NCLEX · PSYCHIATRIC / MENTAL HEALTH NURSING · 2026 TEST PLAN
PSYCHOSOCIAL INTEGRITY · PHARMACOLOGICAL THERAPIES

PTSD.

Post-Traumatic Stress Disorder — trauma- & stressor-related diagnosis, medication management, evidence-based psychotherapy, and patient teaching.

HIGH-YIELD
TRAUMA-FOCUSED
SAFETY · ABCS

01 DEFINITION & OVERVIEW

DSM-5-TR

WHAT IT IS

PTSD is a trauma- and stressor-related disorder developing after **exposure to actual or threatened death, serious injury, or sexual violence** — directly, as a witness, or through repeated exposure (e.g., first responders).

Symptoms span **four clusters**: intrusion, avoidance, negative cognitions/mood, and arousal/reactivity. They must persist **>1 month** and cause significant distress or functional impairment.

Acute Stress Disorder = same symptoms lasting 3 days–1 month. Becomes PTSD once symptoms extend beyond 1 month.

6–7%
U.S. LIFETIME PREVALENCE

>1 mo
SYMPTOM DURATION FOR DX

2×
HIGHER RISK IN WOMEN VS MEN

02 PATHOPHYSIOLOGY

NEUROBIOLOGY · HPA AXIS

i. **TRAUMA EXPOSURE** — actual/threatened harm
→ *ii.* **AMYGDALA OVERDRIVE** — fear circuit hyperactive
→ *iii.* **HIPPOCAMPAL SHRINKAGE** — memory miscoded
→ *iv.* **PFC HYPOACTIVITY** — loss of fear regulation
→ *v.* **HPA DYSREGULATION** — ↑ NE · abnormal cortisol

AMYGDALA
Hyperactive fear processing → exaggerated threat response, flashbacks, hyperarousal.

HIPPOCAMPUS
Reduced volume → inability to contextualize memories as past events → intrusive re-experiencing.

NEUROCHEMISTRY
↑ Norepinephrine (arousal), abnormal cortisol, ↓ Serotonin & GABA → anxiety, insomnia, mood changes.

03 SIGNS & SYMPTOMS

4 DSM-5 CLUSTERS

The DSM-5 divides PTSD symptoms into **four clusters**. *≥1 symptom from each cluster, lasting* **>1 month**, *is required for diagnosis.*

INTRUSION — Cluster B

- **Flashbacks** — dissociative, feels like reliving
- **Nightmares** related to the event
- Recurrent, intrusive memories
- Intense distress at trauma cues
- Physiologic reactivity (↑HR, sweating)

AVOIDANCE — Cluster C

- Avoids **internal reminders** (thoughts, feelings)
- Avoids **external cues** (people, places, activities)
- Refuses to discuss the event
- May isolate or change routines dramatically

NEGATIVE COGNITIONS & MOOD — Cluster D

- **Guilt, shame,** self-blame
- Persistent negative beliefs ("I'm bad")
- **Anhedonia** — loss of interest
- Detachment/estrangement from others
- Dissociative amnesia for trauma details

AROUSAL & REACTIVITY — Cluster E

- **Hypervigilance** — always "on guard"
- **Exaggerated startle** response
- Irritability, angry outbursts
- Sleep disturbance, concentration problems
- Reckless / self-destructive behavior

! RED FLAG FINDINGS — ESCALATE IMMEDIATELY

- ! **Suicidal ideation** — highest priority, 1:1 observation
- ! **Homicidal ideation** — duty to warn / protect
- ! **Active dissociation** — ground & orient first
- ! **Self-harm / cutting** — assess & safety-proof
- ! **Substance abuse** — self-medication risk
- ! **Severe insomnia** > 1 week — worsens symptoms

04 PRIORITY NURSING INTERVENTIONS

ABCS · SAFETY FIRST

PRIORITY #1

Safety Assessment

- **Assess suicide/self-harm** risk every shift
- Remove means; safety-proof environment
- 1:1 observation if actively suicidal
- Contract for safety if appropriate

