**50 item Psychiatric Exam Answers and Rationales**

PSYCHIATRIC NURSING
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CORRECT ANSWERS AND RATIONALE

1. 60 year old post CVA patient is taking TPA for his disease, the nurse understands that this is an example of what level of prevention?

**C. Tertiary** : The client already had stroke, TPA stands for TRANSPLASMINOGEN ACTIVATOR which are thrombolytics, dissolving clots formed in the vessels of the brain. We are just preventing COMPLICATIONS here.

2. A female client undergoes yearly mammography. This is a type of what level of prevention?

**b. secondary** : The client is never sick of anything but we are detecting the POSSIBILITY by giving yearly mammography. Remember that all kinds of tests, case findings and treatment belongs to the secondary level of prevention.

3. A Diabetic patient was amputated following an unexpected necrosis on the right leg, he sustained and undergone BKA. He then underwent therapy on how to use his new prosthetic leg. this is a type of what level of prevention?

**c. tertiary** : Tertiary prevention involves rehabilitation. Client is now being assisted to perform ADLs at his optimum functioning. Remember that all kinds of rehabilitatory and palliative management is included in tertiary prevention.

4. As a care provider, The nurse should do first:

**d. Early recognition of the client's needs.** : we are talking about what should the nurse do first. ASSESSMENT involves early recognition of clients needs. A,B,C are all involve in the intervention phase of the nursing process.

5. As a manager, the nurse should:

**d. Works together with the team**. : As a nurse manager, you should be able to work with the team. A,B,C are not specific of a nurse manager. They can be done by an ordinary R.N.

6. the nurse shows a patient advocate role when

**a. defend the patients right** : An advocate role is shown when the nurse defends the rights of the client. Interceding in behalf of the patient should not be done by a nurse. Counter transference can develop in that case and we should avoid that. Only the family and the health attorney of the patient can intercede or speak for the patient.

7. which is the following is the most appropriate during the orientation phase ?

**d. establishment of regular meeting of schedules** : Orientation phase is synonymous with CONTRACT ESTABLISHMENT. Here, the nurse will establish regular meeting of schedule, agreements and giving the client information that there is a TERMINATION. Letter A and B assesses the client's coping skills, which is in the working phase and so is letter B. In working phase, The nurse assesses the coping skills of the client and formulate plans and intervention to correct deficiencies. Although assessment is also made in the orientation phase, COPING SKILLS are assessed in the working phase.

8. preparing the client for the termination phase begins :

**c. working :** Telling the client that there is a TERMINATION PHASE should be in the ORIENTATION PHASE, however, in preparing the client for the TERMINATION, it should be done in the working phase. The nurse will start to lessen the number of meetings to prevent development of transference or counter transference.

9. a helping relationship is a process characterized by :

**c. growth facilitating :** In psychiatric nursing, The epitome of all nursing goal should focus on facilitating GROWTH of the client.

10. During the nurse patient interaction, the nurse assess the ff: to determine the patients coping strategy :

**d. How does your problem affect your life?** : this is the only question that determines the effects of the problem on the client and the ways she is dealing with it. Letter A can only be answered by FINE and close further communication. B is unrelated to coping strategies. Letter C, asking the client what do you think can help you right now is INAPPROPRIATE for the nurse to ask. The client is in the hospital because she needs help. If she knows something that can help her with her problem she shouldn't be there.

11. As a counselor, the nurse performs which of the ff: task?

**a. encourage client to express feelings and c**oncerns : A counselor is much more of a listener than a speaker. She encourage the client to express feelings and concerns as to formulate necessary response and facilitate a channel to express anger, disappointments and frustrations.

12. Freud stresses out that the EGO

**a. Distinguishes between things in the mind and things in the reality.** : The ego is responsible for distinguishing what is REAL and what is NOT. It is the one that balances the ID and super ego. B and D is a characteristic of the SUPER EGO which is the CONTROLLER of instincts and drives and serve as our CONSCIENCE or the MORAL ARM. The ID is our DRIVES and INSTINCTS that is mediated by the EGO and controlled by the SUPER EGO.

