PLAINWORK

NCLEX-RN Mental Health Practice App: Psychosocial Integrity Questions with Rationales

Free sample: 10 of 65 questions

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Sample

1. During a home visit 4 weeks after birth, a client says, 'I feel nothing when I look at her. I lie awake even when she sleeps, and I think she would be better off with a different mother.' Which action by the nurse is most appropriate?

A. A. Explain that these feelings are the baby blues and will pass without treatment.
B. B. Ask directly whether she has thoughts of harming herself or the baby and screen for depression.
C. C. Suggest that her partner take over the night feedings and review her mood in a month.
D. D. Advise her to stop breastfeeding so that she can get more sleep.

B. Ask directly whether she has thoughts of harming herself or the baby and screen for depression. — Baby blues begin in the first days, are mild and clear within about 2 weeks. Emotional detachment, insomnia and feelings of worthlessness at 4 weeks point to postpartum depression, so the nurse assesses safety directly, screens with a validated tool and arranges referral.

Question and rationale by Plainwork. Reference: ACOG; Maternity and Women's Health Care (Lowdermilk)

2. A client with illness anxiety disorder has visited the clinic six times in three months, convinced he has a serious disease although every test has been normal. He asks for another scan. Which nursing approach is best?

A. A. Suggest that he research his symptoms online and bring a list of possible diagnoses to discuss with the provider
B. B. Offer brief, regularly scheduled visits and acknowledge his distress without reinforcing symptom checking
C. C. Tell him firmly that nothing is wrong and that his symptoms are imagined
D. D. Arrange additional testing each time he reports a new symptom, to reassure him

B. Offer brief, regularly scheduled visits and acknowledge his distress without reinforcing symptom checking — In illness anxiety disorder the distress is real even though tests are normal. Scheduled brief visits with one provider reduce symptom-driven visits and meet the need for attention. The nurse acknowledges the fear, avoids unnecessary repeated testing, and does not argue about the symptoms or feed the checking.

Question and rationale by Plainwork. Reference: American Psychiatric Association, DSM-5-TR, somatic symptom and related disorders; Videbeck, Psychiatric-Mental Health Nursing

3. A nurse makes a home visit to a client 10 days after delivery. The client has barely slept for three nights, is confused, and says the baby 'is not mine and must be saved from the devil.' The husband says she seemed fine at discharge. What is the priority action?

A. A. Tell the husband that these are the baby blues, which are common after birth and should settle within a few days
B. B. Teach the client sleep hygiene and ask the husband to help with night feedings
C. C. Complete a depression screening tool and schedule a follow-up visit for next week
D. D. Make sure the infant is not left alone with the mother, and arrange an emergency psychiatric evaluation

D. Make sure the infant is not left alone with the mother, and arrange an emergency psychiatric evaluation — Sudden confusion, insomnia, delusions and a distorted belief about the baby in the first weeks after birth suggest postpartum psychosis, a psychiatric emergency. There is a real risk of harm to the infant and to the mother, so the infant's safety and immediate evaluation come first. Baby blues are mild, brief and never include delusions.

Question and rationale by Plainwork. Reference: American College of Obstetricians and Gynecologists, clinical practice guideline on mental health conditions in pregnancy and postpartum; Lowdermilk, Maternity and Women's Health Care

4. A nurse finds superficial scratches on the forearm of an inpatient who has borderline personality disorder. The client says, 'It's nothing, it just helps me feel less awful.' Which response is best?

A. A. 'Why would you do this to yourself? You promised the staff that you would stop hurting yourself.'
B. B. Treat the wounds in a matter-of-fact way, then explore what led up to it and plan safer ways to cope
C. C. Remove the client's privileges for the rest of the day so that she learns self-harm has consequences
D. D. Avoid discussing the incident with the client, so that the behavior is not reinforced by attention

B. Treat the wounds in a matter-of-fact way, then explore what led up to it and plan safer ways to cope — Self-injury often relieves intense emotional pain and is not always a suicide attempt, though risk is still assessed. The nurse treats the wound calmly without judgment, explores the feelings and events that came before, and helps the client practice safer coping skills. Shaming, punishing or ignoring the behavior damages the relationship and does not meet the need.

Question and rationale by Plainwork. Reference: Linehan, Cognitive-Behavioral Treatment of Borderline Personality Disorder; American Psychiatric Association, Practice Guideline for the Treatment of Patients With Borderline Personality Disorder

5. A client with anorexia nervosa on an inpatient eating disorders unit has just finished a supervised meal. Which nursing action best supports treatment?

A. A. Offer a larger portion at the next meal as a consequence for eating slowly
B. B. Encourage the client to keep a private food diary and review it at discharge
C. C. Allow the client to use the bathroom alone to maintain dignity
D. D. Stay with the client for a set period after the meal and supervise any bathroom visits

D. Stay with the client for a set period after the meal and supervise any bathroom visits — Clients with anorexia may purge, hide food or exercise secretly after meals. Supervision for a set time after eating, with observed bathroom use, helps keep the meal down and builds a safe routine. Punitive portion changes and private diaries do not provide that safety or the therapeutic support.

