **Agoraphobia**: Fear of escape-limited situations (~20–30 years).
    - **GAD**: Chronic worry (~11–30 years).
- **Applications**:
    - Diagnostic: Use DSM-5-TR criteria, screening tools (e.g., GAD-7, SCARED).

    - Therapeutic: CBT (first-line), SSRIs for moderate-severe cases; avoid benzodiazepines.
    - Preventive: Early intervention reduces chronicity (e.g., CBT for phobias).

- **Exam Pearls**:
    - Know onset ages and duration criteria (e.g., ≥6 months for GAD, phobia; ≥1 month for selective mutism).
    - Questions test differential diagnosis (e.g., anxiety vs. medical, substance-induced).
    - CBT is first-line for all anxiety disorders in children/adults.

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**Role of the PMHNP**

- **Assessment**: Use validated tools (e.g., GAD-7, SCARED) and history to differentiate anxiety disorders.
- **Intervention**: Prioritize CBT; use SSRIs cautiously in pediatrics; address medical/substance causes.
- **Education**: Teach patients/families about anxiety triggers and treatment benefits.
- **Advocacy**: Promote school-based mental health programs for early detection.

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**Question**:

A 12-year-old female presents with excessive worry about school performance, difficulty concentrating, and muscle tension for 7 months, reporting frequent stomachaches. She denies specific triggers or panic attacks. Her parents note she avoids social events due to fear of embarrassment. According to DSM-5-TR criteria, which of the following is the most likely diagnosis?

A. Panic disorder.
B. Separation anxiety disorder.
C. Generalized anxiety disorder and social anxiety disorder.
D. Specific phobia, situational type.

**Correct Answer**:

**C. Generalized anxiety disorder and social anxiety disorder.**

*Rationales*

- **Correct Answer: C. Generalized anxiety disorder and social anxiety disorder**
    - **Rationale**: The patient's excessive worry, difficulty concentrating, muscle tension, and somatic complaints (stomachaches) for 7 months meet DSM-5-TR criteria for **generalized anxiety disorder (GAD)** (Criterion A: excessive worry, Criterion C: ≥1 symptom in children, ≥6 months). Her avoidance of social events due to fear of embarrassment aligns with **social anxiety disorder** (Criterion A: fear of scrutiny, Criterion C: avoidance, ≥6 months). Comorbidity is common in anxiety disorders, and the symptoms fit both diagnoses, guiding PMHNP assessment and treatment (e.g., CBT, possible SSRI).
    - **Why It's High-Yield**: Tests recognition of multiple anxiety disorders and DSM-5-TR criteria application, a key PMHNP exam skill.
- **A. Panic disorder**
    - **Rationale**: Panic disorder requires recurrent unexpected panic attacks with persistent worry or behavior change, which are absent here (no panic attacks reported). The chronic worry and social avoidance better fit GAD and social anxiety.
    - **Exam Tip**: Panic disorder involves discrete attacks, not generalized worry.
- **B. Separation anxiety disorder**
    - **Rationale**: Separation anxiety requires fear of separation from attachment figures (e.g., parents), with symptoms like school refusal or nightmares, not present here. The patient's worry is about performance and social scrutiny, not separation.
    - **Exam Tip**: Check for separation-specific fears in children.
- **D. Specific phobia, situational type**
    - **Rationale**: Specific phobia involves fear of a specific object/situation (e.g., public speaking), not broad social scrutiny or generalized worry. The patient's symptoms are broader, fitting GAD and social anxiety.
    - **Exam Tip**: Specific phobias are narrowly focused, unlike GAD's diffuse worry.

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**Obsessive-Compulsive Disorder (OCD) in the DSM-5-TR**

Obsessive-Compulsive Disorder (OCD) is a mental health condition characterized by persistent, intrusive thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) performed to alleviate anxiety or prevent a feared outcome. For PMHNPs, accurate identification of OCD is critical for differential diagnosis, treatment planning, and addressing associated distress, particularly in psychiatric settings where OCD may co-occur with anxiety, depression, or other

disorders. This review details the DSM-5-TR diagnostic criteria, clinical features, and practical considerations for PMHNPs, with a focus on both pediatric and adult presentations.

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**Major Points**

1. **DSM-5-TR Diagnostic Criteria for OCD**:
    - **A. Presence of obsessions, compulsions, or both**:
        - **Obsessions**:
            1. Recurrent, persistent thoughts, urges, or images experienced as intrusive and unwanted, causing marked anxiety or distress.
            2. Attempts to ignore, suppress, or neutralize them with another thought or action (e.g., compulsion).
        - **Compulsions**:
            1. Repetitive behaviors (e.g., hand-washing, checking) or mental acts (e.g., counting, repeating words) performed in response to an obsession or rigid rules.
            2. Aimed at preventing/reducing anxiety or a dreaded event, though not realistically connected or excessive.
    - **B. Time-consuming** (e.g., >1 hour/day) or cause clinically significant distress or impairment in social, occupational, or other functioning.
    - **C. Not attributable to substances (e.g., drugs), medical conditions, or another mental disorder.**
    - **D. Not better explained by another mental disorder** (e.g., GAD's excessive worry, body dysmorphic disorder's appearance preoccupations, or schizophrenia's delusions).
    - **Specifiers**:
        - Insight: Good/fair (recognizes beliefs as irrational), poor (believes obsessions are true), or absent (convinced obsessions are true).
        - Tic-related: Presence of motor/vocal tics (e.g., Tourette's syndrome).
    - **Prevalence**: ~1.1–1.8% lifetime; affects children and adults, with bimodal onset (~8–12 years and early adulthood ~18–25 years).

2. **Clinical Features**:

    - **Obsessions**: Common themes include contamination (e.g., germs), harm (e.g., hurting others), symmetry (e.g., need for order), or forbidden thoughts (e.g., sexual, religious).
    - **Compulsions**: Common behaviors include washing, checking, ordering, counting, or mental rituals (e.g., silent prayers). May be overt (visible) or covert (mental).
    - **Pediatric Features**: Children may show less insight, with compulsions like excessive reassurance-seeking or ritualized play. Onset often linked to stressors (e.g., school transitions).
    - **Adult Features**: More complex obsessions (e.g., moral scrupulosity) and higher insight; may impair work or relationships.
    - **Comorbidities**: Common with anxiety disorders (~75%), depression (~50%), ADHD (~20%), or tic disorders.

3. **Differential Diagnosis**:

    - **Generalized Anxiety Disorder (GAD)**: Excessive worry about multiple issues, not specific intrusive thoughts or ritualized compulsions.
    - **Body Dysmorphic Disorder**: Preoccupation with perceived physical flaws, not broader obsessive themes.
    - **Obsessive-Compulsive Personality Disorder (OCPD)**: Rigid personality traits (e.g., perfectionism) without intrusive obsessions or compulsions.
    - **Schizophrenia/Schizoaffective Disorder**: Delusions or hallucinations dominate; OCD obsessions are ego-dystonic (unwanted) and lack psychotic features.
    - **Tic Disorders**: Motor/vocal tics, not anxiety-driven rituals; may co-occur with OCD.
    - **Medical Causes**: Rule out neurological conditions (e.g., temporal lobe epilepsy) or substance-induced symptoms (e.g., stimulants).

4. **Mental Health Applications**:

    - **Diagnosis**: Use validated tools like the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) or Children's Y-BOCS for severity; clinical interview to confirm DSM-5-TR criteria.

    - **Treatment**:

        - **First-Line**: Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP), where patients confront obsessions without performing compulsions.
        - **Pharmacotherapy**: SSRIs (e.g., sertraline, fluoxetine) at higher doses (e.g., sertraline 100–200 mg/day); clomipramine (tricyclic) for treatment-resistant cases.
        - **Adjunctive**: Atypical antipsychotics (e.g., risperidone) for severe cases or tic-related OCD.

        - **Pediatric**: ERP is preferred; SSRIs used cautiously with close monitoring (FDA black box warning for suicidality in <25 years).

    - **Prognosis**: Chronic but manageable; ERP achieves ~60% symptom reduction, per 2024 *Journal of Anxiety Disorders*.

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**Safety Issues**

1. **Suicide Risk**:
    - OCD patients, especially with comorbid depression, have elevated suicide risk (~10% ideation, higher in adolescents).
    - **Mitigation**: Screen with C-SSRS; address severe distress or guilt-themed obsessions.

2. **Medication Safety**:

    - SSRIs may increase agitation or suicidality in children/young adults; clomipramine risks cardiac side effects (e.g., QT prolongation).
    - **Mitigation**: Start low (e.g., sertraline 25 mg/day), monitor weekly initially, and obtain ECG for clomipramine.

3. **Functional Impairment**:

    - Time-consuming rituals (e.g., hours spent checking) disrupt school, work, or relationships, increasing distress.
    - **Mitigation**: Prioritize ERP; collaborate with schools for accommodations in pediatric cases.

4. **Misdiagnosis**:

    - OCD rituals may be mistaken for tics, GAD worry, or psychotic delusions, delaying treatment.
    - **Mitigation**: Use Y-BOCS and assess insight to differentiate.

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**High-Yield Information**

- **Key Features**:

    - OCD: Intrusive obsessions + repetitive compulsions, time-consuming (>1 hour/day).
    - Onset: Bimodal (~8–12 years, ~18–25 years); children show less insight.

- **Applications**:
    - Diagnostic: Confirm with Y-BOCS, rule out medical causes (e.g., brain lesions).
    - Therapeutic: ERP (first-line), SSRIs (higher doses), adjunctive antipsychotics.
    - Preventive: Early ERP reduces chronicity and comorbidity risk.
- **Exam Pearls**:
    - OCD obsessions are ego-dystonic (unwanted), unlike OCPD traits or psychotic delusions.
    - Questions test ERP as first-line, SSRI dosing, and differential diagnosis.
    - Insight specifier (good/poor/absent) impacts treatment engagement.

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**Role of the PMHNP**

- **Assessment**: Use Y-BOCS and clinical interviews to confirm OCD and assess severity/insight.
- **Intervention**: Implement ERP, initiate SSRIs cautiously, and monitor for side effects.
- **Education**: Teach patients/families about OCD's neurobiological basis and ERP's effectiveness.
- **Advocacy**: Promote access to specialized CBT/ERP therapists, especially for children.

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**Question**:

A 14-year-old male presents with intrusive thoughts about harming his family, spending 2 hours daily checking locks to prevent "bad things" from happening. He recognizes the thoughts as irrational but feels compelled to perform rituals, causing school absences. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Generalized anxiety disorder; start buspirone 5 mg BID.
B. Schizophrenia; initiate risperidone 0.5 mg daily.
C. Obsessive-compulsive disorder; refer for CBT with exposure and response prevention.
D. Body dysmorphic disorder; start fluoxetine 10 mg daily.

**Correct Answer**:

**C. Obsessive-compulsive disorder; refer for CBT with exposure and response prevention.**

*Rationales*

- **Correct Answer: C. Obsessive-compulsive disorder; refer for CBT with exposure and response prevention**
    - **Rationale**: The patient's intrusive thoughts (harm obsessions) and repetitive checking (compulsions) lasting 2 hours daily, causing distress and impairment (school absences), meet DSM-5-TR criteria for **obsessive-compulsive disorder (OCD)**. His recognition of thoughts as irrational indicates good/fair insight, typical in adolescents. CBT with exposure and response prevention (ERP) is the first-line treatment, per 2024 *Journal of Anxiety Disorders*, as it directly addresses rituals by exposing the patient to obsessions without performing compulsions, achieving ~60% symptom reduction. This aligns with PMHNP priorities for pediatric OCD management.
    - **Why It's High-Yield**: Tests OCD diagnosis and ERP as first-line, a core PMHNP exam competency.
- **A. Generalized anxiety disorder; start buspirone 5 mg BID**
    - **Rationale**: GAD involves excessive worry about multiple issues, not specific intrusive thoughts or rituals. Buspirone is not first-line for pediatric GAD and ineffective for OCD's compulsive behaviors.
    - **Exam Tip**: GAD lacks ritualized compulsions—check for OCD-specific behaviors.
- **B. Schizophrenia; initiate risperidone 0.5 mg daily**
    - **Rationale**: Schizophrenia requires prominent delusions or hallucinations, not present here. The patient's thoughts are ego-dystonic (unwanted), not fixed beliefs, and his insight rules out psychosis. Risperidone is inappropriate without psychotic symptoms.
    - **Exam Tip**: OCD obsessions are intrusive, not delusional; schizophrenia onset is later (~18–25 years).
- **D. Body dysmorphic disorder; start fluoxetine 10 mg daily**
    - **Rationale**: Body dysmorphic disorder involves preoccupation with physical flaws, not harm-related obsessions or checking rituals. Fluoxetine may be used in OCD but is secondary to ERP, which is more effective initially.
    - **Exam Tip**: BDD focuses on appearance, not broad obsessive themes like harm.

**DSM-5-TR for PTSD, Acute Stress Disorder, and Adjustment Disorders**

***Overview***

The DSM-5-TR classifies **Posttraumatic Stress Disorder (PTSD)**, **Acute Stress Disorder (ASD)**, and **Adjustment Disorders** under Trauma- and Stressor-Related Disorders, characterized by psychological distress following exposure to stressors or traumatic events. For PMHNPs, accurate identification is critical for differential diagnosis, treatment planning, and addressing safety concerns, particularly in psychiatric settings where trauma-related symptoms are common. This review details the diagnostic criteria, clinical features, and practical considerations for each disorder, with a focus on pediatric and adult presentations relevant to certification exams.

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**Major Points**

1. **Posttraumatic Stress Disorder (PTSD)**:
    - **DSM-5-TR Criteria**:
        - **A. Exposure to Trauma**: Actual or threatened death, serious injury, or sexual violence (directly experienced, witnessed, learned about, or repeated exposure, e.g., first responders).
        - **B. Intrusion Symptoms** (≥1): Intrusive memories, nightmares, flashbacks, distress, or physiological reactions to trauma cues.
        - **C. Avoidance** (≥1): Avoiding trauma-related thoughts, feelings, or external reminders (e.g., places, people).
        - **D. Negative Alterations in Cognitions/Mood** (≥2): Inability to recall trauma details, negative beliefs (e.g., "I'm broken"), distorted blame, persistent negative emotions, diminished interest, detachment, or inability to experience positive emotions.
        - **E. Arousal/Reactivity** (≥2): Irritability, reckless behavior, hypervigilance, exaggerated startle, poor concentration, sleep disturbance.
        - **F. Duration**: Symptoms last >1 month.
        - **G. Causes significant distress or impairment**.
        - **H. Not due to substances, medical conditions**.
    - **Specifiers**: With dissociative symptoms (depersonalization/derealization); delayed expression (full criteria met after 6 months).
    - **Key Features**:
        - Onset: Any age post-trauma; median ~6 months after event, though delayed onset possible.
        - Symptoms: Intrusive memories, avoidance, hyperarousal, and negative mood changes.

        - Prevalence: ~6–8% lifetime; higher in trauma-exposed groups (e.g., veterans, abuse survivors).

    - **PMHNP Relevance**:

        - Screen with PC-PTSD-5 or PCL-5; assess for comorbidities (e.g., depression, substance use).
        - Treatment: Trauma-focused CBT (e.g., TF-CBT, EMDR), SSRIs (e.g., sertraline, paroxetine FDA-approved).
        - Monitor for suicide risk (~15% ideation in PTSD).

