

**UNIVERSITY OF SWAZILAND
FACULTY OF HEALTH SCIENCES**

FINAL EXAMINATION PAPER DECEMBER 2016

TITLE : MENTAL HEALTH PROBLEMS AND SOCIETY I

COURSE : NUR 552

DURATION : TWO (2) HOURS

MARKS : 75

- INSTRUCTIONS:**
- 1. ANSWER ALL QUESTIONS**
 - 2. EACH QUESTION CARRIES 25 MARKS**

**THIS PAPER IS NOT TO BE OPENED UNTIL PERMISSION HAS BEEN
GIVEN BY THE INVIGILATOR**

Question 1.

Mr. Tladi, a 36-year-old man from Sigombeni is admitted to RFM hospital after ingesting a concoction of battery acid, paraffin and brandy that caused severe burning of the oesophagus and stomach linings. On taking history you learn that he was retrenched from work a year ago. All attempts to find another job were fruitless and six months ago he began to drink and gamble heavily. After stabilisation, Mr. Tladi was transferred to the National Psychiatric Centre where he told the admitting nurse that he felt hopeless and despairing, had nothing to live for and it was his intention to kill himself.

- a) Do a DSM 5 diagnosis of Mr Tladi. (5)
- b) Describe the nursing management Mr. Tladi will require for his condition (20)

TOTAL: 25

Question 2:

- a) In your understanding, describe the general idea of mental health nursing. (8)
- b) Uys and Middleton (2014) use the acronym FARNs to explain important principles in mental health nursing. Describe this acronym and its importance in mental health care. (13).
- c) How is a mental health/psychiatric diagnosis presented in the DSM 5)? (4)

TOTAL: 25

Question 3

Multiple choice questions.

Select the response that that best answers each of the following questions and indicate your choice by writing the letter preceding the response next to the corresponding number e.g. 73=s.

1. While conducting an admission interview with a patient on the substance use unit, the client repeatedly tells the nurse that he is not a drug user although his laboratory results were positive for a variety of controlled substances. The nurse understands the client is using which defence mechanism?
 - a) Intellectualisation
 - b) Rationalisation
 - c) Denial
 - d) Projection

2. What would be important for the nurse to assess for in caring for a patient who has a schizophrenia spectrum disorder?
 - a) Delusions and hallucinations
 - b) Flat affect and bradycardia
 - c) Disorganised thinking (speech)
 - d) a and c

3. A client is on antipsychotic drug therapy. The client has developed Parkinson-like symptoms. What is the nursing interpretation of this observation?
 - a) This is an allergic response to the drug.
 - b) Observations are classified as extrapyramidal side effects.
 - c) Symptoms are cholinergic side effects.
 - d) The client is demonstrating the therapeutic response to the drug.

4. The nurse is caring for a client who has been on Lithium for approximately 3 months. What observation would cause concern regarding Lithium toxicity?
 - a) Tachycardia, hypertension, convulsions.
 - b) Urinary frequency, vomiting, febrile.
 - c) Hypotension, bradycardia, increased thirst.
 - d) Diarrhoea, ataxia, seizures, lethargy.

5. The nurse is admitting an older adult client who is confused, very poorly nourished, and has contusions and bruises and welts over the trunk. What would be the most important nursing intervention at this time?
 - a) Perform a physical assessment.
 - b) Notify the nursing supervisor regarding the client's condition.
 - c) Establish communication and rapport with the client.
 - d) Notify authorities regarding suspected elderly abuse.

6. A client is suspicious about her surroundings and is paranoid toward nursing staff. What therapeutic approach should be avoided?
 - a) Accept the need for the client to be suspicious, and be direct and honest in responses.
 - b) Maintain silence and do not attempt to explain circumstances.
 - c) Make sure you have the client's attention and maintain direct eye contact.
 - d) Sit with the client and console through touch and being very open and friendly.

7. The nurse is concerned a client is becoming depressed. What nursing observations would support the development of depression?
 - a) Flight of ideas, weight loss, lack of interest.
 - b) Insomnia, loss of libido, restlessness.
 - c) Anorexia, psychomotor retardation, poor grooming.
 - d) Hypervigilance, overeating, poor grooming.

8. A client with cocaine abuse problem is on a detoxification protocol. What is an important nursing action?
 - a) Increase the fluid intake.
 - b) Check the vital signs.
 - c) Encourage high sodium diet.
 - d) Check intake and output.

