ATI MENTAL HEALTH
Those 100 questions

A nurse overhears a hospitalized client with mania telling another client, "I'm actually a journalist writing an article for a magazine — I'm just posing as a person with mental illness." How should the nurse respond?
Presenting the client with the actual situation

Rationale: When dealing with a delusional client, it is important for the nurse to state clearly that the nurse does not share the client's perceptions. All three of the other options — ignoring the delusion, taking the client to a quiet room, and supporting the client's denial of illness — do not focus on reality, and they ignore the issue. Presenting the client with the actual situation helps orient the client to reality.
A client who is hallucinating fearfully says to the nurse, "Please tell that demon to get out." How should the nurse respond to the client?
"I know you must be very upset by this, but I don't see a demon."

Rationale: If the client hallucinates, it is best to provide reality-based perceptions and not negate the client's experience, because this may lead to a regressive struggle with the client. Giving advice or false reassurance is incorrect because such techniques indicate that demons actually are present, which feeds into the client's hallucination and reinforces the client's behavior.
The mother of a 3-year-old says, "My child hit his teddy bear after being scolded for picking the neighbors' flowers." Which defense mechanism was the child using?
Displacement

Rationale: The defense mechanism of displacement involves the discharge of intense feelings for one person onto a less threatening substitute person or object to satisfy an impulse. Projection involves attributing an attitude, behavior, or impulse to someone else, such as that which occurs in blaming or scapegoating. Sublimation is rechanneling an impulse into a more socially acceptable object. Identification involves modeling behavior after someone else's.
A client says to the nurse, "Even though my husband and I keep telling them we don't want to have children, our parents are pressuring us to 'start a family.' What should we say to them?" Which of the following responses by the nurse is therapeutic?
"This must be very difficult for both of you."

Rationale: Childless families may elect not to have children or to postpone having them until they have established themselves occupationally or financially. Telling the client to tell the parents that the couple can't have children is incorrect because the client is being encouraged to lie about life decisions rather than helping the parents understand the couple's choices. Asking how they usually cope with such interference is incorrect because it indicates that the nurse is judgmental and has decided that the parents are interfering with the client and spouse. Saying, "Tell them to have more children if they want them so badly," is incorrect because it is sarcastic and ridicules the situation over which the client has expressed concerns.

A young adult client says, "I just can't seem to stop snapping at my parents. I know they work hard to support me, but what do I do when they're so overbearing?" Which responses by the nurse is therapeutic?
"Have you talked to your parents about your frustrations?"

Rationale: The correct response is focused on the client's concerns and encourages the therapeutic technique of formulating a plan of action. "It's important not to be rude to your parents" and "You need to be more patient with your parents" are both nontherapeutic, judgmental responses that do not encourage the client to further explore her feelings and problem-solve. "Snapping at your parents is childish. How could you?" is incorrect because it is sarcastic and condescending, which is nontherapeutic.
A client says, "I have so much trouble caring for my husband's child from his first marriage. I resent the money we have to pay for child support because we have to deprive my own child of things. How can I stop feeling this way?" Which response by the nurse is therapeutic?
"Have you shared your feelings with your husband?"

Rationale: Remarried individuals often encounter problems as a result of the stressors they bring into a marriage without prior discussion with the new partner. Bonding sometimes does always occur when a child is not one's biological offspring. The correct answer is focused on the client's feelings. "Your child benefits from having a sibling" is not facilitative. "I wonder why you married him, knowing that he wouldn't desert his biological child" is incorrect because it prejudges the client. "You need to take a second job to give your child what you think she deserves" is not open ended, does not facilitate feelings, and gives advice.

A client says to the nurse, "My wife retired last year from a lucrative law practice, and I'm really discouraged. I'll be working until I die, even though I helped pay for her education." Which response by the nurse is supportive?
"You sound very troubled by this."

Rationale: Saying that the situation is unfair is judgmental and does not encourage the client to express his feelings; nor does "That's such a tough break for you." Suggesting that the husband approach the spouse for help is incorrect because it prematurely gives advice, a nontherapeutic communication technique. The correct option is focused on the client's feelings.
A gay man is brought to the emergency department by the police. The client tells the nurse, "I was beaten up. I guess I just have to expect this kind of treatment for the rest of my life." Which statement by the nurse is therapeutic?
"You feel that being beaten up goes along with being gay?"

Rationale: Many lesbians and gays encounter harassment or violence in the course of their lives. "I think you should take some self-defense classes" is incorrect because it advises the client, and giving advice is not therapeutic. "Maybe you should be more

discreet when you're in public" also gives advice and presumes that the client has been indiscreet. "Why not try counseling to change your sexual orientation?" is incorrect because it assumes that sexual orientation can or should be changed. The correct option indicates reflection and is focused on the client's feelings.

A client whose spouse recently died is experiencing dysfunctional grieving. Which intervention has priority in the plan of care?

Assessing the client's risk for violence toward self and others

Rationale: The priority intervention for a client with dysfunctional grieving is assessment of the client's risk for violence toward self and others. Although the nurse will assist the client in resolving the grief and monitor the client's sleep pattern, these are not the priority interventions of the options given. Obtaining a prescription for an antidepressant is not a priority.

A nurse develops a plan of care for a client in whom AIDS was recently diagnosed. The client is experiencing difficulty adjusting to the illness. Which interventions are appropriate for this client? Select all that apply.

Assisting the client in verbalizing fears
Helping the client identify sources of hope
Monitoring the client for signs of self-harm
Assisting the client with problem-solving and decision-making

Rationale: Assisting the client with problem-solving and decision-making, helping the client verbalize fears, helping the client identify sources of hope, and monitoring the client for signs of self-harm are all appropriate interventions. In planning care for a client having difficulty adjusting to an illness, the nurse develops interventions to promote social networking that will provide needed support and information to the client.

An emergency department nurse is caring for an older client who is a victim of physical abuse. List in order of priority the following nursing actions, with number 1 representing the first action and number 4 the last.

1. Checking the client for physical injuries
2. Contacting the appropriate state officials to report the abuse
3. Contacting a social worker to assist in planning care for the client
4. Calling a member of the clergy to address the client's spiritual needs

Rationale: The priority intervention in the event of physical abuse is to check the client for physical injuries. The nurse should then fulfill the legal obligation of reporting suspected elder abuse. The next action is to contact the social worker to obtain assistance in planning care for the client. The client may need the social worker's help with housing as well. Last, a referral to a member of the clergy is an appropriate intervention if the client desires it.

The parents of an 18-month-old arrive at the emergency department with their unconscious child. Physical examination reveals bruises on the child's upper arms that resemble grip marks. Which nursing intervention is the priority?

Stabilizing the child's physical condition

Rationale: In all child abuse cases, the primary concern is the physical condition of the

child. Although contacting appropriate state officials to report suspected abuse and securing a safe environment for the child are both interventions that need to be performed, this child is unconscious, so the priority is to stabilize the child's physical condition. Confronting the parents about the abuse at this time may cause resentment and conflict in the parents, and the parents might attempt to leave the emergency department with their child.

A nurse in a women's clinic develops a plan of care for abused women. Which tertiary prevention intervention should be included in the plan of care?

Assisting abused women in overcoming the physical and psychological effects of abuse

Rationale: Primary prevention intervention (here, identifying families at risk for abuse and changing societal views toward domestic abuse) is focused on risk identification and health promotion and prevention of disorders. Secondary prevention interventions (early case-finding and decisive intervention) are focused on early identification and treatment of a problem. Tertiary prevention intervention (helping abused women overcome the physical and psychological effects of abuse) is focused on reducing the residual effects of a disorder and rehabilitation.

