Psychiatric-Mental Health Nursing 8th edition by Videbeck Test Bank

Chapter 1

1. The nurse is assessing the factors contributing to the well-being of a newly admitted client. Which of the following would the nurse identify as having a positive impact on the individual's mental health?
   A) Not needing others for companionship
   B) The ability to effectively manage stress
   C) A family history of mental illness
   D) Striving for total self-reliance
   Ans: B
   Feedback:
   Individual factors influencing mental health include biologic makeup, autonomy, independence, self-esteem, capacity for growth, vitality, ability to find meaning in life, emotional resilience or hardiness, sense of belonging, reality orientation, and coping or stress management abilities. Interpersonal factors such as intimacy and a balance of separateness and connectedness are both needed for good mental health, and therefore a healthy person would need others for companionship. A family history of mental illness could relate to the biologic makeup of an individual, which may have a negative impact on an individual's mental health, as well as a negative impact on an individual's interpersonal and socialñcultural factors of health. Total self-reliance is not possible, and a positive social/cultural factor is access to adequate resources.

2. Which of the following statements about mental illness are true? Select all that apply.
   A) Mental illness can cause significant distress, impaired functioning, or both.
   B) Mental illness is only due to social/cultural factors.
   C) Social/cultural factors that relate to mental illness include excessive dependency on or withdrawal from relationships.
   D) Individuals suffering from mental illness are usually able to cope effectively with daily life.
   E) Individuals suffering from mental illness may experience dissatisfaction with relationships and self.
   Ans: A, D, E
   Feedback:
   Mental illness can cause significant distress, impaired functioning, or both. Mental illness may be related to individual, interpersonal, or social/cultural factors. Excessive dependency on or withdrawal from relationships are interpersonal factors that relate to mental illness. Individuals suffering from mental illness can feel overwhelmed with daily life. Individuals suffering from mental illness may experience dissatisfaction with relationships and self.

3. Which of the following are true regarding mental health and mental illness?
   A) Behavior that may be viewed as acceptable in one culture is always unacceptable in other cultures.
   B) It is easy to determine if a person is mentally healthy or mentally ill.
   C) In most cases, mental health is a state of emotional, psychological, and social wellness evidenced by satisfying interpersonal relationships, effective behavior and coping, positive self-concept, and emotional stability.
   D) Persons who engage in fantasies are mentally ill.
   Ans: C
   Feedback:
   What one society may view as acceptable and appropriate behavior, another society may see that as maladaptive, and inappropriate. Mental health and mental illness are difficult to define precisely. In most cases, mental health is a state of emotional, psychological, and social wellness evidenced by satisfying interpersonal relationships, effective behavior and coping, positive self-concept, and emotional stability. Persons who engage in fantasies may be mentally healthy, but the inability to distinguish reality from fantasy is an individual factor that may contribute to mental illness.

4. A client grieving the recent loss of her husband asks if she is becoming mentally ill because she is so sad. The nurse's best response would be,
   A) ìYou may have a temporary mental illness because you are experiencing so much pain.î
   B) ìYou are not mentally ill. This is an expected reaction to the loss you have experienced.î
   C) ìWere you generally dissatisfied with your relationship before your husband's death?î
   D) ìTry not to worry about that right now. You never know what the future brings.î
   Ans: B
   Feedback:
   Mental illness includes general dissatisfaction with self, ineffective relationships, ineffective coping, and lack of personal growth. Additionally the behavior must not be culturally expected. Acute grief reactions are expected and therefore not considered mental illness. False reassurance or overanalysis does not accurately address the client's concerns.

5. The nurse consults the DSM for which of the following purposes?
   A) To devise a plan of care for a newly admitted client
   B) To predict the client's prognosis of treatment outcomes
   C) To document the appropriate diagnostic code in the client's medical record
   D) To serve as a guide for client assessment
   Ans: D
   Feedback:
   The DSM provides standard nomenclature, presents defining characteristics, and identifies underlying causes of mental disorders. It does not provide care plans or prognostic outcomes of treatment. Diagnosis of mental illness is not within the generalist RN's scope of practice, so documenting the code in the medical record would be inappropriate.

6. Which would be a reason for a student nurse to use the DSM?
   A) Identifying the medical diagnosis
   B) Treat clients
   C) Evaluate treatments
   D) Understand the reason for the admission and the nature of psychiatric illnesses.
   Ans: D
   Feedback:
   Although student nurses do not use the DSM to diagnose clients, they will find it a helpful resource to understand the reason for the admission and to begin building knowledge about the nature of psychiatric illnesses. Identifying the medical diagnosis, treating, and evaluating treatments are not a part of the nursing process.

7. The legislation enacted in 1963 was largely responsible for which of the following shifts in care for the mentally ill?
   A) The widespread use of community-based services
   B) The advancement in pharmacotherapies
   C) Increased access to hospitalization
   D) Improved rights for clients in long-term institutional care
   Ans: A
   Feedback:
   The Community Mental Health Centers Construction Act of 1963 accomplished the release of individuals from long-term stays in state institutions, the decrease in admissions to hospitals, and the development of community-based services as an alternative to hospital care.

8. Which one of the following is a result of federal legislation?
   A) Making it easier to commit people for mental health treatment against their will.
   B) Making it more difficult to commit people for mental health treatment against their will.
   C) State mental institutions being the primary source of care for mentally ill persons.
   D) Improved care for mentally ill persons.
   Ans: B
   Feedback:
   Commitment laws changed in the early 1970s, making it more difficult to commit people for mental health treatment against their will. Deinstitutionalization accomplished the release of individuals from long-term stays in state institutions. Deinstitutionalization also had negative effects in that some mentally ill persons are subjected to the revolving door effect, which may limit care for mentally ill persons.

9. The goal of the 1963 Community Mental Health Centers Act was to
   A) ensure patients' rights for the mentally ill.
   B) deinstitutionalize state hospitals.
   C) provide funds to build hospitals with psychiatric units.
   D) treat people with mental illness in a humane fashion.
   Ans: B
   Feedback:
   The 1963 Community Mental Health Centers Act intimated the movement toward treating those with mental illness in a less restrictive environment. This legislation resulted in the shift of clients with mental illness from large state institutions to care based in the community. Answer choices A, C, and D were not purposes of the 1963 Community Mental Health Centers Act.

10. The creation of asylums during the 1800s was meant to
    A) improve treatment of mental disorders.
    B) provide food and shelter for the mentally ill.
    C) punish people with mental illness who were believed to be possessed.
    D) remove dangerous people with mental illness from the community.
    Ans: B
    Feedback:
    The asylum was meant to be a safe haven with food, shelter, and humane treatment for the mentally ill. Asylums were not used to improve treatment of mental disorders or to punish mentally ill people who were believed to be possessed. The asylum was not created to remove the dangerously mentally ill from the community.

11. The major problems with large state institutions are: Select all that apply.
    A) attendants were accused of abusing the residents.
    B) stigma associated with residence in an insane asylum.
    C) clients were geographically isolated from family and community.
    D) increasing financial costs to individual residents.
    Ans: A, C
    Feedback:
    Clients were often far removed from the local community, family, and friends because state institutions were usually in rural or remote settings. Choices B and D were not major problems associated with large state instructions.

12. A significant change in the treatment of people with mental illness occurred in the 1950s when
    A) community support services were established.
    B) legislation dramatically changed civil commitment procedures.
    C) the Patient's Bill of Rights was enacted.
    D) psychotropic drugs became available for use.
    Ans: D
    Feedback:
    The development of psychotropic drugs, or drugs used to treat mental illness, began in the 1950s. Answer choices A, B, and C did not occur in the 1950s.

13. Before the period of the enlightenment, treatment of the mentally ill included
    A) creating large institutions to provide custodial care.
    B) focusing on religious education to improve their souls.
    C) placing the mentally ill on display for the public's amusement.
    D) providing a safe refuge or haven offering protection.
    Ans: C
    Feedback:
    In 1775, visitors at St. Mary's of Bethlehem were charged a fee for viewing and ridiculing the mentally ill, who were seen as animals, less than human. Custodial care was not often provided as persons who were considered harmless were allowed to wander in the countryside or live in rural communities, and more dangerous lunatics were imprisoned, chained, and starved. In early Christian times, primitive beliefs and superstitions were strong. The mentally ill were viewed as evil or possessed. Priests performed exorcisms to rid evil spirits, and in the colonies, witch hunts were conducted with offenders burned at the stake. It was not until the period of enlightenment when persons who were mentally ill were offered asylum as a safe refuge or haven offering protection at institutions.

14. The first training of nurses to work with persons with mental illness was in 1882 in which state?
    A) California
    B) Illinois
    C) Massachusetts
    D) New York
    Ans: C
    Feedback:
    The first training for nurses to work with persons with mental illness was in 1882 at McLean Hospital in Belmont, Massachusetts.

15. What is meant by the term ìrevolving door effectî in mental health care?
    A) An overall reduction in incidence of severe mental illness
    B) Shorter and more frequent hospital stays for persons with severe and persistent mental illness
    C) Flexible treatment settings for mentally ill
    D) Most effective and least expensive treatment settings
    Ans: B
    Feedback:
    The revolving door effect refers to shorter, but more frequent, hospital stays. Clients are quickly discharged into the community where services are not adequate; without adequate community services, clients become acutely ill and require rehospitalization. The revolving door effect does not refer to flexible treatment settings for mentally ill. Even though hospitalization is more expensive than outpatient treatment, if utilized appropriately could result in stabilization and less need for emergency department visits and/or rehospitalization. The revolving door effect does not relate to the incidence of severe mental illness.

16. Which of the following statements is true of treatment of people with mental illness in the United States today?
    A) Substance abuse is effectively treated with brief hospitalization.
    B) Financial resources are reallocated from state hospitals to community programs and support.
    C) Only 25% of people needing mental health services are receiving those services.
    D) Emergency department visits by persons who are acutely disturbed are declining.
    Ans: C
    Feedback:
    Only one in four (25%) adults needing mental health care receives the needed services. Substance abuse issues cannot be dealt with in the 3 to 5 days typical for admissions in the current managed care environment. Money saved by states when state hospitals were closed has not been transferred to community programs and support. Although people with severe and persistent mental illness have shorter hospital stays, they are admitted to hospitals more frequently. In some cities, emergency department visits for acutely disturbed persons have increased by 400% to 500%.

17. Which of the following is the priority of the Healthy People 2020 objectives for mental health?
    A) Improved inpatient care
    B) Primary prevention of emotional problems
    C) Stress reduction and management
    D) Treatment of mental illness
    Ans: D
    Feedback:
    The objectives are to increase the number of people who are identified, diagnosed, treated, and helped to live healthier lives. The objectives also strive to decrease rates of suicide and homelessness, to increase employment among those with serious mental illness, and to provide more services both for juveniles and for adults who are incarcerated and have mental health problems. Answer choices A, B, and C are not priorities of Healthy People 2020.

18. Which is a positive aspect of treating clients with mental illness in a community-based care?
    A) ìYou will not be allowed to go out with your friends while in the program.î
    B) ìYou will have to have supervision when you want to go anywhere else in the community.î
    C) ìYou will be able to live in your own home while you still see a therapist regularly.î
    D) ìYou will have someone in your home at all times to ask questions if you have any concerns.î
    Ans: C
    Feedback:
    Clients can remain in their communities, maintain contact with family and friends, and enjoy personal freedom that is not possible in an institution. Full-time home care is not included in community-based programs.

19. One of the unforeseen effects of the movement toward community mental health services is
    A) fewer clients suffering from persistent mental illnesses.
    B) an increased number of hospital beds available for clients seeking treatment.
    C) an increased number of admissions to available hospital services.
    D) Longer hospital stays for people needing mental health services.
    Ans: C
    Feedback:
    Although people with severe and persistent mental illness have shorter hospital stays, they are admitted to hospitals more frequently. Although deinstitutionalization reduced the number of public hospital beds by 80%, the number of admissions to those beds correspondingly increased by 90%. The number of individuals with mental illness did not change.

20. Which is included in Healthy People 2020 objectives?
    A) To decrease the incidence of mental illness
    B) To increase the number of people who are identified, diagnosed, treated, and helped to live healthier lives
    C) To provide mental health services only in the community
    D) To decrease the numbers of people who are being treated for mental illness
    Ans: B
    Feedback:
    One of the Healthy People 2020 objectives is to increase the number of people who are identified, diagnosed, treated, and helped to live healthier lives. It may not be possible to decrease the incidence of mental illness. At this time, the focus is on ensuring that persons with mental illness are receiving needed treatment. It may not be possible or desirable to provide mental health services only in the community.

21. A client diagnosed with a mild anxiety disorder has been referred to treatment in a community mental health center. Treatment most likely provided at the center includes
    A) medical management of symptoms.
    B) daily psychotherapy.
    C) constant staff supervision.
    D) psychological stabilization.
    Ans: A
    Feedback:
    Community mental health centers focus on rehabilitation, vocational needs, education, and socialization, as well as on management of symptoms and medication. Daily therapies, constant supervision, and stabilization require a more acute care inpatient setting.

22. Which of the following is defined as an advanced-level function in the practice area of psychiatric mental health nursing?
    A) Case management
    B) Counseling
    C) Evaluation
    D) Health teaching
    Ans: C
    Feedback:
    Advanced-level functions are psychotherapy, prescriptive authority, consultation and liaison, evaluation, and program development and management. Case management, counseling, and health teaching are basic-level functions in the practice area of psychiatric mental health nursing.

23. Psychiatric nursing became a requirement in nursing education in which year?
    A) 1930
    B) 1940
    C) 1950
    D) 1960
    Ans: C
    Feedback:
    It was not until 1950 that the National League for Nursing, which accredits nursing programs, required schools to include an experience in psychiatric nursing.

24. A new graduate nurse has accepted a staff position at an inpatient mental health facility. The graduate nurse can expect to be responsible for basic-level functions, including
    A) providing clinical supervision.
    B) using effective communication skills.
    C) adjusting client medications.
    D) directing program development.
    Ans: B
    Feedback:
    Basic-level functions include counseling, milieu therapy, self-care activities, psychobiologic interventions, health teaching, case management, and health promotion and maintenance. Advanced-level functions include psychotherapy, prescriptive authority for drugs, consultation and liaison, evaluation, program development and management, and clinical supervision.

25. Which one of the following is one of the American Nurses Association standards of practice for psychiatricñmental health nursing?
    A) Prescriptive authority is granted to psychiatricñmental health registered nurses.
    B) All aspects of Standard 5: Implementation may be carried out by psychiatricñmental health registered nurses.
    C) Some aspects of Standard 5: Implementation may only be carried out by psychiatricñmental health advanced practice nurses.
    D) Psychiatricñmental health advanced practice nurses are the only ones who may provide milieu therapy.
    Ans: C
    Feedback:
    Prescriptive authority is used by psychiatricñmental health *advanced practice* registered nurses in accordance with state and federal laws and regulations. Standards $5_{D\tilde{n}G}$ are advanced practice interventions and may be performed only by the psychiatricñmental health advanced practice registered nurse. Psychiatricñmental health registered nurses may provide milieu therapy according to Standard 5_C. This is not restricted to psychiatricñmental health advanced practice nurses.

26. Which of the following is a standard of professional performance?
    A) Assessment
    B) Education
    C) Planning
    D) Implementation
    Ans: B
    Feedback:
    Education is a standard of professional performance. Other standards of professional performance include the quality of practice, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership. Assessment, planning, and implementation are components of the nursing process, not standards of professional performance.

27. Which of the following is a standard of practice?
    A) Quality of care
    B) Outcome identification
    C) Collegiality
    D) Performance appraisal
    Ans: B
    Feedback:
    Standards of practice include assessment, diagnosis, outcomes identification, planning, implementation, coordination of care, health teaching and health promotion, and milieu therapy. The standards of professional performance include quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership.

28. A student appears very nervous on the first day of clinical in a psychiatric setting. The student reviews the instructor's guidelines and appropriately takes which of the following actions? Select all that apply.
    A) Tells the client about personal events and interests
    B) Discusses the anxious feelings with the instructor
    C) Assumes that the client's unwillingness to talk to a student nurse is a personal insult or failure
    D) Builds rapport with the patient before asking personal questions
    E) Consults the instructor if a shocking situation arises
    F) Gravitates to clients that the student may know personally

    Ans: B, D, E

    Feedback:

    Listening carefully, showing genuine interest, and caring about the client are extremely important rather than speaking about oneself. The student must deal with his or her own anxiety about approaching a stranger to talk about very sensitive and personal issues. Student nurses should not see the client's unwillingness to talk to a student nurse as a personal insult or behavior. Being available and willing to listen are often all it takes to begin a significant interaction with someone. Questions involving personal matters should not be the first thing a student says to the client. These issues usually arise after some trust and rapport have been established. The nursing instructor and staff are always available to assist if the client is shocking or distressing to the student. If the student recognizes someone he or she knows, it is usually best for the student to talk with the client and reassure him or her about confidentiality. The client should be reassured that the student will not read the client's record and will not be assigned to work with the client.

29. The appropriate action for a student nurse who says the wrong thing is to
    A) pretend that the student nurse did not say it.
    B) restate it by saying, ìThat didn't come out right. What I meant was...î
    C) state that it was a joke.
    D) ignore the error, since no one is perfect.

    Ans: B

    Feedback:

    No one magic phrase can solve a client's problems; likewise, no single statement can significantly worsen them. Listening carefully, showing genuine interest, and caring about the client are extremely important. A nurse who possesses these elements but says something that sounds out of place can simply restate it by saying, ìThat didn't come out right. What I meant wasÖî Pretending that the student nurse did not say it, stating that it was a joke, and ignoring the error are not likely to help the student nurse build and maintain credibility with the client.

1. **Chapter 2**.The nurse is assessing a patient suffering a head injury as a result of an altercation with two other individuals. The patient has difficulty accurately reporting the events of the altercation and appears very emotional during the assessment. The nurse suspects which part of the brain received the greatest amount of injury?
   A) Cerebrum
   B) Cerebellum
   C) Medulla
   D) Amygdala
   Ans: A
   Feedback:
   The frontal lobes of the cerebrum control the organization of thought, body movement, memories, emotions, and moral behavior. The cerebellum is located below the cerebrum and is the center for coordination of movements and postural adjustments. The medulla, located at the top of the spinal cord, contains vital centers for respiration and cardiovascular functions. The hippocampus and amygdala are involved in emotional arousal and memory.

2. An abnormality of which of the following structures of the cerebrum would be associated with schizophrenia?
   A) Parietal lobes
   B) Frontal lobe
   C) Occipital lobe
   D) Temporal lobes
   Ans: B
   Feedback:
   Abnormalities in the frontal lobes are associated with schizophrenia, attention deficit hyperactivity disorder (ADHD), and dementia. The parietal lobes interpret sensations of taste and touch and assist in spatial orientation. The temporal lobes are centers for the senses of smell and hearing and for memory and emotional expression. The occipital lobe assists in coordinating language generation and visual interpretation, such as depth perception.

3. A patient with bipolar disorder asks the nurse, ìWhy did I get this illness? I don't want to be sick.î The nurse would best respond with,
   A) ìPeople who develop mental illnesses often had very traumatic childhood experiences.î
   B) ìThere is some evidence that contracting a virus during childhood can lead to mental disorders.î
   C) ìSometimes people with mental illness have an overactive immune system.î
   D) ìWe don't fully understand the cause, but mental illnesses do seem to run in families.î

   Ans: D

   Feedback:

   Current theories and studies indicate that several mental disorders may be linked to a specific gene or combination of genes, but that the source is not solely genetic; nongenetic factors also play important roles. A compromised immune system could contribute to the development of a variety of illnesses, particularly in populations already genetically at risk. Maternal exposure to a virus during critical fetal development of the nervous system may contribute to mental illness.

4. Which of the following statements about the neurobiologic causes of mental illness is most accurate?
   A) Genetics and heredity can explain all causes of mental illness.
   B) Viral infection has been proven to be the cause of schizophrenia.
   C) There is no evidence that the immune system is related to mental illness.
   D) Several mental disorders may be linked to genetic and nongenetic factors.

   Ans: D

   Feedback:

   Current theories and studies indicate that several mental disorders may be linked to a specific gene or combination of genes, but that the source is not solely genetic; nongenetic factors also play important roles. Most studies involving viral theories have focused on schizophrenia, but so far none has provided specific or conclusive evidence. A compromised immune system could contribute to the development of a variety of illnesses, particularly in populations already genetically at risk. So far, efforts to link a specific stressor with a specific disease have been unsuccessful. When the inflammatory response is critically involved in illnesses such as multiple sclerosis or lupus erythematosus, mood dysregulation and even depression are common.

5. Which of the following is an inhibitory neurotransmitter?
   A) Dopamine
   B) GABA
   C) Norepinephrine
   D) Epinephrine
   Ans: B
   Feedback:
   GABA is the major inhibitory neurotransmitter in the brain and has been found to modulate other neurotransmitter systems rather than to provide a direct stimulus. Dopamine, norepinephrine, and epinephrine are excitatory neurotransmitters.

6. Which of the following is a neuromodulator?
   A) Neuropeptides
   B) Glutamate
   C) Dopamine
   D) GABA
   Ans: A
   Feedback:
   Neuropeptides are neuromodulators. Glutamate and dopamine are excitatory neurotransmitters. GABA is an inhibitory neurotransmitter.

7. A nurse is leading a medication education group for patients with depression. A patient states he has read that herbal treatments are just as effective as prescription medications. The best response is,
   A) ìWhen studies are published they can be trusted to be accurate.î
   B) ìWe need to look at the research very closely to see how reliable the studies are.î
   C) ìYour prescribed medication is the best for your condition, so you should not read those studies.î
   D) ìSwitching medications will alter the course of your illness. It is not advised.î
   Ans: B
   Feedback:
   Often, reports in the media regarding new research and studies are confusing, contradictory, or difficult for clients and their families to understand. The nurse must ensure that clients and families are well informed about progress in these areas and must also help them to distinguish between facts and hypotheses. The nurse can explain if or how new research may affect a client's treatment or prognosis. The nurse is a good resource for providing information and answering questions.

8. The nurse is preparing a patient for an MRI scan of the head. The nurse should ask the patient,
   A) ìHave you ever had an allergic reaction to radioactive dye?î
   B) ìHave you had anything to eat in the last 24 hours?î
   C) ìDoes your insurance cover the cost of this scan?î
   D) ìAre you anxious about being in tight spaces?î
   Ans: D
   Feedback:
   The person undergoing an MRI must lie in a small, closed chamber and remain motionless during the procedure, which takes about 45 minutes. Those who feel claustrophobic or have increased anxiety may require sedation before the procedure. PET scans require radioactive substances to be injected into the bloodstream. A patient is not required to fast before brain imaging studies. Verifying insurance benefits is not a primary role of the nurse.

9. How should the nurse respond to a family member who asks how Alzheimer's disease is diagnosed?
   A) It is impossible to know for certain that a person has Alzheimer's disease until the person dies and his or her brain can be examined via autopsy.
   B) Positron emission tomography (PET) scans can identify the amyloid plaques and tangles of Alzheimer's disease in living clients.
   C) Alzheimer's disease can be diagnosed by using chemical markers that demonstrate decreased cerebral blood flow.
   D) It will be necessary for the patient to undergo positron emission tomography (PET) scans regularly for a long period of time to know if the patient has Alzheimer's disease.
   Ans: B
   Feedback:
   Positron emission tomography (PET) scans can identify the amyloid plaques and tangles of Alzheimer's disease in living clients. These conditions previously could be diagnosed only through autopsy. Some persons with schizophrenia also demonstrate decreased cerebral blood flow. A limitation of PET scans is that the use of radioactive substances limits the number of times a person can undergo these tests.

10. A patient is being seen in the crisis unit reporting that poison letters are coming in the mail. The patient has no history of psychiatric illness. Which of the following medications would the patient most likely be started on?
    A) Aripiprazole (Abilify)
    B) Risperidone (Risperdal Consta)
    C) Fluphenazine (Prolixin)
    D) Fluoxetine (Prozac)
    Ans: A
    Feedback:
    New-generation antipsychotics are preferred over conventional antipsychotics because they control symptoms without some of the side effects. Injectable antipsychotics, such as Risperdal Consta, are indicated after the client's condition is stabilized with oral doses of these medications. Prozac is an antidepressant and is not indicated to relieve of psychotic symptoms.

11. Which one of the following types of antipsychotic medications is most likely to produce extrapyramidal effects?
    A) Atypical antipsychotic drugs
    B) First-generation antipsychotic drugs
    C) Third-generation antipsychotic drugs
    D) Dopamine system stabilizers
    Ans: B
    Feedback:
    The conventional, or first-generation, antipsychotic drugs are potent antagonists of D2, D3, and D4. This makes them effective in treating target symptoms but also produces many extrapyramidal side effects because of the blocking of the D2 receptors. Newer, atypical or second-generation antipsychotic drugs are relatively weak blockers of D2, which may account for the lower incidence of extrapyramidal side effects. The third generation of antipsychotics, called dopamine system stabilizers, is being developed. These drugs are thought to stabilize dopamine output that results in control of symptoms without some of the side effects of other antipsychotic medications.

12. A patient with schizophrenia is being treated with olanzapine (Zyprexa) 10 mg. daily. The patient asks the nurse how this medicine works. The nurse explains that the mechanism by which the olanzapine controls the patient's psychotic symptoms is believed to be
    A) increasing the amount of serotonin and norepinephrine in the brain.
    B) decreasing the amount of an enzyme that breaks down neurotransmitters.
    C) normalizing the levels of serotonin, norepinephrine, and dopamine.
    D) blocking dopamine receptors in the brain.
    Ans: D
    Feedback:
    The major action of all antipsychotics in the nervous system is to block receptors for the neurotransmitter dopamine. SSRIs and TCSs act by blocking the reuptake of serotonin and norepinephrine. MAOIs prevent the breakdown of MAO, an enzyme that breaks down neurotransmitters. Lithium normalizes the reuptake of certain neurotransmitters such as serotonin, norepinephrine, acetylcholine, and dopamine.

13. A patient with depression has been taking paroxetine (Paxil) for the last 3 months and has noticed improvement of symptoms. Which of the following side effects would the nurse expect the patient to report?
    A) A headache after eating wine and cheese
    B) A decrease in sexual pleasure during intimacy
    C) An intense need to move about
    D) Persistent runny nose
    Ans: B
    Feedback:
    Sexual dysfunction can result from enhanced serotonin transmission associated with SSRI use. Headache caused by hypertension can result when combining MAOIs with foods containing tyramine, such as aged cheeses and alcoholic beverages. SSRIs cause less weight gain than other antidepressants. Dry mouth and nasal passages are common anticholinergic side effects associated with all antidepressants. An intense need to move about (akathisia) is an extrapyramidal side effect that would be expected of an antipsychotic medication. Furthermore, sedation is a common side effect of Paxil.

14. Which one of the following drugs should the nurse expect the patient to require serum level monitoring?
    A) Anticonvulsants
    B) Wellbutrin
    C) Lithium
    D) Prozac
    Ans: C
    Feedback:
    Toxicity is closely related to serum lithium levels and can occur at therapeutic doses. For clients taking lithium and the anticonvulsants, monitoring blood levels periodically is important.

15. Which of the following disorders are extrapyramidal symptoms that may be caused by antipsychotic drugs? Select all that apply.
    A) Akathisia
    B) Pseudoparkinsonism
    C) Neuroleptic malignant syndrome
    D) Dystonia
    E) Anticholinergic effects
    F) Breast tenderness in men and women
    Ans: A, B, D
    Feedback:
    Extrapyramidal symptoms include dystonia, pseudoparkinsonism, and akathisia. Neuroleptic malignant syndrome is also a side effect of antipsychotic drugs but is an idiosyncratic reaction to an antipsychotic drug, not an extrapyramidal symptom. Breast tenderness in men and women is also a potential side effect of antipsychotic drugs that cause elevated prolactin levels, but it is not an extrapyramidal symptom.

16. Which of the following antidepressant drugs is a preferred drug for clients at high risk of suicide?
    A) Tranylcypromine (Parnate)
    B) Sertraline (Zoloft)
    C) Imipramine (Tofranil)
    D) Phenelzine (Nardil)
    Ans: B
    Feedback:
    SSRIs, venlafaxine, nefazodone, and bupropion are often better choices for those who are potentially suicidal or highly impulsive because they carry no risk of lethal overdose, in contrast to the cyclic compounds and the MAOIs. Parnate and Nardil are MAOIs. Tofranil is a cyclic compound.

17. The nurse knows that the client understands the rationale for dietary restrictions when taking MAOI when the client makes which of the following statements?
    A) ìI am now allergic to foods that are high in the amino acid tyramine such as aged cheese, organ meats, wine, and chocolate.î
    B) ìCertain foods will cause me to have sexual dysfunction when I take this medication.î
    C) ìFoods that are high in tyramine will reduce the medication's effectiveness.î
    D) ìI should avoid foods that are high in the amino acid tyramine such as aged cheese, meats, and chocolate because this drug causes the level of tyramine to go up to dangerous levels.î

    Ans: D

    Feedback:

    Because the enzyme MAO is necessary to break down the tyramine in certain foods, its inhibition results in increased serum tyramine levels, causing severe, hypertension, hyperpyrexia, tachycardia, diaphoresis, tremulousness, and cardiac dysrhythmias. Taking an MAOI does not confer allergy to tyramine. Sexual dysfunction is a common side effect of MAOIs. There is no evidence that foods high in tyramine will increase sexual dysfunction or reduce the medication's effectiveness.

18. A client who is taking paroxetine (Paxil) reports to the nurse that he has been nauseated since beginning the medication. Which of the following actions is indicated initially?
    A) Instruct the client to stop the medication for a few days to see if the nausea goes away.
    B) Reassure the client that this is an expected side effect that will improve with time.
    C) Suggest that the client take the medication with food.
    D) Tell the client to contact the physician for a change in medication.

    Ans: C

    Feedback:

    Taking selective serotonin reuptake inhibitors with food usually eliminates nausea. There is a delayed therapeutic response to antidepressants. The client should not stop taking the drug. It would be appropriate to reassure the client that this is an expected side effect that will improve with time, but that would not be done initially. A change in medication may be indicated if the nausea is intolerable or persistent, but that would not be done initially.

19. In planning for a client's discharge, the nurse must know that the most serious risk for the client taking a tricyclic antidepressant is which of the following?
    A) Hypotension
    B) Narrow-angle glaucoma
    C) Seizures
    D) Suicide by overdose
    Ans: D
    Feedback:
    Cyclic antidepressants (including tricyclic antidepressants) are potentially lethal if taken in an overdose. The cyclic antidepressants block cholinergic receptors, resulting in anticholinergic effects such as dry mouth, constipation, urinary hesitancy or retention, dry nasal passages, and blurred near vision. More severe anticholinergic effects such as agitation, delirium, and ileus may occur, particularly in older adults. Other common side effects include orthostatic hypotension, sedation, weight gain, and tachycardia. Clients may develop tolerance to anticholinergic effects (such as orthostatic hypotension and worsening of narrow-angle glaucoma, but these side effects are common reasons that clients discontinue drug therapy. The risk of seizures is increased by bupropion, which is a different type of antidepressant.

20. A client with severe and persistent mental illness has been taking antipsychotic medication for 20 years. The nurse observes that the client's behavior includes repetitive movements of the mouth and tongue, facial grimacing, and rocking back and forth. The nurse recognizes these behaviors as indicative of
    A) extrapyramidal side effects
    B) loss of voluntary muscle control
    C) posturing
    D) tardive dyskinesia
    Ans: D
    Feedback:
    The client's behaviors are classic signs of tardive dyskinesia. Tardive dyskinesia, a syndrome of permanent involuntary movements, is most commonly caused by the long-term use of conventional antipsychotic drugs. Extrapyramidal side effects are reversible movement disorders induced by antipsychotic or neuroleptic medication. The client's behavior is not a loss of voluntary control or posturing.

21. A client is seen in the clinic with clinical manifestations of an inability to sit still and a rigid posture. These side effects would be correctly identified as which of the following?
    A) Tardive dyskinesia
    B) Neuroleptic malignant syndrome
    C) Dystonia
    D) Akathisia
    Ans: D
    Feedback:
    Akathisia is reported by the client as an intense need to move about. The client appears restless or anxious and agitated, often with a rigid posture or gain and a lack of spontaneous gestures. The symptoms of tardive dyskinesia (TD) include involuntary movements of the tongue, facial and neck muscles, upper and lower extremities, and truncal musculature. Tongue thrusting and protruding, lip smacking, blinking, grimacing, and other excessive unnecessary facial movements are characteristic. Neuroleptic malignant syndrome is a potentially fatal reaction manifested by rigidity, high fever, and autonomic instability. Acute dystonia includes acute muscular rigidity and cramping, a stiff or thick tongue with difficulty swallowing, and, in severe cases, laryngospasm and respiratory difficulties.

22. Which of the following is a term used to describe the occurrence of the eye rolling back in a locked position, which occurs with acute dystonia?
    A) Opisthotonus
    B) Oculogyric crisis
    C) Torticollis
    D) Pseudoparkinsonism
    Ans: B
    Feedback:
    Oculogyric crisis is the occurrence of the eye rolling back in a locked position, which occurs with acute dystonia. Opisthotonus is tightness in the entire body with the head back and an arched neck. Torticollis is twisted head and neck. Oculogyric crisis, opisthotonus, and torticollis are manifestations of acute dystonia. Pseudoparkinsonism is drug-induced parkinsonism and is often referred to by the generic label of extrapyramidal side effects.

23. Which of the following medications rarely causes extrapyramidal side effects (EPS)?
    A) Ziprasidone (Geodon)
    B) Chlorpromazine (Thorazine)
    C) Haloperidol (Haldol)
    D) Fluphenazine (Prolixin)
    Ans: A
    Feedback:
    First-generation antipsychotic drugs cause a greater incidence of EPS than do atypical antipsychotic drugs, with ziprasidone (Geodon) rarely causing EPS. Thorazine, Haldol, and Prolixin are all first-generation antipsychotic drugs.

24. Which of the following increases the risk for neuroleptic malignant syndrome (NMS)?
    A) Overhydration
    B) Intake of vitamins
    C) Dehydration
    D) Vegetarian diet
    Ans: C
    Feedback:
    Dehydration, poor nutrition, and concurrent medical illness all increase the risk for NMS. Overhydration is opposite of dehydration and would therefore not increase the risk of NMS. Intake of vitamins would likely reduce the risk of NMS as it would improve nutritional status. Vegetarian diet would not relate to NMS.

25. Which of the following was the first nonstimulant medication specifically designed and tested for ADHD?
    A) Methylphenidate (Ritalin)
    B) Amphetamine (Adderall)
    C) Atomoxetine (Strattera)
    D) Pemoline (Cylert)
    Ans: C
    Feedback:
    Strattera was the first nonstimulant medication specifically designed and tested for ADHD. The primary stimulant drugs used to treat ADHD are methylphenidate (Ritalin), amphetamine (Adderall), and pemoline (Cylert).

26. Which of the following is the primary consideration with clients taking antidepressants?
    A) Decreased mobility
    B) Emotional changes
    C) Suicide
    D) Increased sleep
    Ans: C
    Feedback:
    Suicide is always a primary consideration when treating clients with depression.

27. Which of the following would not be included as a symptom of drug-induced parkinsonism?
    A) Stooped posture
    B) Cogwheel rigidity
    C) Drooling
    D) Tachycardia
    Ans: D
    Feedback:
    Bradycardia (not tachycardia), a stooped posture, cogwheel rigidity, and drooling are all symptoms of pseudoparkinsonism. Other symptoms of pseudoparkinsonism include mask-like facies, decreased arm swing, a shuffling, festinating gait, tremor, and coarse pill-rolling movements of the thumb and fingers while at rest.

28. Which drug classification is the primary medication treatment for schizophrenia?
    A) Anticoagulants
    B) Antidepressants
    C) Antimanics
    D) Antipsychotics
    Ans: D
    Feedback:
    Antipsychotic drugs are the primary medical treatment for clients diagnosed with schizophrenia and are also used in psychotic episodes of acute mania, psychotic depression, and drug-induced psychosis.

29. A client on the unit suddenly cries out in fear. The nurse notices that the client's head is twisted to one side, his back is arched, and his eyes have rolled back in their sockets. The client has recently begun drug therapy with haloperidol (Haldol). Based on this assessment, the first action of the nurse would be to
    A) get a stat. order for a serum drug level.
    B) hold the client's medication until the symptoms subside.
    C) place an urgent call to the client's physician.
    D) give a PRN dose of benztropine (Cogentin) IM.
    Ans: D
    Feedback:
    The client is having an acute dystonic reaction; the treatment is anticholinergic medication. Dystonia is most likely to occur in the first week of treatment, in clients younger than 40 years, in males, and in those receiving high-potency drugs such as Haldol. Immediate treatment with anticholinergic drugs usually brings rapid relief.

30. One week after beginning therapy with thiothixene (Navane), the client demonstrates muscle rigidity, a temperature of 103∞F, an elevated serum creatinine phosphokinase level, stupor, and incontinence. The nurse should notify the physician because these symptoms are indicative of
    A) acute dystonic reaction.
    B) extrapyramidal side effects.
    C) neuroleptic malignant syndrome.
    D) tardive dyskinesia.
    Ans: C
    Feedback:
    The client demonstrates all the classic signs of neuroleptic malignant syndrome. Dystonia involves acute muscular rigidity and cramping, a stiff or thick tongue with difficulty swallowing, and, in severe cases, laryngospasm and respiratory difficulties. Extrapyramidal side effects are reversible movement disorders induced by antipsychotic or neuroleptic medication. Tardive dyskinesia is a late-onset, irreversible neurologic side effect of antipsychotic medications characterized by abnormal, involuntary movements, such as blinking, chewing, and grimacing.

31. A client with bipolar disorder has been taking lithium, and today his serum blood level is 2.0 mEq/L. What effects would the nurse expect to see?
    A) Constipation and postural hypotension
    B) Fever, muscle rigidity, and disorientation
    C) Nausea, diarrhea, and confusion
    D) None; the serum level is in therapeutic range
    Ans: C
    Feedback:
    Serum lithium levels of less than 0.5 mEq/L are rarely therapeutic, and levels of more than 1.5 mEq/L are usually considered toxic. The client would show signs of toxicity with a lithium level of 2.0 mEq/L. Toxic effects of lithium are severe diarrhea, vomiting, drowsiness, muscle weakness, and lack of coordination.

32. For a client taking clozapine (Clozaril), which of the following symptoms should the nurse report to the physician immediately as it may be indicative of a potentially fatal side effect?
    A) Inability to stand still for 1 minute
    B) Mild rash
    C) Photosensitivity reaction
    D) Sore throat and malaise
    Ans: D
    Feedback:
    Clozapine (Clozaril) produces fewer traditional side effects than do most antipsychotic drugs, but it has the potentially fatal side effect of agranulocytosis. This develops suddenly and is characterized by fever, malaise, ulcerative sore throat, and leukopenia. This side effect may not be manifested immediately and can occur up to 24 weeks after the initiation of therapy. Any symptoms of infection must be investigated immediately. Agranulocytosis is characterized by fever, malaise, ulcerative sore throat, and leukopenia. Mild rash and photosensitivity reaction are not serious side effects.

33. A patient with bipolar disorder takes lithium 300 mg three times daily. The nurse evaluates that the dose is appropriate when the patient reports
    A) feeling sleepy and less energetic.
    B) weight gain of 7 pounds in the last 6 months.
    C) minimal mood swings.
    D) increased feelings of self-worth.
    Ans: C
    Feedback:
    Mood-stabilizing drugs are used to treat bipolar disorder by stabilizing the client's mood, preventing or minimizing the highs and lows that characterize bipolar illness, and treating acute episodes of mania. Weight gain is a common side effect, and fatigue and lethargy may indicate mild toxicity. Inflated self-worth is a target symptom of bipolar disorder, which should diminish with effective treatment.

34. When the client experiences facial flushing, a throbbing headache, nausea and vomiting after consuming alcohol while taking Disulfiram (Antabuse), the nurse is aware that this is due to which of the following?
    A) A mild side effect of the medication.
    B) The intended therapeutic result.
    C) An idiosyncratic reaction
    D) A severe allergy to the medication.
    Ans: B
    Feedback:
    Disulfiram is a sensitizing agent that causes an adverse reaction when mixed with alcohol in the body. Five to ten minutes after a person taking disulfiram ingests alcohol, symptoms begin to appear: facial and body flushing from vasodilation, a throbbing headache, sweating, dry mouth, nausea, vomiting, dizziness, and weakness. These symptoms are not mild side effects because these are very uncomfortable symptoms. These symptoms would not be an idiosyncratic reaction because this is the expected reaction. These symptoms are not indicative of a severe allergy to the medication.

35. When the client asks the nurse how long it will take before the SSRI antidepressant medication will be effective, which of the following replies is most accurate and therapeutic?
    A) ìThis is a good medication! It will be effective within 20 minutes of the first dose.î
    B) ìYou will have gradual improvement in symptoms over the next few weeks, but the changes may be so subtle that you may not notice them for a while. It is important for you to keep taking the medication.î
    C) ìIt will probably take months for the medication to work. In the meantime, you should work on improving your attitude.î
    D) ìIf you believe it will work, then it will. You have to have faith!î
    Ans: B
    Feedback:
    SSRIs may be effective in 2 to 3 weeks. Researchers believe that the actions of these drugs are an ìinitiating eventî and that eventual therapeutic effectiveness results when neurons respond more slowly, making serotonin available at the synapses. The medication will not be effective within 20 minutes of the first dose, and it will not likely take months for the medication. Attitude and faith will improve with the medication's effectiveness.

36. A client has a lithium level of 1.2 mEq/L. Which of the following interventions by the nurse is indicated?
    A) Call the physician for an increase in dosage.
    B) Do not give the next dose, and call the physician.
    C) Increase fluid intake for the next week.
    D) No intervention is necessary at this time.
    Ans: D
    Feedback:
    The lithium level is within the therapeutic range. Serum levels of less than 0.5 mEq/L are rarely therapeutic, and a level of more than 1.5 mEq/L is usually considered toxic. Answers A, B, and C are not appropriate interventions for the given lithium level.

37. A patient is seen for frequent exacerbation of schizophrenia due to nonadherence to medication regimen. The nurse should assess for which of the following common contributors to nonadherence?
    A) The patient is symptom-free and therefore does not need to adhere to the medication regimen.
    B) The patient cannot clearly see the instructions written on the prescription bottle.
    C) The patient dislikes the weight gain associated with antipsychotic therapy.
    D) The patient sells the antipsychotics to addicts in the neighborhood.
    Ans: C
    Feedback:
    Patients with schizophrenia are less likely to exercise or eat low-fat nutritionally balanced diets; this pattern decreases the likelihood that they can minimize potential weight gain or lose excess weight. Antipsychotics should be taken regularly and not omitted when free of symptoms. Antipsychotics do not adversely affect vision, nor do they have addictive potential.

38. Which of the following side effects of lithium are frequent causes of noncompliance? Select all that apply.
    A) Metallic taste in the mouth
    B) Weight gain
    C) Acne
    D) Thirst
    E) Lethargy
    Ans: B, E
    Feedback:
    Lethargy and weight gain are difficult to manage or minimize and frequently lead to noncompliance.

39. The nurse is educating a patient and family about strategies to minimize the side effects of antipsychotic drugs. Which of the following should be included in the plan? Select all that apply.
    A) Drink plenty of fruit juice.
    B) Developing an exercise program is important.
    C) Increase foods high in fiber.
    D) Laxatives can be used as needed.
    E) Use sunscreen when outdoors.
    F) For missed doses, take double the dose at the next scheduled time.
    Ans: B, C, E
    Feedback:
    Drinking sugar-free fluids and eating sugar-free hard candy ease dry mouth. The client should avoid calorie-laden beverages and candy because they promote dental caries, contribute to weight gain, and do little to relieve dry mouth. Methods to prevent or relieve constipation include exercising and increasing water and bulk-forming foods in the diet. Stool softeners are permissible, but the client should avoid laxatives. The use of sunscreen is recommended because photosensitivity can cause the client to sunburn easily. If the client forgets a dose of antipsychotic medication, he or she can take the missed dose if it is only 3 or 4 hours late. If the dose is more than 4 hours overdue or the next dose is due, the client can omit the forgotten dose.

40. The nurse has completed health teaching about dietary restrictions for a client taking a monoamine oxidase inhibitor. The nurse will know that teaching has been effective by which of the following client statements?
    A) ìI'm glad I can eat pizza since it's my favorite food.î
    B) ìI must follow this diet or I will have severe vomiting.î
    C) ìIt will be difficult for me to avoid pepperoni.î
    D) ìNone of the foods that are restricted are part of a regular daily diet.î
    Ans: C
    Feedback:
    Pepperoni is one of the foods containing tyramine, so it must be avoided. Particular concern to this client is the potential life-threatening hypertensive crisis if the client ingests food that contains tyramine. Answer choices A, B, and D are inappropriate statements toward effective teaching for the client receiving a monoamine oxidase inhibitor.

41. When teaching a client about restrictions for tranylcypromine (Parnate), the nurse will tell the client to avoid which of the following foods?
    A) Broad beans
    B) Citrus fruit
    C) Egg products
    D) Fried foods
    Ans: A
    Feedback:
    Parnate is a monoamine oxidase inhibitor; clients must avoid tyramine, and broad beans contain tyramine. Answers citrus fruit, egg products, and fried foods are not tyramine-containing foods.

1. **Chapter 3** The nurse understands that crises are self-limiting. This implies that upon evaluation of crisis intervention, the nurse should assess for which outcome?
   A) The patient will identify possible causes for the crisis.
   B) The patient will discover a new sense of self-sufficiency in coping.
   C) The patient will resume the precrisis level of functioning.
   D) The patient will express anger regarding the crisis event.
   Ans: C
   Feedback:
   Crises usually exist for 4 to 6 weeks. At the end of that time, the crisis is resolved in one of three ways. In the first two, the person either returns to his or her precrisis level of functioning or begins to function at a higher level; both are positive outcomes for the individual. The third resolution is that the person's functioning stabilizes at a level lower than precrisis functioning, which is a negative outcome for the individual. Assisting the person to use existing supports or helping the individual find new sources of support can decrease the feelings of being alone or overwhelmed. The patient may develop guilt if he or she examines possible causes for the crisis. Expression of anger at 4 to 6 weeks indicates a less than favorable outcome of crisis intervention.

2. A patient who has been working on controlling impulsive behavior shows a strengthening ego through which of the following behaviors?
   A) Going to therapy only when there is nothing more desirable to do
   B) Weighing the advantages and disadvantages before making a decision
   C) Telling others in the group the right way to act
   D) Reporting having fun at a recent social event
   Ans: B
   Feedback:
   The id is the part of one's nature that reflects basic or innate desires such as pleasure-seeking behavior, aggression, and sexual impulses. The id seeks instant gratification, causes impulsive unthinking behavior, and has no regard for rules or social convention. The superego is the part of a person's nature that reflects moral and ethical concepts, values, and parental and social expectations; therefore, it is in direct opposition to the id. The third component, the ego, is the balancing or mediating force between the id and the superego. The ego represents mature and adaptive behavior that allows a person to function successfully in the world.

3. A patient has just been told she has cervical cancer. When asked about how this is impacting her, she states, ìIt's just an infection; it will clear up.î The statement indicates that this patient
   A) needs education on cervical cancer.
   B) is unable to express her true emotions.
   C) should be immediately referred to a cancer support group.
   D) is using denial to protect herself from an emotionally painful thought.
   Ans: D
   Feedback:
   Ego defense mechanisms are methods of attempting to protect the self and cope with basic drives or emotionally painful thoughts, feelings, or events. Most defense mechanisms operate at the unconscious level of awareness, so people are not aware of what they are doing and often need help to see the reality. Education and referrals are premature at this point in the patient's ability to cope.

4. A teenage patient defies the nurse's repeated requests to turn off the video game and go to sleep. The teen says angrily, ìYou sound just like my mother at home!î and continues to play the video game. The nurse understands that this statement likely indicates
   A) the need of stricter discipline at home.
   B) early signs of oppositional defiant disorder.
   C) viewing the nurse as her mother.
   D) expression of developing autonomy.
   Ans: C
   Feedback:
   Transference occurs when the client displaces onto the therapist attitudes and feelings that the client originally experienced in other relationships. Transference patterns are automatic and unconscious in the therapeutic relationship. The occurrence of transference does not indicate ineffective parenting or disciplinary practices, nor is it indicative of a disorder. Autonomy is developed much earlier in the toddler years.

5. A patient reports a pattern of being suspicious and mistrusting of others, causing difficulty in sustaining lasting relationships. Which stage according to Erikson's psychosocial development was not successfully completed?
   A) Trust
   B) Autonomy
   C) Initiative
   D) Industry
   Ans: A
   Feedback:
   The formation of trust is essential: mistrust, the negative outcome of this stage, will impair the person's development throughout his or her life.

6. The nurse has established a therapeutic relationship with a patient. The patient is beginning to share feelings openly with the nurse. The relationship has entered which phase according to Peplau's theory?
   A) Orientation
   B) Identification
   C) Exploitation
   D) Resolution
   Ans: B
   Feedback:
   The orientation phase is directed by the nurse and involves engaging the client in treatment, providing explanations and information, and answering questions. The identification phase begins when the client works interdependently with the nurse, expresses feelings, and begins to feel stronger. In the exploitation phase, the client makes full use of the services offered. In the resolution phase, the client no longer needs professional services and gives up dependent behavior and the relationship ends.

7. A nurse is meeting with a crisis support group. In efforts to help patients identify with one another, the nurse explains which of the following about the crisis experience?
   A) ìEven happy events can cause a crisis if the stress is overwhelming.î
   B) ìOnly people who have unfortunate life events will experience a crisis.î
   C) ìA person has no control over how a crisis will affect him or her.î
   D) ìPeople can prevent all crises if they develop good coping skills early.î
   Ans: A
   Feedback:
   Not all events that result in crisis are ìnegativeî in nature. Events like marriage, retirement, and childbirth are often desirable for the individual but may still present overwhelming challenges. All individuals can experience a crisis when they confront some life circumstance or stressor that they cannot effectively manage through use of their customary coping skills. A number of factors can influence how a person experiences a crisis.

8. Which of the following theories could be classified as humanistic theories? Select all that apply.
   A) Cognitive therapy
   B) Maslow's hierarchy of needs
   C) Gestalt therapy
   D) Rogers' client-centered therapy
   E) Rational emotive therapy
   F) Piaget's cognitive stages of development
   Ans: B, D
   Feedback:
   Humanism represents a significant shift away from the psychoanalytic view of the individual as a neurotic, impulse-driven person with repressed psychic problems and away from the focus on and examination of the client's past experiences. Humanistic theories include Maslow's hierarchy of needs and Rogers' client-centered therapy. Cognitive therapy is an existential therapy that focuses on immediate thought processingóhow a person perceives or interprets his or her experience and determines how he or she feels and behaves. Gestalt therapy is an existential therapy that emphasizes the person's feelings and thoughts in the here and now. Rational emotive therapy is an existential theory that looks at irrational beliefs and automatic thoughts that make people unhappy. Piaget's cognitive stages of development is a developmental theory.

9. Which of the following are examples of adventitious crises? Select all that apply.
   A) Death of a loved one
   B) Natural disasters
   C) Violent crimes
   D) War
   E) Leaving home for the first time
   Ans: B, C, D
   Feedback:
   Adventitious crises include natural disasters like floods, earthquakes, or hurricanes; war, terrorist attacks; riots; and violent crimes such as rape or murder. Maturational or developmental crises are predictable events in the normal course of life, such as leaving home for the first time, getting married, having a baby, and beginning a career. Situational crises are unanticipated or sudden events that threaten the individual's integrity, such as the death of a loved one, loss of a job, and physical or emotional illness in the individual or family member.

10. A nursing supervisor reprimands an employee for being chronically late for work. If the employee handles the reprimand using the defense mechanism of displacement, he would most likely do which of the following?
    A) Argue with the supervisor that he is usually on time
    B) Make a special effort to be on time tomorrow
    C) Tell fellow employees that the supervisor is picking on him
    D) Tell the unit housekeeper that his work is sloppy
    Ans: D
    Feedback:
    Displacement involves venting feelings toward another, less threatening person. Arguing is denial. Making a special effort is compensation. Telling fellow employees that the supervisor is picking on him is projection.

11. The nurse is assessing a client who is talking about her son's recent death but who shows no emotion of any kind. The nurse recognizes this behavior as which of the following defense mechanisms?
    A) Dissociation
    B) Displacement
    C) Intellectualization
    D) Suppression
    Ans: C
    Feedback:
    The client is aware of the facts of the situation but does not show the emotions associated with the situation. Dissociation involves dealing with emotional conflict by a temporary alteration in consciousness or identity. Displacement is the ventilation of intense feelings toward a person less threatening than the one who aroused those feelings. Suppression is replacing the desired gratification with one that is more readily available.

12. A college student decides to go to a party the night before a major exam instead of studying. After receiving a low score on the exam, the student tells a fellow student, ìI have to work too much and don't have time to study. It wouldn't matter anyway because the teacher is so unreasonable.î The defense mechanisms the student is using are
    A) denial and displacement
    B) rationalization and projection
    C) reaction formation and resistance
    D) regression and compensation
    Ans: B
    Feedback:
    When stating that it wouldn't matter if the student studied, the student is using rationalization, which is excusing own behavior to avoid guilt, responsibility, conflict, anxiety, or loss of self-respect. When stating that the teacher is unreasonable, the student is using projection or the unconscious blaming of unacceptable inclinations or thoughts as an external object. Denial is the failure to acknowledge an unbearable condition. Displacement is the ventilation of intense feelings toward persons less threatening than the one who aroused those feelings. Reaction formation is acting the opposite of what one thinks or feels. Resistance is overt or covert antagonism toward remembering or processing anxiety-producing information. Regression is moving back to a previous developmental stage to feel safe or have needs met. Compensation is overachievement in one area to offset real or perceived deficiencies in another area.

13. A client is supposed to be ambulating ad lib. Instead, he refuses to get out of bed, asks for a bed bath, and makes many demands of the nurses. He also yells that they are lazy and incompetent. The client's behavior is an example of which of the following defense mechanisms?
    A) Introjection
    B) Projection
    C) Rationalization
    D) Reaction formation
    Ans: B
    Feedback:
    Projection is blaming unacceptable thoughts on others; the client cannot accept the fact that he may be lazy or incompetent to care for himself. Introjection is accepting another person's attitudes, beliefs, and values as one's own. Rationalization is excusing one's own behavior to avoid guilt, responsibility, conflict, anxiety, or loss of self-concept. Reaction formation is acting the opposite of what one thinks or feels.

14. A client begins to take stock of his life and look into the future. The nurse assesses that this client is in which of Erikson's developmental stages?
    A) Identity versus role confusion
    B) Industry versus inferiority
    C) Integrity versus despair
    D) Generativity versus stagnation
    Ans: C
    Feedback:
    Erikson's stage of integrity versus despair is when an adult begins to reflect on his or her life. Identity versus role confusion occurs in adolescence when the person is forming a sense of self and belonging. Integrity versus despair occurs in maturity; accepting responsibility for oneself and life is the corresponding task. Generativity versus stagnation occurs in middle adulthood, which includes the tasks of being creative and productive and establishing the next generation.

15. A basic assumption of Freud's psychoanalytic theory is that
    A) all human behavior can be caused and can be explained.
    B) human behavior is entirely unconscious.
    C) free association is the key to understanding.
    D) sexuality does not relate to behavior.
    Ans: A
    Feedback:
    Freud believed that everything we do has meaning, whether it is conscious or unconscious. Freud believed that human behavior can be motivated by subconscious thoughts and feelings but could also be in the preconscious or unconscious. Freud based his theory of childhood development on the belief that sexual energy, termed libido, was the driving force of human behavior.

16. Which of the following is a major developmental task of middle adulthood?
    A) Developing intimacy
    B) Learning to manage conflict
    C) Reexamining life goals
    D) Resolving the past
    Ans: C
    Feedback:
    An important task for middle-aged adults is to examine life goals, ideally with some satisfaction. Developing intimacy occurs in young adulthood. Learning to manage conflict occurs in preschool. Resolving the past and accepting responsibility for oneself and life occur in maturity.

17. Which cognitive mode, according to Harry Stack Sullivan, begins in early childhood as the child begins to connect experiences in sequence?
    A) Prototaxic mode
    B) Parataxic mode
    C) Bitaxic mode
    D) Syntaxic mode
    Ans: B
    Feedback:
    The parataxic mode begins in early childhood as the child begins to connect experiences in sequence. The child may not make logical sense of the experiences, although he or she may not understand what he or she is doing. The prototaxic mode involves brief, unconnected experiences that have no relationship to one another. In the syntaxic mode, the person begins to perceive himself or herself and the world within the context of the environment and can analyze experiences in a variety of settings. There is not a bitaxic mode.

18. Group members are actively discussing a common topic. Members are sharing that they identify with what others are saying. The nurse leader recognizes that the group is in which stage of group development?
    A) Planning
    B) Initial
    C) Working
    D) Termination
    Ans: C
    Feedback:
    The working stage of group development begins as members begin to focus their attention on the purpose or task the group is trying to accomplish. The beginning stage of group development, or the initial stage, commences as soon as the group begins to meet. Members introduce themselves, a leader can be selected, the group purpose is discussed, and rules and expectations for group participation are reviewed. The final stage, or termination, of the group occurs before the group disbands. The work of the group is reviewed, with the focus on group accomplishments or growth of group members.

19. The family members of a patient with bipolar disorder express frustration with the unpredictable behaviors of their loved one. Which group should the nurse suggest as most helpful to this family?
    A) Family therapy group
    B) Family education group
    C) Psychotherapy group
    D) Self-help support group
    Ans: B
    Feedback:
    Family education discusses the clinical treatment of mental illnesses and teaches the knowledge and skills that family members need to cope more effectively. The goals of family therapy groups include understanding how family dynamics contribute to the client's psychopathology, mobilizing the family's inherent strengths and functional resources, restructuring maladaptive family behavioral styles, and strengthening family problem-solving behaviors. The goal of a psychotherapy group is for members to learn about their behavior and to make positive changes in their behavior by interacting and communicating with others. In a self-help group, members share a common experience, but the group is not a formal or structured therapy group.

20. A student nurse attends a self-help group as part of a class assignment. While there the student recognizes a family friend. Upon returning home, the student talks about the experience with the family. The student's actions can be described as
    A) appropriate; persons familiar with group members are allowed self-help group membership.
    B) appropriate; self-help groups are not professional and therefore are open to public knowledge.
    C) inappropriate; most self-help groups have a rule of confidentiality.
    D) inappropriate; the student should not have been allowed to attend the group.
    Ans: C
    Feedback:
    Most self-help groups have a rule of confidentiality: whoever is seen and whatever is said at the meetings cannot be divulged to others or discussed outside the group. In many 12-step programs, such as Alcoholics Anonymous and Gamblers Anonymous, people use only their first names, so their identities are not divulged (although in some settings, group members do know one another's names).

21. The nurse would recommend individual therapy for the patient who expresses a desire to
    A) bring about personal changes.
    B) gain a sense of belonging.
    C) develop leadership skills.
    D) learn more about treatment.
    Ans: A
    Feedback:
    People generally seek individual psychotherapy based on their desire to understand themselves and their behavior, to make personal changes, to improve interpersonal relationships, or to get relief from emotional pain or unhappiness. Groups are recommended for persons to accomplish tasks that require cooperation, collaboration, or working together.

22. Which one of the following statements is most accurate regarding the cohesiveness of a group in group therapy?
    A) It is commonly present in the first meeting of the group.
    B) It is necessary for the group to have maximum cohesiveness, the more the better.
    C) Group cohesiveness is the degree to which members think alike and many things are left unspoken.
    D) Cohesiveness is a desirable group characteristic that is associated with positive group outcomes.
    Ans: D
    Feedback:
    Cohesiveness is a desirable group characteristic that is associated with positive group outcomes. It is not common for the group to be cohesive during the first meeting of the group. During the first meeting, or the initial stage, members introduce themselves and the parameters of the group are established. Group members begin to ìcheck outî one another and the leaders as they determine their levels of comfort in the group setting. Cohesiveness is associated with the working stage of a group that may take two or three sessions in a therapy group because members must develop some level of trust before sharing personal feelings or difficult situations. If a group is ìoverly cohesive,î in that uniformity and agreement become the group's implicit goals, there may be a negative effect on the group outcome as members may not offer needed feedback and this may thwart critical thinking and creative problem solving. Group cohesiveness is the degree to which members work together cooperatively to accomplish the purpose.

23. Which one of the following is an important characteristic of an effective therapistñclient relationship in individual psychotherapy?
    A) Homogeneity between the client and the therapist.
    B) Mutual benefit for the client and the therapist.
    C) The client must adapt to the therapist's style of therapy and theoretical beliefs.
    D) Match between the theoretical beliefs and style of therapy and the client's needs and expectations of therapy.

    Ans: B

    Feedback:

    Compatibility between the therapist and the client is required for therapy to be effective. The client must select a therapist whose theoretical beliefs and style of therapy are congruent with the client's needs and expectations of therapy. It is not required that the client and therapist be the same. The client's benefit is the most important consideration. The client also may have to try different therapists to find a good match.

24. Which of the following is most essential when planning care for a client who is experiencing a crisis?
    A) Explore previous coping strategies
    B) Explore underlying personality dynamics
    C) Focus on emotional deficits
    D) Offer a referral to a self-help group

    Ans: A

    Feedback:

    Crisis intervention focuses on using the person's strengths, such as previous coping skills, and providing support to deal with the current situation. Exploring underlying personality dynamics and focusing on emotional deficits would not help the client in the crisis situation. When the client is in a crisis situation, offering a self-help group would not be appropriate.

25. During the initial interview with a client in crisis, the initial priority is to
    A) assess the adequacy of the support system.
    B) assess for substance use.
    C) determine the precrisis level of functioning.
    D) evaluate the potential for self-harm.

    Ans: D

    Feedback:

    Safety is always the priority; clients in crisis may be suicidal. Assessing the adequacy of the support system, assessing for substance use, and determining the precrisis level of functioning would be important assessments but not as high priority as evaluating the potential for self-harm.

26. Patients on an inpatient psychiatric unit can earn off-unit privileges for daily use of socially appropriate behavior. This is an example of employing which concept of behavior modification?
    A) Systematic desensitization
    B) Negative reinforcement
    C) Classical conditioning
    D) Operant conditioning
    Ans: D
    Feedback:
    The theory of operant conditioning says people learn their behavior from their history or past experiences, particularly those experiences that were repeatedly reinforced. Behavior that is rewarded with reinforcers tends to recur. Positive reinforcers that follow a behavior increase the likelihood that the behavior will recur. In classical conditioning, behavior can be changed through conditioning with external or environmental conditions or stimuli. Negative reinforcement involves removing a stimulus immediately after a behavior occurs so that the behavior is more likely to occur again. In systematic desensitization, the client learns and practices relaxation techniques to decrease and manage anxiety. He or she is then exposed to the least anxiety provoking situation and uses the relaxation techniques to manage the resulting anxiety.

