



A1 PASSERS TRAINING, RESEARCH, REVIEW AND DEVELOPMENT COMPANY
PSYCHIATRIC NURSING
SET I

1. The nurse at a substance abuse center answers the phone. A probation officer asks if a client is in treatment. The nurse responds, "No, the client you're looking for isn't here." Which statement best describes the nurse's response?
 - a. Correct, because she didn't give out information about the client
 - b. A violation of confidentiality because she informed the officer that the client wasn't there**
 - c. A breach of the principle of veracity because the nurse is misleading the officer
 - d. Illegal, because she's withholding information from law enforcement agents
2. Critical pathways of care refer to:
 - a. a care plan that provides outcome-based guidelines with a designated length of stay.**
 - b. a care plan designed for physicians to order medications.
 - c. a design of treatment that includes approved therapies.
 - d. a technique in therapy to care for the client holistically.
3. A nurse places a client in full leather restraints. How often must the nurse check the client's circulation?
 - a. Once per hour
 - b. Once per shift
 - c. Every 10 to 15 minutes**
 - d. Every 2 hours
4. A client in group therapy is restless. His face is flushed and he makes sarcastic remarks to group members. The nurse responds by saying, "You look angry." The nurse is using which technique?
 - a. A broad, opening statement
 - b. Reassurance
 - c. Clarifying
 - d. Making observations**
5. A client is presented with the treatment option of electroconvulsive therapy (ECT). After discussing the treatment with the staff, the client requests that a family member come in to help him decide whether to undergo this treatment. Which document must the client sign before undergoing ECT?
 - a. Informed consent**
 - b. Health care power of attorney
 - c. Voluntary commitment form
 - d. Outpatient commitment form
6. A client in an acute care setting tells the nurse, "I don't think I can face going home tomorrow." The nurse replies, "Do you want to talk more about it?" The nurse is using which technique?
 - a. Presenting reality
 - b. Making observations
 - c. Restating
 - d. Exploring**
7. A client reports losing his job, not being able to sleep at night, and feeling upset with his wife. The nurse responds, "You may want to talk about your employment situation in group today." The nurse is using which therapeutic technique?
 - a. Restating
 - b. Making observations
 - c. Exploring
 - d. Focusing**
8. A client with antisocial personality disorder smokes in prohibited areas and refuses to follow other unit and facility rules. The client persuades others to do his laundry and other personal chores, splits the staff, and will work only with certain nurses. The care plan for this client should focus primarily on:
 - a. consistently enforcing unit rules and facility policy.**
 - b. isolating the client to decrease contact with easily manipulated clients.
 - c. engaging in power struggles with the client to minimize manipulative behavior
 - d. using behavior modification to decrease negative behavior by using negative reinforcement.
9. During the mental status examination, a client may be asked to explain such proverbs as "Don't cry over spilled milk." The purpose of this is to evaluate the client's ability to think
 - a. rationally.
 - b. concretely.
 - c. abstractly.**
 - d. tangentially.
10. Conditions necessary for the development of a positive sense of self-esteem include:
 - a. consistent limits.**
 - b. critical environment
 - c. inconsistent boundaries.
 - d. physical discipline
11. A client with bipolar disorder is taking lithium carbonate (Eskalith) 300 mg t.i.d. His lithium level is 2.7 mEq/L. In assessing the client at his clinic visit, the nurse finds no evidence of lithium toxicity. The first assessment question the nurse should ask before ordering another blood test is:
 - a. whether the client is embarrassed or afraid to report medication problems.
 - b. whether the client is experiencing depression and having suicidal ideation.
 - c. whether the client understands why he's taking this medication.
 - d. when the client took his last dose of lithium.**
12. A client with paranoid schizophrenia started risperidone (Risperdal) 2 weeks ago. Today, he tells the nurse he feels like he has the flu. The nurse's assessment reveals the following: temperature 104.4° F (40.2° C), respirations 24 breaths/minute, blood pressure 130/102 mm Hg, pulse rate 120 beats/minute. The nurse also notes muscle stiffness and pain, excessive sweating and salivation, and changes in mental status. The nurse suspects the client is experiencing:
 - a. the flu.
 - b. malignant hyperthermia.
 - c. neuroleptic malignant syndrome.**
 - d. Septicemia
13. Nursing care for a client after electroconvulsive therapy (ECT) should include:
 - a. nothing by mouth for 24 hours after the treatment because of the anesthetic agent.
 - b. bed rest for the first 8 hours after a treatment.
 - c. assessment of short-term memory loss.**
 - d. no special care.
14. Which action demonstrates the role of the psychiatric nurse in primary prevention?

- a. Handling crisis intervention in an outpatient setting
 - b. Visiting a client's home to discuss medication management
 - c. Conducting a post discharge support group
 - d. **Providing sexual education classes for adolescents**
15. What is the primary indication for electroconvulsive therapy (ECT)?
- a. Severe agitation
 - b. Antisocial behavior
 - c. Noncompliance with treatment
 - d. **Major depression with psychotic features**
16. Which nursing intervention is most important when restraining a violent client?
- a. Reviewing facility policy regarding how long the client may be restrained
 - b. Preparing an as-needed dose of the client's psychotropic medication
 - c. **Checking that the restraints have been applied correctly**
 - d. Asking if the client needs to use the bathroom or is thirsty
17. Touching other people without their permission, reading someone else's mail, and using personal possessions without asking permission are all examples of:
- a. antisocial behavior.
 - b. manipulation.
 - c. **poor boundaries.**
 - d. passive-aggressive behavior.
18. Additive central nervous system (CNS) depression can occur when combining a barbiturate with which drug?
- a. Methylphenidate (Ritalin)
 - b. Cocaine
 - c. **Amitriptyline (Elavil)**
 - d. Amphetamine (Adderall)
19. A client on the behavioral health unit tells a nurse that she was raped 5 months earlier. During the nurse's assessment of this client's sleep patterns, the client complains of having difficulty falling asleep and staying asleep. She attributes her irritability to sleep deprivation. Further questioning reveals that the client can't recall details of the rape, and feels detached when she has sex with her husband. The nurse recognizes that this client is experiencing symptoms of what disorder?
- a. Antisocial personality disorder
 - b. Cypridophobia
 - c. Anhedonia
 - d. **Posttraumatic stress disorder (PTSD)**
20. A client diagnosed with anxiety disorder is ordered buspirone (BuSpar). Teaching instructions for buspirone should include:
- a. a warning that immediate sedation can occur with a resultant drop in pulse.
 - b. a reminder of the need to schedule blood work 1 week after initiating therapy to check blood levels of the drug.
 - c. a warning about medication-related incidence of neuroleptic malignant syndrome.
 - d. **a warning about the drug's delayed therapeutic effect, which occurs in 14 to 30 days.**
21. After seeking help at an outpatient mental health clinic, a client who was raped while walking her dog is diagnosed with posttraumatic stress disorder (PTSD). Three months later, the client returns to the clinic, complaining of feelings of fear, loss of control, and helplessness. Which nursing intervention is most appropriate for this client?
- a. **Exploring the meaning of the traumatic event with the client**
 - b. Allowing the client time to heal
 - c. Giving the client sleep medication, to take as ordered, to restore a normal sleep-wake cycle
 - d. Encouraging the client to attend a rape therapy group
22. During alprazolam (Xanax) therapy, the nurse should be alert for which dose-related adverse reaction?
- a. **Ataxia**
 - b. Hepatomegaly
 - c. Urticaria
 - d. Rash
23. A nurse is interviewing a client with posttraumatic stress disorder (PTSD) when a loud, booming noise from a passing car's radio rattles the windows. The client jumps onto a chair, wide-eyed and frantic. Which statement by the nurse is the most therapeutic response?
- a. "There's no reason to be afraid of a car radio."
 - b. "Take my hand and I'll help you down."
 - c. "Have you experienced this kind of thing before?"
 - d. **"What kinds of feelings are you experiencing?"**
24. A nurse is caring for a client diagnosed with panic disorder. The client begins to hyperventilate. How should the nurse respond initially?
- a. **Stay with the client during the anxiety attack.**
 - b. Shout for help and obtain assistance.
 - c. Teach the client to perform relaxation exercises.
 - d. Help the client explore the reason for his anxiety.
25. A client is admitted to the emergency department with chest pain, palpitations, vertigo, and diaphoresis. When initial assessment indicates no physiological basis for these complaints, the client is referred to a psychiatric clinical nurse-specialist. After determining that the client has experienced four similar episodes in the past month, the nurse specialist suspects that the client has:
- a. **panic disorder.**
 - b. depression.
 - c. schizophrenia.
 - d. obsessive-compulsive disorder.
26. A nurse is in the dining room and overhears a new nurse tell a client with body dysmorphic disorder that she's much too thin and must eat more before she can go home. The client bursts into tears and runs out of the dining room. What is the best way for the nurse to address this situation?
- a. Ask the new nurse how much she knows about the client's specific diagnosis.
 - b. Inform the new nurse that she handled the situation in an inappropriate manner.
 - c. **Ask the new nurse why she made that statement to the client.**
 - d. Ask the new nurse to refrain from speaking with this client in the future.
27. A psychiatric nurse is trying to help a client overcome his fear of public speaking, which is preventing him from advancing in his career. He has conquered some of his other social phobias such as using public restrooms.

During an interview with the nurse to evaluate his progress, the client makes each of the following statements. Which statement is a concern for the nurse?

- a. "One of my subordinates just got a promotion."
 - b. "I try to take deep breaths and remain calm when people talk to me."
 - c. **"It helps me to have one or two drinks at lunch."**
 - d. "I've met a woman I'd like to ask out on a date."
28. A nurse notices that a client with obsessive-compulsive disorder washes his hands for long periods each day. How should the nurse respond to this compulsive behavior?
- a. **By setting aside times during which the client can focus on the behavior**
 - b. By urging the client to reduce the frequency of the behavior as rapidly as possible
 - c. By calling attention to or trying to prevent the behavior
 - d. By discouraging the client from verbalizing his anxieties
29. A client with borderline personality disorder tells a nurse, "You're the only nurse who really understands me. The others are mean." The client then asks the nurse for an extra dose of anti anxiety medication because of increased anxiety. How should the nurse respond?
- a. "I'll talk with the physician right away. I don't think they give you enough medicine."
 - b. **"I'll have to discuss your request with the team. May we talk about how you're feeling right now?"**
 - c. "I don't want to hear you say negative things about the other nurses."
 - d. "You know you can't have extra medication. Why do you keep asking?"
30. A nurse is caring for a client diagnosed with body dysmorphic disorder. When the client verbalizes disapproval of her own physical features, the nurse should:
- a. **encourage the client to talk about her fears and stressful life situations.**
 - b. agree with the client's opinion that one of her physical features is awful.
 - c. ignore the client's comment and talk about less-threatening issues.
 - d. compliment the client on her appearance.
31. The son of a client with Alzheimer's disease reports feeling guilty for wishing, at times, that his father would die. What is the nurse's best response?
- a. "Everyone in your situation must feel like that at times."
 - b. **"Being responsible for your father's care must be difficult."**
 - c. "Perhaps you should consider putting your father in a nursing home."
 - d. "There is no reason to feel guilty. You've given your father excellent care."
32. A 40-year-old executive who was unexpectedly laid off from work 2 days earlier complains of fatigue and an inability to cope. He admits drinking excessively over the previous 48 hours. This behavior is an example of:
- a. alcoholism.
 - b. a manic episode.
 - c. **situational crisis.**
 - d. depression.
33. Which herbal medication is sometimes used to treat depression?
- a. Ginkgo biloba
 - b. Echinacea
 - c. **St. John's wort**
 - d. Ephedra
34. The ability to enter into the life of another person and perceive his current feeling and their meaning is known of the following:
- a. **Empathy**
 - b. Respect
 - c. Genuineness
 - d. Sympathy
35. A nurse is caring for a client diagnosed with antisocial personality disorder. This client has a history of fighting, cruelty to animals, and stealing. Which trait is the nurse likely to uncover during assessment?
- a. History of gainful employment
 - b. Frequent expression of guilt regarding antisocial behavior
 - c. Demonstrated ability to maintain close, stable relationships
 - d. **A low tolerance for frustration**
36. A client with bipolar disorder has been taking lithium carbonate (Lithonate), as prescribed, for the past 3 years. Family members have brought this client to the hospital. The client hasn't slept, bathed, or changed clothes for 4 days; has lost 10 lb (4.5 kg) in the past month; and woke the entire family at 4 a.m. with plans to fly them to Hawaii for a vacation. Based on this information, the nurse understands that:
- a. the family isn't supportive of the client.
 - b. the client has stopped taking his medication.
 - c. the client hasn't accepted his diagnosis of bipolar disorder.
 - d. **the client's lithium level should be measured before he receives the next lithium dose.**
37. Which action is the priority when assessing a suicidal client who has ingested a handful of unknown pills?
- a. Determining if the client was trying to harm himself
 - b. Determining if the client has a support system
 - c. **Determining if the client's physical condition is life-threatening**
 - d. Determining if the client has a history of suicide attempts
38. A client is admitted to the local psychiatric facility with bipolar disorder in the manic phase. The physician decides to start the client on lithium carbonate (Lithonate) therapy. One week after this therapy starts, the nurse notes that the client's serum lithium level is 1 mEq/L. What should the nurse do?
- a. Call the physician immediately to report the laboratory result.
 - b. Observe the client closely for signs and symptoms of lithium toxicity.
 - c. Withhold the next dose and repeat the laboratory test.
 - d. **Continue to administer the medication as ordered.**
39. A client has been taking imipramine (Tofranil), 125 mg by mouth daily, for 1 week. Now the client reports wanting to stop taking the medication because he still feels depressed. At this time, what is the nurse's best response?
- a. "Imipramine may not be the most effective medication for you. You should call your physician for further evaluation."

- b. **"Because imipramine must build to a therapeutic level, it may take 2 to 3 weeks to reduce depression."**
 - c. "The physician may need to increase the dosage for you to get the medication's maximum benefit."
 - d. "Don't abruptly stop taking the medication. If you do, you may experience serious adverse effects."
40. Which client statement leads a nurse to suspect depression?
- a. "My daughter said she isn't coming to visit today because she needs to work late."
 - b. **"I just know my daughter doesn't love me anymore."**
 - c. "I'm very sad about losing my job, but I know things will turn around for me."
 - d. "At least not everything in my life is bad."
41. A client visits a physician's office to seek treatment for depression, feelings of hopelessness, poor appetite, insomnia, fatigue, low self-esteem, poor concentration, and difficulty making decisions. The client states that these symptoms began at least 2 years earlier. Based on this report, the nurse suspects:
- a. cyclothymic disorder.
 - b. atypical affective disorder.
 - c. major depression.
 - d. **dysthymic disorder.**
42. A client with Alzheimer's disease says, "I'm so afraid. Where am I? Where is my family?" How should the nurse respond?
- a. **"You are in the hospital and you're safe here. Your family will return at 10 o'clock, which is 1 hour from now."**
 - b. "You know where you are. You were admitted here 2 weeks ago. Don't worry, your family will be back soon."
 - c. "I just told you that you're in the hospital and your family will be here soon."
 - d. "The name of the hospital is on the sign over the door. Let's go read it again."
43. A nurse admits a client who presents with symptoms of severe depression and a diagnosis of rapid cycling bipolar disorder. Several hours later, the client is pacing in the hall and asks the nurse to determine if he has a fever. His vital signs are: blood pressure of 148/90 mm Hg, pulse of 133 beats/minute, respirations of 24 breaths/minute, temperature of 99.2° F (37.3° C). What do these assessment findings suggest?
- a. An infectious process might be present.
 - b. The client is experiencing a depressive episode.
 - c. The client is experiencing a conversion reaction.
 - d. **The client needs further evaluation for illness.**
44. During an assessment interview, a depressed 15-year-old girl states that she "can't sleep at night." The nurse begins to explore factors that might contribute to this situation by asking if the girl is sexually active. The girl changes the subject. What should the nurse suspect based on the client's response to the assessment question?
- a. **Sexual abuse**
 - b. Narcolepsy
 - c. Spiritual distress
 - d. Pain disorder
45. A client, age 20, is being treated for depression. During a conversation with a nurse, this client states that her father raped her when she was 7 years old. She says she has nightmares about the experience and sometimes relives it. She also reveals that she fears older men. The nurse suspects that the client has:
- a. **posttraumatic stress disorder (PTSD), delayed onset.**
 - b. multiple personality disorder.
 - c. anxiety disorder.
 - d. schizophrenia.
46. Delusional statement of a patient indicates that he is using which of the following defense mechanisms?
- a. Displacement
 - b. **Projection**
 - c. Regression
 - d. Depression
 - e.
47. A client diagnosed with depression tells a nurse that she won't allow herself to cry, "because my crying upsets the whole family." This is an example of:
- a. manipulation.
 - b. insight.
 - c. **rationalization.**
 - d. repression.
48. A nurse is monitoring a client receiving tranylcypromine sulfate (Parnate). Which serious adverse reaction can occur with high dosages of this monoamine oxidase (MAO) inhibitor?
- a. Hypotensive episodes
 - b. **Hypertensive crisis**
 - c. Muscle flaccidity
 - d. Hypoglycemia
49. A client diagnosed with panic disorder and agoraphobia is talking with a nurse about the progress he's made in treatment. Which client statement indicates a positive response to treatment?
- a. **"I went to the mall with my friend last Saturday."**
 - b. "I hyperventilate only when I have a panic attack."
 - c. "I stopped taking my medication last week."
 - d. "Last night I decided to eat more than a bowl of cereal."
50. As a client is being released from restraints, he says, "I'll never get that angry and lose it again. Those restraints were the worst things that ever happened to me." Which response by the nurse is most appropriate?
- a. "Do you really mean what you just said?"
 - b. **"I'd like to talk with you about your experience."**
 - c. "That was the worst thing that ever happened to you?"
 - d. "Someday this experience won't bother you like it does now."
51. Initial interventions for the client with acute anxiety include:
- a. placing the client in a room with another client with acute anxiety.
 - b. **encouraging the client to verbalize his feelings and concerns.**
 - c. touching the client to get his attention.
 - d. touching the client in an attempt to comfort him.