Question and rationale by Plainwork. Reference: American Psychiatric Association, Practice Guideline for the Treatment of Patients With Eating Disorders; Videbeck, Psychiatric-Mental Health Nursing

6. A client hospitalized with major depressive disorder started an antidepressant 10 days ago. Today the client, who had been withdrawn, is cheerful and energetic and has given a watch and some books to a roommate. Which action should the nurse take first?

A. A. Praise the client's progress and encourage attendance at group activities.
B. B. Tell the provider that the client seems ready for discharge planning.
C. C. Document the improved mood as a response to the medication.
D. D. Ask the client directly about thoughts of suicide and whether there is a plan.

D. Ask the client directly about thoughts of suicide and whether there is a plan. — A sudden lift in mood with giving away possessions can mean the client has decided to die and now has the energy to act; early antidepressant treatment is a period of raised risk. Asking directly does not plant the idea and is the first step in assessing risk.

Question and rationale by Plainwork. Reference: Standard psychiatric-mental health nursing texts (Videbeck; Townsend and Morgan; Halter/Varcarolis); American Psychiatric Association, DSM-5-TR (2022)

7. A client with schizophrenia who believes that neighbours placed a transmitter in the client's head is sitting alone, tilting the head as if listening and muttering, 'No, I won't do it.' Which action should the nurse take first?

A. A. Give the prescribed as-needed antipsychotic medication.
B. B. Tell the client firmly that the voices are not real and should be ignored.
C. C. Take the client to a group activity as a distraction.
D. D. Ask the client whether voices are speaking and what they are saying.

D. Ask the client whether voices are speaking and what they are saying. — The behaviour suggests auditory hallucinations, possibly commands. The first step is to assess the content directly, because command hallucinations to harm self or others determine the level of safety precautions.

Question and rationale by Plainwork. Reference: Standard psychiatric-mental health nursing texts (Videbeck; Townsend and Morgan; Halter/Varcarolis); American Psychiatric Association, DSM-5-TR (2022)

8. A client in the emergency department is trembling, breathing rapidly and gasping, 'I can't breathe. I'm going to die.' A cardiac and respiratory cause has been ruled out and the provider diagnoses a panic attack. Which action by the nurse is most appropriate?

A. A. Ask the client to describe what set off the attack.
B. B. Teach a progressive muscle relaxation routine step by step.
C. C. Move the client to a quiet room and leave the client alone to settle.
D. D. Stay with the client, speak in short calm phrases and guide slow breathing.

D. Stay with the client, speak in short calm phrases and guide slow breathing. — At the panic level the perceptual field is closed and the person cannot learn or solve problems. The nurse stays, keeps the client safe, uses brief simple directions and helps slow the breathing until the anxiety falls.

Question and rationale by Plainwork. Reference: Standard psychiatric-mental health nursing texts (Videbeck; Townsend and Morgan; Halter/Varcarolis); American Psychiatric Association, DSM-5-TR (2022)

9. A client with treatment-resistant schizophrenia started clozapine three weeks ago and has become noticeably less distressed by voices. At the clinic visit the client mentions a sore throat, chills and feeling very tired for two days. Which action should the nurse take first?

A. A. Tell the client to hold the next dose, and notify the provider so that a white blood cell count with absolute neutrophil count is obtained today.
B. B. Suggest warm saline gargles and rest, and review the symptoms at the next visit.
C. C. Teach the client that sedation and tiredness are expected early effects of this medication.
D. D. Praise the improvement and remind the client to keep taking every dose.

A. Tell the client to hold the next dose, and notify the provider so that a white blood cell count with absolute neutrophil count is obtained today. — Clozapine can cause severe neutropenia (agranulocytosis), most often in the first months of treatment. Signs of infection such as sore throat, fever, chills and malaise in a client taking clozapine are treated as possible neutropenia until a neutrophil count shows otherwise, so the drug is held and the provider is informed at once.

Question and rationale by Plainwork. Reference: Halter, Varcarolis' Foundations of Psychiatric-Mental Health Nursing; Clozapine prescribing information (FDA label)

10. A client with major depressive disorder began a selective serotonin reuptake inhibitor (SSRI) two weeks ago. At the follow-up visit, which finding requires the nurse's most immediate attention?

A. A. The client reports nausea and loose stools that were worse in the first week.
B. B. The client still wakes at 4 a.m. and says sleep has not improved.
C. C. The client reports mild headaches and feeling 'a bit jittery' in the mornings.
D. D. The client's spouse says the client suddenly has more energy and has given a tool collection to a neighbor, while the client still rates mood as very low.

> **D.** The client's spouse says the client suddenly has more energy and has given a tool collection to a neighbor, while the client still rates mood as very low. — With antidepressants, energy and psychomotor activity often return before mood and hopelessness improve, so the first weeks of treatment are a period of raised suicide risk. Returning energy together with persistent low mood and giving away valued possessions suggests the client may now have both a plan and the energy to act, and calls for a direct suicide risk assessment.
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> Question and rationale by Plainwork. Reference: Halter, Varcarolis' Foundations of Psychiatric-Mental Health Nursing; FDA boxed warning for antidepressants

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