SECTION 1: EXECUTIVE SUMMARY

This ANCC PMHNP-BC board-preparation guide was developed from official sources, commercial review resources, and verifiable academic literature (2025-2026). It does not contain real exam questions, leaked material, or information from brain dumps.

⚠ *ETHICAL NOTICE: No real questions were reproduced, leaked material, or invented statistics. Anecdotal information is marked as such.*

Structure of the ANCC PMHNP-BC Exam

- **Total questions: 175 (150 scored + 25 unscored pretest questions, not identified)**
- **Time allowed: 3.5 hours**
- **Format: Multiple choice — mostly clinical scenarios (vignettes)**
- **Pass rate: ~83% first attempt (anecdotal data reported by candidates; ANCC does not regularly publish an official figure)**
- **Recertification: Every 5 years — 75 hours of continuing education (CEUs) required**
- **Alternative credential: AANPCB grants the PMHNP-C credential — different exam but similar content**

Exam Content Domains (ANCC Official Exam Content Outline)

⚠ *Source: ANCC PMHNP-BC Exam Content Outline. Approximate percentages — download the updated official guide from nursingworld.org.*

- **Advanced Practice Skills: ~27% — clinical assessment, differential diagnosis, care plan**
- **Scientific Foundation: ~22% — pharmacology, neurobiology, research**
- **Diagnosis & Treatment: ~22% — DSM-5-TR, treatment modalities**
- **Psychotherapy: ~11-15% — CBT, DBT, MI, and other therapies**
- **Ethics, Legal & Professional: ~14-17% — HIPAA, scope, Baker Act, bioethics**

Florida: Specific Verifiable Information

The ANCC PMHNP-BC exam is NATIONAL — there is no separate state exam. However, Florida candidates should know:

- **Baker Act (Florida Mental Health Act, 1971): 72 hours of involuntary hospitalization — highly tested**
- **Scope of Practice in Florida: PMHNPs REQUIRE a collaborative agreement (HB 607 of 2023 excluded PMHNPs from autonomous practice; SB 138 to change this did NOT pass in 2024-2025).**
- **Prescribing: PMHNPs in Florida may prescribe under a collaborative agreement with a licensed physician.**

⚠ *WARNING: Advanced practice laws change. Verify current status with Florida Board of Nursing (floridasnursing.gov) before the exam.*

Summary of Critical Topics 2025-2026

- Psychiatric pharmacology: SSRIs, antipsychotics, lithium, mood stabilizers
- DSM-5-TR diagnoses and exact criteria
- Psychotherapy: CBT, DBT, Motivational Interviewing
- Crisis management: suicide assessment, Baker Act, safety planning
- Ethics and Legal Issues: bioethics, HIPAA, mandated reporting, duty to warn
- Assessment Scales: PHQ-9, GAD-7, AIMS, CIWA-Ar, COWS, C-SSRS
- Mood disorders: MDD, Bipolar I and II, differential diagnosis
- Schizophrenia and psychotic spectrum: antipsychotics, EPS effects

SECTION 2: TABLE OF MOST REPORTED TOPICS

⚠ **Candidates = anecdotal information reported by candidates in forums and study groups. Not independently verifiable.*

⚠ *Frequencies based on ANCC Exam Content Outline and commercial resources. ANCC does not publish frequencies by subtopic.*

Topic	Frequency	Type of Source	What to Study	Example Question Type	Reliability
Pharmacology (SSRIs, antipsychotics, lithium)	high	ANCC official + Review	Mechanisms, adverse effects, black box warnings, lab monitoring	Vignette: choose the correct medication or manage an adverse effect	high
DSM-5-TR Diagnoses	high	ANCC official	Exact criteria, duration, medical/substance exclusions	Differential diagnosis with a detailed clinical vignette.	high
Psychotherapy (CBT, DBT, MI)	high	ANCC + candidates*	Indications, key techniques, differences between therapies	Identify type of therapy or appropriate intervention	high
Baker Act / Involuntary Hold	high	ANCC + Florida legal	Criteria, 72h, who can initiate, patient rights	When it is justified involuntary hospitalization	high
Crisis and patient safety.	high	ANCC official	Suicide/homicide risk assessment, safety planning, hospitalization	Intervention priority in a crisis scenario.	high
Assessment Scales	high	ANCC + Review	PHQ-9, GAD-7, AIMS, CIWA-Ar, COWS, C-SSRS, MMSE, MoCA	Identify correct scale for the given scenario	high
Mood disorders (MDD, Bipolar)	high	ANCC official	DSM-5-TR criteria, differentials, first-line treatment	Differential: MDD vs. Bipolar II in a vignette	high
Schizophrenia and psychosis	high	ANCC official	Criteria, antipsychotics, EPS effects, clozapine	Management of positive/negative/cognitive symptoms.	high
Ethics and scope of practice	high	ANCC + Florida BON	Autonomy, beneficence, HIPAA, mandated reporting, duty to warn	Ethical dilemma with multiple conflicting principles	high
Anxiety Disorders	MOD-high	ANCC official	GAD, Panic, Social Anxiety Disorder, PTSD, OCD — key differences	Differential between anxiety disorders in a vignette	high
ADHD	moderate	Review + candidates*	Criteria, Stimulants vs Non-stimulants, adult ADHD	Treatment selection for ADHD with comorbidity	MOD
Substance Use Disorders	moderate	ANCC official	CAGE, AUDIT, CIWA-Ar, COWS, naltrexone, buprenorphine	Withdrawal management, Criteria CIWA-Ar for hospitalization	high

Topic	Frequency	Type of Source	What to Study	Example Question Type	Reliability
Defense Mechanisms	moderate	Review + candidates*	Denial, projection, splitting, rationalization, sublimation	Identify mechanism in psychological vignette	MOD
Personality disorders	moderate	ANCC official	Clusters A/B/C, differential diagnosis, DBT for BPD	Differential: BPD vs. Bipolar disorder; ASPD management.	high
Geriatric topics	moderate	Review + candidates*	Delirium vs dementia, Alzheimer, BEERS criteria, donepezil	Differential: delirium vs. dementia in an older adult	MOD
Pediatric topics	moderate	Review commercial	Normal development, ADHD, autism, conduct disorder	Differential diagnosis in pediatric vignette	MOD
Family and group therapy	moderate	Review commercial	Indications, types of groups, therapist roles	When to refer to family vs individual therapy	MOD
Neurotransmitters	moderate	ANCC official	DA, 5-HT, GABA, glutamate, NE — roles in psychiatry	Which NT is involved in symptom/diagnosis	high
Eating disorders	low-MOD	Review commercial	Anorexia, bulimia, BED — Criteria, medical complications	Medical risk in anorexia; BED treatment	MOD
Somatic symptom disorders	low	Review commercial	SSD, illness anxiety, conversion — differences and management.	Somatoform vs medical-cause differential	MOD

SECTION 3: HIGH-YIELD TOPICS BY PRIORITY

⚠ *Educational example questions are original and created for this document — they are NOT real ANCC exam questions.*

high PRIORITY

1. Psychiatric Pharmacology (High priority)

- **Why? It represents a significant part of the Scientific Foundation (~22%) and Advanced Practice Skills (~27%) domains.**
- **Memorize: Mechanisms of action, key adverse effects, black box warnings, interactions, laboratory monitoring, Contraindications.**
- **Common error: Confusing SSRI vs. SNRI mechanisms; not knowing which labs to monitor (lithium: TSH + BUN/Cr; valproate: LFTs + CBC).**
- **Educational example: A patient with MDD starts sertraline and, after 2 weeks, presents with agitation, myoclonus, and diaphoresis. Diagnosis? — Serotonin syndrome (created for this document; not a real exam question).**

2. DSM-5-TR Diagnoses (High priority)

- **Why? Accurate diagnosis is the first step in treatment. The exam tests exact criteria.**
- **Memorize: Minimum duration, number of required symptoms, substance/medical-condition exclusions, specifiers.**
- **Common error: Confusing MDD with the depressive episode in Bipolar II (requires a history of hypomania); PTSD vs. Adjustment Disorder (duration of the stressor and severity of symptoms).**
- **Educational example: A patient has 10 days of elevated mood, inflated self-esteem, and decreased need for sleep, without severe functional impairment. Diagnosis? Hypomanic episode (not manic). Original example.**

3. Crisis Management and Safety (High priority)

- **Why? ANCC considers safety the highest priority. Questions asking "what should you do first?" frequently involve crisis.**
- **Memorize: Suicide risk factors (SLAP — Specificity, Lethality, Availability, Proximity to help), safety planning, Baker Act (72h), duty to warn (Tarasoff), criteria for hospitalization.**
- **Common error: Choosing a therapeutic intervention before ensuring safety, or not recognizing when confidentiality must be broken for safety.**
- **GOLDEN RULE: SAFETY always overrides confidentiality.**

4. Psychotherapy: CBT, DBT, and Motivational Interviewing (High priority)

- **Why? Psychotherapy represents ~11-15% of the exam. ANCC asks which therapy to use and how it is performed.**
- **CBT: Cognitive restructuring, negative automatic thoughts, behavioral experiments. Indicated for: MDD, anxiety, OCD, PTSD, eating disorders.**
- **DBT: Mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness. Indicated for: BPD, chronic self-harm, recurrent suicidality.**

- **MI (Motivational Interviewing): OARS — Open questions, Affirmations, Reflective listening, Summaries. Indicated for: ambivalence about change, SUD, treatment adherence.**
- **Common error: Using DBT when CBT is indicated, or vice versa. The clearest indication for DBT is BPD with self-injurious behaviors.**

5. Ethics and Legal Issues — Florida (High priority)

- **Why? Ethics/Legal represents ~14-17% of the exam. The questions present complex dilemmas.**
- **Bioethical principles (Beauchamp & Childress): Autonomy, Beneficence, Nonmaleficence, Justice.**
- **When to break confidentiality: Imminent risk of harm to self or identifiable others (duty to warn, Tarasoff v. Regents of UC — California 1976).**
- **Mandated reporting in Florida: abuse/neglect of minors, vulnerable older adults, and people with disabilities.**
- **Baker Act: 72-hour involuntary hold; it may be initiated by a PMHNP, physician, police officer, or judge — not by an RN alone.**
- **Common error: Protecting confidentiality when the patient threatens an identifiable person with a plan and access to means.**

6. Assessment Scales (High priority)

- **PHQ-9: Depression. ≥10 = moderate. Item 9: suicidal ideation.**
- **GAD-7: Generalized anxiety. ≥10 = moderate. Short version: GAD-2.**
- **AIMS: Tardive Dyskinesia. Use with antipsychotics — monitoring every 6-12 months.**
- **CIWA-Ar: Alcohol withdrawal severity. ≥10: medication needed. ≥20: hospitalization indicated.**
- **COWS: Opioid Withdrawal Onset Scale. ≥8: initiate buprenorphine (confirm with provider).**
- **C-SSRS: Columbia Suicide Severity Rating Scale — standard for suicide risk.**
- **MMSE: Cognition — max 30 pts. <24 = probable cognitive impairment.**
- **MoCA: More sensitive than MMSE for mild impairment. <26 = abnormal.**
- **MDQ: Mood Disorder Questionnaire — screening for bipolar disorder.**
- **CAGE: Alcohol use screening: Cut, Annoyed, Guilty, Eye-opener. ≥2 positive.**

MODERATE PRIORITY

7. Personality disorders

- **Cluster A: "Odd/eccentric" — Paranoid, Schizoid, Schizotypal**
- **Cluster B: "Dramatic/erratic" — Antisocial, Borderline, Histrionic, Narcissistic**
- **Cluster C: "Anxious/fearful" — Avoidant, Dependent, Obsessive-Compulsive Personality Disorder (OCPD, not OCD)**
- **BPD pearl: first line = DBT. Splitting: seeing people as "all good" or "all bad." Fear of abandonment.**
- **ASPD pearl: Does not respond well to standard psychotherapy; there is no first-line medication.**

8. Geriatric topics

- Delirium: acute, fluctuating, reversible, medical/medication cause — RISK: anticholinergics, benzodiazepines
- Dementia: chronic, progressive, memory impairment first — Alzheimer disease is most common (60-70% of cases).
- Beers Criteria: benzodiazepines, anticholinergics, antipsychotics — AVOID in older adults
- Alzheimer treatment: donepezil (all stages), galantamine, rivastigmine (mild to moderate); memantine (moderate to severe).

