NGN NCLEX-RN · 2026 TEST PLAN

MASTER REVIEW · VOL. III

Psychosocial *Integrity*

A color-coded master review of the mind, mood, milieu, and the moments where nursing judgment is the intervention.

TEST PLAN WEIGHT	SUBDOMAIN	NGN LAYER
6 – 12%	Client Needs · Category III	Clinical Judgment

§ 01 NCLEX Test Plan & Color Key

Psychosocial Integrity covers the promotion and support of emotional, mental, and social well-being of clients experiencing acute or chronic mental illness, as well as the psychosocial dimensions of *any* clinical situation — childbirth, ICU stays, terminal diagnoses, and end-of-life. This domain is heavily tested through Next Generation NCLEX (NGN) item types because it requires layered **clinical judgment**: recognize cues, analyze them, prioritize hypotheses, generate solutions, take actions, evaluate outcomes.

COLOR SYSTEM USED THROUGHOUT

RED Safety / Priority	ORANGE Action / Intervention	MUSTARD Assess / Cues	GREEN Therapeutic
BLUE Concept / Theory	PLUM Pharmacology	ROSE Communication / Culture	

● TOP PRIORITY ALWAYS

When a Psychosocial item competes with itself: **Safety > Physiologic stability > Therapeutic communication > Teaching**. A suicidal client's safety outranks any conversation. A delirious post-op client's oxygen outranks any reassurance.

§ 02

NGN Item Types You Will See

NGN items measure the six steps of the NCSBN Clinical Judgment Measurement Model. Psychosocial scenarios are favorites for **case studies** because patient cues unfold over multiple shifts.

ITEM TYPE	WHAT IT LOOKS LIKE	PSYCHOSOCIAL EXAMPLE
Extended Multiple Response	Select all that apply with partial credit.	"Which findings indicate worsening depression?"
Cloze (Drop-Down)	Fill blanks in a sentence from menus.	"The client is at greatest risk for ___ related to ___."
Matrix / Grid	Categorize findings (expected, unexpected, urgent).	Sort assessment data on a manic client.
Highlight	Click sentences in a chart that are concerning.	Identify suicide warning signs in a progress note.
Bow-Tie	Center: priority condition; left: actions to take; right: parameters to monitor.	Alcohol withdrawal — assess CIWA, give thiamine, monitor seizures.
Trend / Case Study	Six linked questions about one evolving client.	Postpartum client trending into psychosis over 72 hours.

● THE SIX-STEP JUDGMENT LOOP

1. **Recognize Cues** — what data stands out?
2. **Analyze Cues** — what does it mean?
3. **Prioritize Hypotheses** — most urgent / most likely?
4. **Generate Solutions** — what could be done?
5. **Take Actions** — what will you do first?
6. **Evaluate Outcomes** — did it work?

§ 03

Therapeutic Communication

The single highest-yield topic in psychosocial nursing. The NCLEX rewards responses that are **open-ended, non-judgmental, focused on feelings, and keep the client talking**. It punishes false reassurance, "why" questions, advice-giving, and changing the subject.

✓ Therapeutic — Choose These

- **Active listening** — silence, eye contact, "Mm-hmm."
- **Open-ended** — "Tell me more about that."
- **Reflecting** — "You sound frightened."
- **Restating** — "So you've felt this way for two weeks."
- **Clarifying** — "I'm not sure I follow — could you explain?"
- **Focusing** — "Let's go back to what you said about your husband."
- **Offering self** — "I'll sit with you for a while."
- **Exploring** — "What was that like for you?"
- **Validating reality (with delusions)** — "I don't hear the voices, but I understand they feel real to you."
- **Acknowledging feelings** — never the behavior, the *feeling*.

✗ Non-Therapeutic — Eliminate Immediately

- **False reassurance** — "Everything will be fine."
- **Why questions** — "Why did you do that?"
- **Giving advice** — "You should leave him."
- **Approval / disapproval** — "That's a great choice."
- **Defending** — "The staff here are excellent."
- **Changing the subject** — anything that redirects from feelings.
- **Closed yes/no** when feelings need exploring.
- **Minimizing** — "It could be worse."
- **Stereotyped clichés** — "Time heals all wounds."
- **Agreeing with delusions or hallucinations.**

THE "FEELINGS FIRST" RULE

If two answer choices both seem therapeutic, the one that **names or invites the client's feeling** wins. "You seem worried about the surgery" beats "Surgery is safer than ever."

Special Communication Situations

HALLUCINATIONS

- Present reality without arguing: *"I don't hear any voices, but I can see they're upsetting you."*
- Ask what the voices are saying — assess for **command hallucinations** to harm self or others.
- Distract with reality-based activity; do not touch unexpectedly.

DELUSIONS

- Do not argue, agree, or reinforce the delusion.
- Acknowledge the underlying feeling (fear, grandiosity, suspicion).
- Redirect to reality-based topics. Avoid whispering or laughing within view of a paranoid client.

THE MANIPULATIVE CLIENT

- Set firm, consistent limits; communicate them across all staff to prevent **splitting**.
- State expectations matter-of-factly. Do not argue or take it personally.
- Reward appropriate behavior; do not engage with attention-seeking acts.

THE AGGRESSIVE / ESCALATING CLIENT

- **Safety first**: ensure your exit is unobstructed; remove other clients from area.
- Speak in a calm, low voice; maintain non-threatening posture; respect personal space (4–6 ft).
- Offer choices that allow saving face: "Would you like to walk to your room or sit in the day room?"
- Restraints/seclusion are **last resort** — must have an order, monitored q15 min, time-limited, removed at earliest opportunity.