27. A patient states, ìI hate spending time with my family. They're always on my back about something! I won't do *anything* they ask me to do.î Which response by the nurse reflects a behavioral perspective?
    A) ìLet's play like I'm your parent, and we'll practice some better ways to communicate that won't result in an argument.î
    B) ìSome medicines really help with anger. Are you interested in talking to your physician about starting you on something?î
    C) ìThat's probably your way of getting back at them for being strict with you when you were younger.î
    D) ìIf you agree to start doing what your parents request, then they have agreed to respect your privacy more.î
    Ans: D
    Feedback:
    Behaviorism is a school of psychology that focuses on observable behaviors and what one can do externally to bring about behavior changes. It does not attempt to explain how the mind works. Behavior can be changed through a system of rewards and punishments. Practicing communication is a psychotherapy technique to improve interpersonal relationships. Use of medications is not grounded in behavioral perspective. Analyzing the reasons for the behavior is not grounded in behavioral perspective.

28. A nurse is working with a patient with an eating disorder who refuses to eat a muffin. The nurse asks the patient ìIs there any way that you could see the muffin as just flour and water, basic nutrients your body needs?î In this statement, the nurse is using which type of therapy?
    A) Rational emotive therapy
    B) Cognitive therapy
    C) Gestalt therapy
    D) Reality therapy
    Ans: B
    Feedback:
    Cognitive therapy focuses on immediate thought processing, or how a person perceives or interprets his or her experience and determines how he or she behaves. Rational emotive therapy considers not only thoughts but feelings associated with thoughts. Gestalt therapy focuses on the person's thoughts and feelings in the here and now. Reality therapy challenges people to examine how behavior interferes with life goals.

29. A patient is blaming his impending divorce on the fact that his wife goes out frequently with her girlfriends. If using reality therapy, the nurse would help the patient with which of the following responses?
    A) ìIf you really love her, she should love you as well.î
    B) ìWhat does being divorced mean for you?î
    C) ìHow do you feel about your marriage ending?î
    D) ìWhat role do you think you have played in the end of your marriage?î
    Ans: D
    Feedback:
    Reality therapy challenges clients to examine the ways in which their own behavior thwarts their attempts to achieve life goals. Others are often assigned the blame when people hold onto irrational thinking. The search for meaning is associated with logotherapy. Exploring feelings are associated with gestalt therapy.

30. A nurse is assisting a patient who is working on the technique of systematic desensitization. When the patient feels anxious, the nurse can best use the principles of this technique by stating,
    A) ìUse the deep breathing techniques we practiced yesterday.î
    B) ìWhat is the worst that will happen if you confront this fear?î
    C) ìTell me how you are feeling right now.î
    D) ìI can see you are anxious. Let's stop for a minute.î
    Ans: A
    Feedback:
    Systematic desensitization can be used to help clients overcome irrational fears and anxiety associated with phobias. The client learns and practices relaxation techniques to decrease and manage anxiety. He or she is then exposed to the least anxiety provoking situation and uses the relaxation techniques to manage the resulting anxiety. Confronting irrational thoughts is part of rational emotive therapy. Encouraging expression of feelings is associated with gestalt therapy.

31. The nurse is working with a client who has a history of inflicting spousal abuse. Although the nurse does not condone domestic violence, the nurse treats the client with unconditional positive regard through which of the following?
    A) The nurse tries to understand the feelings that might have led to violent behavior.
    B) The nurse uses honest emotional expression in relating to client.
    C) The client is still viewed as someone worthy of respect and assistance.
    D) The nurse relates to the client as if he were her own spouse.
    Ans: C
    Feedback:
    Unconditional positive regard involves nonjudgmental caring for the client that is not dependent on the client's behavior. Genuineness is a realness or congruence between what the therapist feels and what he or she says to the client. Empathetic understanding is when the therapist senses the feelings and personal meaning from the client and communicates this understanding to the client.

32. A patient is being admitted to an inpatient unit for treatment of anorexia nervosa. Of the following assessment data, which should the nurse place as highest priority in the plan of care?
    A) Weight 24% below normal for height
    B) Distorted body image
    C) Feelings of inadequacy
    D) Frequent vomiting after meals
    Ans: D
    Feedback:
    Maslow's hierarchy of needs hypothesizes that the basic needs at the bottom of the pyramid dominate the person's behavior until those needs were met, at which time the next level of needs would become dominant. Vomiting threatens fluid and electrolyte balance and poses a more acute threat to survival than low weight. Once basic physical needs are met, the higher level needs such as body image and self-esteem can be addressed.

33. The primary purpose for generalist nurses to develop skills with psychosocial interventions is
    A) psychosocial interventions are included on the nursing licensure examinations.
    B) psychosocial interventions are needed in all nursing practice settings.
    C) nurses will be consulted to assist in the care of psychiatric patients in acute care settings.
    D) there are a growing number of nursing practice opportunities in mental health settings.
    Ans: B
    Feedback:
    Nurses often use psychosocial interventions to help meet clients' needs and achieve outcomes in all practice settings, not just mental health. Psychosocial interventions are included on the licensing exam, but that is not the primary reason for developing proficiency. Any health-care personnel will care for psychiatric patients in acute care settings. Current trends reflect a decline in mental health services and employment opportunities.

34. Which of the following considerations should have the most influence in the nurse's choice of the treatment for the client?
    A) The client's feelings and perceptions about his or her situation
    B) The nurse's beliefs about the theories of psychosocial development
    C) The nurse's familiarity with the type of treatment
    D) Any approach to treatment should work with any client.
    Ans: A
    Feedback:
    The client's feelings and perceptions about his or her situation are the most influential factors in determining his or her response to therapeutic interventions, rather than what the nurse believes the client should do. The nurse must examine his or her beliefs about the theories of psychosocial development and realize that many treatment approaches are available. Different treatments may work for different clients: no one approach works for everyone. Becoming familiar with the variety of psychosocial approaches for working with clients will increase the nurse's effectiveness in promoting the client's health and well-being.

35. Which approach to therapy is most effective when planning for a client with negative thinking?
    A) Behavior modification
    B) Client-centered therapy
    C) Cognitive therapy
    D) Reality therapy
    Ans: C
    Feedback:
    Cognitive therapy focuses on changing the client's thinking first, in the belief that then feelings and behavior can change as well. Behavior modification is a method of attempting to strengthen a desired behavior or response by reinforcement, either positive or negative. Client-centered therapy focuses on the role of the client, rather than the therapist, as the key to the healing process. Reality therapy focuses on the person's behavior and how that behavior keeps him or her from achieving life goals.

1. **Chapter 4**Which of the following factors is primarily responsible for the changes in inpatient hospital treatment between the 1980s and the present?
   A) Progress in treatment options for mentally ill persons
   B) The growth of managed care
   C) Less stigma associated with mental illness
   D) The current use of milieu therapy
   Ans: B
   Feedback:
   Managed care exerts cost-control measures such as recertification of admissions, utilization review, and case managementóall of which have altered inpatient treatment significantly. There has been some progress in treatment options for mentally ill persons, but that is not the primary factor that has changed mental health inpatient hospital care. There is lesser stigma associated with mental illness, but that is not the primary factor that has changed mental health inpatient hospital care. In the 1980s, a typical psychiatric unit emphasized milieu therapy, which required long lengths of stay because clients with more stable conditions helped to provide structure and support for newly admitted clients with more acute conditions.

2. The factor having the most influence on the current trend in treatment settings is the fact in recent years,
   A) funding for community programs has been inadequate.
   B) laws have enabled more people to be committed to treatment.
   C) state hospitals have expanded to meet the demand.
   D) community programs have been fully developed to meet treatment needs.
   Ans: A
   Feedback:
   Adequate funding has not kept pace with the need for community programs and treatment. Commitment laws have led to deinstitutionalization. Large state hospitals emptied as a result. Treatment in the community was intended to replace much of state hospital inpatient care, but funding has been inadequate.

3. A patient who has continuously experienced severe symptoms of schizoaffective disorder for the past 17 years is experiencing an acute psychotic episode. Which level of care is most appropriate for this patient at this time?
   A) Partial hospitalization
   B) Residential treatment
   C) Inpatient hospital treatment
   D) Clubhouse
   Ans: C
   Feedback:
   Long-stay clients in an inpatient setting are people with severe and persistent mental illness who continue to require acute care services despite the current emphasis on decreased hospital stays. This population includes clients who were hospitalized before deinstitutionalization and remain hospitalized despite efforts at community placement. It also includes clients who have been hospitalized consistently for long periods despite efforts to minimize their hospital stays. Partial hospitalization is designed for patients transitioning to independent living. Residential treatment and clubhouse model provide supervised independent living.

4. A patient with depression is admitted to an inpatient hospital unit for treatment. The type of therapy most likely provided in this setting includes
   A) leisure skills.
   B) self-monitoring of treatment.
   C) skills for daily living.
   D) talk therapy.
   Ans: D
   Feedback:
   A typical psychiatric unit emphasizes talk therapy, or one-on-one interactions between residents and staff, and milieu therapy, meaning the total environment and its effect on the client's treatment. Partial hospitalization programs teach skills for daily living. Clubhouse models provide patients opportunities for leisure activities and self-monitoring of treatment.

5. Which of the following is the highest priority for admission to inpatient care?
   A) Confusion or disorientation
   B) Need for medication changes
   C) Safety of self or others
   D) Withdrawal from alcohol or other drugs
   Ans: C
   Feedback:
   Safety is a priority; the inpatient setting provides for the safety of the client and/or others. Confusion or disorientation, need for medication changes, and withdrawal from alcohol or other drugs may also require inpatient care but the priority is safety.

6. The priority of inpatient care for people with severe mental illness is
   A) family issues.
   B) insight into illness.
   C) social skills.
   D) symptom management.
   Ans: D
   Feedback:
   Rapid assessment, stabilization of symptoms, and discharge planning are the focus of inpatient care today. Family issues, insight into illness, and social skills would not be priorities of care for clients with severe mental illness.

7. Discharge planning from inpatient care for people with severe mental illness must address which of the following to be effective? Select all that apply.
   A) Finding housing for the client
   B) Finding a job for the client
   C) Finding transportation for the client
   D) Improving family support
   E) Identifying ideal recreational activities
   Ans: A, C
   Feedback:
   Clinicians help clients recognize symptoms, identify coping skills, and choose discharge supports in the inpatient setting. People are able to remain in the community for longer periods of time when discharge planning addresses environmental supports, housing, transportation, and access to community support services. Finding a job for the client may be helpful if appropriate but may not be appropriate for the individual at the time of discharge from inpatient care. Improving family support and identifying ideal recreational activities are desirable but not essential for successful reintegration with the community.

8. Which type of community residential treatment setting is most likely to be permanent in any state?
   A) Halfway house
   B) Respite housing
   C) Independent living programs
   D) Evolving consumer household
   Ans: D
   Feedback:
   Because the evolving consumer household is a permanent living arrangement, it eliminates the problem of relocation. Halfway houses usually serve as temporary placements that provide support as the clients prepare for independence. Clients who are served by respite housing are those who live in group homes or independently most of the time but have a need for ìrespiteî from their usual residences when the client experiences a crisis, feels overwhelmed, or cannot cope with problems or emotions. Independent living programs are available in many states, but may vary a great deal in regard to services provided with some agencies providing a broad range of services or shelter but few services.

9. A patient is being transferred from a group home to an evolving consumer household. The goal of this transition is for the patient to eventually
   A) meet with a therapist on a weekly basis.
   B) resolve crises within a shorter time period.
   C) fulfill daily responsibilities without supervision.
   D) use the increased emotional support of paid staff.
   Ans: C
   Feedback:
   The evolving consumer household is a group-living situation in which the residents make the transition from a traditional group home to a residence where they fulfill their own responsibilities and function without onsite supervision from paid staff.

10. What is an important role of the nurse with regard to residents opposing plans to establish a group home or residential facility in their neighborhood?
    A) To provide information to correct misinformation related to stereotypes of persons with mental illnesses
    B) To persuade neighborhood residents that mentally ill people need safe, affordable, and desirable housing
    C) To provide for the safety and security of the neighborhood
    D) To ensure the security of persons in the group home
    Ans: A
    Feedback:
    Frequently, residents oppose plans to establish a group home or residential facility in their neighborhood. They argue that having a group home will decrease their property values, and they may believe that people with mental illness are violent, will act bizarrely in public, or will be a menace to their children. These people have strongly ingrained stereotypes and a great deal of misinformation. Local residents must be given the facts, and nurses are in a position to advocate for clients by educating members of the community. The neighborhood residents who object to the establishment of a group home or residential setting may not be motivated to understand the needs of mentally ill people. It is not the responsibility for the nurse to provide for the safety and security of the neighborhood or protect the safety and security of persons in the group home.

11. What are the two essential components of transitional care discharge model that is used in Canada and Scotland?
    A) Peer support and bridging staff
    B) Collaboration and funding
    C) Relapse and hospitalization
    D) Poverty and entitlements
    Ans: A
    Feedback:
    Two essential components of the transitional care discharge model are peer support and bridging staff. Peer support is provided by a consumer now living successfully in the community. Bridging staff refers to an overlap between hospital and community careóhospital staff do not terminate their therapeutic relationship with the client until a therapeutic relationship has been established with the community care provider. This model requires collaboration, administrative support, and adequate funding to effectively promote the patient's health and well-being and prevent relapse and rehospitalization. Poverty among people with mental illness is a significant barrier to maintaining housing. Mentally ill persons often rely on government entitlements for their income which forces people to have to choose continuation of the entitlement and dependence versus working inconsistently in unskilled, part-time, and low-paying jobs with no health insurance.

12. Some residential treatment settings are transitional. This means that clients are eventually expected to
    A) become self-sufficient.
    B) find employment.
    C) no longer need medication.
    D) relocate to another setting.
    Ans: D
    Feedback:
    Transitional housing is temporary; clients are expected to move to another residential setting. Clients using transitional treatment settings are not expected to become totally self-sufficient, find employment, or not be in need of medication.

13. The primary advantage of an evolving consumer household is that clients
    A) are provided with adequate income to combat poverty.
    B) do not have to relocate as they become more independent.
    C) have on-site staff supervision 24 hours a day.
    D) receive on-site medical care.
    Ans: B
    Feedback:
    An evolving consumer household is a permanent living situation, eliminating the need to change residential settings as clients gain independence. Many clients in evolving consumer households rely on Social Security Insurance or Social Security Disability Insurance. Clients function without onsite supervision.

14. The primary goal of a psychiatric rehabilitation program is to promote
    A) return to prior level of functioning.
    B) medication compliance.
    C) complete recovery from mental illness.
    D) stabilization and management of symptoms.
    Ans: C
    Feedback:
    Psychiatric rehabilitation goes beyond management of symptoms and medication management to include personal growth, reintegration into the community, empowerment, increased independence, and improved quality of life. It is not a goal of psychiatric rehabilitation to return to the prior level of functioning that may have been dysfunctional. It may not be realistic for the client to completely recover from mental illness, but rehabilitation can improve the quality of life for the client.

15. What is required for a transitional care model to be most effective in promoting the client's health and well-being and prevent relapse and rehospitalization? Select all that apply.
    A) Collaboration
    B) Administrative support
    C) Adequate funding
    D) Family support
    E) Completely different providers
    F) Isolation from peers who successfully live in the community
    Ans: A, B, C
    Feedback:
    Two essential components of transitional care model are peer support and bridging staff. Peer support is provided by a consumer now living successfully in the community. Bridging staff refers to an overlap between hospital and community careóhospital staff do not terminate their therapeutic relationship with the client until a therapeutic relationship has been established with the community care provider. This model requires collaboration, administrative support, and adequate funding to effectively promote the patient's health and well-being and prevent relapse and rehospitalization.

16. A patient has just begun daily participation in a community-based partial hospitalization program. The patient can expect the staff to assist with which of the following treatment goals? Select all that apply.
    A) Stabilizing psychiatric symptoms
    B) Finding a better job
    C) Improving activities of daily living
    D) Learning to structure time
    E) Improved family support
    F) Developing social skills
    Ans: A, C, D, F
    Feedback:
    Partial hospitalization programs are designed to help clients make a gradual transition from being inpatients to living independently and to prevent repeat admissions. In day treatment programs, clients return to home at night; evening programs are just the reverse. Partial hospitalization programs provide assistance with stabilizing psychiatric symptoms, monitoring drug effectiveness, stabilizing living environment, improving activities of daily living, learning to structure time, developing social skills, obtaining meaningful work, paid employment, or a volunteer position, and providing follow-up of any health concerns. Finding a better job and improving family support are not goals of partial hospitalization programs.

17. A patient has just been referred to a psychosocial rehabilitation program. The nurse explains that the benefits of being involved in such a program include: Select all that apply.
    A) continuous monitoring of symptoms.
    B) increased independence.
    C) increased involvement in treatment decisions.
    D) recovery from mental illness.
    E) increased community integration.
    F) greater opportunities for personal growth.
    Ans: B, D, E
    Feedback:
    Goals of psychosocial rehabilitation programs include recovery from mental illness, personal growth, quality of life, community reintegration, empowerment, increased independence, decreased hospital admissions, improved social functioning, improved vocational functioning, continuous treatment, increased involvement in treatment decisions, improved physical health, and a recovered sense of self. Monitoring of symptoms and medication education are major foci of partial hospitalization programs

18. Which type of psychiatric rehabilitation relies on intentional communities and rehabilitation alliances?
    A) Clubhouse model
    B) Assertive community treatment
    C) Group homes
    D) Respite housing
    Ans: A
    Feedback:
    The clubhouse model of psychiatric rehabilitation relies on intentional communities and rehabilitation alliances. Assertiveness community treatment (ACT) has a problem-solving orientation, and staff members who are in the community attend to specific life issues of the client. Group homes are a residential form of treatment for mental illness but do not provide complete psychiatric rehabilitation. Respite housing is temporary housing for mentally ill persons and does not provide complete psychiatric rehabilitation.

19. Which is the orientation of assertive community treatment (ACT)?
    A) Setting limits on mundane life issues
    B) Making a wide range of referrals
    C) Providing services in offices
    D) Problem-solving orientation
    Ans: D
    Feedback:
    An ACT program has a problem-solving orientation: Staff members attend to specific life issues, no matter how mundane. ACT programs provide most services directly rather than relying on referrals to other programs or agencies, and they implement the services in the clients' homes or communities, not in offices.

20. Which of the following are advantages of a crisis resolution team or home treatment team? Select all that apply.
    A) It is a residential treatment setting.
    B) It is more likely to help a client to perceive his or her situation more accurately.
    C) It is designed to assist clients in dealing with mental health crises without hospitalization.
    D) The client may feel better about asking for help.
    E) The client must meet multiple criteria to receive this type of care.
    Ans: B, C, D
    Feedback:
    Crisis resolution or respite care is a type of care for clients who have a perception of being in crisis and needing a more structured environment. A client having access to respite services is more likely to perceive his or her situation more accurately, feel better about asking for help, and avoid hospitalization.

21. A nurse is meeting with the city council to advocate for mentally ill persons and the establishment of a group home in a neighborhood where the plans have been strongly opposed by the neighbors. The nurse can effectively educate the public on the realities of group home by citing research that indicates
    A) property values quickly rebound in neighborhoods that have group homes.
    B) police surveillance will be increased to avert any violence by residents.
    C) most people with mental illness do not represent a significant danger to others.
    D) neighborhoods that provide park areas provide children a centralized and safe place to play.
    Ans: C
    Feedback:
    Frequently, residents oppose plans to establish a group home in their neighborhood, arguing that having a group home will decrease their property values, and they may believe that people with mental illness are violent, will act bizarrely in public, or will be a menace to their children. These people have strongly ingrained stereotypes and a great deal of misinformation.

22. A patient with bipolar disorder has a long history of both hospitalizations and incarcerations. The patient has no permanent residence and has infrequent contact with his family. Upon admission to the inpatient psychiatric unit for stabilization, the nurse documents all of the following in the record. Which of the following data most suggests a positive outcome for this patient?
    A) Reporting meeting with the same case manager monthly for the last 3 years
    B) History of residential stays at several local homeless shelters
    C) Last contact with siblings 4 years ago
    D) Income from day labor for 10 days last month
    Ans: A
    Feedback:
    Results are positive when personal connections with case managers are established. The most recent report from the ACCESS project found frequent shifts between the street, programs, and institutions worsen the lives of the homeless. The degree of social support and employment has direct influence on quality of life.

23. A nurse is orienting to a new position working the infirmary in the state penitentiary. When working with prisoners who are also mentally ill, the nurse examines her own attitudes. Which of the following beliefs should the nurse discuss with her supervisor before caring for incarcerated patients?
    A) People with mental illness are inherently violent.
    B) The mentally ill can get better treatment in prison than in the community.
    C) People with mental illness are more vulnerable to victimization when incarcerated.
    D) Many mentally ill would not be in prison if they were stabilized on medication.
    Ans: A
    Feedback:
    Although it is true that people with major mental illnesses who do not take prescribed medication are at increased risk for being violent, most people with mental illness do not represent a significant danger to others. Criminalization of mental illness refers to the practice of arresting and prosecuting mentally ill offenders, even for misdemeanors, at a rate four times that of the general population in an effort to contain them in some type of institution where they might receive needed treatment. People with a mental illness are more likely to be the victims of violence, both in prisons and in the community.

24. The nurse is part of a group setting up a mobile crisis service in conjunction with the local police department. Community education on which of the following this team will focus includes?
    A) Teaching police officers counseling skills
    B) Crisis counseling services to be provided in the prison system
    C) Educating about the dangers of the mentally ill in the community
    D) Assisting police officers to recognize mental illness
    Ans: D
    Feedback:
    Mobile crisis services are linked to police departments. These professionals are called to the scene when police officers believe mental health issues are involved. Frequently, the mentally ill individual can be diverted to crisis counseling services or to the hospital, if needed, instead of being arrested and going to jail. Often, these same professionals provide education to police to help them recognize mental illness and perhaps change their attitude about mentally ill offenders. They do not provide direct counseling training to police officers.

25. Which of the following are core skill areas that are needed of any effective team member of an interdisciplinary team? Select all that apply.
    A) Interpersonal skills
    B) Teamwork skills
    C) Communication skills
    D) The ability to work independently
    E) Risk assessment and risk management skills
    Ans: A, B, C, E
    Feedback:
    The core skill areas that are needed to function as an effective team member of an interdisciplinary team include interpersonal skills, such as tolerance, patience, and understanding; humanity, such as warmth, acceptance, empathy, genuineness, and nonjudgmental attitude; knowledge base about mental disorders, symptoms, and behavior; communication skills; personal qualities, such as consistency, assertiveness, and problem-solving abilities; teamwork skills, such as collaborating, sharing, and integrating; risk assessment and risk management skills. Members of an interdisciplinary group must work interdependently, not independently.

26. A patient has been started on antidepressants. The interdisciplinary team member most responsible for monitoring effectiveness and side effects of this new medication is the
    A) pharmacist.
    B) psychiatrist.
    C) psychiatric nurse.
    D) psychologist.
    Ans: C
    Feedback:
    The nurse is also an essential team member in evaluating the effectiveness of medical treatment, particularly medications. The pharmacist has a working knowledge of medications but has limited contact with the patient. The primary function of the psychiatrist is diagnosis of mental disorders and prescription of medical treatments. The clinical psychologist practices therapy.

27. A patient is encouraged to join in daily outdoor games with peers on the unit. The interdisciplinary team member who will monitor the patient's involvement will be the
    A) occupational therapist.
    B) recreation therapist.
    C) vocational rehabilitation therapist.
    D) psychiatric nurse.
    Ans: B
    Feedback:
    The recreation therapist helps the client to achieve a balance of work and play in his or her life and provides activities that promote constructive use of leisure or unstructured time. Occupational therapy focuses on the functional abilities of the client and ways to improve client functioning. Vocational rehabilitation includes determining clients' interests and abilities and matching them with vocational choices. The nurse has a solid foundation in health promotion, illness prevention, and rehabilitation in all areas, allowing him or her to view the client holistically. The nurse is also an essential team member in evaluating the effectiveness of medical treatment, particularly medications.

28. A patient with bipolar disorder taking lithium returns from a walk outside and reports feeling shaky and dizzy. The nurse suspects the patient is experiencing a toxic reaction to the lithium and immediately notifies the
    A) psychiatrist.
    B) psychologist.
    C) nurse manager.
    D) recreation therapist.
    Ans: A
    Feedback:
    The primary function of the psychiatrist is diagnosis of mental disorders and prescription of medical treatments. Psychologists participate in the design of therapy programs for groups of individuals. The nurse is an essential team member in evaluating the effectiveness of medical treatment particularly medications. The recreation therapist helps the client to achieve a balance of work and play.

29. A nurse documents that a patient has successfully acquired a job performing janitorial services at a local manufacturing company. The goal of which of the following levels of prevention has been achieved?
    A) Primary prevention
    B) Secondary prevention
    C) Tertiary prevention
    D) Community prevention
    Ans: C
    Feedback:
    Nurses work to provide mental health prevention services to reduce risks to the mental health of persons, families, and communities. Examples include primary prevention, such as stress management education; secondary prevention, such as early identification of potential mental health problems; and tertiary prevention, such as monitoring and coordinating rehabilitation services for the mentally ill.

30. A psychiatric nurse is planning an educational program addressing primary prevention strategies in the community. The nurse explores current research regarding which health-care need?
    A) Influencing schizophrenic patients to adhere to medication regimens
    B) Assisting high school students to effectively manage stress
    C) Coaching patients with depression to obtain employment
    D) Teaching parents the early signs of attention deficit disorder in children
    Ans: B
    Feedback:
    Nurses work to provide mental health prevention services to reduce risks to the mental health of persons, families, and communities. Examples include primary prevention, such as stress management education; secondary prevention, such as early identification of potential mental health problems; and tertiary prevention, such as monitoring and coordinating rehabilitation services for the mentally ill.

31. A psychiatric nurse is planning activities aimed at secondary prevention of mental illness. Which activity would be most appropriate to develop?
    A) Self-esteem building with a local after-school program
    B) Social skills training for chronic schizophrenics
    C) Parenthood classes at a local community center
    D) Depression screening in an assisted living facility
    Ans: D
    Feedback:
    Nurses work to provide mental health prevention services to reduce risks to the mental health of persons, families, and communities. Examples include primary prevention, such as stress management education; secondary prevention, such as early identification of potential mental health problems; and tertiary prevention, such as monitoring and coordinating rehabilitation services for the mentally ill.

32. Which element would be present in an assertive community treatment (ACT) program?
    A) 24-hour-a-day services
    B) Infrequent contact with clients
    C) Many clients to each staff member
    D) Limited length of service
    Ans: A
    Feedback:
    ACT includes a 24-hour-a-day service, many staff members for each client, in-home or community services, intense and frequent contact, and unlimited length of service.

1. **Chapter 5** The nurse understands that empathy is essential to the therapeutic relationship. When a patient makes the statement, ìI am just devastated that my marriage is falling apart,î the nurse can best show empathy through which of the following responses?
   A) ìI feel so bad for what you are going through.î
   B) ìYou feel like your world is falling apart right now.î
   C) ìI have been divorced too. I know how hard it is.î
   D) ìIt will get better; let's talk about it.î
   Ans: B
   Feedback:
   Therapeutic communication techniques, such as reflection, restatement, and clarification, help the nurse to send empathetic messages to the client. The nurse must understand the difference between empathy and sympathy (feelings of concern or compassion one shows for another). Sympathy often shifts the emphasis to the nurse's feelings, hindering the nurse's ability to view the client's needs objectively.

2. The nurse is working with a patient who has quit several jobs and no longer sends financial support to his two children living with their mother. This behavior is in conflict with the nurse's values concerning responsible parenting. When discussing family roles with the patient, the nurse shows positive regard through which statement?
   A) ìHow is not working right now affecting you?î
   B) ìHow do you expect your kids to be provided for?î
   C) ìYou need to somehow find a way to support your children.î
   D) ìCan the children's mother can get by for a while until you get better?î
   Ans: A
   Feedback:
   The nurse who appreciates the client as a unique worthwhile human being can respect the client regardless of his or her behavior, background, or lifestyle. The nurse maintains attention on the client and avoids communicating negative opinions or value judgments about the client's behavior. In using positive regard, the nurse avoids value judgments and shifting of the focus away from the patient.

3. Which of the following statements is true of the component of a therapeutic relationshipóìacceptanceî?
   A) The nurse accepts the behavior of any inappropriate behavior.
   B) It is avoiding judgments of the person, no matter what the behavior is.
   C) It involves punishment for inappropriate behavior.
   D) It is the ability of the nurse to perceive the meanings and feelings of the client and to communicate that understanding to the client.

   Ans: B

   Feedback:

   Acceptance is avoiding judgments of the person, no matter what the behavior is. It means accepting the person but not necessarily the behavior. It does not involve punishment for inappropriate behavior. Empathy is the ability of the nurse to perceive the meanings and feelings of the client and to communicate that understanding to the client.

4. Which of the following behaviors by the nurse demonstrate positive regard? Select all that apply.
   A) Communicating judgments about the client's behavior
   B) Calling the client by name
   C) Spending time with the client
   D) Responding openly
   E) Considering the client's ideas and preference when planning care

   Ans: B, C, D, E

   Feedback:

   Calling the client by name, spending time with the client, and listening and responding openly are measures by which the nurse conveys respect and positive regard to the client. The nurse also conveys positive regard by considering the client's ideas and preferences when planning care. The nurse maintains attention on the client and avoids communicating negative opinions or value judgments about the client's behavior.

5. The nurse initiating a therapeutic relationship with a client should explain the purpose, which is to
   A) alleviate stressors in life.
   B) allow the client to know the nurse's feelings.
   C) establish relationships.
   D) facilitate a positive change.
   Ans: D
   Feedback:
   The client who has unmet or unsatisfactorily met needs seeks to make changes; the nurse facilitates this desire to change. The focus of the therapeutic relationship is on the client's needs, not the nurse's. The orientation phase begins when the nurse and client meet and ends when the client begins to identify problems to examine. During the orientation phase, the nurse establishes roles, the purpose of meeting, and the parameters of subsequent meetings; identifies the client's problems; and clarifies expectations.

6. Which of the following is the most important skill the nurse must bring to the therapeutic nurseñclient relationship?
   A) Confrontation
   B) Empathy
   C) Humor
   D) Reframing
   Ans: B
   Feedback:
   The nurse must be able to express caring and concern for the client. Empathy is the ability of the nurse to perceive the meanings and feelings of the client and to communicate that understanding to the client. The ability to use confrontation, humor and reframing are also important skills but not as important as the skill of empathy.

7. Which is a standard for establishing a code of conduct for living?
   A) Acceptance
   B) Empathy
   C) Values
   D) Positive regard
   Ans: C
   Feedback:
   Values are abstract standards that give a person a sense of right and wrong and establish a code of conduct for living. Acceptance occurs when the nurse does not become upset or respond negatively to a client's outbursts, anger, or acting out. Empathy is the ability of the nurse to perceive the meaning and feelings of the client and to communicate that understanding to the client. Positive regard is an unconditional, nonjudgmental attitude.

8. A nurse makes the statement in a treatment team meeting, ìIt's not worth it to try to teach this patient how to make better choices. He has been here many times before and goes back home and does the same thing.î The nurse is sharing which of the following?
   A) Value
   B) Awareness
   C) Belief
   D) Attitude
   Ans: D
   Feedback:
   Attitudes are general feelings or a frame of reference around which a person organizes knowledge about the world and people. Values are abstract standards that give a person a sense of right and wrong and establish a code of conduct for living. Beliefs are ideas that one holds to be true; for example, ìAll old people are hard of hearing,î and ìIf the sun is shining, it will be a good day.î

9. The client tells the nurse, ìI don't think you can help me. Every time I talk to you, I am reminded of my mother, and I hated her.î The nurse should recognize this as
   A) confrontation.
   B) countertransference.
   C) incongruence.
   D) transference.
   Ans: D
   Feedback:
   Transference occurs when the client unconsciously transfers to the nurse feelings he or she has for significant others. Confrontation is a technique used to highlight the incongruence between a person's verbalizations and actual behavior. Countertransference occurs when the therapist displaces onto the client attitudes or feelings from his or her past. Incongruence occurs when the communication content and process disagree.

10. When preparing for the first clinical experience with patients on a forensic unit at a psychiatric hospital, the nursing instructor discusses students' beliefs and fears surrounding forensic patients. The primary reason for discussing personal beliefs is to
    A) practice reflective communication skills in a role-play situation.
    B) assign the most compatible patients to the students.
    C) assess the appropriateness of the setting for implementing nursing skills.
    D) become aware of possible barriers to developing therapeutic relationships.
    Ans: D
    Feedback:
    Self-awareness allows the nurse to observe, pay attention to, and understand the subtle responses and reactions of clients when interacting with them. Nurses are responsible for caring for patients in all settings and build therapeutic relationship skills regardless of personal beliefs.

11. A nurse is working with a patient whose background is very different from hers. A good question to ask herself to assure she can be effective working with this patient would be,
    A) ìCan this person understand me?î
    B) ìDo I understand this patient's expectations of me?î
    C) ìWhat experiences do I have with people with similar backgrounds?î
    D) ìIs this person going to be able to relate to me?î
    Ans: C
    Feedback:
    To best assess self-awareness, the nurse should ask ìWhat experiences have I had with people from ethnic groups, socioeconomic classes, religions, age groups, or communities different from my own?î The nurse should not focus on the patient when examining self-awareness, rather, how the nurse's experiences have shaped attitudes and beliefs.

12. The client says to the nurse, ìI feel really close to you. You are the only true friend I have.î The most therapeutic response the nurse can make is,
    A) ìI am sure there are other people in your life who are your friends; besides, we just met.î
    B) ìIt makes me feel good that you trust me so much; it is important for the work we are doing together.î
    C) ìSince ours is a professional relationship, let's explore other opportunities in your life for friendship.î
    D) ìWe are not friends. This is strictly professional.î
    Ans: C
    Feedback:
    The nurse's response must let the client know in clear terms that the relationship is professional while not demeaning or ridiculing the client. The other choices would not be appropriate replies in this situation.

13. A client who had been in a substance abuse treatment program asks the nurse for a date after the client is discharged. The nurse talks to the client about the importance of a therapeutic relationship and its characteristics. The nurse is using which of the following techniques?
    A) Defining boundaries
    B) Defining therapy
    C) Letting the client down gently
    D) Reprimanding the client
    Ans: A
    Feedback:
    A therapeutic relationship is professional, and there are no mutual social goals; it is focused on meeting the client's needs and is terminated when the client no longer needs services. It is up to the nurse to maintain professional boundaries. The other choices would be inappropriate techniques to use toward this client.

14. The nurse fails to assess personal values surrounding homosexuality before caring for a patient who is openly gay. The nurse is most at risk for which of the following when working with this patient?
    A) Holding a prejudice toward this patient
    B) Neglecting to include the patient's desires in the plan of care
    C) Being manipulated by this patient
    D) Expressing shock when assessing the patient's history
    Ans: A
    Feedback:
    A person who does not assess personal attitudes and beliefs may hold a prejudice or bias toward a group of people because of preconceived ideas or stereotypical images of that group. It is not uncommon for a person to be ethnocentric about his or her own culture. Failure to consider cultural variations or reactions to initial exposure to variations is less detrimental to the therapeutic relationship than cultural bias. Manipulation results from a failure to maintain boundaries.

15. Which one of the following statements about the nurse and ethnocentrism is true?
    A) Nurses as people may inwardly view their own culture as superior to others.
    B) Ethnocentrism is a desirable trait in a nurse.
    C) Nurses must deny their ethnocentrism.
    D) A nurse must not think of his or her own attitudes and beliefs.
    Ans: A
    Feedback:
    Nurses as people may inwardly view their own culture as superior to others. Ethnocentrism is not uncommon especially when the person has no experience with any culture other than his or her own. It is neither a desirable trait nor an undesirable trait. Nurses must examine their ethnocentrism, and think of their own attitudes and beliefs.

16. A nurse is using the Johari window to identify the degree to which he feels comfortable communicating with others. After completing the exercise, the nurse discovers that quadrant 1 has the longest list of qualities. This indicates which of the following about the nurse?
    A) The nurse conceals personal information about himself.
    B) The nurse needs to increase insight into his own characteristics.
    C) The nurse is open to others.
    D) The patient is sharing more than the nurse in the therapeutic relationship.
    Ans: C
    Feedback:
    When using the Johari window, if quadrant 1 is the largest, this indicates that the nurse is open to others; a smaller quadrant 1 means that the nurse shares little about himself or herself with others. If quadrants 1 and 3 are both small, the person demonstrates little insight.

17. A nurse is assigned to care for a client whose sexual orientation differs from the nurse's sexual orientation. When should the nurse seek clinical supervision?
    A) When the nurse tries to assist the client to change values
    B) To discuss the nurse's feelings about the client with a supervisor
    C) When the nurse begins to empathize with the client
    D) When the nurse identifies anxieties regarding the client's values and sexuality
    Ans: A
    Feedback:
    It is not the nurse's role to change the values of the client. The nurse should empathize with the client and be able to discuss feelings about the client with the nurse's supervisor, including anxieties regarding the client's values and sexuality.

18. A nurse notices a patient sitting quietly alone, eyes downcast, and looking sad. The nurse says to the patient, ìYou look like something is bothering you.î Which pattern of knowing did the nurse use to respond to the patient?
    A) Empirical knowing
    B) Personal knowing
    C) Ethical knowing
    D) Aesthetic knowing
    Ans: B
    Feedback:
    Personal knowing is obtained from life experience. An example would be a client's face shows the panic. Empirical knowing is obtained from the science of nursing. An example would be a client with panic disorder begins to have an attack. Panic attack will raise pulse rate. Ethical knowing is obtained from the moral knowledge of nursing. An example is although the nurse's shift has ended, she remains with the client. Aesthetic knowing is obtained from the art of nursing. Although the client shows outward signals now, the nurse has sensed previously the client's jumpiness and subtle differences in the client's demeanor and behavior.

19. The nurse assesses fine hand tremors in a patient with a history of heavy alcohol use. If the nurse understands that the tremors are a direct result of alcohol use, the nurse is using which pattern of knowing, according to Carper?
    A) Aesthetic knowing
    B) Ethical knowing
    C) Personal knowing
    D) Empirical knowing
    Ans: D
    Feedback:
    Empirical knowing is obtained from the science of nursing. An example would be a client with panic disorder begins to have an attack. Panic attack will raise pulse rate. Personal knowing is obtained from life experience. An example would be a client's face shows the panic. Ethical knowing is obtained from the moral knowledge of nursing. An example is although the nurse's shift has ended, she remains with the client. Aesthetic knowing is obtained from the art of nursing. Although the client shows outward signals now, the nurse has sensed previously the client's jumpiness and subtle differences in the client's demeanor and behavior.

20. A nurse openly admits to not being able to relate to a patient's experience. According to Munhall, this will most likely have what influence on the therapeutic relationship?
    A) The nurse will avoid imposing any values on the patient.
    B) The patient will not trust the nurse's professional abilities.
    C) The nurse will more likely be manipulated by the patient.
    D) The patient will be less likely to self-disclose to the nurse.
    Ans: A
    Feedback:
    Munhall added another pattern of knowing called unknowing: For the nurse to admit she or he does not know the client or the client's subjective world opens the way for a truly authentic encounter. The nurse in a state of unknowing is open to seeing and hearing the client's views without imposing any of his or her values or viewpoints.

21. The nurse and patient are visiting about upcoming sporting events of which they both share an interest. This form of interaction has the potential to threaten the nurseñpatient relationship by
    A) influencing whether the patient likes the nurse or not.
    B) avoiding serious work that can help the patient change.
    C) letting the patient know that the nurse is genuine with diverse interests.
    D) overstepping ethical boundaries that the nurse should maintain.
    Ans: B
    Feedback:
    Small talk or socializing is acceptable in nursing, but for the nurseñclient relationship to accomplish the goals that have been decided on, social interaction must be limited. If the relationship becomes more social than therapeutic, serious work that moves the client forward will not be done.

22. The nurse is mindful of maintaining relationships with patients that are therapeutic. Certain characteristics of the relationships the nurse will foster include: Select all that apply.
    A) offering sound advice to the patient.
    B) establishing boundaries for both the nurse and patient.
    C) maintaining a patient-focus at all times.
    D) sharing personal feelings openly with the patient.
    E) avoiding concern with whether the patient likes the nurse.
    Ans: B, C, E
    Feedback:
    The therapeutic relationship focuses on the needs, experiences, feelings, and ideas of the client only. In the therapeutic relationship, the parameters are clear: the focus is the client's needs, not the nurse's. The nurse should not be concerned about whether or not the client likes him or her or is grateful. A social relationship is focuses on sharing ideas, feelings, and experiences and meets the basic need for people to interact. In social relationships, advice is often given. This should be avoided in therapeutic relationships.

23. One of the primary differences between social and therapeutic relationships is the
    A) amount of emotion invested.
    B) degree of satisfaction obtained.
    C) kind of information given.
    D) type of responsibility involved.
    Ans: D
    Feedback:
    The nurse has the responsibility for the therapeutic relationship. The therapeutic relationship focuses on the needs, experiences, feelings, and ideas of the client only. A social relationship is primarily initiated for the purpose of friendship, socialization, companionship, or accomplishment of a task.

24. During the orientation phase of the nurseñpatient relationship, the nurse directs the patient to do which of the following?
    A) Identify problems to examine
    B) Express needs and feelings
    C) Develop interpersonal skills
    D) Identify self-care strategies
    Ans: A
    Feedback:
    The orientation phase begins when the nurse and client meet and ends when the client begins to identify problems to examine. Expression of feelings and improving interpersonal skills are tasks of the working phase. Self-care strategies are developed and assessed nearing termination.

25. The nurse has been working with a patient with an eating disorder for one week. During the morning treatment team meeting, the treatment plan is updated. Which of the following would be appropriate interventions at this time in the nurseñpatient relationship? Select all that apply.
    A) Exploring perceptions of reality
    B) Promoting a positive self-concept
    C) Explaining the boundaries of the relationship
    D) Working through resistance
    E) Assisting in identifying problems
    Ans: A, B, D
    Feedback:
    Specific tasks of the working phase include maintaining the relationship, gathering more data, exploring perceptions of reality, developing positive coping mechanisms, promoting a positive self-concept, encouraging verbalization of feelings, facilitating behavior change, working through resistance, evaluating progress and redefining goals as appropriate, providing opportunities for the client to practice new behaviors, and promoting independence. Establishing boundaries and identifying problems are completed in the orientation phase.

26. A patient being discharged appears angry with the nurse when the nurse attempts to review discharge instructions with the patient. The nurse can best assist the patient in this stage of the relationship with which of the following responses?
    A) ìWe have to go over these instructions before you can go. Please try to listen.î
    B) ìWould you rather not be discharged today?î
    C) ìI can sense you are angry this morning. Tell me how you feel about being discharged today.î
    D) ìYou should be able to regulate your feelings better by now. Why are you angry?î
    Ans: C
    Feedback:
    Both nurse and client usually have feelings about ending the relationship; the client especially may feel the termination as an impending loss. Often clients try to avoid termination by acting angry or as if the problem has not been resolved. The nurse can acknowledge the client's angry feelings and assure the client that this response is normal to ending a relationship. If the client tries to reopen and discuss old resolved issues, the nurse should identify the client's stalling maneuvers and refocus the client on newly learned behaviors and skills to handle the problem.

27. During a regular home health visit to an elderly client, the nurse observes that the client has feelings of hopelessness and despair. The client says, ìI'm old, and my life has no purpose anymore. But promise me you won't tell anyone.î How should the nurse respond?
    A) ìDon't worry, I won't tell anyone else.î
    B) ìI'm sorry, but I can't keep that kind of secret.î
    C) ìLet's talk about something to cheer you up.î
    D) ìWhat can we do to help you feel better?î
    Ans: B
    Feedback:
    Keeping secrets with a client is not permissible, especially when the client's safety is concerned. The other choices would be inappropriate responses in this situation.

28. What would be the most appropriate action by the student nurse when the client asked the student nurse to keep it secret that the client plans to kill a family member?
    A) The student nurse must respect the client's privacy and not tell anyone.
    B) The student nurse must tell the client that the student nurse cannot keep that secret and then report it to the instructor and/or staff members.
    C) The student nurse must tell the client that the student nurse will keep the secret and then tell the instructor and/or staff members.
    D) The student nurse must tell the instructor and then ask the instructor to keep it secret.
    Ans: B
    Feedback:
    If a client tells a professional that the he or she has homicidal thoughts, the professional is released from privileged communication. The nurse is then required to notify intended victims and police of such a threat. The nurse must report the homicidal threat to the nursing supervisor and attending physician so that both the police and the intended victim can be notified.

29. During the working phase of a therapeutic relationship, which of the following actions by the nurse would best help the client to explore problems?
    A) Comparing past and present coping strategies
    B) Encouraging the client to clarify feelings and behavior
    C) Identifying possible solutions for the client's problems
    D) Referring the client to a self-help group
    Ans: B
    Feedback:
    Helping the client to clarify feelings and behavior is a first step in problem identification and exploration. The nurse must remember that it is the client who examines and explores problem situations and relationships. The nurse must be nonjudgmental and refrain from giving advice. The other choices would not help the client to explore problems.

30. Which of the following occurrences is considered a breach of professional boundaries?
    A) Patient asking a nurse for her phone number
    B) Refusing a gift from a patient
    C) Changing the subject in response to a patient complement
    D) Having a lengthy social conversation with a patient
    Ans: D
    Feedback:
    The nurse must maintain professional boundaries to ensure the best therapeutic outcomes. The nurse must act warmly and empathetically but must not try to be friends with the client. Social interactions that continue beyond the first few minutes of a meeting contribute to the conversation staying on the surface. This lack of focus on the problems erodes the professional relationship. The nurse is responsible for maintaining boundaries in the event of patient inappropriateness.

31. Which of the following statements correctly depict the problem of feeling sympathy toward the client? Select all that apply.
    A) This can cause the nurse to feel sad and be unable to help the client.
    B) When the nurse's behavior is rooted in sympathy, the client finds it easier to manipulate the nurse's feelings.
    C) The client is discouraged from exploring his or her problems, thoughts, and feelings.
    D) The client is discouraged from growth.
    E) The client feels dependent on the nurse.
    Ans: B, C, D, E
    Feedback:
    The nurse who feels sorry for the client often tries to compensate by trying to please him or her. When the nurse's behavior is rooted in sympathy, the client finds it easier to manipulate the nurse's feelings. This discourages the client from exploring his or her problems, thoughts, and feelings; discourages client growth; and often leads to client dependency.

32. How can a nurse avoid the possibility of finding the client's behavior unacceptable or distasteful?
    A) By being aware of the client's behavior and background before beginning the relationship; and exploring the possibility of a conflict of a colleague.
    B) By using silence instead of verbal responses for all instance of the client describing their behavior
    C) By using facial expressions of annoyance if the client expresses behavior that the nurse disapproves of
    D) By turning away from the client when the nurse does not want the client to see his or her facial expression

    Ans: A

    Feedback:

    The nurseñclient relationship can be jeopardized if the nurse finds the client's behavior unacceptable or distasteful and allows these feelings to show by avoiding the client or making verbal responses or facial expressions of annoyance or turning away from the client. The nurse should be aware of the client's behavior and background before beginning the relationship; if the nurse believes there may be conflict, he or she must explore this possibility with a colleague.

33. A nurse and patient have just completed reviewing the patient's take-home medications. The nurse is exemplifying which role during this intervention?
    A) Advocate
    B) Caregiver
    C) Teacher
    D) Parent Surrogate

    Ans: C

    Feedback:

    During the working phase of the nurseñclient relationship, the nurse may teach the client new methods of coping and solving problems. He or she may instruct about the medication regimen and available community resources. The caregiver role is used when the nurse helps the client meet psychosocial or physical needs. When functioning as an advocate, the nurse is acting on the client's behalf when he or she cannot do so. Nurses may need to assume a parental role when the patient needs nurturing or limit setting.

34. An adolescent patient has just been found to have broken one of the unit rules. The nurse imposes the consequence of losing phone privileges. In this instance, the nurse is acting as
    A) advocate.
    B) caregiver.
    C) teacher.
    D) parent surrogate.
    Ans: D
    Feedback:
    During the working phase of the nurseñclient relationship, nurses may need to assume a parental role when the patient needs nurturing or limit-setting. The nurse may also function as a teacher when the client needs to learn new skills, such as methods of coping and solving problems. The caregiver role is used when the nurse helps the client meet psychosocial or physical needs. When functioning as an advocate, the nurse is acting on the client's behalf when he or she cannot do so.

35. Which role of the nurse is most likely to create difficulty for the nurseñclient relationship if the client confuses physical care with intimacy and sexual interest?
    A) Teacher
    B) Caregiver
    C) Advocate
    D) Parent surrogate
    Ans: B
    Feedback:
    Some clients may confuse physical care with intimacy and sexual interest, which can erode the therapeutic relationship. When the nurse is engaged in the role of teacher, the nurse may teach the client new methods of coping and solving problems or he or she may instruct the client about the medication regimen and available community resources. In the advocate role, the nurse informs the client and then supports him or her in whatever decision he or she makes. When a client exhibits child-like behavior or when a nurse is required to provide personal care such as feeding or bathing, the nurse may be tempted to assume the parental role.

36. Which of the following statements is true about a nurse's self-disclosure?
    A) It is the basis for effective communication.
    B) Self-disclosure should be used with all clients to some degree.
    C) The more the nurse discloses, the more the client will disclose.
    D) Self-disclosure on the nurse's part should benefit the client.
    Ans: D
    Feedback:
    Disclosing personal information to a client can be harmful and inappropriate, so it must be planned and considered thoughtfully in advance. The nurse should determine what benefit any given client will gain from nurse self-disclosure; only when that benefit can be clearly identified should self-disclosure be used, and then it should be used judiciously and within the boundaries of the relationship.

1. **Chapter 6** The nurse uses a variety of therapeutic communication skills when working with patients. Which of the following is a therapeutic goal that can be accomplished through the use of therapeutic communication skills?
   A) Inform the patient of priority problems
   B) Assess the patient's perception of a problem
   C) Assist the patient to control emotions
   D) Provide the patient with a plan of action
   Ans: B
   Feedback:
   Therapeutic communication can help nurses to accomplish many goals including identifying the most important concern to the client at that moment, assessing the client's perception of the problem, facilitating the client's expression of emotions, and guiding the client toward identifying a plan of action.

2. Which one of the following goals of therapeutic communication would the nurse strive to attain first?
   A) Facilitate the client's expression of emotions.
   B) Establish a therapeutic nurseñclient relationship.
   C) Teach the client and family necessary self-care skills.
   D) Implement interventions designed to address the client's needs.
   Ans: A
   Feedback:
   Establishing a therapeutic relationship is one of the most important responsibilities of the nurse when working with clients.

3. Which of the following statements is true of empathy? Select all that apply.
   A) It is the ability to place oneself into the experience of another for a moment in time.
   B) It involves interjecting the nurse's personal experiences and interpretations of the situation.
   C) It is developed by gathering information from the client.
   D) It results in negative therapeutic outcomes.
   E) The client must learn to develop empathy for the nurse.
   Ans: A, C
   Feedback:
   Empathy is the ability to place oneself into the experience of another for a moment in time. Nurses develop empathy by gathering as much information about an issue as possible directly from the client to avoid interjecting their personal experiences and interpretations of the situation. It does not result in negative therapeutic outcomes. The nurse must develop empathy with the client.

4. The nurse asks the patient what he would like to talk about. This is an example of
   A) broad opening.
   B) encouraging expression.
   C) focusing.
   D) offering self.
   Ans: A
   Feedback:
   Broad openings allow the client to take the initiative in introducing the topic. Encouraging expression involves asking the client to appraise the quality of his or her experiences. The nurse uses focusing when concentrating on a single point. Offering self occurs when making oneself available.

5. A patient says, ìIts' been so long since I've been with my family.î Which statement by the nurse is an example of restating?
   A) ìYou say you haven't seen your family in a while.î
   B) ìTell me when you last saw your family.î
   C) ìGo on. Tell me more.î
   D) ìWhen was the last time you saw your family?î
   Ans: A
   Feedback:
   Restating is repeating the main idea expressed. Restatement lets the client know that he or she communicated the idea effectively. This encourages the client to continue. Focusing or concentrating on a single point encourages the client to concentrate his or her energies on a specific point, which may prevent a multitude of factors or problems from overwhelming the client. General leads give encouragement to continue. They indicate that the nurse is listening and following what the client is saying without taking away the initiative for the interaction. Placing events in sequence clarifies the relationship of events in time. This helps both the nurse and the client to see them in perspective.

6. The patient expresses frustration that the doctor does not spend enough time with the patient when making rounds. The nurse replies, ìThe doctors are very busy. What can I help you with?î The nurse incorporated which nontherapeutic technique in this response?
   A) Belittling
   B) Defending
   C) Disagreeing
   D) Introducing an unrelated topic
   Ans: B
   Feedback:
   Defending attempts to protect someone or something from verbal attack. This implies that the client has no right to express impressions, opinions, or feelings. Belittling is misjudging the degree of the client's discomfort, which implies that the discomfort is temporary, mild, self-limiting, or not very important. Disagreeing is opposing the client's ideas, which may cause the client to feel defensive about his or her point of view or ideas. Introducing an unrelated topic is evidenced when the nurse changes the subject. This takes away the initiative for the client to interact.

7. A patient asks the nurse what she should do about her ìcheatingî husband. The nurse replies, ìYou should divorce him. You deserve better than that.î The nurse used which communication technique?
   A) Giving information
   B) Verbalizing the implied
   C) Giving advice
   D) Agreeing
   Ans: C
   Feedback:
   The nurse should not give advice, or tell the patient what to do. Advising implies that only the nurse knows what is best for the client. Giving information is therapeutic when the patient needs facts. Verbalizing the implied is a therapeutic communication technique which involves putting clearly into words what the patient has suggested. Verbalizing tends to make the discussion less obscure. Agreeing, or giving approval, indicates the patient is right or wrong. Nurses should remain neutral when using therapeutic communication skills.

8. The nurse asks the client what that experience was like. Which communication skill is the nurse using?
   A) Encouraging expression
   B) Encouraging description of perceptions
   C) Exploring
   D) Requesting an explanation
   Ans: A
   Feedback:
   Encouraging expression is a therapeutic technique and involves asking the client to appraise the quality of his or her experiences. Encouraging description of perceptions is a therapeutic technique and involves asking the client to verbalize what he or she perceives. Exploring is a therapeutic technique that involves delving further into a subject or an idea. Requesting an explanation is a nontherapeutic verbal communication technique that involves asking the client to provide reasons for thoughts, feelings, behaviors, events.

9. Which of the following are nontherapeutic techniques? Select all that apply.
   A) Silence
   B) Voicing doubt
   C) Agreeing
   D) Challenging
   E) Giving approval
   F) Accepting
   Ans: C, D, E
   Feedback:
   Silence is a therapeutic technique that involves the absence of verbal communication, which provides time for the client to put thoughts or feelings into words, to regain composure, or to continue talking. Voicing doubt is a therapeutic technique that involves expressing uncertainty about the reality of the client's perceptions. Agreeing is a nontherapeutic technique that involves indicating accord with the client. Agreeing indicates the client is ìrightî rather than ìwrong,î and there is no opportunity for the client to change his or her mind without being ìwrong.î Challenging is a nonverbal communication technique that involves demanding proof from the client, and this may cause the client to defend delusions or misperceptions more strongly than before. Giving approval is a nontherapeutic communication technique that involves sanctioning the client's behavior or ideas. Accepting is a therapeutic technique that involves indicating reception.

10. Which of the following statements would be an empathetic response in a client interaction?
    A) ìYou must have been embarrassed when your father yelled at you in the grocery store.î
    B) ìYou really should find your own housing and get out of the situation with your father.î
    C) ìWell, it sounds like your father has difficulty controlling his temper.î
    D) ìWhy do you think your father chose that time and place to yell at you?î
    Ans: A
    Feedback:
    This statement conveys the nurse's understanding of the client's feelings. Empathy is the ability to place oneself into the experience of another for a moment in time. Nurses develop empathy by gathering as much information about an issue as possible directly from the client to avoid interjecting their personal experiences and interpretations of the situation. The other choices do not convey empathy.

11. The nurse says to the client, ìYou become very anxious when we start talking about your drinking.î Which of the following techniques is the nurse using?
    A) Confronting behavior
    B) Making an observation
    C) Translating into feelings
    D) Verbalizing the implied
    Ans: B
    Feedback:
    The nurse is stating what he or she sees; the client can validate it or reject it. The nurse is not confronting the behavior in this situation. The nurse is not translating the message into feelings (seeking to verbalize client's feelings that he or she expresses only indirectly), nor is the nurse verbalizing the implied (voicing what the client has hinted at or suggested).

12. The nurse is sitting down with a patient to begin a conversation. Which of the following positions should the nurse take to convey acceptance of the patient?
    A) Leaning forward with arms on the table sitting directly across for the patient
    B) Turned slightly to the side of the patients with arms folded across the chest
    C) Leaning back in the chair next to the patient with legs crossed at the knees
    D) Sitting upright facing the patient with both feet on the floor
    Ans: D
    Feedback:
    Closed body positions, such as crossed legs or arms folded across the chest, indicate that the interaction might threaten the listener who is defensive or not accepting. A better, more accepting body position is to sit facing the client with both feet on the floor, knees parallel, hands at the side of the body, and legs uncrossed or crossed only at the ankle.

13. A patient states, ìI feel fine. It's a good day.î The nurse notes the patient looking away, and a decreasing pitch in his voice while speaking. Which of the following is the most therapeutic response by the nurse?
    A) ìI'm glad you are feeling good today.î
    B) ìI'm not sure I believe you.î
    C) ìTell me what is good about today.î
    D) ìYou say you feel fine, but you don't really sound fine.î
    Ans: D
    Feedback:
    This client's verbal and nonverbal communication seems incongruent. To ensure the accuracy of the patient's messages, the nurse identifies the nonverbal communication and checks its congruency with the content. An example is ìMr. Jones, you said everything is fine today, yet you frowned as you spoke. I sense that everything is not really fineî (verbalizing the implied). ìI'm glad you are feeling good today,î is agreeing or indicating accord with the client. Agreeing leaves no opportunity for the client to change his or her mind without being ìwrong.î ìI'm not sure I believe you could be interpreted as challenging or demanding proof from the client. Challenging causes the client to defend the misperceptions more strongly than before. ìTell me what is good about today,î seems to be asking the client to defend his or her statement.

14. Which of the following statements about verbal and nonverbal communication skills is accurate?
    A) One third of meaning is transmitted nonverbally and two thirds is communicated verbally.
    B) Nonverbal communication is as important, if not more than, verbal communication.
    C) Verbal communication is most important because it is what the patient says.
    D) Verbal communication involves the unconscious mind.
    Ans: B
    Feedback:
    Nonverbal communication is as important as, if not more so than, verbal communication. It is estimated that one third of meaning is transmitted by words and two thirds is communicated nonverbally. Verbal communication is often what the patient says but is not the most important. Nonverbal communication involves the unconscious mind acting out emotions related to the verbal content, the situation, the environment, and the relationship between the speaker and the listener.

15. The nurse must be alert to the nonverbal expressions of the client. Because the meaning attached to nonverbal behavior is subjective, it is important for the nurse to
    A) increase the client's awareness of nonverbal behavior.
    B) investigate the source of nonverbal behavior.
    C) validate the client's feelings.
    D) validate the meaning of the nonverbal behavior.
    Ans: D
    Feedback:
    It is essential to validate the meaning of nonverbal behavior (rather than assuming what it means) before proceeding with anything else. This item is about the nurse's understanding of nonverbal behavior, not the client's. Before the nurse can investigate the source of nonverbal behavior or validate the client's feelings the nurse must be clear about the meaning of the nonverbal behavior.

16. A nurse has invited a patient to sit down and have a conversation. The patient takes the first seat. The nurse pulls up another chair to sit with the patient. Approximately how far from the patient should the nurse place her chair?
    A) 1 to 2 feet
    B) 3 to 4 feet
    C) 6 to 8 feet
    D) 8 to 10 feet
    Ans: B
    Feedback:
    The therapeutic communication interaction is most comfortable when the nurse and client are 3 to 6 feet apart; 0 to 18 inches is comfortable for parents with young children, people who mutually desire personal contact, or people whispering; 2 to 3 feet is comfortable between family and friends who are talking; 4 to 12 feet is acceptable for communication in social, work, and business settings.

17. The nurse is sitting with a patient who is crying. After a few minutes the nurse places one hand on the patient's shoulder. Which of the following best describes the purpose of the nurse's touch with this patient?
    A) To express sympathy to the patient
    B) To assess the patient's skin temperature and circulation status
    C) To offer comfort and support for the patient
    D) To extend an offer of friendship to the patient
    Ans: C
    Feedback:
    Touching a client can be comforting and supportive when it is welcome and permitted. The nurse should not express sympathy to patients, nor should attempt to be ìfriendsî with patients. Physical assessment is not indicated at this time.

18. Which of the following is the best reason that many psychiatric care units have policies against clients touching one another or staff?
    A) Because some clients with mental illness have difficulty knowing when touch is or is not appropriate
    B) Because clients often perceive being touched as a threat and may attempt to protect himself or herself by striking the staff person
    C) Because it can be threatening to both the client and the nurse
    D) Because touching always leads to more touching
    Ans: A
    Feedback:
    Some clients with mental illness have difficulty understanding the concept of personal boundaries or knowing when touch is or is not appropriate. Consequently, most psychiatric inpatient, outpatient, and ambulatory care units have policies against clients touching one another or staff. When a staff member is going to touch a client while performing nursing care, he or she must verbally prepare the client before starting the procedure. A client with paranoia may interpret being touched as a threat and may attempt to protect himself or herself by striking the staff person. Both the client and the nurse can feel threatened if one invades the other's personal or intimate zone, which can result in tension, irritability, fidgeting or even flight. Touching can be comforting and supportive when it is welcome and permitted.

19. A client has been making sexual comments when communicating with the nurse. The nurse wants to spend some time talking to the patient while respecting the patient's right to privacy. Which setting would be the most appropriate setting for the nurse to talk with the client?
    A) In the patient's room when the patient's roommate is present and 3 feet away
    B) At the nurse's station when other clients and visitors are less than 4 feet away
    C) In an interview room in a remote section of the unit with the nurse 1 foot away from the patient
    D) In a quiet corner of the dayroom at least 4 feet away from others
    Ans: D
    Feedback:
    A quiet corner of the dayroom at least 4 feet away from others would allow the patient privacy while being to deter any inappropriate activity would be the most appropriate setting. Being in the patient's room when the patient's roommate is present and 3 feet away or at the nurse's station when other patients and visitors are less than 4 feet away would not allow for the patient's privacy. An interview room in a remote section of the unit would not be a good choice as the area is too isolated. Additionally, the nurse should maintain a distance of more than 1.5 feet away from the patient as closer distances are within the intimate zone.

20. Which of the following distance zones is acceptable for people who mutually desire personal contact?
    A) Social
    B) Intimate
    C) Personal
    D) Public
    Ans: B
    Feedback:
    The intimate zone is the amount of space that is comfortable for parents with young children and those who desire personal contact. The social zone is the distance acceptable for communication in social, work, and business settings. The personal zone is comfortable between family and friends who are talking. The public zone is an acceptable distance between a speaker and an audience.

