1 A client is fearful of driving and enters a behavioral therapy program aimed at helping him overcome his anxiety. Using systematic desensitization, he is able to drive down a familiar street without experiencing a panic attack. The nurse recognizes that to continue positive results, the client must participate in which of the following?

- ☐ Biofeedback
- ☑ Frequent practice
- ☐ Positive reinforcement
- ☐ Therapist modeling

2 When assessing the appropriateness of physical restraint for use with a client, a nurse must be aware of which of the following?

- ☐ Restraints may be used for client safety when staffing is inadequate.
- ☐ Judicious use of restraints can enhance client care.
- ☑ The least restrictive means of restraint should be chosen.
- ☐ Restraints decrease the incidence of falls and injuries.

3 A nurse is working with clients in an acute care mental health facility. When planning client care, the nurse should recognize that which of the following are correct uses of seclusion and/or restraint? (Select all that apply.)

- ☐ Chemical restraints should be the first choice of treatment for a client who is out of control.
- ☐ Seclusion and/or restraint should be implemented to maintain therapeutic milieu.
- ☑ In an emergency, the charge nurse may place a client in seclusion and/or restraint.
- ☑ A client may request to be placed in seclusion.
- ☐ Seclusion and/or restraint may be used as a behavior modification technique.

4 A client has a history of using crack cocaine. The nurse should monitor for which of

the following potential signs of drug withdrawal?

- Client is drowsy most of the time.
- Client speaks rapidly and talks constantly.
- Client has tremors of the hands and eyelids.
- Client mistakes the ceiling tiles for a jail cell.

5 A priority intervention to strengthen coping skills and to foster peer interaction for clients with borderline personality disorder is to

- set firm limits.
- promote change.
- remain friendly.
- teach journaling.

6 Which of the following statements by a client who has been abused indicates understanding of the need for a safety plan?

- "I should hide extra money, car keys, clothes, and copies of important documents inside my house."
- "I will feel safe as soon as I have a protective order in place."
- "I will let my neighbor know when I'm in trouble."
- "I need to identify a particular sign that tells me and my kids that it is time to leave."

7 A nurse is caring for a client who is taking risperidone (Risperdal). The nurse should recognize that an increase in which of the following indicates a potential adverse reaction to the medication?

- Blood glucose
- White blood cell count
- Platelet count
- Serum potassium

8 A client presents to the emergency department following ingestion of an unknown quantity of alcohol and lorazepam (Ativan). In planning care for this client, which of the following requires immediate nursing action?

- ☐ Blood pressure 78/56 mm Hg
- ☉ Respiratory rate 8/min
- ☐ Temperature 38.6°C (101.4°F)
- ☐ Pulse 102/min

9 A client diagnosed with antisocial personality disorder begs a nurse to not report a missed curfew hour. The nurse should recognize this behavior as which of the following?

- ☐ A grandiose sense of self-importance
- ☉ An attempt to avoid consequences
- ☐ An effort to get the nurse in trouble
- ☐ A desire to gain sympathy

10 When a nurse is communicating with a client in the manic phase of bipolar disorder, she should help the client evaluate reality by

- ☐ encouraging details of client ideas and statements.
- ☉ remaining neutral and avoiding power struggles.
- ☐ giving in-depth explanations of nursing expectations.
- ☐ allowing the client to set self-limits of behavior.

11 A nurse working on a medical-surgical unit is receiving several new admissions from the emergency department. Which of the following clients should receive priority if only one private room is available?

- ☐ A client experiencing a panic attack and pacing the floor
- ☐ A client who is depressed and who is tearful and sobbing in her pillow
- ☉ A client who is angry and experiencing command hallucinations

- ☐ A client who is bipolar and is in a hypomanic state

12 A nurse is caring for a client with delirium. Which of the following assessment findings requires immediate intervention by the nurse?

- ☉ Decreased level of consciousness
- ☐ Increased confusion at night
- ☐ Sluggish motor activity
- ☐ Inappropriate speech patterns

13 A nurse is performing an assessment on a client who has expressed suicidal intent due to the recent death of her daughter. The client is distraught and confused. Which of the following nursing interventions takes priority?

- ☐ Arrange for one-to-one observation.
- ☉ Instruct the client to take slow, deep breaths.
- ☐ Ask the client to sign a no-suicide contract.
- ☐ Offer opportunity to talk with a spiritual advisor.