THERAPEUTIC

Trust & Rapport

- **Establish trust** — consistent caregiver
- Use open-ended questions
- **Don't force** trauma disclosure
- Accept patient's pace

ENVIRONMENT

Low-Stim Milieu

- Calm, quiet, predictable setting
- **Announce yourself** before approaching
- Avoid sudden movements, loud noises
- Ask before touching patient

FLASHBACK

Grounding in Crisis

- Stay with patient; speak slowly, calmly
- Orient: **"You're safe, in the hospital"**
- Use 5-4-3-2-1 grounding technique
- Do NOT touch without consent

MONITOR

Co-occurring Risks

- Screen for **substance use** (self-medication)
- Monitor sleep patterns & nightmares
- Assess for depression, panic disorder
- Watch medication adherence

MEDS

Pharmacotherapy

- Administer **SSRIs** as ordered
- Prazosin **at bedtime** for nightmares
- **Avoid benzos** as standing order
- Teach 4–6 weeks to full SSRI effect

SKILLS

Coping Toolkit

- Teach **deep breathing**, progressive relaxation
- Journaling, trigger identification
- Mindfulness & grounding exercises
- Regular exercise & sleep hygiene

SUPPORT

Therapy & Referral

- Refer for **trauma-focused therapy**
- Connect to peer / veteran support group
- Involve family with patient consent
- Coordinate with case management

GROUNDING *5-4-3-2-1 Technique*

USE DURING FLASHBACKS & DISSOCIATION

5	4	3	2	1
SEE	TOUCH	HEAR	SMELL	TASTE
things you can see	things you can feel	sounds around you	scents you notice	taste in your mouth

05 PHARMACOLOGY

SSRI FIRST-LINE · ADJUNCTS · AVOID

★ FIRST-LINE · FDA APPROVED

Sertraline *(Zoloft)* • Paroxetine *(Paxil)*

SSRI

MOA	Blocks serotonin reuptake → ↑ 5-HT availability at synapse.
SIDE FX	**Sexual dysfunction**, GI upset, insomnia/drowsy, weight change, **black-box: suicidal ideation** in <25 yr.
NURSING	Takes **4–6 weeks** for full effect. Do NOT stop abruptly. Assess for **serotonin syndrome** (HTN, fever, clonus, agitation).

Venlafaxine *(Effexor)*

SNRI

MOA	Blocks reuptake of **serotonin + norepinephrine**.
SIDE FX	**HTN** (dose-dependent), nausea, insomnia, sweating, dizziness.
NURSING	**Monitor BP** at every visit. Taper slowly — discontinuation syndrome common. Give with food.

Prazosin *(Minipress)*

A-1 BLOCKER

MOA	Blocks peripheral & central α-1 → ↓ NE effects → **reduces nightmares**.
SIDE FX	**Orthostatic hypotension** (first-dose effect), dizziness, reflex tachycardia, syncope.

Risperidone • Quetiapine

ATYPICAL ANTIPSYCH · ADJUNCT

ROLE	Adjunct only — for **severe hyperarousal, psychotic features,** or treatment-resistant PTSD.

NURSING Give **at bedtime**. Teach to change positions slowly. Check BP lying/sitting/standing. Hold if SBP <90.

SIDE FX Metabolic syndrome (↑glucose, ↑lipids, weight), sedation, EPS, **risk of NMS**.

NURSING Baseline metabolic panel & AIMS. Monitor HgbA1c / lipids. Watch for EPS, tardive dyskinesia.

⚠ GENERALLY AVOID

Benzodiazepines *(lorazepam, alprazolam, diazepam)*

AVOID IN PTSD

WHY AVOID **Worsen long-term PTSD outcomes**; interfere with trauma processing & fear extinction. High risk of **dependence**, tolerance, and disinhibition. Synergistic CNS depression if combined with alcohol/opioids — common PTSD comorbidities.

NCLEX PEARL If a question offers benzos as the "best" choice for a PTSD patient — **it's a trap**. Pick SSRI, prazosin (for nightmares), or psychotherapy referral instead.

