

Chapter 01: Science and the Therapeutic Use of Self in Psychiatric Mental Health Nursing

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

1. Which outcome, focused on recovery, would be expected in the plan of care for a patient living in the community and diagnosed with serious and persistent mental illness? Within 3 months, the patient will demonstrate what behavior?
 - a. Denying suicidal ideation
 - b. Reporting a sense of well-being
 - c. Taking medications as prescribed
 - d. Attending clinic appointments on time

ANS: B

Recovery emphasizes managing symptoms, reducing psychosocial disability, and improving role performance. The goal of recovery is to empower the individual with mental illness to achieve a sense of meaning and satisfaction in life and to function at the highest possible level of wellness. The incorrect options focus on the classic medical model rather than recovery.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Health Promotion and Maintenance

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2. A patient is hospitalized for depression and suicidal ideation after their spouse asks for a divorce. Select the nurse's **most** caring comment.
 - a. "Let's discuss healthy means of coping when you have suicidal feelings."
 - b. "I understand why you're so depressed. When I got divorced, I was devastated too."
 - c. "You should forget about your marriage and move on with your life."
 - d. "How did you get so depressed that hospitalization was necessary?"

ANS: A

The nurse's communication should evidence caring and a commitment to work with the patient. This commitment lets the patient know the nurse will help. Probing and advice are not helpful for therapeutic interventions.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

3. In the shift-change report, an off-going nurse criticizes a patient who wears extremely heavy makeup. Which comment by the nurse who receives the report best demonstrates advocacy?
 - a. "This is a psychiatric hospital, so we expect our patients to behave bizarrely."
 - b. "Let's all show acceptance of this patient by wearing lots of makeup too."
 - c. "Your comments are inconsiderate and inappropriate. Keep the report objective."
 - d. "Our patients need our help to learn behaviors that will help them get along in society."

ANS: D

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Accepting patients' needs for self-expression and seeking to teach skills that will contribute to their well-being demonstrate respect and are important parts of advocacy. The on-coming nurse needs to take action to ensure that others are not prejudiced against the patient. Humor can be appropriate within the privacy of a shift report but not at the expense of respect for patients. Judging the off-going nurse in a critical way will create conflict. Nurses must show compassion for each other.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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4. A nurse assesses a newly admitted patient diagnosed with major depressive disorder. Which statement is an example of "attending"?
 - a. "We all have stress in life. Being in a psychiatric hospital is not the end of the world."
 - b. "Tell me why you felt you had to be hospitalized to receive treatment for your depression."
 - c. "You will feel better after we get some antidepressant medication started for you."
 - d. "I'd like to sit with you for a while, so you may feel more comfortable talking with me."

ANS: D

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Attending is a technique that demonstrates the nurse's commitment to the relationship and reduces feelings of isolation. This technique shows respect for the patient and demonstrates caring. Generalizations, probing, and false reassurances are nontherapeutic.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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5. A patient shows the nurse an article from the Internet about a health problem. Which characteristic of the website's address most alerts the nurse that the site may have biased and prejudiced information?
 - a. Address ends in ".org."
 - b. Address ends in ".com."
 - c. Address ends in ".gov."
 - d. Address ends in ".net."

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ANS: B

Financial influences on a site are a clue that the information may be biased. ".com" at the end of the address indicates that the site is a commercial one. ".gov" indicates that the site is maintained by a government entity. ".org" indicates that the site is nonproprietary; the site may or may not have reliable information, but it does not profit from its activities. ".net" can have multiple meanings.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Health Promotion and Maintenance

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6. A nurse says, "When I was in school, I learned to call upset patients by name to get their attention; however, I read a descriptive research study that says that this approach does not work. I plan to stop calling patients by name." Which statement is the best appraisal of this nurse's comment?

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- a. One descriptive research study rarely provides enough evidence to change practice.

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- b. Staff nurses apply new research findings only with the help from clinical nurse specialists.
- c. New research findings should be incorporated into clinical algorithms before using them in practice.
- d. The nurse misinterpreted the results of the study. Classic tenets of practice do not change.

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ANS: A

Descriptive research findings provide evidence for practice but must be viewed in relation to other studies before practice changes. One study is not enough. Descriptive studies are low on the hierarchy of evidence. Clinical algorithms use flowcharts to manage problems and do not specify one response to a clinical problem. Classic tenets of practice should change as research findings provide evidence for change.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Health Promotion and Maintenance

TOP: Nursing Process: Evaluation

- 7. Two nursing students discuss career plans after graduation. One student wants to enter psychiatric nursing. The other student asks, "Why would you want to be a psychiatric nurse? All they do is talk. You will lose your skills." Select the best response by the student interested in psychiatric nursing.
 - a. "Psychiatric nurses' practice in safer environments than other specialties and nurse-to-patient ratios are better because of the nature of patients' problems."
 - b. "Psychiatric nurses use complex communication skills, as well as critical thinking, to solve multidimensional problems. I'm challenged by those situations."
 - c. "I think I will be good in the mental health field. I do not like clinical rotations in school, so I do not want to continue them after I graduate."
 - d. "Psychiatric nurses do not have to deal with as much pain and suffering as medical-surgical nurses. That appeals to me."

ANS: B

The practice of psychiatric nursing requires a different set of skills than medical-surgical nursing, although substantial overlap does exist. Psychiatric nurses must be able to help patients with medical and mental health problems, reflecting the holistic perspective these nurses must have. Nurse-patient ratios and workloads in psychiatric settings have increased, similar to other specialties. Psychiatric nursing involves clinical practice, not simply documentation. Psychosocial pain is real and can cause as much suffering as physical pain.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

- 8. Which research evidence would most influence a group of nurses to change their practice?
 - a. Expert committee report of recommendations for practice
 - b. Systematic review of randomized controlled trials
 - c. Nonexperimental descriptive study
 - d. Critical pathway

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ANS: B

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Research findings are graded using a hierarchy of evidence. A systematic review of randomized controlled trials is level A and provides the strongest evidence for changing practice. Expert committee recommendations and descriptive studies lend less powerful and influential evidence. A critical pathway is not evidence; it incorporates research findings after they have been analyzed.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

9. A bill introduced in Congress would reduce funding for the care of people diagnosed with mental illnesses. A group of nurses write letters to their elected representatives in opposition to the legislation. Which role have the nurses fulfilled?

- a. Advocacy
- b. Attending
- c. Recovery
- d. Evidence-based practice

ANS: A

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An advocate defends or asserts another's cause, particularly when the other person lacks the ability to do that for him or herself. Examples of individual advocacy include helping patients understand their rights or make decisions. On a community scale, advocacy includes political activity, public speaking, and publication in the interest of improving the individuals with mental illness; the letter-writing campaign advocates for that cause on behalf of patients who are unable to articulate their own needs.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. An informal group of patients discuss their perceptions of nursing care. Which comment best indicates a patient's perception that his or her nurse is caring?

- a. "My nurse always asks me which type of juice I want to help me swallow my medication."
- b. "My nurse explained my treatment plan to me and asked for my ideas about how to make it better."
- c. "My nurse told me that if I take all the medicines the doctor prescribes, I will get discharged soon."
- d. "My nurse spends time listening to me talk about my problems. That helps me feel like I'm not alone."

ANS: D

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Caring evidences empathic understanding as well as competency. It helps change pain and suffering into a shared experience, creating a human connection that alleviates feelings of isolation. The incorrect options give examples of statements that demonstrate advocacy or giving advice.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

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11. A patient who immigrated to the United States from Honduras was diagnosed with schizophrenia. The patient took an antipsychotic medication for 3 weeks but showed no improvement. Which resource should the treatment team consult for information on more effective medications for this patient?

- a. Clinical algorithm
- b. Clinical pathway
- c. Clinical practice guideline
- d. *International Statistical Classification of Diseases and Related Health Problems (ICD)*

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ANS: A

A clinical algorithm is a guideline that describes diagnostic and/or treatment approaches drawn from large databases of information. These guidelines help the treatment team make decisions cognizant of an individual patient's needs, such as ethnic origin, age, or gender. A clinical pathway is a map of interventions and treatments related to a specific disorder. Clinical practice guidelines summarize best practices about specific health problems. The ICD classifies diseases.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

12. A team of nurses wants to integrate evidence-based practice into a facility's clinical pathways. Which step should the team implement first?
- a. Acquire findings from published literature.
 - b. Apply the research findings to clinical practice.
 - c. Assess the outcomes of using new research findings.
 - d. Ask questions to identify clinical problems that should be changed.

ANS: D

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Integrating evidence-based practice is a multistep process rather than a single change event. The first step is to identify clinical problems that should be changed. Each step must proceed in order when integrated into a clinical environment.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

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13. A nurse consistently strives to demonstrate caring behaviors during interactions with patients. Which reaction reported by a patient indicates this nurse is most effective?
- a. Feeling less distrustful of others
 - b. Sensing a connection with others
 - c. Experiencing only minimal uneasiness about the future
 - d. Being somewhat encouraged with efforts to improve

ANS: B

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A patient is likely to respond most to caring with a sense of connectedness with others. The absence of caring can make patients feel some degree of distrustful, disconnection, unease, and discouragement.

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DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

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MULTIPLE RESPONSE

1. An experienced nurse says to a new graduate, “When you’ve practiced as long as I have, you will instantly know how to take care of psychotic patients.” What is the new graduate’s best analysis of this comment? (*Select all that apply.*)
 - a. The experienced nurse may have lost sight of patients’ individuality, which may compromise the integrity of practice.
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 - b. New research findings must be continually integrated into a nurse’s practice to provide the most effective care.
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 - c. Experience provides mental health nurses with the tools and skills needed for effective professional practice.
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 - d. Experienced psychiatric nurses have learned the best ways to care for psychotic patients through trial and error.
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 - e. Effective psychiatric nurses should be continually guided by an intuitive sense of patients’ needs.
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ANS: A, B

Evidence-based practice involves using research findings to provide the most effective nursing care. Evidence is continually emerging; therefore, nurses cannot rely solely on experience. The effective nurse also maintains respect for each patient as an individual. Overgeneralization compromises that perspective. Intuition and trial and error are unsystematic approaches to care.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

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2. Which patient statements identify qualities of nursing practice with high therapeutic value? “My nurse: (*Select all that apply.*)
 - a. “The nurses talk in language I can understand.”
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 - b. “The nursing staff helps me keep track of my medications.”
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 - c. “My nurse is willing to go to social activities with me.”
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 - d. “The staff lets me do whatever I choose without interfering.”
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 - e. “My nurses look at me as a whole person with different needs.”
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ANS: A, B, E

Each correct answer demonstrates caring is an example of appropriate nursing foci: communicating at a level understandable to the patient, using holistic principles to guide care, and providing medication supervision. The incorrect options suggest a laissez-faire attitude on the part of the nurse when the nurse should instead provide thoughtful feedback and help patients test alternative solutions or violate boundaries.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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Chapter 02: Mental Health and Mental Illness

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MULTIPLE CHOICE

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1. An 86 year old, previously healthy and independent, falls after an episode of vertigo. Which statement made by this patient best demonstrates resilience?
 - a. "I knew this would happen eventually."
 - b. "Attending my weekly water aerobics class is too risky."
 - c. "I don't need that silly walker to get around by myself."
 - d. "Maybe some physical therapy will help me with my balance."

ANS: D

Resiliency is the ability to recover from or adjust to misfortune and change. The correct response indicates that the patient is hopeful and thinking positively about ways to adapt to the vertigo. Saying "I knew this would happen eventually" and discontinuing healthy activities suggest a hopeless perspective on the health change. Refusing to use a walker indicates denial.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

2. Which basic intervention should a psychiatric mental health nurse plan to provide for a patient diagnosed with a mood disorder?
 - a. Sharing clinical expertise to enhance patient treatment
 - b. Performing individual or group psychotherapy for the patient
 - c. Using appropriate diagnostic tests to monitor patient condition
 - d. Conducting stress reduction and health maintenance classes

ANS: D

Conducting stress reduction and health maintenance classes is the basic intervention that should be performed by a psychiatric mental health nurse. These classes will provide individualized guidance to patients to prevent or reduce mental illness and improve mental health. Community screenings and stress management classes are examples of health maintenance classes. Consulting nurses from other disciplines to share clinical expertise and enhance patient treatment is an advanced practice psychiatric mental health nursing intervention. Performing individual and group psychotherapy and performing diagnostic tests like blood pressure, etc., are also advanced practice psychiatric mental health nursing interventions.

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DIF: Cognitive Level: Application (Applying)

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MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

3. A patient is admitted to the psychiatric hospital. Which assessment finding best indicates that the patient has a mental illness? The patient:
 - a. describes coping and relaxation strategies used when feeling anxious.
 - b. describes mood as consistently sad, discouraged, and hopeless.
 - c. can perform tasks attempted within the limits of own abilities.
 - d. reports occasional problems with insomnia.

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ANS: B

A patient who reports having a consistently negative mood is describing a mood alteration that affects the ability to function optimistically. The incorrect options describe mentally healthy behaviors and common problems that do not indicate mental illness.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

4. The goal for a patient is to increase resiliency. Which outcome should a nurse add to the plan of care to be achieved within 3 days?
a. Patient describes feelings associated with loss and stress.
b. Patient meet own needs before considering the rights of others.
c. Patient will identify healthy coping behaviors in response to stressful events.
d. Patient will allow others to assume responsibility for major areas of own life.

ANS: C

The patient's ability to identify healthy coping behaviors indicates adaptive, healthy behavior and demonstrates an increased ability to recover from severe stress. Describing feelings associated with loss and stress does not move the patient toward adaptation. The remaining options are maladaptive behaviors.

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DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

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5. A nurse at a behavioral health clinic sees an unfamiliar psychiatric diagnosis on a patient's insurance form. Which resource should the nurse consult to discern the criteria used to establish this diagnosis?
a. A psychiatric nursing textbook
b. *NANDA International (NANDA-I)*
c. A behavioral health reference manual
d. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*

ANS: D

The *DSM-5* gives the criteria used to diagnose each mental disorder. The *NANDA-I* focuses on nursing diagnoses. A psychiatric nursing textbook or behavioral health reference manual may not contain diagnostic criteria.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Safe, Effective Care Environment

6. A nurse must assess several new patients at a community mental health center. Conclusions concerning current functioning should be made on the basis of what factor?
a. The degree of conformity of the individual to society's norms.
b. The degree to which an individual appears logical and rational.
c. A continuum from mentally healthy to mentally unhealthy.
d. The rate of their intellectual and emotional growth.

ANS: C

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Because mental health and mental illness are relative concepts, assessment of functioning is made by using a continuum. Mental health is not based on conformity; some mentally healthy individuals do not conform to society's norms. Most individuals occasionally display illogical or irrational thinking. The rate of intellectual and emotional growth is not the most useful criterion to assess mental health or mental illness.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

7. A 40-year-old adult living with parents' states, "I'm happy but I don't socialize much. My work is routine. When new things come up, my boss explains them a few times to make sure I understand. At home, my parents make decisions for me, and I go along with them." A nurse should identify interventions to improve which patient characteristic?
- a. Self-concept
 - b. Overall happiness
 - c. Appraisal of reality
 - d. Control over behavior

ANS: A

The patient feels the need for multiple explanations of new tasks at work and, despite being 40 years of age, allows both parents to make all decisions. These behaviors indicate a poorly developed self-concept. Although the patient reports being happy, the subsequent comments refute that self-appraisal. The patient's comments do not indicate that he/she is out of touch with reality. The patient's needs are broader than control over own behavior.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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8. A patient tells a nurse, "I have psychiatric problems and am in and out of hospitals all the time. Not one of my friends or relatives has these problems." What is the nurse's best response?
- a. "Comparing yourself with others has no real advantages."
 - b. "Why do you blame yourself for having a psychiatric illness?"
 - c. "Mental illness affects 50% of the adult population in any given year."
 - d. "Are you concerned that others don't experience the same challenges as you?"

ANS: D

Mental illness affects many people at various times in their lives. No class, culture, or creed is immune to the challenges of mental illness. The correct response also demonstrates the use of reflection, a therapeutic communication technique. It is not true that mental illness affects 50% of the population in any given year. Asking patients if they blame themselves is an example of probing.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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9. A critical care nurse asks a psychiatric nurse about the difference between a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* and a nursing diagnosis. What is the psychiatric nurse's best response?
- a. "No functional difference exists between the two diagnoses. Both serve to identify

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- a human deviance.”
- b. “The *DSM-5* diagnosis disregards culture, whereas the nursing diagnosis includes cultural variables.”
 - c. “The *DSM-5* diagnosis profiles present distress or disability, whereas a nursing diagnosis considers past and present responses to actual mental health problems.”
 - d. “The *DSM-5* diagnosis influences the medical treatment; the nursing diagnosis offers a framework to identify interventions for problems a patient has or may experience.”

ANS: D

The medical diagnosis, defined according to the *DSM-5*, is concerned with the patient’s disease state, causes, and cures, whereas the nursing diagnosis focuses on the patient’s response to stress and possible caring interventions. Both the *DSM-5* and a nursing diagnosis consider culture. Nursing diagnoses also consider potential problems.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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- 10. The partner of a patient diagnosed with schizophrenia says, “I don’t understand why childhood experiences have anything to do with this disabling illness.” Which nurse’s response will best help the partner understand this condition?
 - a. “Psychological stress is actually at the root of most mental disorders.”
 - b. “We now know that all mental illnesses are the result of genetic factors.”
 - c. “It must be frustrating for you that your spouse is sick so much of the time.”
 - d. “Research has shown schizophrenia has a biological rather than psychological origin.”

ANS: D

Many of the most prevalent and disabling mental disorders have been found to have strong biological influences. Helping the partner understand the importance of his or her role as a caregiver is also important. Empathy is important but does not increase the spouse’s level of knowledge about the cause of the patient’s condition. Not all mental illnesses are the result of genetic factors. Psychological stress is not at the root of most mental disorders.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

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- 11. Which belief by a nurse supports the highest degree of patient advocacy during a multidisciplinary patient care planning session?
 - a. All mental illnesses are culturally determined.
 - b. Schizophrenia and bipolar disorder are cross-cultural disorders.
 - c. Symptoms of mental disorders are constant from culture to culture.
 - d. Some symptoms of mental disorders may reflect a person’s cultural patterns.

ANS: D

A nurse who understands that a patient’s symptoms are influenced by culture will be able to advocate for the patient to a greater degree than a nurse who believes that culture is of little relevance. All mental illnesses are *not* culturally determined. Schizophrenia and bipolar disorder are cross-cultural disorders, but this understanding has little relevance to patient advocacy. Symptoms of mental disorders change from culture to culture.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

12. A patient's history shows intense and unstable relationships with others. The patient initially idealizes an individual and then devalues the person when the patient's needs are not met. Which aspect of mental health is a problem for this patient?
- a. Effectiveness in work
 - b. Communication skills
 - c. Productive activities
 - d. Maintaining relationships

ANS: D

The information provided centers on relationships with others, which are described as intense and unstable. The relationships of mentally healthy individuals are stable, satisfying, and socially integrated. Data are not present to describe work effectiveness, communication skills, or activities.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

13. In the majority culture of the United States, which individual is at greatest risk to be incorrectly labeled mentally ill?
- a. Person who is usually pessimistic but strives to meet personal goals.
 - b. Wealthy person who gives \$20 bills to needy individuals in the community.
 - c. Person with an optimistic viewpoint about getting his or her own needs met.
 - d. Person who expresses strong beliefs about the existence of alien abductions.

ANS: D

Possessing and expressing unpopular or unsubstantiated beliefs often suggests an individual is mentally unstable. In this situation, cultural norms vary, making it more difficult to make an accurate *DSM-5* diagnosis. The individuals described in the other options are less likely to be labeled as mentally ill.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

14. A participant at a community education conference asks, "What is the most prevalent type of mental disorder in the United States?" What is the nurse's best response?
- a. "Why do you ask?"
 - b. "Schizophrenia"
 - c. "Affective disorders"
 - d. "Anxiety disorders"

ANS: D

The prevalence for schizophrenia is 1.1% per year. The prevalence of all affective disorders (e.g., depression, dysthymic disorder, bipolar) is 9.5%. The prevalence of anxiety disorders is 18.1%.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation

MSC: NCLEX: Health Promotion and Maintenance

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15. A nurse wants to find a description of diagnostic criteria for a person diagnosed with schizophrenia. Which resource should the nurse consult?
- U.S. Department of Health and Human Services abirb.com/test
 - Journal of the American Psychiatric Association*
 - North American Nursing Diagnosis Association International (NANDA-I)*
 - Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* abirb.com/test

ANS: D

The *DSM-5* identifies diagnostic criteria for psychiatric diagnoses. The other sources have useful information but are not the best resources for finding a description of the diagnostic criteria for a psychiatric disorder.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis abirb.com/test

MSC: NCLEX: Health Promotion and Maintenance

MULTIPLE RESPONSE

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1. A patient in the emergency department reports, “I hear voices saying someone is stalking me. They want to kill me because I found the cure for cancer. I will stab anyone that threatens me.” Which aspects of mental health have the greatest immediate concern to a nurse? (*Select all that apply.*)
- Happiness
 - Appraisal of reality
 - Control over behavior
 - Effectiveness in work
 - Healthy self-concept

ANS: B, C, E

The aspects of mental health of greatest concern are the patient’s appraisal of and control over behavior. The patient’s appraisal of reality is inaccurate, and auditory hallucinations are evident, as well as delusions of persecution and grandeur. In addition, the patient’s control over behavior is tenuous, as evidenced by the plan to “stab” anyone who seems threatening. A healthy self-concept is lacking. Data are not present to suggest that the other aspects of mental health (happiness and effectiveness in work) are of immediate concern.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment abirb.com/test

2. Which statements most clearly reflect the stigma of mental illness? (*Select all that apply.*)
- “Many mental illnesses are hereditary.”
 - “Mental illness can be evidence of a brain disorder.”
 - “People claim mental illness, so they can qualify for disability.”
 - “If people with mental illness went to church, they would be fine.”
 - “Mental illness is a result of the breakdown of the American family.”

ANS: C, D, E

Stigma is represented by judgmental remarks that discount the reality and validity of mental illness. Many mental illnesses are genetically transmitted. Neuroimaging can show changes associated with some mental illnesses.

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DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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Chapter 03: Theories and Therapies

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MULTIPLE CHOICE

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1. A 26-month-old child displays negative behaviors. The parent says, "My child refuses toilet training and shouts, 'No!' when given direction. What do you think is wrong?" Select the nurse's best reply.
 - a. "This is normal for your child's age. The child is striving for independence."
 - b. "The child needs firmer control. Punish the child for disobedience and say, 'No.'"
 - c. "There may be developmental problems. Most children are toilet trained by age 2 years."
 - d. "Some undesirable attitudes are developing. A child psychologist can help you develop a remedial plan."

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ANS: A

These negative behaviors are typical of a child around the age of 2 years whose developmental task is to develop autonomy. The incorrect options indicate the child's behavior is abnormal.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

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2. A 26-month-old child displays negative behavior, refuses toilet training, and often shouts, "No!" when given directions. Using Freud's stages of psychosexual development, a nurse would assess the child's behavior is based on which stage?
 - a. Oral
 - b. Anal
 - c. Phallic
 - d. Genital

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ANS: B

In Freud's stages of psychosexual development, the anal stage occurs from age 1 to 3 years and has, as its focus, toilet training and learning to delay immediate gratification. The oral stage occurs between birth and 1 year, the phallic stage occurs between 3 and 5 years, and the genital stage occurs between 13 and 20 years.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

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3. A 26-month-old child displays negative behavior, refuses toilet training, and often shouts, "No!" when given direction. The nurse's counseling with the parent should be based on the premise that the child is engaged in which of Erikson's psychosocial crises?
 - a. Trust versus Mistrust
 - b. Initiative versus Guilt
 - c. Industry versus Inferiority
 - d. Autonomy versus Shame and Doubt

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ANS: D

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The crisis of Autonomy versus Shame and Doubt is related to the developmental task of gaining control of self and environment, as exemplified by toilet training. This psychosocial crisis occurs during the period of early childhood. Trust versus Mistrust is the crisis of the infant, Initiative versus Guilt is the crisis of the preschool and early school-aged child, and Industry versus Inferiority is the crisis of the 6- to 12-year-old child.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Health Promotion and Maintenance

4. A 4-year-old child grabs toys from siblings, saying, “I want that toy now!” The siblings cry, and the child’s parent becomes upset with the behavior. Using the Freudian theory, a nurse can interpret the child’s behavior as a product of impulses originating in the:

- a. id.
- b. ego.
- c. superego.
- d. preconscious.

ANS: A

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The id operates on the pleasure principle, seeking immediate gratification of impulses. The ego acts as a mediator of behavior and weighs the consequences of the action, perhaps determining that taking the toy is not worth the parent’s wrath. The superego would oppose the impulsive behavior as “not nice.” The preconscious is a level of awareness.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Health Promotion and Maintenance

5. The parent of a 4 year old rewards and praises the child for helping a younger sibling, being polite, and using good manners. A nurse supports the use of praise because, according to the Freudian theory, these qualities will likely be internalized and become what part of the child’s personality?

- a. Id
- b. Ego
- c. Superego
- d. Preconscious

ANS: C

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In the Freudian theory, the superego contains the “thou shalts” or moral standards internalized from interactions with significant others. Praise fosters internalization of desirable behaviors. The id is the center of basic instinctual drives, and the ego is the mediator. The ego is the problem-solving and reality-testing portion of the personality that negotiates solutions with the outside world. The preconscious is a level of awareness from which material can be easily retrieved with conscious effort.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation

MSC: NCLEX: Health Promotion and Maintenance

6. A nurse supports parental praise of a child who is behaving in a helpful way. When the individual behaves with politeness and helpfulness in adulthood, which ego ideal will most likely result?

- a. Curiosity
- b. Awareness

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- c. Honesty
- d. Self-esteem

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ANS: D

The individual will be living up to the ego ideal, which will result in positive feelings about self. None of the other characteristics are as closely associated with the ego.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

7. A patient comments, “I never know the right answer” and “My opinion is not important.” Using Erikson’s theory, which psychosocial crisis did the patient have difficulty resolving?
- a. Initiative versus Guilt
 - b. Trust versus Mistrust
 - c. Autonomy versus Shame and Doubt
 - d. Generativity versus Self-Absorption

abirb.com/test

ANS: C

These statements show severe self-doubt, indicating that the crisis of gaining control over the environment is not being successfully met. Unsuccessful resolution of the crisis of Initiative versus Guilt results in feelings of guilt. Unsuccessful resolution of the crisis of Trust versus Mistrust results in poor interpersonal relationships and suspicion of others. Unsuccessful resolution of the crisis of Generativity versus Self-Absorption results in self-absorption that limits the ability to grow as a person.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

8. Which patient statement would lead a nurse to suspect that the developmental task of infancy was not successfully completed?
- a. “I have very warm and close friendships.”
 - b. “I’m afraid to let anyone really get to know me.”
 - c. “I am always right and confident about my decisions.”
 - d. “I’m ashamed that I didn’t do it correctly in the first place.”

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ANS: B

According to Erikson, the developmental task of infancy is the development of trust. The patient’s statement that he or she is afraid of becoming acquainted with others clearly shows a lack of ability to trust other people. Having warm and close friendships suggests the developmental task of infancy was successfully completed. Believing one is always right suggests rigidity rather than mistrust. Feelings of shame suggest failure to resolve the crisis of Initiative versus Guilt.

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DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

9. A nurse assesses that a patient is suspicious and frequently manipulates others. Using the Freudian theory, these traits are related to which psychosexual stage?
- a. Oral
 - b. Anal
 - c. Phallic
 - d. Genital

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ANS: A

According to Freud, each of the behaviors mentioned develops as the result of attitudes formed during the oral stage, when an infant first learns to relate to the environment. Anal stage traits include stinginess, stubbornness, orderliness, or their opposites. Phallic stage traits include flirtatiousness, pride, vanity, difficulty with authority figures, and difficulties with sexual identity. Genital stage traits include the ability to form satisfying sexual and emotional relationships with members of the opposite sex, emancipation from parents, and a strong sense of personal identity.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Health Promotion and Maintenance

10. An adult expresses the wish to be taken care of and often behaves in a helpless fashion. This adult has needs related to which of Freud's stages of psychosexual development?

- a. Latency
- b. Phallic
- c. Anal
- d. Oral

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ANS: D

According to Freud, fixation at the oral stage sometimes produces dependent infantile behaviors in adults. Latency fixations often result in a difficulty identifying with others and developing social skills, resulting in a sense of inadequacy and inferiority. Phallic fixations result in having difficulty with authority figures and poor sexual identity. Anal fixation sometimes results in retentiveness, rigidity, messiness, destructiveness, and cruelty.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Health Promotion and Maintenance

11. A nurse listens to a group of recent retirees. One says, "I volunteer with Meals on Wheels, coach teen sports, and do church visitation." Another laughs and says, "I'm too busy taking care of myself to volunteer. I don't have time to help others." These comments contrast which developmental tasks?

- a. Trust versus Mistrust
- b. Industry versus Inferiority
- c. Intimacy versus Isolation
- d. Generativity versus Self-Absorption

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ANS: D

Both retirees are in middle adulthood, when the developmental crisis to be resolved is Generativity versus Self-Absorption. One exemplifies generativity; the other embodies self-absorption. The developmental crisis of Trust versus Mistrust would show a contrast between relating to others in a trusting fashion and being suspicious and lacking trust. Failure to negotiate the developmental crisis of Industry versus Inferiority would result in a sense of inferiority or difficulty learning and working as opposed to the ability to work competently. Behaviors that would be contrasted in the crisis of Intimacy versus Isolation would be emotional isolation and the ability to love and commit to oneself.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Health Promotion and Maintenance

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12. Cognitive behavioral therapy was provided for a patient who frequently said, "I'm stupid." Which statement by the patient indicates the therapy was effective?
- "I'm disappointed in my lack of ability."
 - "I always fail when I try new things."
 - "Things always go wrong for me."
 - "Sometimes I do stupid things."

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ANS: D

"I'm stupid" is a cognitive distortion or irrational thought. A more rational thought is, "Sometimes I do stupid things." The latter thinking promotes emotional self-control. The incorrect options reflect irrational thinking.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

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13. A student nurse tells the instructor, "I don't need to interact with my patients. I learn what I need to know by observation." The instructor can best interpret the nursing implications of Sullivan's theory by providing what response?
- "Nurses cannot be isolated. We must interact to provide patients with opportunities to practice interpersonal skills."
 - "Observing patient interactions can help you formulate priority nursing diagnoses and appropriate interventions."
 - "I wonder how accurate your assessment of the patient's needs can be if you do not interact with the patient."
 - "Noting patient behavioral changes is important because these signify changes in personality."

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ANS: A

Sullivan believed that the nurse's role includes educating patients and assisting them in developing effective interpersonal relationships. Mutuality, respect for the patient, unconditional acceptance, and empathy are cornerstones of Sullivan's theory. The nurse who does not interact with the patient cannot demonstrate these cornerstones. Observations provide only objective data. Priority nursing diagnoses usually cannot be accurately established without subjective data from the patient. The third response pertains to Maslow's theory. The fourth response pertains to behavioral theory.

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DIF: Cognitive Level: Application (Applying)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

14. A psychiatric technician says, "Little of what takes place on the behavioral health unit seems to be theory based." A nurse educates the technician by identifying which common use of Sullivan's theory?
- Structure of the therapeutic milieu of most behavioral health units
 - Frequent use of restraint and seclusion for behavior modification
 - Assessment tools based on age-appropriate versus arrested behaviors
 - Use of the nursing process to determine the best sequence for nursing actions

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ANS: A

abirb.com/test

abirb.com/test

The structure of the therapeutic environment has, as its foci, an accepting atmosphere and provision of opportunities for practicing interpersonal skills. Both constructs are directly attributable to Sullivan's theory of interpersonal relationships. Sullivan's interpersonal theory did not specifically consider the use of restraint or seclusion. Assessment based on the developmental level is associated with Erikson's theories. The nursing process applies concepts from multiple theories.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

15. A nurse uses Maslow's hierarchy of needs to plan care for a psychotic patient. Which problem will receive priority?
- Refuses to eat or bathe.
 - Reports feelings of alienation from family.
 - Is reluctant to participate in unit social activities.
 - Needs to be taught about medication action and side effects.

ANS: A

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The need for food and hygiene is physiological and therefore takes priority over psychological or meta-needs in care planning.

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

16. Operant conditioning will be used to encourage speech in a child who is nearly mute. Which technique would a nurse include in the treatment plan?
- Ignore the child for using silence.
 - Have the child observe others talking.
 - Give the child a small treat for speaking.
 - Teach the child relaxation techniques, then coax speech.

ANS: C

Operant conditioning involves giving positive reinforcement for a desired behavior. Treats are rewards to reinforce speech. Ignoring the child will not change the behavior. Having the child observe others describes modeling. Teaching relaxation techniques and then coaxing speech is an example of systematic desensitization.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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17. The parent of a child diagnosed with schizophrenia tearfully asks a nurse, "What could I have done differently to prevent this illness?" Select the nurse's most caring response.
- "Although schizophrenia is caused by impaired family relationships, try not to feel guilty. No one can predict how a child will respond to parental guidance."
 - "Most of the damage is done, but there is still hope. Changing your parenting style can help your child learn to cope more effectively with the environment."
 - "Schizophrenia is a biological illness with similarities to diabetes and heart disease. You are not to blame for your child's illness."
 - "Most mental illnesses result from genetic inheritance. Your genes are more at fault than your parenting."

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ANS: C

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Patients and families need reassurance that the major mental disorders are biological in origin and are not the “fault” of parents. Knowing the biological nature of the disorder relieves feelings of guilt over being responsible for the illness. The incorrect responses are neither wholly accurate nor reassuring; they fall short of being reassuring and place the burden of having faulty genes on the shoulders of the parents.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

18. A nurse uses Peplau’s interpersonal therapy while working with an anxious, withdrawn patient. What should the focus of the interventions be?
- a. Changing the patient’s perceptions about self
 - b. Improving the patient’s interactional skills
 - c. Using medications to relieve anxiety
 - d. Reinforcing specific behaviors

ANS: B

The nurse–patient relationship is structured to provide a model for adaptive interpersonal relationships that can be generalized to others. Changing the patient’s perceptions about his- or herself would be appropriate for cognitive therapy. Reinforcing specific behaviors would be used in behavioral therapy. Using medications is the focus of biological therapy.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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19. A patient underwent psychotherapy weekly for 3 years. The therapist used free association, dream analysis, and facilitated transference to help the patient understand unconscious processes and foster personality changes. Which type of therapy was used?
- a. Short-term dynamic psychotherapy
 - b. Transactional analysis
 - c. Cognitive therapy
 - d. Psychoanalysis

ANS: D

The therapy described is traditional psychoanalysis. Short-term dynamic psychotherapy would last less than 1 year. Neither transactional analysis nor cognitive therapy makes use of the techniques described.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

20. An advanced practice nurse determines that a group of patients would benefit from opportunities to practice appropriate social behaviors and learn about basic living skills. The nurse would arrange for what form of therapy?
- a. Milieu therapy
 - b. Cognitive therapy
 - c. Short-term dynamic therapy
 - d. Systematic desensitization

ANS: A

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abirb.com/test

Milieu therapy provides an opportunity for all members of the environment to contribute to the planning and functioning of the setting, practice social behaviors in a safe setting, and gain knowledge in basic living skills. The other therapies are all individual therapies that do not fit the description.

DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

21. A nurse psychotherapist works with an anxious, dependent patient. What therapeutic strategy is most consistent with the framework of psychoanalytic psychotherapy?
- Emphasizing medication compliance
 - Identifying the patient's strengths and assets
 - Offering psychoeducational materials and groups
 - Focusing on feelings developed by the patient toward the nurse

ANS: D

Positive or negative feelings of the patient toward the nurse or therapist represent transference. Transference is a psychoanalytic concept that can be used to explore previously unresolved conflicts. Emphasizing medication compliance is more related to biological therapy. Identifying patient strengths and assets would be consistent with supportive psychotherapy. The use of psychoeducational materials is a common "homework" assignment used in cognitive therapy.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

22. A person tells a nurse, "I was the only survivor in a small plane crash, but three business associates died. I got anxious and depressed and saw a counselor three times a week for a month. We talked about my feelings related to being a survivor, and now I am at peace with the situation." Which type of therapy was used?
- Milieu therapy
 - Psychoanalysis
 - Behavior modification
 - Interpersonal therapy

ANS: D

Interpersonal therapy returns the patient to the former level of functioning by helping the patient come to terms with the loss of friends and guilt over being a survivor. Milieu therapy refers to environmental therapy. Psychoanalysis calls for a long period of exploration of unconscious material. Behavior modification focuses on changing a behavior rather than helping the patient understand what is going on in his or her life.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

23. What cognitive strategy should a nurse use to assist a very dependent patient achieve independence?
- Reveal dream content.
 - Take prescribed medications.
 - Examine thoughts about being autonomous.
 - Role model ways to ask for help from others.

ANS: C

Cognitive theory suggests that one's thought processes are the basis of emotions and behavior. Changing faulty learning makes the development of new adaptive behaviors possible. Revealing dream content would be used in psychoanalytical therapy. Taking prescribed medications is an intervention associated with biological therapy. A dependent patient needs to develop independence.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

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24. A single parent is experiencing feelings of inadequacy related to work and family since one teenaged child ran away several weeks ago. The parent seeks the help of a therapist specializing in cognitive therapy. The psychotherapist who uses cognitive therapy will introduce what intervention?
- Discussing ego states
 - Focusing on unconscious mental processes
 - Negatively reinforcing an undesirable behavior
 - Helping the patient identify and change faulty thinking

ANS: D

Cognitive therapy emphasizes the importance of changing erroneous ways people think about themselves. Once faulty thinking changes, the individual's behavior changes. Focusing on unconscious mental processes is a psychoanalytic approach. Negatively reinforcing undesirable behaviors is behavior modification and discussing ego states relates to transactional analysis.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

25. A person received an invitation to be in the wedding of a friend who lives across the country. The individual is afraid of flying. What type of therapy should the nurse recommend?
- Psychoanalysis
 - Milieu therapy
 - Systematic desensitization
 - Short-term dynamic therapy

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ANS: C

Systematic desensitization is a type of therapy aimed at extinguishing a specific behavior, such as the fear of flying. Psychoanalysis and short-term dynamic therapy are aimed at uncovering conflicts. Milieu therapy involves environmental factors.

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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MULTIPLE RESPONSE

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- A basic level registered nurse works with patients in a community setting. Which groups should this nurse expect to lead? (*Select all that apply.*)
 - Symptom management
 - Medication education

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- c. Family therapy
- d. Psychotherapy
- e. Self-care

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ANS: A, B, E

Symptom management, medication education, and self-care groups represent psychoeducation, a service provided by the basic level registered nurse. Advanced practice registered nurses provide family therapy and psychotherapy.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

2. A patient states, “I’m starting cognitive behavioral therapy. What can I expect from the sessions?” Which responses by the nurse are appropriate? (*Select all that apply.*)
- a. “The therapist will be active and questioning.”
 - b. “You may be given homework assignments.”
 - c. “The therapist will ask you to describe your dreams.”
 - d. “The therapist will help you look at ideas and beliefs you have about yourself.”
 - e. “The goal is to increase your subjectivity about thoughts that govern your behavior.”

ANS: A, B, D

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Cognitive therapists are active rather than passive during therapy sessions because they help patients to reality test their thinking. Homework assignments are given and completed outside the therapy sessions. Homework is usually discussed at the next therapy session. The goals of cognitive therapy are to assist the patient to identify inaccurate cognitions, to reality test their thinking, and to formulate new, accurate cognitions. Dream describing applies to psychoanalysis, not cognitive behavioral therapy. The desired outcome of cognitive therapy is to assist patients in increasing their objectivity, not subjectivity, about the cognitions that influence behavior.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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Chapter 04: Biological Basis for Understanding Psychopharmacology

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A patient asks a nurse, "What are neurotransmitters? My doctor says mine are out of balance." What is the nurse's best response?
 - a. "You must feel relieved to know that your problem has a physical basis."
 - b. "Neurotransmitters are chemicals that pass messages between brain cells."
 - c. "It is a high-level concept to explain. You should ask the doctor to tell you more."
 - d. "Neurotransmitters are substances we eat daily that influence memory and mood."

ANS: B

Stating that neurotransmitters are chemicals that pass messages between brain cells gives the most accurate information. Neurotransmitters are messengers in the central nervous system. They are released from the axon terminal, diffuse across the synapse, and attach to specialized receptors on the postsynaptic neuron. The incorrect responses do not answer the patient's question, are demeaning, and provide untrue and misleading information.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

2. The parent of an adolescent diagnosed with schizophrenia asks a nurse, "My child's doctor ordered a positron-emission tomography (PET) scan. What is that?" What is the nurse's best response?
 - a. "PET uses a magnetic field and gamma waves to identify problems areas in the brain. Does your teenager have any metal implants?"
 - b. "It's a special type of x-ray image that shows structures of the brain and whether a brain injury has ever occurred."
 - c. "PET is a scan that passes an electrical current through the brain and shows brain wave activity. PET can help diagnose seizures."
 - d. "PET is a special scan that shows blood flow and activity in the brain."

ANS: D

The parent is seeking information about PET scans. It is important to use terms the parent can understand. The correct option is the only reply that provides factual information relevant to PET scans. The incorrect responses describe magnetic resonance imaging (MRI), computed tomographic (CT) scans, and electroencephalography (EEG).

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

3. A patient is demonstrating signs of dementia. The health care provider wants to make a differential diagnosis between Alzheimer's disease and multiple infarctions. Which diagnostic procedure should a nurse expect to prepare the patient for first?
 - a. Computed tomography (CT) scan
 - b. Positron emission tomography (PET) scan
 - c. Functional magnetic resonance imaging (fMRI)
 - d. Single-photon emission computed tomography (SPECT) scan

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ANS: A

A CT scan shows the presence or absence of structural changes, including cortical atrophy, ventricular enlargement, and areas of infarction—information that will be helpful to the health care provider. The other tests focus on brain activity and are more expensive; they may be ordered later.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

4. A patient has delusions and hallucinations. Before beginning treatment with a psychotropic medication, the health care provider wants to rule out the presence of a brain tumor. For which test will a nurse need to prepare the patient?

a. Cerebral arteriogram

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b. Functional magnetic resonance imaging (fMRI)

c. Computed tomography (CT) scan or magnetic resonance imaging (MRI)

d. Positron emission tomography (PET) or single-photon emission computed tomography (SPECT)

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ANS: C

A CT scan and an MRI visualize neoplasms and other structural abnormalities. A PET scan, SPECT scan, and fMRI, which give information about brain function, are not indicated. An arteriogram would not be appropriate.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

5. The nurse wants to assess for disturbances in circadian rhythms in a patient admitted for major depressive disorder. Which question best implements this assessment?
 - a. “Do you ever see or hear things that others do not?”
 - b. “Do you have problems with short-term memory?”
 - c. “How would you describe your sleep pattern?”
 - d. “How would you describe your thinking?”

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ANS: C

Mood changes throughout the day are related to circadian rhythms. Questions about sleep pattern would also be relevant to circadian rhythms. The question about seeing or hearing things is relevant to the assessment for illusions and hallucinations. The question about thinking is relevant to the assessment of thought processes. The other question is relevant to assessment of memory.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

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6. A nurse administers a hypnotic medication that potentiates the action of gamma-aminobutyric acid (GABA). Which finding would be expected?
 - a. Reduced anxiety
 - b. Improved memory
 - c. More organized thinking
 - d. Fewer sensory perceptual alterations

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ANS: A

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Increased levels of GABA reduce anxiety; thus, any potentiation of GABA action should result in anxiety reduction. Memory enhancement is associated with acetylcholine and substance P. Thought disorganization is associated with dopamine. GABA is not associated with sensory perceptual alterations.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Evaluation
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7. On the basis of current knowledge of neurotransmitter effects, a nurse anticipates that the treatment plan for a patient with memory difficulties may include medications designed to do what?
- Inhibit GABA production.
 - Increase dopamine sensitivity.
 - Decrease dopamine at receptor sites.
 - Prevent destruction of acetylcholine.

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ANS: D

Increased acetylcholine plays a role in learning and memory. Preventing the destruction of acetylcholine by acetylcholinesterase results in higher levels of acetylcholine, with the potential for improved memory. GABA is known to affect anxiety level rather than memory. Increased dopamine causes symptoms associated with schizophrenia or mania rather than improves memory. Decreasing dopamine at receptor sites is associated with Parkinson disease rather than improving memory.

DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

8. A patient demonstrates disorganized thinking associated related to a diagnosis of schizophrenia. Neuroimaging would most likely show dysfunction in which part of the brain?
- Brainstem
 - Cerebellum
 - Temporal lobe
 - Prefrontal cortex

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ANS: D

The prefrontal cortex is responsible for intellectual functioning. The temporal lobe is responsible for the sensation of hearing. The cerebellum regulates skeletal muscle coordination and equilibrium. The brainstem regulates internal organs.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment
MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

9. A nurse should assess a patient taking a medication with anticholinergic properties for inhibition of what function?
- Parasympathetic nervous system
 - Sympathetic nervous system
 - Reticular activating system
 - Medulla oblongata

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ANS: A

[abirb.com/test](#)

[abirb.com/test](#)

Acetylcholine is the neurotransmitter found in high concentration in the parasympathetic nervous system. When acetylcholine action is inhibited by anticholinergic drugs, parasympathetic symptoms such as blurred vision, dry mouth, constipation, and urinary retention appear. The functions of the sympathetic nervous system, the reticular activating system, and the medulla oblongata are not affected by anticholinergic medications.

DIF: Cognitive Level: Comprehension (Understanding)

[abirb.com/test](#)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

10. The therapeutic action of monoamine oxidase inhibitors (MAOIs) blocks neurotransmitter reuptake, causing what effect?

- a. Increased concentration of neurotransmitters in the synaptic gap
- b. Decreased concentration of neurotransmitters in serum
- c. Destruction of receptor sites
- d. Limbic system stimulation

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ANS: A

If the reuptake of a substance is inhibited, then it accumulates in the synaptic gap and its concentration increases, permitting the ease of the transmission of impulses across the synaptic gap. Normal transmission of impulses across synaptic gaps is consistent with a normal rather than a depressed mood. The other options are not associated with blocking neurotransmitter reuptake.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

11. A patient taking an antipsychotic medication develops restlessness and an uncontrollable need to be in motion. A nurse can correctly analyze that these symptoms are related to which drug action?

- a. Anticholinergic effects
- b. Dopamine-blocking effects
- c. Endocrine-stimulating effects
- d. Ability to stimulate spinal nerves

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ANS: B

Medications that block dopamine often produce disturbances of movement (extrapyramidal side effects) such as akathisia because dopamine affects neurons involved in both the thought processes and movement regulation. Anticholinergic effects include dry mouth, blurred vision, urinary retention, and constipation. Akathisia is not caused by endocrine stimulation or spinal nerve stimulation.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

12. A patient presents with anxiety, increased heart rate, and fear. The nurse would suspect the presence of a high concentration of which neurotransmitter?

- a. GABA
- b. Histamine
- c. Acetylcholine
- d. Norepinephrine

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ANS: D

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Norepinephrine is the neurotransmitter associated with sympathetic nervous system stimulation, preparing the individual for the “fight-or-flight” response. GABA is a mediator of anxiety level. A high concentration of histamine is associated with an inflammatory response. A high concentration of acetylcholine is associated with parasympathetic nervous system stimulation.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

13. A patient reports symptoms of acute anxiety related to the death of a parent in an automobile accident 2 hours earlier. The nurse should anticipate administering a medication from which group for a short-term therapy?
- a. Tricyclic antidepressants
 - b. Atypical antipsychotics
 - c. Anticonvulsants
 - d. Benzodiazepines

ANS: D

abirb.com/test

Benzodiazepines provide anxiety relief but are losing favor among providers due to tolerance, high levels of abuse and recent connects to dementia. Tricyclic antidepressants are used to treat symptoms of depression. Anticonvulsants are used to treat bipolar disorder or seizures. Antipsychotic drugs are used to treat psychosis.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

abirb.com/test

14. A patient is hospitalized for major depressive disorder. A nurse can expect to likely provide the patient with teaching about which medication?
- a. Chlordiazepoxide
 - b. Fluoxetine
 - c. Clozapine
 - d. Tacrine

ANS: B

abirb.com/test

Fluoxetine is a selective serotonin reuptake inhibitor (SSRI), an antidepressant that blocks the reuptake of serotonin with few anticholinergic and sedating side effects; clozapine (Clozaril) is an antipsychotic medication; chlordiazepoxide (Librium) is an anxiolytic drug; and tacrine (Cognex) is used to treat Alzheimer's disease.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

15. A patient hospitalized with a mood disorder has demonstrated aggression, agitation, talkativeness, and irritability. A nurse begins the care plan based on the expectation that the health care provider is most likely to prescribe a medication from what classification?
- a. Anticholinergic
 - b. Mood stabilizer
 - c. Psychostimulant
 - d. Tricyclic antidepressant

ANS: B

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The symptoms describe a manic episode. Mania is effectively treated by the mood stabilizing medication, lithium and selected anticonvulsants such as carbamazepine, valproic acid, and lamotrigine. No drugs from the other classifications listed are effective in the treatment of mania.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

16. A patient prescribed a muscarinic-receptor blocker, will require assess for what side effect?
- Dry mouth
 - Gynecomastia
 - Pseudoparkinsonism
 - Orthostatic hypotension

[abirb.com/test](#)

ANS: A

Muscarinic-receptor blockade includes atropine-like side effects such as dry mouth, blurred vision, and constipation. Gynecomastia is associated with decreased prolactin levels. Movement defects are associated with dopamine blockade. Orthostatic hypotension is associated with α_1 -receptor antagonism.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

17. A patient begins therapy with a first-generation antipsychotic medication. What teaching should a nurse provide related to the drug's strong dopaminergic effect?
- Chew sugarless gum.
 - Increase dietary fiber.
 - Arise slowly from bed.
 - Report muscle stiffness.

[abirb.com/test](#)

ANS: D

First generation antipsychotic medications block dopamine receptors in both the limbic system and basal ganglia. Dystonia is likely to occur early in the course of treatment and is often heralded by sensations of muscle stiffness. Early intervention with an antiparkinsonian medication can increase the patient's comfort and prevent dystonic reactions. The incorrect responses apply to potential anticholinergic effects of first-generation antipsychotic medications.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

18. A nurse can anticipate anticholinergic side effects are likely to occur when a patient is prescribed what medication?
- Lithium
 - Buspirone
 - Risperidone
 - Fluphenazine

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ANS: D

[abirb.com/test](#)

[abirb.com/test](#)

Fluphenazine, a first-generation antipsychotic medication, exerts muscarinic blockade, resulting in dry mouth, blurred vision, constipation, and urinary retention. Lithium therapy is more often associated with fluid balance problems, including polydipsia, polyuria, and edema. Risperidone therapy is more often associated with movement disorders, orthostatic hypotension, and sedation. Buspirone is associated with anxiety reduction without major side effects.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

19. Priority teaching for a patient taking clozapine should include which instruction?

- a. Report sore throat and fever immediately.
- b. Avoid foods high in polyunsaturated fat.
- c. Use water-based lotions for rashes.
- d. Avoid unprotected sex.

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ANS: A

Clozapine therapy may produce agranulocytosis a rare but serious decrease in granulated white blood cells (WBCs); therefore, signs of infection should be immediately reported to the health care provider. In addition, the patient should have white blood cell levels measured weekly. The other options are not relevant to clozapine administration.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

20. The nurse will order a special diet for the patient taking what medication?

- a. Buspirone
- b. Haloperidol
- c. Trazodone
- d. Phenelzine

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ANS: D

Patients taking phenelzine, an MAOI, must be on a tyramine-free diet to prevent hypertensive crisis. None of the other medication require dietary restrictions.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

21. A nurse caring for a patient prescribed a selective serotonin reuptake inhibitor (SSRI) will develop outcome criteria related to what outcome?

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- a. Mood improvement
- b. Logical thought processes
- c. Reduced levels of motor activity
- d. Decreased extrapyramidal symptoms

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ANS: A

SSRIs affect mood, relieving depression in many patients. SSRIs do not act to reduce thought disorders. SSRIs reduce depression but have little effect on motor hyperactivity. SSRIs do not produce extrapyramidal symptoms.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

22. A patient's partner, who is a chemist, asks a nurse how serotonin reuptake inhibitors (SSRIs) lift depression. What response will the nurse provide? [abirb.com/test](#)
- Destroys increased amounts of neurotransmitters.
 - Makes more serotonin available at the synaptic gap.
 - Increases production of acetylcholine and dopamine.
 - Blocks muscarinic and α_1 -norepinephrine receptors.

ANS: B

Depression is thought to be related to the lowered availability of the neurotransmitter serotonin. SSRIs act by blocking the reuptake of serotonin, leaving a higher concentration available at the synaptic cleft. They actually prevent the destruction of serotonin, have no effect on acetylcholine and dopamine production, and do not block muscarinic or α_1 -norepinephrine receptors. [abirb.com/test](#)

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity [abirb.com/test](#)

23. A patient has taken many conventional antipsychotic drugs over the years. The health care provider, who is concerned about early signs of tardive dyskinesia, prescribes risperidone. A nurse planning care for this patient understands what fact about second-generation antipsychotics?
- They are less costly.
 - They have a higher potency.
 - They are more readily available.
 - They produce fewer motor side effects.

ANS: D

Second-generation antipsychotic drugs often exert their action on the limbic system rather than the basal ganglia. The limbic system is not involved in motor disturbances. Atypical antipsychotic medications are not more readily available. They are not considered to be of higher potency; rather, they have different modes of action. Second generation antipsychotic drugs tend to be more expensive. [abirb.com/test](#)

DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Physiological Integrity [abirb.com/test](#)

TOP: Nursing Process: Planning

24. The laboratory report for a patient taking clozapine indicates the patient is experiencing agranulocytosis. The nurse should implement which intervention first?
- Report the laboratory results to the health care provider.
 - Give the next dose of the medication as prescribed.
 - Administer aspirin and force fluids.
 - Repeat the laboratory tests.

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ANS: A

These laboratory values indicate the possibility of agranulocytosis, a serious side effect of clozapine therapy. These results must be immediately reported to the health care provider. The drug should be withheld because the health care provider will discontinue it. The health care provider may repeat the laboratory test, but, in the meantime, the drug should be withheld. Giving aspirin and forcing fluids are measures that are less important than stopping the administration of the drug. [abirb.com/test](#)

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

25. A nurse administering psychotropic medications should be prepared to intervene when giving a drug that blocks the attachment of norepinephrine to α_1 -receptors because the patient may experience what effect?
- a. Increased psychotic symptoms
 - b. Severe appetite disturbance
 - c. Orthostatic hypotension
 - d. Hypertensive crisis

ANS: C

Sympathetic-mediated vasoconstriction is essential for maintaining normal blood pressure in the upright position. Blockage of α_1 -receptors leads to vasodilation and orthostatic hypotension. Orthostatic hypotension may cause fainting and falls. Patients should be taught ways of minimizing this phenomenon.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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MULTIPLE RESPONSE

1. A nurse prepares to administer an antipsychotic medication to a patient diagnosed with schizophrenia. Additional monitoring of the medication's effects and side effects will be most important if the patient is also diagnosed with which health problem? (*Select all that apply.*)
- a. Parkinson disease
 - b. Graves' disease
 - c. Osteoarthritis
 - d. Epilepsy
 - e. Diabetes

ANS: A, D, E

Antipsychotic medications may produce weight gain, which complicates the care of a patient with diabetes, or lowers the seizure threshold (or both), which complicates the care of a patient with epilepsy. Parkinson disease involves changes in transmission of dopamine and acetylcholine; therefore, these drugs also complicate the care of a patient with the disorder. Osteoarthritis and Graves' disease should have no synergistic effect with this medication.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

2. The spouse of a patient diagnosed with schizophrenia asks, "Which neurotransmitters are more active when a person has schizophrenia?" The nurse's response will focus on which neurotransmitters? (*Select all that apply.*)
- a. GABA
 - b. Substance P
 - c. Histamine
 - d. Dopamine
 - e. Norepinephrine

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[abirb.com/test](#)

[abirb.com/test](#)

ANS: D, E

Dopamine plays a role in the integration of thoughts and emotions, and excess dopamine is implicated in the thought disturbances of schizophrenia. Increased activity of norepinephrine also occurs. Substance P is most related to the pain experience. Histamine decrease is associated with depression. Increased GABA is associated with anxiety reduction.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

3. An individual is experiencing problems associated with memory. Which cerebral structures are most likely to be involved in this deficit? (*Select all that apply.*)

- a. Prefrontal cortex
- b. Occipital lobe
- c. Temporal lobe
- d. Parietal lobe
- e. Basal ganglia

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ANS: A, C, D

[abirb.com/test](#)

The prefrontal cortex, parietal, and temporal lobes of the cerebrum play a key role in the storage and processing of memories. The occipital lobe is predominantly involved with vision. The basal ganglia influence the integration of physical movement, as well as some thoughts and emotions.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

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Chapter 05: Settings for Psychiatric Care

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. Planning for patients diagnosed with mental illness is facilitated by understanding that inpatient hospitalization is generally reserved for a patient presenting with what characteristic?
 - a. Presents a clear danger to self or others.
 - b. Consistently noncompliant with medications at home.
 - c. Has no reliable support systems in the local community.
 - d. Develops new symptoms during the course of an illness.

ANS: A

Hospitalization is justified when the patient is a danger to self or others, has dangerously decompensated, or needs intensive medical treatment. The incorrect options do not necessarily describe patients for whom less restrictive treatment is indicated.

DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

2. A patient is hospitalized for a reaction to a psychotropic medication and then is closely monitored for 24 hours. During a pre-discharge visit, the case manager learns the patient received a notice of eviction on the day of admission. What is the most appropriate intervention for the case manager to implement?
 - a. Cancel the patient's discharge from the hospital.
 - b. Contact the landlord who evicted the patient to discuss the situation.
 - c. Arrange a temporary place for the patient to stay until new housing can be secured.
 - d. Document that the patient's recovery will be hampered because of homelessness.

ANS: C

The case manager should intervene by arranging temporary shelter for the patient until suitable housing can be found. This is part of the coordination and delivery of services that falls under the case manager role. The other options are not viable alternatives.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation
MSC: NCLEX: Safe, Effective Care Environment

3. A multidisciplinary health care team meets 12 hours after an adolescent is hospitalized after a suicide attempt. Members of the team report their assessments. What outcome can be expected from this meeting?
 - a. A treatment plan will be formulated.
 - b. The health care provider will order neuroimaging studies.
 - c. The team will request a court-appointed advocate for the patient.
 - d. Assessment of the patient's need for placement outside the home will be undertaken.

ANS: A

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Treatment plans are formulated early in the course of treatment to streamline the treatment process and reduce costs. It is too early to determine the need for alternative post-discharge living arrangements. Neuroimaging is not indicated for this scenario.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Safe, Effective Care Environment

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4. The relapse of a patient diagnosed with schizophrenia is related to medication nonadherence. The patient is hospitalized for 5 days, medication is restarted, and the patient's thoughts are now more organized. The patient's family members are upset and say, "It's too soon for discharge. Hospitalization is needed for at least a month." The nurse should implement what intervention?
 - a. Call the psychiatrist to come explain the discharge rationale.
 - b. Explain that health insurance will not pay for a longer stay for the patient.
 - c. Notify security to handle the disturbance and escort the family off the unit.
 - d. Explain that the patient will continue to improve if medication is taken regularly.

ANS: D

Patients no longer stay in a hospital until all evidence of a symptom disappears. The nurse must assume responsibility to advocate for the patient's right to the least restrictive setting as soon as the symptoms are under control and for the right of citizens to control health care costs. The health care provider will use the same rationale. Shifting blame will not change the discharge. Calling security is unnecessary. The nurse can handle this matter.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

5. A nurse assesses an inpatient psychiatric unit, noting that exits are free from obstruction, no one is smoking, the janitor's closet is locked, and all sharp objects are being used under staff supervision. These observations relate to what nursing responsibility?
 - a. Management of milieu safety
 - b. Coordinating care of patients
 - c. Management of the interpersonal climate
 - d. Use of therapeutic intervention strategies

ANS: A

Members of the nursing staff are responsible for all aspects of milieu management. The observations mentioned in this question directly relate to the safety of the unit. The other options, although part of the nurse's concerns, are unrelated to the observations cited.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

6. The following patients are seen in the emergency department. The psychiatric unit has one bed available. The patient demonstrating which problem should the admitting officer recommend for admission to the hospital?
 - a. Experiencing dry mouth and tremor related to side effects of haloperidol
 - b. Experiencing anxiety after divorcing a spouse after 10 years of marriage
 - c. Has a self-inflicted a superficial cut on the forearm after a family argument
 - d. Has begun hearing voices encouraging her to, "Smother your infant"

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ANS: D

Admission to the hospital would be justified by the risk of patient danger to self or others. The other patients have issues that can be handled with less restrictive alternatives than hospitalization.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis abirb.com/test

MSC: NCLEX: Safe, Effective Care Environment

7. A student nurse prepares to administer oral medication to a patient diagnosed with major depressive disorder. What should the student nurse do when the patient refuses the medication?
 - a. Share with the patient, "I'll get an unsatisfactory grade if I don't give you the medication." abirb.com/test
 - b. Tell the patient, "Refusing your medication is not permitted. You are required to take it."
 - c. Attempt to discuss the patient's concerns about the medication, and report to the staff nurse. abirb.com/test
 - d. Document the patient's refusal of the medication without further comment.

ANS: C

The patient has the right to refuse medication in most cases. The patient's reason for refusing should be ascertained, and the refusal should be reported to a unit nurse. Sometimes refusals are based on unpleasant side effects that can be ameliorated. Threats and manipulation are inappropriate. Medication refusal should be reported to permit appropriate intervention.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment abirb.com/test

8. A nurse surveys the medical records for violations of patients' rights. Which finding signals a violation?
 - a. No treatment plan is present in record. abirb.com/test
 - b. Patient belongings were searched at admission.
 - c. Physical restraints were used to prevent harm to self.
 - d. Patient is placed on one-to-one continuous observation. abirb.com/test

ANS: A

The patient has the right to have a treatment plan. Inspecting a patient's belongings is a safety measure. Patients have the right to a safe environment, including the right to be protected against impulses to harm self that occur as a result of a mental disorder.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

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9. Which principle takes priority for the psychiatric inpatient staff when addressing behavioral crises?
 - a. Resolve behavioral crises using the least restrictive intervention possible.
 - b. Rights of the majority of patients supersede the rights of individual patients.
 - c. Swift intervention is justified to maintain the integrity of the therapeutic milieu.
 - d. Allow patients opportunities to regain control without intervention if the safety of other patients is not compromised. abirb.com/test

ANS: A

The rule of using the least restrictive treatment or intervention possible to achieve the desired outcome is the patient's legal right. Planned interventions are nearly always preferable. Intervention may be necessary when the patient threatens harm to self.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. To provide comprehensive care to patients, which competency is more important for a nurse who works in a community mental health center than a psychiatric nurse who works in an inpatient unit?
 - a. Problem-solving skills
 - b. Calm and caring manner
 - c. Ability to cross service systems
 - d. Knowledge of psychopharmacology

ANS: C

A community mental health nurse must be able to work with schools, corrections facilities, shelters, health care providers, and employers. The mental health nurse working in an inpatient unit needs only to be able to work within the single setting. Problem-solving skills are needed by all nurses. Nurses in both settings must have knowledge of psychopharmacology.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

11. A suspicious and socially isolated patient lives alone, eats one meal a day at a nearby shelter, and spends the remaining daily food allowance on cigarettes. Select the community psychiatric nurse's best initial action.
 - a. Report the situation to the manager of the shelter.
 - b. Tell the patient, "You must stop smoking to save money."
 - c. Assess the patient's weight; determine the foods and amounts eaten.
 - d. Seek hospitalization for the patient while a new plan is being formulated.

ANS: C

Assessment of biopsychosocial needs and general ability to live in the community is called for before any action is taken. Both nutritional status and income adequacy are critical assessment parameters. A patient may be able to maintain adequate nutrition while eating only one meal a day. Nurses assess before taking action. Hospitalization may not be necessary.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

12. A patient diagnosed with schizophrenia has been stable in the community. Today, the spouse reports the patient is expressing delusional thoughts. The patient says, "I'm willing to take my medicine, but I forgot to get my prescription refilled." Which outcome should the nurse add to the plan of care?
 - a. Nurse will obtain prescription refills every 90 days and deliver them to the patient.
 - b. Patient's spouse will mark dates for prescription refills on the family calendar.
 - c. Patient will report to the hospital for medication follow-up every week.
 - d. Patient will call the nurse weekly to discuss medication-related issues.