52. A client admitted to the unit is visibly anxious. When assessing this client, the nurse should expect to see which cardiovascular effect produced by the sympathetic nervous system?
- Syncope
 - Decreased blood pressure
 - Increased heart rate**
 - Decreased pulse rate
53. A client arrives on the psychiatric unit exhibiting extreme excitement, disorientation, incoherent speech, agitation, frantic and aimless physical activity, and grandiose delusion. Which nursing diagnosis takes highest priority for this client at this time?
- Ineffective coping*
 - Hopelessness*
 - Risk for injury**
 - Disturbed personal identity*
54. Before eating a meal, a client with obsessive-compulsive disorder (OCD) must wash his hands for 18 minutes, comb his hair 444 strokes, and switch the bathroom light on and off 44 times. What is the most appropriate goal of care for this client?
- Omit one unacceptable behavior each day.
 - Increase the client's acceptance of therapeutic drug use.
 - Allow ample time for the client to complete all these rituals before each meal.
 - Systematically decrease the number of repetitions of rituals and the amount of time the client spends performing them.**
55. A nurse is caring for a client diagnosed with panic disorder. The client begins to hyperventilate. How should the nurse respond initially?
- Stay with the client during the anxiety attack.**
 - Shout for help and obtain assistance.
 - Teach the client to perform relaxation exercises.
 - Help the client explore the reason for his anxiety.
56. A client with obsessive-compulsive disorder tells a nurse that he must check the lock on his apartment door 25 times before leaving for an appointment. The nurse knows that this behavior represents the client's attempt to:
- call attention to himself.
 - control his thoughts.
 - maintain the safety of his home.
 - reduce anxiety.**
57. Which medications have been found to help reduce or eliminate panic attacks?
- Antidepressants**
 - Anticholinergics
 - Antipsychotics
 - Mood stabilizers
58. During a panic attack, a client runs to the nurse and reports experiencing breathing difficulty, chest pain, and palpitations. The client is pale, with his mouth wide open and his eyebrows raised. What should the nurse do first?
- Assist the client to breathe deeply into a paper bag.**
 - Orient the client to person, place, and time.
 - Set limits for acting out delusional behaviors.
 - Administer an I.M. anxiolytic agent.
59. A painter who recently fractured his tibia worries about his finances because he can't work. To treat his anxiety, his physician orders buspirone (BuSpar), 5 mg by mouth three times per day. Which drugs interact with buspirone?
- Beta-adrenergic blockers
 - Antineoplastic drugs
 - Antiparkinsonian drugs
 - Monoamine oxidase (MAO) inhibitors**
60. A client on the behavioral health unit spends several hours per day organizing and reorganizing his closet. He repeatedly checks to see if his clothing is arranged in the proper order. What term is commonly used to describe this behavior?
- Obsession
 - Compulsion**
 - Exhibitionism
 - Transference
61. A client with chronic schizophrenia receives 20 mg of fluphenazine decanoate (Prolixin Decanoate) by I.M. injection. Three days later, the client has muscle contractions that contort his neck. This client is exhibiting which extrapyramidal reaction?
- Dystonia**
 - Akinesia
 - Akathisia
 - Tardive dyskinesia
62. A client in a catatonic state is admitted to the inpatient unit. The client is emaciated, stares blankly into space, and doesn't respond to verbal or tactile stimuli. In formulating nursing care interventions, the nurse should give priority to:
- providing appropriate interpersonal communications and emotional stimulation.
 - providing a safe, nurturing, and supportive environment for the client.
 - observing and evaluating the client's nutritional needs.**
 - developing a therapeutic nurse-client relationship.
63. Which group of characteristics should a nurse expect to see in the client with schizophrenia?
- Loose associations, grandiose delusions, and auditory hallucinations**
 - Periods of hyperactivity and irritability alternating with depression
 - Delusions of jealousy and persecution, paranoia, and mistrust
 - Sadness, apathy, feelings of worthlessness, anorexia, and weight loss
64. A psychotic client tells the evening nurse that the day nurse put something suspicious in his water with his medication. The nurse replies, "You're worried about your medication?" The nurse's communication is:
- an example of presenting reality.
 - reinforcing the client's delusions.
 - focusing on emotional content.**
 - a technique called mind reading.
65. A client with schizophrenia tells a nurse he hears the voices of his dead parents. To help the client ignore the voices, the nurse should recommend that he:
- sit in a quiet, dark room and concentrate on the voices.
 - listen to a personal stereo through headphones and sing along with the music.**

- c. call a friend and discuss the voices and his feelings about them.
 - d. engage in strenuous exercise.
66. Which nonantipsychotic medication is used to treat some clients with schizoaffective disorder?
- a. Phenelzine (Nardil)
 - b. Chlordiazepoxide (Librium)
 - c. **Lithium carbonate (Lithane)**
 - d. Imipramine (Tofranil)
67. A client with chronic undifferentiated schizophrenia is admitted to the psychiatric unit of a local hospital. During the next several days, the client is seen laughing, yelling, and talking to himself. This behavior is characteristic of:
- a. delusion.
 - b. looseness of association.
 - c. illusion.
 - d. **hallucination.**
68. In a remotivation session with a group of patients, an appropriate topic to discuss is which of the following?
- a. Religion
 - b. Family
 - c. **Sports**
 - d. Love
69. While looking out the window at trees, a client with schizophrenia remarks, "That school across the street has creatures in it that are waiting for me." Which term best describes what the creatures represent?
- a. Anxiety attack
 - b. Projection
 - c. Hallucination
 - d. **Illusion**
70. A client who is experiencing hallucinations asks if a nurse hears the voices that are telling him he should never have been born. The nurse's most appropriate response would be:
- a. **"I don't hear any voices, but I believe you can hear them."**
 - b. "The voices are a symptom of your illness and will go away."
 - c. "Sometimes I hear voices. What are your voices saying?"
 - d. "The voices are coming from inside you. They aren't real."
71. A nurse is providing care for a client with a history of schizophrenia who's experiencing hallucinations. The physician orders 200 mg of haloperidol (Haldol) orally or I.M. every 4 hours as needed. What is the nurse's best action?
- a. Administer the haloperidol orally if the client agrees to take it.
 - b. Call the physician to clarify whether the haloperidol should be administered orally or I.M.
 - c. **Call the physician to clarify the order because the dosage is too high.**
 - d. Withhold haloperidol because it may worsen hallucinations.
72. One of the advantages of the antipsychotic medication risperidone (Risperdal) is:
- a. the absence of anticholinergic effects.
 - b. **a lower incidence of extrapyramidal effects.**
 - c. photosensitivity and sedation.
 - d. no incidence of neuroleptic malignant syndrome.
73. A client with a diagnosis of paranoid schizophrenia asks the nurse, "How do I know what is really in those pills?" The best response is to:
- a. say, "You know this is your medicine."
 - b. **allow the client to open the individual medication wrappers.**
 - c. say, "Don't worry about what's in the pills. It's what the doctor ordered."
 - d. ignore the client's comment because it's probably a joke.
74. An agitated and incoherent client comes to the emergency department with complaints of visual and auditory hallucinations. The history reveals that this client was hospitalized for paranoid schizophrenia from ages 20 to 21. The physician orders haloperidol (Haldol), 5 mg I.M. The nurse understands that this drug is used in this client to treat:
- a. dyskinesia.
 - b. dementia.
 - c. **psychosis.**
 - d. tardive dyskinesia.
75. Which medication can control the extrapyramidal effects associated with antipsychotic agents?
- a. Perphenazine (Trilafon)
 - b. Doxepin (Sinequan)
 - c. **Amantadine (Symmetrel)**
 - d. Clorazepate (Tranxene)
76. A client with paranoid schizophrenia has been experiencing auditory hallucinations for many years. One approach that has proven to be effective is for hallucinating clients to:
- a. take an as-needed dose of psychotropic medication whenever they hear voices.
 - b. **practice saying, "Go away" or "Stop" when they hear voices.**
 - c. sing loudly to drown out the voices and provide a distraction for themselves.
 - d. go to their room until they can't hear the voices.
77. A client with paranoid personality disorder is admitted to a psychiatric facility. Which remark by the nurse would best establish rapport and encourage the client to confide in her?
- a. **"I get upset once in a while, too."**
 - b. "I know just how you feel. I'd feel the same way in your situation."
 - c. "I worry, too, when I think people are talking about me."
 - d. "At times, it's normal not to trust anyone."
78. A nurse must administer a medication to reverse or prevent Parkinson-type symptoms in a client receiving an antipsychotic. The medication the client will likely receive is:
- a. **benztropine (Cogentin).**
 - b. diphenhydramine (Benadryl).
 - c. propranolol (Inderal).
 - d. haloperidol (Haldol).
79. A client with schizophrenia displays a lack of interest in activities, reduced affect, and poor ability to perform activities of daily living. What term would be used to describe this clustering of symptoms?
- a. Positive symptoms
 - b. **Negative symptoms**
 - c. Physiologic symptoms
 - d. Extrapyramidal symptoms
80. A client begins clozapine (Clozaril) therapy after several other antipsychotic agents fail to relieve her psychotic symptoms. The nurse instructs her to return for weekly white blood cell (WBC) counts to assess for which adverse reaction?

- a. Hepatitis
 - b. Infection
 - c. **Granulocytopenia**
 - d. Systemic dermatitis
81. A client is admitted for alcohol withdrawal. The client's last drink was 2 hours before admission. Which finding indicates to the nurse that he is beginning active alcohol withdrawal?
- a. Impending coma
 - b. Manipulating behavior
 - c. **Irritability**
 - d. Perceptual disorders
82. A client is brought to the psychiatric clinic by family members, who tell the admitting nurse that the client repeatedly drives while intoxicated despite their pleas for him to stop doing so. During an interview with the nurse, which client statement most strongly supports a diagnosis of psychoactive substance abuse?
- a. "I'm not addicted to alcohol. In fact, I can drink more than I used to without being affected."
 - b. "I spend only half of my paycheck at the bar."
 - c. "I just drink to relax after work."
 - d. **"I know I've been arrested three times for drinking and driving, but the police are just trying to hassle me."**
83. A nurse must restrain a client to ensure the safety of other clients. When using restraints, which principle is a priority?
- a. Have three staff members present, one to restrain each side of the client's body and one for the head.
 - b. Tie restraints securely to the side rails.
 - c. **Use an organized, efficient team approach to apply and secure the restraints.**
 - d. Secure restraints to the bed with knots to prevent the client from escaping.
84. A client tells a nurse he was involved in a car accident while intoxicated. What would be the most therapeutic response for the nurse to make?
- a. "Why didn't you get someone else to drive you?"
 - b. **"Tell me how you feel about the accident."**
 - c. "You should know better than to drink and drive."
 - d. "I recommend that you attend an Alcoholics Anonymous meeting."
85. A client is demanded by the courts for psychiatric treatment. His police record, which dates to his early teenage years, includes delinquency, running away, auto theft, and vandalism. He dropped out of school at age 16 and has been living on his own since then. His history suggests maladaptive coping, which is associated with:
- a. **antisocial personality disorder.**
 - b. borderline personality disorder.
 - c. obsessive-compulsive personality disorder.
 - d. narcissistic personality disorder
86. A client who's at high risk for suicide needs close supervision. To best ensure the client's safety, the nurse should:
- a. **check the client frequently at irregular intervals.**
 - b. assure the client that she will hold in confidence anything he tells her.
 - c. repeatedly discuss the client's previous suicide attempts with him.
 - d. disregard decreased communication by the client because decreased communication is typical of suicidal clients.
87. A client with a history of polysubstance abuse is admitted to the facility. He complains of nausea and vomiting 24 hours after admission. The nurse who assesses the client notes piloerection, pupillary dilation, and lacrimation. The nurse suspects that the client is going through withdrawal from which substance?
- a. Alcohol
 - b. Cannabis
 - c. Cocaine
 - d. **Opioids**
88. While teaching a group of parents whose children have Tourette syndrome, a nurse is asked about factors associated with its development. Which factor should the nurse include in her response?
- a. Infection and maternal alcohol use during pregnancy
 - b. **Abnormalities in brain neurotransmitters, and the caudate nucleus, and genetics**
 - c. Abnormalities in ventricular structure and function
 - d. Environmental factors and birth-related trauma
89. A client experiencing acute alcohol withdrawal is upset about going through detoxification. Which goal should be the priority for the nurse?
- a. The client will commit to a drug-free lifestyle.
 - b. **The client will work with the nurse to remain safe.**
 - c. The client will drink adequate fluids daily.
 - d. The client will make a personal inventory of strengths.
90. A nurse performing an assessment determines that a client with anorexia nervosa is currently unemployed and has a family history of affective disorders, obesity, and infertility. Based on this information, the nurse should monitor the client for which health concern?
- a. Alcohol abuse
 - b. Avoidance behavior
 - c. **Suicide potential**
 - d. Explosive outbursts
91. A nurse works in a suicide crisis clinic. The clients she should consider to represent the highest risk for suicide are those who state:
- a. "I gave my clothes away because I'm depressed and think about death a lot."
 - b. **"I'm thinking of driving my car into a tree on the way home."**
 - c. "If my life doesn't get better, I might take matters into my own hands."
 - d. "I'm always thinking about dying."
92. After completing chemical detoxification and a 12-step program to treat crack addiction, a client is being prepared for discharge. Which remark by the client indicates a realistic view of his future?
- a. "I'm never going to use crack again."
 - b. "I know what I have to do. I have to limit my crack use."
 - c. **"I'm going to take things 1 day at a time. I know it's going to be hard."**

- d. "I can't touch crack again, but I sure could use a drink. I've earned it."
93. A client is hospitalized with fractures of the right femur and right humerus sustained in a motorcycle accident. Police suspect the client was intoxicated at the time of the accident. Laboratory tests reveal a blood alcohol level of 0.2% (200 mg/dl). The client later admits to drinking heavily for years. During hospitalization, the client periodically complains of tingling and numbness in his hands and feet. The nurse realizes that these symptoms probably result from:
- acetate accumulation.
 - thiamine deficiency.**
 - triglyceride buildup.
 - a below-normal serum potassium level.
94. A nurse is caring for a client diagnosed with bulimia nervosa. The most appropriate initial goal for this client is to:
- avoid shopping for large amounts of food.
 - control eating impulses.
 - identify a connection between anxiety and eating behaviors.**
 - restrict eating to three meals per day.
95. An attorney who throws books and furniture around his office after losing a case is referred to the psychiatric nurse in the law firm's employee assistance program. The nurse knows that the client's behavior most likely represents the use of which defense mechanism?
- Regression**
 - Projection
 - Reaction formation
 - Intellectualization
96. During a private conversation, a client with borderline personality disorder asks a nurse to "keep this secret," then displays multiple, self-inflicted, superficial lacerations on his forearms. What is the nurse's best response?
- "That's it! You're on suicide precautions."
 - "I'm going to tell your physician. Do you want to tell me why you did that?"
 - "Tell me what type of instrument you used. I'm concerned about infection."
 - "The team needs to know when something important occurs in treatment. I need to tell the others, but let's talk about it first."**
97. A client recently admitted to the hospital with sharp, substernal chest pain suddenly complains of palpitations. The client ultimately admits to using cocaine 1 hour before admission. The nurse should immediately assess the client's:
- pulse rate and character.**
 - level of consciousness.
 - neurobehavioral functioning.
 - anxiety level.
98. A nurse is developing a care plan for a client with anorexia nervosa. Which action should the nurse include in the plan?
- Restrict visits with family members until the client begins to eat.
 - Provide privacy for the client during meals.
 - Set up a strict eating plan with the client.**
 - Encourage the client to exercise, which will reduce her anxiety.
99. A client who is a victim of domestic violence tells the nurse she is contemplating leaving the relationship. Which assessment should be a priority for the nurse?
- Reasons for remaining in the abusive relationship
 - Readiness to leave the perpetrator and knowledge of helpful resources**
 - Use of drugs or alcohol to cope with victimization
 - History of previous victimization
100. When doing discharge planning for a hospitalized client with impulse control disorder, a nurse explains how family members can participate effectively in the client's ongoing care. What instruction should the nurse include?
- "After every explosive outburst, reevaluate and change the approach you use."
 - "Recognize initial anger symptoms as soon as possible and have him take medication."
 - "Consistently reward positive behavior and reinforce consequences of negative behavior."**
 - "Persuade him to go to an emergency department and request medication."

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A1 PASSERS TRAINING, RESEARCH, REVIEW AND DEVELOPMENT COMPANY

121. PSYCHIATRIC NURSING

122. SET 2

123.

1. What is a nurse's most important role in caring for a client with a mental health disorder?

- a. To offer advice
 - b. To know how to solve the client's problems
 - c. **To establish trust and rapport**
 - d. To set limits with the client
- 2. A client refuses his evening dose of haloperidol (Haldol), then becomes extremely agitated in the day room while other clients are watching television. He begins cursing and throwing furniture. The nurse's first action is to:
 - a. check the client's medical record for an order for an as-needed dose of medication for agitation.
 - b. place the client in full leather restraints.
 - c. call the physician and report the behavior.
 - d. **remove all other clients from the day room.**
- 3. A client reports severe pain in the back and joints. Upon reviewing the client's history, the nurse notes a diagnosis of depression and frequent hospitalizations for somatic illnesses. What should the nurse encourage this client to do?
 - a. **Tell the physician about the pain so that its cause can be determined.**
 - b. Remember all his previous "health problems" that weren't real.
 - c. Try to get more rest and use relaxation techniques.
 - d. Ignore the pain and focus on happy things.
- 4. The charge nurse in an acute care setting assigns a client who is on one-on-one suicide precautions to a psychiatric aide. This assignment is considered:
 - a. poor nursing practice because a registered nurse should work with this client.
 - b. **reasonable nursing practice because one-on-one requires the total attention of a staff member.**
 - c. outside the responsibility of an aide.
 - d. an illegal delegation.
- 5. What occurs during the working phase of the nurse-client relationship?
 - a. A nurse assesses a client's needs and develops a care plan.
 - b. **A nurse and a client evaluate and modify the goals of the relationship.**
 - c. A nurse and a client discuss their feelings about terminating the relationship.
 - d. A nurse and a client explore each others' expectations of the relationship.
- 6. Nursing implications for a client taking central nervous system (CNS) stimulants include monitoring the client for which conditions?
 - a. Hyperpyrexia, slow pulse, and weight gain
 - b. **Tachycardia, weight loss, and mood swings**
 - c. Hypotension, weight gain, and listlessness
 - d. Increased appetite, slowing of sensorium, and arrhythmias
- 7. Two nurses are discussing a client's condition in the elevator. The employer of the mentioned client overhears the conversation and fires the client. The nurses may be liable for which accusation?
 - a. Assault
 - b. Battery
 - c. Neglect
 - d. **Breach of confidentiality**
- 8. The nurse's goal in crisis intervention is to provide:
 - a. **problem-solving techniques and structured activities.**
 - b. an insight-oriented analytic approach.
 - c. medication to sedate the client.
 - d. nondirective techniques such as free association.
- 9. A client with severe and persistent depression can't decide if he'll undergo electroconvulsive therapy (ECT). His family asks a nurse to convince him that this treatment modality would be beneficial. In educating the family about the client's situation, what statement about client rights should the nurse make?
 - a. "In a situation like this, the family should obtain legal counsel for the client."
 - b. **"The client, treatment team, and family must meet to discuss this treatment option."**
 - c. "You must have the client sign a statement that he understands the treatment benefits but still declines the treatment."
 - d. "You must make the client aware of the moral aspects of refusing treatment."
- 10. Emergency restraints or seclusion may be implemented without a physician's order under which condition?
 - a. **When a licensed practitioner will do a face-to-face assessment within 1 hour**
 - b. Never
 - c. If a voluntary client wants to leave against medical advice
 - d. When a child is acting out
- 11. A patient with delirium usually manifests the inability to name objects. This is known as:
 - a. **Agnosia**
 - b. Apraxia
 - c. Dysgraphia
 - d. Dystonia
- 12. The American Nurses Association (ANA) guidelines state that to serve as a group therapist, a nurse must have what educational background?
 - a. **Master's degree in psychiatric nursing**
 - b. Doctorate in psychiatric nursing
 - c. Associate degree in general nursing
 - d. Baccalaureate degree in general nursing
- 13.
- 14.
- 15. A client stalks a man she met briefly 3 years earlier. She believes he loves her and eventually will marry her and she has been sending him cards and gifts. When she violates a restraining order he has obtained, a

- judge orders her to undergo a 10-day psychiatric evaluation. What is the most probable psychiatric diagnosis for this client?
- Delusional disorder — jealous type
 - Induced psychotic disorder
 - Delusional disorder — erotomanic type**
 - Schizophreniform disorder
16. Conditions necessary for the development of a positive sense of self-esteem include:
- consistent limits.**
 - critical environment
 - inconsistent boundaries
 - physical discipline
17. A client becomes angry and belligerent toward the nurse after speaking on the phone with his mother. The nurse recognizes this as what defense mechanism?
- Rationalization
 - Repression
 - Displacement**
 - Suppression
18. What is a generally accepted criterion of mental health?
- Absence of anxiety
 - Self-acceptance**
 - Ability to control others
 - Happiness
19. A 17-year-old girl rarely expresses her feelings and usually remains passive. When she is angry, however, her face becomes flushed and her blood pressure rises to 170/100 mm Hg. Her parents are passive and easygoing. This adolescent may be using which defense mechanism to handle anger?
- Displacement
 - Introjection**
 - Projection
 - Sublimation
20. A nurse is obtaining a history from a client. The client reports that he is a waiter. When asked about his work environment, the client says, "If customers confront me for not being attentive enough, I just spit on their food." The nurse suspects the client is prone to which type of behavior?
- Obsessive-compulsive
 - Narcissistic
 - Passive-aggressive**
 - Dependent
21. A nurse documents, "The client described her husband's abuse in an emotionless tone and with a flat facial expression." This statement describes the client's:
- feelings.
 - blocking.
 - mood.
 - affect.**
22. Erikson described the psychosocial tasks of the developing person in his theoretical model. He proposed that the primary developmental task of the young adult (ages 18 to 25) is:
- intimacy versus isolation.**
 - industry versus inferiority.
 - generativity versus stagnation.
 - trust versus mistrust.
23. When teaching a group of nurses about posttraumatic stress disorder (PTSD), a nurse-educator explains that this disorder:
- is most common in men ages 30 to 40.
 - is most common in women ages 30 to 40.
 - is most common in men ages 20 to 30.
 - can occur at any age group.**
24. An 18-year-old is highly dependent on her parents and fears leaving home to attend college. Shortly before the fall semester starts, she complains that her legs are paralyzed and is rushed to the emergency department. When physical examination rules out a physical cause for her paralysis, the physician admits the woman to the psychiatric unit, where she is diagnosed with conversion disorder. She asks the nurse, "Why has this happened to me?" What is the nurse's best response?
- "You've developed this paralysis so you will have a reason to stay with your parents. You must deal with this conflict if you want to walk again."
 - "It must be awful not to be able to move your legs. You may feel better if you realize the problem is psychological, not physical."
 - "Your problem is real but, there is no physical basis for it. We'll work on what is going on in your life to find out why it's happened."**
 - "It's common for someone with your personality to develop a conversion disorder during times of stress."
25. During a panic attack, a client hyperventilates, becomes unable to speak, and reports symptoms that mimic those of a heart attack. Which nursing intervention is appropriate?
- Encouraging the client to participate in milieu activities.
 - Encouraging the client to work on a craft project in his room.
 - Encouraging the client to lie down on his bed; then turning off the lights and leaving the room.
 - Accompanying the client to his room; remaining there and providing instructions in short, simple statements.**
26. Which medications have been found to help reduce or eliminate panic attacks?
- Antidepressants**
 - Anticholinergics
 - Antipsychotics
 - Mood stabilizers
27. After learning that a roommate is HIV-positive, a client asks a nurse about moving to another room on the psychiatric unit because he no longer feels "safe." What should the nurse do first?
- Move the client to another room.
 - Ask the client to describe his fears.**
 - Move the client's roommate to a private room.
 - Explain that such a move wouldn't be therapeutic for the client or for his roommate.
28. A nurse in a psychiatric inpatient unit is caring for a client with generalized anxiety disorder. As part of the client's treatment, the psychiatrist orders lorazepam (Ativan), 1 mg by mouth three times per day. During lorazepam therapy, the nurse should remind the client to:
- avoid caffeine.**
 - avoid aged cheeses.