§ 04

Defense Mechanisms

Unconscious mental processes that protect the ego from anxiety. The NCLEX wants you to **recognize** them in a clinical scenario, not analyze them.

MECHANISM	DEFINITION	EXAMPLE
Denial	Refusing to accept reality.	Recently diagnosed alcoholic insists, "I can quit anytime."
Repression	Unconscious blocking of painful thoughts.	Survivor of abuse cannot recall childhood years.
Suppression	Conscious "I'll deal with it later."	"I can't think about my biopsy until after my exam."
Projection	Attributing own feelings to others.	An angry client states, "Everyone here hates me."
Displacement	Redirecting feelings to a safer target.	Yelled at by boss, then yells at spouse.
Reaction Formation	Behaving opposite to true feelings.	Hates new sibling but is overly affectionate.
Rationalization	Logical-sounding excuses.	"I failed because the test was unfair."
Sublimation	Channeling drives into acceptable outlets.	Aggressive teen joins boxing.
Regression	Reverting to earlier developmental stage.	Hospitalized 5-year-old begins thumb-sucking.
Identification	Adopting traits of an admired person.	Adolescent dresses like a celebrity.
Introjection	Internalizing another's values as one's own.	Child adopts parent's prejudices as fact.
Compensation	Excelling in one area to make up for another.	Short student becomes a star debater.
Conversion	Anxiety expressed as physical symptom.	Sudden blindness with no organic cause after a trauma.
Splitting	All-good / all-bad thinking.	"You're the only nurse who cares — the others are awful."
Undoing	Symbolic reversal of an act.	Compulsive handwashing after intrusive thoughts.
Intellectualization	Detaching emotion through analysis.	Cancer patient quotes survival statistics, no affect.

§ 05

Anxiety & Trauma Disorders

Levels of Anxiety

LEVEL	PERCEPTION	BEHAVIOR	NURSING ACTION
Mild	Heightened awareness; learning enhanced.	Restlessness, mild fidgeting.	Encourage problem-solving and learning.
Moderate	Narrowed attention; selective inattention.	Voice tremor, ↑ HR, pacing.	Stay calm, provide gentle structure, redirect focus.
Severe	Greatly reduced perceptual field.	Hyperventilation, dread, somatic complaints.	Stay with client, reduce stimuli, simple short directions.
Panic	Distorted, terror, loss of rational thought.	Inability to communicate, may flee or freeze.	**Stay with client**, ensure safety, low calm voice, may need PRN benzo.

Generalized Anxiety Disorder (GAD)

Excessive worry most days for ≥6 months; restlessness, fatigue, irritability, muscle tension, sleep disturbance.

TX

SSRIs/SNRIs first-line, buspirone, CBT.

Panic Disorder

Recurrent unexpected panic attacks: chest pain, dyspnea, derealization, fear of dying. Peaks in 10 min.

TX

SSRIs long-term; benzos short-term/PRN; CBT; breathing retraining.

Phobias

Persistent fear of specific object/situation. Includes agoraphobia, social anxiety disorder.

TX

Systematic desensitization, exposure therapy, SSRIs.

Obsessive-Compulsive Disorder

Obsessions (thoughts) + compulsions (rituals) that consume >1 hr/day or impair function.

NURSING

Allow ritual initially (interrupting raises anxiety); set limits gradually; SSRIs (high dose) + ERP therapy.

PTSD

Symptoms >1 month after trauma: intrusion (flashbacks, nightmares), avoidance, negative cognition, hyperarousal.

TX

SSRIs (sertraline, paroxetine), prazosin for nightmares, trauma-focused CBT, EMDR.

Acute Stress Disorder

Same as PTSD but symptoms last 3 days – 1 month post-trauma.

NURSING

Allow expression; do not force discussion; ensure safety; psychoeducation.

● **PANIC ATTACK PRIORITY**

Stay with the client. Speak in short, simple sentences. Reduce stimuli. Do *not* leave the client alone or offer detailed teaching during panic — perception is too narrow to learn.

§ 06

Mood Disorders

Major Depressive Disorder

≥5 symptoms ≥2 weeks, including **depressed mood** or **anhedonia**.

MNEMONIC — DEPRESSION

SIG E CAPS

- **S** Sleep changes (insomnia or hypersomnia)
- **I** Interest loss (anhedonia)
- **G** Guilt or worthlessness
- **E** Energy loss / fatigue
- **C** Concentration impaired
- **A** Appetite/weight change
- **P** Psychomotor agitation or retardation
- **S** Suicidal ideation

● HIGHEST-RISK WINDOW

Suicide risk is **greatest as depression begins to lift** (1–2 weeks after antidepressant started). The client now has the energy to act on prior ideation. Maintain close observation during this window.

● NURSING CARE FOR DEPRESSION

- Assess for suicide directly: "Are you thinking about killing yourself?" — does *not* plant the idea.
- Keep environment safe: remove sharps, cords, glass, medications.
- Spend time with client even if non-verbal; sit silently if needed.
- Encourage simple, short tasks the client can succeed at.
- ECT is effective for severe/refractory depression and during pregnancy when meds are contraindicated.

