CHUKA  **UNIVERSITY**

UNIVERSITY EXAMINATIONS

SECOND YEAR EXAMINATION FOR THE AWARD OF DEGREE OF BACHELOR OF SCIENCE (NURSING)

NURS 328: MENTAL HEALTH AND PSYCHIATRIC NURSING

STREAMS: BSC (NURS)Y3S1 **TIME: 3 HOURS**

DAY/DATE: WEDNESDAY 06/12/2017 **8.30 A.M. – 11.30 A.M.**

INSTRUCTIONS:

- **Do not write anything on the question paper**
- **Mobile phones and any other reference material are NOT allowed in the examination room.**
- **The paper has THREE (3) sections. Answer ALL questions**
- **Answer for part A should be on the first page 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.**

PART I: MULTIPLE CHOICE QUESTIONS (20 MARKS)

1. Which intervention is a nurse's priority when working with a client suspected of having a conversion disorder?
   (a) Avoid situations in which secondary gains may occur
   (b) Confront the client with the fact that anxiety is the cause of physical symptoms
   (c) Teach the client alternative coping skills to use ding times of stress
   (d) Monitor assessment, lab report, and vital signs to rule out organic pathology
2. A client has been admitted to an in-patient psychiatric unit expressing suicidal ideations and complains of insomnia and feelings of hopelessness. During an admission assessment, which nursing intervention takes priority?
   (a) Using humor in the interview to uplift the client's mood
   (b) Evaluating blood work, including thyroid paned and electrolytes
   (c) Teaching the client relaxation techniques
   (d) Evaluating any family history of mental illness

3. A client with alcoholism states that he drinks only when he is frustrated by the behaviour of his three adolescent children. Which defense mechanism is the client using?
   (a) Denial
   (b) Projection
   (c) Rationalization
   (d) Sublimation
4. The nurse is evaluating a client who is in manic phase of bipolar disorder and who is on a regimen of lithium carbonate. Which indicates an adverse reaction to the medication?
   (a) Orthostatic hypotension
   (b) Vomiting and diarrhea
   (c) Involuntary movements of mouth and jaw
   (d) Rigidity of posture
5. The nurse is evaluating nursing care for a client with depression. Which finding is the most significant indicator of therapeutic progress? The clients:
   (a) Speech has slowed and become more logical
   (b) Need for sleep has decreased
   (c) Self-concept has become more positive
   (d) Appetite has increased
6. When assessing a client diagnosed with paranoid personality disorder the nurse might identify which characteristic behaviour?
   (a) A lack of empathy
   (b) Shyness and emotional coldness
   (c) Suspiciousness without justification
   (d) A lack of remorse for hurting others
7. A physically abused child diagnosed with conduct disorder bullies and threatens peers on a psychiatric unit. Which nursing diagnosis would take priority?
   (a) Risk for self-mutilationrelated to lower self esteem
   (b) Ineffective individual coping related to physical abuse
   (c) Impaired social interaction related to neurological alterations
   (d) Risk for violence, directed at others related to displaced anger

8. According to the DMS 5, which disorder includes the diagnostic criteria of patterns of negativity, disobedience, and hostile behaviour toward authority figures?
   (a) Separation anxiety disorder
   (b) Oppositional defiant disorder
   (c) Narcissistic personality disorder
   (d) Autistic disorder

9. A client monitored in and out-patient psychiatric clinic is taking clozapine (Clozzril) 50mg bid. The white blood cell (WBC) coutn is 6000/mm3, and the granulocyte count is 1400/mm3. Based on these values, which nursing intervention is appropriate?
   (a) Stop the medication, and call the physician because of the low granulocyte count
   (b) Stop the medication, and call the physician because of the low WBC count
   (c) Give the medication because all of the lab values are normal.
   (d) Give the medication and notify the physician to order a repeat WBC and granulocyte count.

10. The student nurse is learning about dissociative identify disorder. Which statement indicates that learning has occurred?
   (a) "Individuals with dissoviative identity disorder are unable to function in social or occupational situaitons".
   (b) "the transition from one personality to anther is usually sudden, often dramatic, and usually precipitated by stress".
   (c) "Dissociative identify disorder is an Axis II diagnosis, commonly called multiple personality disorder".
   (d) "All personalities are aware of one another, and events that take place are known by all the different personalities".

11. The nurse is assessing a client diagnosed with an autism disorder. According to Mahler's theory of object relations, which describes the client's unmet developmental need?
   (a) The need for survival and comfort
   (b) The need for awareness of an external source of fulfillment
   (c) The need for awareness of separateness of self
   (d) The need for internalization of a sustained image of a love object/person

12. A 16 year old client has complaints of binge eating, abuse of laxatives, and feeling "down" for the last 6 months. Which statement is reflective of this client's symptoms?
    (a) The client meets the criteria for an Axis I diagnosis of bulimia nervosa
    (b) The client meets the criteria for an Axis I diagnosis of anorexia nervosa
    (c) The client needs further assessment to be diagnosed using the DSM-IV-TR
    (d) The client is exhibiting normal developmental tasks according to Erikson.