- c. stay out of the sun. d. maintain an adequate salt intake.
29. A nurse is caring for a client with panic disorder who has difficulty sleeping. Which nursing intervention would best help the client achieve healthy long-term sleeping habits?
- Administering sleeping pills
 - Encouraging the client use relaxation exercises**
 - Suggesting that the client talk with other clients until he feels ready to sleep
 - Telling the client to play ping pong in the day room
30. A woman has become increasingly afraid to ride in elevators. While in an elevator one morning, she experiences shortness of breath, palpitations, dizziness, and trembling. A physician can find no physiological basis for these symptoms and refers her to a psychiatric clinical nurse specialist for outpatient counseling sessions. Which type of therapy is most likely to reduce the client's anxiety level?
- Psychoanalytically oriented psychotherapy
 - Group psychotherapy
 - Systematic desensitization**
 - Referral for evaluation for electroconvulsive therapy
31. Lorazepam (Ativan) is commonly given along with a neuroleptic agent. What is the purpose of administering the drugs together?
- To reduce anxiety and potentiate the neuroleptic's sedative action**
 - To counteract the neuroleptic's extrapyramidal effects
 - To manage depressed clients
 - To increase a client's level of awareness and concentration
32. A client diagnosed as having panic disorder with agoraphobia is admitted to the inpatient psychiatric unit. Until her admission, this client had been a virtual prisoner in her home for 5 weeks, afraid to go outside even to buy food. When planning care for this client, what is the nurse's overall goal?
- To help the client perform self-care activities
 - To help the client function effectively in her environment**
 - To help control the client's symptoms
 - To help the client participate in group therapy
33. A client is scheduled for cardiac catheterization the next morning. His physician ordered temazepam (Restoril), 30 mg by mouth at bedtime, for sedation. Before administering the drug, the nurse should know that:
- sedatives cause predictable responses; hypnotics cause unpredictable ones.
 - sedatives interact with few drugs; hypnotics interact with many.
 - sedatives don't depress respirations; hypnotics do.
 - sedatives reduce excitement; hypnotics induce sleep.**
34. A nurse is instructing a client with bipolar disorder on proper use of lithium carbonate (Eskalith), the drug's adverse effects, and symptoms of lithium toxicity. Which client statement indicates that additional teaching is required?
- "I can still eat my favorite salty foods."
 - "When my moods fluctuate, I'll increase my dose of lithium."**
 - "A good blood level of the drug means the drug concentration has stabilized."
 - "Eating too much watermelon will affect my lithium level."
35. A client with obsessive-compulsive disorder may use reaction formation as a defense mechanism to cope with anxiety and stress. What typically occurs in reaction formation?
- The client assumes an attitude that contradicts an impulse he harbors.**
 - The client believes his thoughts can control other people and events.
 - The client persistently thinks and talks about a particular idea or subject.
 - The client uses a specific act to negate a previous act.
36. Low doses of central nervous system (CNS) depressants produce an initial excitatory response. This reaction is caused by:
- stimulation of the CNS.
 - the depression of acetylcholine.
 - depressant drugs' stimulation of dopamine production.
 - inhibitory brain synapses being depressed before excitatory synapses are depressed.**
37. A client with agoraphobia has been symptom-free for 4 months. Classic signs and symptoms of phobias include:
- insomnia and an inability to concentrate.
 - severe anxiety and fear.**
 - depression and weight loss.
 - withdrawal and failure to distinguish reality from fantasy.
38. A client brought to the emergency department by a police officer states, "I don't know who or where I am." He has no identification but appears to be in good physical health. Physical examination reveals no evidence of trauma or other abnormal findings. The client is admitted to the psychiatric unit for further evaluation and treatment. The nurse anticipates that he'll react to his inability to recall his identity by exhibiting:
- an intense preoccupation with discovering who he is.
 - depression.
 - anger and frustration.
 - complacency.**
39. A client with obsessive-compulsive disorder follows a complicated bedtime routine that includes the use of a nightlight. A nurse notes this behavior in the care plan and passes on the information at change of shift. When the nurse returns the next day, the client states that she's very upset because someone turned off her nightlight. When the nurse investigates, she finds that a newly hired nurse had cared for the client. What would be the nurse's best course of action?
- Document the situation and make an incident report in accordance with hospital protocol.

- b. Instruct the night nurse to follow the care plan more carefully in the future.
 - c. Place a sign at the end of the client's bed stating that she needs a nightlight.
 - d. **Ask the night nurse about her experience of caring for client the previous night.**
40. A client taking lithium is ordered citalopram (Celexa) for panic disorder. Five days after starting the citalopram, the client reports sweating and feelings of anxiety, restlessness, and confusion. The nurse suspects the client is experiencing:
- a. lithium toxicity.
 - b. an anxiety attack.
 - c. **serotonin syndrome.**
 - d. a panic attack.
41. When a client with a conversion disorder reports blindness, ophthalmologic examinations reveal that no physiologic disorder is causing progressive vision loss. The most likely source of this client's reported blindness is:
- a. a family history of major depression.
 - b. **having been forced to watch the torture of a loved one.**
 - c. noncompliance with a psychotropic medication regimen.
 - d. daily use of antianxiety agents and alcoholic beverages.
42. During the client-teaching session, which instruction should the nurse give to a client receiving alprazolam (Xanax)?
- a. "Discontinue the medication immediately if you experience nausea."
 - b. "Notify the physician if you experience urine retention."
 - c. "Apply sunscreen to prevent photosensitivity."
 - d. **"Inform the physician if you become pregnant or intend to do so."**
43. At night, an elderly client with senile dementia wanders into other clients' rooms, awakening them. What is the best nursing intervention for dealing with this client's insomnia and nocturnal roaming?
- a. Administer a benzodiazepine at bedtime as ordered.
 - b. **Administer a low-dose antipsychotic at bedtime as ordered.**
 - c. Administer a barbiturate at bedtime as ordered.
 - d. Lock the client's door at bedtime.
44. A client with major depression sleeps 18 to 20 hours per day, shows no interest in activities he previously enjoyed and reports a 17-lb (7.7-kg) weight loss over the past month. Because this is the client's first hospitalization, the physician is most likely to order:
- a. phenelzine (Nardil).
 - b. thiothixene (Navane).
 - c. **nortriptyline (Pamelor).**
 - d. trifluoperazine (Stelazine).
45. Which adverse reaction to lithium (Eskalith) should the client with bipolar disorder report?
- a. Black tongue
 - b. Increased tearing
 - c. Constipation
 - d. **Persistent GI upset**
46. A client with a diagnosis of borderline personality disorder has attached herself to one nurse and refuses to speak with other staff members. She tells the nurse that the other nurses are mean, withhold her medication, and mistreat her. The staff is discussing this problem at the weekly conference. Which intervention is most appropriate for the nursing staff to implement?
- a. Provide an unstructured environment for the client.
 - b. **Rotate the nurses who are assigned to the client.**
 - c. Ignore the client's behaviors.
 - d. Bend unit rules to meet the client's needs.
47. A nurse is caring for a severely depressed client who is barely functioning. The priority nursing goal for this client would be to:
- a. assess for level of depression and continue antidepressant medication.
 - b. assess for the client's hygiene needs and ensure that these needs are met.
 - c. **assess for and maintain adequate nutrition and hydration.**
 - d. involve the client's family in his care as much as possible.
48. A nurse is frustrated by her inability to make much progress establishing a therapeutic relationship with a client with bipolar disorder. Her most professional response would be to:
- a. ask to be reassigned to another, less-challenging client.
 - b. tell the supervisor that she feels this client would make more progress with another nurse.
 - c. **discuss the situation with a more experienced peer.**
 - d. ask the physician to reevaluate the client's medication.
49. A nurse is instructing a new group of mental health aides. The nurse should teach the aides that setting limits is most important for:
- a. a depressed client.
 - b. **a manic client.**
 - c. a suicidal client.
 - d. an anxious client.
50. A client seeks care because she feels depressed and has gained weight. To treat her atypical depression, the physician orders tranylcypromine sulfate (Parnate), 10 mg by mouth twice per day. When this drug is used to treat atypical depression, what is its onset of action?
- a. 1 to 2 days
 - b. **3 to 5 days**
 - c. 6 to 8 days
 - d. 10 to 14 days
51. A client whose husband has left her is admitted to the hospital with severe depression. The nurse suspects that this client is at risk for suicide. Which question is most appropriate and helpful for the nurse to ask during an assessment for suicide risk?
- a. "Are you sure you want to kill yourself?"
 - b. "If my husband left me, I know I would want to kill myself. Is that how you feel?"
 - c. **"How do you think you would kill yourself?"**
 - d. "Why don't you just look at the positives in your life?"
52. A nurse is caring for a client who has been diagnosed with delirium. Which statement about delirium is true?

- a. It's characterized by an acute onset and lasts about 1 month.
 - b. It's characterized by a slowly evolving onset and lasts about 1 week.
 - c. It's characterized by a slowly evolving onset and lasts about 1 month.
 - d. **It's characterized by an acute onset and lasts hours to a number of days.**
- 53.
- 54.
55. A nurse is administering venlafaxine (Effexor), 75 mg by mouth daily, to a client diagnosed with depression. What type of agent is venlafaxine?
- a. Monoamine oxidase inhibitor
 - b. Tricyclic antidepressant
 - c. **Second-generation antidepressant**
 - d. Lithium derivative
56. A client with a diagnosis of major depression is ordered clonazepam (Klonopin) for agitation in addition to an antidepressant. Client teaching should include which statement?
- a. Clonazepam may interact with organ meats.
 - b. Stop taking the antidepressant.
 - c. **Clonazepam may have a slight depressant effect.**
 - d. Only take the clonazepam when feeling anxious.
57. A client with Alzheimer's disease mumbles incoherently and rambles in a confused manner. To help redirect the client's attention, the nurse should encourage the client to:
- a. **fold towels and pillow cases.**
 - b. play cards with another client.
 - c. participate in a game of charades.
 - d. perform an aerobic exercise.
58. An adolescent becomes increasingly withdrawn, is irritable with family members, and has been getting lower grades in school. After giving away a stereo and some favorite clothes, the adolescent is brought to the community mental health agency for evaluation. This adolescent is at risk for:
- a. **suicide.**
 - b. anorexia nervosa.
 - c. school phobia.
 - d. schizophrenia.
59. A client has been severely depressed since her husband died 6 months earlier. Her physician orders amitriptyline (Elavil), 50 mg by mouth daily. Before administering amitriptyline, the nurse reviews the client's medical history. Which preexisting condition requires cautious use of this drug?
- a. Hiatal hernia
 - b. Hyponatremia
 - c. **Hepatic disease**
 - d. Hypokalemia
60. Which statement should be included when teaching clients about monoamine oxidase (MAO) inhibitors?
- a. **Don't take any prescribed or over-the-counter medications without consulting a physician and pharmacist.**
 - b. Avoid strenuous activity because of the drug's cardiac effects.
 - c. Have blood levels screened weekly for leukopenia.
 - d. Don't take an MAO inhibitor with aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs).
61. A man found wandering in a local park is unable to state who or where he is or where he lives. He is brought to the emergency department, where his identification is eventually discovered. The client's wife states that he was diagnosed with Alzheimer's disease 3 years earlier and has experienced increasing memory loss. She tells a nurse she is worried about how she'll continue to care for him. Which response by the nurse is most helpful?
- a. "Because of the nature of your husband's disease, you should start looking into nursing homes for him."
 - b. **"What aspect of caring for your husband is causing you the greatest concern?"**
 - c. "You may benefit from a support group called Mates of Alzheimer's Disease Clients."
 - d. "Do you have any children or friends who could give you a break from his care every now and then?"
62. While shopping, a nurse meets a neighbor who asks about a friend receiving treatment at the nurse's clinic. What is the nurse's most appropriate response?
- a. **"I'm sorry, I can't disclose client information."**
 - b. "It might be best if you discuss this with the client directly."
 - c. "You should probably try to call her daughter for an update."
 - d. "I can only say she's stable and seems to be doing well."
63. A nurse is caring for a client in an acute manic state. What is the most effective nursing action she can take on behalf of this client?
- a. Assigning him to group activities
 - b. **Reducing stimuli**
 - c. Assisting him with self-care
 - d. Helping him express his feelings
64. A nurse is caring for a client with antisocial personality disorder. Which statement is most appropriate for the nurse to make when explaining unit rules and expectations to this client?
- a. "The other members of the health care team and I would like you to attend group therapy each day."
 - b. "You'll find your condition will improve much more quickly if you attend group therapy each day."
 - c. **"You'll be expected to attend group therapy each day."**
 - d. "Please try to attend group therapy each day."
65. A nurse formulates a nursing diagnosis of *Impaired verbal communication* for a client with schizotypal personality disorder. Based on this nursing diagnosis, which nursing intervention is the priority?
- a. Helping the client participate in social interactions
 - b. **Establishing a one-on-one relationship with the client**
 - c. Establishing alternative forms of communication with the client
 - d. Allowing the client to decide when he wants to communicate verbally with the nurse
66. A client is about to be discharged with a prescription for the antipsychotic agent haloperidol (Haldol), 10 mg by mouth twice per day. During a discharge teaching session, a nurse should provide which instruction to the client?
- a. Take the medication 1 hour before a meal.

- b. Decrease the dosage if signs of illness decrease.
 - c. **Apply a sunscreen before exposure to the sun.**
 - d. Increase the dosage up to 50 mg twice per day if signs of illness don't decrease.
67. A client is experiencing an acute schizophrenic episode. His vivid hallucinations are making him agitated. The nurse's best response at this time is to:
- a. take the client's vital signs.
 - b. **explore the content of the client's hallucinations.**
 - c. tell the client his fear is unrealistic.
 - d. engage the client in reality-oriented activities.
68. A man with a 5-year history of multiple psychiatric admissions is brought to the emergency department by the police. This client was found wandering the streets disheveled, shoeless, and confused. Based on his previous medical records and current behavior, he is diagnosed with chronic undifferentiated schizophrenia. The nurse should assign highest priority to which nursing diagnosis?
- a. **Risk for injury**
 - b. *Impaired verbal communication*
 - c. *Disturbed thought processes*
 - d. *Dressing or grooming self-care deficit*
69. While pacing in the hall, a client with paranoid schizophrenia runs to a nurse and asks, "Why are you poisoning me? I know you work for Central Thought Control! You can keep my thoughts. Give me back my soul!" How should the nurse respond during the early stage of the therapeutic process?
- a. "I'm a nurse. I'm not poisoning you. That would be a violation of the nursing code of ethics."
 - b. **"I'm a nurse, and you're a client in the hospital. I'm not going to harm you."**
 - c. "I'm not poisoning you. And how could I possibly steal your soul?"
 - d. "I sense anger. Are you feeling angry today?"
70. Benztropine (Cogentin) is used to treat the extrapyramidal effects induced by antipsychotics. This drug exerts its effect by:
- a. decreasing the anxiety causing muscle rigidity.
 - b. **blocking cholinergic activity in the central nervous system (CNS).**
 - c. increasing the level of acetylcholine in the CNS.
 - d. increasing norepinephrine in the CNS.
71. A client who's taking antipsychotic medication develops a very high temperature, severe muscle rigidity, tachycardia, and rapid deterioration in mental status. What complication of antipsychotic therapy does the nurse suspect?
- a. Agranulocytosis
 - b. Extrapyramidal effects
 - c. Anticholinergic effects
 - d. **Neuroleptic malignant syndrome**
72. A client who has been hospitalized with disorganized type schizophrenia for 8 years can't perform activities of daily living (ADLs) without staff direction and assistance. The nurse formulates a nursing diagnosis of *Dressing or grooming self-care deficit related to inability to function without assistance*. What is an appropriate goal for this client?
- a. "Client will be able to complete ADLs independently within 1 month."
 - b. "Client will be able to complete ADLs with only verbal encouragement within 1 month."
 - c. **"Client will be able to complete ADLs with assistance in organizing grooming items and clothing within 1 month."**
 - d. "Client will be able to complete ADLs with complete assistance within 1 month."
73. A nurse is teaching a psychiatric client about his ordered drugs, chlorpromazine (Thorazine) and benztropine (Cogentin). Why is benztropine administered?
- a. To reduce psychotic symptoms
 - b. **To reduce extrapyramidal symptoms**
 - c. To control nausea and vomiting
 - d. To relieve anxiety
74. Which nonantipsychotic medication is used to treat some clients with schizoaffective disorder?
- a. Phenelzine (Nardil)
 - b. Chlordiazepoxide (Librium)
 - c. **Lithium carbonate (Lithane)**
 - d. Imipramine (Tofranil)
75. A nurse is aware that antipsychotic medications may cause:
- a. increased insulin production.
 - b. **lower seizure threshold.**
 - c. increased coagulation time.
 - d. increased risk of heart failure.
76. A client tells a nurse that the television newscaster is sending her a secret message. The nurse suspects the client is experiencing:
- a. a delusion.
 - b. flight of ideas.
 - c. **ideas of reference.**
 - d. a hallucination.
77. A client tells a nurse that people from Mars are going to invade the Earth. Which response by the nurse would be therapeutic?
- a. **"That must be frightening to you. Can you tell me how you feel about it?"**
 - b. "There are no people living on Mars."
 - c. "What do you mean when you say they're going to invade the Earth?"
 - d. "I know you believe the Earth is going to be invaded, but I don't believe that."
78. A client with a diagnosis of borderline personality disorder is admitted to the psychiatric unit. The nurse expects the assessment to reveal:
- a. **unpredictable behavior and intense interpersonal relationships.**
 - b. inability to function as a responsible parent.
 - c. somatic symptoms.
 - d. coldness, detachment, and lack of tender feelings.
79. A client has been receiving chlorpromazine (Thorazine), an antipsychotic, to treat his psychosis. Which findings should alert the nurse that the client is experiencing pseudoparkinsonism?
- a. Restlessness, difficulty sitting still, and pacing