13. A 16 year old child is hospitalized, according to Erik Erikson, what is an appropriate intervention?

**a. tell the friends to visit the child** : The child is 16 years old, In the stage of IDENTITY VS. ROLE CONFUSION. The most significant persons in this group are the PEERS. B refers to children in the school age while C refers to the young adulthood stage of INTIMACY VS. ISOLATION. The child is not dying and the situation did not even talk about the child's belief therefore, calling the priest is unnecessary.

**14. NMS is characterized by** :

c. Hypertension, hyperthermia, diaphoresis. : Neuroleptic malignant syndrome is a side effect of neuroleptics. This is characterized by fever, increase in blood pressure and warm, diaphoretic skin.

15. Which of the following drugs needs a WBC level checked regularly?

**b. Clozaril** : Clozapine is a dreaded aypical antipsychotic because it causes severe bone marrow depression, agranulocytosis, infection and sore throat. WBC count is important to assess if the clients immune function is severely impaired. The first presenting sign of agranulocytosis is SORE THROAT.

SITUATION : Angelo, an 18 year old out of school youth was caught shoplifting in a department store. He has history of being quarrelsome and involving physical fight with his friends. He has been out of jail for the past two years

16. Initially, The nurse identifies which of the ff: Nursing diagnosis:

**b. impaired social interaction :** There is no such nursing diagnosis as A , looking at C and D, they are much more compatible to schizophrenia which is not a characteristic of an ANTI SOCIAL P.D which is shown in the situation. Remember that Personality Disorder is FAR from Psychoses. When client exhibits altered thought process or sensory alteration, It is not anymore a personality disorder but rather, a sign and symptom of psychoses.

17. which of the ff: is not a characteristic of PD?

**b. loss of cognitive functioning** : As I said, symptoms of PD will never show alteration in cognitive functioning. They are much more of SOCIAL Disturbances rather than PSYCHOLOGICAL.

18. the most effective treatment modality for persons if anti social PD is

**c. behavior therapy** : The problem of the patient is his behavior. A is done for patient who has insomnia or severe anxiety. B is a therapy that promotes growth by providing a contact, either a person or an environment who will facilitate the growth of an individual. It is a humanistic psychotherapeutic model approach. D is done on clients who are in

crisis like trauma, post traumatic disorders, raped or accidents.

19. Which of the following is not an example of alteration of perception?

**b. flight of ideas** : Flight of ideas is a condition in which patient talks continuously and then switching to unrelated topic. An example is " Ang ganda ng bulaklak na ito no budek? Rose ito hindi ba? Kilala mo ba si jack yung boyfriend ni rose? Grabe yung barko no ang laki laki tapos lumubog lang. Dapat sana nag seaman ako eh, gusto kasi ng nanay ko. ". Loose association is somewhat similar but the switch in topic is more obvious and completely unrelated. Example " Ang cute nung rabbit, paano si paul kasi tanga eh, papapatay ko yan kay albert. Ang ganda nung bag na binigay ni jenny, tanga nga lang yung aswang dun sa kanto. Pero bakit ka ba andito? Wala akong pagkain, Penge ako kotse aakyat ako everest."

A,C,D are all alteration in perception. A refers to a person thinking that everyone is talking about him. C and D are all sensory alterations. The difference is that, in hallucination, there is no need for a stimuli. In illusion, a stimuli [ A phone cord ] is mistakenly identified by the client as something else [ Snake ]

20. The type of anxiety that leads to personality disorganization is :

**d. panic** : Panic is the only level of anxiety that leads to personality disorganization.

21. A client is admitted to the hospital. Twelve hours later the nurse observes hand tremors, hyperexicitability, tachycardia, diaphoresis and hypertension. The nurse suspects alcohol withdrawal. The nurse should ask the client:

**a. at what time was your last drink taken? :** This question will give the nurse idea WHEN will the withdrawal occur. Withdrawal occurs 5 to 10 hours after the last intake of alcohol. This is a crucial and mortality is very high during this period. Client will undergo delirium tremens, seizures and DEATH if not recognize earlier by the nurse. B is very judgmental, C is non specific, whether it is a beer or a wine It is still alcohol and has the same effects. D is a valuable question to determine the chronic effects of alcohol ingestion but asking letter A can broaden the line between life and death.

