# Benha University

# Faculty of nursing

## Fourth Year Final Exam- 1st. Semester

Course title: Psychiatric and Mental Health Nursing

Date: 20/01/2019

Time allowed: 3 hours

| Parts | Questions | Marks |
|---|---|---|
| Part(I) | Multiple-choice questions | ٢٥ |
| Part(II) | True and false | 20 |
| Part(III) | Definitions | 5 |
| Part(IV) | Comparison | 5 |
| Part(V) | Fill in the blanks | 20 |
| Part(VI) | Situation | 5 |
| **Total** | | 80 |

## Part (I): Multiple-choice questions: (25 marks)z

**Circle the best answer:**

**1- The family dynamic theory of somatoform disorders are explain:**

a. Patients have marked deficiency in their abilities to openly express their emotions
b. Patients have failure to resolve their psychological conflict or problems.
c. Patients have ability to express their feeling openly
d. A&B

**2- During a nurse-client interaction, which nursing statement may be little (تستخف) the client's feelings and concerns?**

**a. "Don't worry, Everything will be alright."**
b. You appear uptight."
c. "I notice you have bitten your nails to the quick."
d. "You are jumping to conclusions."

**3 - The prevalence rate is similar in men and women for:**

a. Major depressive disorder.
b. Dysthymic disorder.
c. Bipolar I disorder.
d. Bipolar II disorder.

**4- Anxiety related to exposure to phobic object (cats). A realistic short-term goal for this client would be: within 10 days, client will:**

a. Avoid feared object whenever possible.
b. Face feared object unassisted.
c. State that feared object no longer produces feelings of dread associated with anxiety.
d. Practice relaxation techniques and report less distress related to thoughts of the feared object.

**5- Which activity should the nurse prioritize in therapeutic milieu?**

a. Setting the schedule for the daily unit activities
b. Evaluating clients for medication effectiveness
c. Conducting therapeutic group sessions
d. Searching newly admitted clients for hazardous objects

**6-In evaluating care of a client with schizophrenia, the nurse should keep which point in mind?**

a. Frequent reassessment is needed and is based on the client's response to treatment

b. The family does not need to be included in the care because the client is an adult

c. The client is too ill to learn about his illness

d. Relapse is not an issue for a client with schizophrenia

**7- An individual believes that they are being watched or tormented by agencies or persons in authority with whom they have never interacted is known as a:**

a. Grandiose delusion.
b. Delusion of thought control.
c. Delusion of reference.
d.Persecutory delusion.

**8-Which of the following client behaviors documented in Robert's chart would validate the nursing diagnosis of Risk for other-directed violence?**

a. Robert's description of being endowed with superpowers
b. Frequent angry outburst noted toward peers and staff
c. Refusal to eat cafeteria food
d. Refusal to join in group activities

**9-The nurse working with a client with antisocial personality disorder would expect which of the following behaviors?**

1. Compliance with expectations and rules
2. Exploitation of other clients
3. Seeking special privileges
4. Superficial friendliness toward others
5. Utilization of rituals to allay anxiety
6. Withdrawal from social activities

a. 1, 2 & 3.
b. 2, 3, & 4.
c. 1,3& 4.
d. 4,5& 6.

**10- Assessment of patient reveals severe pathologic mood swings, from hyperactivity and euphoria and depression. Which diagnosis should the nurse suspect?**

a. Dysthymic disorder.
b. Cyclothymic disorder.
c. Bipolar disorder.
d. Depressive disorder.

**11- Parents often transfer feelings of anger or frustration toward their children what is defense mechanism used:**

a. Displacement.
b. Repression.
c. Rationalization.
d. undoing.

**12- Effective treatments for dysthymic disorder include all of the following EXCEPT:**

a. Selective serotonin reuptake inhibitors (SSRIS).
b. Monoamine oxidase inhibitors (MAOIS).
c. Electroconvulsive therapy.
d. Cognitive therapy.

**13- Which of the following are true about the 'Guided Imagery'technique:**

a. It is like vivid daydreaming
b. You need a hypnotist for this technique
c. You need to rest in a sleeping posture
d. All of the above

**14- The characteristics of major depressive episode include all of the following EXCEPT:**

a. Difficult making decisions.
b. Reports vague pains.
c. Inability to concentrate.
d. don't impairment of occupational function.