2. **Acute Stress Disorder (ASD)**:

    - **DSM-5-TR Criteria**:

        - **A. Exposure to Trauma**: Same as PTSD (death, injury, sexual violence).
        - **B. ≥9 Symptoms from 5 Categories** (present 3 days to 1 month post-trauma):

            1. Intrusion (e.g., flashbacks, nightmares).
            2. Negative mood (e.g., inability to feel positive emotions).
            3. Dissociative symptoms (e.g., numbing, derealization).
            4. Avoidance (e.g., avoiding trauma reminders).
            5. Arousal (e.g., hypervigilance, sleep disturbance).

        - **C. Causes significant distress or impairment**.
        - **D. Not due to substances, medical conditions, or other disorders**.

    - **Key Features**:

        - Onset: Within 3 days to 1 month post-trauma; resolves within 1 month or progresses to PTSD.
        - Symptoms: Similar to PTSD but shorter duration; dissociation prominent.
        - Prevalence: ~5–20% in trauma-exposed individuals, depending on trauma severity.

    - **PMHNP Relevance**:

        - Screen with Acute Stress Disorder Interview (ASDI); assess risk of PTSD progression.
        - Treatment: Brief CBT, supportive therapy; avoid benzodiazepines (may prolong symptoms).
        - Monitor for acute suicidality or dissociation.

3. **Adjustment Disorders**:

    - **DSM-5-TR Criteria**:

        - **A. Emotional/behavioral symptoms** within 3 months of an identifiable stressor (e.g., divorce, job loss).
        - **B. Symptoms are clinically significant**: Marked distress out of proportion to stressor or significant impairment in functioning.
        - **C. Does not meet criteria for another mental disorder** (e.g., PTSD, MDD).
        - **D. Not normal bereavement**.
        - **E. Symptoms resolve within 6 months** after stressor or consequences end (chronic if stressor persists).

    - **Subtypes**: With depressed mood, anxiety, mixed anxiety/depressed mood, conduct disturbance, mixed disturbance, unspecified.
    - **Key Features**:

        - Onset: Any age, within 3 months of stressor; resolves within 6 months of stressor cessation.
        - Symptoms: Emotional distress (e.g., sadness, worry), behavioral changes (e.g., aggression).
        - Prevalence: ~5–20% in outpatient settings; higher in adolescents with stressors.

    - **PMHNP Relevance**:

        - Screen with clinical interview; assess stressor impact and duration.
        - Treatment: Supportive therapy, brief CBT; medications (e.g., SSRIs) rarely needed.
        - Adolescents at higher risk for progression to MDD (~20–50%).

---

**Differential Diagnosis**

- **PTSD vs. ASD**: PTSD requires >1 month duration; ASD is 3 days to 1 month with ≥9 symptoms, often dissociative.
- **PTSD/ASD vs. Adjustment Disorder**: PTSD/ASD require traumatic exposure (death/injury/sexual violence); adjustment disorder follows non-traumatic stressors (e.g., divorce).
- **PTSD vs. MDD**: MDD lacks trauma exposure and intrusion symptoms; PTSD has specific trauma-related symptoms.
- **PTSD vs. GAD**: GAD involves generalized worry, not trauma-specific intrusion/avoidance.

- **ASD vs. Brief Psychotic Disorder**: ASD lacks psychotic symptoms (e.g., delusions); brief psychotic disorder is not trauma-specific.
- **Medical/Substance Causes**: Rule out delirium, substance-induced symptoms (e.g., alcohol withdrawal), or medical conditions (e.g., TBI) with labs (e.g., toxicology, imaging).

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**Safety Issues**

1. **Suicide Risk**:
    - PTSD and adjustment disorders (with depressed mood) increase suicidality (~10–15% ideation); ASD has acute risk due to dissociation.
    - **Mitigation**: Use C-SSRS; implement safety plans or hospitalization for severe cases.
2. **Dissociation**:
    - ASD and PTSD (dissociative specifier) may lead to derealization or self-harm, impairing safety.
    - **Mitigation**: Assess dissociation with DES-II; provide grounding techniques.
3. **Medication Safety**:
    - SSRIs (e.g., sertraline) carry suicidality risk in <25 years (FDA black box); benzodiazepines in ASD may worsen dissociation.
    - **Mitigation**: Start SSRIs low, monitor closely; avoid benzodiazepines in trauma disorders.
4. **Misdiagnosis**:
    - Mistaking adjustment disorder for PTSD or MDD delays targeted therapy; ASD may be overlooked as “normal” stress.
    - **Mitigation**: Use trauma history and symptom duration to differentiate.

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**High-Yield Information**

- **Key Features**:
    - **PTSD**: Trauma exposure, intrusion, avoidance, negative mood, arousal (>1 month).
    - **ASD**: Trauma exposure, ≥9 symptoms across 5 categories (3 days–1 month).

    - **Adjustment Disorder**: Non-traumatic stressor, distress/impairment (<6 months post-stressor).

- **Applications**:

    - Diagnostic: Use PC-PTSD-5 (PTSD), ASDI (ASD), clinical interview (adjustment disorder).
    - Therapeutic: Trauma-focused CBT/EMDR for PTSD/ASD; supportive therapy for adjustment disorder.
    - Preventive: Early intervention in ASD reduces PTSD progression (~50% risk).

- **Exam Pearls**:

    - Duration: ASD (3 days–1 month), PTSD (>1 month), adjustment disorder (within 3 months, resolves <6 months).
    - Trauma: PTSD/ASD require severe trauma; adjustment disorder does not.
    - Questions test differential diagnosis and treatment prioritization.

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**Role of the PMHNP**

- **Assessment**: Use validated tools (e.g., PCL-5, C-SSRS) and trauma history to differentiate disorders.
- **Intervention**: Prioritize trauma-focused therapies; use SSRIs cautiously; address safety risks.
- **Education**: Teach patients/families about trauma responses and treatment efficacy.
- **Advocacy**: Promote trauma-informed care and access to therapy for underserved groups.

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**Question**:

A 25-year-old female presents 2 weeks after a car accident with nightmares, flashbacks, avoidance of driving, hypervigilance, and emotional numbing. She reports intense distress and difficulty working. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Adjustment disorder with mixed anxiety and depressed mood; provide supportive therapy.
B. Generalized anxiety disorder; start sertraline 25 mg daily.

C. Acute stress disorder; initiate trauma-focused CBT and monitor for PTSD progression.
D. Posttraumatic stress disorder; prescribe prazosin 1 mg at bedtime for nightmares.

**Correct Answer**:

**C. Acute stress disorder; initiate trauma-focused CBT and monitor for PTSD progression.**

*Rationales*

- **Correct Answer: C. Acute stress disorder; initiate trauma-focused CBT and monitor for PTSD progression**
    - **Rationale**: The patient's symptoms (nightmares, flashbacks, avoidance, hypervigilance, numbing) 2 weeks post-trauma meet DSM-5-TR criteria for **acute stress disorder (ASD)**, requiring ≥9 symptoms across intrusion, negative mood, dissociation, avoidance, and arousal categories (3 days–1 month). Trauma-focused CBT is the first-line treatment, per 2024 *Journal of Traumatic Stress*, reducing symptoms and preventing PTSD progression (~50% risk). Monitoring is critical, as ASD may evolve into PTSD after 1 month.
    - **Why It's High-Yield**: Tests ASD diagnosis based on trauma and duration, with emphasis on trauma-focused therapy, a core PMHNP exam skill.
- **A. Adjustment disorder with mixed anxiety and depressed mood; provide supportive therapy**
    - **Rationale**: Adjustment disorder requires a non-traumatic stressor (e.g., job loss), not a traumatic event like a car accident. The patient's symptoms (flashbacks, hypervigilance) are trauma-specific, ruling out adjustment disorder. Supportive therapy is insufficient for ASD's severity.
    - **Exam Tip**: Adjustment disorder lacks trauma-specific symptoms like flashbacks.
- **B. Generalized anxiety disorder; start sertraline 25 mg daily**
    - **Rationale**: GAD involves chronic, generalized worry, not trauma-related symptoms like flashbacks or avoidance. Sertraline may be used later but is not first-line for ASD, which prioritizes CBT.
    - **Exam Tip**: GAD lacks trauma exposure and specific intrusion symptoms.
- **D. Posttraumatic stress disorder; prescribe prazosin 1 mg at bedtime for nightmares**
    - **Rationale**: PTSD requires symptoms >1 month; the patient's 2-week duration fits ASD. Prazosin targets nightmares but is not first-line for ASD, where trauma-focused CBT is preferred.
    - **Exam Tip**: Duration distinguishes ASD (<1 month) from PTSD (>1 month).

**DSM-5-TR Diagnoses for Presentation Following Spousal Loss**

**Overview**

The loss of a spouse is a significant stressor that can precipitate various psychiatric conditions, including **Adjustment Disorder**, **Major Depressive Disorder (MDD)**, **Persistent Complex Bereavement Disorder (PCBD)** (listed as a condition for further study in DSM-5-TR), **Posttraumatic Stress Disorder (PTSD)**, and **Acute Stress Disorder (ASD)**, depending on the presentation and duration of symptoms. For PMHNPs, accurately identifying these conditions is critical for differential diagnosis, treatment planning, and addressing safety concerns, particularly given the high emotional impact of spousal loss and associated risks (e.g., suicidality). This review details the DSM-5-TR criteria, clinical features, and practical considerations for these disorders in the context of spousal loss.

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**Major Points**

1. **Adjustment Disorder**:
    - **DSM-5-TR Criteria**:
        - **A. Emotional or behavioral symptoms** within 3 months of an identifiable stressor (e.g., spousal loss).
        - **B. Clinically significant symptoms**: Marked distress out of proportion to the expected reaction to the stressor or significant impairment in social, occupational, or other functioning.
        - **C. Does not meet criteria for another mental disorder** (e.g., MDD, PTSD).
        - **D. Not normal bereavement** (i.e., symptoms exceed typical grief in intensity or impairment).
        - **E. Symptoms resolve within 6 months** after the stressor or its consequences end (chronic if stressor persists).
    - **Subtypes**: With depressed mood, anxiety, mixed anxiety/depressed mood, conduct disturbance, mixed disturbance, unspecified.
    - **Key Features**:
        - Onset: Within 3 months of spousal loss; typically resolves within 6 months.
        - Symptoms: Sadness, anxiety, difficulty concentrating, social withdrawal, or mild irritability, disproportionate to expected grief.
        - Prevalence: ~5–20% in outpatient settings; common post-loss.

- **PMHNP Relevance**:
    - Screen with clinical interview; assess stressor impact and duration.
    - Treatment: Supportive therapy, brief CBT; medications (e.g., SSRIs) rarely needed unless severe.
    - Monitor for progression to MDD, especially in older adults (~10–20% risk).

2. **Major Depressive Disorder (MDD)**:
    - **DSM-5-TR Criteria**:
        - **A. ≥5 symptoms for ≥2 weeks**, including depressed mood or anhedonia: sadness, anhedonia, weight/appetite changes, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue, worthlessness/guilt, poor concentration, suicidal thoughts.
        - **B. Causes significant distress or impairment**.
        - **C. Not due to substances, medical conditions, or normal bereavement**.
    - **Key Features**:
        - Onset: Any time post-loss; may persist beyond 6 months, distinguishing from adjustment disorder.
        - Symptoms: Severe, pervasive depression, anhedonia, guilt (e.g., about surviving spouse), or suicidality, impairing functioning (e.g., inability to work).
        - Prevalence: ~10–15% post-bereavement, higher in older adults.
    - **PMHNP Relevance**:
        - Screen with PHQ-9 or GDS-15 (geriatric); assess suicide risk with C-SSRS.
        - Treatment: CBT, interpersonal therapy (IPT), SSRIs (e.g., sertraline); consider hospitalization for severe cases.
        - Differentiate from normal grief: MDD involves pervasive symptoms and significant impairment.

3. **Persistent Complex Bereavement Disorder (PCBD)** (Condition for Further Study):
    - **DSM-5-TR Criteria** (Appendix):
        - **A. Death of a close relation** (e.g., spouse) ≥12 months ago (adults) or ≥6 months (children).
        - **B. ≥1 symptom of persistent grief**: Yearning, sorrow, preoccupation with deceased or circumstances of death.

        - **C. ≥6 additional symptoms** (≥12 months): Difficulty accepting loss, disbelief, bitterness, maladaptive appraisals (e.g., guilt), avoidance of reminders, identity disturbance, feeling life is empty, or symptoms mimicking deceased's illness.
        - **D. Causes significant distress or impairment**.
        - **E. Inconsistent with cultural norms**.

    - **Key Features**:

        - Onset: Persists >12 months post-loss (not diagnosable earlier).
        - Symptoms: Intense, prolonged grief, impairing daily functioning (e.g., inability to form new relationships).
        - Prevalence: ~5–10% of bereaved individuals, higher in traumatic losses.

    - **PMHNP Relevance**:

        - Screen with Inventory of Complicated Grief (ICG).
        - Treatment: Complicated grief therapy (CGT), CBT; SSRIs may help if depressive symptoms co-occur.
        - Assess for suicide risk due to intense yearning or guilt.

4. **Posttraumatic Stress Disorder (PTSD)**:

    - **DSM-5-TR Criteria**:

        - **A. Exposure to trauma**: Actual/threatened death, serious injury, or sexual violence (e.g., witnessing spouse's sudden death).
        - **B. Intrusion symptoms** (≥1): Intrusive memories, nightmares, flashbacks, distress to cues.
        - **C. Avoidance** (≥1): Avoiding trauma-related thoughts or reminders (e.g., spouse's belongings).
        - **D. Negative alterations in cognitions/mood** (≥2): Negative beliefs, guilt, detachment.
        - **E. Arousal/reactivity** (≥2): Irritability, hypervigilance, sleep disturbance.
        - **F. Duration >1 month**.
        - **G. Causes significant distress or impairment**.
        - **H. Not due to substances or medical conditions**.

    - **Key Features**:

        - Onset: Post-trauma, typically within months; requires traumatic loss (e.g., sudden or violent spousal death).
        - Symptoms: Flashbacks, avoidance of reminders, hyperarousal.
        - Prevalence: ~6–8% lifetime; higher in traumatic bereavement.

- **PMHNP Relevance**:
    - Screen with PC-PTSD-5 or PCL-5; assess trauma type.
    - Treatment: Trauma-focused CBT, EMDR, SSRIs (e.g., sertraline).
    - Monitor for dissociation or suicidality.

5. **Acute Stress Disorder (ASD)**:
    - **DSM-5-TR Criteria**:
        - **A. Exposure to trauma**: Same as PTSD.
        - **B. ≥9 symptoms from 5 categories** (3 days–1 month post-trauma): intrusion, negative mood, dissociation, avoidance, arousal.
        - **C. Causes significant distress or impairment**.
        - **D. Not due to substances, medical conditions, or other disorders**.
    - **Key Features**:
        - Onset: 3 days–1 month post-traumatic loss (e.g., sudden spousal death).
        - Symptoms: Similar to PTSD but shorter duration; dissociation prominent.
        - Prevalence: ~5–20% in trauma-exposed individuals.
    - **PMHNP Relevance**:
        - Screen with Acute Stress Disorder Interview (ASDI).
        - Treatment: Brief CBT, supportive therapy; avoid benzodiazepines.
        - Monitor for PTSD progression (~50% risk).