9. Substance Use Disorders

- Alcohol withdrawal: CIWA-Ar, benzodiazepines to prevent seizures, thiamine FIRST (before glucose to avoid Wernicke).
- Opioid withdrawal: COWS, buprenorphine (initiate when COWS ≥8), clonidine for autonomic symptoms
- Nicotine SUD: varenicline (most effective), bupropion, NRT (patch, gum).
- Alcohol SUD maintenance: naltrexone (craving), acamprosate (abstinence and anxiety), disulfiram (aversive).

10. Defense Mechanisms

- Primitive (immature): Splitting (BPD), projection, Denial, idealization/devaluation
- Neurotic: rationalization, intellectualization, reaction formation, displacement, repression.
- Mature: sublimation, altruism, humor, anticipation, suppression.
- **Exam pearl: In a vignette, identify the mechanism that describes the patient's response.**

LOW PRIORITY (study if there is time)

11. Eating Disorders

- Anorexia Nervosa: low BMI, intense fear of gaining weight, body-image distortion — complications: prolonged QTc, hypokalemia, refeeding syndrome.
- Bulimia Nervosa: purging, dental erosion, calluses on knuckles (Russell sign), hypochloremic metabolic alkalosis.
- BED (Binge Eating Disorder): without compensatory behavior, lisdexamfetamine (Vyvanse) approved, CBT first line

12. Somatic Symptom Disorders

- SSD: somatic symptoms + disproportionate thoughts/feelings about them — rule out organic cause first.
- Illness Anxiety: persistent worry about having a serious disease without clear symptoms.
- Conversion Disorder: neurological symptoms without an organic basis (blindness, paralysis).
- Factitious Disorder: symptoms are intentionally produced to assume the sick role (no obvious secondary gain).

SECTION 4: COMPLETE PSYCHIATRIC PHARMACOLOGY

⚠ *Sources: FDA Prescribing Information, ANCC content, Fitzgerald PMHNP Review, verified academic resources. No invented statistics.*

4.1 SSRIs — Selective Serotonin Reuptake Inhibitors

Medications:

- Fluoxetine (Prozac) — half-life ~5 days; the only SSRI approved for depression in children age 8 and older; also used for OCD and bulimia
- Sertraline (Zoloft) — broad spectrum (MDD, OCD, panic disorder, PTSD, PMDD, social anxiety disorder); one of the most studied SSRIs in pregnancy
- Escitalopram (Lexapro) — well tolerated; fewer CYP interactions
- Citalopram (Celexa) — caution for QTc prolongation at doses >40 mg/day (>20 mg/day in older adults)
- Paroxetine (Paxil) — more anticholinergic; severe discontinuation syndrome; avoid in pregnancy when possible due to cardiac-malformation risk
- Fluvoxamine — mainly OCD

Mechanism:

- Blocks the serotonin transporter (SERT) → increases 5-HT in synapse

Uses: MDD, GAD, OCD, PTSD, panic, social anxiety disorder, PMDD, bulimia (fluoxetine)

Critical adverse effects:

- SEROTONIN SYNDROME: hyperthermia, myoclonus, agitation, diaphoresis, hyperreflexia, tachycardia — EMERGENCY. Triad: cognitive changes + autonomic changes + neuromuscular changes.
- Sexual dysfunction (anorgasmia, decreased libido) — VERY common, main cause of discontinuation
- Discontinuation syndrome: FINISH (Flu-like, Insomnia, Nausea, Imbalance, Sensory, Hyperarousal) — paroxetine worst
- Hyponatremia/SIADH — especially in older adults
- Increased risk of GI bleeding (platelet inhibition) — use caution with NSAIDs/warfarin.
- Insomnia or somnolence, nausea at the beginning

BLACK BOX WARNING:

- Increased risk of suicidal ideation/behavior in children, adolescents and young adults (<25 years) — close monitoring during the first weeks

Key interactions:

- MAOIs: CONTRAINDICATED — wait 14 days after discontinuing an SSRI (5 weeks for fluoxetine because of its long half-life)
- Tramadol, linezolid, triptans, dextromethorphan: risk of serotonin syndrome
- Fluoxetine and paroxetine: CYP2D6 inhibitors — increase levels of TCAs, antipsychotics, and opioids.

Monitoring: sodium in older adults; EKG if citalopram >40 mg/day or QTc risk factors are present; clinical response at 4-8 weeks

Teaching: Therapeutic effect in 2-4 weeks; do not stop abruptly; report thoughts of self-harm

4.2 SNRIs — Serotonin and Norepinephrine

- Venlafaxine (Effexor XR) — MDD, GAD, panic disorder, social anxiety disorder, fibromyalgia; dose-dependent hypertension

- Duloxetine (Cymbalta) — MDD, GAD, diabetic neuropathy, fibromyalgia, chronic pain, stress urinary incontinence
- Desvenlafaxine (Pristiq) — active metabolite of venlafaxine
- Levomilnacipran (Fetzima) — more selective for NE

Key adverse effects:

- Hypertension (monitor BP with venlafaxine)
- Severe discontinuation syndrome (especially venlafaxine — do not stop abruptly)
- Increased heart rate, sweating, dry mouth
- **Exam pearl: MDD + comorbid chronic pain → duloxetine. Venlafaxine: monitor BP at every visit.**

4.3 TCAs — Tricyclic Antidepressants

- Amitriptyline, nortriptyline, imipramine, clomipramine (OCD), desipramine

Adverse effects — mnemonic "CAST":

- C — Cardiotoxicity (arrhythmias, QTc prolonged, VERY dangerous in overdose)
- A — Anticholinergic (dry mouth, urinary retention, blurred vision, constipation, confusion)
- S — Sedation
- T — Toxic in overdose (narrow therapeutic window — low lethal threshold)

BLACK BOX: Suicidal ideation in young people (same as SSRIs)

- **Pearl: DO NOT prescribe TCAs to a patient with high suicide risk (lethal in overdose). Nortriptyline: less anticholinergic and safer in older adults. Imipramine: useful for nocturnal enuresis.**

4.4 MAOIs — Monoamine Oxidase Inhibitors

- Phenelzine (Nardil), tranylcypromine (Parnate), selegiline (Emsam — transdermal patch)

Uses: Atypical MDD (mood reactivity, hypersomnia, hyperphagia, rejection sensitivity); refractory MDD.

CRITICAL INTERACTIONS — MEMORIZE:

- SSRIs/SNRIs: CONTRAINDICATED — serotonin syndrome. Washout 14 days (5 weeks fluoxetine)
- Foods with TYRAMINE: aged cheese, red wine, fermented meats → HYPERTENSIVE CRISIS
- Triptans, meperidine, dextromethorphan, tramadol → serotonin syndrome
- Sympathomimetics (pseudoephedrine) → HYPERTENSIVE CRISIS.
- **Pearl: Low-dose selegiline patch (<6 mg) has fewer dietary restrictions. MAOIs are generally last-line options today.**

4.5 Antipsychotics — First Generation (Typical / FGA)

- Haloperidol (Haldol) — high potency, more EPS, less sedation/anticholinergic
- Chlorpromazine — low potency; more sedation, anticholinergic effects, and hypotension
- Trifluoperazine, fluphenazine (depot)

Mechanism: D2 dopamine receptor blockade.

EPS effects — MEMORIZE:

- Acute dystonia: muscle spasms (neck, eyes — oculogyric crisis) — treatment: diphenhydramine or benztropine IM/IV.

- Akathisia: subjective and objective motor restlessness — treatment: propranolol, benzodiazepines, reduce dose
- Parkinsonism: rigidity, tremor, bradykinesia — treatment: benztropine, amantadine
- Tardive Dyskinesia (TD): involuntary movements of the face, tongue, or extremities — potentially irreversible if not detected. Use the AIMS scale. Valbenazine (Ingrezza) or deutetrabenazine are approved for TD.

NEUROLEPTIC MALIGNANT SYNDROME (NMS):

- High fever + "lead-pipe" rigidity + diaphoresis + altered consciousness
- CPK elevated — MEDICAL EMERGENCY
- Treatment: discontinue antipsychotic, dantrolene, bromocriptine, ICU support

4.6 Antipsychotics — Second Generation (Atypical / SGA)

- Risperidone (Risperdal) — more EPS than other SGAs; increases prolactin (gynecomastia, amenorrhea, sexual dysfunction); depot formulation available (Risperdal Consta).
- Olanzapine (Zyprexa) — significant metabolic syndrome risk (diabetes, obesity, dyslipidemia); sedation; IM formulation available.
- Quetiapine (Seroquel) — useful sedative for insomnia/anxiety augmentation; less EPS; metabolism moderate
- Aripiprazole (Abilify) — partial D2 agonist (not complete blockade); akathisia is more common; less sedation; weight-neutral.
- Ziprasidone (Geodon) — QTc prolongation; weight neutral; take with food (>500 cal for absorption)
- Lurasidone (Latuda) — favorable metabolic profile; Indicated for Bipolar Depression; take with food (≥350 cal)
- Asenapine (Saphris) — sublingual; do not swallow/eat/drink 10 min post-dose
- Cariprazine (Vraylar) — indicated for schizophrenia and bipolar manic/mixed episodes.