21. The nurse should use clear concrete messages when working with patients displaying which of the following conditions? Select all that apply.
    A) Anxiety
    B) Anorexia
    C) Dementia
    D) Schizophrenia
    E) Hypochondriasis
    Ans: A, C, D
    Feedback:
    Clients who lose cognitive processing, such as those who are anxious, cognitively impaired, or suffering from some mental disorders, often function at a concrete level of comprehension and have difficulty answering abstract questions. The nurse must be sure that statements and questions are clear and concrete.

22. Which statements are true of concrete and abstract messages? Select all that apply.
    A) Abstract messages include figures of speech that are difficult to interpret.
    B) Abstract messages are important for accurate information exchange.
    C) Concrete messages require the listener to interpret what the speaker says.
    D) Concrete messages are clear, direct, and easy to understand.
    E) Abstract messages are best used for persons who are anxious.
    Ans: A, D
    Feedback:
    Abstract messages include figures of speech that are difficult to interpret. Concrete messages are clear, direct, and easy to understand. Concrete (not abstract) messages are important for accurate information exchange. Abstract (not concrete) messages require the listener to interpret what the speaker says. Concrete (not abstract) messages are best used for persons who are anxious.

23. The nurse asks the patient, ìWhat was it like for you when you first knew you had no place to go?î The patient looks down and pauses for quite some time. Which action by the nurse is most therapeutic?
    A) Change the subject to something the patient will discuss
    B) Encourage the patient to express any unpleasant feelings
    C) Apologize for asking such a personal question
    D) Sit quietly until the patient responds
    Ans: D
    Feedback:
    Silence or long pauses in communication may indicate many different things. The client may be depressed and struggling to find the energy to talk. Sometimes pauses indicate the client is thoughtfully considering the question before responding. At times, the client may seem to be ìlost in his or her own thoughtsî and not paying attention to the nurse. It is important to allow the client sufficient time to respond, even if it seems like a long time.

24. A patient remarks, ìYou know, it's the same thing every time.î The nurse should respond by stating,
    A) ìI understand.î
    B) ìI'm sure everyone is doing their best.î
    C) ìI'm not sure what you mean. Please explain.î
    D) ìIt's the same thing every time?î
    Ans: C
    Feedback:
    Consensual validationósearching for mutual understanding, for accord in the meaning of the words. For verbal communication to be meaningful, it is essential that the words being used have the same meaning for both (all) participants. Sometimes, words, phrases, or slang terms have different meanings and can be easily misunderstood.

25. A patient states, ìRight before I got here I was doing alright. My job was going well, my wife and I were happy, and we just moved into a new apartment.î The nurse responds, ìYou said you and your wife were happy. Tell me more about that.î This is an example of which therapeutic technique?
    A) Encouraging comparison
    B) General lead
    C) Restating
    D) Exploring
    Ans: D
    Feedback:
    Exploringódelving further into a subject or an idea. When clients deal with topics superficially, exploring can help them examine the issue more fully. Any problem or concern can be better understood if explored in depth.

26. A patient is sitting alone, slouched, with eyes closed. The nurse approaches. Which statement is most likely to encourage the patient to talk?
    A) ìIf you are sleepy, would you like me to help you back to your room?î
    B) ìYou look like you are deep in thought.î
    C) ìIs something wrong?î
    D) ìWhy are you sitting with your eyes closed?î
    Ans: B
    Feedback:
    Making observationsóverbalizing what the nurse perceives. Sometimes clients cannot verbalize or make themselves understood. Or the client may not be ready to talk.

27. A patient yells, ìAll the nurses here are so mean. None of you really care about us!î The most therapeutic response would be,
    A) ìI cannot allow you to yell like that.î
    B) ìWe care about you.î
    C) ìOh, really?î
    D) ìYou seem very irritated.î
    Ans: D
    Feedback:
    Reflectingódirecting client actions, thoughts, and feelings back to client. Reflection encourages the client to recognize and accept his or her own feelings. The nurse indicates that the client's point of view has value and that the client has the right to have opinions, make decisions, and think independently.

28. Patient says to the nurse, ìI wonder what's playing at the movie tonight.î The most therapeutic response would be,
    A) ìAre you telling me you would like to go to the movies?î
    B) ìWhy don't you look in the newspaper.î
    C) ìThere's nothing worth watching.î
    D) ìDo you like to go to the movies?î
    Ans: A
    Feedback:
    Verbalizing the impliedóvoicing what the client has hinted at or suggested. Putting into words what the client has implied or said indirectly tends to make the discussion less obscure. The nurse should be as direct as possible without being unfeelingly blunt or obtuse. The client may have difficulty communicating directly. The nurse should take care to express only what is fairly obvious; otherwise, the nurse may be jumping to conclusions or interpreting the client's communication.

29. The client says to the nurse, ìI have special powers because I am the mother of God. I can heal everyone in the hospital.î The nurse's best response would be,
    A) ìThat sounds interesting. What can you do?î
    B) ìIt would be unusual for anyone to have that kind of power.î
    C) ìYou could not heal everyone. No one has that much power.î
    D) ìWell, you can certainly try.î
    Ans: B
    Feedback:
    When the nurse states, ìIt would be unusual for anyone to have that kind of power,î the nurse is voicing doubt or expressing uncertainty about the reality of the client's perceptions. The other choices have demeaning connotations toward the client and should not be used.

30. During the admission interview, the nurse asks the client what led to his hospitalization. The client responds, ìThey lied about me. They said I murdered my mother. You're the killers. You all killed my mother. She died before I was born.î The best initial response by the nurse would be,
    A) ìI just saw your mother. She's fine.î
    B) ìYou're having very frightening thoughts.î
    C) ìWe'll put you in a private room until you're in better control.î
    D) ìIf your mother died before you were born, you wouldn't be here.î
    Ans: B
    Feedback:
    When the nurse states, ìYou're having very frightening thoughts,î the nurse is verbalizing the implied or voicing what the client has hinted or suggested. The other responses would not be the best initial response in this situation.

31. The client stated, ìI was so upset about my sister ignoring me when I was talking about being ashamed.î Which nontherapeutic communication technique would the nurse be using if the nurse would state, ìHow are your stress reduction classes going?î
    A) Changing the subject
    B) Offering advice
    C) Challenging
    D) Disapproving
    Ans: A
    Feedback:
    The nurse did not respond to the client's statement and instead introduced an unrelated topic. Advising would be telling the client what to do. Challenging would be demanding proof from the client. Disapproving would be denouncing the client's behavior or ideas.

32. During the mental status assessment, the client expresses the belief that the CIA is stalking him and plans to kidnap him. The best response by the nurse would be,
    A) ìThat makes no sense at all.î
    B) ìYou can tell me about that after I finish asking these questions.î
    C) ìWhat kinds of things have been happening?î
    D) ìWhy would the CIA be interested in you?î
    Ans: C
    Feedback:
    When the nurse responds, ìWhat kinds of things have been happening?î the nurse is seeking information. ìThat makes no sense at all,î is inappropriate because it may make perfect sense to the client. ìYou can tell me about that after I finish asking these questions,î shows that the nurse is not interested in what the client has to say. ìWhy would the CIA be interested in you,î feeds into the notion that the CIA is stalking the client.

33. The nurse is trying to obtain some information about family relationships from the client. Which of the following statements is best?
    A) ìIs it upsetting for you to talk about your family?î
    B) ìIs your family ready for you to come home?î
    C) ìSo, how is your family?î
    D) ìTell me your feelings about your family situation.î
    Ans: D
    Feedback:
    This statement asks the client to describe or discuss family; all other statements might get only one-word answers.

34. A client is fearful and reluctant to talk. Which of the following techniques is most effective when trying to engage the client in interaction?
    A) Broad opening
    B) Focusing
    C) Giving information
    D) Silence
    Ans: A
    Feedback:
    Broad openings allow the client to say as much or little as he or she wants. Focusing (concentrating on a single point) can be intimidating; giving information (making available the facts that the client needs) and silence do not encourage client interaction.

1. **Chapter 7**The nurse is assessing the anxiety level of a young school-age child. The nurse encourages the child to express feelings through the use of toys in a play situation. The purpose for this approach to assessment is largely related to which of the following?
   A) The child has cognitive impairment and has limited vocabulary skills.
   B) The child has not been intellectually stimulated and can only express self through play.
   C) Children may not have developed the language to fully describe their feelings.
   D) Children will not express themselves openly unless instructed to do so by parents.
   Ans: C
   Feedback:
   A client's age can influence how he or she expresses illness. A young child may lack the understanding and ability to describe his or her feelings, which may make management of the disorder more challenging. Nurses must be aware of the child's level of language and work to understand the experience as he or she describes it.

2. A nurse is teaching decision-making skills to a client with dependent personality disorder. According to Erikson, the likely cause of the client developing dependent personality is failure to meet the critical task of which developmental stage?
   A) Trust
   B) Autonomy
   C) Initiative
   D) Industry
   Ans: D
   Feedback:
   Failure to complete the critical task results in a negative outcome for that stage of development and impedes completion of future tasks. Tasks of trust versus mistrust include viewing the world as safe and reliable and viewing relationships as nurturing, stable, and dependable. In autonomy versus shame and doubt, children achieve a sense of control and free will. In initiative versus guilt, the child begins to develop a conscience, and learns to manage conflict and anxiety. Industry versus inferiority involves school-age children building confidence in their own abilities and taking pleasure in accomplishments.

3. Which one of the following statements is most accurate regarding the age at onset of a mental illness such as schizophrenia?
   A) Persons who are diagnosed at a younger age will more likely have a poorer outcome.
   B) Persons who are diagnosed at a younger age will more likely have a better outcome.
   C) Age at diagnosis is not related to outcomes.
   D) Younger clients have more experiences that will help them.
   Ans: A
   Feedback:
   Persons who are diagnosed with schizophrenia at a younger age at onset have poorer outcomes, such as more negative signs and less effective coping skills, than do people with a later age at onset. A possible reason for this difference is that younger clients have not had experiences of successful independent living or the opportunity to work and be self-sufficient and have a less well-developed sense of personal identity than older clients.

4. Genetics have been shown to play which of the following roles in a person's mental and emotional health?
   A) Several mental disorders appear to run in families.
   B) Specific genes have been linked to certain mental disorders.
   C) Biologic factors can be modified to change the influence on emotional health.
   D) Psychiatric treatment is effective regardless of an individual's biologic influences.
   Ans: A
   Feedback:
   Heredity and biologic factors are not under voluntary control. We cannot change these factors. Research has identified genetic links to several disorders. Although specific genetic links have not been identified for several mental disorders (e.g., bipolar disorder, major depression, and alcoholism), research has shown that these disorders tend to appear more frequently in families. Genetic makeup tremendously influences a person's response to illness and perhaps even to treatment.

5. Which one of the following statements about the roles that biologic makeup plays in a client's emotional responses is most accurate?
   A) Biologic differences can affect a client's response to treatment with psychotropic drugs.
   B) Biologic differences do not affect a client's response to treatment with psychotropic drugs.
   C) Heredity and biologic factors are under voluntary control.
   D) Persons cannot change their health status and improve the ability to cope.
   Ans: A
   Feedback:
   Biologic differences can affect a client's response to treatment with psychotropic drugs. Heredity and biologic factors are not under voluntary control. Persons can change their health status and improve their ability to cope.

6. Which of the following individual factors can a person modify to improve mental and emotional health? Select all that apply.
   A) Serotonin deficiency
   B) Lack of exercise
   C) Poor nutrition
   D) Type I diabetes
   E) Sleeplessness
   Ans: B, C, E
   Feedback:
   Personal health practices, such as exercise, poor nutritional status, lack of sleep, or a chronic physical illness, can influence the client's response to illness. Unlike genetic factors, how a person lives and takes care of himself or herself can alter many of these factors. For this reason, nurses must assess the client's physical health even when the client is seeking help for mental health problems. Serotonin deficiency and type I diabetes are not under voluntary control.

7. The nurse is preparing to administer PRN medication to a client of a Japanese descent who is anxious. The prescription reads, ìAlprazolam (Xanax) 0.25 to 1.0 mg PO PRN.î The best dose for the nurse to give initially is
   A) 0.25 mg.
   B) 0.5 mg.
   C) 0.75 mg.
   D) 1.0 mg.
   Ans: A
   Feedback:
   In general, nonwhites treated with Western dosing protocols have higher serum levels per dose and suffer more side effects. Persons of Asian descent often metabolize drugs more slowly, requiring lower doses to produce therapeutic effects.

8. A client's prognosis is said to be good due to a high degree of self-efficacy. Which of the following is evidence of a high degree of self-efficacy?
   A) The client is self-motivated and asks for help when needed.
   B) The client is able to resist illness when under stress.
   C) The client responds well in stressful situations.
   D) The client uses good problem-solving abilities.
   Ans: A
   Feedback:
   People with high self-efficacy set personal goals, are self-motivated, cope effectively with stress, and request support from others when needed. Hardiness is the ability to resist illness when under stress. Resilience is defined as having healthy responses to stressful circumstances or risky situations. Resourcefulness involves using problem-solving abilities and believing that one can cope with adverse or novel situations.

9. A client is actively involved in community service activities. The benefit of involvement in meaningful daily activities will most directly contribute to which of the following attributes?
   A) Self-efficacy
   B) Resilience
   C) Resourcefulness
   D) Hardiness
   Ans: D
   Feedback:
   Hardiness is the ability to resist illness when under stress. Hardiness has three components: commitmentóactive involvement in life activities; controlóability to make appropriate decisions in life activities; and challengeóability to perceive change as beneficial rather than just stressful. Self-efficacy is a belief that personal abilities and efforts affect the events in our lives. Resilience is defined as having healthy responses to stressful circumstances or risky situations. Resourcefulness involves using problem-solving abilities and believing that one can cope with adverse or novel situations.

10. It is recorded in the client's chart that the family is resilient. The nurse concludes which of the following characteristics about the family life of this client? Select all that apply.
    A) Family members are independent of one another.
    B) Family members spend time together.
    C) Family members engage in recreational activities together.
    D) Family members share the same personal goals.
    E) Family members allow individual members to develop unique daily routines.
    Ans: B, C
    Feedback:
    Factors that are present in resilient families include positive outlook, spirituality, family member accord, flexibility, family communication, and support networks. Resilient families also spend time together, share recreational activities, and participate in family rituals and routines together. Personal goal setting reflects self-efficacy.

11. Spirituality is especially important in helping people cope primarily for which of the following reasons?
    A) Spirituality helps people set personal goals.
    B) Spirituality gives people meaningful daily activities in which to participate.
    C) Spirituality provides a reliable support network.
    D) Spirituality guides beliefs about the meaning of life events.
    Ans: D
    Feedback:
    Spirituality involves the essence of a person's being and his or her beliefs about the meaning of life and the purpose for living. Spirituality is a genuine help to many adults with mental illness, serving as a primary coping device and a source of meaning and coherence in their lives. It may also help to provide a social network, but it serves primarily as a belief system. Personal goal setting is a demonstration of self-efficacy. Hardiness is enhanced through commitment to meaningful daily activities.

12. Which of the following statements about hope and symptoms of mental illness are true? Select all that apply.
    A) Hope is not realistic and therefore is not related to mental well-being.
    B) Persons having more hope experienced fewer actual symptoms.
    C) Hope is a cause of mental illness.
    D) There is not a significant relationship between hopelessness and increased symptoms.
    E) A possible way to help clients manage and decrease symptoms would be to support the development of hope.

    Ans: B, E

    Feedback:

    Persons having more hope experienced fewer actual symptoms. A significant relationship between hopelessness and increased symptoms was also demonstrated. This may indicate that one of the ways to help clients manage and decrease symptoms is having a wellness plan that includes a positive future outlook and support for the development of hope.

13. Which of the following personal characteristics influence a client's response to stressors? Select all that apply.
    A) Self-efficacy
    B) Sense of belonging
    C) Spirituality
    D) Hardiness
    E) Resilience
    F) Resourcefulness

    Ans: A, C, D, E, F

    Feedback:

    Personal characteristics that influence a client's response to stressors include self-efficacy, spirituality, hardiness, resilience, and resourcefulness. Sense of belonging is an interpersonal factor that can influence a client's response to stressors.

14. Which of the following statements about spirituality are true? Select all that apply.
    A) Many clients with mental disorders have disturbing religious delusions.
    B) Religious activities have been shown to be linked with better health and a sense of well-being.
    C) Spirituality only involves religion.
    D) Hope and faith are two critical factors in psychiatric and physical rehabilitation.
    E) Spirituality may include a relationship with the environment.
    Ans: A, B, D, E
    Feedback:
    Many clients with mental disorders have disturbing religious delusions. Religious activities have been shown to be linked with better health and a sense of well-being. Spirituality involves the essence of a person's being and his or her beliefs about the meaning of life and the purpose for living. It may include belief in God or a higher power, the practice of religion, cultural beliefs and practices, and a relationship with the environment. Hope and faith are two critical factors in psychiatric and physical rehabilitation.

15. Individuals who grow up in ìat-riskî environments but are able to become productive, successful citizens are believed to possess which of the following characteristics?
    A) Hardiness
    B) Resilience
    C) Social skills
    D) Tolerance
    Ans: B
    Feedback:
    Resilience is having healthy responses to stressful situations or risky environments. Hardiness is the ability to resist illness when under stress. Social skills are a type of coping strategy. Tolerance is the ability to deal with increasing levels of stress in an adaptive way.

16. Which of the following factors would be the most influential in determining a client's response to a particular stressor?
    A) The client's experience with stress
    B) The client's perception of the stressor
    C) Duration of the stressor
    D) Severity of the stressor
    Ans: B
    Feedback:
    The client will respond to the stressor based on his or her appraisal (perception) of the stressor. Resilience is related to positive outlook. The client's experience with stress, the duration of the stressor, and the severity of the stressor would not be the most influential in determining a client's response to a stressor.

17. The client says to the nurse, ìI know I can learn to cope with my family situation. By getting help here at the clinic, I'll be able to deal with them more effectively, and I won't be so stressed out all the time.î This client is demonstrating a high level of
    A) hardiness.
    B) resilience.
    C) sense of belonging.
    D) self-efficacy.
    Ans: D
    Feedback:
    Self-efficacy is a belief that personal abilities and efforts affect the events in our lives. A person who believes that his or her behavior makes a difference is more likely to take action. Persons with high self-efficacy are self-motivated, get needed support, and cope effectively. Hardiness is the ability to resist illness when under stress. Resilience is defined as having healthy responses to stressful circumstances or risky situations. Sense of belonging is the client's place in the group, family, etc.

18. A client reports feeling like he belongs among his peers with whom he shares a group home. The nurse incorporates this sense of belonging when formulating discharge plans because the nurse understands which of the following?
    A) Living with a peer group often increases anxiety.
    B) Peers may alienate the client from daily living activities.
    C) The client will likely feel needed by his peers.
    D) Peer groups often do too much for each other causing dependency.
    Ans: C
    Feedback:
    An increased sense of belonging is associated with decreased levels of anxiety. Persons with a sense of belonging are less alienated and isolated, have a sense of purpose, believe they are needed by others, and feel productive socially.

19. Which of the following situations would most likely provide social support to a client?
    A) A friend who will share his or her perspective on an issue
    B) The transportation service that provides access to daily rehabilitation services
    C) Fellow teammates participating in a community softball league
    D) The teacher assisting a client to obtain a GED
    Ans: A
    Feedback:
    Social support is emotional sustenance that comes from friends, family members, and even health-care providers who help a person when a problem arises. It is different from social contact, which does not always provide emotional support. An example of social contact is the friendly talk that goes on at parties.

20. A holistic plan of recovery would be especially important to a client from which of the following cultural groups?
    A) American Indian
    B) African American
    C) Mexican American
    D) Arab American
    Ans: A
    Feedback:
    The American Indians' concept of health is holistic and wellness oriented. African Americans and Mexican Americans value feelings of well-being, ability to fulfill role expectations, and being free of pain or excess stress. Arab Americans view health as a gift of God manifested by eating well, meeting social obligations, being in a good mood, and having no stressors or pain.

21. A nurse and a client of Chinese heritage are collaborating on treatment goals. The nurse would document which of the following as the client's priority goal?
    A) The client will be free of pain and excess stress.
    B) The client will express a feeling of balance and harmony.
    C) The client will be free of physical symptoms of illness.
    D) The client will express gratefulness to God for recovery.
    Ans: B
    Feedback:
    Chinese and many other Asian cultures view health as a balance of body, mind, and spirit. Pain-free is a major focus of African American culture. Russians and Latino cultures focus largely on physical aspects of health. Arab cultures view health as a gift of God.

22. The nurse is preparing to conduct an admission assessment interview with a Mexican American client. During the interview, the nurse should respect the client's culture through which behavior?
    A) Greet the client with a hug,
    B) Encourage direct eye contact during questioning
    C) Prohibiting the next of kin to remain present
    D) Introduce self with a handshake
    Ans: D
    Feedback:
    With Mexican Americans touch by strangers is not appreciated, but a handshake is polite and welcomed. Nonverbal communication generally avoids direct eye contact with authority figures. Socially, contact with families comes first.

23. A nurse is working with a Middle-Eastern client being treated for major depression. The client is expressing feelings of guilt for not being able to ìsnap out of it.î A therapeutic response by the nurse would be,
    A) ìYou have to keep trying to feel better.î
    B) ìWhat do you think could have caused your depression?î
    C) ìClinical depression is not something you have brought on yourself.î
    D) ìIt will take several weeks for your medicine to start to help you feel better.î
    Ans: C
    Feedback:
    Arab Americans believe mental illness is something the person can control. Educating about the etiology reduces the guilt associated with having an illness. Suggesting the client keep trying or caused the depression in some way implies that the client is responsible for the illness. Informing about medication ignores the client's feelings of guilt.

24. Several family members arrive to visit an African American client. The nurse can best meet this client's need for socialization by providing the client and family which of the following?
    A) Individual visits to provide the client with a calm environment
    B) Group gatherings and open conversation
    C) Inclusion of ritualistic health practices with the family present
    D) A spiritual healer to remove the illness and protect the family
    Ans: B
    Feedback:
    During illness, families are often a support system for the sick person. Families often feel comfortable demonstrating public affection such as hugging and touching one another. Conversation among family and friends may be animated and loud. Spiritual rituals are more prevalent in Native American cultures.

25. A Filipino client meets the nurse for the first time. The client simply smiles at the nurse when introduced. The nurse interprets this behavior as
    A) a display of being shy and introverted.
    B) a typical greeting for a Filipino client.
    C) constricted verbal skills associated with the client's illness.
    D) a sign that the client may be suspicious of the nurse.
    Ans: B
    Feedback:
    Smiles rather than handshakes are a common form of greeting in Pilipino culture. Filipino clients consider direct eye contact impolite, so there is little direct eye contact with authority figures such as nurses and physicians.

26. Females from which of the following cultures are most likely to be expected to move in with husband's family?
    A) African Americans
    B) Mexican Americans
    C) South Asians
    D) Haitians
    Ans: C
    Feedback:
    African Americans are more likely to have a nuclear family. Mexican Americans mostly live in nuclear families. South Asians expect the daughters to move in with the husband's family. Haitians may have an extended or a nuclear family.

27. Culture has the most influence on a person's health beliefs and practices. African Americans believe that the cause of mental illness occurs because of which of the following?
    A) Lack of harmony of emotions
    B) Supernatural causes
    C) Heredity
    D) Lack of spiritual balance
    Ans: D
    Feedback:
    African Americans believe that mental illness is caused by lack of spiritual balance. Chinese believe that mental illness is caused by lack of harmony of emotions. Haitians believe that mental illness is caused by supernatural causes. Cubans believe that mental illness is hereditary.

28. A client from which of the following cultural groups is likely to prefer closeness in personal space?
    A) Arab Americans
    B) Chinese
    C) Cubans
    D) African Americans
    Ans: A
    Feedback:
    Arab Americans prefer closeness in personal space. Chinese keep respectful distance. Cubans have greatly varying preferences for personal space. African Americans respect privacy and use a respectful approach.

29. Direct eye contact is preferred by which of the following cultures?
    A) Native Americans
    B) Cambodians
    C) Russians
    D) Chinese
    Ans: C
    Feedback:
    Of these cultures, only Russians prefer direct eye contact. Native Americans communicate respect by avoiding eye contact. For Cambodians, eye contact is acceptable, but ìpoliteî women lower their eyes. For Chinese, eye contact is avoided with authority figures.

30. Beliefs about the causes of pain and illness vary among cultures. In the United States (Western culture), pain and illness are generally attributed to
    A) economic class.
    B) psychological influences.
    C) physiologic causes.
    D) sociocultural factors.
    Ans: C
    Feedback:
    Usually, Americans believe that pain and illness arise from physical causes. Two prevalent types of beliefs about what causes illness in non-Western cultures are natural and unnatural or personal. Unnatural or personal beliefs attribute the causes of illness to the active, purposeful intervention of an outside agent, spirit, or supernatural force or deity. The natural view is rooted in a belief that natural conditions or forces, such as cold, heat, wind, or dampness, are responsible for illness.

31. The nurse considers cultural variations pertaining to a client's nonverbal communication. Which of the following is the primary rationale for considering alternative meanings of nonverbal communication?
    A) The nurse must become expert at interpreting the client's gestures.
    B) Nonverbal signs indicative of certain mental illnesses transcend cultural differences.
    C) Mental illnesses impair a client's ability to express nonverbal messages.
    D) Nonverbal messages have different meanings in various cultures.
    Ans: D
    Feedback:
    The nurse should be aware that nonverbal communication has different meanings in various cultures. These differences are important to note because many people make inferences about a person's behavior. The nurse can never know all culturally relevant messages. All communication is culturally relative. Persons with mental illness are fully capable of nonverbal expression.

32. Which of the following cultural phenomena that should be assessed by the nurse includes preference such as touch and eye contact?
    A) Communication
    B) Social organization
    C) Environmental control
    D) Biologic variations
    Ans: A
    Feedback:
    Communication involves verbal and nonverbal communication. Social organization refers to family structure and organization, religious values and beliefs, ethnicity, and culture. Environmental control refers to a client's ability to control the surroundings or direct factors in the environment.

33. Which of the following questions best encourages the client to disclose information the nurse must assess to provide culturally competent care?
    A) ìHow do you want me to help you?î
    B) ìDo you want me to contact your preacher?î
    C) ìWhat special dietary preferences do you have?î
    D) ìWhich family members do you want to receive calls from?î
    Ans: A
    Feedback:
    To provide culturally competent care, the nurse must find out as much as possible about a client's cultural values, beliefs, and health practices. Often, the client is the best source for that information, so the nurse must ask the client what is important to him or her. An open and objective approach to the client is essential. Clients will be more likely to share personal and cultural information if the nurse is genuinely interested in knowing and does not appear skeptical or judgmental. Assuming the client wants a preacher or has dietary preferences is assuming the client's values. Asking about preferred family members does little to assess the nature of family relationships.

34. The nurse is making a cultural assessment of a client. The most important data about a client's cultural beliefs are
    A) objective data about the culture.
    B) subjective data from the client.
    C) subjective data from the family.
    D) subjective data from society.
    Ans: B
    Feedback:
    The client's perception and description of cultural beliefs and values are most important.

35. How might the nurse best provide culturally competent care?
    A) Behave as appropriate for the nurse's culture.
    B) Find out as much as possible about a client's cultural values, beliefs, and health practices.
    C) Know what to expect from many cultural groups.
    D) Validate knowledge about culture through continuing education.
    Ans: B
    Feedback:
    Each client is an individual; the nurse can never assume that any individual client will fit the general preferences of his or her culture.

1. **Chapter 8** When assessing a patient's mental health status, which of the following describe the purpose of the psychosocial assessment? Select all that apply.
   A) To assess the client's current emotional state
   B) To assess the client's mental capacity
   C) To assess the client's behavioral function
   D) To assess the client's plan of care
   E) To assess the client's physical health status
   Ans: A, B, C
   Feedback:
   The purpose of the psychosocial assessment is to construct a picture of the client's current emotional state, mental capacity, and behavioral function. This assessment serves as the basis for developing a plan of care to meet the client's needs. The client's physical health status would need to be completed as another assessment or an extended assessment.

2. Which of the following factors influencing assessment is under the nurse's control?
   A) Client participation and feedback
   B) Client's health status
   C) Nurse's attitude and approach
   D) Client's ability to understand
   Ans: C
   Feedback:
   The factors that influence assessment include client participation and feedback, client's health status, client's ability to understand, client's previous experiences, and misconceptions about health care. The only one of these that is under the control of the nurse is the nurse's attitude and approach.

3. Which of the following are components of the assessment of thought process and content? Select all that apply.
   A) What the client is thinking
   B) Abstract thinking abilities
   C) How the client is thinking
   D) Clarity of ideas
   E) Self-harm or suicide urges
   Ans: A, C, D, E
   Feedback:
   The components of the assessment of thought process and content include content (what the client is thinking), process (how the client is thinking), clarity of ideas, self-harm, or suicide urges. Abstract thinking abilities are an element of the abnormal sensory experiences or misperception assessment.

4. A client is being evaluated for dementia. The nurse knows that a client who is able to complete very few tasks is most likely to have
   A) a greater cognitive deficit.
   B) A less precise mental status exam.
   C) more potential for agitation.
   D) no bearing on mental status.
   Ans: A
   Feedback:
   The fewer tasks the client competes accurately, the greater the cognitive deficit. The other choices are not true.

5. During the assessment, the nurse asks the client to describe his problems. The purpose of this question is to obtain information about the client's
   A) admitting diagnosis.
   B) communication skills.
   C) perception of the problem.
   D) personal needs.
   Ans: C
   Feedback:
   The question will elicit information about the client's view or perspective of the problem.

6. A delusion represents a problem in which of the following areas?
   A) Memory
   B) Motivation
   C) Orientation
   D) Thinking
   Ans: D
   Feedback:
   A delusion is a fixed false idea or thought. Memory relates to the client's knowledge of past events. Motivation relates to the client's interest in doing things. Orientation relates to the client's perception of reality.

7. The nurse asks a patient to list the days of the week in reverse order. The nurse is assessing which of the following?
   A) Concentration
   B) Memory
   C) Orientation
   D) Abstract thinking
   Ans: A
   Feedback:
   The nurse assesses the client's ability to concentrate by asking the client to perform certain tasks such as repeating the days of the week backward. The nurse directly assesses memory, both recent and remote, by asking questions with verifiable answers. Orientation refers to the client's recognition of person, place, and time. Abstract thinking is to making associations or interpretations about a situation or comment.

8. When the nurse asks the client to restate the following in his or her own words, which sensorium and intellectual process is the nurse attempting to identify? The nurse states, ìA stitch in time saves nine.î
   A) The client's orientation
   B) The client's memory
   C) The client's ability to concentrate
   D) The client's ability to use abstract thinking
   Ans: D
   Feedback:
   When the nurse states, ìA stitch in time saves nine,î and asks the client to restate it in his or her own words, the nurse is assessing the client's ability to use abstract thinking. The client's orientation is recognizing person, place, and time. The client's memory, both recent and remote, can be assessed by asking the client questions that have verifiable answers. The client's ability to concentrate can be assessed by asking the client to perform certain tasks including spelling the word ìworldî backward.

9. The nurse is assessing suicide potential in a patient who has expressed hopelessness. In what order does the nurse question the patient about suicidal thoughts?
   A. ìHow would you carry out this plan?î
   B. ìDo you have a plan to kill yourself?î
   C. ìAre you thinking of killing yourself?î
   D. ìHow do you plan to kill yourself?î
   Ans: C, B, D, A
   Feedback:
   Suicide assessment should be performed through direct questioning. First, the nurse would need to know if the patient has ideations: ìAre you thinking about killing yourself?î; then if the patient has a plan, ìDo you have a plan to kill yourself?î If the patient has a plan, then the nurse would ask about method: ìHow do you plan to kill yourself?î If the patient has ideations, a plan, a method, then does the patient have access to that method the nurse asks, ìHow would you carry out this plan? Do you have access to the means to carry out the plan?î

10. The nurse best assesses a patient's memory by asking which of the following questions?
    A) ìDo you have any problems with memory?î
    B) ìWhat did you have for lunch yesterday?î
    C) ìDo you know where you are?î
    D) ìWho is the current president?î
    Ans: D
    Feedback:
    The nurse directly assesses memory, both recent and remote, by asking questions with verifiable answers such as ìWhat is the name of the current president?î The nurse may not be able to verify the accuracy of the client's responses to questions such as ìDo you have any memory problems?î or ìWhat did you do yesterday?î Orientation refers to the client's recognition of person, place, and time.

11. A patient shows no facial expression when engaging in a game with peers during an outing at a park. The nurse uses which of the following terms when documenting the patient's affect?
    A) Blunt affect
    B) Restricted affect
    C) Broad affect
    D) Flat affect
    Ans: D
    Feedback:
    Common terms used in assessing affect include blunted affect: showing little or a slow-to-respond facial expression; broad affect: displaying a full range of emotional expressions; flat affect: showing no facial expression; inappropriate affect: displaying a facial expression that is incongruent with mood or situation, often silly or giddy regardless of circumstances; restricted affect: displaying one type of expression, usually serious or somber.

12. The patient states that he is 14 trillion years old and created the world. The nurse documents this statement as an example of which type of thinking displayed by the patient?
    A) Delusional thinking
    B) Ideas of reference
    C) Word salad
    D) Hallucination
    Ans: A
    Feedback:
    A delusion is a fixed false belief not based in reality. Ideas of reference are client's inaccurate interpretation that general events are personally directed to him or her, such as hearing a speech on the news and believing the message had personal meaning. Word salad is flow of unconnected words that convey no meaning to the listener. Hallucinations are false sensory perceptions or perceptual experiences that do not really exist.

13. A patient is known to express tangential thinking. The nurse would assess for which of the following when interacting with the patient?
    A) Stopping abruptly in the middle of expressing himself
    B) Jumping from one idea to another
    C) Wandering off the topic and never answering the question
    D) Excessive and fast talking about an array of ideas
    Ans: C
    Feedback:
    Tangential thinking is wandering off the topic and never providing the information requested. Thought blocking is stopping abruptly in the middle of a sentence or train of thoughts, sometimes unable to continue the idea. Loose associations are disorganized thinking that jumps from one idea to another with little or no evident relation between the thoughts. Flight of ideas is excessive amount and rate of speech composed of fragmented or unrelated ideas.

14. A nurse can best assess a patient's ability to use abstract thinking by asking the patient which of the following questions?
    A) ìWhat would you do if you found a wallet containing $100 on the sidewalk?î
    B) ìWhat do I mean when I say, 'Don't sweat the small stuff?'î
    C) ìWhat are you going to do next time you hear voices?î
    D) ìCan you begin with the number 100 and subtract 7, and then subtract 7 again?î
    Ans: B
    Feedback:
    The nurse assesses the client's ability to use abstract thinking, which is to make associations or interpretations about a situation or comment. The nurse usually can do so by asking the client to interpret a common proverb. If the client can explain the proverb correctly, his or her abstract thinking abilities are intact. Judgment refers to the ability to interpret one's environment and situation correctly and to adapt one's behavior and decisions accordingly. Insight is the ability to understand the true nature of one's situation and accept some personal responsibility for that situation. The nurse assesses the client's ability to concentrate by asking the client to perform certain tasks such as ìserial sevens.î

15. A patient reported to the nurse that on his way to the clinic, a policeman in a patrol car turned on his lights and pulled him over. When asked what he did next, the patient stated, ìI pulled over, of course.î Which of the following was the nurse trying to assess?
    A) The client's judgment
    B) The client's insight
    C) The client's concentration
    D) The client's self-concept
    Ans: A
    Feedback:
    Judgment refers to the ability to interpret one's environment and situation correctly and to adapt one's behavior and decisions accordingly. Insight is the ability to understand the true nature of one's situation and accept some personal responsibility. Self-concept is the way one views oneself in terms of personal worth and dignity. The nurse assesses the client's ability to concentrate by asking the client to perform certain cognitive tasks. To assess a client's self-concept, the nurse can ask the client to describe himself or herself and what characteristics he or she likes and what he or she would change.

16. The client spoke of a current event in the national news and described it as it relates to the client. Then the client spoke of a historical event and described it as it relates to the client. Which of the following questions might the nurse ask to determine if the client is experiencing ideas of reference?
    A) ìWhere were you when this happened?î
    B) ìWhy do you think that?î
    C) ìAre you sure?î
    D) ìThat is unbelievable!î
    Ans: A
    Feedback:
    Ideas of reference are the client's inaccurate interpretation that general evens are personally directed to him or her, such as hearing a speech on the news and believing the message had personal meaning. ìWhere were you when this happened,î would relate to the place and might give the nurse more information to validate the client's previous comments. ìWhy do you think that,î may be interpreted as the nurse challenging the client. ìAre you sure,î is a closed-ended question and does not encourage the client to elaborate. ìThat is unbelievable,î is a statement rather than a question and could be interpreted as the nurse's opinion of the information provided by the client.

17. Which of the following questions is best to ask when assessing the client's judgment?
    A) ìCan you describe your usual daily activities for me?î
    B) ìIf you found yourself downtown without money or a car, how would you get home?î
    C) ìOn a scale of 1 to 10, how stressed would you rate yourself?î
    D) ìWhat problem would you like to work on while you're hospitalized?î
    Ans: B
    Feedback:
    Judgment refers to the ability to interpret one's environment and situation correctly and to adapt one's own behavior and decisions accordingly. This question will elicit information about the client's problem-solving and decision-making abilities. The other choices do not assess the concept of judgment.

18. The nurse asks the client, ìWhat is similar about a cow and a horse?î and ìWhat do a bus and an airplane have in common?î These questions would best assess which of the following areas?
    A) Intellectual function
    B) Insight
    C) Judgment
    D) Memory
    Ans: A
    Feedback:
    These questions would elicit information about the client's intellectual function. Insight is the ability to understand the true nature of one's situation and accept some personal responsibility for that situation. Judgment refers to the ability to interpret one's environment and situation correctly and to adapt one's behavior and decisions accordingly. Questions about memory would require that the client identify knowledge of past events.

19. Which of the following would best assess a client's judgment?
    A) Counting by serial sevens
    B) Discussing hypothetical situations
    C) Interpreting proverbs
    D) Spelling words backward
    Ans: B
    Feedback:
    The client's judgment can be elicited by asking the client to discuss hypothetical situations, which would indicate one's ability to interpret one's environment and situation correctly and to adapt one's behavior and decisions accordingly. Counting by serial sevens and spelling words backward would assess the client's ability to concentrate. Interpreting proverbs would assess the client's abstract thinking.

20. The nurse plans to assess a patient's self-concept in the admission assessment knowing that self-concept influences which of the following? Select all that apply.
    A) Body image
    B) Cognitive processing
    C) Frequently experienced emotions
    D) Coping strategies
    E) Responsiveness to medications
    Ans: A, C, D
    Feedback:
    Self-concept is the way one views oneself in terms of personal worth and dignity. The client's description of self in terms of physical characteristics gives the nurse information about the client's body image. Also included in an assessment of self-concept are the emotions that the client frequently experiences and whether or not the client is comfortable with those emotions. The nurse also must assess the client's coping strategies. Cognitive processing and response to medications are biologically based.

21. Which of the following are the types of roles that are usually included when assessing roles and relationships? Select all that apply.
    A) Family
    B) Hobbies
    C) Occupation
    D) Activities
    E) Race
    F) Ethnicity
    Ans: A, B, C, D
    Feedback:
    The number and type of roles may vary, but they usually include family, occupation, and hobbies or activities.

22. Knowing that relationships with others are significant to mental health, the nurse effectively assesses a patient's family relationships through which of the following?
    A) ìDo you feel your family helps you?î
    B) ìHow many people are in your family?î
    C) ìWhom are you closest to in your family?î
    D) ìDescribe your relationships with your family.î
    Ans: D
    Feedback:
    The nurse must assess the relationships in the client's life, the client's satisfaction with those relationships, or any loss of relationships. Open-ended questions and statements elicit more descriptive responses from the patient than direct questions.

23. A nurse assesses that a depressed patient is lethargic during the day and does not actively participate in unit activities. The notes from the night shift document that the patient did not sleep well. The most probable interpretation of these data is
    A) the patient's medications are ineffective.
    B) the patient is being kept awake at night due to noise on the unit.
    C) the patient's depressed mood is impairing restful sleep patterns.
    D) the patient is resisting treatment recommendations to participate in unit activities
    Ans: C
    Feedback:
    Emotional problems often affect some areas of physiologic function. Emotional problems can greatly affect eating and sleeping patterns. Therefore, the nurse must assess the client's usual patterns of eating and sleeping and then determine how those patterns have changed.

24. A nurse suspects that a patient is abusing alcohol while taking prescribed medications. The nurse plans to educate the patient on the dangers of mixing medicine with alcohol. Which of the following would be the most effective way for the nurse to approach this subject with the patient?
    A) Firmly inform the patient of the dangers of mixing medications with alcohol.
    B) Recommend a higher level of care, so the patient can be more closely supervised.
    C) Emphasize the importance of truthful information using a nonjudgmental approach
    D) Recognize the patient's right to self-determination and avoid addressing the subject.
    Ans: C
    Feedback:
    Noncompliance with prescribed medications is an important area. If the client has stopped taking medication or is taking medication other than as prescribed, the nurse must help the client feel comfortable enough to reveal this information. The nurse also explores the client's use of alcohol and over-the-counter or illicit drugs. Such questions require nonjudgmental phrasing; the nurse must reassure the client that truthful information is crucial in determining the client's plan of care.

25. The nurse has completed the psychosocial assessment. Which of the following is the best approach toward analysis of the data to identify nursing diagnoses and develop an appropriate plan of care?
    A) Focus on each piece of information obtained from the patient.
    B) Look for patterns reflected in the overall assessment.
    C) Consider only the abnormal findings in the assessment.
    D) Present all data obtained in the treatment team meeting.
    Ans: B
    Feedback:
    After completing the psychosocial assessment, the nurse analyzes all the data that he or she has collected. Data analysis involves thinking about the overall assessment rather than focusing on isolated bits of information. The nurse looks for patterns or themes in the data that lead to conclusions about the client's strengths and needs and to a particular nursing diagnosis. No one statement or behavior is adequate to reach such a conclusion.

26. The nurse reviews results of the Minnesota Multiphasic Personality Inventory (MMPI) recorded in a patient record. While considering the usefulness of these data, the nurse is mindful that the MMPI has which limitation?
    A) The patient must be able to read to complete the MMPI.
    B) The results of the MMPI could be culturally biased.
    C) The MMPI assesses a narrow scope of functioning.
    D) The MMPI does not have established validity.
    Ans: B
    Feedback:
    Both intelligence tests and personality tests are frequently criticized as being culturally biased. It is important to consider the client's culture and environment when evaluating the importance of scores or projections from any of these tests. Objective personality tests compare the client's answers with standard answers or criteria and obtain a score or scores. The MMPI provides scores on 10 clinical scales such as hypochondriasis, depression, hysteria, and paranoia; four special scales such as anxiety and alcoholism; three validity scales to evaluate the truth and accuracy of responses.

27. The client tells the nurse, ìThat new TV anchor is telling the world about me.î This is an example of
    A) ideas of reference.
    B) persecutory delusions.
    C) thought broadcasting.
    D) thought insertion.
    Ans: A
    Feedback:
    The client's inaccurate interpretation that general events are personally directed to him or her is an example of ideas of reference. Persecutory delusions involve the client's belief that ìothersî are planning to harm the client. Thought broadcasting is a delusional belief that others can hear or know what the client is thinking. Thought insertion is a delusional belief that others are putting ideas or thoughts into the client's head.

28. During the admission assessment, the nurse asks the client, ìHow are you feeling?î The client responds, ìI was able to purchase gas for 7 cents a gallon less than yesterday, which saved me a total of 84 cents. My car has a 12-gallon gas tank. Usually I am able to put in 11.7 gallons. I am very happy to have saved so much money.î The nurse recognizes this response as which of the following?
    A) Circumstantial thinking
    B) Echolalia
    C) Flight of ideas
    D) Neologisms
    Ans: A
    Feedback:
    With circumstantial thinking, the client eventually answers a question but only after giving excessive unnecessary detail. Echolalia is repetition or imitation of what someone else says. Flight of ideas is excessive amount and rate of speech composed of fragmented or unrelated ideas. Neologisms are invented words that have meaning only for the client.

29. A client is admitted to the psychiatric unit and states, ìI am president of the largest corporation in the world. Everyone comes to me for advice.î The client is exhibiting which of the following?
    A) Flight of ideas
    B) Thought broadcasting
    C) Delusion
    D) Loose associations
    Ans: C
    Feedback:
    The client has a delusion (a fixed false belief not based in reality) about his superiority over others. Flight of ideas is excessive amount and rate of speech composed of fragmented or unrelated ideas. Thought broadcasting is a delusional belief that others can hear or know what the client is thinking. Loose associations are disorganized thinking that jumps from one idea to another with little or no evident relation between the thoughts.

30. In the space of 5 minutes, the client has been laughing and euphoric, then angry, and then crying for no reason that is apparent to the nurse. This behavior would be best described as
    A) flight of ideas.
    B) lack of insight.
    C) labile mood.
    D) tangential thinking.
    Ans: C
    Feedback:
    Moods that shift rapidly, displaying a range of emotions, are termed labile. Flight of ideas is manifested by excessive amount and rate of speech composed of fragmented or unrelated ideas. Lack of insight would be manifested by the lack of the ability to understand the true nature of one's situation and accept some personal responsibility for that situation. Tangential thinking would be manifested by wandering off the topic and never providing the information requested.

31. Throughout the assessment, the client displays disorganized thinking, jumping from one idea to another with no clear relationship between the thoughts. The nurse would assess the client as having which of the following?
    A) Tangential thinking
    B) Ideas of reference
    C) Loose associations
    D) Word salad
    Ans: C
    Feedback:
    The client displayed ideas that were loosely associated to one another. Tangential thinking is manifested by wandering off the topic and never providing the information requested. Ideas of reference are the client's inaccurate interpretation that general events are personally directed to him or her. Word salad is a flow of unconnected words that convey no meaning to the listener.

32. Sexuality and self-harm behaviors are often difficult areas for nurses to assess. An effective way for nurses to deal with this discomfort includes
    A) recognizing that these areas may also be uncomfortable for the patient to discuss.
    B) share feelings of discomfort with the patient.
    C) defer assessing these areas to a more experienced nurse.
    D) develop a standard question to ask of all patients during this area of assessment
    Ans: A
    Feedback:
    Two areas that may be uncomfortable or difficult for the nurse to assess are sexuality and self-harm behaviors. The beginning nurse may feel uncomfortable, as if prying into personal matters, when asking questions about a client's intimate relationships and behavior and any self-harm behaviors or thoughts of suicide. Asking such questions, however, is essential to obtaining a thorough and complete assessment. The nurse needs to remember that it may be uncomfortable for the client to discuss these topics as well.

33. Which of the following is the most compelling reason for the nurse to discuss matters of sexuality and suicide?
    A) It is required by the law by the federal government and in most states in the union.
    B) It is the nurse's professional responsibility to keep safety needs first and foremost.
    C) This is commonly required documentation for every encounter with every client.
    D) It allows the nurse to gain valuable experience in these kind of difficult discussions.

    Ans: B

    Feedback:

    It is the nurse's professional responsibility to keep the client's safety needs first and foremost, and this includes overcoming any personal discomfort in talking about suicide. This is not required by any laws nor is it commonly required documentation for every encounter with every client. The nurse needs to gain experience in these kind of difficult discussions, but that is not a compelling reason for the nurse to discuss it if not warranted.

1. **Chapter 9** A client made threats to harm his parents if they come too close to him. The parents called 911, and the client is now held involuntarily for a psychiatric evaluation. During this time of involuntary admission, the client retains all client rights except for which of the following?
   A) Confidentiality
   B) Right to freedom
   C) Periodic treatment review
   D) Choice of providers
   Ans: B
   Feedback:
   Civil commitment or involuntary hospitalization curtails the client's right to freedom (the ability to leave the hospital when he or she wishes). All other client rights, however, remain intact.

2. Which of the following would be circumstances when a client could be subjected to involuntary hospitalization? Select all that apply.
   A) When a client states that he or she intends to commit suicide and is making plans to do so.
   B) When a client does not bathe regularly or change clothes often.
   C) When a client states that he or she intends to harm others by a deliberate act.
   D) When a client who has diabetes refuses to follow the prescribed diet.
   E) When a client is unable to control his or her rage and is assaulting everyone around him or her.
   Ans: A, C, E
   Feedback:
   Health-care professionals respect the wishes of a client who does not wish to be hospitalized and treated unless clients are a danger to themselves or others (i.e., they are threatening or have attempted suicide or represent a danger to others). When a client states that he or she intends to commit suicide and is making plans to do so, the client is threatening suicide and could be subjected to involuntary hospitalization. When a client does not bathe regularly or change clothes often, the client is neglecting his or her hygiene, but it is unlikely that this could be construed as an imminent risk of harm to self. When a client states that he or she intends to harm others by a deliberate act, the client could be considered representing a danger to others. When a client who has diabetes refuses to follow the prescribed diet, the client is acting within his or her own right to comply with the recommendations of their health-care provider. When a client is unable to control his or her rage and is assaulting everyone around him or her, the client would be considered a danger to others.

3. A client who has depression is admitted to treatment on a voluntary basis. While in the hospital, the client makes several comments about wanting to ìend it all.î The client decides one day to leave against medical advice. Which of the following would be the most appropriate action by the nursing staff?
   A) Calling security and asking them to detain the client
   B) Allowing the client to leave with community resources for follow-up care
   C) Contacting the psychiatrist for initiation of commitment proceedings
   D) Contacting the client's family to request they convince the client to stay

   Ans: C

   Feedback:

   If a voluntary client who is dangerous to himself or herself or to others signs a request for discharge, the psychiatrist may file for a civil commitment to detain the client against his or her will until a hearing can take place to decide the matter.

4. Which of the following clients would most likely be mandated outpatient treatment?
   A) A client who is addicted to alcohol who has two DUI offenses
   B) A client with schizophrenia who lives in a single family home with siblings
   C) A client with bipolar disorder who has quit three jobs in the last 6 months
   D) A homeless client who has been arrested for petty theft of groceries from a convenience store.

   Ans: A

   Feedback:

   Mandatory outpatient treatment is sometimes also called conditional release or outpatient commitment. Court-ordered outpatient treatment is most common among persons with severe and persistent metal illness who have had frequent and multiple contacts with mental health, social welfare, and criminal justice agencies. This supports the notion that clients are given several opportunities to voluntarily comply with outpatient treatment recommendations and that court-ordered treatment is considered when those attempts have been repeatedly unsuccessful.

5. Under which conditions would it be in the client's best interest for the court to appoint a conservator, or legal guardian? Select all that apply.
   A) Gravely disabled
   B) Mentally incompetent
   C) Noncompliant
   D) Unable to provide basic needs when resources exist
   E) Act only on his or her own interests
   Ans: A, B, D
   Feedback:
   The appointment of a conservator or legal guardian is a separate process from civil commitment. People who are gravely disabled; are found to be incompetent; cannot provide food, clothing, and shelter for themselves even when resources exist; and cannot act in their own best interests may require appointment of a conservator. In these cases, the court appoints a person to act as a legal guardian who assumes many responsibilities for the person.

6. An adolescent on the unit is argumentative with staff and peers. The nurse tells the adolescent, ìArguing is not allowed. One more word and you will have to stay in your room the rest of the day.î The nurse's directive is
   A) inappropriate; room restriction is not treatment in the least restrictive environment.
   B) inappropriate; the adolescent should be offered a sedative before room restriction.
   C) appropriate; room restriction is an effective behavior modification technique.
   D) appropriate; the adolescent should not have conflicts with others.
   Ans: A
   Feedback:
   Clients have the right to treatment in the least restrictive environment appropriate to meet their needs. It means that a client does not have to be hospitalized if he or she can be treated in an outpatient setting or in a group home. It also means that the client must be free of restraint or seclusion unless it is necessary. Verbal and behavioral techniques should be instituted before physical measures such as sedation, restraint, or seclusion.

7. The nurse on an addictive disorders unit receives a phone call inquiring about the status of a client. The caller is not on the client's allowed contact list. Which of the following is the appropriate response by the nurse to the caller?
   A) ìI cannot confirm or deny the existence of any client here.î
   B) ìYou will need to be placed on the client's contact list before I can discuss any information with you.î
   C) ìThe person you are asking for is not a client here.î
   D) ìHold 1 minute while I get the client for you.î
   Ans: A
   Feedback:
   The protection and privacy of personal health information is regulated by the federal government through the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Protected health information is any individually identifiable health information in oral, written, or electronic form. Mental health and substance abuse records have additional special protection under the privacy rules. Requesting placement on the contact list or getting the client verifies the client's presence to the caller. Denying the client's presence affirms the client's existence whether present not, which violates client privacy and confidentiality.

8. Which of the following client situations most urgently requires the nurse to break confidentiality and warn a third party?
   A) An abused woman states, ìI have dreams that he is dead.î
   B) A mother states, ìSometimes I feel like killing my kids!î
   C) A paranoid woman states, ìI'll get them before they get me.î
   D) A jealous man states, ìI am getting my gun and going to shoot my wife's lover!î
   Ans: D
   Feedback:
   Mental health clinicians have a duty to warn identifiable third parties of threats made by clients, even if these threats were discussed during therapy sessions otherwise protected by privilege. The clinician must base his or her decision to warn others on the following: Is the client dangerous to others? Is the danger the result of serious mental illness? Is the danger serious? Are the means to carry out the threat available? Is the danger targeted at identifiable victims? Is the victim accessible?

9. A 22-year-old client has been manipulative of staff and disruptive in the milieu. Although she is not dangerous to herself or others, she has created problems on the unit and clearly is not making progress. The nurses offer prescribed medication, but she consistently refuses ìany drugs.î The staff realizes that legally this client can
   A) be coerced to accept treatment.
   B) be committed by her family to receive needed treatment.
   C) have her family sign permission for treatment.
   D) continue to refuse treatment.
   Ans: D
   Feedback:
   The client maintains the right to refuse treatment even if it is needed when she is not dangerous to herself or others. If a client able to give consent, she cannot be coerced into doing so, have her family sign permission for her, or be committed by the family to receive treatment unless she is a danger to herself or others.

10. A client who had agreed to be hospitalized for depression problems has decided that now she wants to leave the hospital. The mental health staff caring for her realizes that at present she can legally
    A) be discharged if evaluated through administrative hearings.
    B) be retained in the hospital against her will.
    C) leave the hospital after giving written notice of her intent to do so.
    D) leave without discussing the situation with anyone.
    Ans: C
    Feedback:
    Clients who are not dangerous to themselves or others can leave the hospital against medical advice. The other choices are not appropriate.

11. Two nurses are discussing the rights of hospitalized psychiatric clients. Which of the following statements is an error?
    A) Confidentiality allows for the disclosure of information under specific circumstances.
    B) If a committed client is also found to be incompetent, he loses his rights under the Patient's Bill of Rights.
    C) Privileged communication does not apply to medical records, and they can be used in court.
    D) Clients can never be held against their will.
    Ans: B
    Feedback:
    Being committed and/or incompetent does not negate the Patient's Bill of Rights. However, if a guardian is appointed, the client loses the right to enter into legal contracts or agreements that require a signature. Confidentiality does allow for the disclosure of information under specific circumstances such as to another health-care provider who has a need to know or if the client specifically consents that information be shared with persons of his or her choice and also the duty to warn if the client threatens to harm others. Privileged communication relates to the privacy of what was discussed during therapy sessions and this can be documented in medical records. Clients may be held against their will if they are committed to a facility for psychiatric care until they no longer pose a danger to themselves or to anyone else.

12. When is a nurse legally obligated to breach confidentiality?
    A) At any time a client is threatening
    B) If threats are made to an identifiable third party
    C) Whenever the client becomes aggressive
    D) When the client violates the nurse's boundaries
    Ans: B
    Feedback:
    The duty to warn a third party exists when a client threatens harm to that identifiable third party; the client's confidentiality is overridden. Answer choices A, C, and D are not situations in which confidentiality may be breached. Decisions about the duty to warn third parties usually are made by psychiatrists or by qualified mental health therapists in outpatient settings. It is not permissible for a nurse to breach confidentiality at any time a client is threatening, or becomes aggressive or violates the nurse's boundaries.

13. A client was brought to the emergency department by police after neighbors complained that he was loud and disruptive. The client is paranoid and upset and states, ìNo one can be trusted.î Which of the criteria for involuntary admission does this client meet?
    A) Dangerous to self.
    B) Dangerous to others.
    C) Gravely disabled.
    D) He does not meet any of the necessary criteria.
    Ans: D
    Feedback:
    Having a mental illness alone is not sufficient for an involuntary commitment. In this situation, the client is not a danger to himself or others and is not gravely disabled.

14. The physician has prescribed Haldol 10 mg for a severely psychotic client. The client refuses the medication. Which nursing intervention is an appropriate response?
    A) Accept the client's decision
    B) Obtain a discharge order for noncompliance
    C) Tell the client that he is too sick to refuse
    D) Restrain the client and give the medication IM
    Ans: A
    Feedback:
    Clients have the right to refuse medication even when they are psychotic. The client cannot be discharged just because he refuses to take his medications. In this situation, it is not appropriate for the nurse to tell the client that he is too sick to refuse. Restraints are not an appropriate means of getting the client to take the medication.

15. Disclosure of client information beyond the interdisciplinary team without consent of the client is a breach of
    A) beneficence.
    B) confidentiality.
    C) duty.
    D) veracity.
    Ans: B
    Feedback:
    Confidentiality involves the disclosure of information only to authorized individuals. Beneficence is one's duty to benefit or to promote good for others. Duty is the existence of a legally recognized relationship. Veracity is the duty to be honest and truthful.

16. A client who is depressed and suicidal is scheduled for electroconvulsive therapy (ECT), which requires consent. Legally, who should sign the consent for this treatment?
    A) A member of the treatment team
    B) The client
    C) The client's spouse
    D) The psychiatrist
    Ans: B
    Feedback:
    The client has the right to sign (or refuse to sign) the consent. The other parties listed do not have the legal right to sign for the client unless they are the client's legal guardian.

17. A nurse is questioning whether it is ethical to seclude a client because of loud and intrusive behavior on the unit. What is the ethical principle that will best guide the decision on appropriate use of seclusion?
    A) Autonomy
    B) Beneficence
    C) Justice
    D) Veracity
    Ans: A
    Feedback:
    Autonomy refers to the person's right to self-determination and independence. Beneficence refers to one's duty to benefit or to promote good for others. Justice refers to fairness, that is, treating all people fairly and equally without regard for social or economic status, race, sex, marital status, religion, ethnicity, or cultural beliefs. Veracity is the duty to be honest or truthful.

18. A nurse is performing safety assessments on a client in mechanical restrains as required by policy. Which action by the nurse demonstrates the ethical principle of nonmaleficence?
    A) Explaining the behavioral requirements for release of restraint to the client
    B) Assuring that the restraints are not causing injury to the client
    C) Applying restraints based solely on assessment findings and not on attitude toward the client
    D) Releasing the client when stated behavioral control is achieved
    Ans: B
    Feedback:
    Assuring that the restraints are not causing injury to the client is an example of nonmaleficence, or doing no harm. Explaining the behavioral requirements for release of restraint to the client is providing the client the autonomy to choose behaviors. Applying restraints based solely on assessment findings and not on attitude toward the client is displaying justice. Releasing the client when stated behavioral control is achieved is displaying veracity, or being honest and truthful.

19. An adult client is put in restraints after all other attempts to reduce aggression have failed. Which of the following is required now that restraints have been instituted?
    A) Review of the appropriateness of restraints every 8 hours
    B) A face-to-face evaluation by a licensed independent practitioner within 1 hour of restraint.
    C) A documented nursing assessment every 4 hours
    D) Constant one-on-one supervision during the first hour and then video monitoring
    Ans: B
    Feedback:
    For adult clients, use of restraint and seclusion requires a face-to-face evaluation by a licensed independent practitioner within 1 hour of restraint or seclusion and every 8 hours thereafter, a physician's order every 4 hours, documented assessment by the nurse every 1 to 2 hours, and close supervision of the client. Staff must monitor a client in restraints continuously on a 1:1 basis for the duration of the restraint period. A client in seclusion is monitored 1:1 for the first hour and then may be monitored by audio and video equipment.

20. Which of the following are criteria that must be adhered to when instituting the short-term use of restraint or seclusion? Select all that apply.
    A) The client is aggressive.
    B) The client is being punished.
    C) The client is imminently dangerous to himself or herself or to others.
    D) The client is physically and emotionally self-controlled.
    E) All other means of calming the client have been unsuccessful.
    Ans: A, C, E
    Feedback:
    Short-term use of restraint or seclusion is permitted only when the client is imminently aggressive and dangerous to himself or herself or to others, and all other means of calming the client have been unsuccessful. The nurse must frequently contact the client and reassure the client that restraint is a restorative, not a punitive, procedure. If the client is physically and emotionally self-controlled, there is no reason for the client to be restrained or secluded.

21. Placing a client in restraints before using other methods of intervention violates which of the client's rights?
    A) Receive confidential and respectful care
    B) Provide informed consent
    C) Refuse treatment
    D) Receive treatment in the least restrictive environment
    Ans: D
    Feedback:
    The least restrictive environment means that the client must be free of restraint or seclusion unless it is necessary. Less restrictive treatments must be tried and found to be ineffective before more restrictive measures can be used. It is not necessary for the client to provide informed consent for restraints to be used when appropriate. A client may not refuse restraints if they are to be used when appropriate.

22. A malpractice lawsuit was filed after a nurse restrained the client for screaming at and attempting to strike anyone who was within striking distance. The nurse followed agency procedures that were consistent with Joint Commission Standards. For which reason is this malpractice lawsuit most likely to be unsuccessful?
    A) The nurse did not have a duty.
    B) The nurse did not breach duty.
    C) The client did not suffer some type of loss, damage, or injury.
    D) There was no evidence that a breach of duty was a direct cause of the loss, damage, or injury.
    Ans: B
    Feedback:
    For a malpractice suit to be successful, the client or family needs to prove the following four elements: (1) Duty: a legally recognized relationship (i.e., physician to client, nurse to client) existed. The nurse had a duty to the client, meaning that the nurse was acting in the capacity of a nurse. (2) Breach of duty: the nurse (or physician) failed to conform to standards of care, thereby breaching or failing the existing duty. The nurse did not act as a reasonable, prudent nurse would have acted in similar circumstances. (3) Injury or damage: the client suffered some type of loss, damage, or injury. (4) Causation: the breach of duty was the direct cause of the loss, damage, or injury. In other words, the loss, damage, or injury would not have occurred if the nurse had acted in a reasonable, prudent manner. The nurse did have a duty to the client. The nurse did not breach this duty by the nursing actions. The client did experience loss of autonomy from being restrained. Since there was no breach of duty, there was no evidence that a breach of duty was a direct cause of the loss, damage, or injury.