A nurse assists in caring for victims of an explosion at a local industrial plant. The nurse plans to implement crisis interventions, knowing that this incident is characteristic of:

An adventitious crisis

Rationale: Adventitious crises are unpredictable tragedies that occur without warning. An individual may experience crisis, but there is no formal type of crisis known as "individual crisis." A situational crisis occurs when a specific external event disturbs an individual's psychological equilibrium. A maturational crisis involves the normal life transitions that produce changes in individuals and how they perceive themselves, their roles, and their status.

A nurse prepares equipment in the electroconvulsive therapy (ECT) suite for a client who will be arriving shortly for therapy. Which items are essential? Select all that apply.

Pulse oximeter
Suction device
Ventilation equipment

Rationale: In the ECT suite, blood pressure, cardiac, and electroencephalographic monitors are placed on the client to assess vital functions. Whenever ECT is administered, emergency equipment, including oxygen, suction, and ventilation equipment, must also be available. Bath blankets and a thermometer are not essential equipment.

A client with depression says, "I always make mistakes. I never do anything right." Which response by the nurse is therapeutic?

Identifying recent accomplishments that demonstrate the client's abilities

Rationale: Feelings of low self-esteem and worthlessness are common symptoms of the depressed client. Reminders of the client's recent accomplishments or personal successes are ways to interrupt the client's negative self-talk and distorted cognitive view of self. The incorrect options give advice and devalue the client's feelings.

A hospitalized client with a diagnosis of delirium often becomes disoriented and confused during the night. Which intervention does the nurse implement?
Ensuring a low-stimulation environment at night

Rationale: It is important to provide a consistent daily routine and a low-stimulation environment when a client is confused. Noise, including that from radios and televisions, may add to the client's confusion and disorientation. Lighting is an environmental stimulus that helps maintain and improve orientation.
A psychiatric nurse assists victims of a nightclub fire and their families. Which actions on the part of the nurse is the most important intervention in the immediate post disaster period?
Talking to people seeking assistance from the American Red Cross

Rationale: In the immediate post disaster period, it is important that the nurse is present in places, such as morgues, hospitals, and shelters, where victims are likely to gather. Rather than wait for people to identify themselves publicly as being unable to cope with stress, it is suggested that nurses work with the American Red Cross, talk to people waiting in line to apply for assistance, go door to door, or visit a relocation site. The nurse should ask individuals how they are managing their affairs and explore their reactions to the stress.

A psychiatric nurse who is a member of a mobile crisis team is called to deal with a person who is threatening to jump off a bridge in a suicide attempt. On arrival at the site, the nurse immediately:
Tries to communicate with the client and develop a therapeutic relationship

Rationale: When someone is in the act of preparing to commit suicide, the most appropriate action on the part of the nurse is to communicate with the client in an attempt to develop a therapeutic relationship. The nurse should communicate hope, and hope is often the most therapeutic element in any nursing intervention with a suicidal client. Telling the client he is making a mistake is inappropriate. The other incorrect options are also inappropriate and could prompt the client to follow through with the suicide attempt.
A client tells the nurse, "I did my hair just like my favorite math teacher wears hers. I hope I can be a good teacher, too." Which defense mechanism is the client using?
Identification

Rationale: Identification is the process in which a person tries to become like someone he or she admires by taking on the thoughts, mannerisms, or tastes of that person. Projection is attributing one's thoughts or impulses to another person. Regression is retreating to behavior characteristic of an earlier level of development. Intellectualization is the use of excessive reasoning or logic in an attempt to avoid disturbed feelings.
A nurse assesses a new client hospitalized on the mental health unit. The client is experiencing negative thinking and says, "I'm doomed to failure." The nurse recognizes that the client's announcement indicates problems with:

Self-esteem

Rationale: Direct expressions of low self-esteem may include self-criticism. The client exhibits negative thinking and believes that he or she is doomed to failure. The underlying goal of the client is to demoralize himself. The client may describe himself as "stupid," "no good," or a "born loser." The client will view the normal stressors of life as impossible barriers and become preoccupied with self-pity. A body image problem involves the expression of dislike of one's physical appearance. A problem with personal identity involves the expression of dislike of one's characteristics. A problem with role performance involves one's inability to fulfill expected responsibilities.
A psychiatric nurse is sitting with several clients in the day room. A client who has been experiencing delusions and hallucinations says to the nurse, "That television is sending special messages to me." Which of the following responses by the nurse is therapeutic?
"The television is on for everyone."

Rationale: The therapeutic response is the one that provides reality for the client. In the incorrect options, the nurse feeds into the client's delusions or hallucinations and denies the client the opportunity to see reality.
A client with depression says, "My children hate me." Which response by the nurse is therapeutic?
"It sounds like you're having a difficult time with your children."

Rationale: The nurse should use therapeutic communication techniques when responding to a client's comment. In saying, "Your children don't hate you," the nurse is disagreeing with the client's comment. In the other incorrect options, the nurse criticizes the client's children. The correct option is an example of the therapeutic response of reflection.
A client with depression says to the nurse, "My child is dead, and I don't want to live anymore." Which comment by the nurse is therapeutic?
"Tell me more about how you're feeling."

Rationale: In the correct option, the nurse encourages the client to continue expressing her feelings. The incorrect options are nontherapeutic responses in which the nurse does not encourage the client's self-expression.
A client on the mental health unit says to the evening nurse, "The staff on the day shift let me smoke two cigarettes. You only let me smoke one." Which response by the nurse is therapeutic?
"The policy is one cigarette. We'll follow the policy."

Rationale: The correct option is therapeutic because it provides the client with a clear and direct response regarding the policy on the unit. In the incorrect options, the nurse criticizes the day shift staff.
A nurse seeks to deescalate aggressive behavior by a client with schizophrenia. Which actions by the nurse are appropriate in this situation? Select all that apply.
Being assertive with the client
Maintaining a nonaggressive posture

Notifying other staff of the client's behavior

Rationale: To deescalate aggressive behavior, the nurse should maintain a calm demeanor and nonaggressive posture. The nurse should give the client clear instructions that are brief and assertive, but threatening the client with restraint is inappropriate. The nurse should maintain personal space and not stand closer than about 8 feet (2.4 meters) from the client. Standing close to the client will convey a threatening message. For the sake of safety, it is important to notify other staff members of the client's behavior.

A nurse prepares a client for electroconvulsive therapy (ECT). Which concern is of the highest priority?

Risk for aspiration

Rationale: The risk for aspiration is reduced by keeping the client on nothing-by-mouth status for 6 to 8 hours before the procedure, removing dentures, and administering medications as prescribed to diminish oral secretions. Although fear and anxiety may also be concerns, they are of lower priority. Confusion is likely to be a concern after the treatment.

A nurse discovers a hospitalized client with depression wrapping long shreds of torn sheets around his neck. What is the priority nursing concern for this client?

Self-inflicted injury

Rationale: Because the client is depressed and has been found with long shreds of torn sheets hanging around his neck, the nurse must conclude that a risk for self-inflicted injury exists. Safety is always a priority concern. Self-esteem, loss of hope, and coping abilities may also be concerns in this case but are not the priority.

A nurse analyzes assessment findings in a client with physical injuries that are suspected by the staff of having been inflicted during family-related violence. Which factor should the nurse first consider?