Bipolar Disorders

TYPE	DEFINING FEATURE
Bipolar I	≥1 manic episode (≥7 days or any duration if hospitalized).
Bipolar II	≥1 hypomanic episode + ≥1 major depressive episode; never full mania.

TYPE	DEFINING FEATURE
Cyclothymia	≥2 yrs of fluctuating sub-threshold hypomanic and depressive symptoms.

MNEMONIC — MANIA

DIG FAST

- **D** Distractibility
- **I** Indiscretion / impulsivity (spending, sex, risk)
- **G** Grandiosity
- **F** Flight of ideas
- **A** Activity / agitation increased
- **S** Sleep — decreased need
- **T** Talkativeness / pressured speech

CARING FOR THE ACUTELY MANIC CLIENT

- **Reduce stimuli** — quiet room, soft lighting, low-stim activities.
- **Finger foods, high calorie** — the client cannot sit to eat.
- **Limit setting**: short, clear, consistent across all staff.
- **Channel energy** — walking, drawing, repetitive simple tasks.
- Do *not* argue with grandiose claims; redirect.
- Assess fluid balance and sleep; mania can become medical emergency from exhaustion.

§ 07

Schizophrenia & Psychotic Disorders

Schizophrenia: ≥6 months of disturbance with ≥1 month of active-phase symptoms.
Symptoms divide into positive, negative, and cognitive.

Positive Symptoms (added)

Hallucinations, delusions, disorganized speech, disorganized or catatonic behavior. Respond best to typical antipsychotics.

Negative Symptoms (lost)

Affective flattening, alogia (poverty of speech), avolition, anhedonia, asociality. Respond best to atypicals.

Cognitive Symptoms

Impaired attention, working memory, executive function — drives much of the long-term disability.

Other Psychotic Disorders

- **Schizophreniform**: same as schizophrenia but 1–6 months.
- **Brief psychotic disorder**: 1 day – 1 month, full return to baseline.
- **Schizoaffective**: schizophrenia + mood episode (depressive or bipolar type).
- **Delusional disorder**: ≥1 month of delusion(s) without other psychotic features.

● COMMUNICATING WITH THE PSYCHOTIC CLIENT

- Approach calmly from the front; announce yourself.
- Use **concrete, literal language**; avoid idioms ("It's raining cats and dogs").
- Validate the feeling, not the content: "That sounds frightening."
- Do not whisper, laugh, or have unexplained meetings near a paranoid client.
- Allow physical space; one-to-one rather than groups in acute phase.

● COMMAND HALLUCINATIONS

Always ask, "What are the voices saying?" Commands to harm self or others demand **immediate safety precautions**: continuous observation, environmental safety check, possible PRN antipsychotic, notify provider.

§ 08

Personality Disorders

Pervasive, inflexible patterns of inner experience and behavior that deviate from cultural norms; onset by adolescence; cause distress or impairment.

CLUSTER	THEME	DISORDERS	RECOGNIZE
A	"Odd / eccentric"	Paranoid, Schizoid, Schizotypal	Suspicious, isolated, magical thinking
B	"Dramatic / erratic"	Antisocial, Borderline, Histrionic, Narcissistic	Manipulative, attention-seeking, splitting, self-harm
C	"Anxious / fearful"	Avoidant, Dependent, Obsessive-Compulsive PD	Hypersensitive, clingy, perfectionistic

● BORDERLINE PD — HIGH-YIELD

- Pattern: unstable relationships, identity, affect; impulsivity; recurrent self-harm; chronic emptiness; fear of abandonment.
- Uses **splitting** — staff must communicate as a unified team.
- Set **firm, consistent limits**; same expectations from every nurse.
- Gold-standard therapy: **Dialectical Behavior Therapy (DBT)**.
- Self-harm gestures are real risks — do not dismiss as "manipulation."

● ANTISOCIAL PD

- Disregard for others' rights, deceit, impulsivity, lack of remorse, conduct disorder before age 15.
- Maintain clear limits; do not be charmed or threatened into bending rules.
- Document factually; this client may file complaints to manipulate.

§ 09

Substance Use Disorders

The NCLEX expects you to recognize **intoxication vs. withdrawal**, identify life-threatening withdrawal patterns, and intervene.

SUBSTANCE	INTOXICATION	WITHDRAWAL	MEDICAL TX
Alcohol	Slurred speech, ataxia, ↓ inhibition, respiratory depression.	**Life-threatening.** Tremors at 6–12h → DTs at 48–96h: confusion, hallucinations, autonomic instability, seizures.	Benzodiazepines (lorazepam, chlordiazepoxide), thiamine before glucose, folate, CIWA protocol.
Opioids	Pinpoint pupils, sedation, ↓ RR, ↓ BP — overdose lethal from respiratory arrest.	Uncomfortable but rarely lethal: rhinorrhea, lacrimation, yawning, piloerection, diarrhea, dilated pupils, cravings.	Naloxone for overdose; methadone or buprenorphine for maintenance; clonidine adjunct.
Benzodiazepines / Sedatives	Slurred speech, ataxia, drowsiness; respiratory depression with co-use.	**Life-threatening** — tremor, anxiety, seizures, autonomic hyperactivity.	Slow taper; flumazenil only for acute overdose (caution: seizures).
Stimulants (cocaine, meth, amphetamine)	↑ HR, ↑ BP, dilated pupils, agitation, hyperthermia, possible MI/stroke/seizure.	"Crash": fatigue, hypersomnia, ↑ appetite, depression, suicidal ideation.	Supportive; benzodiazepines for agitation; monitor cardiac/neuro; treat hyperthermia.
Cannabis	Conjunctival injection, ↑ appetite, dry mouth, ↑ HR, time distortion.	Mild: irritability, sleep disturbance, ↓ appetite.	Supportive.
Hallucinogens (LSD, PCP)	Perceptual changes, hyperthermia, hypertension; PCP — violence, nystagmus.	No clear withdrawal syndrome; flashbacks possible.	Quiet, low-stim environment ("talk down"); benzos for agitation.
Tobacco / Nicotine	Stimulant effect.	Irritability, anxiety, ↑ appetite, sleep disturbance, cravings.	NRT (patch, gum), bupropion, varenicline.