23. Ensuring that the client has informed consent before agreeing to a treatment regimen displays which of the following ethical principles?
    A) Fidelity
    B) Nonmaleficence
    C) Justice
    D) Autonomy
    Ans: D
    Feedback:
    The nurse respects the client's autonomy through client's rights, informed consent, and encouraging the client to make choices about his or her health care. The nurse has a duty to take actions that promote the client's health (beneficence) and that do not harm the client (nonmaleficence). The nurse must treat all clients fairly (justice), be truthful and honest (veracity), and honor all duties and commitments to clients and families (fidelity).

24. A client being served in a busy inpatient psychiatric unit becomes very noisy and combative. The other clients are complaining about the noise and are afraid that they will be hurt by the client. The nurse determines that the best course of action for all involved is to seclude the client until the client is able to regain control of his behavior. On which ethical principle did the nurse base this decision?
    A) Utilitarianism
    B) Deontology
    C) Nonmaleficence
    D) Veracity
    Ans: A
    Feedback:
    Utilitarianism is a theory that bases decisions on the ìgreatest good for the greatest number.î While the client may experience a temporary loss of freedom, all of the clients on the nursing unit and their visitors will benefit by not being at risk for harm from this client. Deontology is a theory that says decisions should be based on whether or not an action is morally right with no regard for the result or consequences. It may not be considered morally right to deny this client his freedom for any amount of time, irrespective of the consequences (harm to others). Nonmaleficence is the requirement to do no harm to others either intentionally or unintentionally. In this circumstance, it could be argued that secluding the client could be maleficence, but it also could be argued that the other clients' rights to not be harmed would be violated by not secluding this client until he is able to regain control of his behavior. Justice refers to fairness, that is, treating all people fairly and equally without regard for social or economic status, race, sex, marital status, religion, ethnicity, or cultural beliefs. It could be argued that the client was not treated fairly when he was secluded, but it also could be argued that the others were not treated fairly if the client was allowed to continue to freely engage in the disrupting behavior.

25. The nurse is attending an in-service training on safe take-down techniques for aggressive clients. Preparation for safe physical handling prepares the nurse to practice which ethical principle?
    A) Veracity
    B) Nonmaleficence
    C) Justice
    D) Autonomy
    Ans: B
    Feedback:
    Nonmaleficence is the requirement to do no harm to others either intentionally or unintentionally. Safe take-down techniques are used to avoid unintentional harm to the client. Veracity is the duty to be honest or truthful. Justice refers to fairness, that is treating all people fairly and equally without regard for social or economic status, race, sex, marital status, religion, ethnicity, or cultural beliefs. Autonomy refers to the person's right to self-determination and independence.

26. Which of the following dilemmas involve the ethical principle of fidelity? Select all that apply.
    A) When the nurse is unable to agree with the policies or common practices of an agency
    B) When the nurse is faced with a decision to violate a policy that is harmful to the client
    C) When the nurse is certain that clients of different racial and ethnic backgrounds are being treated the same as other clients
    D) When the nurse understands that a combative client must be secluded against their will to prevent harm to others
    E) When the client refuses to take medication and the nurse respects the client's right to refuse medication
    Ans: A, B
    Feedback:
    When the nurse is unable to agree with the policies or common practices of an agency, the nurse is facing a dilemma about fidelity, which refers to the obligation to honor commitments and contracts. When the nurse is faced with a decision to violate a policy that is harmful to the client, the nurse is facing a dilemma about fidelityóthat is, should the nurse be faithful to the employing agency or the individual client being cared for. When the nurse is certain that clients of different racial and ethnic backgrounds are being treated the same as other clients, the nurse is acting in accord with the ethical principle of justice. When the nurse understands that a combative client must be secluded against his or her will to prevent harm to others, the nurse is following the ethical principle of utilitarianism. When a client refuses to take medications and the nurse respects the client's right to refuse medication, the nurse is enacting the ethical principle of autonomy.

27. Which one of the following is the most common reason for ethical dilemmas being a challenge to nurses?
    A) Ethical dilemmas are often charged with emotion.
    B) There are no clear ethical codes established for guidance.
    C) A multitude of laws must be understood to make a clear decision.
    D) Clients are not familiar with the ethical code that nurses must follow.
    Ans: A
    Feedback:
    Ethical dilemmas are often complicated and charged with emotion, making it difficult to arrive at fair or ìrightî decisions. ANA has established a Code of Ethics for Nurses. Few ethical decisions are guided strictly by legal precedent. Clients are not obligated to follow the professions' ethical principles.

28. The term ìstandards of careî refers to expectations of nursing performance. Standards of care are developed from which of the following? Select all that apply.
    A) Code of Ethics for Nurses with Interpretive Statements
    B) Licensure examinations
    C) State Nurse Practice Acts
    D) Agency job descriptions
    E) Professional nursing organizations
    Ans: A, C, D, E
    Feedback:
    Standards of care are developed from professional standards, state nurse practice acts, federal agency regulations, agency policies and procedures, job descriptions, and civil and criminal laws.

29. A client underwent a procedure before the nurse verified the client's signature on the consent form. The client actually did not sign the form before the procedure. If the client is dissatisfied with the outcome of the procedure and files a suit against the health-care team, which kind of case can the client file?
    A) Negligence
    B) Malpractice
    C) Battery
    D) False Imprisonment
    Ans: C
    Feedback:
    Battery involves harmful or unwarranted contact with a client. False imprisonment is defined as the unjustifiable detention of a client such as the inappropriate use of restraint or seclusion. Negligence is an unintentional tort that involves causing harm by failing to do what a reasonable and prudent person would do in similar circumstances. Clients or families can file malpractice lawsuits in any case of injury, loss, or death.

30. The staff on an inpatient psychiatric unit is very busy and fall behind on periodic assessment of a severely depressed client. During the rounds, the client is discovered to have completed a suicide attempt in the bathroom. Which type of lawsuit could the client's family file?
    A) Malpractice
    B) Breach of duty
    C) Assault
    D) Injury or damage
    Ans: A
    Feedback:
    Clients or families can file malpractice lawsuits in any case of injury, loss, or death. Not all injury or harm to a client can be prevented, nor do all client injuries result from malpractice. The issues are whether or not the client's actions were predictable or foreseeable (and, therefore, preventable) and whether or not the nurse carried out appropriate assessment, interventions, and evaluation that met the standards of care. In the mental health setting, lawsuits most often are related to suicide and suicide attempts. Breach of duty and injury or damage are two of the four elements of malpractice. Assault involves causing a person to fear being touched in an injurious way without consent.

1. **Chapter 10** A young couple just ended their relationship after a 9-month engagement. The one of the individuals is seeking short-term counseling to assist in grieving this loss. Which type of loss best describes what this client is experiencing?
   A) Safety loss
   B) Loss of security and sense of belonging
   C) Loss of self-esteem
   D) Loss related to self-actualization
   Ans: B
   Feedback:
   Types of loss include safety loss (loss of a safe environment), loss of security and a sense of belonging (loss of a loved one affects the need to love and the feeling of being loved), loss of self-esteem (any change in how a person is valued at work or in relationships or by him or herself), or loss related to self-actualization (external or internal crisis that blocks or inhibits strivings toward fulfillment).

2. A child who has witnessed the murder of his classmate while at school would experience which kind of loss?
   A) Physiologic loss
   B) Loss of self-esteem
   C) Loss related to self-actualization
   D) Safety loss
   Ans: D
   Feedback:
   Safety loss is the loss of a safe environment. That feeling of safety is shattered when public violence occurs. Examples of physiologic loss include amputation of a limb, a mastectomy or hysterectomy, or loss of mobility. A loss of self-esteem includes any change in how a person is valued at work or in relationships or by himself or herself can threaten self-esteem. Loss related to self-actualization includes an external or internal crisis that blocks or inhibits strivings toward fulfillment that may threaten personal goals and individual potential.

3. Which of the following terms is used to describe the process by which a person experiences the grief?
   A) Anticipatory grieving
   B) Disenfranchised grief
   C) Bereavement
   D) Mourning
   Ans: C
   Feedback:
   Bereavement refers to the process by which a person experiences the grief. Anticipatory grieving is when people facing imminent loss begin to grapple with the very real possibility of the loss or death in the near future. Disenfranchised grief is grief over a loss that is not or cannot be acknowledged openly, mourned publicly, or supported socially. Mourning is the outward expression of grief.

4. A married couple has just received the news that the husband has terminal cancer. The wife tells the nurse, ìMaybe if we get another opinion and start treatment right way there is a chance of survival.î The nurse documents that the wife is expressing signs of which of Kubler-Ross's stages of grief?
   A) Denial
   B) Anger
   C) Bargaining
   D) Depression
   Ans: C
   Feedback:
   Kubler-Ross developed a model of five stages to explain what people experience as they grieve and mourn: (1) Denial is shock and disbelief regarding the loss. (2) Anger may be expressed toward God, relatives, friends, or health-care providers. (3) Bargaining occurs when the person asks God or fate for more time to delay the inevitable loss. (4) Depression results when awareness of the loss becomes acute. (5) Acceptance occurs when the person shows evidence of coming to terms with death.

5. After being laid off from work, a client becomes increasingly withdrawn and fatigued, spends entire days in bed, is unkempt, and is eating and sleeping poorly. The nurse would recognize that the client is in which stage of grieving, according to Kubler-Ross?
   A) Anger
   B) Bargaining
   C) Denial
   D) Depression
   Ans: D
   Feedback:
   The client's symptoms are characteristics of depression, which usually occurs when awareness of the loss becomes acute. Anger may be expressed toward God, relatives, friends, or health-care providers. Bargaining occurs when the person asks God or fate for more time to delay the inevitable loss. Denial is shock and disbelief regarding the loss.

6. The client says to the nurse, ìI really want to see my first grandchild born before I die. Is that too much to ask?î The nurse would recognize that the client is in which stage of grieving, according to Kubler-Ross?
   A) Acceptance
   B) Anger
   C) Bargaining
   D) Depression
   Ans: C
   Feedback:
   Clients often set goals such as living until a certain time or to experience a particular event, and then they will be ready to die: that is the bargain. Acceptance occurs when the person shows evidence of coming to terms with death. Anger may be expressed toward God, relatives, friends, or health-care providers. Depression results when awareness of the loss becomes acute.

7. Kubler-Ross developed a model of five stages to explain what people experience as they grieve and mourn. Which is stage V of Kubler-Ross's stages of grieving?
   A) Denial
   B) Bargaining
   C) Acceptance
   D) Anger
   Ans: C
   Feedback:
   Acceptance occurs when the person shows evidence of coming to terms with death. Denial is shock and disbelief regarding the loss. Bargaining occurs when the person asks God or fate for more time to delay the inevitable loss. Anger may be expressed toward God, relatives, friends, or health-care providers.

8. Friends of a teenage male recently killed in a car accident are discussing their sense of loss. Which of the following comments best indicates that the friends are trying to make sense of the loss cognitively?
   A) ìWhy did he have to die so young?î
   B) ìHe shouldn't have been driving so recklessly.î
   C) ìIf we had only stayed longer, he would not have been on that road.î
   D) ìIt took the ambulance too long to get there.î
   Ans: A
   Feedback:
   One of the cognitive responses to grief involves the grieving person making sense of the loss. He or she undergoes self-examination and questions accepted ways of thinking. The loss challenges old assumptions about life. Anger, sadness, and anxiety are the predominant emotional responses to loss. The grieving person may direct anger and resentment toward the dead person and his or her health practices, family members, or health-care providers or institutions.

9. The nurse is working with a woman who lost her partner nearly 3 weeks prior. The woman has recently become less emotional and expressed that few things in her life have meaning right now. Which response by the nurse is most appropriate at this time?
   A) ìI am concerned. You are starting to show signs of ineffective grieving.î
   B) ìYou must feel some anger. It is alright to let that out.î
   C) ìLet's look at the things in your life that you still enjoy.î
   D) ìYou are just starting to accept that this loss is real.î
   Ans: D
   Feedback:
   As the bereaved person begins to understand the loss's permanence, he or she recognizes that patterns of thinking, feeling, and acting attached to life with the deceased must change. As the person relinquishes all hope of recovering the lost one, he or she inevitably experiences moments of depression, apathy, or despair. The acute sharp pain initially experienced with the loss becomes less intense and less frequent.

10. The nurse is working with a client who lost her youngest child 2 months ago. When the nurse approaches, the client, the client yells, ìI don't want to talk to you. You have no idea what it's like to lose a child!î The nurse bases her response to the client on the understanding of which of the following?
    A) Hostility is a common behavioral response to grief.
    B) It is too soon after the loss to empathize with the client.
    C) Personality traits such as aggressiveness are exaggerated during the grief process.
    D) The nurse may have nonverbally indicated a judgmental attitude toward the client.
    Ans: A
    Feedback:
    Behavioral responses to grief are often the easiest to observe. Irritability and hostility toward others reveal anger and frustration in the grief process.

11. Which of the following are eventual outcomes of the emotional dimension of grieving? Select all that apply.
    A) The survivor begins to reestablish a sense of personal identity, direction, and purpose for living.
    B) The survivor begins to gain independence and confidence.
    C) The survivor develops new ways of managing life and new relationships.
    D) The survivor's life returns to the same state as it was before the loss.
    E) The survivor forgets about the loss.
    Ans: A, B, C
    Feedback:
    Eventually, the bereaved person begins to reestablish a sense of personal identity, direction, and purpose for living. He or she gains independence and confidence. New ways of managing life emerge and new relationships form. The person's life is reorganized and seems ìnormalî again, although different than that before the loss. The person still misses the deceased, but thinking of him or her no longer evokes painful feelings.

12. The nurse is conducting a history and physical exam on a client who is grieving the unwanted loss of a marriage by divorce. Which of the following physical symptoms of grief would the nurse most likely expect to detect in the history?
    A) Headaches
    B) Insomnia
    C) Weight loss
    D) GI upset
    Ans: B
    Feedback:
    Those grieving may complain of insomnia, headaches, impaired appetite, weight loss, lack of energy, palpitations, indigestion, and changes in the immune and endocrine systems. Sleep disturbances are among the most frequent and persistent bereavement-associated symptoms.

13. The nurse is caring for a hospice client whose death is imminent. In preparing the family for the death of their loved one, then nurse prepares to assist the family in which of the following, regardless of the family's cultural preferences? Select all that apply.
    A) Dealing with the shock of losing a loved one
    B) Burial plans after death had occurred
    C) Efforts to stay connected to the client after death
    D) Use of support from family and friends
    E) Anger at the loss of a loved one
    Ans: A, C, E
    Feedback:
    Universal reactions include the initial response of shock and social disorientation, attempts to continue a relationship with the deceased, anger with those perceived as responsible for the death, and a time for mourning. Not all cultures bury their deceased. Some cultures mourn privately, not turning to the support of others.

14. The most effective way for the nurse to provide culturally competent care to individuals who are grieving is which of the following?
    A) Understand the practices associated with a client's culture.
    B) Suggest developing a new ritual to make mourning meaningful.
    C) Ask the client what rituals are personally meaningful.
    D) Contact a spiritual leader from the client's culture to become involved.
    Ans: C
    Feedback:
    Rather than assuming that he or she understands a particular culture's grieving behaviors, the nurse must encourage clients to discover and use what is effective and meaningful to them.

15. A nurse has been caring for a gunshot victim who has just died. Various family and friends are present. One of the visitors privately discloses to the nurse that she and the client were having an illicit affair. Which of the following is the best action by the nurse after learning of this relationship?
    A) Give the name of a clergy to the visitor and suggest she contact him for support
    B) Encourage the visitor to ask for support from the friends who are present
    C) Ignore the information about the affair and tend to the family
    D) Privately offer support to the visitor who was having the affair with the client
    Ans: D
    Feedback:
    Relationships between lovers, friends, neighbors, foster parents, colleagues, and caregivers may be long-lasting and intense, but people suffering loss in these relationships may not be able to mourn publicly with the social support and recognition given to family members. In addition, some relationships are not always recognized publicly or sanctioned socially such as extramarital affairs. The grief process is more complex because the usual supports that facilitate grieving and healing are absent. Therefore, nurses should be mindful to provide needed support.

16. A woman has just had a therapeutic abortion to end an unintended pregnancy. Afterward, the woman cries because although she wanted to have children in future years, this pregnancy was not well-timed. Which type of grief is this woman most likely to experience?
    A) Anticipatory grief
    B) Absence of grief
    C) Complicated grief
    D) Disenfranchised grief
    Ans: D
    Feedback:
    Disenfranchised grief is grief over a loss that is not or cannot be acknowledged openly, mourned, publicly, or supported socially. Anticipatory grief occurs when a person experiences imminent loss and begin to grapple with the very real possibility of loss or death in the near future. It is not absence of grief as the woman is grieving. It is not currently complicated grief as the loss has just occurred and does not seem out of proportion to the loss.

17. Which of the following losses are likely to result in disenfranchised grief? Select all that apply.
    A) A young adult whose spouse has just died suddenly
    B) A family whose long-time pet snake has just died
    C) A nurse who has just witnessed the death of a patient
    D) A couple who has just experienced pregnancy loss
    E) The gay lover of a man who just died from AIDS
    F) The mother and sister of a soldier who was killed in war
    Ans: B, C, D, E
    Feedback:
    Circumstances that can result in disenfranchised grief include a relationship that has no legitimacy, the loss itself is not recognized, the griever is not recognized, or the loss involves social stigma. A young adult whose spouse has just died suddenly is not likely to experience disenfranchised grief because of their legal relationship. A family whose long-time pet snake had died is likely to experience disenfranchised grief because the death of a pet is not seen as socially significant. A nurse who had just witnessed the death of a patient is at risk for disenfranchised grief because the needs of nurses and hospital chaplains are not recognized. A couple who had just experienced a pregnancy loss are at increased risk for disenfranchised grief because the loss of an unborn child is not recognized. The gay lover of a man who just died from AIDS is at risk for disenfranchised grief as the relationship had no legitimacy and the loss involves social stigma. The mother and sister of a soldier who was killed in war would not likely experience disenfranchised grief because they have a kin relationship with the decedent.

18. Which of the following is most likely to prevent the client from experiencing complicated grief?
    A) Tendency to suppress emotions
    B) History of depression
    C) Places trusts familiar others
    D) Dependent on others to meet needs
    Ans: C
    Feedback:
    People who are vulnerable to complicated grieving include those with low self-esteem, low trust in others, a previous psychiatric disorder, previous suicide threats or attempts, or absent or unhelpful family members.

19. Which of the following persons are most likely experiencing complicated grieving? Select all that apply.
    A) The spouse of a person who died 7 years ago and visits the grave several times a day.
    B) The grandchild of a soldier killed in war who visits the grave once a year on Memorial Day.
    C) A driver whose spouse and children all died as a result of his driving drunk.
    D) An adult who insisted for many years that he or she hated his or her deceased parent.
    E) The parent of a child who died after the having left the child in a car on a hot day.
    Ans: A, C, D, E
    Feedback:
    The spouse of a person who died 7 years ago and visits the grave several times a day is likely experiencing complicated grieving as this is a prolonged period of time with expression of grief that is exaggerated. A driver whose spouse and children all died as a result of his driving drunk likely experiences feelings of guilt as well as loss. An adult who insisted for many years that he or she hated his or her deceased parent is likely experiencing complicated grief as he or she has experienced an ambivalent attachment. The parent of a child who died after having left the child in a car on a hot day is likely experiencing guilt as well as loss.

20. The nurse is meeting a client for the first time who has just spontaneously lost her unborn child. After establishing rapport, the priority nursing intervention should focus on which of the following?
    A) Assessing the client's support system
    B) Exploring what this loss means for the client
    C) Discussing helpful ways to cope with the loss
    D) Assessing what knowledge the client desires about the situation
    Ans: B
    Feedback:
    Assessment begins with exploration of the client's perception of the loss. What does the loss mean to the client? The question is valuable for beginning to facilitate the grief process. Further assessment and intervention will be determined based largely on the client's perception of the event.

21. Which of the following are critical components to assess in a grieving person? Select all that apply.
    A) Genetic risk
    B) Perception of the loss
    C) Support system
    D) Coping behaviors
    E) Religion
    Ans: B, C, D
    Feedback:
    The interaction of the dimensions of human response is fluid and dynamic. What a person thinks about during grieving affects his or her feelings, and those feelings influence his or her behavior. The critical factors of perception, support, and coping are interrelated as well and provide a framework for assessing and assisting the client. Genetic risk and religion are not critical components to assess in a grieving person.

22. A client with terminal cancer has been told he has 3 or 4 months to live. Which of the following would indicate to the nurse that further interventions are needed?
    A) The client says he wants to live life to the fullest.
    B) The client hopes for a peaceful and dignified death.
    C) The client is reviewing his life and talking about death.
    D) The client says he is well and is making future plans.
    Ans: D
    Feedback:
    Choice D would indicate that the client is proceeding as though there is no impending loss, so the nurse would need to assist the client with grieving as the client is in denial. The other choices are positive coping behaviors toward death.

23. A young client tells the nurse that her husband died 3 months ago, and she is feeling alone and vulnerable. Which statement by the client would indicate that her coping skills are adequate?
    A) ìI can't understand why this happened to me.î
    B) ìI'm mentally healthy. I can solve my own problems.î
    C) ìI will find a support group.î
    D) ìWhat can I do? My husband abandoned me.î
    Ans: C
    Feedback:
    Finding a support group indicates that the client recognizes her need for help and is taking action to get the support she needs. The other choices are not indications that the client's coping skills are adequate for the situation.

24. A couple came to the emergency department with their 5-month-old son. He was pronounced dead of sudden infant death syndrome (SIDS). In the next day or two, it will be important for this couple to
    A) accept that they could do nothing to prevent this death.
    B) delay the grieving process until they are ready to cope.
    C) minimize their discussion of the death with others.
    D) plan funeral arrangements for their son.
    Ans: D
    Feedback:
    Funerals are often the beginning outward sign of mourning and help begin the grieving process. This couple will need to talk about their son's death repeatedly as they begin to grieve. It will not likely be possible for them to accept that they could do nothing to prevent this death within this time period, but they must begin to hear this. They should not delay the grieving process.

25. The nurse is establishing outcomes for a grieving client. Which of the following is an appropriate outcome?
    A) The client will develop a plan for coping with the loss.
    B) The client will demonstrate self-reliance during the grief process.
    C) The client will suppress emotions related to the loss.
    D) The client will verbalize that loss will not adversely affect the quality of life.
    Ans: A
    Feedback:
    Examples of outcomes for the grieving client are as follows:
    - Identify the effects of his or her loss.
    - Identify the meaning of his or her loss.
    - Seek adequate support while expressing grief.
    - Develop a plan for coping with the loss.
    - Apply effective coping strategies while expressing and assimilating all dimensions of human response to loss in his or her life.
    - Recognize the negative effects of the loss on his or her life.
    - Seek or accept professional assistance if needed to promote the grieving process.

26. The nurse approaches a client who looks very sad and is sitting alone crying. The best response by the nurse in this situation is,
    A) ìI'm sorry you are sad. Is there anything I can do to help you feel better?î
    B) ìPlease don't cry. It will get better.î
    C) ìYou look very sad. What is happening?î
    D) ìWhat is bothering you?î
    Ans: C
    Feedback:
    It is essential to accept the person's feelings without trying to dissuade him or her from feeling angry or upset. The nurse needs to encourage the person to express any and all feelings without trying to calm or placate him or her.

27. A woman has just been served divorce papers from her husband. She has no financial resources and little social support. She states, ìHe's not really leaving. He'll be back.î The most appropriate response by the nurse would be which of the following?
    A) ìHas he done this before?î
    B) ìI'll call social services and get you signed up for financial assistance.î
    C) ìYou have to face reality. Here are the papers.î
    D) ìHow is this affecting you right now?î
    Ans: D
    Feedback:
    Adaptive denial, in which the client gradually adjusts to the reality of the loss, can help the client let go of previous (before the loss) perceptions while creating new ways of thinking about himself or herself, others, and the world. While taking in the loss in its entirety all at once seems overwhelming, gradually dealing with the loss in smaller increments seems much more manageable. Help the client shift from an unconscious mechanism of denial to conscious coping with reality by using reflective communication skills.

28. An elderly woman who lives alone is beginning to have difficulty maintaining her household and performing daily tasks. The nurse asks her to identify someone who can help her. The woman replies, ìI don't need help. I've been managing for years.î Which of the following responses helps the client shift from denial to consciously coping with her situation?
    A) ìYou don't think you need any help? But your family is worried about you.î
    B) ìIt must be hard to lose your independence. I'll ask a social worker to see what can be arranged.î
    C) ìIf you were to need help with your house, who might you ask for help?î
    D) ìIf you don't ask for some help. then the only option is to move to an assisted living facility.î

    Ans: C

    Feedback:

    The nurse can help the client to reach out and accept what others want to give in support of his or her grieving process. Help the client shift from an unconscious mechanism of denial to conscious coping with reality by using reflective communication skills. Do not force people through the coping process by insisting they take certain actions.

29. A client who has been grieving the loss of his wife 2 weeks ago says to the nurse, ìThe best part of my day is when I am back at work. Is that wrong?î The nurse educates that work and other daily activities serve which purpose?
    A) ìYou cannot work effectively this soon. You should finish grieving first.î
    B) ìWorking reminds you of your loss. It may be too early to go back.î
    C) ìWorking is your way of avoiding grief, which will make it harder for you to move on.î
    D) ìWorking is letting you take an emotional break from grieving. There's nothing wrong with that.î

    Ans: D

    Feedback:

    The bereaved person can often take a break from the exhausting process of grieving. Going back to a routine of work or focusing on other members of the family may provide that respite. Familiar routines can affirm the client's talents and abilities and can renew feelings of self-worth.

30. Which of the following are critical components in assessment of a person's grief? Select all that apply.
    A) Adequate perception regarding the loss
    B) Adequate time to experience the loss
    C) Adequate support while grieving for the loss
    D) Adequate opportunities to say goodbye to the person
    E) Adequate coping behaviors during the process
    Ans: A, C, E
    Feedback:
    While observing for client responses in the dimensions of grieving, the nurse explores three critical components in assessment:
    ï Adequate perception regarding the loss
    ï Adequate support while grieving for the loss
    ï Adequate coping behaviors during the process
    The time to experience the loss varies significantly from person to person, and the reality is that there may not be adequate opportunities to say goodbye to the person.

31. A client comes to the physician's office for an annual checkup. During the interview, the nurse learns that the client's husband died unexpectedly of a heart attack 2 months ago. The most appropriate response by the nurse would be,
    A) ìAt least you and your husband enjoyed life right until the end.î
    B) ìIt's better to go quickly like your husband did instead of suffering.î
    C) ìThe loss of your husband must be very painful for you.î
    D) ìYou'll feel better after you get over the shock of your husband's death.î
    Ans: C
    Feedback:
    The nurse makes an empathetic response, acknowledging the client's loss. ìAt least you and your husband enjoyed life right until the end,î is judgmental. ìIt's better to go quickly like your husband did instead of suffering,î does not address the client's grief. ìYou'll feel better after you get over the shock of your husband's death,î is false reassurance.
    Thus, choices A, B, and D would not be the most appropriate responses.

32. A woman has just delivered a stillborn baby boy. Which of the following would be the most appropriate nursing response?
    A) ìCan I do anything for you?î
    B) ìIf something was wrong, it's better this way.î
    C) ìYour son is in heaven with God now.î
    D) ìWould you like to hold your son?î
    Ans: D
    Feedback:
    The opportunity to hold the baby may help the woman deal with the first stage of grieving: denial; it also allows her to express emotions over the loss. Asking the client, ìCan I do anything for you,î is a closed-ended question and will likely be replied to with a yes or no answer. Stating, ìIf something was wrong, it's better this way,î is not sensitive to the woman's loss. Stating ìYour son is in heaven with God now,î would be inappropriate because it may not be consistent with the woman's beliefs.

33. A client is scheduled for a mastectomy for breast cancer. She is quiet, shows little emotion, and states that she has no questions. The nurse's assessment would need to focus on
    A) the client's plans for reconstructive surgery.
    B) the meaning of the mastectomy to the client.
    C) whether the client truly understands the surgery.
    D) why the client seems depressed.
    Ans: B
    Feedback:
    Assessment begins with exploration of the client's perception of the loss. A client who is scheduled for a mastectomy would possibly be having anticipatory loss of a physiologic nature. It would not be appropriate to discuss the client's plans for reconstructive surgery as this is not likely what is causing the client to be quiet and show little emotion. It is important to ascertain whether the client truly understands the surgery when witnessing the client's signature of the operative consent, but there is no indication that this is what is being addressed at this time. It would not be appropriate to assume that the client is depressed or not. It would be better to explore the client's perception of the loss.

1. **Chapter 11** A nurse is working with a client who has frequent angry outbursts. Which of the following statements is most helpful when working with this client?
   A) ìAnger is a normal feeling, and you can use it to solve problems.î
   B) ìYou need to learn to suppress your angry feelings.î
   C) ìYou can reduce your anger by hitting a punching bag.î
   D) ìYou need to learn how to be less assertive in your communications.î
   Ans: A
   Feedback:
   Anger can be a normal and healthy reaction when situations or circumstances are unfair or unjust, personal rights are not respected, or realistic expectations are not met. If the person can express his or her anger assertively, problem solving or conflict resolution is possible. Anger becomes negative when the person denies it, suppresses it, or expresses it inappropriately. A person may deny or suppress (i.e., hold in) angry feelings if he or she is uncomfortable expressing anger. Catharsis can increase rather than alleviate angry feelings. Effective methods of anger expression, such as using assertive communication, to express anger should replace angry aggressive outbursts.

2. Which of the following statements about anger, hostility and aggression are accurate? Select all that apply.
   A) Anger is an emotional response to a real or perceived provocation.
   B) Hostility stimulates the sympathetic nervous system.
   C) Physical aggression involves harming other persons or property.
   D) Anger, hostility, and physical aggression are normal human emotions.
   E) Hostility is also referred to as verbal aggression.
   F) Physical aggression often progresses to hostility.
   Ans: A, C, E
   Feedback:
   Anger is an emotional response to a real or perceived provocation. Anger energizes the body physically for self-defense, when needed, by activating the ìfight-or-flightî response mechanism of the sympathetic nervous system. Hostility is different than anger. Physical aggression is behavior in which a person attacks or injures another person or that involves destruction of property. Hostility is also referred to as verbal aggression. Anger is a normal human emotion. Hostility is an emotion that is expressed through negative behavior. Physical aggression is behavior. Hostility may lead to physical aggression.

3. A married man expresses to the nurse that his wife's frequent nagging angers him. The nurse role-plays assertive communication techniques with the husband. Which of the following indicates the husband understands how to use assertive techniques effectively?
   A) ìI really wish you would stop nagging me.î
   B) ìYou are not perfect either.î
   C) ìI feel unappreciated when you criticize me.î
   D) ìAre you telling me you want me to change?î
   Ans: C
   Feedback:
   The nurse can help clients express anger appropriately by serving as a model and by role-playing assertive communication techniques. Assertive communication uses ìIî statements that express feelings and are specific to the situation; for example, ìI feel angry when you interrupt me,î or ìI am angry that you changed the work schedule without talking to me.î Statements such as these allow appropriate expression of anger and can lead to productive problem-solving discussions and reduced anger.

4. Which one of the following statements about anger is most accurate?
   A) Anger is an abnormal human emotion that is always negative.
   B) It is best to express anger by whatever means possible to minimize its consequences.
   C) Most men are socialized to suppress anger.
   D) Anger awareness and expression are necessary for women's growth and development.
   Ans: D
   Feedback:
   Women must recognize that anger awareness and expression are necessary for their growth and development. Anger is a normal human emotion and is often perceived as a negative feeling. However, anger becomes negative when denied, suppressed, or expressed inappropriately. Anger that is expressed inappropriately can lead to hostility and aggression. Catharsis can increase rather than alleviate angry feelings. Men are often socialized to believe that it is acceptable to express anger, while women are often socialized to maintain and enhance relationships with others and avoid expression of emotions such as anger.

5. At which point in the stages of aggressive incidents is intervention least likely to be effective in preventing physically aggressive behavior?
   A) Triggering
   B) Escalation
   C) Crisis
   D) Postcrisis
   Ans: C
   Feedback:
   Interventions during the triggering and escalation phases are key to prevent physically aggressive behavior. During the crisis phase, behavior escalation may lead to physical aggression. During the postcrisis phase, the physically aggressive behavior has stopped and the client returns to the level of functioning before the aggressive incident.

6. Anger management is likely to be included in the care of clients with which of the following psychiatric diagnoses? Select all that apply.
   A) Alzheimer's dementia
   B) Schizophrenia
   C) Anorexia nervosa
   D) Acute alcohol intoxication
   E) Generalized anxiety disorder
   Ans: A, B, D
   Feedback:
   Although most clients with psychiatric disorders are not aggressive, clients with a variety of psychiatric diagnoses can exhibit angry, hostile, and aggressive behavior. Clients with paranoid delusions may believe others are out to get them; believing they are protecting themselves, they retaliate with hostility or aggression. Some clients have auditory hallucinations that command them to hurt others. Aggressive behavior also is seen in clients with dementia, delirium, head injuries, intoxication with alcohol or other drugs, and antisocial and borderline personality disorders.

7. Which is most likely to be the subject of an aggressive attack from a client with mental illness?
   A) Other people
   B) The client
   C) Animals
   D) Objects
   Ans: B
   Feedback:
   Clients with psychiatric disorders are more likely to hurt themselves than other people.

8. Which psychiatric disorder makes a person most susceptible to anger attacks that do not result in physical aggression?
   A) Delusions
   B) Depression
   C) Dementia
   D) Delirium
   Ans: B
   Feedback:
   Some clients with depression have anger attacks that are sudden intense spells of anger that typically occur in situation where the depressed person feels emotionally trapped. Anger attacks involve verbal expressions of anger or rage but no physical aggression. Persons with delusions, dementia, and delirium are most likely to become physically aggressive.

9. A client is observed pacing the hall with clenched fists and swearing at others. The nurse intervenes immediately to prevent the client from moving to which phase of the aggressing cycle?
   A) Triggering
   B) Escalation
   C) Crisis
   D) Recovery
   Ans: B
   Feedback:
   During escalation, the client's responses represent escalating behaviors that indicate movement toward a loss of control, including pale or flushed face, yelling, swearing, agitated, threatening, demanding, clenched fists, threatening gestures, hostility, loss of ability to solve the problem or think clearly. This phase is followed by the crisis phase. During a period of emotional and physical crisis, the client loses control. Behaviors may include loss of emotional and physical control, throwing objects, kicking, hitting, spitting, biting, scratching, shrieking, screaming, and inability to communicate clearly.

10. The client's son is yelling and is hitting his hand with a rolled up newspaper. Which stage of aggression does the nurse identify that the client's son is exhibiting?
    A) Triggering
    B) Escalation
    C) Crisis
    D) Recovery
    Ans: B
    Feedback:
    During the escalation phase of aggression, a person may exhibit yelling and threatening, clenched fist, threatening gestures. During the triggering phase of aggression, a person may exhibit signs and symptoms and behaviors including restlessness, anxiety, irritability, pacing, muscle tension, rapid breathing, perspiration, loud voice, and anger.

11. The nurse is teaching a client to recognize early signs of anger and aggression. The nurse explores ways that the client can recognize which of the following?
    A) Decreased problem-solving ability
    B) Restlessness and irritability
    C) Remorse
    D) Severe muscle tension
    Ans: B
    Feedback:
    Earliest signs of anger include restlessness, anxiety, irritability, pacing, muscle tension, rapid breathing, perspiration, loud voice, and anger. Escalated signs include pale or flushed face, yelling, swearing, agitation, threatening, demanding, increased muscle tension such as clenched fists, threatening gestures, hostility, and loss of ability to solve the problem or think clearly. Remorse is seen after the anger crisis when attempts are made at reconciliation.

12. A client suddenly jumps up from the chair and begins yelling and cursing at the nurse. Which would be the best response by the nurse?
    A) ìI can see that you need attention; you should calmly ask for what you want.î
    B) ìI don't want to hear that kind of language; don't ever do that again.î
    C) ìI will limit your smoking privileges if you can't control yourself.î
    D) ìYou seem angry. Tell me more about how you're feeling.î
    Ans: D
    Feedback:
    The nurse recognizes and validates the client's feelings and offers to focus on those feelings and what the client needs. In this situation, the client is not at a point where he can be calm. Taking away privileges will not help the current situation. ìI don't want to hear that kind of language; don't ever do that againî is demeaning to the client.

13. A client approaches the nurse and loudly states, ìI'm not putting up with this anymore!î The most appropriate response by the nurse would be which of the following?
    A) ìI can see you are angry. Tell me what's going on.î
    B) ìYou are not allowed to make threats. Please keep your voice down.î
    C) ìWhy do you say that?î
    D) ìYou are here voluntarily. You can leave if you want.î
    Ans: A
    Feedback:
    In the triggering phase, the nurse should approach the client in a nonthreatening, calm manner in order to deescalate the client's emotion and behavior. Conveying empathy for the client's anger or frustration is important. The nurse can encourage the client to express his or her angry feelings verbally, suggesting that the client is still in control and can maintain that control. Use of clear, simple, short statements is helpful.

14. A client is clenching his fists and yelling at another client on the unit. He appears to be close to losing control of his anger. Which of the following actions by the nurse is appropriate at this time?
    A) Clear others out of the immediate area.
    B) Prepare a PRN sedative.
    C) Tell the client to stop and take a time-out.
    D) Alert the security department of an impending aggressive outburst.
    Ans: C
    Feedback:
    If the client progresses to the escalation phase (period when client builds toward loss of control), the nurse must take control of the situation. The nurse should provide directions to the client in a calm, firm voice. The client should be directed to take a time-out for cooling off in a quiet area or his or her room. Clearing others from the area or alerting security does not help the client regain control. Administering a sedative is not the least restrictive intervention at this time.

15. In the psychiatric setting, what is the most effective intervention in preventing the hostile client's behavior from escalating to physical aggression?
    A) Getting as far away from him or her as possible
    B) Engaging the hostile person in dialogue
    C) Yelling at the client to settle down now
    D) Ensuring that the client gets his or her way
    Ans: B
    Feedback:
    In a psychiatric setting, engaging the hostile person is most effective to prevent the behavior from escalating to physical aggression. In the psychiatric setting, it is not possible to get as far away from them as possible. Yelling at the client will likely escalate the hostility. Ensuring that the client gets his or her way may eliminate frustration that may lead to acting out, but is unrealistic and not ultimately helpful to the client.

16. An angry client has just thrown a chair across the room and is racing to pick up another chair to throw. The most appropriate action by the nurse would be which of the following?
    A) Call for an emergency response from trained personnel.
    B) Approach the client and firmly say, ìStop, put it down.î
    C) Calmly call the client by name and encourage verbal expression of anger.
    D) Assist the client to use problem-solving techniques instead of aggression.
    Ans: A
    Feedback:
    When the client becomes physically aggressive (crisis phase), the staff must take charge of the situation for the safety of the client, staff, and other clients. Psychiatric facilities offer training and practice in safe techniques for managing behavioral emergencies, and only staff with such training should participate in the restraint of a physically aggressive client. Verbal expression and problem solving are ineffective once a client has reached the crisis phase. The priority is to maintain safety and regain control.

17. A client who has been physically aggressive arrives at the emergency room for a psychiatric assessment. Which would be the best approach for the nurse to use?
    A) Have a sense of humor to show a lack of fear.
    B) Provide close contact to increase the client's sense of safety.
    C) Use brief statements and questions to obtain information.
    D) Use open-ended questions, so the client can elaborate.
    Ans: C
    Feedback:
    Following an aggressive episode, clients may have difficulty expressing themselves; short, concise statements and questions will get needed information. Humor or open-ended questions may be frustrating or annoying for the client. It is not safe for the nurse to provide close contact under these circumstances.

18. The nurse is interviewing a client with a history of physical aggression. Which of the following should the nurse avoid?
    A) Anticipating that a loss of control is possible and planning accordingly
    B) Explaining the consequences the client will face if control is lost
    C) Interviewing the client with another staff member present
    D) Responding to verbal threats by terminating the interview and obtaining assistance
    Ans: B
    Feedback:
    Giving the client an ultimatum is likely to foster hostile or aggressive behavior; the other measures are all appropriate for a client with a history of aggression.

19. When interacting with a client in the day room, the nurse determines that a violent outburst is imminent. Which of the following should the nurse do first?
    A) Call for assistance.
    B) Give the client choices.
    C) Remove the other clients.
    D) Talk to the client calmly.
    Ans: A
    Feedback:
    Safety is the priority; the nurse needs assistance to remove other clients and to deal with the violent outburst. The other interventions may be implemented after calling for assistance.

20. The client with a history of explosive outbursts becomes angry and states, ìI am really getting angry.î The nurse sees this as
    A) controlling.
    B) manipulation.
    C) progress.
    D) regression.
    Ans: C
    Feedback:
    When the client is able to verbalize angry feelings, this is progress from having an outburst. The client is not trying to control the situation. Manipulation occurs when a person tries to persuade another to act in a desired way. Regression occurs when one retreats to an earlier level of functioning and development.

21. The client identifies anger management as a problem. What is the next step in planning therapeutic interactions?
    A) Give the client a variety of choices on how to express anger.
    B) Give the client permission to be angry.
    C) Point out the senselessness of anger.
    D) Tell the client not to be angry all the time.
    Ans: B
    Feedback:
    Many people view anger as a negative and abnormal feeling in addition to feeling guilty about being angry; the nurse can help the client see anger as a normal, acceptable emotion. Giving choices on how to express anger would not be the next step in the planning stage. Pointing out the senselessness of anger and telling the client not to be angry all the time are not appropriate responses in this situation.

22. The nurse decides to place an aggressive and violent client in mechanical restraints. The nurse bases this decision on which of the following?
    A) Client's mood
    B) Client's safety
    C) Court order
    D) Physician's order
    Ans: B
    Feedback:
    The use of restraints is warranted only when the client's safety is in jeopardy and other, less restrictive measures have not been effective. The nurse does not base her decision on the client's mood or court order. Just because there is a physician's order for use of restraints, this does not mean that they are appropriate in every situation; this is based on nursing judgment.

23. The nurse observes two clients in the day room arguing. One client runs into the corner and huddles while the other follows and continues with verbal abuse. Which is the best action by the nurse?
    A) Take an authoritatively step between the two clients.
    B) Comfort the client huddled in the corner.
    C) Directly address both clients and ask what is going on.
    D) Engage the attention of the client who is still yelling and ask what is happening.
    Ans: D
    Feedback:
    Engaging the attention of the dominant person will diffuse the situation and stop the argument from continuing. The other choices would not be appropriate actions in this situation. The nurse placing herself in between two arguing clients is a safety concern.

24. Which of the following interventions would assist the client with the appropriate expression of anger?
    A) Encourage catharsis
    B) Encourage verbalization
    C) Improve self-esteem
    D) Isolate the client from others
    Ans: B
    Feedback:
    Verbally expressing angry feelings is a safe and appropriate way to deal with anger. Isolation and catharsis can increase angry and hostile feelings. The other choices are not appropriate responses in this situation.

25. A client lost control of his behavior, broke a window, and made verbal threats to staff and other clients. The client was placed in mechanical restraints. Which statement should the nurse make to explain the use of restraints to the client?
    A) ìThe length of time you'll be in restraints is undetermined.î
    B) ìThe staff will monitor your behavior closely.î
    C) ìThis is what happens when you lose control.î
    D) ìThis is a means of keeping you and others safe.î
    Ans: D
    Feedback:
    Use of restraints is a temporary, short-term way of ensuring the safety of everyone until the client regains behavioral control; it is not a punishment. The other choices are not appropriate explanations of the use of restraints.

26. Which of the following interventions are most effective in managing the environment to reduce or eliminate aggressive behavior? Select all that apply.
    A) Planning group activities such as playing games
    B) Scheduling one-to-one interactions with the client
    C) Providing structure and consistency in the unit
    D) Avoiding discussions among clients on the unit
    E) Discouraging clients from negotiating solutions
    Ans: A, B, C
    Feedback:
    Group and planned activities such as playing card games, watching and discussing movies, or participating in informal discussions give the clients the opportunity to talk about events or issues when they are calm. Scheduling one-to-one interactions with clients indicates the nurse's genuine interest in the client and a willingness to listen to the client's concerns, thoughts, and feelings. Knowing what to expect enhances the client's feelings of security. Avoiding discussions does not give clients the opportunity to talk about events or issues when they are calm. If clients have a conflict or dispute with one another, the nurse can offer the opportunity for problem solving or conflict resolution. Expressing angry feelings appropriately, using assertive communication statements, and negotiating a solution are important skills clients can practice. These skills will be useful for the client when he or she returns to the community.

27. Which of the following statements about the crisis phase of aggression when the client becomes physically aggressive is true?
    A) All staff should act to take charge of the situation.
    B) The client must be restrained or sedated at once.
    C) Staff should avoid communicating with the client.
    D) Four to six trained staff members are needed to restrain.
    Ans: D
    Feedback:
    Four to six trained staff members are needed to restrain, with four staff members each handling a limb and one protecting the client's head and one helps control the client's torso, if needed. When a client becomes physically aggressive, the staff must take charge of the situation for the safety of the client, staff, and other clients. Only staff with training in safe techniques for managing behavioral emergencies should participate. All staff may not have had this training, and if the team is not working in a cooperative and coordinated fashion, it is less safe to restrain the client. The nurse should follow the facility's protocols and standards for restraint and seclusion. Staff should inform the client that his or her behavior is out of control and that the staff is taking control to provide safety and prevent injury.

28. After an angry outburst, a client quickly appears more calm and rational. The nurse approaches the client. Which of the following is the most helpful response to the client at this time?
    A) ìWe will have to talk about this later.î
    B) ìYou really scared me. I'm glad you are okay.î
    C) ìWhat happened that got you so upset?î
    D) ìWhat can you do differently next time you get angry?î
    Ans: C
    Feedback:
    As the client regains control (recovery phase), he or she is encouraged to talk about the situation or triggers that led to the aggressive behavior. The nurse should help the client relax, perhaps sleep, and return to a calmer state. Talking about the event at a later time does let the client rest, but it does less to address the client's feelings associated with the angry outburst. It is too early postcrisis to discuss behavior change for the future as the client needs to recover from intense emotions first.

29. After an angry outburst, the client is tearful and remorseful. Which statement by the nurse would be most supportive?
    A) ìYou still need to work on your problem-solving skills.î
    B) ìI will not allow you to get that angry again.'
    C) ìYou should not have let your anger buildup like you did.î
    D) ìWhat could you have done when you first started to feel angry?î
    Ans: D
    Feedback:
    In the postcrisis phase, the nurse should not lecture or chastise the client for the aggressive behavior but should discuss the behavior in a calm, rational manner. The client can be given feedback for regaining control, with the expectation that he or she will be able to handle feelings or events in a nonaggressive manner in the future.

30. One of the first steps that a nurse should take to deal effectively with aggressive clients is which of the following?
    A) Reflect on abilities to handle own feelings of anger
    B) Learn professional skills of anger management
    C) Become proficient using reflective communication techniques
    D) Understand how to activate crisis response teams
    Ans: A
    Feedback:
    The nurse must be aware of how he or she deals with anger before helping clients do so. The nurse who is afraid of angry feelings may avoid a client's anger, which allows the client's behavior to escalate. If the nurse's response is angry, the situation can escalate into a power struggle, and the nurse loses the opportunity to ìtalk downî the client's anger. Identifying how you handle angry feelings is an initial task. Once the nurse understands his or her own experiences with anger, the clients can be helped through learning the use of assertive communication and conflict resolution. Increasing your skills in dealing with your angry feelings will help you to work more effectively with clients. Activating a crisis response is a late option in dealing with anger.

31. Which of the following is most important to maintain therapeutic boundaries when working with aggressive clients?
    A) Encourage clients to express how the nurse can avoid causing emotional irritation.
    B) Discuss difficult patient care situations with a supervisor.
    C) Reflect on your actions that may have instigated the client's anger,
    D) Do not personalize a client's anger
    Ans: D
    Feedback:
    Do not take the client's anger or aggressive behavior personally or as a measure of your effectiveness as a nurse. The client's aggressive behavior, however, does not necessarily reflect the nurse's skills and abilities. Clients should not dictate nurses' behaviors. The nurse is not responsible for angering the client. Individuals are responsible for their own emotional control. If the nurse cannot maintain boundaries, assistance should be sought form a supervisor.

32. Which of the following are important issues for nurses to be aware of when working with angry, hostile, or aggressive clients? Select all that apply.
    A) Nurses must be aware of their own feelings about anger and their use of assertive communication and conflict resolution.
    B) Nurses must not allow themselves to become angry under any circumstances.
    C) Nurses must know that a client's anger or aggressive behavior is preventable by a skilled nurse.
    D) Nurses must discuss situations or the care of potentially aggressive clients with experienced nurses.
    E) Nurses must be calm, nonjudgmental, and nonpunitive when using techniques to control a client's aggressive behavior.
    Ans: A, D, E
    Feedback:
    Nurses must identify how they handle angry feelings and assess their use of assertive communication and conflict resolution. Increasing their skills in dealing with their angry feelings will help the nurses to work more effectively with the client. Nurses must not take the client's anger or aggressive behavior personally or as a measure of their effectiveness as a nurse. Nurses must discuss situations or the care of potentially aggressive clients with experienced nurses. Nurses must be calm, nonjudgmental, and nonpunitive when using techniques to control a client's aggressive behavior.

33. What a culture considers acceptable strongly influences the expression of anger. Which culture-bound syndrome is a dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at other people and objects?
    A) Hwa-Byung
    B) Hwabyeong
    C) Amok
    D) BouffÈe delirante
    Ans: C
    Feedback:
    BouffÈe delirante, a condition observed in West Africa and Haiti, is characterized by a sudden outburst of agitated and aggressive behavior, marked confusion, and psychomotor excitement. Hwa-Byung or hwabyeong is a culture-bound syndrome that literally translates as anger syndrome, or fire illness, attributed to the suppression of anger. Amok is a dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at other people and objects.

1. **Chapter 12** The nurse is collecting assessment data on a client who is suspected to be a victim of violence. Which assessment data would support the suspicion that the client is a victim of abuse? Select all that apply.
   A) The client has few friends.
   B) The client holds a dominant role in the family.
   C) The client is in charge of the family finances.
   D) There is a moderate amount of alcohol use in the home.
   E) The client reports that the father was abusive during childhood.
   Ans: A, D, E
   Feedback:
   One characteristic of violent families is social isolation. Members of these families keep to themselves and usually do not invite others into the home or tell them what is happening. If the client reports that the father was abusive during childhood, that would support the suspicion that the client is a victim of abuse. The abusive family member almost always holds a position of power and control over the victim. The abuser exerts not only physical power but also economic and social control. Substance abuse, especially alcoholism, has been associated with family violence.

2. A young female immigrant presents in the rural health clinic with facial bruising and a fractured nose. The client is reluctant to give details of the nature of her injuries. Which of the following should be a consideration in providing care for this client?
   A) Most views regarding domestic violence are universal across cultures.
   B) She may fear deportation if she seeks public assistance.
   C) Immigrants have expedited access to public legal services.
   D) The nurse should ignore the details and focus on treatment.
   Ans: B
   Feedback:
   Battered immigrant women face legal, social, and economic problems different from US citizens who are battered and from people of other cultural, racial, and ethnic origins who are not battered: The battered woman may come from a culture that accepts domestic violence. She may believe she has less access to legal and social services than do US citizens. If she is not a citizen, she may be forced to leave the United States if she seeks legal sanctions against her husband or attempts to leave him. She is isolated by cultural dynamics that do not permit her to leave her husband; economically, she may be unable to gather the resources to leave, work, or go to school. Language barriers may interfere with her ability to call 911, learn about her rights or legal options, and obtain shelter, financial assistance, or food. The nurse must treat the whole person and encourage the client to share the details in order to protect the client's safety and well-being.

3. Which of the following is the best explanation for why family violence tends to occur over multiple generations of families?
   A) A tendency toward violence is hereditary.
   B) Family violence may be perpetuated between generations of families by role modeling and social learning.
   C) All persons who have become victims of family violence will grow up to perpetrate family violence.
   D) Family violence does not tend to have an intergenerational transmission process.
   Ans: B
   Feedback:
   The intergenerational transmission process shows that patterns of violence are perpetuated from one generation to the next through role modeling and social learning. Not all persons exposed to family violence, however, become abusive or violent as adults.

4. Which of the following are common characteristics of violent families regardless of the type of abuse that exists? Select all that apply.
   A) Abuse of power and control
   B) Alcohol and other drug abuse
   C) Intergenerational transmission
   D) Social isolation
   E) Victim instigates
   Ans: A, B, C, D
   Feedback:
   Research studies have identified some common characteristics of violent families regardless of the type of abuse that exists. They include social isolation, abuse of power and control, alcohol and other drug abuse, intergenerational transmission. The victim does not instigate abuse.

5. Which of the following are common reasons why abused women remain with the abusive partner? Select all that apply.
   A) The abused person is personally and financially dependent on the abuser.
   B) The abused person has low self-esteem and defines her success as a person by the ability to make the relationship work.
   C) The abused person is convinced that she has been abusive toward the abuser at some point and that the abuse is her fault.
   D) The abused person believes that she is unable to function without her husband.
   E) The abused person is afraid that the abuser will kill her if she tries to leave.
   Ans: A, B, D, E
   Feedback:
   Dependency is the trait most commonly found in abused wives who stay with their husbands. Women often cite personal and financial dependency as a reason why they find leaving an abusive relationship extremely difficult. The victim may suffer from low self-esteem and defines her success as a person by her ability to remain loyal to her marriage and ìmake it work.î Some women internalize the criticism they receive and mistakenly believe they are to blame. Women also fear their abuser will kill them if they try to leave. An abuser often has feelings of low self-esteem and poor problem-solving and social skills and may interpret any attempts at defense or any behavior of the abused person as abuse of the perpetrator.

6. Which of the following are typical characteristics of the perpetrator of intimate partner abuse? Select all that apply.
   A) The perpetrator often believes that the partner is his own property.
   B) The perpetrator is often irrationally jealous, even of his own children.
   C) The perpetrator is emotionally immature and needy.
   D) The perpetrator respects his partner.
   E) The perpetrator is intimidated by his partner.
   Ans: A, B, C
   Feedback:
   The perpetrator often believes that the partner is his own property. The perpetrator is often irrationally jealous, even of his own children if the partner pays any attention to them. The perpetrator is emotionally immature and needy. The perpetrator does not respect his partner because if he did, he would not believe that the partner is his own property to do with as he wishes. The perpetrator wants to maintain control over his partner and is therefore not intimidated by the partner but by the thought of the partner not being available.

7. The nurse is caring for a 16-year-old boy with a history of sexual abuse. What might the nurse expect to assess with this client?
   A) The client will experience long-term emotional trauma.
   B) The client will have no ill effects due to his age.
   C) The client will have high self-esteem.
   D) The client will easily share his concerns with the nurse.
   Ans: A
   Feedback:
   Nightmares and flashbacks are common in people who were abused as children regardless of their current age. The client may have ill effects irrespective of the age. The client will likely have low self-esteem. The client will likely have difficulty relating to anyone, including the nurse.

8. Which of the following behaviors would first alert the school nurse or teacher to suspect sexual abuse in a 7-year-old child?
   A) The child has a preference for associating with peers, rather than adults.
   B) The child has learning problems and shyness.
   C) The child tells sexually explicit stories to peers.
   D) The child wears dirty and threadbare clothing.
   Ans: C
   Feedback:
   Children who have sexual knowledge not expected at their age have often been sexually abused. A child who has been sexually abused by an adult may feel more comfortable with peers than with adults. Learning problems, shyness, and wearing dirty and threadbare clothing may be related to many situations other than sexual abuse.

9. Which characteristic of the abuser should the nurse look for when completing the family assessment of a victim on intimate partner violence?
   A) Encourages the partner to have a life outside the intimate relationship
   B) An inflated sense of self-esteem
   C) Needy and possessive of the partner
   D) An ability to feel remorse for the abuse
   Ans: C
   Feedback:
   An abusive husband often believes his wife belongs to him (like property) and becomes increasingly violent and abusive if she shows any sign of independence, such as getting a job or threatening to leave. Typically, the abuser has strong feelings of inadequacy and low self-esteem as well as poor problem-solving and social skills. He is emotionally immature, needy, irrationally jealous, and possessive. By bullying and physically punishing the family, the abuser often experiences a sense of power and control. Therefore, the violent behavior often is rewarding and boosts his self-esteem. A typical pattern of abuse exists: Usually, the initial episode of battering or violence is followed by a period of the abuser expressing regret, apologizing, and promising it will never happen again.

10. Which one of the following statements regarding intimate partner violence is true?
   A) Males are never the victim in intimate partner violence.
   B) It is common for abusers to use one type of abuse only.
   C) Intimate partner violence can exist with former partners.
   D) Psychological abuse is not as harmful as physical abuse.
   Ans: C
   Feedback:
   Intimate partner violence is the mistreatment or misuse of one person by another in the context of an emotionally intimate relationship. The relationship may be spousal, between partners, boyfriend, girlfriend, or an estranged relationship. Ninety to ninety-five percent of domestic violence victims are women. By deduction, this means that 5% to 10% of domestic violence victims are men. The abuse can be emotional or psychological, physical, sexual, or a combination (which is common). All abuse is harmful.

11. The nurse is involved in a community education program for new parents and plans to include information on child abuse. The nurse will teach the parents that the most common form of child abuse is which of the following?
    A) Neglect
    B) Physical abuse
    C) Sexual abuse
    D) Emotional abuse
    Ans: A
    Feedback:
    Sixty-four percent of child maltreatment victims suffered neglect; 16% were physically abused; 8.8% were sexually abused; 6.6% were psychologically or emotionally abused; and 2.2% were medically neglected. Also, 15% suffered ìotherî types of maltreatment such as abandonment, physical threats, and congenital drug addiction.

12. A coherent elderly woman has been financially and emotionally abused by her adult children for the past several years, but has failed to report the abuse to anyone. Which is the most likely reason that the woman neglects to report the abuse?
    A) She cannot claim abuse if there is no evidence of physical harm.
    B) Laws do not provide protection against abuse when the suspect(s) is/are family members.
    C) She has no financial resources to hire legal representation against her children.
    D) She is emotionally close to her children and does not want to bring them harm.
    Ans: D
    Feedback:
    Elders are often reluctant to report abuse, even when they can, because the abuse usually involves family members whom the elder wishes to protect. Victims also often fear losing their support and being moved to an institution.

13. A school nurse is educating a group of adolescent girls about rape and sexual assault. The nurse evaluates the students' understanding when they report which of the following as a high-risk factor regarding the incidence of rape?
    A) The highest incidence of rape occurs in adolescents and young adult women.
    B) Most rapes are committed by strangers.
    C) Most rapes are random acts of violence.
    D) A victim is at highest risk in unfamiliar neighborhoods.
    Ans: A
    Feedback:
    Only 20% of rapes are committed by strangers. A phenomenon called date rape (acquaintance rape) may occur on a first date, on a ride home from a party, or when the two people have known each other for some time. It is more prevalent near college and university campuses. The highest incidence is in girls and women 16 to 24 years of age. Rape most commonly occurs in a woman's neighborhood, often inside or near her home. Most rapes are premeditated.

14. Which of the following are common behavioral and emotional responses to abuse? Select all that apply.
    A) One third of abusive men are likely to have come from violent homes.
    B) Women who grew up in violent homes are 50% more likely to expect or accept violence in their own relationships.
    C) Dependency on the abuser is a common trait found in victims of domestic violence.
    D) The victim caused the abuse.
    E) It is critical for the nurse to demonstrate acceptance after hearing about the abuse so that the victim may begin to gain self-acceptance.

    Ans: A, B, C, E

    Feedback:

    One third of abusive men are likely to have come from violent homes. Women who grew up in violent homes are 50% more likely to expect or accept violence in their own relationships. Dependency on the abuser is a common trait found in victims of domestic violence. The victim may believe that he or she caused the abuse, but this is not accurate. It is critical for the nurse to demonstrate acceptance after hearing about the abuse so that the victim may begin to gain self-acceptance.

15. A woman is in treatment for an anxiety disorder. Her history reveals that she was sexually abused repeatedly by her husband. Which of the following interventions would be appropriate in relation to this piece of data?
    A) Avoid discussing the abuse so as not to upset her.
    B) Encourage her to talk about feelings related to the abuse.
    C) Request an anxiolytic to reduce her anxiety levels.
    D) Help her explore her role in perpetuating the abuse.

    Ans: B

    Feedback:

    Encourage the client to talk about his or her experience(s); be accepting and nonjudgmental of the client's accounts and perceptions. Retelling the experience can help the client to identify the reality of what has happened and help to identify and work through related feelings. Do not imply that the client is responsible for the abuse.

16. The pediatric nurse is caring for a 15-month-old child recently admitted to the hospital for a fractured femur. Which of the following data obtained during the assessment would raise the nurse's suspicion that the child has suffered physical abuse?
    A) The parents appearing overprotective of the child
    B) Bruises over the child's bony prominences
    C) The injury occurring several days before the parents sought treatment
    D) Both parents reporting the exact same details pertaining to the injurious event
    Ans: C
    Feedback:
    Warning signs of abused/neglected children include serious injuries such as fractures, burns, or lacerations with no reported history of trauma; delay in seeking treatment for a significant injury; the child or a parent giving a history inconsistent with severity of injury; inconsistencies or changes in the child's history during the evaluation by either the child or the adult; unusual injuries for the child's age and level of development, such as a fractured femur in a 2-month-old or a dislocated shoulder in a 2-year-old; high incidence of urinary tract infections; bruised, red, or swollen genitalia; tears or bruising of the rectum or vagina; and evidence of old injuries not reported, such as scars, fractures not treated, and multiple bruises that the parent/caregiver cannot explain adequately.

17. A woman has just presented at the emergency department after being raped. The initial nursing action would be to
    A) provide emotional support.
    B) refer her to a rape crisis hotline.
    C) encourage her to file charges immediately.
    D) perform a nursing history and physical as quickly as possible.
    Ans: A
    Feedback:
    In the emergency setting, the nurse is an essential part of the team in providing emotional support to the victim. The nurse should allow the woman to proceed at her own pace and not rush her through any interview or examination procedures. Giving back to the victim as much control as possible is important. Ways to do so include allowing her to make decisions, when possible, about whom to call, what to do next, what she would like done, and so on.

18. The nurse is working in the emergency department with a woman who was raped 1 hour ago. Which of the following is most important for the nurse to remember when planning care?
    A) The client should set aside any angry feelings until physical care is completed.
    B) Evidence collection according to procedures is not as important as treating the client's injuries.
    C) The nurse will need to make decisions for this client.
    D) The woman may feel threatened by some of the procedures.
    Ans: D
    Feedback:
    Many of the examination procedures, such as a pelvic exam, may cause the woman to feel violated again. The client needs emotional support and evidence collection as well as physical care. It would not be appropriate for the nurse to make decisions for this client.