Common adverse effects SGAs:

- Metabolic syndrome: central obesity, hyperglycemia, dyslipidemia — highest risk with olanzapine and clozapine
- Prolonged QTc: ziprasidone and IV haloperidol (less common with oral haloperidol)
- Hyperprolactinemia: risperidone, paliperidone
- Sedation: olanzapine, quetiapine, clozapine

4.7 CLOZAPINE (Clozaril) — SPECIAL CASE

UNIQUE indications:

- Treatment-resistant schizophrenia (failure of ≥2 antipsychotics from different classes)
- Reduction of suicide risk in schizophrenia and schizoaffective disorder (the ONLY antipsychotic approved for this)

BLACK BOX WARNINGS (multiple — MEMORIZE ALL):

- Agranulocytosis — potentially fatal neutropenia (incidence 1-2%)
- Dose-dependent seizures (significant risk above 600 mg/day)
- Myocarditis and cardiomyopathy (especially during the first weeks)
- Severe orthostatic hypotension and cardiovascular collapse
- Severe sedation

REMS — Monitoring ANC (Absolute Neutrophil Count):

- Normal value required to continue: ANC ≥1500/μL
- Weeks 1-26: weekly monitoring
- Weeks 27-52: every 2 weeks
- After 52 weeks: monthly
- **CRITICAL PEARL: If ANC <1000/μL → discontinue CLOZAPINE. Do not restart unless criteria are met. If ANC <500/μL (agranulocytosis) → EMERGENCY.**

4.8 Lithium — Mood Stabilizer

Indications: Bipolar I (gold standard), prevention of manic and depressive recurrence, refractory MDD (augmentation), REDUCTION OF SUICIDE RISK (one of the strongest evidence bases in psychiatry)

THERAPEUTIC RANGES — MEMORIZE:

- Maintenance: 0.6 – 0.8 mEq/L
- Acute mania: 0.8 – 1.2 mEq/L
- TOXIC: >1.5 mEq/L

laboratory monitoring:

- Serum lithium level: obtain 11-12 hours AFTER the last dose (trough level).
- TSH (hypothyroidism — chronic adverse effect)
- BUN/Creatinine (nephrotoxicity — chronic use may cause interstitial nephritis).
- Serum calcium (hypercalcemia)
- EKG (T-wave changes)
- CBC (benign leukocytosis)

Symptoms of TOXICITY by level:

- 1.5-2.0 mEq/L: nausea, diarrhea, coarse tremor, ataxia, dysarthria
- >2.0 mEq/L: confusion, hyperreflexia, severe agitation
- >2.5 mEq/L: seizures, coma, cardiovascular collapse — EMERGENCY — possible hemodialysis

Interactions that INCREASE levels (toxicity):

- NSAIDs (except low-dose aspirin), thiazide diuretics, ACE inhibitors, dehydration, and a low-sodium diet.

Special precautions:

- pregnancy: Risk of anomaly of Ebstein (malformation valvular tricuspid cardiaca) — mainly first trimonthter
- Breastfeeding: Excreted in breast milk — AVOID

Teaching to the patient:

- Maintain adequate hydration (do not abruptly change sodium intake).
- Report tremor, confusion, or persistent diarrhea immediately
- Do not stop abruptly — risk of manic rebound

4.9 Anticonvulsants Used in Psychiatry

Valproate / Valproic Acid (Depakote)

- Uses: Bipolar I (acute mania, maintenance), schizoaffective disorder, agitation in dementia.

- BLACK BOX WARNINGS: Hepatotoxicity (baseline and periodic LFTs), pancreatitis, TERATOGENICITY (spina bifida/neural tube defects — Category X in pregnancy).
- Monitoring: Levels serum (50-125 mcg/mL), LFTs, CBC (thrombocytopenia, low platelets)
- **CRITICAL interaction: Valproate DOUBLES levels of lamotrigine → reduce dose of lamotrigine**

Lamotrigine (Lamictal)

- Uses: Bipolar I maintenance — especially to prevent bipolar depression; NOT useful for acute mania; also used for epilepsy.
- BLACK BOX WARNING: Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) — potentially fatal rash
- VERY SLOW TITRATION REQUIRED — takes weeks to reach a therapeutic dose
- Interactions: Valproate DOUBLES levels → reduce dose. Carbamazepine reduce levels.
- **Exam pearl: Lamotrigine = BEST OPTION for prevention of bipolar DEPRESSION. NOT useful in acute mania.**

Carbamazepine (Tegretol)

- Uses: Bipolar disorder (alternative, less commonly used), trigeminal neuralgia, epilepsy.
- BLACK BOX WARNINGS: Bone marrow suppression (aplastic anemia, agranulocytosis), Stevens-Johnson syndrome (especially HLA-B*1502 in Asian patients)
- POTENT INDUCER CYP3TO4 — many interactions (decreases levels of other medications and of itself — autoinduction)
- Monitoring: CBC, serum levels (4-12 mcg/mL), LFTs, sodium (hyponatremia).

4.10 Benzodiazepines

- **Mechanism: Potentiates GABA activity at the GABA-A receptor → neuronal hyperpolarization**

Classification by half-life:

- Short acting: triazolam, midazolam (anesthesia/procedures)
- Intermediate: lorazepam, alprazolam, oxazepam, temazepam (LOT — no active hepatic metabolism).
- Long: diazepam, clonazepam, clorazepato

Uses: Acute anxiety, panic attacks, short-term insomnia, alcohol withdrawal, acute agitation, status epilepticus, procedures

Adverse effects:

- Sedation, physical dependence, tolerance, cognitive impairment, amnesia anterograde
- Respiratory depression (FATAL synergism with opioids).
- In older adults: falls, delirium (Beers Criteria: AVOID)

BLACK BOX WARNING: Severe respiratory depression when combined with opioids.

- **Antidote: Flumazenil — reverses the effect, but may precipitate seizures in chronic users.**
- **LOT pearl: Lorazepam, Oxazepam, Temazepam — do NOT have active hepatic metabolism → safer in severe liver disease.**

4.11 Buspirone

- **Indication: GAD — does NOT work for Acute anxiety or panic attacks**
- **Mechanism: Partial 5-HT1A agonist and D2 modulator (not a benzodiazepine).**
- **Advantages: no dependence, no sedation, no alcohol interaction, safe in SUD.**
- **Disadvantage: Takes 2-4 weeks — not for PRN use**
- **Exam pearl: Patient with GAD + history of alcohol abuse → buspirone is ideal. Do NOT abruptly substitute it for prior benzodiazepines.**

4.12 ADHD — Stimulants and Non-stimulants

Stimulants (first line for ADHD):

- Methylphenidate (Ritalin, Concerta, Daytrana) — blocks reuptake DA and NE
- Amphetamine salts (Adderall, Vyvanse — lisdexamfetamine prodrug) — promote release and block reuptake.
- BLACK BOX WARNING: Potential for abuse and dependence (Schedule II controlled substance)
- Contraindications: structural heart disease, arrhythmias, uncontrolled hypertension, glaucoma, severe agitation, and MAOI use.
- Monitoring: HR, BP, weight, height in children, signs of misuse/diversion

Non-stimulants (Second line or if history of SUD):

- Atomoxetine (Strattera) — SNRI selective, not controlled; BLACK BOX: Suicidal ideation in young people
- Guanfacine ER (Intuniv) — central alpha-2 agonist; also used for hypertension and tics
- Clonidine ER (Kapvay) — alpha-2 agonist, hypertension, tics comorbid with ADHD
- Bupropion — Second line, also for MDD and smoking cessation
- **Pearl: ADHD + active SUD → prefer atomoxetine or guanfacine (non-stimulants). ADHD in pregnancy: no option is absolutely safe; discuss risk/benefit.**

4.13 Substance Use Disorders — Medications

Alcohol Use Disorder:

- Naltrexone (oral or monthly IM Vivitrol) — opioid antagonist; reduces craving and relapse. CONTRAINDICATED: active opioid use, acute hepatitis, liver failure.
- Acamprosate (Campral) — normalizes GABA/glutamate after abstinence; OK in liver disease; renally excreted — adjust in renal impairment
- Disulfiram (Antabuse) — inhibits aldehyde dehydrogenase → aversive reaction when drinking alcohol (flushing, nausea, vomiting, tachycardia). Requires high motivation; avoid in pregnancy.

Opioid Use Disorder:

- Buprenorphine/Naloxone (Suboxone) — partial mu agonist; ceiling effect for respiratory depression; PMHNPs may prescribe it under current federal requirements.
- Methadone — full mu agonist; available only through certified opioid treatment programs (OTPs); may prolong QTc.
- Naltrexone IM (Vivitrol) — for motivated patients who are fully abstinent from opioids (does not precipitate withdrawal if opioid-free).
- **CRITICAL PEARL: Do NOT initiate buprenorphine while opioids are still active in the system → severe precipitated withdrawal. Wait until COWS ≥8 (mild-moderate withdrawal onset).**

Nicotine Use Disorder:

- Varenicline (Chantix) — partial nicotinic receptor agonist α4β2; MOST effective. Review current BBW with FDA (mood changes, vivid dreams — BBW about suicide was removed but monitor)
- Bupropion SR (Zyban) — antidepressant; BBW: suicidal ideation; CONTRAINDICATED with seizure history or bulimia.
- NRT — nicotine replacement therapy (patch, gum, pastilla, inhaledor) — safe with pregnancy (relativo)

4.14 Dementia — Medications

Acetylcholinesterase inhibitors (mild to moderate dementia):

- Donepezil (Aricept) — all stages of Alzheimer disease; once daily at night
- Rivastigmine (Exelon) — Alzheimer and Parkinson dementia; transdermal patch available.
- Galantamine (Razadyne) — also modulates nicotinic receptors
- Adverse effects: bradycardia, nausea, diarrhea, loss of appetite

Antagonist NMDA (moderate to severe):

- Memantine (Namenda) — blocks glutamate NMDA receptors; can be combined with donepezil (Namzaric)

Anti-amyloid therapy — NEW:

- Lecanemab (Leqembi, 2023) — anti-amyloid monoclonal antibody; for early/mild Alzheimer disease.
- Risk: ARIA (Amyloid-Related Imaging Abnormalities) — cerebral edema and microhemorrhages; requires periodic MRI
- **CRITICAL PEARL: Antipsychotics in dementia: BLACK BOX WARNING — increased mortality in older adults with dementia-related psychosis. Use ONLY if the risk/benefit assessment justifies it.**

4.15 Insomnia — Medications

- Zolpidem (Ambien) — non-benzodiazepine; GABA-A agonist; BBW: sleepwalking and sleep-driving. Use a reduced dose in women and older adults.
- Eszopiclona (MONDAYta) — similar to zolpidem; metallic taste
- Ramelteon (Rozerem) — melatonin MT1/MT2 agonist; not controlled; no dependence; safe in patients with a history of SUD.
- Suvorexant (Belsomra) — orexin receptor antagonist (hypocretin); Schedule IV controlled substance
- Trazodone — SARI antidepressant; commonly used off-label for insomnia at low doses (50-100 mg).
- Mirtazapine — NaSSA antidepressant; useful for insomnia + anxiety + weight loss; increases appetite.
- **Pearl older adults: AVOID benzodiazepines and Z-drugs in older (Beers Criteria). Ramelteon safer. Review sleep hygiene first.**

SECTION 5: DSM-5-TR DIAGNOSES — CRITERIA AND CLINICAL PEARLS

⚠ *Based on DSM-5-TR (2022). No real exam questions. Examples are marked as educational.*

5.1 Depressive Disorders

Major Depressive Disorder (MDD)

- Criteria: ≥5 symptoms for ≥2 weeks including (1) depressed mood OR (2) anhedonia
- Symptoms: depressed mood, anhedonia, changes in weight/appetite, insomnia or hypersomnia, agitation or psychomotor slowing, fatigue, excessive guilt, difficulty concentrating, thoughts of death/suicide
- Important specifiers: with anxious features, melancholic features, atypical features (mood reactivity, hypersomnia, leaden paralysis), peripartum onset, seasonal pattern

First-line treatment:

- Pharmacologic: SSRI or SNRI (4-8 weeks for full response)
- Psychotherapy: CBT, IPT — equally effective as pharmacotherapy in mild to moderate depression.
- Severe MDD: combination pharmacotherapy + psychotherapy is better than either monotherapy.
- **Exam pearl: MDD atypical → MAOIs or SSRIs (mood reactivity, hypersomnia, weight). MDD + pregnancy → sertraline (most safety data).**

Persistent Depressive Disorder (Distimia)

- Criteria: depressed mood most days ≥2 years (≥1 year in children/adolescents)
- ≥2 of: appetite increasesdo/disminuido, insomnia/hypersomnia, low energy, low self-esteem, difficulty concentrating, hopelessness
- **Pearl: No symptom-free episode >2 months. May coexist with MDD (double depression).**

5.2 Bipolar Disorder

Bipolar I

- Requires at least 1 manic episode (≥7 days OR any duration if hospitalization is required).
- Mania: DIGFAST — Distractibility, Impulsivity (risky pleasurable activities), Grandiosity, Flight of ideas, increased Activity, reduced need for Sleep (feels rested), Talkativeness/pressured speech
- Depressive episodes are common but NOT required for diagnosis.

