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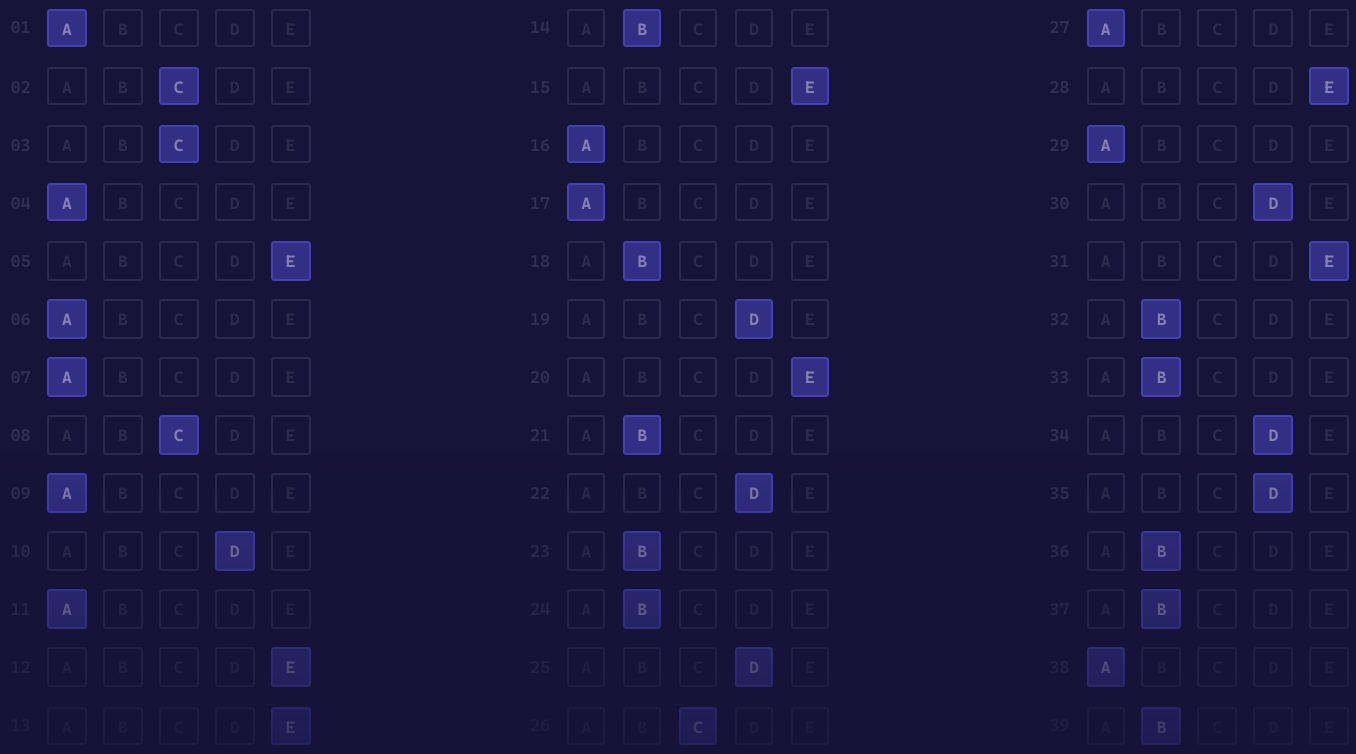

PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RNPSY

Registered 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 `RNPSY`, 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, `RNPSY`
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1 MULTIPLE CHOICE

A nurse is conducting an admission interview with a client diagnosed with major depressive disorder. The client states, 'I don't think anyone would even notice if I disappeared.' Which responses by the nurse demonstrate the appropriate use of therapeutic communication? (Choose two.)

A 'Why would you say that? You have a family who loves you.'

B 'Tell me more about what you mean when you say you feel like disappearing.'

C 'Let's not focus on negative thoughts. Tell me about something good in your life.'

D 'You sound as though you are feeling hopeless right now. Are you having thoughts of harming yourself?'

ANSWER **B · D**

WHY Option B uses the therapeutic technique of exploring, which encourages the client to elaborate on feelings and thoughts. Option D combines reflection and clarification with a direct assessment for suicidal ideation, which is essential when a client hints at self-harm. Option A is nontherapeutic because it uses 'why' questions and offers false reassurance, which can shut down disclosure. Option C is nontherapeutic because it dismisses the client's feelings and uses deflection rather than exploring the underlying emotion.

QUESTION 2 MULTIPLE CHOICE

A client experiencing a panic attack is admitted to the emergency department with chest tightness, shortness of breath, dizziness, and a fear of dying. Which nursing interventions are appropriate at this time? (Choose two.)

A **Remain with the client and speak in short, calm sentences.**

B Encourage the client to take rapid, deep breaths to release tension.

C Teach progressive muscle relaxation techniques during the attack.

D **Reduce environmental stimuli by dimming lights and decreasing noise.**

ANSWER **A · D**

WHY During a panic attack, the nurse should remain with the client, use short calm sentences, and reduce environmental stimuli (dimming lights, decreasing noise) to decrease sensory overload and provide a sense of safety. Option B is incorrect because clients experiencing panic typically hyperventilate; encouraging rapid deep breathing worsens respiratory alkalosis and symptoms. Option C is incorrect because teaching relaxation techniques requires a calm, learning-ready state and is not appropriate during the peak of a panic attack.