- b. Involuntary rolling of the eyes
 - c. Tremors, shuffling gait, and masklike face**
 - d. Extremity and neck spasms, facial grimacing, and jerky movements
80. A client with schizophrenia tells the nurse, "My intestines are rotted from the worms chewing on them." This statement indicates a:
- a. delusion of persecution.
 - c. somatic delusion.**
 - b. delusion of grandeur.
 - d. jealous delusion.
81. Every day for the past 2 weeks, a client with schizophrenia has stood during group therapy and screamed, "Get out of here right now! The elevator bombs are going to explode in 3 minutes!" The next time this happens, how should the nurse respond?
- a. "Why do you think there is a bomb in the elevator?"
 - b. "That is the same thing you said in yesterday's session."
 - c. "I know you think there are bombs in the elevator, but there aren't."**
 - d. "If you have something to say, you must do it according to our group rules."
82. A nurse is caring for a client with schizophrenia. Which outcome requires revising the client's care plan?
- a. The client spends more time by himself.**
 - b. The client doesn't engage in delusional thinking.
 - c. The client doesn't harm himself or others.
 - d. The client demonstrates the ability to meet his own self-care needs.
83. A client is admitted with a diagnosis of schizotypal personality disorder. Which signs would this client exhibit during social situations?
- a. Aggressive behavior
 - b. Paranoid thoughts**
 - c. Emotional affect
 - d. Independence needs
84. A client is unable to get out of bed and get dressed unless a nurse prompts every step. This is an example of which behavior?
- a. Word salad
 - b. Tangential
 - c. Perseveration
 - d. Avolition**
85. A client is admitted for detoxification following a cocaine overdose. The client tells the nurse that he frequently uses cocaine but can control his use if he chooses. Which coping mechanism is the client using?
- a. Withdrawal
 - b. Logical thinking
 - c. Repression
 - d. Denial**
86. A nurse plans to include the parents of a client with anorexia nervosa, in the client's therapy sessions. The nurse should anticipate that the parents will:
- a. tend to overprotect their child.**
 - b. have a history of substance abuse.
 - c. maintain emotional distance from their child.
 - d. alternate between expressing love for and rejection of their child.
87. In a toddler, which injury is most likely the result of child abuse?
- a. A hematoma on the occipital region of the head
 - b. A 1-inch forehead lacerate
 - c. Several small, dime-sized circular burns on the child's back**
 - d. A small isolated bruise on the right lower extremity
88. A client who has been arrested eight times in the past year for driving under the influence is admitted for alcohol treatment by judicial mandate. Which statement is most suggestive of alcohol dependence?
- a. "I never drink alone, so I don't have a problem."**
 - b. "I drink just a little on rare social occasions."
 - c. "I'm a family man, and my family doesn't drink."
 - d. "I've been known to have a beer or two at a ballgame."
89. A client who reports consuming 1 qt of vodka daily is admitted for alcohol detoxification. The nurse anticipates the need to teach the client about which medication?
- a. Clozapine (Clozaril)
 - c. Lorazepam (Ativan)**
 - b. Thiothixene (Navane)
 - d. Lithium carbonate (Eskalith)
90. A client is admitted to the inpatient adolescent unit after being arrested for attempting to sell cocaine to an undercover police officer. A behavior contract is planned. To promote client compliance the nurse should anticipate that the contract will be written:
- a. by the nurse alone.
 - c. jointly by the client and the nurse.**
 - b. by the client alone.
 - d. jointly by the physician and the nurse.
91. A client is being treated for alcoholism. After a family meeting, the client's spouse asks a nurse about ways to help the family deal with the effects of her husband's alcoholism. The nurse should suggest that the family join which organization?
- a. Al-Anon**
 - b. Make Today Count
 - c. Emotions Anonymous
 - d. Alcoholics Anonymous
92. Which condition is commonly seen in clients who abuse cocaine?
- a. Panic attacks
 - b. Bipolar cycling**
 - c. Attention deficits
 - d. Expressive aphasia
93. A physician orders carbamazepine (Tegretol) for a client with the diagnosis of intermittent explosive disorder. Which blood study should be performed before discharge as a baseline for identifying adverse effects of the medication?
- a. Fasting blood glucose
 - b. Complete blood count (CBC)**
 - c. Electrolyte tests
 - d. Cholesterol studies
94. A nurse is caring for an adolescent female who reports amenorrhea, weight loss, and depression. Which additional assessment finding suggests that the woman has an eating disorder?

- a. Hyperkalemia
 - b. Increased blood pressure
 - c. Oily skin
 - d. **Excessive and ritualized exercise**
95. A client newly admitted to a psychiatric inpatient setting demands a soda from a staff member who tells him to wait until lunch arrives in 20 minutes. The client becomes angry, pushes over a sofa, throws an end table, and dumps a potted plant. Which goal should a nurse consider to be of primary importance?
- a. Talking with the client's family about his angry feelings
 - b. Performing an assessment for tardive dyskinesia
 - c. Learning to effectively express needs to staff and others
 - d. **Demonstrating control over aggressive behavior**
96. Eighteen hours after undergoing an emergency appendectomy, a client with a reported history of social drinking displays these vital signs: temperature, 101.6° F (38.7° C); heart rate, 126 beats/minute; respiratory rate, 24 breaths/minute; and blood pressure, 140/96 mm Hg. The client exhibits gross hand tremors and is screaming for someone to kill the bugs in the bed. The nurse should suspect:
- a. a postoperative infection.
 - b. **alcohol withdrawal.**
 - c. septicemia.
 - d. alcohol hallucinosis.
97. A nurse is evaluating for treatment effectiveness in a client being discharged from the intensive outpatient drug and alcohol clinic. Which client behavior would the nurse evaluate as a positive treatment outcome?
- a. The client is following a regular sleeping routine.
 - b. **The client is participating in scheduled group meetings.**
 - c. The client is planning to engage in social activities.
 - d. The client is applying the clinic rules to others.
98. A client is brought to the emergency department after being beaten by her husband, a prominent attorney. The client describes her husband's upbringing as chaotic. The nurse caring for this client understands that this situation is consistent with which fact about family violence:
- a. Open boundaries are common in violent families.
 - b. Violence usually results from a power struggle.
 - c. **Domestic violence and abuse span all socioeconomic classes.**
 - d. Violent behavior is a genetic trait passed from one generation to the next.
99. A nurse performing an assessment determines that a client with anorexia nervosa is currently unemployed and has a family history of affective disorders, obesity, and infertility. Based on this information, the nurse should monitor the client for which health concern?
- a. Alcohol abuse
 - b. Avoidance behavior
 - c. **Suicide potential**
 - d. Explosive outbursts
100. When teaching a client with bulimia nervosa about possible complications, which condition should the nurse emphasize?
- a. Allergies
 - b. Cancer
 - c. **Diabetes mellitus**
 - d. Hepatitis A
101. A client admitted to the psychiatric unit for treatment of substance abuse tells a nurse, "It felt so wonderful to get high." What is an appropriate response?
- a. "If you continue to talk like that, I'm going to stop speaking to you."
 - b. **"You told me you got fired from your last job for missing too many days after taking drugs all night."**
 - c. "Tell me more about how it felt to get high."
 - d. "Don't you know it's illegal to use drugs?"
102. A clinic nurse is assigned to care for a suicidal client. During the pre interaction phase, what should the nurse's priority be?
- a. Assessing the client's home environment and relationships outside the hospital
 - b. **Exploring the nurse's own feelings about suicide**
 - c. Discussing the future with the client
 - d. Referring the client to a member of the clergy to discuss the moral implications of suicide
103. A client with a diagnosis of alcohol intoxication and suspected alcohol dependence is admitted to the psychiatric unit. Other assessment findings include an enlarged liver, jaundice, lethargy, and rambling, incoherent speech. No other information about the client is available. After the nurse completes the initial assessment, what should her first priority be?
- a. **Instituting seizure precautions, obtaining frequently vital signs, and recording fluid intake and output**
 - b. Checking the client's medical records for health history information
 - c. Attempting to contact the client's family to obtain more information about him
 - d. Restricting fluids and leaving the client alone to "sleep off" the episode
104. A client struggling with a binge eating disorder tells a nurse, "I don't know why I eat the way I do each night." What question would be most helpful for the nurse to ask this client?
- a. **"What do you do when you feel stressed or upset?"**
 - b. "Do you worry that bad things will happen to you?"
 - c. "Are there periods of time at night that you can't account for?"
 - d. "Have you experienced changes in your leisure activities?"
- 105.
- 106.
- 107.



109.

108.
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110. PSYCHIATRIC NURSING

111. SET 3

112.

1. A physician has ordered a new antipsychotic medication for a client with schizophrenia whose previous medication no longer provides the expected symptom relief. When the client tells the nurse that his insurance company won't reimburse him for the cost of this new medication, what is the first action the nurse should take to help the client advocate for his needs?
 - a. **Help the client explore other financial options for obtaining medication reimbursement.**
 - b. Suggest that the client contact his state representative about the situation.
 - c. Talk with the client and the physician about whether this particular drug is necessary.
 - d. Teach the client to accept the fact that his insurance company won't reimburse him for the cost of the medication.
2. Which principle of the psychoanalytic model is particularly useful to psychiatric nurses?
 - a. **All behavior has meaning.**
 - b. Behavior that is reinforced will be perpetuated.
 - c. The first 6 years of a person's life determine personality.
 - d. Behavioral deviations result from an incongruence between verbal and nonverbal communication.
3. A nurse working on an inpatient unit is assigned two clients diagnosed with severe depression and suicide attempts. After reviewing the client care assignment, which nursing action should she initiate?
 - a. Consult with the admitting physician about the clients' conditions.
 - b. Ask the supervisor to move both clients to the same room.
 - c. **Request a change in the client care assignment.**
 - d. Document the lack of staffing resources on the clients' charts.
4. Unhealthy personal boundaries are a product of dysfunctional families and a lack of positive role models. Unhealthy boundaries may also be a result of:
 - a. structured limit setting.
 - b. supportive environment.
 - c. **abuse and neglect.**
 - d. direction and attention.
5. During periods of extreme stress a client may experience elevated blood pressure, dilated pupils, and increased respirations. These unconscious responses originate in which part of the brain?
 - a. Limbic system
 - b. Reticular activating system
 - c. **Hypothalamus**
 - d. Somatic nervous system
6. A 22-year-old client loses her fiancé in a drunk-driving accident. She complains of difficulty eating, sleeping, and working. Her reaction is considered:
 - a. a pathologic response to grief.
 - b. **a crisis caused by traumatic stress.**
 - c. a noncrisis situation.
 - d. a crisis of anticipated life transitions.
7. An agitated client demands to see her chart so she can read what has been written about her. Which statement is the nurse's best response to the client?
 - a. "I'm sorry. The chart is the property of the facility. We don't permit clients to read their charts."
 - b. **"You have the right to see your chart. Please discuss your wish with your physician."**
 - c. "You may see your chart after you're discharged."
 - d. "Please discuss this matter with your attorney."
8. A client in the emergency department complains of suicidal ideation and feelings of worthlessness. He has a family history of suicide. The nurse is assessing the client to determine treatment recommendations. The most important factor to consider is:
 - a. **whether the client has an active suicide plan and the means to carry it out.**
 - b. whether the client has made a previous suicide attempt.
 - c. the client's religion and social status.
 - d. social support and marital status.
9. A client is admitted to an inpatient psychiatric unit. After the assessment and admission procedures have been completed, the nurse states, "I'll try to be available to talk with you when needed and will spend time with you each morning from 10:00 until 10:30 in the corner of the dayroom." What is the rationale for communicating these planned nursing interventions?
 - a. **To attempt to establish a trusting relationship**
 - b. To provide a structured environment for the client
 - c. To instill hope in the client
 - d. To provide time for completing nursing responsibilities
10. Which task may be delegated to a nursing assistant in an acute care mental health setting?
 - a. Assessing client's mental status on admission
 - b. **Checking for sharp objects**
 - c. Administering medication
 - d. Discussing the treatment plan
11. Which term refers to the primary unconscious defense mechanism that blocks intense, anxiety-producing situations from a person's conscious awareness?
 - a. Introjection
 - b. Regression
 - c. **Repression**
 - d. Denial
12. Silence in therapeutic communication is:
 - a. a means of disapproval.
 - b. to be avoided because it indicates intolerance and anger.
 - c. **a means of communicating patience and allowing the client space in which to respond.**
 - d. not therapeutic.
13. A nurse is assessing a client with bipolar disorder. Findings include coarse hand tremors, muscle twitching, and mental confusion. These findings suggest:
 - a. hypomania.
 - b. severe lithium toxicity.
 - c. **lithium toxicity.**
 - d. manic behaviors.
14. Which psychological or personality factor is most likely to predispose an individual to medication abuse?

- a. **Low self-esteem and unresolved rage**
 - b. Desire to inflict pain upon one's self
 - c. Dependent personality disorder
 - d. Antisocial personality disorder
15. A client is taking clozapine (Clozaril) and complains of a sore throat. This symptom may be an indication of which adverse reaction?
- a. Extrapyramidal reaction
 - b. Tardive dyskinesia
 - c. Reye's syndrome
 - d. **Agranulocytosis**
16. In group therapy, a client angrily speaks up and responds to a peer, "You're always whining, and I'm getting tired of listening to you! Here is the world's smallest violin playing for you." Which role is the client playing?
- a. Blocker
 - b. Monopolizer
 - c. Recognition seeker
 - d. **Aggressor**
17. A client with a diagnosis of bipolar disorder is energetic, impulsive, and verbalizes loudly in the community room. To prevent injury while complying with the principle of the least-restrictive environment, which action should the nurse take to prevent escalation of the client's mood?
- a. Place the client in seclusion with the door open.
 - b. Obtain a court mandate for a higher level of treatment.
 - c. **Try to channel the client's energy into appropriate activities.**
 - d. Monitor the client for escalation of manipulative behavior.
18. A client on short-term mental health disability leave undergoes required psychiatric evaluation and counseling. He requests that his evaluation and counseling records be e-mailed to his Human Resources representative. How should the nurse respond?
- a. "We need to review our administrative policy with the agency director before we can release records."
 - b. **"It's best not to send your records electronically because doing so might jeopardize your right to privacy."**
 - c. "Think about whether you want us to release your entire counseling record to the company that employs you."
 - d. "The treatment team must review disability-related records before we release them."
19. Mental health laws in each state specify when restraints may be used and which type of restraints may be used. Most laws stipulate that restraints may be used:
- a. for a maximum of 2 hours.
 - b. as necessary to control the client.
 - c. **if a client poses a present danger to himself or others.**
 - d. only with the client's consent.
20. A female client is admitted to the emergency department after being sexually assaulted. The nurse notes that the client is sitting calmly and quietly in the examination room and recognizes this behavior as a protective defense mechanism. What defense mechanism is the client exhibiting?
- a. Intellectualization
 - b. **Denial**
 - c. Regression
 - d. Displacement
21. A client is diagnosed with obsessive-compulsive disorder. Which intervention should the nurse include when developing the care plan for this client?
- a. Setting strict limits on compulsive behavior
 - b. **Giving the client time to perform rituals**
 - c. Increasing environmental stimulation
 - d. Preventing ritualistic behavior
22. When performing a physical examination on an anxious client, a nurse should expect to find which effect produced by the parasympathetic nervous system?
- a. **Hyperactive bowel sounds**
 - b. Decreased urine output
 - c. Constipation
 - d. Muscle tension
23. Which psychological or personality factor is most likely to predispose an individual to medication abuse?
- a. **Low self-esteem and unresolved rage**
 - b. Desire to inflict pain upon one's self
 - c. Dependent personality disorder
 - d. Antisocial personality disorder
24. A client who lost her home and dog in an earthquake tells the admitting nurse at the community health center that she finds it harder and harder to "feel anything." She says she can't concentrate on the simplest tasks, fears losing control, and thinks incessantly about the earthquake. She becomes extremely anxious whenever the earthquake is mentioned and must leave the room if people talk about it. The nurse suspects that this client has:
- a. phobic disorder.
 - b. conversion disorder.
 - c. **posttraumatic stress disorder (PTSD).**
 - d. adjustment disorder.
25. A nurse admits a client with a preliminary diagnosis of acute stress disorder to the mental health unit. As she interviews the client and her son, the nurse's priority concern is:
- a. the son's disapproval of the admission.
 - b. the presence of bruises on the client's body.
 - c. **the client stating she doesn't want to live anymore.**
 - d. the client's report that she hasn't eaten or slept for 2 days.
- 26.
27. The nurse is talking with a woman who is worried that her mother has Alzheimer's disease. The nurse knows that the first sign of dementia is
- a. Disorientation to person, place, or time
 - b. **Memory loss that is more than ordinary forgetfulness**
 - c. Inability to perform self-care tasks without assistance

- d. Variable with different people
28. The nurse has been teaching a caregiver about donepezil (Aricept). The nurse knows that teaching has been effective by which of the following statements?
- "Let's hope this medication will stop the Alzheimer's disease from progressing any further."
 - "It is important to take this medication on an empty stomach."
 - "I'll be eager to see if this medication makes any improvement in concentration."
 - "This medication will slow the progress of Alzheimer's disease temporarily."**
29. When teaching a client about tacrine (Cognex), the nurse will include which of the following?
- Taking tacrine can increase the risk for elevated liver enzymes.**
 - Tacrine causes agranulocytosis in some clients.
 - The most common side effect is skin rash.
 - Tacrine has no known serious side effects.
30. Which of the following statements by the caregiver of a client newly diagnosed with dementia requires further intervention by the nurse?
- "I will remind Mother of things she has forgotten."
 - "I will keep Mother busy with favorite activities as long as she can participate."
 - "I will try to find new and different things to do every day."**
 - "I will encourage Mother to talk about her friends and family."
31. A client with delirium is attempting to remove the intravenous tubing from his arm, saying to the nurse, "Get off me! Go away!" The client is experiencing which of the following?
- Delusions
 - Hallucinations**
 - Illusions
 - Disorientation
32. Which of the following statements indicates the caregiver's accurate knowledge about the needs of a parent at the onset of stage moderate dementia?
- "I need to give my parent a bath at the same time every day."
 - "I need to postpone any vacations for 5 years."
 - "I need to spend time with my parent doing things we both enjoy."**
 - "I need to stay with my parent 24 hours a day for supervision."
33. Which of the following interventions is most appropriate in helping a client with early stage dementia complete ADLs?
- Allow enough time for the client to complete ADLs as independently as possible.**
 - Provide the client with a written list of all the steps needed to complete ADLs.
 - Plan to provide step-by-step prompting to complete the ADLs.
 - Tell the client to finish ADLs before breakfast or the nursing assistant will do them.
34. A client with late moderate stage dementia has been admitted to a long-term care facility. Which of the following nursing interventions will help the client to maintain optimal cognitive function?
- Discuss pictures of children and grandchildren with the client.**
 - Do word games or crossword puzzles with the client.
 - Provide the client with a written list of daily activities.
 - Watch and discuss the evening news with the client.
34. Which of the following statements would indicate that teaching about naltrexone (ReVia) has been effective?
- "I'll get sick if I use heroin while taking this medication."
 - "This medication will block the effects of any opioid substance I take."**
 - "If I use opioids while taking naltrexone, I'll become extremely ill."
 - "Using naltrexone may make me dizzy."
35. Clonidine (Catapres) is prescribed for symptoms of opioid withdrawal. Which of the following nursing assessments is essential before giving a dose of this medication?
- Assess the client's blood pressure.**
 - Determine when the client last used an opiate.
 - Monitor the client for tremors.
36. Which of the following would the nurse recognize as signs of alcohol withdrawal?
- Coma, disorientation, and hypervigilance
 - Tremulousness, sweating, and elevated blood pressure**
 - Increased temperature, lethargy, and hypothermia
 - Talkativeness, hyperactivity, and blackouts
37. Which of the following behaviors would indicate stimulant intoxication?
- Slurred speech, unsteady gait, impaired concentration
 - Hyperactivity, talkativeness, euphoria**
 - Relaxed inhibitions, increased appetite, distorted perceptions
 - Depersonalization, dilated pupils, visual hallucinations
38. The Twelve Steps of AA teach that
- Acceptance of being an alcoholic will prevent urges to drink.**
 - A Higher Power will protect individuals if they feel like drinking.
 - Once a person has learned to be sober, he or she can graduate and leave AA.
 - Once a person is sober, he or she remains at risk to drink.
39. The nurse has provided an in-service program on impaired professionals. She knows that teaching has been effective when the staff identifies the following as the greatest risk for substance abuse among professionals:
- Most nurses are codependent in their personal and professional relationships.
 - Most nurses come from dysfunctional families and are at risk for developing addiction.
 - Most nurses are exposed to various substances and believe they are not at risk to develop the disease.**
 - Most nurses have preconceived ideas about what kind of people become addicted.