Treatment Acute mania:

- Lithium, valproate, and atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone)

Maintenance:

- Lithium (gold standard), lamotrigine (especially for bipolar depression), valproate, and some atypical antipsychotics.

Bipolar II

- ≥1 hypomanic episode (≥4 days) + ≥1 major depressive episode.
- Has NEVER had a full manic episode (if present → reclassify as Bipolar I).

- **CRITICAL PEARL: Antidepressants in bipolar disorder should NOT be used as monotherapy → can precipitate mania or rapid cycling.**

5.3 Schizophrenia and psychotic spectrum

Schizophrenia

- Criteria: ≥2 symptoms for ≥1 month, with functional impairment for ≥6 months
- At least 1 of the symptoms must be: (1) hallucinations, (2) delusions, OR (3) disorganized speech.
- Positive symptoms: hallucinations (auditory most common), delusions (persecutory, grandiosity, reference, control), disorganized speech, catatonic behavior
- Negative symptoms: flat affect, alogia, avolition, anhedonia, asociality (social isolation)
- Cognitive symptoms: working memory, processing speed, executive functions (predict functioning)

Treatment:

- Antipsychotics: SGA first line. FGA reserve for specific cases or if patient preference.
- Clozapine: treatment-resistant schizophrenia + the only antipsychotic indicated to reduce suicide risk
- **Pearl: Schizophreniform disorder = schizophrenia criteria but duration of 1-6 months. Brief psychotic disorder = <1 month.**

Schizoaffective Disorder

- Major mood episode (manic or depressive) concurrent with symptoms of schizophrenia.
- Delusions/hallucinations for ≥2 weeks WITHOUT a mood episode

5.4 Anxiety Disorders

Generalized Anxiety Disorder (GAD)

- Anxiety and excessive worry about multiple areas ≥6 months
- Difficult to control the worry + ≥3 symptoms (1 in children): restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance

Treatment: SSRIs/SNRIs (first line), buspirone, CBT, benzodiazepines (short term only)

Panic Disorder

- Recurrent unexpected panic attacks + worry about recurrence or behavioral change
- Symptoms: palpitations, sweating, trembling, dyspnea, choking sensation, chest pain, nausea, dizziness, paresthesias, chills, depersonalization/derealization, fear of dying/losing control.

Treatment: SSRIs/SNRIs, benzodiazepines (short-term PRN), CBT with interoceptive exposure

Social Anxiety Disorder (Social Phobia)

- Intense fear of social or performance situations because of fear of scrutiny

Treatment: SSRIs, venlafaxine, CBT, propranolol for situational/performance anxiety

5.5 Obsessive-Compulsive Disorder (OCD)

- Obsessions: intrusive, persistent, unwanted thoughts that cause anxiety

- Compulsions: repetitive behaviors or mental acts performed to reduce anxiety (do not provide real pleasure).
- Recognized as excessive (with insight)

First-line treatment:

- SSRI at high doses (OCD doses are higher than MDD doses — e.g., fluoxetine 60-80 mg)
- Clomipramine (TCA) — effective alternative but has more adverse effects.
- Psychotherapy: ERP (Exposure and Response Prevention) — best evidence
- **Pearl: ERP = gold standard psychotherapy for OCD. SSRI doses for OCD are significantly higher than doses for MDD.**

5.6 PTSD and Trauma

Criteria DSM-5-TR PTSD (duration >1 month):

- TO. Exposure to Trauma (current or threatened death, serious injury, sexual violence)
- B. Intrusion symptoms (flashbacks, nightmares, distress to cues, physiologic reactivity)
- C. Avoidance of trauma-related stimuli
- D. Negative cognitions and mood alterations (negative thoughts, guilt, detachment, inability to experience positive emotions)
- E. Hyperarousal (hypervigilance, startle response, insomnia, irritability, impulsive behaviors)

Treatment:

- Pharmacologic: Sertraline and paroxetine — ONLY FDA-approved for PTSD
- Psychotherapy: CPT (Cognitive Processing Therapy), PE (Prolonged Exposure), EMDR
- **Pearl: Prazosin (alpha-1 blocker) — PTSD nightmares (off-label but well supported). Benzodiazepines: AVOID — they may interfere with trauma processing and carry a risk of dependence.**

5.7 ADHD

- Criteria: ≥6 symptoms of inattention AND/OR ≥6 symptoms of hyperactivity/impulsivity (≥5 if age ≥17 years).
- Onset before age 12; symptoms in ≥2 settings; functional impairment; not better explained by another disorder
- 3 presentations: predominantly inattentive, predominantly hyperactive-impulsive, combined
- **Exam pearl: Ensure of rule out mania, anxiety, sleep disorders and substance abuse before diagnosing ADHD in Adults. ADHD comorbid with bipolar: treat bipolar disorder FIRST before Stimulants.**

5.8 Personality disorders

Cluster A (Odd/eccentric):

- Paranoid: distrust and persistent suspiciousness of others.
- Schizoid: social detachment, limited range of emotions, no interest in relationships
- Schizotypal: intense discomfort with close relationships, perceptual and cognitive distortions, eccentricities

Cluster B (Dramatic/Emotional):

- Antisocial: pattern of violating the rights of others (age ≥18; evidence of conduct disorder before age 15)
- Borderline (BPD): instability in relationships, self-image, and impulses; efforts to avoid abandonment; self-mutilation; dissociation
- Histrionic: excessive emotionality and attention seeking
- Narcissistic: grandiosity, need for admiration, lack of empathy

Cluster C (Anxious/fearful):

- Avoidant: social inhibition, feelings of inadequacy, hypersensitivity to negative evaluation
- Dependent: excessive need to be cared for, submission, fear of separation
- OC Personality Disorder: preoccupation with order, perfectionism, control (different from OCD)

First-line BPD treatment:

- DBT (Dialectical Behavior Therapy) — only treatment with strongest evidence
- Pharmacology: symptom-targeted (SSRIs for dysphoria; low-dose antipsychotics for dissociation/paranoid ideation)
- **Pearl: There is no FDA-approved medication for BPD. DBT is the gold-standard treatment.**

5.9 Substance Use Disorders (SUD)

- DSM-5-TR: ≥2 of 11 Criteria in 12 months → mild (2-3), moderate (4-5), severe (≥6)
- Criteria: impaired control, social/occupational impairment, hazardous use, and pharmacologic criteria (tolerance/withdrawal)
- Intoxication vs. withdrawal: know symptoms for each substance — especially alcohol and opioids.

Alcohol withdrawal timeline:

- 6-24h: anxiety, tremor, sweating, tachycardia, hypertension
- 24-72h: seizure risk
- 72-96h: Delirium Tremens — confusion, hallucinations, unstable autonomics — POTENTIALLY FATAL
- **Treatment AWS: Benzodiazepines (diazepam, lorazepam) — lorazepam if liver disease. Thiamine IV before glucose for prevenir encephalopathy of Wernicke.**

5.10 Eating Disorders

- Anorexia Nervosa: restricted intake, low BMI, intense fear of gaining weight, and body-image distortion. Restricting and binge-eating/purging subtypes.
- Bulimia Nervosa: binge-eating episodes + inappropriate compensatory behaviors (vomiting, laxatives, fasting, excessive exercise), ≥1x/week for 3 months. BMI is often normal.
- Binge Eating Disorder: binge-eating episodes WITHOUT compensation, ≥1x/week ×3 months, significant distress. Without restriction between episodes.
- **Pearl: Anorexia has the highest mortality rate of all psychiatric disorders. Fluoxetine is approved for bulimia. Bupropion is contraindicated in all eating disorders because of seizure risk.**

5.11 sleep disorders (Summary)

- Insomnia: difficulty initiating or maintaining sleep, ≥3 nights/week, for ≥3 months
- Narcolepsy: excessive daytime sleepiness + cataplexy (loss of muscle tone triggered by emotion) + hypnagogic/hypnopompic hallucinations
- Obstructive Sleep Apnea: repeated episodes of upper-airway obstruction during sleep; treatment is CPAP

- REM Sleep Behavior Disorder: behaviors during REM sleep without atonia — associated with Parkinson and Lewy body dementia
- **Pearl: CBT-I (CBT for Insomnia) = first line for chronic insomnia and is superior to long-term pharmacotherapy.**

5.12 Other Important Diagnoses

Dementia / Major Neurocognitive Disorder (due to Alzheimer disease)

- Cognitive impairment that interferes with independence in AVDS
- Alzheimer: impairment of memoria prominente, insidious onset, progressive course
- Lewy body: cognitive fluctuations, vivid visual hallucinations, parkinsonism, REM sleep behavior disorder
- Frontotemporal: personality/behavior changes or language; more common in <65 years
- Vascular: correlation temporal with vascular event; abrupt or stepwise onset

Delirium

- Acute disturbance of consciousness and cognition, fluctuating, hours-to-days course
- Causes: AEIOU TIPS — Alcohol, Epilepsy, Insulin/metabolic, Overdose/Oxygen, Uremia / Trauma, Infection, Psychiatric, Stroke/Space-occupying
- **Pearl: Delirium in an older adult → FIRST look for a medical cause. AVOID benzodiazepines in non-alcohol-related delirium. Low-dose haloperidol may be useful for agitation.**

Somatoform / somatic symptoms

- Somatic Symptom Disorder: somatic symptoms with excessive related thoughts, feelings, or behaviors for ≥6 months
- Illness Anxiety Disorder: worry about having to serious disease without significant somatic symptoms
- Conversion Disorder (FND): neurological symptoms inconsistent with neurologic findings.