ANS: B

The nurse should use the patient's support system to meet patient needs whenever possible. Delivery of medication by the nurse should be unnecessary if the patient or a significant other can be responsible. The patient may not need more intensive follow-up as long as he or she continues to take the medications as prescribed. No patient issues except failure to obtain medication refills were identified.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

13. A community mental health nurse has worked for 6 months to establish a relationship with a delusional, suspicious patient. The patient recently lost employment and stopped taking medications because of inadequate money. The patient says, "Only a traitor would make me go to the hospital." Which solution is best?
- a. Arrange a bed in a local homeless shelter with nightly onsite supervision.
 - b. Negotiate a way to provide medication so the patient can remain at home.
 - c. Hospitalize the patient until the symptoms have stabilized.
 - d. Seek inpatient hospitalization for up to 1 week.

ANS: B

Hospitalization may damage the nurse–patient relationship even if it provides an opportunity for rapid stabilization. If medication can be obtained and restarted, the patient can possibly be stabilized in the home setting, even if it takes a little longer. A homeless shelter is inappropriate and unnecessary. Hospitalization may be necessary later, but a less restrictive solution should be tried first because the patient is not dangerous.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

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14. A community psychiatric nurse facilitates medication adherence for a patient by having the health care provider prescribe medications by injection every 3 weeks at the clinic. For this plan to be successful, which factor will be of critical importance?
- a. Attitude of significant others toward the patient
 - b. Nutritional services in the patient's neighborhood
 - c. Level of trust between the patient and the nurse
 - d. Availability of transportation to the clinic

ANS: D

The ability of the patient to get to the clinic is of paramount importance to the success of the plan. The depot medication relieves the patient of the necessity to take medication daily, but if he or she does not receive the injection at 3-week intervals, noncompliance will again be the issue. Attitude toward the patient, trusting relationships, and nutrition are important but not fundamental to this particular problem.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

abirb.com/test

15. Which assessment finding for a patient living in the community requires priority intervention by the nurse?
- a. Receives Social Security disability income plus a small check from a trust fund.
 - b. Lives in an apartment with two patients who attend day hospital programs.

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- c. Has a sibling who is interested and active in care planning.
- d. Purchases and uses marijuana on a frequent basis.

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ANS: D

Patients who regularly buy illegal substances often become medication noncompliant. Medication noncompliance, along with the disorganizing influence of illegal drugs on cellular brain function, promotes relapse. The remaining options do not suggest problems.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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16. A patient tells the nurse at the clinic, “I haven’t been taking my antidepressant medication as directed. I leave out the midday dose. I have lunch with friends and don’t want them to ask me about the pills.” What is the nurse’s most appropriate intervention?
- a. Investigate the possibility of once-daily dosing of the antidepressant.
 - b. Suggest to the patient to take the medication when no one is watching.
 - c. Explain how taking each dose of medication on time relates to health maintenance.
 - d. Add the following nursing diagnosis to the plan of care: ineffective therapeutic regimen management, related to lack of knowledge.

ANS: A

Investigating the possibility of once-daily dosing of the antidepressant has the highest potential for helping the patient achieve compliance. Many antidepressants can be administered by once-daily dosing, a plan that increases compliance. Explaining how taking each dose of medication on time relates to health maintenance is reasonable but would not achieve the goal; it does not address the issue of stigma. The self-conscious patient would not be comfortable doing this. A better nursing diagnosis would be related to social stigma. The question asks for an intervention, not analysis.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. A community psychiatric nurse assesses that a patient diagnosed with a mood disorder is more depressed than on the previous visit a month ago; however, the patient says, “I feel the same.” Which intervention supports the nurse’s assessment while preserving the patient’s autonomy?
- a. Arrange for a short hospitalization.
 - b. Schedule weekly clinic appointments.
 - c. Refer the patient to the crisis intervention clinic.
 - d. Call the family and ask them to observe the patient closely.

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ANS: B

Scheduling clinic appointments at shorter intervals will give the opportunity for more frequent assessment of symptoms and allow the nurse to use early intervention. If the patient does not admit to having a crisis or problem, a referral would be useless. The remaining options may produce unreliable information, violate the patient’s privacy, and waste scarce resources.

DIF: Cognitive Level: Analysis (Analyzing)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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18. A patient hurriedly tells the community mental health nurse, “Everything’s a disaster! I can’t concentrate. My disability check didn’t come. My roommate moved out, and I can’t afford the rent. My therapist is moving away. I feel like I’m coming apart.” What should be the immediate focus of nursing care?
- Assisting with the clarification of personal values
 - Helping the patient cope with feelings of abandonment
 - Assisting with the management of anxiety that may lead to psychological disequilibrium
 - Facilitating the clarification of the patient’s misperceptions of the environment

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ANS: C

Subjective and objective data suggest the patient is experiencing anxiety caused by multiple threats to security needs; therefore, interventions will focus on assisting the patient to cope with anxiety. While the patient may have feelings of abandonment, this is only one aspect of the anxiety. Data are not present to suggest the patient’s personal values are unclear or that the patient is misperceiving the environment.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

19. Which patient would a nurse refer to partial hospitalization?
- One who spent yesterday in the 24-hour supervised crisis care center and continues to be actively suicidal.
 - One who is experiencing agoraphobia and panic episodes and who would benefit from psychoeducation for relaxation therapy.
 - One who has a therapeutic lithium level and reports regularly for blood tests and clinic follow-up.
 - One who states, “I’m not sure I can avoid using alcohol when my spouse goes to work every morning.”

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ANS: D

This patient could profit from the structure and supervision provided by spending the day at the partial hospitalization program. During the evening, at night, and on weekends, the spouse could assume supervision responsibilities. The patient who is actively suicidal needs inpatient hospitalization. The patient in need of psychoeducation can be referred to home care. The patient who reports regularly for blood tests and clinical follow-up can continue on the same plan.

DIF: Cognitive Level: Analysis (Analyzing)

abirb.com/test

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

20. What is an example of a lack of parity in health care delivery today?
- Payment for psychiatric health care is not equal to that of physical health care.
 - Medicare is provided for only those 65 years of age and older.
 - There is a sufficient need for mental health care providers.
 - Most psychiatric care is provided on an outpatient basis.

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ANS: A

Financing psychiatric care has been complicated by lack of parity, or equal payment for physical as compared to psychiatric disorders. None of the other options relate to parity.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

MULTIPLE RESPONSE

1. A nurse can best address factors of critical importance to successful community treatment for persons with mental illness by including assessments related to which of the following? (Select all that apply.)
- a. Housing adequacy and stability abirb.com/test
 - b. Income adequacy and stability abirb.com/test
 - c. Family and other support systems abirb.com/test
 - d. Early psychosocial development abirb.com/test
 - e. Substance abuse history and current use abirb.com/test

ANS: A, B, C, E

Early psychosocial developmental history is less relevant to successful outcomes in the community than the assessments listed in the other options. If a patient is homeless or fears homelessness, focusing on other treatment issues is impossible. Sufficient income for basic needs and medication is necessary. Adequate support is a requisite to community placement. Substance abuse undermines medication effectiveness and interferes with community adjustment.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

2. A community member asks a nurse, "People diagnosed with mental illnesses used to go to a state hospital. Why has that changed?" Select the nurse's accurate responses. (Select all that apply.)
- a. "Science has made significant improvements in drugs for mental illness, so now many people may live in their communities." abirb.com/test
 - b. "A better selection of less restrictive settings is now available in communities to care for individuals with mental illness." abirb.com/test
 - c. "National rates of mental illness have declined significantly. The need for state institutions is actually no longer present." abirb.com/test
 - d. "Most psychiatric institutions were closed because of serious violations of patients' rights and unsafe conditions." abirb.com/test
 - e. "Federal legislation and payment for treatment of mental illness have shifted the focus to community rather than institutional settings." abirb.com/test

ANS: A, B, E

The community is a less restrictive alternative than hospitals for the treatment of people with mental illness. Funding for treatment of mental illness remains largely inadequate but now focuses on community rather than institutional care. Antipsychotic medications improve more symptoms of mental illness; hence, management of psychiatric disorders has improved. Rates of mental illness have increased, not decreased. Hospitals were closed because funding shifted to the community. Conditions in institutions have improved.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

Chapter 06: Legal and Ethical Basis for Practice

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. How does a psychiatric nurse best implement the ethical principle of autonomy?
 - a. By intervening when a self-mutilating patient attempts to harm self.
 - b. Staying with a patient who is demonstrating a high level of anxiety
 - c. Suggesting that two patients who are fighting be restricted to the unit.
 - d. Exploring alternative options with a patient, regarding medications.

ANS: D

abirb.com/test

Autonomy is the right to self-determination, that is, to make one's own decisions. When the nurse explores options with the patient, the patient is better equipped to make an informed, autonomous decision. Staying with a highly anxious patient or intervening with a self-mutilating patient demonstrates beneficence and fidelity. Suggesting that two fighting patients be restricted to the unit demonstrates the principles of fidelity and justice.

DIF: Cognitive Level: Application (Applying)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

2. Which action by a psychiatric nurse best supports a patient's right to be treated with dignity and respect?
 - a. Consistently addressing a patient by title and surname
 - b. Strongly encouraging a patient to participate in the unit milieu
 - c. Discussing a patient's condition with another health care provider in the elevator
 - d. Informing a treatment team that a patient is too drowsy to participate in care planning

ANS: A

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A simple way of showing respect is to address the patient by title and surname rather than assuming that the patient would wish to be called by his or her first name. Discussing a patient's condition with a health care provider in the elevator violates confidentiality.

Informing a treatment team that the patient is too drowsy to participate in care planning violates patient autonomy. Encouraging a patient to participate in the unit milieu exemplifies beneficence and fidelity.

DIF: Cognitive Level: Application (Applying)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

3. Two hospitalized patients resort to physical fighting when they are in the same room. During a team meeting, a nurse asserts that safety is of paramount importance and therefore the treatment plans should call for both patients to be secluded to prevent them from injuring each other. Which does this assertion indicate about the nurse who presented it?
 - a. Reveals that the nurse has a strong sense of justice.
 - b. Values the reinforcement of the autonomy of the two patients.
 - c. Has a poor understanding of the civil rights of the two patients.
 - d. Doesn't understand the actions that constitute the intentional tort of battery.

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ANS: C

Patients have a right to treatment in the least restrictive setting. Less restrictive measures should be tried first. Unnecessary seclusion may result in a charge of false imprisonment. Seclusion removes the patient's autonomy. The principle by which the nurse is motivated is beneficence, not justice. The tort represented is false imprisonment, not battery.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

4. In a team meeting, a nurse says, "I'm concerned whether we are behaving ethically by using restraint to prevent one patient from self-mutilation while the care plan for another patient who has also self-mutilated calls for one-on-one supervision." Which ethical principle most clearly applies to this situation?
- a. Beneficence
 - b. Autonomy
 - c. Fidelity
 - d. Justice

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[abirb.com/test](#)

ANS: D

The nurse is concerned about justice, that is, the fair treatment with the least restrictive methods for both patients. Beneficence means promoting the good of others. Autonomy is the right to make one's own decisions. Fidelity is the observance of loyalty and commitment to the patient.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

5. Which scenario is an example of a tort?
- a. The primary nurse completes the plan of care for a patient but takes a full 24 hours after the admission to do so.
 - b. An advanced practice nurse recommends that a patient who has a history of danger to self and others be voluntarily hospitalized when reporting audio hallucinations.
 - c. A patient's admission status is changed from involuntary to voluntary after the patient's hallucinations subside after medication is started.
 - d. A nurse gives an as-needed dose of an antipsychotic drug to a patient to prevent any possible violence because the unit is short staffed.

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[abirb.com/test](#)

ANS: D

A tort is a civil wrong against a person that violates his or her rights. Giving unnecessary medication for the convenience of staff members controls behavior in a manner similar to secluding a patient; thus, false imprisonment is a possible charge. None of the other options exemplify a tort since none violates a patient's rights.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Safe, Effective Care Environment

6. A nurse's neighbor asks, "Why aren't people with mental illness kept in state institutions anymore?" What is the nurse's best response?
- a. "Many people are still in psychiatric institutions. Inpatient care is needed because many people who are mentally ill are violent."
 - b. "Less restrictive settings are now available to care for individuals with mental

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illness.”

- c. “Our nation has fewer persons with mental illness; therefore, fewer hospital beds are needed.”
- d. “Psychiatric institutions are no longer popular as a consequence of negative stories in the press.”

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ANS: B

abirb.com/test

The community is a less restrictive alternative than hospitals for the treatment of people with mental illness. The remaining options are incorrect and part of the stigma of mental illness.

DIF: Cognitive Level: Application (Applying)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

7. Which nursing intervention demonstrates false imprisonment?

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- a. A confused and combative patient says, “I’m getting out of here and no one can stop me.” The nurse restrains this patient without a health care provider’s order and then promptly obtains an order.
- b. A patient has been irritating, seeking the attention of nurses most of the day. Now a nurse escorts the patient down the hall, saying, “Stay in your room or you’ll be put in seclusion.”
- c. An involuntarily hospitalized patient with suicidal ideation runs out of the psychiatric unit. A nurse rushes after the patient and convinces the patient to return to the unit.
- d. An involuntarily hospitalized patient with suicidal ideation attempts to leave the unit. A nurse calls the security team and uses established protocols to prevent the patient from leaving.

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abirb.com/test

ANS: B

abirb.com/test

False imprisonment involves holding a competent person against his or her will. Actual force is not a requirement of false imprisonment. The individual needs only to be placed in fear of imprisonment by someone who has the ability to carry out the threat. The patient in one distractor is not competent, and the nurse is acting beneficently. The patients in the other distractors have been admitted as involuntary patients and should not be allowed to leave without permission of the treatment team.

DIF: Cognitive Level: Application (Applying)

abirb.com/test

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

8. A patient should be considered for involuntary commitment for psychiatric care when demonstrating what behavior?

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- a. Nonadherent with the treatment regimen.
- b. Sells and distributes illegal drugs.
- c. Threatens to harm self and others.
- d. Fraudulently files for bankruptcy.

abirb.com/test

ANS: C

abirb.com/test

Involuntary commitment protects patients who are dangerous to themselves or others and cannot care for their own basic needs. Involuntary commitment also protects other individuals in society. Nonadherence to treatment is a patient right of competent patients. The behaviors described in the other options are illegal actions but are not sufficient to require involuntary hospitalization.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

9. A nurse at the mental health center prepares to administer a scheduled injection of haloperidol decanoate to a patient diagnosed with schizophrenia. As the nurse swabs the site, the patient shouts, "Stop! I don't want to take that medicine anymore. I hate the side effects." Select the nurse's best initial action.
- Stop the medication administration procedure and say to the patient, "Tell me more about the side effects you've been having."
 - Say to the patient, "Since I've already drawn the medication in the syringe, I'm required to give it, but let's talk to the doctor about skipping next month's dose."
 - Proceed with the injection but explain to the patient that other medications are available that may help reduce the unpleasant side effects.
 - Notify other staff members to report to the room for a show of force and proceed with the injection, using restraint if necessary.

ANS: A

abirb.com/test

Patients with mental illness retain their civil rights unless clear, cogent, and convincing evidence of dangerousness exists. The patient in this situation presents no evidence of being dangerous. The nurse, as an advocate and educator, should seek more information about the patient's decision and should not force the medication.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation

MSC: NCLEX: Safe, Effective Care Environment

10. Several nurses are concerned that agency policies related to restraint and seclusion are inadequate. Which statement about the relationship of substandard institutional policies and individual nursing practice should guide nursing practice?
- The policies do not absolve an individual nurse of the responsibility to practice according to the professional standards of nursing care.
 - Agency policies are the legal standard by which a professional nurse must act and therefore override other standards of care.
 - In an institution with substandard policies, the nurse has a responsibility to inform the supervisor and leave the premises.
 - Interpretation of policies by the judicial system is rendered on an individual basis and therefore cannot be predicted.

ANS: A

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Nurses are professionally bound to uphold the American Nurses Association (ANA) standards of practice, regardless of lesser standards established by a health care agency or state. Conversely, if the agency standards are higher than the ANA standards of practice, the agency standards must be upheld. The courts may seek to establish the standard of care through the use of expert witnesses when the issue is clouded.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Safe, Effective Care Environment

11. A newly admitted patient who is acutely psychotic is a private patient of the senior psychiatrist. To whom does the psychiatric nurse who is assigned to this patient owe the duty of care?

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- a. Health care provider
- b. Profession
- c. Hospital
- d. Patient

abirb.com/test

ANS: D

Although the nurse is accountable to the health care provider, the agency, the patient, and the profession, the duty of care is owed to the patient.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

12. What action by a nurse constitutes a breach of a patient's right to privacy?

- a. Asking a family to share information about a patient's prehospitalization behavior.
- b. Discussing the patient's history with other staff members during care planning.
- c. Documenting the patient's daily behaviors during hospitalization.
- d. Releasing unauthorized information to the patient's employer.

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ANS: D

The release of information without patient authorization violates the patient's right to privacy. The other options are acceptable nursing practices.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

13. An adolescent hospitalized after a violent physical outburst tells the nurse, "I'm going to kill my father, but I know you can't tell anyone." What is the nurse's best response?

- a. "You're right. Federal law requires me to keep that information private."
- b. "Those kinds of thoughts will make your hospitalization even longer."
- c. "You really should share these kinds of thoughts with your psychiatrist."
- d. "I am required to share information like this with your treatment team."

ANS: D

abirb.com/test

Breach of nurse-patient confidentiality does not pose a legal dilemma for the nurse in this circumstance because a team approach to the delivery of psychiatric care presumes communication of patient information to other staff members to develop treatment plans and outcome criteria. The patient should know that the team may have to warn the father of the risk for harm.

DIF: Cognitive Level: Application (Applying)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

14. A voluntarily hospitalized patient tells the nurse, "Get me the forms I need to sign so I can leave this place now." What is the nurse's best initial response?

- a. "I can't give you those forms without your health care provider's knowledge."
- b. "I will get them for you, but let's talk about your decision to leave treatment."
- c. "Since you signed your consent for treatment, you may leave if you desire."
- d. "I'll get the forms for you right now and bring them to your room."

ANS: B

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abirb.com/test

A patient who has been voluntarily admitted as a psychiatric inpatient has the right to demand and obtain release in most states. However, as a patient advocate, the nurse is responsible for weighing factors related to the patient's wishes and best interests. By asking for information, the nurse may be able to help the patient reconsider the decision. The statement that discharge forms cannot be given without the health care provider's knowledge is *not* true. Facilitating discharge without consent is not in the patient's best interest before exploring the reason for the request.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

15. The family of a patient whose insurance will not pay for continuing hospitalization considers transferring the patient to a public psychiatric hospital. The family expresses concern that the patient will "never get any treatment." Which reply by the nurse would be most helpful?
 - a. "Under the law, treatment must be provided. Hospitalization without treatment violates patients' rights."
 - b. "That's a justifiable concern because the right to treatment extends only to the provision of food, shelter, and safety."
 - c. "Much will depend on other patients, because the right to treatment for a psychotic patient takes precedence over the right to treatment of a patient who is stable."
 - d. "All patients in public hospitals have the right to choose both a primary therapist and a primary nurse."

ANS: A

The right to medical and psychiatric treatment was conferred on all patients hospitalized in public mental hospitals with the enactment of the federal Hospitalization of Mentally Ill Act in 1964. Stating that the concern is justifiable supports the family's erroneous belief. The provisions mentioned in the third and fourth options are not part of this or any other statute governing psychiatric care.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

16. Which individual diagnosed with a mental illness may need emergency or involuntary hospitalization for mental illness?
 - a. The patient who resumes using heroin while still taking methadone.
 - b. The patient who reports hearing angels playing harps during thunderstorms.
 - c. The patient who throws a heavy plate at a waiter at the direction of command hallucinations.
 - d. The patient who does not show up for an outpatient appointment with the mental health nurse.

ANS: C

Throwing a heavy plate is likely to harm the waiter and is evidence of being dangerous to others. This behavior meets the criteria for emergency or involuntary hospitalization for mental illness. The behaviors in the other options evidence mental illness but not dangerousness.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Safe, Effective Care Environment

17. A patient being treated in an alcohol rehabilitation unit reveals to the nurse, “I feel terrible guilt for sexually abusing my 6-year-old child before I was admitted.” Based on state and federal law, what action is the nurse expected to take?
- Anonymously report the abuse by telephone to the local child abuse hotline.
 - Replying, “I’m glad you feel comfortable talking to me about it.”
 - Respecting the nurse–patient relationship of confidentiality.
 - Filing a written report on the agency letterhead.

ANS: A

Laws regarding reporting child abuse discovered by a professional during a suspected abuser’s alcohol or drug treatment differ by state. Federal law supersedes state law and prohibits disclosure without a court order except in instances in which the report can be made anonymously or without identifying the abuser as a patient in an alcohol or drug treatment facility. Anonymously reporting the abuse by telephone to the local child abuse hotline meets federal criteria. Respecting nurse–patient confidentiality and replying “I’m glad you feel comfortable talking to me about it” do not accomplish reporting. Filing a written report on agency letterhead violates federal law.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

18. The spouse of a patient who experiences delusions asks the nurse, “Are there any circumstances under which the treatment team is justified in violating the patient’s right to confidentiality?” What is the nurse’s best response?
- “We can’t violate that confidence under any circumstances.”
 - “We can do that only at the discretion of the psychiatrist.”
 - “We are obligated to answer questions asked by law enforcement.”
 - “We are not bound if the patient threatens the life of another person.”

ANS: D

The duty to warn a person whose life has been threatened by a patient under psychiatric treatment overrides the patient’s right to confidentiality. The right to confidentiality is not suspended at the discretion of the therapist or for legal investigations.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

19. A nurse cares for an older adult patient admitted for treatment of depression. The health care provider prescribes an antidepressant medication, but the dose is more than the usual adult dose. The nurse is obligated to take what action?
- Implement the order as written but document the concern.
 - Hold the medication and then notify the health care provider.
 - Consult a drug reference if a pharmacist is not available.
 - Give the usual geriatric dosage at the scheduled times.

ANS: B

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abirb.com/test

The dose of an antidepressant medication for older adult patients is often less than the usual adult dose. The nurse should withhold the medication and consult the health care provider who wrote the order. The nurse's duty is to intervene and protect the patient. Consulting a drug reference or pharmacist is unnecessary because the nurse already knows the dose is excessive. Implementing the order is negligent. Giving the usual geriatric dose would be wrong; a nurse without prescriptive privileges cannot change the dose.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

20. A patient diagnosed with schizophrenia believes evil spirits are being summoned by a local minister and verbally threatens to bomb a local church. What principle governs the proper action in this situation?
- a. Need for authorization
 - b. Duty to warn and protect
 - c. Patient right to confidentiality
 - d. Patient's right to self-actualization

[abirb.com/test](#)

ANS: B

The duty of a health care professional is to warn or notify an intended victim after a threat of harm has been made. Informing a potential victim of a threat is a legal responsibility of the health care professional and *not* considered a violation of confidentiality. None of the other options is applicable to this situation.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

21. After leaving work, a staff nurse realizes that documentation of the administration of a medication to a patient was omitted. This off-duty nurse telephones the unit and tells the nurse, "Please document the administration of the medication I forgot to do. My password is alpha1." What action should the on-duty nurse take?
- a. Suggest the nurse return and document.
 - b. Refer the matter to the charge nurse to resolve.
 - c. Access the record and document the information.
 - d. Report the request to the patient's health care provider.

[abirb.com/test](#)

ANS: B

At most hospitals, termination is a possible penalty for unauthorized entry into a patient record. Referring the matter to the charge nurse will allow the observance of hospital policy while ensuring that documentation occurs. Making an exception and fulfilling the request places the on-duty staff nurse in jeopardy. Reporting the request to the patient's health care provider would be unnecessary. Accessing the record and documenting the information would be unnecessary when the charge nurse can resolve the problem.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

22. A patient diagnosed with mental illness asks a psychiatric technician, "What's the matter with me?" The technician replies, "Your wing nuts need tightening." The nurse who overheard the exchange should take action based on what principle?
- a. Violation of the patient's right to be treated with dignity and respect

[abirb.com/test](#)

- b. The nurse's obligation to report caregiver negligence
- c. Preventing defamation of the patient's character
- d. Supervisory liability

abirb.com/test

ANS: A

Patients have the right to be treated with dignity and respect. Patients should never be made the butt of jokes about their illness. Patient emotional abuse has been demonstrated, not negligence. The technician's response was not clearly defamation. Patient abuse, not supervisory liability, is the issue.

DIF: Cognitive Level: Comprehension (Understanding)

abirb.com/test

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

23. Which documentation of a patient's behavior best demonstrates a nurse's observations?
- a. Isolates self from others. Frequently fell asleep during group. Vital signs stable.
 - b. Calmer and more cooperative. Participated actively in group. No evidence of psychotic thinking.
 - c. Appeared to hallucinate. Patient frequently increased volume on television, causing conflict with others
 - d. Wears four layers of clothing. States, "I need protection from dangerous bacteria trying to penetrate my skin."

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ANS: D

The documentation states specific observations of the patient's appearance and the exact statements made. The other options are vague or subjective statements and can be interpreted in different ways.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse volunteers for a committee that must revise the hospital policies and procedures for suicide precautions. Which resources would provide the best guidance? (Select all that apply.)
- a. *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition) (*DSM-5*)
 - b. State's nurse practice act
 - c. State and federal regulations that govern hospitals
 - d. Summary of common practices of several local hospitals
 - e. *American Nurses Association Scope and Standards of Practice* st

ANS: C, E

Regulations regarding hospitals provide information about the minimal standard. The American Nurses Association (ANA) national standards focus on elevating practice by setting high standards for nursing practice. The *DSM-5* and the state's nurse practice act would not provide relevant information. A summary of common practices of several local hospitals cannot be guaranteed to be helpful because the customs may or may not comply with laws or best practices.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

abirb.com/test

2. In which situations does a nurse have a duty to intervene and report? (Select all that apply.)
- A peer is unable to write behavioral outcomes.
 - A health care provider consults the *Physicians' Desk Reference*.^{abirb.com/test}
 - A peer tries to provide patient care in an alcohol-impaired state.
 - A team member has violated the boundaries of a vulnerable patient.
 - A patient refuses a medication prescribed by a licensed health care provider.^{abirb.com/test}

ANS: C, D

Both instances jeopardize patient safety. The nurse must practice within the Code of Ethics for Nurses. A peer being unable to write behavioral outcomes is a concern but can be informally resolved. A health care provider consulting the *Physicians' Desk Reference* is acceptable practice.^{abirb.com/test}

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Safe, Effective Care Environment

3. Which situations qualify as abandonment on the part of a nurse? (Select all that apply.)
- The nurse allows a patient with acute mania to refuse hospitalization without taking further action.^{abirb.com/test}
 - The nurse terminates employment without referring a seriously mentally ill patient for aftercare.
 - The nurse calls police to bring a suicidal patient to the hospital after a suicide attempt.^{abirb.com/test}
 - The nurse refers a patient with persistent paranoid schizophrenia to community treatment.^{abirb.com/test}
 - The nurse asks another nurse to provide a patient's care because of concerns about countertransference.^{abirb.com/test}

ANS: A, B

Abandonment arises when a nurse does not place a patient safely in the hands of another health professional before discontinuing treatment. Calling the police to bring a suicidal patient to the hospital after a suicide attempt and referring a patient with schizophrenia to community treatment both provide for patient safety. Asking another nurse to provide a patient's care because of concerns about countertransference demonstrates self-awareness.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Safe, Effective Care Environment

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abirb.com/test

MULTIPLE CHOICE

1. A new staff nurse completes orientation to the psychiatric unit. This nurse will expect to ask an advanced practice nurse to perform which action for patients?
 - a. Perform mental health assessment interviews.
 - b. Establish therapeutic relationships.
 - c. Prescribe psychotropic medication.
 - d. Individualize nursing care plans.

ANS: C

Prescriptive privileges are granted to Master's-prepared nurse practitioners who have taken special courses on prescribing medications. The nurse prepared at the basic level performs mental health assessments, establishes relationships, and provides individualized care planning.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

2. A newly admitted patient diagnosed with major depressive disorder has lost 20 pounds over the past month and has admitted having suicidal ideations. The patient has taken an antidepressant medication for 1 week without remission of symptoms. Select the priority nursing diagnosis.
 - a. Imbalanced nutrition: Less than body requirements
 - b. Chronic low self-esteem
 - c. Risk for suicide
 - d. Hopelessness

ANS: C

Risk for suicide is the priority diagnosis when the patient has both suicidal ideation and a plan to carry out the suicidal intent. Imbalanced nutrition, hopelessness, and chronic low self-esteem may be applicable nursing diagnoses, but these problems do not affect patient safety as urgently as a suicide attempt.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

3. A patient diagnosed with major depressive disorder has lost 20 pounds in 1 month. The patient has chronic low self-esteem and a plan for suicide. The patient has taken an antidepressant medication for 1 week. Which nursing intervention is most directly related to this priority: "Patient will refrain from gestures and attempts to harm self"?
 - a. Implement suicide prevention interventions.
 - b. Frequently offer high-calorie snacks and fluids.
 - c. Assist the patient to identify three personal strengths.
 - d. Observe patient for therapeutic effects of antidepressant medication.

ANS: A

Implementing suicide precautions is the only option related to patient safety. The other options, related to nutrition, self-esteem, and medication therapy, are important but are not priorities.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

[abirb.com/test](#)

4. A patient's nursing diagnosis is Insomnia. The desired outcome is: "Patient will sleep for a minimum of 5 hours nightly by October 31." On November 1, a review of the sleep data shows the patient sleeps an average of 4 hours nightly and takes a 2-hour afternoon nap. Which evaluation should be documented?
- a. Consistently demonstrated
 - b. Often demonstrated
 - c. Sometimes demonstrated
 - d. Never demonstrated

ANS: D

[abirb.com/test](#)

Although the patient is sleeping 6 hours daily, the total is not in one uninterrupted session at night. Therefore, the outcome must be evaluated as never demonstrated.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

TOP: Nursing Process: Evaluation

5. A patient's nursing diagnosis is Insomnia. The desired outcome is: "Patient will sleep for a minimum of 5 hours nightly by October 31." On November 1, a review of the sleep data shows the patient sleeps an average of 4 hours nightly and takes a 2-hour afternoon nap. What is the nurse's next action?
- a. Continue the current plan without changes.
 - b. Remove this nursing diagnosis from the plan of care.
 - c. Write a new nursing diagnosis that better reflects the problem.
 - d. Revise the outcome target date and interventions.

ANS: D

Sleeping a total of 5 hours at night remains a reasonable outcome. The plan of care may be revised on the basis of the evaluation. Extending the time frame for attaining the outcome is appropriate. Examining interventions might result in planning an activity during the afternoon rather than permitting a nap. Continuing the current plan without changes is inappropriate. At the very least, the time in which the outcome is to be attained must be extended. Removing this nursing diagnosis from the plan of care could be used when the outcome goal has been met and the problem resolved. Writing a new nursing diagnosis is inappropriate because no other nursing diagnosis relates to the problem.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Evaluation

6. A patient begins a new program to assist with building social skills. In which part of the plan of care should a nurse record the item "Encourage patient to attend one psychoeducational group daily"?
- a. Assessment
 - b. Analysis

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- c. Planning
- d. Implementation
- e. Evaluation

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ANS: D

Interventions (implementation) are the nursing prescriptions to achieve the outcomes. None of the other options focus on this aspect of nursing care.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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7. Before assessing a new patient, a nurse is told by another health care worker, "I know that patient. No matter how hard we work, there isn't much improvement by the time of discharge." What action will the nurse take to provide appropriate care for this patient?
 - a. Document the other worker's assessment of the patient.
 - b. Assess the patient based on data collected from all sources.
 - c. Validate the worker's impression by contacting the patient's significant other.
 - d. Discuss the worker's impression with the patient during the assessment interview.

ANS: B

Assessment should include data obtained from both the primary and reliable secondary sources. Biased assessments by others should be evaluated as objectively as possible by the nurse, keeping in mind the possible effects of countertransference. None of the remaining options effectively form the basis for appropriate nursing care.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

8. A nurse works with a patient to establish outcomes. The nurse believes that one outcome suggested by the patient is not in the patient's best interest. What is the nurse's best action?
 - a. Remain silent.
 - b. Educate the patient that the outcome is not realistic.
 - c. Explore with the patient possible consequences of the outcome.
 - d. Formulate a more appropriate outcome without the patient's input.

ANS: C

The nurse should not impose outcomes on the patient; however, the nurse has a responsibility to help the patient evaluate what is in his or her best interest. Exploring possible consequences is an acceptable approach.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

9. A patient states, "I'm not worth anything. I have negative thoughts about myself. I feel anxious and shaky all the time. Sometimes I feel so sad that I want to go to sleep and never wake up." Which nursing intervention should have the highest priority?
 - a. Self-esteem-building activities
 - b. Anxiety self-control measures
 - c. Sleep enhancement activities
 - d. Suicide prevention

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ANS: D

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The nurse should place priority on monitoring and reinforcing suicide self-restraint because it relates directly and immediately to patient safety. Patient safety is always a priority concern. The nurse should monitor and reinforce all patient attempts to control anxiety, improve sleep patterns, and develop self-esteem while giving priority attention to suicide self-restraint.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning
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10. Select the best outcome for a patient with this nursing diagnosis: impaired social interaction, related to sociocultural dissonance as evidenced by stating, "Although I'd like to, I don't join in because I don't speak the language very well." What should the focus of an appropriate outcome be?
- Demonstrating improved social skills
 - Expressing a desire to interact with others
 - Becoming more independent in decision making
 - Selecting and participating in one group activity per day

ANS: D

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The outcome describes social involvement on the part of the patient. Neither cooperation nor independence has been an issue. The patient has already expressed a desire to interact with others. Outcomes must be measurable. Two of the distractors are not measurable.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

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11. Nursing behaviors associated with the implementation phase of the nursing process are concerned with the responsibilities of the psychiatric mental health nurse?
- Participating in the mutual identification of patient outcomes
 - Gathering accurate and sufficient patient-centered data
 - Comparing patient responses and expected outcomes
 - Carrying out interventions and coordinating care

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ANS: D

Nursing behaviors relating to implementation include using available resources, performing interventions, finding alternatives when necessary, and coordinating care with other team members.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

12. Which statement made by a patient during an initial assessment interview should serve as the priority focus for the plan of care?
- "I can always trust my family."
 - "It seems like I always have bad luck."
 - "You never know who will turn against you."
 - "I hear evil voices that tell me to do bad things."

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ANS: D

The statement regarding evil voices tells the nurse that the patient is experiencing auditory hallucinations. The other statements are vague and do not clearly identify the patient's chief symptom.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

13. Which entry in the medical record best meets the requirement for problem-oriented charting?
- "A: Pacing and muttering to self. P: Sensory perceptual alteration, related to internal auditory stimulation. I: Given fluphenazine 2.5 mg at 0900 and went to room to lie down. E: Calmer by 0930. Returned to lounge to watch TV."
 - "S: States, 'I feel like I'm ready to blow up.' O: Pacing hall, mumbling to self. A: Auditory hallucinations. P: Offer haloperidol 2 mg. I: haloperidol 2 mg at 0900. E: Returned to lounge at 0930 and quietly watched TV."
 - "Agitated behavior. D: Patient muttering to self as though answering an unseen person. A: Given haloperidol 2 mg and went to room to lie down. E: Patient calmer. Returned to lounge to watch TV."
 - "Pacing hall and muttering to self as though answering an unseen person. haloperidol 2 mg administered at 0900 with calming effect in 30 minutes. Stated, 'I'm no longer bothered by the voices.'"

ANS: B

Problem-oriented documentation uses the first letter of key words to organize data: S for subjective data, O for objective data, A for assessment, P for plan, I for intervention, and E for evaluation. The distractors offer examples of PIE charting, focus documentation, and narrative documentation.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

14. A nurse assesses an older adult patient brought to the emergency department by a family member. The patient was wandering outside, saying, "I can't find my way home." The patient is confused and unable to answer questions. What is the nurse's best action to provide effective nursing care?
- Document the patient's mental status. Obtain other assessment data from the family member.
 - Record the patient's answers to questions on the nursing assessment form.
 - Ask an advanced practice nurse to perform the assessment interview.
 - Call for a mental health advocate to maintain the patient's rights.

ANS: A

When the patient (primary source) is unable to provide information, secondary sources should be used, in this case the family member. Later, more data may be obtained from other relatives or neighbors who are familiar with the patient. An advanced practice nurse is not needed for this assessment; it is within the scope of practice of the staff nurse. Calling a mental health advocate is unnecessary.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

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15. A nurse asks a patient, "If you had fever and vomiting for 3 days, what would you do?" Which aspect of the mental status examination is the nurse assessing?
- Behavior
 - Cognition

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- c. Affect and mood
- d. Perceptual disturbances

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ANS: B

Assessing cognition involves determining a patient's judgment and decision-making capabilities. In this case, the nurse expects a response of "Call my doctor" if the patient's cognition and judgment are intact. If the patient responds, "I would stop eating," or "I would just wait and see what happened," the nurse would conclude that judgment is impaired. The other options refer to other aspects of the examination.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

16. An adolescent asks a nurse conducting an assessment interview, "Why should I tell you anything? You'll just tell my parents whatever you find out." What is the nurse's best reply regarding patient confidentiality?
- a. "That is not true. What you tell us is private and held in strict confidence. Your parents have no right to know."
 - b. "Yes, your parents may find out what you say, but it is important that they know about your problems."
 - c. "What you say about feelings is private, but some things, like suicidal thinking, must be reported to the treatment team."
 - d. "It sounds as though you are not really ready to work on your problems and make changes."

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ANS: C

The patient has a right to know that most information will be held in confidence but that certain material must be reported or shared with the treatment team, such as threats of suicide, homicide, use of illegal drugs, or issues of abuse. The first response is not strictly true. The second response will not inspire the confidence of the patient. The fourth response is confrontational.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

17. A nurse assessing a new patient asks, "What is meant by the saying, 'You can't judge a book by looking at the cover'?" Which aspect of cognition is the nurse assessing?
- a. Mood
 - b. Attention
 - c. Orientation
 - d. Abstraction

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ANS: D

Patient interpretation of proverbial statements gives assessment information regarding the patient's ability to abstract, which is an aspect of cognition. Mood, orientation, and attention span are assessed in other ways.

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DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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18. When a nurse assesses an older adult patient, the patient's answers seem vague or unrelated to the questions. The patient also leans forward and frowns, listening intently to the nurse. What would be an appropriate question for the nurse to ask in this situation?
- "Are you having difficulty hearing when I speak?"
 - "How can I make this assessment interview easier for you?"
 - "I notice you are frowning. Are you feeling annoyed with me?"
 - "You're having trouble focusing on what I'm saying. What is distracting you?"

ANS: A

The patient's behaviors may indicate difficulty hearing. Identifying any physical need, the patient may have at the onset of the interview and making accommodations are important considerations. By asking if the patient is annoyed, the nurse is jumping to conclusions. Asking how to make the interview easier for the patient may not elicit a concrete answer. Asking about distractions is a way of asking about auditory hallucinations, which is not appropriate because the nurse has observed that the patient seems to be listening intently.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

19. At one point in an assessment interview a nurse asks, "Does your faith help you in stressful situations?" This question would be asked during the assessment of what focus?
- Culture
 - Religious affiliation
 - Educational background
 - Coping strategies

ANS: D

When discussing coping strategies, the nurse might ask what the patient does when upset, what usually relieves stress, and to whom the patient goes to talk about problems. The question regarding whether the patient's faith helps deal with stress fits well here. It would seem out of place if introduced during exploration of the other topics.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

20. When a new patient is hospitalized, a nurse takes the patient on a unit tour, explains the rules of the unit, and discusses the daily schedule. The nurse is engaged in what aspect of care?
- Counseling
 - Health teaching
 - Milieu management
 - Psychobiological intervention

ANS: C

Milieu management provides a therapeutic environment in which the patient can feel comfortable and safe while engaging in activities that meet the patient's physical and mental health needs. Counseling refers to activities designed to promote problem solving and enhanced coping and includes interviewing, crisis intervention, stress management, and conflict resolution. Health teaching involves identifying health educational needs and giving information about these needs. Psychobiological interventions involve medication administration and monitoring response to medications.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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21. After formulating the nursing diagnoses for a new patient, what is the next action a nurse should take?
- Design interventions to include in the plan of care.
 - Determine the goals and outcome criteria.
 - Implement the nursing plan of care.
 - Complete the spiritual assessment.

ANS: B

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The third step of the nursing process is planning and outcome identification. Outcomes cannot be determined until the nursing assessment is complete and the nursing diagnoses have been formulated.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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22. Select the most appropriate label to complete this nursing diagnosis: _____, related to feelings of shyness and poorly developed social skills as evidenced by watching television alone at home every evening.
- Deficient knowledge
 - Ineffective coping
 - Powerlessness
 - Social isolation

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ANS: D

Nursing diagnoses are selected on the basis of the etiological factors and assessment findings or evidence. In this instance, the evidence shows social isolation that is caused by shyness and poorly developed social skills.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

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MSC: NCLEX: Psychosocial Integrity

23. What does the Q and S relate to in the acronym QSEN?
- Qualitative Standardization
 - Quality and Safety
 - Quantitative Statements
 - Quick Standards

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ANS: B

QSEN represents national initiatives centered on patient safety and quality. The primary goal of QSEN is to prepare future nurses with the knowledge, skills, and attitudes to increase the quality, care, and safety in the health care setting in which they work.

DIF: Cognitive Level: Knowledge (Remembering)

TOP: Nursing Process: N/A

MSC: NCLEX: Safe, Effective Care Environment

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24. A nurse documents: "Patient is mute, despite repeated efforts to elicit speech. Makes no eye contact. Is inattentive to staff. Gazes off to the side or looks upward rather than at the speaker." Which nursing diagnosis should be considered?

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- a. Defensive coping
- b. Decisional conflict
- c. Risk for other-directed violence
- d. Impaired verbal communication

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ANS: D

The defining characteristics are more related to the nursing diagnosis of impaired verbal communication than to the other nursing diagnoses.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis abirb.com/test

MSC: NCLEX: Psychosocial Integrity

25. Which action by the nurse is **best** associated with the demonstration of empathy?

- a. Observing the patient's physical behavior and nonverbal communications
- b. Encouraging the patient time to express their concerns and physical needs
- c. Providing a therapeutic milieu where the patient is provided safety
- d. Encouraging the patient to communicate with their support system

ANS: A

Particularly, in the area of psychiatric nursing, observation is not only important for clinical diagnosis, but it is also a first step in being empathetic. To be able to empathize, one must be able to recognize emotions, which inherently requires the skill of observation. While the other options are appropriate, none are as directly associated with the developing empathy with a patient.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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MULTIPLE RESPONSE

1. A nurse assesses a patient who reluctantly participates in activities, answers questions with minimal responses, and rarely makes eye contact. What information should be included when documenting the assessment? (*Select all that apply.*)
 - a. Uncooperative patient
 - b. Patient's subjective responses
 - c. Only data obtained from the patient's verbal responses
 - d. Description of the patient's behavior during the interview
 - e. Analysis of why the patient is unresponsive during the interview

ANS: B, D

Both the content and process of the interview should be documented. Providing only the patient's verbal responses creates a skewed picture of the patient. Writing that the patient is uncooperative is subjectively worded. An objective description of patient behavior is preferable. Analysis of the reasons for the patient's behavior is speculation, which is inappropriate.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

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2. Why is it important for a nurse to possess an appropriate degree of assertiveness? (*Select all that apply.*)
- a. Reduces interpersonal stress. abirb.com/test
 - b. Builds effective team relationships. abirb.com/test
 - c. Supports development of technical nursing skills. abirb.com/test
 - d. Reduces potential for the increased risk of client injury. abirb.com/test
 - e. Supports the delivery of effective, appropriate nursing care. abirb.com/test

ANS: A, B, D, E

Assertiveness is one of the most important skills for nurses in the workplace to reduce their interpersonal stress, build effective team relationships and to provide sufficient nursing care. A nurse's ability to be assertive is key not only to preventing medical errors but also to reducing patients' risk and improving nursing care as nurses are able to observe and act on early signs of unsafe conditions in the provision of care. Assertiveness is not related directly to the development of technical nursing skills.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

3. What information is conveyed by nursing diagnoses? (*Select all that apply.*)
- a. Medical judgments about the disorder abirb.com/test
 - b. Goals and outcomes for the plan of care abirb.com/test
 - c. Unmet patient needs currently present abirb.com/test
 - d. Supporting data that validate the diagnoses abirb.com/test
 - e. Probable causes that will be targets for nursing interventions abirb.com/test

ANS: C, D, E

Nursing diagnoses focus on phenomena of concern to nurses rather than on medical diagnoses. Goals and outcomes are part of the planning phase.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis abirb.com/test

MSC: NCLEX: Safe, Effective Care Environment

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MULTIPLE CHOICE

1. A patient says to the nurse, "I dreamed I was stoned. When I woke up, I felt emotionally drained, as though I hadn't rested well." Which comment would be appropriate if the nurse seeks clarification?
 - a. "It sounds as though you were uncomfortable with the content of your dream."
 - b. "I understand what you're saying. Bad dreams leave me feeling tired, too."
 - c. "So, all in all, you feel as though you had a rather poor night's sleep?"
 - d. "Can you give me an example of what you mean by 'stoned'?"

ANS: D

The technique of clarification is therapeutic and helps the nurse examine the meaning of the patient's statement. Asking for a definition of "stoned" directly asks for clarification.

Restating that the patient is uncomfortable with the dream's content is parroting, a nontherapeutic technique. The other responses fail to clarify the meaning of the patient's comment.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A patient diagnosed with schizophrenia tells the nurse, "The CIA is monitoring us through the fluorescent lights in this room. Be careful what you say." Which response by the nurse would be most therapeutic?
 - a. "Let's talk about something other than the CIA."
 - b. "It sounds like you're concerned about your privacy."
 - c. "The CIA is prohibited from operating in health care facilities."
 - d. "You have lost touch with reality, which is a symptom of your illness."

ANS: B

It is important not to challenge the patient's beliefs, even if they are unrealistic. Challenging undermines the patient's trust in the nurse. The nurse should try to understand the underlying feelings or thoughts the patient's message conveys. The correct response uses the therapeutic technique of reflection. The other comments are nontherapeutic. Asking to talk about something other than the concern at hand is changing the subject. Saying that the CIA is prohibited from operating in health care facilities gives false reassurance. Stating that the patient has lost touch with reality is truthful but uncompassionate.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

3. The patient says, "My marriage is just great. My spouse and I usually agree on everything." The nurse observes the patient's foot moving continuously as the patient twirls a shirt button. What type of communication is the patient presenting?
 - a. Clear
 - b. Mixed
 - c. Precise

- d. Inadequate

ANS: B

Mixed messages involve the transmission of conflicting or incongruent messages by the speaker. The patient's verbal message that all is well in the relationship is modified by the nonverbal behaviors denoting anxiety. Data are not present to support the choice of the verbal message being clear, explicit, or inadequate.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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4. A nurse interacts with a newly hospitalized patient. Which nursing statement reflects the communication technique of "offering self"?
- "I've also had traumatic life experiences. Maybe it would help if I told you about them."
 - "Why do you think you had so much difficulty adjusting to this change in your life?"
 - "I hope you will feel better after getting accustomed to how this unit operates."
 - "I'd like to sit with you for a while to help you get comfortable talking to me."

ANS: D

"Offering self" is a technique that should be used in the orientation phase of the nurse-patient relationship. Sitting with the patient, an example of "offering self," helps build trust and conveys that the nurse cares about the patient. Two incorrect responses are ineffective and nontherapeutic. The other incorrect response is therapeutic but an example of "offering hope."

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

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5. Which technique will best communicate to a patient that the nurse is interested in listening?
- Restate a feeling or thought the patient has expressed.
 - Ask a direct question, such as, "Did you feel angry?"
 - Make a judgment about the patient's problem.
 - Say, "I understand what you're saying."

ANS: A

Restating allows the patient to validate the nurse's understanding of what has been communicated. Restating is an active listening technique. Judgments should be suspended in a nurse-patient relationship. Closed-ended questions such as "Did you feel angry?" ask for specific information rather than show understanding. When the nurse simply states that he or she understands the patient's words, the patient has no way of measuring the understanding.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

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6. A patient discloses several concerns and associated feelings. If the nurse wants to seek clarification, which comment would be appropriate?
- "What are the common elements here?"
 - "Tell me again about your experiences."
 - "Am I correct in understanding that...?"
 - "Tell me everything from the beginning."

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ANS: C

Asking, “Am I correct in understanding that...?” permits clarification to ensure that both the nurse and patient share mutual understanding of the communication. Asking about common elements encourages comparison rather than clarification. The remaining responses are implied questions that suggest the nurse was not listening.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

7. A patient tells the nurse, “I don’t think I will ever get out of here.” Select the nurse’s most therapeutic response.

a. “Don’t talk that way. Of course, you will leave here.”

b. “Keep up the good work and you certainly will.”

c. “You don’t think you’re making progress?”

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d. “Everyone feels that way sometimes.”

ANS: C

By asking if the patient does not believe that progress has been made, the nurse is reflecting by putting into words what the patient is hinting. By making communication more explicit, issues are easier to identify and resolve. The remaining options are nontherapeutic techniques. Telling the patient not to “talk that way” is disapproving. Saying that everyone feels that way at times minimizes feelings. Telling the patient that good work will always result in success is falsely reassuring.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

8. Documentation in a patient’s chart shows, “Throughout a 5-minute interaction, patient fidgeted and tapped left foot, periodically covered face with hands, and looked under chair while stating, ‘I enjoy spending time with you.’” Which analysis is most accurate?
- a. Patient is giving positive feedback about the nurse’s communication techniques.
- b. Nurse is viewing the patient’s behavior through a cultural filter.
- c. Patient’s verbal and nonverbal messages are incongruent.
- d. Patient is demonstrating psychotic behaviors.

ANS: C

When a verbal message is not reinforced with nonverbal behavior, the message is confusing and incongruent. Some clinicians call it a “mixed message.” It is inaccurate to say that the patient is giving positive feedback about the nurse’s communication techniques. The concept of a cultural filter is not relevant to the situation; a cultural filter determines what a person will pay attention to and what he or she will ignore. Data are insufficient to draw the conclusion that the patient is demonstrating psychotic behaviors.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

9. While talking with a patient diagnosed with major depressive disorder, a nurse notices the patient is unable to maintain eye contact. The patient’s chin lowers to the chest while the patient looks at the floor. Which aspect of communication has the nurse assessed?
- a. Nonverbal communication
- abirb.com/test
- b. A message filter

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- c. A cultural barrier
- d. Social skills

ANS: A

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Eye contact and body movements are considered nonverbal communication. Insufficient data are available to determine the level of the patient's social skills or whether a cultural barrier exists.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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10. During the first interview with a parent whose child died in a car accident, the nurse feels empathic and reaches out to take the patient's hand. Select the correct analysis of the nurse's behavior.
- a. It shows empathy and compassion. It will encourage the patient to continue to express feelings.
 - b. The gesture is premature. The patient's cultural and individual interpretation of touch is unknown.
 - c. The patient will perceive the gesture as intrusive and overstepping boundaries.
 - d. The action is inappropriate. Patients in a psychiatric setting should not be touched.

ANS: B

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Touch has various cultural and individual interpretations. Nurses should refrain from using touch until an assessment can be made regarding the way in which the patient will perceive touch. The other options present prematurely drawn conclusions.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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11. A school-age child tells the school nurse, "Other kids call me mean names and will not sit with me at lunch. Nobody likes me." Select the nurse's most therapeutic response.
- a. "Just ignore them and they will leave you alone."
 - b. "You should make friends with other children."
 - c. "Call them names if they do that to you."
 - d. "Tell me more about how you feel."

ANS: D

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The correct response uses exploring, a therapeutic technique. The distractors give advice, a nontherapeutic technique.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

12. An African-American patient says to a Caucasian nurse, "There's no sense talking. You wouldn't understand because you live in a white world." What would be the nurse's best action?
- a. Explain, "Yes, I do understand. Everyone goes through the same experiences."
 - b. Say, "Please give an example of something you think I wouldn't understand."
 - c. Reassure the patient that nurses interact with people from all cultures.
 - d. Change the subject to one that is less emotionally disturbing.

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ANS: B

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Having the patient speak in specifics rather than globally helps the nurse understand the patient's perspective. This approach helps the nurse engage the patient.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

13. A Filipino-American patient avoided eye contact when interacting with the nurse. The nurse concluded that the patient had low self-esteem. Interventions were used to raise the patient's self-esteem; however, after 3 weeks, the patient's eye contact did not improve. What is the most accurate analysis of this scenario?

- a. The patient's eye contact should have been directly addressed by role-playing to increase comfort with eye contact.
- b. The nurse should not have independently embarked on treatment planning for this patient.
- c. The patient's poor eye contact is indicative of anger and hostility that remain unaddressed.
- d. The nurse should have assessed the patient's culture before concluding the patient had low self-esteem.

ANS: D

The amount of eye contact in which a person engages is often culturally determined. In some cultures, eye contact is considered insolent, whereas in other cultures, eye contact is expected. Asian Americans, including persons from the Philippines, often prefer not to engage in direct eye contact.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

14. When a female Mexican-American patient and a female nurse sit together, the patient often holds the nurse's hand. The patient also links arms with the nurse when they walk. The nurse is uncomfortable with this behavior and thinks the patient is misunderstanding the nurse-patient relationship. Which alternative is a more accurate assessment?
- a. The patient is accustomed to touch during conversations, as are members of many Hispanic subcultures.
 - b. The patient understands that touch makes the nurse uncomfortable and controls the relationship based on that factor.
 - c. The patient is afraid of being alone. When touching the nurse, the patient is reassured and comforted.
 - d. The nurse is quick to make assumptions.

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ANS: A

The most likely answer is that the patient's behavior is culturally influenced. Hispanic women frequently touch women they consider to be their friends. Although the other options are possible, they are less likely.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

15. A Puerto Rican-American patient uses dramatic body language when describing emotional discomfort. Which analysis most likely explains the patient's behavior?
- a. A histrionic personality disorder is likely.

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- b. A belief that dramatic body language is sexually appealing.
- c. Wishes to impress staff with the degree of emotional pain.
- d. Belongs to a culture in which dramatic body language is the norm.

ANS: D

Members of Hispanic-American subcultures tend to use high affect and dramatic body language as they communicate. The other options are more remote possibilities.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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16. During an interview, a patient attempts to shift the focus from self to the nurse by asking personal questions. How should the nurse respond?
- a. "You've turned the tables on me."
 - b. "Nurses direct the interviews with patients."
 - c. "Do not ask questions about my personal life."
 - d. "The time we spend together is to discuss your concerns."

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ANS: D

When a patient tries to focus on the nurse, the nurse should refocus the discussion back onto the patient. Telling the patient that interview time should be used to discuss patient concerns refocuses discussion in a neutral way. Telling patients not to ask about the nurse's personal life shows indignation. Saying that nurses prefer to direct the interview reflects superiority. Saying "You've turned the tables on me" states the fact but does not refocus the interview.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

17. Which principle should guide the nurse in determining the extent of silence to use during patient interview sessions?
- a. Nurses are responsible for breaking silences.
 - b. Patients withdraw if silences are prolonged.
 - c. Silence can provide meaningful moments for reflection.
 - d. Silence helps patients know that what they said is understood.

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ANS: C

Silence can be helpful to both participants by giving each an opportunity to contemplate what has transpired, weigh alternatives, and formulate ideas. A nurse breaking silences is not a principle related to silences. Saying that patients withdraw during long silences or that silence helps patients know that they are understood are both inaccurate statements. Feedback helps patients know they have been understood.

DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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18. A patient is having difficulty making a decision. The nurse has mixed feelings about whether to provide advice. Which principle usually applies about giving advice?
- a. It is rarely helpful.
 - b. It fosters independence.
 - c. It lifts the burden of personal decision making.
 - d. It helps the patient develop feelings of personal adequacy.

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ANS: A

Giving advice fosters dependence on the nurse and interferes with the patient's right to make personal decisions. Giving advice also robs patients of the opportunity to weigh alternatives and to develop problem-solving skills. Furthermore, it contributes to patient feelings of personal inadequacy. It also keeps the nurse in control and feeling powerful.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

19. The relationship between a nurse and patient as it relates to status and power is best described by which term?
- a. Symmetric
 - b. Complementary
 - c. Incongruent
 - d. Paralinguistic

ANS: B

When a difference in power exists, as between student and teacher or nurse and patient, the relationship is said to be *complementary*. Symmetrical relationships exist between individuals of like or equal status. *Incongruent* and *paralinguistic* are not terms used to describe relationships.

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DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

20. A patient with severe depression states, "God is punishing me for my past sins." What is the nurse's best response?
- a. "Why do you think that?"
 - b. "You sound very upset about this."
 - c. "You believe God is punishing you for your sins?"
 - d. "If you feel this way, you should talk to a member of your clergy."

ANS: B

The nurse reflects on the patient's comment, a therapeutic technique to encourage sharing for perceptions and feelings. The incorrect responses reflect probing, closed-ended comments, and giving advice, all of which are nontherapeutic.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. A patient cries as the nurse explores the patient's relationship with a deceased parent. The patient says, "I shouldn't be crying like this. It happened a long time ago." Which responses by the nurse will facilitate communication? (*Select all that apply.*)
- a. "Why do you think you are so upset?"
 - b. "I can see that you feel sad about this situation."
 - c. "The loss of your parent is very painful for you."
 - d. "Crying is a way of expressing the hurt you're experiencing."
 - e. "Let's talk about something else because this subject is upsetting you."

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ANS: B, C, D

Reflecting (“I can see that you feel sad” or “This is very painful for you”) and giving information (“Crying is a way of expressing hurt”) are therapeutic techniques. “Why” questions often imply criticism or seem intrusive or judgmental, and they are difficult to answer. Changing the subject is a barrier to communication.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. Which benefits are most associated with the use of telehealth? (*Select all that apply.*)

- a. Cost savings for patients
- b. Maximization of care management
- c. Access to services for patients in rural areas
- d. Prompt reimbursement by third-party payers
- e. Rapid development of trusting relationships with patients

ANS: A, B, C

Use of telehealth technologies has shown that they can maximize health and improve disease management skills and confidence with the disease process. Many rural patients have felt disconnected from services; telehealth technologies can solve these problems. Although telehealth’s improved health outcomes regularly show cost savings for payers, one significant barrier is the current lack of reimbursement for remote patient monitoring by third-party payers. Telehealth is not associated with rapid development of trusting relationships.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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Chapter 09: Therapeutic Relationships and the Clinical Interview

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A nurse assesses a confused older adult. The nurse experiences sadness and reflects, “The patient is like one of my grandparents, so helpless.” What feelings does the nurse describe?
 - a. Transference
 - b. Countertransference
 - c. Catastrophic reaction
 - d. Defensive coping reaction

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ANS: B

Countertransference is the nurse’s transference or response to a patient that is based on the nurse’s unconscious needs, conflicts, problems, or view of the world.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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2. Which statement shows a nurse has empathy for a patient who made a suicide attempt?
 - a. “You must have been very upset when you tried to hurt yourself.”
 - b. “It makes me sad to see you going through such a difficult experience.”
 - c. “If you tell me what is troubling you, I can help you solve your problems.”
 - d. “Suicide is a drastic solution to a problem that may not be such a serious matter.”

ANS: A

Empathy permits the nurse to see an event from the patient’s perspective, understand the patient’s feelings, and communicate this to the patient. The incorrect responses are nurse centered (focusing on the nurse’s feelings rather than the patient’s), belittling, and sympathetic.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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3. After several therapeutic encounters with a patient who recently attempted suicide, which occurrence should cause the nurse to consider the possibility of countertransference?
 - a. The patient’s reactions toward the nurse seem realistic and appropriate.
 - b. The patient states, “Talking to you feels like talking to my parents.”
 - c. The nurse feels unusually happy when the patient’s mood begins to lift.
 - d. The nurse develops a trusting relationship with the patient.

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ANS: C

Strong positive or negative reactions toward a patient, or an overidentification with a patient signal possible countertransference. Nurses must carefully monitor their own feelings and reactions to detect countertransference and then seek supervision. Realistic and appropriate reactions from a patient toward a nurse are desirable. One incorrect response suggests transference. A trusting relationship with the patient is desirable.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

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MSC: NCLEX: Psychosocial Integrity

4. A patient says, "Please don't share information about me with the other people." How should the nurse respond?
 - a. "I won't share information with others without your permission, but I will share information about you with other staff members."
 - b. "A therapeutic relationship is just between the nurse and the patient. It's up to you to tell others what you want them to know."
 - c. "It really depends on what you choose to tell me. I will be glad to disclose at the end of each session what I will report to others."
 - d. "I cannot tell anyone about you. It will be as though I am talking about my own problems, and we can help each other by keeping it between us."

ANS: A

A patient has the right to know with whom the nurse will share information and that confidentiality will be protected. Although the relationship is primarily between the nurse and patient, other staff members need to know pertinent data. The other incorrect responses promote incomplete disclosure on the part of the patient, require daily renegotiation of an issue that should be resolved as the nurse–patient contract is established, and suggest mutual problem solving. The relationship must be patient centered.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

5. A nurse is talking with a patient, and 5 minutes remain in the session. The patient has been silent for most of the session. Another patient comes to the door of the room, interrupts, and says to the nurse, "I really need to talk to you right now." What action is most appropriate?
 - a. Saying to the interrupting patient, "I am not available to talk with you at the present time."
 - b. Ending the unproductive session with the current patient and spend time with the patient who has just interrupted.
 - c. Inviting the interrupting patient to join in the session with the current patient.
 - d. Telling the patient who interrupted, "This session will end in 5 minutes; then, I will talk with you."

ANS: D

When a specific duration for a session has been set, the nurse must adhere to the schedule. Leaving the first patient would be equivalent to abandonment and would destroy any trust the patient had in the nurse. Adhering to the contract demonstrates that the nurse can be trusted and that the patient and the sessions are important. The incorrect responses preserve the nurse–patient relationship with the silent patient but may seem abrupt to the interrupting patient, abandon the silent patient, or fail to observe the contract with the silent patient.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

6. Termination of a therapeutic nurse–patient relationship with a patient has been successful when nurse engages in what action?
 - a. Avoids upsetting the patient by shifting focus to other patients before the discharge.
 - b. Gives the patient a personal telephone number and permission to call after

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- discharge.
- c. Discusses with the patient changes that have happened during the relationship and evaluates the outcomes.
 - d. Offers to meet the patient for coffee and conversation three times a week after discharge.

ANS: C

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Summarizing and evaluating progress help validate the experience for the patient and the nurse and facilitate closure. Termination must be discussed; avoiding the discussion by spending little time with the patient promotes feelings of abandonment. Successful termination requires that the relationship be brought to closure without the possibility of dependency-producing ongoing contact.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Safe, Effective Care Environment

- 7. What patient behavior is the desirable outcome for the orientation stage of a nurse–patient relationship?
 - a. Gaining a sense of independence
 - b. Building rapport and trust with the nurse
 - c. Assuming self-responsibility and autonomy
 - d. Effective resolution of feelings of transference

ANS: B

The development of rapport and trust is necessary before the relationship can progress to the working phase. Behaviors indicating a greater sense of independence, self-responsibility, and resolved transference occur in the working phase.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

- 8. During which phase of the nurse–patient relationship can the nurse anticipate that identified patient issues will be explored and resolved?
 - a. Preorientation
 - b. Orientation
 - c. Working
 - d. Termination

ANS: C

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During the working phase, the nurse strives to assist the patient in making connections among dysfunctional behaviors, thinking, and emotions and offers support while alternative coping behaviors are tried.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

- 9. At what point in the nurse–patient relationship should a nurse plan to first address termination?
 - a. In the orientation phase
 - b. During the working phase
 - c. In the termination phase

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- d. When the patient initially brings up the topic

ANS: A

The patient has a right to know the conditions of the nurse–patient relationship. If the relationship is to be time limited, then the patient should be informed of the number of sessions. If it is open ended, then the termination date will not be known at the outset and the patient will know that the issue will be negotiated at a later date.^{abirb.com/test} The nurse is responsible for bringing up the topic of termination early in the relationship, usually during the orientation phase.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

10. Why should the nurse introduce the matter of a contract during the first session with a new patient?
- To specify what the nurse will do for the patient
 - To explain the participation and responsibilities of each party
 - To indicate the feeling tone established between the participants
 - To prevent either party from prematurely ending the relationship

ANS: B

A contract emphasizes that the nurse works *with* the patient rather than doing something *for* the patient. “Working with” is a process that suggests each party is expected to participate and share responsibility for the outcomes. Contracts do not, however, stipulate roles or feeling tone, or that premature termination is forbidden.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

11. As a nurse escorts a patient being discharged after treatment for major depressive disorder, the patient gives the nurse a gold necklace with a heart pendant and says, “Thank you for helping mend my broken heart.” Which is the nurse’s best response?
- “Accepting gifts violates the policies and procedures of the facility.”
 - “I’m glad you feel so much better now. Thank you for the beautiful necklace.”
 - “I’m glad I could help you, but I can’t accept the gift. My reward is seeing your renewed sense of hope.”
 - “Helping people is what nursing is all about. It’s rewarding to me when patients recognize how hard we work.”