40. A client comes to day treatment intoxicated, but says he is not. The nurse identifies that the client is exhibiting symptoms of:
- Denial**
 - Reaction formation
 - Projection
 - Transference
41. The client tells the nurse that she takes a drink every morning to calm her nerves and stops her tremors. The nurse realizes the client is at risk for
- An anxiety disorder
 - A neurological disorder
 - Physical dependence**
 - Psychological addiction
42. Which of the following are considered the positive signs of schizophrenia?
- Delusions, anhedonia, ambivalence
 - Hallucinations, illusions, ambivalence
 - Delusions, hallucinations, disordered thinking**
 - Disordered thinking, anhedonia, illusions
43. The family of a client with schizophrenia asks the nurse about the difference between conventional and atypical antipsychotic medications. The nurse's answer is based on which of the following?
- Atypical antipsychotics are newer medications but act in the same ways as conventional antipsychotics.
 - Conventional antipsychotics are dopamine antagonists; atypical antipsychotics inhibit the reuptake of serotonin.
 - Conventional antipsychotics have serious side effects; atypical antipsychotics have virtually no side effects.
 - Atypical antipsychotics are dopamine and serotonin antagonists; conventional antipsychotics are only dopamine antagonists.**
44. The nurse is planning discharge teaching for a client taking clozapine (Clozaril). Which of the following is essential to include?
- Caution the client not to be outdoors in the sunshine without protective clothing.
 - Remind the client to go to the lab to have blood drawn for a white blood cell count.**
 - Instruct the client about dietary restrictions.
 - Give the client a chart to record a daily pulse rate.
45. The nurse is caring for a client who has been taking fluphenazine (Prolixin) for 2 days. The client suddenly cries out, his neck twists to one side, and his eyes appear to roll back in the sockets. The nurse finds the following prn medications ordered for the client. Which one should the nurse administer?
- Benztropine (Cogentin) 2 mg p.o., BID, prn
 - Fluphenazine (Prolixin) 2 mg p.o., TID, prn
 - Haloperidol (Haldol) 5 mg IM, prn extreme agitation
 - Diphenhydramine (Benadryl) 25 mg IM, prn**
46. Which of the following statements would indicate that family teaching about schizophrenia had been effective?
- "If our son takes his medication properly, he won't have another psychotic episode."
 - "I guess we'll have to face the fact that our daughter will eventually be institutionalized."
 - "It's a relief to find out that we did not cause our son's schizophrenia."**
 - "It is a shame our daughter will never be able to have children."
47. When the client describes fear of leaving his apartment as well as the desire to get out and meet others, it is called
- Ambivalence**
 - Anhedonia
 - Alogia
 - Avoidance
48. The client who hesitates 30 seconds before responding to any question is described as having
- Blunted affect
 - Latency of response**
 - Paranoid delusions
 - Poverty of speech
49. The overall goal of psychiatric rehabilitation is for the client to gain
- Control of symptoms
 - Freedom from hospitalization
 - Management of anxiety
 - Recovery from the illness**
50. Which of the following is the best action for the nurse to take when assessing a child who might be abused?
- Confront the parents with the facts and ask them what happened.
 - Consult with a professional member of the health team about making a report.**
 - Ask the child which of his parents caused this injury.
 - Say or do nothing; the nurse has only suspicions, not evidence.
51. Which of the following interventions would be most helpful for a client with dissociative disorder having difficulty expressing feelings?
- Distraction
 - Reality orientation
 - Journaling**
 - Grounding techniques
52. Which of the following is true about touching a client who is experiencing a flashback?
- The nurse should stand in front of the client before touching.
 - The nurse should never touch a client who is having a flashback.
 - The nurse should touch the client only after receiving permission to do so.**
 - The nurse should touch the client to increase feelings of security.
53. Which of the following is true about domestic violence between same-sex partners?
- Such violence is less common than that between heterosexual partners.
 - The frequency and intensity of violence are greater than between heterosexual partners.
 - Rates of violence are about the same as between heterosexual partners.**
 - None of the above.

54. The nurse working with a client during a flashback says, "I know you're scared, but you're in a safe place. Do you see the bed in your room? Do you feel the chair you're sitting on?" The nurse is using which of the following techniques?
- Distraction
 - Reality orientation
 - Relaxation
 - Grounding**
55. Which of the following assessment findings might indicate elder self-neglect?
- Hesitancy to talk openly with nurse
 - Inability to manage personal finances**
 - Missing valuables that are not misplaced
 - Unusual explanations for injuries
56. Which type of child abuse can be most difficult to treat effectively?
- Emotional**
 - Neglect
 - Physical
 - Sexual
57. Women in battering relationships often remain in those relationships as a result of faulty or incorrect beliefs. Which of the following beliefs is valid?
- If she tried to leave, she would be at increased risk for violence.**
 - If she would do a better job of meeting his needs, the violence would stop.
 - No one else would put up with her dependent, clinging behavior.
 - She often does things that provoke the violent episodes.
58. Client: "I had an accident." Nurse: "Tell me about your accident." This is an example of which therapeutic communication technique?
- Making observations
 - Offering self
 - General lead**
 - Reflection
59. "Earlier today you said you were concerned that your son was still upset with you. When I stopped by your room about an hour ago, you and your son seemed relaxed and smiling as you spoke to each other. How did things go between the two of you?" This is an example of which therapeutic communication technique?
- Consensual validation**
 - Encouraging comparison
 - Accepting
 - General lead
60. "Why do you always complain about the night nurse? She is a nice woman and a fine nurse, and has five kids to support. You're wrong when you say she is noisy and uncaring." This example reflects which non therapeutic technique?
- Requesting an explanation
 - Defending**
 - Disagreeing
 - Advising
61. "How does Jerry make you upset?" is a non therapeutic communication technique because it
- Gives a literal response
 - Indicates an external source of the emotion**
 - Interprets what the client is saying
 - Is just another stereotyped comment
62. Client: "I was so upset about my sister ignoring my pain when I broke my leg." Nurse: "When are you going to your next diabetes education program?" This is a non therapeutic response because the nurse has
- Used testing to evaluate the client's insight
 - Changed the topic**
 - Exhibited an egocentric focus
 - Advised the client what to do
63. When the client says, "I met Joe at the dance last week," what is the best way for the nurse to ask the client to describe her relationship with Joe?
- "Joe who?"
 - "Tell me about Joe."
 - "Tell me about you and Joe."**
 - "Joe, you mean that blond guy with the dark blue eyes?"
64. Which of the following is a concrete message?
- "Help me put this pile of books on Marsha's desk."**
 - "Get this out of here."
 - "When is she coming home?"
 - "They said it is too early to get in."
65. Which of the following theorists believed that a corrective interpersonal relationship with the therapist was the primary mode of treatment?
- Sigmund Freud
 - William Glasser
 - Hildegard Peplau
 - Harry Stack Sullivan**
66. Dream analysis and free association are techniques in which of the following?
- Client-centered therapy
 - Gestalt therapy
 - Logotherapy
 - Psychoanalysis**
67. Four levels of anxiety were described by:
- Erik Erikson
 - Sigmund Freud
 - Hildegard Peplau**
 - Carl Rogers
68. Correcting how one thinks about the world and oneself is the focus of
- Behaviorism
 - Cognitive therapy**
 - Psychoanalysis
 - Reality therapy
69. The personality structures of id, ego, and superego were described by:
- Sigmund Freud**
 - Hildegard Peplau
 - Frederick Perls
 - Harry Stack Sullivan
70. The nursing role that involves being a substitute for another, such as a parent, is called
- Counselor
 - Resource person
 - Surrogate**
 - Teacher
71. Psychiatric rehabilitation focuses on
- Client's strengths**
 - Medication compliance

- c. Social skills deficits
 - d. Symptom reduction
72. When a nurse develops feelings toward a client that are based on the nurse's past experience, it is called
- a. **Countertransference**
 - b. Role reversal
 - c. Transference
 - d. Unconditional regard
73. A group that was designed to meet weekly for 10 sessions to deal with feelings of depression would be a(n)
- a. **Closed group**
 - b. Educational group
 - c. Open group
 - d. Support group
74. Which of the following is important for nurses to remember when administering psychotropic drugs to nonwhites?
- a. **Lower doses may be used to produce desired effects.**
 - b. Fewer side effects occur with nonwhite clients.
 - c. Response to the drug will be similar to that in whites.
 - d. No generalization can be made.
75. Which of the following states the naturalistic view of what causes illness?
- a. Illness is a natural part of life and, therefore, unavoidable.
 - b. **Illness is caused by cold, heat, wind, and dampness.**
 - c. Only natural agents will be effective in treating illness.
 - d. Outside agents, such as evil spirits, upset the body's natural balance.
76. Which of the following is most influential in determining health beliefs and practices?
- a. **Cultural factors**
 - b. Individual factors
 - c. Interpersonal factors
 - d. All of the above are equally influential.
77. Marijuana is classified as:
- a. **Hallucinogen**
 - b. Narcotic
 - c. Sedative-hypnotic
 - d. Psychostimulant
- 78.
79. A shy, young man takes a public speaking course which emphasizes making friends and influencing people. He is attempting to cover up his shape by becoming proficient in speaking to a group. This defense mechanism is;
- a. Dissociation
 - b. identification
 - c. Sublimation
 - d. **Compensation**
80. Which of the following assessments indicates positive growth and development for a 30-yearold adult?
- a. Dissatisfaction with body image
 - b. **Enjoys social activities with three or four close friends**
 - c. Frequently changes jobs to "find the right one"
 - d. Planning to move from parental home in near future
81. Which of the following statements would cause concern for achievement of developmental tasks f a 55-year old woman?
- a. "I feel like I'm taking care of my parents now."
 - b. "I really enjoy just sitting around visiting with friends."
 - c. **"My children need me now just as much as when they were small."**
 - d. "When I retire, I want a smaller house to take care of."
82. Which of the following client statements would indicate self-efficacy?
- a. "I like to get several opinions before deciding a course of action."
 - b. **"I know if I can learn to relax, I will feel better."**
 - c. "I'm never sure if I'm making the right decision."
 - d. "No matter how hard I try, I will never make the best decision."
82. Which of the following is an example of assertive communication?
- a. "I wish you would stop making me angry."
 - b. **"I feel angry when you walk away when I'm talking."**
 - c. "You never listen to me when I'm talking."
 - d. "You make me angry when you interrupt me."
83. Which of the following statements about anger is true?
- a. Expressing anger openly and directly usually leads to arguments.
 - b. **Anger results from being frustrated, hurt, or afraid.**
 - c. Suppressing anger is a sign of maturity.
 - d. Angry feelings are a negative response to a situation.
- 83.
84. Which of the following types of drugs requires cautious use with potentially aggressive clients?
- a. Antipsychotic medications
 - b. **Benzodiazepines**
 - c. Mood stabilizers
 - d. Lithium
85. A client is pacing in the hallway with clenched fists and a flushed face. He is yelling and swearing. Which phase of the aggression cycle is he in?
- a. Anger
 - b. Triggering
 - c. **Escalation**
 - d. Crisis
86. The nurse observes a client muttering to himself and pounding his fist in his other hand while pacing in the hallway. Which of the following principles should guide the nurse's action?
- a. Only one nurse should approach an upset client to avoid threatening the client.
 - b. **Clients who can verbalize angry feelings are less likely to become physically aggressive.**
 - c. Talking to a client with delusions will not be helpful, because the client has no ability to reason.
 - d. Verbally aggressive clients often calm down on their own if the staff doesn't bother them.



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1. Sofia was very kind to her intelligent sister but deep inside had hostile feelings towards her. She is manifesting which type of defense mechanism?
2.
 - a. projection
 - b. displacement
 - c. **reaction formation**
 - d. psychoanalytic
 - t.
3. In the therapeutic nurse patient relationship, the nurse should focus on the client's
 - a. Appearance
 - b. **Feelings**
 - c. Thoughts
 - d. Behavior
4. Hospitals established by Dorothea Dix were designed to provide which of the following?
 - a. **Asylum**
 - b. Confinement
 - c. Therapeutic milieu
 - d. Public safety
5. Hildegard Peplau is best known for her writing about which of the following?
 - a. Community based care
 - b. Humane treatment
 - c. Psychopharmacology
 - d. **Therapeutic nurse – client relationship**
6.
 7. A basic concept in psychiatric nursing is that behavior is:
 - a. Cannot be observed
 - b. Cannot be understood
 - c. **Meaningful or purposeful**
 - d. Main indicator of one's personality
 8. Building trust is important in
 - a. **The orientation phase of the relationship**
 - b. The problem identification subphase of the relationship
 - c. All phases of the relationship
 - d. The exploitation sub phase of the relationship
 9. Abstract standards that provide a person with his or her code of conduct are
 - a. **Values**
 - b. Attitudes
 - c. Beliefs
 - d. Personal philosophy
 10. Ideas that one holds as true are
 - a. Values
 - b. Attitudes
 - c. **Beliefs**
 - d. Personal philosophy
 11. The emotional frame of reference by which one sees the world is created by
 - a. Values
 - b. **Attitudes**
 - c. Beliefs
 - d. Personal philosophy
 10. The nurse observes that a client with bipolar disorder is pacing in the hall, talking loudly and rapidly, and using elaborate hand gestures. The nurse concludes that the client is demonstrating which of the following?
 - a. Aggression
 - b. Anger
 - c. Anxiety
 - d. **Psychomotor agitation**
 11. A client with bipolar disorder begins taking lithium carbonate (Lithium) 300 mg four times a day. After 3 days of therapy, the client says "My hands are shaking." The best response by the nurse is
 - a. **"Fine motor tremors are an early effect of lithium therapy that usually subsides in a few weeks."**
 - b. "It is nothing to worry about unless it continues for the next month."
 - c. "Tremors can be an early sign of toxicity, but we'll keep monitoring your lithium level to make sure you're okay."
 - d. "You can expect tremors with Lithium. You seem very concerned about such a small tremor."
 12. What are the most common types of side effects from SSRIs?
 - a. **Dizziness, drowsiness, dry mouth**
 - b. Convulsions, respiratory difficulties
 - c. Diarrhea, weight gain
 - d. Jaundice, agranulocytosis
 13. The nurse observes that a client with depression sat at the table with two other clients during lunch. The best feedback the nurse could give the client is:
 - a. "Do you feel better after talking with others during lunch?"
 - b. "I'm so happy to see you interacting with other clients."
 - c. **"I see you were sitting with others at lunch today."**
 - d. "You must feel much better than you were a few days ago."
 14. Which of the following typifies the speech of a person in the acute phase of mania?
 - a. **Flight of ideas**
 - b. Psychomotor retardation
 - c. Hesitant
 - d. Mutism
 15. What is the rationale for a person taking lithium to have enough water and salt in his or her diet?
 - a. Salt and water are necessary to dilute lithium to avoid toxicity.
 - b. Water and salt convert lithium into a usable solute.

- c. Lithium is metabolized in the liver, necessitating increased water and salt.
 - d. Lithium is a salt that has greater affinity for receptor sites than sodium chloride.**
16. Identify the serum lithium level for maintenance and safety.
- a. 0.1 to 1.0 mEq/L
 - b. 0.5 to 1.5 mEq/L**
 - c. 10 to 50 mEq/L
 - d. 50 to 100 mEq/L
17. A client says to the nurse, "You are the best nurse I've ever met. I want you to remember me." What is an appropriate response by the nurse?
- a. "Thank you. I think you are special too."
 - b. "I suspect you want something from me. What is it?"
 - c. "You probably say that to all your nurses."
 - d. "Are you thinking of suicide?"**
18. A client with mania begins dancing around the day room. When she twirled her skirt in front of the male clients, it was obvious she had no underpants on. The nurse distracts her and takes her to her room to put on underpants. The nurse acted as she did to
- a. Minimize the client's embarrassment about her present behavior.**
 - b. Keep her from dancing with other clients.
 - c. Avoid embarrassing the male clients who are watching.
 - d. Teach her about proper attire and hygiene.
19. When working with a client with a paranoid personality disorder, the nurse would use which of the following approaches?
- a. Cheerful
 - b. Friendly
 - c. Serious**
 - d. Supportive.
20. Which of the following underlying emotions is commonly seen in a passive-aggressive personality disorder?
- a. Anger**
 - b. Depression
 - c. Fear
 - d. Guilt.
21. Cognitive restructuring techniques include all of the following except
- a. Decatastrophizing
 - b. Positive self-talk
 - c. Reframing
 - d. Relaxation**
22. Transient psychotic symptoms that occur with borderline personality disorder are most likely treated with which of the following?
- a. Anticonvulsant mood stabilizers
 - b. Antipsychotics**
 - c. Benzodiazepines
 - d. Lithium
23. Clients with a histrionic personality disorder are most likely to benefit from which of the following nursing interventions?
- a. Cognitive restructuring techniques
 - b. Improving community functioning
 - c. Providing emotional support
 - d. Teaching social skills**
24. When interviewing any client with a personality disorder, the nurse would assess for which of the following?
- a. Ability to charm and manipulate people
 - b. Desire for interpersonal relationships
 - c. Disruption in some aspects of his or her life**
 - d. Increased need for approval from others
25. The nurse would assess for which of the following characteristics in a client with narcissistic personality disorder?
- a. Entitlement**
 - b. Fear of abandonment
 - c. Hypersensitivity
 - d. Suspiciousness
26. The most important short-term goal for the client who tries to manipulate others would be to
- a. Acknowledge own behavior**
 - b. Express feelings verbally
 - c. Stop initiating arguments
 - d. Sustain lasting relationships
27. In caring for client with anorexia nervosa, the appropriate attitudes of the nurse are the following?
- a. Consistency and friendliness
 - b. Accepting and non judgmental**
 - c. Firm and directive
 - d. Non-confrontational and accepting
28. Research has shown that scheduled, intermittent hospital admissions result in which of the following?
- a. Fewer inpatient hospital stays
 - b. Increased sense of control for the client**
 - c. Feelings of failure when hospitalized
 - d. Shorter hospital stays
29. A common side effect of benzodiazepine anti-anxiety medication is:
- a. Fatigue
 - b. Dizziness**
 - c. Headache
 - d. Hypertension
30. Which of the following is the desired effect of antipsychotic drugs?
- a. Reduce anxiety related to the neurotic disorder
 - b. Decrease delusions**
 - c. Suppress the start of seizure
 - d. Increase the level of dopamine
31. Which of the following interventions is an example of primary prevention implemented by a public health nurse?
- a. Reporting suspected child abuse
 - b. Monitoring compliance with medications for a client with schizophrenia
 - c. Teaching effective problem-solving skills to high school students**
 - d. Helping a client to apply for disability benefits