● CIWA-AR — ALCOHOL WITHDRAWAL

Score 10 items (nausea, tremor, anxiety, agitation, sweats, headache, sensory disturbances, orientation). Higher score = more medication. Score >15 = severe; risk of seizures and DTs. Always pair with **thiamine (banana bag)** to prevent Wernicke encephalopathy.

● MAINTENANCE PHARMACOLOGY (MEMORIZE)

- **Disulfiram** — produces severe reaction with any alcohol (incl. mouthwash, cologne). Teach to read labels.
- **Naltrexone** — opioid antagonist; reduces cravings for alcohol and opioids.
- **Acamprosate** — reduces post-acute withdrawal cravings for alcohol.
- **Methadone / Buprenorphine** — opioid agonist therapy.

Substance Use in Pregnancy & Newborns

- **Fetal Alcohol Spectrum**: smooth philtrum, thin upper lip, small palpebral fissures, growth restriction, CNS dysfunction.
- **Neonatal Abstinence Syndrome (opioids)**: high-pitched cry, hypertonia, tremors, poor feeding, sneezing, diarrhea. Tx: swaddling, low stimuli, rooming-in, morphine if severe (Finnegan score).

§ 10

Eating Disorders

● MEDICAL PRIORITIES ABOVE ALL

Eating disorders are the most lethal psychiatric illnesses. **Always assess for medical instability first**: low body weight, bradycardia, hypotension, electrolyte imbalance, arrhythmias, dehydration. Stabilize before any psychotherapy goal.

Anorexia Nervosa

Restriction of intake leading to significantly low body weight; intense fear of weight gain; distorted body image.

FINDINGS

Bradycardia, hypotension, hypothermia, lanugo, amenorrhea, electrolyte imbalances, osteopenia.

RISK

Refeeding syndrome — life-threatening shifts in phosphate, magnesium, potassium when nutrition resumes too quickly. Refeed slowly, monitor electrolytes daily.

Bulimia Nervosa

Recurrent binge episodes with compensatory behaviors (purging, laxatives, fasting, exercise). Usually normal or above-normal weight.

FINDINGS

Russell sign (knuckle calluses), enamel erosion, parotid swelling, hypokalemia, metabolic alkalosis, esophageal tears.

Binge Eating Disorder

Recurrent binges without compensatory behaviors; often associated with obesity and comorbid depression.

TX

CBT, lisdexamfetamine (FDA-approved), SSRIs, structured eating.

● INPATIENT NURSING CARE

- Structured supervised meals; remain with client during meals and for 1 hour after to prevent purging.
- Daily weights — same time, same scale, gown only, after voiding, back to scale.
- Monitor electrolytes, EKG, vital signs; emphasize medical recovery before psychological focus.
- Therapeutic relationship: matter-of-fact, non-power-struggle approach.
- Family-Based Therapy (Maudsley) — gold standard for adolescents.

§ 11

Cognitive Disorders

Delirium vs. Dementia vs. Depression — The Three D's

FEATURE	DELIRIUM	DEMENTIA	DEPRESSION (PSEUDODEMENTIA)
Onset	**Acute, hours to days**	Insidious, months to years	Subacute, weeks to months
Course	Fluctuates, often worse at night ("sundowning" in dementia too)	Steadily progressive	Diurnal variation; worse in morning
Reversibility	**Usually reversible** — find the cause	Mostly irreversible	Reversible with treatment
Attention	Markedly impaired	Normal early, impaired late	May be impaired by apathy
Memory	Recent and immediate impaired	Recent first, then remote	"I don't know" responses
Hallucinations	Common, especially visual	Sometimes (Lewy body classic)	Rare, mood-congruent if present
Priority Action	**Find and treat the cause**	Maintain function & safety	Treat depression; reassess cognition

● DELIRIUM = MEDICAL EMERGENCY

Always investigate cause: **infection (UTI, pneumonia)**, hypoxia, electrolyte imbalance, medications (especially anticholinergics, opioids, benzos in elderly), pain, post-op, dehydration, alcohol/sedative withdrawal, hypoglycemia, hepatic/renal failure. The mantra: *old + sudden confusion = sepsis or hypoxia until proven otherwise.*

Dementia (Major Neurocognitive Disorder)

Alzheimer's Disease

Most common type. Gradual short-term memory loss → language → executive function → ADLs → personality.

MEDS

Cholinesterase inhibitors (donepezil, rivastigmine, galantamine); memantine (NMDA antagonist) for moderate-severe.

Vascular

Stepwise decline after strokes; preserve cardiovascular health.

Lewy Body

Visual hallucinations, parkinsonism, fluctuating cognition, REM sleep behavior disorder. **Avoid antipsychotics** — severe sensitivity.

