CHUKA  **UNIVERSITY**

UNIVERSITY EXAMINATIONS

THIRD YEAR EXAMINATION FOR THE AWARD OF DEGREE OF BACHELOR OF BACHELOR OF SCIENCE IN NURSING

NURU 377: MENTAL HEALTH & PSYCHIATRIC NURSING II

STREAMS: BSc NURSING (Y3T3) **TIME: 2 HOURS**

DAY/DATE: WEDNESDAY 5/12/2018 **8.30 A.M - 10.30 A.M.**

INSTRUCTIONS:

1. Do not write anything on the question paper.
2. Mobile phones and any other reference materials are NOT allowed in the examination room.
3. The paper has three sections. Answer ALL the questions.
4. All your answers for Section I (MCQs) should be on page one of the answer booklet. Number ALL your answers and indicate the order of appearance in the space provided in the cover page of the examination answer booklet.
5. Write your answers legibly and use your time wisely

SECTION 1: MULTIPLE CHOICE QUESTIONS (20MARKS)

1. A client with obsessive-compulsive disorder is hospitalized in an intpatient unit. Which nursing response is most therapeutic?
   (a) Accepting the client's obsessive-compulsive behaviors
   (b) Challenging the client's obsessive-compulsive behaviors
   (c) Preventing the client's obsessive-compulsive behaviors
   (d) Rejecting the client's obsessive-compulsive behaviors

2. A client experiencing severe depression is admitted to the in-patient psychiatry unit. During initial assessment, she says, 'I feel like killing myself, but I would not do that because of my children". The nurse's priority action would be:
   (a) Explore the reasons that the client might want to take her life
   (b) Determine the severity of her suicidal risk
   (c) Prevent the client from harming herself
   (d) Guide her to consider alternative ways of coping

3. A patient is newly admitted to the psychiatric unit with a diagnosis of bipolar disorder, manic phase. Which of the following activities would be most appropriate for the patient?
   (a) Doing crossword puzzles.
   (b) Reading quietly in a quiet place
   (c) Playing a game of table tennis
   (d) Working with modeling clay

4. A nurse assesses a patient who has schizophrenia of the paranoid type. Which of the following behaviours should the nurse expect to observe?
   (a) Elated effect and hyperactivity
   (b) Obsessive thoughts
   (c) Hallucinations and delusions
   (d) Manipulation and narcissism

5. The nurse should assess a patient who has bipolar disorder, manic episode for which of the following manifestations?
   (a) Waxy flexibility
   (b) Flat affect
   (c) Flight of ideas
   (d) Hypersomnia

6. Which of the following actions should a nurse include in the care plan of patients with bulimia?
   (a) Stay with the patient for one hour after meals
   (b) Decrease environmental stimuli
   (c) Weigh the patient twice a day
   (d) Discourage verbalization about out-control eating

7. A 75-year old client has neurocognitive disorder of the Alzheimer's type and confabulates. The nurse understands that this client:
   (a) Denies confusion by being jovial
   (b) Pretends to be someone else
   (c) Rationalizes various behaviors
   (d) Fills memory gaps with fantasy

8. Which patient behaviors should the nurse suspect as related to alcohol withdrawal?
   (a) Hyperalert state, jerky movements, easily startled
   (b) Tachycardia, diaphoresis, elevated blood pressure
   (c) Peripheral vascular collapse, electrolyte imbalance
   (d) Paranoid delusions, fever, fluctuating levels of consciousness

9. The nurse is assessing a client diagnosed with disorganized schizophrenia. Which symptoms should the nurse expect the client to exhibit?
   (a) Markedly regressive, primitive behavior and extremely poor contact reality. Affect is flat or grossly inappropriate. Personal appearance is neglected, and social impairment is extreme.
   (b) Marked abnormalities in motor behavior manifested in extreme psychomotor retardation with pronounced decrease in spontaneous movements and activity. Waxy flexibility is exhibited.
   (c) The client is exhibiting delusions of persecution or grandeur. Auditory hallucinations related to a persecutory theme are present. The client is tense, suspicious and guarded, and may be argumentative, hostile and aggressive.
   (d) The client has a history of active psychotic symptoms, but prominent psychotic symptoms are currently not exhibited.