32. The primary purpose of psychiatric rehabilitation is to
 - a. Control psychiatric symptoms
 - b. Manage client's medications
 - c. **Promote the recovery process**
 - d. Reduce hospital readmissions
33. Managed care provides funding for psychiatric rehabilitation programs to
 - a. Develop vocational skills
 - b. Improve medication compliance
 - c. **Provide community skills training**
 - d. Teach social skill
34. The mentally ill homeless population benefits most from
 - a. Case management services
 - b. Outpatient psychiatric care to manage psychiatric symptoms
 - c. Stable housing in a residential neighborhood
 - d. **A combination of housing, rehabilitation services, and community support**
35. Which of the following accurately lists Bowlby's phases of the grieving process?
 - a. Denial, anger, depression, bargaining, acceptance
 - b. Shock, outcry, and denial; intrusion of thought, distractions, and obsessive reviewing of the loss; confiding in others to emot and cognitively restructure an account of the loss
 - c. **Numbness and denial of the loss, emotional yearning for the loved one and protesting permanence of the loss, cognitive disorganization and emotional despair, reorganizing and reintegrating a sense of self**
 - d. Reeling, feeling, dealing, healing
36. Which of the following give cues to the nurse that a client may be grieving for a loss?
 - a. Sad affect, anger, anxiety, and sudden changes in mood
 - b. **Thoughts, feelings, behavior, and physiologic complaints**
 - c. Hallucinations, panic level of anxiety, sense of impending doom
 - d. Complaints of abdominal pain, diarrhea, and loss of appetite
37. Situations that are considered risk factors for complicated grief are
 - a. inadequate support and old age
 - b. childbirth, marriage, and divorce
 - c. **death of a spouse or child, death by suicide, sudden and unexpected death**
 - d. inadequate perception of the grieving crisis
38. Physiologic responses of complicated grieving include
 - a. tearfulness when recalling significant memories of the lost one
 - b. impaired appetite, weight loss, lack of energy, palpitations
 - c. depression, panic disorders, chronic grief
 - d. **impaired immune system, increased serum prolactin level, increased mortality rate from heart disease**
39. Critical factors for successful integration of loss during the grieving process are
 - a. **the client's adequate perception, adequate support, and adequate coping**
 - b. the nurse's trustworthiness and healthy attitudes about grief
 - c. accurate assessment and intervention by the nurse or helping person
 - d. the client's predictable and steady movement from one stage of the process to the next
40. Which of the following is an example of an open ended question?
 - a. Who is the current president of the United States?
 - b. **What concerns you most about your health?**
 - c. What is your address?
 - d. Have you lost any weight recently?
41. Which of the following is an example of a closed ended question?
 - a. How have you been feeling lately?
 - b. How is your relationship with your wife?
 - c. Have you had any health problems recently?
 - d. **Where are you employed?**
42. Which of the following is not included in the assessment of sensorium and intellectual processes?
 - a. Concentration
 - b. Memory
 - c. **Judgment**
 - d. Orientation
43. Assessment data about the client's speech patterns are categorized in which of the following areas?
 - a. History
 - b. **General appearance and motor behavior**
 - c. Sensorium and intellectual processes
 - d. Self-concept
44. When the nurse is assessing whether or not the client's ideas are logical and make sense, the nurse is examining which of the following?
 - a. Thought content
 - b. **Thought process**
 - c. Memory
 - d. Sensorium
45. The nurse who uses self-disclosure should:
 - a. **refocus on the client's experience as quickly as possible.**
 - b. allow the client to ask questions about her own experience.
 - c. discuss her experience in detail.
 - d. have the client explain his perception of what the nurse has revealed.
46. The client who believes everyone is out to get him is experiencing a(n)
 - a. **Delusion**
 - b. Hallucination
 - c. Idea of reference
 - d. Loose association
47. To assess the client's ability to concentrate, the nurse would instruct the client to do which of the following?
 - a. Explain what "A rolling stone gathers no moss" means.

- b. Name the last three presidents.
 - c. Repeat the days of the week backward.**
 - d. Tell what a typical day is like.
48. The nurse is caring for a client with a conversion disorder. Which of the following assessments will the nurse expect to see?
- a. Extreme distress over the physical symptom
 - b. Indifference about the physical symptom**
 - c. Labile mood
 - d. Multiple physical complaints.
49. Which of the following statements would indicate that teaching about somatization disorder has been effective?
- a. "The doctor believes I am faking my symptoms."
 - b. "If I try harder to control my symptoms, I will feel better."
 - c. "I will feel better when I begin handling stress more effectively."**
 - d. "Nothing will help me feel better physically."
50. Paroxetine (Paxil) has been prescribed for a client with a somatoform disorder. The nurse instructs the client to watch for which of the following side effects?
- a. Constipation
 - b. Increased appetite
 - c. Increased flatulence
 - d. Nausea**
51. Emotion-focused coping strategies are designed to accomplish which of the following outcomes?
- a. Helping the client manage difficult situations more effectively
 - b. Helping the client manage the intensity of symptoms**
 - c. Teaching the client the relationship between stress and physical symptoms
 - d. Relieving the client's physical symptoms.
52. Which of the following is true about clients with hypochondriasis?
- a. They may interpret normal body sensations as signs of disease.**
 - b. They often exaggerate or fabricate physical symptoms for attention.
 - c. They do not show signs of distress about their physical symptoms.
 - d. All of the above are true statements.
53. The client's family asks the nurse "What is hypochondriasis?" The best response by the nurse is "Hypochondriasis is
- a. A persistent preoccupation with getting a serious disease."**
 - b. An illness not fully explained by a diagnosed medical condition."
 - c. Characterized by a variety of symptoms over a number of years."
 - d. The eventual result of excessive worrying about diseases."
54. A client with somatization disorder has been attending group therapy. Which of the following statements indicates that therapy is having a positive outcome for this client?
- a. "I feel better physically just from getting a chance to talk."**
 - b. "I haven't said much, but I get a lot from listening to others."
 - c. "I shouldn't complain too much; my problems aren't as bad as others."
 - d. "The other people in this group have emotional problems."
55. A client who developed numbness in the right hand could not play the piano at a scheduled recital. The consequence of the symptom, not having to perform, is best described as
- a. Emotion-focused coping
 - b. Phobia
 - c. Primary gain**
 - d. Secondary gain
56. Treating clients with anorexia nervosa with a selective serotonin reuptake inhibitor antidepressant such as fluoxetine (Prozac) may present which of the following problems?
- a. Clients object to the side effect of weight gain.
 - b. Fluoxetine can cause appetite suppression and weight loss.**
 - c. Fluoxetine can cause clients to become giddy and silly.
 - d. Clients with anorexia get no benefit from fluoxetine.
57. Which of the following is an example of a cognitive-behavioral technique?
- a. Distraction
 - b. Relaxation
 - c. Self-monitoring**
 - d. Verbalization of emotions
58. The nurse is working with a client with anorexia nervosa. Even though the client has been eating all her meals and snacks, her weight has remained unchanged for 1 week. Which of the following interventions is indicated?
- a. Supervise the client closely for 2 hours after meals and snacks.**
 - b. Increase the daily caloric intake from 1,500 to 2,000 calories.
 - c. Increase the client's fluid intake.
 - d. Request an order from the physician for fluoxetine.
59. Which of the following statements is true?
- a. Anorexia nervosa was not recognized as an illness until the 1960s.
 - b. Cultures where beauty is linked to thinness have an increased risk for eating disorders.**
 - c. Eating disorders are a major health problem only in the United States and Europe.
 - d. Persons with anorexia nervosa are popular with their peers as a result of their thinness.
60. All but which of the following are initial goals for treating the severely malnourished client with anorexia nervosa?
- a. Correction of body image disturbance**
 - b. Correction of electrolyte imbalances
 - c. Nutritional rehabilitation
 - d. Weight restoration

61. The nurse is evaluating the progress of a client with bulimia. Which of the following behaviors would indicate that the client is making positive progress?
- The client can identify calorie content for each meal.
 - The client identifies healthy ways of coping with anxiety.**
 - The client spends time resting in her room after meals.
 - The client verbalizes knowledge of former eating patterns as unhealthy.
62. A teenage girl is being evaluated for an eating disorder. Which of the following would suggest anorexia nervosa?
- Guilt and shame about eating patterns
 - Lack of knowledge about food and nutrition
 - Refusal to talk about food-related topics
 - Unrealistic perception of body size**
63. A client with bulimia is learning to use the technique of self-monitoring. Which of the following interventions by the nurse would be most beneficial for this client?
- Ask the client to write about all feelings and experiences related to food.**
 - Assist the client to make out daily meal plans for one week.
 - Encourage the client to ignore feelings and impulses related to food.
 - Teach the client about nutrition content and calories of various foods.
64. During a shift report, a nurse learns that she will be providing care for a client who's vulnerable to panic attack. Treatment for panic attacks includes behavioral therapy, supportive psychotherapy, and medication such as:
- barbiturates.
 - antianxiety drugs.**
 - depressants.
 - amphetamines.
65. A client admitted to the psychiatric unit for treatment of a panic attack comes to the nurses' station in obvious distress. After finding the client short of breath, dizzy, trembling, and nauseated, a nurse should first:
- ask the client why he is upset.
 - administer an antianxiety medication, as ordered, and instruct the client to lie down in his room.
 - escort the client to a quiet area and suggest that he use a relaxation exercise he's been taught.**
 - assure the client that his symptoms will disappear after he lies down and relaxes.
66. A nurse is caring for a veteran with a history of explosive anger, unemployment, and depression since being discharged from the service. The client reports feeling ashamed of being "weak" and of letting past experiences control his thoughts and actions in the present. What is the nurse's best response?
- "Many people who've been in your situation experience similar emotions and behaviors."**
 - "You can change your behavior if you're motivated to do so."
 - "It isn't too late for you to make changes in your life."
 - "Weak people don't want to make changes in their lives."
67. A 40-year-old client is admitted for a surgical biopsy of a suspicious lump in her left breast. When the nurse arrives to take the client to surgery, she is tearfully completing a letter to her two children. She tells the nurse, "I want to leave this for my children in case anything goes wrong today." Which response by the nurse would be most therapeutic?
- "In case anything goes wrong? What are your thoughts and feelings right now?"**
 - "I can understand that you're nervous, but this really is a minor procedure. You'll be back in your room before you know it."
 - "Try to take a few deep breaths and relax. I have some medication that will help."
 - "I'm sure your children know how much you love them. You'll be able to talk to them on the phone in a few hours."
68. A client who recently developed paralysis of the arms is diagnosed with conversion disorder after tests fail to uncover a physical cause for the paralysis. Which intervention should the nurse include in the care plan for this client?
- Exercising the client's arms regularly**
 - Insisting that the client eat without assistance
 - Working with the client rather than with the family
 - Teaching the client how to use nonpharmacologic pain-control methods
69. Which drugs are known to be effective in treating obsessive-compulsive disorder (OCD)?
- Benzotropine (Cogentin) and diphenhydramine (Benadryl)
 - Chlordiazepoxide (Librium) and diazepam (Valium)
 - Fluvoxamine and clomipramine (Anafranil)**
 - Divalproex (Depakote) and lithium (Lithobid)
70. During the admission assessment, a client with a panic disorder begins to hyperventilate and says, "I'm going to die if I don't get out of here right now!" What is the nurse's best response?
- "Just calm down. You're overly anxious."
 - "What do you think is causing your panic attack?"
 - "You can rest alone in your room until you feel better."
 - "You're having a panic attack. I'll stay here with you."**
71. A nurse must assess a client's judgment to determine his mental status. To best accomplish this, the nurse should have the client:
- interpret proverbs.
 - spell words backward.
 - count by serial sevens.
 - discuss hypothetical ethical situations.**
72. A voluntary client in a facility decides to leave the unit before treatment is complete. To detain the client, the nurse refuses to return the client's personal effects. This action is an example of:
- false imprisonment.**
 - limit setting.
 - slander.
 - violation of confidentiality.

73. A physician orders a new medication for a client with generalized anxiety disorder. During medication teaching, which statement or question by the nurse is most appropriate?
- "Take this medication. It will reduce your anxiety."
 - "Do you have any concerns about taking the medication?"**
 - "Trust us. We wouldn't ask you to take it if it were dangerous."
 - "How can we help you if you won't cooperate?"
74. Nursing care for a client with schizophrenia must be based on valid psychiatric and nursing theories. A nurse's interpersonal communication with the client and specific nursing interventions must be:
- clearly identified, with boundaries and specifically defined roles.
 - warm and nonthreatening.
 - centered on clearly defined limits and expression of empathy.
 - flexible enough for the nurse to adjust the care plan as the situation warrants.**
75. A client with active psychosis is admitted to the psychiatric unit. The physician diagnoses schizophrenia after ruling out several other conditions. Schizophrenia is characterized by:
- loss of identity and self-esteem.
 - multiple personalities and decreased self-esteem.
 - disturbances in affect, perception, and thought content and form.**
 - persistent memory impairment and confusion.
76. A dual-diagnosed client, who has recently stabilized after experiencing a crisis resulting from a psychotic episode, tells a nurse he's interested in living in the community. When referring this client to a residential rehabilitation facility, the nurse should communicate:
- the need to form a treatment alliance at the residential rehabilitation facility.
 - the client's return to pre-crisis level of functioning.
 - that documentation of the client's improved functioning is available.**
 - that the client's chronic symptoms have resolved.
77. One of the causes of schizophrenia involves an overstimulation of:
- Dopamine**
 - Epinephrine
 - Norepinephrine
 - Serotonin
78. A college student is outraged by the recent end of his long-term relationship. For his creative writing class, he writes an essay on anger management. Which defense mechanism is he using?
- Repression
 - Introjection
 - Undoing
 - Sublimation**
79. A client diagnosed with schizoaffective disorder is suffering from schizophrenia with elements of which other disorder?
- Personality disorder
 - Mood disorder**
 - Thought disorder
 - Amnesic disorder
80. When discharging a client after treatment for a dystonic reaction, an emergency department nurse must ensure that the client understands:
- results of treatment are rapid and dramatic but may not last.
 - although uncomfortable, this reaction isn't serious.
 - the client shouldn't buy drugs on the street.
 - the client must take benztropine (Cogentin) as ordered to prevent a return of symptoms.**
81. A client is brought to the facility in an agitated state and admitted to the psychiatric unit for observation and treatment. While putting personal items away, the client talks rapidly and folds and unfolds garments several times. He can't seem to settle down. Which nursing diagnosis is most applicable at this time?
- Disturbed personal identity*
 - Anxiety**
 - Compromised family coping*
 - Powerlessness*
82. A client is admitted to the psychiatric emergency department. His significant other reports that he has difficulty sleeping, has poor judgment, and is incoherent at times. The client's speech is rapid and loose. He reports being a special messenger from the Messiah. He has a history of depressed mood for which he has been taking an antidepressant. Which diagnosis should the nurse suspect?
- Schizophrenia
 - Paranoid personality
 - Bipolar disorder**
 - Obsessive-compulsive disorder (OCD)
83. A client with schizophrenia, who has a history of being placed in seclusion for physically assaulting other clients, is showing signs of increased agitation. The nurse observes that he's scraping his face and eyes with his fingernails and injuring himself. All nursing attempts to reduce this behavior have failed. What should the nurse do next?
- Contact the physician and apply physical restraints as instructed by the physician.
 - Apply physical restraints to protect the client, then contact the physician for orders.**
 - Place the client in seclusion and contact the physician for further orders.
 - Call security to restrain the client and put him in seclusion for the safety of the unit.
84. Which response demonstrates that the parents of a child with newly diagnosed schizophrenia understand their child's diagnosis?
- "We'll watch him swallow his daily pills and call the physician if he doesn't."**
 - "As long as we're understanding and supportive, he'll eventually be fine."
 - "The illness is a result of drug abuse during early adolescence."
 - "His grandfather is an alcoholic. Being around him caused our son to have this problem."
85. A client with a history of heroin addiction is admitted to the hospital intensive care unit with a diagnosis of opioid drug overdose. While talking with a nurse, the client's father states that he's going to have his son declared legally incompetent. Which response by the nurse is most therapeutic?
- "Your son is ill and can't make decisions about himself and his safety right now, but this situation is temporary."**
 - "You don't have the right to declare your son incompetent. He has rights, too."
 - "I'll help you contact the hospital legal representative for help with the paperwork."
 - "If you become your son's guardian, you'll be responsible for his finances and for paying for his treatment."
86. A nurse explains the guidelines for the unit's seclusion room to a client with an impulse control disorder. Which client statement indicates that the nurse has adequately communicated the client's rights?

- a. **"Although I don't think I will, I can ask to go into seclusion, but I know you can make me go into the seclusion room."**
 b. "If I lose my temper in the community room, I'll be locked up in the seclusion room."
 c. "When I go into seclusion, I won't be able to see my physician until I calm myself down."
 d. "Every time I decide that I won't attend a group meeting, I'll be put in seclusion."
87. A nurse is assessing a 15-year-old female who's being admitted for treatment of anorexia nervosa. Which clinical manifestation is the nurse most likely to find?
 a. Tachycardia
 b. Warm, flushed extremities
 c. **Muscle weakness**
 d. Coarse hair growth
88. A nurse is evaluating a client for probable amphetamine overdose. Which assessment finding supports this diagnosis?
 a. Hypotension
 b. **Tachycardia**
 c. Hot, dry skin
 d. Constricted pupils
89. When planning care for a client who has ingested phencyclidine (PCP), the nurse's highest priority should be meeting the:
 a. client's physical needs.
 b. **client's safety needs.**
 c. client's psychosocial needs.
 d. client's medical needs.
90. Which is the drug of choice for treating Tourette syndrome?
 a. Fluoxetine (Prozac)
 b. Fluvoxamine (Luvox)
 c. **Haloperidol (Haldol)**
 d. Paroxetine (Paxil)
91. A 16-year-old male is admitted to the facility after acting out his aggressions inappropriately at school. To better understand possible contributing factors, the nurse should assess for:
 a. **viewing of televised violence.**
 b. passive parents.
 c. an internal locus of control.
 d. a single-parent family.
92. On discharge after treatment for alcoholism, a client plans to take disulfiram (Antabuse) as prescribed. When teaching the client about this drug, the nurse emphasizes the need to:
 93. **a. Avoid all products containing alcohol**
 94. b. Adhere to concomitant vitamin B therapy
 95. c. Return for monthly blood drug level monitoring
 96. d. Limit alcohol consumption to a moderate level
- 97.
98. A husband and wife seek emergency crisis intervention because he slapped her repeatedly the night before. The husband indicates that his childhood was marred by an abusive relationship with his father. To assess for the likelihood of further violence and abuse, the nurse should determine that the husband:
 a. has moderate impulse control.
 b. trusts his wife and supports her independence.
 c. **has learned violence as an acceptable behavior.**
 d. feels secure in his relationship with his wife.
99. A nurse is caring for a client being treated for alcoholism. Before initiating therapy with disulfiram (Antabuse), the nurse teaches the client that he must read labels carefully on which product?
 a. Carbonated beverages
 b. **Aftershave lotion**
 c. Toothpaste
 d. Cheese
100. Which foods are contraindicated for a client taking tranylcypromine (Parnate)?
 a. Whole grain cereals and bagels
 b. **Chicken livers, Chianti wine, and beer**
 c. Oranges and vodka
 d. Chicken, rice, and apples
101. Which classification of drugs is the most potentially fatal if a client takes an overdose?
 a. Antihistamines
 b. Dopaminergics
 c. Phenothiazine antipsychotics
 d. **Tricyclic antidepressants**
102. A client diagnosed with major depression has started taking amitriptyline (Elavil), a tricyclic antidepressant. What is a common adverse effect of this drug?
 a. Weight loss
 b. **Dry mouth**
 c. Hypertension
 d. Muscle spasms
103. A client is in the first stage of Alzheimer's disease. The nurse should plan to focus this client's care on:
 a. offering nourishing finger foods to help maintain the client's nutritional status.
 b. **providing emotional support and individual counseling.**
 c. monitoring the client to prevent minor illnesses from turning into major problems.
 d. suggesting new activities for the client and family to enjoy together.
104. A client is in the manic phase of bipolar disorder. To help the client maintain adequate nutrition, the nurse should plan to:
 a. provide large, attractive meals.
 b. **offer finger foods and sandwiches.**
 c. provide a stimulating mealtime environment.
 d. let the client choose his favorite foods.
105. According to Freud's psychosexual theory, the ego has several functions. The primary function of the ego is to:
 a. serve as the source of instinctual drives.
 b. stimulate psychic energy.
 c. operate as a conscience that controls unacceptable drives.
 d. **test reality and direct behavior.**



114. PSYCHIATRIC NURSING

115. SET 5

116.