Frontotemporal

Personality and behavior changes early; disinhibition, apathy, language problems before memory loss.

CARING FOR THE CLIENT WITH DEMENTIA

- Maintain consistent routine and caregivers; minimize change.
- Use short, simple sentences; give one direction at a time.
- Validate feelings; redirect rather than argue or correct.
- For agitation: rule out unmet need (pain, hunger, toilet, fatigue) before medicating.
- Sundowning: increase daytime activity, daylight exposure, calm evening routine, nightlight.
- Ensure safety: door alarms, ID bracelet, medication lock-up, remove driving privileges when unsafe.

§ 12

Crisis Intervention & Suicide Risk

Crisis Intervention Principles

Crisis is a state of disequilibrium that overwhelms usual coping. It is **time-limited (4–6 weeks)** and resolves with new equilibrium — adaptive or maladaptive.

1. **Ensure safety.**
   Stabilize physical environment; remove means of harm.
2. **Establish rapport.**
   Calm presence, active listening, validate distress.
3. **Identify the precipitating event.**
   "Why now?" — recent loss, change, threat, anniversary.
4. **Mobilize resources & coping.**
   Past coping that worked, current supports, professional services.
5. **Plan & follow-up.**
   Concrete next steps, written safety plan, scheduled check-in.

Suicide Risk Assessment

● DIRECT QUESTIONING SAVES LIVES

Ask plainly: *"Are you thinking about killing yourself?"* Asking does **not** plant the idea; it gives permission to disclose. If yes: assess **plan, means, intent, timing, lethality**. A specific, available, lethal plan with stated intent is the highest acuity.

RISK FACTORS (MEMORIZE CATEGORIES, NOT NUMBERS)

- **Demographics**: previous attempts (#1 predictor), male sex, older age, LGBTQ+ youth, Veterans, indigenous populations.
- **Psychiatric**: depression, bipolar, schizophrenia, substance use, PTSD, recent psychiatric discharge.
- **Medical**: chronic pain, terminal illness, TBI.
- **Psychosocial**: recent loss, isolation, hopelessness, access to lethal means, financial/legal crisis.
- **Warning signs (acute)**: giving away possessions, sudden calm after depression, talking about being a burden, saying goodbye, finalizing affairs.

INPATIENT SUICIDE PRECAUTIONS

- **1:1 continuous observation** for high acuity (within arm's reach, even in bathroom).
- Q15-minute checks for moderate; document each check.
- Environmental safety: no shoelaces, belts, drawstrings, sharp objects; weighted shower curtains; safety mirrors.
- Search belongings on admission and after passes.
- Mouth check after every medication.
- Develop a written **safety plan** with the client (warning signs, internal coping, social contacts, professional contacts, crisis line, restricting access to means).

THREE HIGH-RISK DISCHARGE WINDOWS

1. First two weeks after antidepressant initiation (energy returns before mood lifts).
2. First 30 days after psychiatric hospital discharge.
3. The day depression visibly "lifts" — the decision may be made.

§ 13

Abuse & Neglect

Nurses are **mandated reporters** for suspected child abuse, elder abuse, and dependent adult abuse. Reasonable suspicion is sufficient; proof is not required. Document objectively, in the client's own words and quotes when possible.

POPULATION	RED FLAGS
Child	Injuries inconsistent with story or developmental stage; multiple stages of healing; bruises in non-bony areas; immersion burns (stocking/glove pattern); fearful around caregiver; "frozen watchfulness"; failure to thrive; sexually explicit knowledge or behavior beyond age.
Intimate Partner	Injuries on central body (face, breasts, abdomen) inconsistent with explanation; partner answers questions; delays seeking care; controlling partner; somatic complaints; depression/PTSD; pregnancy and postpartum are highest-risk windows.
Older Adult	Pressure injuries, dehydration, unexplained weight loss, poor hygiene, contractures, missed medications; over-sedation; financial exploitation; caregiver answers and refuses to leave room.

● WHEN YOU SUSPECT ABUSE

- Interview the client **alone**, in a safe, private setting.
- Use open-ended, non-leading questions: "Tell me how this happened."
- Document objectively — exact words in quotes, body diagram, photos with consent and per policy.
- Treat injuries; preserve evidence (do not bathe, do not wash clothing in sexual assault).
- Do not promise confidentiality you cannot keep — explain mandated reporting.
- **Report** to appropriate agency (CPS, APS, law enforcement) per state law.
- Provide resources (shelter hotline, advocacy); do *not* pressure the client to leave — leaving is the most dangerous time in IPV. Plan with them.

● SURVIVOR-CENTERED COMMUNICATION

- Believe the client. Do not ask "why didn't you leave?" or "what did you do to provoke?"
- Empower choice: the survivor has had control taken away — give it back in every interaction.
- Acknowledge the courage to disclose.

§ 14

Grief, Loss & End-of-Life

Kübler-Ross Stages

Not linear. Not required. Clients may skip, repeat, or experience simultaneously. Recognize the cue, do not force progression.

STAGE	WHAT IT SOUNDS LIKE	THERAPEUTIC RESPONSE
Denial	"There must be a mistake."	Don't argue; be present; provide accurate information when asked.
Anger	"Why me? Why now?"	Don't take personally; allow expression; ensure safety.
Bargaining	"If I just live to see my daughter graduate..."	Listen; don't dismiss; don't make false promises.
Depression	Sadness, withdrawal, weeping.	Be present, allow sadness, sit silently, assess for clinical depression / suicide.
Acceptance	Calm, peaceful, may want to settle affairs.	Support legacy work, life review, comfort care.