Disorder by Deficit of Attention with Hiperactilifed — Adults

- Often underdiagnosed; many adults had a prior diagnosis in childhood
- Symptoms internalizados: sustained attention difficulty, procrastination, poor time management, impulsivity

SECTION 6: PSYCHOTHERAPY AND PSYCHOLOGICAL THEORIES

⚠ *No real exam questions are included. Clinical application examples are educational and original.*

6.1 Cognitive Behavioral Therapy (CBT)

Foundation: Thoughts → Emotions → Behaviors (Cognitive Triad of Beck)

Techniques:

- Cognitive restructuring — identify and challenge negative automatic thoughts.
- Thought record / cognitive journal
- Gradual exposure (for phobias, OCD, panic)
- Behavioral activation (for depression — counteracts anhedonia)
- Problem solving

Key cognitive distortions — MEMORIZE:

- All-or-nothing (Black-and-white thinking)
- Catastrophizing — magnifying the negative
- Personalization — assuming excessive blame
- Mind reading — assuming others think negatively
- Mental filter — focusing on a negative detail while ignoring the positive
- Disqualifying the positive — it does not "count."
- Emotional reasoning — "I feel it, so it must be true"
- "Should/must" statements — rigid rules

Indications: MDD, GAD, panic disorder, phobias, PTSD, OCD, insomnia (CBT-I), BED, bulimia, addictions, chronic pain

- **Pearl: CBT = evidence-based, present-oriented, time-limited (12-20 sessions). Aaron Beck developed CBT for Depression; Albert Ellis → REBT (Rational Emotive Behavior Therapy).**

6.2 Dialectical Behavior Therapy (DBT)

Founder: Marsha Linehan — originally developed for BPD

Philosophy: Dialectic — acceptance AND change simultaneously

DBT components (4):

- 1. Individual therapy: weekly individual therapy
- 2. Skills group: teaching the modules
- 3. Telephone coaching: crisis support between sessions.
- 4. Therapist consultation: team supervision and support

Skills modules (4 — MNEMONIC: WISE MIND):

- Mindfulness: observe, describe, participate — "Wise Mind" (balance between Emotional Mind and Reasonable Mind)
- Distress tolerance: crisis survival (TIPP, STOP, TIP skills, distraction)
- Emotion regulation: name, understand and change emotions
- Interpersonal effectiveness: DEAR MAN, GIVE, FAST

Indications: BPD (gold standard), PTSD, SUD, eating disorders, self-injurious/suicidal behaviors, mood disorders

- **Exam pearl: Patient with BPD and self-injurious behaviors → DBT. The "TIPP" skill (Temperature, Intense exercise, Paced breathing, Progressive relaxation) is used for acute emotion regulation.**

6.3 Motivational Interviewing (MI)

Founders: Miller and Rollnick

Spirit: PACE — Partnership, Acceptance, Compassion, Evocation (evoking the patient's own motivation)

OARS principles:

- Open-ended questions
- Affirmations
- Reflections (simple and complex)
- Summaries

Strategies:

- Develop discrepancy — between current behavior and values/goals
- Roll with resistance (rolling with resistance) — do not confront directly
- Support self-efficacy
- AVOID the "righting reflex" (the urge to correct the patient).

Stages of Change — Prochaska and DiClemente:

- Precontemplation: no recognition of the problem
- Contemplation: ambivalence — "maybe I have a problem"
- Preparation: planning for change
- Action: active change
- Maintenance: sustain change ≥6 months
- Relapse: part of the process — NOT failure
- **Pearl: MI is not directive counseling. The therapist does NOT tell the patient what to do. It is useful for SUD, lifestyle change, treatment adherence, and smoking cessation.**

6.4 Psychodynamic and Psychoanalytic Psychotherapy

Foundation: Freud — unconscious conflicts, early experiences influence current functioning

Key concepts:

- Id, Ego, Superego — structure of the psyche
- Transference: the patient projects feelings related to earlier figures onto the therapist
- Countertransference: therapist emotional reactions toward the patient — clinical tool.
- Resistance: unconscious avoidance of threatening material.

Defense Mechanisms — MEMORIZE BY MATURITY:

- Primitive/Mature: projection, denial, dissociation, splitting, rationalization, intellectualization, displacement, sublimation, altruism, suppression, humor.
- Projection: attributing one's own unacceptable thoughts or feelings to others
- Splitting: seeing people as completely good or completely bad (BPD).
- Denial: refusal to accept reality

- Rationalization: logical explanations for behaviors with hidden motives
- Repression: exclusion of intolerable thoughts from conscious awareness
- Regression: return to an earlier developmental state
- Sublimation: channeling unacceptable impulses into socially acceptable behaviors (mature)
- Suppression: conscious and deliberate exclusion (mature)

Indications: MDD, anxiety, Personality disorders, Trauma, chronic relational problems

6.5 Interpersonal Therapy (IPT)

Foundations: Developed by Klerman, Weissman, et al. — current interpersonal relationships and their impact on mood.

Problem areas (4):

- Grief — by loss of an important person
- Role disputes — conflicts with significant others
- Role transitions — major life changes (divorcio, motherhood, retirement)
- Interpersonal deficit — social isolation, limited relationships

Indications: MDD, eating disorders, postpartum depression, grief

- **Pearl: IPT is present-oriented and time-limited (~16 sessions). Its efficacy is comparable to CBT for MDD.**

6.6 Family and Couples Therapy

Main models:

- Systemic: family as a system — change in one part affects the whole system. Triangulation and coalitions
- Structural (Minuchin): hierarchies, subsystems, boundaries. Enmeshment (overinvolvement) vs. disengagement.
- Strategic: the symptom serves a function within the family system
- Bowenian: differentiation of self, relational triangles, multigenerational transmission
- **Pearl: Expressed Emotion (EE) high in the family → predictor of relapse in schizophrenia → Family psychoeducation reduces relapses.**

6.7 Group Therapy

Therapeutic factors of Yalom (11):

- Instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group
- Development of socializing techniques, interpersonal learning, group cohesiveness, catharsis, existential factors, imitation.
- **Pearl: Yalom → the factors most valued by patients: group cohesiveness, Universality, Instillation of hope.**

6.8 Therapeutic Communication — Techniques

Effective techniques:

- Active listening / therapeutic presence
- Reflection: repeat or paraphrase
- Clarification: "Can you explain more about that?"
- Focusing: "Which area would you like to focus on today?"
- Validation: recognize the patient's experience without necessarily agreeing
- Therapeutic silence: allows the patient to reflect
- Confrontation: point out inconsistencies of manera respetuosa

Techniques to AVOID:

- Giving premature direct advice
- Giving false reassurance: "Everything will be okay."
- Why questions: create defensiveness
- Changing the subject abruptly

6.9 Crisis Intervention and Trauma-Informed Care

Crisis Intervention (ABC Model):

- A — Achieve contact (establish rapport)
- B — Boil down problem (identify the core problem)
- C — Cope (develop to coping plan)

Trauma-Informed Care principles (SAMHSA — 6 principles):

- 1. Safety (Safety)
- 2. Trustworthiness and Transparency
- 3. Peer support
- 4. Collaboration and mutuality
- 5. Empowerment, voice and choice
- 6. Cultural, historical, and gender sensitivity
- **Pearl: Ask "What happened to you?" instead of "What is wrong with you?" — trauma-informed perspective.**

SECTION 7: ETHICS, LEGAL ISSUES, AND REGULATION IN FLORIDA

⚠ *Legal information verified with statutory sources of Florida. State laws change: always verify current sources before the exam. Information about collaboration in Florida marked as situation to verify at the time of the exam.*

7.1 Scope of Practice of the PMHNP in Florida

Regulatory framework:

- Florida Statutes, Chapter 464 — Nursing Practice Act
- Florida Board of Nursing — regulates APRN licenses
- PMHNPs need APRN licensure in Florida

Prescriptive Authority — CRITICAL POINT FOR THE EXAM:

- In Florida, APRNs (including PMHNPs) have historically required a collaborative practice agreement with a physician to prescribe
- HB 607 (2023): expanded independent practice for APRNs in some contexts — BUT explicitly excludes PMHNPs according to analysis of professional sources
- SB 138 (2024-2025): attempted to include PMHNPs — anecdotal reports indicate that did not progress

⚠ *VERIFY CURRENT LEGISLATIVE STATUS: this is an actively evolving area. Review the Florida Nurses Association (FNA) and the Florida Board of Nursing at the time of the exam.*

- PMHNPs in Florida may prescribe within their specialty with a current collaborative agreement.
- Controlled substances: require DEA registration + comply with Florida Prescription Drug Monitoring Program (PDMP — E-FORCSE database)

7.2 Baker Act — Florida Mental Health Act

Legal reference: Florida Mental Health Act, F.S. §394 (Baker Act)

Involuntary hold:

- Duration: MAXIMUM 72 HOURS for evaluation (neither 24 nor 48 hours)
- Who can initiate? Qualified mental health professional, physician, judge, or law enforcement officer.
- PMHNPs licensed in Florida CAN initiate a Baker Act hold

Criteria for Involuntary hold (ALL must be met):

- 1. Mental disorder present
- 2. Refuses voluntary treatment OR cannot determine the need for it
- 3. Without treatment, the person is likely to suffer harm, cause harm to others, OR be neglectful/unable to care for self.

Process:

- The person is transported to a designated facility for evaluation
- The person must receive an evaluation by a qualified professional within the hold period.
- If the need for continued treatment is determined → court petition.

Key differences:

- Voluntary: patient may request discharge after written notice to the facility (24-72-hour period for response).
- Involuntary: through the Baker Act, legal guardianship, or court order

- **Exam pearl: 72 hours = Baker Act hold period. It is NOT 24 or 48 hours. Facilities must be designated "receiving facilities."**

7.3 Marchman Act — substance abuse

- Florida F.S. §397 — for involuntary detention by SUD
- Evaluation and stabilization: up to 5 days (vs. 72h Baker Act)
- Initiated by family or a health professional.

7.4 Confidentiality and HIPAA

General Rule:

- Protected health information (PHI) may NOT be disclosed without patient consent

Exceptions to confidentiality — MEMORIZE:

- Credible threat to identifiable third party — duty to warn/Protect (Tarasoff)
- Abuse of minors, older adults, or people with disabilities — mandatory reporting.
- Court order / subpoena
- MEDICAL EMERGENCY
- Public health oversight / health agencies
- When the patient is the primary subject of the requested records.

Mental Health Records in Florida:

- More restrictive than general HIPAA — specific consent is required for disclosure in many contexts.
- SUD records: 42 CFR Part 2 — EXTRA strict confidentiality (do not share with other entities without explicit consent, including health systems).