22. client with a history of schizophrenia has been admitted for suicidal ideation. The client states "God is telling me to kill myself right now." The nurse's best response is:

**a. I understand that god's voice are real to you, But I don't hear anything. I will stay with you.** : The nurse should first ACKNOWLEDGE that the voices are real to the patient and then, PRESENT REALITY by telling the patient that you do not hear anything. The third part of the nursing intervention in hallucination is LESSENING THE STIMULI by either staying with the patient or removing the patient from a highly stimulating place.
Telling the client that the voices is part of his illness is not therapeutic. People with schizophrenia do not think that they are ILL. Letter C and D disregards the client's concern and therefore, not therapeutic.

23. In assessing a client's suicide potential, which statement by the client would give the nurse the HIGHEST cause for concern?

**c. I’ve thought about taking pills and alcohol till I pass out** : This is the only statement of the client that contains a specific and technical plan. B,D are all indicative of suicidal ideation but it contains no specific plans to carry out the objective. Letter A admits the client thinks of hurting himself, but not doing it because it scares him, therefore, it is not indicative of suicidal ideation.

24. A client with paranoid schizophrenia has persecutory delusions and auditory hallucinations and is extremely agitated. He has been given a PRN dose of Thorazine IM. Which of the following would indicate to the nurse that the medication is having the desired effect?

**c. Stops pacing and sits with the nurse** : Thorazine is a neuroleptic. Desired effect evolve on controlling the client’s psychoses. Letter A is the side effect of the drug, which is not desired. B and D indicates that the drug is not effective in controlling the client’s agitation, restlessness and disorders of perception.

25. A client who was wandering aimlessly around the streets acting inappropriately and appeared disheveled and unkempt was admitted to a psychiatric unit and is experiencing auditory and visual hallucinations. The nurse would develop a plan of care based on:

**c. schizophrenia** : When disorders of perception and thoughts came in, The only feasible diagnosis a doctor can make is among the choices is schizophrenia. A,B and D can occur in normal individuals without altering their perceptions. Schizophrenia is characterized by disorders of thoughts, hallucination, delusion, illusion and disorganization.

26. A decision is made to not hospitalize a client with obsessive-compulsive disorder. Of the following abilities the client has demonstrated, the one that probably most influenced the decision not to hospitalize him is his ability to:

**c. Perform activities of daily living** : If a client can do ADLs , there is no reason for that client to be hospitalized.

27. A client is admitted to the inpatient psychiatric unit. He is unshaven, has body odor, and has spots on his shirt and pants. He moves slowly, gazes at the floor, and has a flat affect. The nurse's highest priority in assessing the client on admission would be to ask him:

**b. If he is thinking about hurting himself** : The client shows typical sign and symptoms of DEPRESSION. Moving slowly, gazes on the floor, blank stares and showing flat affect. The highest priority among depressed client is assessing any suicide plans or ideation for the nurse to establish a no suicide contract early on or, in any case client do not participate in a no suicide contract, a 24 hour continuous monitoring is established.

28. The nurse should know that the normal therapeutic level of lithium is :

**a. .6 to .12 meq/L** : According to brunner and suddarths MS nursing, The normal therapeutic level of lithium is .6 to 1.2 meq/L. Some books will say .5 to 1.5 meq/L.