Types of Grief

- **Anticipatory**: before the death/loss occurs — common in chronic illness.
- **Normal/uncomplicated**: gradually integrates over months; oscillating waves.
- **Complicated/prolonged**: persistent intense yearning >12 months adults / >6 months children; impaired functioning.
- **Disenfranchised**: not socially recognized (miscarriage, death of pet, ex-spouse, stigmatized losses).

End-of-Life Care

● FIVE COMFORT PRIORITIES AT END-OF-LIFE

1. **Pain & symptom control** — opioids titrated to comfort; rule of double effect protects this.
2. **Air hunger** — opioids reduce sense of dyspnea; oxygen for comfort, not numbers.
3. **Secretions** — anticholinergics (glycopyrrolate, scopolamine), repositioning; suctioning often increases distress.
4. **Skin & mouth care** — frequent oral swabs, lip balm, repositioning q2h, pressure-relieving surfaces.
5. **Presence** — hearing is often the last sense to go; encourage family to talk to client.

● HOSPICE VS. PALLIATIVE

- **Palliative**: at any stage of serious illness, alongside curative treatment, focused on quality of life.
- **Hospice**: prognosis ≤6 months, comfort-focused, curative treatment discontinued; can be at home, facility, or inpatient.

Signs of Imminent Death (hours-days)

- Cool, mottled extremities; cyanosis
- Cheyne-Stokes respirations; "death rattle" from pooled secretions
- Decreased urine output
- Decreased level of consciousness; restlessness or terminal agitation
- Loss of swallow and gag reflex; jaw drop

● POSTMORTEM CARE

- Identify cultural/religious rituals before bathing or moving the body.
- Allow family time at the bedside; ask what they need.
- Remove tubes and lines unless coroner's case; place in supine position with head slightly elevated; close eyes; gently close mouth (rolled towel under chin).
- Identify with two tags (toe and shroud); document time and persons present.

§ 15

Cultural & Spiritual Care

Cultural competence is **not** memorizing what each culture believes — it is *asking* each client how their culture and beliefs shape their care preferences, and avoiding stereotyping.

● UNIVERSAL PRINCIPLES

- Use a **professional medical interpreter**, not family — especially not children. Look at the client, not the interpreter.
- Ask about decision-making: in many cultures the family or eldest decides, not the individual.
- Respect modesty, gender preferences for caregivers, food restrictions, and timing of prayer.
- Inquire about traditional remedies — many interact with prescribed medications.
- Ask about disclosure preferences for serious diagnoses; not all cultures share Western full-disclosure ethic.
- Avoid eye-contact, touch, and personal-space assumptions; norms vary widely.

Spiritual Care

- Spiritual distress: questioning meaning, anger at God, isolation from faith community — common at end-of-life and after trauma.
- Ask about practices the client wants to continue (prayer, sacraments, scripture, rituals).
- Offer chaplaincy referral; respect refusals.
- Be aware of cultural beliefs about death, autopsy, organ donation, withdrawal of life-sustaining treatment.

● COMMON RELIGIOUS CONSIDERATIONS (ASK, DON'T ASSUME)

- **Jehovah's Witness** — refuses whole blood and primary components; some accept albumin/factors. Document specifically.
- **Islam** — Ramadan fasting (clarify if illness exempts), modesty, halal diet, prayer times, family gender preferences.
- **Judaism (Orthodox)** — kosher diet, Sabbath restrictions, autopsy preferences, burial timing.
- **Buddhism / Hinduism** — preferences for vegetarian diet, time for meditation/prayer, post-death rituals.
- **Christian Science** — may decline most medical treatment; ethical and legal nuances apply, especially with minors.

§ 16

Therapeutic Milieu

The "milieu" is the entire physical and social environment of the inpatient unit, intentionally structured for healing. Every staff–client interaction is therapeutic.

● FIVE CORE FUNCTIONS (GUNDERSON)

- **Containment** — physical and psychological safety; structure prevents harm.
- **Support** — clients feel cared for and accepted.
- **Structure** — predictable schedule, rules, expectations.
- **Involvement** — clients participate in unit life and their own treatment.
- **Validation** — clients are recognized as individuals with worth.

Restraints & Seclusion

● ALWAYS THE LAST RESORT

- Try **least restrictive** interventions first: verbal de-escalation, environmental changes, PRN medication, voluntary time-out.
- Requires a provider order: type, reason, time-limited.
- In emergencies a nurse may initiate; provider must evaluate within 1 hour (face-to-face).
- Maximum order duration: **4 hours adults / 2 hours adolescents (9–17) / 1 hour children <9**; may be renewed.
- Continuous observation; assess circulation, ROM, hydration, toileting, vital signs per policy (often q15 min).
- Release at earliest opportunity; debrief with client and team.
- Document: behavior leading up, less-restrictive measures tried, type and time, monitoring, release.

Voluntary vs. Involuntary Admission

STATUS	CHARACTERISTICS
Voluntary	Client signs in; retains right to refuse treatment and request discharge (may require waiting period for evaluation).
Emergency / Involuntary	For imminent danger to self or others, or grave disability; time-limited (typically 72 hours); requires hearing for longer commitment; specific criteria vary by state.
Long-term Commitment	Court-ordered; due-process hearing; least restrictive setting; periodic review.