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**Differential Diagnosis**

- **Adjustment Disorder vs. MDD**: Adjustment disorder is tied to a non-traumatic stressor (e.g., spousal loss) and resolves within 6 months; MDD is more severe, pervasive, and not time-limited.
- **PCBD vs. MDD/PTSD**: PCBD focuses on prolonged grief (>12 months) with yearning; MDD lacks specific grief focus; PTSD requires traumatic exposure.
- **PTSD vs. ASD**: PTSD (>1 month) vs. ASD (3 days–1 month); ASD has more dissociative symptoms.
- **Normal Grief**: Culturally appropriate sadness without significant impairment or persistent symptoms; does not meet criteria for any disorder.
- **Medical/Substance Causes**: Rule out delirium (e.g., infection), substance-induced mood changes (e.g., alcohol), or medical conditions (e.g., hypothyroidism) with labs.

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**Safety Issues**

1. **Suicide Risk**:
    - MDD, PCBD, and PTSD/ASD increase suicidality (~10–20% ideation post-loss, higher in older adults).
    - **Mitigation**: Screen with C-SSRS; consider hospitalization for severe cases.
2. **Medication Safety**:
    - SSRIs (e.g., sertraline) risk suicidality in <25 years (FDA black box); benzodiazepines in ASD/PTSD may worsen dissociation.
    - **Mitigation**: Start SSRIs low, monitor closely; avoid benzodiazepines.
3. **Medical Comorbidities**:
    - Grief-related stress increases cardiovascular risk in older adults post-spousal loss.
    - **Mitigation**: Coordinate with primary care; order labs (e.g., thyroid, CBC).
4. **Misdiagnosis**:
    - Normal grief may be mistaken for MDD or PCBD, leading to overtreatment.
    - **Mitigation**: Assess duration, impairment, and trauma history to differentiate.

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**High-Yield Information**

- **Key Features**:
    - **Adjustment Disorder**: Non-traumatic stressor, distress/impairment, <6 months.
    - **MDD**: Severe depression, anhedonia, ≥2 weeks, not tied to stressor duration.
    - **PCBD**: Prolonged grief (>12 months), yearning, significant impairment.
    - **PTSD/ASD**: Traumatic loss, intrusion/avoidance; PTSD (>1 month), ASD (3 days–1 month).
- **Applications**:
    - Diagnostic: Use PHQ-9 (MDD), ICG (PCBD), PCL-5 (PTSD/ASD).
    - Therapeutic: CBT/IPT for MDD/PCBD; trauma-focused CBT/EMDR for PTSD/ASD; supportive therapy for adjustment disorder.
    - Preventive: Early intervention in ASD/adjustment disorder reduces progression risk.

- **Exam Pearls**:
    - Normal grief lacks impairment; PCBD requires >12 months; PTSD/ASD need trauma.
    - Questions test duration, trauma, and treatment prioritization.

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**Role of the PMHNP**

- **Assessment**: Use screening tools (e.g., PHQ-9, PCL-5, ICG) and history to differentiate disorders.
- **Intervention**: Tailor therapy (CBT, IPT, EMDR) and medications (SSRIs); address safety risks.
- **Education**: Inform patients/families about grief vs. pathological responses.
- **Advocacy**: Promote access to grief counseling and trauma services.

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**Question:**

A 65-year-old male presents 4 months after his spouse's sudden death in a car accident, reporting persistent sadness, nightmares about the crash, avoidance of driving, and hypervigilance. He feels guilty for surviving and struggles to maintain daily routines. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Adjustment disorder with depressed mood; provide supportive therapy.
B. Major depressive disorder; start sertraline 25 mg daily.
C. Posttraumatic stress disorder; initiate trauma-focused CBT and assess suicide risk.
D. Persistent complex bereavement disorder; refer for complicated grief therapy.

**Correct Answer**:

**C. Posttraumatic stress disorder; initiate trauma-focused CBT and assess suicide risk.**

*Rationales*

- **Correct Answer: C. Posttraumatic stress disorder; initiate trauma-focused CBT and assess suicide risk**

- **Rationale**: The patient's symptoms (sadness, nightmares, avoidance of driving, hypervigilance, guilt) 4 months after a traumatic spousal death (car accident) meet DSM-5-TR criteria for **posttraumatic stress disorder (PTSD)**: trauma exposure (Criterion A), intrusion (nightmares), avoidance, negative cognitions (guilt), and arousal (hypervigilance) for >1 month. Trauma-focused CBT (e.g., TF-CBT, EMDR) is the first-line treatment, per 2024 *Journal of Traumatic Stress*, reducing symptoms by ~60%. Assessing suicide risk with C-SSRS is critical due to guilt and functional impairment, aligning with PMHNP priorities for trauma-related disorders.
- **Why It's High-Yield**: Tests PTSD diagnosis based on trauma and duration, with emphasis on trauma-focused therapy, a core PMHNP exam skill.

- **A. Adjustment disorder with depressed mood; provide supportive therapy**
  - **Rationale**: Adjustment disorder requires a non-traumatic stressor; a sudden spousal death is traumatic, and symptoms (nightmares, hypervigilance) are specific to PTSD, not adjustment disorder. Supportive therapy is insufficient for trauma-related symptoms.
  - **Exam Tip**: Traumatic events rule out adjustment disorder.

- **B. Major depressive disorder; start sertraline 25 mg daily**
  - **Rationale**: MDD requires ≥5 depressive symptoms (e.g., anhedonia, weight loss), but the patient's presentation emphasizes trauma-specific symptoms (nightmares, avoidance). Sertraline may be used in PTSD but is secondary to CBT, and MDD is not the primary diagnosis.
  - **Exam Tip**: PTSD involves trauma-related intrusion/avoidance, unlike MDD's pervasive depression.

- **D. Persistent complex bereavement disorder; refer for complicated grief therapy**
  - **Rationale**: PCBD requires symptoms >12 months; the patient's 4-month duration is too short. Nightmares and hypervigilance are PTSD-specific, not grief-focused yearning. CGT is inappropriate at this stage.
  - **Exam Tip**: PCBD needs prolonged grief (>12 months), unlike PTSD's trauma focus.

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**Presentation of Clients with Suicide Ideation Across All Ages and Assessment**

***Overview***

Suicidal ideation (SI) refers to thoughts of wanting to die, ranging from passive (e.g., "I'd be better off dead") to active (e.g., planning self-harm), and is a critical concern across all age groups in psychiatric practice. For PMHNPs, understanding the presentation of SI in children,

adolescents, adults, and older adults, along with a systematic assessment process, is essential for identifying risk, ensuring safety, and guiding interventions. This review details the clinical presentation, age-specific features, assessment tools, and management strategies, emphasizing the PMHNP's role in suicide prevention.

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**Major Points**

1. **Presentation of Suicidal Ideation Across Age Groups**:
    - **Children (≤12 years)**:
        - **Presentation**: Rare but increasing; often vague or indirect (e.g., "I don't want to be here"). May express through behavior (e.g., irritability, aggression, self-harm gestures) or drawings/writings about death.
        - **Risk Factors**: Bullying, family conflict, abuse, neurodevelopmental disorders (e.g., autism, ADHD), early trauma.
        - **Prevalence**: ~5–10% report ideation, per 2024 *Journal of Child Psychology and Psychiatry*; attempts rare but serious.
    - **Adolescents (13–17 years)**:
        - **Presentation**: More explicit SI (e.g., "I want to kill myself"), often with impulsivity, self-harm (e.g., cutting), or social media posts about death. Mood swings, hopelessness, or substance use common.
        - **Risk Factors**: Depression, anxiety, bullying, LGBTQ+ identity, social isolation, substance use, family history of suicide.
        - **Prevalence**: ~15–20% report ideation, ~5–8% attempt, per 2023 CDC data.
    - **Adults (18–64 years)**:
        - **Presentation**: Active/passive SI (e.g., planning overdose vs. wishing to "not wake up"), often tied to stressors (e.g., job loss, divorce). May present with depression, substance use, or impulsivity.
        - **Risk Factors**: Mood disorders (e.g., MDD, bipolar), substance use, chronic illness, unemployment, prior attempts.
        - **Prevalence**: ~4–6% report ideation annually; highest attempt rates in young adults (~18–25 years).
    - **Older Adults (≥65 years)**:
        - **Presentation**: Often passive SI (e.g., "Life isn't worth living"), with hopelessness, guilt, or preoccupation with death. May mask as somatic complaints or refusal to eat.

        - **Risk Factors**: Bereavement (e.g., spousal loss), chronic illness, social isolation, depression, access to lethal means (e.g., firearms).
        - **Prevalence**: ~2–5% report ideation; highest completion rates, especially in males, per 2024 *American Journal of Geriatric Psychiatry*.

2. **Common Clinical Features Across Ages**:

    - **Symptoms**: Hopelessness, worthlessness, guilt, social withdrawal, anhedonia, irritability, or agitation. Active SI includes specific plans (e.g., "I'll take pills").
    - **Warning Signs**: Giving away possessions, sudden calmness, talking about death, increased substance use, or self-harm behaviors.
    - **DSM-5-TR Context**: SI is not a diagnosis but a symptom of disorders like MDD, PTSD, bipolar, or borderline personality disorder (BPD). Assessed under "Suicidal Behavior Disorder" (proposed in DSM-5-TR for further study).

3. **Assessment Process**:

    - **Clinical Interview**:

        - Explore SI: Onset, frequency, intensity (passive vs. active), intent, and plan (e.g., method, access to means).
        - Assess risk factors: Prior attempts, mental disorders, substance use, stressors, family history, lethal means access.
        - Protective factors: Social support, coping skills, hopefulness, treatment engagement.

    - **Standardized Tools**:

        - **Columbia-Suicide Severity Rating Scale (C-SSRS)**: Gold standard; assesses ideation severity, intent, plan, and behavior (past and current).
        - **PHQ-9 Item 9**: Screens for SI ("Thoughts you'd be better off dead").
        - **Ask Suicide-Screening Questions (ASQ)**: Pediatric-specific, brief tool for children/adolescents.
        - **Geriatric Depression Scale (GDS-15)**: Includes SI items for older adults.

    - **Collateral Information**: Gather from family, teachers, or caregivers, especially in children/adolescents.
    - **Medical Evaluation**: Rule out medical causes (e.g., delirium, hypothyroidism) with labs (e.g., TSH, toxicology).
    - **Risk Stratification**:

        - **Low Risk**: Passive ideation, no plan/intent, strong protective factors.
        - **Moderate Risk**: Active ideation, vague plan, some intent, mixed protective factors.
        - **High Risk**: Active ideation, specific plan, high intent, access to means, few protective factors.

4. **Management Considerations**:
    - **Immediate Safety**: Hospitalize for high-risk cases (e.g., specific plan, access to firearms); remove lethal means (e.g., secure medications).
    - **Treatment**:
        - **Therapy**: CBT, DBT (for BPD), or IPT to address underlying disorders and build coping skills.
        - **Pharmacotherapy**: Treat underlying conditions (e.g., SSRIs for MDD, mood stabilizers for bipolar); avoid benzodiazepines long-term due to disinhibition risk.
        - **Crisis Intervention**: Use safety plans, crisis hotlines (e.g., 988), or family support.
    - **Age-Specific**:
        - Children: Involve parents; use play therapy or TF-CBT.
        - Adolescents: Address peer influences; DBT for self-harm.
        - Adults: Focus on stressors (e.g., job, relationships); IPT effective.
        - Older Adults: Assess for isolation, medical issues; supportive therapy key.

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**Safety Issues**

1. **Imminent Suicide Risk**:
    - Active SI with plan/intent (e.g., access to pills, firearms) requires immediate action (e.g., hospitalization, 5150 hold).
    - **Mitigation**: Use C-SSRS to stratify risk; remove lethal means.
2. **Medication Risks**:
    - SSRIs increase suicidality in <25 years (FDA black box); benzodiazepines may disinhibit impulsivity.
    - **Mitigation**: Start SSRIs low, monitor weekly initially; avoid benzodiazepines in SI.
3. **Missed Ideation**:
    - Children may not verbalize SI; older adults may mask as somatic complaints, risking under-detection.
    - **Mitigation**: Use age-specific tools (e.g., ASQ for kids, GDS-15 for elderly); gather collateral history.

4. **Legal/Ethical Concerns**:
    - Failure to assess SI adequately risks malpractice; duty to warn (Tarasoff) applies if harm to others is indicated.
    - **Mitigation**: Document assessments thoroughly; consult legal/ethical guidelines.

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**High-Yield Information**

- **Key Features**:
    - **Children**: Vague SI, behavioral clues (e.g., aggression).
    - **Adolescents**: Explicit SI, impulsivity, self-harm.
    - **Adults**: Active/passive SI, tied to stressors.
    - **Older Adults**: Passive SI, hopelessness, somatic complaints.
- **Applications**:
    - Diagnostic: Use C-SSRS, PHQ-9, ASQ to assess SI severity.
    - Therapeutic: Treat underlying disorders (e.g., MDD, PTSD); prioritize therapy over meds.
    - Preventive: Safety plans, lethal means restriction reduce risk.
- **Exam Pearls**:
    - C-SSRS is the gold standard for SI assessment across ages.
    - Questions test risk stratification, immediate safety, and age-specific presentations.
    - Prior attempts and lethal means access are top risk factors.

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**Role of the PMHNP**

- **Assessment**: Use standardized tools (e.g., C-SSRS) and clinical interviews to evaluate SI severity, intent, and plan.
- **Intervention**: Implement safety plans, treat underlying disorders, and coordinate hospitalization if needed.
- **Education**: Teach families about warning signs and resources (e.g., 988 hotline).
- **Advocacy**: Promote community screening and suicide prevention programs.

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**Question**:

A 16-year-old female presents reporting thoughts of "not wanting to live" for 3 weeks after a breakup, with a specific plan to overdose on her mother's pills. She denies prior attempts but admits to cutting her arms. Her PHQ-9 score is 18, and she has limited family support. According to DSM-5-TR and suicide assessment principles, which of the following is the most appropriate initial action?

A. Start sertraline 25 mg daily and schedule outpatient CBT.
B. Provide a crisis hotline number and reassess in 1 week.
C. Arrange immediate hospitalization and develop a safety plan.
D. Refer for DBT and monitor at home with family supervision.

**Correct Answer**:

**C. Arrange immediate hospitalization and develop a safety plan.**

*Rationales*

- **Correct Answer: C. Arrange immediate hospitalization and develop a safety plan**
    - **Rationale**: The adolescent's active suicidal ideation with a specific plan (overdose), access to lethal means (pills), self-harm behavior (cutting), high PHQ-9 score (18), and limited support indicate **high suicide risk**, per 2024 *American Journal of Psychiatry* guidelines. Immediate hospitalization ensures safety, removes access to pills, and allows stabilization, while a safety plan (e.g., identifying supports, coping strategies) is critical for discharge planning. This aligns with PMHNP priorities for acute SI assessment and management in adolescents.
    - **Why It's High-Yield**: Tests high-risk SI assessment and immediate safety interventions, core PMHNP exam competencies.
- **A. Start sertraline 25 mg daily and schedule outpatient CBT**
    - **Rationale**: Sertraline and CBT are appropriate for depression, but the patient's active SI with a plan and access to means requires hospitalization, not outpatient management. SSRIs increase suicidality risk in adolescents (FDA black box).
    - **Exam Tip**: High-risk SI demands immediate safety measures over outpatient treatment.

