Achievable

NCLEX-RN DUMP SHEET

Psychotic, personality, substance use, and eating disorders

Psychosis

- **Positive symptoms** (additions) — hallucinations (**auditory most common**), delusions, disorganized speech, bizarre behavior
- **Negative symptoms** (losses) — flat affect, alogia, avolition, anhedonia, withdrawal. **Frequently mistaken for depression or laziness**
- **Hallucinations** — acknowledge the experience without validating it: "I don't hear the voices, but I know this is frightening." Assess for **command hallucinations** and act on them immediately
- **Delusions** — never argue with one and never agree with one. Redirect to reality; address the feeling behind the belief
- **Typical antipsychotics** — higher EPS risk (dystonia, akathisia, parkinsonism). **Atypicals** — lower EPS, higher metabolic risk. Long-term use: watch for **tardive dyskinesia**
- **Schizophrenia** ≥6 months · **brief psychotic disorder** >1 day but <1 month · **delusional disorder** ≥1 month of non-bizarre delusions

Personality disorders

- **Cluster A** odd/eccentric — paranoid, schizoid, schizotypal · **Cluster B** dramatic/erratic — antisocial, borderline, narcissistic, histrionic · **Cluster C** anxious/fearful — avoidant, dependent, OCPD
- Mostly **ego-syntonic** — the client does not see the behavior as a problem, which is why insight-oriented work fails
- **Care is structure, consistency, and boundaries.** Stay emotionally neutral, set limits respectfully, document objectively, **keep staff consistent to prevent splitting**
- **Borderline** — self-harm, fear of abandonment, DBT. **Antisocial** — disregard for rules, no remorse, risk to others
- **No medication cures a personality disorder** — psychotherapy is the treatment

Substance use

- **Alcohol withdrawal timeline** — 6—12 h tremors, anxiety, insomnia, nausea, tachycardia → 12—24 h hallucinations → **24—48 h seizures (peak)** → **48—96 h delirium tremens** (severe confusion, agitation, fever, severe hypertension)
- **Alcohol and benzodiazepine withdrawal can be fatal.** Opioid withdrawal is rarely fatal but extremely distressing
- Use **CIWA-Ar**, give benzodiazepines, **thiamine before glucose**, seizure precautions, monitor electrolytes
- **Wernicke's** (acute) — confusion, ataxia, ophthalmoplegia. **Korsakoff** (chronic) — memory loss, confabulation
- **Opioid intoxication** — pinpoint pupils, respiratory depression, ↓consciousness. **Withdrawal** — muscle aches, diarrhea, vomiting, yawning, goosebumps
- **Stimulant intoxication** — agitation, tachycardia, hypertension, dilated pupils, paranoia. **Withdrawal** — fatigue, depression, hypersomnia, increased appetite
- **MAT** — methadone (full agonist), buprenorphine (partial), naltrexone (antagonist); for alcohol: naltrexone, disulfiram, acamprosate
- **Harm reduction** — naloxone education, referrals, overdose prevention. Never moralize. Relapse is not failure

Eating disorders

- **Anorexia** — restriction, intense fear of weight gain, distorted body image, **bradycardia, hypotension, hypothermia**, lanugo, electrolyte imbalance. Among the highest mortality of any psychiatric disorder. **Normal weight does not rule it out (atypical anorexia)**
- **Bulimia** — bingeing with compensatory behavior; often normal weight; **dental erosion**, parotid swelling, **Russell sign** (callused knuckles), **hypokalemia**
- **Refeeding syndrome** — electrolyte shifts, especially **hypophosphatemia**, during nutritional rehabilitation
- **Medical stability is the priority, not weight.** Monitor cardiac rhythm and electrolytes, supervise meals and the post-meal period, restrict exercise, use neutral language, **avoid power struggles over food**