19. A young woman telephones the emergency department and loudly tells the nurse, ìI've been raped! Please help me!î Which of the following is the priority for the nurse to determine?
    A) If the client was in a safe place, her condition, and if transportation is available
    B) If the client knew her assailant, knew her location, and had notified the police
    C) If the client has insurance, if she could get to the hospital by herself, and if pregnancy is a possibility
    D) If the client had bathed, douched, or changed clothes
    Ans: A
    Feedback:
    If the client is injured, she may need immediate medical attention; if she is in a safe place, she can talk to the nurse on the phone. All other questions can wait until the client's safety is ensured.

20. The school nurse is teaching a health class about recognizing the signs of abusive relationships. The nurse describes the cycle of violence. The nurse would document effective teaching if the students identify the cycle of violence to be which of the following patterns? Select the order in which the events occur.
    A. Tension building
    B. Honeymoon period
    C. Violent behavior
    D. Period of remorse
    Ans: A, C, D, B
    Feedback:
    The tension-building phase begins; there may be arguments, stony silence, or complaints from the husband. The tension ends in another violent episode after which the abuser once again feels regret and remorse and promises to change. This cycle continually repeats itself. Each time, the victim keeps hoping the violence will stop.

21. The nurse is discussing expectations of raising a child with a pregnant teenager expecting her first baby. The father will not be a participant in the parenting. Which of the following statements made by the expectant mother would be of greatest concern to the nurse?
    A) ìI am going to rely on my sisters for a lot of help raising my baby.î
    B) ìI was raised with very strict discipline.î
    C) ìMy child will love me unlike my parents ever did.î
    D) ìI am not sure how I am going to pay for all the things my child will need.î
    Ans: C
    Feedback:
    In some instances, the parent feels the need to have children to replace his or her own faulty and disappointing childhood; the parent wants to feel the love between child and parent that he or she missed as a child. The reality of the tremendous emotional, physical, and financial demands that comes with raising children usually shatters these unrealistic expectations. When the parent's unrealistic expectations are not met, abuse often follows. Having a support system and a sense of discipline can contribute to effective parenting. Financial worries may be a concern, but relying on a baby to meet emotional needs is a high-risk dynamic for child abuse.

22. The community health nurse meets with the family members of an elderly client. The nurse includes which of the following in the plan of care as a preventive measure to guard against elder abuse?
    A) Reassure the primary caregiver that he or she in the best position to provide care to the elder
    B) Teach the primary caregiver skills to meet all of the elder's needs
    C) Assist in the transfer of legal authority for elder care to the primary caregiver
    D) Provide the primary caregiver with additional resources to meet the elder's needs
    Ans: D
    Feedback:
    Elder abuse may develop gradually as the burden of care exceeds the caregiver's physical or emotional resources. Relieving the caregiver's stress and providing additional resources may help to correct the abusive situation and keep the caregiving relationship intact.

23. The nurse at a university health services clinic has been asked to meet with a freshman class of women about warning signs of relationship violence. The nurse points out which of the following danger signs the students should be alert for in a date?
    A) Dislikes your fiends
    B) Acts indifferent to your life choices
    C) Is excessively jealous
    D) Views you as superior to himself
    Ans: C
    Feedback:
    Warning signs of relationship violence include gets jealous for no reason; tells you with whom you may be friends or how you should dress, or tries to control other elements of your life; does not view you as an equal: sees himself as smarter or socially superior; is angry or threatening to the point that you have changed your life or yourself so you would not anger him.

24. A female college student comes to the counseling center and tells the nurse she is afraid of her boyfriend. She states, ìHe is so jealous and overprotective; he wants to know where I am and who I'm with every minute.î Which of the following is most likely true of the situation?
    A) The student is overreacting.
    B) This is a situation requiring a restraining order.
    C) The student's boyfriend is simply insecure and needs reassurance.
    D) This is characteristic of the tension-building phase of the violence cycle.
    Ans: D
    Feedback:
    In tension building, the abuser attempts to establish complete control over all the person's actions. It is more appropriate for the nurse to listen to the client, rather than to judge whether the client is overreacting. This may or may not require a restraining order. The student's boyfriend is insecure and needs reassurance, but that is not the only concern.

25. The nurse is working with a client at the battered women's shelter who is in a violent and abusive relationship. The client is considering a separation and asks the nurse, ìWhat do you think about that?î Which is the best response by the nurse?
    A) ìBatterers never change, so it would be best for you to leave.î
    B) ìIf you don't leave, he'll think you're going to continue to endure his abuse.î
    C) ìIf you leave, maybe he'll see that he has to change his behavior.î
    D) ìYou may be in more physical danger after you leave him.î
    Ans: D
    Feedback:
    Statistics indicate that violence increases when the victim attempts to leave or end the relationship. It is not appropriate for the nurse to offer advice such as this. It is not the victim's fault whether the victim stays or not. ìIf you leave, maybe he'll see that he has to change his behavior,î is not appropriate as it minimizes the situation.

26. The nurse is assessing an elderly female in the emergency department. There are many bruises present on her body in varying stages of healing. After documenting the bruising in the assessment, what should the nurse do next?
    A) Ask the client when and how the bruises occurred
    B) Call the nursing supervisor immediately
    C) Follow the facility's policy and procedures for reporting abuse
    D) Notify the physician that abuse is suspected
    Ans: A
    Feedback:
    The nurse should not assume the bruises were caused by abuse; the client's explanation is an important step in the assessment of potential abuse. A nurse must assess for abuse prior to getting the supervisor and physician involved. Reporting abuse would be initiated after a thorough assessment.

27. A nurse is working with a client who has a history of repeated abusive intimate relationships. The nurse has difficulty understanding why a woman would repeatedly enter into relationships with abusive partners. When working with this client, the nurse can best maintain a therapeutic relationship through which of the following approaches?
    A) Keeping focused on the client's feelings about her life situation
    B) Honestly asking the client why she repeats the cycles of victimization
    C) Convincing the client to develop a self-rescue plan
    D) Not prying into the details of the client's private life

    Ans: A

    Feedback:

    Nurses may believe that a woman who stays in an abusive relationship might deserve or enjoy the abuse or that abuse between husband and wife is private. The nurse may also feel horror or revulsion. Because clients often watch for the nurse's reaction, containing these feelings and focusing on the client's needs are important. The nurse must be prepared to listen to the client's story, no matter how disturbing, and support and validate the client's feelings with comments such as ìThat must have been terrifyingî or ìSounds like you were afraid for your life.î The nurse must remember that he or she cannot fix or change things; the nurse's role is to listen and convey acceptance and support for the client.

1. **Chapter 13** Which of the following statements regarding the individual responses to trauma and stressors is a positive outcome?
   A) Many individuals are unable to cope with the event, manage their stress and emotions, or resume the daily activities of their lives.
   B) Some individuals may develop enhanced coping as a result of dealing with the stressor.
   C) These events are only significant in individuals who have risk for or actual mental health problems or issues.
   D) Large numbers or groups of people may be affected by a traumatic event.
   Ans: B
   Feedback:
   People may experience events in their lives that are extraordinary in intensity or severity, well beyond the stress of daily life. These traumatic events or stressors would be expected to disrupt the life of anyone who experienced them, not just individuals at risk for mental health problems or issues. These events and stressors may affect individuals or large numbers and groups of people. While all persons experiencing events such as these manifest anxiety, insomnia, difficulty coping, grief, or any variety of responses, most work through the experience and return to their usual level of coping and equilibriumóperhaps even enhanced coping as a result of dealing with the event.

2. What is the major difference between posttraumatic stress disorder (PTSD) and acute stress disorder?
   A) In acute stress disorder, the client is likely to develop exacerbation of symptoms.
   B) In PTSD, the recovery rate is 80% within 3 months.
   C) The severity and duration of the trauma are the most important variables in acute stress disorder.
   D) In PTSD, the symptoms occur 3 months or more after the trauma.
   Ans: D
   Feedback:
   In acute stress disorder, the symptoms occur 2 days to 4 weeks after a traumatic event and are resolved within 3 months of the event. In PTSD, the symptoms occur 3 months or more after the trauma. In PTSD, the client is likely to develop exacerbation of symptoms. The severity and duration of the trauma and the proximity of the person to the event are the most important factors affecting the likelihood of developing PTSD. In PTSD, complete recovery occurs within 3 months for about 50% of people.

3. Which of the following statements about posttraumatic stress disorder is accurate?
   A) Estimates are that the disorder is very rare.
   B) Estimates are that up to 60% of people at risk develop PTSD.
   C) Only 20% of victims of rape develop PTSD.
   D) PTSD symptoms usually begin at the time of the trauma
   Ans: B
   Feedback:
   Estimates are that up to 60% of people at risk develop PTSD.

4. Which of the following might the nurse recognize as longer-term responses to trauma and stress? Select all that apply.
   A) Acute stress disorder
   B) Posttraumatic stress disorder
   C) Adjustment disorder
   D) Reactive attachment disorder
   E) Dissociative disorder
   Ans: B, C, D, E
   Feedback:
   Acute stress disorder usually occurs from 2 days to 4 weeks after a trauma. Posttraumatic stress disorder usually begins 3 months after the trauma. All of the rest of these are longer-term responses to trauma and stress.

5. Which of the following would the nurse know are the major elements of posttraumatic stress disorder (PTSD)? Select all that apply.
   A) Trying to avoid any places or people or situations that may trigger memories of the trauma
   B) Reexperiencing the trauma through dreams or recurrent and intrusive thoughts
   C) Becoming increasingly more isolated
   D) Emotional numbing such as feeling detached from others
   E) Being on guard, irritable, or experiencing hyperarousal
   Ans: B, D, E
   Feedback:
   The three major elements of PTSD are reexperiencing the trauma through dreams or recurrent and intrusive thoughts, showing emotional numbing such as feeling detached from others, and being on guard, irritable, or experiencing hyperarousal. The client may also experience a numbing of general responsiveness and may try to avoid any places or people or situations that may trigger memories of the trauma, but these are not the major elements of PTSD.

6. Which of the following are events that a person may experience, witness, or be confronted by that may trigger posttraumatic stress disorder (PTSD)? Select all that apply.
   A) Being a survivor of a tsunami that resulted in thousands of deaths
   B) Being stranded at the office during a typical winter storm that was anticipated
   C) Being a marine in a combat situation where the entire platoon was wiped out except for one person
   D) Being hidden in a closet and hearing the entire family murdered by someone who broke into the home
   E) Watching televised segments of the moment when the plane hit the second tower on 9/11

   Ans: A, C, D, E

   Feedback:

   Examples of events that may cause PTSD include someone experiencing, witnessing, or being confronted by a traumatic event such as a natural disaster, combat, or an assault. The person with PTSD was exposed to an event that posed actual or threatened death or serious injury and responded with intense fear, helplessness, or terror. Being a survivor of a tsunami that resulted in thousands of deaths, being a marine in a combat situation where the entire platoon was wiped out except for one person, and being hidden in a closet and hearing the entire family murdered by someone who broke into the house would be situations where the person was exposed to an event that posed actual or threatened death or serious injury and responded with intense fear, helplessness, or terror.

7. Three years after the death of her father in an ICU, the infection prevention nurse was visiting an ICU in a different hospital to complete a chart review. At one point, the nurse looked at a bed where the patient who had the same diagnosis as her father had and saw her father's facial features on the patient and had a sense of panic. In a few moments, the nurse realized that the patient in the bed was not her father. Which of these manifestations of PTSD was this nurse experiencing?
   A) A flashback
   B) Emotional numbing
   C) Hyperarousal
   D) A dream

   Ans: A

   Feedback:

   This nurse was experiencing a flashback where similar circumstances triggered a sensation that the stressful experience were happening again.

8. A client is seeking counseling due to difficulty coping with being a victim of a violent attack 16 months ago. The initial medical diagnosis is to rule out posttraumatic stress disorder (PTSD). Which would the nurse assess for when determining the major elements of PTSD? Select all that apply.
   A) Reexperiencing the trauma through dreams or recurrent and intrusive thoughts
   B) Showing emotional numbing such as feeling detached from others
   C) Being on guard, irritable, or experiencing hyperarousal
   D) Feeling mildly anxious
   E) Occurs 2 weeks after the trauma
   Ans: A, B, C
   Feedback:
   The three major elements of PTSD are reexperiencing the trauma through dreams or recurrent and intrusive thoughts, showing emotional numbing such as feeling detached from others, and being on guard, irritable, or experiencing hyperarousal. Feeling mildly anxious is not a major element of PTSD as the person is likely to feel very anxious. Occurring 2 weeks after the trauma would likely be acute stress disorder as PTSD symptoms occur 3 months or more after the trauma.

9. A man is discovered wandering the street, looking confused and stepping out into traffic. When emergency responders approach the man, he cannot recall his name or where he lives. The responders transport the man to the mental health crisis unit for further evaluation. Which of the following are the man most likely suffering from? Select all that apply.
   A) Depersonalization disorder
   B) Dissociative identity disorder
   C) Repressed memories
   D) Dissociative amnesia
   E) False memory syndrome
   Ans: A, B, D
   Feedback:
   With dissociative amnesia, the client cannot remember important personal information. With dissociative personality disorder, the client displays two or more distinct identities or personality states that recurrently take control of his or her behavior. With depersonalization disorder, the client has persistent or recurring feeling of being detached from his or her mental processes or body (depersonalization) or sensation of being in a dream-like state where the environment seems foggy or unreal (derealization). The client is not psychotic or out of touch with reality. Repressed memories are when a person is unable to consciously recall memories of childhood abuse. False memory syndrome can occur during psychotherapy when the client is encouraged to imagine false memories of childhood sexual abuse.

10. The police find a woman wandering around a parking lot, singing very loudly. They bring her to the hospital; she has no knowledge of what she has been doing for the past 12 hours and is dressed in unfamiliar clothing. This is an example of
    A) dissociation.
    B) manipulation.
    C) psychosis.
    D) regression.
    Ans: A
    Feedback:
    The client experienced a temporary alteration in conscious awareness. This situation is not an example of manipulation. The woman is not experiencing psychosis. Regression occurs when there is a retreat to an earlier stage of development and comfort.

11. Which of the following statements by the nurse would be most appropriate to a colleague who very quietly and numbly tells the nurse that she had arrived at the scene of an automobileñpedestrian accident and unsuccessfully performed CPR on a victim 3 days ago? The nurse and her colleague are sitting in the break room and no one else is present.
    A) ìTell me what you saw.î
    B) ìThat is horrible!î
    C) ìWhy did you perform CPR?î
    D) ìI know how you feel; the same thing happened to me several years ago and I never recovered.î
    Ans: A
    Feedback:
    One of the most effective ways of avoiding pathologic responses to trauma is effectively dealing with the trauma soon after it occurs. Describing what the colleague saw may be very helpful to him or her. ìThat is horrible,î is a judgment and is not likely to be helpful. ìWhy did you perform CPR,î might make the colleague feel defensive. ìI know how you feel; the same thing happened to me several years ago and I never recovered,î is nonsupportive and robs the colleague of any hope that he or she will recover.

12. Which of the following outcomes would take priority for a client who has survived trauma or abuse? Select all that apply.
    A) The client will demonstrate healthy, effective ways of dealing with the stress.
    B) The client will be physically safe.
    C) The client will establish a social support system in the community.
    D) The client will distinguish between ideas of self-harm and taking action on those ideas.
    E) The client will express emotions nondestructively.
    Ans: B, D
    Feedback:
    It is the highest priority that the client be physically safe. Because persons who have survived trauma or abuse may have thoughts of self-harm, it is also critical that the client will distinguish between ideas of self-harm and taking action on those ideas. The other objectives are not as high a priority as safety and ideas of self-harm.

13. A fireman survived a fire after escaping a blaze. Several other firefighters were trapped in the burning building and died. After working with this firefighter in counseling, the nurse evaluates which of the following as positive outcomes for this client? Which will the nurse evaluate as positive outcomes for this client? Select all that apply.
    A) The client will verbalize feelings of stress related to returning to work.
    B) The client will express guilt openly through nondestructive means.
    C) The client will identify a social support system within the community.
    D) The client will report nightmares and flashbacks of the fire.
    Ans: A, B, C
    Feedback:
    Treatment outcomes for clients who have survived trauma or abuse may include verbalizing feelings, expressing emotions nondestructively, and establishing a social support system in the community. An absence of stress is an unrealistic outcome. Reporting symptoms of PTSD such as nightmares and flashbacks does not indicate positive treatment outcomes.

14. Which of the following is true about the use of touch with a client with dissociative identity disorder?
    A) It is best not to touch the client without his or her permission.
    B) Make sure the client knows the touch is friendly and supportive.
    C) Touch the client only if you are in his or her direct line of vision.
    D) Touching will convey a sense of security to the client.
    Ans: A
    Feedback:
    Clients interpret touch differently, so it is important to assess each client's comfort with being touched; these clients often have a history of abuse, so permission should be given before touch is used.

15. Which of the following interventions would be most effective for friends and family members to implement in order to boost the self-esteem of a person who has just experienced trauma or abuse?
    A) To identify a list of support people or activities in the community
    B) To remind them to calm down when they appear to be experiencing a flashback
    C) To encourage them to tell their story repeatedly to everyone they meet
    D) To help them to refocus their view of themselves from being victims to being survivors

    Ans: D

    Feedback:

    Often it is useful to view the client as a survivor of trauma or abuse rather than as a victim. For these clients, who believe they are worthless and have no power over the situation, it helps to refocus their view of themselves from being victims to being survivors. Defining themselves as survivors allows them to see themselves as strong enough to survive their ordeal. It is a more empowering image than seeing oneself as a victim. It would be beneficial for the client to identify a list of support people or activities in the community, but this would be to establish social support and not promote their self-esteem. It would not be helpful for anyone to tell the client to calm down when he or she appears to be experiencing a flashback or to encourage him or her to tell his or her story repeatedly.

16. A nurse is providing education about trauma and its effects to a community group in a community that has just been hit by a devastating tornado. One of the participants asked about what kind of support a survivor of the tornado will need. Which would be the best response of the nurse?
    A) If a person is willing to share his or her feelings about what has happened, he or she is not dealing with their feelings effectively.
    B) It is counterproductive for people to share what has happened to them and their feelings about it as there is nothing more to be done.
    C) If a person is reluctant to share his or her feelings, he or she may be denying his or her importance and may be at increased risk for future problems such as PTSD.
    D) It is best to wait until a survivor's life has returned to normal before dealing with the trauma.

    Ans: C

    Feedback:

    Some people more easily express their feelings and talk about stressful, upsetting, or overwhelming events. They may do so with family, friends, or professionals. Others are more reluctant to open up and disclose their personal feelings. They are more likely to ignore the feelings, deny their importance, or insist ìI'm fine, I'm over it.î By doing that, they increase the risk for future problems such as PTSD. One of the most effective ways of avoiding pathologic responses to trauma is effectively dealing with the trauma soon after it occurs.

17. Which of the following should be an action of a nurse who is having feelings of judgment regarding a client's contributory behavior to an automobile accident that resulted in deaths?
    A) Discussing the nurse's personal feelings with a peer or a counselor
    B) Acknowledging the judgment regarding the client's contributory behavior to the client
    C) Sharing the client's horror and encouraging him or her to avoid thinking about it
    D) Letting the client know that he or she is now traumatized beyond repair
    Ans: A
    Feedback:
    When the traumatized client causes a car accident that injured or killed others, it may be more challenging to provide unconditional support and withhold judgment of the client's contributory behavior. Remaining nonjudgmental of the client is important, but does not happen automatically. The nurse may need to deal with personal feelings by talking to a peer or counselor. If the nurse is overwhelmed by the violence or death in a situation, the client's feelings of being victimized to traumatized beyond repair are confirmed. Conveying empathy and validating client's feelings and experiences in a calm, yet caring professional, manner are more helpful than sharing the client's horror.

1. **Chapter 14** The nurse knows that which of the following are stages in Selye's general adaptation syndrome? Select all that apply.
   A) Alarm reaction stage
   B) Resistance stage
   C) Coping stage
   D) Exhaustion stage
   E) Panic stage
   Ans: A, B, D
   Feedback:
   The stages in Selye's general adaptation syndrome include the alarm reaction stage, the resistance stage, and the exhaustion stage. Selye did not identify either a coping stage or a panic stage.

2. The nurse knows that which one of the following statements is true about stress and anxiety?
   A) All people handle stress in the same way.
   B) Stress is a person's reaction to anxiety.
   C) Anxiety occurs when a person has trouble dealing with life situations, problems, and goals.
   D) Stress is the wear and tear that life causes on the body.
   Ans: D
   Feedback:
   Stress is the wear and tear that life causes on the body. It occurs when a person has difficulty dealing with life situations, problems, and goals. Each person handles stress differently. Anxiety is a vague feeling of dread or apprehension; it is a response to external or internal stimuli that can have behavioral, emotional, cognitive, and physical symptoms. Anxiety is a response to stress.

3. The nursing student answers the test item correctly when identifying which one of the following statements is true?
   A) Anxiety and fear are the same.
   B) Anxiety is unavoidable.
   C) Anxiety is always harmful.
   D) Fear is feeling threatened by an unknown entity.
   Ans: B
   Feedback:
   Anxiety is distinguished from fear, which is feeling afraid or threatened by a clearly identifiable external stimulus that represents danger to the person. Anxiety is unavoidable in life and can serve many positive functions such as motivating the person to take action to solve a problem or to resolve a crisis.

4. The student nurse correctly identifies that which one of the following statements applies to the parasympathetic nervous system?
   A) It is activated during the alarm reaction stage.
   B) It is activated during the resistance stage.
   C) It is activated during the exhaustion stage.
   D) It is commonly referred to as the fight, flight, or freeze response.
   Ans: B
   Feedback:
   In the alarm reaction stage, stress stimulates the body to send messages to the hypothalamus to the glands, which stimulates the sympathetic nervous system. Sympathetic nerve fibers ìcharge upî the vital signs at any hint of danger to prepare the body's defensesófight, flight, or freeze. The adrenal glands release adrenaline (epinephrine), which causes the body to take in more oxygen, dilate the pupils, and increase arterial pressure and heart rate while constricting the peripheral vessels and shunting blood from the gastrointestinal and reproductive systems and increasing glycogenolysis to release free glucose for the heart, muscles, and central nervous system. When the danger has passed, parasympathetic nerve fibers reverse this process and return the body to normal operating conditions until the next sign of threat reactivates the sympathetic nervous system. During the resistance stage of the generalized anxiety syndrome, if the threat has ended, the parasympathetic nervous system is stimulated and the body responses relax. If the threat persists, the body will eventually enter the exhaustion stage when the body stores are depleted as a result of the continual arousal of the physiologic responses and little reserve capacity.

5. The nurse plans to teach a client about dietary modifications to manage diabetes. Teaching would be most effective if the client displayed which one of the following characteristics?
   A) Focusing only on immediate task
   B) Faster rate of speech
   C) Narrowed perceptual field
   D) Heightened focus
   Ans: D
   Feedback:
   Mild anxiety is associated with increased learning ability. It involves a sensation that something is different and warrants special attention. Sensory stimulation increases and helps the person focus attention to learn, solve problems, think, act, feel, and protect himself or herself. Mild anxiety often motivates people to make changes or to engage in goal-directed activity. Focusing only on immediate task, a faster rate of speech, and a narrowed perceptual field are associated with moderate levels of anxiety.

6. A client says to the nurse, ìI just can't talk in front of the group. I feel like I'm going to pass out.î The nurse assesses the client's anxiety to be at which level?
   A) Mild
   B) Moderate
   C) Severe
   D) Panic
   Ans: C
   Feedback:
   Physiologic responses to severe anxiety include headache, nausea, vomiting, diarrhea, trembling, rigid stance, vertigo, pale, tachycardia, and chest pain.

7. A student is preparing to give a class presentation. A few minutes before the presentation is to begin, the student seems nervous and distracted. The student is looking at and listening to the peer speaker and occasionally looking at note cards. When the peer speaker asks a question of the group, the student is able to answer correctly. The professor understands that the student is likely experiencing which level of stress?
   A) Mild
   B) Moderate
   C) Severe
   D) Panic
   Ans: B
   Feedback:
   Moderate anxiety is the disturbing feeling that something is definitely wrong; the person becomes nervous or agitated. In moderate anxiety, the person can still process information, solve problems, and learn new things with assistance from others. He or she has difficulty concentrating independently but can be redirected to the topic. Mild anxiety is a sensation that something is different and warrants special attention. Sensory stimulation increases and helps the person focus attention to learn, solve problems, think, act, feel, and protect himself or herself. As the person progresses to severe anxiety and panic, more primitive survival skills take over, defensive responses ensue, and cognitive skills decrease significantly. A person with severe anxiety has trouble thinking and reasoning.

8. A client who suffers from frequent panic attacks describes the attack as feeling disconnected from himself. The nurse notes in the client's chart that the client reports experiencing
   A) hallucinations.
   B) depersonalization.
   C) derealization.
   D) denial.
   Ans: B
   Feedback:
   During a panic attack, the client may describe feelings of being disconnected from himself or herself (depersonalization) or sensing that things are not real (derealization). Denial is not admitting reality. Hallucinations involve sensing something that is not there.

9. Which of the following statements about the use of defense mechanisms in persons with anxiety disorders are accurate? Select all that apply.
   A) Defense mechanisms are a human's attempt to reduce anxiety.
   B) Persons are usually aware when they are using defense mechanisms.
   C) Defense mechanisms can be harmful when overused.
   D) Defense mechanisms are cognitive distortions.
   E) The use of defense mechanisms should be avoided.
   F) Defense mechanisms can control the awareness of anxiety.
   Ans: A, C, D, F
   Feedback:
   Freud described defense mechanisms as the human's attempt to control awareness of and to reduce anxiety. Defense mechanisms are cognitive distortions that a person uses unconsciously to maintain a sense of being in control of a situation, to lessen discomfort, and to deal with stress. Because defense mechanisms arise from the unconscious, the person is unaware of using them. Some people overuse defense mechanisms, which stops them from learning a variety of appropriate methods to resolve anxiety-producing situations. The dependence on one or two defense mechanisms also can inhibit emotional growth, lead to poor problem-solving skills, and create difficulty with relationships.

10. Which one of the following can be a positive outcome of using defense mechanisms?
    A) Defense mechanisms can inhibit emotional growth.
    B) Defense mechanisms can lead to poor problem-solving skills.
    C) Defense mechanisms can create difficulty with relationships.
    D) Defense mechanisms can help a person to reduce anxiety.
    Ans: D
    Feedback:
    Defense mechanisms can help a person to reduce anxiety. This is the only positive outcome of using defense mechanisms. The dependence on defense mechanisms can inhibit emotional growth, lead to poor problem-solving skills, and create difficulty with relationships. These are all negative outcomes of using defense mechanisms.

11. Which of the following best explains the etiology of anxiety disorders from an interpersonal perspective?
    A) Anxiety is learned in childhood through interactions with caregivers.
    B) Anxiety is learned throughout life as a response to life experiences.
    C) Anxiety stems from an unconscious attempt to control awareness.
    D) Anxiety results from conforming to the norms of a cultural group.
    Ans: A
    Feedback:
    Interpersonal theory proposes that caregivers can communicate anxiety to infants or children through inadequate nurturing, agitation when holding or handling the child, and distorted messages. In adults, anxiety arises from the person's need to conform to the norms and values of his or her cultural group. Psychoanalytic theories describe reducing anxiety through the use of defense mechanisms. Defense mechanisms are cognitive distortions that a person uses unconsciously to maintain a sense of being in control of a situation, to lessen discomfort, and to deal with stress.

12. Which of the following theories about anxiety is based upon intrapsychic theories?
    A) A person's innate anxiety is the stimulus for behavior.
    B) Anxiety is generated from problems in interpersonal relationships.
    C) A nurse can help the client to achieve health by attending to interpersonal and physiologic needs.
    D) Anxiety is learned through experiences.
    Ans: A
    Feedback:
    Theories of anxiety can be classified as intrapsychic/psychoanalytic theories, interpersonal theories, and behavioral theories. Freud's intrapsychic theory views a person's innate anxiety as the stimulus for behavior. Interpersonal theories include Sullivan's theory that anxiety is generated from problems in interpersonal relationships and Peplau's belief that humans exist in interpersonal and physiologic realms. Behavioral theorists view anxiety as being learned through experiences.

13. Which of the following are interpersonal theories regarding the etiologies of major anxiety disorders? Select all that apply.
    A) Sigmund Freud's theory
    B) Henry Stack Sullivan's theory
    C) Hildegard Peplau's theory
    D) Pavlov's theory
    Ans: B, C
    Feedback:
    Theories of anxiety can be classified as intrapsychic/psychoanalytic theories, interpersonal theories, and behavioral theories. Freud's intrapsychic theory views a person's innate anxiety as the stimulus for behavior. Interpersonal theories include Sullivan's theory that anxiety is generated from problems in interpersonal relationships and Peplau's belief that humans exist in interpersonal and physiologic realms. Behavioral theorists view anxiety as being learned through experiences.

14. The student nurse correctly identifies that according to Selye (1956, 1974), which stage of reaction to stress stimulates the body to send messages from the hypothalamus to the glands and organs to prepare for potential defense needs?
    A) Resistance
    B) Exhaustion
    C) Alarm reaction
    D) Autonomic
    Ans: C
    Feedback:
    In the alarm reaction stage, stress stimulates the body to send messages from the hypothalamus to the glands and organs to prepare for potential defense needs. In the resistance stage, the digestive system reduces function to shunt blood to areas needed for defense. The exhaustion stage occurs when the person has responded negatively to anxiety and stress. There is no autonomic stage.

15. A nurse is working with a client to develop assertive communication skills. The nurse documents achievement of treatment outcomes when the client makes a statement such as,
    A) ìI'm sorry. I'm not picking this up very quickly.î
    B) ìI feel upset when you interrupt me.î
    C) ìYou are pushing me too hard.î
    D) ìI'm not going to let people push me around anymore.î
    Ans: B
    Feedback:
    Assertiveness training helps the person take more control over life situations. Techniques help the person negotiate interpersonal situations and foster self- assurance. They involve using ìIî statements to identify feelings and to communicate concerns or needs to others.

16. A client experiences panic attacks when confronted with riding in elevators. The therapist is teaching the client ways to relax while incrementally exposing the client to getting on an elevator. This technique is called
    A) systematic desensitization.
    B) flooding.
    C) cognitive restructuring.
    D) exposure therapy.
    Ans: A
    Feedback:
    One behavioral therapy often used to treat phobias is systematic (serial) desensitization, in which the therapist progressively exposes the client to the threatening object in a safe setting until the client's anxiety decreases. Flooding is a form of rapid desensitization in which a behavioral therapist confronts the client with the phobic object (either a picture or the actual object) until it no longer produces anxiety. Cognitive restructuring involves challenging the client's irrational beliefs. Exposure therapy is similar to flooding.

17. Which techniques would be most effective for a client who has situational phobias? Select all that apply.
    A) Flooding
    B) Reminding the person to calm down
    C) Systematic desensitization
    D) Assertiveness training
    E) Decatastrophizing
    Ans: A, C
    Feedback:
    Systematic desensitization is when the therapist progressively exposes the client to a threatening object in a safe setting until the client's anxiety decreases. Flooding is a form of rapid desensitization in which the behavior therapist confronts the client with the phobic object until it no longer produces anxiety. Systematic desensitization and flooding are behavioral therapies used in the treatment of phobias. Assertiveness training would help the person to take more control over life situations. Decatastrophizing helps the client to realistically appraise the situation. These are both used for general anxiety. When a person is exposed to a phobic object, the person is not likely in control. Reminding a person to calm down is not at all an effective way to manage anxiety.

18. A client is currently experiencing a panic attack. Which of the following is the most appropriate response by the nurse?
    A) ìJust try to relax.î
    B) ìThere is nothing here to harm you.î
    C) ìYou are safe. Take a deep breath.î
    D) ìWhat are you feeling right now?î
    Ans: C
    Feedback:
    Nursing interventions for panic disorder include providing a safe environment and ensuring the client's privacy during a panic attack, remaining with the client during a panic attack, helping the client to focus on deep breathing, talking to the client in a calm, reassuring voice, teaching the client to use relaxation techniques, helping the client to use cognitive restructuring techniques, and the engaging client to explore how to decrease stressors and anxiety-provoking situations.

19. A client states, ìI will just die if I don't get this job.î The nurse then asks the client, ìWhat will be the worst that will happen if you don't get the job?î The nurse is using this response to
    A) appraise his situation more realistically.
    B) assist the client to make alternative plans for the future.
    C) assess if the client has health problems compounded by stress.
    D) clarify the client's meaning.
    Ans: A
    Feedback:
    Decatastrophizing involves the therapist's use of questions to more realistically appraise the situation. The therapist may ask, ìWhat is the worst that could happen? Is that likely? Could you survive that? Is that as bad as you imagine?î

20. Which of the following statements about the assessment of persons with anxiety and anxiety disorders is most accurate?
    A) When an elder person has an onset of anxiety for the first time in his or her life, it is possible that the anxiety is associated with another condition.
    B) Panic attacks are the most common late-life anxiety disorders.
    C) An elder person with anxiety may be experiencing ruminative thoughts.
    D) Agoraphobia that occurs in late life may be related to trauma experienced or anticipated.

    Ans: A

    Feedback:

    Anxiety that starts for the first time in late life is frequently associated with another condition such as depression, dementia, physical illness, or medication toxicity or withdrawal. Phobias, particularly agoraphobia, and GAD are the most common late-life anxiety disorders. Most people with late-onset agoraphobia attribute the start of the disorder to the abrupt onset of a physical illness or as a response to a traumatic event such as a fall or mugging. Ruminative thoughts are common in late-life depression and can take the form of obsessions such as contamination fears, pathologic doubt, or fear of harming others.

21. The nurse enters the client's room and finds the client anxiously pacing the floor. The client begins shouting at the nurse, ìGet out of my room!î The best intervention by the nurse would be to
    A) approach the client and ask, ìWhat's wrong?î
    B) call for help and say, ìCalm down.î
    C) turn and walk away from the room without saying anything.
    D) stand at the doorway and say, ìYou seem upset.î

    Ans: D

    Feedback:

    Staying with the client while allowing personal space is an important and safe intervention; this therapeutic communication technique is designed to get the client to communicate feelings. It may not be safe for the nurse to approach the client. Help is not needed at this time, and saying, ìCalm down,î is not effective. Turning and walking away from the client may seem like rejection and may worsen the client's anxiety as well as damage the nurseñclient relationship.

22. Which of the following are cognitiveñbehavioral therapy techniques that may be used effectively with anxious clients? Select all that apply.
    A) Positive reframing
    B) Decatastrophizing
    C) Assertiveness training
    D) Humor
    E) Unlearning
    Ans: A, B, C, E
    Feedback:
    Positive reframing means turning negative messages into positive messages. Decatastrophizing involves the therapist's use of questions to more realistically appraise the situation. Assertiveness training helps the person take more control over life situations. Positive reframing, decatastrophizing, and assertiveness training are cognitiveñbehavioral therapy techniques. Humor is not a cognitiveñbehavioral therapy technique. Unlearning is the theory underlying behavioral therapy.

23. The nurse is teaching about postoperative wound care. As the wound is uncovered, the client begins mumbling, breathing rapidly, and trying to get out of bed, and the client does not respond when the nurse calls his name. Which of the following should be the nurse's first action?
    A) Ask the client to describe his feelings.
    B) Proceed with wound care quickly.
    C) Replace the dressing on the wound.
    D) Get the assistance of another nurse.
    Ans: C
    Feedback:
    The client has severe anxiety; the priority is to lower the client's anxiety level. The first action should be to replace the dressing on the wound to decrease the client's level of anxiety and to prevent contamination of the wound before a new dressing can be applied. The other choices could be done after replacing the dressing on the wound.

24. The nursing student understands correctly when identifying which objective is appropriate for all clients with anxiety disorders?
    A) The client will experience reduced anxiety and accept the fact that underlying conflicts cannot be treated.
    B) The client will experience reduced anxiety and develop alternative responses to anxiety-provoking situations.
    C) The client will experience reduced anxiety and learn to control primitive impulses.
    D) The client will experience reduced anxiety and strive for insight through psychoanalysis.
    Ans: B
    Feedback:
    A primary client outcome is improved adaptive coping skills.

25. When a client is experiencing a panic attack while in the recreation room, what interventions are the nurse's first priorities? Select all that apply.
    A) Provide a safe environment.
    B) Request a prescription for an antianxiety agent.
    C) Offer the client therapy to calm down
    D) Ensure the client's privacy.
    E) Engage the client in recreational activities.
    Ans: A, D
    Feedback:
    During a panic attack, the nurse's first concern is to provide a safe environment and to ensure the client's privacy. If the environment is overstimulating, the client should move to a less stimulating place. Decreasing external stimuli will help lower the client's anxiety level. The client's safety is priority. Anxious behavior can be escalated by external stimuli. In a large area, the client can feel lost and panicked, but a smaller room can enhance a sense of security. An antianxiety agent may be helpful, but it is not the priority. It would likely be stimulating to engage the client in recreational activities.

26. A client is learning to cope with anxiety and stress. The expected outcome is that the client will
    A) change reactions to stressors.
    B) ignore situations that cause stress.
    C) limit major stressors in his or her life.
    D) avoid anxiety at all costs.
    Ans: A
    Feedback:
    Stress and anxiety in life are unavoidable; managing the effects of stress is a reasonable goal for treatment. It is not possible or desirable to avoid anxiety at all costs as anxiety is a warning that the client is not dealing with stress effectively. Learning to heed this warning and to make needed changes is a healthy way to deal with the stress of daily events.

27. A client asks the nurse, ìWhy do I have to go to counseling? Why can't I just take medications?î The best response by the nurse would be,
    A) ìBoth therapies are effective. You can eventually choose one or the other.î
    B) ìYou cannot get the full effect of your medications without cognitive therapy as well.î
    C) ìAs soon as your medications reach therapeutic level, you can omit the therapy.î
    D) ìMedications combined with therapy help you change how well you function.î
    Ans: D
    Feedback:
    Treatment for anxiety disorders usually involves medication and therapy. This combination produces better results than either one alone.

28. A client asks how his prescribed alprazolam (Xanax) helps his anxiety disorder. The nurse explains that antianxiety medications such as alprazolam affect the function of which neurotransmitter that is believed to be dysfunctional in anxiety disorders?
    A) Serotonin
    B) Norepinephrine
    C) GABA
    D) Dopamine
    Ans: C
    Feedback:
    Gamma-aminobutyric acid (GABA) is the amino acid neurotransmitter believed to be dysfunctional in anxiety disorders. GABA reduces anxiety, and norepinephrine increases it; researchers believe that a problem with the regulation of these neurotransmitters occurs in anxiety disorders. Serotonin is usually implicated in psychosis and mood disorders. Dopamine is indicated in psychosis.

29. The nurse is teaching a client with an anxiety disorder ways to manage anxiety. The nurse suggests which of the following schedules for practicing stress management techniques?
    A) Practice the techniques each morning and night as part of a daily routine.
    B) Use the techniques as needed when experiencing severe anxiety.
    C) Practice the techniques when relatively calm.
    D) Expect to practice the techniques when meeting with a therapist.
    Ans: C
    Feedback:
    The nurse can teach the client relaxation techniques to use when he or she is experiencing stress or anxiety, including deep breathing, guided imagery and progressive relaxation, and cognitive restructuring techniques. For any of these techniques, it is important for the client to learn and to practice them when he or she is relatively calm.

30. The nurse is educating a client and family about managing panic attacks after discharge from treatment. The nurse includes which of the following in the discharge teaching? Select all that apply.
    A) Continued development of positive coping skills
    B) Weaning off of medications as necessary
    C) Lessening the amount of daily responsibilities
    D) Continued practice of relaxation techniques
    E) Development of a regular exercise program
    Ans: A, D, E
    Feedback:
    Client/family education for panic disorder includes reviewing breathing control and relaxation techniques, discussing positive coping strategies, encouraging regular exercise, emphasizing the importance of maintaining prescribed medication regimen and regular follow-up, describing time management techniques such as creating ìto doî lists with realistic estimated deadlines for each activity, crossing off completed items for a sense of accomplishment, saying ìno,î and stressing the importance of maintaining contact with community and participating in supportive organizations. Medication should be adhered to as prescribed. Daily responsibilities cannot be avoided, rather should be successfully accomplished.

31. When teaching a client with generalized anxiety disorder, which is the highest priority for the nurse to teach the client to avoid?
    A) Caffeine
    B) High-fat foods
    C) Refined sugars
    D) Sodium
    Ans: A
    Feedback:
    The effects of caffeine are similar to some anxiety symptoms, and, therefore, caffeine ingestion will worsen anxiety. The other types of foods are also potentially harmful to physical as well as psychological health, but the worst offender is caffeine.

32. An anxiolytic agent, lorazepam (Ativan), has been prescribed for the client. Which of the following statements by the client would indicate to the nurse that client education about this medication has been effective?
    A) ìMy anxiety will be eliminated if I take this medication as prescribed.î
    B) ìThis medication presents no risk of addiction or dependence.î
    C) ìI will probably always need to take this medication for my anxiety.î
    D) ìThis medication will relax me, so I can focus on problem solving.î
    Ans: D
    Feedback:
    Anxiolytics are designed for short-term use to relieve anxiety. These drugs are designed to relieve anxiety so that the person can deal more effectively with whatever crisis or situation is causing stress. Benzodiazepines have a tendency to cause dependence. Clients need to know that antianxiety agents are aimed at relieving symptoms such as anxiety but do not treat the underlying problems that cause the anxiety.

33. Which of the following would be key points for the nurse to remember when working with persons who are suffering from anxiety disorders?
    A) It is important for the nurse to ìfixî the client's problems.
    B) Remember to practice techniques to manage stress and anxiety in your own life.
    C) If you have any uncomfortable feelings, do not tell anyone about them.
    D) Remember that only people who suffer from anxiety disorders have stress that can interfere with daily life and work.
    Ans: B
    Feedback:
    It is critical for the nurse to remember to practice techniques to manage stress and anxiety in his or her own life. Remember that everyone occasionally suffers from stress and anxiety that can interfere with daily life and work. It is important for the nurse to avoid falling into the pitfall of trying to ìfixî the client's problems. It is important that the nurse should discuss any uncomfortable feelings with a more experienced nurse for suggestions on how to deal with his or her feelings toward these clients.

34. Which of the following are reasons that the nurse must understand why and how anxiety behaviors work? Select all that apply.
    A) To provide better care for the client
    B) To help understand the role anxiety plays in performing nursing responsibilities
    C) To help the nurse to mask his or her own feelings of anxiety
    D) So the nurse can identify that his or her own needs are more important than the clients
    E) To help nurses to function at a high level

    Ans: A, B, E

    Feedback:

    Nurses must understand why and how anxiety behaviors work, not just for client care but to help understand the role anxiety plays in performing nursing responsibilities. Nurses are expected to function at a high level and to avoid allowing their own feelings and needs to hinder the care of their clients, but as emotional beings, nurses are just as vulnerable to stress and anxiety as others, and they have needs of their own.

1. **Chapter 15** The nursing student correctly identifies which of the following statements are true of the etiology of OCD? Select all that apply.
   A) The cognitive model for OCD etiology focuses on childhood and environmental experiences of growing up.
   B) The etiology of OCD is not definitively explained at this time.
   C) OCD is caused by immune dysfunction.
   D) The primary etiology of OCD is genetics.
   E) Cognitive models may partially explain why people develop OCD.
   Ans: A, B, E
   Feedback:
   Different studies of the etiology of OCD show promise, but have yet to definitively explain how or why people develop OCD. Cognitive models of OCD have been long accepted as a partial explanation for OCD. The cognitive model focuses on childhood and environmental experiences of growing up. Heritable, genetic factors are a significant influence on thinking, and environmental influences are not solely responsible. Immune dysfunction may play a role in the etiology of OCD.

2. Which of the following are features of the thinking of a person who has OCD according to the cognitive model? Select all that apply.
   A) The person with OCD employs a minimalist approach to all aspects of his or her life.
   B) The person with OCD believes one's thoughts are overly important and has a need to control those thoughts as they overestimate the threat posed by their thoughts.
   C) The person with OCD is always aware that his or her behavior is related to OCD.
   D) The person with OCD is concerned with perfectionism and has an intolerance of uncertainty.
   E) The person with OCD has an inflated personal responsibility
   Ans: B, D, E
   Feedback:
   The cognitive model describes the person's thinking as (1) believing one's thoughts are overly important; that is, ìIf I think it, it will happen,î and therefore having a need to control those thoughts; (2) perfectionism and the intolerance of uncertainty; and (3) inflated personal responsibility (from a strict moral or religious upbringing) and overestimation of the threat posed by one's thoughts. The person with OCD would not employ a minimalist approach to all aspects of his or her lifeóhe or she is likely to perform some tasks at extreme levels. The persons with OCD may not always be aware that their behavior is related to OCD.

3. The nurse is caring for her first client with obsessiveñcompulsive disorder. During the treatment team meeting, the nurse shares her frustration as to the client's inability to stop washing his hands. The nurse manager offers which one of the following explanations?
   A) The hand washing represents a way to exert independence from the staff.
   B) The client is not aware of the excessive hand washing.
   C) The client does not think anything is abnormal with washing his hands repeatedly.
   D) The client feels terrible but cannot stop washing his hands to try to get rid of his anxiety.

   Ans: D

   Feedback:

   It may be difficult for nurses and others to understand why the person cannot simply stop performing the bizarre behaviors interfering with his or her life. Nurses must understand what anxiety behaviors are and how anxiety behaviors work, not just for client care but to help understand the role anxiety plays in performing nursing responsibilities.

4. The nurse correctly identifies that which of OCDs self-soothing behaviors may involve self-destruction of the body of a person who has OCD? Select all that apply.
   A) Dermatillomania
   B) Trichotillomania
   C) Onychophagia
   D) Kleptomania
   E) Oniomania

   Ans: A, B, C

   Feedback:

   Dermatillomania, or skin-picking, is a self-soothing behavior; that is, the behavior is an attempt of people to soothe or comfort themselves, not that picking itself is necessarily a positive sensation. Trichotillomania, or chronic, repetitive hair pulling, is a self-soothing behavior that can cause distress and functional impairment. Onychophagia, or nail biting, is a self-soothing behavior. Kleptomania, or compulsive stealing, and oniomania, or compulsive buying, are reward-seeking behaviors.

5. The student nurse correctly identifies that which of the following are characteristics of hoarding disorder? Select all that apply.
   A) Excessive acquisition of animals or apparently useless things
   B) Cluttered living spaces that become uninhabitable
   C) Significant distress or impairment for the individual
   D) Obsessive cleaning of environment
   E) Disposing of articles that are of no value
   Ans: A, B, C
   Feedback:
   Hoarding involves excessive acquisition of animals or apparently useless things; cluttered living spaces that become uninhabitable; and significant distress or impairment for the individual. Obsessive cleaning of the environment and disposing of articles that are of no value are not characteristics of hoarding.

6. The nurse is aware that a person who repeatedly seeks cosmetic surgery to correct a perceived flaw in his or her appearance may have which of the following disorders?
   A) Hoarding disorder
   B) Body dysmorphic disorder
   C) Pyromania
   D) Body identity integrity disorder
   Ans: B
   Feedback:
   Body dysmorphic disorder is a preoccupation with imagined or slight defect in physical appearance that causes significant distress for the individual and interferes with functioning in daily life. Elective cosmetic surgery is sought repeatedly to ìfix the flaw,î yet after surgery, the person is still dissatisfied or finds another flaw in appearance. It becomes a vicious cycle. Hoarding disorder is a progressive, debilitating, compulsive disorder that involves excessive acquisition of animals or apparently useless things; cluttered living spaces that become uninhabitable; and significant distress or impairment for the individual. Pyromania is the desire to start fires. Body identity integrity disorder is the term given to people who feel alienated from a part of their body and desire amputation.

7. Which of the following statements about the typical history of illness that would be assessed in a client who has OCD is consistent with OCD?
   A) OCD usually requires hospitalization.
   B) OCD treatment is usually outpatient.
   C) OCD only affects the client's ability to perform ADLs and work, not his or her leisure life.
   D) Most people seek treatment as soon as they observe the symptoms.
   Ans: B
   Feedback:
   The client usually seeks treatment only when obsessions become too overwhelming or when compulsions interfere with daily life (work, ADLs, or leisure) or both. Clients are hospitalized only when they have become completely unable to carry out their daily routines. Most treatment is outpatient. The client often reports that rituals began many years before; some begin as early as childhood. The more responsibility the client has as he or she gets older, the more the rituals interfere with the ability to fulfill these responsibilities.

8. Which of the following would be appropriate outcomes for a client with OCD? Select all that apply.
   A) The client will stop engaging in the compulsive activity.
   B) The client will spend less time performing rituals.
   C) The client will complete daily routine activities within a realistic time frame.
   D) The client will conceal the behavior from all persons to avoid anxiety.
   E) The client will demonstrate effective use of behavior therapy techniques.
   Ans: B, C, E
   Feedback:
   Outcomes for clients with OCD include the following:
   ï The client will complete daily routine activities within a realistic time frame.
   ï The client will demonstrate effective use of relaxation techniques.
   ï The client will discuss feelings with another person.
   ï The client will demonstrate effective use of behavior therapy techniques.
   ï The client will spend less time performing rituals.

9. Which of the following is the most important variable in determining the likelihood of success in improving life for a client with OCD?
   A) The client must be willing to make changes in his or her behavior.
   B) The client must acknowledge that the behavior is not in his or her control.
   C) The client must allow the nurse to decide the appropriate intervention for him or her.
   D) The client must be willing to try all new relaxation techniques.
   Ans: A
   Feedback:
   The most important variable is that the client is willing to make changes in his or her behavior. The nurse must not interrupt the client from performing rituals as this will cause anxiety, and the client will need to begin the ritual again. The client and nurse together must determine which interventions will be used. The client will likely need to use relaxation techniques but should have input into deciding which ones.

10. Which of the following is an important part of therapeutic communication for clients who have OCD?
   A) To encourage the client to keep the obsession secret.
   B) To encourage the client to discuss his or her obsession with the nurse.
   C) The nurse must have the same obsession as the client.
   D) The nurse must instruct the client to discuss the obsession.
   Ans: B
   Feedback:
   The nurse encourages the client to talk about the feelings and to describe them in as much detail as the client can tolerate. Because many clients try to hide their rituals and to keep obsessions secret, discussing these thoughts, behaviors, and resulting feelings with the nurse is an important step. It is not necessary for the nurse to have the same obsession as the client.

11. Which of the following interventions by the nurse will increase the client's sense of security?
   A) Allowing the client to perform the rituals
   B) Distracting the client from rituals with other activities
   C) Encouraging the client to talk about the purpose of the rituals
   D) Stopping the client from performing the rituals
   Ans: A
   Feedback:
   The client performs rituals to decrease anxiety and will feel most secure when performing the rituals. The other choices would not promote a sense of security of the client.

12. Before eating a meal, a client with obsessiveñcompulsive disorder must wash her hands for 14 minutes, comb her hair for 114 strokes, and switch the light off and on 44 times. When evaluating the progress of the client, what is the most important treatment objective for this client?
    A) Allow ample time for completion of all rituals before each meal.
    B) Gradually decrease the amount of time spent for performing rituals.
    C) Increase the client's acceptance of the need for medication to control rituals.
    D) Omit one ritualistic behavior every 4 days until all rituals are eliminated.
    Ans: B
    Feedback:
    Treatment has been effective when OCD symptoms no longer interfere with the client's ability to carry out responsibilities. When obsessions occur, the client manages resulting anxiety without engaging in complicated or time-consuming rituals. He or she reports regained control over his or her life and the ability to tolerate and manage anxiety with minimal disruption. Ritualistic behaviors may be decreased gradually over time.

13. Which of the following treatment modalities is most effective for OCD?
    A) Behavioral techniques
    B) Medication
    C) Behavioral techniques and medication
    D) Ignoring it
    Ans: C
    Feedback:
    Behavioral techniques and medication are the most effective treatment modalities for OCD. This would be more effective than either behavioral techniques or medication alone. It is not appropriate to ignore OCD as it will only get worse until the client is unable to engage in activities of daily living.

14. Which of the following is essential for the nurse to communicate to the client with OCD and to the client's family?
    A) The client's diagnosis should be kept secret from everyone outside the immediate family and friends.
    B) The importance of medication compliance and that it may be necessary for medication to be changed to find the one that works best.
    C) It is important for the client to avoid following a routine.
    D) It is helpful for others to give unsolicited advice about other activities the client with OCD can engage in.

    Ans: B

    Feedback:

    Teaching about the importance of medication compliance to combat OCD is essential. It is neither possible nor desirable to keep the client's diagnosis a secret. To accomplish tasks efficiently, the client initially may need additional time to allow for rituals. When the client has completed the ritual or the tie allotted has passed, the client must then engage in the expected activity. At home, the client can continue to follow a daily routine or written schedule that helps him or her to stay on tasks and accomplish activities and responsibilities. It is not helpful for others to give unsolicited advice about other activities the client with OCD can engage in as this will add to the guilt and shame that people with OCD experience.

15. The nurse is providing education to a group of persons from several community agencies about hoarding by elder persons. Which of the following is important for the nurse to emphasize?
    A) Treatment will likely start to be effective in the short term.
    B) If the person had help to clean up his or her environment, the hoarding would be cured.
    C) It is not beneficial to tell the client that his or her thoughts and rituals interfere with his or her life or that his or her ritual actions really have no lasting effect on anxiety.
    D) One agency should be able to address all of the client's needs.

    Ans: C

    Feedback:

    Treatment for hoarding in older adults may need to continue over a long period of time to reach successful outcomes. Most persons who are hoarders will not seek assistance to clean up their environment because they feel ashamed. If the environment were to be cleaned up and no other intervention employed, the person would continue to hoard. It is not beneficial to tell the clients that their thoughts and rituals interfere with their life or that their ritual actions really have no lasting effect on anxietyóthey already know that. Multiple community agencies may be needed to deal with hoarding in the older adult.

16. Which of the following is the desired outcome for a client with OCD?
    A) That the client will no longer experience any signs or symptoms of OCD
    B) That the client will no longer experience anxiety
    C) That the OCD symptoms no longer interfere with the client's responsibilities
    D) To relieve the client with OCD of any responsibilities

    Ans: C

    Feedback:

    Treatment has been effective when OCD symptoms no longer interfere with the client's ability to carry out responsibilities. The client will likely continue to experience signs or symptoms of OCD and anxiety, but the client will be able to manage the resulting anxiety without engaging in complicated or time-consuming rituals. It is not possible or desirable to relieve the client with OCD of any responsibilities.

17. Which of the following are important for the nurse to remember when teaching relaxation and behavioral techniques to a client with OCD? Select all that apply.
    A) It is important to teach the client to use relaxation techniques when the client's anxiety is low.
    B) The nurse may teach the client about relaxation techniques when the client is experiencing anxiety.
    C) The client must be willing to engage in exposure and response prevention.
    D) The client must be forced to use relaxation techniques.
    E) It is unnecessary to assess the baseline of ritualistic behaviors in the client with OCD.

    Ans: A, B, C

    Feedback:

    The intervention should take place when the client's anxiety is low, so he or she can learn more effectively. The nurse may teach the client about relaxation techniques when the client is experiencing anxiety. The client must be willing to engage in exposure and response prevention. The client cannot be forced to use relaxation techniques. It is necessary to assess the baseline of frequency and duration of anxiety and ritualistic behaviors in the client with OCD.

18. The student nurse correctly identifies that which one of the following statements is true regarding clients with OCD?
    A) Since the client is aware that his or her behavior is bizarre, the client should just stop the behavior.
    B) Clients with OCD seem normal on the outside but suffer from overwhelming fear and anxiety.
    C) Once a person is successfully treated for OCD, he or she has been cured.
    D) Persons with OCD must avoid stress.

    Ans: B

    Feedback:

    Most times, clients with OCD seem normal on the outside but suffer from overwhelming fear and anxiety. OCD is often chronic in nature, with symptoms that wax and wane over time. Just because the client has some success in managing thoughts and rituals, it does not mean he or she will never need professional help in the future. It is not likely possible for persons with OCD to avoid stress.

1. **Chapter 16** The most commonly supported neuroanatomic theory of schizophrenia suggests which etiology?
   A) Excessive amounts of dopamine and serotonin in the brain
   B) Ineffective ability of the brain to use dopamine and serotonin
   C) Insufficient amounts of dopamine in the brain
   D) Decreased brain tissue in the frontal and temporal regions of the brain
   Ans: D
   Feedback:
   Decreased brain tissue in the frontal and temporal regions of the brain is the most commonly supported neuroanatomic theory that suggests the etiology of schizophrenia. The other theories are neurochemical.

2. The nurse reviews current literature and identifies that which of the following are included in current studies of biologic theories regarding the etiology of schizophrenia? Select all that apply.
   A) That there is a particular pathologic structure associated with the disease.
   B) That genetics is the cause of schizophrenia.
   C) Persons with schizophrenia have decreased brain volume and abnormal brain function in the frontal and temporal areas of persons with schizophrenia.
   D) The brain activity of persons with schizophrenia differs from people who do not have schizophrenia.
   E) That the etiology of schizophrenia may be related to the body's response to exposure of a virus.
   Ans: B, C, D, E
   Feedback:
   In the first half of the 20th century, studies focused on trying to find a particular pathologic structure associated with the disease, largely through autopsy. Such a site was not discovered. The biologic theories of schizophrenia focus on genetic factors, neuroanatomic and neurochemical factors (structure and function of the brain), and immunovirology (the body's response to exposure to a virus).

3. The student nurse correctly recognizes that which one of the following findings is best supported by genetic studies in the etiology of schizophrenia?
   A) If a person has schizophrenia, distant relatives are also at risk.
   B) That there is no relationship at all between schizophrenia and genetics.
   C) That there is a weak correlation between genetics and schizophrenia.
   D) That schizophrenia is at least partially inherited.
   Ans: D
   Feedback:
   The most important studies have centered on twins; these findings have demonstrated that if one identical twin has schizophrenia, the other twin has a 50% chance of developing it as well. Fraternal twins have only a 15% risk. This finding indicates that schizophrenia is at least partially inherited.

4. The nurse is assessing for negative symptoms of schizophrenia in a newly admitted client. The nurse would note which behavior as indicative of a negative symptom?
   A) Difficulty staying on subject when responding to assessment questions
   B) Belief of owning a transportation device allowing for travel to the center of the Earth
   C) Hesitant to answer the nurse's questions during the assessment interview
   D) Mimicking the postural changes made by the nurse during the assessment interview

   Ans: C

   Feedback:

   A negative symptom of schizophrenia is alogia, or the tendency to speak very little or to convey little substance of meaning (poverty of content). Associative looseness (fragmented or poorly related thoughts and ideas), delusions (fixed false beliefs that have no basis in reality), and echopraxia (imitation of the movements and gestures of another person whom the client is observing) are all positive symptoms.

5. The client with schizophrenia believes the student nurses are there to spy on the clients. The client is suffering from which of the following symptoms?
   A) Hallucinations
   B) Delusions
   C) Anhedonia
   D) Ideas of reference

   Ans: B

   Feedback:

   Delusions are fixed false beliefs that have no basis in reality. Hallucinations are false sensory perceptions or perceptual experiences that do not exist in reality. Ideas of reference are false impressions that external events have special meaning for the person. Anhedonia is feeling no joy or pleasure from life or any activities or relationships.

6. The client with schizophrenia makes the following statement, ìI just don't know how to count. The sky turned to fire. I have a ball in my head.î The nurse documents this entire statement as an example of
   A) flight of ideas.
   B) ideas of reference.
   C) delusional thinking.
   D) associative looseness.
   Ans: D
   Feedback:
   Associative looseness is demonstrated through fragmented or poorly related thoughts and ideas. The series of disconnected thoughts best exemplifies this concept. Some of the statements contain delusions, or fixed false beliefs that have no basis in reality. Flight of ideas refers to rapidly flowing thoughts that are more connected than the client's statement. Ideas of reference are false impressions that external events have special meaning for the person.

7. A person suffering from schizophrenia has little emotional expression when interacting with others. The nurse would document the client's affect as which of the following? Select all that apply.
   A) Flat
   B) Blunt
   C) Bright
   D) Inappropriate
   E) Pleasant
   Ans: A, B
   Feedback:
   Clients with schizophrenia are often described as having blunted affect (few observable facial expressions) or flat affect (no facial expression). The client may exhibit an inappropriate expression or emotions incongruent with the context of the situation. It is not likely that the affect of a person with schizophrenia would be pleasant.

8. A client who has schizophrenia is having a conversation with the nurse suddenly stops talking in the middle of a sentence. The client is experiencing which type of thought disruption?
   A) Thought withdrawal
   B) Thought insertion
   C) Thought blocking
   D) Thought broadcasting
   Ans: C
   Feedback:
   The nurse can assess thought content by evaluating what the client actually says. For example, clients may suddenly stop talking in the middle of a sentence and remain silent for several seconds to 1 minute (thought blocking). They also may state that they believe others can hear their thoughts (thought broadcasting), that others are taking their thoughts (thought withdrawal), or that others are placing thoughts in their mind against their will (thought insertion).

9. During the nursing assessment, a client describes constantly hearing voices mumbling in the background. The client denies that the voices are telling him to do anything harmful. The nurse documents that the client is experiencing which of the following?
   A) Command hallucinations
   B) Auditory hallucinations
   C) Olfactory hallucinations
   D) Gustatory hallucinations
   Ans: B
   Feedback:
   Auditory hallucinations, the most common type, involve hearing sounds, most often voices, talking to or about the client. Command hallucinations are voices demanding that the client take action, often to harm self or others, and are considered dangerous. Olfactory hallucinations involve smells or odors. Gustatory hallucinations involve a taste lingering in the mouth or the sense that food tastes like something else.

10. A client with schizophrenia reads the advice column in the newspaper daily. When asked why the client is so interested in the advice column, the client replies, ìThis person is my guide and tells me what I must do every day.î The nurse would best describe this type of thinking as which of the following?
    A) Referential delusion
    B) Grandiose delusion
    C) Thought insertion
    D) Personalization
    Ans: A
    Feedback:
    Referential delusions or ideas of reference involve the client's belief that television broadcasts, music, or newspaper articles have special meaning for him or her. Grandiose delusions are characterized by the client's claim to association with famous people or celebrities, or the client's belief that he or she is famous or capable of great feats. Thought insertion is the belief that others are placing thoughts in their mind against their will. Personalization is not a psychotic characteristic of schizophrenia.

11. The nurse is preparing a client with schizophrenia for discharge. The nurse asks the client, ìHow are you going to care for yourself at home?î The purpose of the nurse's question is to assess the client's
    A) self concept.
    B) judgment.
    C) insight.
    D) social support system.
    Ans: C
    Feedback:
    Insight refers to the client's degree of self-awareness and realistic view of life. It can be severely impaired in schizophrenia. Over time, some clients can learn about the illness, anticipate problems, and seek appropriate assistance as needed. Judgment refers to appropriate decision-making ability and is based on the ability to interpret the environment correctly. At times, lack of judgment is so severe that clients cannot meet their needs for safety and protection and place themselves in harm's way.