ANS: C

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Accepting a gift creates a social rather than a therapeutic relationship with the patient and blurs the boundaries of the relationship. A caring nurse will acknowledge the patient’s gesture of appreciation, but the gift should not be accepted.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

12. Which remark by a patient indicates passage from the orientation phase to the working phase of a nurse–patient relationship?
- “I don’t have any problems.”
 - “It is so difficult for me to talk about my problems.”
 - “I don’t know how talking about things twice a week can help.”

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- d. “I want to find a way to deal with my anger without becoming violent.”

ANS: D

Thinking about a more constructive approach to dealing with anger indicates a readiness to make a behavioral change. Behavioral change is associated with the working phase of the relationship. Denial is often seen in the orientation phase. It is common early in the relationship, before rapport and trust are firmly established, for a patient to express difficulty in talking about problems. Stating skepticism about the effectiveness of the nurse–patient relationship is more typically a reaction during the orientation phase.

DIF: Cognitive Level: Analysis (Analyzing)

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MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

13. A nurse explains to the family of a patient who is mentally ill how the nurse–patient relationship differs from social relationships. Which is the best explanation?
- “The focus is on the patient. Problems are discussed by the nurse and patient, but solutions are implemented by the patient.”
 - “The focus shifts from nurse to patient as the relationship develops. Advice is given by both, and solutions are implemented.”
 - “The focus of the relationship is socialization. Mutual needs are met, and feelings are openly shared.”
 - “The focus is the creation of a partnership in which each member is concerned with the growth and satisfaction of the other.”

ANS: A

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Only the correct response describes the elements of a therapeutic relationship. The remaining responses describe events that occur in social or intimate relationships.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

14. How should the nurse who wants to demonstrate genuineness with a patient diagnosed with schizophrenia do so most effectively?
- By restating what the patient says.
 - By using congruent communication strategies.
 - By using self-disclosure in patient interactions.
 - By consistently interpreting the patient’s behaviors.

ANS: B

Genuineness is a desirable characteristic involving an awareness of one’s own feelings as they arise and the ability to communicate them when appropriate. The incorrect options are undesirable in a therapeutic relationship.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

15. A nurse caring for a withdrawn, suspicious patient recognizes the development of feelings of anger toward the patient. How should the nurse respond?
- By suppressing the angry feelings.
 - By expressing the anger openly and directly with the patient.
 - By telling the nurse manager to assign the patient to another nurse.
 - By discussing the anger with a clinician during a supervisory session.

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ANS: D

The nurse is accountable for the relationship. Objectivity is threatened by strong positive or negative feelings toward a patient. Supervision is necessary to work through a countertransference of feelings.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

16. A nurse wants to enhance the growth of a patient by showing positive regard. What nursing action is consistent with this wish?
- a. Making patient rounds daily
 - b. Staying with a tearful patient
 - c. Administering daily medication as prescribed
 - d. Examining personal feelings about a patient

ANS: B

Staying with a crying patient offers support and shows positive regard. Administering daily medication and making rounds are tasks that could be part of an assignment and do not necessarily reflect positive regard. Examining feelings regarding a patient addresses the nurse's ability to be therapeutic.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity

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17. A patient says, "I've done a lot of cheating and manipulating in my relationships." What nonjudgmental response by the nurse is most appropriate?
- a. "How do you feel about that?"
 - b. "It's good that you realize this."
 - c. "That's not a good way to behave."
 - d. "Have you outgrown that type of behavior?"

ANS: A

Asking a patient to reflect on feelings about his or her actions does not imply any judgment about those actions, and it encourages the patient to explore feelings and values. The remaining options offer negative judgments.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity

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18. A patient says, "People should be allowed to commit suicide without interference from others." A nurse replies, "You're wrong. Nothing is bad enough to justify death." What is the best analysis of this interchange?
- a. The patient is correct.
 - b. The nurse is correct.
 - c. Neither person is totally correct.
 - d. Differing values are reflected in the two statements.

ANS: D

Values guide beliefs and actions. The individuals stating their positions place different values on life and autonomy. Nurses must be aware of their own values and be sensitive to the values of others.

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DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation
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19. Which issues should a nurse address during the first interview with a patient diagnosed with a psychiatric disorder?
- Trust, congruence, attitudes, and boundaries
 - Goals, resistance, unconscious motivations, and diversion
 - Relationship parameters, the contract, confidentiality, and termination
 - Transference, countertransference, intimacy, and developing resources

ANS: C

Relationship parameters, the contract, confidentiality, and termination are issues that should be considered during the orientation phase of the relationship. The remaining options are issues that are dealt with later.

DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
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20. During the first interview, a nurse notices that the patient does not make eye contact. What can the nurse correctly assume from this behavior?
- The patient is not truthful.
 - The patient is feeling sad.
 - The patient has a poor self-concept.
 - The need for more information is required to draw a conclusion.

ANS: D

The data are insufficient to draw a conclusion. The nurse must continue to assess.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

21. Which behavior shows that a nurse values autonomy?
- Setting limits on a patient's romantic overtures toward the nurse
 - Suggesting one-on-one supervision for a patient who is suicidal
 - Informing a patient that the spouse will not be in during visiting hours
 - Helping the patient weigh the consequences of their behaviors and decisions

ANS: D

A high level of valuing is acting on one's belief. Autonomy is supported when the nurse helps the patient weigh alternatives and their consequences before the patient makes a decision. Autonomy or self-determination is not the issue in any of the other behaviors.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

22. As a nurse discharges a patient, the patient gives the nurse a card of appreciation made in an arts and crafts group. What is the nurse's best action?
- Accept the card while recognizing the effectiveness of the relationship and the patient's thoughtfulness.
 - Inform the patient that accepting gifts violates the policies of the facility. Decline the card regretfully.

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- c. Acknowledge the patient's transition through the termination phase but decline the card.
- d. Accept the card and invite the patient to return to participate in other arts and crafts groups.

ANS: A

The nurse must consider the meaning, timing, and value of the gift. In this instance, the nurse should accept the patient's expression of gratitude.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation
[abirb.com/test](#)

23. A patient says, "I'm still on restriction, but I want to attend some off-unit activities. Would you ask the doctor to change my privileges?" What is the nurse's best response?
- a. "Why are you asking me when you're able to speak for yourself?"
 - b. "I will be glad to address it when I see your doctor later today."
 - c. "That's a good topic for you to take up with your doctor."
 - d. "Do you think you can't speak to a doctor?"

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ANS: C

Nurses should encourage patients to work at their optimal level of functioning. A nurse does not act for the patient unless it is necessary. Acting for a patient increases feelings of helplessness and dependency.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe, Effective Care Environment

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24. A community mental health nurse has worked with a patient for 3 years but is moving out of the city and terminates the relationship. What is the role of the new nurse who begins working with this patient?
- a. Beginning at the orientation phase
 - b. Resuming the working relationship
 - c. Entering into a social relationship
 - d. Returning to the emotional catharsis phase

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ANS: A

After the termination of a long-term relationship, the patient and new nurse usually have to begin at ground zero, the orientation phase, to build a new relationship. If termination is successfully completed, then the orientation phase sometimes progresses quickly to the working phase. Other times, even after successful termination, the orientation phase may be prolonged.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

25. As a patient diagnosed with mental illness is being discharged from a facility, a nurse invites the patient to the annual staff picnic. What is the best analysis of this scenario?
- a. The invitation facilitates dependency on the nurse.
 - b. The nurse's action blurs the boundaries of the therapeutic relationship.
 - c. The invitation is therapeutic for the patient's diversional activity deficit.
 - d. The nurse's action assists the patient's integration into community living.

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ANS: B

The invitation creates a social relationship rather than a therapeutic relationship.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

26. A nurse says, "I am the only one who truly understands this patient. Other staff members are too critical." What does the nurse's statement indicate?
- Boundary blurring
 - Sexual harassment
 - Positive regard
 - Advocacy

ANS: A

When the role of the nurse and the role of the patient shift, boundary blurring may arise. In this situation, the nurse is becoming overinvolved with the patient as a probable result of unrecognized countertransference. When boundary issues occur, the need for supervision exists. The situation does not describe sexual harassment. Data are not present to suggest positive regard or advocacy.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

MULTIPLE RESPONSE

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1. Which descriptors exemplify consistency regarding therapeutic nurse–patient relationships? (*Select all that apply.*)
- Having the same nurse care for a patient on a daily basis
 - Encouraging a patient to share initial impressions of staff
 - Providing a schedule of daily activities to a patient
 - Setting a time for regular sessions with a patient
 - Offering solutions to a patient's problems

ANS: A, C, D

Consistency implies predictability. Having the same nurse see the patient daily, providing a daily schedule of patient activities, and setting a regular time for sessions help a patient to predict what will happen during each day and to develop a greater degree of security and comfort. Encouraging a patient to share initial impressions of staff and giving advice are not related to consistency and would not be considered a therapeutic intervention.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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2. A nurse ends a relationship with a patient. Which actions by the nurse should be included in the termination phase? (*Select all that apply.*)
- Focus dialog with the patient on problems that may occur in the future.
 - Help the patient express feelings about the relationship with the nurse.
 - Help the patient prioritize and modify socially unacceptable behaviors.
 - Reinforce expectations regarding the parameters of the relationship.
 - Help the patient identify strengths, limitations, and problems.

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ANS: A, B

The correct actions are part of the termination phase. The other actions are used in the working and orientation phases.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

3. A new psychiatric nurse is providing care to a parent diagnosed with bipolar disorder. This nurse angrily recalls embarrassing events concerning the parent's behavior in the community. Select the best ways for this nurse to cope with these feelings. (*Select all that apply.*)
- a. Seeking ways to use the understanding gained from childhood to help patients cope with their own illnesses
 - b. Recognizing that these feelings are unhealthy and try to suppress them when working with patients
 - c. Recognizing that psychiatric nursing is not an appropriate career choice and explore other nursing specialties
 - d. Beginning new patient relationships by saying, "My own parent had mental illness, so I accept it without stigma"
 - e. Recognizing that the feelings may add sensitivity to the nurse's practice, but supervision is important

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ANS: A, E

The nurse needs to explore these feelings. An experienced psychiatric nurse is a resource who may be helpful. The knowledge and experience gained from the nurse's relationship with a parent who is mentally ill may contribute sensitivity to a compassionate practice.

Self-disclosure and suppression are not adaptive coping strategies. The nurse should not give up on this area of practice without first seeking ways to cope with the memories.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

4. A new nurse tells a mentor, "I want to convey to my patients that I am interested in them and that I want to listen to what they have to say." Which behaviors are helpful in meeting the nurse's goal? (*Select all that apply.*)
- a. Sitting behind a desk, facing the patient
 - b. Introducing self to a patient and identifying own role
 - c. Using facial expressions that convey interest and encouragement
 - d. Assuming an open body posture and sometimes mirror imaging
 - e. Maintaining control of the topic under discussion by asking direct questions

ANS: B, C, D

Trust is fostered when the nurse gives an introduction and identifies his or her role. Facial expressions that convey interest and encouragement support the nurse's verbal statements to that effect and strengthen the message. An open body posture conveys openness to listening to what the patient has to say. Mirror imaging enhances patient comfort. A desk would place a physical barrier between the nurse and patient. A face-to-face stance should be avoided when possible, and a less intense, 90- or 120-degree angle is used to permit either party to look away without discomfort. Once introductions have been made, the nurse focuses the interview on the patient by using open-ended questions, such as, "Where should we start?"

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation **MSC:** NCLEX: Psychosocial Integrity

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MULTIPLE CHOICE

1. Which scenario best demonstrates an example of eustress?
 - a. A child loses a beloved family pet.
 - b. A single male prepares to take a 1-week vacation to a tropical island with a group of close friends.
 - c. A couple receives a bank notice there were insufficient funds in their account for a recent rent payment.
 - d. A married female receives notification that their current employer is experiencing financial problems and some workers will be terminated.

ANS: B

Eustress is beneficial stress; it motivates people to develop skills they need to solve problems and meet personal goals. Positive life experiences produce eustress. Going on a tropical vacation is an exciting, relaxing experience and an example of eustress. Losing the family pet, worrying about employment security, and having financial problems are examples of distress, a negative experience that drains energy and can lead to significant emotional problems.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

2. A patient diagnosed with liver failure has been on the transplant waiting list 8 months. The patient says, "Why is it taking so long to have the surgery? Maybe I'm meant to die for all the bad things I've done." The nurse should document the patient's comment in which section of the assessment?
 - a. Physical
 - b. Spiritual
 - c. Financial
 - d. Psychological

ANS: B

Stress can be evident in a person's spirituality. This patient's comment indicates questioning of one's place in the universe and consequences for wrongdoing, both are elements of spirituality. Stress can be related to psychological, physical, or psychosocial well-being, but spirituality is the best answer.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

3. A person with a fear of heights drives across a high bridge. Which structure will stimulate a response from the autonomic nervous system?
 - a. Thalamus
 - b. Parietal lobe
 - c. Hypothalamus
 - d. Pituitary gland

ANS: C

The individual will find this experience stressful. The hypothalamus functions as the command-and-control center when receiving stressful signals. The hypothalamus responds to signals of stress by engaging the autonomic nervous system. The parietal lobe is responsible for the interpretation of other sensations. The thalamus processes messages associated with pain and wakefulness. The pituitary gland may be involved in other aspects of the person's response but would not stimulate the autonomic nervous system.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

4. A person with a fear of closes spaces enters into an elevator. Which division of the autonomic nervous system is stimulated in response to this experience?
 - a. Limbic system
 - b. Peripheral nervous system
 - c. Sympathetic nervous system
 - d. Parasympathetic nervous system

ANS: C

The autonomic nervous system is made up of the sympathetic (fight-or-flight response) and parasympathetic (relaxation response) nervous systems. In times of stress, the sympathetic nervous system is stimulated. A person fearful of heights would experience stress associated with the experience of driving across a high bridge. The peripheral nervous system responds to messages from the sympathetic nervous system. The limbic system processes emotional responses but is not specifically part of the autonomic nervous system.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

5. A patient is brought to the emergency department after a motorcycle accident. The patient is alert, responsive, and diagnosed with a broken leg. The patient's vital signs are temperature (T), 98.6° F; pulse (P), 72 beats/min (bpm); and respirations (R), 16 breaths per minute. After being informed that surgery is required for the broken leg, which vital sign readings would be expected?
 - a. T, 98.6°; P, 64; R, 14
 - b. T, 98.6°; P, 68; R, 12
 - c. T, 98.6°; P, 62; R, 16
 - d. T, 98.6°; P, 84; R, 22

ANS: D

The patient would experience stress associated with the anticipation of surgery. In times of stress, the sympathetic nervous system takes over (fight-or-flight response) and sends signals to the adrenal glands, thereby releasing epinephrine. The circulating epinephrine increases the heart rate. Respirations increase, bringing more oxygen to the lungs.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

6. As part of the stress response, the HPA axis is stimulated. Which structures make up this system?
 - a. Hippocampus, parietal lobe, and amygdala

- b. Hypothalamus, pituitary gland, and adrenal glands
- c. Hind brain, pyramidal nervous system, and anterior cerebrum
- d. Hepatic artery, parasympathetic nervous system, and acoustic nerve

ANS: B

As part of the physiological response of stress, the hypothalamus stimulates the HPA axis, which is made up of the hypothalamus, pituitary gland, and adrenal glands.

DIF: Cognitive Level: Knowledge (Remembering)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

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7. Cortisol is released in response to a patient's prolonged stress. Which initial effect would the nurse expect to result from the increased cortisol level?
- a. Diuresis and electrolyte imbalance
 - b. Focused and alert mental status
 - c. Drowsiness and lethargy
 - d. Restlessness and anxiety

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ANS: B

Cortisol is the primary stress hormone and is released in response to prolonged stress. Cortisol helps supply cells with amino acids and fatty acids for energy supply, as well as diverting glucose from muscles for use by the brain. As a result, the brain stays alert and focused. The distractors present effects that would not be expected.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

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8. A soldier returns to the United States from active duty in a combat zone. The soldier is diagnosed with posttraumatic stress disorder (PTSD). The nurse's highest priority is to screen this soldier for which problem?
- a. Major depressive disorder
 - b. Bipolar disorder
 - c. Schizophrenia
 - d. Dementia

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ANS: A

Major depressive disorder frequently co-occurs with PTSD. The incidence of the disorders identified in the distractors is similar to the general population.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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9. A soldier returns to the United States from active duty in a combat zone. The soldier is diagnosed with posttraumatic stress disorder (PTSD). Which comment by the soldier requires the nurse's immediate attention?
- a. "It's good to be home. I missed my family and friends."
 - b. "I saw my best friend get killed by a roadside bomb. It should have been me instead."
 - c. "Sometimes I think I hear bombs exploding, but it's just the noise of traffic in my hometown."
 - d. "I want to continue my education but I'm not sure how I will fit in with other college students."

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ANS: B

The correct response indicates the soldier is thinking about death and feeling survivor's guilt. These emotions may accompany suicidal ideation, which warrants the nurse's follow-up assessment. Suicide is a high risk among military personnel diagnosed with PTSD. One distractor indicates flashbacks, which is common with individuals with PTSD but is not solely indicative of further problems. The other distractors are normal emotions associated with returning home and change.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Psychosocial Integrity

10. A veteran of the war in Afghanistan was diagnosed with posttraumatic stress disorder (PTSD). The veteran says, "If there's a loud noise at night, I get under my bed because I think we're getting bombed." What type of experience has the veteran described?
- a. Illusion
 - b. Flashback
 - c. Nightmare
 - d. Auditory hallucination

ANS: B

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Flashbacks are dissociative reactions in which an individual feels or acts as if the traumatic event were recurring. Illusions are misinterpretations of stimuli; although the experience is similar, the more accurate term is *flashback* because of the diagnosis of PTSD. Auditory hallucinations have no external stimuli. Nightmares commonly accompany PTSD, but this experience is stimulated by an actual environmental sound.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

11. A soldier returned 1 year ago from Afghanistan and was diagnosed with posttraumatic stress disorder (PTSD). Which social event would most likely be disturbing for this soldier?
- a. Halloween festival with neighborhood children
 - b. Singing carols around a Christmas tree
 - c. Family outing to the seashore
 - d. Fireworks display on July 4th

ANS: D

Exploding noises associated with fireworks are most likely to provoke exaggerated responses for this soldier. The distractors are not associated with offensive sounds.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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12. A soldier served in combat zones in Iraq in 2010 and was deployed to Afghanistan in 2014. When is it most important for the nurse to screen for signs and symptoms of posttraumatic stress disorder (PTSD)?
- a. Immediately upon return to the United States from Afghanistan
 - b. Before departing Afghanistan to return to the United States
 - c. Two years after returning from Afghanistan
 - d. Screening should be ongoing

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ANS: D

PTSD can have a long lag time—months to years. Screening should be ongoing.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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13. A nurse designs a plan of exercise for a patient experiencing stress. What rationale should the nurse cite when presenting this plan to the treatment team?
- Exercise will stimulate endorphins and improve the patient's feelings of well-being.
 - Exercise prevents damage from overstimulation of the sympathetic nervous system.
 - Exercise detoxifies the body by removing metabolic wastes and other toxins.
 - Exercise will prevent exacerbation of the stress by the limbic system.

ANS: A

Exercise is a stress reduction strategy that stimulates endorphins and improves patient's feelings of well-being. The other options are not accurate.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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14. A veteran of military combat tells the nurse, "I saw a child get blown up over a year ago, and now I keep seeing bits of flesh everywhere. I see something red and the visions race back to my mind." Which phenomenon associated with posttraumatic stress disorder (PTSD) is this veteran describing?
- Re-experiencing
 - Hyperarousal
 - Avoidance
 - Psychosis

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ANS: A

Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic events are often associated with PTSD. The veteran has described intrusive thoughts and visions associated with re-experiencing the traumatic event. This description does not indicate psychosis, hypervigilance, or avoidance.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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15. A soldier who served in a combat zone returned to the United States. The soldier's spouse complains to the nurse, "We had planned to start a family, but now he won't talk about it. He won't even look at children." The spouse is describing which symptom associated with posttraumatic stress disorder (PTSD)?
- Re-experiencing
 - Hyperarousal
 - Avoidance
 - Psychosis

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ANS: C

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Physiological reactions to reminders of the event include a persistent avoidance of the stimuli associated with the trauma; the individual avoids talking about the event or avoids activities, people, or places that arouse memories of the trauma. Avoidance is exemplified by a sense of foreshortened future and estrangement. No evidence suggests that this soldier is having a hyperarousal reaction or is re-experiencing war-related traumas. Psychosis is not evident.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

16. A soldier returned home last year after deployment to a war zone. The soldier's spouse reports, "We were going to start a family but now he won't talk about it. He will not look at children. I wonder if we're going to make it as a couple." What response best addresses the spouse's concerns?
- "Posttraumatic stress disorder often changes a person's sexual functioning."
 - "I encourage you to continue to participate in social activities where children are present."
 - "Have you talked with your spouse about these reactions? Sometimes we just need to confront behavior."
 - "Posttraumatic stress disorder often strains relationships. I will suggest some community resources for help and support."

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ANS: D

Posttraumatic stress disorder (PSTD) precipitates changes that often lead to divorce.

Providing support to both the veteran and spouse is important. Confrontation will not be effective. Although providing information is important, ongoing support is more effective.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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17. A nurse talks with the caregiver of a combat veteran diagnosed with severe traumatic brain injuries. The caregiver says, "I don't know how much longer I can do it. My whole life is consumed with taking care of my partner." Which response best addresses the needs of the caregiver?
- "How are you taking care of yourself?"
 - "Let's review your partner's diagnostic results."
 - "I have some web-based programs for you to visit."
 - "Your partner is lucky to have someone so devoted."

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ANS: A

The caregiver is the focus of the nurse's attention. The caregiver is suffering. The nurse must be empathetic and assess how the caregiver is caring for self. Reassurance and isolated computer activities do not help. The partner is already aware of the diagnostic results.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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18. A family member asks the nurse, "Do you think stress and physical illness are connected? Since my father's death, my mother has had shingles and the flu, but she's usually not one who gets sick." Which answer by the nurse best reflects current knowledge about long term effects of stress?
- "It is probably a coincidence. Emotions and physical responses travel on different

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- tracts of the nervous system.”
- b. “You may be paying more attention to your mother since your father died and noticing more things such as minor illnesses.” abirb.com/test
 - c. “So far, research on emotions or stress and becoming ill more easily is unclear. We do not know for sure if there is a link.” abirb.com/test
 - d. “Negative emotions and stress may interfere with the body’s ability to protect itself and can increase the likelihood of infection.” abirb.com/test

ANS: D

The correct answer best explains the research. Research supports a link between negative emotions and/or prolonged stress and impaired immune system functioning. Activation of the immune system signals the central nervous system to initiate myriad responses to stress. Prolonged stress suppresses the immune system and lowers resistance to infections.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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MULTIPLE RESPONSE

1. An individual has been diagnosed with a dissociative disorder. Which comorbid psychiatric disorders are most likely to accompany this type of mental illness? (*Select all that apply.*)
 - a. Substance abuse disorders
 - b. Depression
 - c. Eating disorders
 - d. Personality disorders
 - e. Schizophrenia

ANS: A, B, C, D

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Comorbid psychiatric disorders associated with dissociative disorders include: substance use disorders, depression and anxiety disorders, eating disorders, PTSD, and personality disorders. Schizophrenia is not associated with this type of disorder.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

2. Which experiences are most likely to precipitate posttraumatic stress disorder (PTSD)? (*Select all that apply.*)
 - a. An 8-year-old child watches an R-rated movie with both parents.
 - b. A young adult jumps from a bridge with a bungee cord with a best friend.
 - c. An adolescent is kidnapped and held for 2 years in the home of a sexual predator.
 - d. A passenger is in a bus that overturns on a sharp curve in the road, tumbling down an embankment.
 - e. An adult is trapped for 3 hours at an angle in an elevator after a portion of the supporting cable breaks.

ANS: C, D, E

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PTSD usually follows a traumatic event that is outside the range of usual experience. Examples are childhood physical abuse, torture or kidnapping, military combat, sexual assault, and natural disasters such as floods, tornados, earthquakes, and tsunamis; human disasters such as a bus or elevator accident or crime-related events such as being taken hostage are additional examples. The common element in these experiences is the individual's extraordinary helplessness or powerlessness in the face of such stressors. Bungee jumping by adolescents is part of the developmental task and might be frightening but in an exhilarating way rather than a harmful way. A child may be disturbed by an R-rated movie, but the presence of the parents would modify the experience in a positive way.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

3. A nurse assesses the health status of veterans of the war in Afghanistan. Screening will be a priority for signs and symptoms of which health problems? (*Select all that apply.*)
 - a. Schizophrenia
 - b. Eating disorder
 - c. Traumatic brain injury
 - d. Seasonal affective disorder
 - e. Posttraumatic stress disorder

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ANS: C, E

TBI and PTSD each occur in approximately 20% of soldiers who experienced combat. Some soldiers have both problems. The incidence of disorders identified in the distractors would be expected to parallel the general population.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

4. A professor's 4-year-old child has a temperature of 101.6° F, diarrhea, and complains of stomach pain. The professor is scheduled to teach three classes today. Which actions by the professor demonstrate effective parenting? (*Select all that apply.*)
 - a. Telephoning a grandparent to stay with the child at home for the day
 - b. Telephoning a colleague to teach his classes and staying home with the sick child
 - c. Taking the child to the university and keeping the child in a private office for the day
 - d. Taking the child to a day care center and hoping day care workers will not notice the child is sick
 - e. Giving the child one dose of ibuprofen (Motrin) and taking the child to the day care center

ANS: A, B

The correct responses demonstrate fulfillment of the role as a parent. The distractors indicate the professor has not cared for the sick child in an effective way. Taking the child to a day care center exposes other children to a potential infection. Taking the child to one's office does not keep the child comfortable or provide for the child while the professor is teaching.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Health Promotion and Maintenance

TOP: Nursing Process: Evaluation

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Chapter 11: Anxiety, Anxiety Disorders, and Obsessive-Compulsive and Related Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

1. A nurse wishes to teach alternative coping strategies to a patient experiencing severe anxiety.
The nurse will first need to:
 - a. verify the patient's learning style.
 - b. create outcomes and a teaching plan.
 - c. lower the patient's current anxiety level.
 - d. assess how the patient uses defense mechanisms.

ANS: C

A patient experiencing severe anxiety has a significantly narrowed perceptual field and difficulty attending to events in the environment. A patient experiencing severe anxiety will not learn readily. Determining preferred modes of learning, devising outcomes, and constructing teaching plans are relevant to the task but are not the priority measure. The nurse has already assessed the patient's anxiety level. Using defense mechanisms does not apply.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

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2. A patient approaches the nurse and impatiently blurts out, "You've got to help me! Something terrible is happening. My heart is pounding." The nurse responds, "It's almost time for visiting hours. Let's get your hair combed." Which approach has the nurse used?
 - a. Bringing up an irrelevant topic
 - b. Responding to physical needs
 - c. Addressing false cognitions
 - d. Focusing

ANS: A

The patient is experiencing anxiety. The nurse has closed off patient-centered communication by changing the subject. The introduction of an irrelevant topic makes the nurse feel better. The nurse may be uncomfortable dealing with the patient's severe anxiety. The nurse has not responded to the patient's physical needs. There is no evidence of false cognition. Focusing is a therapeutic communication technique used to concentrate attention on a single issue.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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3. A patient experiencing moderate anxiety says, "I feel undone." An appropriate response for the nurse would be:
 - a. "Why do you suppose you are feeling anxious?"
 - b. "What would you like me to do to help you?"
 - c. "I'm not sure I understand. Give me an example."
 - d. "You must get your feelings under control before we can continue."

ANS: C

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Increased anxiety results in scattered thoughts and an inability to articulate clearly. Clarification helps the patient identify his or her thoughts and feelings. Asking the patient why he or she feels anxious is nontherapeutic, and the patient will not likely have an answer. The patient may be unable to determine what he or she would like the nurse to do to help. Telling the patient to get his or her feelings under control is a directive the patient is probably unable to accomplish.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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4. A patient with a high level of motor activity runs from chair to chair and cries, “They’re coming! They’re coming!” The patient does not follow instructions or respond to verbal interventions from staff. The initial nursing intervention of highest priority is to:
 - a. provide for patient safety.
 - b. increase environmental stimuli.
 - c. respect the patient’s personal space.
 - d. encourage the clarification of feelings.

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ANS: A

Safety is of highest priority; the patient who is experiencing panic is at high risk for self-injury related to an increase in non-goal-directed motor activity, distorted perceptions, and disordered thoughts. The goal should be to decrease the environmental stimuli.

Respecting the patient’s personal space is a lower priority than safety. The clarification of feelings cannot take place until the level of anxiety is lowered.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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5. A patient with a high level of motor activity runs from chair to chair and cries, “They’re coming! They’re coming!” The patient is unable to follow instructions or respond to verbal interventions from staff. Which nursing diagnosis has the highest priority?
 - a. Risk for injury
 - b. Self-care deficit
 - c. Disturbed energy field
 - d. Disturbed thought processes

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ANS: A

A patient who is experiencing panic-level anxiety is at high risk for injury, related to an increase in non-goal-directed motor activity, distorted perceptions, and disordered thoughts. Existing data do not support the nursing diagnoses of self-care deficit or disturbed energy field. This patient has disturbed thought processes, but the risk for injury has a higher priority.

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DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Safe, Effective Care Environment

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6. A supervisor assigns a worker a new project. The worker initially agrees but feels resentful. The next day, when asked about the project, the worker says, “I’ve been working on other things.” When asked 4 hours later, the worker says, “Someone else was using the copier, so I couldn’t finish it.” The worker’s behavior demonstrates the use of what mechanism?
 - a. Acting out

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- b. Projection
- c. Suppression
- d. Passive aggression

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ANS: D

A passive-aggressive person deals with emotional conflict by indirectly expressing aggression toward others. Compliance on the surface masks covert resistance. Resistance is expressed through procrastination, inefficiency, and stubbornness in response to assigned tasks. Acting out refers to behavioral expression of conflict. Projection is a form of blaming. Suppression is the conscious denial of a disturbing situation or feeling.

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DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

7. A patient is undergoing diagnostic tests. The patient says, "Nothing is wrong with me except a stubborn chest cold." The spouse reports that the patient smokes, coughs daily, has recently lost 15 pounds, and is easily fatigued. Which defense mechanism is the patient using?
- a. Displacement
 - b. Regression
 - c. Projection
 - d. Denial

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ANS: D

Denial is an unconscious blocking of threatening or painful information or feelings. Regression involves using behaviors appropriate at an earlier stage of psychosexual development. Displacement shifts feelings to a more neutral person or object. Projection attributes one's own unacceptable thoughts or feelings to another.

DIF: Cognitive Level: Understanding (Comprehension)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

8. A patient with a mass in the left upper lobe of the lung is scheduled for a biopsy. The patient has difficulty understanding the nurse's comments and asks, "What are they going to do?" Assessment findings on the patient include a tremulous voice, respirations 28 breaths per minute, and pulse rate 110 beats/min. What is the patient's level of anxiety?
- a. Mild
 - b. Moderate
 - c. Severe
 - d. Panic

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ANS: B

Moderate anxiety causes the individual to grasp less information and reduces his or her problem-solving ability to a less-than-optimal level. Mild anxiety heightens attention and enhances problem-solving abilities. Severe anxiety causes great reduction in the perceptual field. Panic-level anxiety results in disorganized behavior.

DIF: Cognitive Level: Understanding (Comprehension)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

9. A patient who is preparing for surgery has moderate anxiety and is unable to understand preoperative information. Which nursing intervention is appropriate?
- a. Reassure the patient that all nurses are skilled in providing postoperative care.

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- b. Describe the procedure again in a calm manner, using simple language.
- c. Tell the patient that the staff is prepared to promote recovery.
- d. Encourage the patient to express feelings to his or her family.

ANS: B

Providing information in a calm, simple manner helps the patient grasp the important facts. Introducing extraneous topics as described in the incorrect options will further scatter the patient's attention.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

10. A nurse encourages an anxious patient to talk about feelings and concerns. What is the rationale for this intervention?

- a. Offering hope allays and defuses the patient's anxiety
- b. Concerns stated aloud become less overwhelming and help decrease feelings of isolation
- c. Anxiety is reduced by focusing on and validating what is occurring in the environment
- d. Encouraging patients to explore alternatives increases the sense of control and lessens anxiety

ANS: B

All principles listed are valid, but the only rationale directly related to the intervention of assisting the patient to talk about feelings and concerns is the one that states that concerns spoken aloud become less overwhelming, less socially isolating, and help problem solving to begin.

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. Which assessment question would be most appropriate for the nurse to ask a patient who is at risk for developing generalized anxiety disorder (GAD)?

- a. "Have you been a victim of a crime or seen someone badly injured or killed?"
- b. "Do you feel especially uncomfortable in social situations involving people?"
- c. "Do you repeatedly do certain things over and over again?"
- d. "Do you find it difficult to control your worrying?"

ANS: D

Patients with GAD frequently engage in excessive worrying. They are less likely to engage in ritualistic behavior, fear social situations, or have been involved in a highly traumatic event.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

12. A patient in the emergency department has no physical injuries but exhibits disorganized behavior and incoherence after a minor traffic accident. In which room should the nurse place the patient?

- a. Interview room furnished with a desk and two chairs.
- b. Small, empty storage room with no windows or furniture.
- c. Room with an examining table, instrument cabinets, desk, and chair.
- d. Nurse's office, furnished with chairs, files, magazines, and bookcases.

ANS: A

Individuals who are experiencing severe to panic-level anxiety require a safe environment that is quiet, non-stimulating, structured, and simple. A room with a desk and two chairs provides simplicity, few objects with which the patient could cause self-harm, and a small floor space around which the patient can move. A small, empty storage room without windows or furniture would be like a jail cell. The nurse's office or a room with an examining table and instrument cabinets may be overstimulating and unsafe.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

13. A person has minor physical injuries after an automobile accident. The person is unable to focus and says, "I feel like something awful is going to happen." This person has nausea, dizziness, tachycardia, and hyperventilation. What is this person's level of anxiety?
- a. Mild
 - b. Moderate
 - c. Severe
 - d. Panic

ANS: C

The person whose anxiety is severe is unable to solve problems and may have a poor grasp of what is happening in the environment. Somatic symptoms such as those described are usually present. The individual with mild anxiety is only mildly uncomfortable and may even find his or her performance enhanced. The individual with moderate anxiety grasps less information about a situation and has some difficulty with problem solving. The individual in panic-level anxiety demonstrates significantly disturbed behavior and may lose touch with reality.

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

14. Two staff nurses applied for a charge nurse position. After the promotion was announced, the nurse who was not promoted said, "The nurse manager had a headache the day I was interviewed." Which defense mechanism is evident?
- a. Introjection
 - b. Conversion
 - c. Projection
 - d. Splitting

ANS: C

Projection is the hallmark of blaming, scapegoating, thinking prejudicially, and stigmatizing others. Conversion involves the unconscious transformation of anxiety into a physical symptom. Introjection involves intense, unconscious identification with another person.

Splitting is the inability to integrate the positive and negative qualities of oneself or others into a cohesive image.

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

15. A patient tells a nurse, "My new friend is the most perfect person one could imagine—kind, considerate, and good looking. I can't find a single flaw." This patient is demonstrating which defense mechanism?

- a. Denial
- b. Projection
- c. Idealization
- d. Compensation

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ANS: C

Idealization is an unconscious process that occurs when an individual attributes exaggerated positive qualities to another. Denial is an unconscious process that calls for the nurse to ignore the existence of the situation. Projection operates unconsciously and results in blaming behavior. Compensation results in the nurse unconsciously attempting to make up for a perceived weakness by emphasizing a strong point.

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

16. A patient experiences an episode of severe anxiety. Of these medications in the patient's medical record, which is most appropriate to administer as a short-term therapy?
- a. Buspirone
 - b. Lorazepam
 - c. Amitriptyline
 - d. Desipramine

abirb.com/test

ANS: B

Lorazepam is a benzodiazepine medication used to treat anxiety on a **short-term basis** only. Buspirone is long acting and not useful as an as-needed drug. Amitriptyline and desipramine are tricyclic antidepressants and considered second- or third-line agents.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. Two staff nurses applied for promotion to nurse manager. Initially, the nurse not promoted had feelings of loss but then became supportive of the new manager by helping make the transition smooth and encouraging others. Which term best describes the nurse's response?
- a. Altruism
 - b. Sublimation
 - c. Suppression
 - d. Passive aggression

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ANS: A

Altruism is the mechanism by which an individual deals with emotional conflict by meeting the needs of others and vicariously receiving gratification from the responses of others. The nurse's reaction is conscious, not unconscious. No evidence of aggression is exhibited, and no evidence of conscious denial of the situation exists. Passive aggression occurs when an individual deals with emotional conflict by indirectly and unassertively expressing aggression toward others.

DIF: Cognitive Level: Understanding (Comprehension)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

18. A person who feels unattractive repeatedly says, "Although I'm not beautiful, I am smart." This is an example of which defense mechanism?
- a. Repression

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- b. Devaluation
- c. Identification
- d. Compensation

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ANS: D

Compensation is an unconscious process that allows an individual to make up for deficits in one area by excelling in another area to raise self-esteem. Repression unconsciously puts an idea, event, or feeling out of awareness. Identification is an unconscious mechanism calling for an imitation of the mannerisms or behaviors of another. Devaluation occurs when the individual attributes negative qualities to self or to others.

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DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

19. A person who is speaking about a contender for a significant other's affection says in a gushy, syrupy voice, "What a lovely person. That's someone I simply adore." The individual is demonstrating what defense mechanism?

- a. Reaction formation
- b. Repression
- c. Projection
- d. Denial

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ANS: A

Reaction formation is an unconscious mechanism that keeps unacceptable feelings out of awareness by using the opposite behavior. Instead of expressing hatred for the other person, the individual gives praise. Denial operates unconsciously to allow an anxiety-producing idea, feeling, or situation to be ignored. Projection involves unconsciously disowning an unacceptable idea, feeling, or behavior by attributing it to another. Repression involves unconsciously placing an idea, feeling, or event out of awareness.

[/test](#)

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

20. An individual experiencing sexual dysfunction blames it on their partner and suggests the person is both unattractive and unromantic. Which defense mechanism is evident?

- a. Rationalization
- b. Compensation
- c. Introjection
- d. Regression

[abirb.com/test](#)

ANS: A

Rationalization involves unconsciously making excuses for one's behavior, inadequacies, or feelings. Regression involves the unconscious use of a behavior from an earlier stage of emotional development. Compensation involves making up for deficits in one area by excelling in another area. Introjection is an unconscious, intense identification with another person.

[/test](#)

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

21. A student says, "Before taking a test, I feel a heightened sense of awareness and restlessness." The nurse can correctly assess that the student's response is a result of what?

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- a. Cultural influence
- b. Displacement
- c. Trait anxiety
- d. Mild anxiety

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ANS: D

Mild anxiety is rarely obstructive to the task at hand. It may be helpful to the patient because it promotes study and increases awareness of the nuances of questions. The incorrect responses have different symptoms.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

22. A student says, "Before taking a test, I feel a heightened sense of awareness and restlessness." What nursing intervention is most helpful for assisting the student?
- a. Explaining that the symptoms are the result of mild anxiety and discussing the helpful aspects
 - b. Advising the student to discuss this experience with a health care provider
 - c. Encouraging the student to begin antioxidant vitamin supplements
 - d. Listening without comment

ANS: A

Teaching about the symptoms of anxiety, their relation to precipitating stressors, and, in this case, the positive effects of anxiety serves to reassure the patient. Advising the patient to discuss the experience with a health care provider implies that the patient has a serious problem. Listening without comment will do no harm but deprives the patient of health teaching. Antioxidant vitamin supplements are not useful in this scenario.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

23. A person consistently rationalizes their cruel and abusive behavior. Which comment is most characteristic of this person defense mechanism?
- a. "I don't know why it happens."
 - b. "I have always had poor impulse control."
 - c. "That person should not have provoked me."
 - d. "Inside I am a coward who is afraid of being hurt."

ANS: C

Rationalization consists of justifying one's unacceptable behavior by developing explanations that satisfy the teller and attempt to satisfy the listener. The abuser is suggesting that the abuse is not his or her fault; it would not have occurred except for the provocation by the other person.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

24. A patient experiencing severe anxiety suddenly begins running and shouting, "I'm going to explode!" The nurse should implement which intervention to best maximize the patient's safety?
- a. State, "I'm not sure what you mean. Give me an example."
 - b. Chase after the patient while giving instructions to stop running.

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- c. Retrain the patient in a basket-hold to increase feelings of control.
- d. Assemble several staff members and state, "We will help you regain control."

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ANS: D

The safety needs of the patient and other patients are a priority. The patient is less likely to cause self-harm or hurt others when several staff members take responsibility for providing limits. The explanation given to the patient should be simple and neutral. Simply being told that others can help provide the control that has been lost may be sufficient to help the patient regain control. Running after the patient will increase the patient's anxiety. More than one staff member is needed to provide physical limits if they become necessary. Asking the patient to give an example is futile; a patient in panic processes information poorly.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

25. A person who has been unable to leave home for more than a week because of severe anxiety says, "I know it does not make sense, but I just can't bring myself to leave my apartment alone." Which nursing intervention is appropriate when implementing cognitive restructuring?
- a. Teach the person to use positive self-talk.
 - b. Assist the person to apply for disability benefits.
 - c. Ask the person to explain why the fear is so disabling.
 - d. Advise the person to accept the situation and use a companion.

ANS: A

This intervention, a form of cognitive restructuring, replaces negative thoughts such as "I can't leave my apartment" with positive thoughts such as "I can control my anxiety." This technique helps the patient gain mastery over the symptoms. The other options reinforce the sick role.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

26. Which comment by a person experiencing severe anxiety indicates the possibility of obsessive-compulsive disorder?
- a. "I check where my car keys are eight times."
 - b. "My legs often feel weak and spastic."
 - c. "I'm embarrassed to go out in public."
 - d. "I keep reliving the car accident."

ANS: A

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Recurring doubt (obsessive worry) and the need to check (compulsive behavior) suggest obsessive-compulsive disorder. The repetitive behavior is designed to decrease anxiety but fails and must be repeated. The statement, "My legs feel weak most of the time," is more in keeping with a somatoform disorder. Being embarrassed to go out in public is associated with an avoidant personality disorder. Reliving a traumatic event is associated with posttraumatic stress disorder.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

27. Alprazolam is prescribed for a patient experiencing acute anxiety. Health teaching should include which instructions?

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- a. Report drowsiness.
- b. Eat a tyramine-free diet.
- c. Avoid alcoholic beverages.
- d. Adjust dose and frequency based on anxiety level.

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ANS: C

Drinking alcohol or taking other anxiolytic medications along with the prescribed benzodiazepine should be avoided because depressant effects of both drugs will be potentiated. Tyramine-free diets are necessary only with monoamine oxidase inhibitors (MAOIs). Drowsiness is an expected effect and needs to be reported only if it is excessive. Patients should be taught not to deviate from the prescribed dose and schedule for administration.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

28. Which client statement most supports a diagnosis of agoraphobia?

- a. "Being afraid to go out seems ridiculous, but I can't go out the door."
- b. "I'm sure I'll get over not wanting to leave home soon. It takes time."
- c. "When I have a good incentive to go out, I can do it."
- d. "My family says they like it now that I stay home."

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ANS: A

Individuals who are agoraphobic generally acknowledge that the behavior is not constructive and that they do not really like it. Patients state they are unable to change the behavior. Patients with agoraphobia are not optimistic about change. Most families are dissatisfied when family members refuse to leave the house.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

29. A patient has the nursing diagnosis anxiety as evidenced by an inability to control compulsive cleaning. Which phrase referring to the likely trigger correctly completes the etiological portion of the diagnosis?

- a. Ensuring the health of household members
- b. Attempting to avoid interactions with others
- c. Having persistent thoughts about bacteria, germs, and dirt
- d. Needing approval for cleanliness from friends and family

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ANS: C

Many compulsive rituals accompany obsessive thoughts. The patient uses these rituals to relieve anxiety. Unfortunately, the anxiety relief is short lived, and the patient must frequently repeat the ritual. The other options are unrelated to the dynamics of compulsive behavior.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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30. A patient performs ritualistic hand washing. What should the nurse do to help the patient develop more effective coping strategies?

- a. Allow the patient to set a hand-washing schedule.
- b. Encourage the patient to participate in social activities.

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- c. Encourage the patient to discuss hand-washing routines.
- d. Focus on the patient's symptoms rather than on the patient.

ANS: B

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Because patients diagnosed with obsessive-compulsive disorder become overly involved in rituals, promoting involvement with other people and activities is necessary to improve the patient's coping strategies. Daily activities prevent the constant focus on anxiety and its symptoms. The other interventions focus on the compulsive symptom.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

31. For a patient experiencing panic, which nursing intervention should be implemented first?
- a. Teaching relaxation techniques
 - b. Administering an anxiolytic medication
 - c. Providing calm, brief, directive communication
 - d. Gathering a show of force in preparation for gaining physical control

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ANS: C

Calm, brief, directive verbal interaction can help the patient gain control of the overwhelming feelings and impulses related to anxiety. Patients experiencing panic-level anxiety are unable to focus on reality; thus, learning relaxation techniques is virtually impossible. Administering an anxiolytic medication should be considered if providing calm, brief, directive communication is ineffective. Although the patient is disorganized, violence may not be imminent, ruling out the intervention of preparing for physical control until other, less-restrictive measures are proven ineffective.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

32. Which assessment finding indicates that a patient with moderate-to-severe anxiety has successfully lowered the anxiety level to mild?
- a. Patient asks, "What's the matter with me?"
 - b. Patient stays in a room alone and paces rapidly.
 - c. Patient successfully concentrates on what the nurse is saying.
 - d. Patient states, "I don't want anything to eat. My stomach is upset."

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ANS: C

The ability to concentrate and attend to reality is increased slightly in mild anxiety and decreased in moderate-, severe-, and panic-level anxiety. Patients with high levels of anxiety often ask, "What's the matter with me?" Staying in a room alone and pacing suggest moderate anxiety. Expressing a lack of hunger is not necessarily a criterion for evaluating anxiety.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Physiological Integrity

abirb.com/test

TOP: Nursing Process: Evaluation

33. A patient tells the nurse, "I don't go to restaurants because people might laugh at the way I eat, or I could spill food and be laughed at." The nurse assesses this behavior as consistent with which mental health diagnosis?
- a. Acrophobia
 - b. Agoraphobia
 - c. Social anxiety disorder

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d. Posttraumatic stress disorder (PTSD)

ANS: C

The fear of a potentially embarrassing situation represents social anxiety disorder (social phobia). Acrophobia is the fear of heights. Agoraphobia is the fear of a place in the environment. Posttraumatic stress disorder is associated with a major traumatic event.

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DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

34. A patient checks and rechecks electrical cords related to an obsessive thought that the house may burn down. The nurse and patient explore the likelihood of an actual fire. The patient states that a house fire is not likely. This counseling demonstrates the principles of which cognitive-based therapy?

a. Flooding

b. Desensitization

c. Controlled relaxation

d. Thought restructuring

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ANS: D

Cognitive restructuring involves the patient in testing automatic thoughts and drawing new conclusions. Desensitization involves a graduated exposure to a feared object. Relaxation training teaches the patient to produce the effects of calmness. Flooding exposes the patient to a large number of undesirable stimuli in an effort to extinguish the anxiety response.

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DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

35. A patient reports having a fear of public speaking. The nurse should be aware that social anxiety disorders (social phobias) are often treated with which type of medication?

a. Beta blockers

b. Antipsychotic medications

c. Tricyclic antidepressant agents

d. Monoamine oxidase inhibitors

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ANS: A

Beta blockers, such as propranolol, are often effective in preventing symptoms of anxiety associated with social phobias. Neuroleptic medications are major tranquilizers and not useful in treating social phobias. Tricyclic antidepressants are rarely used because of their side effect profile. MAOIs are administered for depression and only by individuals who can observe the special diet required.

DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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36. A patient tells the nurse, "I wanted my health care provider to prescribe diazepam for my anxiety disorder, but buspirone was prescribed instead. Why?" The nurse's reply should be based on the knowledge of which characteristic of buspirone?

a. It does not produce blood dyscrasias.

b. It is not known to cause dependence.

c. It can be administered as needed.

d. It is faster acting than diazepam.

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abirb.com/test

ANS: B

Buspirone is considered effective in the long-term management of anxiety because it is not habituating. Because it is long acting, buspirone is not valuable as an as-needed or as a fast-acting medication. The fact that buspirone does not produce blood dyscrasias is less relevant in the decision to prescribe buspirone.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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MULTIPLE RESPONSE

1. A child is placed in a foster home after being removed from parental contact because of both physical and verbal abuse. The child is apprehensive and overreacts to environmental stimuli. The foster parents ask the nurse how to help minimize the child's anxious behaviors. What should the nurse recommend? (*Select all that apply.*)
 - a. Use a calm manner and low voice.
 - b. Maintain simplicity in the environment.
 - c. Avoid repetition in what is said to the child.
 - d. Minimize opportunities for exercise and play.
 - e. Explain and reinforce reality to avoid distortions.

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ANS: A, B, E

The child can be hypothesized to have moderate-to-severe anxiety. A calm manner calms the child. A simple, structured, predictable environment is less anxiety provoking and reduces overreaction to stimuli. Calm, simple explanations that reinforce reality validate the environment. Repetition is often needed when the child is unable to concentrate because of elevated levels of anxiety. Opportunities for play and exercise should be provided as avenues to reduce anxiety. Physical movement helps channel and lower anxiety. Play also helps by allowing the child to act out concerns.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A nurse plans health teaching for a patient diagnosed with generalized anxiety disorder (GAD) who takes lorazepam. What information should be included? (*Select all that apply.*)
 - a. Use caution when operating machinery.
 - b. Allow only tyramine-free foods in diet.
 - c. Restrict intake of caffeine.
 - d. Avoid using alcohol and other sedatives.
 - e. Take the medication on an empty stomach.

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ANS: A, C, D

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Caffeine is a central nervous system stimulant that acts as an antagonist to the benzodiazepine lorazepam. Daily caffeine intake should be reduced to the amount contained in one cup of coffee. Benzodiazepines are sedatives, thus the importance of exercising caution when driving or using machinery and the importance of not using other central nervous system depressants such as alcohol or sedatives to avoid potentiation. Benzodiazepines do not require a special diet. Food will reduce gastric irritation from the medication.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

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MSC: NCLEX: Physiological Integrity

3. Which assessment questions are most relevant to ask a patient with possible obsessive-compulsive disorder? (*Select all that apply.*)
- a. "Have you been a victim of a crime or seen someone badly injured or killed?"
 - b. "Are there certain social situations that cause you to feel especially uncomfortable?"
 - c. "Do you have to do things in a certain way to feel comfortable?"
 - d. "Is it difficult to keep certain thoughts out of awareness?"
 - e. "Do you do certain things over and over again?"

ANS: C, D, E

The correct questions refer to obsessive thinking and compulsive behaviors. The incorrect responses are more pertinent to a patient with suspected posttraumatic stress disorder or with suspected social anxiety disorder (social phobia).

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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Chapter 12: Somatic Symptom Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A medical-surgical nurse works with a patient diagnosed with a somatic system disorder. Care planning is facilitated by understanding that the patient will probably present what behavior?
 - a. Readily seek psychiatric counseling.
 - b. Being resistant to accepting psychiatric help.
 - c. Attending psychotherapy sessions without encouragement.
 - d. Being eager to discover the true reasons for physical symptoms.

ANS: B

Patients with somatic system disorders go from physician to physician trying to establish a physical cause for their symptoms. When a psychological basis is suggested and a referral for counseling is offered, these patients reject both.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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2. A patient whose blindness is related to a functional neurological (conversion) disorder appears to be unconcerned about this problem. Which understanding should guide the nurse's planning for this patient?
 - a. Suppressing accurate feelings regarding the problem.
 - b. Anxiety is relieved through the physical symptom.
 - c. Emotional needs are met through hospitalization.
 - d. The patient refuses to disclose genuine fears.

ANS: B

Psychoanalytic theory suggests conversion reduces anxiety through the production of a physical symptom that is symbolically linked to an underlying conflict. Conversion, not suppression, is the operative defense mechanism in this disorder. The other distractors oversimplify the dynamics, suggesting that only dependency needs are of concern, or suggest conscious motivation (conversion operates unconsciously).

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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3. A patient's blindness is related to a functional neurological (conversion) disorder. To help the patient eat, the nurse should implement what intervention?
 - a. Establishing a "buddy" system with other patients who can feed the patient at each meal
 - b. Expecting the patient to self-feed after explaining the arrangement of the food on the tray
 - c. Directing the patient to locate items on the tray independently with feeding being unassisted
 - d. Addressing the needs of other patients in the dining room, and then feeding this patient

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ANS: B

The patient is expected to maintain some level of independence by feeding himself or herself, whereas the nurse is supportive in a matter-of-fact way. The distractors support dependency or offer little support.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

4. A patient with blindness related to a functional neurological (conversion) disorder states, "All the doctors and nurses in this hospital stop by often to check on me. Too bad people outside the hospital don't find me interesting." Which nursing diagnosis is most relevant?
- a. Social isolation
 - b. Chronic low self-esteem
 - c. Interrupted family processes
 - d. Ineffective health maintenance

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ANS: B

The patient mentions that the symptoms make people more interested, which indicates that the patient believes he or she is uninteresting and unpopular without the symptoms, thus supporting the nursing diagnosis of chronic low self-esteem. Defining characteristics for the other nursing diagnoses are not present in this scenario.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

5. To assist a patient diagnosed with a somatic system disorder, which nursing intervention is of highest priority?
- a. Implying that somatic symptoms are not real
 - b. Helping the patient suppress feelings of anger
 - c. Shifting the focus from somatic symptoms to feelings
 - d. Investigating each physical symptom as soon as it is reported

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ANS: C

Shifting the focus from somatic symptoms to feelings or to neutral topics conveys an interest in the patient as a person rather than as a condition. The need to gain attention with the use of symptoms is reduced over the long term. A desired outcome is that the patient expresses feelings, including anger, if it is present. Once physical symptoms have been investigated, they do not need to be reinvestigated each time the patient reports them.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

6. A patient who fears serious heart disease was referred to the mental health center by a cardiologist after diagnostic evaluation showed no physical illness. The patient says, "My heart misses beats. I'm frequently absent from work. I don't go out much because I need to rest." Which health problem is most likely?
- a. Depersonalization disorder
 - b. Antisocial personality disorder
 - c. Illness anxiety disorder
 - d. Persistent depressive disorder

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[abirb.com/test](#)

ANS: C

Illness anxiety disorder (hypochondriasis) involves a preoccupation with fears of having a serious disease, even when evidence to the contrary is available. The preoccupation causes impairment in social or occupational functioning. Depersonalization disorder involves recurrent periods of feeling unreal, detached, outside of the body, numb, dreamlike, or a distorted sense of time or visual perception. Persistent depressive disorder (dysthymia) is a disorder of lowered mood. Antisocial disorder applies to a personality disorder in which the individual has little regard for the rights of others.

DIF: Cognitive Level: Understanding (Comprehension)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

7. A nurse assessing a patient diagnosed with a somatic system disorder is most likely to note what patient characteristic?

- a. Readily sees a relationship between symptoms and interpersonal conflicts.
- b. Rarely derives personal benefit from the symptoms.
- c. Has little difficulty communicating emotional needs.
- d. Has unmet needs related to comfort and activity.

ANS: D

The patient diagnosed with a somatic system disorder frequently has altered comfort and activity needs. In addition, hygiene, safety, and security needs may also be compromised. The patient is rarely able to see a relation between symptoms and events in his or her life, which is readily discernible to health professionals. Patients with somatic system disorders often derive secondary gain from their symptoms and/or have considerable difficulty identifying feelings and conveying emotional needs to others.

DIF: Cognitive Level: Understanding (Comprehension)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

8. To plan effective care for patients diagnosed with somatic system disorders, the nurse should understand that patients have difficulty giving up the symptoms because of what characteristic?

- a. They are generally chronic in nature.
- b. They have a physiological basis.
- c. They can be voluntarily controlled.
- d. They provide relief from health anxiety.

ANS: D

At the unconscious level, the patient's primary gain from the symptoms is anxiety relief. Considering that the symptoms actually make the patient more psychologically comfortable and may also provide a secondary gain, patients frequently and fiercely cling to the symptoms. The symptoms tend to be chronic; however, this does not explain why they are difficult to give up. The symptoms are not under voluntary control or physiologically based.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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9. A patient diagnosed with a somatic symptom disorder has the nursing diagnosis: Interrupted family processes, related to patient's disabling symptoms as evidenced by the spouse and children assuming roles and tasks that previously belonged to patient. What is an appropriate outcome for this patient?
- Assumes roles and functions of the other family members.
 - Demonstrate a resumption of former roles and tasks.
 - Focuses energy on problems occurring in the family.
 - Relies on family members to meet personal needs.

ANS: B

The patient with a somatic symptom disorder has typically adopted a sick role in the family, characterized by dependence. Increasing independence and the resumption of former roles are necessary to change this pattern. The distractors are inappropriate outcomes.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Health Promotion and Maintenance

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10. Which medication would the nurse expect to be prescribed for a patient diagnosed with a somatic symptom disorder?
- Narcotic analgesics for use as needed for acute pain
 - Antidepressant medications to treat underlying depression
 - Long-term use of benzodiazepines to support coping with anxiety
 - Conventional antipsychotic medications to correct cognitive distortions

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ANS: B

Various types of antidepressants may be helpful in somatic disorders directly by reducing depressive symptoms and hence somatic responses, but also indirectly by affecting nerve circuits that affect not only mood, but also fatigue, pain perception, GI distress, and other somatic symptoms. Patients may benefit from short-term use of anti-anxiety medication (benzodiazepines) but require careful monitoring because of risks of dependence.

Conventional antipsychotic medications would not be used, although selected atypical antipsychotics may be useful. Narcotic analgesics are not indicated.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Pharmacological and Parenteral Therapies

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11. Which patient statement best supports the diagnosis of somatic disorders?
- "I can't do much because of the severe pain."
 - "I feel as if I'm living in a fuzzy dream state."
 - "I feel like different parts of my body are at war."
 - "I feel very anxious and worried about my problems."

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ANS: A

The patient diagnosed with somatic disorders is preoccupied and disabled as a result of somatic pain or some other disability. The distractors are more consistent with depersonalization, generalized anxiety disorder, or dissociative identity disorder.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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12. A college student reports that, "My vision is too blurry to read effectively, especially when it's time to be studying for a test." Which health problem should be considered initially?

- a. Malingering
- b. Illness anxiety
- c. Factitious disorder
- d. Functional neurological disorder

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ANS: A

Malingering is intentionally faking or exaggerating symptoms for an obvious benefit such as money, housing, medications, avoiding work, or criminal prosecution. Functional neurological disorder (FND) involves chronic or brief symptoms of altered voluntary motor or sensory function that cause substantial distress or psychosocial impairment. Individuals with illness anxiety disorder are preoccupied with having or eventually developing a serious illness. The essential feature of factitious disorder is intentionally faking symptoms in order to assume the sick role, that is, to be a patient.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

13. A nurse assesses a patient diagnosed with functional neurological (conversion) disorder. Which comment best supports this diagnosis?

- a. "Since my father died, I've been short of breath and had sharp pains that go down my left arm, but I think it's just indigestion."
- b. "I have daily problems with nausea, vomiting, and diarrhea. My skin is very dry and I think I'm getting seriously dehydrated."
- c. "Sexual intercourse is painful. I pretend as if I'm asleep so I can avoid it. I think it's starting to cause problems with my marriage."
- d. "I get choked very easily and have trouble swallowing when I eat. I think I might have cancer of the esophagus."

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ANS: A

Patients with functional neurological (conversion) disorder often demonstrate a lack of concern regarding the seriousness of symptoms. In addition, a specific cause for the development of the symptoms is identifiable; in this instance, the death of a parent precipitates the stress. The incorrect options suggest other types of somatic symptom disorders.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

14. An adult diagnosed with conversion (functional neurobiological symptom) disorder says, "Our family has gotten along over the years by working together. My partner cooks and the children clean house." Understanding of this disorder will provide what rationalization for this statement?

- a. Patient is receiving secondary gains from the symptoms.
- b. Patient has problems with sexual identity and satisfaction.
- c. Patient will be resistant to developing a trusting relationship.
- d. Patient will benefit from confrontation about physical complaints.

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ANS: A

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Being able to avoid traditional family role responsibilities by adopting a sick role can be seen as a “payoff.” Receiving a payoff is another way of saying that the individual receives secondary gain from the symptoms. Data are not present to permit choice of the incorrect options.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

15. Instructions concerning what stress management technique should be included in the care plan of a patient diagnosed with a somatic symptom disorder? [abirb.com/test](#)
- a. Mindful awareness
 - b. Positive self-talk
 - c. Take a time out
 - d. Meditation
- [abirb.com/test](#)

ANS: D

Meditation has been shown to be effective in managing stress associated with somatic symptom disorders. Mindful awareness and positive self-talk are associated with anxiety management while the concept of a time out helps manage anger.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

16. For a patient diagnosed with somatic symptom disorder, what statement would effectively complete the long-term outcome of “Within 4 weeks, the patient will demonstrate an ability to?”
- a. Functioning independently on a basic level.”
 - b. Verbalizing feelings of physical and emotional safety.”
 - c. Regularly attending prescribed diversional activity groups.”
 - d. Identifying personal coping patterns that are proving to be ineffective.”

ANS: D

The ability to identify and recognize as relevant the ineffective coping patterns that contribute to the somatic symptoms is an appropriate outcome. A patient may verbalize feeling safe, to function independently on a basic level, and to attend diversional activities without addressing the factors significant to resolving somatic symptom disorders.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

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MSC: NCLEX: Psychosocial Integrity

17. A patient has been diagnosed with a somatic symptoms disorder after various testing has failed to confirm a physiological cause for the patient’s reports of back pain. What intervention by the nurse demonstrates the appropriate response when the patient continues to monopolize the group discussion with about back pain?
- a. Acknowledge the presence of pain but then redirect to another topic.
 - b. Offer to discuss the back pain with the patient after the group session is over.
 - c. In a matter-of-fact manner tell the patient that their pain is somatic in nature.
 - d. Offer to discuss additional pain medication with the patient’s health care provider.

ANS: A

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After physical complaints have been investigated and a somatic symptom diagnosis is made, avoid further reinforcement of the somatic complaints by directing focus away from physical symptoms. The presence of the pain should not be denied but reinforcing or rewarding such behavior should not be engaged in.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

18. A nurse physically assessing a patient diagnosed with somatic disorder should understand that which intervention is the priority?
- a. Provide a thorough physical examination.
 - b. Avoid detailed discussion of the reported complaints.
 - c. Avoid suggesting the appropriateness of any medical testing.
 - d. Focus on both prescribed and OTC medications the client is taking.

ANS: A

It is always important to ensure that an underlying medical condition has been eliminated from the differential diagnosis and so it is vital that the assessment be thorough. This understanding makes the other options incomplete or inappropriate.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Safe, Effective Care Environment

19. A patient reporting stomach pain says, "I have seen 10 different health care providers but all of them tell me I don't have stomach cancer." Which term might be appropriate in describing this report?
- a. Somatic symptom disorder
 - b. Factitious disorder
 - c. Illness anxiety
 - d. Malingering

ANS: C

Individuals with illness anxiety disorder are preoccupied with having or eventually developing a serious illness. The patient is apprehensive of a particular illness despite continuous negative medical evaluations and assurances. Malingering is intentionally faking or exaggerating symptoms for an obvious benefit such as money, housing, medications, avoiding work, or criminal prosecution. Malingering is a behavior and not a psychiatric disorder.

"Somatization," defined as a process by which psychological distress is expressed as physical symptoms without a known organic source, causes substantial distress and psychosocial impairment with or without a known general medical disease. The essential feature of factitious disorder is intentionally faking symptoms in order to assume the sick role, that is, to be a patient. In addition, there are no obvious external benefits such as financial gain or avoiding work or criminal prosecution.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

20. A patient reports fears of having cervical cancer and says to the nurse, "I've had Pap smears by six different doctors. The results are normal, but I'm sure that's because of errors in the laboratory." Which disorder would the nurse suspect?

- a. Functional neurological (conversion) disorder
- b. Illness anxiety disorder (hypochondriasis)
- c. Derealization disorder
- d. Dissociative amnesia with fugue

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ANS: B

Patients with illness anxiety disorder (hypochondriasis) have fears of serious medical problems such as cancer or heart disease. These fears persist, despite medical evaluations, and interfere with daily functioning. No complaints of pain are made, and no evidence of dissociation or conversion exists. Derealization disorder involves recurrent periods of feeling unreal, detached, outside of the body, numb, dreamlike, or a distorted sense of time or visual perception.