1. Which of the following criteria would indicate improvement in an outpatient who has anorexia nervosa?
 117. **A. The patient identifies the relationship between emotions and eating behaviors.**
 118. B. The patient develops a plan to control negative feelings.
 119. C. The patient reports putting "thin" clothes on display in her room as a reminder to maintain proper weight.
 120. D. The patient avoids contact with her dysfunctional family.
2. Prior to assisting with electroconvulsive therapy, the nurse notices the signature of the patient's significant other on the consent form. Which of the following actions should the nurse take first?
 121. **A. Check to verify the legal guardianship for this patient**
 122. B. Ask the patient to explain why the form doesn't have the patient's own signature
 123. C. Proceed with the treatment
 124. D. Call a third party to witness the signature.
3. A patient is being treated for incapacitating ritualistic behavior. Which of the following behaviors would indicate to a nurse that the patient is achieving a short-term goal?
 125. A. The patient gives up the rituals
 126. B. The patient identifies control mechanisms
 127. **C. The patient resumes activities of daily living.**
 128. D. The patient gains insight into childhood trauma.
4. An 85-year-old patient who lives alone and has major depression is being prepared for discharge. Which of the following nursing actions would be most therapeutic initially?
 129. **A. Contact the patient's religious group to obtain a visitor passes**
 130. B. Arrange for food delivery by a home delivered meals program
 131. C. Enroll the patient in a day-care center
 132. D. Refer the patient to social services
5. A boss telephones an employee who is intoxicated, and the employee's spouse reports that the employee is ill. The spouse's behavior is an example of.

133. A. dependency	135. C. enmeshment
134. B. enabling	136. D. transference
6. A patient who is admitted for treatment of an eating disorder displays controlling behaviors, takes responsibility for others' actions, and has difficulty identifying feelings. These manifestations suggest.

7. A. learned helplessness.	9. C. dependency
8. B. manipulation	10. D. codependency
11. Which of the following behaviors is most indicative of impairment due to substance abuse in a nurse?
 12. A. Patients report that the nurse is always distracted and tired during the shift
 13. **B. Patients report experiencing pain despite documented administration of pain medication**
 14. C. Patients report that valuables are missing
 15. D. Patients report rude treatment by the nurse
16. The outcome that would be most appropriate for a patient who has a diagnosis of agoraphobia would be that the patient will

17. A. go shopping in town	19. C. handles money without wearing gloves.
18. B. touch the neighbor's dog	20. D. bathes only once a day.
21. A male patient's yearly laboratory screening reveals an elevated serum prostate-specific antigen (PSA) level. To which of the following nursing diagnoses should a nurse give priority for this patient?

22. A. Defensive Coping	24. C. Anxiety
23. B. Hopelessness	25. D. Social isolation
26. A schizophrenic patient says to a nurse, "You are wearing a pretty red dress. Tomatoes are red. Vegetables make you healthy. I am not healthy," a nurse should recognize that these statements are an example of

27. A. echolalia	29. C. neologisms
28. B. confabulation	30. D. looseness of association
31. The nurse provides information to a depressed patient and his family about electroconvulsive therapy (ECT). Which of the following statements would the nurse include in the teaching?
 32. **A. "The patient will have minimal muscle twitching during treatment."**
 33. B. "The patient must be in restraints following the treatment."
 34. C. "The patient will remain awake and alert during treatment."
 35. D. "The patient must remain flat on his back for one hour after treatment"
36. Disulfiram (Antabuse) is prescribed for a patient. Which of the following comments, if made by the patient, would indicate a correct understanding of the action of this medication?
 37. **A. "I'll drink fruit juice at social gatherings"**
 38. B. "I'll take my pulse four times each day"
 39. C. "I'll lie down for half an hour after I take the pill"
 40. D. "I'll take an antacid before my antabuse"
41. Which of the following statements, if made by a patient who is beginning lithium carbonate (Eskalith) therapy, would indicate a need for further teaching?
 42. **A. "I will take my entire daily lithium dose at bedtime"**
 43. B. "I will continue to use salt as a seasoning"
 44. C. "I will come to the clinic to have my blood tested"
 45. D. "I will report nausea and vomiting to my nurse"
 - 46.

47. A patient says to the nurse, "If you give me a cigarette, I'll go to group therapy." Which of the following responses by the nurse be therapeutic?
48. A. "Here are your cigarettes."
- 49. B. "All patients on this unit are expected to go to group therapy."**
50. C. "You can have one cigarette, then you must go to group therapy."
51. D. "Other patients do not ask me for special treatment. Why are you the only one?"
52. During the initial phase of a therapeutic relationship, a nurse should discuss which of the following topics with the patient?
- 53. A. Maintaining confidentiality**
54. B. Developing new coping skills
55. C. Gaining insight into behavior
56. D. Discussing previous faulty relationships
57. A Patient is receiving a selective serotonin reuptake inhibitor (SSRI). Which of the following instructions should a nurse give to the patient?
- 58. A. "This medication may make you feel sleepy"**
- 59. B. "You may notice some nervousness or anxiety until you adjust to your medicine"**
60. C. "Muscle cramping, especially of your neck, may occur:
61. D. "You will need to avoid cheese, wine and yeast products while you are on this medication."
62. A 14- year- old is admitted to the hospital after being hit by a car while riding her bicycle. She has a closed head injury and was unconscious for several minutes after the accident. While assessing the child, the nurse obtains all of the following data. Which finding definitely requires further investigation?
63. A. The child does not remember the accident
64. B. The child asks what day it is
- 65. C. The child has clear drainage from the left ear**
66. D. The child's pupils constrict in response to light.
67. Which of the following stressors would a nurse recognize as having the greatest impact on a hospitalized adolescent?
68. A. Separation from family
69. B. Fear of death
70. C. Loss of academic standing
- 71. D. Physical disfigurement**
19. Which of the following comments by a patient should indicate to a nurse that the patient has ideas of reference?
- 72. A. "Those other nurses are talking about me"**
73. B. "The nurse explained how my medication works"
74. C. "Do all the nurse here have a college degree?"
75. D. "Will a nurse lead group therapy today?"
20. A patient expresses many physical complaints during the first two weeks on the alcohol rehabilitation unit. The results of physical examination have been negative. The patient frequently approaches staff members to request medication for her discomfort. Based on the patient's behavior, which of the following interpretations is correct?
76. A. The patient is trying to make the staff feel guilty
- 77. B. The patient is attempting to relieve her anxiety**
78. C. The patient is experiencing organic pain from alcohol withdrawal
79. D. The patient is using a more mature way of meeting her needs than alcohol.
21. When admitting a four – day – old Hispanic infant to the pediatric unit, the nurse notes irregular bluish discoloration over the infant's sacrum and buttocks. The nurse should recognize that this is a
80. A. sign of child abuse and is reportable.
81. B. manifestation of a rare bleeding disorder
- 82. C. normal variation in the skin assessment of a newborn**
83. D. Result of a traumatic birth injury.
22. A 26- year- old woman is brought to the psychiatric unit because of suicidal thoughts. To determine if one- to- one observation is indicated for the woman, the nurse should determine if
84. A. anyone is the woman's has attempted suicide.
- 85. B. the woman has a plan for suicide.**
86. C. the woman has had a recent loss.
87. D. the woman has a social support system.
23. In which of the following ways should the nurse intervene when a patient repeatedly talks about the past?
88. A. Help the patient to establish goals for the future
89. B. Give the patient a diversional activity
90. C. Ask the patient to think of recent pleasures
- 91. D. Encourage the patient to share memories**
24. A patient who has begun taking a tricyclic antidepressant is given instructions regarding its use. Which of the following comments would indicate that the patient understands the information?
92. A. "I like active exercise, but I won't be able to do it while I'm on this medicine."
93. B. "This medicine will make my ears ring, but I guess I can tolerate that."
94. C. "I won't eat cheese if one of my visitors brings me some."
- 95. D. "I don't feel any better, but I've only been taking the medicine for a week."**
25. A woman who is dependent on alcohol is admitted to the detoxification unit. The answer to which of the following questions is essential for the nurse to obtain from the patient immediately?
96. A. How does her husband react to her problem?
- 97. B. When did she have her last drink?**
98. C. How old she was when she began to drink?
99. D. What did she eat in the past four hours?
- 100.

26. When discussing methods of stress reduction with a patient, the nurse should use which of following approaches first?
101. A. Explain to the patient the physiological effects of stress
 102. B. Teach the patient relaxation techniques that reduce stress
 - 103. C. Determine if the patient is able to identify sources of stress**
 104. D. Describe to the patient the benefits of active exercise in coping with stress
 - 105.
106. Situation: Andy, 30 years old, was admitted to the psychiatric ward because of religious preoccupation, deterioration in self-care and disturbed thoughts. He believes that he committed a lot of sins. He is threatened by people reaching out to him. His fasting for several days was not sufficient for him to feel forgiven.
27. Andy is demonstrating;
- a. **Religious delusion**
 - b. Delusion of grandeur
 - c. Somatic delusion
 - d. Delusion of being controlled
28. A delusion is a;
- a. Psychomotor disturbance
 - b. Mood disturbance
 - c. **Disturbance of thought**
 - d. Disturbance of perception
29. The nursing goal for Andy is to;
- a. Have him see a priest for confession
 - b. Encourage him to pray to atone for his sins
 - c. Help him to develop a positive self image
 - d. **Socialize him with a group to keep him in touch with reality**
30. Francis who is addicted to cocaine withdraws from the drug. Nurse Ron should expect to observe:
31. a. Hyperactivity
 32. **b. Depression**
 33. c. Suspicion
 34. d. Delirium
35. Nurse John is aware that a serious effect of inhaling cocaine is?
36. **a. Deterioration of nasal septum**
 37. b. Acute fluid and electrolyte imbalances
 38. c. Extra pyramidal tract symptoms
 39. d. Esophageal varices
40. A tentative diagnosis of opiate addiction, Nurse Candy should assess a recently hospitalized client for signs of opiate withdrawal. These signs would include:
41. a. Rhinorrhea, convulsions, subnormal temperature
 42. b. Nausea, dilated pupils, constipation
 43. c. Lacrimation, vomiting, drowsiness
 44. **d. Muscle aches, papillary constriction, yawning**
45. A 48 year old male client is brought to the psychiatric emergency room after attempting to jump off a bridge. The client's wife states that he lost his job several months ago and has been unable to find another job. The primary nursing intervention at thistime would be to assess for:
46. a. A past history of depression
 47. **b. Current plans to commit suicide**
 48. c. The presence of marital difficulties
 49. d. Feelings of excessive failure
50. Before helping a male client who has been sexually assaulted, nurse Maureen should recognize that the rapist is motivated by feelings of:
51. **a. Hostility**
 52. b. Inadequacy
 53. c. Incompetence
 54. d. Passion
55. When working with children who have been sexually abused by a family member it is important for the nurse to understand that these victims usually are overwhelmed with feelings of:
56. a. Humiliation
 57. b. Confusion
 58. **c. Self blame**
 59. d. Hatred
60. Joy who has just experienced her second spontaneous abortion expresses anger towards her physician, the hospital and the "rotten nursing care". When assessing the situation, the nurse recognizes that the client may be using the coping mechanism of:
61. a. Projection
 62. **b. Displacement**
 63. c. Denial
 64. d. Reaction formation
65. The most critical factor for nurse Linda to determine during crisis intervention would be the client's:
66. **a. Available situational supports**
 67. b. Willingness to restructure the personality
 68. c. Developmental theory
 69. d. Underlying unconscious conflict
70. Nurse Trish suggests a crisis intervention group to a client experiencing a developmental crisis. These groups are successful because the:
71. a. Crisis intervention worker is a psychologist and understands behavior patterns
 72. b. Crisis group supplies a workable solution to the client's problem
 73. c. Client is encouraged to talk about personal problems
 74. **d. Client is assisted to investigate alternative approaches to solving the identified problem**
75. Nurse Ronald could evaluate that the staff's approach to setting limits for a demanding, angry client was effective if the client:
76. a. Apologizes for disrupting the unit's routine when something is needed
 77. b. Understands the reason why frequent calls to the staff were made
 78. **c. Discuss concerns regarding the emotional condition that required hospitalizations**
 79. d. No longer calls the nursing staff for assistance
80. Nurse John is aware that the therapy that has the highest success rate for people with phobias would be:
81. a. Psychotherapy aimed at rearranging maladaptive thought process
 82. b. Psychoanalytical exploration of repressed conflicts of an earlier development phase
 83. **c. Systematic desensitization using relaxation technique**

84. d. Insight therapy to determine the origin of the anxiety and fear
- 85.
86. 41. When nurse Hazel considers a client's placement on the continuum of anxiety, a key in determining the degree of anxiety being experienced is the client's:
87. a. **Perceptual field**
88. b. Delusional system
89. c. Memory state
90. d. Creativity level
91. 42. In the diagnosis of a possible pervasive developmental autistic disorder. The nurse would find it most unusual for a 3 year old child to demonstrate:
92. a. An interest in music
93. b. An attachment to odd objects
94. c. Ritualistic behavior
95. d. **Responsiveness to the parents**
96. 43. Malou with schizophrenia tells Nurse Melinda, "My intestines are rotted from worms chewing on them." This statement indicates a:
97. a. Jealous delusion
98. b. **Somatic delusion**
99. c. Delusion of grandeur
100. d. Delusion of persecution
101. 44. Andy is admitted to the psychiatric unit with a diagnosis of borderline personality disorder. Nurse Hilary should expect the assessment to reveal:
102. a. Coldness, detachment and lack of tender feelings
103. b. Somatic symptoms
104. c. Inability to function as responsible parent
105. d. **Unpredictable behavior and intense interpersonal relationships**
106. 45. PROPRANOLOL (Inderal) is used in the mental health setting to manage which of the following conditions?
107. a. **Antipsychotic – induced akathisia and anxiety**
108. b. Obsessive – compulsive disorder (OCD) to reduce ritualistic behavior
109. c. Delusions for clients suffering from schizophrenia
110. d. The manic phase of bipolar illness as a mood stabilizer
111. 46. Which medication can control the extra pyramidal effects associated with antipsychotic agents?
112. a. Clorazepate (Tranxene)
113. b. **Amantadine (Symmetrel)**
114. c. Doxepin (Sinequan)
115. d. Perphenazine (Trilafon)
116. 47. Which of the following statements should be included when teaching clients about monoamine oxidase inhibitor (MAOI) antidepressants?
117. a. Don't take aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs)
118. b. Have blood levels screened weekly for leucopenia
119. c. **Avoid strenuous activity because of the cardiac effects of the drug**
120. d. Don't take prescribed or over the counter medications without consulting the physician
121. 48. Kris periodically has acute panic attacks. These attacks are unpredictable and have no apparent association with a specific object or situation. During an acute panic attack, Kris may experience:
122. a. Heightened concentration
123. b. **Decreased perceptual field**
124. c. Decreased cardiac rate
125. d. Decreased respiratory rate
126. 49. Initial interventions for Marco with acute anxiety include all except which of the following?
127. a. **Touching the client in an attempt to comfort him**
128. b. Approaching the client in calm, confident manner
129. c. Encouraging the client to verbalize feelings and concerns
130. d. Providing the client with a safe, quiet and private place
131. 50. Nurse Jessie is assessing a client suffering from stress and anxiety. A common physiological response to
132. stress and anxiety is:
133. a. Urticaria
134. b. Vertigo
135. c. Sedation
136. d. **Diarrhea**
137. 51. When performing a physical examination on a female anxious client, nurse Nelli would expect to find which of the following effects produced by the parasympathetic system?
138. a. Muscle tension
139. b. **Hyperactive bowel sounds**
140. c. Decreased urine output
141. d. Constipation
142. 52. Which of the following drugs have been known to be effective in treating obsessive-compulsive disorder (OCD)?
143. a. Divalproex (depakote) and Lithium (lithobid)
144. b. Chlordiazepoxide (Librium) and diazepam (valium)
145. c. **Fluvoxamine (Luvox) and clomipramine (anafranil)**
146. d. Benzotropine (Cogentin) and diphenhydramine (benadryl)
147. 53. Tony with agoraphobia has been symptom-free for 4months. Classic signs and symptoms of phobia include:
148. a. **Severe anxiety and fear**
149. b. Withdrawal and failure to distinguish reality from fantasy
150. c. Depression and weight loss
151. d. Insomnia and inability to concentrate
152. 54. Which nursing action is most appropriate when trying to diffuse a client's impending violent behavior?
153. a. Place the client in seclusion
154. b. Leaving the client alone until he can talk about his feelings
155. c. Involving the client in a quiet activity to divert attention
156. d. **Helping the client identify and express feelings of anxiety and anger**