12. All of the following are nursing diagnoses identified for a client with schizophrenia. The student nurse correctly anticipates which diagnosis will resolve when the client's negative symptoms improve?
    A) Impaired verbal communication
    B) Risk for other-directed violence
    C) Disturbed thought processes
    D) Social isolation
    Ans: D
    Feedback:
    NANDA diagnoses commonly established based on the assessment of psychotic symptoms or positive signs are as follows:
    - Risk for other-directed violence
    - Risk for suicide
    - Disturbed thought processes
    - Disturbed sensory perception
    - Disturbed personal identity
    - Impaired verbal communication
    NANDA diagnoses based on the assessment of negative signs and functional abilities include the following:
    - Self-care deficits
    - Social isolation
    - Deficient diversional activity
    - Ineffective health maintenance
    - Ineffective therapeutic regimen management

13. All of the following are included in the plan of care for a client with schizophrenia. Which nursing intervention should the nurse perform first when caring for this client?
    A) Observe for signs of fear or agitation
    B) Maintain reality through frequent contact
    C) Encourage to participate in the treatment milieu
    D) Assess community support systems
    Ans: A
    Feedback:
    Safety for both the client and the nurse is the priority when providing care for the client with schizophrenia. The nurse must observe for signs of building agitation or escalating behavior such as increased intensity of pacing, loud talking or yelling, and hitting or kicking objects. The nurse must then institute interventions to protect the client, nurse, and others in the environment.

14. A client with schizophrenia is seen sitting alone and talking out loud. Suddenly, the client stops and turns as if listening to someone. The nurse approaches and sits down beside the client. Which of the following is the best initial response by the nurse?
    A) ìYou must be pretty bored to be sitting here talking to an invisible person.î
    B) ìI don't hear or see anyone else; what are you hearing and seeing?î
    C) ìI can tell you are hearing voices, but they are not real.î
    D) ìHow long have you known the person you are talking to?î
    Ans: B
    Feedback:
    Intervening when the client experiences hallucinations requires the nurse to focus on what is real and to help shift the client's response toward reality. Initially, the nurse must determine what the client is experiencingóthat is, what the voices are saying or what the client is seeing. In command hallucinations, the client hears voices directing him or her to do something, often to hurt self or someone else. For this reason, the nurse must elicit a description of the content of the hallucination so that health-care personnel can take precautions to protect the client and others as necessary. The nurse might say, ìI don't hear any voices; what are you hearing?î ìHow long have you known the person you are talking to?î would reinforce the client's hallucination.

15. A client states, ìI am dead. I have come back from the dead.î An appropriate response by the nurse is,
    A) ìWhat is it like to feel dead?î
    B) ìNo you did not die. People don't come back from the dead.î
    C) ìShow me what you did in art therapy this morning.î
    D) ìI'll get your medicine and you'll feel better.î
    Ans: C
    Feedback:
    The client experiencing delusions utterly believes them and cannot be convinced they are false or untrue. It is the nurse's responsibility to present and maintain reality by making simple statements. The nurse must avoid openly confronting the delusion or arguing with the client about it. The nurse also must avoid reinforcing the delusional belief by ìplaying alongî with what the client says.

16. A client diagnosed with schizophrenia is laughing and talking while sitting alone. Which of the following is the best response by the nurse?
    A) State, ìCan you share your joke with me?î
    B) To sit with the client quietly until the client is ready to talk
    C) State, ìTell me what's happening.î
    D) State, ìYou look lonely here. Let's join the others in the day room.î
    Ans: C
    Feedback:
    Having the client tell the nurse what is happening explores what the client is experiencing and engages the client in reality interaction. Answer choices A, B, and C are not appropriate responses by the nurse in this situation.

17. A college freshman is admitted to the hospital with a diagnosis of schizophrenia. Friends reported that she had been in her room for 2 days in a trance-like state, not eating nor speaking to anyone. Which of the following is the highest priority for this client?
    A) Assessing fluid intake and output
    B) Completing an assessment of mental status
    C) Obtaining more data about her college experiences
    D) Providing for adequate rest
    Ans: A
    Feedback:
    Physiologic homeostasis is a priority for this client. Completing an assessment of mental status, obtaining data about college experiences, and providing adequate rest are not the highest priority.

18. The client with schizophrenia tells the nurse that rats have started to eat his brain. The best response by the nurse would be,
    A) ìHave you discussed this with your physician?î
    B) ìHow could that be possible?î
    C) ìYou cannot have rats in your brain.î
    D) ìYou look OK to me.î
    Ans: A
    Feedback:
    This sounds like a new symptom, so talking with the physician is important; the client may need to have his medication reevaluated. ìHow could that be possible,î puts the client on the defensive. ìYou cannot have rats in your brain,î refers to the response as being unbelievable. ìYou look OK to me,î is inappropriate and not therapeutic.

19. A client who has suspicion has been placed in a room with a roommate. The night nurse reports that this client has been awake for the past 3 nights. The likely explanation for his wakefulness is which of the following?
    A) He is fearful of what his roommate might do to him while he sleeps.
    B) He is a light sleeper and unaccustomed to a roommate.
    C) He is watching for an opportunity to escape.
    D) He is worrying about his family problems.
    Ans: A
    Feedback:
    Clients who have suspicion trust no one and believe others are going to harm them. Being fearful of his roommate, being a light sleeper and unaccustomed to a roommate, and worrying about family problems would not be the most likely reasons why this client has been awake for the past three nights. The other explanations are not as likely.

20. A client with schizophrenia is reluctant to take his prescribed oral medication. The most therapeutic response by the nurse to this refusal is,
    A) ìI can see that you're uncomfortable now, so we can wait until tomorrow.î
    B) ìIf you refuse these pills, you'll have to get an injection.î
    C) ìWhat is it about the medicine that you don't like?î
    D) ìYou know you have to take this medicine for your own good.î
    Ans: C
    Feedback:
    Asking the client why he does not like his medication explores the client's reason for refusal, which is the first step in resolving the issue. The nurse must determine the barriers to compliance for each client. Threatening the client with an injection is assault. Waiting until tomorrow puts off the inevitable. Telling him it is for his own good is not the most therapeutic response in order to get the client to take his medication.

21. The nurse observes a client with schizophrenia sitting alone, laughing occasionally, and turning his head as if listening to another person. The nurse assesses this behavior to indicate that the client is experiencing auditory hallucinations and says,
    A) ìAre you hearing something?î
    B) ìIt's a beautiful day, isn't it?î
    C) ìWould you like to go to your room to talk?î
    D) ìWould you like to take some of your PRN medication?î
    Ans: A
    Feedback:
    Asking the client if he is hearing something validates the nurse's assessment and focuses on the client's experience. The other choices do not address the situation of the client experiencing auditory hallucinations at the present time.

22. A client with schizophrenia is admitted to the inpatient unit. He does not speak when spoken to but has been observed talking to himself on occasion. What would be the priority objective at this time?
    A) The client will begin talking with other clients
    B) The client will express his feelings freely
    C) The client will increase his socialization with others
    D) The client will increase his reality orientation
    Ans: D
    Feedback:
    The client needs to be oriented to reality before he can participate in other therapeutic activities. The other choices would not be priority goals for this patient right now.

23. The nurse enters the room of a client with schizophrenia the day after he has been admitted to an inpatient setting and says, ìI would like to spend some time talking with you.î The client stares straight ahead and remains silent. The best response by the nurse would be,
    A) ìI can see you want to be alone. I'll come back another time.î
    B) ìYou don't need to talk right now. I'll just sit here for a few minutes.î
    C) ìI've got some other things I can do now. I hope you'll feel like talking later.î
    D) ìYou would feel better if you would tell me what you're thinking.î
    Ans: B
    Feedback:
    This response indicates acceptance of the client and shows genuine interest in him, building rapport and trust. Initially, the client may tolerate only 5 or 10 minutes of contact at one time. Establishing a therapeutic relationship takes time, and the nurse must be patient. The nurse must maintain nonverbal communication with the client, especially when verbal communication is not very successful. This involves spending time with the client, perhaps through fairly length periods of silence. The presence of the nurse is a contact with reality for the client and also can demonstrate the nurse's genuine interest and caring to the client. The other choices are not consistent with what is therapeutic for the client.

24. One evening, a client with schizophrenia leaves his room and begins marching in the hall. When approached by the nurse, the client says, ìGod says I'm supposed to guard the area.î Which of the following responses would be best?
    A) ìI understand you hear a voice. You and I are the only ones in the hall, and I don't hear a voice.î
    B) ìThe voices are part of your illness, and they will leave in time.î
    C) ìThis guarding responsibility can make you tired. You rest for now, and I'll guard a while.î
    D) ìYou are just imagining these things. Do not pay any attention to the voices.î
    Ans: A
    Feedback:
    Acknowledging that the client hears a voice validates that the client's experience is real to him, while presenting reality. ìThe voices are part of your illness, and they will leave in time,î is not appropriate to the client's statement. ìThis guarding responsibility can make you tired. You rest for now, and I'll guard a while,î reinforces the client's delusion. ì'You are just imagining these things. Do not pay any attention to the voices,î does not deal with the patient in a serious manner.

25. When performing discharge planning for a client who has schizophrenia, the nurse anticipates barriers to adhering to the medication regimen. The nurse assesses which of the following as improving the likelihood that the client will follow the prescribed medication regimen? Select all that apply.
    A) Short-term memory intact
    B) History of missing appointments
    C) Receives monthly disability checks
    D) Walking is primary mode of transportation
    E) States location of pharmacy nearest his residence
    Ans: A, C, E
    Feedback:
    Sometimes clients intend to take their medications as prescribed but have difficulty remembering when and if they did so. They may find it difficult to adhere to a routine schedule for medications. Clients may have practical barriers to medication compliance, such as inadequate funds to obtain expensive medications, lack of transportation or knowledge about how to obtain refills for prescriptions, or inability to plan ahead to get new prescriptions before current supplies run out.

26. A client with schizophrenia is attending a follow-up appointment at the community mental health clinic. The client reports to the nurse, ìI stopped taking the antipsychotic medication because I can't get a hard-on with my girlfriend anymore.î Which of the following should the nurse recommend to enhance the client's well-being?
    A) ìIt sounds like that is a problem for you. Don't you still find her to be sexy enough?î
    B) ìSexual dysfunction is a temporary side effect and should get better once your body is used to the medication.î
    C) ìYou should avoid having sex with your girlfriend anyway. Do you really want her to get pregnant?î
    D) ìIt is important for you to take an antipsychotic medication. You may need a different type that will be less likely to affect your sexual functioning. I would like to call your physician about this.î

    Ans: D

    Feedback:

    Some side effects, such as those affecting sexual functioning, are embarrassing for the client to report, and the client may confirm these side effects only if the nurse directly inquires about them. This may require a call to the client's physician or primary provider to obtain a prescription for a different type of antipsychotic.

27. Which of the following questions would best help the nurse to evaluate the effectiveness of antipsychotic medications for a client who has schizophrenia? Select all that apply.
    A) Have the symptoms you were experiencing disappeared?
    B) If the symptoms have not disappeared, are you able to carry out your daily life despite the persistence of some psychotic symptoms?
    C) Are you committed to taking the medication as prescribed?
    D) Are you satisfied with your quality of life?
    E) Do you have access to community agencies that will help you to live successfully in this community?

    Ans: A, B, C, D

    Feedback:

    The client's perception of the success of treatment plays a part in evaluation. In a global sense, evaluation of the treatment of schizophrenia is based on the following:
    ï Have the client's psychotic symptoms disappeared? If not, can the client carry out his or her daily life despite the persistence of some psychotic symptoms?
    ï Does the client understand the prescribed medication regimen? Is he or she committed to adherence to the regimen?
    ï Does the client believe that he or she has a satisfactory quality of life?
    The question, ìDo you have access to community agencies that will help you to live successfully in this community?î is an appropriate question to ask to evaluate the plan of care but does not directly relate to antipsychotic medications.

28. A client with schizophrenia has returned to the clinic because of an increase in symptoms. The client reports he stopped taking his meds because he did not like the side effects. The nurse educates the client about managing uncomfortable side effects. Which of the following is included in the teaching plan? Select all that apply.
    A) Suck on hard candy as desired
    B) Spend at least 30 minutes outside in the sun daily
    C) Use stool softeners as needed
    D) Decrease the amount of daily fluid intake
    E) Maintain a balanced calorie-controlled diet

    Ans: A, C, E

    Feedback:

    Unwanted side effects are frequently reported as the reason clients stop taking medications. Interventions, such as eating a proper diet and drinking enough fluids, using a stool softener to avoid constipation, sucking on hard candy to minimize dry mouth, or using sunscreen to avoid sunburn, can help to control some of these uncomfortable side effects.

29. The nurse is working with a client with schizophrenia, disorganized type. It is time for the client to get up and eat breakfast. Which of the following statements by the nurse would be most effective in helping the client prepare for breakfast?
    A) ìI'll expect you in the dining room in 20 minutes.î
    B) ìIt's time to put your dress on now.î
    C) ìStay right there and I'll get your clothes for you.î
    D) ìWhy don't you stay here and I'll get your tray for you.î

    Ans: B

    Feedback:

    Clients with schizophrenia may have significant self-care deficits. The client needs clear direction, with tasks broken into small steps, to begin to participate in her own self-care. The other choices do not support the client effectively. ìI'll expect you in the dining room in 20 minutes,î is authoritarian and does not allow the client dignity. ìStay right here, and I'll get your clothes for you,î is also authoritarian and does not allow the client dignity. ìWhy don't you stay here and I'll get your tray for you,î is kinder but it robs the client of the opportunity to do for himself or herself as much as possible.

30. The parents of a young adult male who has schizophrenia ask how they can recognize when their son is beginning to relapse. The nurse teaches the family to look for which of the following? Select all that apply.
    A) Excessive sleeping
    B) Fatigue
    C) Irritability
    D) Increased inhibition
    E) Negativity
    Ans: B, C, E
    Feedback:
    Teaching the client and family members to prevent or manage relapse is an essential part of a comprehensive plan of care. This includes providing facts about schizophrenia, identifying the early signs of relapse, and teaching health practices to promote physical and psychological well-being. Early signs of relapse include impaired cause-and-effect reasoning, impaired information processing, poor nutrition, lack of sleep, lack of exercise, fatigue, poor social skills, social isolation, loneliness, interpersonal difficulties, lack of control, irritability, mood swings, ineffective medication management, low self-concept, looking and acting different, hopeless feelings, loss of motivation, anxiety and worry, disinhibition, increased negativity, neglecting appearance, and forgetfulness.

31. A client asks the nurse upon discharge, ìWhat should I do if I forget to take my medicine?î The nurse should explain to the client which of the following?
    A) ìJust double the dose next time it is scheduled.î
    B) ìSkip that dose and resume your regular with the next dose.î
    C) ìDon't miss doses, or you will not maintain therapeutic drug levels.î
    D) ìIf you remember within 3 to 4 hours later than it is due, take it then. If you remember more than 4 hours after it was due, do not take that dose.î
    Ans: D
    Feedback:
    If a client forgets a dose of antipsychotic medication, advise the client to take it if the dose is only 3 to 4 hours late. If the missed dose is more than 4 hours late or the next dose is due, ask the client to omit the forgotten dose.

32. Which of the following are central components of a psychiatric rehabilitation and recovery program? Select all that apply.
    A) Working with clients to have an improved quality of life according to society's point of view
    B) Working with clients to manage their own lives
    C) Working with clients to make effective treatment decisions
    D) Working with clients to have an improved quality of life according to his or her point of view.
    E) Working with clients to diagnose their problem early
    Ans: B, C, D
    Feedback:
    Psychiatric rehabilitation has the goal of recovery for clients with major mental illness that goes beyond symptom control and medication management. Working with clients to manage their own lives, make effective treatment decisions, and have an improved quality of lifeófrom the client's point of viewóare central components of such programs.

33. A student nurse is having a first experience in an inpatient psychiatric unit and is frightened by the behaviors of the clients with schizophrenia. The student should take which of the following actions to deal with fear?
    A) Express fear to the psychiatrist during rounds
    B) Pretend to not be afraid
    C) Stay in an open area while talking with the clients
    D) Insist that the instructor accompanies the student at all times.
    Ans: C
    Feedback:
    The nurse also may be genuinely frightened or threatened if the client's behavior is hostile or aggressive. The nurse must acknowledge these feelings and take measures to ensure his or her safety. This may involve talking to the client in an open area rather than in a more isolated location or having an additional staff person present rather than being alone with the client. If the nurse pretends to be unafraid, the client may sense the fear anyway and feel less secure, leading to a greater potential for the client to lose personal control. It is not possible for the instructor to accompany the student at all times.

34. Which of the following attitudes would be best for the nurse when the client who has schizophrenia acts as though the nurse is not trustworthy or that his or her integrity is being questioned?
    A) That the client is correct and the nurse is not trustworthy
    B) That the client wants to insult the nurse
    C) That the client's behavior is a part of the illness
    D) That the nurse's actions have failed
    Ans: C
    Feedback:
    Suspicious or paranoid behavior on the client's part may make the nurse feel as though he or she is not trustworthy or that his or her integrity is being questioned. The nurse must recognize this type of behavior as part of the illness and not interpret or respond to it as a personal affront. The nurse must not take responsibility for the success or failure of treatment efforts or view the client's status as a personal success or failure.

1. **Chapter 17** Which best explains the neurochemical processes responsible for depression?
   A) Increased activity of dopamine
   B) Decreased glucocorticoid activity
   C) Decreased serotonin and norepinephrine activity
   D) Potentiating of the kindling process
   Ans: C
   Feedback:
   Deficits of serotonin, its precursor tryptophan, or a metabolite (5-hydroxyindole acetic acid, or 5-HIAA) of serotonin found in the blood or cerebrospinal fluid occur in people with depression. Norepinephrine levels may be deficient in depression and increased in mania. Elevated glucocorticoid activity is associated with the stress response, and evidence of increased cortisol secretion is apparent in about 40% of clients with depression. Kindling is the process by which seizure activity in a specific area of the brain is initially stimulated.

2. Which is a freudian explanation of the etiology of depression?
   A) Depression is a reaction to a distressing life experience.
   B) Depression results from being raised by rejecting or unloving parents.
   C) Depression results from cognitive distortions.
   D) Depression is anger turned inward.
   Ans: D
   Feedback:
   Freud looked at the self-depreciation of people with depression and attributed that self-reproach to anger turned inward related to either a real or perceived loss. Meyer viewed depression as a reaction to a distressing life experience such as an event with psychic causality. Horney believed that children raised by rejecting or unloving parents were prone to feelings of insecurity and loneliness. Beck saw depression as resulting from specific cognitive distortions in susceptible people.

3. Which statements about the etiology of bipolar disorder do most psychoanalytical theories subscribe to? Select all that apply.
   A) Norepinephrine levels may be increased in mania.
   B) Manic episodes are a ìdefenseî against underlying depression.
   C) Acetylcholine seems to be implicated in mania.
   D) The id takes over the ego and acts as an undisciplined hedonistic being (child).
   Ans: B, D
   Feedback:
   Most psychoanalytic theories of mania view manic episodes as a ìdefenseî against underlying depression, with the id taking over the ego and acting as an undisciplined hedonistic being (child). Norepinephrine levels may be increased in mania, and acetylcholine seems to be implicated in mania, but these are neurochemical theories.

4. Which variables represent the highest risk for developing major depressive disorder? Select all that apply.
   A) Male gender
   B) Mood disorder in first-degree relatives
   C) Substance abuse
   D) Divorced
   E) Older adult
   Ans: B, D
   Feedback:
   Major depression is twice as common in women and has a 1.5 to 3 times greater incidence in first-degree relatives than in the general population. Incidence of depression decreases with age in women and increases with age in men. Single and divorced people have the highest incidence. Depression in prepubertal boys and girls occurs at an equal rate.

5. A concerned family member tells the nurse, ìI am concerned about my brother. He has been acting very different lately.î Knowing the family has a history of bipolar disorder, the nurse inquires further about this. Which behavior during the past week might indicate that the brother has bipolar disorder?
   A) Taking unnecessary risks
   B) Sleeping more
   C) Intense focus
   D) Showing low self-esteem
   Ans: A
   Feedback:
   The diagnosis of a manic episode or mania requires at least 1 week of unusual and incessantly heightened, grandiose, or agitated mood in addition to three or more of the following symptoms: exaggerated self-esteem; sleeplessness; pressured speech; flight of ideas; reduced ability to filter extraneous stimuli; distractibility; increased activities with increased energy; and multiple, grandiose, high-risk activities involving poor judgment and severe consequences, such as spending sprees, sex with strangers, and impulsive investments.

6. A client is admitted for major depression. What should the nurse expect to find during assessment?
   A) Anhedonia, feelings of worthlessness, and difficulty focusing
   B) Depressed mood, guilt, and pressured speech
   C) Changes in sleep pattern, tired, and grandiose mood
   D) Difficulty focusing, feelings of helplessness, and flight of ideas
   Ans: A
   Feedback:
   Symptoms of major depressive disorder include depressed mood; anhedonism (decreased attention to and enjoyment from previously pleasurable activities); unintentional weight change of 5% or more in a month; change in sleep pattern; agitation or psychomotor retardation; tiredness; worthlessness or guilt inappropriate to the situation (possibly delusional); difficulty thinking, focusing, or making decisions; or hopelessness, helplessness, and/or suicidal ideation. Grandiose mood, pressured speech, and flight of ideas are associated with mania.

7. A client has just been diagnosed as having major depression. At which time would the nurse expect the client to be at highest risk for self-harm?
   A) Immediately after a family visit
   B) On the anniversary of significant life events in the client's life
   C) During the first few days after admission
   D) Approximately 2 weeks after starting antidepressant medication
   Ans: D
   Feedback:
   Observe the client closely for suicide potential, especially after antidepressant medication begins to raise the client's mood. Risk for suicide increases as the client's energy level is increased by medication. The other choices are not significantly associated with increased risk for suicide.

8. The nurse is planning care for a client with major depression. Which is an appropriate expected outcome?
   A) The client will avoid causing harm to others.
   B) The client will be free from stress.
   C) The client will independently carry out activities of daily living.
   D) The client will not experience agitation.
   Ans: C
   Feedback:
   Expected outcomes for the depressed client include the following:
   ï The client will not injure himself or herself.
   ï The client will independently carry out activities of daily living (showering, changing clothing, grooming).
   ï The client will establish a balance of rest, sleep, and activity.
   ï The client will establish a balance of adequate nutrition, hydration, and elimination.
   ï The client will evaluate self-attributes realistically.
   ï The client will socialize with staff, peers, and family/friends.
   ï The client will return to occupation or school activities.
   ï The client will comply with the antidepressant regimen.
   ï The client will verbalize symptoms of a recurrence.
   Avoiding agitation and harm to others are outcomes more appropriate for a client with mania. It is unrealistic to be completely free from stress.

9. A client who is depressed begins to cry and states, ìI'm just really sick of feeling this way. Nothing ever seems to go right in my life.î Which would be the most appropriate response by the nurse?
   A) ìDon't cry. Try to look at the positive side of things.î
   B) ìYou are feeling really sad right now. It's a hard time.î
   C) ìHang in there. Your medication will start helping in a few days.î
   D) ìNothing ever goes right?î
   Ans: B
   Feedback:
   Do not cut off interactions with cheerful remarks or platitudes. Do not belittle the client's feelings. Accept the client's verbalizations of feelings as real, and give support for expressions of emotions, especially those that may be difficult for the client (like anger). Allow (and encourage) the client to cry. It is important that the nurse does not attempt to ìfixî the client's difficulties

10. A client who is manic threatens others on the unit. Which would be the initial nursing action in response to this behavior?
    A) Administering a sedative that has been prescribed to be used PRN.
    B) Insisting the client take a ìtime-outî in his room
    C) Clearing the area of all other clients
    D) Setting limits on aggressive and intimidating behavior
    Ans: D
    Feedback:
    Because of the safety risks that clients in the manic phase take, safety plays a primary role in care, followed by issues related to self-esteem and socialization. It is necessary to set limits when they cannot set limits on themselves. Giving the client the opportunity to exercise self-control is most therapeutic. If the client cannot control his or her behavior, then more restrictive measures can be taken, such as room restriction or sedation. Clearing the area is not necessary during limit setting and may cause excessive panic on the part of other clients. When setting limits, it is important to clearly identify the unacceptable behavior and the expected, appropriate behavior. All staff must consistently set and enforce limits for those limits to be effective.

11. Which meal would the nurse provide to best meet the nutritional needs of a client who is manic?
    A) Peanut butter sandwich, chips, cola
    B) Fried chicken, mashed potatoes, milk
    C) Ham sandwich, cheese slices, milk
    D) Spaghetti, garlic bread, salad, tea
    Ans: C
    Feedback:
    Finger foods, or things clients can eat while moving around, are the best options to improve nutrition. Such foods should be as high in calories and protein as possible.

12. A client who is manic states, ìWhat time is it? I have to see the doctor. Is breakfast here yet? I've got to see the doctor first. Can I get my cereal out of the kitchen?î Which would be the most appropriate response by the nurse?
    A) ìPlease slow down. I'm not sure what you need first.î
    B) ìYou will have to be quiet and have breakfast after the doctor comes.î
    C) ìAre you hungry?î
    D) ìYour thoughts seem to be racing this morning.î
    Ans: A
    Feedback:
    The speech of manic clients may be pressured: rapid, circumstantial, rhyming, noisy, or intrusive with flights of ideas. The nurse must keep channels of communication open with clients, regardless of speech patterns. The nurse can say, ìPlease speak more slowly. I'm having trouble following you.î This puts the responsibility for the communication difficulty on the nurse rather than on the client.

13. A client with mania is demonstrating hypersexual behavior by blowing kisses to other clients, making suggestive remarks, and removing some articles of clothing. Which nursing intervention would be most appropriate at this time?
    A) Accompany the client to his or her room to get dressed.
    B) Put the client in seclusion for his or her own protection.
    C) Tell other clients to ignore the behavior because it is harmless.
    D) Tell the client that the behaviors have to stop right now.
    Ans: A
    Feedback:
    Redirecting the client to appropriate behavior without confrontation is most effective. Seclusion is not an appropriate intervention for this situation. Ignoring the behavior is not indicated. The client is in the manic phase; telling him or her to stop the behavior may make the behaviors escalate.

14. The client with mania attempts to hit the nurse. Which is the best response by the nurse?
    A) ìDo not swing at me again. If you cannot control yourself, we will help you.î
    B) ìIf you do that one more time, you will be put in seclusion immediately.î
    C) ìStop that. I didn't do anything to provoke an attack.î
    D) ìWhy do you continue that kind of behavior? You know I won't let you do it.î
    Ans: A
    Feedback:
    This response firmly states behavioral expectations and lets the client know his behavior will be safely controlled if he is unable to do so. The other choices are not appropriate responses to this situation.

15. During report, the nurse learns that a client with mania has not slept since admission 2 days ago. On entering the day room, the nurse finds this client dancing to loud music. Which would be the most appropriate statement by the nurse?
    A) ìDo you think you could sit still for a few minutes so we can talk?î
    B) ìHow are you ever going to get any rest if you keep that music on?î
    C) ìLet's go to the conference room and talk for a while.î
    D) ìTurn the radio down so we can hear ourselves talk.î
    Ans: C
    Feedback:
    Redirecting the client to a quieter, smaller room will decrease external stimuli and promote calmness, so the client will eventually rest and sleep.

16. At 1 AM, the client with mania rushes to the nurses' station and demands that the psychiatrist come to the unit now to write an order for a pass to go home. What would be the nurse's most therapeutic response?
    A) ìGo to the day room and wait while I call your psychiatrist.î
    B) ìDon't be unreasonable. I can't call the psychiatrist at this time of night.î
    C) ìI can't call the psychiatrist now, but you and I can talk about your request for a pass.î
    D) ìYou must really be upset to want a pass immediately; I'll give you some medication.î
    Ans: C
    Feedback:
    This response states a limit on an unreasonable request while providing the opportunity to discuss the request. Answer choices A, B, and D are not therapeutic.

17. A client with mania is in the dining room at lunchtime and is observed taking food from other clients' trays. The nurse's intervention should be based on which rationale?
    A) As soon as lunch is over, the client will calm down.
    B) Other clients need to be protected from the intrusive behavior.
    C) The client's behavior is not an imminent threat to anyone's physical safety.
    D) The client needs food and fluids in any way possible.
    Ans: B
    Feedback:
    The nurse must set limits on this intrusive behavior because other clients have the right to be protected. The client is in the manic phase; the client may not calm down after lunch. The behavior could be an imminent threat to individual safety for many reasons, infection control included. The client's need for food and fluids does not supersede any of the other clients' needs for food and fluids.

18. A client with bipolar disorder is admitted to the psychiatric unit. The client is talking loudly, walking back and forth rapidly, and exhibiting a short attention span. Which nursing intervention should occur first?
    A) Decrease the client's environmental stimuli.
    B) Give the client feedback about his behavior.
    C) Introduce the client to other staff on the unit.
    D) Tell the client about hospital rules and policies.
    Ans: A
    Feedback:
    When the client is agitated, decreasing stimuli is the priority. Answer choices A, B, and C are not priority interventions.

19. The nurse observes a client sitting alone at a table, looking sad and preoccupied. The nurse sits down and says, ìI saw you sitting alone and thought I might keep you company.î The client turns away from the nurse. Which would be the most therapeutic nursing intervention?
    A) Move to another chair closer to the client and say, ìThe staff is here to help you.î
    B) Move to a chair a little further away and say, ìWe can just sit together quietly.î
    C) Remain in place and say, ìHow are you feeling today?î
    D) Say, ìI'll visit with you a little later,î and leave the client alone for a while.
    Ans: B
    Feedback:
    Moving away gives the client more personal space; staying with the client indicates acceptance and genuine interest. It is not necessary for the nurse to talk to the client the entire time; rather, silence can convey that clients are worthwhile even if they are not interacting.

20. A client with depression appears lethargic and apathetic but agrees to participate in a leisure activity group. Which nursing intervention is most likely to help the client successfully participate?
    A) Allowing the client to direct her participation at her own pace
    B) Giving the client several choices of projects, so she can choose her favorite
    C) Staying away from the client during the session to encourage free expression
    D) Structuring the activity to facilitate completion of one specific task
    Ans: D
    Feedback:
    The client needs to experience success in the group but is unlikely to do that independently. The other choices would not be appropriate actions for the client who is lethargic and apathetic.

21. A client asks the nurse why he has to go to therapy and cannot just take his prescribed antidepressant medication. Which would be the most therapeutic nursing intervention?
    A) Stating, ìThe effects of medications will not last forever. You will need to eventually learn to function without them.î
    B) Stating, ìMedications help your brain function better, but the therapy helps you achieve lasting behavior change.î
    C) Stating, ìBoth are recommended. Since your insurance covers both, that is the best plan for you.î
    D) Asking, ìDo you have reservations about going to therapy?î
    Ans: B
    Feedback:
    Clients and family should know that treatment outcomes are best when psychotherapy and antidepressants are combined. Psychotherapy helps clients to explore anger, dependence, guilt, hopelessness, helplessness, object loss, interpersonal issues, and irrational beliefs. The goal is to reverse negative views of the future, improve self-image, and help clients gain competence and self-mastery.

22. A client who has been discharged home on Celexa (citalopram) calls the nurse complaining that the medication causes her to feel too drowsy. The nurse should make which of the following suggestions?
    A) Make an appointment to change to a different medication.
    B) Take the medication at night.
    C) Be patient while this early side effect subsides.
    D) Skip a dose if drowsiness is excessive.
    Ans: B
    Feedback:
    Citalopram (Celexa) causes drowsiness, sedation, insomnia, nausea, vomiting, weight gain, constipation, and diarrhea. Nursing implications for drowsiness and sedation include instructing the client to administer the dose at 6 PM or later.

23. The wife of a client with bipolar disorder calls the nurse expressing distress about recent spending patterns of her husband. The nurse suggests the wife implement the limit-setting skills she has learned in family therapy. In this instance, the nurse's action would be considered
    A) inappropriate; the nurse should not give advice to the wife.
    B) inappropriate; the husband has the legal right to spend personal money.
    C) appropriate; the wife is responsible for the husband's actions since he has a mental illness.
    D) appropriate; the wife needs support in setting boundaries.
    Ans: D
    Feedback:
    Family members often say they know clients have stopped taking their medication when, for example, clients become more argumentative, talk about buying expensive items that they cannot afford, hotly deny anything is wrong, or demonstrate any other signs of escalating mania. People sometimes need permission to act on their observations.

24. A client is being discharged on lithium. The nurse encourages the client to follow which health maintenance recommendations? Select all that apply.
    A) Weigh self weekly at the same time of day.
    B) Drink a 2-L bottle of decaffeinated fluid daily.
    C) Do not alter dietary salt intake.
    D) See the doctor if you get the flu.
    E) Restrict involvement in intense exercise.
    Ans: B, C, D
    Feedback:
    Clients should drink adequate water (approximately 2 L/day) and continue with the usual amount of dietary table salt. Having too much salt in the diet because of unusually salty foods or the ingestion of salt-containing antacids can reduce receptor availability for lithium and increase lithium excretion, so the lithium level will be too low. If there is too much water, lithium is diluted, and the lithium level will be too low to be therapeutic. Drinking too little water or losing fluid through excessive sweating, vomiting, or diarrhea increases the lithium level, which may result in toxicity. Monitoring daily weights and the balance between intake and output and checking for dependent edema can be helpful in monitoring fluid balance. The physician should be contacted if the client has diarrhea, fever, flu, or any condition that leads to dehydration.

25. The nurse is teaching a 70-year-old man about his depression. Which statement by the client would indicate that teaching has been effective?
    A) ìAll old people get depressed at times.î
    B) ìI'm glad I'll feel better in 2 or 3 days.î
    C) ìI never knew depression could just happen for no specific reason.î
    D) ìWhen I reduce the stress in my life, the depression will go away.î
    Ans: C
    Feedback:
    Depression can be endogenous, with no external cause or event. Clients must understand that depression is an illness, not a lack of willpower or motivation. Major depression typically involves 2 or more weeks of a sad mood or lack of interest in life activities with at least four other symptoms of depression.

26. Which individual is at highest risk for committing suicide?
    A) A 71-year-old male, alcohol user, independent minded
    B) A 16-year-old female, diabetic, two best friends
    C) A 47-year-old male, schizophrenic, unemployed
    D) A 57-year-old female, depression, active in church
    Ans: A
    Feedback:
    In the United States, men commit approximately 72% of suicides, which is roughly three times the rate of women, although women are four times more likely than men to attempt suicide. Adults older than age 65 years compose 10% of the population but account for 25% of suicides. Suicide is the second leading cause of death (after accidents) among people 15 to 24 years of age. Clients with psychiatric disorders, especially depression, bipolar disorder, schizophrenia, substance abuse, posttraumatic stress disorder, and borderline personality disorder, are at increased risk for suicide. Chronic medical illnesses associated with increased risk for suicide include cancer, HIV or AIDS, diabetes, cerebrovascular accidents, and head and spinal cord injury. Environmental factors that increase suicide risk include isolation, recent loss, lack of social support, unemployment, critical life events, and family history of depression or suicide.

27. Which is a possible explanation for the increased risk of suicide in persons who have had a relative who committed suicide?
    A) The relative's suicide offers a sense of ìpermissionî or acceptance of suicide as a method of escaping a difficult situation.
    B) Many people with depression who have suicidal ideation lack the energy to implement suicide plans, but antidepressant treatment can actually give clients with depression the energy to act on suicidal ideation.
    C) Suicide is more likely to occur in April when natural energy from increased sunlight may give the client the energy to act on suicidal ideation.
    D) The relative's suicide caused the family members to realize that suicide is emotionally harmful to the ones left behind and vow not to consider suicide.

    Ans: A

    Feedback:

    Those with a relative who committed suicide are at increased risk for suicide: the closer the relationship, the greater the risk. One possible explanation is that the relative's suicide offers a sense of ìpermissionî or acceptance of suicide as a method of escaping a difficult situation. Treatment with antidepressants and spring increase in sunlight and energy may give a person with suicidal ideation the energy to act on it. If a relative commits suicide, the family members may recognize that suicide is emotionally harmful to the ones left behind and vow not to consider suicideóthis does not increase the risk of suicide.

28. Which time periods during antidepressant therapy are persons most likely to commit suicide? Select all that apply.
    A) After starting antidepressant therapy but not having reached the therapeutic level
    B) After having reached the therapeutic level of antidepressants and maintained it for several years
    C) If the client has made a choice to discontinue antidepressant therapy without medical supervision and is becoming gradually more depressed
    D) If the client does not adhere to the medication regimen and takes antidepressant medications irregularly
    E) Prior to initiating antidepressant therapy but before the depression results in lack of energy

    Ans: A, C, D, E

    Feedback:

    After starting antidepressant therapy but not having reached the therapeutic level, the client is still troubled with depression and may have the energy to execute any suicide ideation. If the client has made the choice to discontinue antidepressant therapy without medical supervision and is becoming gradually more depressed does not adhere to the medication regimen and takes antidepressant medications irregularly, or prior to initiating antidepressant therapy but before the depression results in lack of energy, the client may be motivated to commit suicide because of the depression that is not effectively treated by a therapeutic level of antidepressant medications and yet still have enough energy to execute any suicide ideation. After having reached the therapeutic level of antidepressant medications and having maintained it for several years, the client is not likely at an increased risk for suicide.

29. Which client is at highest risk for carrying out a suicide plan?
    A) A client who plans to take a bottle of sleeping pills.
    B) A client who says, ìMy life is over.î
    C) A client who has a private gun collection.
    D) A client who says, ìI'm going to jump off the next bridge I see.î

    Ans: C

    Feedback:

    When a client admits to having suicidal thoughts, the next step is to determine potential lethality, including a specific plan and lethality of means. Specific and positive answers to lethality assessment questions increase the client's likelihood of committing suicide.

30. A client who is depressed states, ìI think my family would be better off without me. They don't need to worry.î Which would be the most appropriate response by the nurse?
    A) ìAre you planning to commit suicide?î
    B) ìWhat do you think they are worried about?î
    C) ìWhere are you going?î
    D) ìYou don't mean that. Your family loves you.î
    Ans: A
    Feedback:
    The nurse never ignores any hint of suicidal ideation regardless of how trivial or subtle it seems and the client's intent or emotional status. Asking clients directly about thoughts of suicide is important.

31. A visitor comes to see a client who is suicidal. Upon entering the unit, the nurse notices that the visitor has brought the client a can of his favorite soda. Which action should the nurse take at his time?
    A) Confiscate the soda can as a restricted item.
    B) Pour the soda into a plastic cup.
    C) Ask the visitor to place the soda can at the nurse's desk until he or she leaves.
    D) Ask the visitor not to bring outside items on the unit in the future.
    Ans: B
    Feedback:
    For clients who are suicidal, staff members remove any item they can use to commit suicide, such as sharp objects, shoelaces, belts, lighters, matches, pencils, pens, and even clothing with drawstrings. The client could access the soda can and commit self-harm.

32. A client who just went through an upsetting divorce is threatening to commit suicide with a handgun. The client is involuntarily admitted to the psychiatric unit. Which nursing diagnosis has the highest priority?
    A) Hopelessness related to recent divorce
    B) Ineffective coping related to inadequate stress management
    C) Spiritual distress related to conflicting thoughts about suicide and sin
    D) Risk for suicide related to a highly lethal plan
    Ans: D
    Feedback:
    Safety is the priority. The overall goal for the client who is suicidal is to first keep the client safe and later to help him or her to develop new coping skills that do not involve self-harm. The other choices would not be the highest priority diagnosis for this client.

33. The nursing instructor is conducting a preconference with a group of nursing students on a psychiatric unit. Which statement made by a student reflects the greatest barrier to being able to provide professional care to the client who is suicidal?
    A) ìI just don't understand why anyone would want to kill themselves.î
    B) ìI think suicide is wrong and selfish.î
    C) ìI get frustrated when my client negates all the positives I try to point out.î
    D) ìI can see how much my client is hurting inside.î
    Ans: B
    Feedback:
    Some health-care professionals consider suicidal people to be failures, immoral, or unworthy of care. These negative attitudes may result from several factors. They may reflect society's negative view of suicide: many states still have laws against suicide, although they rarely enforce these laws. If this anxiety is not resolved, the staff person can demonstrate avoidance, demeaning behavior, and superiority to suicidal clients. Therefore, to be effective, the nurse must be aware of his or her own feelings and beliefs about suicide.

34. Which may contribute to a staff person being less effective in dealing with a person who is at increased risk for suicide? Select all that apply.
    A) Negative societal view of suicide
    B) Feeling inadequate and anxious about suicide and/or his or her own mortality
    C) Having personally considered suicide but decided against it and not having dealt with the associated anxiety
    D) Being unaware of his or her own feelings and beliefs about suicide
    E) Implementing nursing interventions to decrease the risk of suicide
    Ans: A, B, C, D
    Feedback:
    Some health-care professionals consider suicidal people to be failures, immoral, or unworthy of care. These negative attitudes may result from several factors. They may reflect society's negative view of suicide. Health-care professionals may feel inadequate and anxious dealing with suicidal clients, or they may be uncomfortable about their own mortality. Many people have had thoughts about ìending it all,î even if for a fleeting moment when life is not going well. The scariness of remembering such flirtations with suicide causes anxiety. If this anxiety is not resolved, the staff person can demonstrate avoidance, demeaning behavior, and superiority to suicidal clients. Therefore, to be effective, the nurse must be aware of his or her own feelings and beliefs about suicide.

1. **Chapter 18** Which disorder is characterized by pervasive mistrust and suspiciousness of others?
   A) Paranoid personality disorder
   B) Schizoid personality disorder
   C) Histrionic personality disorder
   D) Dependent personality disorder
   Ans: A
   Feedback:
   Paranoid personality disorder is characterized by pervasive mistrust and suspiciousness of others. Schizoid personality disorder is characterized by a pervasive pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal settings. Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking. Dependent personality disorder is characterized by a pervasive and excessive need to be taken care of, which leads to submissive and clinging behavior and fears of separation.

2. Of the following personality disorders, which are most likely related to lack of caring about others? Select all that apply.
   A) Schizotypal personality disorder
   B) Borderline personality disorder
   C) Antisocial personality disorder
   D) Narcissistic personality disorder
   E) Obsessiveñcompulsive personality disorder
   Ans: A, C, D
   Feedback:
   Schizotypal personality disorder is characterized by a pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships as well as by cognitive or perceptual distortions and behavioral eccentricities. Borderline personality disorder is characterized by a pervasive pattern of unstable interpersonal relationships, self-image, and affect as well as marked impulsivity. Antisocial personality disorder is characterized by a pervasive pattern of disregard for and violation of the rights of othersóand with the central characteristics of deceit and manipulation. Narcissistic personality disorder is characterized by a pervasive pattern of grandiosity, need for admiration, and lack of empathy. Obsessiveñcompulsive personality disorder is characterized by a pervasive pattern of preoccupation with perfectionism, mental and interpersonal control, and orderliness at the expense of flexibility, openness, and efficiency.

3. Which would most likely be a type of behavior that would be manifested by a client who has histrionic personality disorder?
   A) Insisting that others follow the rules of the unit
   B) Wondering why others are being friendly to her
   C) Having a tantrum if not getting enough attention
   D) Getting others to make decisions for her
   Ans: C
   Feedback:
   Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking. Clients usually seek treatment for depression, unexplained physical problems, and difficulties in relationships. Obsessiveñcompulsive personality disorder is characterized by a pervasive pattern of preoccupation with perfectionism, mental and interpersonal control, and orderliness at the expense of flexibility, openness, and efficiency. Dependent personality disorder is characterized by a pervasive and excessive need to be taken care of, which leads to submissive and clinging behavior and fears of separation.

4. A nursing student appears to cooperate with the group but does not complete agreed upon tasks at the appropriate time repeatedly and then display negativity. The nursing student may be showing signs of which personality disorder or behavior?
   A) Paranoid
   B) Borderline
   C) Narcissistic
   D) Passive-aggressive behavior
   Ans: D
   Feedback:
   Passive-aggressive behavior is characterized by a negative attitude and a pervasive pattern of passive resistance to demands for adequate social and occupational performance. These clients may appear cooperative, even ingratiating, or sullen and withdrawn, depending on the circumstances. Paranoid personality disorder is characterized by pervasive mistrust and suspiciousness of others. Borderline personality disorder is characterized by a pervasive pattern of unstable interpersonal relationships, self-image, and affect as well as marked impulsivity. Narcissistic personality disorder is characterized by a pervasive pattern of grandiosity, need for admiration, and lack of empathy.

5. Which thought process would cause a client with antisocial personality disorder to want to do everything for himself?
   A) Belief in his own self-worth
   B) Inability to delay gratification
   C) Rewards for competitive behavior
   D) Sense of mistrust of others
   Ans: D
   Feedback:
   Clients believe others are just like them, that is, ready to exploit and use others for their own gain. These clients are devoid of personal emotions, and actually the self is quite shallow and empty. These clients view relationships as serving their needs and pursue others only for personal gain. There is no competition because these clients believe they are only taking care of themselves because no one else will.

6. What would the nurse expect to assess in a client with narcissistic personality disorder?
   A) Genuine concern for others
   B) Mistrust of others
   C) Grandiose and superior self-concept
   D) Dependence on others for decision making
   Ans: C
   Feedback:
   Clients with narcissistic personality disorder believe themselves superior to others and expect to be treated as such.

7. Which term describes the extent to which a person considers himself to be an integral part of the universe?
   A) Cooperativeness
   B) Self-directedness
   C) Self-transcendence
   D) Character
   Ans: C
   Feedback:
   Self-transcendence describes the extent to which a person considered himself or herself to be an integral part of the universe. Cooperativeness refers to the extent to which a person sees himself or herself as an integral part of human society. Self-directedness is the extent to which a person is responsible, reliable, resourceful, goal oriented, and self-confident. Character consists of concepts about the self and the external world.

8. A person with temperament traits of high harm avoidance would most likely suffer from which personality disorder?
   A) Schizoid
   B) Avoidant
   C) Narcissistic
   D) Antisocial
   Ans: B
   Feedback:
   The four temperament traits are harm avoidance, novelty seeking, reward dependence, and persistence. People with high harm avoidance exhibit fear of uncertainty, social inhibition, shyness with strangers, rapid fatigability, and pessimistic worry in anticipation of problems. Avoidant personalities are individuals who appear anxious or fearful. Schizoid personality disorder is a related disorder that is characterized by a pervasive pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal settings. Narcissistic personality disorder is characterized by a pervasive pattern of grandiosity, need for admiration, and lack of empathy. Antisocial personality disorder is characterized by a pervasive pattern of disregard for and violation of the rights of othersóand with the central characteristics of deceit and manipulation.

9. Which of the following is a psychosocial explanation for the development of personality disorders?
   A) Highly self-directed people reflect uncooperativeness and intolerance.
   B) Cooperative people become increasingly helpless over time.
   C) Failure to complete a developmental task jeopardizes future personality development.
   D) Self-transcendence contributes to self-consciousness and materialism.
   Ans: C
   Feedback:
   Failure to complete a developmental task jeopardizes the person's ability to achieve future developmental tasks. Self-directed people are realistic and effective and can adapt their behavior to achieve goals. Highly cooperative people are described as empathic, tolerant, compassionate, supportive, and principled. People low in self-directedness are helpless and unreliable. Self-transcendence describes the extent to which a person considers himself or herself to be an integral part of the universe.

10. The nurse is planning the type of approach that will be most effective in developing a therapeutic relationship with the client. The nurse should use a matter-of-fact approach with clients with which types of personality disorders? Select all that apply.
    A) Paranoid
    B) Antisocial
    C) Schizotypal
    D) Narcissistic
    E) Avoidant
    Ans: A, B, D
    Feedback:
    Paranoid, antisocial, and narcissistic personalities need a serious, straightforward approach that includes limit setting and a matter-of-fact approach. Schizotypal personalities need to improve community functioning through social skills training. Avoidant personalities require support and reassurance to promote self-esteem.

11. The nurse is teaching a client with paranoid personality disorder to validate ideas with another person before taking action on him. Which is the best rationale for this intervention?
    A) It will assist the client to start basing decisions and actions on reality.
    B) It will help the client understand the origins of his or her paranoid thinking.
    C) It will help the client learn to trust other people.
    D) It will teach the client to differentiate when his or her suspicions are true.
    Ans: A
    Feedback:
    One of the most effective interventions with paranoid or suspicious clients is helping clients to learn to validate ideas before taking action; however, this requires the ability to trust and to listen to one person. The rationale for this intervention is that clients can avoid problems if they can refrain from taking action until they have validated their ideas with another person. This helps prevent clients from acting on paranoid ideas or beliefs. It also assists them to start basing decisions and actions on reality.

12. The nurse is teaching a client with schizoid personality to function more comfortably with others in the community. Which nursing intervention would be effective to improve the client's social skills?
    A) Teach the client to make necessary requests in writing or over the phone.
    B) Accompany the client during initial interactions in the community.
    C) Suppress the display of any unusual behaviors in public.
    D) Assist in developing an explanation for bizarre behaviors to offer to others in the community.

    Ans: A

    Feedback:

    Because face-to-face contact is more uncomfortable, clients may be able to make written requests or to use the telephone for business. The nurse can also role-play interactions that clients would have with people; this allows clients to practice clear and logical requests to obtain services or to conduct personal business. It helps to identify one person with whom clients can discuss unusual or bizarre beliefs, such as a social worker or a family member. These clients are uncomfortable around others, and this is not likely to change and cannot be suppressed.

13. Which of the following is a realistic outcome for the care of a person with a personality disorder?
    A) Outcomes that focus on satisfaction with daily life
    B) Outcomes that focus on the client's perception of others
    C) Outcomes that focus on increased client insight
    D) Outcomes that focus on change in behavior

    Ans: D

    Feedback:

    The treatment focus often is behavioral change. Although treatment is unlikely to affect the client's insight or view of the world and others, it is possible to make changes in behavior.

14. A client with antisocial personality disorder is begging to use the phone to call his wife, even though it is against the unit rules. The client begs, ìIt is just this once, and she will be so hurt if I don't call her.î Which would be the most appropriate response by the nurse?
    A) ìOnly to help your wife, you can call this time.î
    B) ìI will get in trouble with my supervisor if I let you call.î
    C) ìYou may not use the phone to call your wife.î
    D) ìYou cannot call because you need to focus on your recovery while you are here, not your wife.î

    Ans: C

    Feedback:

    The client may attempt to bend the rules ìjust this onceî with numerous excuses and justifications. The nurse's refusal to be manipulated or charmed will help decrease manipulative behavior. Avoid any discussion about why requirements exist. State the requirement in a matter-of-fact manner. Avoid arguing with the client.

15. Which is the main reason why the periodic team meetings are important when caring for a client with antisocial personality?
    A) The team needs to consider updating treatment recommendations as the client improves.
    B) Rotating team members need to be apprised of the care planned for the client.
    C) Staff frustrations in caring for the client need to be processed.
    D) Team consistency is important to prevent manipulation by the client.

    Ans: D

    Feedback:

    Be consistent and firm with the care plan. Do not make independent changes in rules or consequences. Any change should be made by the staff as a group and conveyed to all staff members working with this client. Consistency is essential. If the client can find just one person to make independent changes, any plan will become ineffective. Client changes can be expected to be gradual and minimal. While all team members need to be apprised of the treatment plan, the main reason is to avoid inconsistencies. Staff's frustrations must be dealt with appropriately, but the primary focus for all treatment planning should be centered on meeting the client's needs.

16. A client with borderline personality disorder says to the nurse, ìI feel so comfortable talking with you. You seem to have a special way about you that really helps me.î Which would be the most appropriate response by the nurse?
    A) ìI'm glad you feel comfortable with me.î
    B) ìI'm here to help you just as all the staffs are.î
    C) ìYou feel others don't understand you?î
    D) ìI cannot be your friend. We need to be clear on that.î
    Ans: B
    Feedback:
    For the borderline personality disorder client, personal boundaries are unclear, and clients often have unrealistic expectations. Clients easily can misinterpret the nurse's genuine interest and caring as a personal friendship, and the nurse may feel flattered by a client's compliments. The nurse must be quite clear about establishing the boundaries of the therapeutic relationship to ensure that neither the client's nor the nurse's boundaries are violated.

17. When establishing a relationship with a client who has borderline personality disorder, which is most important for the nurse to do?
    A) Aggressively confront the client about boundary violations.
    B) Limit interactions to 10 minutes at a time.
    C) Respect the client's boundaries at all times.
    D) Tell the client the relationship will last as long as the client wishes.
    Ans: C
    Feedback:
    Clients with borderline personality disorder have issues with boundaries; by respecting the client's boundaries, the nurse can assist the client to develop better boundary control.

18. When planning care for a client with passive-aggressive personality disorder, the nurse will need to include interventions for which behavior?
    A) Avoidance of anxiety-provoking situations
    B) Compulsive needs for perfection and praise
    C) Dependence on others for decisions
    D) Procrastination and intentional inefficiency
    Ans: D
    Feedback:
    People who behave in a passive-aggressive way often do things late or in error as a means of protest rather than directly expressing their dissatisfaction or unwillingness. Answer choice A is consistent with anxiety disorders. Answer choice B correlates with behaviors seen in obsessiveñcompulsive disorder. Dependence on others for decisions occurs in clients with dependent personality disorder.

19. Which nursing interventions are most important in a plan of care for a client with histrionic personality disorder? Select all that apply.
    A) Teach social skills.
    B) Assist the client to eliminate passive behavior.
    C) Provide factual feedback about behavior.
    D) Try to meet the client's needs for attention.
    E) Acceptance of the behavior.
    Ans: A, C
    Feedback:
    Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking. Appropriate nursing interventions include teaching social skills and providing factual feedback about behavior. Acceptance of the behavior will cause the behavior to be intensified. Trying to meet the client's needs for attention is an inappropriate intervention since these clients are already seeking attention.

20. A client with dependent personality disorder has a goal to increase her problem-solving skills. Which client behavior would indicate progress toward meeting that goal?
    A) Asking questions
    B) Being polite
    C) Controlling emotional outbursts
    D) Requesting assistance appropriately
    Ans: A
    Feedback:
    Clients with dependent personality disorder are very passive, so asking questions to gain information is an assertive first step in problem solving. Being polite, controlling emotional outbursts, and requesting assistance appropriately are not behaviors that would increase problem-solving skills.

21. The nurse is talking to a client with schizoid personality disorder about finding a job. Which suggestion by the nurse would be most helpful?
    A) ìBeing a loner really limits your employment opportunities.î
    B) ìMaybe your friend could see if there is a night position available at the convenience store.î
    C) ìPerhaps working part-time at a fast-food restaurant would be something you could do.î
    D) ìThere is a job posting at the hospital for a file clerk in medical records.î
    Ans: D
    Feedback:
    Clients with schizoid disorder often work well in jobs with minimal interpersonal demands. ìBeing a loner really limits your employment opportunities,î is not a positive suggestion for this client. ìMaybe your friend could see it there is a night position available at a convenience store,î does not promote independence in finding a job, and a job at a convenience store would entail interpersonal demands. ìPerhaps working part-time at a fast-food restaurant would be something you could do,î would not be correct because working in a fast-food restaurant would involve the use of many interpersonal skills.

22. Which are important in the limit-setting technique to deal with manipulative behavior? Select all that apply.
    A) Stating the behavioral limit
    B) Identifying the consequences if the limit is exceeded
    C) Identifying the expected or desired behavior
    D) Providing choices
    E) Allowing flexibility
    Ans: A, B, C
    Feedback:
    Limit setting is an effective technique that involves three steps:
    1. Stating the behavioral limit (describing the unacceptable behavior)
    2. Identifying the consequences if the limit is exceeded
    3. Identifying the expected or desired behavior
    Providing choices and allowing flexibility would be counterproductive as the expectations must be consistent.

23. The nurse teaches an antisocial client to take a time-out in his room when challenged by another person instigating an argument. What is the main reason for the time-out?
    A) It allows time for the instigator to leave the area.
    B) It allows adequate space between the client and the instigating individual.
    C) It prevents the client from experiencing negative consequences of behavior.
    D) It allows an opportunity for the client to regain control of emotions.
    Ans: D
    Feedback:
    Managing emotions, especially anger and frustration, can be a major problem. Taking a time-out or leaving the area and going to a neutral place to regain internal control are often helpful strategies. Time-outs help clients to avoid impulsive reactions and angry outbursts in emotionally charged situations, regain control of emotions, and engage in constructive problem solving.

24. A nurse is teaching a client with borderline personality disorder to reshape thinking patters. Which is an example of a cognitive restructuring technique that would be helpful for this client?
    A) When negative thoughts begin, tell yourself ìstop.î
    B) Learn to look at situations realistically rather than assuming the worst.
    C) Recognize negative thoughts and replace them with positive ones.
    D) Express needs using ìIî statements.
    Ans: C
    Feedback:
    Cognitive restructuring is a technique useful in changing patterns of thinking by helping clients to recognize negative thoughts and feelings and to replace them with positive patterns of thinking. Thought stopping is a technique to alter the process of negative or self-critical thought patterns. When the thoughts begin, the client may actually say ìStop!î in a loud voice to stop the negative thoughts. Decatastrophizing is a technique that involves learning to assess situations realistically rather than always assuming a catastrophe will happen. Assertive communication involves using ìIî statements.

25. Upon admission, a client with a personality disorder identified the following as areas of concern for which the client would like help. According to studies, which will most likely be addressed by the health-care team?
    A) Psychological distress
    B) Self-care
    C) Sexual expression
    D) Budgeting
    Ans: A
    Feedback:
    The treatment of individuals with a personality disorder often focuses on mood stabilization, decreasing impulsivity, and developing social and relationship skills. In addition, clients perceive unmet needs in a variety of areas, such as self-care (keeping clean and tidy); sexual expression (dissatisfaction with sex life); budgeting (managing daily finances); psychotic symptoms; and psychological distress. Typically psychotic symptoms and psychological distress are often the only areas addressed by health-care providers.

26. A female client with borderline personality was formerly cooperative with the treatment regimen. Suddenly, the client believes the staff is working against her and is refusing all interaction and participation in treatment. The nurse feels very frustrated by this client's behavior. What is the best action for the nurse to take regarding personal frustration with this client?
    A) Discuss the feelings of frustration with the client in a one-to-one interaction.
    B) Discuss the frustration with a colleague or supervisor in a private setting.
    C) Set aside the frustration and focus on reassessing the client's needs.
    D) Research the client's diagnosis further to better understand the client's behaviors.
    Ans: B
    Feedback:
    Because clients with personality disorders take a long time to change their behaviors, attitudes, or coping skills, nurses working with them easily can become frustrated or angry. These clients continually test the limits, or boundaries, of the nurseñclient relationship with attempts at manipulation. Nurses must discuss feelings of anger or frustration with colleagues to help them recognize and cope with their own feelings.

27. Which challenges are posed when working with clients with personality disorders? Select all that apply.
    A) Clients with personality disorders are obviously unable to function more effectively.
    B) It can take a long time to change their behaviors, attitudes, or coping skills.
    C) The nurse can easily but mistakenly believe the client simply lacks motivation or the willingness to make changes.
    D) Clients with personality disorders challenge the ability of therapeutic staff to work as a team.
    E) Team members may have differing opinions about individual clients.

    Ans: B, C, D, E

    Feedback:

    It can take clients with a personality disorder a long time to change their behaviors, attitudes, or coping skills; and nurses working with them easily can become frustrated or angry. The nurse can easily but mistakenly believe the client simply lacks motivation or the willingness to make changes because clients with personality disorders look as though they are capable of functioning more effectively. Clients with personality disorders challenge the ability of therapeutic staff to work as a team. Team members may have differing opinions about individual clients.

28. Which techniques are important for nurses caring for clients with personality disorders to use in order to effectively provide care? Select all that apply.
    A) Discuss feelings of anger or frustration with colleagues to help them recognize and cope with their own feelings.
    B) Considering the client to be a personal friend.
    C) Employ ongoing communication with team members to remain firm and consistent about expectations for clients.
    D) Solving the problems of the client.
    E) Understanding that behavior changes in clients with personality disorders can occur quickly.

    Ans: A, C

    Feedback:

    Talking to colleagues about feelings of frustration will help you to deal with your emotional responses, so you can be more effective with clients. Clear, frequent communication with other health-care providers can help to diminish the client's manipulation. Set realistic goals and remember that behavior changes in clients with personality disorders take a long time. Progress can be very slow.

1. **Chapter 19** A community health nurse is planning a substance abuse prevention program. Which group would be the best target audience for the nurse to plan a program?
   A) Teenagers in a high school health class
   B) School-age children in an after-school program
   C) Parents attending a parentñteacher association meeting
   D) Elementary school teachers and counselors
   Ans: B
   Feedback:
   Forty-three percent of all Americans have been exposed to alcoholism in their families. Children of alcoholics are four times more likely than the general population to develop problems with alcohol. Many adult people in treatment programs as adults report having had their first drink of alcohol as a young child, when they were younger than age 10. With the increasing rates of use being reported among young people today, this problem could spiral out of control unless great strides can be made through programs for prevention, early detection, and effective treatment.

2. Which statements are important reasons for why the problem of substance abuse must be addressed? Select all that apply.
   A) Increasing numbers of infants are suffering the physiologic and emotional consequences of prenatal exposure to alcohol or drugs.
   B) Chemical abuse results in increased violence.
   C) Drug abuse costs business and industry an estimated $102 billion annually.
   D) Alcohol abuse is a too frequent cause of or contributor to death.
   E) Substance abuse is decreasing.
   Ans: A, B, C, D
   Feedback:
   Increasing numbers of infants are suffering the physiologic and emotional consequences of prenatal exposure to alcohol or drugs. Chemical abuse results in increased violence. Drug abuse costs business and industry an estimated $102 billion annually. Alcohol abuse is a too frequent cause of or contributor to death. Substance use/abuse and related disorders are a national health problem.

3. Which of the following groups could benefit most from prevention programs?
   A) Children, prior to first use
   B) Adults who have already engaged in substance abuse
   C) Older adults
   D) Infants
   Ans: A
   Feedback:
   Poor outcomes have been associated with an earlier age at onset and longer periods of substance use. Children who have not yet used substances may be easily influenced because of their age and the fact that they have not already become addicted. Adults who have already engaged in substance abuse will not benefit as greatly from prevention programs as will children. Older adults will not benefit as greatly from prevention programs as will children. Infants will not benefit from prevention programs as they do not have self-efficacy.

4. Which of the following neurochemical influences is a probable cause of substance abuse?
   A) Imbalances of serotonin and norepinephrine in the brain
   B) Inhibition of GABA in the brain
   C) Excessive serotonin activity in the CNS
   D) Stimulation of dopamine pathways in the brain
   Ans: D
   Feedback:
   Neurochemical influences on substance use patterns have been studied primarily in animal research (Jaffe & Anthony, 2005). The ingestion of mood-altering substances stimulates dopamine pathways in the limbic system, which produces pleasant feelings or a ìhighî that is a reinforcing, or positive, experience.