DIF: Cognitive Level: Understanding (Comprehension)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

21. A patient diagnosed with somatic symptom disorder says, "I have pain from an undiagnosed injury. I can't take care of myself. I need pain medicine six or seven times a day. I feel like a baby because my family has to help me so much." It is important for the nurse to conduct what focused assessment?
- a. Mood
 - b. Cognitive style
 - c. Secondary gains
 - d. Identity and memory

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ANS: C

Secondary gains should be assessed. The patient's dependency needs may be met through care from the family. When secondary gains are prominent, the patient is more resistant to giving up the symptom. The scenario does not allude to a problem of mood. Cognitive style and identity and memory assessment are of lesser concern because the patient's diagnosis has been established.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

22. What are the causes of somatic system disorders generally related to?
- a. Faulty perceptions of body sensations
 - b. Traumatic childhood events
 - c. Culture-bound phenomena
 - d. Mood instability

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ANS: A

Structural or functional abnormalities of the brain have been suggested to lead to the somatic system disorders, resulting in disturbed processes of perception and interpretation of bodily sensations. Furthermore, cognitive theorists believe patients misinterpret the meaning of certain bodily sensations and then become excessively alarmed by them. Traumatic childhood events are related to the dissociative disorders. Culture-bound phenomena may explain the prevalence of some symptoms but cannot explain the cause. Somatic system disorders are not a facet of mood instability; however, depression may coexist with a somatic system disorder.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

23. What is the primary difference between somatic system disorders and dissociative disorders?
- They are under voluntary control
 - They are related to resolved stress.
 - They are generally strongly cultural bound.
 - They are psychological stress expressed through somatic symptoms.

ANS: D

Somatic symptom disorders are expressions of unresolved emotional trauma characterized by the presence of one or more physical symptoms without a known organic source that causes substantial distress and psychosocial impairment with or without a known general medical disease. Somatic system disorders are neither under voluntary control nor are they cultural bound.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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24. A patient says, “I know I have a brain tumor despite the results of the magnetic resonance image (MRI). The radiologist is wrong. People who have brain tumors vomit, and yesterday I vomited all day.” Which response by the nurse fosters cognitive restructuring?
- “You do not have a brain tumor. The more you talk about it, the more it reinforces your illogical thinking.”
 - “Let’s see whether any other explanations for your vomiting are possible.”
 - “You seem so worried. Let’s talk about how you’re feeling.”
 - “We should talk about something else.”

ANS: B

Questioning the evidence is a cognitive restructuring technique. Identifying causes other than the feared disease can be helpful in changing distorted perceptions. Distraction by changing the subject will not be effective.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

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25. Which treatment modality should a nurse recommend to help a patient diagnosed with somatic symptom disorder cope more effectively?
- Flooding
 - Relaxation
 - Response prevention
 - Systematic desensitization

ANS: B

Pain, a common complaint in patients diagnosed with somatic symptom disorder, increases when the patient has muscle tension. Relaxation can diminish the patient’s perceptions of the intensity of pain. The distractors are modalities useful in treating selected anxiety disorders.

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DIF: Cognitive Level: Understanding (Comprehension)

MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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26. A patient diagnosed with somatic symptom disorder tells the nurse, "It's starting again. I feel as though my heart is beating out of my chest and I can't breathe." The nurse should provide what response to best address the patient's symptoms? abirb.com/test
- "I'll call your health care provider and see if I can give you a sedative."
 - "Do you think you will feel better with some oxygen?"
 - "We've talked about how being dramatic is helpful."
 - "Has something happened to make you anxious?" abirb.com/test

ANS: D

Patients with somatic symptom disorders have difficulty communicating their emotional needs. As children, their family communication style may have neglected the appropriate expression of anger, depression, fear, and other emotions, and thus they do not recognize feelings nor understand how to relate to them. The feeling of anxiety may cause tightness in the stomach, nausea, rapid heartbeat, shortness of breath, dizziness, sweating, and tensing of muscles such as the hands or jaw. If a person is taught to consider the relationship of emotions to physical symptoms, the person will likely identify that he or she is anxious. Offering medical interventions are not addressing the likely trigger for the symptoms. Accusing the patient of being dramatic will likely serve to only increase the anxiety already being experienced.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

27. A patient diagnosed with somatic symptom disorder has been in treatment for 4 weeks. The patient says, "Although I'm still having pain, I notice it less and am able to perform more activities." The nurse should evaluate the treatment plan using what phrase:
- unsuccessful.
 - minimally successful.
 - partially successful.
 - totally achieved. abirb.com/test

ANS: C

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Decreased preoccupation with symptoms and an increased ability to perform activities of daily living suggest partial success of the treatment plan. Total success is rare because of patient resistance.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

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MULTIPLE RESPONSE

1. A patient diagnosed with somatic symptom disorder says, "Why has God chosen me to be sick all the time and unable to provide for my family? The burden on my family is worse than the pain I bear." Which nursing diagnoses apply to this patient? (Select all that apply.)
- Spiritual distress
 - Decisional conflict
 - Adult failure to thrive
 - Impaired social interaction
 - Ineffective role performance abirb.com/test

ANS: A, E

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The patient's verbalization is consistent with spiritual distress. Moreover, the patient's description of being unable to provide for and burdening the family suggests ineffective role performance. No data support diagnoses of adult failure to thrive, impaired social interaction, or decisional conflict.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis [abirb.com/test](#)

MSC: NCLEX: Psychosocial Integrity

2. A nurse assesses a patient suspected to have somatic system disorder. Which findings support the diagnosis? (*Select all that apply.*)

- a. Female
- b. Reports frequent dizziness
- c. Complains of heavy menstrual bleeding
- d. First diagnosed with psoriasis at 12 years of age
- e. Reports of back pain, painful urination and frequent diarrhea

ANS: A, B, C, E

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No chronic disease explains the symptoms for patients with somatic system disorder. Patients report multiple symptoms; gastrointestinal, sexual, and pseudoneurological symptoms are common. This disorder is more common in women than in men.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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3. A patient with a diagnosis of somatic symptom disorder is being assessed. What assessment questions are appropriate and therapeutic in nature? (*Select all that apply.*)

- a. "Would you consider yourself to be mentally ill?"
- b. "Do you have periods of depression or extreme sadness?"
- c. "Have you ever been told that your symptoms are not real?"
- d. "Are you able to care for yourself and meet your own basic needs?"
- e. "How do the members of your immediate family react to your illness?"

ANS: B, D, E

The assessment should address possible comorbid conditions like depression, the patient's ability to meet their basic needs independently, and the dynamics of the family regarding the existence of the sick role and secondary benefits. The remaining options are likely to increase the patient's stress and foster anger, either of which are therapeutic.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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Chapter 13: Personality Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A therapist recently convicted of multiple counts of Medicare fraud says, “Sure I overbilled. Why not? Everyone takes advantage of the government, so I did too.” These statements demonstrate which personal characteristic?
 - a. Shame
 - b. Anxiousness
 - c. Superficial remorse
 - d. Absence of guilt

ANS: D

Rationalization is being used to explain behavior and deny wrongdoing. The individual who does not believe he or she has done anything wrong will not exhibit anxiety, remorse, or guilt about the act. The patient’s remarks cannot be assessed as expressing shame. Lack of trust or concern that others are determined to cause harm is not evident.

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DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

2. Which intervention is appropriate for a patient diagnosed with an antisocial personality disorder who frequently manipulates others?
 - a. Refer the patient’s requests to identified staff.
 - b. Explore the patient’s feelings of fear and inferiority.
 - c. Provide negative reinforcement for acting-out behavior.
 - d. Ignore, rather than confront, inappropriate behavior.

ANS: A

Manipulative patients frequently make requests of many different staff members, hoping someone will give in. Having only one decision maker provides consistency and avoids the potential for playing one staff member against another. Positive reinforcement of appropriate behaviors is more effective than negative reinforcement. The behavior should not be ignored; judicious use of confrontation is necessary. Patients with antisocial personality disorders rarely have feelings of fear and inferiority.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

3. As a nurse prepares to administer an oral medication to a patient diagnosed with a borderline personality disorder, the patient says, “Just leave it on the table. I’ll take it when I finish combing my hair.” What is the nurse’s best response?
 - a. “Alright. I’ll be back to make sure you’ve taken it.”
 - b. “I’m worried that you might not take it. I will come back later.”
 - c. “I must watch you take the medication. Please take it now.”
 - d. “Why don’t you want to take your medication now?”

ANS: C

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The individual with a borderline personality disorder characteristically demonstrates manipulative, splitting, and self-destructive behaviors. Consistent limit setting is vital for the patient's safety, as well as to prevent splitting other staff members.^{abirb.com/test} "Why" questions are not therapeutic.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

4. What is an appropriate initial outcome for a patient diagnosed with a personality disorder who frequently manipulates others?
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 - a. The patient will identify when feeling angry.
 - b. The patient will use manipulation only to get legitimate needs met.
 - c. The patient will acknowledge manipulative behavior when it is called to their attention.
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 - d. The patient will accept fulfillment of their requests within an hour rather than immediately.

ANS: C

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Acknowledging manipulative behavior is an early outcome that paves the way for taking greater responsibility for controlling manipulative behavior at a later time. Identifying anger relates to anger and aggression control. Using manipulation to get legitimate needs is an inappropriate outcome. Ideally, the patient will use assertive behavior to promote the fulfillment of legitimate needs. Accepting fulfillment of requests within an hour rather than immediately relates to impulsivity and immediacy control.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

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5. Consider these comments made to three different nurses by a patient diagnosed with an antisocial personality disorder: "You're a better nurse than the day shift nurse said you were"; "Another nurse said you don't do your job right"; "You think you're perfect, but I've seen you make three mistakes." Collectively, these interactions can be appropriately assessed using what term?
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 - a. Paranoia
 - b. Entitlement
 - c. Manipulation
 - d. Pathological lying

ANS: C

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Patients manipulate and control staff members in various ways. By keeping staff members off balance or fighting among themselves, the person with an antisocial personality disorder is left to operate as he or she pleases. Paranoia is the irrational and persistent feeling that people are "out to get you." Entitlement is a belief that one has the right to take what they want, treat others unfairly, destroy the property of others, and even hurt others if it is in their best interest. They do not adhere to traditional values or standards. Pathological liar seems to lie for no apparent reason.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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6. A nurse reports to the interdisciplinary team that a patient diagnosed with an antisocial personality disorder lies to other patients, verbally abuses a patient diagnosed with dementia, and flatters the primary nurse. This patient is detached and superficial during counseling sessions. Which behavior most clearly warrants limit setting?
- Flattering the nurse
 - Lying to other patients
 - Verbal abuse of another patient
 - Detached superficiality during counseling

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ANS: C

Limits must be set in areas in which the patient's behavior affects the rights of others. Limiting verbal abuse of another patient is a priority intervention. The other concerns should be addressed during therapeutic encounters.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

7. A patient diagnosed with borderline personality disorder has a history of self-mutilation and suicide attempts. The patient reveals feelings of depression and anger with life. The treatment team suggests the use of a medication. Which type of medication should the nurse expect?
- Selective serotonin reuptake inhibitor (SSRI)
 - Monoamine oxidase inhibitor (MAOI)
 - Benzodiazepine
 - Antipsychotic

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ANS: A

There is no medication to specifically treat a personality disorder, but SSRI antidepressants or mood stabilizers may be used for relief of symptoms that coexist. SSRIs are used to treat depression. Many patients with borderline personality disorder are fearful of taking something over which they have little control. Because SSRIs have a good side effect profile, the patient is more likely to comply with the medication. Low-dose antipsychotic or anxiolytic medications are not supported by the data given in this scenario. MAOIs require great diligence in adherence to a restricted diet and are rarely used for patients who are impulsive.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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8. A person's partner filed charges of battery. The person has a long history of acting-out behaviors and several arrests. Which statement by the person suggests an antisocial personality disorder?
- "I have a quick temper, but I can usually keep it under control."
 - "I've done some stupid things in my life, but I've learned a lesson."
 - "I'm feeling terrible about the way my behavior has hurt my family."
 - "I get tired of being nagged. They deserved the beating."

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ANS: D

The patient with an antisocial personality disorder often impulsively acts out feelings of anger and feels no guilt or remorse. Patients with antisocial personality disorders rarely seem to learn from experience or feel true remorse. Problems with anger management and impulse control are common.

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DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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9. What is the priority nursing diagnosis for a patient diagnosed with antisocial personality disorder who has made threats against staff, ripped art off the walls, and thrown objects?
- a. Disturbed sensory perception—auditory
 - b. Risk for other-directed violence
 - c. Ineffective denial
 - d. Ineffective coping

ANS: B

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Violence against property, along with threats to harm staff, makes this diagnosis the priority. Patients with antisocial personality disorders rarely have psychotic symptoms. When patients with antisocial personality disorders use denial, they use it effectively. Although ineffective coping applies, the risk for violence is a higher priority.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis abirb.com/test

MSC: NCLEX: Safe, Effective Care Environment

10. A patient diagnosed with a personality disorder has used manipulation to get their needs met. The staff decides to apply limit setting interventions. What is the correct rationale for this action?
- a. It provides an outlet for feelings of anger and frustration.
 - b. It respects the patient's wishes so assertiveness will develop. abirb.com/test
 - c. External controls are necessary while internal controls are developed.
 - d. Anxiety is reduced when staff members assume responsibility for the patient's behavior.

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ANS: C

A lack of internal controls leads to manipulative behaviors such as lying, cheating, conning, and flattering. To protect the rights of others, external controls must be consistently maintained until the patient is able to behave appropriately.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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11. A patient diagnosed with borderline personality disorder and a history of self-mutilation has now begun dialectical behavior therapy (DBT) on an outpatient basis. Today the patient telephones to say, "I'm feeling empty and want to cut myself." The nurse should implement what intervention?
- a. Arrange for emergency inpatient hospitalization.
 - b. Send the patient to the crisis intervention unit for 8 to 12 hours.
 - c. Assist the patient to identify the trigger situation and choose a coping strategy.
 - d. Advise the patient to take an antianxiety medication to decrease the anxiety level.

ANS: C

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The patient has responded appropriately to the urge for self-harm by calling a helping individual. A component of dialectical behavior therapy is telephone access to the therapist for “coaching” during crises. The nurse can assist the patient to choose an alternative to self-mutilation. The need for a protective environment may not be necessary if the patient is able to use cognitive strategies to determine a coping strategy that reduces the urge to mutilate. Taking a sedative and going to sleep should not be the first-line intervention; sedation may reduce the patient’s ability to weigh alternatives to mutilating behavior.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

12. What is the most challenging nursing intervention for patients diagnosed with personality disorders who use manipulation to get their needs met?
 - a. Supporting behavioral change
 - b. Monitoring suicide attempts
 - c. Maintaining consistent limits
 - d. Using aversive therapy

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ANS: C

Maintaining consistent limits is by far the most difficult intervention because of the patient’s superior skills at manipulation. Supporting behavioral change and monitoring patient safety are less difficult tasks. Aversive therapy would probably not be part of the care plan; positive reinforcement strategies for acceptable behavior are more effective than aversive techniques.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

13. The history shows that a newly admitted patient has impulsivity. The nurse would expect behavior characterized by what behavior?
 - a. Adherence to a strict moral code
 - b. Manipulative, controlling strategies
 - c. Postponing gratification to an appropriate time
 - d. Little time elapsed between thought and action

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ANS: D

The impulsive individual acts in haste without taking time to consider the consequences of the action. None of the other options describes impulsivity.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

14. A patient tells a nurse, “I sometimes get into trouble because I make quick decisions and act on them.” Which response by the nurse would be most therapeutic?
 - a. “Let’s consider the benefits of stopping to think the consequences.”
 - b. “It sounds as though you’ve developed some insight into your situation.”
 - c. “I’ll bet you have some interesting stories to share about overreacting.”
 - d. “It’s good that you’re showing readiness for behavioral change.”

ANS: A

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The patient is showing openness to learning techniques for impulse control. One technique is to teach the patient to stop and think before acting impulsively. The patient can then be taught to evaluate the outcomes of possible actions and choose an effective action. The incorrect responses shift the encounter to a social level or are judgmental.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

15. A patient diagnosed with borderline personality disorder has been hospitalized several times after self-inflicted lacerations. The patient remains impulsive. Dialectical behavior therapy starts on an outpatient basis. Which nursing diagnosis is the focus of this therapy?

- a. Risk for self-mutilation
- b. Impaired skin integrity
- c. Risk for injury
- d. Powerlessness

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ANS: A

Risk for self-mutilation is a nursing diagnosis relating to patient safety needs and is therefore a high priority. Impaired skin integrity and powerlessness may be appropriate foci for care but are not the priority or related to this therapy. Risk for injury implies accidental injury, which is not the case for the patient diagnosed with borderline personality disorder.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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16. Which statement made by a patient diagnosed with borderline personality disorder indicates the treatment plan is effective?

- a. "I think you are the best nurse on the unit."
- b. "I'm never going to get high on drugs again."
- c. "I hate my doctor for not giving me what I ask for."
- d. "I felt empty and wanted to cut myself, so I called you."

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ANS: D

Seeking a staff member instead of impulsively self-mutilating shows an adaptive coping strategy. The incorrect responses demonstrate idealization, devaluation, and wishful thinking.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

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17. When preparing to interview a patient diagnosed with narcissistic personality disorder, a nurse can anticipate the assessment findings will include what characteristics?

- a. Preoccupation with minute details; perfectionist
- b. Charming, dramatic, seductive; seeking admiration.
- c. Difficulty being alone; indecisiveness, submissiveness.
- d. Lack of empathy, exploitative, and arrogance.

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ANS: D

abirb.com/test

abirb.com/test

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, the characteristics of lacking empathy, exploitation of others, and arrogance are consistent with narcissistic personality disorder. Charm, drama, seductiveness, and admiration seeking are observed in patients diagnosed with histrionic personality disorder. Preoccupation with minute details and perfectionism are observed in individuals diagnosed with obsessive-compulsive personality disorder. Patients diagnosed with dependent personality disorder often express difficulty being alone and are indecisive and submissive.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

18. For which patient behavior would limit setting be most essential?
 - a. Clings to the nurse and asks for advice about inconsequential matters.
 - b. Is flirtatious and provocative with staff members of the opposite sex.
 - c. Is hypervigilant and refuses to attend unit activities as prescribed.
 - d. Urges a suspicious patient to hit anyone who stares at them.

ANS: D

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The correct option is an example of a manipulative behavior. Because manipulation violates the rights of others, limit setting is absolutely necessary. Furthermore, limit setting is necessary in this case because the safety of patients is at risk. Limit setting may be occasionally used with dependent behavior (clinging to the nurse) and histrionic behavior (flirting with staff members), but other therapeutic techniques are also useful. Limit setting is not needed for a patient who is hypervigilant and refuses to attend unit activities; rather, the need to develop trust is central to patient compliance.

TOP: Nursing Process: Planning

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Safe, Effective Care Environment

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19. A nurse in the emergency department tells an adult, "Your mother had a serious stroke." The adult tearfully says, "Who will take care of me now?" Which term best describes this behavior?
 - a. Histrionic
 - b. Dependent
 - c. Narcissistic
 - d. Borderline

ANS: B

abirb.com/test

The main characteristic of the dependent personality is a pervasive need to be taken care of that leads to submissive behaviors and a fear of separation. Histrionic behavior is characterized by flamboyance, attention seeking, and seductiveness. Narcissistic behavior is characterized by grandiosity and exploitative behavior. Patients with borderline personality disorder demonstrate separation anxiety, impulsivity, and splitting.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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20. Others describe a worker as very shy and lacking in self-confidence. This worker stays in an office cubicle all day and seldom comes out for breaks or lunch. Which term best describes this behavior?
 - a. Avoidant

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abirb.com/test

- b. Dependent
- c. Histrionic
- d. Paranoid

abirb.com/test

ANS: A

Patients with avoidant personality disorder are timid, socially uncomfortable, and withdrawn and avoid situations in which they might fail. They believe themselves to be inferior and unappealing. Individuals with dependent personality disorder are clinging, needy, and submissive. Individuals with histrionic personality disorder are seductive, flamboyant, shallow, and attention seeking. Individuals with paranoid personality disorder are suspicious and hostile and project blame.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

21. What is the priority intervention for a nurse beginning a therapeutic relationship with a patient diagnosed with a schizotypal personality disorder?
- a. Respect the patient's need for periods of social isolation.
 - b. Prevent the patient from violating the nurse's rights.
 - c. Engage the patient in many community activities.
 - d. Teach the patient how to match clothing.

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ANS: A

Patients diagnosed with schizotypal personality disorder are eccentric and often display perceptual and cognitive distortions. They are suspicious of others and have considerable difficulty trusting. They become highly anxious and frightened in social situations, thus the need to respect their desire for social isolation. Teaching the patient to match clothing is not the priority intervention. Patients diagnosed with schizotypal personality disorder rarely engage in behaviors that violate the nurse's rights or exploit the nurse.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

22. A patient diagnosed with borderline personality disorder self-inflicted wrist lacerations after gaining new privileges on the unit. The cause of the self-mutilation is probably related to what trigger?
- a. An inherited disorder that manifests itself as an incapacity to tolerate stress.
 - b. The use of projective identification and splitting to bring anxiety to manageable levels.
 - c. A constitutional inability to regulate affect, predisposing to psychic disorganization.
 - d. The fear of abandonment associated with progress toward autonomy and independence.

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ANS: D

Fear of abandonment is a central theme for most patients diagnosed with borderline personality disorder. This fear is often exacerbated when patients diagnosed with borderline personality disorder experience success or growth. The incorrect options are not associated with self-mutilation.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Evaluation

abirb.com/test

MSC: NCLEX: Safe, Effective Care Environment

23. A patient diagnosed with borderline personality disorder has self-inflicted wrist lacerations. The health care provider prescribes daily dressing changes. The nurse performing this care should focus on what?

- a. Encouraging the patient to express anger
- b. Providing care in a kind but matter-of-fact manner
- c. Demonstrating sympathy and concern
- d. Offering to listen to the patient's feelings about cutting

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ANS: B

A matter-of-fact approach does not provide the patient with positive reinforcement for self-mutilation. The goal of providing emotional consistency is supported by this approach. The incorrect options provide positive reinforcement of the behavior.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

24. A nurse set limits for a patient diagnosed with a borderline personality disorder. The patient tells the nurse, "You used to care about me. I thought you were wonderful. Now I can see I was mistaken. You're terrible." This outburst can be documented using what term?

- a. Denial
- b. Splitting
- c. Reaction formation
- d. Separation-individuation strategies

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ANS: B

Splitting involves loving a person and then hating the person; the patient is unable to recognize that an individual can have both positive and negative qualities. Denial is an unconscious motivated refusal to believe something. Reaction formation involves unconsciously doing the opposite of a forbidden impulse. Separation-individuation strategies refer to childhood behaviors related to developing independence from the caregiver.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

25. Which characteristic of individuals diagnosed with personality disorders makes it most necessary for staff to schedule frequent meetings?

- a. Ability to achieve true intimacy
- b. Flexibility and adaptability to stress
- c. Ability to evoke interpersonal conflict
- d. Inability to develop trusting relationships

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ANS: C

Frequent team meetings are held to counteract the effects of the patient's attempts to split staff and set them against one another, causing interpersonal conflict. Patients with personality disorders are inflexible and demonstrate maladaptive responses to stress. They are usually unable to develop true intimacy with others and are unable to develop trusting relationships. Although problems with trust may exist, it is not the characteristic that requires frequent staff meetings.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

[abirb.com/test](#)

MSC: NCLEX: Safe, Effective Care Environment

26. A patient who has been diagnosed with schizoid personality disorder is newly admitted to the unit. What is the best initial nursing intervention?
- Set firm limits.
 - Engage in trust building.
 - Involve in milieu and group activities.
 - Encourage identification and expression of feelings.

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ANS: B

Trust building is essential to developing a nurse–patient relationship. Firm limit setting is rarely necessary when working with a patient with schizoid PD. Involvement in activities might be difficult at first, because the patient will be highly uncomfortable around people. The patient must trust the nurse before responding to encouragement to express feelings.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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MULTIPLE RESPONSE

1. A nurse plans the care for an individual diagnosed with antisocial personality disorder. Which characteristic behaviors will the nurse expect? (*Select all that apply.*)
- Reclusive behavior
 - Callous attitude
 - Perfectionism
 - Aggression
 - Clinginess
 - Anxiety

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ANS: B, D

Individuals diagnosed with antisocial personality disorders characteristically demonstrate manipulative, exploitative, aggressive, callous, and guilt-instilling behaviors. Individuals diagnosed with antisocial personality disorders are more extroverted than reclusive, rarely show anxiety, and rarely demonstrate clinging or dependent behaviors. Individuals diagnosed with antisocial personality disorders are more likely to be impulsive than to be perfectionists.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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2. For which patients diagnosed with personality disorders would a family history of similar problems be most likely? (*Select all that apply.*)
- Obsessive-compulsive
 - Antisocial
 - Dependent
 - Schizotypal
 - Narcissistic

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ANS: A, B, D

Some personality disorders have evidence of genetic links; therefore, the family history would show other family members with similar traits. Heredity plays a role in schizotypal and antisocial problems, as well as obsessive-compulsive personality disorder.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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Chapter 14: Eating Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. Over the past year, a woman has cooked gourmet meals for her family but eats only tiny servings. She wears layered, loose clothing and now has amenorrhea. Her current weight is 95 pounds, a loss of 35 pounds. Which medical diagnosis is most likely?
 - a. Binge-eating disorder
 - b. Anorexia nervosa
 - c. Bulimia nervosa
 - d. Pica

ANS: B

Overly controlled eating behaviors, extreme weight loss, amenorrhea, preoccupation with food, and wearing several layers of loose clothing to appear larger are part of the clinical picture of an individual with anorexia nervosa. The individual with bulimia usually is near normal weight. The binge eater is often overweight. Pica refers to eating nonfood items.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

2. Disturbed body image is the nursing diagnosis for a patient diagnosed with an eating disorder. Which outcome indicator is most appropriate to monitor?
 - a. Weight, muscle, and fat are congruent with height, frame, age, and sex.
 - b. Calorie intake is within the required parameters of the treatment plan.
 - c. Weight reaches the established normal range for the patient.
 - d. The patient expresses satisfaction with body appearance.

ANS: D

Body image disturbances are considered improved or resolved when the patient is consistently satisfied with his or her own appearance and body function. This consideration is subjective. The other indicators are more objective but less related to the nursing diagnosis.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

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3. A patient who was referred to the eating disorders clinic has lost 35 pounds in the past 3 months. To assess the patient's oral intake, the nurse should ask which assessment question?
 - a. "Do you often feel fat?"
 - b. "Who plans the family meals?"
 - c. "What do you eat in a typical day?"
 - d. "What do you think about your present weight?"

ANS: C

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Although all the questions might be appropriate to ask, only “What do you eat in a typical day?” focuses on the eating patterns. Asking if the patient often feels fat focuses on distortions in body image. Questions about family meal planning are unrelated to eating patterns. Asking for the patient’s thoughts on present weight explores the patient’s feelings about weight.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

4. A patient diagnosed with anorexia nervosa virtually stopped eating 5 months ago and has lost 25% of body weight. A nurse asks, “Describe what you think about your present weight and how you look.” Which response by the patient is most consistent with the diagnosis?
 - a. “I am fat and ugly.”
 - b. “What I think about myself is my business.”
 - c. “I am grossly underweight, but that’s what I want.”
 - d. “I am a few pounds overweight, but I can live with it.”

ANS: A

Patients diagnosed with anorexia nervosa do not recognize their thinness. They perceive themselves to be overweight and unattractive. The patient with anorexia will usually disclose perceptions about self to others. The patient with anorexia will persist in trying to lose more weight.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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5. A patient was diagnosed with anorexia nervosa. The history shows the patient virtually stopped eating 5 months ago and has lost 25% of body weight. The patient’s current serum potassium is 2.7 mg/dL. Which nursing diagnosis is most applicable?
 - a. Adult failure to thrive, related to abuse of laxatives as evidenced by electrolyte imbalances and weight loss
 - b. Disturbed energy field, related to physical exertion in excess of energy produced through caloric intake as evidenced by weight loss and hyperkalemia
 - c. Ineffective health maintenance, related to self-induced vomiting as evidenced by swollen parotid glands and hyperkalemia
 - d. Imbalanced nutrition: less than body requirements, related to malnutrition as evidenced by loss of 25% of body weight and hypokalemia

ANS: D

The patient’s history and laboratory results support the correct nursing diagnosis. Available data do not confirm that the patient uses laxatives, induces vomiting, or exercises excessively. The patient has hypokalemia rather than hyperkalemia. There is no evidence of failure to thrive at this time.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis

MSC: NCLEX: Physiological Integrity

6. Outpatient treatment is planned for a patient diagnosed with anorexia nervosa. Select the most important outcome related to the nursing diagnosis: imbalanced nutrition: less than body requirements. Within 1 week, the expectation is that the patient will demonstrate what?
 - a. Weigh self accurately using balanced scales.
 - b. Limit exercise to less than 2 hours daily.

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- c. Select clothing that fits properly.
- d. Gain $\frac{1}{2}$ to $\frac{3}{4}$ pound.

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ANS: D

Only the outcome of a gain of $\frac{1}{2}$ to $\frac{3}{4}$ pound can be accomplished within 1 week when the patient is an outpatient. The focus of an outcome is not on the patient weighing self. Limiting exercise and selecting proper clothing are important, but weight gain takes priority.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

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MSC: NCLEX: Physiological Integrity

7. Which nursing intervention has priority as a patient diagnosed with anorexia nervosa begins to gain weight?
- a. Assess for depression and anxiety.
 - b. Observe for adverse effects of refeeding.
 - c. Communicate empathy for the patient's feelings.
 - d. Help the patient balance energy expenditure and caloric intake.

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ANS: B

The nursing intervention of observing for adverse effects of refeeding most directly relates to weight gain and is a priority. Assessing for depression and anxiety and communicating empathy relate to coping. Helping the patient balance energy expenditure and caloric intake is an inappropriate intervention.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

8. A patient diagnosed with anorexia nervosa is resistant to weight gain. What is the rationale for establishing a contract with the patient to participate in measures designed to produce a specified weekly weight gain?
- a. Because severe anxiety concerning eating is expected, objective and subjective data must be routinely collected.
 - b. Patient involvement in decision making increases a sense of control and promotes compliance with the treatment.
 - c. A team approach to planning the diet ensures that physical and emotional needs of the patient are met.
 - d. Because of increased risk for physical problems with refeeding, obtaining patient permission is required.

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ANS: B

A sense of control for the patient is vital to the success of therapy. A diet that controls weight gain can allay patient fears of a too-rapid weight gain. Data collection is not the reason for contracting. A team approach is wise but is not a guarantee that the patient's needs will be met. Permission for treatment is a separate issue. The contract for weight gain is an additional aspect of treatment.

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DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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abirb.com/test

9. The nursing care plan for a patient diagnosed with anorexia nervosa includes the intervention “Monitor for complications of refeeding.” Which body system should a nurse closely monitor for dysfunction?
- a. Renal
 - b. Endocrine
 - c. Central nervous
 - d. Cardiovascular

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ANS: D

Refeeding resulting in a too-rapid weight gain can overwhelm the heart, resulting in cardiovascular collapse. Associated complications of this shift can include heart failure, arrhythmias, respiratory failure, muscle breakdown, and death. Focused assessment becomes a necessity to ensure patient physiological integrity. The other body systems are not initially involved in the refeeding syndrome.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

10. A psychiatric clinical nurse specialist uses cognitive therapy techniques with a patient diagnosed with anorexia nervosa. Which statement by the staff nurse supports this type of therapy?
- a. “What are your feelings about not eating the food that you prepare?”
 - b. “You seem to feel much better about yourself when you eat something.”
 - c. “It must be difficult to talk about private matters to someone you just met.”
 - d. “Being thin does not seem to solve your problems. You are thin now but still unhappy.”

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ANS: D

Cognitive behavioral therapy is used to diminish distortions in the patient’s thinking that result in problematic attitudes and eating-disordered behaviors. The correct response is the only strategy that attempts to question the patient’s distorted thinking.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. An appropriate intervention for a patient diagnosed with bulimia nervosa who binges, and purges is to teach the patient what intervention?
- a. Eat a small meal after purging.
 - b. Avoid skipping meals or restricting food.
 - c. Concentrate oral intake after 4 pm daily.
 - d. Understand the value of reading journal entries aloud to others.

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ANS: B

One goal of health teaching is the normalization of eating habits. Food restriction and skipping meals lead to rebound bingeing. Teaching the patient to eat a small meal after purging will probably perpetuate the need to induce vomiting. Teaching the patient to concentrate intake after 4 pm will lead to late-day bingeing. Journal entries are private.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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12. What behavior by a nurse caring for a patient diagnosed with an eating disorder indicates the nurse needs supervision?
- The nurse's comments are compassionate and nonjudgmental.^{abirb.com/test}
 - The nurse uses an authoritarian manner when interacting with the patient.
 - The nurse teaches the patient to recognize signs of increasing anxiety and ways to intervene.
 - The nurse refers the patient to a self-help group for individuals with eating disorders.

ANS: B

In the effort to motivate the patient and take advantage of the decision to seek help and be healthier, the nurse must take care *not* to cross the line toward authoritarianism and assume the role of a parent. The helpful nurse uses a problem-solving approach and focuses on the patient's feelings of shame and low self-esteem. Referral to a self-help group is an appropriate intervention.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation
[abirb.com/test](#)

13. A nursing diagnosis for a patient diagnosed with bulimia nervosa is: ineffective coping, related to feelings of loneliness as evidenced by overeating to comfort self, followed by self-induced vomiting. The best outcome related to this diagnosis is that within 2 weeks the patient will demonstrate what?
- Appropriate expression of angry feelings
 - Verbalization of two positive things about self
 - Verbalization the importance of eating a balanced diet
 - Identification of two alternative methods of coping with loneliness

ANS: D

The outcome of identifying alternative coping strategies is most directly related to the diagnosis of ineffective coping. Verbalizing positive characteristics of self and verbalizing the importance of eating a balanced diet are outcomes that might be used for other nursing diagnoses. Appropriately expressing angry feelings is not measurable.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

14. Which nursing intervention has the highest priority for a patient diagnosed with bulimia nervosa?
- Assist the patient to identify triggers to binge eating.
 - Provide corrective consequences for weight loss.
 - Explore patient needs for health teaching.
 - Assess for signs of impulsive eating.

ANS: A

For most patients with bulimia nervosa, certain situations trigger the urge to binge; purging then follows. The triggers are often anxiety-producing situations. Identifying these triggers makes it possible to break the binge-purge cycle. Because binge eating and purging directly affect physical status, the need to promote physical safety assumes the highest priority. The question calls for an intervention rather than an assessment.

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15. One bed is available on the inpatient eating disorders unit. Which patient experiencing a weight should be admitted?
- 150 to 100 pounds over a 4-month period. Vital signs: temperature, 35.9° C; pulse, 38 beats/min; blood pressure, 60/40 mm Hg.
 - 120 to 90 pounds over a 3-month period. Vital signs: temperature, 36° C; pulse, 50 beats/min; blood pressure, 70/50 mm Hg.
 - 110 to 70 pounds over a 4-month period. Vital signs: temperature, 36.5° C; pulse, 60 beats/min; blood pressure, 80/66 mm Hg.
 - 90 to 78 pounds over a 5-month period. Vital signs: temperature, 36.7° C; pulse, 62 beats/min; blood pressure, 74/48 mm Hg.

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ANS: A

Physical criteria for hospitalization include weight loss of more than 30% of body weight within 6 months, temperature below 36° C (hypothermia), heart rate less than 40 beats/min, and systolic blood pressure less than 70 mm Hg.

16. While providing health teaching for a patient diagnosed with bulimia nervosa, what information should a nurse emphasize?
- Self-monitoring of daily food and fluid intake.
 - Establishing the desired daily weight gain.
 - Recognizing symptoms of hypokalemia.
 - Self-esteem maintenance.

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ANS: C

Hypokalemia results from potassium loss associated with vomiting. Physiological integrity can be maintained if the patient can self-diagnose potassium deficiency and adjust the diet or seek medical assistance. Self-monitoring of daily food and fluid intake is not useful if the patient purges. Daily weight gain may not be desirable for a patient with bulimia nervosa. Self-esteem is an identifiable problem but is of lesser priority than the risk for hypokalemia.

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17. As a patient admitted to the eating disorders unit undresses, a nurse observes that the patient's body is covered by fine, downy hair. The patient weighs 70 pounds and is 5 feet, 4 inches tall. Which condition should be documented?
- Amenorrhea
 - Alopecia
 - Lanugo
 - Stupor

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[abirb.com/test](#)

ANS: C

The fine, downy hair noted by the nurse is called *lanugo*. It is frequently seen in patients with anorexia nervosa. None of the other conditions can be supported by the data the nurse has gathered.

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DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

18. A patient being admitted to the eating disorders unit has a yellow cast to the skin and fine downy hair covering the body. The patient weighs 70 pounds; height is 5 feet, 4 inches. The patient is quiet and says only, "I won't eat until I look thin." What is the priority initial nursing diagnosis?
- Anxiety, related to fear of weight gain
 - Disturbed body image, related to weight loss
 - Ineffective coping, related to lack of conflict resolution skills
 - Imbalanced nutrition: less than body requirements, related to self-starvation

ANS: D

The physical assessment shows cachexia, which indicates imbalanced nutrition. Addressing the patient's self-starvation is the priority above the incorrect responses.

DIF: Cognitive Level: Analysis (Analyzing) abirb.com/test
TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
MSC: NCLEX: Physiological Integrity

19. A nurse conducting group therapy on the eating disorders unit schedules the sessions immediately after meals for what primary purpose?
- Maintaining patients' concentration and attention
 - Shifting the patients' focus from food to psychotherapy abirb.com/test
 - Focusing on weight control mechanisms and food preparation
 - Processing the heightened anxiety associated with eating

ANS: D

Eating produces high anxiety for patients with eating disorders. Anxiety levels must be lowered if the patient is to be successful in attaining therapeutic goals. Shifting the patients' focus from food to psychotherapy and focusing on weight control mechanisms and food preparation are not desirable. Maintaining patients' concentration and attention is important, but not the primary purpose of the schedule.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning abirb.com/test
MSC: NCLEX: Psychosocial Integrity

20. Physical assessment of a patient diagnosed with bulimia nervosa often reveals what data?
- Prominent parotid glands abirb.com/test
 - Peripheral edema
 - Thin, brittle hair
 - Amenorrhea

ANS: A

Prominent parotid glands are associated with repeated vomiting. The other options are signs of anorexia nervosa and are not usually observed in bulimia.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

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21. Which personality characteristic is a nurse most likely to assess in a patient diagnosed with anorexia nervosa?

- a. Carefree flexibility
- b. Rigidity, perfectionism
- c. Open displays of emotion
- d. High spirits and optimism

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[abirb.com/test](#)

ANS: B

Rigid thinking, inability to demonstrate flexibility, and difficulty changing cognitions are characteristic of patients diagnosed with eating disorders. The incorrect options are rare in a patient with anorexia nervosa. Inflexibility, controlled emotions, and pessimism are more the norm.

DIF: Cognitive Level: Comprehension (Understanding)

[abirb.com/test](#)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

22. Which assessment finding for a patient diagnosed with an eating disorder meets a criterion for hospitalization?

- a. Urine output: 40 mL/hr
- b. Pulse rate: 58 beats/min
- c. Serum potassium: 3.4 mEq/L
- d. Systolic blood pressure: 62 mm Hg

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ANS: D

Systolic blood pressure less than 70 mm Hg is an indicator for inpatient care. Many people without eating disorders have bradycardia (pulse less than 60 beats/min). Urine output should be more than 30 mL/hr. A potassium level of 3.4 mEq/L is within the normal range.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

23. Which statement is a nurse most likely to hear from a patient diagnosed with anorexia nervosa?

- a. "I would be happy if I could lose 20 more pounds."
- b. "My parents don't pay much attention to me."
- c. "I'm thin for my height."
- d. "I have nice eyes."

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ANS: A

Patients with eating disorders have distorted body images and cognitive distortions. They see themselves as overweight even when their weight is subnormal. "I'm thin for my height" is therefore unlikely to be heard from a patient with anorexia nervosa. Poor self-image precludes making positive statements about self, such as "I have nice eyes." Many patients with eating disorders see supportive others as intrusive and out of tune with their needs.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

24. Which nursing diagnosis is more applicable for a patient diagnosed with anorexia nervosa who restricts intake and is 20% below normal weight than for a 130-pound patient diagnosed with bulimia nervosa who purges?

- a. Powerlessness

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[abirb.com/test](#)

- b. Ineffective coping
- c. Disturbed body image
- d. Imbalanced nutrition: less than body requirements

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ANS: D

The patient with bulimia nervosa usually maintains a close to normal weight, whereas the patient with anorexia nervosa may approach starvation. The incorrect options may be appropriate for patients with either anorexia nervosa or bulimia nervosa.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis abirb.com/test

MSC: NCLEX: Physiological Integrity

25. An outpatient diagnosed with anorexia nervosa has begun refeeding. Between the first and second appointments, the patient gained 8 pounds. The nurse should implement what intervention to assess patient safety?
- a. Assess lung sounds and extremities.
 - b. Suggest the use of an aerobic exercise program. abirb.com/test
 - c. Positively reinforce the patient for the weight gain.
 - d. Establish a higher goal for weight gain the next week.

ANS: A

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Weight gain of more than 2 to 5 pounds weekly may overwhelm the heart's capacity to pump, leading to cardiac failure. The nurse must assess for signs of pulmonary edema and congestive heart failure. The incorrect options are undesirable because they increase the risk for cardiac complications. abirb.com/test

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

26. When observing a patient diagnosed with anorexia nervosa vigorously exercising before gaining the agreed-upon weekly weight, what response should the nurse provide?
- a. "You and I will have to sit down and discuss this problem." abirb.com/test
 - b. "It bothers me to see you exercising. You'll lose more weight."
 - c. "Let's discuss the relationship between exercise and weight loss and how that affects your body." abirb.com/test
 - d. "According to our agreement, no exercising is permitted until you have gained a specific amount of weight."

ANS: D

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A matter-of-fact statement that the nurse's perceptions are different helps avoid a power struggle. Treatment plans have specific goals for weight restoration. Exercise is limited to promote weight gain. Patients must be held accountable for required behaviors. abirb.com/test

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

27. A patient diagnosed with anorexia nervosa has a body mass index (BMI) of 14.8 kg/m². Which assessment finding is most likely to accompany this value?
- a. Cachexia
 - b. Leukocytosis
 - c. Hyperthermia

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d. Hypertension

ANS: A

The BMI value indicates extreme malnutrition. Cachexia is a hallmark of this problem. The patient would be expected to have leukopenia rather than leukocytosis. Hypothermia and hypotension are likely assessment findings.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

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MULTIPLE RESPONSE

1. A patient referred to the eating disorders clinic has lost 35 pounds in 3 months and has developed amenorrhea. For which physical manifestations of anorexia nervosa should a nurse assess? (*Select all that apply.*)

- a. Hypothermia
- b. Parotid swelling
- c. Constipation
- d. Hypotension
- e. Dental caries
- f. Lanugo

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[abirb.com/test](#)

ANS: A, C, D, F

Constipation related to starvation is often present. Hypothermia and hypotension is often present because of dehydration. Lanugo is often present and is related to starvation. Parotid swelling is associated with bulimia. Dental caries are associated with bulimia.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

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2. A patient diagnosed with anorexia nervosa is hospitalized for treatment. What features should the milieu provide? (*Select all that apply.*)

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- a. Flexible mealtimes
- b. Unscheduled weight checks
- c. Adherence to a selected menu
- d. Observation during and after meals
- e. Monitoring during bathroom trips
- f. Privileges correlated with emotional expression

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ANS: C, D, E

Priority milieu interventions support the restoration of weight and a normalization of eating patterns. These goals require close supervision of the patient's eating habits and the prevention of exercise, purging, and other activities. Menus are strictly adhered to. Patients are observed during and after meals to prevent them from throwing away food or purging. All trips to the bathroom are monitored. Mealtimes are structured, not flexible. Weighing is performed on a regular schedule. Privileges are correlated with weight gain and treatment plan compliance.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

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Chapter 15: Mood Disorders: Depression

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A patient became severely depressed when the last of six children moved out of the home 4 months ago. The patient repeatedly says, "No one cares about me. I'm not worth anything." Which response by the nurse would be the most helpful? abirb.com/test
 - a. "Things will look brighter soon. Everyone feels down once in a while."
 - b. "The staff here cares about you and wants to try to help you get better."
 - c. "It is difficult for others to care about you when you repeatedly say negative things about yourself."
 - d. "I'll sit with you for 10 minutes now and return for 10 minutes at lunchtime and again at 2:30 this afternoon."

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ANS: D

Spending time with the patient at intervals throughout the day shows acceptance by the nurse and helps the patient establish a relationship with the nurse. The therapeutic technique is called *offering self*. Setting definite times for the therapeutic contacts and keeping the appointments show predictability on the part of the nurse, an element that fosters the building of trust. The incorrect responses would be difficult for a person with profound depression to believe, provide trite reassurance, and are counterproductive. The patient is unable to say positive things at this point.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A patient became depressed after the last of six children moved out of the home 4 months ago. The patient has been self-neglectful, slept poorly, lost weight, and repeatedly says, "No one cares about me anymore. I'm not worth anything." Select an appropriate initial outcome.
 - a. The patient will verbalize realistic positive characteristics about self by (date).
 - b. The patient will consent to take antidepressant medication regularly by (date).
 - c. The patient will initiate social interaction with another person daily by (date).
 - d. The patient will identify two personal behaviors that alienate others by (date).

ANS: A

Low self-esteem is reflected by making consistently negative statements about self and self-worth. Replacing negative cognitions with more realistic appraisals of self is an appropriate intermediate outcome. The incorrect options are not as clearly related to the nursing diagnosis. Outcomes are best when framed positively; identifying two personal behaviors that might alienate others is a negative concept.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

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MSC: NCLEX: Psychosocial Integrity

3. A nurse wants to reinforce positive self-esteem for a patient diagnosed with major depressive disorder. Today, the patient is wearing a new shirt and has neat, clean hair. Which remark is most appropriate?

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- a. "You look nice this morning."
- b. "You are wearing a new shirt."
- c. "I like the shirt you're wearing."
- d. "You must be feeling better today."

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ANS: B

Patients with depression usually see the negative side of things. The meaning of compliments may be altered to "I didn't look nice yesterday" or "They didn't like my other shirt." Neutral comments such as an observation avoid negative interpretations. Saying "You look nice" or "I like your shirt" gives approval (nontherapeutic techniques). Saying "You must be feeling better today" is an assumption, which is nontherapeutic.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

4. An adult diagnosed with major depressive disorder was treated with medication and cognitive behavioral therapy. The patient now recognizes how passivity contributed to the depression. Which intervention should the nurse suggest?
- a. Social skills training
 - b. Relaxation training classes
 - c. Use of complementary therapy
 - d. Learning desensitization techniques

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ANS: A

Social skills training is helpful in treating and preventing the recurrence of depression. Training focuses on assertiveness and coping skills that lead to positive reinforcement from others and the development of a patient's support system. The use of complementary therapy refers to adjunctive therapies such as herbals. Assertiveness would be of greater value than relaxation training because passivity is a concern. Desensitization is used in the treatment of phobias.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

5. What is a priority nursing intervention for a patient diagnosed with major depressive disorder?
- a. Distracting the patient from self-absorption
 - b. Carefully and inconspicuously observing the patient around the clock
 - c. Allowing the patient to spend long periods alone in self-reflection
 - d. Offering opportunities for the patient to assume a leadership role in the therapeutic milieu

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ANS: B

Approximately two-thirds of people with depression contemplate suicide. Patients with depression who exhibit feelings of worthlessness are at higher risk. Regularly planned observations of the patient with depression may prevent a suicide attempt on the unit.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

6. When counseling patients diagnosed with major depressive disorder, how will an advanced practice nurse likely address the negative thought patterns?
- a. Psychoanalytic therapy

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- b. Desensitization therapy
- c. Cognitive behavioral therapy
- d. Alternative and complementary therapies

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ANS: C

Cognitive behavioral therapy attempts to alter the patient's dysfunctional beliefs by focusing on positive outcomes rather than negative attributions. The patient is also taught the connection between thoughts and resultant feelings. Research shows that cognitive behavioral therapy involves the formation of new connections among nerve cells in the brain and that it is at least as effective as medication. Evidence does not support superior outcomes for the other psychotherapeutic modalities mentioned.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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7. A patient says to the nurse, "My life does not have any happiness in it anymore. I once enjoyed holidays, but now they're just another day." How would the nurse document the patient's statement?
- a. Vegetative
 - b. Anhedonia
 - c. Euphoria
 - d. Anergia

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ANS: B

Anhedonia is a common finding in many types of depression and refers to feelings of a loss of pleasure in formerly pleasurable activities. Vegetative symptoms refer to somatic changes associated with depression. Euphoria refers to an elated mood. Anergia means *without energy*.

DIF: Cognitive Level: Comprehension (Understanding) abirb.com/test
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

8. A patient diagnosed with major depressive disorder is taking a tricyclic antidepressant. The patient says, "I don't think I can keep taking these pills. They make me so dizzy, especially when I stand up." The nurse should implement what intervention?
- a. Explain how to manage postural hypotension and educate the patient that side effects go away after several weeks. abirb.com/test
 - b. Tell the patient that the side effects are a minor inconvenience compared with the feelings of depression.
 - c. Withhold the drug, force oral fluids, and notify the health care provider to examine the patient. abirb.com/test
 - d. Teach the patient how to use pursed-lip breathing.

ANS: A

Drowsiness, dizziness, and postural hypotension usually subside after the first few weeks of therapy with tricyclic antidepressants. Postural hypotension can be managed by teaching the patient to stay well hydrated and rise slowly. Knowing these facts may be enough to convince the patient to remain medication compliant. The minor inconvenience of side effects as compared with feelings of depression is a convincing reason to remain on the medication. Withholding the drug, forcing oral fluids, and having the health care provider examine the patient are unnecessary steps. Independent nursing action is appropriate. Pursed-lip breathing is irrelevant.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

9. A patient diagnosed with major depressive disorder is receiving imipramine 200 mg every night at bedtime. Which assessment finding would prompt the nurse to collaborate with the health care provider regarding potentially hazardous side effects of this drug?
- Dry mouth
 - Blurred vision
 - Nasal congestion
 - Urinary retention

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ANS: D

All the side effects mentioned are the result of the anticholinergic effects of the drug. Only urinary retention and severe constipation warrant immediate medical attention. Dry mouth, blurred vision, and nasal congestion may be less troublesome as therapy continues.

DIF: Cognitive Level: Application (Applying) [abirb.com/test](#)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

10. A patient diagnosed with major depressive disorder tells the nurse, “Bad things that happen are always my fault.” To assist the patient in reframing this overgeneralization, how should the nurse respond?
- “I really doubt that one person can be blamed for all the bad things that happen.”
 - “Let’s look at one bad thing that happened to see if another explanation exists.”
 - “You are being exceptionally hard on yourself when you say those things.”
 - “How does your belief in fate relate to your cultural heritage?”

ANS: B

[abirb.com/test](#)

By questioning a faulty assumption, the nurse can help the patient look at the premise more objectively and reframe it as a more accurate representation of fact. The incorrect responses are judgmental, irrelevant to an overgeneralization, and cast doubt without requiring the patient to evaluate the statement.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. A nurse worked with a patient diagnosed with major depressive disorder who was severely withdrawn and dependent on others. After 3 weeks, the patient did not improve. The nurse is at risk for what emotional response?
- Overinvolvement
 - Guilt and despair
 - Disinterest and apathy
 - Ineffectiveness and frustration

[abirb.com/test](#)

ANS: D

Nurses may have expectations for self and patients that are not wholly realistic, especially regarding the patient’s progress toward health. Unmet expectations result in feelings of ineffectiveness, anger, or frustration. Guilt and despair might be observed when the nurse experiences feelings about patients because of sympathy. Disinterest and apathy are possible but not the most likely result. The correct response is more global than over-involvement.

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DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

12. A patient diagnosed with major depressive disorder begins selective serotonin reuptake inhibitor (SSRI) antidepressant therapy. Priority information given to the patient and family should include a directive to do what?
- Avoid exposure to bright sunlight.
 - Report increased suicidal thoughts.
 - Restrict sodium intake to 1 g daily.
 - Maintain a tyramine-free diet.

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ANS: B

Some evidence indicates that suicidal ideation may worsen at the beginning of antidepressant therapy; thus, close monitoring is necessary. Avoiding exposure to bright sunlight and restricting sodium intake are unnecessary. Tyramine restriction is associated with monoamine oxidase inhibitor (MAOI) therapy.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

13. A nurse teaching a patient about a tyramine-restricted diet would approve which meal?
- Mashed potatoes, ground beef patty, corn, green beans, apple pie
 - Avocado salad, ham, creamed potatoes, asparagus, chocolate cake
 - Macaroni and cheese, hot dogs, banana bread, caffeinated coffee
 - Noodles with cheddar cheese sauce, smoked sausage, lettuce salad, yeast rolls

ANS: A

The correct answer describes a meal that contains little tyramine. Vegetables and fruits contain little or no tyramine, and fresh ground beef and apple pie should be safe. The other meals contain various amounts of tyramine-rich foods or foods that contain vasopressors: avocados, ripe bananas (banana bread), sausages and hot dogs, smoked meat (ham), cheddar cheese, yeast, caffeine drinks, and chocolate.

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DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

14. What is the focus of priority nursing care for the period immediately after a patient has an electroconvulsive therapy (ECT) treatment?
- Supporting physiological stability
 - Reducing disorientation and confusion
 - Monitoring pupillary responses
 - Assisting the patient to plan for the future

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[abirb.com/test](#)

ANS: A

During the immediate post-treatment period, the patient is recovering from general anesthesia, hence the need to establish and support physiological stability. Monitoring pupillary responses is not a priority. Reducing disorientation and confusion is an acceptable intervention but not the priority. Assisting the patient to plan for the future is inappropriate in the immediate post-treatment period because the patient may be confused.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

15. A nurse provided medication education for a patient who is prescribed phenelzine for depression. Which patient behavior indicates effective learning? [abirb.com/test](#)
- Monitors sodium intake and weight daily.
 - Wears support stockings and elevates the legs when sitting.
 - Consults the pharmacist when selecting over-the-counter medications.
 - Can identify foods with high selenium content, which should be avoided.

ANS: C

Over-the-counter medicines may contain vasopressor agents or tyramine, a substance that must be avoided when the patient takes MAOI antidepressants. Medications for colds, allergies, or congestion or any preparation that contains ephedrine or phenylpropanolamine may precipitate a hypertensive crisis. MAOI antidepressant therapy is unrelated to the need for sodium limitation, support stockings, or leg elevation. MAOIs interact with tyramine-containing foods, not selenium, to produce dangerously high blood pressure.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Evaluation
[abirb.com/test](#)

16. A patient's employment is terminated, and major depressive disorder develops shortly afterward. The patient says to the nurse, "I'm not worth the time you spend with me. I'm the most useless person in the world." Which nursing diagnosis applies?
- Powerlessness
 - Defensive coping
 - Situational low self-esteem
 - Disturbed personal identity

ANS: C

The patient's statements express feelings of worthlessness and most clearly relate to the nursing diagnosis of situational low self-esteem. Insufficient information exists to justify the other diagnoses.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

17. A patient diagnosed with major depressive disorder does not interact with others except when addressed and then only in monosyllables. The nurse wants to show nonjudgmental acceptance and support for the patient. Select the nurse's most effective approach to communication.
- Make observations on neutral topics.
 - Ask the patient direct questions.
 - Phrase questions to require "yes" or "no" answers.
 - Frequently reassure the patient to reduce guilt feelings.

ANS: A

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[abirb.com/test](#)

Making observations about neutral topics such as the environment draws the patient into the reality around him or her but places no burdensome expectations on the patient for answers. Acceptance and support are shown by the nurse's presence. Direct questions may make the patient feel that the encounter is an interrogation. Open-ended questions are preferable if the patient is able to participate in dialog. Platitudes are never acceptable; they minimize patient feelings and can increase feelings of worthlessness.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

18. A patient being treated for major depressive disorder has taken 300 mg amitriptyline daily for a year. The patient calls the case manager at the clinic and says, "I stopped taking my antidepressant 2 days ago. Now I am having cold sweats, nausea, a rapid heartbeat, and nightmares." How should the nurse advise the patient?
- a. "Go to the nearest emergency department immediately."
 - b. "Do not be alarmed. Take two aspirin and drink plenty of fluids."
 - c. "Take one dose of the antidepressant, and then come to the clinic to see the health care provider."
 - d. "Resume taking the antidepressant for 2 more weeks, and then discontinue it again."

[abirb.com/test](#)

ANS: C

The patient has symptoms associated with abrupt withdrawal of the tricyclic antidepressant. Taking a dose of the drug will ameliorate the symptoms. Seeing the health care provider will allow the patient to discuss the advisability of going off the medication and to be given a gradual withdrawal schedule if discontinuation is the decision. This situation is not a medical emergency, although it calls for medical advice. Resuming taking the antidepressant for 2 more weeks and then discontinuing again would produce the same symptoms the patient is experiencing.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

19. Which documentation indicates the treatment plan of a patient diagnosed with major depressive disorder was effective?
- a. Slept 6 hours uninterrupted. Sang with activity group. Anticipates seeing grandchild.
 - b. Slept 10 hours uninterrupted. Attended craft group; stated "project was a failure, just like me."
 - c. Slept 5 hours with brief interruptions. Personal hygiene adequate with assistance. Weight loss of 1 pound.
 - d. Slept 7 hours uninterrupted. Preoccupied with perceived inadequacies. States, "I feel tired all the time."

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[abirb.com/test](#)

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ANS: A

Sleeping 6 hours, participating in a group activity, and anticipating an event are all positive happenings. All the other options show at least one negative finding.

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

[abirb.com/test](#)

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20. A woman gave birth to a healthy newborn 1 month ago. The patient now reports she cannot cope and is unable to sleep or eat. She says, "I feel like a failure. This baby is the root of my problems." What is the priority nursing diagnosis? [abirb.com/test](#)
- a. Insomnia
 - b. Ineffective coping
 - c. Situational low self-esteem
 - d. Risk for other-directed violence [abirb.com/test](#)

ANS: D

When a new mother develops depression with a postpartum onset, ruminations or delusional thoughts about the infant often occur. The risk for harming the infant is increased; thus, it becomes the priority diagnosis. The other diagnoses are relevant but are of lower priority.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Health Promotion and Maintenance

21. A patient diagnosed with major depressive disorder repeatedly tells staff members, "I have cancer. It's my punishment for being a bad person." Diagnostic tests reveal no cancer. Select the priority nursing diagnosis.
- a. Powerlessness [abirb.com/test](#)
 - b. Risk for suicide
 - c. Stress overload
 - d. Spiritual distress [abirb.com/test](#)

ANS: B

A patient with depression who feels so worthless as to believe cancer is deserved is at risk for suicide. Safety concerns take priority over the other diagnoses listed. [abirb.com/test](#)

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity [abirb.com/test](#)

22. Which beverage should the nurse offer to a patient diagnosed with major depressive disorder who refuses solid food?
- a. Tomato juice [abirb.com/test](#)
 - b. Orange juice
 - c. Hot tea
 - d. Milk [abirb.com/test](#)

ANS: D

Milk is the only beverage listed that provides protein, fat, and carbohydrates. In addition, milk is fortified with vitamins. [abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

23. During a psychiatric assessment, the nurse observes a patient's facial expressions that are without emotion. The patient says, "Life feels so hopeless to me. I've been feeling sad for several months." How should the nurse document the patient's affect and mood?
- a. Affect depressed; mood flat [abirb.com/test](#)
 - b. Affect flat; mood depressed [abirb.com/test](#)

[abirb.com/test](#)

- c. Affect labile; mood euphoric
- d. Affect and mood are incongruent

[abirb.com/test](#)

ANS: B

Mood is a person's self-reported emotional feeling state. Affect is the emotional feeling state that is outwardly observable by others.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

24. A disheveled patient with severe depression and psychomotor retardation has not bathed for several days. What action should the nurse take?
- a. Avoid forcing the issue.
 - b. Bringing up the issue at the community meeting.
 - c. Calmly telling the patient, "You must bathe daily."
 - d. Firmly and neutrally assisting the patient with showering.

ANS: D

[abirb.com/test](#)

When patients are unable to perform self-care activities, staff members must assist them rather than ignore the issue. Better grooming increases self-esteem. Calmly telling the patient to bathe daily and bringing up the issue at a community meeting are punitive.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

25. A patient was started on escitalopram 5 days ago and now says, "This medicine isn't working." What is the nurse's best intervention?
- a. Discussing with the health care provider the need to change medications
 - b. Reassuring the patient that the medication will be effective soon
 - c. Explaining the time lag before antidepressants relieve symptoms
 - d. Critically assessing the patient for symptom relief

ANS: C

[abirb.com/test](#)

Escitalopram is an SSRI antidepressant. Between 1 and 3 weeks of treatment are usually necessary before a relief of symptoms occurs. This information is important to share with patients.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation

MSC: NCLEX: Physiological Integrity

26. A nurse is caring for a patient with low self-esteem. Which nonverbal communication should the nurse anticipate?
- a. Arms crossed
 - b. Staring at the nurse
 - c. Smiling inappropriately
 - d. Eyes casted downward

ANS: D

[abirb.com/test](#)

Nonverbal communication is usually considered more powerful than verbal communication. Downward-casted eyes suggest feelings of worthlessness or hopelessness.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

27. A patient diagnosed with major depressive disorder was hospitalized for 8 days. Treatment included six electroconvulsive therapy sessions and aggressive dose adjustments of antidepressant medications. The patient owns a small business and was counseled not to make major decisions for a month. Select the correct rationale for this counseling.
- Temporary memory impairments and confusion can be associated with electroconvulsive therapy.
 - Antidepressant medications alter catecholamine levels, which impair decision-making abilities.
 - Antidepressant medications may cause confusion related to a limitation of tyramine in the diet.
 - The patient needs time to reorient him or herself to a pressured work schedule.

ANS: A

Recent memory impairment or confusion or both are often present during and for a short time after electroconvulsive therapy. An inappropriate business decision might be made because of forgotten and important details. The incorrect responses contain rationales that are untrue. The patient needing time to reorient himself or herself to a pressured work schedule is less relevant than the correct rationale.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

28. A nurse instructs a patient taking a drug that inhibits the action of monoamine oxidase (MAO) to avoid certain foods and drugs because of what risk?
- Hypotensive shock
 - Hypertensive crisis
 - Cardiac dysrhythmia
 - Cardiogenic shock

ANS: B

Patients taking MAOIs must be on a tyramine-free diet to prevent hypertensive crisis. In the presence of MAOIs, tyramine is not destroyed by the liver and, in high levels, produces intense vasoconstriction, resulting in elevated blood pressure.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

MULTIPLE RESPONSE

- The admission note indicates a patient diagnosed with major depressive disorder has displayed symptomology of both anergia and anhedonia. For which measures should the nurse plan? (*Select all that apply.*)
 - Channeling excessive energy
 - Reducing guilty ruminations
 - Instilling a sense of hopefulness
 - Assisting with self-care activities
 - Accommodating psychomotor retardation

ANS: C, D, E

Anhedonia refers to the inability to find pleasure or meaning in life; thus, planning should include measures to accommodate psychomotor retardation, assist with activities of daily living, and instill hopefulness. Anergia is the lack of energy, not excessive energy. Anhedonia does not necessarily imply the presence of guilty ruminations.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
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2. A student nurse caring for a patient diagnosed with major depressive disorder reads in the patient's medical record, "This patient shows vegetative signs of depression." Which nursing diagnoses most clearly relate to the vegetative signs? (*Select all that apply.*)
- a. Imbalanced nutrition: less than body requirements
 - b. Chronic low self-esteem
 - c. Sexual dysfunction
 - d. Self-care deficit
 - e. Powerlessness
 - f. Insomnia

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ANS: A, C, D, F

Vegetative signs of depression are alterations in the body processes necessary to support life and growth, such as eating, sleeping, elimination, and sexual activity. These diagnoses are more closely related to vegetative signs than to diagnoses associated with feelings about self.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis [abirb.com/test](#)

MSC: NCLEX: Psychosocial Integrity

3. A patient diagnosed with major depressive disorder will begin electroconvulsive therapy tomorrow. Which interventions are routinely implemented before the treatment? (*Select all that apply.*)
- a. Administer pretreatment medication 30 to 45 minutes before treatment.
 - b. Withhold food and fluids for a minimum of 6 hours before treatment.
 - c. Remove dentures, glasses, contact lenses, and hearing aids.
 - d. Restrain the patient in bed with padded limb restraints.
 - e. Assist the patient to prepare an advance directive.

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ANS: A, B, C

The correct interventions reflect routine electroconvulsive therapy preparation, which is similar to preoperative preparation: sedation and anticholinergic medication before anesthesia, maintaining nothing-by-mouth status to prevent aspiration during and after treatment, airway maintenance, and general safety by removing prosthetic devices. Restraint is not part of the pretreatment protocol. An advance directive is prepared independent of this treatment.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

4. A patient diagnosed with major depressive disorder shows vegetative signs of depression. Which nursing actions should be implemented? (*Select all that apply.*)
- a. Offer laxatives, if needed.
 - b. Monitor food and fluid intake.
 - c. Provide a quiet sleep environment.