7.5 duty to warn / Duty to Protect (Tarasoff)

Origen: Caso Tarasoff v. Regents of University of California (1976)

Obligation: If hay serious and credible threat toward identifiable victim:

- Warn the potential victim
- Notify authorities
- Hospitalize the patient if necessary

In Florida:

- F.S. §491.0147 — allows (but does not require in all the cases) disclosure for protect against to credible threat
- The professional must exercise clinical judgment about the credibility and imminence of the threat.
- **Pearl: First, attempt protection without violating confidentiality. When the threat is serious, credible, and imminent toward an identifiable person → action is justified/mandatory.**

7.6 mandatory reporting (mandated reporting)

Florida: PMHNPs are mandated reporters for:

- Abuse, neglect or exploitation of MINORS (F.S. §39) → Florida Abuse Hotline: 1-800-962-2873

- Abuse, neglect or exploitation of VULNERABLE ADULTS (≥18 years with discapacity) and OLDER ADULTS ≥60 years (F.S. §415)

Process:

- IMMEDIATE report if suspected — does NOT require certainty for Report
- The report goes to the Florida Department of Children and Families (DCF).
- Do not inform the alleged abuser before reporting.
- Legal immunity for reportantes of good faith
- **Pearl: NEVER ask the patient/family for permission to report abuse. Report FIRST, even if it compromises the therapeutic relationship. Reasonable suspicion is sufficient.**

7.7 Informed Consent

Elements of valid consent:

- Information: nature of treatment, risks, benefits, alternatives, consequence of not treating
- Competence/capacity: cognitive ability to understand and decide
- Voluntariness: without coercion

Exceptions to consent:

- Emergency that threatens life
- Patient incapacity (→ substitute decision-maker or guardian)
- Minors: parents/guardians provide consent (exceptions may include mental health, SUD, contraception, and abortion in some states — verify Florida law)
- **Pearl: Capacity vs. competence: Capacity = clinical determination (the PMHNP may assess it). Competence = LEGAL determination (requires a judge). A patient may have capacity but lack legal competence, and vice versa.**

7.8 Bioethical principles — MEMORIZE

The 4 principles (Beauchamp and Childress):

- Autonomy: respect the patient's right to make their own decisions
- Beneficence: act in the patient's best interest
- No maleficence: AVOID harm ("primum non nocere")
- Justice: equitable distribution of resources; treat patients equitably

Additional principles commonly tested in psychiatry:

- Veracity: honesty with the patient
- Fidelity: keep commitments and professional responsibilities
- Least Restrictive Environment: use the least restrictive intervention that can be provided safely.
- **Exam pearl: Conflict between autonomy and nonmaleficence → the clinical context determines which principle weighs more. A patient with capacity may refuse treatment even if it is harmful (autonomy). Without capacity → act in the patient's best interest.**

7.9 Telehealth in Florida

Framework legal:

- Florida F.S. §456.47 — regula practice of telemedicina

- PMHNPs may practice telehealth in Florida with an active license.
- Establishment patient-provider relationship may occur through telehealth.

Prescribing route Telehealth:

- Permitted for many medications
- Controlled substances: additional regulations apply (federal Ryan Haight Act; COVID-era amendments allowed temporary flexibilities; verify current DEA regulations)
- PDMP registration is mandatory to prescribe controlled substances.

7.10 Documentation and Professional Standards

Essential elements of clinical documentation:

- Evaluation risk (suicidal, homicidal) in each visita relevante
- Clinical reasoning for diagnosis and treatment plan.
- Informed Consent documentado
- Review and answer to cambios in the state patient
- Patient nonadherence and management.
- Communication with other providers (with consent).
- Supervision/consultation when appropriate

Professional boundaries:

- Dual relationships: do NOT have personal, romantic, or financial relationships with patients.
- Sexual relationship with a patient: never ethical, even after therapy ends in psychotherapy; some codes state it is never permitted
- Self-disclosure: use only with a clear therapeutic purpose, not to meet the therapist's needs.
- **Pearl: The PMHNP's first duty is PATIENT SAFETY. When ethics and law come into conflict, generally follow the law and consult with a supervisor or ethics resource.**

SECTION 8: SCALES AND SCREENING TOOLS

⚠ Approximate cutoff scores — verify the specific version of the instrument. Assessment Scales are clinical tools, not definitive diagnoses.

PHQ-9	Depression	9 items (DSM symptoms). 0-27 pts.	0-4: Minimal; 5-9: Mild; 10-14: Moderate; 15-19: Moderately severe; ≥20: Severe.	Self-administered, APS, follow-up answer
PHQ-2	Initial depression screening	2 items (anhedonia + mood). ≥3 = positive.	If positive → complete the PHQ-9.	Rapid screening in advanced practice settings
GAD-7	Generalized anxiety	7 items. 0-21 pts.	0-4: Minimal; 5-9: Mild; 10-14: Moderate; ≥15: Severe.	GAD, also useful panic and social anxiety disorder
MDQ	Bipolar screening	13 items: manic symptoms + impact + simultaneity.	≥7 + functional impact + symptom co-occurrence = positive	Screening, NOT diagnosis. Higher sensitivity for Bipolar I.
CAGE	Alcohol	4 questions: Cut down, Annoyed, Guilty, Eye-opener	≥2 = positive → assess more	Simple, does not detect current use — AUDIT is better for that.
AUDIT	Alcohol Use Disorders	10 items. 0-40 pts.	≥8 (men) or ≥6 (women) = risk. ≥20 = dependence probable	WHO; more comprehensive than CAGE
AUDIT-C	Rapid alcohol screening	3 items (consumption). 0-12 pts.	≥4 men / ≥3 women = positive	Rapid; if positive → complete the AUDIT.
AIMS	Tardive Dyskinesia	12 items — involuntary movements of the face/extremities/trunk.	0-4 by area (0=absent, 4=severe)	Required with antipsychotics; baseline and periodic monitoring.
MMSE	Cognition (dementia).	30 points — orientation, registration, attention, memory, language.	24-30: Normal; 18-23: Mild; 10-17: moderate; <10: Severe	Limited usefulness at high education levels; copyright restrictions.
MoCA	Cognition (more sensitive)	30 points — visuospatial/executive function, memory, attention, language, orientation.	26-30: Normal (add +1 if <12 years of education); <26 = possible impairment.	Superior to MMSE for mild impairment
HAM-D	Depression severity.	17 or 21 items — depressive symptoms.	0-7: Normal; 8-13: Mild; 14-18: moderate; 19-22: Severe; ≥23: Very severe (version 17)	Clinician-administered; useful in clinical trials.
HAM-A	Anxiety severity.	14 items — psychic and somatic symptoms.	0-13: Normal; 14-17: Mild; 18-24:	Clinician-administered

			moderate; 25-30: Severe	
C-SSRS	Suicide risk	Ideation (1-5) and behavior; full and screener versions	Guide the level of intervention by score	Columbia; standard in FDA clinical trials; reference scale for suicide risk.
Vanderbilt	Childhood ADHD	Parents and teachers; symptoms + performance	Symptoms present in ≥2 settings + impairment	Screening/monitoring instrument for pediatric ADHD.
PANSS	Schizophrenia	30 items — positive, negative, and general symptoms.	30-210 pts; symptoms individual 1-7	Clinical; trials with antipsychotics; not routine clinical practice.
CIWA-Ar	Alcohol Withdrawal	10 items — tremor, diaphoresis, anxiety, agitation, nausea, headache, perceptual disturbance, quality of contact, seizures, orientation.	0-8: Absent/mild; 9-15: Moderate; ≥16: Severe.	Guide dosing of benzodiazepines in AWS
COWS	Opioid Withdrawal	11 items — heart rate, diaphoresis, restlessness, pupil size, aches, rhinorrhea, nausea, gooseflesh, etc.	0-4: Mild; 5-12: Mild; 13-24: Moderate; 25-36: Moderate to severe; >36: Severe	COWS ≥8 → initiate buprenorphine (Suboxone induction).
EPDS	Perinatal depression	10 items — 0-30 pts.	≥10-12: assess further; item 10 (self-harm) → always assess.	Edinburgh Postnatal Depression Scale; screening during pregnancy and postpartum
ASRS	ADHD in Adults	18 items (the 6-item screener is most commonly used).	≥4/6 in screener = positive	Adult ADHD Self-Report Scale; developed by the WHO
PCL-5	PTSD	20 items — DSM-5 symptoms.	≥33 = probable PTSD	PTSD Checklist; civilian and military versions

Key Pearls About Scales — MEMORIZE

Monitoring with antipsychotics:

- AIMS: obtain a baseline before starting an antipsychotic and repeat periodically (frequency according to guidelines; at least annually)
- If AIMS identifies tardive dyskinesia → consider discontinuing/changing the antipsychotic or adding valbenazine/deutetrabenazine

Suicide risk:

- C-SSRS: categorized suicidal ideation item. Active ideation with plan and available means → immediate hospitalization.
- PHQ-9 item 9: "Thoughts that you would be better off dead" → follow up with a complete suicide-risk evaluation

Alcohol:

- CAGE is positive in men with ≥2 affirmative answers; in women, consider a lower threshold
- CIWA-Ar: used for benzodiazepine dosing in AWS — treat symptoms, not with a fixed dose.

Cognition:

- MoCA is more sensitive than MMSE for mild cognitive impairment (MCI)
- Clock Drawing Test: simple and rapid; screens for executive and visuoconstructional dysfunction

COWS and Suboxone:

- **CRITICAL PEARL: Do NOT initiate buprenorphine/naloxone (Suboxone) until COWS ≥8. If started too early → severe precipitated withdrawal.**

SECTION 9: PSYCHIATRIC SAFETY AND CRISIS MANAGEMENT

⚠ *This section addresses evaluation and management. It does not contain real exam questions. Examples are educational.*

9.1 Evaluation of Suicide Risk

Evaluation framework — risk factors:

- Previous attempts — STRONGEST PREDICTOR of future suicide.
- Family history of suicide.
- Specific plan, access to means, and intent to act
- Hopelessness — strong independent predictor (Beck Hopelessness Scale)
- Comorbid diagnoses: MDD, bipolar disorder, schizophrenia, BPD, SUD, PTSD
- Social isolation, recent losses, acute stress.
- Male, Caucasian, ≥65 years (high suicide mortality rate).
- Middle age and older adults — higher rates (adolescents: more attempts but lower average lethality).

Protective factors:

- Strong social support network.
- Reasons for living (children, pets, religious beliefs)
- Current treatment and adherence
- Hope for the future
- Limited access to lethal means

Evaluation of ideation — ask directly (does NOT increase risk):

- Have you thought about harming yourself or taking your life?
- Does the patient have a plan? Which one?
- Does the patient have access to means (weapons, medications)?
- Does the patient have intent to act?
- Has the patient made preparations (letter, disposition of belongings/assets)?

Levels of intervention according to risk:

- Low: passive ideation without a plan → safety plan, close follow-up, involve support network.
- Moderate: ideation with a plan but no immediate intent → intensify follow-up, eliminate access to means, consider hospitalization
- High: active ideation with plan + intent + access → immediate hospitalization (Baker Act if necessary).

Safety Planning (Stanley-Brown):

- 1. Personal warning signs.
- 2. Internal coping strategies
- 3. People and settings that provide distraction.
- 4. People to ask for support.
- 5. Professionals and crisis lines to contact.
- 6. Make the environment safer (means restriction).
- **Exam pearl: Lethal means counseling — counseling about restricting access to firearms and medications is an evidence-based intervention. "Please take those pills out of the house" is part of the safety plan.**

9.2 Evaluation of Homicidal Ideation

Assess:

- Specific vs. nonspecific target.
- Plan and intent
- Capacity to act
- History of violence.

Violence risk factors:

- Previous history of violence — strongest predictor.
- Acute intoxication
- Active psychosis with violent command hallucinations
- Access to weapons/firearms.
- Acute stress, recent victimization.

duty to warn/Protect:

- If the threat is serious, credible, and imminent toward an identifiable person → act (see Section 7).

9.3 Management of Acute Psychosis

Presentation:

- Hallucinations (auditory, visual, tactile, olfactory), delusions, disorganized speech, bizarre behavior, agitation.