The client's vital signs

Rationale: When data obtained from a client who may have been involved in family violence are being analyzed, the physiological well-being of the client is the first concern. The correct option is the only one that directly addresses physiological assessment.

A nurse is caring for a victim of sexual assault. The client's physical assessment is complete. The client's psychological reaction to the assault includes fear, confusion, disorganization, and restlessness. How should the nurse interpret these behaviors?

Normal reactions to a traumatic event

Rationale: During the acute phase following the sexual assault, the client may display any of a wide range of emotional and somatic responses. All of the symptoms noted in the question are part of a normal reaction to an intensely difficult crisis. Although the client's initial reactions may be predictive of later problems, they do not constitute an abnormal initial response. Therefore the remaining options are incorrect.

The wife of an alcoholic client began attending Al-Anon groups three weeks ago. The nurse determines that the wife is benefiting from the group when she states:
"Now I realize that I didn't deserve the beatings my husband inflicted on me."

Rationale: Al-Anon support groups specifically help families of alcoholics cope with the problems that arise from living with an alcoholic. The wife's recognition that the beatings were not deserved is the healthiest response, identifying an understanding that the client (husband) is responsible for his behavior and cannot be allowed to blame family members for loss of control. The nonalcoholic partner should not feel responsible when the spouse loses control. Codependency is not a healthy response. The group is a place to work on issues rather than an escape.
A client says, "I've had so many crying spells over the past several weeks. My doctor says it's probably depression." The nurse sees that the client is sitting slumped in the chair and that the client's clothing is baggy. Further assessment of this client should be focused on:
Weight loss

Rationale: All of the options are problems that should be addressed; however, the weight loss is the priority, because the obvious ill fit of clothing could signify a substantial problem with nutrition. The client has already told the nurse that the crying spells have been a problem. The need for medication was not addressed in the question. Sleep is affected by depression and should be addressed; however, weight loss is the most important item requiring further assessment.
A client says, "I spend hours each evening reviewing my day to see whether I behaved appropriately or should have done something differently. I tell myself to snap out of it, but I'm still doing it! It takes me 2 or 3 hours each morning to get dressed, because I want my clothes to be just right." Which problem is evident in these statements?
Obsessive-compulsive disorder

Rationale: Obsessions are persistent intrusive thoughts that the affected person tries to ignore or suppress. This client wants to "snap out of" this daily review, but the thoughts continue for hours. Compulsions are repetitive behaviors that the client feels driven to perform, such as changing clothes frequently until they are "just right." Agoraphobia, major depression, and attention deficit-hyperactivity disorder are not associated with the characteristics described in the question.
A phlebotomist prepares to draw blood from a client experiencing delusions. While in the laboratory, the client begins shouting, "You're all bloodsuckers. Get me out of here." Which response by the nurse is therapeutic?
"It must be scary to think others want to hurt you."

Rationale: The correct option recognizes the client's feelings and helps the client focus on the emotion underlying the delusion but does not argue with it. One danger in directly attempting to change the client's mind is that the client may cling more strongly to the delusion. The inappropriate responses deny or argue with the client's beliefs, which may jeopardize the nurse-client relationship

A drunken client is awaiting treatment in the emergency department. The client becomes loud and aggressive when told that there will be a short delay before treatment. Which response by the nurse is therapeutic?
Offering to take the client to an examination room until treatment can be started

Rationale: Safety of the client, other clients, and staff is of priority concern. Offering to take the client to an examination room until she is treated separates the client from others and provides a less stimulating environment where the client can maintain her dignity. Waiting until the behavior escalates before intervening is incorrect because it allows the client to become even more agitated and a threat to others. Attempting to talk with the client to deescalate behavior is not likely to be productive, because the client is intoxicated and her reasoning impaired. Informing the client that she will be asked to leave if the behavior continues would only further aggravate an already agitated individual.
As the nurse prepares a client for a coronary artery bypass graft, the client asks, "Will I be OK?" Which response by the nurse is therapeutic?
"Let's talk about how you're feeling."

Rationale: The correct response offers self and encourages the client to share feelings and fears. The incorrect options block communication and may increase the client's anxiety. False reassurance is nontherapeutic. The client needs an opportunity to talk about the impending surgery.
A nurse prepares to care for a client with a diagnosis of Tourette syndrome. The medical record indicates that the client experiences motor tics. Which finding would the nurse expect to note during assessment of this client?
Tongue protrusion

Rationale: Tourette syndrome involves motor and verbal tics that cause marked distress and significant impairment of social and occupational function. Motor tics usually involve the head but may also involve the torso and limbs. The most common first symptom is a single tic, such as eye-blinking. Other motor tics include tongue protrusion, touching, squatting, hopping, skipping, retracing of steps, and twirling when walking. Vocal tics include words and sounds such as barks, grunts, yelps, clicks, snorts, sniffs, and coughs. Coprolalia, the uttering of obscenities, is present in some individuals with this disorder.
A nurse assesses a client with early-onset Alzheimer's disease. The nurse asks the client, "How was your weekend?" The client responds by saying, "It was great. I discussed war campaigns with the president and had dinner at the White House." Which defense mechanism is evident?
Confabulation

Rationale: Confabulation is a defense mechanism and an unconscious attempt to maintain self-esteem by providing information that is not true about an event or situation. Hiding is a form of denial and an unconscious protective defense against the terrifying possibility of losing one's place in the world. Apraxia is characterized by the

loss of purposeful movement in the absence of motor or sensory impairment. Perseveration is the repetition of phrases or behaviors.

A nurse reviews the record of a client and notes that the client experiences flashbacks. Which of the following conditions is most often associated with flashbacks?

Hallucinogenic drug use

Rationale: Flashbacks, a common effect of hallucinogenic drugs, are transitory recurrences in perceptual disturbance caused by a person's earlier hallucinogenic drug experiences. They occur when the person is in a drug-free state. Visual distortions, time expansion, loss of ego boundaries, and intense emotions may occur. The experience of flashbacks is also characteristic of posttraumatic stress disorder. They do not occur in schizophrenia or obsessive-compulsive disorder. Anxiety disorder is a term that encompasses posttraumatic stress disorder as one of its components.

After an attack in a park while jogging, a client experiences posttraumatic stress disorder. The client, visibly anxious, tells the nurse that she now avoids all exercise and parks but says, "I don't want to feel this way." Which response by the nurse is appropriate?

"I can see that you're upset about this. Let's talk some more about it."

Rationale: The therapeutic response encourages the client's expressions of feelings by indicating that the nurse is aware of the client's feelings and promoting continued communication. Each of the incorrect options neither acknowledges the client's concerns nor encourages further communication. Giving advice and false reassurance are not therapeutic techniques.

A client hospitalized in a mental health unit is restrained after becoming extremely violent. Which finding indicates to the nurse that the client can be removed from the restraints?

The client initiates no aggressive acts for 30 minutes after the release of two leg restraints

Rationale: The best indicator that the client's behavior is under control is when the client refrains from aggression after partial release from the restraints. Generally a structured reintegration, begun by reducing a client's four-point restraints to two-point restraints, is initiated. If the client continues to exhibit nonaggressive behavior, the remaining restraints are removed. The incorrect options are not indicators that the client's behavior is under control.

A client with bipolar disorder has been hospitalized for 4 days. Today in group therapy the client offered helpful suggestions in regard to another client's problem. The nurse concludes that the client's behavior is representative of

Improvement

Rationale: The behavior demonstrated by the client is appropriate during hospitalization. There is no evidence in the question that the client is acting out (which is an attention-seeking behavior), being manipulative, or seeking attention.