06 NCLEX TEST TRAPS

WRONG → RIGHT

✗ TRAP ANSWER	→	✓ BEST ANSWER
"Insist the patient describe the traumatic event in detail now." Forcing disclosure re-traumatizes and damages therapeutic trust.	→	**"Allow the patient to discuss the trauma at their own pace."** Trust & timing are therapeutic — never coerce disclosure.
Administer lorazepam PRN for anxiety as first-line PTSD therapy. Benzos worsen PTSD outcomes and carry dependence risk.	→	**Administer scheduled SSRI (sertraline/paroxetine)** — first-line FDA-approved pharmacotherapy for PTSD.
"The SSRI will work within a few days." Misleads the patient and leads to early discontinuation.	→	**"Full effect takes 4–6 weeks; continue daily even if you feel no change yet."**
Grab the patient and shake them out of a flashback. Touch without consent can escalate dissociation or trigger a fight response.	→	**Speak calmly, orient to reality, use 5-4-3-2-1 grounding.** Ask before any physical contact.
Tell the veteran "I know exactly how you feel." False empathy invalidates unique trauma experience.	→	**"This sounds very difficult. Tell me more about what you're experiencing."** Open-ended, non-judgmental presence.
Give prazosin in the morning to prevent nightmares. Wrong timing — and adds daytime orthostatic risk.	→	**Give prazosin at bedtime**; monitor for first-dose orthostatic hypotension; teach to rise slowly.

07 PATIENT EDUCATION

MEDS · LIFESTYLE · THERAPY

Rx MEDICATION & LIFESTYLE TEACHING

- ✓ Take SSRI **daily at the same time**, even when feeling better.
- ✓ **Do NOT stop abruptly** — taper under provider guidance to avoid discontinuation syndrome.
- ✓ Expect **4–6 weeks** for full therapeutic effect.
- ✓ Report **any new suicidal thoughts** immediately (black-box warning).
- ✓ **Avoid alcohol and recreational drugs** — they worsen symptoms & interact.
- ✓ Change positions slowly on prazosin (orthostatic hypotension).
- ✓ Maintain a consistent **sleep schedule**; avoid caffeine after noon.
- ✓ Regular **exercise**, mindfulness, journaling reduce arousal symptoms.
- ✓ Identify personal **triggers** and build a written coping plan.
- ✓ Attend all follow-up appointments and therapy sessions.

Ψ EVIDENCE-BASED PSYCHOTHERAPY

- ✓ **Trauma-focused therapy** is the cornerstone of treatment — meds support, therapy heals.
- ✓ Encourage engagement even when it feels uncomfortable — avoidance sustains PTSD.
- ✓ Support groups (veterans, survivors) reduce isolation & shame.
- ✓ Family education improves outcomes — with patient's consent.

CBT Cognitive Behavioral Therapy — reframes distorted thoughts.

CPT Cognitive Processing Therapy — challenges "stuck" beliefs.

PE Prolonged Exposure — gradual safe re-engagement with cues.

EMDR Eye Movement Desensitization & Reprocessing — bilateral stim.

08 MEMORY BOOSTERS

MNEMONICS · PATTERN RECOGNITION

TRAUMA

DIAGNOSTIC CRITERIA

T	R	A	U	M	A
TRAUMATIC EVENT	REEXPERIENCING	AVOIDANCE	UNABLE TO FUNCTION	MONTH OR MORE	AROUSAL ↑

THERAPY TOOLKIT *"CEPT"*

- ***C*** — CBT / CPT (cognitive reframing)
- ***E*** — EMDR (eye movement reprocessing)
- ***P*** — Prolonged Exposure therapy
- ***T*** — Trauma-focused group & family support

DRUG PEARLS *"SPA"*

- ***S*** — ***S*** SRIs first-line (Sertraline, Paroxetine)
- ***P*** — ***P*** razosin at bedtime for nightmares
- ***A*** — ***A*** void benzos (dependence, worsens PTSD)

PATTERN

Veteran + startle + nightmares = think PTSD.

PATTERN

Nightmares in PTSD → Prazosin PM.

PATTERN

Flashback? Safety → orient → ground.