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- d. Eliminate all daily caffeine intake.
- e. Restrict the intake of processed foods.

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ANS: A, B, C

The correct options promote a normal elimination pattern. Although excessive intake of stimulants such as caffeine may make the patient feel jittery and anxious, small amounts may provide useful stimulation. No indication exists that processed foods should be restricted.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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5. A patient being treated with paroxetine 50 mg/day orally for major depressive disorder reports to the clinic nurse, "I took a few extra tablets earlier in the day and now I feel bad." Which aspects of the nursing assessment are most critical? (*Select all that apply.*)
- a. Vital signs
 - b. Urinary frequency
 - c. Increased suicidal ideation
 - d. Presence of abdominal pain and diarrhea
 - e. Hyperactivity or feelings of restlessness

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ANS: A, D, E

The patient is taking the maximum dose of this SSRI and has ingested an additional unknown amount of the drug. Central serotonin syndrome must be considered. Symptoms include abdominal pain, diarrhea, tachycardia, elevated blood pressure, hyperpyrexia, increased motor activity, and muscle spasms. Central serotonin syndrome may progress to a full medical emergency if not treated early. Although assessing for suicidal ideation is never inappropriate, in this situation physiological symptoms should be the initial focus. The patient may have urinary retention, but frequency would not be expected.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

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Chapter 16: Bipolar Spectrum Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A person is directing traffic on a busy street while shouting and making obscene gestures at passing cars. The person has not slept or eaten for 3 days. What features of mania are evident?
 - a. Increased muscle tension and anxiety
 - b. Vegetative signs and poor grooming
 - c. Poor judgment and hyperactivity
 - d. Cognitive deficit and sad mood

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ANS: C

Hyperactivity (directing traffic) and poor judgment (putting self in a dangerous position) are characteristic of manic episodes. The distractors do not specifically apply to mania.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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2. A patient diagnosed with bipolar disorder is dressed in a red leotard and brightly colored scarves. The patient cusses while twirling and shadowboxing. Then the patient says gaily, "Do you like my scarves? Here...they are my gift to you." How should the nurse document the patient's mood?
 - a. Labile and euphoric
 - b. Irritable and belligerent
 - c. Highly suspicious and arrogant
 - d. Excessively happy and confident

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ANS: A

The patient has demonstrated angry behavior and pleasant, happy behavior within seconds of each other. Excessive happiness indicates euphoria. Mood swings are often rapid and seemingly without understandable reason in patients who are manic. These swings are documented as *labile*. Irritability, belligerence, excessive happiness, and confidence are not entirely correct terms for the patient's mood. A high level of suspicion is not evident.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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3. A patient experiencing mania has not eaten or slept for 3 days. Which nursing diagnosis has priority?
 - a. Risk for injury
 - b. Ineffective coping
 - c. Impaired social interaction
 - d. Ineffective therapeutic regimen management

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ANS: A

Although each of the nursing diagnoses listed is appropriate for a patient having a manic episode, the priority lies with the patient's physiological safety. Hyperactivity and poor judgment place the patient at risk for injury.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis [abirb.com/test](#)

MSC: NCLEX: Safe, Effective Care Environment

4. A patient diagnosed with bipolar disorder is hyperactive and manic after discontinuing lithium. The patient threatens to hit another patient. Which comment by the nurse is appropriate?
- “Stop that! No one did anything to provoke an attack by you.”
 - “If you do that one more time, you will be secluded immediately.”
 - “Do not hit anyone. If you are unable to control yourself, we will help you.”
 - “You know we will not let you hit anyone. Why do you continue this behavior?”

ANS: C

When the patient is unable to control his or her behavior and violates or threatens to violate the rights of others, limits must be set in an effort to de-escalate the situation. Limits should be set in simple, concrete terms. The incorrect responses do not offer appropriate assistance to the patient and threaten the patient with seclusion as punishment.^{abirb.com/test} Asking “why” does not provide for environmental safety.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment [abirb.com/test](#)

5. This nursing diagnosis applies to a patient experiencing mania: imbalanced nutrition: less than body requirements, related to insufficient caloric intake and hyperactivity as evidenced by 5-pound weight loss in 4 days. What is the most appropriate outcome related to patient behavior?
- Asking staff for assistance with feeding within 4 days
 - Drinking six servings of a high-calorie, high-protein drink each day
 - Consistently sitting with others for at least 30 minutes at mealtime within 1 week
 - Wearing appropriate attire for age and gender within 1 week while in the psychiatric unit [abirb.com/test](#)

ANS: B

High-calorie, high-protein food supplements will provide the additional calories needed to offset the patient’s extreme hyperactivity. Sitting with others or asking for assistance does not mean the patient will eat or drink. Appropriate attire is unrelated to the nursing diagnosis.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification [abirb.com/test](#)

MSC: NCLEX: Physiological Integrity

6. A patient develops mania after discontinuing lithium. New prescriptions are written to resume lithium twice daily and begin olanzapine. This is the expected reaction to the addition of olanzapine to the medication regimen?
- Minimize the side effects of lithium.
 - Bring hyperactivity under rapid control. [abirb.com/test](#)
 - Enhance the antimanic actions of lithium.
 - Provide long-term control of hyperactivity.

ANS: B

Manic symptoms are controlled by lithium only after a therapeutic serum level is attained. Because this takes several days to accomplish, a drug like olanzapine with rapid onset is necessary to reduce the hyperactivity initially. Antipsychotic drugs neither enhance lithium's antimanic activity nor minimize the side effects. Lithium is used for long-term control.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning
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7. A patient diagnosed with bipolar disorder has rapid cycles. The health care provider prescribes an anticonvulsant medication. To prepare teaching materials, which drug should the nurse anticipate will be prescribed?
- a. Phenytoin
 - b. Clonidine
 - c. Carbamazepine
 - d. Chlorpromazine

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ANS: C

Some patients with bipolar disorder, especially those who have only short periods between episodes, have a favorable response to the anticonvulsants carbamazepine and valproate. Phenytoin is also an anticonvulsant but is not used for mood stabilization. Carbamazepine seems to work better in patients with rapid cycling and in severely paranoid, angry patients with manic episodes.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning
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8. This is the primary reason that the cause of bipolar disorder has not been determined?
- a. Several factors, including genetics, are implicated.
 - b. Brain structures were altered by trauma early in life.
 - c. Excess norepinephrine is probably a major factor.
 - d. Excess sensitivity in dopamine receptors may exist.

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ANS: A

At this time, the interplay of complex independent variables is most likely the best explanation of the cause for bipolar disorder. Various theories implicate genetics, endocrine imbalance, early stress, and neurotransmitter imbalances. All the remaining options are too narrow in their scope.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

9. The spouse of a patient diagnosed with bipolar disorder asks what evidence supports the possibility of genetic transmission of bipolar disorders. What response supported by research should the nurse provide?
- a. "A high proportion of patients diagnosed with bipolar disorders are found among creative writers."
 - b. "A higher rate of relatives diagnosed with bipolar disorder is found among patients with bipolar disorder."
 - c. "Patients diagnosed with bipolar disorder have higher rates of relatives who respond in an exaggerated way to daily stresses."
 - d. "More individuals diagnosed with bipolar disorder come from high socioeconomic

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and educational backgrounds.”

ANS: B

Evidence of genetic transmission is supported when twins or relatives of patients with a particular disorder also show an incidence of the disorder that is higher than the incidence in the general public. The incorrect options do not support the theory of genetic transmission of bipolar disorder.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

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10. A patient diagnosed with bipolar disorder commands other patients, “Get me a book. Take this stuff out of here,” and other similar demands. What is the best initial approach by the nurse to interrupt this behavior without entering into a power struggle?
 - a. Distraction: “Let’s go to the dining room for a snack.”
 - b. Humor: “How much are you paying servants these days?”
 - c. Limit setting: “You must stop ordering other patients around.”
 - d. Honest feedback: “Your controlling behavior is annoying others.”

ANS: A

The distractibility characteristic of manic episodes can assist the nurse to direct the patient toward more appropriate, constructive activities without entering into a power struggle. Humor usually backfires by either encouraging the patient or inciting anger. Limit setting and honest feedback may seem heavy-handed to a labile patient and may incite anger.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. A nurse reviewing the laboratory results for a patient diagnosed with bipolar disorder notes the lithium level as 1 mEq/L. How will the nurse interpret this information about the medication level?
 - a. It requires no additional nursing intervention.
 - b. It is below recognized therapeutic serum limits.
 - c. It is above recognized therapeutic serum limits.
 - d. It indicates a need for immediate medical intervention.

ANS: A

The normal range for a blood sample taken 8 to 12 hours after the last dose of lithium is 0.4 to 1 mEq/L.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

12. The nurse is monitoring a patient closely for signs and symptoms of Stevens-Johnson syndrome. Which medication is likely the trigger for such a syndrome?
 - a. Clonazepam
 - b. Risperidone
 - c. Lamotrigine
 - d. Aripiprazole

ANS: C

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Lamotrigine is a first-line treatment for bipolar depression and is approved for acute and maintenance therapy. It is generally well-tolerated, but there are two concerns with this agent. One is a rare but serious dermatological reaction: a potentially life-threatening rash called Stevens-Johnson syndrome and the other is aseptic meningitis. None of the other options are associated with this complication.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

13. When a hyperactive patient experiencing acute mania is hospitalized, what initial nursing intervention is a priority?
- Allowing the patient to act out his or her feelings
 - Setting limits on the patient's behavior as necessary
 - Providing verbal instructions to the patient to remain calm
 - Restraining the patient to reduce hyperactivity and aggression

ANS: B

This intervention provides support through the nurse's presence and provides structure as necessary while the patient's control is tenuous. Acting out may lead to the loss of behavioral control. The patient will probably be unable to focus on instructions and comply. Restraint is used only after other interventions have proved ineffective.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

14. At a unit meeting, staff members discuss the decor for a special room for patients experiencing mania. What select is the **best** option?
- Extra-large window with a view of the street
 - Neutral walls with pale, simple accessories
 - Brightly colored walls and print drapes
 - Deep colors for walls and upholstery

ANS: B

The environment for a patient experiencing mania should be as simple and as nonstimulating as possible. Patients experiencing mania are highly sensitive to environmental distractions and stimulation. Draperies present a risk for injury.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

15. A patient experiencing acute mania has exhausted the staff members by noon. The patient has joked, manipulated, insulted, and been aggressive all morning. Staff members are feeling defensive and fatigued. Which is the best action?
- Confer with the health care provider regarding use of seclusion for this patient.
 - Hold a staff meeting to discuss consistency and limit setting approaches.
 - Conduct a meeting with all patients to discuss the behavior.
 - Explain to the patient that the behavior is unacceptable.

ANS: B

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When staff members are overwhelmed, the patient has succeeded in keeping the environment unsettled and avoided outside controls on behavior. Staff meetings can help minimize staff splitting and feelings of anger, helplessness, confusion, and frustration. Criteria for seclusion have not been met.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

16. A patient experiencing acute mania undresses in the group room and dances. What should be the nurse's first intervention?
- Quietly ask the patient, "Why don't you put on your clothes?"
 - Firmly tell the patient, "Stop dancing, and put on your clothing."
 - Put a blanket around the patient and walk with the patient to a quiet room.
 - Allow the patient stay in the group room while moving the other patients to a different area.

ANS: C

Patients must be protected from the embarrassing consequences of their poor judgment whenever possible. Protecting the patient from public exposure by matter-of-factly covering the patient and removing him or her from the area with a sufficient number of staff members to avoid argument and provide control is an effective approach.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. A patient experiencing acute mania waves a newspaper and says, "I must have my credit card and use the computer right now. A store is having a big sale and I need to order 10 dresses and four pairs of shoes." What is the nurse's most appropriate intervention?
- Suggesting to the patient to ask a friend to do the shopping and bring purchases to the unit
 - Inviting the patient to sit with the nurse and look at new fashion magazines
 - Telling the patient that computer use is not allowed until self-control improves
 - Asking whether the patient has enough money to pay for the purchases

ANS: B

Situations such as this offer an opportunity to use the patient's distractibility to the staff's advantage. Patients become frustrated when staff members deny requests that the patient sees as entirely reasonable. Distracting the patient can avoid power struggles. Suggesting that a friend do the shopping would not satisfy the patient's need for immediacy and would ultimately result in the extravagant expenditure. Asking whether the patient has enough money would likely precipitate an angry response.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

18. A patient diagnosed with bipolar disorder is being treated on an outpatient basis with lithium carbonate 300 mg three times daily and has now reported being nauseated. To reduce the nausea, what will the nurse suggest the lithium be taken with?
- Food
 - An antacid
 - A large glass of juice

- d. An antiemetic medication

ANS: A

Some patients find that taking lithium with meals diminishes nausea. The incorrect options are less helpful.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

19. A health teaching plan for a patient taking lithium should include which instructions?
- a. Maintain normal salt and fluids in the diet.
 - b. Drink twice the usual daily amount of fluids.
 - c. Double the lithium dose if diarrhea or vomiting occurs.
 - d. Avoid eating aged cheese, processed meats, and red wine.

ANS: A

Sodium depletion and dehydration increase the chance for developing lithium toxicity. The incorrect options offer inappropriate information.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

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20. Which nursing diagnosis would most likely apply to both a patient diagnosed with major depressive disorder (MDD) as well as one experiencing acute mania?
- a. Deficient diversional activity
 - b. Disturbed sleep pattern
 - c. Fluid volume excess
 - d. Defensive coping

ANS: B

Patients diagnosed with mood disorders, both depression and mania, experience sleep pattern disturbances. Assessment data should be routinely gathered about this possible problem. Deficient diversional activity is more relevant for patients diagnosed with MDD. Defensive coping is more relevant for patients experiencing mania. Fluid volume excess is less relevant for patients diagnosed with mood disorders than is deficient fluid volume.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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21. Which dinner menu is best suited for the patient diagnosed with bipolar disorder experiencing acute mania?
- a. Spaghetti and meatballs, salad, a banana
 - b. Beef and vegetable stew, a roll, chocolate pudding
 - c. Broiled chicken breast on a roll, an ear of corn, apple
 - d. Chicken casserole, green beans, flavored gelatin with whipped cream

ANS: C

The correct foods provide adequate nutrition but, more importantly, are finger foods that the hyperactive patient could “eat on the run.” The foods in the incorrect options cannot be eaten without utensils.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

22. What is the focus of outcome identification for the treatment plan of a patient presenting with grandiose thinking associated with acute mania?
- Maintaining an interest in the environment
 - Developing an optimistic outlook
 - Self-control of distorted thinking
 - Stabilizing the sleep pattern

ANS: C

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The desired outcome is that the patient will be able to control the grandiose thinking associated with acute mania as evidenced by making realistic comments about self, abilities, and plans. Patients with acute mania are already unduly optimistic as a result of their use of denial, and they are overly interested in their environment. Sleep stability is a desired outcome but is not related to distorted thought processes.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

23. Which documentation indicates that the treatment plan for a patient experiencing acute mania has been effective?
- "Converses without interrupting; clothing matches; participates in activities."
 - "Irritable, suggestible, distractible; napped for 10 minutes in afternoon."
 - "Attention span short; writing copious notes; intrudes in conversations."
 - "Heavy makeup; seductive toward staff; pressured speech."

ANS: A

The descriptors given indicate the patient is functioning at an optimal level, using appropriate behavior, and thinking without becoming overstimulated by unit activities. The incorrect options reflect manic behavior.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

24. A patient experiencing mania dances around the unit, seldom sits, monopolizes conversations, interrupts, and intrudes. Which nursing intervention will best assist the patient with energy conservation?
- Monitor physiological functioning.
 - Provide a subdued environment.
 - Supervise personal hygiene.
 - Observe for mood changes.

ANS: B

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All the options are reasonable interventions with a patient with acute mania, but providing a subdued environment directly relates to the outcome of energy conservation by decreasing stimulation and helping balance activity and rest.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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25. A patient diagnosed with bipolar disorder has been hospitalized for 7 days and has taken lithium 600 mg three times daily. Staff members observe increased agitation, pressured speech, poor personal hygiene, hyperactivity, and bizarre clothing. What is the nurse's best intervention?
- Educate the patient about the proper ways to perform personal hygiene and coordinate clothing.
 - Continue to monitor and document the patient's speech patterns and motor activity.
 - Ask the health care provider to prescribe an increased dose and frequency of lithium.
 - Consider the need to check the lithium level. The patient may not be swallowing medications.

ANS: D

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The patient is continuing to exhibit manic symptoms. The lithium level may be low as a result of "cheeking" the medication a form of nonadherence to the medication therapy. The prescribed dose is high, so one would not expect a need for the dose to be increased.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Physiological Integrity

26. A patient experiencing acute mania has disrobed in the hall three times in 2 hours. What intervention should the nurse implement?
- Place the patient in the seclusion room.
 - Ask if the patient finds clothes bothersome.
 - Tell the patient that others feel embarrassed.
 - Arrange for one-on-one supervision.

ANS: D

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A patient who repeatedly disrobes, despite verbal limit setting, needs more structure.

One-on-one supervision may provide the necessary structure. Asking whether the patient is bothered by clothing serves no purpose. Telling the patient that others are embarrassed will not make a difference to the patient whose grasp of social behaviors is impaired by the illness. Seclusion is not the appropriate intervention especially since the patient is not a threat to self or others.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

27. A patient experiencing acute mania is dancing atop the pool table in the recreation room. The patient waves a pool cue in one hand and says, "I'll protect myself if anyone comes near me." What is the nurse's first intervention?
- Telling the patient, "You need to be secluded."
 - Demanding the patient, "get down from the table."
 - Clearing the room of all other patients.
 - Assembling staff for a show of force.

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ANS: C

Safety is of primary importance. Once other patients are out of the room, a plan for managing this patient can be implemented. Making demands or assembling a show of force is likely to anger or frighten the patient and increase this risk for violence.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning
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28. After hospital discharge, what is the priority intervention for a patient diagnosed with bipolar disorder who is taking antimanic medication?
- Decreasing physical activity
 - Increasing food and fluids
 - Meeting self-care needs
 - Psychoeducation

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ANS: D

During the continuation phase of treatment for bipolar disorder, the physical needs of the patient are not as important an issue as they were during the acute episode. After hospital discharge, the treatment focuses on maintaining medication adherence and preventing a relapse, both of which are fostered by ongoing psychoeducation.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

29. A patient receiving lithium should be assessed for which evidence of early toxicity?
- Pharyngitis, mydriasis, and dystonia
 - Alopecia, purpura, and drowsiness
 - Diarrhea, thirst, and vomiting
 - Ascites, dyspnea, and edema

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ANS: C

Diarrhea, thirst, and vomiting are early signs of lithium toxicity. Problems mentioned in the incorrect options are unrelated to lithium therapy.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity
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30. A patient diagnosed with bipolar disorder is in the maintenance phase of treatment. The patient asks, “Do I have to keep taking this lithium even though my mood is stable now?” Select the nurse’s most appropriate response.
- “You will be able to stop the medication in approximately 1 month.”
 - “Taking the medication every day helps prevent relapses and recurrences.”
 - “Usually patients take this medication for approximately 6 months after discharge.”
 - “It’s unusual that the health care provider has not already stopped your medication.”

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ANS: B

Patients diagnosed with bipolar disorder may be indefinitely maintained on lithium to prevent recurrences. Helping the patient understand this need promotes medication compliance. The incorrect options offer incorrect or misleading information.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity
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31. A patient prescribed lithium telephones the nurse at the clinic to say, "I've had severe diarrhea 4 days. I feel very weak and unsteady when I walk. My usual hand tremor has gotten worse. What should I do?" What instructions should the nurse provide? [abirb.com/test](#)
- a. "Restrict oral fluids for 24 hours and stay in bed."
 - b. "Have someone bring you to the clinic immediately."
 - c. "Drink a large glass of water with 1 teaspoon of salt added."
 - d. "Take an over-the-counter antidiarrheal medication hourly until the diarrhea subsides."

ANS: B

The symptoms described suggest lithium toxicity. The patient should have a lithium level drawn and may require further treatment. Because neurological symptoms are present, the patient should not drive and should be accompanied by another person. The incorrect options will not address the patient's symptoms. Restricting oral fluids will make the situation worse.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity [abirb.com/test](#)

32. Lithium is prescribed for a new patient. Which information from the patient's history indicates that monitoring serum concentrations of the drug will be especially challenging and critical? [abirb.com/test](#)
- a. Arthritis
 - b. Epilepsy
 - c. Exercise-induced asthma
 - d. Congestive heart failure [abirb.com/test](#)

ANS: D

The patient with congestive heart failure will likely need diuretic drugs, which will complicate the maintenance of the fluid balance necessary to avoid lithium toxicity. Neither arthritis, epilepsy, nor asthma directly involves fluid balance and kidney function.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity [abirb.com/test](#)

MULTIPLE RESPONSE

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1. A patient diagnosed with bipolar disorder is being treated as an outpatient during a hypomanic episode. Which suggestions should the nurse provide to the family to assist in managing these behaviors? (*Select all that apply.*) [abirb.com/test](#)
- a. Provide structure.
 - b. Limit credit card access.
 - c. Encourage group social interaction.
 - d. Limit work to half days.
 - e. Monitor the patient's sleep patterns. [abirb.com/test](#)

ANS: A, B, E

[abirb.com/test](#)

[abirb.com/test](#)

[abirb.com/test](#)

A patient with hypomania is expansive, grandiose, and labile; uses poor judgment; spends inappropriately; and is overstimulated by a busy environment. Providing structure helps the patient maintain appropriate behavior. Financial irresponsibility may be avoided by limiting access to cash and credit cards. Continued decline in sleep patterns may indicate the condition has evolved to full mania. Group socialization should be kept to a minimum to reduce stimulation. A full leave of absence from work is necessary to limit stimuli and to prevent problems associated with poor judgment and the inappropriate decision making that accompany hypomania.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

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TOP: Nursing Process: Planning

2. A nurse prepares the plan of care for a patient experiencing a manic episode. Which nursing diagnoses are most appropriate? (*Select all that apply.*)
a. Imbalanced nutrition: more than body requirements
b. Disturbed thought processes
c. Sleep deprivation
d. Chronic confusion
e. Social isolation

ANS: B, C

abirb.com/test

People with mania are hyperactive and often do not take the time to eat and drink properly. Their high levels of activity consume calories; therefore, deficits in nutrition may occur. Sleep is reduced. Their socialization is impaired but not isolated. Confusion may be acute but not chronic.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
MSC: NCLEX: Psychosocial Integrity

abirb.com/test

3. A patient tells the nurse, “I am so ashamed of being bipolar. When I’m manic, my behavior embarrasses my family. Even if I take my medication, there’s no guarantee I won’t have a relapse. I am such a burden to my family.” These statements support which nursing diagnoses? (*Select all that apply.*)
a. Powerlessness
b. Defensive coping
c. Chronic low self-esteem
d. Impaired social interaction
e. Risk-prone health behavior

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ANS: A, C

Chronic low self-esteem and powerlessness are interwoven in the patient’s statements. No data support the other diagnoses.

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DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
MSC: NCLEX: Psychosocial Integrity

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MULTIPLE CHOICE

1. A person diagnosed with schizophrenia has had difficulty keeping a job because of severe paranoia. Today the person shouts, "They're all plotting to destroy me." Select the nurse's most therapeutic response.
 - a. "Everyone here is trying to help you. No one wants to harm you."
 - b. "Feeling that people want to destroy you must be very frightening."
 - c. "That is not true. People here are trying to help if you will let them."
 - d. "Staff members are health care professionals who are qualified to help you."

ANS: B

Resist focusing on content; instead, focus on the feelings the patient is expressing. This strategy prevents arguing about the reality of delusional beliefs. Such arguments increase patient anxiety and the tenacity with which the patient holds to the delusion. The other options focus on content and provide opportunity for argument.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A newly admitted patient diagnosed with schizophrenia is hypervigilant and constantly scans the environment. The patient states, "I saw two doctors talking in the hall. They were plotting to kill me." The nurse may correctly assess this as what classic behavior?
 - a. Echolalia
 - b. An idea of reference
 - c. A delusion of infidelity
 - d. An auditory hallucination

ANS: B

Ideas of reference are misinterpretations of the verbalizations or actions of others that give special personal meanings to these behaviors; for example, when seeing two people talking, the individual assumes they are talking about him or her. The other terms do not correspond with the scenario.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

3. A patient diagnosed with schizophrenia says, "My coworkers are out to get me. I also saw two doctors plotting to overdose me." What term identifies how this patient is perceiving the environment?
 - a. Disorganized
 - b. Unpredictable
 - c. Dangerous
 - d. Bizarre

ANS: C

The patient sees the world as hostile and dangerous. This assessment is important because the nurse can be more effective by using empathy to respond to the patient. Data are not present to support any of the other options.

[abirb.com/test](#)

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

4. When a patient diagnosed with schizophrenia was discharged 6 months ago, haloperidol was prescribed. The patient now says, "I stopped taking those pills. I didn't like how it made me feel." What likely side effects did the patient experience?
- a. Sedation and muscle stiffness
b. Sweating, nausea, and diarrhea
c. Mild fever, sore throat, and skin rash
d. Headache, watery eyes, and runny nose

[abirb.com/test](#)

ANS: A

Typical antipsychotic drugs often produce sedation and extrapyramidal side effects such as stiffness and gait disturbance. The side effects mentioned in the other options are usually not associated with typical antipsychotic therapy or would not have the effect described by the patient.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

5. A nurse works with a patient diagnosed with schizophrenia regarding the importance of medication management. The patient repeatedly says, "I don't like taking pills." Which treatment strategy should the nurse discuss with the patient and health care provider?
- a. Use of long-acting antipsychotic injections
b. Addition of a benzodiazepine, such as lorazepam
c. Adjunctive use of an antidepressant, such as amitriptyline
d. Inpatient hospitalization because of the high risk for exacerbation of symptoms

[abirb.com/test](#)

ANS: A

Medications such as paliperidone, fluphenazine decanoate, and haloperidol decanoate are long-acting forms of antipsychotic medications. They are administered by depot injection every 2 to 4 weeks, thus reducing daily opportunities for nonadherence. The incorrect options do not address the patient's dislike of taking pills.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

[abirb.com/test](#)

6. A patient's care plan includes monitoring for auditory hallucinations. Which assessment findings suggest the patient may be hallucinating?
- a. Aloofness, haughtiness, suspicion
b. Darting eyes, tilted head, mumbling to self
c. Elevated mood, hyperactivity, distractibility
d. Performing rituals, avoiding open places

[abirb.com/test](#)

[abirb.com/test](#)

ANS: B

Clues to hallucinations include looking around the room as though to find the speaker; tilting the head to one side as though intently listening; and grimacing, mumbling, or talking aloud as though responding conversationally to someone.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

7. A health care provider considers which antipsychotic medication to prescribe for a patient diagnosed with schizophrenia who has auditory hallucinations and poor social functioning. The patient is also overweight. Which drug should the nurse advocate?
- a. Clozapine
 - b. Ziprasidone
 - c. Olanzapine
 - d. Aripiprazole

abirb.com/test

ANS: D

Aripiprazole is an atypical antipsychotic medication that is effective against both positive and negative symptoms of schizophrenia. It causes little or no weight gain and no increase in glucose, high- or low-density lipoprotein cholesterol levels, or triglycerides, making it a reasonable choice for a patient with obesity or heart disease. Clozapine may produce agranulocytosis, making it a poor choice as a first-line agent. Ziprasidone may prolong the QT interval, making it a poor choice for a patient with cardiac disease. Olanzapine fosters weight gain.

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Physiological Integrity

abirb.com/test

TOP: Nursing Process: Planning

8. A patient diagnosed with schizophrenia tells the nurse, “I eat skiller. Tend to end. Easter. It blows away. Get it?” Select the nurse’s best response.
- a. “Nothing you are saying is clear.”
 - b. “Your thoughts are very disconnected.”
 - c. “Try to organize your thoughts, and then tell me again.”
 - d. “I am having difficulty understanding what you are saying.”

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ANS: D

When a patient’s speech is loosely associated, confused, and disorganized, pretending to understand is useless. The nurse should tell the patient that he or she is having difficulty understanding what the patient is saying. If a theme is discernible, ask the patient to talk about the theme. The incorrect options tend to place blame for the poor communication with the patient. The correct response places the difficulty with the nurse rather than being accusatory.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

abirb.com/test

9. A patient diagnosed with schizophrenia is demonstrating catatonia. The patient has little spontaneous movement and waxy flexibility. Which patient needs are of priority importance?
- a. Psychosocial
 - b. Physiological
 - c. Self-actualization
 - d. Safety and security

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ANS: B

abirb.com/test

abirb.com/test

Physiological needs must be met to preserve life. A patient who is catatonic may need to be fed by hand or tube, toileted, and given range-of-motion exercises to preserve physiological integrity. The assessment findings do not suggest safety concerns. Higher-level needs (psychosocial and self-actualization) are of lesser concern.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning
abirb.com/test

10. A patient diagnosed with schizophrenia is stuporous, demonstrates little spontaneous movement, and has waxy flexibility. The patient's activities of daily living are severely compromised. An appropriate outcome is that the patient will:
 - a. demonstrate increased interest in the environment by the end of week 1.
 - b. perform self-care activities with coaching by the end of day 3.
 - c. gradually take the initiative for self-care by the end of week 2.
 - d. voluntarily accept tube feeding by day 2.

ANS: B

Outcomes related to self-care deficit nursing diagnoses should deal with increasing the patient's ability to perform self-care tasks independently, such as feeding, bathing, dressing, and toileting. Performing the tasks with coaching by the nursing staff denotes improvement over the complete inability to perform the tasks. The incorrect options are not directly related to self-care activities; they are difficult to measure and are unrelated to maintaining nutrition.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

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11. A nurse observes a patient standing immobile, facing the wall with one arm extended in a salute. The patient remains immobile in this position for 15 minutes, moving only when the nurse gently lowers the arm. What is the name of this phenomenon?
 - a. Echolalia
 - b. Waxy flexibility
 - c. Depersonalization
 - d. Thought withdrawal

ANS: B

Waxy flexibility is the ability to hold distorted postures for extended periods, as though the patient were molded in wax. Echolalia is a speech pattern. Depersonalization refers to a feeling state. Thought withdrawal refers to an alteration in thinking.

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DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment
MSC: NCLEX: Psychosocial Integrity

abirb.com/test

12. Which patient diagnosed with schizophrenia would be expected to have the lowest level of overall functioning?
 - a. 39 years old; paranoid ideation since age 35 years
 - b. 32 years old; isolated episodes of catatonia since age 24 years; stable for 3 years
 - c. 19 years old; diagnosed with schizophreriform disorder 6 months ago
 - d. 40 years old; frequent relapses since age 18; often does not take medication as prescribed

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ANS: D

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The 40-year-old patient who has been diagnosed with schizophrenia since 18 years of age could logically be expected to have the lowest overall level of functioning secondary to deterioration associated with frequent relapses. The 39-year-old patient who has had paranoid ideation since 35 years of age could be expected to have a higher-level because schizophrenia of short duration may be less impairing than other types. The patient who has had episodes of catatonia since the age of 24 years has been stable for more than 3 years, suggesting a higher functional ability. The 19-year-old patient diagnosed with schizopreniform disorder has been ill for only 6 months, and disability is likely to be minimal.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

13. A patient presenting with delusions of persecution about being poisoned has refused all hospital meals for 3 days. Which intervention is most likely to be acceptable to the patient?
 - a. Allow the patient to have supervised access to food vending machines.
 - b. Allow the patient to telephone a local restaurant to deliver meals.
 - c. Offer to taste each portion on the tray for the patient.
 - d. Begin tube feedings or total parenteral nutrition.

ANS: A

The patient who is delusional about food being poisoned is likely to believe restaurant food might still be poisoned and to say that the staff member tasting the food has taken an antidote to the poison before tasting. Attempts to tube feed or give nutrition intravenously are considered aggressive and usually promote violence. Patients often perceive foods in sealed containers, packages, or natural shells as being safe.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

abirb.com/test

14. A community mental health nurse wants to establish a relationship with a very withdrawn patient diagnosed with schizophrenia. The patient lives at home with a supportive family. Select the nurse's best plan.
 - a. Visit daily for 4 days, then visit every other day for 1 week; stay with the patient for 20 minutes; accept silence; state when the nurse will return.
 - b. Arrange to spend 1 hour each day with the patient; focus on asking questions about what the patient is thinking or experiencing; avoid silences.
 - c. Visit twice daily; sit beside the patient with a hand on the patient's arm; leave if the patient does not respond within 10 minutes.
 - d. Visit every other day; remind the patient of the nurse's identity; encourage the patient to talk while the nurse works on reports.

ANS: A

Severe constraints on the community mental health nurse's time will probably not allow more time than what is mentioned in the correct option, yet important principles can be used. A severely withdrawn patient should be met "at the patient's own level," with silence accepted. Short periods of contact are helpful to minimize both the patient's and the nurse's anxiety. Predictability in returning as stated will help build trust. An hour may be too long to sustain a home visit with a withdrawn patient, especially if the nurse persists in leveling a barrage of questions at the patient. Twice-daily visits are probably not possible and leaving after 10 minutes would be premature. Touch may be threatening. Working on reports suggests the nurse is not interested in the patient.

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15. Patients diagnosed with schizophrenia who are suspicious and withdrawn generally present with what additional characteristic?
- Universally fear sexual involvement with therapists. [abirb.com/test](#)
 - Are socially disabled by the positive symptoms of schizophrenia.
 - Exhibit a high degree of hostility as evidenced by rejecting behavior.
 - Avoid relationships because they become anxious with emotional closeness. [abirb.com/test](#)

ANS: D

When an individual is suspicious and distrustful and perceives the world and the people in it as potentially dangerous, withdrawal into an inner world can be a defense against uncomfortable levels of anxiety. When someone attempts to establish a relationship with such a patient, the patient's anxiety rises until trust is established. No evidence suggests that withdrawn patients with schizophrenia universally fear sexual involvement with therapists. In most cases, it is not considered true that withdrawn patients with schizophrenia are socially disabled by the positive symptoms of schizophrenia or exhibit a high degree of hostility by demonstrating rejecting behavior. [abirb.com/test](#)

16. A newly admitted patient diagnosed with schizophrenia says, "The voices are bothering me. They yell and tell me I'm bad. I have got to get away from them." Select the nurse's most helpful reply.
- "Do you hear the voices often?"
 - "Do you have a plan for getting away from the voices?" [abirb.com/test](#)
 - "I will stay with you. Focus on what we are talking about, not the voices."
 - "Forget about the voices. Ask some other patients to sit and talk with you." [abirb.com/test](#)

ANS: C

Staying with a distraught patient who is hearing voices serves several purposes: ongoing observation, the opportunity to provide reality orientation, a means of helping dismiss the voices, the opportunity of forestalling an action that would result in self-injury, and general support to reduce anxiety. Asking if the patient hears voices is not particularly relevant at this point. Asking if the patient plans to "get away from the voices" is relevant for assessment purposes but is less helpful than offering to stay with the patient while encouraging a focus on their discussion. Asking other patients to talk incorrectly shifts responsibility for intervention from the nurse to other patients. [abirb.com/test](#)

17. A patient diagnosed with schizophrenia has taken fluphenazine 5 mg orally twice daily for 3 weeks. The nurse now assesses a shuffling, propulsive gait; a masklike face; and drooling. Which term applies to these symptoms?
- Neuroleptic malignant syndrome
 - Hepatocellular effects
 - Pseudoparkinsonism [abirb.com/test](#)

d. Akathisia

ANS: C

Pseudoparkinsonism induced by antipsychotic medication mimics the symptoms of Parkinson disease. It frequently appears within the first month of treatment. Hepatocellular effects would produce abnormal liver test results. Neuroleptic malignant syndrome is characterized by autonomic instability. Akathisia produces motor restlessness.

[abirb.com/test](#)

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

18. A patient diagnosed with schizophrenia is acutely disturbed and violent. After several doses of haloperidol, the patient is calm. Two hours later the nurse sees the patient's head rotated to one side in a stiff position; the lower jaw is thrust forward, and the patient is drooling. Which effect is the patient demonstrating?
- a. Acute dystonic reaction
 - b. Tardive dyskinesia
 - c. Waxy flexibility
 - d. Akathisia

ANS: A

Acute dystonic reactions involve painful contractions of the tongue, face, neck, and back; opisthotonus and oculogyric crisis may be observed. Dystonic reactions are considered emergencies that require immediate intervention. Tardive dyskinesia involves involuntary spasmodic muscular contractions that involve the tongue, fingers, toes, neck, trunk, or pelvis; it appears after prolonged treatment. Waxy flexibility is a symptom observed in catatonic schizophrenia. Akathisia is evidenced by internal and external restlessness, pacing, and fidgeting.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

19. An acutely violent patient diagnosed with schizophrenia receives several doses of haloperidol. Two hours later the nurse notices the patient's head rotated to one side in a stiffly fixed position; the lower jaw is thrust forward, and the patient is drooling. Which intervention by the nurse is indicated?
- a. Administer diphenhydramine 50 mg IM from the PRN medication administration record.
 - b. Reassure the patient that the symptoms will subside. Practice relaxation exercises with the patient.
 - c. Give trihexyphenidyl 5 mg orally at the next regularly scheduled medication administration time.
 - d. Administer atropine sulfate 2 mg subcutaneously from the PRN medication administration record.

ANS: A

Diphenhydramine, trihexyphenidyl, benztrapine, and other anticholinergic medications may be used to treat dystonias. Swallowing will be difficult or impossible; therefore, oral medication is not an option. Medication should be administered immediately; therefore, the intramuscular route is best. In this case, the best option given is diphenhydramine.

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[abirb.com/test](#)

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

20. A patient has taken trifluoperazine 30 mg/day orally for 3 years. The clinic nurse notes that the patient grimaces and constantly smacks both lips. The patient's neck and shoulders twist in a slow, snakelike motion. Which problem would the nurse suspect?
a. Agranulocytosis
b. Tardive dyskinesia
c. Tourette syndrome
d. Anticholinergic effects

ANS: B

Tardive dyskinesia is a neuroleptic-induced condition involving the face, trunk, and limbs. Involuntary movements such as tongue thrusting; licking; blowing; irregular movements of the arms, neck, and shoulders; rocking; hip jerks; and pelvic thrusts are observed. These symptoms are frequently not reversible, even when the drug is discontinued. The scenario does not present evidence consistent with the other disorders mentioned. Agranulocytosis is a blood disorder. Tourette syndrome is a condition in which tics are present. Anticholinergic effects include dry mouth, blurred vision, flushing, constipation, and dry eyes.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Evaluation

21. A nurse sits with a patient diagnosed with schizophrenia. The patient starts to laugh uncontrollably, although the nurse has not said anything funny. Select the nurse's best response.
a. "Why are you laughing?"
b. "Please share the joke with me."
c. "I don't think I said anything funny."
d. "You are laughing. Tell me what's happening."

ANS: D

The patient is likely laughing in response to inner stimuli such as hallucinations or fantasy. Focusing on the hallucinatory clue (i.e., the patient's laughter) and then eliciting the patient's observation is best. The incorrect options are less useful in eliciting a response; no joke may be involved, "Why" questions are difficult to answer, and the patient is probably not focusing on what the nurse has said in the first place.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

22. Which symptoms are expected for a patient diagnosed with schizophrenia who has disorganization?
a. Extremes of motor activity, from excitement to stupor
b. Socially withdrawal and ineffective communication
c. Severe anxiety with ritualistic behavior
d. Highly suspicious, delusional behavior

ANS: B

Patients with disorganization demonstrate the most regressed and socially impaired behaviors. Communication is often incoherent, with silly giggling and loose associations predominating. Highly suspicious, delusional behavior relates more to paranoia. Extremes of motor activity, from excitement to stupor, relate to catatonia. Severe anxiety and ritualistic behaviors relate to obsessive-compulsive disorder.

DIF: Cognitive Level: Comprehension (Understanding) abirb.com/test
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

23. What assessment findings mark the prodromal stage of schizophrenia?
- Withdrawal, magical thinking, poor concentration, and perceptual disturbances
 - Auditory hallucinations, ideas of reference, thought insertion, and broadcasting
 - Stereotyped behavior, echopraxia, echolalia, and waxy flexibility
 - Loose associations, concrete thinking, and echolalia neologisms

ANS: A

Early prodromal symptoms include social withdrawal and deterioration in functioning, depressive mood, perceptual disturbances, magical thinking, and peculiar behavior. Changes in self-care, sleeping or eating patterns, and changes in school or work performance may also be evidenced. The incorrect options each list the positive symptoms of schizophrenia that are more likely to be apparent during the acute stage of the illness.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity abirb.com/test

24. A patient diagnosed with schizophrenia says, “Everyone has skin lice that jump on you and contaminate your blood.” Which problem is evident?
- Poverty of content
 - Concrete thinking
 - Neologisms
 - Paranoia

ANS: D

The patient’s unrealistic fear of contamination indicates paranoia. Neologisms are invented words. Concrete thinking involves literal interpretation. Poverty of content refers to an inadequate fund of information.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity abirb.com/test

25. A patient diagnosed with schizophrenia demonstrates paranoid thinking. The patient angrily tells a nurse, “You are mean and nasty. No one trusts you or wants to be around you.” What is the likely motivation behind this behavior?
- Attempting to manipulate the nurse by using negative comments
 - The prelude to disorganization and catatonia in the near future
 - Jealousy of the nurse’s position of power in the relationship
 - Identifying another person’s shortcomings in order to preserve his or her own self-esteem

ANS: D

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abirb.com/test

Patients with paranoid ideation often use disparaging comments to preserve their own self-esteem. There is no evidence the patient is trying to manipulate the nurse or is jealous. This behavior is not predictive of catatonia or disorganization.[com/test](#)

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

26. A patient diagnosed with schizophrenia says, "High heat. Last time here. Did you get a coat?" What type of verbalization is evident?
- a. Neologism
 - b. Idea of reference
 - c. Thought broadcasting
 - d. Associative looseness

[abirb.com/test](#)

ANS: D

Looseness of association refers to jumbled thoughts incoherently expressed to the listener. Neologisms are newly coined words. Ideas of reference are a type of delusion. Thought broadcasting is the belief that others can hear one's thoughts.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

27. A patient diagnosed with schizophrenia has taken a first-generation antipsychotic medication for a year. Hallucinations are less intrusive, but the patient continues to have apathy, poverty of thought, and social isolation. The nurse expects a change to which medication?
- a. Haloperidol
 - b. Olanzapine
 - c. Chlorpromazine
 - d. Diphenhydramine

[abirb.com/test](#)

ANS: B

Olanzapine is an atypical antipsychotic medication that targets both positive and negative symptoms of schizophrenia. Haloperidol and chlorpromazine are first-generation (conventional) antipsychotic agents that target only positive symptoms. Diphenhydramine is an antihistamine.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

28. The family of a patient diagnosed with schizophrenia is unfamiliar with the illness and their role in recovery. Which type of therapy should the nurse recommend?
- a. Psychoeducational
 - b. Psychoanalytic
 - c. Transactional
 - d. Family

[abirb.com/test](#)

ANS: A

A psychoeducational group explores the causes of schizophrenia, the role of medications, the significance of medication compliance, and the importance of support for the ill member of the family, and also provides recommendations for living with a person with schizophrenia. Such a group can be of practical assistance to the family members. The other types of therapy do not focus on psychoeducation.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

29. A patient diagnosed with schizophrenia has been stable for a year; however, the family now reports the patient is tense, sleeps 3 to 4 hours per night, and has difficulty concentrating. The patient says, “Demons *are* in the basement and they can come through the floor.” The nurse can correctly assess this information as what?
- a. Need for psychoeducation
 - b. Medication nonadherence
 - c. Chronic deterioration
 - d. Relapse

ANS: D

[abirb.com/test](#)

Signs of potential relapse include feeling tense, difficulty concentrating, trouble sleeping, increased withdrawal, and increased bizarre or magical thinking. Medication noncompliance may not be implicated. Relapse can occur even when the patient is regularly taking his or her medication. Psychoeducation is more effective when the patient’s symptoms are stable. Chronic deterioration is not the best explanation.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

30. A patient diagnosed with schizophrenia begins to talk about “cracklomers” in the local shopping mall. The term “cracklomers” should be documented using what term?
- a. Neologism
 - b. Concrete thinking
 - c. Thought insertion
 - d. An idea of reference

ANS: A

[abirb.com/test](#)

A neologism is a newly coined word having special meaning to the patient. “Cracklomers” is not a known word. Concrete thinking refers to the inability to think abstractly. Thought insertion refers to thoughts of others that are implanted in one’s mind. An idea of reference is a type of delusion in which trivial events are given personal significance.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

31. A patient diagnosed with schizophrenia anxiously says, “I can see the left side of my body merging with the wall, then my face appears and disappears in the mirror.” What phenomena is the patient describing?
- a. Derealization
 - b. Concrete thinking
 - c. Abstract thinking
 - d. Depersonalization

ANS: D

[abirb.com/test](#)

[abirb.com/test](#)

[abirb.com/test](#)

Depersonalization: a nonspecific feeling of having lost one's identity; the self is different or unreal. People may be concerned that body parts do not belong to them, or they may have an acute sensation that the body has drastically changed. Derealization is the false perception that the environment has changed. Concrete thinking refers to an overemphasis on specific details and a literal interpretation of ideas. It is contrasted with abstract thinking. People who think in an abstract way look at the broader significance of ideas and information rather than the concrete details.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

32. A patient diagnosed with schizophrenia has auditory hallucinations. The patient anxiously tells the nurse, "The voice is telling me to do things." Select the nurse's priority assessment question.
- a. "How long has the voice been directing your behavior?"
b. "Do the messages from the voice frighten you?"
c. "Do you recognize the voice speaking to you?"
d. "What is the voice telling you to do?"

abirb.com/test

ANS: D

Learning what a command hallucination is telling the patient to do is important; the command often places the patient or others at risk for harm. Command hallucinations can be terrifying and may pose a psychiatric emergency. The incorrect questions are of lesser importance than identifying the command.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

33. A patient receiving risperidone reports severe muscle stiffness at 10:30 am. By noon, the patient is diaphoretic, drooling, and has difficulty swallowing. By 4:00 pm, vital signs are body temperature, 102.8° F; pulse, 110 beats/min; respirations, 26 breaths per minute; and blood pressure, 150/90 mm Hg. Select the nurse's best analysis and action.
- a. Agranulocytosis. Institute reverse isolation.
b. Tardive dyskinesia. Withhold the next dose of medication.
c. Cholestatic jaundice. Begin a high-protein, low-fat diet.
d. Neuroleptic malignant syndrome. Immediately notify the health care provider.

ANS: D

Taking an antipsychotic medication coupled with the presence of extrapyramidal symptoms, such as severe muscle stiffness and difficulty swallowing, hyperpyrexia, and autonomic symptoms (pulse elevation), suggest neuroleptic malignant syndrome, a medical emergency. The symptoms given in this scenario are not consistent with the medical problems listed in the incorrect options.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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34. A patient diagnosed with schizophrenia begins a new prescription for lurasidone HCl. The patient is 5 feet 6 inches tall and currently weighs 204 pounds. Which topic is most important for the nurse to include in the teaching plan related to this medication?
- a. How to recognize tardive dyskinesia?

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- b. Weight management strategies.
- c. Ways to manage constipation.
- d. Sleep hygiene measures.

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ANS: B

Lurasidone HCl (Latuda) is an atypical antipsychotic medication. The incidence of weight gain, diabetes, and high cholesterol is high with this medication.^mThe patient is overweight now, so weight management is especially important. The incidence of tardive dyskinesia is low with atypical antipsychotic medications. Constipation may occur, but it is less important than weight management. This drug usually produces drowsiness.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

35. A patient diagnosed with schizophrenia has auditory hallucinations, delusions of grandeur, poor personal hygiene, and motor agitation. Which assessment finding would the nurse regard as a negative symptom of schizophrenia?
- a. Auditory hallucinations
 - b. Delusions of grandeur
 - c. Poor personal hygiene
 - d. Motor agitation

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ANS: C

Negative symptoms include apathy, anhedonia, poor social functioning, and poverty of thought. Poor personal hygiene is an example of poor social functioning. The distractors are positive symptoms of schizophrenia.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment
MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. The family members of a patient newly diagnosed with schizophrenia state that they do not understand what has caused the illness. The nurse's response should be based on which models? (*Select all that apply.*)
- a. Neurobiological
 - b. Environmental
 - c. Family theory
 - d. Genetic
 - e. Stress

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ANS: A, D

Compelling evidence exists that schizophrenia is a neurological disorder probably related to neurochemical abnormalities, neuroanatomical disruption of brain circuits, and genetic vulnerability. Stress and family disruption may contribute but are not considered etiological factors. Environmental factors are not recognized as causative variables in schizophrenia.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation
MSC: NCLEX: Physiological Integrity

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2. A nurse at the mental health clinic plans a series of psychoeducational groups for persons diagnosed with schizophrenia. Which two topics would take priority? (*Select all that apply.*)
- a. How to complete an application for employment? abirb.com/test
 - b. The importance of correctly taking your medication.
 - c. How to dress when attending community events?
 - d. How to give and receive compliments? abirb.com/test
 - e. Ways to quit smoking.

ANS: B, E

Stabilization is maximized by the adherence to the antipsychotic medication regimen. Because so many patients with schizophrenia smoke cigarettes, this topic relates directly to the patients' physiological well-being. The other topics are also important but are not priority topics.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning | Nursing Process: Outcomes Identification

MSC: NCLEX: Health Promotion and Maintenance

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3. A patient diagnosed with schizophrenia is hospitalized after arguing with coworkers and threatening to harm them. The patient is aloof and suspicious and says, "Two staff members I saw talking were plotting to assault me." Based on data gathered at this point, which nursing diagnoses relate? (*Select all that apply.*)
- a. Risk for other-directed violence
 - b. Disturbed thought processes
 - c. Risk for loneliness
 - d. Spiritual distress
 - e. Social isolation

ANS: A, B

Delusions of persecution and ideas of reference support the nursing diagnosis of disturbed thought processes. Risk for other-directed violence is substantiated by the patient's paranoia and feeling endangered by persecutors. Fearful individuals may strike out at perceived persecutors or attempt self-harm to get away from persecutors. Data are not present to support the other diagnoses.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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Chapter 18: Neurocognitive Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. An older adult takes digoxin and hydrochlorothiazide daily, as well as lorazepam as needed for anxiety. Over 2 days, this adult developed confusion, slurred speech, an unsteady gait, and fluctuating levels of orientation. These findings are most characteristic of which adverse reaction to the medication therapy?
 - a. Delirium
 - b. Dementia
 - c. Amnestic syndrome
 - d. Alzheimer's disease

ANS: A

Delirium is characterized by an abrupt onset of fluctuating levels of awareness, clouded consciousness, perceptual disturbances, and disturbed memory and orientation. The onset of dementia or Alzheimer's disease, a type of dementia, is more insidious. Amnestic syndrome involves memory impairment without other cognitive problems.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

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2. A patient experiencing fluctuating levels of awareness, confusion, and disturbed orientation shouts, "Bugs are crawling on my legs! Get them off!" Which problem is the patient experiencing?
 - a. Aphasia
 - b. Dystonia
 - c. Tactile hallucinations
 - d. Mnemonic disturbance

ANS: C

The patient feels bugs crawling on both legs, although no sensory stimulus is actually present. This description coincides with the definition of a hallucination, a false sensory perception. Tactile hallucinations may be part of the symptom constellation of delirium. Aphasia refers to a speech disorder. Dystonia refers to excessive muscle tonus. Mnemonic disturbance is associated with dementia rather than delirium.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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3. A patient experiencing fluctuating levels of consciousness, disturbed orientation, and perceptual alteration begs, "Someone get these bugs off me." What is the nurse's best response?
 - a. "There are no bugs on your legs. Your imagination is playing tricks on you."
 - b. "Try to relax. The crawling sensation will go away sooner if you can relax."
 - c. "Don't worry. I will have someone stay here and brush off the bugs for you."
 - d. "I don't see any bugs, but I know you are frightened so I will stay with you."

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ANS: D

When hallucinations are present, the nurse should acknowledge the patient's feelings and state the nurse's perception of reality, but not argue. Staying with the patient increases feelings of security, reduces anxiety, offers the opportunity for reinforcing reality, and provides a measure of physical safety. Denying the patient's perception without offering help does not emotionally support the patient. Telling the patient to relax makes the patient responsible for self-soothing. Telling the patient that someone will brush the bugs away supports the perceptual distortions.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

4. What is the priority nursing diagnosis for a patient experiencing fluctuating levels of consciousness, disturbed orientation, and visual and tactile hallucinations?
 - a. Bathing/hygiene self-care deficit related to altered cerebral function as evidenced by confusion and inability to perform personal hygiene tasks
 - b. Risk for injury related to altered cerebral function, misperception of the environment, and unsteady gait
 - c. Disturbed thought processes related to medication intoxication as evidenced by confusion, disorientation, and hallucinations
 - d. Fear related to sensory perceptual alterations as evidenced by hiding from imagined ferocious dogs

ANS: B

The physical safety of the patient is the highest priority among the diagnoses given. Many opportunities for injury exist when a patient misperceives the environment as distorted, threatening, or harmful; when the patient exercises poor judgment; and when the patient's sensorium is clouded. The other diagnoses may be concerns but are lower priorities.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Safe, Effective Care Environment

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5. What is the priority nursing intervention for a patient diagnosed with delirium who has fluctuating levels of consciousness, disturbed orientation, and perceptual alterations?
 - a. Avoidance of physical contact
 - b. High level of sensory stimulation
 - c. Careful observation and supervision
 - d. Application of wrist and ankle restraints

ANS: C

Careful observation and supervision are of ultimate importance because an appropriate outcome would be that the patient remains safe and free from injury. Physical contact during care cannot be avoided. Restraint is a last resort, and sensory stimulation should be reduced.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

6. Which environmental adjustment should the nurse make for a patient experiencing delirium with perceptual alterations?
 - a. Keep the patient by the nurse's desk while the patient is awake. Provide rest

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- periods in a room with a television on.
- b. Light the room brightly, day and night. Awaken the patient hourly to assess mental status.
 - c. Maintain soft lighting day and night. Keep a radio on low volume continuously.
 - d. Provide a well-lit room without glare or shadows. Limit noise and stimulation.

ANS: D

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A quiet, shadow-free room offers an environment that produces the fewest sensory perceptual distortions for a patient experiencing cognitive impairment associated with delirium. The other options have the potential to produce increased perceptual alterations.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

- 7. Which description of patient behavior best applies to a hallucination?
 - a. Looking at shadows on a wall and says, "I see scary faces"
 - b. Stating, "I feel bugs crawling on my legs and biting me"
 - c. Becoming anxious when the nurse leaves his or her bedside
 - d. Trying to hit the nurse when vital signs are taken

ANS: B

A hallucination is a false sensory perception occurring without a corresponding sensory stimulus. Feeling bugs on the body when none are present is a tactile hallucination.

Misinterpreting shadows as faces is an illusion. An illusion is a misinterpreted sensory perception. The incorrect options are examples of behaviors that sometimes occur during delirium and are related to fluctuating levels of awareness and misinterpreted stimuli.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

- 8. Consider these health problems: Lewy body disease, Pick disease, and Parkinson's disease. Which term unifies these problems?
 - a. Intoxication
 - b. Dementia
 - c. Delirium
 - d. Amnesia

ANS: B

The listed health problems are all forms of dementia.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

- 9. When used for treatment of patients diagnosed with Alzheimer's disease, which medication would be expected to antagonize N-methyl-D-aspartate (NMDA) channels rather than cholinesterase?
 - a. Donepezil
 - b. Rivastigmine
 - c. Memantine
 - d. Galantamine

ANS: C

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Memantine blocks the NMDA channels and is used in moderate-to-late stages of the disease. Donepezil, rivastigmine, and galantamine are all cholinesterase inhibitors. These drugs increase the availability of acetylcholine and are most often used to treat mild-to-moderate Alzheimer's disease.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

10. An older adult was stopped by police for driving through a red light. When asked for a driver's license, the adult hands the police officer a pair of sunglasses. What sign of dementia is evident?
- a. Aphasia
 - b. Apraxia
 - c. Agnosia
 - d. Memory impairment

ANS: C

Agnosia refers to the loss of sensory ability to recognize objects. Aphasia refers to the loss of language ability. Apraxia refers to the loss of purposeful movement. No evidence of memory loss is revealed in this scenario.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

11. An older adult drove to a nearby store but was unable to remember how to get home or state an address. When police took the person home, the spouse reported frequent wandering into neighbors' homes. Which stage of Alzheimer's disease is evident?
- a. 1 (mild)
 - b. 2 (moderate)
 - c. 3 (moderate to severe)
 - d. 4 (late)

ANS: B

In stage 2 (moderate), deterioration is evident. Memory loss may include the inability to remember addresses or the date. Activities such as driving may become hazardous, and frustration by the increasing difficulty of performing ordinary tasks may be experienced. Hygiene may begin to deteriorate. Stage 3 (moderate to severe) finds the individual unable to identify familiar objects or people and needing direction for the simplest of tasks. In stage 4 (late), the ability to talk and walk is eventually lost, and stupor evolves.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

12. Which condition is characterized with apolipoprotein E (apoE) malfunction, neuritic plaques, neurofibrillary tangles, granulovascular degeneration, and brain atrophy?
- a. Alzheimer's disease
 - b. Wernicke encephalopathy
 - c. Central anticholinergic syndrome
 - d. Acquired immunodeficiency syndrome (AIDS)-related dementia

ANS: A

The problems are all aspects of the pathophysiological characteristics of Alzheimer's disease. These characteristics are not noted in any of the other options.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

13. A patient diagnosed with stage 1 mild Alzheimer's disease tires easily and prefers to stay home rather than attend social activities. The spouse does the grocery shopping because the patient cannot remember what to buy. Which nursing diagnosis applies at this time?
- a. Complicated grieving
 - b. Impaired memory
 - c. Self-care deficit
 - d. Caregiver role strain

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ANS: B

Memory impairment is present and expected in stage 1 mild Alzheimer's disease. Patients diagnosed with early Alzheimer's disease often have difficulty remembering names, so socialization is minimized. Data are not present to support the other diagnoses.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

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MSC: NCLEX: Psychosocial Integrity

14. A patient has progressive memory deficit associated with dementia. Which nursing intervention would best help the individual function in the environment?
- a. Assist the patient to perform simple tasks by giving step-by-step directions.
 - b. Reduce frustration by performing activities of daily living for the patient.
 - c. Stimulate intellectual function by discussing new topics with the patient.
 - d. Promote the use of the patient's sense of humor by telling jokes.

ANS: A

Patients with a cognitive impairment should perform all tasks of which they are capable. When simple directions are given in a systematic fashion, the patient is better able to process information and perform simple tasks. Stimulating intellectual functioning by discussing new topics is likely to prove frustrating for the patient. Patients with cognitive deficits may lose their sense of humor and find jokes meaningless.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

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15. Two patients in a residential care facility are diagnosed with dementia. One shouts to the other, "Move along, you're blocking the road." The other patient turns, shakes a fist, and shouts, "I know what you're up to; you're trying to steal my car." What is the nurse's best action?
- a. Administer one dose of an antipsychotic medication to both patients.
 - b. Reinforce reality. Say to the patients, "Walk along in the hall. This is not a traffic intersection."
 - c. Separate and distract the patients. Take one to the day room and the other to an activities area.
 - d. Step between the two patients and say, "Please quiet down. We do not allow violence here."

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ANS: C

Separating and distracting prevents escalation from verbal to physical acting out. Neither patient loses self-esteem during this intervention. Medication is probably not necessary. Stepping between two angry, threatening patients is an unsafe action, and trying to reinforce reality during an angry outburst will probably not be successful when the patients are cognitively impaired.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

16. An older adult patient in an intensive care unit is experiencing visual and auditory illusions. Which nursing intervention will be most helpful?
- Keep the room brightly lit at all times.
 - Place personally meaningful objects in view.
 - Place large clocks and calendars on the wall.
 - Assess the patient's for use of glasses and hearing aids.

ANS: D

Illusions are sensory misperceptions. Glasses and hearing aids help clarify sensory perceptions. Without glasses, clocks, calendars, and personal objects are meaningless. Round-the-clock lighting promotes sensory overload and sensory perceptual alterations.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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17. A patient diagnosed with stage 2 moderate Alzheimer's disease calls the police saying, "An intruder is in my home." Police investigate and discover the patient misinterpreted a reflection in the mirror as an intruder. This phenomenon can be characterized using which term?
- Hyperorality
 - Aphasia
 - Apraxia
 - Agnosia

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ANS: D

Agnosia is the inability to recognize familiar objects, parts of one's body, or one's own reflection in a mirror. Hyperorality refers to placing objects in the mouth. Aphasia refers to the loss of language ability. Apraxia refers to the loss of purposeful movements, such as being unable to dress.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

18. During morning care, an assistive personnel asks a patient diagnosed with dementia, "How was your night?" The patient replies, "It was lovely. I went out to dinner and a movie with my friend." Which term applies to the patient's response?
- Sundown syndrome
 - Confabulation
 - Perseveration
 - Delirium

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ANS: B

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Confabulation is the making up of stories or answers to questions by a person who does not remember. It is a defensive tactic to protect self-esteem and prevent others from noticing memory loss. The patient's response was not sundown syndrome.^{abirb.com/test} Perseveration refers to repeating a word or phrase over and over. Delirium is not present in this scenario.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

19. A patient diagnosed with Alzheimer's disease wanders at night. Which action should the nurse recommend for a family to use in the home to enhance safety?^{abirb.com/test}
- Place throw rugs on tile or wooden floors.
 - Place locks at the tops of doors.
 - Encourage daytime napping.
 - Obtain a bed with side rails.

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ANS: B

Placing door locks at the top of the door makes it more difficult for the patient with dementia to unlock the door because the ability to look up and reach upward is diminished. All throw rugs should be removed to prevent falls. The patient will try to climb over side rails, increasing the risk for injury and falls. Day napping should be discouraged with the hope that the patient will sleep during the night.^{abirb.com/test}

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

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20. Goals and desired outcomes for an older adult patient experiencing delirium caused by fever and dehydration will focus on what?^{abirb.com/test}
- Returning to premorbid levels of function
 - Identifying stressors negatively affecting self
 - Demonstrating motor responses to noxious stimuli
 - Exerting control over responses to perceptual distortions

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ANS: A

The desired overall goal is that the patient with delirium will return to the level of functioning held before the development of delirium since the condition is usually temporary in nature. Demonstrating motor responses to noxious stimuli is an appropriate indicator for a patient whose arousal is compromised. Identifying stressors that negatively affect the self is too nonspecific to be useful for a patient experiencing delirium. Exerting control over responses to perceptual distortions is an unrealistic indicator for the patient with sensorium problems related to delirium.^{abirb.com/test}

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

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MSC: NCLEX: Physiological Integrity

21. An older adult diagnosed with moderate-stage Alzheimer's disease forgets where the bathroom is and has episodes of incontinence. Which intervention should the nurse suggest to the patient's family?^{abirb.com/test}
- Labeling the bathroom door
 - Taking the older adult to the bathroom hourly
 - Placing the older adult in disposable adult diapers

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- d. Making sure the older adult does not eat nonfood items

ANS: A

A patient with moderate Alzheimer's disease has memory loss that begins to interfere with activities. This patient may be able to use environmental cues such as labels on doors to compensate for memory loss. Regular toileting may be helpful, but a 2-hour schedule is often more reasonable. Placing the patient in disposable diapers is more appropriate as a later stage intervention. Making sure the patient does not eat nonfood items will be more relevant when the patient demonstrates hyperorality.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

22. A patient diagnosed with dementia no longer recognizes family members. The family asks how long it will be before their family member recognizes them when they visit. What is the nurse's best reply?
- a. "Your family member will never again be able to identify you."
 - b. "I think that is a question the health care provider should answer."
 - c. "One never knows. Consciousness fluctuates in persons with dementia."
 - d. "It is disappointing when someone you love no longer recognizes you."

ANS: D

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Therapeutic communication techniques can assist family members to come to terms with the losses and irreversibility dementia imposes on both the loved one and themselves. Two of the incorrect responses close communication. The nurse should take the opportunity to foster communication. Consciousness does not fluctuate in patients with dementia.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

23. A patient diagnosed with severe dementia no longer recognizes family members and becomes anxious and agitated when they attempt reorientation. Which alternative could the nurse suggest to the family members?
- a. Wear large name tags.
 - b. Focus interaction on familiar topics.
 - c. Frequently repeat the reorientation strategies.
 - d. Strategically place large clocks and calendars.

ANS: B

Reorientation may seem like arguing to a patient experiencing cognitive deficits and increases the patient's anxiety. Validating, talking with the patient about familiar, meaningful things, and reminiscing give meaning to existence both for the patient and family members. The option that suggests using validating techniques when communicating is the only option that addresses an interactional strategy. Wearing large name tags and strategically placing large clocks and calendars are reorientation strategies. Frequently repeating the reorientation strategies is inadvisable; patients with dementia sometimes become more agitated with reorientation.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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24. What is the priority nursing need for a patient diagnosed with late-stage dementia?