9. The nurse is caring for a client who is confused. What would be a priority of care for this client?
- Frequent orientation to person, place and time.
 - Offering frequent meals that are easy to eat.
 - Assisting the client to select comfortable clothing.
 - Arranging for a pastor from the client's church to visit.
10. A nurse whose family has a history of drug use makes derogatory comments while caring for a substance use problem. What might be an explanation for the nurse's behaviour? The nurse:
- Is unaware of her feelings when working with this type of client.
 - Has an issue with denial and repression.
 - Is experiencing a need to act out feelings.
 - Feels this type of client is insensitive and should be dealt with honestly.
11. A client is observed by the nurse opening and closing his fist, and mumbling angrily while walking back and forth in his room. The nurse should:
- Leave the client alone.
 - Give PRN Ativan for anxiety.
 - Attempt to determine the source of anxiety.
 - Call for help to restrain the patient.
12. What is the most important goal in planning the care for a client with a diagnosis of schizophrenia spectrum disorder?
- To set limits.
 - To promote expression of feelings.
 - To encourage group participation in activities.
 - To build trust.
13. A psychotic client is belligerent and agitated, making aggressive gestures and pacing in the hallway. To ensure a safe environment, which of the following is the nurse's highest priority?
- Assist other staff in restraining the client.
 - Provide comfort and consolation to the other clients on the unit.
 - Ask the patient politely to calm down and regain control over his or her behaviour.
 - Provide safety for the client and other clients on the unit.
14. A client with depression who was admitted to the psychiatric unit the previous day suddenly begins smiling and stating that the episode of depression has lifted. Which changes should the nurse make in the client's treatment plan?
- Allow the client to spend time off the unit.
 - Reduce the dosage of antidepressants.
 - Increase the level of suicide precautions.
 - Allow increased "in room" activities.

15. A patient admitted for obsessive compulsive behaviour repeatedly cleans the bathroom. The client has become angry and has started kicking and biting another client for occupying the bathroom. Which of the following actions should the nurse take first?
- Physically restrain the client.
 - Provide a safe environment for both clients.
 - Notify the risk management department.
 - Administer a medication to provide chemical restraint.
16. A client with obsessive compulsive disorder spends many hours during the day and night washing his hands. When initially planning for a safe environment, the nurse allows the client to continue this behaviour because:
- It relieves the client's anxiety.
 - It increases his self-esteem.
 - It decreases the chance of infection.
 - It gives the client a feeling of self-control.
17. Which statement made by a nursing student indicates an understanding of the concepts associated with suicide and suicide intentions?
- "Only psychotic individuals commit suicide".
 - "Suicide attempts are just attention-seeking behaviours".
 - "Many individuals who really do kill themselves have talked about their suicidal intentions to others".
 - "Suicide runs in the family, so there is nothing that health care personnel can do about it".
18. A client has an order for valproic acid 250 mg once daily. To maximise the client's safety, the nurse plans to schedule the medication
- With lunch.
 - At bedtime.
 - After breakfast.
 - Before breakfast.
19. Which of the following statements about tardive dyskinesia is true?
- It is a rare side effect of psychotropic drugs.
 - It is usually reversible.
 - It may occur after long-term use of psychotropic drugs.
 - It usually appears within hours after psychotropic drug administration.
20. Symbolic satisfaction of wishes through non-rational thought best describes the defence mechanism
- Denial.
 - Fantasy.
 - Rationalisation.
 - Displacement.

21. Denial, projection and rationalisation are examples of disturbances in
- Association.
 - Reality testing.
 - Thought content.
 - Thought process.
22. Photosensitisation is a side effect associated with the use of
- Lithium carbonate.
 - Chlorpromazine.
 - Thioridazine.
 - Methylphenidate hydrochloride.
23. Which of the following behaviours is most indicative that the client may be contemplating suicide?
- The client reports sleep disturbances.
 - The client cries for long periods of time.
 - The client spends long periods of time alone.
 - The client tells the nurse that she plans to use a belt to hang herself.
24. A nurse is collecting data from a client admitted in the mental health unit. The client's homestead was rased by a veld fire 2 months ago and is complaining of insomnia, difficulty concentrating, hypervigilance and nervousness. The nurse recognises these symptoms to be indicative of:
- Phobia.
 - Dissociative disorder.
 - Trauma and stressor-related disorder.
 - Obsessive compulsive disorder.
25. A nurse is caring for a client with psychomotor agitation. Which activity should be most appropriate for the nurse to plan for the client?
- Playing chess.
 - Playing table tennis.
 - Reading magazines.
 - Playing simple card games.

TOTAL: 25