14 A nurse is about to interview an adolescent client who has been involved in sexually risky behavior to support her drug habit. For interaction between the client and the nurse to be therapeutic, the nurse must

- ☉ have self-awareness of potential preconceived ideas.
- ☐ convey a message of hope for the future to the client.
- ☐ ask what is happening to make the client act in such a manner.
- ☐ set firm ground rules for each counseling session.

15 During an examination in the emergency department, a nurse notes multiple bruises

on the shoulders and back of an older adult client. Which of the following should be the nurse's priority action?

- ☐ Notify the primary care provider.
- ☑ Ask the client how he sustained the injuries.
- ☐ Arrange for case management referral.
- ☐ Inquire about the client's living arrangements.

16 A nurse should make the assessment that an adult client is experiencing acute mania if the client

- ☐ displays a decreased attention span.
- ☐ retreats to her room to avoid contact with others.
- ☐ writes flowery and lengthy letters to famous people.
- ☑ exhibits disorganization and chaos.

17 A nurse is assessing a client at her 12-week prenatal visit. The client has a history of prior drug abuse. The nurse recognizes that the client should be assessed for a potential relapse when which of the following assessment findings are found?

- ☐ Heightened anxiety
- ☑ Unexplained pain
- ☐ Increased fatigue
- ☐ Lack of empathy

18 Upon admission, a client was combative and uncooperative. His treatment plan includes the use of seclusion. The client is currently cooperative and participating in unit activities. Which of the following should the nurse do with the original treatment plan?

- ☐ Update the treatment plan with the next behavior change.
- ☑ Leave the treatment plan as written to include seclusion.
- ☐ Remove seclusion from the treatment plan.
- ☐ Consult with the treatment team regarding seclusion.

19 A nurse is updating the treatment plan for a client with schizophrenia. Which of the following information is most useful when planning for discharge?

- ☐ Legal history
- ☐ Activity level
- ☒ Housing adequacy
- ☐ Cultural beliefs

20 A nurse is providing teaching to the family of a client who is dependent on alcohol. The family is learning how to recognize and decrease codependent behaviors. Which of the following statements indicates that the family needs further teaching?

- ☐ "We will attend family events that have already been scheduled."
- ☐ "We will hold him responsible for any continued use of substances."
- ☒ "We will routinely search for and remove any alcohol in his home."
- ☐ "We will not let our moods be changed by his behavior."

21 A client approaches the nurses' station and states, "I need to sleep in the dayroom tonight; my roommate is snoring and I'll never get to sleep." Which of the following responses by the nurse is appropriate?

- ☐ "It's against hospital policy to allow patients to sleep in the dayroom."
- ☐ "The doctor prescribed a sleeping pill for you. How about trying that?"
- ☒ "Let me review the bed assignment and see if there is another room available."
- ☐ "What strategies have you tried to help you fall asleep?"

22 A nurse is performing a mental status exam on a client with schizophrenia. Which of the following findings should the nurse recognize as an indication of an alteration in thought process?

- ☒ Delusions

- [ ] Hallucinations
- [ ] Rapid rate of speech
- [ ] Robot-like repetitive actions

23 A nurse is providing teaching to the family of a client with schizophrenia. Which of the following statements by a family member indicates a need for further teaching?

- [x] "We will pretend to see the hallucinations in order to keep her calm."
- [ ] "We will contact the provider if she experiences command hallucinations."
- [ ] "She may be more thirsty due to her medications."
- [ ] "She may be having a relapse if she stops attending social events."

24 A woman who has been repeatedly abused by her partner presents to the emergency department for treatment of severe contusions. As her injuries are being treated, she tells the nurse, "He almost killed me this time. I guess I'm going to have to do something." Which of the following should the nurse include in the treatment plan? (Select all that apply.)

- [x] Help the client devise a safety plan.
- [x] Report the abuse to mandated authorities.
- [x] Provide emergency telephone numbers.
- [x] Encourage the client to join a support group.
- [ ] Tell the client to talk to her domestic partner.

25 A nurse is assessing a client who is experiencing a severe level of anxiety. Which of the following is the appropriate nursing intervention?

- [x] Reinforce reality to decrease distortions.
- [ ] Ask the client clarifying questions.
- [ ] Encourage the client to problem solve.
- [ ] Demonstrate interest in the client's activities.

26 A client has been prescribed bupropion (Wellbutrin). A nurse should question administration of this medication to a client with a history of

- diabetes mellitus.
- ulcerative colitis.
- hypertension.
- seizures.