A client says to the nurse, "My cancer is going to shorten my life, so I'm making a will that leaves my money to charity. Do you think I can get into heaven that way?" Which response by the nurse is therapeutic?
"You feel that a charitable contribution will get you into heaven if your cancer ends your life?"

Rationale: The correct option involves the therapeutic communication technique of reflection, in which the ideas of the client are presented back to the client for the client to consider. It is employed when a client asks the nurse for approval or judgment because it helps the nurse intervene with a nonjudgmental response. The client is expressing concern, and, although the illness may be cured, it is vital to actively listen and to be sensitive to expression of concerns and fear. The incorrect options give an opinion, express approval, use false reassurance, or offer advice and lectures to the client, all of which are closed-ended techniques that do not facilitate expressions of feelings.
A nurse is providing medication instructions to a client who is starting disulfiram. Which statements by the client indicate that the client understands the information? Select all that apply.
"It's important to take this medication every day."
"I need to check the labels on over-the-counter medications carefully."

Rationale: Disulfiram can help motivated clients avoid impulsive drinking of alcohol because it interacts with alcohol, resulting in unpleasant physical effects. The medication must be taken daily and is often administered under supervision. The medication reaction begins minutes to a half-hour after alcohol use, and the effects — facial flushing, headache, neck pain, tachycardia, decreased blood pressure, sweating, nausea and vomiting, and respiratory distress — may last for as long as 2 hours. The client should avoid "hidden" sources of alcohol in foods and other medications. The client should also avoid inhaling fumes from alcohol-containing substances such as wood stain, paint, and furniture-stripping products.
A nurse counsels a client with an alcohol disorder and the client's spouse. The spouse says, "I've covered up the drinking because I made a commitment to our marriage, but now our children won't come to visit." The nurse should refer the spouse to a support group for:
Codependents

Rationale: The description of the spouse's behavior indicates that the spouse is codependent. Codependence involves overly responsible behavior; that is, doing for another person what that person could be doing for himself or herself. The incorrect options identify addicted people, not people connected to the addict, and a person who is involved with caring for an addicted significant other on a daily basis.
A client hospitalized with severe depression is withdrawn and exhibits poor motivation and concentration. Which activity should the nurse plan for this client?
Drawing

Rationale: When a client is severely depressed, the client should be involved in

activities that require little concentration and have no elements of being "right" or "wrong." As the client's condition improves, the client may become involved in activities with small groups, such as cooking class, dance therapy, and small group discussions.
A nurse cares for a severely depressed client who is mute. Which comment by the nurse to the client is appropriate?
"There are many new pictures on the wall."

Rationale: When a client is not ready to talk, direct questions may raise the client's anxiety level. Pointing to commonalities in the environment draws the client into, and reinforces, reality. The nurse should avoid platitudes, which tend to minimize the client's feelings and can increase feelings of guilt and worthlessness. The nurse also should avoid statements that provide false reassurance.
A nurse provides dietary instructions to a client who will be taking tranylcypromine. Which foods should the nurse tell the client to avoid? Select all that apply.
Avocado
Pickled herring

Rationale: Tranylcypromine is a monoamine oxidase inhibitor (MAOI). The client taking an MAOI needs to avoid consuming tyramine-containing foods. This includes all cheeses except cottage and cream cheese and Danish Brie and Danish Camembert. Other foods containing tyramine include avocado, bananas, caviar, canned figs, pickled herring, liver, smoked foods, yeast extracts, and broadbean pods.
A client, upset, says, "My ex-wife's new husband is being relocated to a job across the country, so now I'll only see my child on holidays and school vacations." Which response by the nurse is therapeutic?
"This must be very difficult for your child to move away from you, school, and friends."

Rationale: The therapeutic nursing response is the one that supports the client in seeing events from his child's viewpoint. Adults are better able to adjust to life changes than are younger people. It is important that both parents focus on the disruption that a move causes for children, not just themselves. Asking, "Can you relocate to be closer to your child?" is advice, which is nontherapeutic. Saying, "That's too bad. Maybe the court can stop your ex-wife from moving away" is a social response that offers a conflict-oriented suggestion. Asking, "Have you talked to your ex-wife about giving custody to you and your new wife?" offers a suggestion that is not supportive and is conflict-oriented.
A nurse provides medication instructions to a client who is taking lithium carbonate . Which statements by the client indicate an understanding of the instructions? Select all that apply.
"I should take this medication with my meals."
"I need to call my doctor if I get diarrhea or vomiting or start to sweat a lot."
"My blood level of medication needs to be monitored closely while I take this medication."

Rationale: Lithium carbonate is used to treat bipolar disorder. Lithium is irritating to the gastric mucosa and therefore should be taken with meals. Because the therapeutic and toxic dosage ranges are so close, the lithium blood level must be monitored very

closely, with more frequent checks at first and a check every several months thereafter. The client should be instructed to stop taking the medication if excessive diarrhea, vomiting, or diaphoresis occurs and to inform the health care provider if any of these problems develops, because it could be an indication of toxicity. The client should weigh him- or herself several times a week (not several times a day). A normal diet and normal salt and fluid intake (1500 to 3000 mL/day of fluid, or six 12-oz [180 ml] glasses) should be maintained, because lithium decreases sodium reabsorption in the renal tubules, which could result in sodium depletion. A low sodium intake causes an increase in lithium retention and could lead to toxicity.

Buspirone hydrochloride is prescribed for a client with an anxiety disorder. The nurse, providing information to the client about the medication, should tell the client that:

Mild dizziness and nervousness may occur

Rationale: Buspirone hydrochloride is used in the management of anxiety disorders. Dizziness, nausea, headaches, nervousness, lightheadedness, and excitement, which generally are not major problems, are side effects of the medication. The advantage of this medication is that it is not sedating or addicting. The medication takes 2 to 4 weeks for therapeutic effects to appear.

A nurse cares for a hospitalized client who has been taking clozapine for the treatment of schizophrenia. Which laboratory result will the nurse specifically check to assess the client for an adverse reaction associated with the use of this medication?

White blood cell count

Rationale: Clozapine is often reserved for clients with treatment resistant illness because of its side effects of agranulocytosis, seizures, and myocarditis. Prescribers must follow a treatment protocol that incude entering clients in a national registry, monitoring white blood cell count weekely for 6 months and then biweekly for as long as clients are taking the medication, and writing prescriptions for only 1 to 2 weeks at a time. For the refractory client, however, clozapine may make a significant difference in treatment outcome. The remaining laboratory tests are not associated with the use of this medication.

A nurse employed in a prison infirmary cares for a client recuperating from a stab wound. The client says, "You have beautiful eyes, and you smell nice." Which response or action on the part of the nurse would be therapeutic?

"I'm here to change your dressing, not discuss my eyes or how I smell."

Rationale: A client in prison is knowledgeable about the rules for behavior in the correctional setting. Many clients will test the nurse's capacity to be manipulated and will make inappropriate statements. These behaviors should be addressed directly. The nurse should define his or her role without being judgmental or providing an opening for a regressive struggle. Social responses or saying nothing may be misinterpreted by the client as an indication that the nurse welcomes the compliments

A nurse is caring for a client hospitalized with depression. Which comment by the nurse upon entering the client's room is appropriate?

"You're wearing a new dress this morning."