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- a. Promotion of self-care activities
- b. Meaningful verbal communication
- c. Maintenance of nutrition and hydration
- d. Prevention of the patient from wandering

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ANS: C

In late-stage dementia, the patient has often forgotten how to eat, chew, and swallow.

Nutrition and hydration needs must be met if the patient is to live. The patient is incapable of self-care, ambulation, or verbal communication.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

25. Which nursing intervention is appropriate to use for patients diagnosed with either delirium or dementia?
- a. Speak in a loud, firm voice.
 - b. Touch the patient before speaking.
 - c. Reintroduce the health care worker at each contact.
 - d. When the patient becomes aggressive, use physical restraint instead of medication.

ANS: C

Short-term memory is often impaired in patients with delirium and dementia. Reorientation to staff is often necessary with each contact to minimize misperceptions, reduce anxiety level, and secure cooperation. Loud voices may be frightening or sound angry. Speaking before touching prevents the patient from feeling threatened. Physical restraint is not appropriate; the least restrictive measure should be used.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

26. A hospitalized patient experiencing delirium misinterprets reality and a patient diagnosed with dementia wanders about the home. Which outcome is the priority in both scenarios?
- a. Patient will remain safe in the environment.
 - b. Patient will participate actively in self-care.
 - c. Patient will communicate verbally.
 - d. Patient will acknowledge reality.

ANS: A

Risk for injury is the nurse's priority concern in both scenarios. Safety maintenance is the desired outcome. The other outcomes may not be realistic.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Safe, Effective Care Environment

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MULTIPLE RESPONSE

1. A patient diagnosed with moderate to severe Alzheimer's disease has a dressing and grooming self-care deficit. Designate the appropriate interventions to include in the patient's plan of care. (*Select all that apply.*)
- a. Provide clothing with elastic and hook-and-loop closures.

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- b. Label clothing with the patient's name and name of the item.
- c. Administer antianxiety medication before bathing and dressing.
- d. Provide necessary items and direct the patient to proceed independently.
- e. If the patient resists, use distraction and then try again after a short interval.

ANS: A, B, E

Providing clothing with elastic and hook-and-loop closures facilitates patient independence. Labeling clothing with the patient's name and the name of the item maintains patient identity and dignity (and provides information if the patient has agnosia). When a patient resists, using distraction and trying again after a short interval are appropriate because patient moods are often labile; the patient may be willing to cooperate during a later opportunity. Providing the necessary items for grooming and directing the patient to proceed independently are inappropriate. Staff members are prepared to coach by giving step-by-step directions for each task as it occurs. Administering anxiolytic medication before bathing and dressing is inappropriate. This measure would result in unnecessary overmedication.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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2. Which assessment findings would the nurse expect in a patient experiencing delirium? (*Select all that apply.*)

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- a. Impaired level of consciousness
- b. Disorientation to place and time
- c. Wandering attention
- d. Apathy
- e. Agnosia

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ANS: A, B, C

Disorientation to place and time is an expected finding. Orientation to person (self) usually remains intact. Attention span is short, and difficulty focusing or shifting attention as directed is often noted. Patients with delirium commonly experience illusions and hallucinations.

Fluctuating levels of consciousness are expected. Agnosia occurs with dementia. Apathy is associated with depression.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

3. A nurse should anticipate that which symptoms of Alzheimer's disease will become apparent as the disease progresses from stage 3, moderate to severe to stage 4, late stage? (*Select all that apply.*)

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- a. Agraphia
- b. Hyperorality
- c. Fine motor tremors
- d. Hypermetamorphosis
- e. Improvement of memory

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ANS: A, B, D

[abirb.com/test](#)

The memories of patients with Alzheimer's disease continue to deteriorate. These patients demonstrate the inability to read or write (agraphia), the need to put everything into the mouth (hyperorality), and the need to touch everything (hypermetamorphosis). Fine motor tremors are associated with alcohol withdrawal delirium, not dementia. Memory does not improve.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
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Chapter 19: Substance-Related and Addictive Disorders

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A patient with a history of daily alcohol abuse was hospitalized at 0200 today. When would the nurse expect withdrawal symptoms to peak?
 - a. Between 0800 and 1000 today (6 to 8 hours after drinking stopped)
 - b. Between 0200 tomorrow and hospital day 2 (24 to 48 hours after drinking stopped)
 - c. About 0200 on hospital day 3 (72 hours after drinking stopped)
 - d. About 0200 on hospital day 4 (96 hours after drinking stopped)

ANS: B

Alcohol withdrawal usually begins 2 to 8 hours after cessation or significant reduction of alcohol intake. It peaks between 24 and 48 hours, then resolves or progresses to delirium.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

2. A woman in the last trimester of pregnancy drinks 8 to 12 ounces of alcohol daily. The nurse plans for the delivery of an infant who presents with what related characteristic?
 - a. Jaundice
 - b. Dependent on alcohol
 - c. Healthy but underweight
 - d. Facial abnormalities and cognitive impairment

ANS: D

Fetal alcohol syndrome is the result of alcohol's inhibiting fetal development in the first trimester. The fetus of a woman who drinks that much alcohol will probably have this disorder. Alcohol use during pregnancy is not likely to produce the findings listed in the distractors.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

3. A patient was admitted 1 day ago with a hip fracture sustained in a fall while intoxicated. The patient points to the Buck's traction and screams, "Somebody tied me up with ropes." The patient's response is described by what term?
 - a. An illusion
 - b. A delusion
 - c. Hallucinations
 - d. Hypnagogic phenomenon

ANS: A

The patient is misinterpreting a sensory perception when seeing a rope instead of traction. Illusions are common in early withdrawal from alcohol. A delusion is a fixed, false belief. Hallucinations are sensory perceptions occurring in the absence of a stimulus. Hypnagogic phenomena are sensory disturbances that occur between waking and sleeping.

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DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

4. A patient was admitted 48 hours ago for injuries sustained while intoxicated. The patient is shaky, irritable, anxious, and diaphoretic. The pulse rate is 130 beats/min. The patient shouts, "Snakes are crawling on my bed. I've got to get out of here." What is the most accurate assessment of the situation?
- a. The patient is attempting to obtain attention by manipulating staff.
 - b. The patient may have sustained a head injury before admission.
 - c. The patient has symptoms of alcohol withdrawal delirium.
 - d. The patient is having a recurrence of an acute psychosis.

ANS: C

Symptoms of agitation, elevated pulse, and perceptual distortions point to alcohol withdrawal delirium, a medical emergency. The findings are inconsistent with manipulative attempts, head injury, or functional psychosis.

DIF: Cognitive Level: Application (Applying) abirb.com/test
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

5. A patient admitted yesterday for injuries sustained in a fall while intoxicated believes snakes are crawling on the bed. The patient is anxious, agitated, and diaphoretic. What is the priority nursing diagnosis?
- a. Disturbed sensory perception
 - b. Ineffective coping
 - c. Ineffective denial
 - d. Risk for injury

ANS: D

Clouded sensorium, agitation, sensory perceptual distortions, and poor judgment increase the risk for injury. Disturbed sensory perception is an applicable diagnosis, but safety has a higher priority. The scenario does not provide data to support the other diagnoses.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
MSC: NCLEX: Physiological Integrity abirb.com/test

6. A patient admitted yesterday for injuries sustained while intoxicated believes the window blinds are snakes trying to get into the room. The patient is anxious, agitated, and diaphoretic. Which medication can the nurse anticipate the health care provider will prescribe?
- a. Monoamine oxidase inhibitor, such as phenelzine
 - b. Phenothiazine, such as thioridazine
 - c. Benzodiazepine, such as lorazepam
 - d. Narcotic analgesic, such as morphine

ANS: C

This patient is experiencing alcohol withdrawal delirium. Sedation allows for the safe withdrawal from alcohol. Benzodiazepines are the drugs of choice in most regions because of their high therapeutic safety index and anticonvulsant properties. Antidepressant, antipsychotic, and opioid medications will not relieve the patient's symptoms.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

7. A hospitalized patient, injured in a fall while intoxicated, believes spiders are spinning entrapping webs in the room. The patient is anxious, agitated, and diaphoretic. Which nursing intervention has priority?
- Check the patient every 15 minutes.
 - Rigorously encourage fluid intake.
 - Provide one-on-one supervision.
 - Keep the room dimly lit.

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ANS: C

[abirb.com/test](#)

This patient is experiencing alcohol withdrawal delirium. One-on-one supervision is necessary to promote physical safety until sedation reduces the patient's feelings of terror. Checks every 15 minutes would not be sufficient to provide for safety. A dimly lit room promotes illusions. Oral fluids are important, but safety is a higher priority.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

8. A patient with a history of daily alcohol use says, "Drinking helps me cope with being a single parent." Which response by the nurse would help the individual conceptualize the drinking more objectively?
- "Sooner or later, alcohol will kill you. Then what will happen to your children?"
 - "I hear a lot of defensiveness in your voice. Do you really believe this?"
 - "If you were coping so well, why were you hospitalized again?"
 - "Tell me what happened the last time you drank."

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ANS: D

The individual is rationalizing. The correct response will help the patient see alcohol as a cause of the problems, not the solution. This approach can also help the patient become receptive to the possibility of change. The incorrect responses directly confront and attack defenses against anxiety that the patient still needs. They reflect the nurse's frustration with the patient.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. A patient asks for information about the goals of Alcoholics Anonymous (AA). Which is the nurse's best response?
- "It is a self-help group with the goal of sobriety."
 - "It is a form of group therapy led by a psychiatrist."
 - "It is a group that learns about drinking from a group leader."
 - "It is a network that advocates strong punishment for drunk drivers."

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ANS: A

AA is a peer support group for recovering alcoholics. The goal is to maintain sobriety. Neither professional nor peer leaders are appointed.

[abirb.com/test](#)

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

[abirb.com/test](#)

10. Police bring a patient to the emergency department after an automobile accident. The patient is ataxic with slurred speech and mild confusion. The blood alcohol level is 400 mg/dL. Considering the relationship between behavior and blood alcohol level, which conclusion can the nurse draw?
- The patient rarely drinks alcohol.
 - The patient has a high tolerance to alcohol.
 - The patient has been treated with disulfiram.
 - The patient has recently ingested both alcohol and sedative drugs.

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ANS: B

A nontolerant drinker would be in a coma with a blood alcohol level of 400 mg/dL. The fact that the patient is walking and talking shows a discrepancy between blood alcohol level and expected behavior. It strongly suggests that the patient's body has become tolerant to the drug. If disulfiram and alcohol are ingested together, then an entirely different clinical picture would result. The blood alcohol level gives no information about the ingestion of other drugs.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

11. A patient admitted to an alcoholism rehabilitation program says, "I'm just a social drinker. I usually have a drink or two at brunch, a few cocktails in the afternoon, wine at dinner, and several drinks during the evening." The patient is using which defense mechanism?
- Rationalization
 - Introjection
 - Projection
 - Denial

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ANS: D

Minimizing one's drinking is a form of denial of alcoholism. The patient's own description indicates that "social drinking" is not an accurate name for the behavior. Projection involves blaming another for one's faults or problems. Rationalization involves making excuses.

Introjection involves taking a quality into one's own system.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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12. A new patient in an alcoholism rehabilitation program says, "I'm just a social drinker. I usually have a drink or two at brunch, a few cocktails in the afternoon, wine at dinner, and a few drinks in the evening." Which response by the nurse will help the patient view the drinking more honestly?
- "I see," and use interested silence.
 - "I think you may be drinking more than you report."
 - "Being a social drinker involves having a drink or two once or twice a week."
 - "You describe drinking steadily throughout the day and evening. Am I correct?"

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ANS: D

The answer summarizes and validates what the patient reported but is accepting rather than strongly confrontational. Defenses cannot be removed until healthier coping strategies are in place. Strong confrontation does not usually take place so early in treatment.

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DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

13. During the third week of treatment, the spouse of a patient in an alcoholism rehabilitation program says, "After discharge, I think everything will be just fine." Which remark by the nurse will be most helpful to the spouse?
- "It is good that you're supportive of your spouse's sobriety and want to help maintain it."
 - "Although sobriety solves some problems, new ones may emerge as one adjusts to living without alcohol."
 - "It will be important for you to structure life to avoid as much stress as possible. You will need to provide social protection."
 - "Remember that alcoholism is a disorder of self-destruction. You will need to observe your spouse's behavior carefully."

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ANS: B

During recovery, patients identify and use alternative coping mechanisms to reduce their reliance on alcohol. Physical adaptations must occur. Emotional responses, formerly dulled by alcohol, are now fully experienced and may cause considerable anxiety. These changes inevitably have an effect on the spouse and children, who should be given anticipatory guidance and accurate information.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

abirb.com/test

14. The treatment team plans care for a person diagnosed with schizophrenia and cannabis abuse. The person has recently used cannabis daily and is experiencing increased hallucinations and delusions. Which principle applies to care planning?
- Consider each disorder primary and provide simultaneous treatment.
 - The person will benefit from treatment in a residential treatment facility.
 - Withdraw the person from cannabis, and then treat the schizophrenia.
 - Treat the schizophrenia first, and then establish the goals for the treatment of substance abuse.

ANS: A

Dual diagnosis (co-occurring disorders) clinical practice guidelines for both outpatient and inpatient settings suggest that the substance disorder and the psychiatric disorder should both be considered primary and receive simultaneous treatments. Residential treatment may or may not be effective.

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DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

abirb.com/test

15. When working with a patient beginning treatment for alcohol abuse, what is the nurse's most therapeutic approach?
- Empathetic, supportive
 - Strong, confrontational
 - Skeptical, guarded
 - Cool, distant

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ANS: A

abirb.com/test

abirb.com/test

Support and empathy assist the patient to feel safe enough to start looking at problems. Counseling during the early stage of treatment needs to be direct, open, and honest. The other approaches will increase patient anxiety and cause the patient to cling to defenses.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

16. A patient comes to an outpatient appointment obviously intoxicated. The nurse should implement what intervention?
- Exploring the patient's reasons for drinking today
 - Arranging admission to an inpatient psychiatric unit
 - Coordinating emergency admission to a detoxification unit
 - Telling the patient, "We cannot see you today because you've been drinking"

[abirb.com/test](#)

ANS: D

One cannot conduct meaningful therapy with an intoxicated patient. The patient should be taken home to recover and then make another appointment. Hospitalization is not necessary.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. When a person first begins drinking alcohol, two drinks produce relaxation and drowsiness. After 1 year of drinking, four drinks are needed to achieve the same relaxed, drowsy state. Why does this change occur?
- Tolerance develops.
 - The alcohol is less potent.
 - Antagonistic effects occur.
 - Hypomagnesemia develops.

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ANS: A

Tolerance refers to needing higher and higher doses of a drug to produce the desired effect. The potency of the alcohol is stable. Neither hypomagnesemia nor antagonistic effects would account for this change.

[abirb.com/test](#)

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

18. Which statement most accurately describes substance addiction?
- A chronic, relapsing brain disease associated with craving and a lack of control over use of a substance.
 - A disorder associated with tolerance to a substance as well as withdrawal symptoms if use is abruptly discontinued.
 - Behaviors associated with habitual use of a substance for the single purpose of altering one's mood, emotion, or state of consciousness.
 - A behavioral disorder associated with selected personality features.

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Addiction is a disease which involves a lack of control over substance use as well as craving. Habitual use of a substance relates to abuse, not addiction. Tolerance and withdrawal symptoms, when intake is reduced or stopped, are not necessarily part of the disease.

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DIF: Cognitive Level: Knowledge (Remembering)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

19. A patient admitted for a heroin overdose received naloxone. The patient's breathing pattern improved. Two hours later, the patient reports muscle aches, abdominal cramps, gooseflesh and says, "I feel terrible." Which analysis is correct?
- The patient is exhibiting a prodromal symptom of seizures.
 - An idiosyncratic reaction to naloxone is occurring.
 - Symptoms of opiate withdrawal are present.
 - The patient is experiencing a relapse.

ANS: C

abirb.com/test

The symptoms given in the question are consistent with narcotic withdrawal and result from administration of naloxone. Early symptoms of narcotic withdrawal are flulike in nature. Seizures are more commonly observed in alcohol withdrawal syndrome.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Physiological Integrity

abirb.com/test

20. In the emergency department, a patient's vital signs are: blood pressure (BP), 66/40 mm Hg; pulse (P), 140 beats/min (bpm); and respirations (R), 8 breaths per minute and shallow. The patient overdosed on illegally obtained hydromorphone. What is the priority outcome for this patient?
- Within 8 hours, vital signs will stabilize as evidenced by BP greater than 90/60 mm Hg, P less than 100 bpm, and respirations at or above 12 breaths per minute.
 - The patient will be able to describe a plan for home care and achieve a drug-free state before being released from the emergency department.
 - The patient will attend daily meetings of Narcotics Anonymous within 1 week of beginning treatment.
 - The patient will identify two community resources for the treatment of substance abuse by discharge.

ANS: A

abirb.com/test

Hydromorphone is an opiate drug. The correct answer is the only one that relates to the patient's physical condition. It is expected that vital signs will return to normal when the CNS depression is alleviated. The distractors are desired outcomes later in the plan of care.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Physiological Integrity

abirb.com/test

21. Select the nursing intervention necessary after administering naloxone to a patient experiencing an opiate overdose.
- Monitor the airway and vital signs every 15 minutes.
 - Insert a nasogastric tube and test gastric pH.
 - Treat hyperpyrexia with cooling measures.
 - Insert an indwelling urinary catheter.

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ANS: A

abirb.com/test

abirb.com/test

Narcotic antagonists such as naloxone quickly reverse CNS depression; however, because the narcotics have a longer duration of action than antagonists, the patient may lapse into unconsciousness or require respiratory support again. The incorrect options are measures unrelated to naloxone use.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

22. A graduate nurse worked at a hospital for several months, resigned, and then took a position at another hospital. In the new position, the nurse often volunteers to be the medication nurse. After several serious medication errors, an investigation reveals that the nurse was diverting patient narcotics for self-use. What early indicator of the nurse's drug use was evident?
- a. Changing employment after only several months
 - b. Seeking to be assigned as a medication nurse
 - c. Frequent socializes with unit staff after work
 - d. Recent graduate

ANS: B

[abirb.com/test](#)

The nurse intent on diverting drugs for personal use often attempts to isolate him- or herself from peers rather than being sociable. The person seeks access to medications, which is a component of drug-seeking behavior. Length of nursing experience is no indicator of potential drug abuse.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation
[abirb.com/test](#)

23. A nurse with a history of narcotic abuse is found unconscious in the hospital locker room after overdosing. The nurse is transferred to an inpatient substance abuse unit for care. Which attitudes or behaviors by nursing staff may be enabling?
- a. Conveying understanding that pressures associated with nursing practice underlie substance abuse
 - b. Pointing out that work problems are the result, but not the cause, of substance abuse
 - c. Conveying empathy when the nurse discusses fears of disciplinary action by the state board of nursing
 - d. Providing health teaching about stress management

ANS: A

Enabling denies the seriousness of the patient's problem or supports the patient as he or she shifts responsibility from self to circumstances. The incorrect options are therapeutic and appropriate.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment
MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

24. Which treatment approach is most appropriate for a patient with poor social skills who has been treated several times for substance addiction but has relapsed?
- a. 1-week detoxification program
 - b. Long-term outpatient therapy
 - c. 12-step self-help program
 - d. Residential program

[abirb.com/test](#)

[abirb.com/test](#)

ANS: D

Residential programs and therapeutic communities have goals of complete change in lifestyle, abstinence from drugs, elimination of criminal behaviors, development of employable skills, self-reliance, and honesty. Residential programs are more effective than outpatient programs or short-term programs for patients with poor social skills.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

25. Which nursing diagnosis would likely apply both to a patient diagnosed with schizophrenia as well as a patient diagnosed with amphetamine-induced psychosis?
- Powerlessness
 - Disturbed thought processes
 - Ineffective thermoregulation
 - Impaired oral mucous membrane

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ANS: B

Both types of patients commonly experience paranoid delusions; thus, the nursing diagnosis of disturbed thought processes is appropriate for both. The incorrect options are not specifically applicable to both.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

abirb.com/test

26. Which is an important nursing intervention when giving care to a patient withdrawing from a central nervous system (CNS) stimulant?
- Make physical contact by frequently touching the patient.
 - Offer intellectual activities requiring concentration.
 - Avoid manipulation by denying the patient's requests.
 - Observe for depression and suicidal ideation.

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ANS: D

Rebound depression occurs with the withdrawal from CNS stimulants, probably related to neurotransmitter depletion. Touch may be misinterpreted if the patient is experiencing paranoid tendencies. Concentration is impaired during withdrawal. Denying requests is inappropriate; maintaining established limits will suffice.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

27. Which assessment findings best correlate to the withdrawal from central nervous system depressants?
- Dilated pupils, tachycardia, elevated blood pressure, elation
 - Labile mood, lack of coordination, fever, drowsiness
 - Nausea, vomiting, diaphoresis, anxiety, tremors
 - Excessive eating, constipation, headache

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abirb.com/test

ANS: C

The symptoms of withdrawal from various CNS depressants are similar. Generalized seizures are possible.

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DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

28. A patient has smoked two packs of cigarettes daily for many years. When the patient does not smoke or tries to cut back, anxiety, craving, poor concentration, and headache result. What does this scenario describe?
- a. Substance abuse
 - b. Substance addiction
 - c. Substance intoxication
 - d. Recreational use of a social drug

[abirb.com/test](#)

ANS: B

Nicotine meets the criteria for a *substance*. Criteria for addiction are present: compulsive use, craving, tolerance and withdrawal symptoms. The scenario does not meet the criteria for substance abuse, intoxication, or recreational use of a social drug.

DIF: Cognitive Level: Comprehension (Understanding) [abirb.com/test](#)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

29. Which assessment findings will the nurse expect in an individual who has just injected heroin?
- a. Anxiety, restlessness, paranoid delusions
 - b. Heightened sexuality, insomnia, euphoria
 - c. Muscle aching, dilated pupils, tachycardia
 - d. Drowsiness, constricted pupils, slurred speech

[abirb.com/test](#)

ANS: D

Heroin, an opiate, is a CNS depressant. Blood pressure, pulse, and respirations are decreased, and attention is impaired. The incorrect options describe behaviors consistent with amphetamine use, symptoms of narcotic withdrawal, and cocaine abuse.

DIF: Cognitive Level: Application (Applying) [abirb.com/test](#)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

30. A newly hospitalized patient has needle tracks on both arms. A friend states that the patient uses heroin daily but has not used in the past 24 hours. The nurse should assess the patient withdrawal symptoms?
- a. Slurred speech, excessive drowsiness, and bradycardia
 - b. Paranoid delusions, tactile hallucinations, and panic
 - c. Runny nose, yawning, insomnia, and chills
 - d. Anxiety, agitation, and aggression

[abirb.com/test](#)

ANS: C

Early signs and symptoms of narcotic withdrawal resemble symptoms of onset of a flulike illness, but without temperature elevation. The incorrect options reflect signs of intoxication or CNS depressant overdose and CNS stimulant or hallucinogen use.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

[abirb.com/test](#)

31. A nurse is called to the home of a neighbor and finds an unconscious person still holding a medication bottle labeled “lorazepam.” What is the nurse’s first action?
- Test reflexes.
 - Check pupils.
 - Initiate vomiting.
 - Establish a patent airway.

[abirb.com/test](#)

ANS: D

Lorazepam is a benzodiazepine. Maintaining a patent airway is the priority when the patient is unconscious. Assessing neurological function by testing reflexes and checking pupils can wait. Vomiting should not be induced when a patient is unconscious because of the danger of aspiration.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

32. An adult in the emergency department states, “I feel restless. Everything I look is wavy. Sometimes I’m outside my body looking at myself. I hear colors. I think I’m losing my mind.” Vital signs are slightly elevated. The nurse should suspect what triggered these reports?
- Cocaine overdose
 - Schizophrenic episode
 - Phencyclidine (PCP) intoxication
 - Lysergic acid diethylamide (LSD) ingestion

[abirb.com/test](#)

ANS: D

The patient who has ingested LSD often experiences synesthesia (visions in sound), depersonalization, and concerns about going “crazy.” Synesthesia is not common in schizophrenia. CNS stimulant overdose more commonly involves elevated vital signs and assaultive, grandiose behaviors. PCP use commonly causes bizarre or violent behavior, nystagmus, elevated vital signs, and repetitive jerking movements.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

33. In what significant ways is the therapeutic environment different for a patient who has ingested lysergic acid diethylamide (LSD) than for a patient who has ingested phencyclidine (PCP)?
- For LSD ingestion, one person stays with the patient and provides verbal support. For PCP ingestion, a regimen of limited contact with staff members is maintained, and continual visual monitoring is provided.
 - For PCP ingestion, the patient is placed on one-on-one intensive supervision. For LSD ingestion, a regimen of limited interaction and minimal verbal stimulation is maintained.
 - For LSD ingestion, continual moderate sensory stimulation is provided. For PCP ingestion, continual high-level stimulation is provided.
 - For LSD ingestion, the patient is placed in restraints. For PCP ingestion, seizure precautions are implemented.

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[abirb.com/test](#)

ANS: A

[abirb.com/test](#)

[abirb.com/test](#)

Patients who have ingested LSD respond well to being “talked down” by a supportive person. Patients who have ingested PCP are very sensitive to stimulation and display frequent, unpredictable, and violent behaviors. Although one person should perform care and talk gently to the patient, no one individual should be alone in the room with the patient. An adequate number of staff members should be gathered to manage violent behavior if it occurs.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

34. When assessing a patient who has ingested flunitrazepam, what should the nurse expect?
- Acrophobia
 - Hypothermia
 - Hallucinations
 - Anterograde amnesia

[abirb.com/test](#)

ANS: D

Flunitrazepam is known as roofies, produces disinhibition, and a relaxation of voluntary muscles, as well as anterograde amnesia for events that occur. The other options do not reflect symptoms commonly observed after use of this drug.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment
MSC: NCLEX: Physiological Integrity

35. A patient is admitted in a comatose state after ingesting five capsules of lorazepam. A friend of the patient says, “Often my friend drinks, along with taking more of the drug than is prescribed.” What is the effect of the use of alcohol with this drug?
- The drug’s metabolism is stimulated.
 - The drug’s effect is diminished.
 - A synergistic effect occurs.
 - There is no effect.

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ANS: C

Both lorazepam and alcohol are CNS depressants and have synergistic effects. Taken together, the action of each would potentiate the other.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment
MSC: NCLEX: Physiological Integrity

36. Which medication is the nurse most likely to see prescribed as part of the treatment plan for both a patient in an alcoholism treatment program and a patient in a program for the treatment of opioid addiction?
- Methadone
 - Bromocriptine
 - Disulfiram
 - Naltrexone

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ANS: D

Naltrexone is useful for treating both opioid and alcohol addictions. As an opioid antagonist, it blocks the action of opioids. Because it blocks the mechanism of reinforcement, it also reduces or eliminates alcohol craving.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

[abirb.com/test](#)

MSC: NCLEX: Physiological Integrity

37. Select the most appropriate outcome for a patient completing the fourth alcohol detoxification program in 1 year. Before discharge, what will the patient do?
- Use rationalization in healthy ways.
 - State, "I see the need for ongoing treatment."
 - Identify constructive outlets for expression of anger.
 - Develop a trusting relationship with one staff member.

ANS: B

The answer refers to the need for ongoing treatment after detoxification and is the best goal related to controlling relapse. The scenario does not provide enough information to know whether anger has been identified as a problem. A trusting relationship, although desirable, would not help the patient maintain sobriety.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

38. Which question has the highest priority when assessing a newly admitted patient with a history of alcohol abuse?
- "Have you ever had blackouts?"
 - "When did you have your last drink?"
 - "Has drinking caused you any problems?"
 - "When did you decide to seek treatment?"

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[abirb.com/test](#)

ANS: B

Learning when the patient had the last drink is essential to knowing when to begin to observe for symptoms of withdrawal. The other questions are relevant but of lower priority.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

39. A patient in an alcohol treatment program says, "I have been a loser all my life. I'm so ashamed of what I have put my family through. Now, I'm not even sure I can succeed at staying sober." Which nursing diagnosis applies?
- Chronic low self-esteem
 - Situational low self-esteem
 - Disturbed personal identity
 - Ineffective health maintenance

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[abirb.com/test](#)

ANS: A

Low self-esteem is present when a patient sees himself or herself as inadequate. It is a chronic problem because it is a lifelong feeling for the patient. Data are not present to support the other options.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

40. Which documentation indicates that the treatment plan for a patient in an alcohol treatment program was effective?

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- a. Is abstinent for 10 days and states, "I can maintain sobriety one day at a time." Spoke with employer, who is willing to allow the patient to return to work in 3 weeks.
- b. Is abstinent for 15 days and states, "My problems are under control." Plans to seek a new job where coworkers will not know history.
- c. Attends AA daily; states many of the members are "real" alcoholics and says, "I may be able to help some of them find jobs at my company."
- d. Is abstinent for 21 days and says, "I know I can't handle more than one or two drinks in a social setting."

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ANS: A

The answer reflects the AA beliefs. The incorrect options each contain a statement that suggests early relapse.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

41. Which assessment findings support a nurse's suspicion that a patient has been using inhalants?
- a. Pinpoint pupils and respiratory rate of 12 breaths per minute
 - b. Perforated nasal septum and hypertension
 - c. Drowsiness, euphoria, and constipation
 - d. Nosebleed, muscle wasting, and impaired hearing

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ANS: D

Users can experience nausea and nosebleeds and lose their sense of hearing or smell. Chronic use can lead to muscle wasting and reduced muscle tone. The incorrect options relate to cocaine snorting and opioid abuse.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

MULTIPLE RESPONSE

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1. A patient undergoing alcohol rehabilitation decides to accept disulfiram therapy to avoid impulsively responding to drinking cues. Which information should be included in the discharge teaching for this patient? (*Select all that apply.*)
- a. Avoid aged cheeses.
 - b. Read labels of all liquid medications.
 - c. Wear sunscreen and avoid bright sunlight.
 - d. Maintain an adequate dietary intake of sodium.
 - e. Avoid breathing fumes of paints, stains, and stripping compounds.

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ANS: B, E
The patient must avoid hidden sources of alcohol. Many liquid medications, such as cough syrups, contain small amounts of alcohol that could trigger an alcohol-disulfiram reaction. Using alcohol-based skin products such as aftershave or cologne; smelling alcohol-laden fumes; and eating foods prepared with wine, brandy, beer, or spirits of any sort may also trigger reactions. The other options do not relate to hidden sources of alcohol.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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2. A nurse can assist a patient diagnosed with addiction and the patient's family in which aspects of relapse prevention? (*Select all that apply.*)
- a. Rehearsing techniques to handle anticipated stressful situations
b. Advising the patient to accept residential treatment if relapse occurs
c. Assisting the patient to identify life skills needed for effective coping
d. Isolating self from significant others and social situations until sobriety is established
e. Teaching the patient about the physical changes to expect as the body adapts to functioning without substances

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ANS: A, C, E

Nurses can be helpful as a patient assesses needed life skills and in providing appropriate referrals. Anticipatory problem solving and role-playing are good ways of rehearsing effective strategies for handling stressful situations. The nurse can participate in role-playing and help the patient evaluate the usefulness of new strategies. The nurse can also provide valuable information about the physiological changes that can be expected and the ways in which to cope with these changes. Residential treatment is not usually necessary after relapse. Patients need the support of friends and family to establish and maintain sobriety.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

3. While caring for a patient with a methamphetamine overdose, which tasks are the priorities of care? (*Select all that apply.*)
- a. Administration of naloxone (Narcan)
b. Vitamin B₁₂ and folate supplements
c. Restoring nutritional integrity
d. Prevention of seizures
e. Reduction of fever

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ANS: D, E

Hyperpyrexia and convulsions are common when a patient has overdosed on a CNS stimulant. These problems are life threatening and take priority. Naloxone (Narcan) is administered for opiate overdoses. Vitamin B₁₂ and folate may be helpful for overdoses from solvents, gases, or nitrates. Nutrition is not a priority in an overdose situation.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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Chapter 20: Crisis and Mass Disaster

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A patient comes to the clinic with superficial cuts on the left wrist. The patient paces around the room sobbing but cringes when approached and responds to questions with only shrugs or monosyllables. What is the nurse's best initial statement to this patient?
 - a. "Everything is going to be all right. You are here at the clinic, and the staff will keep you safe."
 - b. "I see you are feeling upset. I am going to stay and talk with you to help you feel better."
 - c. "You need to try to stop crying so we can talk about your problems."
 - d. "Let's set some guidelines and goals for your visit here."

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ANS: B

A crisis exists for this patient. The two primary thrusts of crisis intervention are to provide for the safety of the individual and use anxiety-reduction techniques to facilitate the use of inner resources. The nurse offers therapeutic presence, which provides caring, ongoing observation relative to the patient's safety. The incorrect responses use nontherapeutic techniques, including false reassurance and giving advice.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A patient comes to the clinic with superficial cuts on the left wrist. The patient is pacing and sobbing. After a few minutes with the nurse, the patient is calmer. What should the nurse ask to determine the patient's perception of the precipitating event?
 - a. "Tell me why you were crying."
 - b. "How did your wrist get injured?"
 - c. "How can I help you feel more comfortable?"
 - d. "What was happening just before you started feeling this way?"

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ANS: D

A clear definition of the immediate problem provides the best opportunity to find a solution. Asking about recent upsetting events permits the assessment of the precipitating event. Asking "why" questions are a nontherapeutic communication technique.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

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3. A patient comes to the crisis center saying, "I'm in a terrible situation. I don't know what to do." The triage nurse can initially assume that the patient is experiencing what?
 - a. Suicidal ideations
 - b. Anxiety and fear
 - c. Misperceived reality
 - d. Homicidal ideations

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ANS: B

abirb.com/test

abirb.com/test

Individuals in crisis are universally anxious. They are often frightened and may be mildly confused. Perceptions are often narrowed. None of the other options are supported with behaviors.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

4. An adolescent comes to the crisis clinic and reports sexual abuse by an uncle. The patient told the parents about the uncle's behavior, but the parents did not believe the adolescent. What type of crisis exists?

- a. Maturational
- b. Adventitious
- c. Situational
- d. Organic

[abirb.com/test](#)

ANS: B

An adventitious crisis is a crisis of disaster that is not a part of everyday life; it is unplanned or accidental. Adventitious crises include natural disasters, national disasters, and crimes of violence. Sexual molestation falls within this classification. Maturational crisis occurs as an individual arrives at a new stage of development, when old coping styles may be ineffective. Situational crisis arises from an external source such as a job loss, divorce, or other loss affecting self-concept or self-esteem. Organic is not a type of crisis.

DIF: Cognitive Level: Comprehension (Understanding)

[abirb.com/test](#)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

5. Which patient statement best suggests they have returned to a pre-crisis level of functioning?
- a. "My boss told me I am doing well and up for a promotion."
 - b. "I understand that bad things can happen to really good people."
 - c. "Going to my support group regularly has made a big difference."
 - d. "I'm much more comfortable asking for help than before my divorce."

ANS: A

Resolution of a crisis can result in a return to pre-crisis functioning, or a higher or lower level of functioning. The goal of crisis intervention is a return to at least pre-crisis functioning level. A good job performance evaluation is suggestive of pre-crisis functioning." The other options suggest that the patient is working toward that goal.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

6. An adult seeks counseling after the spouse is murdered. The adult angrily says, "I hate the monster that did this. It has ruined my life. During the trial, I don't know what I'll do if the jury doesn't return a guilty verdict." What is the nurse's highest priority question?
- a. "What do you mean when you say 'monster'?"
 - b. "What resources do you need to help you cope with this situation?"
 - c. "Would you consider hurting yourself or the person on trial?"
 - d. "Are you having thoughts of hurting yourself or others?"

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ANS: D

[abirb.com/test](#)

The highest nursing priority is safety. The nurse should assess suicidal and homicidal potentials. The incorrect options may be important but not the highest priority.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

7. A woman says, "I can't take anymore! Last year my husband had an affair. Three months ago, I found a lump in my breast. Yesterday my daughter said she's quitting college." What type of crisis is this person experiencing?

- a. Maturational
- b. Adventitious
- c. Situational
- d. Recurring

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ANS: C

A situational crisis arises from an external source and involves a loss of self-concept or self-esteem. An adventitious crisis is a crisis of disaster, such as a natural disaster or crime of violence. Maturational crisis occurs as an individual arrives at a new stage of development, when old coping styles may be ineffective. No classification of recurring crisis exists.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

8. A woman says, "I can't take anymore! Last year my husband had an affair and now we don't communicate. Three months ago, I found a lump in my breast. Yesterday my daughter said she's quitting college." What is the nurse's priority assessment?
- a. Identifying measures useful to help improve the couple's communication
 - b. Discussing the patient's feelings about the possibility of having a mastectomy
 - c. Determining whether the husband is still engaged in an extramarital affair
 - d. Clarifying what the patient means by "I can't take it anymore!"

ANS: D

During crisis intervention, the priority concern is patient safety. This question helps assess personal coping skills. The other options are incorrect because the focus of crisis intervention is on the event that occurred immediately before the patient sought help.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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9. A woman says, "I can't take anymore, and I have no children or husband to turn to! This last year has been on crisis after another." If this person's immediate family is unable to provide sufficient situational support, what should the nurse do?
- a. Suggest hospitalization for a short period.
 - b. Ask what other relatives or friends are available for support.
 - c. Tell the patient, "You must be strong. Don't let this crisis overwhelm you."
 - d. Foster insight by relating the present situation to earlier situations involving loss.

ANS: B

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abirb.com/test

The assessment of situational supports should continue. Although the patient's nuclear family may not be supportive, other situational supports may be available. If they are adequate, admission to an inpatient unit will be unnecessary. Psychotherapy is not appropriate for crisis intervention. Advice is usually nontherapeutic.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

10. A woman says, "I can't take anymore! Last year my husband was diagnosed with cancer. Three months ago, I lost my job. Yesterday my daughter said she's quitting college and moving in with her boyfriend." Which issue should be the focus for crisis intervention?
- a. Possible mastectomy
 - b. Disordered family communication
 - c. Effects of the divorce
 - d. Coping with the reaction to the daughter's events

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ANS: D

The focus of crisis intervention is on the most recent problem—the straw that broke the camel's back.” The patient has coped with the breast lesion, the divorce, and the disordered communication. Disequilibrium occurs only with the introduction of the daughter leaving college and moving.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

abirb.com/test

11. A patient visiting the crisis clinic for the first time asks, "How long will I be coming here?" The nurse's reply should consider that the usual duration of crisis intervention is how long in weeks?
- a. 1 to 2
 - b. 3 to 4
 - c. 4 to 6
 - d. 6 to 12

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ANS: C

The disorganization associated with crisis is so distressing that it usually cannot be tolerated for more than 4 to 6 weeks. If the crisis is not resolved by that time, the individual usually adopts dysfunctional behaviors that reduce anxiety without solving the problem. Crisis intervention can shorten the duration.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

12. An adult tells the nurse, "I can't take anymore! My mother passed away, my husband lost his job and yesterday my daughter told me she's quitting college and moving in with her boyfriend." What is the priority nursing diagnosis?
- a. Fear, related to impending breast surgery
 - b. Deficient knowledge, related to breast lesion
 - c. Ineffective coping, related to perceived loss of daughter
 - d. Impaired verbal communication, related to spousal estrangement

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ANS: C

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This nursing diagnosis is the priority because it reflects the precipitating event associated with the patient's crisis. Data are not present to make the other diagnoses of deficient knowledge, fear, or impaired verbal communication.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

13. When responding to a natural disease, after rescue and evacuation efforts are completed, what intervention will be the focus of the triage process?
- a. Planning the physical rebuilding of the community
 - b. Coordinating food and shelter services
 - c. Arranging for temporary schools
 - d. Debriefing first responders

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ANS: B

The first needs during a disaster include rescue and evacuation efforts, food and shelter, medical attention, and physical safety. While important all the other options are addressed after immediate needs are addressed.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

14. Which situation demonstrates the use of primary care related to crisis intervention?
- a. Implementing suicide precautions for a patient with depression
 - b. Teaching stress-reduction techniques to a beginning student nurse
 - c. Assessing coping strategies used by a patient who has attempted suicide
 - d. Referring a patient with schizophrenia to a partial hospitalization program

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ANS: B

Primary crisis intervention promotes mental health and reduces mental illness. The incorrect options are examples of secondary or tertiary interventions.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

15. A victim of intimate partner violence comes to the crisis center seeking help. The nurse uses crisis intervention strategies that focus on what?
- a. Supporting emotional security and re-establishing equilibrium
 - b. Offering long-term resolution of issues precipitating the crisis
 - c. Promoting growth of the individual
 - d. Providing legal assistance

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ANS: A

[abirb.com/test](#)

Strategies of crisis intervention are directed toward the immediate cause of the crisis and are aimed at bolstering the emotional security and re-establishing equilibrium, rather than focusing on underlying issues and long-term resolutions. The goal is to return the individual to the pre-crisis level of function. Crisis intervention is, by definition, short term. Promoting growth is a focus of long-term therapy. Providing legal assistance might be applicable.

DIF: Cognitive Level: Application (Applying)

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MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

[abirb.com/test](#)

16. After celebrating a 40th birthday, an individual becomes concerned with the loss of youthful appearance. What type of crisis has occurred?
a. Reactive
b. Situational
c. Maturational
d. Adventitious

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abirb.com/test

ANS: C

Maturational crises occur when a person arrives at a new stage of development and finds that old coping styles are ineffective but has not yet developed new strategies. Situational crises arise from sources external to the individual, such as divorce and job loss. No classification called reactive crisis exists. Adventitious crises occur when disasters such as natural disasters (e.g., floods, hurricanes), war, or violent crimes disrupt coping styles.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

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17. Which scenario is an example of an adventitious crisis?
a. Death of a child from sudden infant death syndrome
b. Being fired from a job because of company downsizing
c. Retirement of a 55 year old
d. A riot at a rock concert

ANS: D

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The rock concert riot is unplanned, accidental, violent, and not a part of everyday life. The incorrect options are examples of situational or maturational crises.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

18. Which agency provides coordination in the event of a terrorist attack?
a. U.S. Food and Drug Administration (FDA)
b. Environmental Protection Agency (EPA)
c. National Incident Management System (NIMS)
d. Federal Emergency Management Agency (FEMA)

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ANS: C

The NIMS provides a systematic approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector during disaster situations.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

abirb.com/test

19. During the initial interview at the crisis center, a patient says, "I've been served with divorce papers. I'm so upset and anxious that I can't think clearly." What could the nurse say to assess personal coping skills?
a. "What would you like us to do to help you feel more relaxed?"
b. "In the past, how did you handle difficult or stressful situations?"
c. "Do you think you deserve to have things like this happen to you?"
d. "I can see you are upset. You can rely on us to help you feel better."

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ANS: B

The correct answer is the only option that assesses coping skills. The incorrect options offer unrealistic reassurance, are concerned with self-esteem, and ask the patient to decide on treatment at a time when he or she “cannot think clearly.”

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

20. An adult has cared for a debilitated parent for 10 years. The parent’s condition recently declined, and the health care provider recommended placement in a skilled care facility. The adult says, “I’ve always been able to care for my parents. Nursing home placement goes against everything I believe.” Successful resolution of this person’s crisis will most closely relate to what?
- a. Resolving the feelings associated with the threat to the person’s self-concept
 - b. Maintaining the ability to identify situational supports in the community
 - c. Relying on the assistance from role models within the person’s culture
 - d. Mobilizing automatic relief behaviors by the person

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ANS: A

The patient’s crisis clearly relates to a loss of (or threatened change in) self-concept. Her capacity to care for her parents, regardless of the deteriorating condition, has been challenged. Crisis resolution involves coming to terms with the feelings associated with this loss.

Identifying situational supports is relevant but less so than coming to terms with the threat to self-concept. Reliance on lessons from role models can be helpful but is not the primary factor associated with resolution in this case. Automatic relief behaviors are not helpful and are part of the fourth phase of crisis.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

21. Which premise is most useful to a nurse planning crisis intervention for any patient?
- a. The patient is experiencing a state of disequilibrium.
 - b. The patient is experiencing a type of mental illness.
 - c. The patient poses a threat of violence to others.
 - d. The patient has a high potential for self-injury.

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ANS: A

Disequilibrium is the only answer universally true for all patients in crisis. A crisis represents a struggle for equilibrium when problems seem unsolvable. Crisis does not reflect mental illness. The potential for self-violence or other-directed violence may or may not be a factor in crisis.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

22. A nurse assesses an adult experiencing a crisis. What question asked by the nurse will best determine situational support?
- a. “Has anything upsetting occurred in the past few days?”
 - b. “Who can be helpful to you during this time?”
 - c. “How does this problem affect your life?”
 - d. “What led you to seek help at this time?”

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ANS: B

Only the correct answer focuses on situational support. The incorrect options focus on the patient's perception of the precipitating event.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

23. An adult comes to the crisis clinic after being terminated from a job of 15 years. The patient says, "I don't know what to do. How can I get another job? Who will pay the bills? How will I feed my family?" Which nursing diagnosis applies?
- a. Hopelessness
 - b. Powerlessness
 - c. Chronic low self-esteem
 - d. Disturbed thought processes

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ANS: B

The patient describes feelings of the lack of control over life events. No direct mention is made of hopelessness or chronic low self-esteem. The patient's thought processes are not shown to be altered at this point.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

[abirb.com/test](#)

MSC: NCLEX: Psychosocial Integrity

24. A troubled adolescent opened fire in a high school cafeteria, fatally shooting three people and injuring many others. Hundreds of parents come to the high school after hearing the news reports. After the police arrest the shooter, which action should occur next?
- a. Ask the police to encircle the school campus with yellow tape to prevent parents from entering.
 - b. Announce over the loudspeakers, "The campus is now secure. Please return to your classrooms."
 - c. Require parents to pass through metal detectors and then allow them to look for their children in the school.
 - d. Designate zones according to the alphabet, and direct students to the zones based on their surnames to facilitate reuniting them with their parents.

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ANS: D

Chaos is likely among students and desperate parents. A directive approach is best. Once the scene is secure, creative solutions are needed. Creating zones by letters of the alphabet helps anxious parents and their children to unite. Preventing parents from uniting with their children would further incite the situation.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation

[abirb.com/test](#)

MSC: NCLEX: Safe, Effective Care Environment

25. After completing the contracted number of visits to the crisis clinic, an adult says, "I've emerged from this as a stronger person. You supported me while I worked through my feelings of loss and helped me find community resources. I'm benefiting from a support group." The nurse can evaluate the patient's feelings about the care received as what?
- a. Marginally satisfied
 - b. Somewhat satisfied

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- c. Moderately satisfied
- d. Very satisfied

ANS: D

The patient mentions a number of indicators that suggest a high degree of satisfaction with psychological care received. No indicators express low-to-moderate satisfaction.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

26. At the last contracted visit in the crisis intervention clinic, ~~an adult~~ says, "I've emerged from this a stronger person. You helped me feel like my life is back in balance." The nurse responds, "I think it would be worthwhile to have two more sessions to explore why your reactions were so intense." Which analysis applies?
- a. The patient is experiencing transference.
 - b. The patient demonstrates a need for continuing support.
 - c. The nurse is having difficulty terminating the relationship.
 - d. The nurse is empathizing with the patient's feelings of dependency.

ANS: C

The nurse's remark is clearly an invitation to work on other problems and prolong contact with the patient. The focus of crisis intervention is on the problem that precipitated the crisis, not other issues. The scenario does not describe transference. The patient's need for continuing support is not demonstrated in the scenario. The scenario does not describe dependency needs.

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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

27. Which health care worker should be referred to critical incident stress debriefing?
- a. Nurse who works at an oncology clinic where patients receive chemotherapy.
 - b. Case manager whose patients are seriously mentally ill and are being cared for at home.
 - c. Health care employee who worked 8 hours at the information desk of an intensive care unit.
 - d. Emergency medical technician (EMT) who treated victims of a car bombing at a department store.

ANS: D

Although each of the individuals mentioned experiences job-related stress on a daily basis, the person most in need of critical incident stress debriefing is the EMT, who experienced an adventitious crisis event by responding to a bombing and provided care to victims of trauma.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

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TOP: Nursing Process: Planning

MULTIPLE RESPONSE

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1. A nurse driving home after work comes upon a serious automobile accident. The driver gets out of the car with no apparent physical injuries. Which assessment findings would be expected from the driver immediately after this event? (*Select all that apply.*)

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- a. Difficulty using a cell phone
- b. Long-term memory losses
- c. Fecal incontinence
- d. Rapid speech
- e. Trembling

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ANS: A, D, E

[abirb.com/test](#)

Immediate responses to crisis commonly include shock, numbness, denial, confusion, disorganization, difficulty with decision making, and physical symptoms such as nausea, vomiting, tremors, profuse sweating, and dizziness associated with anxiety. Incontinence and long-term memory losses would not be expected.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

Chapter 21: Child, Partner, and Elder Violence

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A nurse visits the home of an 11-year-old child and finds the child caring for three younger siblings. Both parents are at work. The child says, "I want to go to school but we can't afford a babysitter. It doesn't matter; I'm too dumb to learn." What preliminary assessment is evident?
 - a. Insufficient data are present to make an assessment.
 - b. Child and siblings are experiencing neglect.
 - c. Children are at high risk for sexual abuse.
 - d. Children are experiencing physical abuse.

ANS: B

A child is experiencing neglect when the parents take away the opportunity to attend school. The other children may also be experiencing physical neglect, but more data should be gathered before making the actual assessment. The information presented does not indicate a high risk for sexual abuse, and no concrete evidence of physical abuse is present.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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2. An 11-year-old child is absent from school to care for siblings while the parents work. The family cannot afford a babysitter. When asked about the parents, the child reluctantly says, "My parents don't like me. They call me stupid and say I never do anything right." Which type of abuse is likely?
 - a. Sexual
 - b. Physical
 - c. Emotional
 - d. Economic

ANS: C

Examples of emotional abuse include having an adult demean a child's worth or frequently criticize or belittle a child. No data support physical battering or endangerment, sexual abuse, or economic abuse.

abirb.com/test

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

3. What feelings are most commonly experienced by nurses working with abusive families?
 - a. Outrage toward the victim and sympathy for the abuser
 - b. Sympathy for the victim and anger toward the abuser
 - c. Unconcern for the victim and dislike for the abuser
 - d. Vulnerability for self and empathy with the abuser

ANS: B

Intense protective feelings, sympathy for the victim, and anger and outrage toward the abuser are common emotions of a nurse working with an abusive family.

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DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

4. Which rationale best explains why a nurse should be aware of personal feelings while working with a family experiencing family violence?
- Self-awareness protects one's own mental health.
 - Strong negative feelings interfere with assessment and judgment.
 - Strong positive feelings lead to under involvement with the victim.
 - Positive feelings promote the development of sympathy for patients.

ANS: B

Strong negative feelings cloud the nurse's judgment and interfere with assessment and intervention, no matter how well the nurse tries to cover or deny personal feelings. Strong positive feelings lead to overinvolvement with the victim.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

5. A clinic nurse interviews an adult patient accompanied by a partner who reports fatigue, back pain, headaches, tension, and sleep disturbances. The patient then becomes reluctant to provide more information and wants to leave. How can the nurse best serve the patient?
- Explore the possibility of patient social isolation.
 - Have the partner leave the patient alone to continue the assessment.
 - Ask whether the patient has ever had psychiatric counseling in the past.
 - Ask the patient to disrobe so that assessment for signs of physical abuse can occur.

ANS: B

In this situation, the nurse should consider the possibility that the patient is a victim of intimate partner violence. Although the patient is reluctant to discuss issues, he or she may be willing to speak more candidly if the partner is not in the room. None of the other options focus on the client's reluctance to continue the assessment process.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

6. A patient at the emergency department is diagnosed with a concussion. The patient is accompanied by a spouse who insists on staying in the room and answering all questions. The patient avoids eye contact and has a sad affect and slumped shoulders. Assessment of which additional problem has priority?
- Risk of intimate partner violence
 - Phobia of crowded places
 - Migraine headaches
 - Depressive symptoms

ANS: A

The diagnosis of a concussion suggests violence as a possible cause. The patient is exhibiting indicators of abuse including fearfulness, depressed affect, poor eye contact, and a possessive spouse. The patient may be also experiencing depression, anxiety, and migraine headaches, but the nurse's advocacy role necessitates an assessment for intimate partner violence.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

7. What is a nurse's legal responsibility if child abuse or neglect is suspected?
- Discuss the findings with the child's teacher, principal, and school psychologist.
 - Report the suspected abuse or neglect according to state regulations.
 - Document the observations and speculations in the medical record.
 - Continue the assessment.

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ANS: B

Each state has specific regulations for reporting child abuse that must be observed. The nurse is usually a mandated reporter. The reporter does not need to be sure that abuse or neglect has occurred but only that it is suspected. Speculation should not be documented; only the facts are recorded.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

8. Several children are seen in the emergency department for treatment of illnesses and injuries. Which finding would create a high index of suspicion for child abuse?
- Repeated middle ear infections
 - Severe colic
 - Bite marks
 - Croup

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ANS: C

Injuries such as immersion or cigarette burns, facial fractures, whiplash, bite marks, traumatic injuries, bruises, and fractures in various stages of healing suggest the possibility of abuse. In older children, vague complaints such as back pain may also be suspicious. Ear infections, colic, and croup are not problems induced by violence.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Safe, Effective Care Environment

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9. An 11-year-old child says, "My parents don't like me. They call me stupid and say I never do anything right, but it doesn't matter. I'm too dumb to learn." Which nursing diagnosis applies to this child?
- Chronic low self-esteem, related to negative feedback from parents
 - Deficient knowledge, related to interpersonal skills with parents
 - Disturbed personal identity, related to negative self-evaluation
 - Complicated grieving, related to poor academic performance

ANS: A

The child has indicated a belief in being too dumb to learn. The child receives frequent negative and demeaning feedback from the parents. Deficient knowledge is a nursing diagnosis that refers to knowledge of health care measures. Disturbed personal identity refers to an alteration in the ability to distinguish between self and nonself. Grieving may apply, but a specific loss is not evident in this scenario. Low self-esteem is more relevant to the child's statements.

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DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

[abirb.com/test](#)

MSC: NCLEX: Psychosocial Integrity

10. An adult has recently been absent from work for 3-day periods on several occasions. Each time, the individual returns to work wearing dark glasses. Facial and body bruises are apparent. What is the occupational health nurse's priority assessment?
- a. Interpersonal relationships
 - b. Work responsibilities
 - c. Socialization skills
 - d. Physical injuries

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ANS: D

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The individual should be assessed for possible battering. Physical injuries are abuse indicators and are the primary focus for assessment. No data support the other options.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

11. An adult has recently been absent from work for 3-day periods on several occasions. Each time, this person returns to work wearing dark glasses. Facial and body bruises are apparent. What is the occupational health nurse's priority assessment question?
- a. "Do you drink excessively?"
 - b. "Did your partner beat you?"
 - c. "How did this happen to you?"
 - d. "What did you do to deserve this?"

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ANS: C

[abirb.com/test](#)

Obtaining the person's explanation is necessary. If the explanation does not match the injuries or if the victim minimizes the injuries, abuse should be suspected.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

12. An employee has recently been absent from work on several occasions. Each time, this employee returns to work wearing dark glasses. Facial and body bruises are apparent. During the occupational health nurse's interview, the employee says, "My partner beat me, but it was because there are problems at work." What should the nurse's next action be?
- a. Notify the police.
 - b. Refer the employee to a shelter.
 - c. Notify the adult protective agency.
 - d. Document injuries with a body map.

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ANS: D

Documentation of the injuries provides a basis for possible legal intervention. The abused adult will need to make the decision to involve the police. Because the worker is not an older adult and is competent, the adult protective agency is unable to assist. A shelter may be suggested later, but it is not the next action.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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13. A patient tells the nurse, "My husband is abusive only when he drinks too much. His family was like that when he was growing up. He always apologizes and regrets hurting me." What risk factor was most predictive for the husband to become abusive?^{abirb.com/test}
- a. History of family violence
 - b. Loss of employment
 - c. Abuse of alcohol
 - d. Poverty

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ANS: A

An abuse-prone individual is an individual who has experienced family violence and was often abused as a child. This phenomenon is part of the cycle of violence. The other options may be present but are not as predictive.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

14. An adult tells the nurse, "My partner abuses me only when drinking. The drinking has increased lately, but I always get an apology afterward and a box of candy. I've considered leaving but haven't been able to bring myself to actually do it." Which phase in the cycle of violence prevents the patient from leaving?
- a. Tension building
 - b. Acute battering
 - c. Honeymoon
 - d. Recovery

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ANS: C

The honeymoon stage is characterized by kindly, loving behaviors toward the abused spouse when the perpetrator feels remorseful. The victim believes the promises and drops plans to leave or seek legal help. The tension-building stage is characterized by minor violence in the form of abusive verbalization or pushing. The acute battering stage involves the abuser beating the victim. The violence cycle does not include a recovery stage.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

15. After treatment for a detached retina, a victim of intimate partner violence says, "My partner only abuses me when intoxicated. I've considered leaving, but I was brought up to believe you stay together, no matter what happens. I always get an apology, and I can tell my partner feels bad after hitting me." Which nursing diagnosis applies?
- a. Social isolation, related to lack of community support system
 - b. Risk for injury, related to partner's physical abuse when intoxicated
 - c. Deficient knowledge, related to resources for escape from the abusive relationship
 - d. Disabled family coping, related to uneven distribution of power within a relationship

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ANS: B

Risk for injury is the priority diagnosis because the partner has already inflicted physical injury during violent episodes. The episodes are likely to become increasingly violent. Data are not present that show social isolation or disabled family coping, although both are common among victims of violence. Deficient knowledge does not apply to this patient's use of defense mechanisms.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis [abirb.com/test](#)

MSC: NCLEX: Safe, Effective Care Environment

16. A victim of physical abuse by an intimate partner is treated for a broken wrist. The patient has considered leaving but says, "You stay together, no matter what happens." Which outcome should be met before the patient leaves the emergency department? The patient will:
- limit contact with the abuser by obtaining a restraining (protective) order.
 - name two community resources that can be contacted. [abirb.com/test](#)
 - demonstrate insight into the abusive relationship.
 - facilitate counseling for the abuser.

ANS: B

The only outcome indicator clearly attainable within this time is for a staff member to provide the victim with information about community resources that can be contacted. The development of insight into the abusive relationship requires time. Securing a restraining (protective) order can be quickly accomplished but not while the patient is in the emergency department. Facilitating the abuser's counseling may require weeks or months.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

[abirb.com/test](#)

MSC: NCLEX: Safe, Effective Care Environment

17. An older adult diagnosed with dementia lives with family and attends an adult day care center. A nurse at the center notices the adult has a disheveled appearance, a strong odor of urine, and bruises on the limbs and back. What type of abuse might be occurring?
- Psychological
 - Financial
 - Physical
 - Sexual

ANS: C

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The assessment of physical abuse is supported by the nurse's observation of bruises. Physical abuse includes evidence of improper care, as well as physical endangerment behaviors such as reckless behavior toward a vulnerable person that could lead to serious injury. No data substantiate the other options.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

18. An older adult diagnosed with Alzheimer's disease lives with family. During the week, the person attends a day care center while the family is at work. In the evenings, members of the family provide care. Which factor makes this patient most vulnerable to abuse?
- Dementia
 - Living in a rural area
 - Being part of a busy family
 - Being home only in the evening

ANS: A

Older adults, particularly those with cognitive impairments, are at high risk for abuse. The other characteristics are not identified as placing an individual at high risk for abuse.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

19. An older adult, diagnosed with Alzheimer's disease, lives with family and has multiple bruises. The home health nurse talks with the older adult's daughter, who becomes defensive and says, "My mother often wanders at night. Last night she fell down the stairs." Which nursing diagnosis has priority?
- Risk for injury, related to cognitive impairment and lack of caregiver supervision
 - Noncompliance, related to confusion and disorientation as evidenced by lack of cooperation
 - Impaired verbal communication, related to brain impairment as evidenced by the confusion
 - Insomnia, related to cognitive impairment as evidenced by wandering at night

ANS: A

The patient is at high risk for injury because of her confusion. The risk increases when caregivers are unable to provide constant supervision. No assessment data support the diagnoses of impaired verbal communication or noncompliance. Sleep pattern disturbance certainly applies to this patient; however, the diagnosis risk for injury is a higher priority.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Safe, Effective Care Environment

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20. An older adult diagnosed with dementia lives with family and attends day care. After observing poor hygiene, the nurse at the center talks with the patient's adult child. This caregiver becomes defensive and says, "It takes all my time and energy to care for my mother. She's awake all night. I never get any sleep." Which nursing intervention has priority?
- Teach the caregiver more about the effects of dementia.
 - Secure additional resources for the mother's evening and night care.
 - Support the caregiver to grieve the loss of the mother's ability to function.
 - Teach the family how to give physical care more effectively and efficiently.

ANS: B

The patient's child and family were coping with care until the patient began to stay awake at night. The family needs assistance with evening and night care to resume their pre-crisis state of functioning. Secondary prevention calls for the nurse to mobilize community resources to relieve overwhelming stress. The other interventions may then be accomplished.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

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21. A patient has a history of physical violence against family members when frustrated and then experiences periods of remorse after each outburst. The patient attends anger management classes. Which finding indicates success in this plan of care?
- The patient expresses frustration verbally instead of physically.
 - The patient explains the rationale for behaviors to the victim.
 - The patient identifies three personal strengths.
 - The patient agrees to seek counseling.

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ANS: A

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The patient will develop a healthier way of coping with frustration if it is expressed verbally instead of physically. The incorrect options do not confirm the achievement of outcomes.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

22. Which referral is most appropriate for a woman who is severely beaten by her husband, has no relatives or friends in the community, is afraid to return home, and has limited financial resources?
- Support group
 - Law enforcement
 - Women's shelter
 - Vocational counseling

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ANS: C

Because the woman has no safe place to go, referral to a shelter is necessary. The shelter will provide other referrals as necessary. None of the other options proves the necessary level of safety.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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23. Which family scenario presents the greatest risk for family violence?
- An unemployed husband with low self-esteem, a wife who loses her job, and a developmentally delayed 3-year-old child
 - A husband who finds employment 2 weeks after losing his previous job, a wife with stable employment, and a child diagnosed with attention deficit disorder
 - A single mother with an executive position, a gifted and talented child, and a widowed grandmother living in the home to provide child care
 - A single homosexual male parent and an adolescent son who has just begun dating girls

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ANS: A

The family with an unemployed husband with low self-esteem, a newly unemployed wife, and a developmentally challenged young child has the greatest number of stressors. The other families described have fewer negative events occurring.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Psychosocial Integrity

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MULTIPLE RESPONSE

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1. A 10-year-old child cares for siblings while the parents work because the family cannot afford a babysitter. This child says, "My father doesn't like me. He calls me stupid all the time." The mother says the father is easily frustrated and has trouble disciplining the children. The community health nurse should consider which resources to stabilize the home situation? *(Select all that apply.)*
- Parental sessions to teach child-rearing practices
 - Anger management counseling for the father
 - Continuing home visits to provide support

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- d. Safety plan for the wife and children
- e. Foster placement of the children in foster care

ANS: A, B, C

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Anger management counseling for the father is appropriate. Support for this family will be an important component of treatment. By the wife's admission, the family has deficient knowledge of parenting practices. Whenever possible, the goal of intervention should be to keep the family together; thus, removing the children from the home should be considered a last resort. Physical abuse is not suspected, so a safety plan is not a priority at this time.

DIF: Cognitive Level: Analysis (Analyzing)

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MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

2. A nurse assists a victim of intimate partner violence to create a plan for escape if it becomes necessary. The plan should include which components? (*Select all that apply.*)

- a. Keep a cell phone fully charged.
- b. Hide money with which to buy new clothes.
- c. Have the telephone number for the nearest shelter. abirb.com/test
- d. Take enough toys to amuse the children for 2 days.
- e. Secure a supply of current medications for self and children.
- f. Determine a code word to signal children that it is time to leave.
- g. Assemble birth certificates, Social Security cards, and licenses.

ANS: A, C, E, F, G

The victim must prepare for a quick exit and so should assemble necessary items. Keeping a cell phone fully charged will help with access to support persons or agencies. The individual should be advised to hide a small suitcase containing a change of clothing for self and for each child. Taking a large supply of toys would be cumbersome and might compromise the plan. People are advised to take one favorite small toy or security object for each child, but most shelters have toys to further engage the children. Accumulating enough money to purchase clothing may be difficult.

DIF: Cognitive Level: Application (Applying)

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MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

3. A community health nurse visits a family with four children. The father behaves angrily, finds fault with a child, and asks twice, "Why are you such a stupid kid?" The wife says, "I have difficulty disciplining the children. It's so frustrating." Which comments by the nurse will facilitate the interview with these parents? (*Select all that apply.*)

- a. "Tell me how you punish your children."
- b. "How do you stop your baby from crying?"
- c. "Caring for four small children must be difficult."
- d. "Do you or your husband ever beat the children?" abirb.com/test
- e. "Calling children 'stupid' injures their self-esteem."