27 A client who is anorexic is participating in family therapy with her parents. The mother tells the client, "You look great." The client interprets this comment to mean she looks fat. This response indicates that which of the following is present?

- Difficulty being assertive
- Depression and abuse history
- Lack of personal identity
- Low self-esteem and self-doubt

28 A client is brought to the community mental health center by her family, who is concerned that she is not adjusting to the recent death of her spouse. Which of the following activities indicates dysfunctional grief?

- Rejection of repeated requests by the family to participate in grief counseling
- Expression of periods of intense emotion during significant times, such as holidays and anniversaries
- Turning down repeatedly of invitations to dinner by a recently widowed friend of the family
- Setting a place for the deceased at the dinner table each evening

29 A nurse is assessing a client who recently lost his wife and children in a house fire. Which of the following client statements indicates that the client understands adequate support systems when he is feeling overwhelmed?

- "I can call my sister in another state to come visit me."

- ☐ "I like to go to the local coffee shop to find people to talk to."
- ☑ "I have the number of my local mental health facility."
- ☐ "I know I can increase my antianxiety medication when needed."

30 A nurse plans the care for a client who is addicted to cocaine but who is also taking the prescription medication phenelzine (Nardil) for severe depression. The nurse understands that careful monitoring of which of the following potential side effects will be needed?

- ☐ Serotonin syndrome
- ☐ Cardiac toxicity
- ☑ Hypertensive crisis
- ☐ Urinary retention

31 A nurse is caring for a client with a recent loss. Which of the following is the most appropriate initial nursing intervention?

- ☐ Ask the client if his spiritual advisor is needed.
- ☐ Administer the Life-Changing Events Questionnaire.
- ☑ Sit silently with the client as he expresses his feelings.
- ☐ Refer the client for an antidepressant prescription.

32 A mental health nurse works with clients to help them realize that they are not alone in their situations. Which of the following types of treatment should the nurse recognize will help the clients achieve this goal?

- ☐ Individual counseling
- ☐ Family therapy
- ☑ Group therapy
- ☐ Behavior modification

33 When working with a client diagnosed with obsessive-compulsive disorder, which of

the following should the nurse anticipate being included in the client's plan of care?

- ☐ Validation therapy
- ☐ Reality orientation therapy
- ☐ Aversion therapy
- ☉ Behavioral therapy

34 A client with acute mania begins to taunt other clients in the dayroom. He becomes very intrusive. The nurse should intervene by

- ☐ ignoring the behavior so as not to increase attention to the client.
- ☐ telling the client to stop, or he will have to go to the quiet room.
- ☐ administering an as-needed dose of lorazepam (Ativan) to the client.
- ☉ redirecting the client to a solitary activity with an aide.

35 A nurse is interviewing a new client in a mental health facility. Which of the following must occur if a therapeutic nurse-client relationship is to be established?

- ☐ The nurse is seen as a friend.
- ☉ Confidentiality is maintained unless client safety is compromised.
- ☐ The nurse is seen as an authority figure.
- ☐ A written contract is established to clarify the steps of the treatment plan.

36 A nurse is caring for a client who has recently lost his job and is depressed. Which of the following should the nurse ask to assess the client's personal coping skills?

- ☐ "Can you describe how you are currently feeling?"
- ☐ "Who is available to help you in difficult times?"
- ☉ "How have you dealt with similar situations in the past?"
- ☐ "Do you see your current situation affecting your future?"

37 A client who is developmentally disabled is in a group home facility. He has been stealing personal belongings from other residents of the facility. Which of the following nursing interventions is appropriate?

- Positive reinforcement to increase desired behavior
- Crisis intervention to decrease anxiety
- Aversion therapy to provide distraction
- Systematic desensitization to extinguish the behavior

38 A client diagnosed with bipolar disorder is started on lithium. He calls the clinic a week later and reports that he is experiencing a fine hand tremor and mild thirst. The nurse should anticipate giving the client which of the following instructions?

- Continue the medication, as these symptoms are expected.
- Stop the medication and go to the closest emergency department.
- Skip today's medication and resume taking the lithium tomorrow.
- Discontinue the medication and come in for a serum lithium level to be drawn.

39 A nurse should recognize that which of the following tasks is accomplished during the working phase of a therapeutic relationship?

- Achieve predetermined goals.
- Establish boundaries between the nurse and the client.
- Inform the client of rights regarding confidentiality.
- Set short- and long-term objectives for the future.