Rationale: The depressed client sees the negative side of everything. Giving recognition without giving approval is therapeutic. The incorrect options give approval or false reassurance, both nontherapeutic communication strategies. Saying, "You look nice this morning" or "I like the way you did your hair" might be interpreted as "I did not look nice yesterday" or "The nurse didn't like the way I did my hair yesterday."

A nurse plans care for a client experiencing psychomotor agitation. Which activities would be appropriate for the client? Select all that apply.

Playing table tennis

Filling cups with ice for afternoon snacks

Rationale: It is best to provide the client with psychomotor agitation activities that involve the use of the hands and gross motor movement such as table tennis, volleyball, finger painting, drawing, working with clay, and exercising. Filling cups with ice also achieves this intent. These activities provide the client a more appropriate way of discharging motor tension than pacing or wringing the hands. Playing simple card games and reading magazines are sedentary activities. Playing chess requires concentration and intensive use of thought processes.

A nurse develops a plan of care for a client with depression who has experienced a 24-lb (11 kg) weight loss in the past 2 months. Which intervention should the nurse include in the plan of care?

Sitting with the client to make food and fluid choices from the menu

Rationale: The client should be asked which foods or drinks he or she likes and offered choices. Sitting with the client during the activity is therapeutic use of self by the nurse. This strategy, reinforcing the idea that someone cares, may raise the client's self-esteem and serve as an incentive for the client to eat. Simply offering high-calorie meals and snacks does not ensure that the client will eat. The client is more likely to eat the foods provided if he or she has selected the foods. Someone should remain with the client during meals.

A client with delirium suddenly picks up a can of soda from the meal tray and threatens to throw it at the nurse. How should the nurse respond?

"Hitting me or anyone else is not allowed."

Rationale: When a client's behavior becomes physically abusive, the nurse must set limits on the behavior. Communication with a client experiencing delirium should be simple and clear. The incorrect options threaten the client and jeopardize the client's rights.

A client with obsessive-compulsive disorder, upset and agitated, walks repeatedly around the nursing unit, following the same route each time. The client says to the nurse, "Walk with me." Which response by the nurse is appropriate?

"I can see that you're upset. I can walk and talk with you for 15 minutes."

Rationale: The correct response acknowledges the client's feelings and provides an avenue for release of the client's anxieties. Each of the incorrect options is a block to

communication. The wording of the incorrect options does not acknowledge the client's feelings.
A client hospitalized with schizophrenia says to the nurse, "Get your goat. Go out and vote. Don't be a cut throat. Row your boat." How should the nurse document the client's behavior?
Clang associations

Rationale: Repetition of words or phrases that are similar in sound but in no other way, known as clang association, is an assessment finding in some clients with schizophrenia. Clang associations often take the form of rhyme. Echolalia, the pathological repeating of another's word, is often seen in people with catatonia. Word salad is a mixture of phrases that is meaningless to the listener and perhaps to the speaker as well. Thought broadcasting is the belief that others can know one's thoughts.
A client is hospitalized after falling asleep at the wheel of the) car, hitting and killing a pedestrian crossing the street. The nurse caring for the client notes that the client is crying and upset. What is the appropriate reaction by the nurse?
Saying to the client, "I see that you're crying. I'm here to talk to you."

Rationale: Making a neutral observation and offering self are therapeutic communication techniques. In the interest of safety, the client needs supervision. The nurse should assess the client and provide comfort measures before administering a sedative or contacting the healthcare provider. Additionally, a prescription must be obtained before administering a sedative. Telling the client that the pedestrian's death was a result of his falling asleep at the wheel is inappropriate and a block to communication.
A nurse is assigned to care for a client with a diagnosis of catatonic stupor. When the nurse enters the client's room, the client is lying on the bed in a fetal position. What should the nurse do?
Sit beside the client in silence

Rationale: Clients who are withdrawn may be immobile and mute and require consistent, repeated approaches. Interventions include the establishment of interpersonal contact and maintenance of safety. The nurse facilitates communication with the client by sitting in silence, asking open-ended questions, and pausing to provide opportunities for the client to respond. The client should not be left alone. It is not appropriate to place the client in a public place. Asking direct questions of this client is not therapeutic.
A client diagnosed with schizophrenia tells the nurse. "There are voices outside the window telling me what to do all the time. Can you hear them? What should I tell them?" How should the nurse respond initially?
"What are the voices telling you?"

Rationale: The nurse should first assess the situation. When a client is experiencing an auditory hallucination, it is important initially to determine what the voices are saying or telling the client to do. Suicidal or homicidal messages, if heard by the client, necessitate the implementation of safety measures as a priority. The incorrect options

are inappropriate and do not reinforce reality or provide important information to the nurse.

A client has a diagnosis of dependent personality disorder. Which goal is most appropriate for this client?

Using the problem-solving process effectively

Rationale: The client with dependent personality disorder exhibits an unusually strong need to be cared for and has difficulty making personal choices and every day decisions in fear of making the wrong decision. An appropriate goal would be for the client to use the problem-solving process effectively in everyday situations. The client described in the question does not exhibit any suicidal traits, nor does he suffer from an obsessive-compulsive personality disorder or an anxiety disorder.

A nurse completes the initial assessment for a new client in a maximum-security prison who has been sentenced to serve a life sentence without parole. What should the nurse include as a priority in the treatment plan for this client?

Assessment for suicide risk

Rationale: The nurse preparing a treatment plan for a client in prison must integrate the built-in realities and limitations of the correctional setting and its compulsory regimen into the treatment plan. The incidence of suicide among inmates in correctional settings is higher than that among the general population. Assessment for self-violence and suicidal potential is critical for a client who has been sentenced to serve life without parole. Rehabilitation and vocational training are of limited use for such a client. Assessment for homicide risk may be a part of the plan but is not the priority. Additionally, there is no information in the question to support an assessment for homicide risk.

A home health nurse provides instructions to the spouse of a client taking tacrine hydrochloride for the management of moderate dementia associated with Alzheimer's disease. Which information should the nurse provide to the spouse?

"If you see a change in the color of the skin or stool, notify the healthcare provider."

Rationale: Liver toxicity is an adverse effect of tacrine and may be signaled by changes in the color of the skin or stool. The client or spouse should never be instructed to double the next dose of any medication if the previous dose is missed. Tacrine may be administered between meals on an empty stomach or, if gastrointestinal upset occurs, with meals. Flu-like symptoms (i.e., headache, nausea, vomiting, diarrhea, dizziness) are frequent side effects of the medication.

The lithium level in a client taking lithium carbonate is 2.3 mEq/L. Which assessment finding would the nurse expect to note in the client based on this laboratory value?