QUESTION 3 SINGLE CHOICE

A client taking haloperidol develops a high fever (40.5°C/105°F), severe muscle rigidity, altered consciousness, and autonomic instability. Which condition should the nurse suspect?

A **Neuroleptic malignant syndrome**

B Tardive dyskinesia

C Serotonin syndrome

D Akathisia

ANSWER **A**

WHY Neuroleptic malignant syndrome (NMS) is a life-threatening reaction to antipsychotic medications such as haloperidol, characterized by hyperthermia, severe muscle rigidity (lead-pipe rigidity), altered mental status, and autonomic instability (tachycardia, labile blood pressure, diaphoresis). It requires immediate discontinuation of the antipsychotic and emergency medical management. Tardive dyskinesia is characterized by involuntary, repetitive movements of the face, tongue, and extremities. Serotonin syndrome is associated with serotonergic agents and features clonus, hyperreflexia, and diarrhea. Akathisia is a feeling of motor restlessness.

QUESTION 4 SINGLE CHOICE

A client with bipolar I disorder is started on valproic acid. Which laboratory test should the nurse monitor closely during the first several months of therapy?

A **Serum ammonia and liver function tests**

B Thyroid-stimulating hormone (TSH) and free T4

C Serum potassium and magnesium

D Fasting blood glucose and lipid panel

ANSWER **A**

WHY Valproic acid is associated with hepatotoxicity (elevated liver enzymes) and, less commonly, hyperammonemia, particularly in the first six months of therapy. Baseline and periodic liver function tests and ammonia levels are required. Thyroid function is monitored with lithium, not valproic acid. Electrolytes and glucose/lipids are not directly affected by valproic acid in routine monitoring.

QUESTION 5 SINGLE CHOICE

A client with paranoid schizophrenia believes the food is being poisoned and refuses to eat. Which nursing intervention is most appropriate initially?

A Insist that the client eat to maintain adequate nutrition.

B **Offer sealed, pre-packaged food items the client can open themselves.**

C Tell the client that the staff would not poison the food.

D Document the refusal and do not offer food until the client asks.

ANSWER **B**

WHY Clients with paranoid delusions may fear contamination or poisoning. Offering sealed, pre-packaged items the client can open themselves respects the client's experience while supporting nutritional intake. Insisting the client eat increases anxiety and resistance. Arguing with the delusion is nontherapeutic. Withholding food until the client asks neglects the nurse's responsibility to meet basic nutritional needs.

QUESTION 6 SINGLE CHOICE

Which client statement indicates the highest immediate suicide risk and requires the nurse to implement continuous one-to-one observation?

A 'I feel hopeless about my future.'

B **'I have thought about how I would end my life, and I have the means at home.'**

C 'Sometimes I wish I could just go to sleep and not wake up.'

D 'My family would be better off without me around.'

ANSWER **B**

WHY The highest immediate risk is indicated by the presence of a specific plan, the means to carry it out, and intent (plan + means + intent = highest risk). Options A, C, and D reflect passive suicidal ideation or hopelessness and require assessment but not necessarily continuous observation. Option B demonstrates an active, specific plan with available means and warrants the highest level of precaution.

QUESTION 7 SINGLE CHOICE

A client on an inpatient psychiatric unit becomes increasingly loud, paces the hallway, and clenches his fists while shouting at another peer. Which action should the nurse take first?

A Call for a show of force from several staff members.

B **Approach the client calmly and direct him to a quiet area.**

C Administer a prn intramuscular antipsychotic medication.

D Place the client in seclusion immediately to protect others.

ANSWER **B**

WHY The least restrictive intervention should always be tried first. Approaching the client calmly, using a calm tone, and redirecting him to a quieter area allows verbal de-escalation and may prevent escalation to physical aggression. Calling a show of force, administering forced IM medication, and seclusion are more restrictive interventions reserved for situations where less restrictive measures have failed or there is imminent danger.

QUESTION 8 SINGLE CHOICE

A client who chronically uses alcohol is admitted 24 hours after his last drink. Which findings should the nurse anticipate?

A Sedation, slurred speech, and impaired coordination

B **Tactile hallucinations, tachycardia, and elevated blood pressure**

C Pinpoint pupils, respiratory depression, and decreased level of consciousness

D Increased appetite, lethargy, and bradycardia

ANSWER **B**

WHY Alcohol withdrawal typically begins 6 to 24 hours after the last drink and is characterized by autonomic hyperactivity (tachycardia, hypertension, diaphoresis), tremors, anxiety, agitation, nausea, and, in severe cases, tactile or visual hallucinations progressing to delirium tremens. Option A describes intoxication. Option C describes opioid overdose or intoxication. Option D does not accurately describe a recognized withdrawal syndrome.

QUESTION 9 SINGLE CHOICE

A military veteran diagnosed with posttraumatic stress disorder (PTSD) is having a flashback during a group session. Which nursing intervention is most appropriate?

A Encourage the client to describe the flashback in detail to the group for processing.

B **Speak to the client in a calm, reassuring manner and guide him to a quiet environment.**

C Ask the group members to interpret what the client is experiencing.

D Remind the client that the traumatic event is in the past and is no longer real.

ANSWER **B**

WHY During a flashback, the client is reliving the event and needs grounding techniques. Speaking calmly and guiding the client to a quiet environment helps reduce stimulation, supports safety, and aids in reorientation. Asking the client to describe it in detail is overwhelming and inappropriate in a group setting. Having peers interpret the experience is nontherapeutic. Telling the client the event is in the past dismisses his current experience and is nontherapeutic.