5. The nurse is assessing a client's risk factors for developing a substance abuse disorder. Which family characteristics would the nurse identify as a significant risk factor?
   A) One parent who is an alcoholic
   B) Parents who practiced strict discipline
   C) Overprotective parents
   D) Being raised in an urban area
   Ans: A
   Feedback:
   The strongest indication of risk factors comes from studies that indicate children of alcoholic parents are four times as likely to develop alcoholism that of nonalcoholic parents. Some theorists also believe that inconsistency in the parent's behavior, poor role modeling, and lack of nurturing pave the way for the child to adopt a similar style of maladaptive coping, stormy relationships, and substance abuse. Others hypothesize that even children who abhorred their family lives are likely to abuse substances as adults because they lack adaptive coping skills and cannot form successful relationships. Urban areas where drugs and alcohol are readily available also have high crime rates, high unemployment, and substandard school systems that contribute to high rates of cocaine and opioid use and low rates of recovery.

6. A client reports drinking one to two drinks when drinking behavior first began. Now the client reports drinking at least six drinks with every episode in order to ìhave a good time.î Which term would best describe this phenomenon?
   A) Dependence
   B) Intoxication
   C) Tolerance
   D) Withdrawal
   Ans: C
   Feedback:
   As the person continues to drink, he or she often develops a tolerance for alcohol; that is, he or she needs more alcohol to produce the same effect. Intoxication is use of a substance that results in maladaptive behavior. Withdrawal syndrome refers to the negative psychological and physical reactions that occur when use of a substance ceases or dramatically decreases. Substance dependence also includes problems associated with addiction such as tolerance, withdrawal, and unsuccessful attempts to stop using the substance.

7. The nurse is talking with the friend of a client with alcoholism. The friend tells the nurse that his relationship with the client was codependent and enabling. Which is an example of codependent behavior?
   A) The friend called Alcoholics Anonymous when the client expressed a need to stop drinking.
   B) The friend called the client every night to make sure he got home safely and went looking for him if he was not at home.
   C) The friend confronted the client on the effect of his drinking on their relationship.
   D) The friend refused to go out drinking with the client to celebrate the client's birthday.
   Ans: B
   Feedback:
   Codependent behavior appears helpful on the surface but actually prolongs the drinking behavior. The other choices are not examples of codependent behavior.

8. When interviewing the family members of a client being treated for substance abuse problems, which behavior would alert the nurse to the possibility of codependency?
   A) Being flexible but angry
   B) Blaming themselves for the family's problems
   C) Expressing thoughts and feelings openly
   D) Taking pleasure in self-accomplishments
   Ans: B
   Feedback:
   Self-blame is an example of maladaptive coping or codependent behavior. The other choices do not correlate with codependency behaviors.

9. The nurse is discussing the principles of 12-step programs for recovery with a client. Which statement is consistent with the principles of 12-step programs?
   A) The client will need to abstain from all substances for successful recovery.
   B) Once sober, the person can safely return to life as it was before becoming addicted.
   C) The prognosis for recovery is enhanced with the aid of maintenance medications.
   D) Recovery requires adherence to a plan of achieving long-term goals.
   Ans: A
   Feedback:
   Alcoholics Anonymous (AA) developed the 12-step program model for recovery, which is based on the philosophy that total abstinence is essential and that alcoholics need the help and support of others to maintain sobriety. Key slogans reflect the ideas in the 12 steps, such as ìone day at a timeî (approach sobriety one day at a time), ìeasy does itî (don't get frenzied about daily life and problems), and ìlet go and let Godî (turn your life over to a higher power).

10. Which characteristic of the 12-step program distinguishes it from other programs?
    A) The philosophy that it is possible to reduce the use of substances without abstaining.
    B) It is a self-help group that does not necessarily use health professionals as leaders.
    C) Persons who use this program are independent in their sobriety.
    D) Infrequent attendance is usually successful.
    Ans: B
    Feedback:
    Alcoholics Anonymous (AA) was founded in the 1930s by alcoholics. This self-help group developed the 12-step program model for recovery, which is based on the philosophy that total abstinence is essential and that alcoholics need the help and support of others to maintain sobriety. Regular attendance at meetings is emphasized.

11. Which slogans would be used in a 12-step program? Select all that apply.
    A) ìPull yourself together.î
    B) ìGet control of your problem.î
    C) ìOne day at a time.î
    D) ìEasy does it.î
    E) ìLet go and let God.î
    Ans: C, D, E
    Feedback:
    Before the illness of addiction was fully understood, most of the society and even the medical community viewed chemical dependency as a personal problem; the user was advised to ìpull yourself togetherî and ìget control of your problem.î Key slogans in AA reflect the ideas in the 12 steps, such as ìOne day at a timeî (approach sobriety one day at a time), ìeasy does itî (don't get frenzied about daily life and problems, and ìlet go and let Godî (turn your life over to a higher power).

12. The nurse is assessing the drinking history of a client being admitted for alcohol abuse. Which statement would the nurse expect the client to make?
    A) ìI really need some help. My drinking is tearing my family apart.î
    B) ìI have tried so many times to stop drinking. It is so hard.î
    C) ìI don't really have a problem with alcohol. I've just been having a streak of bad luck lately.î
    D) ìI have no intention to stop drinking. I like the way it makes me feel.î
    Ans: C
    Feedback:
    Substance use typically includes the use of defense mechanisms, especially denial. Clients may deny directly having any problems or may minimize the extent of problems or actual substance use. During assessment of thought process and content, clients are likely to minimize their substance use, blame others for their problems, and rationalize their behavior. They may believe that they could quit ìon their ownî if they wanted to, and they continue to deny or minimize the extent of the problem. Upon admission, the nurse would not expect the client have the insight to know how badly help is needed, or to express powerlessness over alcohol. The client would have some motivation for treatment if admission was underway. Often the motivation is external, such as pressure from family or employers.

13. A client in treatment for drug abuse makes the statement, ìI am a winner. You all are the losers because you can't beat this on your own.î What common characteristic of persons addicted to drugs is revealed in this statement?
    A) Realistic understanding of successful recovery of drug addiction
    B) Indication of an underlying personality disorder
    C) Brain damages resulting from chronic drug use
    D) Defending against a negative self-concept
    Ans: D
    Feedback:
    Clients generally have low self-esteem, which they may express directly or to cover with grandiose behavior. They do not feel adequate to cope with life and stress without the substance and often are uncomfortable around others when not using. They often have difficulty identifying and expressing true feelings.

14. A client is being discharged from treatment for addiction to cocaine. Which statement made by the client would cause the most concern for the nurse?
    A) ìI am going to take up a new hobby. It's time to start something new.î
    B) ìI can still hang out with my old friends. I am just not going to use.î
    C) ìI'm not very comfortable with being alone yet.î
    D) ìShooting baskets helps me not think about getting high.î
    Ans: B
    Feedback:
    Clients are likely to have exercised poor judgment. They may still believe they can control the substance use. The nurse can help clients to find ways to relieve stress or anxiety that do not involve substance use. Relaxing, exercising, listening to music, or engaging in activities may be effective. Clients also may need to develop new social activities or leisure pursuits if most of their friends or habits of socializing involved the use of substances. Acknowledging difficulties shows insight into the changes needed for recovery. Assuming that old friends will not be a relapse trigger shows a lack of understanding of the relapse dynamics associated with former leisure activities.

15. A client is being discharged on disulfiram (Antabuse). Which instruction for Antabuse should the client receive?
    A) Take disulfiram with food to avoid stomach upset.
    B) Skip the daily dose of disulfiram on days when consumption of alcoholic beverages is likely.
    C) Read products labels carefully to avoid all products containing alcohol.
    D) Disulfiram will prevent the desire to drink alcoholic beverages.
    Ans: C
    Feedback:
    The client must avoid a wide variety of products that contain alcohol such as cough syrup, lotions, mouthwash, perfume, aftershave, vinegar, and vanilla and other extracts. The client must read product labels carefully, because any product containing alcohol can produce symptoms. Ingestion of alcohol may cause unpleasant symptoms for 1 to 2 weeks after the last dose of disulfiram.

16. The client asks the nurse, ìWhat will happen if I drink while taking Antabuse?î What should be the nurse's reply?
    A) ìYou will not want to drink while taking Antabuse. It reduces the cravings.î
    B) ìYou will not get any effect from the alcohol you drink.î
    C) ìAntabuse will reverse the effects of alcohol.î
    D) ìYou will experience a severe reaction, including a throbbing headache and vomiting.î
    Ans: D
    Feedback:
    Disulfiram (Antabuse) may be prescribed to help deter clients from drinking. If a client taking disulfiram drinks alcohol, a severe adverse reaction occurs with flushing, a throbbing headache, sweating, nausea, and vomiting. In severe cases, severe hypotension, confusion, coma, and even death may result.

17. A nurse is exploring treatment options with a client addicted to heroin. Which information regarding the use of methadone is important for the nurse to include?
    A) Unlike heroin, methadone is nonaddicting.
    B) Methadone will meet the physical need for opiates without producing cravings for more.
    C) Methadone will produce a high similar to heroin.
    D) People taking methadone run the same risks associated with IV drug use as those taking heroin.
    Ans: B
    Feedback:
    Methadone, a potent synthetic opiate, is used as a substitute for heroin in some maintenance programs. The client takes one daily dose of methadone, which meets the physical need for opiates but does not produce cravings for more. Methadone does not produce the high associated with heroin. The client has essentially substituted his or her addiction to heroin for an addiction to methadone; however, methadone is safer because it is legal, controlled by a physician, and available in tablet form. The client avoids the risks of intravenous drug use, the high cost of heroin (which often leads to criminal acts), and the questionable content of street drugs.

18. A client with a history of heavy alcohol use, whose last drink was 24 hours ago, is seen in the emergency department. The client is oriented but is tremulous, weak, and sweaty and has some gastrointestinal (GI) symptoms. Which of the following is typical of these symptoms?
    A) Alcohol withdrawal syndrome
    B) Continuing intoxication
    C) Delirium tremens
    D) WernickeñKorsakoff syndrome
    Ans: A
    Feedback:
    Withdrawal from alcohol produces shakiness, weakness, diaphoresis, and GI symptoms. These are not symptoms of continuing intoxication. Delirium tremens produce hypertension, delusions, hallucinations, and agitated behavior. Wernicke-Korsakoff syndrome is a type of dementia caused by long-term, excessive alcohol intake that results in a chronic thiamine or vitamin B_6 deficiency.

19. A client with alcohol dependence is admitted to the hospital with pancreatitis. Which intervention should be included in the client's plan of care?
    A) Fluid restriction of 1000 mL per 24 hours
    B) Glucometer checks b.i.d.
    C) High-protein diet
    D) Protective isolation precautions
    Ans: B
    Feedback:
    Pancreatitis can cause elevated serum glucose levels. The other choices are not necessarily appropriate.

20. A client is admitted for a drug overdose with a Barbiturate? Which is the priority nursing action when planning care for this client?
    A) Check the client's belongings for additional drugs.
    B) Pad the side rails of the bed because seizures are likely.
    C) Prepare a dose of ipecac, an emetic.
    D) Monitor respiratory function.
    Ans: D
    Feedback:
    CNS depressants depress respiratory functioning. Answer choices A, B, and C would not be priority nursing actions in this situation.

21. A client is readmitted to the substance abuse program for the second time in 6 months for alcohol abuse. On admission, he tells the nurse, ìI am so ashamed.î What should the nurse reply?
    A) ìI really thought you would make it.î
    B) ìTell me what has happened since your last admission.î
    C) ìYou have nothing to be ashamed of.î
    D) ìWhy did you start drinking again?î
    Ans: B
    Feedback:
    This is a therapeutic communication technique designed to help the client talk about himself and his current situation.

22. A client has been admitted to the inpatient unit after using inhalants recently. Which is an antidote to treat inhalant toxicity?
    A) Ativan
    B) Narcan
    C) Antabuse
    D) There is no antidote
    Ans: D
    Feedback:
    There is no antidote or specific medication to treat inhalant toxicity. Ativan, Narcan, and Antabuse are not used to treat inhalant toxicity.

23. The nurse is coleading a family therapy group with a client addicted to alcohol. Which statement made by the wife indicates the need for additional education regarding alcoholism as a family illness?
    A) ìI have to call in sick for my husband when he is too hung over to go to work.î
    B) ìLast time he got arrested, I just let him sit in jail.î
    C) ìWe have separated our finances so that I will not go broke.î
    D) ìI take my kids with me to Al-anon meetings every week.î
    Ans: A
    Feedback:
    Alcoholism (and other substance abuse) often is called a family illness. One type of codependent behavior is called enabling, which is a behavior that seems helpful on the surface but actually perpetuates the substance use. Family members should be referred to Al-anon 12-step self-help groups.

24. A nurse is working with a couple seeking counseling for marital discord. The history indicates the husband was treated for substance abuse 4 years ago and attends AA meetings occasionally. Which statement made by the recovering husband should alert the nurse for the need for further education?
    A) ìI still need to go to AA meetings even though I have been sober for years.î
    B) ìAfter all these years, I just don't have the will power to stop if I started using again.î
    C) ìShe gets upset when I hang out with my old buddies on the weekends.î
    D) ìI wish I could be able to handle just one beer with dinner.î
    Ans: C
    Feedback:
    Family members and friends should be aware that clients who begin to revert to old behaviors, return to substance-using acquaintances, or believe they can ìhandle myself nowî are at high risk for relapse, and loved ones need to take action. The nurse must dispel myths and misconceptions such as, ìIt's a matter of will power,î ìI can't be an alcoholic if I only drink beer or if I only drink on weekends,î ìI can learn to use drugs socially,î or ìI'm okay now; I could handle using once in a while.î

25. A client calls the emergency department of the local hospital reporting that after 16 years of heavy drinking, he is tired and wants to quit ìcold turkey.î What would be the best response by the nurse?
    A) ìIt is not safe to stop drinking suddenly without medicine.î
    B) ìYou sound really motivated. Come in and we will help you find a treatment center.î
    C) ìAfter a few days of rest, you should feel much better as long as you do not drink anything.î
    D) ìYou will likely feel anxious and get a severe headache. Treat these symptoms with acetaminophen and rest, and come in if they do not get better in 3 to 5 days.î
    Ans: A
    Feedback:
    Because alcohol withdrawal can be life threatening, detoxification needs to be accomplished under medical supervision. If the client's withdrawal symptoms are mild and he or she can abstain from alcohol, he or she can be treated safely at home. For more severe withdrawal or for clients who cannot abstain during detoxification, a short admission of 3 to 5 days is the most common setting. Some psychiatric units also admit clients for detoxification, but this is less common.

26. An unconscious client is admitted to the emergency department after a motor vehicle accident. The client's blood alcohol level upon admission was 1.7. The client's family soon arrives, reporting that the client is an uncle who is visiting from out of town. They cannot give much more history other than that he is a ìsocial drinker.î After being transported to the unit, the client starts sweating and has elevated vital signs. What information should the nurse request of the family?
    A) Who is the next of kin?
    B) For what occasion is the uncle visiting from out of town?
    C) Does the uncle have a history of any sort of anxiety disorder?
    D) Are there other indications that the client may be a heavy drinker?
    Ans: D
    Feedback:
    It is important to assess the situation thoroughly and since the client is unconscious, he cannot communicate what is happening to the staff. The best chance for the staff to understand what is going on would be to inquire further of the relatives. If the client is experiencing withdrawal, detoxification needs to be initiated immediately under medical supervision. Symptoms of withdrawal usually begin 4 to 12 hours after cessation or marked reduction of alcohol intake. Symptoms include coarse hand tremors, sweating, elevated pulse and blood pressure, insomnia, anxiety, and nausea or vomiting. Severe or untreated withdrawal may progress to transient hallucinations, seizures, or deliriumócalled delirium tremens (DTs). Alcohol withdrawal usually peaks on the second day and is over in about 5 days.

27. The nurse is coleading a family therapy group for clients and families of drug-addicted individuals. The family of a cocaine addict is angry and cannot understand why the client cannot just stop using. The nurse guides the group to discuss their understanding of the nature of addiction. Which statements would the nurse identify as an accurate understanding of the nature of addiction? Select all that apply.
    A) It is a medical illness that is progressive.
    B) The client will eventually be cured.
    C) Relapses and remissions are part of the illness.
    D) Clients can learn to get control over the substance.
    Ans: A, C
    Feedback:
    Alcoholism (and other substance abuse) often is called a family illness. All those who have a close relationship with a person who abuses substances suffer emotional, social, and sometimes physical anguish. Client and family members need facts about the substance, its effects, and recovery. The nurse must dispel myths and misconceptions such as, ìIt's a matter of will power,î ìI can't be an alcoholic if I only drink beer or if I only drink on weekends,î ìI can learn to use drugs socially,î or ìI'm okay now; I could handle using once in a while.î

28. The wife of a client who is alcoholic asks the nurse how to respond to him in a helpful way when he is disruptive in family life. Which is the nurse's best response?
    A) ìHelp him avoid embarrassment by supporting him when he makes excuses for failing to meet obligations.î
    B) ìInclude him in family outings even when he is drinking.î
    C) ìSearch the house regularly for alcohol.î
    D) ìTry to maintain a normal home environment for yourself and the children.î
    Ans: D
    Feedback:
    Focusing on self and family members is the first step in breaking codependent behavior. Answer choices A, B, and C would not be the best response.

29. A client will be taking disulfiram (Antabuse) after discharge from an alcohol treatment program. Which statement would indicate that teaching has been effective?
    A) ìAntabuse is safe to take with any over-the-counter cold medication.î
    B) ìAntabuse will block my cravings for alcohol, so I'll have less desire to drink.î
    C) ìDrinking alcohol while taking Antabuse can cause dangerous symptoms.î
    D) ìIf I drink while taking Antabuse, it will make me vomit before the alcohol affects me.î
    Ans: C
    Feedback:
    Taking alcohol in any form while taking Antabuse causes a severe adverse reaction. Antabuse is not safe to take with OTC medications. It does not block cravings for alcohol. Antabuse does not restrict the effect of alcohol on the body.

30. A nurse suspects a coworker is signing out narcotics for clients and is using them herself. Which action should be taken by the nurse who has these suspicions?
    A) Ignore suspicions and leave it to the supervisor to intervene.
    B) Report the observations to the supervisor.
    C) Follow behind the coworker to ensure client comfort and safety.
    D) Confront the coworker about suspicions.
    Ans: B
    Feedback:
    Nurses have an ethical responsibility to report suspicious behavior to a supervisor and, in some states, a legal obligation as defined in the state's nurse practice act. Nurses should not try to handle such situations alone by warning the coworker; this often just allows the coworker to continue to abuse the substance without suffering any repercussions.

31. Which are general warning signs of substance abuse that a nurse should be alert for in coworkers? Select all that apply.
    A) Poor work performance
    B) Frequent absenteeism
    C) Unusual behavior
    D) Slurred speech
    E) Isolation from peers
    F) Substance abuse is not a problem in health professionals
    Ans: A, B, C, D, E
    Feedback:
    General warning signs of abuse include poor work performance, frequent absenteeism, unusual behavior, slurred speech, and isolation from peers. Physicians, dentists, and nurses have far higher rates of dependence on controlled substances, than other professionals of comparable educational achievement. One reason is thought to be the ease of obtaining controlled substances. Health-care professionals also have higher rates of alcoholism than the general population.

32. The nurse is working in an intensive care unit and observes that some clients do not respond to injections of diazepam (Valium) when the injections are given by a particular nurse. This nurse returns from lunch exhibiting slurred speech and euphoria. Which is the best action for the nurse to take?
    A) Ask other nurses if they have noticed anything unusual.
    B) Call the manager and report the observations.
    C) Observe the nurse as injections are prepared and administered.
    D) Tell the nurse, ìI know you've been stealing Valium.î
    Ans: B
    Feedback:
    Any suspicions should be communicated to someone in a supervisory position so that effective action can be taken.

33. A peer reports for work looking unkempt and disheveled. Her movements are uncoordinated, and her breath smells like mouthwash. Another nurse suspects this peer is intoxicated. What should be the action of the nurse who suspects that a peer is intoxicated?
    A) Immediately call the supervisor to report the peer's behavior.
    B) Ask the peer if she feels alright and express concern.
    C) Give the peer some information about the hospital's employee assistance program.
    D) Ignore the situation until someone else validates the observations.
    Ans: B
    Feedback:
    Client safety is a priority; the impaired nurse should not be caring for clients. After client safety is ensured, the nurse should call the supervisor to handle the situation. It is not the nurse's responsibility to give out information on the hospital's employee assistance program. It is not appropriate to ignore the situation.

34. A client is readmitted to the detox unit for the fourth time in 3 years. The nurse states in the morning report, ìNot again! Why should we keep trying to help this guy? He obviously doesn't want it.î What does this statement reflect?
    A) The nurse lacks the self-awareness to work effectively with this addicted client.
    B) The nurse understands the cycle of remission and relapse characteristic of addiction.
    C) The nurse has repressed negative emotions from past experiences with addiction.
    D) The nurse is trying to conceal his or her own addictions.
    Ans: A
    Feedback:
    Many clients experience periodic relapses. For some, being sober is a lifelong struggle. The nurse may become cynical or pessimistic when clients return for multiple attempts at substance use treatment. Such thoughts as ìhe deserves health problems if he keeps drinkingî or ìshe should expect to get hepatitis or HIV infection if she keeps doing intravenous drugsî are signs that the nurse has some self-awareness problems that prevent him or her from working effectively with clients and their families. It is not appropriate to assume that the nurse is trying to conceal his or her own addictions.

35. Which reasons make it necessary for the nurse to examine his or her beliefs and attitudes about substance abuse? Select all that apply.
    A) The nurse may be overly harsh and critical of the client.
    B) The nurse may unknowingly act out old family roles and engage in enabling behavior.
    C) The nurse or close friends and family of the nurse may abuse substances.
    D) The nurse may have different attitudes about various substances of abuse.
    E) The nurse is not likely to have had any experience with substance abuse.

    Ans: A, B, C, D

    Feedback:

    The nurse must examine his or her beliefs and attitudes about substance abuse. A history of substance abuse in the nurse's family can strongly influence his or her interaction with clients. The nurse may be overly harsh and critical. Conversely, the nurse may unknowingly act out old family roles and engage in enabling behavior. Examining one's own substance use or use by close friends and family may be difficult and unpleasant but is necessary if the nurse is to have therapeutic relationships with clients. The nurse also might have different attitudes about various substances of abuse. Health-care professionals also have higher rates of alcoholism than the general population. With the pervasive nature of substance abuse nationally, odds are great that nurses and other health professionals have been affected by substance abuse in their lives.

1. **Chapter 20** A 15-year-old female is admitted for treatment of anorexia nervosa. Which is characteristic of anorexia nervosa?
   A) Body weight less than normal for age, height, and overall physical health
   B) Amenorrhea for at least two cycles
   C) Absence of hunger feelings
   D) Erosion of dental enamel
   Ans: A
   Feedback:
   Anorexia nervosa is a life-threatening eating disorder characterized by the client's refusal or inability to maintain a minimally normal body weight, intense fear of gaining weight or becoming fat, significantly disturbed perception of the shape or size of the body, and steadfast inability or refusal to acknowledge the seriousness of the problem or even that one exists. Clients with anorexia have a body weight that is less than the minimum expected weight, considering their age, height, and overall physical health. In addition, clients have a preoccupation with food and food-related activities and can have a variety of physical manifestations. Physical problems or anorexia nervosa include amenorrhea, constipation, overly sensitive to cold, lanugo hair on body, hair loss, dry skin, dental caries, pedal edema, bradycardia, enlarged parotid glands, hypothermia, and electrolyte imbalance. These clients do not lose their appetites. They still experience hunger but ignore it and signs of physical weakness and fatigue. Dental erosion is characteristic of bulimia nervosa.

2. The nurse is assessing a client with bulimia nervosa. Which of the following symptoms would the nurse expect to find? Select all that apply.
   A) Cold intolerance
   B) Normal weight for height
   C) Dental erosion
   D) Hypotension
   E) Metabolic alkalosis
   Ans: B, C, E
   Feedback:
   The weight of clients with bulimia usually is in the normal range, although some clients are overweight or underweight. Recurrent vomiting destroys tooth enamel, and incidence of dental caries and ragged or chipped teeth increases in these clients. Metabolic alkalosis often results from vomiting. Cold intolerance and hypotension are symptoms associated with emaciation seen in anorexia nervosa.

3. Which eating disorder is characterized by consuming an amount of food much larger than a person would normally eat and of near-normal weight? Afterward, the client may purge the food or exercise excessively, and between binges, the client may eat low-calorie foods or fast.
   A) Anorexia nervosa
   B) Bulimia nervosa
   C) Pica
   D) Rumination
   Ans: B
   Feedback:
   Bulimia nervosa, often simply called bulimia, is an eating disorder characterized by recurrent episodes of binge eating followed by inappropriate compensatory behaviors to avoid weight gain, such as purging, fasting, or excessively exercising. The amount of food consumed during a binge episode is much larger than a person would normally eat. Between binges, the client may eat low-calorie foods or fast. Anorexia nervosa is a life-threatening eating disorder characterized by the client's refusal or inability to maintain a minimally normal body weight, intense fear of gaining weight or becoming fat, significantly disturbed perception of the shape or size of the body, and steadfast inability or refusal to acknowledge the seriousness of the problem or even that one exists. The weight of clients with bulimia usually is in the normal range. Pica is persistent ingestion of nonfood substances. Rumination is repeated regurgitation of food that is then rechewed, reswallowed, or spit out.

4. When working with the family of a client with anorexia nervosa, which of the following issues must be addressed?
   A) Codependence
   B) Control issues
   C) Self-discipline
   D) Sexual identity
   Ans: B
   Feedback:
   Clients with anorexia often believe the only control they have is over their eating and weight; all other aspects of their life are controlled by their family. Codependence, self-discipline, and sexual identity are not pertinent issues to address with the family.

5. During an initial interview at a clinic, a young female client states that there is nothing wrong with her. Which would indicate to the nurse that this client might have anorexia nervosa?
   A) Episodes of overeating and excessive weight gain
   B) Expressions of a positive self-concept
   C) Flexible thought patterns and spontaneity
   D) Severe weight loss due to self-imposed dieting
   Ans: D
   Feedback:
   Clients with anorexia starve themselves and lose a large proportion of body weight, yet call it dieting. In anorexia nervosa, clients do not have excessive weight gain or overeat. Clients have a negative self-concept. Clients with anorexia nervosa exhibit inflexible thinking and limited spontaneity.

6. What is the primary difference between anorexia nervosa and bulimia nervosa?
   A) Anorexia has a psychological basis, whereas the cause of bulimia is biologic.
   B) Clients who are anorexic are proud of their control over eating, and clients with bulimia are ashamed of their behavior.
   C) Bulimia can be life threatening, whereas anorexia is seldom so.
   D) There is no real difference between these two types of disorders.
   Ans: B
   Feedback:
   Clients with bulimia know their behavior is pathologic and are ashamed of it; clients with anorexia think they are fine and see no problem with their weight-control efforts. Anorexia nervosa is a life-threatening eating disorder. Studies of anorexia nervosa and bulimia nervosa have shown that these disorders tend to run in families.

7. While assessing the family dynamics of a client with an eating disorder, which of the following does the nurse most likely discover?
   A) Multiple siblings
   B) Lack of interest in the client by other family members
   C) Supportive and encouraging relationships
   D) Over controlling parents
   Ans: D
   Feedback:
   Two essential tasks of adolescence are the struggle to develop autonomy and the establishment of a unique identity. Autonomy may be difficult in families that are overprotective or in which enmeshment (lack of clear role boundaries) exists. Such families do not support members' efforts to gain independence, and teenagers may feel as though they have little or no control over their lives. They begin to control their eating through severe dieting and thus gain control over their weight. Losing weight becomes reinforcing: by continuing to lose, these clients exert control over one aspect of their lives.

8. The nurse understands that which biologic factors may influence the development of an eating disorder? Select all that apply.
   A) Family history of eating disorders
   B) Dysfunction of the hypothalamus
   C) Norepinephrine imbalances
   D) First-degree relatives with psychotic disorder
   E) Decreased serotonin levels
   Ans: A, B, C, E
   Feedback:
   Studies of anorexia nervosa and bulimia nervosa have shown that these disorders tend to run in families, or it may directly involve a dysfunction of the hypothalamus. A family history of mood or anxiety disorders (e.g., obsessiveñcompulsive disorder) places a person at risk for an eating disorder. Low norepinephrine levels are seen in clients during periods of restricted food intake. Also, low epinephrine levels are related to the decreased heart rate and blood pressure seen in clients with anorexia. Low levels of serotonin as well as low platelet levels of monoamine oxidase have been found in clients with bulimia and the binge and purge subtype of anorexia nervosa.

9. Which factors may contribute to the frequency of eating disorders in adolescents? Select all that apply.
   A) Media portrayal of slimness as an ideal
   B) Body dissatisfaction in adolescent females
   C) Stress-free existence of adolescents
   D) Body image disturbance
   E) Seeking autonomy
   F) Seeking to develop a unique identity
   Ans: A, B, D, E, F
   Feedback:
   Two essential tasks of adolescence are the struggle to develop autonomy and the establishment of a unique identity. In families in which enmeshment exists, adolescents begin to control their eating through severe dieting and thus gain control over their weight. Adolescent girls who express body dissatisfaction are most likely to experience adverse outcomes. The need to develop a unique identity, or a sense of who one is as a person, is another essential task of adolescence. It coincides with the onset of puberty, which initiates many emotional and physiologic changes. Self-doubt and confusion can result if the adolescent does not measure up to the person she or he wants to be. Advertisements, magazines, and movies that feature thin models reinforce the cultural belief that slimness is attractive. Body image disturbance occurs when there is an extreme discrepancy between one's body image and the perceptions of others and extreme dissatisfaction with one's body image.

10. Several medications are prescribed for a client who has anorexia. Which medication may be prescribed to help treat the client's distorted body image?
    A) Amitriptyline (Elavil)
    B) Cyproheptadine (Periactin)
    C) Olanzapine (Zyprexa)
    D) Fluoxetine (Prozac)
    Ans: C
    Feedback:
    Several classes of drugs have been studied, but few have shown clinical success. Amitriptyline (Elavil) and the antihistamine cyproheptadine (Periactin) in high doses (up to 28 mg/day) can promote weight gain in clients with anorexia nervosa. Olanzapine (Zyprexa) has been used with success because of its antipsychotic effect (on bizarre body image distortions) and associated weight gain. Fluoxetine (Prozac) has some effectiveness in preventing relapse in clients whose weight has been partially or completely restored. However, close monitoring is needed because weight loss can be a side effect.

11. The nurse uses cognitiveñbehavioral approaches to assist the client with bulimia toward recovery. Which statement by the nurse would be consistent with this approach?
    A) ìIs there any way you can look at that sandwich as fuel for your body?î
    B) ìYou have to eat in moderation for good nutrition.î
    C) ìYou seem to have a really hard time controlling your eating patterns.î
    D) ìIs this your way of showing your family that you can make decisions?î
    Ans: A
    Feedback:
    CBT has been found to be the most effective treatment for bulimia. This outpatient approach often requires a detailed manual to guide treatment. Strategies designed to change the client's thinking (cognition) and actions (behavior) about food focus on interrupting the cycle of dieting, binging, and purging and altering dysfunctional thoughts and beliefs about food, weight, body image, and overall self-concept.

12. Which may help a person to overcome an eating disorder that causes weight gain?
    A) Being ashamed of his or her body image
    B) Believing that gaining weight is a side effect of unhealthy lifestyle behaviors and losing weight is a side effect of healthy lifestyle behaviors
    C) Being reminded that every morsel of food he or she consumes will make him or her fat
    D) Knowing that his or her current weight is abnormal
    Ans: B
    Feedback:
    Cognitiveñbehavioral therapy has been found to be the most effective treatment for bulimia. Strategies designed to change the client's thinking (cognition) and actions (behavior) about food focus on interrupting the cycle of dieting, binging, and purging and altering dysfunctional thoughts and beliefs about food, weight, body image, and overall self-concept. All of the other statements are factors that may reinforce the continuing cycle of an eating disorder.

13. The nurse is assessing a client with an eating disorder. Which personality characteristic would the nurse expect to detect when interacting with the client?
    A) Careless
    B) Outspoken
    C) Defiance
    D) Eager to please
    Ans: D
    Feedback:
    Family members often describe clients with anorexia nervosa as perfectionists with above-average intelligence, achievement oriented, dependable, eager to please, and seeking approval before their condition began. Parents describe clients as being ìgood, causing us no troubleî until the onset of anorexia. Likewise, clients with bulimia often are focused on pleasing others and avoiding conflict.

14. When documenting the mental status exam findings in the chart of a client with anorexia, the nurse notes poor judgment and insight. Which client statement would support this impression?
    A) ìI know I have a problem. I need help.î
    B) ìOthers are just trying to keep me from looking good.î
    C) ìI know my weight is a little below normal.î
    D) ìThose weight charts are for normal people. I am not normal.î
    Ans: B
    Feedback:
    Clients with anorexia have very limited insight and poor judgment about their health status. They do not believe they have a problem; rather, they believe others are trying to interfere with their ability to lose weight and to achieve the desired body image. Facts about failing health status are not enough to convince these clients of their true problems.

15. All of the following nursing diagnoses are appropriate for the care of a client with anorexia. Which nursing diagnosis has the highest priority?
    A) Activity intolerance
    B) Ineffective coping
    C) Chronic low self-esteem
    D) Imbalanced nutrition: less than body requirements
    Ans: D
    Feedback:
    Nursing diagnoses for clients with eating disorders include imbalanced nutritionóless than/more than body requirements, activity intolerance, ineffective coping, and chronic low self-esteem. When prioritizing nursing diagnoses, physical needs must be met before psychosocial needs (apply Maslow's hierarchy of needs). Of the physical needs, nutritional imbalances pose a more acute threat than decreased activity levels. When addressing psychosocial needs, improving coping skills will eventually lead to rise in self-esteem.

16. Which nursing intervention would be most likely to help the client with anorexia to establish healthy eating patterns?
    A) Leave the client alone to relax during meals.
    B) Offer liquid protein supplements if the client is unable to complete meal.
    C) Observe the client for 30 minutes after all meals.
    D) Weigh the client weekly in the same clothing at the same time of day.
    Ans: B
    Feedback:
    Nursing interventions designed to establish nutritional eating patterns include sitting with the client during meals and snacks, giving a liquid protein supplement to replace any food not eaten to ensure consumption of the total number of prescribed calories, adhering to treatment program guidelines regarding restrictions, observing the client following meals and snacks for 1 to 2 hours, weighing client daily in uniform clothing, and being alert for attempts to hide or discard food or inflate weight.

17. The nurse is assisting the client with anorexia to express feelings more openly. Which response by the nurse would be most likely to encourage expression of feelings?
    A) ìAre you sad?î
    B) ìYou look anxious.î
    C) ìTell me what you are feeling right now.î
    D) ìTell me when you feel bad.î
    Ans: C
    Feedback:
    Because clients with anorexia have problems with self-awareness, they often have difficulty identifying and expressing feelings. Therefore, they often express these feelings in terms of somatic complaints such as feeling fat or bloated. The nurse can help clients begin to recognize emotions by asking them to describe how they are feeling and allowing adequate time for response. The nurse should not ask, ìAre you sad?î or ìAre you anxious?î because a client may quickly agree rather than struggle for an answer. The nurse encourages the client to describe her or his feelings. This approach can eventually help clients to recognize their emotions and to connect them to their eating behaviors.

18. The nurse is teaching a client with bulimia to use self-monitoring techniques. Which client statement would let the nurse know that this has been effective?
    A) ìI am learning to recognize events and emotions that trigger my binges and am working on responses other than binging and purging.î
    B) ìI am beginning to understand how my lack of self-control is hurting me.î
    C) ìI am keeping a record of everything I eat and how I am feeling every day.î
    D) ìI am getting more comfortable confronting people when I have conflict with them.î

    Ans: A

    Feedback:

    Self-monitoring is a cognitiveñbehavioral technique designed to help clients with bulimia. The nurse encourages clients to keep a diary of all food eaten throughout the day, including binges, and to record moods, emotions, thoughts, circumstances, and interactions surrounding eating and binging or purging episodes. In this way, clients begin to see connections between emotions and situations and eating behaviors. The nurse can then help clients to develop ways to manage emotions such as anxiety by using relaxation techniques or distraction with music or another activity.

19. The nurse understands that before a client with an eating disorder can accept their body image, he or she must first learn effective coping skills. Which statement best describes the relationship between body image and coping skills?
    A) Coping skills are dependent on a supportive upbringing.
    B) When body image is positive, the client will develop better coping skills.
    C) Being able to cope in healthy ways improves the ability to accept a realistic body image.
    D) Neurotransmitters that are deficient in clients with eating disorders prohibit the development of effective coping skills.

    Ans: C

    Feedback:

    When clients experience relief from emotional distress, have increased self-esteem, and can meet their emotional needs in healthy ways, they are more likely to accept their weight and body image.

20. When preparing a client with bulimia for discharge, the nurse suggests that the client and family continue with family therapy on an outpatient basis. Which of the following is the rationale for this suggestion?
    A) Family members often need to learn role independence and autonomy.
    B) Family members need to learn to monitor for signs of client relapse.
    C) Family relationships need to be strengthened due to a lifetime of disengagement.
    D) Family members often feel jealous of the attention the client has been receiving in treatment.

    Ans: A

    Feedback:

    Dysfunctional relationships with significant others often are a primary issue for clients with eating disorders. In addition, support groups in the community or via the internet can offer support, education, and resources to clients and their families or significant others.

21. Which nursing diagnosis would be most difficult to successfully resolve in a client who had anorexia nervosa?
    A) Imbalanced nutritionóless than body requirements
    B) Disturbed body image
    C) Deficient knowledge (nutritious eating patterns)
    D) Social isolation

    Ans: B

    Feedback:

    The client's dissatisfaction with body image is an enduring belief pattern that is firmly ingrained and, therefore, very difficult to change. Imbalanced nutritionóless than body requirements, deficient knowledge (nutritious eating patterns), and social isolation are nursing diagnoses that can be worked through with education and support more easily than the diagnosis of disturbed body image.

22. Which of the following interventions would be appropriate for a client with anorexia nervosa?
    A) Allowing the client to eat whenever she feels hungry
    B) Insisting that the client sit in the dining room until all food is eaten
    C) Having the client in view of staff for 90 minutes after each meal
    D) Permitting the client to eat any food she chooses, as long as she is eating

    Ans: C

    Feedback:

    Many clients with anorexia also have purging behavior; even those who have not purged previously may begin to do so when they are unable to restrict their eating. Answer choices A, B, and D do not promote healthy eating behaviors.

23. Which is the primary objective of nursing interventions in the care of a client with anorexia nervosa?
    A) Changing her irrational thinking about her body
    B) Establishing a target weight to be achieved by discharge
    C) Restoring nutritional status to normal
    D) Gaining insight into the effects of anorexia on her physical health
    Ans: C
    Feedback:
    Physiologic safety and homeostasis are the priority concerns. Changing of thought pattern, establishing a target weight, and gaining insight into the effects of anorexia on her physical health are not immediate goals in the management of anorexia nervosa.

24. Which nursing statement is most effective in communicating a positive expectation of the client?
    A) ìI'll give you 90 minutes to eat.î
    B) ìI will allow you space to eat in peace.î
    C) ìI will sit here quietly with you while you eat.î
    D) ìThere are people who would truly appreciate this food.î
    Ans: C
    Feedback:
    This statement reflects the nurse's expectation that the client will eat, yet the nurse still will provide adequate supervision. The other choices are not appropriate means of assuming a positive expectation of the client.

25. A 16-year-old female with anorexia nervosa is admitted to the unit. Which is the most appropriate short-term outcome?
    A) The client will accept herself as having value and worth.
    B) The client will admit she has a fear of gaining weight.
    C) The client will follow a nutritionally balanced diet for her age.
    D) The client will identify her problems and potential alternative coping strategies.
    Ans: B
    Feedback:
    Admitting her fears is an initial step in recovery. Accepting herself as having value and worth, following a nutritionally balanced diet, and identifying problems and potential alternative coping strategies are examples of long-term outcomes.

26. A nurse is presenting information to a community group about health. Which information should the nurse provide regarding calorie restriction diets at an early age in children?
    A) Dieting helps build a positive self-image in children.
    B) Dieting during childhood restricts essential nutrients needed for normal growth.
    C) Dieting at an early age teaches healthy eating habits.
    D) Dieting at an early age may lead to the development of eating disorders.
    Ans: D
    Feedback:
    A specific cause for eating disorders is unknown. Initially, dieting may be the stimulus that leads to their development. Dieting is also associated with the risk factor of dissatisfaction with body image. Children need well-balanced diets rather than calorie restriction diets. Eating patterns during childhood are often carried into adulthood.

27. The nurse is teaching the family of a client who has bulimia about nutritional needs. Which dietary pattern would be most helpful to assist the client in recovering from bulimia?
    A) Provide the client a diet of mainly vegetables and salads.
    B) Encourage the entire family to engage in a balanced and regular dietary pattern.
    C) Encourage autonomy by allowing the client to have total control over food choices.
    D) Insist that the client complete all meals provided.
    Ans: B
    Feedback:
    The nurse provides extensive teaching about basic nutritional needs and the effects of restrictive eating, dieting, and the binge and purge cycle. Clients need encouragement to set realistic goals for eating throughout the day. Eating only salads and vegetables during the day may set up clients for later binges as a result of too little dietary fat and carbohydrates. The client with an eating disorder will not make healthy food choices independently. It is also not possible for family and friends to force the client to eat.

28. Which of the following would be most supportive for family and friends of a client with an eating disorder?
    A) Emotional support, love, and attention
    B) Focus on food intake, calories, and weight
    C) Unlimited access to unhealthy foods that the client enjoys
    D) Positive reinforcement for weight gain
    Ans: A
    Feedback:
    The nurse explains to family and friends that they can be most helpful by providing emotional support, love, and attention. They can express concern about the client's health, but it is rarely helpful to focus on food intake, calories, and weight. Eating disorders can be viewed on a continuum with clients with anorexia eating too little or starving themselves, clients with bulimia eating chaotically, and clients with obesity eating too much.

29. The nurse has been teaching the client's family about the client's eating disorder, anorexia nervosa. Which statement would indicate that teaching was effective?
    A) ìWe will eat our evening meals together with no exceptions.î
    B) ìWe will negotiate resolutions to family conflicts.î
    C) ìWe will spend less time discussing troublesome family members.î
    D) ìWe will give her frequent encouragement for eating well and maintaining her weight.î
    Ans: B
    Feedback:
    Families of clients with eating disorders typically put too much emphasis on food and are less skilled at discussing family conflicts and allowing the client to begin gaining independence. ìWe will eat our evening meals together with no exception,î allows little or no compromise; the client needs to be able to make decisions for him or herself. ìWe will spend less time discussing troublesome family members,î indicates that the client is a problem to the family. ìWe will give her frequent encouragement for eating well and maintaining her weightî indicates that family members can express concern about the client's health, but it is rarely helpful to focus on food intake, calories, and weight.

30. The nurse has been teaching a client about bulimia. Which statement by the client indicates that the teaching has been effective?
    A) ìI know if I eat pasta, I'll binge.î
    B) ìI'll eat small meals and snacks regularly.î
    C) ìI'll take my medication when I feel the urge to binge.î
    D) ìI'll limit my intake of carbohydrates and fats.î
    Ans: B
    Feedback:
    Teaching is effective when the client recognizes the need to return to nutritious eating patterns. Answer choices A, C, and D would not be appropriate responses to teaching regarding bulimia nervosa.

31. A client who has an eating disorder is becoming dependent on the nurse for direction in food choices. Which approach by the nurse would demonstrate the nurse's self-awareness?
    A) Approach the client with an adult-like objectivity.
    B) Give the support and direction that the client is seeking.
    C) Give approval for positive changes seen in the client.
    D) Take care of the needs that the client is neglecting.
    Ans: A
    Feedback:
    Avoid sounding parental when teaching about nutrition or why laxative use is harmful. Presenting information factually without chiding the client will obtain more positive results. Be empathetic and nonjudgmental, although this is not easy. Remember the client's perspective and fears about weight and eating. Do not label clients as ìgoodî when they avoid purging or eat an entire meal. Otherwise, clients will believe they are ìbadî on days when they purge or fail to eat enough food.

1. **Chapter 21** Psychosomatic illness refers to physical symptoms that are either created or worsened by psychic influences. Which conditions are thought to be attributed to the connection between mind and body? Select all that apply.
   A) Diabetes
   B) Arthritis
   C) Hypertension
   D) Headache
   E) Colitis
   Ans: A, C, D, E
   Feedback:
   The term psychosomatic is used to convey the connection between the mind (psyche) and the body (soma) in states of health and illness. Essentially, the mind can cause the body to create physical symptoms or to worsen physical illnesses. Real symptoms can begin, continue, or be worsened as a result of emotional factors. Examples include diabetes, hypertension, and colitis, all of which are medical illnesses influenced by stress and emotions. In addition, stress can cause physical symptoms unrelated to a diagnosed medical illness such as ìtension headaches.î

2. Which of the following are possible with psychosomatic illness? Select all that apply.
   A) Real symptoms can begin.
   B) Real symptoms can continue.
   C) Real symptoms can worsen.
   D) Unrelated symptoms can occur.
   E) Clients can control these symptoms.
   Ans: A, B, C, D
   Feedback:
   The term psychosomatic is used to convey the connection between the mind (psyche) and the body (soma) in states of health and illness. Essentially, the mind can cause the body to create physical symptoms or to worsen physical illnesses. Real symptoms can begin, continue, or be worsened as a result of emotional factors. Examples include diabetes, hypertension, and colitis, all of which are medical illnesses influenced by stress and emotions. In addition, stress can cause physical symptoms unrelated to a diagnosed medical illness. Clients do not willfully control the physical symptoms.

3. The client asks the nurse, ìWhat does having psychosomatic symptoms mean?î What should the nurse reply?
   A) ìIt means you're not physically sick.î
   B) ìIt means that stress and/or emotions are causing your symptoms.î
   C) ìIt means that you'll be well when you get your life in order.î
   D) ìIt means that your symptoms are a product of your imagination.î
   Ans: B
   Feedback:
   Clients who do not cope well with stress or emotions develop physical symptoms that are real as a means of coping. Answer choices A, C, and D are inappropriate responses.

4. Which is the primary gain associated with developing physical symptoms in response to stress?
   A) Accept dependency
   B) Decrease anxiety
   C) Experience attention
   D) Suppress anger
   Ans: B
   Feedback:
   Primary gain is always relief of stress, anxiety, or conflicting/unacceptable emotions. They are the direct external benefits that being sick provides, such as relief from anxiety, conflict, or distress.

5. A client with a somatic symptom illness asks what is causing her physical symptoms. Which would be the appropriate explanation for the nurse to offer?
   A) Physical symptoms can be attributed to an organic cause.
   B) Physical symptoms are deliberately expressed in order to benefit in some way.
   C) Physical symptoms are independent of the amount of the client's psychic distress.
   D) Physical symptoms are an involuntary way of dealing with psychic conflict.
   Ans: D
   Feedback:
   Somatic symptom illnesses can be characterized as the presence of physical symptoms that suggest a medical condition without a demonstrable organic basis to account fully for them. The three central features of somatic symptom are as follows: physical complaints suggest major medical illness, but have no demonstrable organic basis; psychological factors and conflicts seem important in initiating, exacerbating, and maintaining the symptoms; and symptoms or magnified health concerns are not under the client's conscious control.

6. The husband of a woman with a somatic symptom illness asks the nurse why the doctors cannot find anything wrong with her. Which would be the appropriate explanation for the nurse to offer?
   A) ìShe is not really experiencing the symptoms. She is making them up to get attention.î
   B) ìThere is no physical cause. Mental distress is causing the symptoms, even though she is not aware of it.î
   C) ìShe controls the symptoms when she isn't feeling much stress. It is hard to diagnose when the symptoms are intermittent.î
   D) ìThere is a physical cause. It just has not been detected yet.î
   Ans: B
   Feedback:
   Clients are convinced they harbor serious physical problems despite negative results during diagnostic testing. They actually experience these physical symptoms as well as the accompanying pain, distress, and functional limitations such symptoms induce. Clients do not willfully control the physical symptoms. Nurses must remember that these clients really experience the symptoms they describe and cannot voluntarily control them.

7. Which is the primary gain for a client with conversion disorder?
   A) Emotional detachment
   B) Emotional support from family
   C) Identification of anxious feelings
   D) Relief from emotional conflict
   Ans: D
   Feedback:
   An emotional conflict precedes the development of conversion disorder; the conversion disorder relieves that specific emotional conflict. Emotional detachment and emotional support from the family or identification of anxious feelings are not examples of primary gain in clients diagnosed with conversion disorder. Secondary gains are the internal or personal benefits received from others because one is sick, such as attention from family members.

8. A client with somatic symptom illness tells the nurse that she is sick so often that her husband and children take over most of the household duties, such as cooking, cleaning, doing laundry, and so forth. Which is this evidence of?
   A) Dysfunctional family unit
   B) Primary gain
   C) Role reversal
   D) Secondary gain
   Ans: D
   Feedback:
   Secondary gains involve increased attention and relief from normal responsibilities and expectations when clients are ill. This is not an example of a dysfunctional family unit or role reversal. A primary gain is the direct external benefits that being sick provides.

9. Psychosocial theorists propose that somatic symptom illnesses are an indirect expression of stress and anxiety through physical symptoms. Which is the primary defense mechanism used in somatoform disorders?
   A) Somatization
   B) Identification
   C) Internalization
   D) Repression
   Ans: C
   Feedback:
   Psychosocial theorists believe that people with somatic symptom illnesses keep stress, anxiety, or frustration inside rather than expressing them outwardly. This is called internalization. Clients express these internalized feelings and stress through physical symptoms (somatization). Both internalization and somatization are unconscious defense mechanisms. Identification is trying to ease distress by emulating others whom one admires. Repression is the unconscious exclusion of distressing situations from one's memory.

10. Which are the factors that are currently considered to be possible reasons for the increased incidence of somatization in women? Select all that apply.
    A) Boys in the United States are taught to be stoic and to ìtake it like a man,î causing them to offer fewer physical complaints as adults.
    B) Women seek medical treatment more often than men, and it is more socially acceptable for them to do so.
    C) Childhood sexual abuse, which is related to somatization, happens more frequently to girls.
    D) Women more often receive treatment for psychiatric disorders with strong somatic components such as depression.
    E) Unexplained female pains result from migration of the uterus throughout the woman's body.

    Ans: A, B, C, D

    Feedback:

    Somatization is associated most often with women, as evidenced by the old term hysteria (Greek for ìwandering uterusî). Ancient theorists believed that unexplained female pains resulted from migration of the uterus throughout the woman's body. Psychosocial theorists posit that increased incidence of somatization in women may be related to various factors:

    ï Boys in the United States are taught to be stoic and to ìtake it like a man,î causing them to offer fewer physical complaints as adults.

    ï Women seek medical treatment more often than men, and it is more socially acceptable for them to do so.

    ï Childhood sexual abuse, which is related to somatization, happens more frequently to girls.

    ï Women more often receive treatment for psychiatric disorders with strong somatic components such as depression.

11. A client is seen in the primary care clinic complaining of headaches. The client appears extremely distressed and insists that she must have a brain tumor. Which diagnosis is most probable for this client?
    A) Conversion disorder
    B) Pain disorder
    C) Brain cancer
    D) Hypochondriasis

    Ans: D

    Feedback:

    Hypochondriasis is preoccupation with the fear that one has a serious disease (disease conviction) or will get a serious disease (disease phobia). It is thought that clients with this disorder misinterpret bodily sensations or functions. Conversion disorder, sometimes called conversion reaction, involves unexplained, usually sudden deficits in sensory or motor function. Pain disorder has the primary physical symptom of pain, which generally is unrelieved by analgesics and greatly affected by psychological factors in terms of onset, severity, exacerbation, and maintenance.

12. An actor has prepared extensively for his first stage production. On the morning of the opening of the play, the actor awakens with laryngitis. From which disorder is the actor most likely suffering?
    A) Acute upper respiratory infection
    B) Conversion disorder
    C) Hysteria
    D) Somatization disorder
    Ans: B
    Feedback:
    Conversion disorder, sometimes called conversion reaction, involves unexplained, usually sudden deficits in sensory or motor function (e.g., blindness, paralysis). These deficits suggest a neurologic disorder but are associated with psychological factors. There is usually significant functional impairment. The term hysteria refers to multiple physical complaints with no organic basis; the complaints are usually described dramatically. Somatization disorder is characterized by multiple physical symptoms and includes a combination of pain and gastrointestinal, sexual, and pseudoneurologic symptoms.

13. The nurse is planning care for a client with somatic symptom illness disorder. Which should the nurse plan to reassess on a daily basis?
    A) Sensory deficits experienced by the client
    B) Character of pain reported by the client
    C) Frequency of generalized somatic complaints
    D) Signs of possible neurologic disorders
    Ans: C
    Feedback:
    Somatic symptom illness is characterized by multiple physical symptoms. The frequency of generalized somatic complaints will give the nurse information about the current status of the disorder. Conversion disorder involves unexplained, usually sudden deficits in sensory or neurologic motor function and might be manifested by sensory deficits being experienced by the client. Pain disorder has the primary physical symptom of pain and would be reassessed with the description of the character of any pain reported by the client. If the nurse would reassess for signs of possible neurologic disorders, it may serve to reinforce to the client that there might be something wrong.

14. A newly graduated nurse is scheduled to take the NCLEX-RN examination in 3 days. On awakening today, the graduate cannot see anything at all but tells fellow classmates, ìOh, don't worry; it will all work out.î Which might this statement result from?
    A) La belle indifference
    B) Regression
    C) Malingering
    D) Undoing
    Ans: A
    Feedback:
    People with a conversion disorder may be seemed to lack concern or distress about the functional loss. This is called la belle indifference. Regression would be when the person reverted to a previous level of functioning. Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding work, evading criminal prosecution, obtaining financial compensation, or obtaining drugs. This is not an example of undoing.

15. A middle-aged client goes to the physician falsely complaining of hip pain. The client's intention is to fake chronic hip pain to apply for disability benefits from the government. Which best reflects the client's potential diagnosis?
    A) Malingering
    B) Hypochondriasis
    C) Factitious disorder
    D) Munchausen's syndrome by proxy
    Ans: A
    Feedback:
    Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms; it is motivated by external incentives such as avoiding work, evading criminal prosecution, obtaining financial compensation, or obtaining drugs. Hypochondriasis is preoccupation with the fear that one has a serious disease (disease conviction) or will get a serious disease (disease phobia). Factitious disorder occurs when a person intentionally produces or feigns physical or psychological symptoms solely to gain attention. Munchausen's syndrome by proxy occurs when a person inflicts illness or injury on someone else to gain the attention of emergency medical personnel or to be a ìheroî for saving the victim.

16. Which of the following accurately describes how somatic symptoms are distinguished from factitious disorders and malingering?
    A) Munchausen's syndrome cannot be controlled by persons who have it.
    B) Persons who experience somatic disorders intentionally produce symptoms for some external purpose or gain.
    C) In malingering or factitious disorders, people willfully control the symptoms, and in somatic symptom illnesses, clients do not voluntarily control their physical symptoms.
    D) People who experience somatic symptom illnesses can stop the physical symptoms as soon as they have gained what they wanted.

    Ans: C

    Feedback:

    In malingering or factitious disorders, people willfully control the symptoms, and in somatic symptom illnesses, clients do not voluntarily control their physical symptoms. Munchausen's disorder is the common term for factitious disorder, imposed on self and occurs when a person intentionally produces or feigns physical or psychological symptoms solely to gain attention. People with factitious disorders may even inflict injury on themselves to receive attention. Persons who experience somatic disorders are unable to control their symptoms. People who experience somatic symptom illnesses cannot stop their physical symptoms. However, people who malinger can stop the physical symptoms as soon as they have gained what they wanted.

17. Which of the following terms are applicable when a person inflicts illness or injury on someone else to gain the attention of emergency medical personnel or to be a ìheroî for saving the victim?
    A) Malingering
    B) Factitious disorder
    C) Munchausen's syndrome by proxy
    D) Induced illness

    Ans: C

    Feedback:

    A variation of factitious disorder, imposed on others, is commonly called Munchausen's syndrome by proxy and occurs when a person inflicts illness or injury on someone else to gain the attention of emergency medical personnel or to be a ìheroî for saving the victim. Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms; it is motivated by external incentives such as avoiding work, evading criminal prosecution, obtaining financial compensation, or obtaining drugs. Factitious disorder, imposed on self, occurs when a person intentionally produces or feigns physical or psychological symptoms solely to gain attention. Induced illness is another name for factitious disorder.

18. The nurse is caring for a client who was in a motorcycle accident 2 months ago. The client says he still has terrible neck pain, but he will be better once he gets ìa big insurance settlement.î What condition might the nurse suspect?
    A) Hypochondriasis
    B) La belle indifference
    C) Conversion reaction
    D) Malingering
    Ans: D
    Feedback:
    Malingering is suspected when the client is exaggerating physical complaints for some type of material gain. Hypochondriasis is a preoccupation with the fear that one has a serious disease. La belle indifference is a seeming lack of concern or distress about a functional loss. A conversion reaction involves unexplained, usually sudden, deficits in sensory or motor function related to an emotional conflict the client experiences but does not handle directly.

19. A client is seeking relief for undiagnosed pain. There is no history of significant physical illness. The history reveals that the client was laid off 4 months ago from her job. Which statement made by the client would most strongly suggest a somatoform disorder?
    A) ìI have been having a hard time lately. It's hard not working like I'm used to.î
    B) ìI seem to have more pain now that I got laid off.î
    C) ìI probably just overexerted myself working around the house. It's hard to slow down.î
    D) ìI'm sure they will figure out what is wrong with me.î
    Ans: B
    Feedback:
    Clients are unlikely to be able to think about or to respond to questions about emotional feelings. They will answer questions about how they feel in terms of physical health or sensations. For example, the nurse may ask, ìHow did you feel about having to quit your job?î The client might respond, ìWell, I thought I'd feel better with the extra rest, but my back pain was just as bad as ever.î Recognizing the emotional difficulties of a lifestyle change or feeling relaxed about symptoms is not expected for a client with a somatic symptom illness.

20. The nurse performs a thorough physical examination for a client being admitted for a somatic symptom illness. Which of the following is the best rationale for the physical exam?
    A) Ease the client's mind that the nurse is looking for physical illness.
    B) Physical disorders underlie somatic disorders.
    C) Physical exams are reimbursed by third-party payers.
    D) Underlying pathology should be ruled out.
    Ans: D
    Feedback:
    The nurse must investigate physical health status thoroughly to ensure that there is no underlying organic pathology requiring treatment. When a client has been diagnosed with a somatic symptom illness, it is important not to dismiss all future complaints because at any time the client could develop a physical condition that would require medical attention.

21. The client states, ìI can't go to group today. I have a very upset stomach this morning.î Which would be the nurse's most appropriate response?
    A) ìYou have to go to group. The doctor has ordered it.î
    B) ìOkay, you can miss this time.î
    C) ìI know you don't feel well, but it's important for you to participate in therapy.î
    D) ìYou aren't really feeling nauseous. It is part of your illness.î
    Ans: C
    Feedback:
    The challenge for the nurse is to validate the client's feelings while encouraging her or him to participate in activities. The nurse should not strip clients of their somatizing defenses until adequate assessment data are collected and other coping mechanisms are learned. The nurse should not attempt to confront clients about somatic symptoms or attempt to tell them that these symptoms are not ìreal.î They are very real to clients who actually experience the symptoms and associated distress.

22. The nurse has encouraged the client with a somatic symptom illness to keep a journal. Which treatment outcome might be met by journaling?
    A) The nurse will control external stressors that trigger the patient's physical symptoms.
    B) The nurse will assess the onset of physical symptoms.
    C) The client will express emotions privately.
    D) The client will identify the occurrence of physical symptoms when stressed.
    Ans: D
    Feedback:
    Teaching about the relationship between stress and physical symptoms is a useful way to help clients begin to see the mindñbody relationship. Clients may keep a detailed journal of their physical symptoms. The nurse might ask them to describe the situation at the time such as whether they were alone or with others, whether any disagreements were occurring, and so forth. The journal may help clients to see when physical symptoms seemed worse or better and what other factors may have affected that perception.

23. The nurse is working with the client to develop emotion-focused coping strategies. Which should the nurse include as an emotion-focused coping strategy?
    A) Problem solving
    B) Assertiveness techniques
    C) Role-playing
    D) Deep breathing techniques
    Ans: D
    Feedback:
    Emotion-focused coping strategies include progressive relaxation, deep breathing, guided imagery, and distractions such as music or other activities. Problem-focused coping strategies include learning problem-solving methods, applying the process to identified problems, and role-playing interactions with others.

24. The nurse is identifying outcomes for a client with a somatic symptom illness. Which is an appropriate outcome to include in the plan of care?
    A) The client will verbally express his or her emotions.
    B) The client will be free from stress.
    C) The client will demonstrate alternative ways to avoid stressful situations.
    D) The client will verbalize acceptance of physical symptoms.
    Ans: A
    Feedback:
    Treatment outcomes for clients with a somatic symptom illness may include the following: the client will identify the relationship between stress and physical symptoms; the client will verbally express emotional feelings; the client will follow an established daily routine; the client will demonstrate alternative ways to deal with stress, anxiety, and other feelings; the client will demonstrate healthier behaviors regarding rest, activity, and nutritional intake. It is unrealistic for the client to be free from stress or avoid stressful situations.

25. A client with recurrent headaches has been told by the physician that the cause is likely psychosomatic. The client reports this conversation to the nurse and says, ìThat just can't be true! My head hurts so bad sometimes that it makes me sick to my stomach.î Which is the nurse's best response?
    A) To give the client some privacy and time to calm down
    B) To say nothing and sit quietly with the client
    C) ìThe pain in your head is very real.î
    D) ìWell, that's not what your doctor thinks.î
    Ans: C
    Feedback:
    When the nurse says, ìThe pain in your head is very real,î the nurse is validating the client's pain as real. The client is asking for some type of validation. In the situation presented, the client's headaches are very real to him or her. The client needs to talk out the feelings regarding what the physician has told him or her. It would be inappropriate for the nurse to say nothing. To give the client some privacy and time to calm down is not indicated. ìWell, that's not what your doctor thinks,î would put the client on the defensive.

26. Which are appropriate long-term treatment outcomes for clients who have somatic symptom illness? Select all that apply.
    A) The client will assume responsibility for self-care activities.
    B) The client will identify the relationship between stress and physical symptoms.
    C) The client will learn to vary his or her schedule.
    D) The client will verbally express emotional feelings.
    E) The client will demonstrate alternative ways to deal with stress, anxiety, and other feelings.

    Ans: B, D, E

    Feedback:

    Somatic symptom illnesses are chronic or recurrent, so changes are likely to occur slowly. If treatment is effective, the client should make fewer visits to the physician as a result of physical complaints, use less medication and more positive coping techniques, and increased functional abilities. Improved family and social relationships are also a positive outcome that may follow improvements in the client's coping abilities. Treatment outcomes for clients with a somatic symptom illness may include the following:

    ï The client will identify the relationship between stress and physical symptoms.
    ï The client will verbally express emotional feelings.
    ï The client will follow an established daily routine.
    ï The client will develop alternative ways to deal with stress, anxiety, and other feelings.
    ï The client will demonstrate healthier behaviors regarding rest, activity, and nutritional intake.