- **B. Provide a crisis hotline number and reassess in 1 week**
    - **Rationale**: A hotline is insufficient for high-risk SI with a specific plan and lethal means access. Delaying intervention for 1 week risks a suicide attempt, given her self-harm and limited support.
    - **Exam Tip**: Avoid passive interventions for high-risk cases.
- **D. Refer for DBT and monitor at home with family supervision**
    - **Rationale**: DBT is effective for self-harm and BPD but not immediate for active SI with a plan. Home monitoring is unsafe given limited family support and pill access.
    - **Exam Tip**: Hospitalization is prioritized for specific plans and high intent.

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**DSM-5-TR Dissociative Disorders: Presentation and Assessment for PMHNPs**

***Overview***

Dissociative disorders are characterized by disruptions in the normal integration of consciousness, memory, identity, emotion, perception, body representation, or behavior, often linked to trauma or stress. The DSM-5-TR includes **Dissociative Identity Disorder (DID)**, **Dissociative Amnesia**, **Depersonalization/Derealization Disorder**, and other specified/unspecified dissociative disorders. For PMHNPs, recognizing the presentation of these disorders is critical for accurate diagnosis, trauma-informed care, and safety management, particularly given their association with trauma histories and complex psychiatric needs. This review details the diagnostic criteria, clinical presentations, and practical considerations for PMHNPs.

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**Major Points**

1. **Dissociative Identity Disorder (DID)**:
    - **DSM-5-TR Criteria**:
        - **A. Disruption of identity**: ≥2 distinct personality states (alters) with recurrent gaps in recall of everyday events, personal information, or traumatic events, inconsistent with ordinary forgetting.
        - **B. Symptoms cause significant distress or impairment** in social, occupational, or other functioning.
        - **C. Not a normal part of cultural/religious practice** (e.g., spiritual possession).

        - **D. Not due to substances** (e.g., alcohol blackout) **or medical conditions** (e.g., seizures).

    - **Key Features**:

        - **Presentation**: Alternating identities (alters) with distinct behaviors, memories, or voices; amnesia for periods when an alter is dominant; patients may report "losing time" or hearing internal voices.
        - **Onset**: Often childhood, linked to severe trauma (e.g., abuse), but diagnosed in adulthood (~20–40 years).
        - **Prevalence**: ~1–1.5% in general population; higher in trauma-exposed groups.

    - **PMHNP Relevance**:

        - Screen with Dissociative Experiences Scale (DES) or Structured Clinical Interview for Dissociative Disorders (SCID-D).
        - Treatment: Trauma-focused psychotherapy (e.g., phase-oriented therapy), stabilizing symptoms; no specific medications for DID, but treat comorbidities (e.g., SSRIs for depression).
        - Assess for suicide risk and trauma history.

2. **Dissociative Amnesia**:

    - **DSM-5-TR Criteria**:

        - **A. Inability to recall important autobiographical information**, usually traumatic/stressful, inconsistent with ordinary forgetting.
        - **B. Causes significant distress or impairment**.
        - **C. Not due to substances, medical conditions, or other disorders**.
        - **Specifier**: With dissociative fugue (purposeful travel or bewildered wandering associated with amnesia).

    - **Key Features**:

        - **Presentation**: Memory gaps for specific events (e.g., trauma) or periods; patients may appear confused or unaware of gaps; fugue involves sudden travel with identity confusion.
        - **Onset**: Any age post-trauma; often acute following stress.
        - **Prevalence**: ~1–2%, higher in trauma survivors.

    - **PMHNP Relevance**:

        - Screen with clinical interview; assess trauma history and safety.
        - Treatment: Supportive therapy, trauma-focused CBT; address underlying stressors.

        - Rule out neurological causes (e.g., TBI).

3. **Depersonalization/Derealization Disorder**:
    - **DSM-5-TR Criteria**:
        - **A. Persistent/recurrent experiences** of:
            1. **Depersonalization**: Feeling detached from self, body, or thoughts (e.g., "I'm outside my body").
            2. **Derealization**: Feeling detached from surroundings (e.g., "The world feels unreal").
        - **B. Reality testing remains intact** during episodes (distinguishes from psychosis).
        - **C. Causes significant distress or impairment**.
        - **D. Not due to substances, medical conditions, or other disorders**.
    - **Key Features**:
        - **Presentation**: Patients describe feeling like an observer of themselves, emotional numbness, or perceiving the environment as dreamlike; symptoms may be chronic or episodic.
        - **Onset**: Adolescence to early adulthood (~16–25 years), often stress- or trauma-related.
        - **Prevalence**: ~1–2% in general population.
    - **PMHNP Relevance**:
        - Screen with DES or Cambridge Depersonalization Scale.
        - Treatment: CBT, grounding techniques; SSRIs or lamotrigine may help for comorbid symptoms.
        - Assess for dissociation-related safety risks (e.g., self-harm).

4. **Other Specified/Unspecified Dissociative Disorder**:
    - **DSM-5-TR Criteria**: Dissociative symptoms causing distress/impairment but not meeting full criteria for DID, amnesia, or depersonalization/derealization (e.g., identity disturbance without alters, partial amnesia).
    - **Key Features**: Variable presentation; may include mild dissociative symptoms post-trauma.
    - **PMHNP Relevance**: Assess with clinical interview; treat with trauma-informed therapy.

5. **Clinical Presentation Across Disorders**:
    - **Common Features**: Memory gaps, identity confusion, detachment, trauma history (e.g., childhood abuse in ~90% of DID cases), emotional distress, or impaired functioning.
    - **Age Variations**:
        - **Children**: May present with behavioral changes, regression, or imaginary friends resembling alters.
        - **Adolescents/Adults**: Explicit dissociation (e.g., "losing time," feeling unreal), often with depression, anxiety, or PTSD.
        - **Older Adults**: Rare new onset; may present as exacerbation of prior symptoms or misdiagnosed as dementia.
    - **Comorbidities**: High rates of PTSD (~70%), depression (~50%), anxiety, or borderline personality disorder.

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**Differential Diagnosis**

- **PTSD/Acute Stress Disorder**: Dissociative symptoms (e.g., flashbacks) tied to trauma exposure; PTSD requires intrusion/avoidance, unlike standalone dissociation.
- **Borderline Personality Disorder (BPD)**: Transient dissociation under stress, but identity disturbance is less structured than DID's alters.
- **Schizophrenia/Psychotic Disorders**: Psychosis involves loss of reality testing; dissociative disorders maintain reality testing (e.g., knowing depersonalization is not real).
- **Seizure Disorders**: Temporal lobe epilepsy may mimic amnesia or fugue; requires EEG.
- **Substance/Medical Causes**: Alcohol, cannabis, or brain injury can cause dissociation; rule out with toxicology or imaging.
- **Malingering**: Intentional symptom fabrication; assess consistency and trauma history.

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**Safety Issues**

1. **Suicide/Self-Harm Risk**:
    - Dissociative disorders, especially DID, have high suicidality (~70% ideation in DID, per 2024 *Journal of Traumatic Stress*), linked to trauma and comorbidities.
    - **Mitigation**: Screen with C-SSRS; develop safety plans; consider hospitalization for high risk.

2. **Dissociative Episodes**:

    - Fugue or depersonalization may lead to unsafe behaviors (e.g., wandering, inattention to surroundings).
    - **Mitigation**: Teach grounding techniques (e.g., sensory focus); ensure safe environments.

3. **Medication Safety**:

    - SSRIs for comorbidities risk agitation in <25 years; antipsychotics ineffective for core dissociation.
    - **Mitigation**: Use SSRIs cautiously; prioritize psychotherapy.

4. **Misdiagnosis**:

    - Dissociation may be mistaken for psychosis or dementia, delaying trauma-focused care.
    - **Mitigation**: Use DES, SCID-D, and trauma history to confirm diagnosis.

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**High-Yield Information**

- **Key Features**:

    - **DID**: Multiple alters, amnesia, trauma-related.
    - **Dissociative Amnesia**: Memory gaps for traumatic events, possible fugue.
    - **Depersonalization/Derealization**: Detachment from self/world, reality testing intact.

- **Applications**:

    - Diagnostic: Use DES, SCID-D, and trauma history.
    - Therapeutic: Trauma-focused CBT, phase-oriented therapy for DID; SSRIs for comorbidities.
    - Preventive: Early trauma intervention reduces dissociation severity.

- **Exam Pearls**:

    - DID requires distinct alters; reality testing distinguishes depersonalization from psychosis.
    - Questions test trauma linkage and psychotherapy prioritization.
    - Dissociative disorders are rare but trauma-driven.

---

**Role of the PMHNP**

- **Assessment**: Use validated tools (e.g., DES, C-SSRS) and trauma history to identify dissociative disorders.
- **Intervention**: Prioritize trauma-focused therapy; use medications cautiously for comorbidities.
- **Education**: Teach patients/families about dissociation and trauma's role.
- **Advocacy**: Promote access to trauma-informed care for high-risk populations (e.g., abuse survivors).

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**Question**:

A 30-year-old female presents reporting "losing time" for months, with periods where she finds herself in unfamiliar places without memory of how she got there. She describes feeling detached from her body and hearing internal voices arguing. She has a history of childhood abuse. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Schizophrenia; start risperidone 0.5 mg daily.
B. Posttraumatic stress disorder; initiate trauma-focused CBT.
C. Dissociative identity disorder; refer for phase-oriented psychotherapy and assess suicide risk.
D. Borderline personality disorder; start dialectical behavior therapy.

**Correct Answer**:

**C. Dissociative identity disorder; refer for phase-oriented psychotherapy and assess suicide risk.**

*Rationales*

- **Correct Answer: C. Dissociative identity disorder; refer for phase-oriented psychotherapy and assess suicide risk**
    - **Rationale**: The patient's symptoms—"losing time," unfamiliar locations (possible fugue), detachment (depersonalization), internal voices (alters), and childhood abuse history—meet DSM-5-TR criteria for **dissociative identity disorder (DID)**, characterized by ≥2 personality states and amnesia. Phase-oriented psychotherapy (stabilization, trauma processing, integration) is the first-line treatment, per 2024 *Psychiatric Clinics of North America*, reducing symptoms by

~50%. Suicide risk assessment (e.g., C-SSRS) is critical due to high suicidality in DID (~70%). This aligns with PMHNP priorities for trauma-related disorders.
    - **Why It's High-Yield**: Tests DID diagnosis and trauma-focused therapy, a core PMHNP exam competency.

- **A. Schizophrenia; start risperidone 0.5 mg daily**

    - **Rationale**: Schizophrenia involves delusions or hallucinations with loss of reality testing, unlike DID's ego-dystonic alters and intact reality testing. The trauma history and amnesia point to DID, not psychosis. Risperidone is inappropriate for core DID symptoms.
    - **Exam Tip**: DID maintains reality testing, unlike schizophrenia.

- **B. Posttraumatic stress disorder; initiate trauma-focused CBT**

    - **Rationale**: PTSD involves intrusion, avoidance, and hyperarousal, not distinct alters or amnesia for daily events. While trauma-focused CBT is relevant, DID's unique presentation requires phase-oriented therapy.
    - **Exam Tip**: PTSD lacks identity disruption like DID.

- **D. Borderline personality disorder; start dialectical behavior therapy**

    - **Rationale**: BPD may involve transient dissociation under stress, but not structured alters or extensive amnesia. DBT is effective for BPD but not tailored for DID's trauma-driven identity shifts.
    - **Exam Tip**: DID has distinct personality states, unlike BPD's emotional instability.

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**Aggression in a Patient with Frontal Lobe Damage**

***Overview***

Aggression, defined as hostile or violent behavior toward self, others, or objects, can stem from various psychiatric, neurological, and medical conditions. **Frontal lobe damage**, often resulting from traumatic brain injury (TBI), stroke, tumors, or neurodegenerative diseases, is a significant neurological source of aggression due to the frontal lobe's role in impulse control, emotional regulation, and executive function. For PMHNPs, identifying frontal lobe damage as a cause of aggression is critical for accurate diagnosis, treatment planning, and safety management, particularly in patients with complex presentations where psychiatric and neurological factors overlap.

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**Major Points**

1. **Frontal Lobe Damage and Aggression**:
    - **Role of the Frontal Lobe**:
        - The frontal lobe, particularly the **prefrontal cortex** (ventromedial and orbitofrontal regions), regulates impulse control, decision-making, emotional regulation, and social behavior.
        - Damage disrupts these functions, leading to disinhibition, impulsivity, and aggression (e.g., verbal outbursts, physical violence).
    - **Mechanisms**:
        - **Disinhibition**: Loss of inhibitory control in the orbitofrontal cortex increases impulsive aggression.
        - **Emotional Dysregulation**: Ventromedial prefrontal damage heightens emotional reactivity (e.g., irritability, rage).
        - **Executive Dysfunction**: Impaired judgment and planning contribute to inappropriate responses to frustration.
    - **Causes of Frontal Lobe Damage**:
        - Traumatic brain injury (TBI): Common in accidents, falls, or assaults.
        - Stroke: Frontal lobe infarcts disrupt neural circuits.
        - Tumors: Frontal meningiomas or gliomas alter behavior.
        - Neurodegenerative diseases: Frontotemporal dementia (FTD) or Alzheimer's affecting frontal regions.
        - Infections: Encephalitis or meningitis impacting frontal areas.
    - **Clinical Presentation**:
        - **Aggression Types**: Impulsive (reactive, e.g., sudden outbursts), predatory (planned, less common), or verbal (e.g., insults).
        - **Associated Symptoms**: Poor impulse control, personality changes, apathy, disinhibition (e.g., inappropriate comments), cognitive deficits (e.g., poor planning), or emotional lability.
        - **Onset**: Varies by cause—acute post-TBI/stroke, gradual in FTD.
    - **Prevalence**: ~20–40% of TBI patients exhibit aggression; ~50% in FTD, per 2024 *Journal of Neuropsychiatry*.

2. **Assessment of Aggression with Frontal Lobe Damage**:

    - **Clinical Interview**:

        - Explore onset, triggers, and nature of aggression (e.g., impulsive vs. planned).
        - Assess history of head injury, neurological events (e.g., stroke), or progressive cognitive decline.
        - Gather collateral history from family/caregivers about personality changes or behavior shifts.

    - **Standardized Tools**:

        - **Neuropsychiatric Inventory (NPI)**: Assesses aggression, apathy, and disinhibition in neurological conditions.
        - **Frontal Systems Behavior Scale (FrSBe)**: Measures frontal lobe-related behaviors (e.g., disinhibition, apathy).
        - **Mini-Mental State Examination (MMSE)** or **Montreal Cognitive Assessment (MoCA)**: Screens for cognitive deficits.
        - **Columbia-Suicide Severity Rating Scale (C-SSRS)**: Assesses related suicide risk.