**15- Which of the following is true about 'deep breathing relaxation technique':**

a. It can be self-taught
b. It releases tension from the body and clears your mind
c. You have to do this under-water
d. Only 'A' & 'B' are true

**16- Which of the following brain abnormalities is not associated with schizophrenia?**

a. Reduction in the prefrontal areas
b. Shrinking of the ventricles
c. An abnormal connection between the prefrontal cortex and the amygdala and hippocampus
d. Inactivity of the prefrontal cortex

**17- …….. is the most important community resources for prevention, treatment, and rehabilitation of mental disorders:**

**a- Community mental health centers**
b- Homeless services
c- Halfway houses
d -outpatient-clinics.

**18-** Milieu Therapy is a form of _____ that involves the use of therapeutic communities.

*a. Psychotherapy*
b. Cognitive behavioral therapy
c. Family therapy
d. Integrative psychotherapy

**19- In planning care for the schizophrenic client with negative symptoms,the nurse would anticipate a problem with:**

a. Auditory hallucinations.
b. Bizarre behaviors.
c. Ideas of reference.
d. Motivation for activities

**20- Patient is allowed to FEEL as he does but limitations are put on his:**

a. Thought.
b. Perception.
c. Behavior.
d. Mood.

٢١- Continuous prediction of patients' behavior improves skill of:

a. Observation.
b. Evaluation.
c. Experience.
d. Communication

**22- 25-Select the impairment in thought process that most likely applies to each patient:**

**a-** Circumstantiality
**b-** Echolalia
**c-** Flight of ideas
**d-** Loose associations
**e-** Perseveration

**22**-A 50-year- old woman is asked during a psychiatric examination if she had ever been a patient in a psychiatric hospital. She responds," That was the summer we were at the beach; it rained for two weeks. I was sad, but my sister Sarah didn't help. She and I have never really gotten along."

**23**-A 27- year- old man is brought to the emergency department for evaluation. He appears confused but gives his name. When asked his occupation, he says,"Ali was a carpenter. I'm the right hand of god. I don't offend(الاساءة)anyone.

**24-**A30-year- old man who is being treated for bipolar illness as discontinued his medication for several months. He is brought to the clinic in an agitated state when asked how he is feeling, he replies "I'm wonderful, the most wonderful in the universe. The universal gym is my invention.

**25**-A 29- year- old woman with chronic schizophrenia rocks in her chair and does not seem to respond to an examiner's questions except to say, "No hope, no hope, no hope."

| **Question number** | **22** | **23** | **24** | **25** |
|---|---|---|---|---|
| **Answer letter** | a | d | c | e |

## Part (II): True and false (20 Marks)

**II -Read each statement carefully and circle (T) if the statement is true and (F) if statement false.**

| Items | T | F |
|---|---|---|
| 1-Psychosis is caused by functional disorder of the nervous system | | ***F*** |
| 2-Psychotherapy is more effective than medication for management mental illness. | | ***F*** |
| 3- The nurse should be listening carefully to the patient to show surprise. | | ***F*** |
| 4- Somatoform disorders characterized by symptoms that are intentionally produced to relieve anxiety. | | **F** |
| 5- The ego operates in the reality principle and is characterized by secondary process thinking. | ***T*** | |
| 6- Suppression is a unpleasant, unacceptable ideas or impulses are involuntary stored in the unconscious mind. | | **F** |
| 7-Isolation is a process of separation an unacceptable feeling, idea or impulse from one's thought. | **T** | |
| 8- Erogenous zone is centered on the anus in the oral stage of psychoanalytical theory. | | **F** |
| 9-Foster homes should be arranged for elderly patients who have no family. | **T** | |
| 10- Patients with severe anxiety have feeling of unreality as depersonalization and derealization | | **F** |
| 11- Acceptance means complete permissiveness that convey to patient respect as an individual human being. | | ***F*** |
| 12-Pressure can force the person to speed up and intensity effort. | **T** | |
| 13- Individuals with Schizophrenia have a much higher risk for attempting and completing suicide than the general population. | **T** | |
| 14- Cluster A personality disorders are common in biological relatives of patient with schizophrenia | **T** | |
| 15- Professional relationship focuses upon the personal and emotional needs of the nurses. | | ***F*** |
| 16-Body dysmorphic disorder usually caused by eating disorder. | | **F** |
| 17-Accepting patient's silence can be very reassurance to the patient. | **T** | |
| 18- Consistency helps the patient to know what to expect to reduce his anxiety. | **T** | |
| 19- In avoidance-avoidance conflict the person hold two incompatible goals. | | ***F*** |
| 20- Empathy gives the nurse sense of responsibility in helping the patient. | **T** | |

**Part(III): Define the following:** **(5 Marks)**

**1- Somatization disorder-:**

It is characterized by ongoing reporting and experience a wide range of symptoms that are not medically well explained and cause significant impairment in social and occupational functioning.

**2- Clarifying:**

Trying to clear up confusion about events or people, the nurse asks specific questions until the information is completely understood.