40 A nurse is caring for a child with a diagnosis of terminal brain cancer. The mother states, "I feel numb and can't believe this is happening to us." Which of the following interventions is the first priority?

- Explore effective ways of family coping.

- [x] Encourage the family's expression of feelings.
- [ ] Discuss the disease and its symptoms with family members.
- [ ] Instruct the family about anticipatory grieving.

41 A 14-year-old client who is pregnant asks the nurse if she should keep her infant or give it up for adoption. Which of the following responses by the nurse is therapeutic?

- [ ] "How would you feel if you decided to give the baby up for adoption?"
- [ ] "Do you think that keeping the baby is in the baby's best interest?"
- [x] "How do you feel about making this decision?"
- [ ] "Do you think you should discuss this with your parents?"

42 A nurse is assisting a family of a client with Alzheimer's disease who is being discharged home. Which of the following should the nurse include in the teaching?

- [ ] Use of restraints for client safety
- [ ] Limitation of daytime physical activity
- [ ] Special dietary needs required for this condition
- [x] Communication techniques to prevent escalating anger

43 A nurse should recognize that a client with a mental health disorder who is from a non-Western culture is most likely to be misdiagnosed due to which of the following?

- [x] Improper use of assessment tools
- [ ] Lack of English proficiency
- [ ] Presence of genetic variances
- [ ] Socioeconomic status

44 A nurse is caring for a client with a personality disorder who uses guilt as a way to gain staff attention. Which of the following actions should the nurse take?

- ☐ Assess the client for perceptual distortions.
- ☐ Challenge the client's irrational thoughts.
- ☐ Use verbal techniques of de-escalation.
- ☑ Remain neutral toward the client's comments.

45 A client was admitted to a psychiatric unit 1 week ago for treatment and observation following an intentional overdose. Today, the client appears cheerful and motivated. The nurse should suspect that the client

- ☐ is getting more sleep due to medication.
- ☐ has made friends in a support group.
- ☑ has finalized a suicide plan.
- ☐ is responding to treatment and is less depressed.

46 A hospice nurse has been caring for a client from the Middle East. The client dies in his home and his mother immediately begins screaming, crying, and appears to be out of control. The nurse should inform the client's concerned spouse, who is American, that her mother-in-law's reaction is an

- ☐ unacceptable outlet of grief, which requires intervention as soon as possible.
- ☐ example of disenfranchised grief, which should be tolerated by the spouse.
- ☐ unhealthy preoccupation with the dead loved one, which will lessen in time.
- ☑ appropriate expression of mourning, which should be accepted by the rest of the family.

47 An older-adult client presents to a mental health clinic. He is tearful and reports sleep disturbances. He states, "All of my friends have died, and my children are too busy for me." Which of the following is the priority action by the nurse?

- ☐ Contact the client's family for support.
- ☑ Administer the Geriatric Depression Scale.
- ☐ Refer the client to his provider for an antidepressant medication.
- ☐ Encourage the client to join a senior support group.

48 A nurse is leading a medication education group. A client is interruptive, seldom allowing the other group members to participate. Which of the following nursing actions is appropriate?

- Help the group to voice concerns about the monopolizing behavior.
- Reprimand the client for the disruptive behavior.
- Continue teaching without responding to the client's comments.
- Change the subject to a less controversial topic.

49 A client with schizophrenia displays severe negative symptoms of the disorder. Which of the following nursing interventions supports the therapeutic treatment plan for these symptoms?

- Direct the client to perform her own daily hygiene and grooming tasks.
- Assist the client to recognize somatic and thought-broadcasting delusions.
- Manage the client's loud rambling and incoherent communication patterns.
- Use medication to decrease frequency of auditory and visual hallucinations.

50 A nurse is assessing a client whom she believes is a victim of physical abuse by her partner. Which of the following places the client at greatest risk?

- Pregnancy
- High-school education
- 25 years of age
- Eligibility for financial assistance

51 To assist a client in initially managing stress, which of the following is most appropriate for a nurse to recommend?

- Request an anxiolytic from the provider.
- Encourage elimination of caffeine.
- Keep a journal of stressful experiences.

- Attend a stress-management workshop.

52 A nurse is caring for a client who attempted suicide and is newly admitted to an acute care mental health facility. The client now denies suicidal ideation or a suicide plan. She appears calm and optimistic. Which of the following nursing interventions is appropriate at this time?

- Discuss future plans with the client.
- Place the client on one-to-one observation.
- Ask the client to sign a no-suicide contract.
- Chart a positive response to antidepressant medication.