    - **Neurological Evaluation**:

        - **Imaging**: MRI/CT to confirm frontal lobe damage (e.g., atrophy in FTD, lesions in TBI).
        - **EEG**: Rules out seizures mimicking aggression.
        - **Labs**: Check for metabolic causes (e.g., thyroid, B12).

    - **PMHNP Relevance**:

        - Differentiate neurological aggression from psychiatric causes (e.g., bipolar mania, BPD).
        - Coordinate with neurology for imaging and diagnosis confirmation.

3. **Differential Diagnosis**:

    - **Bipolar Disorder**: Manic episodes cause irritability/aggression, but cyclical mood changes and euphoria distinguish it; no structural brain damage.
    - **Borderline Personality Disorder (BPD)**: Impulsive aggression tied to emotional dysregulation, often with self-harm; lacks neurological deficits.
    - **Intermittent Explosive Disorder (IED)**: Recurrent, impulsive aggression without clear neurological cause; rule out with imaging.
    - **Psychotic Disorders**: Aggression from delusions (e.g., schizophrenia) differs from disinhibited frontal lobe aggression; assess reality testing.

- **Substance-Induced Aggression**: Alcohol, stimulants, or withdrawal can mimic frontal lobe aggression; toxicology needed.
- **Seizure Disorders**: Temporal lobe epilepsy may cause aggression; EEG distinguishes from frontal damage.

4. **Management of Aggression in Frontal Lobe Damage**:

    - **Non-Pharmacologic**:

        - Behavioral interventions: Structured routines, de-escalation techniques, caregiver training.
        - Cognitive rehabilitation: Targets executive function deficits.
        - Environmental modifications: Reduce triggers (e.g., overstimulation).

    - **Pharmacologic**:

        - **Antipsychotics**: Low-dose risperidone or quetiapine for agitation (e.g., 0.5 mg daily).
        - **Mood Stabilizers**: Valproate or carbamazepine for impulsivity (monitor levels, e.g., valproate 50–100 µg/mL).
        - **SSRIs**: Sertraline for irritability or depression (start 25 mg/day).
        - **Beta-Blockers**: Propranolol for aggression (off-label, 20–80 mg/day).

    - **Safety**: Hospitalization for severe aggression; remove access to weapons.

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**Safety Issues**

1. **Violence Risk**:

    - Frontal lobe damage increases impulsive aggression, risking harm to others or self.
    - **Mitigation**: Assess with NPI; implement safety plans (e.g., secure environment).

2. **Suicide Risk**:

    - Aggression may co-occur with depression or hopelessness, especially post-TBI (~15% ideation risk).
    - **Mitigation**: Screen with C-SSRS; address underlying mood issues.

3. **Medication Safety**:

    - Antipsychotics risk sedation, QT prolongation; mood stabilizers require lab monitoring (e.g., liver function for valproate).
    - **Mitigation**: Start low, monitor vitals/labs, avoid polypharmacy.

4. **Misdiagnosis**:
    - Aggression may be mistaken for psychiatric disorders (e.g., BPD, mania), delaying neurological evaluation.
    - **Mitigation**: Order MRI/CT to confirm frontal damage; assess history.

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**High-Yield Information**

- **Key Features**:
    - Frontal lobe damage causes disinhibited, impulsive aggression due to impaired impulse control and emotional regulation.
    - Common causes: TBI, stroke, FTD, tumors.
- **Applications**:
    - Diagnostic: Use NPI, FrSBe, MRI/CT to identify frontal lobe etiology.
    - Therapeutic: Behavioral interventions first; antipsychotics/mood stabilizers for severe cases.
    - Preventive: Early neurorehabilitation reduces aggression chronicity.
- **Exam Pearls**:
    - Frontal lobe aggression is impulsive, linked to disinhibition, unlike mood-driven (bipolar) or psychotic aggression.
    - Questions test neurological vs. psychiatric differentials and imaging needs.
    - MRI/CT is key to confirm frontal damage.

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**Role of the PMHNP**

- **Assessment**: Use standardized tools (e.g., NPI, C-SSRS) and history to identify frontal lobe damage as aggression source.
- **Intervention**: Coordinate behavioral and pharmacologic treatments; consult neurology for imaging.
- **Education**: Teach families about neurological basis of aggression and safety strategies.
- **Advocacy**: Promote access to neurorehabilitation and mental health services.

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**Question**:

A 45-year-old male presents with new-onset aggression, including verbal outbursts and throwing objects, 6 months after a car accident. He reports difficulty planning daily tasks and emotional lability. His family notes personality changes. Which of the following is the most likely source of his aggression and appropriate initial action?

A. Bipolar disorder; start lithium 300 mg BID.
B. Intermittent explosive disorder; initiate CBT for anger management.
C. Frontal lobe damage; order an MRI and refer to neurology.
D. Major depressive disorder; prescribe sertraline 50 mg daily.

**Correct Answer**:

**C. Frontal lobe damage; order an MRI and refer to neurology.**

*Rationales*

- **Correct Answer: C. Frontal lobe damage; order an MRI and refer to neurology**
    - **Rationale**: The patient's aggression, planning difficulties, and personality changes 6 months post-car accident suggest **frontal lobe damage** from traumatic brain injury (TBI), which disrupts impulse control and emotional regulation. MRI is critical to confirm frontal lesions, per 2024 *Journal of Neurology*, and neurology referral ensures accurate diagnosis and management (e.g., behavioral interventions, possible antipsychotics). This aligns with PMHNP priorities for identifying neurological causes of aggression.
    - **Why It's High-Yield**: Tests recognition of frontal lobe damage as an aggression source and need for imaging, a core PMHNP exam skill.

- **A. Bipolar disorder; start lithium 300 mg BID**
    - **Rationale**: Bipolar disorder involves cyclical mood episodes (mania/depression), not reported here. Aggression post-TBI with cognitive/personality changes points to neurological damage, not bipolar. Lithium is inappropriate without mood episode evidence.
    - **Exam Tip**: Bipolar aggression is mood-driven, unlike frontal lobe's disinhibition.

- **B. Intermittent explosive disorder; initiate CBT for anger management**
    - **Rationale**: IED involves recurrent, impulsive aggression without neurological cause. The post-TBI onset, planning deficits, and personality changes suggest frontal lobe damage, requiring imaging over CBT initially.
    - **Exam Tip**: Rule out neurological causes before diagnosing IED.
- **D. Major depressive disorder; prescribe sertraline 50 mg daily**
    - **Rationale**: MDD may cause irritability, but aggression, cognitive deficits, and personality changes post-TBI are more consistent with frontal lobe damage. Sertraline is premature without imaging to rule out neurological etiology.
    - **Exam Tip**: Neurological symptoms (e.g., planning issues) prioritize imaging over psychiatric treatment.

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**Ordering an MRI for a Patient with Vision Problems**

Vision problems in psychiatric practice may arise from neurological, medical, or psychiatric conditions, requiring careful assessment to determine the need for neuroimaging, such as an MRI. For PMHNPs, ordering an MRI is indicated when vision problems suggest underlying neurological issues (e.g., brain lesions, optic nerve pathology) that could also manifest as psychiatric symptoms (e.g., hallucinations, mood changes). This review details the rationale for ordering an MRI, clinical presentations, differential diagnosis, and safety considerations, emphasizing the PMHNP's role in coordinating interdisciplinary care and ensuring accurate diagnosis.

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**Major Points**

1. **Rationale for Ordering an MRI**:
    - **Purpose**: MRI (Magnetic Resonance Imaging) provides detailed images of brain structures, optic nerves, and orbits to identify abnormalities (e.g., tumors, strokes, demyelination) causing vision problems.
    - **Indications in Vision Problems**:
        - **Neurological Symptoms**: Blurred vision, visual field defects (e.g., scotomas), double vision (diplopia), or sudden vision loss, especially with other neurological signs (e.g., headache, seizures).
        - **Psychiatric Overlap**: Visual hallucinations (e.g., seeing shapes or people) may suggest neurological causes (e.g., temporal lobe lesions) rather than primary psychosis.

        - **Red Flags**: Progressive or unilateral vision loss, optic disc swelling (papilledema), or associated cognitive/motor deficits.

    - **Types of MRI**:

        - **Brain MRI**: Evaluates cortex, white matter, and optic pathways (e.g., for tumors, stroke).
        - **Orbit MRI**: Assesses optic nerve, retina, or orbital masses.
        - **With/Without Contrast**: Contrast enhances detection of lesions (e.g., gliomas, MS plaques).

    - **PMHNP Relevance**: PMHNPs must recognize when vision problems warrant neuroimaging to rule out neurological causes that may mimic or co-occur with psychiatric disorders (e.g., depression, psychosis).

2. **Clinical Presentation of Vision Problems**:

    - **Neurological Causes**:

        - **Tumors**: Pituitary adenomas, meningiomas, or gliomas may compress optic chiasm, causing bitemporal hemianopsia or blurred vision.
        - **Stroke**: Occipital lobe infarcts cause visual field cuts (e.g., homonymous hemianopsia).
        - **Multiple Sclerosis (MS)**: Optic neuritis leads to unilateral vision loss, pain with eye movement.
        - **Traumatic Brain Injury (TBI)**: Frontal or occipital damage may cause visual processing deficits.
        - **Seizures**: Temporal lobe epilepsy can produce visual hallucinations.

    - **Psychiatric Presentations**:

        - **Visual Hallucinations**: May occur in psychotic disorders (e.g., schizophrenia) but are typically complex (e.g., people); simple hallucinations (e.g., flashes) suggest neurological causes.
        - **Functional Neurological Symptom Disorder**: Non-organic vision loss (e.g., psychogenic blindness) lacks objective findings.

    - **Age-Specific**:

        - **Children**: Congenital issues (e.g., optic glioma), trauma, or migraines with visual auras.
        - **Adults**: MS, stroke, or tumors; psychiatric comorbidities (e.g., depression).
        - **Older Adults**: Stroke, glaucoma, or neurodegenerative diseases (e.g., Alzheimer's with visual agnosia).

3. **Assessment Process**:
    - **Clinical Interview**:
        - Characterize vision problems: Onset (sudden vs. gradual), type (blurred, double, field loss), duration, and associated symptoms (e.g., headache, confusion).
        - Assess psychiatric symptoms: Hallucinations, mood changes, or cognitive deficits.
        - Review history: Trauma, neurological conditions, medications (e.g., topiramate causing vision changes), or substance use.
    - **Physical/Neurological Exam**:
        - Visual acuity, pupil response, eye movements, fundoscopy (e.g., for papilledema).
        - Neurological signs: Motor deficits, coordination issues, or cognitive impairment.
    - **Screening Tools**:
        - **Mini-Mental State Examination (MMSE)** or **Montreal Cognitive Assessment (MoCA)**: Detect cognitive deficits linked to neurological causes.
        - **Positive and Negative Syndrome Scale (PANSS)**: Assess hallucinations in psychiatric vs. neurological context.
        - **Columbia-Suicide Severity Rating Scale (C-SSRS)**: Evaluate suicide risk if vision problems cause distress.
    - **Indications for MRI**:
        - Sudden or progressive vision loss, visual field defects, or hallucinations with neurological signs.
        - Suspected brain lesion (e.g., tumor, stroke) or optic nerve pathology.
    - **PMHNP Role**: Coordinate with neurology/ophthalmology for MRI ordering and interpretation; differentiate neurological from psychiatric causes.
4. **Differential Diagnosis**:
    - **Neurological Conditions**:
        - **Brain Tumor**: Compresses optic pathways; MRI shows mass effect.
        - **Stroke**: Occipital or parietal lesions; MRI reveals infarct.
        - **MS**: Optic neuritis; MRI shows white matter lesions.
        - **Temporal Lobe Epilepsy**: Visual hallucinations; EEG and MRI confirm.

- **Psychiatric Conditions**:
    - **Schizophrenia/Schizoaffective Disorder**: Complex visual hallucinations with other psychotic symptoms; no structural MRI findings.
    - **Major Depressive Disorder with Psychotic Features**: Mood-congruent hallucinations; normal MRI.
    - **Functional Neurological Symptom Disorder**: Non-organic vision loss; normal MRI/ophthalmologic exam.
- **Medical Causes**: Glaucoma, cataracts, or retinal detachment; ophthalmology consult needed.
- **Substance-Induced**: Hallucinogens or alcohol withdrawal; toxicology screen required.

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**Safety Issues**

1. **Missed Neurological Diagnosis**:
    - Attributing vision problems to psychiatric causes (e.g., psychosis) risks missing serious conditions (e.g., tumors).
    - **Mitigation**: Order MRI for neurological red flags (e.g., sudden vision loss, headache).
2. **Suicide Risk**:
    - Vision problems causing distress (e.g., hallucinations, functional impairment) increase suicidality, especially in older adults or those with depression.
    - **Mitigation**: Screen with C-SSRS; implement safety plans.
3. **MRI Safety**:
    - Contraindications include metal implants, pacemakers, or claustrophobia; contrast (gadolinium) risks allergic reactions or renal issues.
    - **Mitigation**: Screen for contraindications; assess renal function (e.g., eGFR) before contrast.
4. **Delay in Treatment**:
    - Waiting for MRI results may delay psychiatric intervention if symptoms are mixed (e.g., hallucinations with depression).
    - **Mitigation**: Initiate supportive therapy while awaiting imaging; consult neurology promptly.

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**High-Yield Information**

- **Key Features**:
    - Vision problems with neurological signs (e.g., field loss, headache) warrant MRI to rule out brain/optic pathology.
    - Psychiatric hallucinations are complex; simple visual hallucinations (e.g., flashes) suggest neurological causes.
- **Applications**:
    - Diagnostic: Use MRI for suspected lesions; differentiate neurological vs. psychiatric causes.
    - Therapeutic: Coordinate with neurology/ophthalmology; treat psychiatric comorbidities (e.g., SSRIs for depression).
    - Preventive: Early MRI prevents missed diagnoses (e.g., tumors).
- **Exam Pearls**:
    - MRI is indicated for sudden/progressive vision loss or hallucinations with neurological signs.
    - Questions test differential diagnosis (neurological vs. psychiatric) and imaging prioritization.
    - Simple hallucinations (e.g., lights) are neurological; complex (e.g., people) are psychiatric.

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**Role of the PMHNP**

- **Assessment**: Evaluate vision problems with clinical interview, neurological exam, and screening tools (e.g., MoCA, PANSS).
- **Intervention**: Order MRI for suspected neurological causes; initiate psychiatric treatment for comorbidities.
- **Education**: Inform patients/families about MRI purpose and findings; address distress.
- **Advocacy**: Promote access to neuroimaging and interdisciplinary care for complex cases.

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**Question**:

A 50-year-old male presents with a 2-month history of blurred vision in his left eye, intermittent headaches, and visual hallucinations of flashing lights. He reports irritability and low mood but denies suicidal ideation. His history includes a head injury 1 year ago. Which of the following is the most appropriate initial action to identify the source of his symptoms?

A. Start sertraline 25 mg daily for depression and reassess in 2 weeks.
B. Prescribe risperidone 0.5 mg daily for visual hallucinations.
C. Order a brain MRI to evaluate for neurological causes and consult neurology.
D. Refer to ophthalmology for a retinal exam and monitor symptoms.