10. The nurse tells group members that they will be working on expressing conflicts during the current group session. Which phase of group development is represented?
   (a) Formation phase
   (b) Orientation phase
   (c) Working phase
   (d) Termination phase

11. On an in-patient psychiatric unit, the nurse explores feelings about working with a woman who continually has allowed her husband to abuse her and her children physically and verbally. The interaction would occur in which phase of the nurse-client relationship?
   (a) Pre-interaction phase
   (b) Orientation phase
   (c) Working phase
   (d) Termination phase

12. Which of the following behaviors by an adolescent patient suspected of having an anxiety disorder would best support a nursing diagnosis of high risk for violence, self directed?
   (a) Poor impulse control
   (b) Criticism of others
   (c) Poor concentration
   (d) Low achievement in school

13. A client has been placed in seclusion because the client has been deemed a danger to others. Which is the priority nursing intervention for this client?
   (a) Have little contact with the client to decrease stimulation
   (b) Provide the client with privacy to maintain confidentiality
   (c) Maintain contact with the client and assure the client that seclusion is a way to maintain the client's safety.
   (d) Teach the client relaxation techniques and effective coping strategies to deal with anger.

14. A client who is delirious yells out to the nurse, "You are an idiot, get me your supervisor." Which is the best nursing response in this situation?
    (a) "You need to calm down and listen to what I am saying."
    (b) "You're very upset, I'll call my supervisor."
    (c) "You're going through a difficult time. I'll stay with you."
    (d) "Why do you feel that my calling the supervisor will solve anything?"

15. Which would the nurse expect to assess in a client diagnosed with fetishism?
    (a) History of exposing genitalia to strangers
    (b) History of sexually arousing fantasies involving non living objects
    (c) History of urges to touch and rub against non-consenting individuals
    (d) History of fantasies involving the act of being humiliated, beaten or bound

16. A client is diagnosed with male orgasmic disorder. Which assessed behavior supports this diagnosis?
    (a) Inability to maintain an erection
    (b) A delay in or absence of ejaculation following normal sexual excitement
    (c) Premature ejaculation
    (d) Dyspareunia

17. The nursing student is learning about the sexual disorder of paraphilia. Which student statement indicates that learning has occurred?
    (a) "The term 'paraphilia' is used to identify repetitive or preferred sexual fantasies or behaviors."
    (b) "Individuals diagnosed with a paraphilia experience extreme personal distress and frequently seek treatment."
    (c) "Oral-genital, anal, homosexual, and sexual contact with animals is currently viewed as paraphilia."
    (d) "Most individuals with a paraphilia are women, and more than 50% of these individual have onset of their paraphilic arousal after age 18."

18. Which is a predisposing factor in the diagnosis of autism?
    (a) Having a sibling diagnosed with mental retardation
    (b) Congenital rubella
    (c) Dysfunctional family systems.
    (d) Inadequate ego development

19. Which is a DSM 5 criterion for the diagnosis of attention-deficit/hyperactivity disorder?
    (a) Inattention
    (b) Recurrent and persistent thoughts
    (c) Physical aggression
    (d) Anxiety and panic attacks

20. The nursing lecturer is preparing to teach nursing students about oppositional defiant disorder (ODD). Which fact should be included in the lesson plan?
    (a) Prevalence of ODD is higher in girls than in boys
    (b) The diagnosis of ODD occurs before the age of 3 years
    (c) The diagnosis of ODD occurs no later than early adolescence
    (d) The diagnosis of ODD is not developmental antecedent to conduct disorder

SHORT ANSWER QUESTIONS (30 MARKS)

1. State FIVE (5) criterion A DSM 5 diagnostic criteria for Major Depressive Disorder. [5 Marks]

2. State FIVE nursing interventions in alcohol withdrawal syndrome. [5 Marks]

3. Using the nursing process, outline the nursing management of a child with attention-hyperactivity disorder. [8 Marks]

4. State six (6) adverse reactions and side effects of Lithium carbonate. [6 Marks]

LONG ANSWER QUESTION (20 MARKS)

1. Mr. K is seen at the emergency outpatient unit with a provisional diagnosis of schizophrenia.
    (a) Describe the five key features that define psychotic disorders. [10 Marks]
    (b) Using the nursing process, outline the nursing management of Mr. K. [10 Marks]

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