53 A client with major depressive disorder is being treated with individual and family therapy. Which of the following factors within the client's family should the nurse identify as interfering with the client's recovery?

- Triangulation is present among the family members.
- Positive and negative feelings are shared among the family members.
- Boundaries are understood by the parents and child in this family.
- The client verbalizes a high level of differentiation between family members.

54 A client who is withdrawing from alcohol has tremors, increased vital signs, and is diaphoretic. Which of the following medications should the nurse administer to manage withdrawal symptoms?

- Bupropion (Zyban)
- Naltrexone (Revia)
- Disulfiram (Antabuse)
- Chlordiazepoxide (Librium)

55 After assessing a client in a crisis situation, a nurse determines that the client is safe. Which of the following is now the highest priority for this client?

- ☐ Involve the client in planning interventions.
- ☐ Find out about the client's social supports.
- ☐ Teach the client specific coping skills to handle stressful situations.
- ☑ Assist the client to lower his anxiety level.

56 A client with paranoid schizophrenia comes to the nursing station and tells the nurse that he is hearing voices. Which of the following is the appropriate nursing response?

- ☐ "That must be very frightening for you."
- ☐ "Do you recognize the voices?"
- ☑ "What are the voices saying to you?"
- ☐ "I don't hear the voices."

57 A nurse assesses a client and determines that family therapy would be helpful. Which of the following statements by the nurse is therapeutic?

- ☐ "Family counseling helped my family."
- ☐ "Let me sign you up for family therapy."
- ☑ "Sometimes family therapy can bring about change."
- ☐ "Do you think a family counselor would help?"

58 A rape/trauma nurse is caring for a woman in the emergency department. The client states that she was beaten and sexually assaulted by a male friend. After a rapid assessment, which of the following actions should the nurse plan to take next?

- ☐ Conduct a pregnancy test.
- ☐ Request a mental health consult for the client.
- ☑ Provide a trained advocate to stay with the client.
- ☐ Offer prophylactic medication to prevent STDs.

59 A nurse is teaching a family member appropriate measures to reduce anxiety for a client who frequently experiences panic attacks. Which of the following statements by the family member indicates that teaching regarding environmental stimuli during panic attacks has been understood?

- ☐ "I will play soothing music for him while we talk."
- ☉ "I will stay alone with him in a quiet room."
- ☐ "I will distract him by turning on the television."
- ☐ "I will get his attention by speaking in a loud voice."

60 A home health nurse is assessing the emotional reaction of a client whose spouse died 3 months ago. Which of the following assessment findings indicates that the client is experiencing pathologic intensification of the grief process?

- ☐ The client frequently recalls negative experiences that occurred during her marriage.
- ☉ The client states she no longer leaves her home except to go to work.
- ☐ The client relates that she has bad dreams several times a week.
- ☐ The client says she has difficulty concentrating on her daily activities.

61 A nurse's initial step in assisting a client who is in a crisis is to assess the client's

- ☐ situational supports.
- ☐ coping mechanisms.
- ☐ spiritual beliefs.
- ☉ perception of the problem.

62 A 13-year-old client, who is diagnosed with post-traumatic stress disorder, is admitted to a psychiatric unit. He is experiencing bedwetting. Which of the following is the most appropriate intervention by the nurse?

- ☐ Accept the behavior.
- ☐ Place the client in a private room.
- ☐ Alert the physician to order medication.

- [x] Arrange the client's bed so that it is near the bathroom.

63 A client who has just been physically assaulted states, "I don't remember what happened to me." The nurse should analyze this behavior as being indicative of which of the following defense mechanisms?

- [ ] Denial
- [x] Dissociation
- [ ] Rationalization
- [ ] Displacement

64 A client has begun pacing the dayroom, clenching and unclenching her fists, yelling obscenities, and verbally threatening other clients. Which of the following actions should the nurse take first?

- [ ] Administer medication as needed.
- [ ] Escort the client to a secluded area.
- [x] Call extra personnel for assistance.
- [ ] Place the client in restraints.

65 A client who is receiving treatment for a mood disorder tells the nurse that she is going to apply for a job at the hospital. Which of the following responses by the nurse creates a potential barrier to further therapeutic communication in this situation?

- [ ] "What influenced you to make this decision?"
- [x] "I agree completely with your decision."
- [ ] "Tell me what interests you about working at the hospital."
- [ ] "You seem very comfortable with your decision."