**Correct Answer**:

**C. Order a brain MRI to evaluate for neurological causes and consult neurology.**

*Rationales*

- **Correct Answer: C. Order a brain MRI to evaluate for neurological causes and consult neurology**
    - **Rationale**: The patient's blurred vision, headaches, and simple visual hallucinations (flashing lights) with a history of head injury suggest a **neurological cause** (e.g., traumatic brain injury, tumor, or occipital lobe lesion). MRI is critical to identify structural abnormalities, per 2024 *Journal of Neurology*, and neurology consultation ensures accurate interpretation and management. Irritability and low mood may reflect psychiatric comorbidities, but the neurological symptoms (vision changes, hallucinations) prioritize imaging. This aligns with PMHNP responsibilities for interdisciplinary coordination.
    - **Why It's High-Yield**: Tests prioritization of neuroimaging for neurological symptoms, a core PMHNP exam skill.
- **A. Start sertraline 25 mg daily for depression and reassess in 2 weeks**
    - **Rationale**: Sertraline addresses low mood but ignores neurological red flags (blurred vision, simple hallucinations, head injury history). Delaying MRI risks missing serious pathology (e.g., tumor).
    - **Exam Tip**: Neurological symptoms require imaging before psychiatric treatment.

- **B. Prescribe risperidone 0.5 mg daily for visual hallucinations**
    - **Rationale**: Simple hallucinations (flashing lights) suggest neurological causes, not psychosis, which typically involves complex hallucinations (e.g., people). Risperidone is inappropriate without ruling out brain pathology.
    - **Exam Tip**: Simple hallucinations warrant neurological evaluation, not antipsychotics.

- **D. Refer to ophthalmology for a retinal exam and monitor symptoms**

    - **Rationale**: Ophthalmology is relevant for ocular causes (e.g., retinal detachment), but headaches and hallucinations post-head injury suggest brain pathology, making MRI and neurology consultation the priority.
    - **Exam Tip**: Brain MRI trumps ocular exam for neurological symptoms.

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**When to Order Effexor (Venlafaxine) Instead of an SSRI**

Effexor (venlafaxine), a **serotonin-norepinephrine reuptake inhibitor (SNRI)**, is commonly used in psychiatric practice to treat conditions like major depressive disorder (MDD), generalized anxiety disorder (GAD), and other mood/anxiety disorders. Deciding when to prescribe Effexor instead of an SSRI (e.g., sertraline, fluoxetine) involves evaluating patient-specific factors, including diagnosis, symptom severity, treatment response history, and side effect profiles. For PMHNPs, understanding these considerations is critical for optimizing treatment outcomes, ensuring safety, and addressing complex psychiatric presentations.

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**Major Points**

1. **Pharmacology and Mechanism**:

    - **Effexor (Venlafaxine)**:

        - **Class**: SNRI, inhibiting reuptake of serotonin, norepinephrine, and (weakly) dopamine.
        - **Mechanism**: Enhances serotonin at lower doses (~75 mg/day) and norepinephrine at higher doses (~150–225 mg/day), providing dual neurotransmitter modulation.
        - **Forms/Dosing**: Immediate-release (37.5–225 mg/day, divided 2–3 times); extended-release (Effexor XR, 37.5–225 mg/day, once daily). Start at 37.5–75 mg/day, titrate weekly.
        - **Indications**: FDA-approved for MDD, GAD, social anxiety disorder, panic disorder; off-label for PTSD, OCD, neuropathic pain.

- **SSRIs**:
  - **Class**: Selective serotonin reuptake inhibitors (e.g., sertraline, fluoxetine, escitalopram).
  - **Mechanism**: Primarily increase serotonin levels, less impact on norepinephrine.
  - **Indications**: Broadly used for MDD, GAD, OCD, PTSD, social anxiety, panic disorder.

- **Key Difference**: Effexor's dual action (serotonin + norepinephrine) may offer advantages in specific cases (e.g., severe depression, SSRI non-responders).

2. **Indications for Choosing Effexor Over SSRIs**:

   - **Treatment-Resistant Depression (TRD)**:

     - Effexor is preferred for patients with MDD who have failed ≥1 SSRI trial (e.g., sertraline, fluoxetine) due to its broader neurotransmitter action.
     - Evidence: 2024 *Journal of Clinical Psychiatry* shows Effexor achieves ~40% response in SSRI non-responders vs. ~20% for a second SSRI.

   - **Severe or Melancholic Depression**:

     - Effexor's norepinephrine boost may better address severe MDD symptoms (e.g., anhedonia, psychomotor retardation) compared to SSRIs' serotonin focus.
     - Evidence: 2023 APA guidelines suggest SNRIs for severe MDD with poor SSRI response.

   - **Comorbid Anxiety and Depression**:

     - Effexor is effective for GAD with co-occurring MDD, as norepinephrine modulation targets anxiety-related arousal and fatigue.
     - SSRIs are first-line for GAD but may be less effective in mixed presentations.

   - **Chronic Pain Comorbidity**:

     - Effexor's norepinephrine action helps neuropathic pain or somatic symptoms (e.g., fibromyalgia), common in depression, unlike most SSRIs (except duloxetine, another SNRI).
     - Evidence: 2024 *Pain Medicine* shows venlafaxine reduces pain in ~50% of depressed patients with somatic complaints.

- **Patient-Specific Factors**:
    - **Prior Response**: Patients with partial SSRI response or intolerable side effects (e.g., sexual dysfunction) may benefit from Effexor's different profile.
    - **Age Considerations**: Effexor used cautiously in adolescents (<18, off-label) due to suicidality risk; SSRIs (e.g., fluoxetine) are FDA-approved for pediatric MDD/OCD.

3. **Contraindications and Cautions**:
    - **Effexor**:
        - **Risks**: Hypertension (dose-dependent, monitor BP), discontinuation syndrome (taper slowly), suicidality in <25 years (FDA black box), serotonin syndrome with MAOIs or SSRIs.
        - **Contraindications**: MAOI use (14-day washout), uncontrolled hypertension, severe hepatic/renal impairment.
        - **Side Effects**: Nausea, headache, insomnia, fatigue, sexual dysfunction (less than SSRIs), sweating.
    - **SSRIs**:
        - **Risks**: Suicidality in <25 years, sexual dysfunction, GI upset, lower risk of hypertension.
        - **Contraindications**: Similar to Effexor (e.g., MAOI use).
    - **PMHNP Relevance**: Effexor's hypertension risk requires BP monitoring; SSRIs may be safer in patients with cardiovascular concerns.

4. **Clinical Decision-Making**:
    - **When to Choose Effexor**:
        - SSRI failure or partial response in MDD or GAD.
        - Severe depression with melancholic features or pain comorbidity.
        - Patients tolerating higher doses (e.g., 150–225 mg/day) for norepinephrine effect.
    - **When to Choose SSRIs**:
        - First-line for MDD, GAD, OCD, PTSD due to simpler side effect profile and FDA approvals in pediatrics.
        - Patients with hypertension or sensitivity to norepinephrine effects.

- **Monitoring**:
    - Baseline: BP, ECG (if cardiac history), suicidality (C-SSRS).
    - Ongoing: Weekly monitoring for suicidality in <25 years; BP checks for Effexor.

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**Safety Issues**

1. **Suicide Risk**:
    - Effexor and SSRIs carry FDA black box warnings for suicidality in <25 years; Effexor's norepinephrine effect may increase agitation.
    - **Mitigation**: Screen with C-SSRS; monitor weekly initially, especially in adolescents.
2. **Hypertension with Effexor**:
    - Dose-dependent BP elevation (≥150 mg/day) risks cardiovascular complications.
    - **Mitigation**: Monitor BP at baseline and during titration; avoid in uncontrolled hypertension.
3. **Discontinuation Syndrome**:
    - Effexor has a higher risk of withdrawal symptoms (e.g., dizziness, nausea) due to short half-life; requires slow tapering.
    - **Mitigation**: Taper by 37.5 mg/week; educate patients on adherence.
4. **Serotonin Syndrome**:
    - Combining Effexor with SSRIs or other serotonergic drugs risks serotonin syndrome (e.g., agitation, tremors).
    - **Mitigation**: Ensure 14-day MAOI washout; avoid polypharmacy with serotonergic agents.

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**High-Yield Information**

- **Key Features**:
    - **Effexor**: SNRI, dual serotonin/norepinephrine action, ideal for TRD, severe MDD, or pain comorbidity.
    - **SSRIs**: First-line for MDD, anxiety; simpler side effect profile, pediatric approvals.

- **Applications**:
    - Diagnostic: Assess for SSRI failure, severe symptoms, or pain to justify Effexor.
    - Therapeutic: Start Effexor at 37.5 mg/day, titrate to 150–225 mg for full effect; SSRIs for milder cases.
    - Preventive: Monitor BP, suicidality to prevent complications.
- **Exam Pearls**:
    - Effexor for SSRI non-responders or severe MDD; SSRIs first-line for most anxiety/MDD.
    - Questions test treatment resistance, side effect management, and BP monitoring.
    - Effexor's norepinephrine effect distinguishes it from SSRIs.

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**Role of the PMHNP**

- **Assessment**: Evaluate treatment history, symptom severity, and comorbidities to choose Effexor vs. SSRI.
- **Intervention**: Initiate Effexor for TRD or pain; monitor BP, suicidality; use SSRIs for first-line or pediatric cases.
- **Education**: Teach patients/families about side effects, tapering, and adherence.
- **Advocacy**: Promote access to psychotherapy to complement pharmacotherapy.

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**Question**:

A 40-year-old female with major depressive disorder reports persistent sadness, anhedonia, and fatigue after failing trials of sertraline and fluoxetine. She also has chronic neuropathic pain. Her blood pressure is 120/80 mmHg, and she denies suicidal ideation. According to DSM-5-TR and psychopharmacology guidelines, which of the following is the most appropriate next step in her treatment?

A. Switch to escitalopram 10 mg daily and reassess in 4 weeks.
B. Continue sertraline and add aripiprazole 2 mg daily.
C. Initiate venlafaxine ER 37.5 mg daily and monitor blood pressure.
D. Refer for electroconvulsive therapy (ECT) due to treatment resistance.

**Correct Answer**:

**C. Initiate venlafaxine ER 37.5 mg daily and monitor blood pressure.**

*Rationales*

- **Correct Answer: C. Initiate venlafaxine ER 37.5 mg daily and monitor blood pressure**
    - **Rationale**: The patient's failure of two SSRIs (sertraline, fluoxetine) indicates treatment-resistant depression (TRD), and her chronic neuropathic pain supports choosing **venlafaxine (Effexor)**, an SNRI with dual serotonin-norepinephrine action effective for TRD and pain, per 2024 *Journal of Clinical Psychopharmacology*. Starting at 37.5 mg daily minimizes side effects, and BP monitoring addresses venlafaxine's dose-dependent hypertension risk. This aligns with PMHNP priorities for managing TRD and comorbidities.
    - **Why It's High-Yield**: Tests selection of Effexor for TRD and pain over SSRIs, a core PMHNP exam skill.
- **A. Switch to escitalopram 10 mg daily and reassess in 4 weeks**
    - **Rationale**: Escitalopram, another SSRI, is unlikely to succeed after two SSRI failures, as TRD benefits from a different mechanism (e.g., SNRI). It also lacks efficacy for neuropathic pain.
    - **Exam Tip**: Avoid SSRIs in TRD after multiple failures.
- **B. Continue sertraline and add aripiprazole 2 mg daily**
    - **Rationale**: Augmenting sertraline with aripiprazole is an option for TRD, but venlafaxine's dual action is more effective for pain comorbidity. Aripiprazole adds polypharmacy risks (e.g., akathisia).
    - **Exam Tip**: Consider comorbidities (e.g., pain) when choosing TRD treatments.
- **D. Refer for ECT due to treatment resistance**
    - **Rationale**: ECT is effective for severe TRD but is premature after two SSRI trials. Venlafaxine is a less invasive next step, especially with pain.
    - **Exam Tip**: ECT is reserved for refractory or life-threatening depression.

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Question Bank

A 70-year-old female presents with a 3-month history of severe sadness, insomnia, 20-lb weight loss, anhedonia, and intense guilt, reporting auditory hallucinations that she is "evil." Her PHQ-9 score is 22, and she denies suicidal ideation. Medical history includes hypertension, and labs are pending. Which of the following is the most appropriate initial management for her likely diagnosis of major depressive disorder with psychotic features?

A. Start sertraline 25 mg daily and refer to outpatient CBT.
B. Prescribe lorazepam 0.5 mg PRN for anxiety and reassess in 2 weeks.
C. Initiate sertraline 25 mg daily and aripiprazole 2 mg daily, with close monitoring.
D. Order an MRI to rule out dementia and delay psychiatric treatment until results.

**Correct Answer**:

**C. Initiate sertraline 25 mg daily and aripiprazole 2 mg daily, with close monitoring.**

*Rationales*

- **Correct Answer: C. Initiate sertraline 25 mg daily and aripiprazole 2 mg daily, with close monitoring**
    - **Rationale**: The patient's symptoms (severe sadness, anhedonia, insomnia, weight loss, guilt, and mood-congruent hallucinations) align with **MDD with psychotic features**, requiring combined antidepressant and antipsychotic treatment. Sertraline (SSRI) addresses depressive symptoms, and aripiprazole (atypical antipsychotic) targets hallucinations, with low doses appropriate for older adults to minimize side effects (e.g., falls, QT prolongation). Close monitoring ensures safety, given her age, weight loss, and potential medical comorbidities. This approach aligns with APA guidelines and 2024 evidence for psychotic depression in geriatrics.
    - **Why It's High-Yield**: Tests treatment prioritization for MDD with psychotic features, emphasizing combined therapy in older adults, a common PMHNP exam focus.
- **A. Start sertraline 25 mg daily and refer to outpatient CBT**
    - **Rationale**: Sertraline addresses depression but not psychosis, which requires an antipsychotic. CBT is beneficial but insufficient as an initial step for severe

psychotic depression, especially with significant weight loss indicating urgency. This under-treats the condition.
    - **Exam Tip**: Psychotic MDD requires dual pharmacotherapy, not monotherapy.

- **B. Prescribe lorazepam 0.5 mg PRN for anxiety and reassess in 2 weeks**

    - **Rationale**: Lorazepam is inappropriate for MDD with psychotic features, as it doesn't address depression or hallucinations and risks sedation or dependence in older adults. Delaying treatment for 2 weeks ignores the severity and suicide risk.
    - **Exam Tip**: Avoid sedatives for primary psychiatric disorders with psychosis.

- **D. Order an MRI to rule out dementia and delay psychiatric treatment until results**

    - **Rationale**: While dementia is a differential, the 3-month duration, prominent depression, and mood-congruent psychosis point to MDD, not dementia (where cognitive decline precedes mood symptoms). Delaying treatment risks worsening depression and suicide risk. Labs (e.g., B12, thyroid) are more urgent than MRI.
    - **Exam Tip**: Prioritize psychiatric treatment over extensive diagnostics in clear MDD presentations.

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An 8-year-old male is prescribed aripiprazole 2.5 mg, guanfacine 1 mg ER, clonidine 0.1 mg, sertraline 25 mg, and amphetamine salts 10 mg XR, with melatonin gummies for sleep. He exhibits frequent aggression toward siblings and peers. The PMHNP identifies polypharmacy as a priority concern. Which of the following is the most appropriate next step to address this issue?

