NCLEX-RN Study Guide

Domain 3 Study Guide

Psychosocial Integrity

Exam Weight: 6–12% of Exam

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Domain Overview

Psychosocial Integrity encompasses the nurse's role in supporting the mental, emotional, and social well-being of clients across the lifespan. This domain covers therapeutic communication, mental health disorders, crisis intervention, grief, coping mechanisms, and psychosocial aspects of physical illness.

Therapeutic Communication

Technique	Description	Example
Active Listening	Full attention; non-verbal engagement	Maintaining eye contact; nodding
Reflection	Restating the emotional content	"It sounds like you're feeling anxious."
Clarification	Seeking to understand unclear statements	"Can you tell me more about that?"
Open-ended questions	Encourages elaboration	"How have you been feeling lately?"
Silence	Allows client time to process	Sitting quietly with the client
Summarizing	Reviewing key points of conversation	"So what I'm hearing is..."
Focusing	Directing attention to one topic	"Let's talk more about your pain."

Non-Therapeutic Communication (AVOID)

Technique	Why It's Harmful	Example to Avoid
False reassurance	Dismisses client's concerns	"Everything will be fine."
Giving advice	Removes client autonomy	"You should just leave him."
Changing the subject	Avoids important topics	Redirecting when client discusses death
Closed-ended questions	Limits communication	"Are you feeling better today?"
Judgmental responses	Creates shame/guilt	"Why would you do that?"
Agreeing with delusions	Reinforces false beliefs	"Yes, the TV is sending you messages."

NCLEX Tip: When a client expresses suicidal ideation, ALWAYS ask directly: "Are you thinking about hurting yourself?" Asking does not plant the idea — it opens the door to intervention.

Mental Health Disorders

Mood Disorders

Disorder	Key Features	Priority Nursing Interventions

Major Depressive Disorder	Depressed mood ≥2 weeks; anhedonia; sleep/appetite changes; fatigue; worthlessness; suicidal ideation	Suicide risk assessment; safety planning; antidepressants (SSRIs); therapeutic relationship
Bipolar I	At least one manic episode (≥7 days); may have depressive episodes	Safety during mania (impulsivity); lithium monitoring; sleep regulation
Bipolar II	Hypomanic episodes + major depressive episodes; no full mania	Monitor for depression; medication adherence; mood charting
Dysthymia (PDD)	Chronic mild depression ≥2 years	Long-term therapy; medication; lifestyle modifications

Anxiety Disorders

Disorder	Key Features	Nursing Interventions
Generalized Anxiety	Excessive worry ≥6 months; muscle tension; fatigue	Relaxation techniques; CBT; buspirone or SSRIs
Panic Disorder	Recurrent unexpected panic attacks; fear of future attacks	Stay with client; calm voice; breathing techniques; benzodiazepines (acute)
PTSD	Flashbacks; nightmares; hypervigilance; avoidance after trauma	Trauma-informed care; EMDR; prazosin for nightmares; SSRIs
OCD	Obsessions + compulsions; time-consuming; distressing	Do not interrupt rituals abruptly; CBT with ERP; SSRIs (high doses)
Social Anxiety	Fear of social situations; avoidance	Gradual exposure; beta-blockers for performance anxiety; SSRIs

Psychotic Disorders

Symptom Type	Examples	Nursing Approach
Positive Symptoms	Hallucinations, delusions, disorganized speech/behavior	Do not argue with delusions; acknowledge feelings; antipsychotics
Negative Symptoms	Flat affect, alogia, avolition, anhedonia, social withdrawal	Structured activities; social skills training; atypical antipsychotics
Cognitive Symptoms	Impaired memory, attention, executive function	Simple instructions; written reminders; consistent routine

NCLEX Tip: Clozapine (Clozaril) requires weekly WBC monitoring due to risk of agranulocytosis. Clients must be registered in the REMS program. Absolute neutrophil count must be ≥1500/mm³ to continue therapy.

Crisis Intervention and Suicide Risk

Suicide Risk Assessment

Risk Factor	Protective Factor
Previous suicide attempt (strongest predictor)	Strong social support
Access to lethal means (firearms, medications)	Religious/cultural beliefs against suicide
Specific plan with timeline	Reasons for living (children, pets)
Male gender (higher completion rate)	Engaged in mental health treatment
Substance use disorder	Problem-solving ability
Recent major loss or stressor	Sense of purpose/meaning
Hopelessness (Beck Hopelessness Scale)	Future orientation

Crisis Intervention Steps (Roberts' 7-Stage Model)

- 1. Assess lethality and safety needs
- 2. Establish rapport and therapeutic relationship
- 3. Identify the major problem/precipitating event
- 4. Deal with feelings and provide support
- 5. Explore possible alternatives
- 6. Formulate an action plan
- 7. Follow up and evaluate

Grief and Loss (Kübler-Ross)

Stage	Behaviors	Nursing Response
Denial	"This can't be happening." Shock, disbelief	Allow expression; do not force acceptance; provide accurate information
Anger	"Why me?" Rage, resentment, blame	Do not take anger personally; allow expression; set limits on harmful behavior
Bargaining	"If I do X, maybe..." Making deals	Listen; do not dismiss; provide spiritual support if desired
Depression	Sadness, withdrawal, crying, hopelessness	Sit with client; therapeutic silence; assess for clinical depression
Acceptance	Coming to terms; planning; peace	Support; involve in end-of-life planning; family support

NCLEX Tip: Grief stages are not linear — clients may move back and forth between stages. Complicated grief (persistent, debilitating grief >12 months) requires professional intervention.

Substance Use Disorders

Substance	Withdrawal Timeline	Key Withdrawal Symptoms	Treatment
Alcohol	6-24 hr (mild); 24-48 hr (seizures); 48-72 hr (DTs)	Tremors, diaphoresis, tachycardia, seizures, delirium tremens	Benzodiazepines (CIWA protocol); thiamine; IV fluids
Opioids	8-24 hr (short-acting); 36-48 hr (long-acting)	Yawning, lacrimation, rhinorrhea, piloerection, N/V/D, muscle cramps	Methadone, buprenorphine; clonidine for symptoms; NOT life-threatening
Benzodiazepines	1-4 days	Anxiety, tremors, seizures (can be fatal)	Gradual taper; seizure precautions
Stimulants (cocaine, meth)	Hours to days	Crash: fatigue, depression, hypersomnia, increased appetite	Supportive care; antidepressants for prolonged depression
Nicotine	24-48 hr peak	Irritability, anxiety, difficulty concentrating, increased appetite	NRT; varenicline; bupropion; behavioral support