13. A nurse is assessing a client in the mental health clinic. For 3 weeks, the client has been exhibiting eccentric behaviours with blunted affect. There is impairment in the client's role functioning. These symptoms are reflective of which phase in the development of schizophrenia?
    (a) Phase I – schizoid personality
    (b) Phase II – prodromal phase
    (c) Phase III – schizophrenia
    (d) Phase IV – residual phase

14. A client experiencing dementia is becoming increasingly agitated and confused. Which intervention should the nurse implement first?
    (a) Request a physician's order for lab tests to rule our infections
    (b) Assess the client's vital signs and any obvious physiological changes
    (c) Call pharmacy to determine possible medication incompatibilities
    (d) Document the findings, and notify the oncoming shift regarding the situation.

15. On an in –patient psychiatric unit, a nurse is completing a risk assessment on a newly admitted client with increased levels of anxiety. The nurse would document which cognitive symptom expressed by the client?
    (a) Gritting of the teeth
    (b) Changes in tone of voice
    (c) Increased energy
    (d) Misperceptions of stimuli

16. A young male patient tells the nurse that he strongly detest being male. This is likely to be an example of;
    (a) Fetishism
    (b) Frotteurism
    (c) Transexualism
    (d) Gender dysphoria

17. A client diagnosed with fear of cockroaches begins a therapeutic process in which the client must remain alone in a room infested with the insects for 1 hour. This is called_____therapy.

18. Which situation reflects the defense mechanism of displacement?
    (a) A disgruntled employee confronts and shouts at his boss
    (b) A disgruntled employee takes his boss and his wife out to dinner
    (c) A disgruntled employee inappropriately punished his son
    (d) A disgruntled employee tells his son how much he likes his job and boss

19. Which statement about attention deficit hyperactivity disorder (ADHD) is true?
    (a) ADHD is characterized by a persistent pattern of withdrawal into self
    (b) ADHD is frequently diagnosed before age 2 years
    (c) ADHD occurs equally among girls and boys
    (d) ADHD is characterized by a persistentpattern of inattention

20. The nurse is interacting with a client on the in-patient unit. The client states, “most forward action grows life double plays circle uniform”. Which charting entry should be the nurse document about this exchange?
    (a) “Client is experiencing circumstantiality”.
    (b) “Client is communicating by the use of word salad”.
    (c) “Client is communicating tangetiality”.
    (d) “Client is perseverating”.

PART II: SHORT ANSWER QUESTIONS (40 MARKS)

1. State five (5) functions of the community health nurse in regard to mental health and psychiatric nursing. [5 marks]
2. State four (4) symptoms of alcohol withdrawal delirium. [4 marks]
3. Using DMS 5, describe the criteria for diagnosis of major depressive disorder (MDD). [5 marks]
4. Describe the signs and symptoms of lithium carbonate side effects and toxicity.[5 marks]
5. Using DSM 5, describe the diagnostic criteria for schizophrenia. [5 marks]
6. Describe four (4) personality disorders. [6 marks]
7. List five (5) typesof phobia with possible interventions for each [5 marks]
8. State five (5) characteristics of therapeutic groups. [5 marks]

PART III: LONG ANSWER QUESTIONS (40 MARKS)

1. Mr. M, 56 years of age, is a university lecturer. He feels he is getting old. He keeps forgetting things and writes notes to himself on scraps of paper. One day on the job, he forgets momentarily which class to teach. When it was time to go home he could not remember that he drove to work thus he walks home. At home Mr. M flies off the handle when his wife suggests that they invite the new neighbours for dinner. It is hard for him to admit that anything new confuses him, and he often forgets names and sometimes loses the thread to conversations. He is moody and depressed. Mr. M is bewildered, upset and tearful that something is terribly wrong. He is a voluntary patient in your psychiatric clinic.
   (a) Using DSM 5 criteria, describe the three main cognitivedisorders. [6 marks]
   (b) Using the cognitive model, develop a nursing care plan for Mr. M. [14 marks]
2. Sophia, a 30 year old nurse, began to experience tension, irritably and sleep disturbances after her mother's death from heart disease. On several occasions, Sophia had awakened gasping for breath. Her heart pounds and she feels a tight sensation like a band around her chest. Her pulse typically increases to more than 110 beats per minute, and she experiences dizziness. She fears that she is going to die.

She telephones her friend who finds her wringing her hands, moaning and appearing totally disorganized. She is brought to the clinic where the attending doctors finds no apparent organic basis for the episodes.

(a) State the probable diagnosis based on DSM-5 [2 marks]

(b) Using DSM 5 criteria, describe three other types of anxiety disorders.[6 marks]

(c) Using a conceptual model of your choice model, develop a nursing care plan for Sophia. [12 marks]