CLIENT RIGHTS RETAINED

- Right to refuse treatment (with exceptions for imminent danger).
- Right to communicate, see visitors, send/receive mail.
- Right to keep personal items unless contraindicated for safety.
- Right to informed consent.
- Right to least restrictive environment.
- Right to confidentiality (HIPAA still applies).

§ 17

Psychotropic Medications

Antidepressants

CLASS	EXAMPLES	WATCH FOR
SSRIs	Sertraline, fluoxetine, escitalopram, citalopram, paroxetine	GI upset, sexual dysfunction, insomnia, ↑ suicide risk <25 (black box). 2–4 wk for effect. Discontinuation syndrome — taper.
SNRIs	Venlafaxine, duloxetine, desvenlafaxine	Same as SSRIs + ↑ BP; useful for neuropathic pain.
Atypicals	Bupropion, mirtazapine, trazodone, vilazodone	Bupropion ↓ seizure threshold (avoid in eating disorders); mirtazapine — sedation, weight gain; trazodone — priapism, sleep aid use.
TCAs	Amitriptyline, nortriptyline, imipramine	Anticholinergic effects, orthostasis, **lethal in overdose** (cardiac).
MAOIs	Phenelzine, tranylcypromine, selegiline	**Hypertensive crisis** with tyramine foods (aged cheese, cured meats, wine, soy, tap beer) and many drugs. 14-day washout.

● SEROTONIN SYNDROME

Triggered by combining serotonergic agents (SSRI + SNRI + MAOI + tramadol + linezolid + St. John's wort + triptans). **Recognize**: agitation, confusion, autonomic instability (tachycardia, hyperthermia, diaphoresis), neuromuscular hyperactivity (tremor, clonus, hyperreflexia, rigidity). **Action**: stop all serotonergic agents, supportive care, cyproheptadine if severe.

Mood Stabilizers

● LITHIUM — HIGH-YIELD

- **Therapeutic level: 0.6–1.2 mEq/L**; toxicity ≥1.5; lethal >2.0.
- Narrow therapeutic window — monitor levels every 5–7 days initially, then every 2–3 months.
- Toxicity early: GI upset, fine tremor, polyuria, polydipsia.
- Toxicity late: coarse tremor, ataxia, confusion, seizures, arrhythmias, coma.
- **Maintain stable salt and fluid intake** — dehydration, low-sodium diet, NSAIDs, ACE inhibitors, thiazides ↑ levels.
- Baseline and ongoing: thyroid, renal function, pregnancy test (Ebstein anomaly).

● ANTICONVULSANT MOOD STABILIZERS

- **Valproic acid / divalproex** — monitor LFTs, platelets, ammonia. Teratogenic (neural tube defects).
- **Lamotrigine** — slow titration to avoid **Stevens-Johnson syndrome**; teach to report any rash.
- **Carbamazepine** — monitor CBC (agranulocytosis, aplastic anemia), Na (SIADH), LFTs; many drug interactions.

Antipsychotics

GENERATION	EXAMPLES	KEY ADVERSE EFFECTS
First-Gen (Typical)	Haloperidol, fluphenazine, chlorpromazine	EPS, tardive dyskinesia, NMS; better for positive symptoms.
Second-Gen (Atypical)	Risperidone, olanzapine, quetiapine, aripiprazole, ziprasidone, lurasidone	Metabolic syndrome (weight, glucose, lipids), some EPS, sedation.
Clozapine	Reserved for treatment-resistant schizophrenia	**Agranulocytosis** (weekly–monthly ANC monitoring), myocarditis, seizures, severe sedation, hypersalivation.

● EXTRAPYRAMIDAL SYMPTOMS (EPS)

- **Acute dystonia** (hours-days) — sustained muscle contractions, torticollis, oculogyric crisis. Tx: IM benztropine or diphenhydramine STAT.
- **Akathisia** (days-weeks) — inner restlessness, can't sit still. Tx: ↓ dose, propranolol, benzodiazepine.
- **Pseudoparkinsonism** (weeks) — tremor, rigidity, bradykinesia, mask face. Tx: anticholinergic (benztropine).
- **Tardive dyskinesia** (months-years) — involuntary lip-smacking, tongue movements, choreoathetoid limb movements. **Often irreversible.** Use AIMS to screen. Tx: switch to atypical, valbenazine, deutetrabenazine.

● NEUROLEPTIC MALIGNANT SYNDROME (NMS)

Medical emergency — mortality up to 10%. Recognize: **hyperthermia, lead-pipe rigidity, autonomic instability, altered mental status, ↑ CK, ↑ WBC, myoglobinuria → renal failure**. Action: **stop antipsychotic immediately**, ICU supportive care, cooling, IV fluids, dantrolene or bromocriptine.

Anxiolytics & Sedatives

● BENZODIAZEPINES

- Lorazepam, alprazolam, diazepam, clonazepam, midazolam.
- Fast relief of anxiety, panic, alcohol withdrawal, status epilepticus.
- Risks: sedation, falls (elderly), respiratory depression with opioids, dependence, withdrawal seizures.
- Antidote: **flumazenil** (use cautiously — can precipitate withdrawal seizures).
- Short-term use; taper to discontinue.

● BUSPIRONE

- Non-sedating anxiolytic; no dependence; takes 1–2 weeks for effect.
- Not for acute anxiety; not a PRN agent.
- Avoid grapefruit; do not combine with MAOIs.