Blurred vision

Rationale: This laboratory result indicates lithium toxicity. The maintenance blood level of lithium should range between 0.4 and 1.3 mEq/L. At levels of 1.5 to 2.0 mEq/L, the client will experience vomiting, diarrhea, coarse hand tremors, confusion, lack of coordination, and muscle hyperirritability. At levels of 2.0 to 2.5 mEq/L, the client will experience blurred vision, muscle twitching, hypotension, a large output of dilute urine,

stupor, or seizures. At a level of 2.5 mEq/L or higher, urinary and fecal incontinence occurs. Cardiac dysrhythmias, peripheral vascular collapse, and death may also occur.
Lorazepam has been prescribed for a client for management of anxiety. Which finding in the client's history would indicate the nurse the need to confer with the healthcare provider before administering the medication?
Narrow-angle glaucoma

Rationale: Lorazepam is contraindicated in people with hypersensitivity to benzodiazepines, as well as coma, pre-existing central nervous system depression, uncontrolled severe pain, and narrow-angle glaucoma. It is also contraindicated in women who are pregnant or breastfeeding. Lorazepam is safe for clients with diabetes, hypothyroidism, and coronary artery disease.
A nurse assesses a client hospitalized with schizophrenia for whom risperidone has been prescribed. Which laboratory test result should the nurse check before administering the first dose of this medication?
Liver function studies

Rationale: Baseline assessment before the initiation of risperidone treatment includes kidney and liver function tests. This medication is used with caution, generally with an initial dosage reduction, in clients with renal or hepatic impairment, clients with underlying cardiovascular disorders, and older or debilitated clients. Risperidone does not alter clotting factors, so the incorrect options do not apply.
A client in the mental health unit points to another client and says to the nurse, "He's been working with the Taliban, pouring anthrax into our water supply." How should the nurse respond to the client?
"Are you saying that you don't feel safe about drinking our water?"

Rationale: The nurse appropriately responds by addressing the client's feelings associated with the delusional thinking. The correct response involves reflection, a therapeutic communication technique. After responding to the client's feelings, the nurse should address the client in an open, honest, and matter-of-fact way to ease the client's suspiciousness. The incorrect responses do not deal directly with the client's concerns, which may result in a regressive struggle with the client.
A nurse develops a plan of care for a depressed client who is complaining of feelings of hopelessness and helplessness. Which interventions should the nurse include? Select all that apply.
Assisting the client in identifying sources of hope
Giving the client time to respond during communication
Offering simple activities that provide the client an opportunity to be successful

Rationale: The nurse should establish rapport by sharing time and offering supportive companionship. The nurse should assist the client in identifying source of hope and give the client time to respond. Successful accomplishment of simple activities will help the client achieve a sense of success. Superficial and social discussions are not helpful. Avoiding serious issues is a social rather than a therapeutic approach and may further

depress the client. Remember, the client is working through depression. Negative issues should be discussed so that the client may explore effective coping skills.
A nurse plans care for a client with an obsessive-compulsive disorder (OCD). Which nursing intervention should receive priority?
Establishing a trusting nurse-client relationship

Rationale: Establishment of a trusting nurse-client relationship is the foundation for giving effective nursing care to the client with a mental health disorder. The nursing interventions identified in each of the other options may be appropriate but are not the priority.
A client with a panic disorder has been medicated with alprazolam.Which assessment finding suggests that the client is experiencing a side effect of the medication?
Confusion

Rationale: Alprazolam is an antianxiety agent (benzodiazepine) used in the short-term management of panic disorder. Central nervous system side effects include disorientation, confusion, drowsiness, and clumsiness. Increased anxiety is not a side effect of the medication. The medication can cause both physical and psychological dependence, so it is used with caution.
A client experienced the sudden onset of blindness, but extensive testing revealed no organic reason that the client could not see. The nurse later learned that the blindness developed after the client witnessed a fire at a neighboring house in which the family of three died. Which problem should the nurse suspect?
Conversion disorde

Rationale: A conversion disorder is an alteration or loss of a physical function that cannot be explained by any known pathophysiological mechanism. It is often an expression of a psychological need or conflict. Psychosis is a state in which a person's mental capacity to recognize reality, communicate, and relate to others is impaired, thus interfering with the person's capacity to deal with life demands. Repression is a coping mechanism in which unacceptable feelings are kept out of awareness. A dissociative disorder is a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness.
A mental health nurse finds a client in the hospital day room self-inflicting cigarette burns. After removing the cigarette and attending to the burns, what is the nurse's next action?
Instituting one-on-one nursing supervision

Rationale: Safety is the nurse's first priority. When a client inflicts harm on him- or herself, immediate one-on-one nursing supervision should be instituted. Next, the psychiatrist should be notified regarding the incident. The client should not be restrained or placed in seclusion, because these actions violate the client's rights.
A client is unwilling to leave the house for fear of doing "something bizarre in public." As a result, the client remains homebound except when accompanied by her husband. The nurse analyzes this data and determines that the client is experiencing:

Agoraphobia

Rationale: Agoraphobia is a fear of open spaces and the fear of being trapped in a situation from which there may not be an escape. Agoraphobia includes the possibility of experiencing a sense of helplessness or embarrassment if a phobic attack occurs. Avoidance of such situations usually results in a reduction in social and professional interactions. Social phobia is focused more on a specific situation, such as the fear of speaking, performing, or eating in public. Clients with hypochondriacal symptoms focus their anxiety on physical complaints and are preoccupied with their health. Claustrophobia is a fear of closed-in places.

A client states to a nurse, "I feel like putting an end to my misery." How should the nurse respond to the client?

"Tell me more about what you feel like doing."

Rationale: All suicidal threats must be taken seriously, and their meaning must be thoroughly explored. Clichés and false reassurance block communication and devalue the client. "Why" questions request an explanation from the client when the client may not have one.

A nurse uses the proverb "People in glass houses shouldn't throw stones" to assess the abstract thinking ability of a client with schizophrenia. Which response by the client demonstrates that the capacity for abstract thinking is intact?

"I shouldn't tell someone not to do something that I'm doing myself."

Rationale: Abstract thinking is the ability to discern meaning from a situation. Responses from a client with schizophrenia may be inappropriate because the client interprets words literally (concretely) rather than abstractly. Clients with schizophrenia often have difficulty with concreteness and symbolism. The incorrect options are indicative of concrete thinking and do not reflect an ability to think abstractly.

Amitriptyline hydrochloride has been prescribed for a client with depression, and the nurse provided medication instructions. Which statements by the client indicate that the teaching was effective? Select all that apply.

"I can chew sugarless gum if my mouth feels dry."

"I'm allowed to eat prunes every other day to prevent constipation."

Rationale: Amitriptyline is a tricyclic antidepressant. It has anticholinergic effects, including dry mouth and constipation. Sugarless gum and high-fiber foods may produce relief from these side effects. This medication has sedative effects, so a single maintenance dose is usually taken at bedtime. All of the other client statements regarding this medication indicate misinformation on the part of the client. It will take several weeks for the client to experience relief from depression. Selected cheese products should be avoided by the client taking monoamine oxidase inhibitors (MAOI) antidepressants, not tricyclics.

A nurse reviews assessment data for a client admitted to the mental health unit and notes that that the client is experiencing anxiety because of a situational crisis. Which event could cause this type of crisis?

Loss of a job

Rationale: A situational crisis arises from external rather than internal sources. Situations that could precipitate this type of crisis include loss of or change of a job, the death of a loved one, abortion, change in financial status, divorce, the addition of new family members, pregnancy, and severe illness. Recent sexual assault, witnessing a fatal automobile accident, and destruction of one's home by a hurricane are all examples of adventitious crises

A nurse develops a plan of care for a client with a diagnosis of posttraumatic stress disorder. Which goal for the client is appropriate?

Reporting a decrease in nightmares

Rationale: Appropriate goals for the client with posttraumatic stress disorder include reporting an increase in restful sleep periods and a decrease in nightmares or flashbacks. Decreased time spent in ritualistic behaviors and increased control over intrusive thoughts and rituals are appropriate goals for clients with obsessive-compulsive disorder. Reframing anxiety-provoking situations is an appropriate goal for a client with a phobia.

A nurse reviews the laboratory results of a client taking lithium carbonate. Which serum electrolyte value would the nurse identify as a precipitating factor for lithium toxicity?