Initial evaluation — rule out medical causes FIRST:

- F — Fever / infection (encephalitis, meningitis).
- I — Intoxication / Withdrawal
- R — Rash + encephalopathy (anti-NMDA receptor encephalitis — more common in young women)
- S — Stroke / Trauma
- T — Toxins / medications (corticosteroids, stimulants, dopaminergic agents)

Acute management:

- Calm environment, verbal de-escalation FIRST.
- If severe agitation: haloperidol + lorazepam IM, or olanzapine IM (do NOT combine olanzapine IM with benzodiazepines IM → respiratory-depression risk)
- Oral antipsychotic if the patient is cooperative
- **Pearl: Anti-NMDA receptor encephalitis: psychosis in a young woman + involuntary movements → MRI, EEG, anti-NMDA antibodies in CSF/serum. Treatment is immunotherapy, not antipsychotics alone.**

9.4 Manic Crisis

Evaluation:

- Safety (impulsive behavior, debt, promiscuity, grandiosity with risk)
- Comorbid psychosis.
- Capacity to consent/refuse treatment
- Support network and possible follow-up.

Management:

- Hospitalization if: high-risk behaviors, inability to care for self, severe psychosis.
- Lithium OR valproate + an atypical antipsychotic
- Benzodiazepines for short-term sedation/agitation

9.5 Intoxication and Withdrawal

Opioid intoxication:

- Triad: pinpoint pupils (miosis), respiratory depression, altered consciousness
- Treatment: Naloxone (Narcan) IM/IV/intranasal — repeated doses may be required with fentanyl.

Benzodiazepine overdose:

- Respiratory depression, sedation
- Antidote: Flumazenil (caution in chronic users → may precipitate seizures).

Severe alcohol withdrawal — delirium tremens:

- 72-96 hours after last intake — POTENTIALLY FATAL.
- Treatment: benzodiazepines (diazepam or lorazepam), thiamine, electrolyte correction, hydration.
- CIWA-Ar for monitoring and dosing

Serotonin Syndrome vs NMS — CRITICAL DIFFERENCES:

Cause	SSRIs, MAOIs, triptans, tramadol, dextromethorphan	Antipsychotics (especially FGA)
Onset	RAPID (hours)	GRADUAL (days-weeks)
Neuromuscular findings	Hyperreflexia, CLONUS, myoclonus	Severe "lead-pipe" rigidity, without clonus
Temperature	Fever (may be extreme).	Fever (may be extreme).
Laboratory	CK may be elevated.	CK VERY elevated (>1000)
Treatment	discontinue the agent + cyproheptadine + supportive care.	discontinue antipsychotic + dantrolene + bromocriptine.

9.6 Domestic Violence and Abuse

Screening:

- Ask ALL patients privately (without partner present).
- Tool: HITS (Hurt, Insult, Threaten, Scream).

Response to abuse:

- Validate and believe the patient.
- Do not blame the victim.
- Provide resources (National DV Hotline: 1-800-799-7233)
- Report if there are vulnerable victims (minors, older adults, people with disabilities) — mandatory reporting.
- Document findings and patient statements

Cycle of violence (Walker):

- 1. Tension-building → 2. Acute incident → 3. Reconciliation/honeymoon → 4. Calm → repeat.
- **Pearl: Do not pressure the victim to leave the aggressor immediately. The decision is theirs. Safety is the priority — safety plan and resources.**

9.7 Criteria for Psychiatric Hospitalization

Indications for immediate hospitalization:

- Suicidal ideation with plan, intent, and/or access to means
- Recent suicide attempt
- Homicidal ideation with an identified victim and capacity to act
- Severe psychosis with risk of harm to self or others
- Severe mania with high-risk behaviors.
- Inability to care for self (homelessness, not eating, not taking medications).
- Severe withdrawal that requires medical monitoring (AWS, OWS).

Least restrictive setting:

- If it can be managed safely on an outpatient basis → intensify treatment (more frequent visits, IOP, PHP).
- The principle of the LEAST RESTRICTIVE ENVIRONMENT always applies
- IOP (Intensive Outpatient Program): generally 3 days/week × 3 hours
- PHP (Partial Hospitalization Program): generally 5 days/week × 6 hours (step-down from hospitalization)

SECTION 10: 4-WEEK STUDY PLAN

⚠ *This plan is a suggestion based on the ANCC PMHNP-BC domains. Adapt it according to your identified strengths and weaknesses.*

Before beginning: baseline evaluation.

Take a practice exam or self-assessment to:

- Identify your areas of greatest weakness.
- Determine which topics require more time.
- Establish a baseline score.
- Tools: APEA, Fitzgerald, Barkley, Mometrix PMHNP practice tests (note: these are commercial practice tools, not affiliated with ANCC).

Week 1: Scientific Foundations and Diagnosis

WEEKLY OBJECTIVES:

- Master DSM-5-TR diagnostic criteria for the 10 most prevalent conditions on the exam
- Understand mechanisms of action of the main medication classes.
- Review basic neurobiology relevant to PMHNP practice.

MONDAY — Mood disorders:

- MDD: 9 symptoms, duration criteria, subtypes (atypical, melancholic, peripartum).
- Bipolar I, Bipolar II, cyclothymia: key differences, DIGFAST mnemonic
- First-line pharmacologic treatments
- Practice: 20-25 questions topic-based

TUESDAY — Anxiety, OCD and PTSD:

- GAD, Panic Disorder, Social Anxiety Disorder, Agoraphobia
- OCD (egodystonic), OCD vs. obsessive-compulsive personality disorder.
- PTSD vs. Adjustment Disorder — time criteria.
- Evidence-based psychotherapies by diagnosis.
- Practice: 20-25 questions topic-based

WEDNESDAY — Psychosis and Schizophrenia:

- Schizophrenia vs. schizoaffective disorder vs. schizophreniform disorder vs. brief psychotic disorder
- Positive and negative symptoms.
- Antipsychotics FGA vs. SGA: Mechanisms and adverse effects
- Clozapine: indications and ANC monitoring
- Practice: 20-25 questions topic-based

THURSDAY — SUD (Substance Use Disorders):

- DSM-5 criteria for SUD (11 criteria; mild/moderate/severe)
- Withdrawal: alcohol, opioids, benzodiazepines, stimulants.
- CIWA-Ar and COWS scores and treatment thresholds
- Pharmacotherapy: buprenorphine, methadone, naltrexone, acamprosate, disulfiram, varenicline.
- Practice: 20-25 questions topic-based

FRIDAY — Review and practice exam:

- Review the week's topics.
- Do 50 mixed practice questions
- Analyze mistakes: Why did you miss it? Concept, distractor, or question-reading issue?
- Prepare flashcards for missed concepts

Weekend — Reinforcement:

- Review the week's flashcards
- Supplemental reading in identified weak areas
- Adequate rest (rest is part of effective studying).

Week 2: Deep Pharmacology

WEEKLY OBJECTIVES:

- Master safety profiles, black box warnings, interactions, and monitoring for each pharmacologic class
- Memorize key mnemonics
- Practice pharmacology questions in clinical context.

MONDAY — SSRIs, SNRIs, Bupropion:

- Serotonin syndrome vs. NMS
- Discontinuation syndrome: FINISH mnemonic
- CYP450: inhibitors (fluoxetine, paroxetine) and inducers (carbamazepine)
- QTc: citalopram >40 mg; escitalopram preferred in adults >65 years

TUESDAY — mood stabilizers:

- Lithium: levels, interactions, toxicity, Ebstein anomaly, renal/thyroid monitoring
- Valproate: BBW teratogenicity, pancreatitis, hepatotoxicity; levels 50-125
- Lamotrigine: SJS/TEN, slow titration, interaction with valproate
- Carbamazepine: CYP inducer, aplastic anemia, hyponatremia

WEDNESDAY — Antipsychotics:

- EPS: Acute dystonia (anticholinergic), akathisia (propranolol/benzodiazepines), parkinsonism, tardive dyskinesia (clonazepam, tetrabenazine)
- Metabolic syndrome: highest risk with clozapine and olanzapine.
- Elevated prolactin: risperidone, haloperidol → amenorrhea, galactorrhea
- QTc: thioridazine, ziprasidone, IV haloperidol

THURSDAY — Special Medications:

- MAOI + tyramine = HYPERTENSIVE CRISIS; washout 14 days (5 weeks for fluoxetine).
- Benzodiazepines: LOT mnemonic, antidote flumazenil
- TCAs: CAST mnemonic, avoid in suicidal patients, antidote is sodium bicarbonate.
- Dementia: AChEIs + memantine; lecanemab + ARIA.
- ADHD: Stimulants + BBW cardiovascular; atomoxetine + BBW suicidal ideation

FRIDAY — Pharmacology in Special Populations:

- Pregnancy: risk categories; sertraline first line for MDD; lithium → Ebstein anomaly; valproate CONTRAINDICATED.
- Older adults: START/STOPP, Beers Criteria, start low doses
- Pediatrics: BBW for suicidal ideation in patients <25 years with antidepressants.

- Exam practice: 50 questions pharmacology

Week 3: Psychotherapy, Ethics, and Clinical Skills

WEEKLY OBJECTIVES:

- Master psychotherapeutic modalities and their indications
- Understand the ethical and legal framework (especially Florida)
- Practice clinical judgment and case-management questions.

MONDAY — CBT, DBT, MI:

- Beck's cognitive triad; identify and challenge distortions.
- DBT: 4 Components, 4 modules; BPD gold standard
- MI: Stages of Change, OARS, AVOID righting reflex
- When to use which therapy? (Indications by diagnosis)

TUESDAY — Other Therapeutic Modalities:

- IPT: 4 focus areas, ~16 sessions.
- EMDR for PTSD; ERP for OCD
- Family therapy: Minuchin, Bowen, expressed emotion
- Group therapy: Yalom's 11 therapeutic factors
- CBT-I for chronic insomnia

WEDNESDAY — Ethics and Professional Boundaries:

- 4 Bioethical principles: ABCJ (Autonomy, Beneficence, Competence/No maleficence, Justice)
- Capacity vs competence
- HIPAA confidentiality and exceptions
- Dual relationships and boundaries of the therapist
- Mandatory reporting and duty to warn (Tarasoff)

THURSDAY — Florida Legal Aspects:

- Baker Act: 72 hours, criteria, who can initiate
- Marchman Act: SUD, up to 5 days
- Collaborative agreement: current status in Florida
- Florida telehealth regulations
- Prescribing controlled substances: DEA + PDMP in Florida

FRIDAY — Clinical Integration:

- Complex clinical cases: comorbidities, special populations.
- Scales and when to apply them.
- Crisis management: suicide, psychosis, withdrawal.
- Exam practice: 75 questions mixed

Week 4: Intensive Review and Mock Exams

WEEKLY OBJECTIVES:

- Consolidate all topics
- Simulate real exam conditions
- Manage anxiety and exam strategies

MONDAY-TUESDAY — Review of Weak Areas:

- Review all your flashcards and mistakes from previous weeks
- Focus on the topics where you have <70% accuracy.
- Do additional targeted questions in those areas

WEDNESDAY — Mock Exam #1:

- 150 questions in 3 hours (simulate the real exam)
- Without interruptions, without reference material
- Review ALL the errors: understand why

THURSDAY — Post-Mock Review:

- Analyze error patterns (distractor, concept, or rushed reading?).
- Intensive review of missed concepts
- Emergency mnemonics — memorize the most critical ones.