29. The patient complaint of vomiting, diarrhea and restlessness after taking lithane. The nurse's initial intervention is :

**a. Recognize that this is a sign of toxicity and withhold the next medication**. : The nurse should recognize that this is an early s/s of lithium toxicity. Taking the clients vital signs will not confirm diarrhea, vomiting or restlessness. Notifying the physician is unnecessary at this point and the physician will likely to withhold the medication.

30. The client is taking TOFRANIL. The nurse should closely monitor the patient for :

**c. Increase Intra Ocular Pressure** : Tofranil is a neuroleptic. It is well known that this is the antipsychotic that increases the IOP and contraindicated in patients with glaucoma. Hypertension is not specific with TOFRANIL. All neuroleptics can cause NMS or the neuroleptic malignant syndrome.

31. A client was hospitalized with major depression with suicidal ideation for 1 week. He is taking venlafaxine (Effexor), 75 mg three times a day, and is planning to return to work. The nurse asks the client if he is experiencing thoughts of self-harm. The client responds, "I hardly think about it anymore and wouldn't do anything to hurt myself." The nurse judges:

**c. The depression to be improving and the suicidal ideation to be lessening.** : too obvious, no need to rationalize.

32. The client is taking sertraline (Zoloft), 50 mg q AM. The nurse includes which of the following in the teaching plan about Zoloft?

**a. Zoloft causes erectile dysfunction in men** : When you take zoloft, mag zozoloft ka nalang sa buhay. Because it causes erectile dysfuntion and decrease libido. Letter B and C are specific of TCAs. Zoloft will exert its effects as early as 1 week.

33. After 3 days of taking haloperidol, the client shows an inability to sit still, is restless and fidgety, and paces around the unit. Of the following extrapyramidal adverse reactions, the client is showing signs of:

**b. Akathisia :** The client shows sign of motor restlessness, which is specific for Akathisia or MAKATI SYA.

34. After 10 days of lithium therapy, the client's lithium level is 1.0 mEq/L. The nurse knows that this value indicates which of the following?

**b. An anticipated therapeutic blood level of the drug.**

35. When caring for a client receiving haloperidol (Haldol), the nurse would assess for which of the following?

**b. Extrapyramidal symptoms** : Haldol is a neuroleptic, Specific to these neuroleptics are the EPS. The client will likely be hypotensive than hypertensive because neuroleptics causes postural hypotension, The client will complaint of dry mouth due to its anticholinergic properties. Dizziness and drowsiness are side effects of neuroleptics but not oversedation.

36. A client is brought to the hospital's emergency room by a friend, who states, "I guess he had some bad junk (heroin) today." In assessing the client, the nurse would likely find which of the following symptoms?

**c. Decreased respirations, constricted pupils, and pallor**. : Heroin is a narcotic. Together with morphine, meperidine, codeine and opiods, they are DEPRESSANTS and will cause decrease respiration, constricted pupils and pallor due to vasoconstriction.

37. The client has been taking the monoamine oxidase inhibitor (MAOI) phenelzine (Nardil), 10 mg bid. The physician orders a selective serotonin reuptake inhibitor (SSRI), paroxetine (Paxil), 20 mg given every morning. The nurse:
**b. Questions the physician about the order** : 2 anti depressants cannot be given at the same time unless the other one is tapered while the other one is given gradually.

38. Which of the following client statements about clozapine (Clozaril) indicates that the client needs additional teaching?

**d. "I need to call my doctor whenever I notice that I have a fever or sore throat."** : Clozapine causes AGRANULOCYTOSIS and bone marrow depression. Early s/s includes fever and sore throat. The medication is to be withheld this time or the patient might develop severe infection leading to death.

39. A client has been taking lithium carbonate (Lithane) for hyperactivity, as prescribed by his physician. While the client is taking this drug, the nurse should ensure that he has an adequate intake of:

**a. Sodium** : The levels of lithium in the body are dependent on sodium. The higher the sodium, The lower the levels of lithium. Clients should have an adequate intake of sodium to prevent sudden increase in the levels of lithium leading to toxicity and death.