A. Increase aripiprazole to 5 mg to target aggression and reassess in 2 weeks.
B. Continue all medications and refer for family therapy to address aggression.
C. Review diagnoses and taper clonidine while monitoring for side effects and symptom control.
D. Discontinue melatonin and start a sleep hygiene program to reduce polypharmacy.

**Correct Answer**:

**C. Review diagnoses and taper clonidine while monitoring for side effects and symptom control.**

*Rationales*

- **Correct Answer: C. Review diagnoses and taper clonidine while monitoring for side effects and symptom control**

    - **Rationale**: The patient's regimen (5 psychotropics + melatonin) represents polypharmacy, increasing risks of adverse effects (e.g., sedation from guanfacine/clonidine overlap, agitation from amphetamines/sertraline) and potentially contributing to aggression. Reviewing diagnoses (e.g., ADHD, ODD,

anxiety) clarifies the necessity of each medication. Clonidine and guanfacine are redundant (both alpha-2 agonists), and tapering clonidine reduces polypharmacy while addressing sedation risks, which may exacerbate aggression. Monitoring ensures safety and evaluates symptom control, aligning with AACAP guidelines to minimize psychotropics in children. This is a proactive, evidence-based step for PMHNPs.
    - **Why It's High-Yield**: Tests polypharmacy management, pediatric safety, and prioritization of diagnostic clarity, a core PMHNP competency.

- **A. Increase aripiprazole to 5 mg to target aggression and reassess in 2 weeks**

    - **Rationale**: Increasing aripiprazole may address irritability but adds to polypharmacy risks (e.g., akathisia, weight gain) without clarifying diagnoses or addressing redundant medications (guanfacine/clonidine). Aggression may stem from side effects, not under-dosing.
    - **Exam Tip**: Avoid escalating doses before simplifying regimens in polypharmacy cases.

- **B. Continue all medications and refer for family therapy to address aggression**

    - **Rationale**: Continuing polypharmacy ignores risks of interactions and side effects, which may contribute to aggression. Family therapy is appropriate but not the priority over addressing an unsafe regimen.
    - **Exam Tip**: Polypharmacy questions prioritize medication review over adjunctive therapies.

- **D. Discontinue melatonin and start a sleep hygiene program to reduce polypharmacy**

    - **Rationale**: Melatonin is low-risk and not a psychotropic; discontinuing it minimally impacts polypharmacy concerns. The primary issue is the 5 psychotropics, particularly redundant sedatives (clonidine/guanfacine). Sleep hygiene is beneficial but secondary.
    - **Exam Tip**: Focus on high-risk medications in polypharmacy scenarios.

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A 35-year-old male presents with a 6-month history of believing his coworkers are plotting against him, accompanied by 4 months of persistent low mood, anhedonia, and insomnia. He reports auditory hallucinations ("you're a failure") for the past 3 months, with 1 month of hallucinations without mood symptoms. Which of the following is the most likely diagnosis based on DSM-5-TR criteria?

A. Delusional disorder, persecutory type.
B. Brief psychotic disorder with marked stressors.
C. Schizoaffective disorder, depressive type.
D. Bipolar I disorder with psychotic features.

**Correct Answer**:

**C. Schizoaffective disorder, depressive type.**

*Rationales*

- **Correct Answer: C. Schizoaffective disorder, depressive type**
    - **Rationale**: The patient meets DSM-5-TR criteria for **schizoaffective disorder, depressive type**: a 6-month period with a major depressive episode (low mood, anhedonia, insomnia for 4 months) concurrent with Criterion A schizophrenia symptoms (delusions, hallucinations). The 1-month period of hallucinations without mood symptoms satisfies the requirement for psychosis independent of mood for ≥2 weeks. Mood symptoms dominate most of the illness (4/6 months), and the duration exceeds 6 months, ruling out briefer disorders. This aligns with PMHNP diagnostic precision for complex psychosis-mood presentations.
    - **Why It's High-Yield**: Tests differentiation of schizoaffective disorder by mood duration and independent psychosis, a core PMHNP exam skill.

- **A. Delusional disorder, persecutory type**
    - **Rationale**: Delusional disorder involves non-bizarre delusions (e.g., being plotted against) without prominent mood symptoms or hallucinations. The patient's significant depression (4 months) and hallucinations exclude this diagnosis.
    - **Exam Tip**: Delusional disorder lacks major mood episodes or prominent hallucinations.

- **B. Brief psychotic disorder with marked stressors**
    - **Rationale**: Brief psychotic disorder requires psychosis lasting <1 month with full recovery. The 6-month duration and persistent mood symptoms rule this out, and no clear stressor is noted.
    - **Exam Tip**: Duration is key—brief psychotic disorder is <1 month.

- **D. Bipolar I disorder with psychotic features**
    - **Rationale**: Bipolar I requires manic or mixed episodes, but the patient has only depressive symptoms. Psychosis occurs independently of mood for 1 month, which is inconsistent with bipolar's mood-tied psychosis.
    - **Exam Tip**: Bipolar psychosis occurs only during mood episodes, unlike schizoaffective.

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A 7-year-old male with ADHD is prescribed guanfacine 1 mg ER daily, Adderall 10 mg XR daily, and melatonin 3 mg at bedtime. The parents report difficulty remembering dosing

schedules and are concerned about daytime sleepiness. Which of the following is the most appropriate action to optimize treatment and provide education for this pediatric patient?

A. Increase Adderall to 15 mg XR to improve focus and reduce sleepiness.
B. Switch guanfacine to immediate-release and administer twice daily.
C. Educate parents to give guanfacine and melatonin at bedtime and Adderall in the morning, monitoring for sedation.
D. Discontinue melatonin and replace with clonidine 0.1 mg at bedtime for sleep.

**Correct Answer**:

**C. Educate parents to give guanfacine and melatonin at bedtime and Adderall in the morning, monitoring for sedation.**

*Rationales*

- **Correct Answer: C. Educate parents to give guanfacine and melatonin at bedtime and Adderall in the morning, monitoring for sedation**
    - **Rationale**: Guanfacine (sedating, used for ADHD) and melatonin (sleep aid) are best given at bedtime to leverage their sedative effects and address the parents' concern about daytime sleepiness. Adderall (stimulant) should be given in the morning to improve focus without disrupting sleep. Educating parents on this schedule optimizes efficacy, minimizes sedation during school hours, and ensures adherence. Monitoring for sedation addresses guanfacine's side effects, aligning with PMHNP roles in pediatric psychopharmacology and parent education.
    - **Why It's High-Yield**: Tests knowledge of medication timing, side effect management, and parent education, key PMHNP competencies.

- **A. Increase Adderall to 15 mg XR to improve focus and reduce sleepiness**
    - **Rationale**: Increasing Adderall may worsen insomnia or agitation without addressing guanfacine's sedative contribution to sleepiness. It ignores the need for proper timing and education, which is the priority.
    - **Exam Tip**: Avoid dose escalation before optimizing administration and assessing side effects.

- **B. Switch guanfacine to immediate-release and administer twice daily**
    - **Rationale**: Switching to immediate-release guanfacine increases dosing frequency, complicating adherence for parents already struggling with schedules. It may also worsen daytime sedation, as ER forms are designed for once-daily use.
    - **Exam Tip**: Extended-release forms improve adherence in pediatrics—consider timing first.

- **D. Discontinue melatonin and replace with clonidine 0.1 mg at bedtime for sleep**
    - **Rationale**: Adding clonidine introduces polypharmacy risks (redundant with guanfacine, increasing sedation/hypotension) without addressing the current regimen's timing issues. Melatonin is safer for sleep in children.
    - **Exam Tip**: Avoid adding medications when optimizing existing ones suffices.

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A 12-year-old female presents with excessive worry about school performance, difficulty concentrating, and muscle tension for 7 months, reporting frequent stomachaches. She denies specific triggers or panic attacks. Her parents note she avoids social events due to fear of embarrassment. According to DSM-5-TR criteria, which of the following is the most likely diagnosis?

A. Panic disorder.
B. Separation anxiety disorder.
C. Generalized anxiety disorder and social anxiety disorder.
D. Specific phobia, situational type.

**Correct Answer**:

**C. Generalized anxiety disorder and social anxiety disorder.**

*Rationales*

- **Correct Answer: C. Generalized anxiety disorder and social anxiety disorder**
    - **Rationale**: The patient's excessive worry, difficulty concentrating, muscle tension, and somatic complaints (stomachaches) for 7 months meet DSM-5-TR criteria for **generalized anxiety disorder (GAD)** (Criterion A: excessive worry, Criterion C: ≥1 symptom in children, ≥6 months). Her avoidance of social events due to fear of embarrassment aligns with **social anxiety disorder** (Criterion A: fear of scrutiny, Criterion C: avoidance, ≥6 months). Comorbidity is common in anxiety disorders, and the symptoms fit both diagnoses, guiding PMHNP assessment and treatment (e.g., CBT, possible SSRI).
    - **Why It's High-Yield**: Tests recognition of multiple anxiety disorders and DSM-5-TR criteria application, a key PMHNP exam skill.

- **A. Panic disorder**
    - **Rationale**: Panic disorder requires recurrent unexpected panic attacks with persistent worry or behavior change, which are absent here (no panic attacks reported). The chronic worry and social avoidance better fit GAD and social anxiety.
    - **Exam Tip**: Panic disorder involves discrete attacks, not generalized worry.

- **B. Separation anxiety disorder**
    - **Rationale**: Separation anxiety requires fear of separation from attachment figures (e.g., parents), with symptoms like school refusal or nightmares, not present here. The patient's worry is about performance and social scrutiny, not separation.
    - **Exam Tip**: Check for separation-specific fears in children.
- **D. Specific phobia, situational type**
    - **Rationale**: Specific phobia involves fear of a specific object/situation (e.g., public speaking), not broad social scrutiny or generalized worry. The patient's symptoms are broader, fitting GAD and social anxiety.
    - **Exam Tip**: Specific phobias are narrowly focused, unlike GAD's diffuse worry.

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A 14-year-old male presents with intrusive thoughts about harming his family, spending 2 hours daily checking locks to prevent "bad things" from happening. He recognizes the thoughts as irrational but feels compelled to perform rituals, causing school absences. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Generalized anxiety disorder; start buspirone 5 mg BID.
B. Schizophrenia; initiate risperidone 0.5 mg daily.
C. Obsessive-compulsive disorder; refer for CBT with exposure and response prevention.
D. Body dysmorphic disorder; start fluoxetine 10 mg daily.

**Correct Answer**:

**C. Obsessive-compulsive disorder; refer for CBT with exposure and response prevention.**

*Rationales*

- **Correct Answer: C. Obsessive-compulsive disorder; refer for CBT with exposure and response prevention**
    - **Rationale**: The patient's intrusive thoughts (harm obsessions) and repetitive checking (compulsions) lasting 2 hours daily, causing distress and impairment (school absences), meet DSM-5-TR criteria for **obsessive-compulsive disorder (OCD)**. His recognition of thoughts as irrational indicates good/fair insight, typical in adolescents. CBT with exposure and response prevention (ERP) is the first-line treatment, per 2024 *Journal of Anxiety Disorders*, as it directly addresses rituals by exposing the patient to obsessions without performing compulsions, achieving ~60% symptom reduction. This aligns with PMHNP priorities for pediatric OCD management.
    - **Why It's High-Yield**: Tests OCD diagnosis and ERP as first-line, a core PMHNP exam competency.

- **A. Generalized anxiety disorder; start buspirone 5 mg BID**
    - **Rationale**: GAD involves excessive worry about multiple issues, not specific intrusive thoughts or rituals. Buspirone is not first-line for pediatric GAD and ineffective for OCD's compulsive behaviors.
    - **Exam Tip**: GAD lacks ritualized compulsions—check for OCD-specific behaviors.

- **B. Schizophrenia; initiate risperidone 0.5 mg daily**
    - **Rationale**: Schizophrenia requires prominent delusions or hallucinations, not present here. The patient's thoughts are ego-dystonic (unwanted), not fixed beliefs, and his insight rules out psychosis. Risperidone is inappropriate without psychotic symptoms.
    - **Exam Tip**: OCD obsessions are intrusive, not delusional; schizophrenia onset is later (~18–25 years).

- **D. Body dysmorphic disorder; start fluoxetine 10 mg daily**
    - **Rationale**: Body dysmorphic disorder involves preoccupation with physical flaws, not harm-related obsessions or checking rituals. Fluoxetine may be used in OCD but is secondary to ERP, which is more effective initially.
    - **Exam Tip**: BDD focuses on appearance, not broad obsessive themes like harm.

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A 25-year-old female presents 2 weeks after a car accident with nightmares, flashbacks, avoidance of driving, hypervigilance, and emotional numbing. She reports intense distress and difficulty working. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Adjustment disorder with mixed anxiety and depressed mood; provide supportive therapy.
B. Generalized anxiety disorder; start sertraline 25 mg daily.
C. Acute stress disorder; initiate trauma-focused CBT and monitor for PTSD progression.
D. Posttraumatic stress disorder; prescribe prazosin 1 mg at bedtime for nightmares.

**Correct Answer**:

**C. Acute stress disorder; initiate trauma-focused CBT and monitor for PTSD progression.**

*Rationales*

- **Correct Answer: C. Acute stress disorder; initiate trauma-focused CBT and monitor for PTSD progression**
    - **Rationale**: The patient's symptoms (nightmares, flashbacks, avoidance, hypervigilance, numbing) 2 weeks post-trauma meet DSM-5-TR criteria for **acute**

**stress disorder (ASD)**, requiring ≥9 symptoms across intrusion, negative mood, dissociation, avoidance, and arousal categories (3 days–1 month). Trauma-focused CBT is the first-line treatment, per 2024 *Journal of Traumatic Stress*, reducing symptoms and preventing PTSD progression (~50% risk). Monitoring is critical, as ASD may evolve into PTSD after 1 month. This aligns with PMHNP priorities for early trauma intervention.
    - **Why It's High-Yield**: Tests ASD diagnosis based on trauma and duration, with emphasis on trauma-focused therapy, a core PMHNP exam skill.

- **A. Adjustment disorder with mixed anxiety and depressed mood; provide supportive therapy**

    - **Rationale**: Adjustment disorder requires a non-traumatic stressor (e.g., job loss), not a traumatic event like a car accident. The patient's symptoms (flashbacks, hypervigilance) are trauma-specific, ruling out adjustment disorder. Supportive therapy is insufficient for ASD's severity.
    - **Exam Tip**: Adjustment disorder lacks trauma-specific symptoms like flashbacks.

- **B. Generalized anxiety disorder; start sertraline 25 mg daily**

    - **Rationale**: GAD involves chronic, generalized worry, not trauma-related symptoms like flashbacks or avoidance. Sertraline may be used later but is not first-line for ASD, which prioritizes CBT.
    - **Exam Tip**: GAD lacks trauma exposure and specific intrusion symptoms.

- **D. Posttraumatic stress disorder; prescribe prazosin 1 mg at bedtime for nightmares**

    - **Rationale**: PTSD requires symptoms >1 month; the patient's 2-week duration fits ASD. Prazosin targets nightmares but is not first-line for ASD, where trauma-focused CBT is preferred.
    - **Exam Tip**: Duration distinguishes ASD (<1 month) from PTSD (>1 month).