ANS: A, B, C

An interview with possible abusing individuals should be built on concern and carried out in a nonthreatening, nonjudgmental way. Empathetic remarks are helpful in creating rapport.

Questions requiring a descriptive response are less threatening and elicit more relevant information than questions that can be answered by "yes" or "no."

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DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

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Chapter 22: Sexual Violence

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A nurse works with a person who was raped 4 years ago. This person says, "It took a long time for me to recover from that horrible experience." Which term should the nurse use when referring to this person?
a. Victim
b. Survivor
c. Plaintiff
d. Perpetrator

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ANS: B

A survivor is an individual who has experienced sexual assault, participated in interventions, and is moving forward in life. Victim refers to a person who experienced a recent sexual assault. Plaintiff refers to a person bringing a civil complaint to the court system. Perpetrator refers to a person who commits a crime.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. A person was abducted and raped at gunpoint. The nurse observes this person is confused, talks rapidly in disconnected phrases, and is unable to concentrate or make simple decisions. What is the person's level of anxiety?
a. Minimal
b. Mild
c. Moderate
d. High

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ANS: D

Anxiety is the result of a personal threat to the victim's safety and security. In this case, the person's symptoms of rapid, dissociated speech, confusion, and indecisiveness indicate severe anxiety. "Minimal" is not a level of anxiety. Mild and moderate levels of anxiety allow the person to function at a higher level.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

3. A person was abducted and raped at gunpoint by an unknown assailant. Which assessment finding best indicates the person is in the acute phase of rape trauma syndrome?
a. Confusion and disbelief
b. Decreased motor activity
c. Flashbacks and dreams
d. Fears and phobias

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ANS: A

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Shock, emotional numbness, confusion, disbelief, restlessness, and agitated motor activity depict the acute phase of rape trauma syndrome. Flashbacks, dreams, fears, and phobias occur in the long-term reorganization phase of rape trauma syndrome. Decreased motor activity, by itself, is not an indicative of any particular phase.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

4. A nurse interviews a person abducted and raped at gunpoint by an unknown assailant. The person says, "I can't talk about it. Nothing happened. I have to forget!" What is the person's present coping strategy?

- a. Somatic reaction
- b. Repression
- c. Projection
- d. Denial

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ANS: D

Disbelief is a common finding during the acute stage following sexual assault. Denial is evidence of the disbelief. This mechanism may be unconsciously used to protect the person from the emotionally overwhelming reality of rape. The patient's statements do not reflect somatic symptoms, repression, or projection.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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5. A child was abducted and raped. Which personal reaction by the nurse could interfere with the child's care?

- a. Disgust
- b. Concern
- c. Empathy
- d. Compassion

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ANS: A

Feelings of empathy, concern, and compassion are helpful. Disguise, on the other hand, may make objectivity impossible and can increase the child's anxiety and shame.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

6. A nurse working in the county jail interviews a man who recently committed a violent sexual assault against a woman. Which comment from this perpetrator is most likely?

- a. "She was very beautiful."
- b. "She wanted sex the sex."
- c. "I have issues with my mother."
- d. "I've been depressed for a long time."

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ANS: B

Rape involves a need for control, power, degradation, and dominance over others. The correct response shows a lack of remorse or guilt, which is a common characteristic of an antisocial personality. The incorrect responses show an appreciation for women, psychological conflict, and self-disclosure, which are not expected from a perpetrator of sexual assault.

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DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

7. A rape victim asks an emergency department nurse, "Maybe I did something to cause this attack. Was it my fault?" Which response by the nurse is the most therapeutic?
- Pose questions about the rape, helping the patient explore why it happened.
 - Reassure the victim that the outcome of the situation will be positive.
 - Make decisions for the victim because of the temporary confusion.
 - Support the victim to separate issues of vulnerability from blame.

ANS: D

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Although the victim may have made choices that increased vulnerability, the victim is not to blame for the rape. The incorrect options either suggest the use of a nontherapeutic communication technique or do not permit the victim to restore control. No confusion is evident.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

8. A rape victim tells the nurse, "I should not have been out on the street alone." Which is the nurse's most therapeutic response?
- "Rape can happen anywhere."
 - "Blaming yourself only increases your anxiety and discomfort."
 - "You believe this would not have happened if you had not been alone?"
 - "You are right. You should not have been alone on the street at night."

ANS: C

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A reflective communication technique is helpful. Looking at one's role in the event serves to explain events that the victim would otherwise find incomprehensible. The incorrect options discount the victim's perceived role and interfere with further discussion.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. The nursing diagnosis rape trauma syndrome applies to a rape victim in the emergency department. Which outcome should occur before the patient's discharge?
- Patient states, "I feel safe and entirely relaxed."
 - Memory of the rape is less vivid and frightening.
 - Physical symptoms of pain and discomfort are no longer present.
 - Patient agrees to keep a follow-up appointment with the rape crisis center.

ANS: D

Agreeing to keep a follow-up appointment is a realistic short-term outcome. The incorrect options are unlikely to occur during the limited time the victim is in the emergency department.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

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10. The nurse cares for a victim of a violent sexual assault. What is the most therapeutic intervention?

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- a. Use accepting, nurturing, and empathetic communication techniques.
- b. Educate the victim about strategies to avoid attacks in the future.
- c. Discourage the expression of feelings until the victim stabilizes.^{abirb.com/test}
- d. Maintain a matter-of-fact manner and objectivity.

ANS: A

Victims require the nurse to provide unconditional acceptance of them as individuals, because they often feel guilty and engage in self-blame. The nurse must be nurturing if the victim's needs are to be met and must be empathetic to convey understanding and to promote an establishment of trust. It is premature to focus on avoidance strategies now. The remaining options do not promote acceptance.^{abirb.com/test}

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. What is the primary motivator for most rapists?
- a. Anxiety
 - b. Need for humiliation
 - c. Overwhelming sexual desires
 - d. Desire to inflict violence or control others

ANS: D

Rape is not a crime of sex; rather, it is a crime of power, control, and violence. The perpetrator wishes to subjugate the victim. The dynamics listed in the other options are not the major motivating factors for rape.^{abirb.com/test}

DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

12. A nurse working a rape telephone hotline should focus communication with callers toward what intervention?
- a. Arranging long-term counseling
 - b. Serving as a sympathetic listener
 - c. Obtaining information to relay to the local police
 - d. Explaining immediate steps that a victim of rape should take

ANS: D

The telephone counselor establishes where the victim is and what has happened and provides the necessary information to enable the victim to decide what steps to take immediately. Long-term aftercare is not the focus until immediate problems are resolved. The victim remains anonymous. The incorrect options are inappropriate or incorrect because counselors should be empathetic rather than sympathetic.^{abirb.com/test}

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

13. A rape victim tells the emergency department nurse, "I feel so dirty. Please let me take a shower before the doctor examines me." How should the nurse respond to the request?
- a. Arrange for the patient to shower.
 - b. Explain that washing would destroy evidence.
 - c. Give the patient a basin of hot water and towels.
 - d. Instruct the victim to wash above the waist only.

ANS: B

No matter how uncomfortable, the patient should not bathe until the forensic examination is completed. The collection of evidence is critical if the patient is to be successful in court. The incorrect options would result in the destruction of evidence or are untrue.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

14. Which situation constitutes consensual sex rather than rape?
 - a. After coming home intoxicated from a party, a person forces the spouse to have sex. The spouse objects.
 - b. A person's lover pleads to have oral sex. The person gives in but then regrets the decision.
 - c. A person is beaten, robbed, and forcibly subjected to anal penetration by an assailant.
 - d. A physician gives anesthesia for a procedure and has intercourse with an unconscious patient.

ANS: B

Only the correct answer describes a scenario in which the sexual contact is consensual. Consensual sex is not considered rape if the participants are, at least, the age of majority.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

15. When a victim of sexual assault is discharged from the emergency department, the nurse should arrange for which intervention?
 - a. Secure support from the victim's family.
 - b. Provide referral information verbally and in writing.
 - c. Advise the victim to try not to think about the assault.
 - d. Offer to stay with the victim until stability is regained.

ANS: B

Immediately after the assault, rape victims are often disorganized and unable to think well or remember what they have been told. Written information acknowledges this fact and provides a solution. The incorrect options violate the patient's right to privacy, evidence a rescue fantasy, and offer a platitude that is neither therapeutic nor effective.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

16. A victim of a sexual assault that occurred approximately 1 hour earlier sits in the emergency department rocking back and forth and repeatedly saying, "I can't believe I've been raped." This behavior is characteristic of which phase of the rape trauma syndrome?
 - a. Anger phase
 - b. Acute phase
 - c. Outward adjustment phase
 - d. Long-term reorganization phase

ANS: B

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The victim's response is typical of the acute phase and evidences cognitive, affective, and behavioral disruptions. The response is immediate and does not include a display of behaviors suggestive of the outward adjustment, long-term reorganization, or anger phases.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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17. A survivor in the long-term organization (delayed) phase of the rape trauma syndrome has experienced intrusive thoughts of the rape and developed a fear of being alone. Which finding demonstrates this survivor has made improvement?
- a. The survivor expresses a need to regularly withdraw from social situations.
 - b. The survivor describes personal coping strategies for fearful situations.
 - c. The survivor uses increased activity to reduce feelings of fear.
 - d. The survivor expresses a deep desire to be with others.

ANS: B

The correct response shows a willingness and ability to take personal action to reduce the disabling fear. The incorrect responses demonstrate continued ineffective coping.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

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18. A patient comes to the hospital for treatment of injuries sustained during a rape. The patient abruptly decides to decline treatment and return home. Before the patient leaves, the nurse should provide what support?
- a. Assure the patient, "Before you leave you receive prophylactic treatment for sexually transmitted infections (STIs)."
 - b. Provide written information concerning the physical and emotional reactions that may be experienced.
 - c. Explain the need and importance of human immunodeficiency virus (HIV) testing in this situation.
 - d. Offer both verbal and written information about locally available legal resources.

ANS: B

All information given to a patient before he or she leaves the emergency department should be in writing. Patients who are anxious are unable to concentrate and therefore cannot retain much of what is verbally imparted. Written information can be read and referred to at later times. Presenting legal information is not an appropriate nursing intervention. Treatment for sexually transmitted infections is important but at this point it is premature to do so without sufficient assessment and testing.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

19. An unconscious person is brought to the emergency department by a friend. The friend found the person in a bedroom at a college fraternity party. Semen is observed on the person's underclothes. What is the priority action they staff members should focus on?
- a. Maintaining effective gas exchange
 - b. Preserving all rape evidence
 - c. Interviewing the friend for additional information
 - d. Determining whether any alcohol or drug were ingested

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ANS: A

Because the patient is unconscious, the risk for respiratory depression and airway obstruction is present; therefore, the nurse's priority focus is to maintain gas exchange. The incorrect options are of lower priority than preserving physiological functioning.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

20. A victim of a violent rape has been in the emergency department for 3 hours. Evidence collection is complete. As discharge counseling begins, the victim says softly, "I will never be the same again. I can't face my friends. There is no sense of trying to go on." Select the nurse's most important response.
- a. "Are you thinking of suicide?"
 - b. "It will take time, but you will feel the same as before."
 - c. "Your friends will understand when you tell them."
 - d. "You will be able to find meaning in this experience as time goes on."

ANS: A

The victim's words suggest hopelessness. Whenever hopelessness is present, so is the risk for suicide. The nurse should directly address the possibility of suicidal ideation with the victim. The other options attempt to offer reassurance before making an assessment.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment
MSC: NCLEX: Psychosocial Integrity

21. A nurse cares for a rape victim who was given flunitrazepam by the assailant. Which condition has priority?
- a. Decreased consciousness
 - b. Seizure activity of any kind
 - c. Hypotonia of voluntary muscles
 - d. Signs and symptoms of respiratory depression

ANS: D

Monitoring for respiratory depression takes priority over hypotonia, seizures, or coma in this situation.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Intervention
MSC: NCLEX: Physiological Integrity

22. When working with rape victims, what is the focus of initial care?
- a. Collecting forensic evidence
 - b. Notifying law enforcement
 - c. Helping the victim feel safe
 - d. Documenting the victim's comments

ANS: C

The first focus of care is helping the victim feel safe. An already vulnerable individual may view assessment questions and the physical procedures as intrusive violations of privacy and even physically threatening. The patient might decline to have evidence collected or to involve law enforcement.

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MULTIPLE RESPONSE

1. When an emergency department nurse teaches a victim of rape about reactions that may occur during the long-term organization (delayed) phase, which symptoms should be included? (*Select all that apply.*)
 - a. Development of fears and phobias
 - b. Decreased motor activity
 - c. Feelings of numbness
 - d. Flashbacks, dreams
 - e. Syncopal episodes

ANS: A, C, D

These reactions are common to the long-term organization phase. Victims of rape frequently have a period of increased motor activity rather than decreased motor activity during the long-term reorganization phase. Syncopal episodes are not expected.

2. A person was abducted and raped at gunpoint by an unknown assailant. Which interventions should the nurse use while caring for this person in the emergency department? (*Select all that apply.*)
 - a. Allow the person to talk at a comfortable pace.
 - b. Pose questions in nonjudgmental, empathic ways.
 - c. Place the person in a private room with a caregiver.
 - d. Reassure the person that a family member will arrive as soon as possible.
 - e. Invite family members to the examination room and involve them in taking the history.
 - f. Put an arm around the person to offer reassurance that the nurse is caring and compassionate.

ANS: A, B, C

Neutral, nonjudgmental care and emotional support are critical to crisis management for the victim of rape. The rape victim should have privacy but not be left alone. Some rape victims prefer not to have family members involved. The patient's privacy may be compromised by the presence of family. The rape victim's anxiety may escalate when he or she is touched by a stranger, even when the stranger is a nurse.

3. Which activities are in the scope of practice of a sexual assault nurse examiner (SANE)? (*Select all that apply.*)
 - a. Requiring HIV testing of a victim
 - b. Collecting and preserving evidence
 - c. Providing long-term counseling for rape victims
 - d. Obtaining signed consents for photographs and examinations
 - e. Providing pregnancy and sexually transmitted disease prophylaxis

ANS: B, D, E

HIV testing is not mandatory for a victim of sexual assault. Long-term counseling would be provided by other members of the team. The other activities would be included within the practice role of this specially trained nurse.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

4. After assessing a victim of sexual assault, which terms could the nurse use in the documentation? (*Select all that apply.*)

- a. Alleged
- b. Reported
- c. Penetration
- d. Intercourse
- e. Refused
- f. Declined

ANS: B, C, F

The nurse should refrain from using pejorative language when documenting assessments of victims of sexual assault. “Reported” should be used instead of “alleged.” “Penetration” should be used instead of “intercourse.” “Declined” should be used instead of “refused.”

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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Chapter 23: Suicidal Thoughts and Behavior

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. Which change in brain biochemical function is most associated with suicidal behavior?
 - a. Dopamine excess
 - b. Serotonin deficiency
 - c. Acetylcholine excess
 - d. Gamma-aminobutyric acid deficiency

ANS: B

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Research suggests that low levels of serotonin may play a role in the decision to commit suicide. The other neurotransmitter alterations have not been implicated in suicidal crises.

DIF: Cognitive Level: Comprehension (Understanding)

[abirb.com/test](#)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

2. After failing two tests, a college student cried for hours and then tried to telephone a parent but got no answer. The student then gave several expensive sweaters to a roommate. Which behavior provides the strongest clue of an impending suicide attempt?
 - a. Calling parents
 - b. Excessive crying
 - c. Giving away sweaters
 - d. Staying alone in a dorm room

ANS: C

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Giving away prized possessions may signal that the individual thinks he or she will have no further need for the items, such as when a suicide plan has been formulated. Calling parents and crying do not provide clues to suicide, in and of themselves. Remaining in the dormitory would be an expected behavior because the student has nowhere else to go.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

3. A nurse uses the modified SAD PERSONS scale to interview a patient. This tool provides data relevant to assessing what?
 - a. Current stress level
 - b. Mood disturbance
 - c. Suicide potential
 - d. Level of anxiety

ANS: C

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The modified SAD PERSONS tool evaluates major risk factors in suicide potential: sex, age, depression, previous attempt, ethanol use, rational thinking loss, stated future intent, organized plan, separated/widowed/divorced, and sickness. The tool does not have appropriate categories to provide information on the other options listed.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

4. When a person intentionally overdoses on antidepressant drugs, which nursing diagnosis has the highest priority?
- Powerlessness
 - Social isolation
 - Risk for suicide
 - Ineffective management of the therapeutic regimen

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ANS: C

This diagnosis is the only one with life-or-death ramifications and is therefore higher in priority than the other options.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Physiological Integrity

5. A person attempts suicide by overdose, is treated in the emergency department, and then hospitalized. What is the best initial patient outcome?
- Will verbalize a will to live by the end of the second hospital day.
 - Can describe two new coping mechanisms by the end of the third hospital day.
 - Accurately delineate personal strengths by the end of first week of hospitalization.
 - Exercise suicide self-restraint by refraining from gestures or attempts to harm self for 24 hours.

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ANS: D

Suicide self-restraint relates most directly to the priority problem of risk for suicide. The incorrect outcomes are related to hope, coping, and self-esteem.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

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6. A college student who attempted suicide by overdose is hospitalized. When the parents are contacted, they respond, "There must be a mistake. This could not have happened. We've given our child everything." What emotional response does the parents' reaction reflect?
- Denial
 - Anger
 - Anxiety
 - Projection

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ANS: A

The parents' statements indicate denial. Denial or minimization of suicidal ideation or attempts is a defense against uncomfortable feelings. Family members are often unable to acknowledge suicidal ideation in someone close to them. The feelings suggested in the distractors are not clearly described in the scenario.

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DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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7. An adolescent tells the school nurse, "My friend threatened to take an overdose of pills." The nurse talks to the friend who verbalized the suicide threat. What is the most critical question for the nurse to ask?
- a. "What makes you want to kill yourself?"
 - b. "Do you have access to medications?"
 - c. "Have you been taking drugs and alcohol?"
 - d. "Did something happen with your parents?"

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ANS: B

The nurse must assess the patient's access to the means to carry out the plan and, if there is access, alert the parents to remove them from the home. The other questions may be important to ask but are not the most critical.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

8. An adult after an attempted suicide is hospitalized and takes an antidepressant medication for 5 days. The patient is now more talkative and shows increased energy. Select the highest priority nursing intervention.
- a. Supervise the patient 24 hours a day.
 - b. Begin discharge planning for the patient.
 - c. Refer the patient to art and music therapists.
 - d. Consider the discontinuation of suicide precautions.

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ANS: A

The patient now has more energy and may have decided on suicide, especially considering the history of the prior suicide attempt. The patient is still a suicide risk; therefore, continuous supervision is indicated. None of the remaining options provides the safety interventions required.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

9. A nurse and patient construct a no-suicide contract. Select the preferable wording for the contract.
- a. "I will not try to harm myself during the next 24 hours."
 - b. "I will not make a suicide attempt while I am hospitalized."
 - c. "For the next 24 hours, I will discuss any thoughts of killing or harming myself with staff."
 - d. "I will not kill myself until I call my primary nurse or a member of the staff."

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ANS: C

The correct answer leaves no loopholes. The wording about not harming oneself and not making an attempt leaves loopholes or can be ignored by the patient who thinks, "I am not going to harm myself, I am going to kill myself," or "I am not going to attempt suicide, I am going to commit suicide." A patient may call a therapist and leave the telephone to carry out the suicidal plan.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation

MSC: NCLEX: Safe, Effective Care Environment

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10. A tearful, anxious patient at the outpatient clinic reports, "I should be dead." The initial task of the nurse conducting the assessment interview is to focus on what?
- Assessing the lethality of any suicide plan
 - Encouraging expression of anger
 - Establishing a rapport with the patient
 - Determining risk factors for suicide

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ANS: C

Establishing rapport will allow the nurse to obtain relevant assessment data such as the presence of a suicide plan, the lethality of a suicide plan, and the presence of risk factors for suicide.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. What is the most helpful response for a nurse to make when a patient being treated as an outpatient states, "I am considering suicide."?
- "I'm glad you shared this. Please do not worry. We will handle it together."
 - "I think you should admit yourself to the hospital to get help."
 - "We need to talk about the good things you have to live for."
 - "Bringing this up is a very positive action on your part."

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ANS: D

This response gives the patient reinforcement and validation for making a positive response rather than acting out the suicidal impulse. It gives neither advice nor false reassurance, and it does not imply stereotypes such as, "You have a lot to live for." It uses the patient's ambivalence and sets the stage for more realistic problem-solving strategies.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

12. Which intervention should a nurse recommend for the distressed family and friends of someone who has successfully committed suicide?
- Participating in reminiscence therapy
 - Attending a self-help group for survivors
 - Contracting for two sessions of group therapy
 - Completing a psychological postmortem assessment

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ANS: B

Survivors need outlets for their feelings about the loss and the deceased person. Self-help groups provide peer support while survivors work through feelings of loss, anger, and guilt. Psychological postmortem assessment would not provide the support necessary to work through feelings of loss associated with the suicide of a family member. Reminiscence therapy is not geared to loss resolution. Contracting for two sessions of group therapy would probably not provide sufficient time to work through the issues associated with a death by suicide.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

13. Which statement provides the best rationale for why a nurse should closely monitor a severely depressed patient during antidepressant medication therapy?

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- a. As depression lifts, physical energy becomes available to carry out suicide.
- b. Suicide may be precipitated by a variety of internal and external events.
- c. Suicidal patients have difficulty using social supports.[abirb.com/test](#)
- d. Suicide is an impulsive act.

ANS: A

Antidepressant medication has the objective of relieving depression. The risk for suicide is greater as the depression lifts, primarily because the patient has more physical energy at a time when he or she may still have suicidal ideation. The other options have little to do with nursing interventions relating to antidepressant medication therapy.
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DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

14. A nurse assesses a patient who reports a 3-week history of depression and crying spells. The patient says, "My business is bankrupt, and I was served with divorce papers." Which subsequent statement by the patient alerts the nurse to a concealed suicidal message?
- a. "I wish I were dead."
[abirb.com/test](#)
 - b. "Life is not worth living."
 - c. "I have a plan that will fix everything."
 - d. "My family will be better off without me."
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ANS: C

Verbal clues to suicide may be overt or covert. The incorrect options are overt references to suicide. The correct option is more veiled. It alludes to the patient's suicide as being a way to "fix everything" but does not say it outright.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

15. A depressed patient says, "Nothing matters anymore." What is the most appropriate response by the nurse?
- a. "Are you having thoughts of suicide?"
[abirb.com/test](#)
 - b. "I am not sure I understand what you are trying to say."
 - c. "Try to stay hopeful. Things have a way of working out."
 - d. "Tell me more about what interested you before you began feeling depressed."

ANS: A

The nurse must make overt what is covert; that is, the possibility of suicide must be openly addressed. Often, patients feel relieved to be able to talk about suicidal ideation.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment
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16. A nurse counsels a patient with recent suicidal ideation. Which is the nurse's most therapeutic comment?
- a. "Let's make a list of all your problems and think of solutions for each one."
 - b. "I'm happy you're taking control of your problems and trying to find solutions."
 - c. "When you have bad feelings, try to focus on positive experiences from your life."
 - d. "Let's consider which problems are most important and focus on discussing them."
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ANS: D

The nurse helps the patient develop effective coping skills. He or she assists the patient to reduce the overwhelming effects of problems by prioritizing them. The incorrect options continue to present overwhelming approaches to problem solving.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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17. When assessing a patient's plan for suicide, what aspect has priority?
- a. Patient's financial and educational status
 - b. Patient's insight into suicidal motivation
 - c. Availability of means and lethality of method
 - d. Quality and availability of patient's social support

ANS: C

If a person has definite plans that include choosing a method of suicide readily available, and if the method is one that is lethal (i.e., will cause the person to die with little probability for intervention), the suicide risk is considered high. These areas provide a better indication of risk than the areas mentioned in the other options.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

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18. Which understanding about individuals who attempt suicide will help a nurse plan the care for a suicidal patient?
- a. Every suicidal person is mentally ill.
 - b. Every suicidal person is intent on dying.
 - c. Every suicidal person is cognitively impaired.
 - d. Every suicidal person experiencing hopelessness.

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ANS: D

Hopelessness is the characteristic common among people who attempt suicide. The incorrect options reflect myths about suicide. Not all who attempt suicide are intent on dying. Not all are mentally ill or cognitively impaired.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

19. Which statement by a patient during an assessment interview should alert the nurse to the patient's need for immediate, active intervention?
- a. "I am mixed up, but I know I need help."
 - b. "I have no one for help or support."
 - c. "It is worse when you are a person of color."
 - d. "I tried to get attention before I shot myself."

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ANS: B

Lack of social support and social isolation increase the suicide risk. The willingness to seek help lowers the risk. Being a person of color does not suggest a higher risk; more whites commit suicide than do individuals of other racial groups. Attention seeking is not correlated with a higher risk of suicide.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

20. What feeling experienced by a patient should be assessed by the nurse as most predictive of elevated suicide risk?

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- a. Hopelessness
- b. Sadness
- c. Anxiety
- d. Anger

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ANS: A

Of the feelings listed, hopelessness is most closely associated with increased suicide risk. Depression, aggression, impulsivity, and shame are other feelings noted as risk factors for suicide.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

21. Four individuals have given information about their suicide plans. Which plan evidences the highest suicide risk?

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- a. Jumping from a 100-foot-high railroad bridge located in a deserted area late at night
- b. Turning on the oven and letting gas escape into the apartment during the night
- c. Cutting the wrists in the bathroom while the spouse reads in the next room
- d. Overdosing on aspirin with codeine while the spouse is out with friends

ANS: A

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This is a highly lethal method with little opportunity for rescue. The other options are lower lethality methods with higher rescue potential.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

22. Which individual in the emergency department should be considered at the highest risk for completing suicide?

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- a. An adolescent Asian-American girl with superior athletic and academic skills who has asthma
- b. A 38-year-old single African-American female church member with fibrocystic breast disease
- c. A 60-year-old married Hispanic man with 12 grandchildren who has type 2 diabetes
- d. A 79-year-old single white man with cancer of the prostate gland

ANS: D

High risk factors include being an older adult, single, and male and having a co-occurring medical illness. Cancer is one of the somatic conditions associated with increased suicide risk. Protective factors for African-American women and Hispanic individuals include strong religious and family ties. Asian Americans have a suicide rate that increases with age.

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DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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23. A nurse answers a suicide crisis line. A caller says, “I live alone in a home several miles from my nearest neighbors. I have been considering suicide for 2 months. I have had several drinks and now my gun is loaded. I’m going to shoot myself in the heart.” How would the nurse assess the lethality of this plan?

- a. No risk
- b. Low level
- c. Moderate level
- d. High level

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ANS: D

The patient has a highly detailed plan, a highly lethal method, the means to carry it out, lowered impulse control because of alcohol ingestion, and a low potential for rescue.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

24. A staff nurse tells another nurse, “I evaluated a new patient using the modified SAD PERSONS scale and got a score of 10. I’m wondering if I should send the patient home.” Select the best reply by the second nurse.

- a. “That action would seem appropriate.”
- b. “A score over 8 requires immediate hospitalization.”
- c. “I think you should strongly consider hospitalization for this patient.”
- d. “Give the patient a follow-up appointment. Hospitalization may be needed soon.”

ANS: B

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The modified SAD PERSONS scale score of 0 to 5 suggests home care with follow-up. A score of 6 to 8 requires psychiatric consultation. A score over 8 calls for hospitalization.

DIF: Cognitive Level: Application (Applying)

[TOP: abirb.com/test](#) Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

25. A patient recently hospitalized for 2 weeks committed suicide during the night. Which initial measure will be most helpful for staff members and other patients regarding this event?

- a. Request the public information officer to address inquiries from the local media.
- b. Hold a staff meeting to express feelings and plan the care for other patients.
- c. Ask the patient’s roommate not to discuss the event with other patients.
- d. Quickly discharge as many patients as possible to prevent panic.

ANS: B

Interventions should be aimed at helping the staff and patients come to terms with the loss and to grow because of the incident. Then, a community meeting should be scheduled to allow other patients to express their feelings and request help. Staff members should be prepared to provide additional support and reassurance to patients and should seek opportunities for peer support. The incorrect options will not control information or may result in unsafe care.

DIF: Cognitive Level: Application (Applying)

[TOP: abirb.com/test](#)

MSC: NCLEX: Safe, Effective Care Environment

26. A severely depressed patient who has been on suicide precautions tells the nurse, “I am feeling a lot better, so you can stop watching me. I have taken too much of your time already.” Which is the nurse’s best response?

- a. “I wonder what this sudden change is all about. Please tell me more.”

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- b. "I am glad you are feeling better. The team will consider your request."
- c. "You should not try to direct your care. Leave that to the treatment team."
- d. "Because we are concerned about your safety, we will continue with our plan."

ANS: D

When a patient seeks to have precautions lifted by professing to feel better, the patient may be seeking greater freedom in which to attempt suicide. Changing the treatment plan requires careful evaluation of outcome indicators by the staff. The incorrect options will not cause the patient to admit to a suicidal plan, do not convey concern for the patient, or suggest that the patient is not a partner in the care process.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

27. A new nurse says to a peer, "My new patient is diagnosed with bipolar disorder. At least I won't have to worry about suicide risk." Which response by the peer would be most helpful?
- a. "Let's reconsider your plan. Suicide risk is high in patients diagnosed with bipolar disorder."
 - b. "Suicide is a risk for any patient diagnosed with bipolar disorder who uses alcohol or drugs."
 - c. "The thought processes of patients diagnosed with bipolar disorder are usually too disorganized to attempt suicide."
 - d. "Racing thoughts during mania often prompt suicide among patients diagnosed with bipolar disorder."

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ANS: A

Epidemiological surveys have demonstrated that 90% of suicide completers had a diagnosable psychiatric condition at the time of the event. People with mood disorders, especially major depressive disorder and bipolar disorder, are responsible for approximately 50% of completed suicides. The correct response is the most global answer.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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28. The parents of identical twins ask a nurse for advice when one twin committed suicide a month ago. Now the parents are concerned that the other twin may also have suicidal tendencies. Which comment by the nurse is accurate?
- a. "Genetics are associated with suicide risk. Monitoring and support are important."
 - b. "Apathy underlies suicide. Instilling motivation is the key to health maintenance."
 - c. "Your child is unlikely to act out suicide when identifying with a suicide victim."
 - d. "Fraternal twins are at higher risk for suicide than identical twins."

ANS: A

Twin studies suggest the presence of genetic factors in suicide; however, separating genetic predisposition to suicide from predisposition to depression or alcoholism is difficult. Primary interventions can be helpful in promoting and maintaining health and possibly counteracting the genetic load. The incorrect options are untrue statements or oversimplifications.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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MULTIPLE RESPONSE

1. A college student failed two examinations. The student cried for hours and then tried to call a parent but got no answer. The student then suspended access to his social networking web site. Which suicide risk factors are present? (*Select all that apply.*)
 - a. History of earlier suicide attempt
 - b. Co-occurring medical illness
 - c. Recent stressful life event
 - d. Self-imposed isolation
 - e. Shame or humiliation

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ANS: C, D, E

Failing examinations in the academic major constitutes a recent stressful life event. Shame and humiliation related to the failure can be hypothesized. The inability to contact parents can be seen as a recent lack of social support, as can the roommate's absence from the dormitory. Terminating access to one's social networking site represents self-imposed isolation. This scenario does not provide data regarding a history of an earlier suicide attempt, a family history of suicide, or of co-occurring medical illness.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

2. A patient with suicidal impulses is on the highest level of suicide precautions. Which measures should the nurse incorporate into the patient's plan of care? (*Select all that apply.*)
 - a. Allow no glass or metal on meal trays.
 - b. Remove all potentially harmful objects from the patient's possession.
 - c. Maintain arm's length, one-on-one nursing observation around the clock.
 - d. Check the patient's whereabouts every hour. Make verbal contact at least three times each shift.
 - e. Check the patient's whereabouts every 15 minutes and make frequent verbal contacts.
 - f. Keep the patient within visual range while he or she is awake. Check every 15 to 30 minutes while the patient is sleeping.

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ANS: A, B, C

One-on-one observation is necessary for anyone who has limited control over suicidal impulses. Plastic dishes on trays and the removal of potentially harmful objects from the patient's possession are measures included in any level of suicide precautions. The remaining options are used in less stringent levels of suicide precautions.

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DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

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3. A nurse assesses five newly hospitalized patients. Which patients have the highest suicide risk? (*Select all that apply.*)
 - a. An 82-year-old white man
 - b. A 17-year-old white female adolescent
 - c. A 39-year-old African-American man
 - d. A 29-year-old African-American woman
 - e. A 22-year-old man with a traumatic brain injury

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ANS: A, B, E

Whites have suicide rates almost twice those of nonwhites, and the rate is particularly high for older adult men, adolescents, and young adults. Other high-risk groups include young African-American men, Native-American men, older Asian Americans, and persons with traumatic brain injury.

DIF: Cognitive Level: Analysis (Analyzing)

[abirb.com/test](#)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

4. A nurse assesses the health status of soldiers returning from a war zone. Screening for which health problems will be a priority? (*Select all that apply.*)

- a. Schizophrenia
- b. Eating disorder
- c. Traumatic brain injury
- d. Oppositional defiant disorder
- e. Posttraumatic stress disorder

ANS: C, E

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The incidence of TBI is very high in veterans and this problem is associated with an increased risk of dying by suicide compared with people without brain injuries. Many soldiers also have posttraumatic stress disorder, which contributes to increased suicide risk. The incidence of disorders identified in the distractors would be expected to parallel the general population.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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Chapter 24: Anger, Aggression, and Violence

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. Which behavior best demonstrates aggression?
 - a. Stomping away from the nurses' station, darting to another room, and grabbing a snack from another patient
 - b. Bursting into tears, leaving the community meeting, and sitting on a bed hugging a pillow and sobbing
 - c. Telling the primary nurse, "I felt angry when you said I could not have a second helping at lunch"
 - d. Telling the medication nurse, "I am not going to take that or any other medication you try to give me"

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ANS: A

Aggression is harsh physical or verbal action that reflects rage, hostility, and the potential for physical or verbal destructiveness. Aggressive behavior violates the rights of others. The incorrect options do not feature violation of another's rights.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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2. Which scenario predicts the highest risk for directing violent behavior toward others?
 - a. Major depressive disorder with delusions of worthlessness
 - b. Obsessive-compulsive disorder; performing many rituals
 - c. Paranoid delusions of being followed by a military attack team
 - d. Completion of alcohol withdrawal and beginning a rehabilitation program

ANS: C

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The correct answer illustrates the greatest disruption of ability to perceive reality accurately. People who feel persecuted may strike out against those believed to be persecutors. The patients identified in the distractors have better reality-testing ability.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Safe, Effective Care Environment

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3. A patient is hospitalized after an arrest for breaking windows in the home of a former intimate partner. The history reveals childhood abuse by a punitive parent, torturing family pets, and an arrest for disorderly conduct. Which nursing diagnosis has priority?
 - a. Risk for injury
 - b. Post-trauma response
 - c. Disturbed thought processes
 - d. Risk for other-directed violence

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ANS: D

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The defining characteristics for risk for other-directed violence include a history of being abused as a child, having committed other violent acts, and demonstrating poor impulse control. The defining characteristics for the other diagnoses are not present in this scenario.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Analysis | Nursing Process: Diagnosis

MSC: NCLEX: Psychosocial Integrity

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4. A confused older adult patient in a skilled care facility is sleeping. A health care worker enters the room quietly and touches the bed to see if it is wet. The patient awakens and hits the health care worker in the face. Which statement best explains the patient's action?
 - a. Older adult patients often demonstrate exaggerations of behaviors used earlier in life.
 - b. Crowding in skilled care facilities increases individual tendencies toward violence.
 - c. The patient interpreted the health care worker's behavior as potentially harmful.
 - d. This patient learned violent behavior by watching other patients act out.

ANS: C

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Confused patients are not always able to evaluate accurately the actions of others. This patient behaved as though provoked by the intrusive actions of the staff member.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

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5. A patient is pacing the hall near the nurses' station and swearing loudly. An appropriate initial intervention for the nurse would be to address the patient by name and say what?
 - a. "What is going on?"
 - b. "Quiet down immediately. You are scaring others."
 - c. "I'd like to talk with you about how you're feeling right now."
 - d. "You must go to your room and try to get control of yourself."

ANS: C

Intervention should begin with an analysis of the patient and situation. With the correct response, the nurse is attempting to hear the patient's feelings and concerns, which leads to the next step of planning an intervention. The incorrect responses are authoritarian, creating a power struggle between the patient and nurse.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

6. A patient has been responding to auditory hallucinations throughout the day. The patient approaches the nurse, shaking a fist and shouting, "Back off!" and then goes into the day room. As the nurse follows the patient into the day room, the nurse should take what precaution?
 - a. Making sure adequate physical space exists between the nurse and the patient
 - b. Moving into a position that allows the patient to be close to the door
 - c. Maintaining one arm's length distance from the patient
 - d. Sitting down in a chair near the patient

ANS: A

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[abirb.com/test](#)

Making sure space is present between the nurse and the patient avoids invading the patient's personal space. Personal space needs increase when a patient feels anxious and threatened. Allowing the patient to block the nurse's exit from the room is not wise. Closeness may be threatening to the patient and provoke aggression. Sitting is inadvisable until further assessment suggests the patient's aggression is abating. One arm's length is inadequate space.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

7. An intramuscular dose of antipsychotic medication needs to be administered to a patient who is becoming increasingly more aggressive. The patient is in the day room where there are other patients. When entering the day room what response should the nurse make?
 - a. States, "Would you like to come to your room and take some medication your doctor prescribed for you?"
 - b. Accompanied by three staff members and states, "Please come to your room so I can give you some medication that will help you feel more comfortable."
 - c. Initiates process to place the patient in a basket-hold and then state, "I am going to take you to your room to give you an injection of medication to calm you."
 - d. Accompanied by two security guards and tell the patient, "You can come to your room willingly so I can give you this medication or the security guards will take you there."

ANS: B

A patient gains feelings of security if he or she sees that others are present to help with control. The nurse gives a simple direction, honestly states what is going to happen, and reassures the patient that the intervention will be helpful. This positive approach assumes that the patient can act responsibly and will maintain control. Physical control measures should be used only as a last resort. The security guards are likely to intimidate the patient and increase feelings of vulnerability.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

8. After an assault by a patient, a nurse has difficulty sleeping, startles easily, and is preoccupied with the incident. The nurse says, "I dread facing potentially violent patients. They make me so angry" Which response would be the most urgent reason for this nurse to seek supervision?
 - a. Startle reactions
 - b. Difficulty sleeping
 - c. Expression of anger
 - d. Preoccupation with the incident

ANS: C

The expression of patient-focused anger signals an urgent need for professional supervision to work through anger and counter the aggressive feelings. The distractors are normal in a person who has been assaulted. Nurses are usually relieved with crisis intervention and follow-up designed to give support, help the individual regain a sense of control, and make sense of the event.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

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9. The staff development coordinator plans to teach use of physical management techniques when patients become assaultive. Which topic should be emphasized?
- Practice and teamwork
 - Spontaneity and surprise
 - Caution and superior size
 - Diversion and physical outlets

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ANS: A

Intervention techniques are learned behaviors that must be practiced to be used in a smooth, organized fashion. Every member of the intervention team should be assigned a specific task to carry out before beginning the intervention. The other options are useless if the staff does not know how to use physical techniques and how to apply them in an organized fashion.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. An adult patient assaulted another patient and was restrained. One hour later, which statement by this restrained patient necessitates the nurse's immediate attention?
- "I hate all of you!"
 - "My fingers are tingly."
 - "You wait until I tell my lawyer."
 - "It was not my fault. The other patient started it."

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ANS: B

The correct response indicates impaired circulation and necessitates the nurse's immediate attention. The incorrect responses indicate that the patient has continued aggressiveness and agitation.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Safe, Effective Care Environment

11. Which is an effective nursing intervention to assist an angry patient to learn to manage anger without violence?
- Help the patient identify a thought that increases anger, find proof for or against the belief, and substitute reality-based thinking.
 - Provide negative reinforcement such as restraint or seclusion in response to angry outbursts, whether or not violence is present.
 - Use aversive conditioning, such as popping a rubber band on the wrist, to help extinguish angry feelings.
 - Administer an antipsychotic or antianxiety medication when the patient feels angry.

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ANS: A

Anger has a strong cognitive component; therefore, using cognition to manage anger is logical. The incorrect options do nothing to help the patient learn anger management.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

12. Which assessment finding presents the greatest risk for violent behavior?
- Severe agoraphobic
 - A history of intimate partner violence

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- c. Reports of bizarre somatic delusions
- d. Verbalization of hopelessness and powerlessness

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ANS: B

A history of prior aggression or violence is the best predictor of patients who may become violent. Patients diagnosed with anxiety disorders are not particularly prone to violence unless panic occurs. Patients experiencing hopelessness and powerlessness may have coexisting anger, but violence is not often demonstrated. Patients experiencing paranoid delusions are at greater risk for violence than those with bizarre somatic delusions.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

13. A patient being admitted suddenly pulls a knife from a coat pocket and threatens, "I will kill anyone who tries to get near me." An emergency code is called. The patient is safely disarmed and placed in seclusion. What is the justification for the use of seclusion?
- a. Patient demonstrates a thought disorder, rendering rational discussion ineffective.
 - b. Patient's actions present a clear and present danger to others.
 - c. Patient demonstrates an apparent and plausible escape risk.
 - d. Patient's actions display features of psychotic thinking.

ANS: B

The patient's threat to kill self or others with the knife he possesses constitutes a clear and present danger to self and others. The distractors are not sufficient reasons for seclusion.

DIF: Cognitive Level: Comprehension (Understanding)

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MSC: NCLEX: Safe, Effective Care Environment

14. A patient sits in silence for 20 minutes after a therapy appointment, appearing tense and vigilant. The patient abruptly stands and paces back and forth, clenching and unclenching fists, and then stops and stares in the face of a staff member. What is the likely conclusion regarding the patient's behavior?
- a. Patient is demonstrating withdrawal behaviors.
 - b. Patient is trying to work through angry feelings.
 - c. Patient is attempting to use relaxation strategies.
 - d. Patient is exhibiting clues to potential aggression.

ANS: D

The description of the patient's behavior shows the classic signs of someone whose potential for aggression is increasing. None of the other options are supported by the behavior.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

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15. A cognitively impaired patient has been a widow for 30 years. This patient is frantically trying to leave the unit, saying, "I have to go home to cook dinner before my husband arrives from work." To intervene with validation therapy, what should the nurse first say?
- a. "You must come away from the door."
 - b. "You have been a widow for many years."
 - c. "You want to go home to prepare your husband's dinner?"
 - d. "Was your husband angry if you did not have dinner ready on time?"

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ANS: C

Validation therapy meets the patient “where she or he is at the moment” and acknowledges the patient’s wishes. Validation does not seek to redirect, reorient, or probe. The incorrect options do not validate the patient’s feelings.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

16. A patient with a history of anger and impulsivity is hospitalized after an accident resulting in injuries. When in pain, the patient loudly scolds the nurse for “not knowing enough to give me pain medicine when I need it.” Which intervention would best address this problem?
- Tell the patient to notify the nurse 30 minutes before the pain returns so the medication can be prepared.
 - Urge the health care provider to change the prescription for pain medication from as needed to a regular schedule.
 - Tell the patient that verbal assaults on nurses will not shorten the wait for pain medication.
 - Have the clinical nurse leader request a psychiatric consultation.

ANS: B

Scheduling the medication at specific intervals will help the patient anticipate when the medication can be given. Receiving the medication promptly on schedule, rather than expecting nurses to anticipate the pain level, should reduce anxiety and anger. The patient cannot predict the onset of pain before it occurs.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. A patient has a history of impulsively acting out anger by striking others. Which would be an appropriate plan for avoiding such incidents?
- Explain that restraint and seclusion will be used if violence occurs.
 - Help the patient identify incidents that trigger impulsive acting out.
 - Offer one-on-one supervision to help the patient maintain control.
 - Administer lorazepam every 4 hours to reduce the patient’s anxiety.

ANS: B

Identifying trigger incidents allows the patient and nurse to plan interventions to reduce irritation and frustration that lead to acting out anger and to put more adaptive coping strategies eventually into practice. None of the other options allow for self-reflection and understanding of the causes of the aggressive behavior.

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TOP: Nursing Process: Planning

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

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18. A patient with severe physical injuries is irritable, angry, and belittles the nurses. As a nurse changes a dressing, the patient screams, “Don’t touch me! You are so stupid. You will make it worse!” Which intervention uses a cognitive technique to help this patient?
- Discontinue the dressing change without comments and leave the room.
 - Stop the dressing change, saying, “Perhaps you would like to change your own dressing.”
 - Continue the dressing change, saying, “Do you know this dressing change is

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needed so your wound will not get infected?"

- d. Continue the dressing change, saying, "Unfortunately, you have no choice. Your doctor ordered this dressing change."

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ANS: C

Anger is cognitively driven. The correct answer helps the patient test his cognitions and may help lower his anger. The incorrect options will escalate the patient's anger by belittling or escalating the patient's sense of powerlessness.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

19. Which medication should a nurse administer to provide immediate intervention for a psychotic patient whose aggressive behavior continues to escalate despite verbal intervention?
- a. Lithium
b. Trazodone
c. Olanzapine
d. Valproic acid

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ANS: C

Olanzapine is a short-acting antipsychotic drug that is useful in calming angry, aggressive patients regardless of their diagnosis. The other drugs listed require long-term use to reduce anger. Lithium is for patients with bipolar disorder. Trazodone is for patients with depression, insomnia, or chronic pain. Valproic acid is for patients with bipolar disorder or borderline personality disorder.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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20. An emergency department nurse realizes that the spouse of a patient is becoming increasingly irritable while waiting. Which intervention should the nurse use to prevent escalation of anger?
- a. Explain that the patient's condition is not life threatening.
b. Periodically provide an update and progress report on the patient.
c. Explain that all patients are treated in order, based on their medical needs.
d. Suggest that the spouse return home until the patient's treatment is completed.

ANS: B

Periodic updates reduce anxiety and defuse anger. This strategy acknowledges the spouse's presence and concerns. The incorrect options are likely to increase anger because they imply that the anxiety is inappropriate.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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21. Confirmation of a history of what scenario from a patient's record indicates compromised coping skills and the need for careful assessment of the risk for violence?
- a. Childhood trauma
b. Family involvement
c. Academic problems
d. Daily substance abuse

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ANS: D

The nurse should suspect compromised coping skills in a patient with daily substance abuse. He or she is often anxious, may be concerned about inadequate pain relief, and may have a personality style that externalizes blame. The incorrect options do not signal as high a degree of risk as substance abuse.

DIF: Cognitive Level: Comprehension (Understanding) [abirb.com/test](#)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

22. A patient diagnosed with pneumonia has been hospitalized for 4 days. Family members describe the patient as “a difficult person who finds fault with everyone.” The patient verbally abuses nurses for providing poor care. What is the most likely explanation for this behavior?
- Poor child-rearing that did not teach respect for others.
 - Automatic thinking, leading to cognitive distortion. [abirb.com/test](#)
 - Personality style that externalizes problems.
 - Delusions that others wish to deliver harm.

ANS: C

[abirb.com/test](#)

Patients whose personality style causes them to externalize blame see the source of their discomfort and anxiety as being outside themselves. They displace anger and are often unable to soothe themselves. The incorrect options are less likely to have a bearing on this behavior. [abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

23. A patient with burn injuries has demonstrates good coping skills for several weeks. Today, a new nurse is poorly organized and does not follow the patient’s usual schedule. By mid-afternoon, the patient is angry and loudly complains to the nurse manager. Which is the nurse manager’s best response?
- Explain the reasons for the disorganization and take over the patient’s care for the rest of the shift.
 - Acknowledge and validate the patient’s distress and ask, “What would you like to have happen?” [abirb.com/test](#)
 - Apologize and explain that the patient will have to accept the situation for the rest of the shift.
 - Ask the patient to control the anger and explain that allowances must be made for new staff members. [abirb.com/test](#)

ANS: B

When a patient with good coping skills is angry and overwhelmed, the goal is to reestablish a means of dealing with the situation. The nurse should solve the problem with the patient’s input by acknowledging the patient’s feelings, validating them as understandable, apologizing if necessary, and then seeking an acceptable solution. Often patients can tell the nurse what they would like to have happen as a reasonable first step. [abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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24. When a patient’s aggression quickly escalates, which principle applies to the selection of nursing interventions?
- Staff members should match the patient’s affective level and tone of voice. [abirb.com/test](#)

[abirb.com/test](#)

- b. Ask the patient what intervention would be most helpful.
- c. Immediately use physical containment measures.
- d. Begin with the least restrictive measure possible.

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ANS: D

Standards of care require that staff members use the least restrictive measure possible. This becomes the guiding principle for intervention. Physical containment is seldom the least restrictive measure. Asking the out-of-control patient what to do is rarely helpful. It may be an effective strategy during the pre-assaultive phase but is less effective during escalation.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

25. A new patient immediately requires seclusion on admission. The assessment is incomplete, and the health care provider has not examined the patient. Immediately after safely secluding the patient, which action has priority?
- a. Provide an opportunity for the patient to go to the bathroom.
 - b. Notify the health care provider and obtain a seclusion order.
 - c. Notify the hospital risk manager.
 - d. Debrief the staff.

ANS: B

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Emergency seclusion can be affected by a credentialed nurse but must be followed by securing a medical order within the period specified by the state and agency. The incorrect options are not immediately necessary from a legal standpoint.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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MULTIPLE RESPONSE

1. A patient with a history of command hallucinations approaches the nurse, yelling obscenities. The patient mumbles and then walks away. The nurse follows. Which nursing actions are most likely to be effective in de-escalating this scenario? (*Select all that apply.*)
- a. State the expectation that the patient will stay in control.
 - b. State that the patient cannot be understood when mumbling.
 - c. Tell the patient, "You are behaving inappropriately."
 - d. Offer to provide the patient with medication to help.
 - e. Speak in a firm but calm, caring voice.

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ANS: A, D, E

Stating the expectation that the patient will maintain control of behavior reinforces positive, healthy behavior, and avoids challenging the patient. Offering an as-needed medication provides support for the patient trying to maintain control. A firm but calm voice will likely comfort and calm the patient. Belittling remarks may lead to aggression. Criticism will probably prompt the patient to begin shouting.

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DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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2. A nurse directs the intervention team who must take an aggressive patient to seclusion. Other patients were removed from the area. Before approaching the patient, the nurse should ensure that which actions are taken by staff? (*Select all that apply.*) abirb.com/test
- a. Remove jewelry, glasses, and harmful items from the patient and staff members.
 - b. Appoint a person to clear a path and open, close, or lock doors.
 - c. Quickly approach the patient and grab the closest extremity.
 - d. Select the person who will communicate with the patient.
 - e. Move behind the patient to use the element of surprise.

ANS: A, B, D

Injury to staff members and to the patient should be prevented. Only one person should explain what will happen and direct the patient; this person might be the nurse or staff member who has a good relationship with the patient. A clear pathway is essential; those restraining a limb cannot use keys, move furniture, or open doors. The nurse is usually responsible for administering the medication once the patient is restrained. Each staff member should have an assigned limb rather than just grabbing the closest limb. This system could leave one or two limbs unrestrained. Approaching in full view of the patient reduces suspicion. abirb.com/test

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

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3. Which central nervous system structures are most associated with anger and aggression? (*Select all that apply.*) abirb.com/test

- a. Amygdala
- b. Cerebellum
- c. Basal ganglia
- d. Temporal lobe
- e. Parietal lobe

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ANS: A, D

The amygdala mediates anger experiences and helps a person judge an event as either rewarding or aversive. The temporal lobe, which is part of the limbic system, also plays a role in aggressive behavior. The cerebellum manages equilibrium, muscle tone, and movement. The basal ganglia are involved in movement. The parietal lobe is involved in interpreting sensations. abirb.com/test

DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Physiological Integrity

TOP: Nursing Process: Planning

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4. Which behaviors are most consistent with the clinical picture of a patient who is becoming increasingly aggressive? (*Select all that apply.*) abirb.com/test

- a. Pacing
- b. Crying
- c. Withdrawn affect
- d. Rigid posture with clenched jaw
- e. Staring with narrowed eyes into the eyes of another

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ANS: A, D, E

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Crying and a withdrawn affect are not cited by experts as behaviors indicating that the individual has a high potential to behave violently. The other behaviors are consistent with the increased risk for other-directed violence.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

5. Because an intervention is required to control a patient's aggressive behavior, a critical incident debriefing takes place. Which topics should be the focus of the discussion? (*Select all that apply.*)

- a. Patient behavior associated with the incident
- b. Genetic factors associated with aggression
- c. Intervention techniques used by staff
- d. Effect of environmental factors
- e. Review of theories of aggression

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ANS: A, C, D

The patient's behavior, the intervention techniques used, and the environment in which the incident occurred are important to establish realistic outcomes and effective nursing interventions. Discussing the views about the theoretical origins of aggression is less effective.

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DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Evaluation

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Chapter 25: Care for the Dying and Those Who Grieve

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A nurse counsels a person whose spouse recently died. The nurse uses cheer and humor to lift the person's spirits. At one point, the widowed person smiles briefly. What analysis of this scenario is correct?
 - a. The nurse's technique was effective.
 - b. Use of humor should be added to the plan of care.
 - c. This approach may prove useful in other, similar situations.
 - d. The nurse needs help developing therapeutic communication skills.

ANS: D

The nurse needs help to arrive at a more therapeutic approach. Attempts at cheering up a patient who is grieving serve only to emphasize the disparity between the patient's mood and that of others. Active listening should be the technique used by the nurse. The incorrect options suggest the approach is therapeutic when it is not.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

2. A patient's fiancé died in an automobile accident several days ago. The patient reports crying and experiencing feelings of guilt and anger. This behavior is characteristic of which aspect of grief?
 - a. Denial
 - b. Reorganization
 - c. Development of awareness
 - d. Preoccupation with the loss

ANS: C

As denial fades, an awareness of the finality of the loss develops and is accompanied by painful feelings of loss, anger with others, and guilt for taking or not taking specific actions. Reorganization implies the movement toward healing. Denial is manifested by the inability to believe the reality of an event. Preoccupation with the lost object would involve the patient dwelling on thoughts of the deceased.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

3. After the death of a spouse, an adult repeatedly says, "I should have made him go to the doctor when he said he didn't feel well." What response is this individual likely experiencing?
 - a. Preoccupation with the image of the deceased
 - b. Sensations of somatic distress
 - c. Anger
 - d. Guilt

ANS: D

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Guilt is evident by the bereaved person's self-reproach. Preoccupation refers to dwelling on images of the deceased. Somatic distress would involve bodily symptoms. Anger is not evident from data given in this scenario.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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4. A person whose spouse died 2 years earlier tells friends, "I think I'm ready to start going out socially, maybe even take someone to dinner." What does this comment best demonstrate about the individual's state of mind?
- a. Is denying the significance of the loss.
 - b. Is in a period of grief resolution.
 - c. Is actively working through grief.
 - d. Is experiencing intrusion.

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ANS: B

Toward the end of the grief process, the person renews his or her interest in people and activities. This behavior indicates resolution. At the same time, the person is released from the relationship with the deceased. The patient has progressed beyond grief. The patient is seeking to move into new relationships so that he or she is not alone. None of the other options demonstrates this progress.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

5. After the death of his wife, a man tells the nurse, "I can't live without her. She was my whole life." Which is the nurse's most therapeutic reply?
- a. "Each day will get a little better."
 - b. "Her death is a terrible loss for you."
 - c. "Remember, she's no longer suffering."
 - d. "Your friends will help you cope with this."

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ANS: B

The correct response demonstrates the use of reflection, a therapeutic communication technique. A statement that validates the bereaved person's loss is more helpful than clichés and it signifies understanding. The incorrect options are clichés or giving advice, a nontherapeutic technique.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

6. Shortly after a man's wife dies, the man approaches the nurse who cared for his wife during her final hours of life and says angrily, "If you had given your undivided attention, she would still be alive." Which analysis applies?
- a. The husband will pursue legal action regarding the nurse's negligence.
 - b. Anger is a phenomenon experienced during grieving.
 - c. The husband had ambivalent feelings about his wife.
 - d. In some cultures, grief is expressed exclusively by anger.

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ANS: B

[abirb.com/test](#)

[abirb.com/test](#)

Anger may protect the bereaved from facing the devastating reality of the loss. Anger expressed during mourning is not directed toward the nurse personally, although accusations and blame may make him or her feel as though it is. Legal action is not likely based on the scenario.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

7. After her husband died of heart failure, a wife approaches the nurse who cared for her husband. In the hospital hallway, the wife shouts angrily, “He’d still be alive if you’d given him your undivided attention!” Which response should the nurse implement?
 - a. “I understand you’re feeling upset. Let’s go to our conference room, and I’ll stay with you until your family comes.”
 - b. “Your husband’s heart was severely damaged and could no longer pump. There’s nothing anyone could have done.”
 - c. “I will call the nursing supervisor to discuss this matter with you.”
 - d. “It will be all right if you cry. Crying is a normal grief response.”

ANS: A

When a bereaved family member behaves in a disturbed manner, the nurse should show patience and tact while offering sympathy and warmth. Moving the individual to a private area so as not to disturb others is important. The incorrect options are defensive, evasive, or placating.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

8. An adult who was widowed 18 months ago says, “I can now remember good times we shared without getting upset. Sometimes I even think about the disappointments. I’ve become accustomed to sleeping in our bed alone.” How is the work of mourning best characterized?
 - a. It is beginning.
 - b. It is progressing abnormally.
 - c. It is at or near completion.
 - d. It has not yet begun.

ANS: C

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The work of mourning has been successfully completed when the bereaved can remember both the positive and negative memories about the deceased and when the task of restructuring the relationship with the deceased is completed.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Evaluation

MSC: NCLEX: Psychosocial Integrity

9. What situation makes the mourning process more difficult for the bereaved?
 - a. They were relatively independent of the deceased.
 - b. They have experienced many previous losses.
 - c. They accept that death is expected for everyone.
 - d. They had resolved conflicts with the deceased.

ANS: B

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Factors that have negative effects on the mourning process include a high dependency on the deceased, ambivalence toward the deceased, a poor or absent support system, a high number of past losses or other recent losses, poor physical or mental health, and young age of the deceased. Data do not support the incorrect options.

DIF: Cognitive Level: Comprehension (Understanding)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

10. A patient newly diagnosed with pancreatic cancer says, "My father also died of pancreatic cancer. I took care of him during his illness. I can't go through that." Select the highest priority nursing diagnosis.
- a. Anticipatory grieving
 - b. Ineffective coping
 - c. Ineffective denial
 - d. Risk for suicide

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ANS: D

The patient's statement has a subtle message of suicide. Suicide is a risk for people with major losses, including terminal disease. The nurse will need to monitor the suicide risk vigilantly. The other diagnoses may apply but are lower priority.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

11. A nurse talks with a person whose spouse died suddenly while jogging. Which is the appropriate statement for the nurse?
- a. "At least your spouse did not suffer."
 - b. "It's better to go quickly as your spouse did."
 - c. "The loss of your spouse must be very painful for you."
 - d. "You'll begin to feel better after you get over the shock."

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ANS: C

The most helpful responses by others validate the bereaved person's experience of loss. Avoid banalities; they increase the individual's sense of isolation.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

12. A recently widowed patient tells the health care provider, "I have so much epigastric discomfort. I wonder if I have an ulcer." Diagnostic tests are negative. What does the symptom likely demonstrate?
- a. Early reorganization behavior
 - b. Disorganization and depression
 - c. Preoccupation with the deceased
 - d. Normal phenomenon of mourning

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ANS: D

Sensations of somatic distress are often experienced during the acute stage of grieving. They include tightness in the throat, shortness of breath, exhaustion, and pain or sensations such as those experienced by the deceased person.

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13. Which finding indicates the successful completion of an individual's grieving process?
- For 2 years, a person has kept the deceased spouse's belongings in their usual places.
 - After 15 months, a widowed person realistically remembers both the pleasures and disappointments of the relationship with the spouse.
 - 3 years after the death, a person talks about the spouse as if the spouse was still alive and weeps when others mention the spouse's name.
 - 18 months after the spouse's death, a person says, "I never cry or have feelings of loss even though we were always very close."

ANS: B

The work of grieving is over when the bereaved can remember the individual realistically and acknowledge both the pleasure and disappointments associated with the loved one. The individual is then free to enter into new relationships and activities. The other options suggest unresolved grief.

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14. A child drowned while swimming in a local lake 4 years ago. Which behavior indicates that the parents are effectively coping with their loss?
- Prohibits their other children from going swimming.
 - Sets a place for the deceased child at the family dinner table.
 - Keeps their child's room exactly as the child left it 4 years ago.
 - Throw flowers on the lake at each anniversary date of the accident.

ANS: D

The loss of a child is among the highest-risk situations for dysfunctional grieving. The parents who throw flowers across the lake on each anniversary date of the accident are effectively using a ritual to express their feelings openly. The other behaviors indicate the parents are isolating themselves or denying their feelings or both.

15. A patient diagnosed with metastatic brain cancer says, "I'm dying, but I'm still living. I want to be in control as long as I can." Which reply shows the nurse was actively listening?
- "Our staff will do their best to help you feel comfortable."
 - "Most people do not know how to help and are afraid of death."
 - "Although your body is frail, your mind and spirit are healthy."
 - "You want people to stop focusing on your weaknesses."

ANS: C

The patient is asking for acknowledgment that he or she is not totally sick; even in the terminal state, strengths and capabilities are present. The correct response provides that acknowledgment through use of reflection. The other responses are nontherapeutic.

16. A terminally ill patient says, "I know I'm not going to get well, but still." and the patient's voice trails off. Which response by the nurse is therapeutic? [abirb.com/test](#)
- "What do you hope for?"
 - "No, you're not going to get well."
 - "Do you have questions about what is happening?"
 - "I'm happy you are being realistic about your future."

ANS: A

This open-ended response is an example of following the patient's lead. It provides an opportunity for the patient to speak about whatever is on his or her mind. The incorrect options are not therapeutic; they block further communication, refocus the conversation, give advice, or suggest the nurse is uncomfortable with the topic.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

17. A woman whose husband is terminally ill says, "I don't want to cry in front of him. I don't want him to know how soon death will occur or how sad I am." Which response by the nurse would be most therapeutic?
- "I'm glad you are protecting him at a time when he is so vulnerable."
 - "He might be more comforted than disturbed by your tears."
 - "It's important for you to know that time is running out."
 - "You definitely need to be honest about your feelings."

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ANS: B

Many people try to protect the dying person from experiencing emotions; however, emotional honesty is important to both the patient and the family. The patient may be comforted to know that the family is facing the inevitable. Giving advice and making judgmental statements are not helpful.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

18. A family of a terminally ill patient asks the nurse, "What can we say when our family member mentions death is coming soon?" Which response could the nurse suggest?
- "We think you will be around for a long time."
 - "We don't want you to give up trying to get well."
 - "We don't think we're ready to talk about this yet."
 - "We feel so sad when we think of life without you."

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ANS: D

This response is emotionally honest. It will allow the family opportunities to express emotions and further resolve issues in the relationship and explore end-of-life developmental opportunities. The incorrect options are evasive.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

19. As death approaches, a patient diagnosed with acquired immunodeficiency syndrome (AIDS) says, "I don't want to see a lot of visitors anymore. Just my parents and my sibling can come in for a while each day." What action should the nurse take?

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- a. Ask the patient to reconsider the decision because many interested and caring friends can be sources of support.
- b. Discuss the request with the parents and sibling. Suggest that they explain the patient's decision to friends.
- c. Suggest that the patient discuss these wishes with the health care provider.
- d. Place a "no visitors" sign on the patient's door.

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ANS: B

As many patient's approach death, they begin to withdraw. In the stage of acceptance, many patients are exhausted and tired, and interactions of a social nature are a burden. Many prefer to have someone present at the bedside who will sit without constantly talking. The correct response demonstrates the nurse's advocacy for the patient's preferences.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

20. A nurse manager notices that a staff member spends minimal time with a patient diagnosed with AIDS who is terminally ill. The patient says, "I'm having intense emotional reactions to this illness. Sometimes I feel angry, but other times I feel afraid or abandoned." The nurse manager can correctly hypothesize that the most likely reason for the staff member's avoidance is triggered by what?
- a. Fear of infection transmission.
 - b. Feelings of inadequacy in dealing with complex emotional needs.
 - c. Belief that the patient needs time alone with family and friends.
 - d. Knowledge that the patient's former lifestyle included high-risk behaviors.

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ANS: B

Many nurses tend to be more comfortable with meeting physical needs than in focusing on complex emotional needs. Standard precautions are necessary for all patients. The patient's lifestyle is irrelevant.

