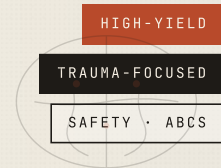


● NCLEX · PSYCHIATRIC / MENTAL HEALTH NURSING · 2026 PSYCHOSOCIAL INTEGRITY · PHARMACOLOGICAL THERAPIES
TEST PLAN

PTSD.

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



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

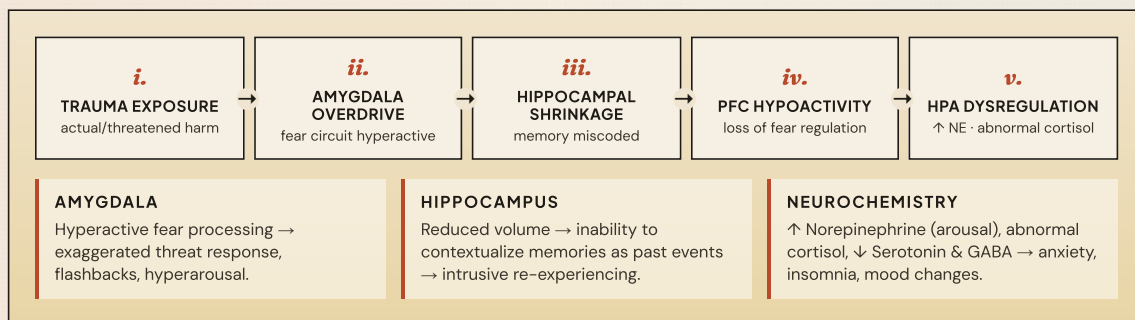
2×

HIGHER RISK IN WOMEN VS MEN

02

PATHOPHYSIOLOGY

NEUROBIOLOGY · HPA AXIS



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

SEE

things you can see

4

TOUCH

things you can feel

3

HEAR

sounds around you

2

SMELL

scents you notice

1

TASTE

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.

PTSD — NCLEX Mental Health Infographic

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.

Benzodiazepines (*lorazepam, alprazolam, diazepam*)

▲ **GENERALLY AVOID**

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**

"Insist the patient describe the traumatic event in detail now." Forcing disclosure re-traumatizes and damages therapeutic trust.



✓ **BEST ANSWER**

"Allow the patient to discuss the trauma at their own pace." Trust & timing are therapeutic — never coerce disclosure.

✗ **TRAP ANSWER**

Administer lorazepam PRN for anxiety as first-line PTSD therapy. Benzos worsen PTSD outcomes and carry dependence risk.



✓ **BEST ANSWER**

Administer scheduled SSRI (sertraline/paroxetine) — first-line FDA-approved pharmacotherapy for PTSD.

✗ **TRAP ANSWER**

"The SSRI will work within a few days." Misleads the patient and leads to early discontinuation.



✓ **BEST ANSWER**

"Full effect takes 4–6 weeks; continue daily even if you feel no change yet."

✗ **TRAP ANSWER**

Grab the patient and shake them out of a flashback. Touch without consent can escalate dissociation or trigger a fight response.



✓ **BEST ANSWER**

Speak calmly, orient to reality, use 5–4–3–2–1 grounding. Ask before any physical contact.

✗ **TRAP ANSWER**

Tell the veteran "I know exactly how you feel." False empathy invalidates unique trauma experience.



✓ **BEST ANSWER**

"This sounds very difficult. Tell me more about what you're experiencing." Open-ended, non-judgmental presence.

✗ **TRAP ANSWER**

Give prazosin in the morning to prevent nightmares. Wrong timing — and adds daytime orthostatic risk.



✓ **BEST ANSWER**

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 TRAUMATIC EVENT	R REEXPERIENCING	A AVOIDANCE	U UNABLE TO FUNCTION	M MONTH OR MORE	A 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.

NCLEX Mental Health Series
DISORDER

POST-TRAUMATIC STRESS

PSYCHOSOCIAL INTEGRITY · PHARM THERAPIES ·
2026