40. The client has been taking clomipramine (Anafranil) for his obsessive-compulsive disorder. He tells the nurse, "I'm not really better, and I've been taking the medication faithfully for the past 3 days just like it says on this prescription bottle." Which of the following actions would the nurse do first?

**a. Tell the client to continue taking the medication as prescribed because it takes 5 to 10 weeks for a full therapeutic effect**. : Anafranil is an anti depressant, effects are noticeable within 1 to 2 weeks.

41. The nurse judges correctly that a client is experiencing an adverse effect from amitriptyline hydrochloride (Elavil) when the client demonstrates:

**d. Urinary retention :** Elavil is an TC antidepressant. It should not cause insomnia. Hypertension are specific of MAOI anti depressants when tyramine is ingested. Due to the anticholinergic s/e of TCAs, Urinary retention is an adverse effect.

42. Which of the following health status assessments must be completed before the client starts taking imipramine (Tofranil)?

**a. Electrocardiogram (ECG).** : Aside from tonometry or IOP measurement, Client should undergo regular ECG schedule. Most TCAs causse tachycardias and ECG changes, an ECG should be done before the client takes the medication.

43. A client comes to the outpatient mental health clinic 2 days after being discharged from the hospital. The client was given a 1-week supply of clozapine (Clozaril). The nurse reviews information about clozapine with the client. Which client statement indicates an accurate understanding of the nurse's teaching about this medication?

**b."I need to keep my appointment here at the hospital this week for a blood test."** : Regular blood check up is required for patients taking clozaril. As frequent as every 2 weeks. Clozapine can cause bone marrow depression, therefore, frequent blood counts are necessary.

44. The client is taking risperidone (Risperdal) to treat the positive and negative symptoms of schizophrenia. Which of the following negative symptoms will improve?.

**d. Asocial behaviour and anergia** : A,B and C are all positive symptoms of schizophrenia. Negative symptoms includes anhedonia, anergia, associative looseness and Asocial behavior.

45. The nurse would teach the client taking tranylcypromine sulfate (Parnate) to avoid which food because of its high tyramine content?

**b. Aged cheeses.** : This is high in tyramine, and therefore, removed from patients diet to prevent hypertensive crisis.

46. Which of the following clinical manifestations would alert the nurse to lithium toxicity?

**d.Anorexia with nausea and vomiting.**

47. The client with depression has been hospitalized for 3 days on the psychiatric unit. This is the second hospitalization during the past year. The physician orders a different drug, tranylcypromine sulfate (Parnate), when the client does not respond positively to a tricyclic antidepressant. Which of the following reactions should the client be cautioned about if her diet includes foods containing tryaminetyramine?

**d. Hypertensive crisis.**

48. After the nurse has taught the client who is being discharged on lithium (Eskalith) about the drug, which of the following client statements would indicate that the teaching has been successful?

c. **"I'll call my doctor right away for any vomiting, severe hand tremors, or muscle weakness."** : This is a sign of light lithium toxicity. Increasing fluid intake will cause dilutional decrease of lithium level. Restriction of sodium will cause dilutional increase in lithium level.

49. A nurse is caring for a client with Parkinson's disease who has been taking carbidopa/levodopa (Sinemet) for a year. Which of the following adverse reactions will the nurse monitor the client for?

**c. hypotension** : Hypotension, dizziness and lethargy are side effects of anti parkinson drugs like levodopa and carbidopa.

50. A client is taking fluoxetine hydrochloride (Prozac) for treatment of depression. The client asks the nurse when the maximum therapeutic response occurs. The nurse's best response is that the maximum therapeutic response for fluoxetine hydrochloride may occur in the:

**c. Third week** : A and B are similar, therefore , removed them first. Recognizing that most antidepressants exerts their effects within 2-3 weeks will lead you to letter C.

DISCLAIMER: Answers to the above questions are all accurate and correct and researched thoroughly with all my skills and capabilities . If you disagree with any answers form the above rationales, please comment up and we can work on it.