Sodium 130 mEq/L (130 mmol/L)

Rationale: Sodium depletion decreases the renal excretion of lithium, thereby causing the medication to accumulate and become toxic. The client should be instructed to maintain a normal sodium intake. The normal sodium level ranges from 135 to 145 mEq/L (135-145 mmol/L). The normal calcium level is 8.2 to 10.2 mg/dL (2.15-2.55 mmol/L). The sodium of 145 mEq/L and the calcium levels identified in the options are all normal values.

A client with a personality disorder will begin recreational therapy as a component of the treatment plan. This treatment modality is most helpful for clients who:

Have difficulty socializing

Rationale: Recreational therapy helps clients with personality disorders explore ways to enjoy themselves without the use of self-destructive behaviors such as the abuse of alcohol or drugs. This modality is helpful to clients who have difficulty socializing, because recreation strengthens social skills. Art therapy may be helpful for a client with anger issues. The client who is exhibiting violent behavior may require medication therapy. Movement therapy may be helpful for clients who become "numb" when experiencing intense feelings.

A nurse monitors a client in seclusion. The client calmly says to the nurse, "I'm no longer a threat to myself or others." The nurse interprets this statement as an indication that the client may be:

Ready to come out of seclusion

Rationale: When the client demonstrates calm behavior and communicates he or she is no longer a threat to self or others, the nurse gathers additional assessment data to

determine whether it is safe for the client to come out of seclusion. There is no relationship between the client's statement and the nurse interpreting that the client is manipulating the nurse, ready to perform self-care activities, and needing to communicate and socialize with others.

A nurse receives a telephone call from a client who states, "I'm going to kill myself, and I have a loaded gun in my lap." The nurse should first:

Keep the client talking and encourage her to express her feelings

Rationale: In a crisis, the nurse must take an authoritative, active role to promote the client's safety. A loaded gun in front of a client who verbalizes suicidal intent is a crisis. The client's safety is of prime concern. Keeping the client on the phone and encouraging her to express her feelings is the best first action. Once a rapport has been established with the client, the nurse can ask the client for her name and address so help can be provided. Taken prematurely, this action could anger the client, causing her to hang up. Telling the client that she is making a big mistake and asking whether there is a neighbor close by are inappropriate and could also anger the client, causing her to hang up. Additionally, the incorrect options do not address the client's thoughts and feelings.

A nurse monitors a depressed adolescent who may be suicidal. Which behavior indicates that the client is at high risk for suicide?

Giving a cherished book of poems to another client

Rationale: A depressed, suicidal client often gives away that which is of value to him or her as a way of saying goodbye and wanting to be remembered. Refusing to communicate, attempting to manipulate others, and continually arguing with family members when they visit are often typical of any adolescent.

A client prepares to attend an Alcoholics Anonymous meeting for the first time. Which step, the first in the 12-step program, should the nurse discuss with the client?

Admitting to having a problem

Rationale: The first step in the 12-step program is admitting that a problem exists. Stating that drinking will stop and discontinuing relationships with friends who drink are unrealistic as first steps in the process to recovery. Although identifying healthy alternatives to drinking may be a useful strategy, it is not the first step.

A client with mania is placed in seclusion after an outburst of violent behavior that includes physically assaulting another client. As the client is secluded, the nurse should:

Inform the client, "You are being secluded to help you regain control of yourself"

Rationale: The client is removed to a nonstimulating environment because of his or her behavior. It is best to inform the client directly of the purpose of the seclusion. Remaining silent because verbal interaction would be too stimulating, telling the client he or she is not allowed to rejoin the others until able to behave, and asking the client whether he or she understands why the seclusion are all nontherapeutic approaches. Not letting the client rejoin the others also implies punishment.

A client with severe depression tells the nurse, "I'm feeling much better now." The client demonstrates increased interaction and energy levels. The nurse implements one-on-one supervision because the behavior indicates that the client:
Now has the energy to carry out a suicide plan

Rationale: The client now has the energy to act on a suicide plan. Suicidal clients may appear to be feeling better immediately before making an attempt. Some clients experience a feeling of relief when the decision to commit suicide has been made and plans have been finalized. An elopement risk, a need interpersonal support, and a need for reinforcement of positive behaviors are incorrect interpretations of the client's behaviors.
A woman arrives at the emergency department accompanied by her husband, seeking care for cuts to her eye and multiple contusions. The client has been in the emergency department numerous times for similar injuries and the nurse suspects that the husband is inflicting the injuries. Which action should the nurse take?
Taking the client to a private area to conduct the interview

Rationale: Client safety is the most important consideration for the nurse. Taking the client to a private area is essential, because the husband is battering the client she is unlikely to be truthful about her injuries in his presence. Some women are fearful of being harmed by the partner or want to protect the partner. Confronting the husband is incorrect because it is the nurse's responsibility to support the client in making an appropriate decision, not to make it for her. Asking the client whether she is planning to divorce is not an example of therapeutic communication, and the client is unlikely to be truthful in the presence of the husband. Challenging the husband might cause him to take his wife away or not bring her next time she needs care.
A client says to the nurse, "I'm divorced and my children live in other parts of the country. They never visit or phone me. I feel so lonely. No one would notice if I were gone." The nurse should make which response to the client?
"Things seem very bleak to you right now. Are you thinking of harming yourself?"

Rationale: The nurse is responsible to clarify the client's statement, even though it is a passive one of low lethality. In the correct option, the nurse uses the therapeutic communication technique of focusing and questioning. This option also allows the nurse to assess the suicidal ideation passively expressed by the client. Giving advice is a nontherapeutic communication technique that does not allow the nurse to assess the potential for suicide. The incorrect options, respectively, are directive, judgmental, and falsely reassuring. (Also, the "silver lining" comment is a cliché.
A nurse works during the evening shift. Which actions should be performed for a client who will undergo electroconvulsive therapy (ECT) on the next day? Select all that apply.
Helping the client reduce anxiety about the procedure
Having the client shampoo and dries her hair, cleaning it of all hairspray and creams

Rationale: The nurse should help reduce any anxiety the client might have with regard to the procedure. The client should shampoo and dry her hair the night before ECT treatment and not use hairsprays or creams before ECT to reduce the risk of burns.

Restricting visitors or participation in unit activities is unnecessary. The client is kept NPO for 6 to 8 hours before treatment. Discussion of the risks, benefits, and alternatives to ECT is the responsibility of the healthcare provider when obtaining the client's informed consent.

A client admitted to the mental health unit with depression is unclean, has body odor, and is inappropriately dressed. An accompanying family member is embarrassed about the client's appearance. When planning care, it is most important for the client and family member to understand that:

The nurse will help the client meet hygiene needs until the client is able to do so

Rationale: Both the client and family need to know that the nurse will assist the client until is able to resume self-care activities. A client with depression has decreased energy and is subject to psychomotor retardation, so, assistance is necessary. Indicating that self-esteem needs to take priority over appearance, that hygiene is not important, and that peer pressure will soon have the client attending to hygiene needs are all incorrect conclusions.

A depressed client tells the nurse, "I'm powerless, and I'm not worthy of having friends. Sometimes I take too many pills." The nurse's priority in planning care for this client is:

Continual assessments for suicidal ideation

Rationale: Client safety always takes priority over other nursing care concerns. Therefore the nurse should continually assess the client for suicidal ideation. The other options are correct nursing measures for a depressed client, but they are not the priority.