Stimulants & ADHD Agents

- Methylphenidate, amphetamine salts, lisdexamfetamine — Schedule II; monitor growth, BP, appetite, sleep; give early in day.
- Atomoxetine (non-stimulant) — black box for suicidal ideation in adolescents; takes weeks.
- Guanfacine, clonidine — adjuncts; monitor BP, sedation.

Other High-Yield Agents

- **Naltrexone** — alcohol/opioid use disorder; ensure opioid-free 7–10 days before starting.
- **Disulfiram** — aversive reaction with alcohol; avoid all hidden sources (sauces, mouthwash, aftershave).
- **Methadone / buprenorphine-naloxone** — opioid agonist therapy; reduces overdose and relapse.
- **Esketamine** intranasal — treatment-resistant depression; REMS program; monitor 2 hours post-dose.

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NGN Test-Taking Strategy

● DECISION HIERARCHY WHEN STUCK

1. **Safety** trumps all else.
2. **ABCs** + airway-threatening complications (delirium, seizure risk in withdrawal).
3. **Acute > chronic**; new findings > baseline.
4. **Unstable > stable**; potentially lethal > uncomfortable.
5. **Therapeutic communication** answers: pick the one that addresses feelings and keeps the client talking.
6. **Maslow**: physiologic → safety → love/belonging → esteem → self-actualization.
7. **Nursing process**: assess before intervene, intervene before evaluate.
8. When two answers seem equally right — choose the *least invasive* or the one that *collects more data first*.

● COMMUNICATION QUESTION FILTERS

- **Eliminate**: any answer with "why," "don't worry," "everything will be fine," advice, or staff defense.
- **Eliminate**: closed-ended questions when feelings are unexplored.
- **Choose**: open-ended, feelings-focused, validating, reflecting answers.
- If two are therapeutic, the one that **names the feeling** wins.

● MATRIX / SATA TIP

Read each option as a **true/false** against the stem — independently. Don't compare options to each other. With NGN partial credit, getting some right still earns points; do not skip.

● BOW-TIE STRATEGY

1. **Center first**: identify the priority condition the cues describe (e.g., "alcohol withdrawal," "serotonin syndrome").
2. **Left side**: actions targeting that condition (treatments, safety measures).
3. **Right side**: parameters that prove the condition is improving or worsening.

§ 19

Quick Reference & Mnemonics

SUICIDE RISK

SAD PERSONS

- **S** Sex (male)
- **A** Age (<19 or >45)
- **D** Depression
- **P** Previous attempt
- **E** Ethanol or substance use
- **R** Rational thinking loss (psychosis)
- **S** Social supports lacking
- **O** Organized plan
- **N** No spouse / single
- **S** Sickness (chronic illness)

SEROTONIN SYNDROME

HARM

- **H** Hyperthermia, Hypertension
- **A** Autonomic instability, Agitation
- **R** Rigidity, Reflexes ↑ (clonus)
- **M** Mental status change, Myoclonus

NMS

FEVER

- **F** Fever (hyperthermia)
- **E** Encephalopathy (altered mental status)
- **V** Vitals unstable (autonomic)
- **E** Elevated CK / enzymes
- **R** Rigidity (lead-pipe)

ALCOHOL WITHDRAWAL TIMELINE

6 · 12 · 48 · 96

- **6h** Tremors, anxiety, autonomic activity begin
- **12–24h** Alcoholic hallucinosis (vivid, often visual; sensorium intact)
- **24–48h** Withdrawal seizures peak
- **48–96h** Delirium tremens — confusion, fever, autonomic storm

LITHIUM TOXICITY

LITH

- **L** Levels > 1.5 mEq/L
- **I** Interactions: NSAIDs, ACEi, thiazides ↑ level
- **T** Tremor (fine → coarse), Thyroid issues
- **H** Hydration & sodium — keep stable

DEMENTIA CARE

CALM

- **C** Consistent caregivers and routine
- **A** Avoid arguing — validate, redirect
- **L** Limit choices and stimulation
- **M** Meet basic needs first when agitated (pain, toilet, hunger, fatigue)

THERAPEUTIC COMMUNICATION

SOLER

- **S** Sit squarely facing the client
- **O** Open posture (uncrossed)
- **L** Lean slightly toward client
- **E** Eye contact (culturally appropriate)
- **R** Relax

One-Line Reminders

- SAFETY Suicide risk peaks as depression starts to lift — energy returns first.
- SAFETY Old + sudden confusion = sepsis or hypoxia until proven otherwise.
- ACTION Manic clients eat finger foods walking — they cannot sit still.
- ACTION Anorexia: medical stability first, therapy second; watch refeeding syndrome.
- THERAPY When in doubt on a communication question, name the feeling.
- THERAPY Validate the feeling, not the delusion or hallucination.
- MEDS Lithium ↔ stable salt and water, no NSAIDs without provider.
- MEDS MAOIs + tyramine = hypertensive crisis.
- MEDS Lamotrigine + rash = stop and report (Stevens-Johnson risk).
- MEDS Clozapine = weekly to monthly ANC; report sore throat or fever.
- COMM Use professional medical interpreters, never family — especially never children.
- COMM Ask each client about their preferences; do not assume by background.
- CONCEPT Crisis is time-limited (4–6 weeks); the goal is restored equilibrium.
- ASSESS "Tell me what the voices are saying" — screen for command hallucinations.
- ASSESS Direct suicide questions don't plant ideas; they save lives.