27. The family members of a client with somatic symptom illness report to the nurse that every time they invite the client to join in an activity the client declines, saying things like, ìI wish I could, but I feel so terrible.î Which of the following approaches should the nurse suggest to encourage activity?
    A) ìWhat does your pain feel like right now?î
    B) ìYou are fine, the doctor said so. Let's go.î
    C) ìI know this is difficult, but exercise is important. It will be a short walk.î
    D) ìI'll let you rest. Let me know when you feel better.î

    Ans: C

    Feedback:

    The nurse must help the client and family learn how to establish a daily routine that includes improved health behaviors. Family members should expect resistance, including protests from the client that she or he does not feel well enough to do these things. The challenge is to validate the client's feelings while encouraging her or him to participate in activities.

28. The husband of a client with hypochondriasis has accompanied his wife to the follow-up doctor's visit. While waiting for the doctor, the husband expresses to the nurse his frustration with his wife's obsession about illness. He asks the nurse, ìWhat can I do?î The best response by the nurse would be,
    A) ìTry ignoring her complaints, and they should subside.î
    B) ìTry finding an activity you enjoy doing together to help her feel better overall.î
    C) ìTry to be the client and understand that she is worried that she is sick.î
    D) ìTry to give her some sort of reward when she resists complaining about her illnesses.î

    Ans: B

    Feedback:

    Building a trusting relationship with the client, providing empathy and support, and being sensitive to rather than dismissive of complaints are skills that the nurse can use in any setting where clients are seeking assistance. Encouraging clients to find pleasurable activities or hobbies may help to meet their needs for attention and security.

29. Which statement would indicate to the nurse that the client has understood somatic symptom illness?
    A) ìAs soon as my symptoms go away, I'll be my old self again.î
    B) ìHow I handle stress and emotions can affect my physical health.î
    C) ìI have to avoid stress all my life to avoid getting sick again.î
    D) ìTaking medication won't help my pain since it's caused by stress.î

    Ans: B

    Feedback:

    Clients who come to understand that how they cope with stress affects their physical health demonstrate an understanding of somatization disorder. Clients with somatization disorder eventually may be treated in mental health settings. It is an unreality to avoid all stress in one's life.

30. A client yells at the nurse, ìYou are all quacks! Can't you see I am sick?î Which knowledge would help the nurse to work most effectively with this client?
    A) Client progress is expected to be very slow.
    B) Physical illness is the root of the client's problems.
    C) The client will never be free of somatic symptoms.
    D) The nurse has done everything possible to treat the client.
    Ans: A
    Feedback:
    Clients who cope through physical symptoms can be frustrating for the nurse. Initially, they are unwilling to consider that anything other than major physical illness is the root of all their problems. The client's progress is slow and painstaking, if any change happens at all. The nurse should be realistic about the small successes that can be achieved in any given period. To enhance the ongoing relationship, the nurse must be able to accept the client and his or her continued complaints and criticisms while remaining nonjudgmental.

1. **Chapter 22** The nurse is assessing a 16-month-old child during a well-baby checkup. Which of the following behaviors would be consistent with autism spectrum disorder? Select all that apply.
   A) The child displays little eye contact with others.
   B) The child thrives on changes in routine.
   C) The child makes few facial expressions toward others.
   D) The child does not like repetition.
   E) The child answers questions verbally.

   Ans: A, C, D

   Feedback:

   Children with autism display little eye contact with and make few facial expressions toward others; they use limited gestures to communicate. They have limited capacity to relate to peers or parents. They lack spontaneous enjoyment, express no moods or emotional affect, and cannot engage in play or make-believe with toys. There is little intelligible speech. These children engage in stereotyped motor behaviors such as hand flapping, body twisting, or head banging.

2. A mother expresses concern to the nurse that the child's regularly scheduled vaccines may not be safe. The mother states that she has heard reports that they cause autism. The most appropriate response by the nurse is,
   A) ìIt is recommended that you wait until the child is older to vaccinate.î
   B) ìThere are safer alternative immunizations available now.î
   C) ìThere has been no research to establish a relationship between vaccines and autism.î
   D) ìThe risks do not outweigh the benefits of immunization against childhood diseases.î

   Ans: C

   Feedback:

   The National Institute of Child Health and Human Development, Centers for Disease control (CDC) and the Academy of Pediatrics have all conducted research studies for several years and have concluded that there is no relationship between vaccines and autism and that the MMR vaccine is safe.

3. A parent is concerned that his child might suffer from attention deficit hyperactivity disorder (ADHD). Which of the following behaviors reported by the parent would be consistent with this diagnosis?
   A) The child interrupts others.
   B) The child has been hoarding objects.
   C) The child has lots of friends.
   D) The child is excelling academically in school.
   Ans: A
   Feedback:
   By the time the child starts school, symptoms of ADHD begin to interfere significantly with behavior and performance. He or she cannot listen to directions or complete tasks. The child interrupts and blurts out answers before questions are completed. Academic performance suffers because the child makes hurried, careless mistakes in schoolwork, often loses or forgets homework assignments, and fails to follow directions. Socially, peers may ostracize or even ridicule the child for his or her behavior. The child often loses necessary things.

4. Which of the following symptoms are characteristic of ADHD? Select all that apply.
   A) Enuresis
   B) Inattentiveness
   C) Encopresis
   D) Overactivity
   E) Impulsiveness
   Ans: B, D, E
   Feedback:
   ADHD is characterized by inattentiveness, overactivity, and impulsiveness. Encopresis is the repeated passage of feces into inappropriate places such as clothing or the floor by a child who is at least 4 years of age either chronologically or developmentally. Enuresis is the repeated voiding of urine during the day or at night into clothing or bed by a child at least 5 years of age either chronologically or developmentally. Encopresis and enuresis are elimination disorders that are unrelated to ADHD.

5. Which of the following are common coexisting psychiatric disorders for adults with ADHD? Select all that apply.
   A) Social phobia
   B) Bipolar disorder
   C) Obsessiveñcompulsive disorder
   D) Major depression
   E) Alcohol dependence
   Ans: A, B, D, E
   Feedback:
   Approximately 70% to 75% of adults with ADHD have at least one coexisting psychiatric diagnosis, with social phobia, bipolar disorder, major depression, and alcohol dependence being the most common.

6. A nurse asks an assigned client, ìHow are you doing today?î The client responds with ìdoing today, doing today, doing today.î Which speech pattern disturbance is this an example of?
   A) Reactive attachment disorder
   B) Stereotypic movement disorder
   C) Selective mutism
   D) Echolalia
   Ans: D
   Feedback:
   Echolalia is repeating the last heard sound, word, or phrase. Stereotypic movement disorders include waving, rocking, twirling objects, biting fingernails, handing the head, biting or hitting oneself, or picking at the skin or body orifices. Selective mutism is characterized by persistent failure to speak in social situations where speaking is expected.

7. Which of the following terms describes the repeating of one's own words or sounds?
   A) Coprolalia
   B) Palilalia
   C) Echolalia
   D) None of the above
   Ans: B
   Feedback:
   Palilalia is the repeating of one's own words or sounds. Coprolalia is the use of socially unacceptable words, which are frequently obscene. Echolalia is the repeating of the last heard sound, word, or phrase.

8. Which of the following disorders involves problems with forming sounds associated with speech?
   A) Phonologic disorder
   B) Mixed receptiveñexpressive language disorder
   C) Expressive language disorder
   D) Stuttering
   Ans: A
   Feedback:
   Phonologic disorder involves problems with articulation. Mixed receptiveñexpressive language disorder includes problems of expressive language disorder along with difficulty understanding and determining the meaning of words and sentences. Expressive language disorder involves an impaired ability to communicate through verbal and sign language. Stuttering is a disturbance of the normal fluency and time patterning of speech.

9. A parent of a child with autism spectrum disorder asks the nurse if there is anything that can be done to control the child's tantrums. Which option should the nurse inform the parents that may be appropriate?
   A) Give the child rewards for resisting tantrums.
   B) Reason with the child why tantrums are not effective.
   C) Place the child in a time-out when tantrums occur.
   D) Explore the use of antipsychotic medications to control tantrums.
   Ans: D
   Feedback:
   Pharmacologic treatment with antipsychotics, such as haloperidol (Haldol) or risperidone (Risperdal), may be effective for specific target symptoms such as temper tantrums, aggressiveness, self-injury, hyperactivity, and stereotyped behaviors.

10. A child with ADHD complains to his parents that he does not like the side effects of his medicine, Adderall. The parents ask the nurse for suggestions to reduce the medication's negative side effects. The nurse can best help the parents by offering which advice?
    A) Give the child his medicine at night.
    B) Have the child eat a good breakfast and snacks late in the day and at bedtime.
    C) Limit the number of calories the child eats each day.
    D) Let the child take daytime naps.
    Ans: B
    Feedback:
    Giving stimulants during daytime hours usually effectively combats insomnia. Eating a good breakfast with the morning dose and substantial nutritious snacks late in the day and at bedtime helps the child to maintain an adequate dietary intake. Daytime napping for a child with ADHD is unrealistic and not developmentally necessary.

11. The nurse is assisting a child with ADHD to complete his ADLs. Which is the best approach for nurse to use with this child?
    A) Break tasks into small steps.
    B) Let the child complete tasks at his own pace.
    C) Offer rewards when all tasks are completed.
    D) Set a time limit to complete all tasks.
    Ans: A
    Feedback:
    Before beginning any task, adults must gain the child's full attention. The adult should tell the child what needs to be done and break the task into smaller steps if necessary. This approach prevents overwhelming the child and provides the opportunity for feedback about each set of problems he or she completes.

12. Which of the following would be important circumstances to gather assessment data for a child with ADHD? Select all that apply.
    A) Direct observation of the child
    B) Reviewing the client's record
    C) Interviewing the client's parents
    D) Interviewing the client's teachers
    E) Assessing the client in a group of peers
    Ans: A, C, D, E
    Feedback:
    During assessment, the nurse gathers information through direct observation and from the child's parents, day care providers (if any), and teachers. Assessing the child in a group of peers is likely to yield useful information because the child's behavior may be subdued or different in a focused one-to-one interaction with the nurse. Reviewing the client's record will not yield much assessment data.

13. Which one of the following nursing interventions should take priority for a child with ADHD?
    A) Structured daily routine
    B) Ensuring the child's safety and that of others
    C) Simplifying instructions and directions
    D) Improved role performance
    Ans: B
    Feedback:
    Safety of the child and others is always a priority. The other nursing interventions are appropriate for a child with ADHD, but the priority is safety.

14. An 8-year-old with attention deficit hyperactivity disorder is jumping off the bed onto a chair. Which should be the nurse's first step?
    A) ìI need to talk to you.î
    B) ìStop that right now.î
    C) ìYou are going to hurt yourself.î
    D) ìWhy are you jumping off the bed?î
    Ans: B
    Feedback:
    If the child is engaged in a potentially dangerous activity, the first step is to stop the behavior. Attempting to talk to or reason with a child engaged in a dangerous activity is unlikely to succeed because his or her ability to pay attention and to listen is limited.

15. The mother of a 6-year-old boy with attention deficit hyperactivity disorder asks to speak to the nurse about her son's disruptive behavior. The nurse would be most therapeutic by saying which of the following?
    A) ìYour son is a cute child, but he needs to calm down.î
    B) ìIt must be difficult to handle your son at home.î
    C) ìYou need to take a firmer approach with your son.î
    D) ìYour son sure is active.î
    Ans: B
    Feedback:
    Parents find themselves chronically exhausted mentally and physically. Parents need support and reassurance, and making a statement about the difficulties of handling the child at home validates the mother's feelings. It is not appropriate to say, ìYour son is a cute child, but he needs to calm down.î It may make the parents defensive to say, ìYou need to take a firmer approach with your son.î ìYour son sure is activeî is not a therapeutic response.

16. A child with attention deficit hyperactivity disorder is taking methylphenidate (Ritalin) in divided doses. If the child takes the first dose at 8 AM, which behavior might the school nurse expect to see at noon?
    A) Increased impulsivity or hyperactive behavior
    B) Lack of appetite for lunch
    C) Sleepiness or drowsiness
    D) Social isolation from peers
    Ans: A
    Feedback:
    Ritalin has a short half-life, so doses are needed about every 4 hours during the day to maintain symptom control. Giving stimulants during daytime hours usually effectively combats insomnia.

17. The parents of an autistic child ask the nurse, ìWill my child ever be normal?î Which would be the most appropriate response by the nurse?
    A) ìYou seem worried about your child's future.î
    B) ìAutistic children can fully recover with the right treatment and education.î
    C) ìYour child should outgrow autistic traits by adolescence.î
    D) ìYour child will probably always have some autistic traits.î
    Ans: D
    Feedback:
    Autistic traits persist into adulthood, and most people with autism remain dependent to some degree on others. Manifestations vary from little speech and poor daily living skills throughout life to adequate social skills that allow relatively independent functioning. Social skills rarely improve enough to permit marriage and child rearing.

18. The parents of a child with ADHD express to the nurse, ìWe get so frustrated when our son never minds us.î Which parenting strategies should the nurse discuss with the parents? Select all that apply.
    A) Use time-out for behavior control.
    B) Provide occasional rewards and consequences for behavior.
    C) Give verbal reprimands for negative behavior.
    D) Resist giving praise until fully compliant with requests.
    E) Use a point system for positive and negative behavior.
    Ans: A, C, E
    Feedback:
    Educating parents and helping them with parenting strategies are crucial components of effective treatment of ADHD. Effective approaches include providing consistent rewards and consequences for behavior, offering consistent praise, using time-out, and giving verbal reprimands. Additional strategies are issuing daily report cards for behavior and using point systems for positive and negative behavior.

19. Which one of the following statements about educating parents of a child with ADHD is true?
    A) It is unimportant to educate the family members about ADHD as they already know the problem too well.
    B) Parents feel empowered and relieved to have specific strategies that can help them and their child be more successful.
    C) It is important for the nurse to spend the majority of his or her time with parents of children with ADHD in talking to the parents.
    D) If the child receives special school services under the Individuals with Disabilities Education Act, there is no need for further services.

    Ans: B

    Feedback:

    Parents feel empowered and relieved to have specific strategies that can help them and their child be more successful. Including parents in planning and providing care for the child with ADHD is important. The nurse must listen to the parents' feelings. The education of a child with ADHD is important, but the child is only in school for part of their day. The parents must deal with the child and the other aspects of the child's life at all times.

20. A nurse is providing education to a group of parents who have children with ADHD. Which of the following statements would be accurate and should be included in the education? Select all that apply.
    A) Medication alone will adequately treat children with ADHD.
    B) It is important for parents of children with ADHD to learn how to rebuild their child's self-esteem.
    C) Because raising a child with ADHD can be frustrating and exhausting, it often helps parents to attend support groups that can provide information and encouragement from other parents with the same problems.
    D) ADHD is not the fault of the parents or the child, and that techniques and school programs are available to help.
    E) Children with ADHD do not qualify for special school services under the Individuals with Disabilities Education Act.

    Ans: B, C, D

    Feedback:

    Although medication can help reduce hyperactivity and inattention and allow the child to focus during school, it is by no means a cure-all. The child needs strategies and practice to improve social skills and academic performance. Because these children are often not diagnosed until the second or third grade, they may have missed much basic learning for reading and math. Parents should know that it takes time for them to catch up with other children of the same age. Most of these children have low self-esteem because they have been labeled as having behavior problems and have been corrected continually by parents and teachers for not listening, not paying attention, and misbehaving. Parents must understand how to help rebuild their child's self-esteem. Parents should give positive comments as much as possible to encourage the child and acknowledge his or her strengths. One technique to help parents to achieve a good balance is to ask them to count the number of times they praise or criticize their child each day for several days. ADHD is not the fault of the parents or the child, and that techniques and school programs are available to help. Children with ADHD do qualify for special school services under the Individuals with Disabilities Education Act.

21. When teaching the parents of a child with attention deficit hyperactivity disorder (ADHD), which statement by the parents would indicate the need for further teaching?
    A) ìWe'll have him do his homework at the kitchen table with his brothers and sisters.î
    B) ìWe'll make sure he completes one task before going on to another.î
    C) ìWe'll set up rules with specific times for eating, sleeping, and playing.î
    D) ìWe'll use simple, clear directions and instructions.î

    Ans: A

    Feedback:

    The child with ADHD cannot accomplish complex tasks, such as homework, in a noisy or chaotic setting where there are a lot of distractions. The other choices do not indicate the need for further teaching.

22. Which statement would indicate that medication teaching for the parents of a 6-year-old child with attention deficit hyperactivity disorder (ADHD) has been effective?
    A) ìWe'll teach him the proper way to take the medication, so he can manage it independently.î
    B) ìWe'll be sure he takes Ritalin at the same time every day, just before bedtime.î
    C) ìWe're so glad that Ritalin will eliminate the problems of ADHD.î
    D) ìWe'll be sure to record his weight on a weekly basis.î
    Ans: D
    Feedback:
    Stimulant medications used to treat ADHD can suppress appetite, and the child may lose or fail to gain weight properly. The client is too young to manage his medications independently. Ritalin should be given in divided doses. Ritalin reduces hyperactivity, impulsivity, and mood lability and helps the child to pay attention more appropriately.

23. The mother of a 15-year-old boy tells the nurse that her son is becoming more assertive in conflict situations and wants to get a job. She asks if it is healthy for a 15-year-old to be so independent. Which is valid information for the nurse to offer the mother?
    A) His behaviors reflect normal growth and development.
    B) He is overly independent.
    C) It sounds like he is trying to avoid her.
    D) She should observe for signs of substance abuse.
    Ans: A
    Feedback:
    The behaviors described by the mother are typical in terms of growth and development for a 15-year-old. The other choices are not found to give valid information to the mother regarding increased adolescent independence.

24. The nurse understands that when working with a child with a mental health problem, the family must be included in the care. Which is one of the best ways the nurse can advocate for the child?
    A) Support transferring the child to a healthy living environment.
    B) Teach the parents age-appropriate expectations of the child.
    C) Reinforce the parents' expectations of the child's behavior.
    D) Interpret the child's thoughts and feelings to the parent.
    Ans: B
    Feedback:
    Working with parents is a crucial aspect of dealing with children with these disorders. Parents often have the most influence on how these children learn to cope with their disorders. The nurse can teach parents age-appropriate activities and expectations for clients.

25. For which reason is it crucial for nurses to advocate for children and adolescents regarding psychiatric disorders?
    A) It is much more difficult to diagnose psychiatric disorders in children and adolescents.
    B) It is not necessary because psychiatric disorders do not occur in children and adolescents.
    C) Children and adolescents experience some of the same mental health problems as adults.
    D) Psychiatric disorders in children manifest themselves very quickly.
    Ans: A
    Feedback:
    It is much more difficult to diagnose psychiatric disorders in children and adolescents. Many of the same psychiatric disorders that affect adults also occur in children and adolescents, but because psychiatric disorders in children are difficult to diagnose, they do not manifest themselves very quickly.

26. For which reasons is it more difficult to diagnose psychiatric disorders in children than in adults? Select all that apply.
    A) Children usually lack the abstract cognitive abilities and verbal skills to describe what is happening.
    B) Because they are constantly changing and developing, children are unable to discriminate unusual or unwanted symptoms from normal feelings and sensations.
    C) Behaviors that are appropriate for a child of one developmental level may be inappropriate for a child of a different developmental level.
    D) Sometimes, children ìoutgrowî psychiatric disorders.
    E) Children and adolescents experience some of the same mental health problems as adults and are diagnosed using the same criteria as for adults.
    Ans: A, B, C
    Feedback:
    Psychiatric disorders are not diagnosed as easily in children as they are in adults. Children usually lack the abstract cognitive abilities and verbal skills to describe what is happening. Because they are constantly changing and developing, children have limited sense of a stable, normal self to allow them to discriminate unusual or unwanted symptoms from normal feelings and sensations. Additionally, behaviors that are normal in a child of one age may indicate problems in a child of another age. Sometimes the manifestations of psychiatric disorders in adults are less of a problem than they were for the child at a younger age, but this does not make it more difficult to diagnose psychiatric disorders in children than in adults. Children and adolescents experience some of the same mental health problems as adults and are diagnosed using the same criteria as for adults, but this does not make it more difficult for children to be diagnosed.

27. The nurse has been working with the family of a small child with a psychiatric disorder. The nurse is feeling very frustrated because the parents refuse to implement effective parenting skills that the nurse has taught. What is the best action for the nurse at this time?
    A) Review effective disciplinary practices with the parents again.
    B) Refer the parents to a family therapist.
    C) Try to remember that the parents are trying to the best of their ability to carry out the suggestions.
    D) Explore alternative living arrangements for the child.
    Ans: C
    Feedback:
    The nurse's beliefs and values about raising children affect how he or she deals with children and parents. The nurse must not be overly critical about how parents handle their children's problems until the situation is fully understood: Caring for a child as a nurse is very different from being responsible around the clock. The parents likely have other obstacles to carrying out effective discipline. Teaching again is not likely to effect change. Given their own skills and problems, parents often give their best efforts. Given the opportunity, resources, support, and education, many parents can improve their parenting. It is premature to refer to family therapy or remove the child from the home. Emotional barriers to effective parenting should be explored first.

28. When the prognosis of improvement in a child with psychiatric disorders is poor, what can the nurse do to positively influence children and adolescents and their parents?
    A) Continue to remind the child and parents that the prognosis for improvement is very poor.
    B) Encourage the parents to believe that the child will recover spontaneously.
    C) Assist the child and the parents to develop coping mechanisms.
    D) Focus on their problems instead of their strengths and assets.
    Ans: C
    Feedback:
    Working with children and adolescents can be both rewarding and difficult. Many disorders of childhood such as severe developmental disorders severely limit the child's abilities. It may be difficult for the nurse to remain positive with the child and parents when the prognosis for improvement is poor. Even in overwhelming and depressing situations, the nurse has an opportunity to positively influence children and adolescents, who are still in crucial phases of development. The nurse often can help these clients to develop coping mechanisms they will use through adulthood. It is important to remember to focus on the client's and parents' strengths and assets, not just their problems.

1. **Chapter 23** A child is expelled from school for repeated fighting and vandalizing school property. The school nurse and counselor meet with the parents to explain that the child may benefit from counseling as the child is experiencing signs of which disorder?
   A) Oppositional defiant disorder
   B) Asperger's syndrome
   C) Attention deficit hyperactivity disorder
   D) Conduct disorder
   Ans: D
   Feedback:
   Conduct disorder is characterized by persistent antisocial behavior in children and adolescents that significantly impairs their ability to function in social, academic, or occupational areas. Behavioral symptoms include physical fights, destruction of property, vandalism, and serious violation of rules among others. ODD consists of an enduring pattern of uncooperative, defiant, and hostile behavior toward authority figures without major antisocial violations. Asperger's disorder is a pervasive developmental disorder characterized by the same impairments of social interaction and restricted stereotyped behaviors seen in autistic disorder, but there are no language or cognitive delays. Attention deficit hyperactivity disorder (ADHD) is characterized by inattentiveness, overactivity, and impulsiveness.

2. A child has been displaying behaviors associated with conduct disorder. The nurse should further assess for which common risk factors seen in children with conduct disorder. Select all that apply.
   A) Poor family functioning
   B) Strict disciplinary practices
   C) Family history of substance abuse
   D) Possible child abuse
   E) Poverty conditions
   Ans: A, C, D, E
   Feedback:
   Risk factors include poor parenting, low academic achievement, poor peer relationships, low self-esteem, poor family functioning, marital discord, family history of substance abuse and psychiatric problems, child abuse, inconsistent parental responses, exposure to violence in the media, and community socioeconomic disadvantages such as inadequate housing, crowded conditions, and poverty. Protective factors include resilience, family support, positive peer relationships, and good health.

3. Which are characteristics of intermittent explosive disorder (IED)? Select all that apply.
   A) The episode may occur with seemingly no warning.
   B) They usually last less than 30 minutes.
   C) Afterward, the person with IED will not have any remorse.
   D) It involves repeated episodes of impulsive, aggressive, violent behavior, and angry verbal outbursts.
   E) The intensity of the emotional outburst is usually within proportion to the stressor or situation.

   Ans: A, B, D

   Feedback:

   Intermittent explosive disorder (IED) involves repeated episodes of impulsive, aggressive, violent behavior and angry verbal outbursts, usually lasting less than 30 minutes. During these episodes, there may be physical injury to others, destruction of property, and injury to the individual as well. The intensity of the emotional outburst is grossly out of proportion to the stressor or situation. The episode may occur with seemingly no warning. Afterward, the individual may be embarrassed and feel guilty or remorseful for his or her actions, but that does not prevent future impulsive, aggressive outbursts.

4. Which disorder is exemplified by vandalism, conning others, running away from home, verbal bullying and intimidation, drinking alcohol, and sexual promiscuity?
   A) Intermittent explosive disorder
   B) Mild conduct disorder
   C) Oppositional defiance Disorder
   D) Moderate conduct disorder

   Ans: D

   Feedback:

   Examples of moderate conduct disorder include vandalism, conning others, running away from home, verbal bullying and intimidation, drinking alcohol, and sexual promiscuity. Intermittent explosive disorder (IED) involves repeated episodes of impulsive, aggressive, violent behavior and angry verbal outbursts, usually lasting less than 30 minutes. In mild conduct disorder, the child has some conduct problems that cause relatively minor harm to others. Examples include repeated lying, truancy, minor shoplifting, and staying out late without permission. Oppositional defiant disorder (ODD) consists of an enduring pattern of uncooperative, defiant, disobedient, and hostile behavior toward authority figures without major antisocial violations.

5. An 11-year-old child talks to the school nurse about a single episode of disruptive behavior in class. The child states, ìI had a stomachache and felt like vomiting. I couldn't help it. I was just so mad at my dad.î Which would be the most appropriate response by the nurse?
   A) ìI can see that you're angry. Let's look at better ways to express it.î
   B) ìI can understand your anger, but you can't disrupt the classroom.î
   C) ìIf you can get rid of your anger, perhaps your stomachache will go away.î
   D) ìPerhaps it would be helpful if you let your dad know you're angry.î
   Ans: A
   Feedback:
   A child at this age may have difficulty expressing negative or intense emotions verbally; the nurse's response helps teach the child appropriate expressions of anger.

6. The nurse is using limit setting with a child diagnosed with conduct disorder. Which statement reflects the most effective way for the nurse to set limits with the child?
   A) ìThat is not allowed here. You will lose a privilege. You need to stop.î
   B) ìStop what you are doing. Go to your room.î
   C) ìI would appreciate if you would not do that.î
   D) ìWhy do you do these things?î
   Ans: A
   Feedback:
   The nurse must set limits on unacceptable behavior at the beginning of treatment. Limit setting involves three steps: (1) informing clients of the rule or limit; (2)explaining the consequences if clients exceed the limit; and (3) stating expected behavior.

7. A client with conduct disorder starts yelling at another client and calling the client insulting names. Which is the most appropriate response by the nurse?
   A) ìHow would you feel if someone yelled at you like that?î
   B) ìWhat's the matter with you? Don't you know any better?î
   C) ìYelling at others is unacceptable. You need to let staff know you're upset.î
   D) ìYou're still having problems controlling your anger.î
   Ans: C
   Feedback:
   The nurse must show acceptance of clients as worthwhile persons even if their behavior is unacceptable. This means that the nurse must be matter of fact about setting limits and must not make judgmental statements about clients. He or she must focus only on the behavior.

8. Which is the most commonly used treatment for oppositional defiant disorder?
   A) Pharmacologic treatment
   B) Parent training models of behavioral interventions
   C) Individual therapy
   D) ìBoot campî
   Ans: B
   Feedback:
   Treatment for ODD is based on parent management training models of behavioral interventions. These programs are based on the idea that ODD problem behaviors are learned and inadvertently reinforced in the home and school. Older children may also benefit from individual therapy in addition to the behavioral program. There is little evidence that medications help ODD behaviors; however, successful pharmacologic treatment of comorbid disorders such as ADHD may also decrease the severity of ODD symptoms. Dramatic interventions, such as ìboot campî or incarceration, have not proved effective and may even worsen the situation.

9. Which is likely to be most effective for adolescents with conduct disorder?
   A) Involvement with the legal system
   B) Focusing on the parenting education
   C) Incarceration
   D) Early intervention
   Ans: D
   Feedback:
   Many treatments have been used for conduct disorder with only modest effectiveness. Early intervention is more effective, and prevention is more effective than treatment. Dramatic interventions, such as ìboot campî or incarceration, have not proved effective and may even worsen the situation. Treatment must be geared toward the client's developmental age. For school-aged children with conduct disorder, the child, family, and school environment are the focus of treatment. Adolescents rely less on their parents and more on peers, so treatment for this age group includes individual therapy. Many adolescent clients have some involvement with the legal system as a result of criminal behavior, but this is a consequence of and not a treatment for conduct disorder.

10. A 14-year-old girl is being treated for conduct disorder. She refuses to attend class today, stating that yesterday the other nurse told her she did not have to go to class if she did not want to. Which would be the best response by the nurse?
    A) ìFine, but you're confined to your room.î
    B) ìMissing class is against the rules.î
    C) ìYou and I both know you're lying.î
    D) ìWhy do you keep fighting the system?î
    Ans: B
    Feedback:
    Reinforcing rules avoids a power struggle; the nurse must set limits on the unacceptable behavior of missing class. The nurse can negotiate with a client a behavioral contract outlining expected behaviors, limits, and rewards to increase treatment compliance.

11. The nurse is meeting with a family of a client with conduct disorder. The nurse discusses changes the parents can make to help their child change problematic behaviors. Which parenting technique would the nurse encourage the parents to use?
    A) Provide consistent consequences for behaviors.
    B) Set earlier curfews than the child's peers adhere to.
    C) Release the child from household responsibilities until he can demonstrate dependable behavior.
    D) Avoid discussing feelings and expectations with the child.
    Ans: A
    Feedback:
    Parents need to replace old patterns such as yelling, hitting, or simply ignoring behavior with more effective strategies. The nurse can teach parents age-appropriate activities and expectations for clients such as reasonable curfews, household responsibilities, and acceptable behavior at home. The parents may need to learn effective limit setting with appropriate consequences. Parents often need to learn to communicate their feelings and expectations clearly and directly to these clients. Some parents may need to let clients experience the consequences of their behavior rather than rescuing them.

12. Which are most likely included in the history of a child with conduct disorder? Select all that apply.
    A) Disturbed relationships with peers
    B) Major antisocial violations
    C) Aggression toward people or animals
    D) Destruction of property
    E) Serious violation of rules
    Ans: A, C, D, E
    Feedback:
    Children with conduct disorder have a history of disturbed relationships with peers, aggression toward people or animals, destruction of property, deceitfulness or theft, and serious violation of rules (e.g., truancy, running away from home, and staying out all night without permission). Major antisocial violations would be indicative of antisocial behavior.

13. Which steps are involved in limit setting? Select all that apply.
    A) State expected behavior.
    B) Inform clients or the rule or limit.
    C) Threaten incarceration.
    D) Explain the consequences if clients exceed the limit.
    E) Occasionally limit enforcement.
    Ans: A, B, D
    Feedback:
    Limit setting involves three steps:
    1. Inform clients of the rule or limit.
    2. Explain the consequences if clients exceed the limit.
    3. State expected behavior.
    Threatening the client with incarceration is not likely effective. Providing consistent limit enforcement with no exceptions by all members of the health-care team, including parents, is essential.

14. Which is true of the time-out strategy that may be used for persons with conduct disorder?
    A) It is a punishment.
    B) It should only be used as a last resort.
    C) Eventually, the goal is for the client to avoid time-out.
    D) Time-out is retreat to a neutral place, so clients can regain self-control.
    Ans: D
    Feedback:
    Time-out is retreat to a neutral place, so clients can regain self-control. It is not a punishment. When a client's behavior begins to escalate, such as when he or she yells at or threatens someone, a time-out may prevent aggression or acting out. Staff may need to institute a time-out for clients if they are unwilling or unable to do so. Eventually, the goal for clients is to recognize signs of increasing agitation and take a self-instituted time-out to control emotions and outbursts.

15. The nurse understands that when working with a child with a disruptive behavior disorder, the family must be included in the care. Which is one of the best ways the nurse can advocate for the child?
    A) Support transferring the child to a healthy living environment.
    B) Teach the parents age-appropriate expectations of the child.
    C) Reinforce the parents' expectations of the child's behavior.
    D) Interpret the child's thoughts and feelings to the parent.
    Ans: B
    Feedback:
    Working with parents is a crucial aspect of dealing with children with these disorders. Parents often have the most influence on how these children learn to cope with their disorders. The nurse can teach parents age-appropriate activities and expectations for clients.

16. Which are actions of the parents of a child with conduct disorders that may contribute to the problems of the child? Select all that apply.
    A) The parents may not behave appropriately themselves because of a lack of knowledge.
    B) The parents blame the school when the child causes a disturbance in school and receives detention.
    C) The parents engage in yelling at, hitting, or simply ignoring the behavior of their child.
    D) The parents make reasonable curfews that are appropriate for the age of the client.
    E) The parents establish household responsibilities that are appropriate for the age of the client.

    Ans: A, B, C

    Feedback:

    Parents may also need help in learning social skills, solving problems, and behaving appropriately. Often, parents have their own problems, and they have had difficulties with the client for a long time before treatment was instituted. Parents need to replace old patterns such as yelling, hitting, or simply ignoring behavior with more effective strategies. The nurse can teach parents age-appropriate activities and expectations for clients such as reasonable curfews, household responsibilities, and acceptable behavior at home. Some parents may need to let clients experience the consequences of their behavior rather than rescuing them.

17. When presenting information about conduct disorders to a community group, the nurse is asked, ìwhich is the best setting for care of a client with conduct disorders when parents cannot provide safe, structured environments and adequate supervision for the client?î Which would be the most appropriate reply by the nurse?
    A) The acute care setting
    B) School
    C) Residential treatment settings
    D) Jail-diversion program

    Ans: C

    Feedback:

    Group homes, halfway houses, and residential treatment settings are designed to provide safe, structured environments and adequate supervision if that cannot be provided at home. Clients with conduct disorder are seen in acute care settings only when their behavior is severe and only for short periods of stabilization. Clients with legal issues may be placed in detention facilities, jails, or jail-diversion programs.

18. Which is an effective way for parents to deal with problem behaviors in children and to prevent later development of conduct disorders?
    A) Administering medications
    B) Avoiding setting limits
    C) Group-based parenting classes
    D) Being overprotective of the child
    Ans: C
    Feedback:
    Parental behavior profoundly influences children's behavior. Group-based parenting classes are effective to deal with problem behaviors in children and prevent later development of conduct disorders.

19. The nurse has been working with the family of a small child with oppositional defiant disorder. The nurse is feeling very frustrated because the parents refuse to implement effective parenting skills that the nurse has taught. What is the best nursing action at this time?
    A) Review effective disciplinary practices with the parents again.
    B) Refer the parents to a family therapist.
    C) Try to remember that the parents are trying to the best of their ability to carry out the suggestions.
    D) Explore alternative living arrangements for the child.
    Ans: C
    Feedback:
    The nurse's beliefs and values about raising children affect how he or she deals with children and parents. The nurse must not be overly critical about how parents handle their children's problems until the situation is fully understood: Caring for a child as a nurse is very different from being responsible around the clock. The parents likely have other obstacles in carrying out effective discipline. Teaching again is not likely to effect change. It is premature to refer to family therapy or remove the child from the home. Emotional barriers to effective parenting should be explored first.

20. Which may be concerns that a nurse has when caring for clients who have conduct disorders? Select all that apply.
    A) Thinking that the client should be able to refrain from hostility and aggression through use of will power.
    B) Having conflicted feelings regarding holding clients accountable for their behaviors without having a punitive attitude.
    C) Discussing feelings, fears, or frustrations with colleagues.
    D) Having anxiety and fears for the nurse's personal safety.
    E) Believing that aggression is the most productive way to deal with aggression.
    Ans: A, B, D
    Feedback:
    The nurse's beliefs and values about raising children affect how he or she deals with children and parents. The nurse may also have personal feelings about the disruptive and/or aggressive behaviors, such as thinking the client should be able to refrain from hostility and aggression through use of will power. It can be difficult to reconcile holding clients accountable for their behaviors, but avoiding a purely punitive attitude. Working with aggressive clients of any age may provoke anxiety and fears for personal safety in the nurse. It is important for the nurse to discuss feelings, fears, or frustrations with colleagues to keep negative emotions from interfering with the ability to provide care to clients with problems with aggression.

21. Which are important points for the nurse to consider when working with clients with disruptive behavior disorders and their families? Select all that apply.
    A) Most behavior disorders are caused by being raised by parents who had behavior disorders in their own childhoods.
    B) Remember to focus on the client's strengths and assets, as well as their problems.
    C) Transient conduct disorders are common in all children.
    D) Avoid a ìblamingî attitude toward clients and/or families.
    E) Focus on positive actions to improve situations and/or behaviors.
    Ans: B, D, E
    Feedback:
    Points to consider when working with clients with disruptive behavior disorders and their families include the following:
    ï Remember to focus on the client's strengths and assets, as well as their problems.
    ï Avoid a blaming attitude toward clients and/or families; rather focus on positive actions to improve situations and/or behaviors.
    There is a familial tendency for behavior disorders, but that is not the only cause for behavior disorders. Conduct disorders are not common in all children, but it can be difficult to distinguish normal child behavior from conduct disorders at times.

22. Which is the most important reason for the nurse who cares for children with conduct disorders to discuss feelings, fears, or frustrations with colleagues?
    A) To make the nurse feel better and avoid burnout.
    B) To encourage camaraderie between colleagues.
    C) To keep negative emotions from interfering with the ability to provide care to clients with problems with aggression.
    D) To ensure that all caregivers have the same attitudes and beliefs about children with conduct disorders.

    Ans: C

    Feedback:

    It is important for the nurse to discuss feelings, fears, or frustrations with colleagues to keep negative emotions from interfering with the ability to provide care to clients with problems with aggression. It may also make the nurse feel better and avoid burnout, but that is not the most important reason to do so. It may encourage camaraderie between colleagues, but that is not the most important reason for the nurse to do so. It will not be possible to ensure that all caregivers have the same attitudes and beliefs about children with conduct disorders, but they must be consistent with limit setting, irrespective of their own attitudes and beliefs.

1. **Chapter 24** During the change of shift report in the intensive care unit, the nurse learns that a client has developed signs of delirium over the past 8 hours. Which behavior documented in the nursing notes would be consistent with delirium?
   A) Unable to identify a water pitcher
   B) Unable to transfer to sitting position
   C) Difficulty with verbal expression
   D) Disoriented to person
   Ans: D
   Feedback:
   Delirium usually develops over a short period, sometimes a matter of hours, and fluctuates, or changes, throughout the course of the day. Clients with delirium have difficulty paying attention, are easily distracted and disoriented, and may have sensory disturbances such as illusions, misinterpretations, or hallucinations. Dementia symptoms include aphasia (deterioration of language function), apraxia (impaired ability to execute motor functions despite intact motor abilities), and agnosia (inability to recognize or name objects despite intact sensory abilities).

2. A nurse working in an assisted living facility is holding an in-service for the nursing assistants. The nurse reviews common behaviors associated with cognitive deterioration associated with dementia. Which would cause the nurse to know that the assistants correctly understood if it were expressed during a posttest?
   A) The clients should be able to ask us for items they need.
   B) The clients may not recognize their family when they come to visit.
   C) The clients who are ambulatory can still carry out activities of daily living independently.
   D) The clients should know when to come to the dining room for meals.
   Ans: B
   Feedback:
   Dementia is a mental disorder that involves multiple cognitive deficits, primarily memory impairment, and at least one of the following cognitive disturbances: (1) aphasia, which is deterioration of language function; (2) apraxia, which is impaired ability to execute motor functions despite intact motor abilities; (3) agnosia, which is inability to recognize or name objects despite intact sensory abilities; and (4) disturbance in executive functioning, which is the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior.

3. Which is believed to be a risk factor specific to the development of delirium?
   A) Increased severity of physical illness
   B) Older age
   C) Baseline cognitive impairment
   D) Gradual decline in functioning
   Ans: A
   Feedback:
   An estimated 10% to 15% of people in the hospital for general medical conditions are delirious at any given time. Onset is sudden. Delirium is common in older, acutely ill clients. Risk factors for delirium include increased severity of physical illness, older age, and baseline cognitive impairment such as that seen in dementia. Children may be more susceptible to delirium, especially that related to a febrile illness or certain medications such as anticholinergics. Delirium usually develops over a short period, sometimes a matter of hours, and fluctuates, or changes, throughout the course of a day. Prevalence of dementia also rises with age, and progression is gradual.

4. Which patient is most likely suffering from dementia?
   A) A 90-year-old male who has experienced progressive mental decline that started with forgetfulness
   B) An 80-year-old female who has been in excellent health until she was admitted through the emergency department with a severe urinary tract infection and is now very anxious and is threatening staff
   C) A 6-year-old child who has just been administered conscious sedation for a closed reduction of a fractured wrist and says that her parents have three sets of eyes
   D) A 22-year-old male who was involved in a motorcycle crash without wearing a helmet now unable to remember where he is
   Ans: A
   Feedback:
   Memory impairment is the prominent early sign of dementia. The course of dementia is usually progressive. A 90-year-old gentleman who has experienced progressive mental decline that started with forgetfulness is most likely suffering from dementia. An 80-year-old lady who has been in excellent health until she was admitted through the emergency department with a severe urinary tract infection is likely experiencing delirium. Delirium almost always results from an identifiable physiologic, metabolic, or cerebral disturbance or from drug intoxication or withdrawal. The 6-year-old who has just been administered conscious sedation is likely delirious. A 22-year-old male who was involved in a motorcycle crash without wearing a helmet and now cannot remember where he is likely experiencing an amnestic disorder.

5. A client with dementia is unable to recognize ordinary objects, such as a pen or notebook. Which would this be a symptom of?
   A) Agnosia
   B) Amnesia
   C) Apraxia
   D) Aphasia
   Ans: A
   Feedback:
   Agnosia is the inability to recognize familiar objects. Amnesia is failure to remember past events. Apraxia is impairment in the ability to execute motor functions despite intact motor abilities. Aphasia is a deterioration of language function.

6. Which client would have an increased risk for delirium?
   A) An elderly woman with abdominal pain
   B) A 3-year-old child with a temperature of 103.2∞F
   C) A middle-aged woman newly diagnosed with multiple sclerosis
   D) A young adult male with gastroenteritis and dehydration
   Ans: B
   Feedback:
   Young children with high fever are at risk for delirium. The other choices would not be the most likely candidates for increased risk for delirium.

7. The nurse is caring for a client with cognitive impairment. To determine whether the client is suffering from delirium or dementia, the nurse reviews the symptoms and course of each disorder. Place the letter ìAî beside terms describing delirium and the letter ìBî beside terms describing dementia.
   ____ Rapid onset
   ____ Progressive decline
   ____ Long-term memory impairment
   ____ Slurred speech
   ____ Hallucinations
   Ans: A, B, B, A, A
   Feedback:
   Onset of delirium is rapid, but of dementia is gradual. Duration of delirium is brief, but of dementia is progressing. Delirium affects only short-term memory. Dementia begins with short-term memory loss and progresses to long-term memory loss. Slurred speech is characteristic of delirium. Speech with dementia is unchanged until the client begins to develop aphasia. Visual and tactile hallucinations are common with delirium, but rarely experienced with dementia.

8. The daughter of a woman with dementia asks the nurse if her mother will ever be able to live independently again. Which would be the most appropriate response by the nurse?
   A) ìYou sound like you aren't ready for her to be dependent on caregivers.î
   B) ìHer confusion is a temporary complication of her physical illness and should subside when the illness gets better.î
   C) ìSymptoms of dementia gradually get worse. Unfortunately she will not be independent again.î
   D) ìWith early treatment, mild dementia can be reversed. It may be possible.î
   Ans: C
   Feedback:
   The prognosis for dementia involves progressive deterioration of physical and mental abilities until death. Typically, in the later stages, clients have minimal cognitive and motor function, are totally dependent on caregivers, and are unaware of their surroundings or people in the environment. They may be totally uncommunicative or make unintelligible sounds or attempts to verbalize. Delirium secondary to physical illness will subside with physical recovery.

9. Which statement made by the nurse would be most appropriate to an 89-year-old patient who is confused but has no history of dementia and is hospitalized for an acute urinary tract infection?
   A) ìYou are likely to become progressively more confused now.î
   B) ìThis should be just a temporary situation.î
   C) ìDon't worry about it; everyone is confused when they are in the hospital.î
   D) ìI know things are upsetting and confusing right now, but your confusion should clear as you get better.î
   Ans: D
   Feedback:
   ìI know things are upsetting and confusing right now, but your confusion should clear as you get better,î would be validating and giving information and would provide realistic reassurance to the client who has delirium as this is often an acute and temporary situation in elderly people who are acutely ill and have other risk factors such as medications and illness and age. ìYou are likely to become progressively more confused now,î is inaccurate as the person likely has delirium, and this will be an acute and temporary situation. ìThis should be just a temporary situationî provides some reassurance but no validation. ìDon't worry about it; everyone is confused when they are in the hospitalî is inaccurate.

10. Which distinguishes delirium from dementia?
    A) Delirium has an acute onset and is progressive in course.
    B) Delirium has a gradual onset and can be resolved.
    C) Dementia has a gradual onset and is progressive in course.
    D) Dementia has an acute onset and can be resolved.
    Ans: C
    Feedback:
    Delirium has a sudden onset, and the underlying cause is treatable; by contrast, dementia has a gradual onset and is progressive rather than treatable.

11. The nurse is performing a health history with a client exhibiting signs of delirium. The nurse asks the client and family members about possible causes of the delirious state. Which would the nurse likely attribute as underlying causes for the client's delirium? Select all that apply.
    A) Recent alcohol use
    B) Dehydration
    C) Use of antihistamines
    D) Sleep disturbances
    E) Use of megadoses of vitamins
    F) Exposure to paint or gasoline
    Ans: A, B, C, D, F
    Feedback:
    Because the causes of delirium are often related to medical illness, alcohol, or other drugs, the nurse obtains a thorough history of these areas. The nurse may need to obtain information from family members if a client's ability to provide accurate data is impaired. Information about drugs should include prescribed medications, alcohol, illicit drugs, and over-the-counter medications. Physiologic or metabolic causes include hypoxemia, electrolyte disturbances, renal or hepatic failure, hypoglycemia or hyperglycemia, dehydration, sleep deprivation, thyroid or glucocorticoid disturbances, thiamine or vitamin B_{12} deficiency, vitamin C, niacin, or protein deficiency, cardiovascular shock, brain tumor, head injury, and exposure to gasoline, paint solvents, insecticides, and related substances. Infectious processes include sepsis, urinary tract infection, pneumonia, meningitis, encephalitis, HIV, and syphilis.

12. A client voluntarily admitted to the inpatient psychiatric unit is currently experiencing mild delirium. The client approaches the nurse and states, ìI'm going to take walk outside. I'll be back in about 10 minutes.î Which is the most appropriate nursing action?
    A) Further assess the client's motives for wanting to walk.
    B) Give the client permission to go on a walk on the grounds.
    C) Tell the client the walk is not allowed and restrict him to the unit.
    D) Designate a staff member to accompany the client on the walk.
    Ans: D
    Feedback:
    The nurse teaches clients to request assistance for activities such as getting out of bed or going to the bathroom. If clients cannot request assistance, they require close supervision to prevent them from attempting activities they cannot perform safely alone. The nurse responds promptly to calls from clients for assistance and checks clients at frequent intervals.

13. A client with dementia is starting pharmacotherapy to slow the progression of cognitive decline. The client has a history of moderate but steady alcohol use over the past 45 years. Which medication should the nurse question as least suitable for this client?
    A) Tacrine (Cognex)
    B) Memantine (Namenda)
    C) Donepezil (Aricept)
    D) Rivastigmine (Exelon)
    Ans: A
    Feedback:
    Tacrine (Cognex) is a cholinesterase inhibitor; however, it elevates liver enzymes in about 50% of clients using it. Lab tests to assess liver function are necessary every 1 to 2 weeks; therefore, tacrine is rarely prescribed. Memantine (Namenda) is an NMDA receptor antagonist that can slow the progression of Alzheimer's in the moderate or severe stages. Donepezil (Aricept), rivastigmine (Exelon), and galantamine (Reminyl) are cholinesterase inhibitors and have shown modest therapeutic effects and temporarily slow the progress of dementia.

14. The nursing supervisor in an extended care facility is managing the environment to best help the clients with dementia. Which should the nurse include in planning the living environment?
    A) Plan for the same caregivers to provide care to individuals as much as possible.
    B) Open the windows and doors to allow fresh air to circulate through the environment.
    C) Provide a buffet-style menu with many food choices.
    D) Assign peer-led exercise activates on a daily basis.
    Ans: A
    Feedback:
    A structured environment and established routines can reassure clients with dementia. Familiar surroundings and routines help to eliminate some confusion and frustration from memory loss. Providing the same caregiver establishes familiarity and routine. Safety considerations involve protecting against injury, meeting physiologic needs, and managing risks posed by the environment. Open doors pose a safety risk of wandering away. Buffet-style meals require the client to make too many choices, thus adding to frustration. The nurse encourages clients to engage in physical activity because they may not initiate such activities independently; many clients tend to become sedentary as cognitive abilities diminish. Clients often are quite willing to participate in physical activities but cannot initiate, plan, or carry out those activities without assistance.

15. The nurse encourages the client with dementia to meet nutritional needs. Which is the best approach to assist in meeting adequate dietary intake?
    A) Sit with the client as long as necessary to complete the meal.
    B) Provide entertainment during meals such as television or music.
    C) Avoid between-meal snacks to encourage appetite.
    D) Serve meals in small, bite-size pieces.
    Ans: D
    Feedback:
    Clients may eat poorly because of limited appetite or distraction at mealtimes. The nurse addresses this problem by providing foods clients like, sitting with clients at meals to provide cues to continue eating, having nutritious snacks available whenever clients are hungry, and minimizing noise and undue distraction at mealtimes. Clients who have difficulty manipulating utensils may be unable to cut meat or other foods into bite-sized pieces. The food should be cut up when it is prepared, not in front of clients, to deflect attention from their inability to do so. Food that can be eaten without utensils, or finger foods such as sandwiches and fresh fruits, may be best.

16. The nurse caring for an elderly woman with dementia has asked the woman's children to bring old photo albums when they visit. Which best describes the usefulness of viewing photos when caring for the dementia client?
    A) Viewing photos is a form of reminiscence therapy for the client.
    B) Sharing photos will encourage interaction with other clients.
    C) This can help the children to correctly identify old photographs.
    D) Talking about the photos will encourage the client to live in the past.
    Ans: A
    Feedback:
    Reminiscence therapy (thinking about or relating personally significant past experiences) is an effective intervention for clients with dementia. Rather than lamenting that the client is ìliving in the past,î this therapy encourages family and caregivers also to reminisce with the client. Reminiscing uses the client's remote memory, which is not affected as severely or quickly as recent or immediate memory. Photo albums may be useful in stimulating remote memory, and they provide a focus on the client's past.

17. The nurse is encouraging a group of clients with dementia to join in upper body range of motion exercises using light dumbbells. Which technique will most likely result in the greatest amount of participation?
    A) Show an instructional video just prior to the activity.
    B) Describe the exercise immediately before performing it.
    C) Demonstrate the exercises while clients simultaneously perform them.
    D) Perform the same routine daily to avoid the need for repeated instruction.
    Ans: C
    Feedback:
    The nurse encourages clients to engage in physical activity because they may not initiate such activities independently; many clients tend to become sedentary as cognitive abilities diminish. Clients often are quite willing to participate in physical activities but cannot initiate, plan, or carry out those activities without assistance.

18. A client with dementia gets angry and begins to yell at the nurse during mealtime. The nurse leaves the client's side for 5 to 10 minutes and then returns. Which of the following best explains the nurse's behavior?
    A) The nurse was unsure of how to calm the client.
    B) The nurse was frustrated and needed to take a ìtime-out.î
    C) The nurse gave the client a chance to calm down before resuming the meal.
    D) The nurse stepped away to verify the safety of other clients.
    Ans: C
    Feedback:
    Time away involves leaving clients for a short period and then returning to them to reengage in interaction. For example, the client may get angry and yell at the nurse for no discernible reason. The nurse can leave the client for about 5 or 10 minutes and then return without referring to the previous outburst. The client may have little or no memory of the incident and may be pleased to see the nurse on his or her return.

19. Which is the most effective intervention for clients with delirium?
    A) Giving detailed explanations
    B) Managing environmental stimuli
    C) Promoting rest with PRN medications
    D) Providing activities for distraction
    Ans: B
    Feedback:
    Clients with delirium become overstimulated easily; their ability to process environmental stimuli is impaired.

20. The nurse is assessing a client with early signs of dementia. What is the nurse trying to determine when the nurse asks the client what he ate for breakfast that morning?
    A) Orientation
    B) Food preferences
    C) Recent memory
    D) Remote memory
    Ans: C
    Feedback:
    The initial sign of dementia is memory loss for recent events that exceeds normal forgetfulness. Asking what the client ate for breakfast is not determining orientation, food preferences, or remote memory.

21. The nurse is working with a client who has hallucinations and delusions. The client tells the nurse she cannot take a shower because she is waiting for her husband to take her home. Which response by the nurse is best in this situation?
    A) ìIt would be best if you just took your shower now.î
    B) ìYou seem anxious and upset.î
    C) ìYou have plenty of time to shower before it's time to go home.î
    D) ìWhy are you thinking you're going home?î
    Ans: C
    Feedback:
    This is an example of going along with, rather than correcting, the client's misperception so that she can get on with her daily activities and not focus on being upset about not going home. The other choices are not the best responses in this situation.

22. The nurse is caring for a client with Alzheimer's disease. The nurse observes that the client's pacing and mumbling to himself increase at mealtime and shift change. Which intervention should the nurse implement first?
    A) Administer an antianxiety drug such as lorazepam (Ativan) at these times.
    B) Explain the unit routine and the reasons for increased activity to the client.
    C) Keep unit activity to a minimum.
    D) Move the client to a quieter area during these times.
    Ans: D
    Feedback:
    The nurse must alter the environment because the client will not learn new coping skills for frustrating or overly stimulating situations. Administering an antianxiety agent or explaining the routine of the unit and reasons for increased activity to the client may be done but would not be the initial intervention. The unit activity does not need to be kept to a minimum.

23. The nurse is developing interventions to promote socialization in a client with moderate dementia. Which would provide a safe and secure environment for the client?
    A) A card game with other clients
    B) An activity with the nurse
    C) Decorating a bulletin board with the group
    D) Morning stretch group with music
    Ans: B
    Feedback:
    The client has to interact only with the nurse, who will behave in a predictable way and will focus on the client's needs, without undue or unexpected disruptions. Group activities do not provide a safe and secure environment like an activity done with the nurse does.

24. The daughter of a client with dementia has been the primary caregiver for 5 months. The daughter expresses to the nurse, ìAt times it is so overwhelming! I feel I do not have a life anymore!î Which is the most helpful response by the nurse?
    A) ìAre you saying you don't want to care for your mother anymore?î
    B) ìI know it is really hard. It takes a lot of work and you are doing such a good job.î
    C) ìYour mother really appreciates what you do for her. You are the best one to care for her.î
    D) ìHere is the number of a caregivers' support group. How do you think you would feel talking with others in the same situation?î

    Ans: D

    Feedback:

    Caregivers need outlets for dealing with their own feelings. Support groups can help them to express frustration, sadness, anger, guilt, or ambivalence; all these feelings are common. Attending a support group regularly also means that caregivers have time with people who understand the many demands of caring for a family member with dementia. The client's physician can provide information about support groups, and the local chapter of the National Alzheimer's Disease Association is listed in the phone book. Area hospitals and public health agencies also can help caregivers to locate community resources. The nurse should understand that the caregiver is asking for help when expressing frustration. The nurse should not dismiss the caregiver's feelings or in any way induce additional guilt.

25. Which statement by the nurse would be most appropriate to the family member who is the primary caregiver to a client with dementia?
    A) ìMost people seek help when they really need it.î
    B) ìWhat is wrong with your family? Can't they see you need help?î
    C) ìYou should be grateful that you still have your family member around.î
    D) ìYes, it is important for you to spend some time relaxing and doing what you like to do. This will help you to be better prepared to manage the demands of the caregiver role.î

    Ans: D

    Feedback:

    Caregivers need support to maintain personal lives. They need to continue to socialize with friends and to engage in leisure activities or hobbies rather than focus solely on the client's care. Caregivers who are rested, are happy, and have met their own needs are better prepared to manage the rigorous demands of the caregiver role. Most caregivers need to be reminded to take care of themselves; this act is not selfish but really is in the client's best long-term interests. Many times caregivers will say they will seek help when they really need it. However, they must maintain their own well-being and not wait until they are exhausted before seeking relief. The primary caregiver may believe other family members should volunteer to help without being asked, but other family members may believe that the primary caregiver chose to take on the responsibility and do not feel obligated to help out regularly. It is important for the family to express their feelings and ideas and to participate in caregiving according to their own expectations. Many families need assistance to reach this type of compromise. Asking the caregiver what is wrong with his or her family and pointing out that the caregiver needs help are not helpful to the caregiver. It would be better for the nurse to encourage family members to share their feelings and to compromise for the best interests of the client. Telling the caregiver that he or she should be grateful will only increase the caregiver's sense of guilt, which is not productive.

26. A client with moderate Alzheimer's disease is living with her grown daughter. Which statement by the daughter would indicate the need for intervention by the nurse?
    A) ìIt's distressing when my mother forgets my name.î
    B) ìI wish my sister would come to visit more often.î
    C) ìMother won't let anyone else do anything for her.î
    D) ìTaking care of my mother is a big responsibility.î

    Ans: C

    Feedback:

    When the caregiver feels as though no one else can provide care, the risk for role strain is markedly increased. The other choices do not require intervention by the nurse.

27. A nurse is educating a group of elderly community members about cognitive disorders. Which would the nurse include as a measure most likely to prevent Alzheimer's disease and other dementias?
    A) Crafts
    B) Cooking
    C) Watching television
    D) Reading
    Ans: D
    Feedback:
    People who regularly participate in brain-stimulating activities such as reading books and newspapers or doing crossword puzzles are less likely to develop Alzheimer's disease than those who do not. Engaging in leisure-time physical activity during midlife and having a large social network are associated with a decreased risk for Alzheimer's disease in later life.

28. The caregiver of a client with Alzheimer's disease reports to the nurse that often the client will suddenly become angry during meals and nothing seems to calm him down. The nurse teaches the caregiver to use distraction techniques. Which response would be best to teach as an example of this technique?
    A) ìLet's look at what is on television.î
    B) ìIf you stop yelling, I will get your dessert.î
    C) ìDon't you want to finish your meal?î
    D) ìI don't understand what you are saying.î
    Ans: A
    Feedback:
    Distraction involves shifting the client's attention and energy to a more neutral topic. For example, the client may display a catastrophic reaction to the current situation, such as jumping up from dinner and saying, ìMy food tastes like poison!î The nurse might intervene with distraction by saying, ìCan you come to the kitchen with me and find something you'd like to eat?î or ìYou can leave that food. Can you come and help me find a good program on television?î (redirection/distraction). Influencing behavior with a reward is a behavioral technique. Asking a direct question is ineffective. Clarification is used to try to determine meaning behind the client's message.

29. The adult son of a client with dementia asks the nurse how he should respond when his mother repeatedly says she has had a busy day at work. The mother has not worked in over 20 years. Which is the best guidance that the nurse could offer?
    A) Ask her to explain what she did at work today that kept her busy.
    B) Go along with her thought of it having been a busy day, but do not refer to her work.
    C) Reorient her that she is at home and did not go to work.
    D) Give her 5 to 10 minutes of rest, and she will have no memory of the incident.
    Ans: B
    Feedback:
    Going along means providing emotional reassurance to clients without correcting their misperception or delusion. The nurse does not engage in delusional ideas or reinforce them, but he or she does not deny or confront their existence. For example, a client is fretful, repeatedly saying, ìI'm so worried about the children. I hope they're okayî and speaking as though his adult children were small and needed protection. The nurse could reassure the client by saying, ìThere's no need to worry; the children are just fineî (going along). Time away is an effective technique for aggression.

30. The grown daughter of a woman with Alzheimer's disease reports to the nurse that she is trying to keep her mother's condition from worsening by asking her questions whenever they are together. Which will be accomplished by this intervention?
    A) Decrease environmental misinterpretation
    B) Improve memory retention
    C) Increase frustration
    D) Slow the progress of the disease
    Ans: C
    Feedback:
    Alzheimer's disease is progressive; clients do not learn new information, and they become frustrated when asked to perform tasks they are not capable of doing.

31. A new nurse has been working with clients with Alzheimer's disease for almost 6 months. During a staff meeting, the nurse expresses frustration because the same instructions have to be given to clients on a daily basis. The nurse states, ìI feel like all my work doesn't do them any good.î Which should the nurse's supervisor encourage the nurse to do?
    A) Cease giving instructions because the clients will not remember them anyway.
    B) Try to stay supportive and meet the clients' needs at the current moment.
    C) Seek counseling if personal feelings get in the way of client care.
    D) Consider transferring to a different client care specialty area.
    Ans: B
    Feedback:
    Teaching is a fundamental role for nurses, but teaching clients who have dementia can be especially challenging and frustrating. These clients do not retain explanations or instructions, so the nurse must repeat the same things continually.
    The nurse must be careful not to lose patience and not to give up on these clients. Discussing these frustrations with others can help the nurse to avoid conveying negative feelings to clients and families or experiencing professional and personal burnout. The nurse must remain positive and supportive to clients and family.

32. Which are possible sources of frustrations for nurses caring for persons with dementia? Select all that apply.
    A) The clients do not retain explanations or instructions, so the nurse must repeat the same things continually.
    B) The nurse may get little or no positive response or feedback from clients with dementia.
    C) It can be difficult to remain positive and supportive to clients and family because the outcome is so bleak.
    D) It can be helpful for the nurse to talk to colleagues or even a counselor about personal feelings of depression and grief as the dementia progresses.
    E) The clients may seem not to hear or respond to anything the nurse does.

    Ans: A, B, C, E

    Feedback:

    Working with and caring for clients with dementia can be exhausting and frustrating for both the nurse and caregiver. Teaching is a fundamental role for nurses, but teaching clients who have dementia can be especially challenging and frustrating. These clients do not retain explanations or instructions, so the nurse must repeat the same things continuously. The nurse may begin to feel that repeating instructions or explanations does not good because clients do not understand or remember them. The nurse may get little or no positive response or feedback from clients with dementia. It can be difficult to deal with feelings about caring for people who will never get better and go home. As dementia progresses, clients may seem not to hear or respond to anything the nurse says or does. Remaining positive and supportive to clients and family can be difficult when the outcome is so bleak. The nurse may need to deal with personal feelings of depression and grief as the dementia progresses; he or she can do so by discussing the situation with colleagues or even a counselor, but this is an intervention instead of a source of frustration for the nurse.