A client with obsessive-compulsive disorder is hospitalized because his ritualistic behaviors have become so time-consuming that the client is unable to maintain employment. The initial priority nursing intervention is to:

Allow the client time to perform the rituals

Rationale: Compulsive rituals are used to manage the client's anxiety, even though the behavior is maladaptive. It is usually not helpful to interfere prematurely with a ritual unless it threatens the client's health. Providing the client with unit rules, assisting the client in carrying out rituals, and confronting the client about poor use of time are not therapeutic interventions and would increase the client's anxiety.

A client who recently witnessed a murder says, "I feel like I'm losing my mind. I keep hearing the gunshots and seeing the victim lying on the ground." In light of the client's statement, the nurse should:

Support the client in talking about the event and related feelings

Rationale: It is most important to support the client to talk about the event and feelings related to it. Teaching the client relaxation techniques may be helpful at some point, but the client must first express his feelings about the experience. Trying to distract the client from thinking about the event or asking the healthcare provider to prescribe an antianxiety medication does not respond to the client's needs.

A client compulsively makes and remakes the bed numerous times and often misses breakfast and some morning activities because of this ritual. Which nursing action is appropriate?
Offering reflective feedback such as "I see you made your bed several times. That takes a lot of energy."

Rationale: Reflective feedback lets the client know that the nurse acknowledges the behavior and understands that it can be very tiring. Verbalizing even tactful disapproval would increase the client's anxiety and reinforce the need to perform the ritual. Helping with the ritual is nontherapeutic and reinforces the behavior. Teaching the client about the role of neurotransmitters in compulsive behavior does not focus on the client's feelings.
A client with paranoid schizophrenia has been agitated, threatening and shouting at others, and refusing to participate in therapy. Projection and denial are evident in these behaviors. The appropriate nursing action is to:
Acknowledge the client's anxiety and then set limits on the behavior

Rationale: Denial is a failure to recognize what is occurring in a situation and generates inappropriate behavior. Projection involves attributing an attitude, behavior, or impulse to someone else. Setting limits on unacceptable and inappropriate behaviors in a nondefensive manner is most appropriate in this situation. It also helps ensure the safety of others. Accepting the behavior without comment, exploring past experiences of acting out with the client, and collecting information from the client to develop a database do not provide interventions that directly relate to the client's behavior,
A home care nurse visits a depressed older adult client in whom type 2 diabetes mellitus was recently diagnosed. As the nurse teaches about insulin injections, the client says, "I don't think I'll ever learn to stick this needle in myself." Which response by the nurse is therapeutic?
"Perhaps you could start by telling me what troubles you most about injecting yourself."

Rationale: In listening to the client's fears, the nurse allows the client to vent, establishes a one-on-one relationship, and identifies areas in which the client will require emotional support. It may not be possible for the client to discontinue insulin, regardless of his compliance with the prescribed diet and exercise. The nurse should not begin teaching until the client is able to accept the need for injections. Clichés and false reassurances are nontherapeutic responses that minimize the client's feelings and risk belittling the client.
A nurse is caring for a client with a phobia who is to be treated with systematic desensitization. The nurse, explaining this form of behavior modification to the client, and tells the client that the therapy:
Involves exposing the client for short periods to the phobic object while the client is in a relaxed state

Rationale: Systematic desensitization is a form of therapy used for some clients with phobias. The client is introduced, in short periods of exposure, to the phobic object while in a relaxed state. Gradually exposure is increased until the anxiety about or fear

of the object or situation has ceased. Using medication, encouraging self-control, and using a positive stimulus to avoid the negative stimulus are incorrect because they do are not focused on helping the client cope with the phobia.
A visitor brings a wrapped gift to a suicidal client under one-on-one suicide precautions. Which action should the nurse take?
Asking the client to open the gift

Rationale: The nurse must be concerned with the safety of the client. The visitor may or may not be aware of the client's suicidal thoughts or the hospital's safety policies. The client should open the gift in the presence of the nurse so that sharp or unsafe objects may be locked in the client's safety box. Reinforcing the safety policies with the client, telling the client what a beautiful package it is, and letting the visitor spend time alone with the client are all inappropriate interventions that do not help ensure the client's safety.

THOSE 40 QUESTIONS

schizo client returns to facility hallucinating and unkempt, nurse assessment should focus on
physical needs (appearance/behavior could be because of physical injury or fluid/electrolyte imbalance
client taking triclyclic antidepressants with what symptom should be immediately brought to dr attention
urinary retention (serious side effect that could have consequences, wheras the hand tremor is only temporary)
pt having tremors, drooling and is restless after taking thioridazine hydrochloride
administer benztropine mesylate (helps with extrapyramidal symptoms)
pt taking haldol says med makes him restless and paces the hallway, this side effect is called
akathisia
OCD repetativeness does what for the client
relieves anxiety
schizophrenic ryhming is
clang association

anxiety client in a panic, what should the nurse do first
speak in a calm manner
OCD behavior is what defense mechanism
undoing
pt teaching about valium/diazepam
valium can be habit forming
can lead to lithium toxicity
fasting
most common side effect of tricyclic antidepressants

drowsiness
schizo client says "change, change the range, manage the change" this is called
clanging
pt flushed and says going to die, dyspnea, chest pain. level of anxiety is
panic
for OCD client, nurse should initially do what for treatment?
allow extra time for OCD tasks to keep anxiety at manageable level
when asked if he had visitors yesterday, the older adult client says church people visited him, when only his child visited him, he is displaying
confabulation (avoids embarassment of memory loss)
agoraphbobia patients use which defense mechanism
displacement (anxiety displaced to another object or situation)
symptom of cocain intoxication
paranoia (and enlarged pupils)
nurse tell client taking lithium to
maintain adequate daily intake of sodium and fluid

witness to crime has severe headache when asked to identify perp, this is what defense mechanism
conversion
best approach to help severe anxiety pt
move client to calm, non-stimulating environment
education for schizo client taking thorazine
thorazine will help control symptoms of your illness
somatization disorder uses what defense mechanism
repression
client with depression is asked to teach nurse to embroider, this is because
use clients personal strength to boost self esteem
agoraphobic pt is getting better when they are able to attend a
unit picnic in a local park
client with hypocondriasis scares other pt's away with constant reporting of physical problems, in order to reduce social isolation, nurse should
ask client to participate in group diversional activities
bipolar med safe for pregnancy
paxil/paroxetine
best meal for bipolar client during manic episode
chicken nuggets, ear of corn, apple (eat on the run, easy to manipulate/best for hyperactive client with short attention span)
xanax teaching
increase fluids to prevent dry mouth
common side effect of benzodiazepine antianxiety meds
dizziness
ativan teaching
discuntinue over time, taper off

can't leave house alone, afraid to go outside
agoraphobia
hypocondrial disorder
preoccupation with physical health
OCD behaviors
method of reducing anxiety
best for client in early stage of alcohol withdrawal
rest and nutrition
do not mix what drug with nardil/phenelzine (an MAOI)
pseudoephedrine/sudafed, can cause hypertensive crisis
while weening off of long used antipsychotic, nurse should look for symptoms of tradive dyskinesia such as
involuntary grimmacing, lip smacking, tongue protrusion
first action for nurse when anxiety client is in panic mode
reduce clients immediate anxiety
educating on seroquel med
weight gain is less common with seroquel than with other atypical antipsychotic meds
interviewing new schizo client experiencing hallucinations, nurse should first establish rapport with client
manic client says apple going out of business because his computer program is revolutionizing the business, the nurse knows he is experiencing a
grandiose delusion