DIF: Cognitive Level: Comprehension (Understanding)

[abirb.com/test](#)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

21. A terminally ill patient tells the nurse, "Life has been good. I am proud of my education. I overcame adversity with willpower. I always gave my best and expected things to turn out well. I intend to die as I lived: optimistically." The nurse planning care for this patient recognizes a critical need to focus on maintaining the patient's state of mind?
- a. Providing aggressive pain and symptom management
 - b. Helping the patient reassess and explore existing conflicts
 - c. Assisting the patient to focus on the meaning in life and death
 - d. Supporting the patient's use of personal resources to meet challenges

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ANS: D

The patient whose intrinsic strength and endurance have been a hallmark often wishes to approach dying by staying optimistic and in control. Helping the patient use his or her resources to meet challenges is appropriate. None of the other options focus on personal state of mind

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

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22. The partner of a patient in hospice care angrily tells the nurse, "The care provided by the aide and other family members is inadequate, so I must do everything myself. Can't anyone do anything right?" How best should the palliative care nurse respond?
- Providing teaching about anticipatory grieving
 - Assigning new personnel to the patient's care
 - Arranging hospitalization for the patient
 - Refer the partner for crisis counseling

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ANS: A

The behaviors described in this scenario are consistent with anticipatory grieving. The spouse needs to be taught about the process of anticipatory grieving and to receive counseling to validate what she is experiencing and to enhance coping. The incorrect options are not appropriate to the situation and do not respond to the spouse's needs.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

23. An individual was killed during a store robbery 2 weeks ago. The widowed spouse, who was diagnosed 6 years ago with schizoaffective disorder, cries spontaneously when talking about the death. Which is the nurse's most therapeutic comment?
- "I'm worried about how much you're crying. Your grief over your spouse's death has gone on too long."
 - "The unexpected death of your spouse must be painful. I'm glad you're able to talk to me about your feelings."
 - "This loss is harder to accept because of your mental illness. Let's refer you to the partial hospitalization program."
 - "Your crying shows me you aren't coping well. I made an appointment for you to see the psychiatrist for medication adjustment."

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ANS: B

The patient is expressing feelings related to the loss, and this is an expected and healthy behavior. This patient is at risk for dysfunctional grieving because of the history of a severe psychiatric illness, but the nurse's priority intervention is to form a therapeutic alliance and support the patient's expression of feelings. The patient's crying 2 weeks after the spouse's death is expected and normal.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

24. Children of a widowed parent confer with the nurse; their surviving parent repeatedly relates the details of finding the deceased parent not breathing, performing cardiopulmonary resuscitation, going to the hospital by ambulance, and seeing the pronouncement of death. The family asks, "What can we do?" How should the nurse best counsel the family?
- Encouraging them to share their own feelings with the surviving parent and ask for the retelling to stop
 - Support the ideas that retelling the story should be limited to once daily to avoid unnecessary stimulation
 - Share with them that retelling memories is to be expected as part of the aging process
 - Reassure them that repeating the story is a helpful and a necessary part of grieving

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ANS: D

Nurses are encouraged to tell bereaved patients that telling the personal story of loss as many times as needed is acceptable and healthy; repetition is a helpful and necessary part of grieving. Limits should not be placed on the retelling. None of the remaining options appropriately educate the family on the purpose of retelling one's personal story.

DIF: Cognitive Level: Application (Applying)

[abirb.com/test](#)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

25. A widow grieving her husband's sudden and unexpected death tells the nurse, "I'm not feeling well. Yesterday, I saw my husband walk through the door, stop, and smile at me. Then he just faded away." Which is the nurse's most appropriate action?
- a. Assess for recent substance abuse.
 - b. Suggest a referral to the mental health clinic.
 - c. Arrange for an evaluation for antidepressant medication.
 - d. Counsel the widow that visualizations are a normal part of grieving.

ANS: D

[abirb.com/test](#)

Grieving patients often dream about, visualize, think about, or search for the lost loved one. The patient should be told that this is considered a normal phenomenon and not a sign of mental illness. Visualization does not suggest substance abuse or mental illness in this case.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

26. A grieving patient tells a nurse, "It's been 8 months since my spouse died. I thought I would feel better by now, but lately I feel worse. I have no energy. I am lonely, but I don't want to be around people. What should I do?" What is the nurse's best counsel?
- a. Seek psychotherapy.
 - b. Become active in a church.
 - c. Go to the spouse's grave every day.
 - d. Understand this is a normal response.

ANS: D

The patient needs understanding and support that the feelings are normal. Although feelings of depression generally decline over the period of a year after the death of a loved one, the decline is not linear. Loneliness and aimlessness are most pronounced 6 to 9 months after the death. The patient should be educated about normal phenomena experienced during bereavement. The other options are not clearly indicated.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

[abirb.com/test](#)

27. A nurse cared for a terminally ill patient for over a month and always looked forward to spending time with the patient. When the patient died, the nurse experienced sadness and felt mildly depressed. Eventually, the nurse explains these feelings to a mentor. What should be the mentor's focus should counseling the nurse?
- a. Implementing stress-reduction strategies
 - b. Seeking therapy for dysfunctional grief
 - c. Discussing the experience of disenfranchised grief
 - d. Considering taking a leave of absence to pursue healing

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ANS: C

The nurse is experiencing disenfranchised grief. Nurses often incur loss that is not openly acknowledged or publicly mourned. The loss of a patient may not be recognized or acknowledged by others; therefore, the grief is solitary and uncomforted and may be difficult to resolve.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

MULTIPLE RESPONSE

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1. Which actions by a nurse contribute to protecting the rights of patients who are terminally ill? (*Select all that apply.*)
 - a. Maintain hope for a positive prognosis.
 - b. Hug the patient when sadness is expressed.
 - c. Offer choices that promote personal control.
 - d. Provide interventions that convey respect.
 - e. Support the patient's quest for spiritual growth.

ANS: C, D, E

The answers support the rights of the individual who is dying. Touch should be nurturing but may leave the patient uncomfortable and confused if inappropriate. Acting on false information robs a patient of the opportunity for honest dialog and places barriers to achieving end-of-life developmental opportunities.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

2. Which statements by a patient who is terminally ill give the nurse information relevant to spiritual assessment? (*Select all that apply.*)
 - a. "I feel an inner peace with my decision to use hospice services."
 - b. "I trust my health care provider to prescribe enough medication to keep me free of pain."
 - c. "I have prepared advance directives to spare my children the need to make difficult decisions."
 - d. "I plan to use these last weeks to experience the process of dying as fully as I experienced the richness of living."
 - e. "Listening to hymns helps deepen my relaxation and the relief I get from my pain medication."

ANS: A, D, E

Spirituality encompasses finding meaning in the process of living and dying, as well as hope and inner peace. Listening to hymns identifies an activity that connects the patient to his or her beliefs and is helpful in calming anxieties. The other options are not directly related to spiritual aspects.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

3. Psychotherapy for individuals at risk for complicated grief focuses on which goals? (*Select all that apply.*)

[abirb.com/test](#)

- a. Exploring emotional responses to a loss
- b. Identifying ways to break bonds with the deceased
- c. Solving problems related to moving forward in life
- d. Learning about the stages and symptoms of grieving
- e. Using antipsychotic medications for dysfunctional grief

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ANS: A, C, D

[abirb.com/test](#)

Psychotherapy is offered when a problem—not necessarily dysfunctional grief—exists or is anticipated. It focuses on emotional responses to loss and problem solving related to moving forward in life. Anxiety and/or depression may develop, even with normal grief, and require the short-term use of anxiolytic or antidepressant medications; however, antipsychotic drugs would not be expected. Physical symptoms such as weakness, anorexia, shortness of breath, tightness of the chest, dry mouth, and gastrointestinal disturbances may accompany acute grief, but the development of actual complications indicates dysfunctional grief.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

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Chapter 26: Children and Adolescents

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A 5-year-old child moves and talks constantly. The child awakens before the parents every morning. The child attends kindergarten, but the teacher reports difficulty handling the behavior. What is this child's most likely problem?
a. Tic disorder
b. Oppositional defiant disorder (ODD)
c. Intellectual development disorder (IDD)
d. Attention-deficit/hyperactivity disorder (ADHD)

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ANS: D

The constant motion and excessive talkativeness suggest ADHD. Tic disorder is associated with stereotypical, rapid, and involuntary motor movements. Developmental delays would be observed if intellectual development disorder was present. ODD includes serious violations of the rights of others.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

2. The health care provider prescribes medication for a child diagnosed with attention-deficit/hyperactivity disorder (ADHD). What is the desired behavior for which the nurse should monitor?
a. Increased expressiveness in communicating with others.
b. Improved ability for cooperative play with other children.
c. Ability to identify anxiety and implement self-control strategies.
d. Improved socialization skills with other children and authority figures.

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ANS: B

The goal is improvement in the child's hyperactivity, distractibility, and play. The incorrect options are more relevant for a child with a developmental or anxiety disorder.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Outcomes Identification

MSC: NCLEX: Psychosocial Integrity

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3. A 5-year-old child diagnosed with attention-deficit/hyperactivity disorder (ADHD) bounces out of a chair in the waiting room, runs across the room, and begins to slap another child. What is the nurse's best action?
a. Call for emergency assistance from another staff member.
b. Instruct the parents to take the child home immediately.
c. Direct this child to stop, and then comfort the other child.
d. Take the child into another room with toys to act out feelings.

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ANS: D

abirb.com/test

abirb.com/test

The use of play to express feelings is appropriate; the cognitive and language abilities of the child may require the acting out of feelings if verbal expression is limited. The incorrect options provide no outlet for feelings or opportunity to develop coping skills.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

[abirb.com/test](#)

4. A desired outcome for a 12-year-old diagnosed with oppositional defiant disorder (ODD) is to improve relationships with other children. Which treatment modality should the nurse suggest for the plan of care?
- a. Bibliotherapy
 - b. Music therapy
 - c. Social skills groups
 - d. Behavior modification

[abirb.com/test](#)

ANS: C

Social skills training teaches the child to recognize the impact of his or her behavior on others. It uses instruction, role-playing, and positive reinforcement to enhance social outcomes. The other therapies would have lesser or no impact on peer relationships.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

5. A child diagnosed with attention-deficit/hyperactivity disorder (ADHD) is going to begin medication therapy. The nurse should plan to teach the family about which classification of medications?
- a. Central nervous system stimulants and nonstimulants
 - b. Monoamine oxidase inhibitors (MAOIs)
 - c. Antipsychotic medications
 - d. Anxiolytic medications

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ANS: A

Central nervous system stimulants and nonstimulants increase blood flow to the brain and have proven helpful in reducing hyperactivity in children and adolescents with ADHD. The other medication categories listed would not be appropriate.

[abirb.com/test](#)

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

[abirb.com/test](#)

6. A nurse will prepare teaching materials regarding which medication for the parents of a child diagnosed with enuresis?
- a. Haloperidol
 - b. Desmopressin
 - c. Methylphenidate
 - d. Carbamazepine

[abirb.com/test](#)

ANS: C

Pharmacological treatment of enuresis commonly includes desmopressin, oxybutynin, various stimulants, indomethacin, and/or SSRI antidepressants. Limited evidence exists for the use of imipramine. None of the other drugs are appropriate to treat enuresis.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

[abirb.com/test](#)

MSC: NCLEX: Physiological Integrity

7. Shortly after a 15-year-old's parents announce a plan to divorce, the adolescent stops participating in sports, sits alone at lunch, and avoids former friends. The adolescent says, "All the other kids have families. If my parents loved me, then they would stay together." Which nursing intervention is most appropriate?
- a. Develop a plan for activities of daily living.
 - b. Communicate disbelief relative to the adolescent's feelings.
 - c. Assist the adolescent to differentiate reality from perceptions.
 - d. Assess and document the adolescent's level of depression daily.

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ANS: C

The patient's perceptions that "all the other kids" are from two-parent households and that he or she is different are not based in reality. Assisting the patient to test the accuracy of the perceptions is helpful.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

8. When group therapy is to be used as a treatment modality, the nurse should suggest placing a 9-year-old in a group that focuses on what?
- a. Play activities exclusively.
 - b. Group discussion exclusively.
 - c. Talk focused on a specific issue.
 - d. Play and then talk about the play activity.

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[abirb.com/test](#)

ANS: D

Group therapy for young children takes the form of play. For elementary school children, therapy combines play and talk about the activity. For adolescents, group therapy involves more talking.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. When assessing a 2-year-old diagnosed with autism spectrum disorder, what should a nurse expects?
- a. Hyperactivity and attention deficits
 - b. Failure to develop interpersonal social skills
 - c. History of disobedience and destructive acts
 - d. High levels of anxiety when separated from a parent

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ANS: B

Autism spectrum disorder involves distortions in the development of social skills and language that include perception, motor movement, attention, and reality testing. Caretakers frequently mention the child's failure to develop interpersonal skills. The distractors are more relevant to ADHD, separation anxiety, and CD.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

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10. A 4-year-old child cries and screams from the time the parents leave the child at preschool until the child is picked up 4 hours later. The child is calm and relaxed when the parents are present. The parents ask, "What should we do?" What is the nurse's best recommendation?
- "Send a picture of yourself to school to keep with the child."
 - "Arrange with the teacher to let the child call home at playtime."
 - "Talk with the school about withdrawing the child until maturity increases."
 - "Talk with your health care provider about a referral to a mental health professional."

ANS: D

Separation anxiety disorder becomes apparent when the child is separated from the attachment figure. The symptoms are considered normal up to age 1. Often, the first-time separation occurs when the child goes to kindergarten or nursery school. Separation anxiety may be based on the child's fear that something will happen to the attachment figure. The child needs professional help. None of distractors accounts for the severity and length of the child's reaction.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. A 15-year-old adolescent has run away from home six times. After the adolescent was arrested for prostitution, the parents told the court, "We can't manage our teenager." The adolescent is physically abusive to the mother and defiant with the father. The adolescent's problem is most consistent with criteria for which disorder?
- Attention-deficit/hyperactivity disorder (ADHD)
 - Childhood depression
 - Conduct disorder (CD)
 - Autism spectrum disorder (ASD)

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ANS: C

CDs are manifested by a persistent pattern of behavior in which the rights of others and age-appropriate societal norms are violated. The *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) (*DSM-5*) identifies CDs as serious violations of rules. The patient's clinical manifestations do not coincide with the other disorders listed.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

12. A 15-year-old adolescent is referred to a residential program after an arrest for theft and running away from home. At the program, the adolescent refuses to participate in scheduled activities and pushes a staff member, causing a fall. Which approach by the nursing staff would be most therapeutic?
- Neutrally permit refusals.
 - Coax to gain compliance.
 - Offer rewards in advance.
 - Establish firm limits.

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ANS: D

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Firm limits are necessary to ensure physical safety and emotional security. Limit setting will also protect other patients from the teenager's thoughtless or aggressive behavior. Permitting refusals to participate in the treatment plan, coaxing, and bargaining are strategies that do not help the patient learn to abide by rules or structure.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

13. An adolescent diagnosed with generalized anxiety disorder says, "My parents focus all their attention on my brother instead of me. He's perfect in their eyes." Which type of therapy might promote the greatest change in this adolescent's behavior?

- a. Bibliotherapy
- b. Play therapy
- c. Family therapy
- d. Behavior modification therapy

[abirb.com/test](#)

ANS: C

Family therapy focuses on problematic family relationships and interactions. The patient has identified problems within the family. Bibliotherapy and play therapy are appropriate for children rather than adolescents. The adolescent's problem is interpersonal and relates to relationships and self-perception; therefore, behavior modification therapy would not help.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

[abirb.com/test](#)

14. A nurse assesses a 3-year-old diagnosed with autism spectrum disorder. Which finding is most associated with the child's disorder?

- a. Has occasional toileting accidents.
- b. Is unable to read children's books.
- c. Cries when separated from a parent.
- d. Continuously rocks in place for 30 minutes.

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ANS: D

Autism spectrum disorder involves distortions in development of social skills and language that include perception, motor movement, attention, and reality testing. Body rocking for extended periods suggests autism spectrum disorder. The distractors are expected findings for a 3-year-old.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

15. Which finding would prompt the nurse to carefully assess an 8-year-old child for development of a psychiatric disorder?

- a. Being raised by a parent with chronic major depressive disorder
- b. Moving to three new homes over a 2-year period
- c. Not being promoted to the next grade
- d. Having an imaginary friend

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ANS: A

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[abirb.com/test](#)

If the caregiver is unable to respond positively to the child, there is an increased risk of insecure attachment, developmental problems, and mental disorders. The chronicity of the parent's depression means it has been a consistent stressor.^bThe other factors do not create ongoing stress.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

16. A nurse assesses the four children below. Which assessment findings should prompt the nurse to refer the child for further evaluation?
- a. A 4-year-old who stuttered for 3 weeks after the birth of a sibling.
 - b. A 9-month-old who does not eat vegetables and likes to be rocked.
 - c. A 3-month-old who cries after feeding until burped and sucks a thumb.
 - d. A 3-year-old who is mute, passive toward adults, and twirls while walking.

ANS: D

Symptoms consistent with an autistic spectrum disorder (ASD) are evident in the correct answer. The behaviors of the other children are expected and within normal ranges.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

17. The child most likely to receive propranolol to manage tremors is one diagnosed with which disorder?
- a. Attention-deficit/hyperactivity disorder (ADHD)
 - b. Posttraumatic stress disorder (PTSD)
 - c. A motor disorder
 - d. Separation anxiety

ANS: C

Propranolol is useful for managing tremors associated with various motor disorders. This medication is not indicated in any of the other disorders.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

18. A 12-year-old child has been the neighborhood bully for several years. The parents say, "We can't believe anything our child says." Recently, the child shot a dog with a pellet gun and set fire to a trash bin outside a store. The child's behaviors are most consistent with which disorder?
- a. Conduct disorder (CD)
 - b. Defiance of authority
 - c. Anxiety over separation from a parent
 - d. Attention-deficit/hyperactivity disorder (ADHD)

ANS: A

The behaviors mentioned are most consistent with the *DSM-5* criteria for CD: aggression against people and animals; destruction of property; deceitfulness; rule violations; and impairment in social, academic, or occupational functioning. The behaviors are not consistent with ADHD and separation anxiety and are more pervasive than defiance of authority.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

19. The parent of a child diagnosed with Tourette's disorder says to the nurse, "I think my child is faking the tics because they come and go." Which response by the nurse is accurate?
- a. "Perhaps your child was misdiagnosed."
 - b. "Your observation indicates the medication is effective."
 - c. "Tics often change frequency or severity. That does not mean they aren't real."
 - d. "This finding is unexpected. How have you been administering your child's medication?"

ANS: C

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Tics are sudden, rapid, involuntary, repetitive movements, or vocalizations characteristic of Tourette's disorder. They often fluctuate in frequency and severity and are reduced or absent during sleep.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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20. An 11-year-old child, who has been diagnosed with oppositional defiant disorder (ODD), becomes angry over the rules at a residential treatment program and begins shouting at the nurse. What is the best method to defuse the situation?
- a. Assign the child to a short time-out.
 - b. Administer an antipsychotic medication.
 - c. Place the child in a therapeutic hold.
 - d. Call a staff member to seclude the child.

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ANS: A

Time-out is a useful strategy for interrupting the angry expression of feelings and allows the child an opportunity to exert self-control. This method is the least restrictive alternative of those listed and should be tried before resorting to more restrictive measures.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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21. When a 5-year-old child is disruptive, the nurse says, "You must take a time-out." The expectation is that the child will demonstrate what behavior?
- a. Go to a quiet room until called for the next meal.
 - b. Slowly count to 20 before returning to the group activity.
 - c. Sit on the edge of the activity until able to regain self-control.
 - d. Sit quietly on the lap of a staff member until able to apologize for the behavior.

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ANS: C

Time-out is designed so that staff can be consistent in their interventions. Time-out may require having the child sit on the periphery of an activity until he or she gains self-control and reviews the episode with a staff member. Time-out may not require having the child go to a designated room and does not involve special attention such as holding. Having the child count to 10 or 20 is not sufficient.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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22. A parent diagnosed with schizophrenia and her 13-year-old child live in a homeless shelter. The child has formed a trusting relationship with a shelter volunteer. The child says, "My three friends and I got an A on our school science project." abirb.com/test The nurse can assess that the child is demonstrating what characteristic?
- a. Resiliency
 - b. Shy temperament
 - c. Early posttraumatic stress disorder
 - d. Uses intellectualization to deal with problems

ANS: A

Resiliency enables a child to handle the stresses of a difficult childhood. Resilient children can adapt to changes in the environment, take advantage of nurturing relationships with adults other than parents, distance themselves from emotional chaos occurring within the family, learn, and use problem-solving skills. None of the distractors demonstrate a means of handling stress.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

23. A parent diagnosed with schizophrenia and 13-year-old child live in a homeless shelter. The child has formed a trusting relationship with a volunteer. The teen says, "I have three good friends at school. We talk and sit together at lunch." What is the nurse's best suggestion to the treatment team?
- a. Suggest foster home placement.
 - b. Seek assistance from an intimate partner violence program.
 - c. Make referrals for existing and emerging developmental problems.
 - d. Encourage healthy characteristics and existing environmental supports.

ANS: D

Because the teenager shows no evidence of poor mental health, the best action would be to foster existing healthy characteristics and environmental supports. No other option is necessary or appropriate under the current circumstances. abirb.com/test

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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24. Which behavior indicates that the treatment plan for a child diagnosed with autism spectrum disorder was effective?
- a. Plays with one toy for 90 minutes.
 - b. Repeats words spoken by a parent.
 - c. Holds the parent's hand while walking.
 - d. Spins around and claps hands while walking.

ANS: C

Holding the hand of another person suggests relatedness. Usually, a child with autism would resist holding someone's hand and stand or walk alone, perhaps flapping arms or moving in a stereotypical pattern. The other options reflect behaviors that are consistent with autistic disorder.

DIF: Cognitive Level: Analysis (Analyzing)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

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MULTIPLE RESPONSE

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1. What are the primary distinguishing factors between the behavior of children diagnosed with oppositional defiant disorder (ODD) and those diagnosed with conduct disorder (CD)? The child diagnosed with: (*Select all that apply.*)
a. ODD relives traumatic events by acting them out.
b. ODD tests limits and disobeys authority figures.
c. ODD has difficulty separating from the parents.
d. CD uses stereotypical or repetitive language.
e. CD often violates the rights of others.

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ANS: B, E

Children with ODD are negativistic, disobedient, and defiant toward authority figures without seriously violating the basic rights of others, whereas children with CD frequently behave in ways that violate the rights of others and age-appropriate societal norms. Reliving traumatic events occurs with posttraumatic stress disorder. Stereotypical language behaviors are observed in autistic children. Separation problems with resultant anxiety occur with separation anxiety disorder.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

2. A nurse prepares the plan of care for a 15-year-old adolescent diagnosed with moderate intellectual developmental disorder (IDD) is believed capable of ultimately functioning at a second-grade level. What are the highest outcomes realistic for this person to demonstrate within 5 years? (*Select all that apply.*)
a. Live unaided in an apartment.
b. Obtain employment in a local sheltered workshop.
c. Correctly use public buses to travel in the community.
d. Independently perform his or her own personal hygiene.
e. Complete high school or earn a general equivalency diploma (GED).

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ANS: B, C, D

Individuals with moderate intellectual developmental disorder progress academically to about a second-grade level. These people can learn to travel in familiar areas and perform unskilled or semiskilled work. With supervision, they can function in the community, but independent living is not likely.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

3. A nurse prepares to lead a discussion at a community health center regarding children's health. The nurse wants to use current terminology when teaching about these issues. Which terms are appropriate for the nurse to use? (*Select all that apply.*)
a. Mental retardation
b. Asperger's disorder
c. Autism spectrum disorder
d. Pervasive developmental disorder
e. Intellectual development disorder

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ANS: C, E

Using dated terminology contributes to the stigma and misconceptions about mental illness. It's important for the nurse to use current terminology. The term mental retardation has been replaced with intellectual development disorder. The term autism spectrum disorder now encompasses Asperger's disorder and pervasive developmental disorder.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

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Chapter 27: Adults

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. Health maintenance and promotion efforts for patients diagnosed with severe mental illness should include education about the importance of what regular intervention?
 - a. Home safety inspections
 - b. Monitoring of self-care abilities
 - c. Screening for cancer, hypertension, and diabetes
 - d. Determination of adequacy of a patient's support system

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ANS: C

Individuals diagnosed with severe and persistent mental illness have an increased prevalence of medical disorders. Patients should be taught the importance of regular visits to a primary care physician for screening for these illnesses. Home safety inspections are more often suggested for patients with physical impairments. Caregivers and family members usually evaluate self-care abilities, rather than the patient. Assessment of a patient's support system is not usually considered part of health promotion and maintenance.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Health Promotion and Maintenance

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2. How is severe and persistent mental best characterized?
 - a. Mental illness with longer than 2 weeks' duration.
 - b. Major ongoing mental illness marked by significant functional impairments.
 - c. Mental illness accompanied by physical impairment and severe social problems.
 - d. Major mental illness that cannot be treated to prevent deterioration of cognitive and social abilities.

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ANS: B

“Severe mental illness” has replaced the phrase “chronic mental illness.” Global impairments in function are evident, including social skills. Physical impairments may or may not be present. Severe mental illness can be treated, but remissions and exacerbations are part of the course of the illness. The distractors fail to effectively address the issue of functional impairment.

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DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

3. A 37 year old is involuntarily committed to outpatient treatment after sexually molesting a 12-year-old child. The patient says, “That girl looked like she was 19 years old.” Which defense mechanism is this patient using?
 - a. Denial
 - b. Identification
 - c. Displacement
 - d. Rationalization

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ANS: D

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Rationalization is used to justify upsetting behaviors by creating reasons that would allow the individual to believe that the behaviors were warranted or appropriate. The patient is rationalizing molestation of a minor. Denial is used to avoid dealing with the problems and responsibilities related to one's behaviors. Identification is incorporating the image of an emulated person and then acting, thinking, and feeling like that person. Displacement is the discharge of pent-up feelings onto something or someone else in the environment that is less threatening than the original source of the feelings.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

4. Which nursing diagnosis is likely to apply to the plan of care for a homeless individual diagnosed with severe and persistent mental illness?
 - a. Insomnia
 - b. Substance abuse
 - c. Chronic low self-esteem
 - d. Impaired environmental interpretation syndrome

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ANS: C

Many individuals with severe mental illness do not live with their families and are homeless. Life on the street or in a shelter has a negative influence on the individual's self-esteem, making this nursing diagnosis one that should be considered. Insomnia may be noted in some patients but is not a universal problem. While substance abuse may be a comorbid problem, it is not an approved North American Nursing Diagnosis Association International (NANDA-I) diagnosis. Impaired environmental interpretation syndrome refers to persistent disorientation, which is not observed in a majority of the homeless population.

DIF: Cognitive Level: Analysis (Analyzing)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

5. A patient diagnosed with schizophrenia tells the community mental health nurse, "I threw away my pills because they interfere with God's voice." The nurse identifies what as the likely cause of the patient's ineffective management of the medication regimen?
 - a. Inadequate discharge planning
 - b. Poor therapeutic alliance with clinicians
 - c. Impaired reasoning secondary to schizophrenia
 - d. Dislike of the side effects of antipsychotic medications

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ANS: C

The patient's ineffective management of the medication regimen is most closely related to impaired reasoning abilities. The patient believes in being an exalted person who hears God's voice, rather than an individual with a serious mental illness who needs medication to control symptoms. Data do not suggest that any of the other factors often relate to medication nonadherence.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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6. A patient diagnosed with severe and persistent mental illness lives independently. This patient often has command hallucinations and shouts warnings to neighbors. After a short hospitalization, the patient's landlord says, "You can't come back here. You cause too much trouble." What problem is the patient experiencing?
- Grief
 - Stigmatization
 - Recidivism
 - Lack of insurance parity

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ANS: B

The inability to obtain shelter because of negative attitudes about mental illness is an example of stigmatization. Stigma is defined as damage to reputation, shame, and ridicule society places on mental illness. Data are not present to identify grief as the patient's problem. Recidivism refers to repetition of a previous offense. Insurance parity is not relevant to this scenario.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

7. A person diagnosed with severe and persistent mental illness enters a shelter for the homeless. Which intervention should be the nurse's initial priority? [abirb.com/test](#)
- Develop a relationship.
 - Find supported employment.
 - Administer prescribed medication.
 - Teach appropriate health care practices.

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ANS: A

Basic psychosocial needs do not change because a person is homeless. The nurse's initial priority should be establishing rapport. Once a trusting relationship is established, then the nurse can pursue other interventions.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

8. A patient diagnosed with severe and persistent mental illness lives in a homeless shelter. The priority nursing diagnosis for this patient is Powerlessness. Which intervention should be included in the plan of care?
- Encourage mutual goal setting.
 - Verbally communicate empathy.
 - Reinforce participation in activities.
 - Demonstrate an accepting attitude.

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ANS: A

Mutual goal setting is an intervention designed to promote feelings of personal autonomy and dispel feelings of powerlessness. Although it might be easier and faster for the nurse to establish a plan and outcomes, this action contributes to the patient's sense of powerlessness. Involving the patient in decision making empowers the patient and reduces feelings of powerlessness.

DIF: Cognitive Level: Application (Applying)

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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9. A homeless patient diagnosed with severe and persistent mental illness became suspicious and delusional. The patient was given depot antipsychotic medication and housing was arranged at a local shelter. After 2 weeks, which statement by the patient indicates significant improvement?
- "I am feeling safe and comfortable here. Nobody bothers me."
 - "They will not let me drink. They have many rules in the shelter."
 - "Those guys are always watching me. I think someone stole my shoes."
 - "That shot made my arm sore. I'm not going to take any more of them."

ANS: A

Evaluation of a patient's progress is made based on patient satisfaction with the new health status and the health care team's estimation of improvement. For a formerly delusional patient to admit to feeling comfortable and free of being "bothered" by others denotes an improvement in the patient's condition. The other options suggest that the patient is in danger of relapse.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. For patients diagnosed with severe and persistent mental illness, what is the major advantage of case management?
- Modification of traditional psychotherapy
 - Efficient access and use of resources
 - Focus on social skills training and self-esteem building
 - Bringing groups of patients together to discuss common problems

ANS: B

The case manager not only provides entrance into the system of care, but he or she also coordinates the multiple referrals that so often confuse the patient who is severely and persistently mentally ill and the patient's family. Case management promotes the efficient use of services. The other options are lesser advantages or may be irrelevant.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

11. The father of a child diagnosed with schizophrenia says, "I lost my job, so we have no health insurance." The mother says, "I must watch this child all the time. Without supervision, our child becomes violent and destructive." A sibling says, "My parents don't pay attention to me." These comments signify what related stress?
- Life-cycle stressors
 - Psychobiological issues
 - Family burden of mental illness
 - Stigma associated with mental illness

ANS: C

Family burden refers to the meaning that the experience of living with a person who is mentally ill has for families. The stressors mentioned are not related to life-cycle issues. The stressors described are psychosocial. Stigma refers to shame and ridicule associated with mental illness.

DIF: Cognitive Level: Application (Applying)

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12. The parent of an adult diagnosed with severe and persistent mental illness asks the nurse, “Why are you making a referral to that vocational rehabilitation program? My child won’t ever be able to hold a job.” Which is the nurse’s best reply?
- a. “We made this referral to maintain eligibility for federal funding.”
 - b. “Are you concerned that we’re trying to make your child too independent?”
 - c. “If you think the program would be detrimental, we can postpone it for a time.”
 - d. “Most patients are capable of employment at some level, competitive or supported.”

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ANS: D

Studies have shown that most patients who complete vocational rehabilitation programs are capable of some level of employment; also, they demonstrate significant improvement in assertiveness and work behaviors, as well as decreased depression, and improved self-esteem and socialization.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

13. An adult says, “When I was a child, I took medication because I couldn’t follow my teachers’ directions. I stopped taking it when I was about 13. I still have trouble getting organized, which causes difficulty at my job.” Which disorder is most likely?
- a. Stress intolerance disorder
 - b. Generalized anxiety disorder (GAD)
 - c. Borderline personality disorder
 - d. Adult attention-deficit/hyperactivity disorder (ADHD)

ANS: D

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Adult ADHD is usually diagnosed in early life and treated until adolescence. Treatment is often stopped because professionals think the disorder resolves itself because the hyperactive impulsive behaviors may diminish; the inattentive and disorganized behaviors tend to persist, however. Stress intolerance disorder is not found in the *DSM-5*. The scenario description is inconsistent with generalized anxiety disorder and borderline personality disorder.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

14. A patient says, “I often make careless mistakes and have trouble staying focused. Sometimes it’s hard to listen to what someone is saying. I have problems putting things in the right order and often lose equipment.” Which problem should the nurse document?
- a. Inattention
 - b. Impulsivity
 - c. Hyperactivity
 - d. Social impairment

ANS: A

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Inattention refers to the failure to stay focused. A number of the other problems are the result of failure to pay attention, which contributes to problems with organization. Impulsivity refers to acting without thinking through the consequences. Hyperactivity refers to excessive motor activity. Social impairment refers to the failure to use appropriate social skills.

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DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

15. A nurse prepares for an initial interview with a patient with suspected adult attention-deficit/hyperactivity disorder (ADHD). Questions should be focused to elicit information about which problem?
a. Headaches
b. Inattention
c. Sexual impulses
d. Trichotillomania

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ANS: B

Inattention usually persists from childhood into adult ADHD, although hyperactivity, impulsivity, and social impairments may also be present. Headaches would not be expected. Sexual impulses may be affected by adult ADHD, but this area is assessed later. Trichotillomania refers to pulling out one's hair as a tension-relieving behavior.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

16. A nurse prepares a plan of care for a patient diagnosed with adult attention-deficit/hyperactivity disorder (ADHD). Which intervention should be included?
a. Remind the patient of priorities and deadlines.
b. Teach work-related skills such as basic computer literacy.
c. Establish penalties for failing to organize and prioritize tasks.
d. Give encouragement and strategies for managing and organizing.

ANS: D

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The nurse's major responsibilities lie with encouraging the patient to learn and use necessary skills, assisting the patient to stay on task. The nurse is not an ever-present taskmaster or disciplinarian. The nurse does not teach work-related skills; vocational staff members assume those types of tasks.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

17. The treatment team believes medication will help a patient diagnosed with adult attention-deficit/hyperactivity disorder (ADHD). Which class of medications does the nurse expect will be prescribed?
a. Benzodiazepines
b. Stimulants
c. Antipsychotics
d. Anxiolytics

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ANS: B

Stimulants, such as methylphenidate and amphetamines, provide the basis for treatment of both adult and childhood ADHD. They are the most commonly used medications; therefore, the nurse could expect the health care provider to prescribe a drug in this class. None of the other drugs listed as options have proved useful in the treatment of ADHD.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

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MSC: NCLEX: Psychosocial Integrity

18. An adult diagnosed with attention-deficit/hyperactivity disorder (ADHD) says, "I've always been stupid. I never had friends when I was a child. My parents often punished me because I made mistakes. Now, I can't keep a job." The nurse managing care should consider suggesting what intervention?
- a. Aversive therapy to extinguish negative behaviors.
 - b. Cognitive therapy to help address internalized beliefs.
 - c. Group therapy to allow comparison of feelings with others.
 - d. Vocational counseling to identify needed occupational skills.

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ANS: B

Cognitive therapy and knowledge of ADHD will make it possible for the patient to reframe the past and present in a more positive and realistic light and to challenge internalized false beliefs about self this improving self-image. Aversive therapy would not be useful for the patient. Group therapy may be valuable later to allow for the testing of new coping behaviors in a safe environment. Vocational counseling can help the patient explore suitable career options while pursuing treatment.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

19. A nurse counsels a patient diagnosed with serious and persistent mental illness. The patient lives at home with family. Which resource could the nurse suggest assisting the patient and family to cope with the stigma of mental illness as well as provide support and education?
- a. American Psychiatric Association (APA)
 - b. National Alliance on Mental Illness (NAMI)
 - c. Community Mental Health Centers (CMHCs)
 - d. Programs of Assertive Community Treatment (PACT)

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ANS: B

Stigma represents the bias and prejudice commonly held regarding mental illness. NAMI actively seeks to dispel misconceptions about mental illness. The organization also offers patient and family support and education about living with mental illness. Community Mental Health Centers (CMHCs) are government agencies that provide outpatient services to persons diagnosed with SPMI. The APA is the professional organization of psychiatrists. Programs of Assertive Community Treatment (PACT) use a treatment team approach to improve symptom management and quality of life for persons diagnosed with SPMI.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Safe, Effective Care Environment

20. Which nursing action should occur first when preparing to work with a patient who has a problem of sexual functioning?
- a. Acquire knowledge of the patient's sexual roles and preferences.
 - b. Develop an understanding of human sexual responses.
 - c. Assess the patient's sexual functioning.
 - d. Clarify the nurse's own personal values.

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ANS: D

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abirb.com/test

Before a nurse can be helpful to patients with sexual dysfunction, he or she must be aware of and comfortable with his or her own feelings about sex and sexuality. Nurses must be comfortable with the idea that patients have a right to their own values and must avoid criticism and censure.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

21. A patient tells the nurse, "My sexual functioning is normal when my partner wears lace. Without it, I'm not interested in sex." This comment evidences which sexual disorder?
- a. Exhibitionism
 - b. Voyeurism
 - c. Pedophilia
 - d. Fetishism

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ANS: D

A person with a sexual fetish finds it necessary to have some external object present, in fantasy or in reality, to be sexually satisfied. Exhibitionism refers to exposing one's genitalia publicly. Voyeurism refers to viewing others in intimate situations. Pedophilia refers to the preference for having sexual relations with a child.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

22. A man tells the nurse, "All my life, I have felt and acted like a woman while living in a man's body. For the past year, I have lived and dressed as a woman. I changed jobs to protect my new identity." Which request is the patient likely to make to the health care provider?
- a. "Can you refer me for psychological testing?"
 - b. "Will you prescribe hormonal therapy?"
 - c. "Will you alter my medical records?"
 - d. "What should I tell my parents?"

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ANS: B

Before sexual reassignment surgery, the step that follows living as a member of the other sex is hormone therapy. The patient's decision to live as a woman makes this a natural request. Psychological testing occurs before sexual reassignment surgery, often after hormone therapy has begun. The patient has likely told his parents by this point.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

23. The manager of a health club put a hidden camera in the women's locker room and videotaped women as they showered and dressed. Which sexual dysfunction is evident?
- a. Frotteurism
 - b. Exhibitionism
 - c. Pedophilia
 - d. Voyeurism

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ANS: D

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abirb.com/test

Voyeurism is the viewing of others in intimate situations such as undressing, bathing, or having sexual relations. Voyeurs are often called “peeping Toms.” Frotteurism is touching or rubbing against a nonconsenting person to achieve sexual gratification. Exhibitionists are interested in exposing their genitals to others. Pedophiles seek sexual contact with prepubescent children.

DIF: Cognitive Level: Comprehension (Understanding) abirb.com/test
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

24. Before working with patients regarding sexual concerns, what is a prerequisite for providing nonjudgmental care?
- a. Sympathy
 - b. Assertiveness training
 - c. Sexual self-awareness
 - d. Effective communication

ANS: C

Only when a nurse has accepted his or her own feelings and values related to sexuality can he or she provide fully nonjudgmental care to a patient. If the nurse is uncomfortable, the patient might misinterpret discomfort as disapproval. The distractors are not prerequisites.

DIF: Cognitive Level: Comprehension (Understanding) abirb.com/test
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

25. An adult has been feeling significant tension since losing a home through foreclosure. This person goes to a park, feeds the birds, and then impulsively exposes himself to a group of parents and children. Which term applies to this behavior?
- a. Voyeurism
 - b. Frotteurism
 - c. Exhibitionism
 - d. Sexual masochism

ANS: C

Exhibitionism is obtaining sexual pleasure from exposing one's genitalia to unsuspecting strangers. Voyeurism refers to obtaining sexual pleasure from observing people who are naked. Frotteurism is associated with obtaining sexual arousal by rubbing one's genitals against an unsuspecting person. Sexual masochism refers to deriving sexual pleasure from being humiliated, beaten, or otherwise made to suffer.

DIF: Cognitive Level: Comprehension (Understanding) abirb.com/test
TOP: Nursing Process: Planning
MSC: NCLEX: Physiological Integrity

26. A nurse cares for a patient diagnosed with paraphilia. The nurse expects the health care provider may prescribe which type of medication to reduce paraphilic behaviors?
- a. Stimulants
 - b. Erectile dysfunction medication
 - c. Atypical antipsychotic medication
 - d. Mood stabilizer

ANS: D

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abirb.com/test

Pharmacological treatment typically involves medications that reduce impulsive or compulsive behavior, such as antidepressants, naltrexone, antipsychotics, mood stabilizers, or medications that interfere with the production of sexual hormones in order to reduce sexual urges. The other medications are not indicated for this disorder.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Health Promotion and Maintenance

TOP: Nursing Process: Planning
[abirb.com/test](#)

27. A patient diagnosed with severe and persistent mental illness who recently moved to a homeless shelter says, "My life is out of control. I'm like a leaf at the mercy of the wind." The nurse formulates the diagnosis Powerlessness. Outcomes will focus on which goal?
- a. Instilling hope
 - b. Controlling anxiety
 - c. Planning social activities
 - d. Developing personal autonomy

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ANS: D

Powerlessness is associated with feeling unable to control events in one's life. It is often associated with low self-esteem. The goal is to increase one's sense of autonomy. The scenario does not indicate hopelessness or anxiety. Socialization is not the primary need.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

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MULTIPLE RESPONSE

1. Which information should a nurse include in health teaching for adults diagnosed with attention-deficit/hyperactivity disorder (ADHD) and their significant others? (*Select all that apply.*)
 - a. Tendency for genetic transmission
 - b. Prevention strategies related to substance abuse
 - c. Negative reinforcement strategies to help modify behaviors
 - d. Selective serotonin reuptake inhibitors (SSRIs) are usually prescribed for hyperactivity
 - e. Cognitive therapy may help resolve internalized negative beliefs about self

ANS: A, B, E

Evidence suggests that ADHD has a biological basis. This fact can help adults with the disorder to cope with low self-esteem. Cognitive therapy is helpful in reframing negative beliefs about self. Adults diagnosed with ADHD have a higher incidence of substance abuse problems. Psychostimulant medications, rather than SSRIs, are usually prescribed.

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DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

2. An adult patient tells the case manager, "I don't have bipolar disorder anymore, so I don't need medicine. After I was in the hospital last year, you helped me get an apartment and disability checks. Now I'm bored and don't have any friends." Which resources should the nurse suggest for the patient? (*Select all that apply.*)
 - a. Psychoeducation classes

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- b. Vocational rehabilitation
- c. Social skills training
- d. Homeless shelter
- e. Crisis intervention

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ANS: A, B, C

The patient does not understand the illness and the need for adhering to the medication regimen. Psychoeducation for the patient (and family) can address this lack of knowledge. Work gives meaning and purpose to life; vocational rehabilitation can assist with this aspect of care. The patient, who considers himself friendless, could also profit from social skills training to improve the quality of interpersonal relationships. Many patients with severe mental illness have such poor communication skills that others are uncomfortable interacting with them. Interactional skills can be effectively taught by breaking down each skill into small verbal and nonverbal components. The patient presently has a home and does not require the services of a homeless shelter. The nurse case manager functions in the role of crisis stabilizer, so no related referral is needed.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

3. Which economic factors are most critical to the success of discharge planning for a patient diagnosed with severe and persistent mental illness? (*Select all that apply.*)
- a. Access to housing
 - b. Individual psychotherapy
 - c. Income to meet basic needs
 - d. Availability of health insurance
 - e. Ongoing interdisciplinary evaluation

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ANS: A, C, D

The success of discharge planning requires careful attention to the patient's economic status. Access to housing is the first priority of the seriously mentally ill, and lack of income and health insurance is a barrier to effective treatment and rehabilitation. Although important aspects of ongoing care of the seriously mentally ill patient, ongoing interdisciplinary evaluation and individual psychotherapy are not economic factors.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Evaluation

4. Which statements most clearly indicate that the speaker views mental illness with stigma? (*Select all that apply.*)
- a. "Everyone is a little bit crazy."
 - b. "If people with mental illness would go to church, their problems would be solved with faith."
 - c. "Many mental illnesses are genetically transmitted. It is no one's fault that the illness occurs."
 - d. "Anyone can have a mental illness. War or natural disasters can be too stressful for healthy people."
 - e. "People with mental illness are lazy. They expect the government to take care of everything they need."

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ANS: A, B, E

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Stigma is represented by judgmental remarks that discount the reality and validity of mental illness. It is evidenced in stereotypical statements, by oversimplification, and by multiple other messages of guilt or shame.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

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Chapter 28: Older Adults

Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 4th Edition

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MULTIPLE CHOICE

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1. A student nurse visiting a senior center tells the instructor, "It's so depressing to see all these old people. They are so weak and frail. They are probably all confused." The student is expressing what attitude?
 - a. Reality
 - b. Ageism
 - c. Empathy
 - d. Distrust

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ANS: B

Ageism is defined as a bias against older people because of their age. None of the other options can be identified from the ideas expressed by the student.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Health Promotion and Maintenance

2. A community mental health nurse plans an educational program for staff members at a home health agency that specializes in the care of older adults. What topic is of high priority?
 - a. Identifying depression in older adults
 - b. Providing cost-effective foot care for older adults
 - c. Identifying nutritional deficiencies in older adults
 - d. Psychosocial stimulation for those who live alone

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ANS: A

Depression is the most common, most debilitating, and also most treatable psychiatric disorder in the older adult. Home health staff are often better versed in the physical aspects of care and less knowledgeable about mental health topics. Statistics show that older adult patients with mental health problems are less likely than young adults to be diagnosed accurately. This is especially true for those with depression and anxiety, both of which are likely to be misinterpreted as normal aging. Undiagnosed and untreated depression and anxiety result in unnecessary suffering. The other options are of lesser importance.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Planning

MSC: NCLEX: Psychosocial Integrity

3. Which is the best statement for a nurse to use when beginning an interview with an older adult patient?
 - a. "Hello, [call patient by first name]. I am going to ask you some questions to get to know you better."
 - b. "Hello. My name is [nurse's name]. I am a nurse. Please tell me how you would like to be addressed by the staff."
 - c. "I am going to ask you some questions about yourself. I would like to call you by your first name if you don't mind."
 - d. "You look as though you are comfortable and ready to participate in an admission interview. Shall we get started?"

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ANS: B

The correct response identifies the nurse's role and politely seeks direction for addressing the patient in a way that will make him or her comfortable. This is particularly important when a considerable age difference exists between the nurse and the patient. The nurse should address a patient by name but should not assume the patient wants to be called by his or her first name. The nurse should always introduce himself or herself.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

4. A 75-year-old patient comes to the clinic reporting frequent headaches. After an introduction at the beginning of the interview, what should the nurse address?
 - a. Initiate a neurological assessment.
 - b. Assess if the patient can hear the spoken word clearly.
 - c. Suggest that the patient lie down in a darkened room to rest.
 - d. Administer medication to relieve the patient's pain prior to the assessment.

ANS: B

Before proceeding, the nurse should assess the patient's ability to hear questions. Hearing ability often declines with age. Impaired hearing could lead to inaccurate answers. The nurse should not administer medication (an intervention) until after the assessment is complete.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

5. Which statement about aging provides the best rationale for focused assessment of older adult patients?
 - a. Older adults are often socially isolated and lonely.
 - b. As people age, they become more rigid in their thinking.
 - c. The majority of older adults sleep more than 12 hours per day.
 - d. The senses of vision, hearing, touch, taste, and smell decline with age.

ANS: D

Only the correct answer is true and cues the nurse to assess carefully the sensory functions of the older adult patient. The incorrect options are myths about aging.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

6. A nurse asks the following questions while assessing an older adult. The nurse will add the Geriatric Depression Scale as part of the assessment if the patient answers "yes" to which question?
 - a. "Would you say your mood is often sad?"
 - b. "Are you having any trouble with your memory?"
 - c. "Have you noticed an increase in your alcohol use?"
 - d. "Do you often experience moderate-to-severe pain?"

ANS: A

Sadness may be a symptom of depression. Sad moods occurring with regularity should signal the need to assess further for other symptoms of depression. The incorrect options do not focus on mood.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

7. A 78-year-old nursing home resident diagnosed with hypertension and cardiac disease is usually alert and oriented. This morning, however, the resident says, "My family visited during the night. They stood by the bed and talked to me." In reality, the patient's family lives 200 miles away. The nurse should first suspect what as the trigger for the resident's experience?
- A side effects associated with medications.
 - Early Alzheimer's disease associated with advanced age.
 - A transient ischemic attack and developed sensory perceptual alterations.
 - Previously unidentified alcohol abuse and is beginning alcohol withdrawal delirium.

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ANS: A

A resident taking medications is at high risk for becoming confused because of medication side effects, drug interactions, and delayed excretion. The nurse should report the event and continue to assess for cognitive impairment. Symptoms of dementia develop slowly but persist over time. Alcohol abuse and withdrawal are not the nurse's first suspicion in this scenario.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Safe, Effective Care Environment

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8. A health care provider writes these new prescriptions for a resident in a skilled care facility: "2 g sodium diet; restraint as needed; limit fluids to 2000 mL daily; 1 dose milk of magnesia 30 mL orally if no bowel movement occurs for 3 days." Which prescription should the nurse question?
- Restraint
 - Fluid restriction
 - Milk of magnesia
 - Sodium restriction

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ANS: A

Restraints may be applied only on the written order of the health care provider that specifies the duration during which the restraints can be used. The Joint Commission guidelines and Omnibus Budget Reconciliation Act regulations also mandate a number of other conditions that must be considered and documented before restraints are used. The other orders may be appropriate for implementation.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Safe, Effective Care Environment

9. If an older adult patient must be physically restrained, who is responsible for the patient's safety?
- Nurse assigned to care for the patient.
 - Nursing assistant who applies the restraint.
 - Health care provider who ordered the application of the restraint.
 - Family member who agrees to the application of the restraint.

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ANS: A

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Although restraint is ordered by a health care provider, it is carried out by a nursing staff member. The nurse caring for the patient is responsible for the safe application of restraining devices and for providing safe care while the patient is restrained. Nurses may delegate the application of restraining devices and the care of the patient in restraint but remain responsible for outcomes. Even when the family agrees to restraint, nurses are responsible for ensuring safe outcomes.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. An older adult patient brings a bag of medication to the clinic. The nurse finds one bottle labeled "Ativan" and one labeled "lorazepam," and both are labeled "Take two times daily." Bottles of hydrochlorothiazide, Inderal, and rofecoxib, each labeled "Take one daily," are also included. Which conclusion is accurate?
- a. Rofecoxib should not be taken with Ativan.
 - b. The patient's blood pressure is likely to be very high.
 - c. This patient should not self-administer any medication.
 - d. Lorazepam and Ativan are the same drug; consequently, the dose is excessive.

ANS: D

Lorazepam and Ativan are generic and trade names for the same drug, creating an accidental overdose situation. The patient needs medication education and help with proper, consistent labeling of bottles. No evidence suggests that the patient is unable to self-administer medication. The distractors are not factual statements.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

11. An advance directive gives valid direction to health care providers when a patient is demonstrating what characteristic?
- a. Aggression
 - b. Dehydration
 - c. Ineffective verbally communicate
 - d. Unable to make health care decisions

ANS: D

Advance directives are invoked when patients are unable to make their own decisions.

Aggression, dehydration, or an inability to speak does not mean the patient is unable to make a decision.

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DIF: Cognitive Level: Comprehension (Understanding)

MSC: NCLEX: Safe, Effective Care Environment

TOP: Nursing Process: Planning

12. A patient asks the nurse, "I already have a living will. Why should I have a durable power of attorney for health care also?" The nurse should provide what as the truth related to a durable power of attorney for health care?
- a. It gives your agent the authority to make decisions about your care if you are unable to during any illness.
 - b. It can be given only to a relative, usually the next of kin, who has your best interests at heart.
 - c. It authorizes your physician to make decisions about your care that are in your best

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interest.

- d. It can be used only if you have a terminal illness and become incapacitated.

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ANS: A

A durable power of attorney for health care is an instrument that appoints a person other than a health care provider to act as an individual's agent in the event that he or she is unable to make medical decisions. The patient does not have to be terminally ill or incompetent for the appointed person to act on his or her behalf.

DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

13. Recognizing the risk for acquired immunodeficiency syndrome (AIDS) among older adults, nurses should provide health teaching focused on what?

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- a. Discouraging sexual expression
- b. Using birth control measures
- c. Avoiding blood transfusions
- d. Encouraging condom use

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ANS: D

Safe sex continues to be important and should be taught to the older adult population. Because the risk for pregnancy is nonexistent in postmenopausal women, condom use is diminished, which places older adults at risk for AIDS and other sexually transmitted diseases. Sexual expression is a basic human need. Little to no danger exists from blood transfusions.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Health Promotion and Maintenance

14. A 79-year-old white man tells a visiting nurse, "I've been feeling sad lately. My family and friends are all dead. My money is running out, and my health is failing." How should the nurse analyze this comment?

- a. Normal negativity of older adults
- b. Evidence of suicide risk
- c. A cry for sympathy
- d. Normal grieving

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ANS: B

The patient describes the loss of significant others, economic insecurity, and declining health. He describes mood alteration and expresses the thought that he has little to live for. Combined with his age, sex, and single status, each is a risk factor for suicide. Older adult white men have the highest risk for completed suicide.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

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MSC: NCLEX: Psychosocial Integrity

15. A patient tells the nurse of the recent deaths of a spouse of 50 years as well as an adult child in an automobile accident. The patient has no other family and only a few friends in the community. What is the priority nursing diagnosis?

- a. Spiritual distress, related to being angry with God for taking the family
- b. Risk for suicide, related to recent deaths of significant others
- c. Anxiety, related to sudden and abrupt lifestyle changes

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- d. Social isolation, related to loss of existing family

ANS: B

The patient appears to be experiencing normal grief related to the loss of the family; however, because of age and social isolation, the risk for suicide should be determined and has high priority. No defining characteristics exist for the diagnosis of anxiety or spiritual distress. Risk for suicide is a higher priority than social isolation.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Diagnosis | Nursing Process: Analysis

MSC: NCLEX: Psychosocial Integrity

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16. When making a distinction as to whether a patient is experiencing confusion related to depression or dementia, what information would be most important for the nurse to consider?
- The patient with dementia is persistently angry and hostile.
 - Early morning agitation and hyperactivity occur in dementia.
 - Confusion seems to worsen at night when dementia is present.
 - A patient who is depressed is preoccupied with somatic symptoms.

ANS: C

Both dementia and depression in older adults may produce symptoms of confusion. Noting whether the confusion seems to increase at night, which occurs more often with dementia than with depression, will help distinguish whether depression or dementia is producing the confused behavior. The other options are not necessarily true.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

17. An 80-year-old patient has difficulty walking because of arthritis and says, “It’s awful to be old. Every day is a struggle. No one cares about old people.” Which is the nurse’s most therapeutic response?
- “Everyone here cares about old people. That’s why we work here.”
 - “It sounds like you’re having a difficult time. Tell me about it.”
 - “Let’s not focus on the negative. Tell me something good.”
 - “You are still able to get around, and your mind is alert.”

ANS: B

The nurse uses therapeutic communication and empathic understanding to encourage the patient to express frustration and clarify the “struggle” for the nurse. The other options are nontherapeutic and block communication.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation

MSC: NCLEX: Psychosocial Integrity

[abirb.com/test](#)

18. A 74-year-old patient is regressed and apathetic. This patient responds to others only when they initiate the interaction. Which therapy would be most useful to promote resocialization?
- Medication
 - Re-motivation
 - Group psychotherapy
 - Individual psychotherapy

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ANS: B

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Re-motivation therapy is designed to re-socialize patients who are regressed and apathetic by focusing on a single topic, creating a bridge to reality as group members talk about the world in which they live and work, and hobbies related to the topic. Group leaders give group members acceptance and appreciation.

DIF: Cognitive Level: Application (Applying)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
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19. A clinic nurse interviews four patients between 70 and 80 years of age. Which patient should have further assessment regarding the risk of alcohol addiction?
- a. One with a history of intermittent problems of alcohol misuse early in life and who now consumes one glass of wine nightly with dinner.
 - b. One with no history of alcohol-related problems until age 65 years, when the patient began to drink alcohol daily “to keep my mind off my arthritis.”
 - c. One who drank socially throughout adult life and continues this pattern, saying, “I’ve earned the right to do as I please.”
 - d. One who abused alcohol between the ages of 25 and 40 years but now abstains and occasionally attends Alcoholics Anonymous.

ANS: B

Alcohol addiction can develop at any age, and the geriatric population is particularly at risk. The geriatric problem drinker is defined as someone who has no history of alcohol-related problems but develops an alcohol-abuse pattern in response to the stresses of aging. The incorrect responses profile alcohol use that is not problematic.

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DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Assessment

MSC: NCLEX: Psychosocial Integrity

20. A tricyclic antidepressant is prescribed for an older adult patient diagnosed with major depressive disorder. Nursing assessment should include careful collection of information regarding what focus?
- a. Use of other prescribed medications and over-the-counter products
 - b. Evidence of pseudoparkinsonism or tardive dyskinesia
 - c. A history of psoriasis and any other skin disorders
 - d. A current immunization status

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ANS: A

Drug interactions, with both prescription and over-the-counter products, can be problematic for the geriatric patient taking tricyclic antidepressant medications. Careful collection of information is important. The incorrect options do not pose problems with tricyclic antidepressant medications.

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DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Assessment

MSC: NCLEX: Physiological Integrity

21. An older adult with a history of major depressive disorder has taken an antidepressant daily for 3 years. The patient tells the nurse, “I want to stop taking this medication. I don’t think I need it anymore.” What is the nurse’s best response to assure safety the patient’s safety?
- a. “Why do you think you don’t need this medication anymore?”
 - b. “Have you talked with your family members about this decision?”
 - c. “If you stop the medication, your depression will return worse than ever.”

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- d. “This medication should be gradually stopped. Let’s talk to your health care provider about a plan.”

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ANS: D

It is the patient’s right to decide whether to take the medication. Some patients experience discontinuation symptoms if medications in this group are stopped abruptly. A gradual discontinuation is needed. The incorrect options may be reasonable statements but are not directly related to safety.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

22. When admitting older adult patients, health care agencies receiving federal funds must provide written information about what topic?

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- a. Advance health care directives
- b. The financial status of the institution
- c. How to sign out against medical advice
- d. The institution’s policy on the use of restraints

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ANS: A

The Patient Self-Determination Act of 1990 requires that patients have the opportunity to prepare advance directives. None of the distractors are addressed by this Act.

DIF: Cognitive Level: Knowledge (Remembering)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

23. What is the highest priority for assessment by nurses caring for older adults who self-administer medications?

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- a. Use of multiple drugs with anticholinergic effects
- b. Overuse of medications for erectile dysfunction
- c. Misuse of antihypertensive medications
- d. Trading medications with others

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ANS: A

Anticholinergic effects are cumulative in older adults and often have adverse consequences related to accidents and injuries. The incorrect options may be relevant but are not of the highest priority.

DIF: Cognitive Level: Application (Applying)

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

24. A nurse and social worker co-lead a reminiscence group for six “baby boomer” adults. Which activity is appropriate to include in the group?

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- a. Post-World War II music
- b. Learning to send and receive email
- c. Discussing national leadership during the Vietnam War
- d. Identifying the most troubling story in today’s newspaper

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ANS: A

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“The baby boomer generation (individuals born between 1946 and 1964). This group would be familiar with events and circumstances associated with post World War II culture. Reminiscence groups share memories of the past. Sending and receiving email is not an aspect of reminiscence. The other incorrect options are less relevant to this age group.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning
[abirb.com/test](#)

25. A nurse wants to perform a preliminary assessment for suicidal ideation in an older adult patient. Which question would obtain the desired data?
- a. “What thoughts do you have about a person’s right to take his or her own life?”
b. “If you felt suicidal, would you communicate your feelings to anyone?”
c. “Do you have any risk factors that potentially contribute to suicide?”
d. “Do you think you are vulnerable to developing a depressed mood?”

ANS: A

The correct response is clear, direct, respectful, and open-ended. It will produce information relative to the acceptability of suicide as an option to the patient. If the patient deems suicide unacceptable, then no further assessment is necessary. If the patient deems suicide as acceptable, then the nurse can continue to assess the patient’s intent, plan, and means to carry out the plan, as well as the lethality of the chosen method. The incorrect options are less direct.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

26. A nurse and social worker co-lead a reminiscence group for eight adults aged 65 to 70. Which activity is most appropriate to include in the group?
- a. Singing a song from World War II
b. Learning how to join an online social network
c. Discussing national leadership during the Vietnam War
d. Identifying the most troubling story in today’s newspaper

ANS: C

“Young-old” adults are persons 65 to 74 years of age. These adults were attuned to conflicts in national leadership associated with the Vietnam War. Reminiscence groups share memories of the past. Learning how to join a social network would not be an aspect of reminiscence. Singing a song from World War II is more appropriate for an elite old reminiscence group. The other incorrect option is less relevant to this age group.

DIF: Cognitive Level: Analysis (Analyzing)
MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Planning

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MULTIPLE RESPONSE

1. A nurse leads a staff development session about ageism among health care workers. What information should the nurse include about the consequences of ageism? (*Select all that apply.*)
- a. Failure of older adults to receive necessary medical information
b. Development of public policy that favors programs for older adults
c. Staff shortages because caregivers prefer working with younger adults

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- d. Perception that older adults consume a small share of medical resources
- e. More ancillary than professional personnel discriminate with regard to age

ANS: A, C

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Because of society's negative stereotyping of older adults as having little to offer, some staff members avoid working with older patients. Staff shortages in long-term care facilities are often greater than those for acute care settings. Older adult patients often receive less information about their conditions and are offered fewer treatment options than younger patients; some health care staff members perceive them as less able to understand. This problem exists among professional and ancillary personnel. Public policy discriminates against programs for older adults. Societal anger exists because older adults are perceived to consume a disproportionately large share of the medical resources.

DIF: Cognitive Level: Comprehension (Understanding)

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TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

2. Which beliefs facilitate provision of safe, effective care for older adult patients? (*Select all that apply.*)

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- a. Sexual interest declines with aging.
- b. Older adults are able to learn new tasks.
- c. Aging results in a decline in restorative sleep.
- d. Older adults are prone to become crime victims.
- e. Older adults are usually lonely and socially isolated.

ANS: B, C, D

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Myths about aging are common and can negatively impact the quality of care older patients receive. Older individuals are more prone to become crime victims. A decline in restorative sleep occurs as one ages. Learning continues long into life. These factors affect care delivery.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Planning

MSC: NCLEX: Health Promotion and Maintenance

3. A nurse assessing an older adult patient for depression should include questions about mood as well as which other symptoms? (*Select all that apply.*)

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- a. Increased appetite
- b. Sleep pattern changes
- c. Anhedonia and anergia
- d. Increased social isolation
- e. Increased concern with bodily functions

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ANS: B, C, D, E

These symptoms are often noted in older adult patients experiencing depression. Somatic symptoms are often present but are missed by nurses as being related to depression. Anorexia, rather than polyphagia (increased eating), is observed in major depressive disorder. Low self-esteem is more often associated with major depressive disorder.

DIF: Cognitive Level: Application (Applying)

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TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

4. An older patient reports drinking a six-pack of beer daily. The patient tells the community health nurse, "I've been having trouble with my arthritis lately, so I take acetaminophen four times a day for pain." What are the nurse's priority interventions? (*Select all that apply.*)

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- a. Inquiring about sleep disturbances caused by mixing alcohol and analgesic medications
- b. Determining the safety of the daily acetaminophen dose the patient is ingesting
- c. Advising the patient of harmful effects of alcohol and acetaminophen on the liver
- d. Suggesting an increase in the acetaminophen dose because alcohol produces faster excretion
- e. Assessing the patient for declining functional status associated with medication-induced dementia

ANS: B, C

The nurse should be concerned with the patient's use of alcohol and acetaminophen because the toxicity of acetaminophen is enhanced by alcohol and by the age-related decrease in clearance. The nurse must determine whether the acetaminophen dose is within safe limits or is excessive and provide this information to the patient. Next, the nurse must provide health education regarding the danger of combined use of acetaminophen and alcohol. The patient will need to discontinue or reduce alcohol intake. Another analgesic with less hepatotoxicity could be used. Additional acetaminophen would cause greater liver damage. The scenario does not suggest dementia.

DIF: Cognitive Level: Analysis (Analyzing)

TOP: Nursing Process: Planning

MSC: NCLEX: Physiological Integrity

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5. A nurse caring for an older adult patient population should be familiar with which legal and ethical issues that are common concerns for this group? (*Select all that apply.*)

- a. Physical abuse
- b. Autonomous decision making
- c. Emotional abuse
- d. Financial abuse
- e. Need for medication therapy

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ANS: A, C

Among the most important of many legal and ethical issues for practicing nurses to be familiar with are the following: decision making about health care and the various forms of elder abuse. Medication therapy does not appear as a common source of concern for this age group.

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DIF: Cognitive Level: Comprehension (Understanding)

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

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