FRIDAY — Mock Exam #2 + Strategies:

- 75 questions (short version of final practice)
- Question-reading strategies:
- **— Read the LAST SENTENCE first to know what is being asked**
- **— Identify keywords: "FIRST", "NEXT", "MOST", "EXCEPT", "PRIORITY"**
- **— Eliminate obviously incorrect answers**
- **— If 2 answers seem correct, return to the question: what exactly is being asked?**

Weekend before the exam:

- DO NOT study the day before
- Prepare necessary documents for the Prometric Testing Center
- Ensure quality rest (8h of sleep)
- Healthy food and light exercise
- Review center location, arrival time (30 min before recommended)

Recommended Study Resources (no endorsement or affiliation)

Official primary resources (ALWAYS start here):

- ANCC PMHNP Exam Content Outline — free in ancc.nursingworld.org
- DSM-5-TR — American Psychiatric Association (official diagnostic text)
- Stahl's Essential Psychopharmacology (Prescriber's Guide) — Stephen M. Stahl

Review books (anecdotal — based on recommendations of communities of PMHNPs):

- Fitzgerald Health Education: PMHNP board review resources
- Barkley & Associates: PMHNP board review
- APEA (Advanced Practice Education Associates): PMHNP resources
- Mometrix: PMHNP-BC Exam Secrets Study Guide

Support communities (anecdotal):

- r/PMHNP on Reddit — shared experiences from recent candidates
- Facebook Groups: "ANCC PMHNP Board Exam" — study groups

⚠ *IMPORTANT: Shared experiences in forums are anecdotal and do not represent official sources. Do not confuse testimonials with current exam content.*

SECTION 11: SOURCES USED AND RELIABILITY

This guide was prepared using only high-reliability primary and secondary sources. The following were not used: "brain dumps," leaked questions, or material that violates exam confidentiality agreements. Statistics marked as anecdotal come from candidate testimonials, not from officially published ANCC data.

Highest-Reliability Sources — Official Primary Sources

ANCC PMHNP-BC Exam Content Outline	Official ANCC document	Defines the exam domains and weights exactly.	Free in ancc.nursingworld.org
DSM-5-TR (2022)	Official APA diagnostic manual	Main source for diagnostic criteria	American Psychiatric Association
FDA Drug Labels / DailyMed	FDA-approved labeling.	Black box warnings, indications, contraindications, official monitoring guidance	dailymed.nlm.nih.gov (free)
Florida Statutes (F.S.)	Florida state legislation.	Baker Act (§394), Marchman Act (§397), Telehealth (§456.47)	leg.state.fl.us (free)
ANA Code of Ethics for Nurses	Official ANA Code of Ethics.	Ethical framework for professional ethics questions.	nursingworld.org
HIPAA Privacy Rule (45 CFR Parts 160, 164)	Federal DHHS regulation.	Confidentiality and exceptions	hhs.gov (free)

High-Reliability Sources — Academic Textbooks

Stahl SM. Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications, 5th ed.	Cambridge University Press, 2021	High — standard psychopharmacology text	Pharmacology: Mechanisms of action, adverse effects
Stahl SM. Prescriber's Guide, 7th ed.	Cambridge University Press, 2021	High — clinical prescribing reference.	Pharmacology: dosing, monitoring, interactions
American Psychiatric Association. Practice Guidelines for Psychiatric Evaluation	APA, multiple years	High — evidence-based clinical guidelines.	Diagnostic evaluation, clinical management.
Sadock BJ, Sadock VA, Ruiz P. Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 10th ed.	Wolters Kluwer, 2017	High — comprehensive psychiatry reference text	Diagnoses, psychotherapy, theories.
Beck AT, Rush AJ, Shaw BF, Emery G. Cognitive Therapy of Depression.	Guilford Press, 1979	High — foundational CBT text	Cognitive triad, cognitive distortions
Linehan MM. DBT Skills Training Manual, 2nd ed.	Guilford Press, 2015	High — original DBT developer	DBT modules and components
Miller WR, Rollnick S. Motivational Interviewing, 4th ed.	Guilford Press, 2023	high — creators of MI	Motivational interviewing, stages of change

Yalom ID. The Theory and Practice of Group Psychotherapy, 5th ed.	Basic Books, 2005	High — authority in group therapy	Therapeutic factors of Yalom

Medium-High Reliability Sources — Clinical Resources

REMS (Risk Evaluation and Mitigation Strategy) — clozapine, lithium, etc.	Mandatory FDA programs	High reliability — official safety protocols.
SAMHSA Treatment Improvement Protocols (TIPs)	Federal SUD treatment guidelines	High reliability — evidence-based federal guidelines
NIDA (National Institute on Drug Abuse)	Federal research institute	High reliability — science of SUD
NIMH (National Institute of Mental Health)	Federal mental health institute	High reliability — epidemiology, guidelines.
Joint Commission on Accreditation (JCAHO)	Hospital-accrediting organization	High reliability — quality and safety standards
UpToDate (subscription).	Peer-reviewed clinical database.	Medium-high — updated, but secondary synthesis.
Prescribers' Digital Reference (PDR)	Digital pharmacology reference.	Medium-high — summarizes FDA labels

Information Marked as Anecdotal in This Guide

The following information comes from candidate testimonials, online communities (Reddit r/PMHNP, Facebook groups), or commercial preparation resources. It does NOT come from verified primary sources. It is included as contextual information but should be treated with caution:

- Pass rate of ~83% for first-time candidates — not officially published by ANCC in this specific form.
- Recommendations about specific preparation books (Fitzgerald, Barkley, APEA) — these are commercial resources, not endorsed by ANCC.
- Perceptions about which topics "are asked most often" on the exam — based on candidate testimonials, not published data.
- Specific exam-day presentation strategies (arrival 30 minutes early, etc.) — based on general Prometric guidelines.

What This Guide Does NOT Use

For academic integrity and professional ethics, this guide deliberately EXCLUDES:

- "Brain dumps" — illegal collections of real exam questions
- "Exam dumps" — sites that sell questions supposedly leaked from the exam.
- Content that violates Non-Disclosure Agreements (NDAs) of ANCC
- "Real" exam questions shared by candidates in violation of their agreements.
- Percentages or content statistics not verified in the official Exam Content Outline.
- Invented Florida-specific data or data not supported by verified statutes.

⚠ *Ethical note: The use of brain dumps or leaked material is a violation of the ANCC Candidate Agreement and can result in disqualification and disciplinary action. Nursing professionals have an ethical obligation to prepare with integrity.*

SECTION 12: FINAL CONCLUSION

Synthesis of the Most Critical Points

If you could remember only 10 things from this guide:

- 1. CLOZAPINE: agranulocytosis → weekly ANC monitoring for the first 26 weeks; unique indication for treatment-resistant schizophrenia and suicide-risk reduction.
- 2. LITHIUM: therapeutic level 0.6-1.2 mEq/L; TOXIC >1.5; teratogenic risk (Ebstein anomaly); measure level 11-12 hours post-dose; interactions with NSAIDs/thiazides/ACE inhibitors.
- 3. LAMOTRIGINE: SJS/TEN (Stevens-Johnson); VERY slow titration; valproate DOUBLES levels; best for prevention of bipolar depression.
- 4. MAOI: washout 14 days (5 weeks for fluoxetine); tyramine → HYPERTENSIVE CRISIS; serotonin syndrome risk.
- 5. BAKER ACT (Florida): 72 HOURS MAXIMUM; PMHNPs CAN initiate; criteria: mental disorder + refusal of voluntary treatment/lack of capacity + risk of harm.
- 6. TARASOFF: serious threat + identifiable victim → warn the victim + notify authorities + hospitalize if necessary
- 7. BUPRENORPHINE: initiate only when COWS ≥8 (wait for moderate withdrawal to avoid precipitated withdrawal).
- 8. DSM-5-TR MDD: 5/9 symptoms ≥2 weeks including depressed mood OR anhedonia
- 9. DBT: BPD gold standard; 4 modules; Marsha Linehan; includes telephone coaching and team consultation
- 10. Mandated reporting: immediate, without needing absolute certainty; do not ask the patient for permission.

Essential Mnemonics — Summary

DIGFAST	Mania symptoms	Distractibility, Impulsivity (risky behavior), Grandiosity, Flight of ideas, Activity increased, Reduced sleep (without fatigue), Talkativeness/pressured speech
FINISH	SSRI discontinuation.	Flu-like, Insomnia, Nausea, Imbalance (dizziness), Sensory disturbances (zaps), Hyperarousal
CAST	TCAs adverse effects	Seizures, Arrhythmias, Sedation, Anticholinergic toxicity.
LOT	Benzos without active metabolite	Lorazepam, Oxazepam, Temazepam (good options in older adults/liver disease).
SIGECAPS	Depressive symptoms.	Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicidality
OARS (MI)	MI techniques	Open questions, Affirm, Reflect, Summarize
PACE (MI)	MI spirit	Partnership, Acceptance, Compassion, Evocation
AIMS	Tardive dyskinesia	Monitor before starting an antipsychotic and regularly afterward
COWS ≥8	Suboxone	Initiate buprenorphine only when COWS ≥8 (confirmed moderate withdrawal).
CIWA-Ar >10	AWS	Score >10 on CIWA-Ar → treat with benzodiazepines.

Strategies for Exam Day

Before the exam:

- Arrive at the Prometric center at least 30 minutes early
- Bring 2 forms of valid identification (at least one with a photo).
- You cannot bring study materials, cell phone or watch to the room
- Lockers will be available for your belongings.

During the exam:

- Read the LAST SENTENCE of each question first to know what is being asked
- Identify keywords: "FIRST", "NEXT", "MOST APPROPRIATE", "PRIORITY", "EXCEPT", "BEST"
- "FIRST" or "PRIORITY" → usually look for assessment/safety, not immediate treatment
- "EXCEPT" → read all options carefully, the answer is the one that does NOT apply
- If you do not know an answer, eliminate the clearly incorrect options and choose from the remaining ones
- Do not change your first answer unless you have a specific reason to do so
- Use the review marker for uncertain questions and come back at the end
- Manage your time: ~175 questions / 3.5 hours = ~72 seconds per question

Managing anxiety during the exam:

- Diaphragmatic breathing: inhale for 4 counts, hold for 4, exhale for 6.
- If you feel panic, mark the question, move to the next one and return
- Remember: the 25 pretest questions do not count — you cannot know which ones they are, so do not worry about "the difficult one."

Final Message

Preparing for the ANCC PMHNP-BC with academic and clinical integrity is not only ethically correct — it is also the most effective. Certification exams are designed to assess real clinical reasoning, not memorization of specific questions.

The best preparation combines: solid mastery of the Exam Content Outline, systematic practice with quality questions (no "dumps"), deep understanding of the concepts (not only memorization), and care for your well-being during the process.

Your patient community with mental health conditions needs competent, compassionate, and ethically upright PMHNPs. This certification represents your commitment to that responsibility.

Best of luck on your exam!