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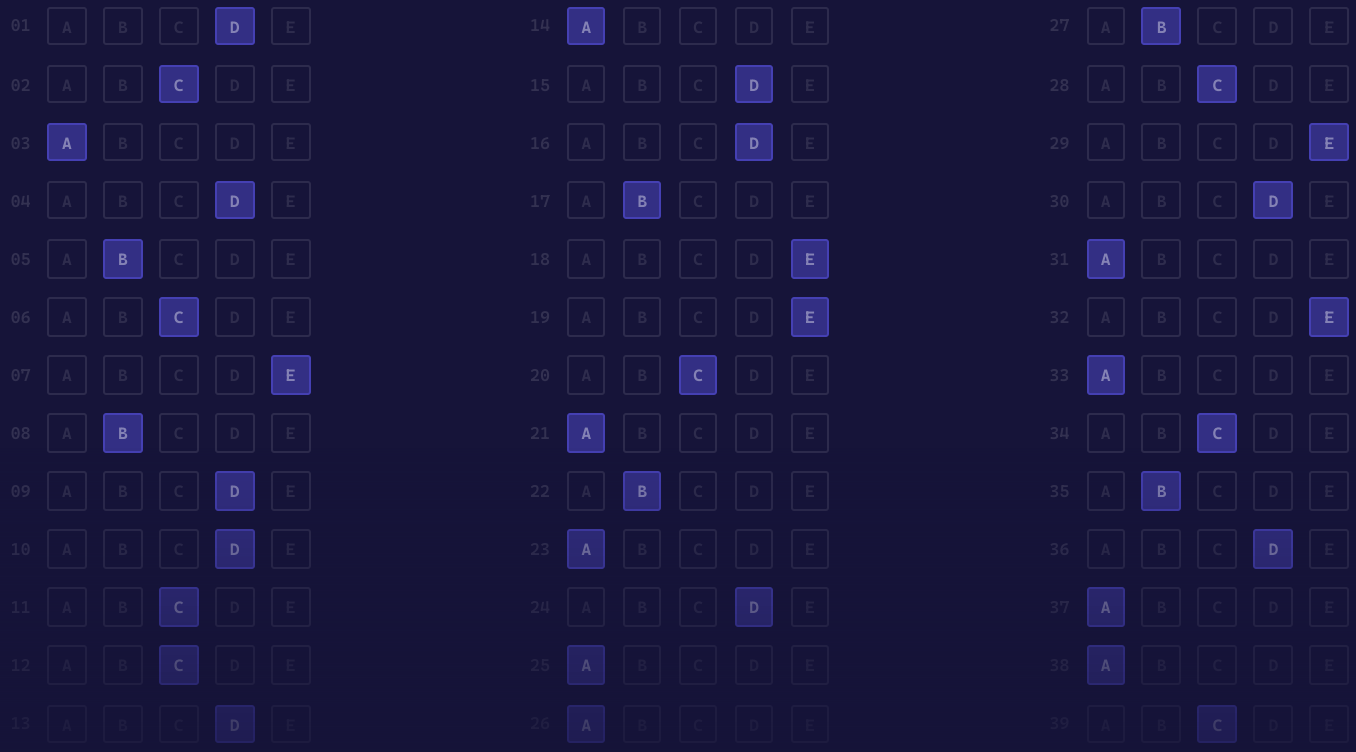

PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

PNPSY

Practical Nursing Psy/Mental Health

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

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Before you begin

What this is

9 practice questions for Elsevier Remotely Proctored Exams `PNPSY`, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, `PNPSY`
- the question number
- the email address on your order

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QUESTION 1 MULTIPLE CHOICE

A client diagnosed with major depressive disorder has been withdrawn and non-verbal during morning care. Which therapeutic communication techniques are most appropriate for the LPN/LVN to use at this time? (Choose two.)

A **Sitting quietly with the client for several minutes without requiring conversation**

B Asking multiple direct questions about the client's feelings to encourage expression

C Offering broad openings such as 'Tell me what you are thinking about'

D Telling the client that everyone feels sad sometimes and to cheer up

E **Using silence as a therapeutic tool while observing nonverbal cues**

ANSWER **A** · **E**

WHY Sitting quietly with the client and using silence are both recognized therapeutic techniques when a client is nonverbal. Broad openings can also be useful but may be overwhelming for a withdrawn client; the best two choices focus on nonverbal acceptance and observation. Giving advice ('cheer up') and asking multiple direct questions are non-therapeutic.

QUESTION 2 MULTIPLE CHOICE

A nurse is caring for a client with post-traumatic stress disorder (PTSD) following a motor vehicle accident. Which manifestations should the nurse expect to assess? (Choose two.)

A **Hypervigilance and exaggerated startle response**

B **Recurrent intrusive memories or nightmares of the event**

C Elevated mood and increased energy with decreased need for sleep

D Flat affect with no recall of the traumatic event

E Persistent feelings of grandiosity and invincibility

ANSWER **A** · **B**

WHY Hypervigilance with exaggerated startle response and recurrent intrusive memories/nightmares are hallmark PTSD symptoms. Elevated mood and decreased sleep are more consistent with mania, and grandiosity is not characteristic of PTSD. Flat affect may occur but total amnesia is not typical.

QUESTION 3 SINGLE CHOICE

A client experiencing a panic attack reports chest tightness, shortness of breath, dizziness, and a fear of dying. What is the priority nursing action?