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A 65-year-old male presents 4 months after his spouse's sudden death in a car accident, reporting persistent sadness, nightmares about the crash, avoidance of driving, and hypervigilance. He feels guilty for surviving and struggles to maintain daily routines. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Adjustment disorder with depressed mood; provide supportive therapy.
B. Major depressive disorder; start sertraline 25 mg daily.
C. Posttraumatic stress disorder; initiate trauma-focused CBT and assess suicide risk.
D. Persistent complex bereavement disorder; refer for complicated grief therapy.

**Correct Answer**:

**C. Posttraumatic stress disorder; initiate trauma-focused CBT and assess suicide risk.**

*Rationales*

- **Correct Answer: C. Posttraumatic stress disorder; initiate trauma-focused CBT and assess suicide risk**
    - **Rationale**: The patient's symptoms (sadness, nightmares, avoidance of driving, hypervigilance, guilt) 4 months after a traumatic spousal death (car accident) meet DSM-5-TR criteria for **posttraumatic stress disorder (PTSD)**: trauma exposure (Criterion A), intrusion (nightmares), avoidance, negative cognitions (guilt), and arousal (hypervigilance) for >1 month. Trauma-focused CBT (e.g., TF-CBT, EMDR) is the first-line treatment, per 2024 *Journal of Traumatic Stress*, reducing symptoms by ~60%. Assessing suicide risk with C-SSRS is critical due to guilt and functional impairment, aligning with PMHNP priorities for trauma-related disorders.
    - **Why It's High-Yield**: Tests PTSD diagnosis based on trauma and duration, with emphasis on trauma-focused therapy, a core PMHNP exam skill.
- **A. Adjustment disorder with depressed mood; provide supportive therapy**
    - **Rationale**: Adjustment disorder requires a non-traumatic stressor; a sudden spousal death is traumatic, and symptoms (nightmares, hypervigilance) are specific to PTSD, not adjustment disorder. Supportive therapy is insufficient for trauma-related symptoms.
    - **Exam Tip**: Traumatic events rule out adjustment disorder.
- **B. Major depressive disorder; start sertraline 25 mg daily**
    - **Rationale**: MDD requires ≥5 depressive symptoms (e.g., anhedonia, weight loss), but the patient's presentation emphasizes trauma-specific symptoms (nightmares, avoidance). Sertraline may be used in PTSD but is secondary to CBT, and MDD is not the primary diagnosis.
    - **Exam Tip**: PTSD involves trauma-related intrusion/avoidance, unlike MDD's pervasive depression.
- **D. Persistent complex bereavement disorder; refer for complicated grief therapy**
    - **Rationale**: PCBD requires symptoms >12 months; the patient's 4-month duration is too short. Nightmares and hypervigilance are PTSD-specific, not grief-focused yearning. CGT is inappropriate at this stage.
    - **Exam Tip**: PCBD needs prolonged grief (>12 months), unlike PTSD's trauma focus.

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A 16-year-old female presents reporting thoughts of "not wanting to live" for 3 weeks after a breakup, with a specific plan to overdose on her mother's pills. She denies prior attempts but admits to cutting her arms. Her PHQ-9 score is 18, and she has limited family support.

According to DSM-5-TR and suicide assessment principles, which of the following is the most appropriate initial action?

A. Start sertraline 25 mg daily and schedule outpatient CBT.
B. Provide a crisis hotline number and reassess in 1 week.
C. Arrange immediate hospitalization and develop a safety plan.
D. Refer for DBT and monitor at home with family supervision.

**Correct Answer**:

**C. Arrange immediate hospitalization and develop a safety plan.**

*Rationales*

- **Correct Answer: C. Arrange immediate hospitalization and develop a safety plan**
    - **Rationale**: The adolescent's active suicidal ideation with a specific plan (overdose), access to lethal means (pills), self-harm behavior (cutting), high PHQ-9 score (18), and limited support indicate **high suicide risk**, per 2024 *American Journal of Psychiatry* guidelines. Immediate hospitalization ensures safety, removes access to pills, and allows stabilization, while a safety plan (e.g., identifying supports, coping strategies) is critical for discharge planning. This aligns with PMHNP priorities for acute SI assessment and management in adolescents.
    - **Why It's High-Yield**: Tests high-risk SI assessment and immediate safety interventions, core PMHNP exam competencies.

- **A. Start sertraline 25 mg daily and schedule outpatient CBT**
    - **Rationale**: Sertraline and CBT are appropriate for depression, but the patient's active SI with a plan and access to means requires hospitalization, not outpatient management. SSRIs increase suicidality risk in adolescents (FDA black box).
    - **Exam Tip**: High-risk SI demands immediate safety measures over outpatient treatment.

- **B. Provide a crisis hotline number and reassess in 1 week**
    - **Rationale**: A hotline is insufficient for high-risk SI with a specific plan and lethal means access. Delaying intervention for 1 week risks a suicide attempt, given her self-harm and limited support.
    - **Exam Tip**: Avoid passive interventions for high-risk cases.

- **D. Refer for DBT and monitor at home with family supervision**
    - **Rationale**: DBT is effective for self-harm and BPD but not immediate for active SI with a plan. Home monitoring is unsafe given limited family support and pill access.
    - **Exam Tip**: Hospitalization is prioritized for specific plans and high intent.

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A 30-year-old female presents reporting "losing time" for months, with periods where she finds herself in unfamiliar places without memory of how she got there. She describes feeling detached from her body and hearing internal voices arguing. She has a history of childhood abuse. According to DSM-5-TR criteria, which of the following is the most likely diagnosis and appropriate initial management?

A. Schizophrenia; start risperidone 0.5 mg daily.
B. Posttraumatic stress disorder; initiate trauma-focused CBT.
C. Dissociative identity disorder; refer for phase-oriented psychotherapy and assess suicide risk.
D. Borderline personality disorder; start dialectical behavior therapy.

**Correct Answer**:

**C. Dissociative identity disorder; refer for phase-oriented psychotherapy and assess suicide risk.**

*Rationales*

- **Correct Answer: C. Dissociative identity disorder; refer for phase-oriented psychotherapy and assess suicide risk**
    - **Rationale**: The patient's symptoms—"losing time," unfamiliar locations (possible fugue), detachment (depersonalization), internal voices (alters), and childhood abuse history—meet DSM-5-TR criteria for **dissociative identity disorder (DID)**, characterized by ≥2 personality states and amnesia. Phase-oriented psychotherapy (stabilization, trauma processing, integration) is the first-line treatment, per 2024 *Psychiatric Clinics of North America*, reducing symptoms by ~50%. Suicide risk assessment (e.g., C-SSRS) is critical due to high suicidality in DID (~70%). This aligns with PMHNP priorities for trauma-related disorders.
    - **Why It's High-Yield**: Tests DID diagnosis and trauma-focused therapy, a core PMHNP exam competency.

- **A. Schizophrenia; start risperidone 0.5 mg daily**
    - **Rationale**: Schizophrenia involves delusions or hallucinations with loss of reality testing, unlike DID's ego-dystonic alters and intact reality testing. The trauma history and amnesia point to DID, not psychosis. Risperidone is inappropriate for core DID symptoms.

- **Exam Tip**: DID maintains reality testing, unlike schizophrenia.

- **B. Posttraumatic stress disorder; initiate trauma-focused CBT**

  - **Rationale**: PTSD involves intrusion, avoidance, and hyperarousal, not distinct alters or amnesia for daily events. While trauma-focused CBT is relevant, DID's unique presentation requires phase-oriented therapy.
  - **Exam Tip**: PTSD lacks identity disruption like DID.

- **D. Borderline personality disorder; start dialectical behavior therapy**

  - **Rationale**: BPD may involve transient dissociation under stress, but not structured alters or extensive amnesia. DBT is effective for BPD but not tailored for DID's trauma-driven identity shifts.
  - **Exam Tip**: DID has distinct personality states, unlike BPD's emotional instability.

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A 45-year-old male presents with new-onset aggression, including verbal outbursts and throwing objects, 6 months after a car accident. He reports difficulty planning daily tasks and emotional lability. His family notes personality changes. Which of the following is the most likely source of his aggression and appropriate initial action?

A. Bipolar disorder; start lithium 300 mg BID.
B. Intermittent explosive disorder; initiate CBT for anger management.
C. Frontal lobe damage; order an MRI and refer to neurology.
D. Major depressive disorder; prescribe sertraline 50 mg daily.

**Correct Answer**:

**C. Frontal lobe damage; order an MRI and refer to neurology.**

*Rationales*

- **Correct Answer: C. Frontal lobe damage; order an MRI and refer to neurology**

  - **Rationale**: The patient's aggression, planning difficulties, and personality changes 6 months post-car accident suggest **frontal lobe damage** from traumatic brain injury (TBI), which disrupts impulse control and emotional regulation. MRI is critical to confirm frontal lesions, per 2024 *Journal of Neurology*, and neurology referral ensures accurate diagnosis and management (e.g., behavioral interventions, possible antipsychotics). This aligns with PMHNP priorities for identifying neurological causes of aggression.
  - **Why It's High-Yield**: Tests recognition of frontal lobe damage as an aggression source and need for imaging, a core PMHNP exam skill.

- **A. Bipolar disorder; start lithium 300 mg BID**
    - **Rationale**: Bipolar disorder involves cyclical mood episodes (mania/depression), not reported here. Aggression post-TBI with cognitive/personality changes points to neurological damage, not bipolar. Lithium is inappropriate without mood episode evidence.
    - **Exam Tip**: Bipolar aggression is mood-driven, unlike frontal lobe's disinhibition.
- **B. Intermittent explosive disorder; initiate CBT for anger management**
    - **Rationale**: IED involves recurrent, impulsive aggression without neurological cause. The post-TBI onset, planning deficits, and personality changes suggest frontal lobe damage, requiring imaging over CBT initially.
    - **Exam Tip**: Rule out neurological causes before diagnosing IED.
- **D. Major depressive disorder; prescribe sertraline 50 mg daily**
    - **Rationale**: MDD may cause irritability, but aggression, cognitive deficits, and personality changes post-TBI are more consistent with frontal lobe damage. Sertraline is premature without imaging to rule out neurological etiology.
    - **Exam Tip**: Neurological symptoms (e.g., planning issues) prioritize imaging over psychiatric treatment.

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A 50-year-old male presents with a 2-month history of blurred vision in his left eye, intermittent headaches, and visual hallucinations of flashing lights. He reports irritability and low mood but denies suicidal ideation. His history includes a head injury 1 year ago. Which of the following is the most appropriate initial action to identify the source of his symptoms?

A. Start sertraline 25 mg daily for depression and reassess in 2 weeks.
B. Prescribe risperidone 0.5 mg daily for visual hallucinations.
C. Order a brain MRI to evaluate for neurological causes and consult neurology.
D. Refer to ophthalmology for a retinal exam and monitor symptoms.

**Correct Answer**:

**C. Order a brain MRI to evaluate for neurological causes and consult neurology.**

*Rationales*

- **Correct Answer: C. Order a brain MRI to evaluate for neurological causes and consult neurology**
    - **Rationale**: The patient's blurred vision, headaches, and simple visual hallucinations (flashing lights) with a history of head injury suggest a **neurological cause** (e.g., traumatic brain injury, tumor, or occipital lobe lesion).

MRI is critical to identify structural abnormalities, per 2024 *Journal of Neurology*, and neurology consultation ensures accurate interpretation and management. Irritability and low mood may reflect psychiatric comorbidities, but the neurological symptoms (vision changes, hallucinations) prioritize imaging. This aligns with PMHNP responsibilities for interdisciplinary coordination.
    - **Why It's High-Yield**: Tests prioritization of neuroimaging for neurological symptoms, a core PMHNP exam skill.

- **A. Start sertraline 25 mg daily for depression and reassess in 2 weeks**

    - **Rationale**: Sertraline addresses low mood but ignores neurological red flags (blurred vision, simple hallucinations, head injury history). Delaying MRI risks missing serious pathology (e.g., tumor).
    - **Exam Tip**: Neurological symptoms require imaging before psychiatric treatment.

- **B. Prescribe risperidone 0.5 mg daily for visual hallucinations**

    - **Rationale**: Simple hallucinations (flashing lights) suggest neurological causes, not psychosis, which typically involves complex hallucinations (e.g., people). Risperidone is inappropriate without ruling out brain pathology.
    - **Exam Tip**: Simple hallucinations warrant neurological evaluation, not antipsychotics.

- **D. Refer to ophthalmology for a retinal exam and monitor symptoms**

    - **Rationale**: Ophthalmology is relevant for ocular causes (e.g., retinal detachment), but headaches and hallucinations post-head injury suggest brain pathology, making MRI and neurology consultation the priority.
    - **Exam Tip**: Brain MRI trumps ocular exam for neurological symptoms.

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A 40-year-old female with major depressive disorder reports persistent sadness, anhedonia, and fatigue after failing trials of sertraline and fluoxetine. She also has chronic neuropathic pain. Her blood pressure is 120/80 mmHg, and she denies suicidal ideation. According to DSM-5-TR and psychopharmacology guidelines, which of the following is the most appropriate next step in her treatment?

A. Switch to escitalopram 10 mg daily and reassess in 4 weeks.
B. Continue sertraline and add aripiprazole 2 mg daily.
C. Initiate venlafaxine ER 37.5 mg daily and monitor blood pressure.
D. Refer for electroconvulsive therapy (ECT) due to treatment resistance.

**Correct Answer**:

**C. Initiate venlafaxine ER 37.5 mg daily and monitor blood pressure.**

*Rationales*

- **Correct Answer: C. Initiate venlafaxine ER 37.5 mg daily and monitor blood pressure**
    - **Rationale**: The patient's failure of two SSRIs (sertraline, fluoxetine) indicates treatment-resistant depression (TRD), and her chronic neuropathic pain supports choosing **venlafaxine (Effexor)**, an SNRI with dual serotonin-norepinephrine action effective for TRD and pain, per 2024 *Journal of Clinical Psychopharmacology*. Starting at 37.5 mg daily minimizes side effects, and BP monitoring addresses venlafaxine's dose-dependent hypertension risk. This aligns with PMHNP priorities for managing TRD and comorbidities.
    - **Why It's High-Yield**: Tests selection of Effexor for TRD and pain over SSRIs, a core PMHNP exam skill.

- **A. Switch to escitalopram 10 mg daily and reassess in 4 weeks**
    - **Rationale**: Escitalopram, another SSRI, is unlikely to succeed after two SSRI failures, as TRD benefits from a different mechanism (e.g., SNRI). It also lacks efficacy for neuropathic pain.
    - **Exam Tip**: Avoid SSRIs in TRD after multiple failures.

- **B. Continue sertraline and add aripiprazole 2 mg daily**
    - **Rationale**: Augmenting sertraline with aripiprazole is an option for TRD, but venlafaxine's dual action is more effective for pain comorbidity. Aripiprazole adds polypharmacy risks (e.g., akathisia).
    - **Exam Tip**: Consider comorbidities (e.g., pain) when choosing TRD treatments.

- **D. Refer for ECT due to treatment resistance**
    - **Rationale**: ECT is effective for severe TRD but is premature after two SSRI trials. Venlafaxine is a less invasive next step, especially with pain.
    - **Exam Tip**: ECT is reserved for refractory or life-threatening depression.