**3- Community mental health:**

- It represents all mental health activities carried out in a community.
- It is the sum of preventive and curative measures aimed at fitting the individual for satisfactory and useful life within his own social.

**4-Personality disorders:**

Collection of personality trait that become so rigid or fixed cause inner distress and behavioral dysfunction

**5- Hypomanic Episode:**

A hypomanic episode is similar to a manic episode but the symptoms are less severe and need only last four days in a row. Hypomanic symptoms do not lead to the major problems that mania often causes and the person is still able to function.

## Part (IV): Compare between neurosis and psychosis:

| Items | Neurosis | Psychosis |
|---|---|---|
| 1- personality | Little change or normal | Marked change |
| 2- thinking | Slightly disturbed | Marked disordered |
| 3- contact with reality | In contact with reality | Loss of contact |
| 4- orientation | Intact | Lacking |
| 5- In sight | Good | Partial or lacking |
| 6- perceptual disturbance | Absent | Frequently present |
| 7- Mood | Reactive | Disordered |
| 8- Types | -Anxiety<br>-Obsessive-compulsive disorder<br>-Post-traumatic stress - disorder<br>-Dissociative disorder | - Schizophrenia<br>- Delusional Disorder |

## Part (V): (25 Marks)

### A- Fill in the blanks: (20 Marks)

**1- Signs and symptoms of mental illness:**

a. Changes in sleep, appetite, and energy level.
b. Severe mood swings.
c. Persistent thoughts or compulsions, hearing voices.
d. Social withdrawal.
e. Feeling sad, hopeless, or agitated.
f. Having trouble performing everyday tasks.
g. Wanting to hurt himself or others.
h. Inability to cope with problems and daily living activity
i. Excessive anxiety, suspiciousness, blaming others.
j. Abuse of alcohol or drugs

**2- DSM-IV-TR diagnostic criteria of conversion disorder:**

1- At least one symptom or deficit in sensory or voluntary motor function suggest neurological or medical condition and not limited to pain or sexual dysfunction .

2- Finding from investigation can't explain condition (not due to neurological or general medical condition or substance use) .

3- Conflict or other stressor that precede symptom suggest related psychological factor

4- The symptoms are not intentionally produced.

5- Conditions are severe enough to cause social and occupational impairment .

**3- The importance of defense mechanism:**

- Reduce or cope anxiety or fear
- Resolve emotional or mental conflict
- Protect one's self-esteem
- Protect one's sense of security

**4- Goals of therapeutic communication:**

- Establish a therapeutic nurse- client relationship.
- Identify client's concerns, needs and problems.
- Assess client's perception of the problem.
- Guide client towards a satisfying and socially acceptable solution.
- Teach the client and family necessary self – care skills.
- Facilitate the client expression of emotions.
- Implement interventions designed to address the client’s needs.

**5- Advantages of psychiatric units in general hospitals.**

1- Early treatment is made available to persons in the community.

2- The stigma associated with mental illness is reduced and admissions to mental hospitals are decreased.

3- There is consultative sharing between the medical and psychiatric staffs which results in understanding of emotional aspects of illness.

**6- Treatment of the anxiety disorder:**

a- Medication.

b- Psychotherapy

c- Cognitive-behavioral therapy: Dietary and lifestyle changes.

d- Relaxation Training and Related Therapies

**7- Main attitudes used by nurses in Milieu therapy**

***a*-**Indulgence:

b-Active friendliness:

c-Passive friendliness

d-Attitude of matter of factness

e-Watchfulness:

f-Kind firmness:

**8- Guidelines for effective visualization:**

a. Loosen your clothing and make sure your breathing is not restricted and lie dowen in comfortable place

b- close your eyes and take full ,deep breath . exhale slowly and easily allow your breathe to become slow

e- imagine that with each breath.you can breath away tensionand anxiety

f- lets your thoughts drift through your consciousness, as you allow them to leave,floating on white puffy cloud

**9- Characteristics of avoidance personality disorders:**

a-preoccupation of being rejected or criticize in social situation

b. Un willing to get involved with people unless certain being linked

c. Restrain with intimate relationship because fear of being shamed

d. Intense anger or in ability to control anger

**10- The most common initial symptoms in the onset of mania are**

a. Elated mood.

b. Increase activity.

c. Though process (flight of idea)

**11- The main principles in creating a therapeutic relationship - are:**

a. To follow the principles of psychiatric nursing

b. To understand the patient, his needs, and his way of expressing it.

c. To understand her self, and to develop awareness of" what" she is doing "why" she is doing.

d. . To benefit from her previous experiences with mental patients.

e. To develop team work, where free discussion should take place between nurses about their feeling for the patients and their feeling about each patient.