A **Encourage the client to take slow, deep breaths and remain with the client**

B Encourage the client to lie down and close their eyes

C Tell the client to stop focusing on physical symptoms

D Offer the client caffeine to improve energy

ANSWER **A**

WHY During a panic attack, the priority is to provide safety and reduce hyperventilation by coaching slow, deep breathing while remaining with the client. Dismissing the client's symptoms or giving caffeine (a stimulant) would worsen the panic response.

QUESTION 4 SINGLE CHOICE

A client with paranoid schizophrenia refuses to take prescribed antipsychotic medication, stating, 'I don't need it.' The client is alert and has no court-appointed guardian. What is the most appropriate nursing action?

A **Document the refusal and report to the health care provider; assess the client's understanding and capacity**

B Administer the medication by force to ensure compliance

C Tell the client they will be discharged if they do not comply

D Hide the medication in food without informing the client

ANSWER **A**

WHY An alert adult with decision-making capacity has the right to refuse medication. The nurse should document the refusal, notify the provider, and assess the client's understanding of the risks and benefits. Coercing, deceiving, or forcing medication violates the client's rights except in documented emergency situations.

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QUESTION 5 SINGLE CHOICE

A client with major depressive disorder states, 'I feel like a failure as a parent.' Which response by the nurse best demonstrates the therapeutic technique of reflection?

A **'You feel like you have failed as a parent.'**

B 'Don't be so hard on yourself; you're a good parent.'

C 'Why do you think you have failed?'

D 'Many parents feel that way at some point.'

ANSWER **A**

WHY Reflection restates or paraphrases the client's feelings/content back to the client so they can hear and examine what was said. Option A mirrors the client's expressed feeling. Option B is reassurance, which can discount feelings. Option C asks 'why,' which can put the client on the defensive. Option D is generalization/minimization, which can close exploration. Reflection invites the client to continue exploring the feeling.

QUESTION 6 SINGLE CHOICE

A client admitted for alcohol withdrawal is being assessed 24 hours after the last drink. Which finding should the nurse report to the provider immediately as a possible indicator of progression toward delirium tremens?

A **Tactile, visual, or auditory hallucinations**

B Mild tremor and diaphoresis

C Headache and irritability

D Nausea with one episode of vomiting

ANSWER **A**

WHY Delirium tremens (DTs) typically develops 48 to 96 hours after the last drink and is marked by severe autonomic instability, profound confusion, and hallucinations. The onset of hallucinations in a withdrawing client signals progression toward DTs and must be reported immediately. Mild tremor, diaphoresis, headache, irritability, and nausea are expected findings of earlier alcohol withdrawal (6 to 24 hours) and are managed but are not the most urgent indicator of severe withdrawal.

QUESTION 7 SINGLE CHOICE

A client with obsessive-compulsive disorder (OCD) spends several hours each morning repeating a hand-washing ritual and becomes visibly distressed when interrupted. Which nursing intervention is most appropriate initially?

A **Establish a consistent routine and gradually limit the time allotted for the ritual**

B Forcefully stop the ritual and redirect the client to group therapy

C Allow unlimited time for the ritual until the client feels ready to stop

D Ignore the behavior to avoid reinforcing it with attention

ANSWER **A**

WHY OCD is best managed with a structured, consistent approach and graded exposure with response prevention; the nurse should establish a routine and gradually decrease the time available for the ritual while supporting the client through the resulting anxiety. Forcefully stopping the ritual (B) increases anxiety and can escalate behavior. Allowing unlimited time (C) reinforces the compulsion. Ignoring (D) abandons the therapeutic relationship and does not treat the disorder. The initial step is structure with gradual limits.

QUESTION 8 SINGLE CHOICE

A nurse is assessing a client with major depressive disorder for suicide risk. Which client statement indicates the highest immediate risk for suicide?

A **'I have thought about how I would end my life, and I have pills at home that I could use.'**

B 'I feel sad most days, but I can still enjoy a walk with my dog.'

C 'I wish things were different than they used to be.'

D 'My family would miss me if I were gone.'

ANSWER **A**

WHY The combination of a specific plan, identified means (pills at home), and intent places this client at the highest immediate risk and requires a safe environment and continuous monitoring. Option B shows some preserved pleasure and no plan. Option C is vague, passive wishing without a plan. Option D reflects a protective factor (perceived impact on family) but does not, by itself, negate risk when a plan is present. Plan plus means is the highest-risk cue.

QUESTION 9 SINGLE CHOICE

A client diagnosed with schizophrenia tells the nurse, 'The FBI has been sending me messages through the ceiling tiles.' Which response by the nurse best demonstrates therapeutic communication?

A **'That sounds frightening. I don't see any wires or microphones in the ceiling.'**

B 'You are wrong; the FBI doesn't send messages through ceilings.'

C 'Why would the FBI be interested in you?'

D 'Let's not talk about that. Tell me about your morning.'

ANSWER **A**

WHY Presenting reality ('I don't see any wires') while acknowledging the client's feelings ('that sounds frightening') avoids reinforcing the delusion and avoids arguing, which can damage the therapeutic relationship. Telling the client they are wrong (B) is confrontational and can increase agitation. Asking 'why' (C) demands justification for the delusion and can increase anxiety. Changing the subject (D) dismisses the client's experience without offering reality testing.

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