12- **Freud's stages of personality development theory are:**

1-Oral stage (Birth – 18 months):

2-Anal Stage (1 .5 – 3 years):

3-Phallic stage (3-6 years)

4. Latency Stage (6-12):

5. Genital stage (12years to old)**:**

**Part (VI) Situation**

Mr. Kareem, a 26- year-old decide to stop taking his drugs because he didn't think he needed it anymore. Within a few days of stopping the medication, he was unable to leave the house for fear of someone harming him, started to see things without any stimuli . Although he liked his job at the local cannery and knew he had the chance to earn more money in the near future. He refused to go to his work for fear that he would hit by a bus on his way there. So he was fired because of his poor attendance, relapsed and requiring hospitalization.

1- What is the diagnosis of this case? Paranoid schizophrenia
2- What is the expectation of his prognosis? Good prognosis
3- Write three nursing diagnosis and write intervention for one of them?

**1-**Alteration of thought process related to delusional thinking, hereditary factors , chemical imbalance Evidenced by limited or no attention span and lack of concentration, inconsistent verbal and non verbal communication

**Long term goal**

- The client will maintain an optimal level of functioning despite the presence of disorganized thinking.

**Short term goal**

- The client will identify the symptoms of illness and discuss feelings precipitated by unrealistic thoughts (delusional thinking )
- The client will be able to manage consequences of delusional thinking

**Intervention**

- Talk to the client in simple and honest manner .
- Avoid making promises you cannot realistically kept
- Assign the same staff member to work with the client.
- Begin with one interaction then progress to small group
- Help the client identify and use thought stopping techniques.
- Don't challenge the content of disorganized thought
- Encourage the client to discuss how disturbing thoughts present problems in the client everyday life and to discuss feelings associated with disturbing thoughts to help focuses on reality.
- Teach the client to focus on the nurses or other caregiver's voice when disturbing thought occur that help client to maintain attention on reality
- Encourage the client to verbalize negative or disturbing thoughts that arise from interactions with the staff which helps the client examine misinterpretation of the speech and actions of others.
- Help the clients improve his grooming by assisting them
- Spend time with the client.
- Give reward about the pt accomplishment

**2-Social isolation related to depression** evidenced by little or no interaction with staff and other clients, staying alone, little or no eye contact ,sad facial expression

**Long term goal**

- The client will increase socialization in a clinical setting.

**Short term goal**

- The client will have a number of safe predictable interaction with the nurse

**Intervention**

- Establish frequent brief contacts with client.
- During initial interaction maintain distance of one arms length from the client.

- Allow the client to initiate and direct the interaction
- Establish an activity schedule and assist the client in choosing one or more activity to attend.
- prepare the client for a group by discussing how to interact and what to say to peers to promote the client comfort and self esteem.
- Give positive feed back for all attempts at social interaction to reinforce desired behavior and promote self esteem.

**3-Sensory / perceptual alteration related** to: Brain dysfunction, Loss of ego boundaries evidenced by increases attention to irrational sound, voices or images, limited or no interaction with others, Inability to concentrate, inappropriate responses to reality.

**Intervention**

- Monitor the client for sign of hallucination such as looking around the room, moving the head to one side, talking to himself.
- Encourage the client to share content of hallucination with the nurse.
- Don't deny the client's experience but explain that the client's sensory perceptions are not shared by other people.
- Talk to the client when the client is actively hallucinating to offer a competing stimuli.
- Teach the client distraction technique.
- Provide the client with opportunities to become involved in concrete activities as art, music and so on

**4- Impaired verbal communication** Related to sever anxiety, disorganized thinking evidenced by use of symbolic speech as neologism, use concrete communication only, incongruent verbal and nonverbal communication, difficulty maintaining eye contact, speaking very little.

**Intervention**

- Make time for exclusive one to one interaction with the client.

- Provide the client with support and positive conversational experiences by talking with the client about personal interests, hobbies.
- Observe and monitor the client's verbal and nonverbal communication.
- Orient client to reality as required. Call the client by name. Validate those aspects of communication that help differentiate between what is real and not real.

**5-Risk for violence related to** lack of trust, lack of impulse control, delusion or hallucination Evidence by increase psychomotor activity, verbalization about previous violent actions

**Intervention**

- Maintain a quiet non stimulating environment by reducing noise, limiting the number of people in the room and dimming lights.
- Administer medications as ordered
- At the first signs of agitation give the client options for handling the agitation, such as going to a less stimulating environment and staying with the nurse and verbalizing feelings.
- Remove all dangerous object.
- Use physical restrains only if all other options have failed and the situation has become an emergency.
- Observe the restrained client at least every 15 minutes at least every 2/h and monitor circulation of extremities carefully.
- Assist the client with basic needs such as eating, drinking and elimination while restrained