157. 55. Rosana is in the second stage of Alzheimer's disease who appears to be in pain. Which question by Nurse Jenny would best elicit information about the pain?
158. a. "Where is your pain located?" 160. c. "Can you describe your pain?"
159. **b. "Do you hurt? (pause) "Do you hurt?"** 161. d. "Where do you hurt?"
162. 56. Nursing preparation for a client undergoing electroconvulsive therapy (ECT) resembles those used for:
163. **a. General anesthesia** 165. c. Neurologic examination
164. b. Cardiac stress testing 166. d. Physical therapy
167. 57. Jose who is receiving monoamine oxidase inhibitor antidepressant should avoid tyramine, a compound
169. found in which of the following foods?
170. a. Figs and cream cheese 172. **c. Aged cheese and Chianti wine**
171. b. Fruits and yellow vegetables 173. d. Green leafy vegetables
174. 58. Erlinda, age 85, with major depression undergoes a sixth electroconvulsive therapy (ECT) treatment. When assessing the client immediately after ECT, the nurse expects to find:
175. a. Permanent short-term memory loss and hypertension
176. b. Permanent long-term memory loss and hypomania
177. c. Transitory short-term memory loss and permanent long-term memory loss
178. **d. Transitory short and long term memory loss and confusion**
179. 59. Barbara with bipolar disorder is being treated with lithium for the first time. Nurse Clint should observe the client for which common adverse effect of lithium?
180. **a. Polyuria** 182. c. Constipation
181. b. Seizures 183. d. Sexual dysfunction
184. 60. Nurse Fred is assessing a client who has just been admitted to the ER department. Which signs would suggest an overdose of an antianxiety agent?
185. a. Suspiciousness, dilated pupils and incomplete BP
186. b. Agitation, hyperactivity and grandiose ideation
187. c. Combativeness, sweating and confusion
188. **d. Emotional lability, euphoria and impaired memory**
189. 61. Discharge instructions for a male client receiving tricyclic antidepressants include which of the following information?
190. 191. a. Restrict fluids and sodium intake 193. c. Discontinue if dry mouth and blurred vision occur
192. **b. Don't consume alcohol** 194. d. Restrict fluid and sodium intake
195. 62. Important teaching for women in their childbearing years who are receiving antipsychotic medications includes which of the following?
196. a. Increased incidence of dysmenorrhea while taking the drug
197. b. Occurrence of incomplete libido due to medication adverse effects
198. **c. Continuing previous use of contraception during periods of amenorrhea**
199. d. Instruction that amenorrhea is irreversible
200. 63. A client refuses to remain on psychotropic medications after discharge from an inpatient psychiatric unit. Which information should the community health nurse assess first during the initial follow-up with this client?
201. a. Income level and living arrangements
202. b. Involvement of family and support systems
203. c. Reason for inpatient admission
204. **d. Reason for refusal to take medications**
205. 64. The nurse understands that the therapeutic effects of typical antipsychotic medications are associated with which neurotransmitter change?
206. **a. Decreased dopamine level** 208. c. Stabilization of serotonin
207. b. Increased acetylcholine level 209. d. Stimulation of GABA
210. 65. Which of the following best explains why tricyclic antidepressants are used with caution in elderly patients?
211. a. Central Nervous System effects 213. c. Gastrointestinal system effects
212. **b. Cardiovascular system effects** 214. d. Serotonin syndrome effects
215. 66. A client with depressive symptoms is given prescribed medications and talks with his therapist about his belief that he is worthless and unable to cope with life. Psychiatric care in this treatment plan is based on which framework?
216. a. Behavioral framework 218. c. Interpersonal framework
217. **b. Cognitive framework** 219. d. Psychodynamic framework
220. 67. A nurse who explains that a client's psychotic behavior is unconsciously motivated understands that the client's disordered behavior arises from which of the following?
221. a. Abnormal thinking 223. **c. Internal needs**
222. b. Altered neurotransmitters 224. d. Response to stimuli
225. 68. A client with depression has been hospitalized for treatment after taking a leave of absence from work. The client's employer expects the client to return to work following inpatient treatment. The client tells the nurse, "I'm no good. I'm a failure". According to cognitive theory, these statements reflect:
226. a. Learned behavior
227. b. Punitive superego and decreased self-esteem
228. **c. Faulty thought processes that govern behavior**

229. d. Evidence of difficult relationships in the work environment
230. 69. The nurse describes a client as anxious. Which of the following statement about anxiety is true?
231. a. Anxiety is usually pathological 233. c. Anxiety is usually harmful
232. b. Anxiety is directly observable **234. d. Anxiety is a response to a threat**
235. 70. A client with a phobic disorder is treated by systematic desensitization. The nurse understands that this approach will do which of the following?
- 236. a. Help the client execute actions that are feared**
237. b. Help the client develop insight into irrational fears
238. c. Help the client substitute one fear for another
239. d. Help the client decrease anxiety
240. 71. Which client outcome would best indicate successful treatment for a client with an antisocial personality disorder?
241. a. The client exhibits charming behavior when around authority figures
- 242. b. The client has decreased episodes of impulsive behaviors**
243. c. The client makes statements of self-satisfaction
244. d. The client's statements indicate no remorse for behaviors
245. 72. The nurse is caring for a client with an autoimmune disorder at a medical clinic, where alternative medicine is used as an adjunct to traditional therapies. Which information should the nurse teach the client to help foster a sense of control over his symptoms?
246. a. Pathophysiology of disease process 248. c. Side effects of medications
247. b. Principles of good nutrition **249. d. Stress management techniques**
250. 73. Which of the following is the most distinguishing feature of a client with an antisocial personality disorder?
251. a. Attention to detail and order **254. d. Disregard for social and legal norms**
252. b. Bizarre mannerisms and thoughts
253. c. Submissive and dependent behavior
255. 74. Which nursing diagnosis is most appropriate for a client with anorexia nervosa who expresses feelings of guilt about not meeting family expectations?
256. a. Anxiety 258. c. Defensive coping
257. b. Disturbed body image **259. d. Powerlessness**
260. 75. A nurse is evaluating therapy with the family of a client with anorexia nervosa. Which of the following would indicate that the therapy was successful?
- 261. a. The parents reinforced increased decision making by the client**
262. b. The parents clearly verbalize their expectations for the client
263. c. The client verbalizes that family meals are now enjoyable
264. d. The client tells her parents about feelings of low self esteem
265. 76. A client with dysthymic disorder reports to a nurse that his life is hopeless and will never improve in the future. How can the nurse best respond using a cognitive approach?
266. a. Agree with the client's painful 268. c. Deny that the situation is hopeless
- feelings **269. d. Present a cheerful attitude**
267. b. Challenge the accuracy of the client's belief
270. 77. A client with major depression has not verbalized problem areas to staff or peers since admission to a psychiatric unit. Which activity should the nurse recommend to help this client express himself?
- 271. a. Art therapy in a small group** 273. c. Reading a self-help book on depression
272. b. Basketball game with peers on the unit 274. d. Watching movie with the peer group
275. 78. The home health psychiatric nurse visits a client with chronic schizophrenia who was recently discharged after a prolong stay in a state hospital. The client lives in a boarding home, reports no family involvement, and has little social interaction. The nurse plan to refer the client to a day treatment program in order to help him with:
276. a. Managing his hallucinations **278. c. Social skills training**
277. b. Medication teaching 279. d. Vocational training
280. 79. Which activity would be most appropriate for a severely withdrawn client?
- 281. a. Art activity with a staff member** 283. c. Team sport in the gym
282. b. Board game with a small group of clients 284. d. Watching TV in the dayroom
285. 80. Joe is a client of the psychiatric day treatment program. He has been referred by his probation officer for treatment after an arrest for driving under the influence of substances. Joe has a history of many arrests for assault, grand larceny, and other serious crimes and has served two prison sentences. His diagnosis is antisocial personality disorder. When he arrives at the day treatment unit for the day's activities, Joe says to the nurse, "Wow, you look great today! I'm so glad you're on duty today. You're the best nurse who works here, you know." This comment of Joe's is an example of what type of behavior commonly associated with antisocial personality disorder?
- a. Impulsivity
- b. Manipulation**
- c. Exploitation of others
- d. Inability to delay gratification
286. 81. Which of the following therapies is considered best for the client with antisocial personality disorder?
- a. Milieu therapy** c. Individual psychotherapy
- b. Family therapy d. Pharmacological therapy

- e. 82. Looking at the slightly bleeding paper cut she has just received, Linda screams, "Somebody help me, quick! I'm bleeding. Call 911! Hurry!" This response may reflect behavior associated with which personality disorder?
- a. Schizoid
 - b. Obsessive-compulsive
 - c. **Histrionic**
 - d. Paranoid
83. John had an extra calendar of the new year and left it on Andrew's desk as a gift. Andrew thinks, "I wonder what he wants from me?" This thought by Andrew may be associated with which personality disorder?
- a. Schizotypal
 - b. Narcissistic
 - c. Avoidant
 - d. **Paranoid**
84. Fred works long hours at his job as a research analyst. He then goes home where he lives alone. He has no friends and seldom speaks to others. This behavior is reflective of which personality disorder?
- a. Paranoid
 - b. **Schizoid**
 - c. Passive-Aggressive
 - d. Avoidant
85. When a new graduate nurse comes up with a plan and shows Thelma how everyone can be guaranteed every other weekend off, Thelma responds, "We can't make these kinds of changes! Who do you think you are? We've always done it this way, and we will continue to do it this way!" Thelma's statement reflects behavior associated with which personality disorder?
- a. Dependent
 - b. Histrionic
 - c. Passive-aggressive
 - d. **Obsessive-compulsive**

86.

87. SITUATION: As Eleanor, age 79, became increasingly unable to fulfill her self-care needs, her children, who lived in a distant city, agreed it would be best for her to move to a nursing home near them. Eleanor became depressed when she knew she would have to sell her home that she had lived in for more than 50 years. The physician prescribed an antidepressant for Eleanor.

88.

89. Which of the following physiological changes in the elderly may require special consideration when prescribing psychotropic medications for them?

- a. Changes in cortical and intellectual functioning
- b. Changes in cardiac and respiratory functioning
- c. Changes in liver and kidney functioning**
- d. Changes in endocrine and immune functioning

90. However, she does not respond to the medication and becomes more depressed. She tells the nurse, "I don't want to live here. I would rather die than live here." After hearing Eleanor make this statement, the nurse would be expected to add which of the following nursing diagnoses to Eleanor's care plan?

- a. Risk for self-mutilation
- b. Risk for self-directed violence**
- c. Risk for violence towards others
- d. Risk for injury

91. When Eleanor does not respond to the antidepressant medication, the physician considers another therapy. Which of the following is he likely to choose?

- a. Electroconvulsive therapy**
- b. Neuroleptic therapy
- c. An antiparkinsonian agent
- d. Anxiolytic therapy

92. Which of the following therapies is commonly used and has been found to be effective in decreasing depression in the elderly person?

- a. Behavior therapy
- b. Group therapy
- c. Orientation therapy
- d. Reminiscence therapy**

93. Which of the following nursing interventions would help Eleanor be as independent as possible in her self-care activities?

- a. Assign a variety of caregivers so that one person does not become used to doing everything for Eleanor
- b. Allow Eleanor a specified amount of time to complete activities of daily living (ADLs), then finish them for her.
- c. Tell her at the beginning of each day what is expected of her that day
- d. Allow ADLs to follow her home routine as closely as possible.**

94.

95. Situation: Tessa, a 27-year-old mother of three children, is admitted to a dual-diagnosis program for clients with mental illness and substance abuse. Tessa has been HIV-positive for 5 years. She was infected with HIV by contaminated needles used to inject heroin IV. Her husband recently died from AIDS. Her diagnoses are major depression; alcohol dependence; and opioid dependence, in remission.

96.

97. Which of the following data is most useful to determine Tessa's stage of HIV disease.

- a. T4-cell count**
- b. Hemoglobin and hematocrit
- c. Date of seroconversion
- d. Presence of opportunistic infection

98. She is found to be in early-stage HIV disease. She states, "I don't need to be treated for AIDS. I've never had any symptoms." The nurse's response is based on the knowledge that:

- a. Tessa is most likely in denial about her illness
- b. Tessa is lying about having no symptoms
- c. The physician will likely prescribe an antiviral medication for her
- d. Individual in early-stage disease may not have symptoms for many years**

99. She is found to be early stage-stage HIV disease. Tessa says to the nurse, "I'm so afraid my kids are going to get the disease from me." To help Tessa prevent this from happening, which of the following should she be instructed to do?

- a. Wear a face mask when preparing their food
- b. When hands are chapped or cut, wear protective gloves when preparing their food
- c. Do not kiss them on the lips or face**
- d. All family members should use disposable dishes and utensils from which to eat

100. She is found to be early stage-stage HIV disease. She continues to be followed for her HIV disease by her family physician and remains symptom-free for 3 years. During one visit, her physician notices an enlarged lymph node in her armpit and one in the region. Tessa's temperature is 100.9 degree F. The physician suspects that Tessa has progressed to middle-stage HIV disease. He orders a lymphocyte count. If his suspicion is correct, what would he expect the blood test to show?

- a. A T4-cell count between 700 and 800 mm³
- b. A T4-cell count between 500 and 600 mm³
- c. A T4-cell count between 200 and 500 mm³**
- d. A T4-cell count below 200 mm³

101. Which of the following statements is true about hospice services?

- a. Staff is on-call families on a 24-hour basis**
- b. Hospice services to the family will be discontinued upon a client's death
- c. The hospice will ensure that the client is hospitalized at the time of death
- d. None of the above

102.

103. Situation: Roberta is a 43-year-old married woman who has called in sick to work for 3 days. When she finally returns to work, her makeup cannot conceal bruises on her face. A coworker who is a good friend mentions the

bruises and says that they look like the bruises she used to have after being beaten by her former husband. Roberta says, "It was an accident. He just had a terribly day at work. He's being so kind and gentle now. Yesterday he brought me flowers. He says he's going to get a new job, so it won't ever happen again."

104.

105. Which phase of the cycle of battering does Roberta's response represent?

- a. Phase I: The Tension-Building Phase
- b. Phase II: The acute Battering Incident
- c. **Phase III: The Honeymoon Phase**
- d. Phase IV: The Resolution Phase

106. Roberta's co-worker recommends that Roberta seek assistance from her employee assistance program. Roberta refuses because she believes her husband has reformed. What is the best alternative suggestion her coworker can make at this point?

- a. Buy a gun
- b. File for divorce
- c. Press charge of assault and battery
- d. **Carry the number of the safe house for battered women**

107. Katie is a 9-year-old third grader. Her teacher, Mrs. Small, notices that Katie has had an open lesion on her left arm for a week. The lesion, which has never been covered with a bandage, appears to have become infected. Katie is often absent from school and seems apathetic and tired when she attends. Other children in the classroom avoid her, and Mrs. Small has overheard them talking about Katie stealing food from them at lunchtime. Mrs. Small's observations are indications of which of the following?

- a. **Physical neglect**
- b. Emotional injury
- c. Physical abuse
- d. Sexual abuse

108. Teresa, an unmarried 37-year-old woman, has recently been referred from her family physician to a psychiatrist with the complaint of "anxiety attacks" These attacks occurs in the evening before bedtime, and Teresa has also been experiencing insomnia. When she does get to sleep, she often has nightmares. She tells the psychiatrist that her father has recently been diagnosed with an inoperable brain tumor. What might the psychiatrist suspect after making his initial assessment of Teresa?

- a. Possible depressive disorder
- b. **Possible history of childhood incest**
- c. Possible anticipatory grieving
- d. Possible history of childhood physical abuse

109. The police escort Zoe, a 29-year-old married stock market analyst, to the emergency department (ED) of an inner-city hospital. She is sobbing, her clothing is torn, and she has superficial cuts on her neck and chest. She was leaving her office after working late and was accosted from behind as she bent to unlock her car, which was parked at the periphery of the parking lot. Her assailant raped her and stole her purse and her car. She walked to a nearby telephone, dialed 911, and a police car was dispatched to assist her. Upon arrival at the ED, the triage nurse immediately calls a member of the sexual assault crisis team, who arrives within 20 minutes and remains with Zoe throughout her stay in the ED. What is the most therapeutic thing for the nurse to say to Zoe when she arrives at the ED?

- a. **"You are safe now."**
- b. "I'll call your husband"
- c. "The police will want to interview you."
- d. "We'll have to take photographs of those wounds."



113.

114.

1. A nurse is planning a psychotherapy group for a number of clients. One task of the group leader or the entire group is to establish the rules for the group. The nurse knows that these rules deal with the following, EXCEPT:
A. confidentiality
B. punctuality
C. **responsibility**
D. social contact
2. Nurse Ronie is caring for Alex, a 21-year old male diagnosed with borderline personality disorder. Which interventions should Nurse Ronie perform for this type of personality disorder?
A. **setting limits on manipulative behavior**
B. allowing the client to set limits
C. using restraints judiciously
D. encouraging acting out behaviour
3. Which of the following behaviours would indicate amphetamine intoxication?
A. anxiety, depression, paranoid ideation
B. **hyperactivity, talkativeness, euphoria**
C. apathy, lethargy, listlessness
D. impaired motor coordination, inappropriate laughter, impaired judgment and short term memory
4. Manny, a 23-year old husband, says he is experiencing a crisis right now. A crisis can best be defined as
A. an disequilibrium in life
B. a threat to balance
C. **a turning point in one's life that has an overwhelming emotional response**
D. a situation requiring help other than personal resources
5. A popular pop singer was admitted to the hospital due to excessive weight loss. The singer was diagnosed with anorexia nervosa. After the patient stabilized from her condition, the parents, the client and the psychiatrist decided to initiate a behaviour modification program is that:
A. punishes negative reactions
B. deconditions the patient to fear to gaining weight
C. **rewards positive behaviour**
D. control the behaviour of the patient
6. A client is exhibiting withdrawn patterns of behaviour. The nurse is aware that this type of behaviour eventually produces feelings of
A. anger
B. paranoia
C. **loneliness**
D. repression
7. Clarisse has phobia with dogs since 8. The nurse should anticipate that a problem for this client would be:
A. avoiding dogs
B. **denial that a phobia exists**
C. anxiety when discussing the phobia
D. distortion of reality when completing daily routines
8. During a nurse-client relationship meeting, the client stated that he get his sexual arousal by peeping at women while they are taking a bath. Based on this information, the nurse knows that the client is experiencing a psychosexual disorder known as:
A. **voyeurism**
B. fetishism
C. frotteurism
D. sexual masochism
9. A young businessman who went bankrupt has been hospitalized after an attempted suicide. The client is being treated with milieu therapy. The nurse is aware that this therapeutic modality consists of:
A. using positive reinforcement to reduce guilt
B. psychotherapy
C. providing individual, group, family therapy
D. **practicing interpersonal relationship skills**
10. Mark, a chronic alcoholic has promised to her loved one to stop his bad habit of drinking alcohol. After 6 hours of cessation of alcohol intake, the client experiences alcohol withdrawal symptoms. The nurse should assess a client for the presence of:
A. yawning, anxiety, convulsions
B. **tremors, anxiety, profuse diaphoresis**
C. disorientation, paranoia, tachycardia
D. irritability, heightened alertness, jerky movements
11. Nurse Patricia is working with Ms. Alexis who is diagnosed with anorexia nervosa. She has been eating all her snacks and meals, but her weight remains the same after 2 weeks. Which of the following actions should Nurse Patricia do?
A. increasing caloric intake from 1500 to 2000 per day
B. increasing daily fluid intake
C. **close monitoring of Ms. Alexis 2 hours after meals and snacks**
D. ask the doctor for a prescription of Prozac
12. Nanding a 22-year old teacher, has recently completed college and has passed the board exams. He was hired in a public school and has come to health clinic for a pre-employment check-up. During the health history, the new employee states "I feel so anxious about starting teaching." He is able to connect with his feelings and actions but he constantly focuses on his attention on starting the new job. The nurse determines that the client is exhibiting:
A. panic level of anxiety
B. mid level of anxiety
C. **moderate level of anxiety**
D. severe level of anxiety
13. Renel, has been taking MAO inhibitors as his antidepressant meds. He is scheduled for discharge in the afternoon. Regarding dietary considerations, what should the nurse tell the client to avoid eating?
A. pork, spinach, and cottage cheese
B. milk, peanut butter, and cream cheese
C. **cheese, beer, and products with chocolate**
D. orange drinks, fresh apples, and ice cream
14. During a group session at the Chinese Psychiatric ward, one of the client with a manic disorder started to undress and display his sexual organs. The most appropriate nursing action is which of the following?

15. **A. bring the client to the room and get him on his clothes**
16. B. ask the client to leave
17. C. tell the client to stop doing that
18. D. refer the client to another group
15. A client with phobia is being evaluated by the nurse. The client has successfully achieved the long term goal of mobilizing effective coping responses when the client states, "When I feel anxious I will :"
- A. "Take my medications."
- B. "Do yoga and pray."
- C. "Avoid the situation that precipitated the anxiety."
- D. "Carefully examine what precipitated my anxiety."**
16. Nurse Leonora knows that all of the following are central features of somatoform disorders except:
- A. physical complaints suggesting major medical illness but have no demonstrable organic basis
- B. psychological factors that seem important in initiating, exacerbating, and maintaining the symptoms
- C. symptoms or magnified health concerns that are not under the client's conscious control.
- D. none of the above**
17. Johnny, 7 years old was being suspected of being abused at home. When a diagnosis of child abuse is established, a nursing care priority would be:
- A. staying with the parents while they visit
- B. protecting the well-being of the child**
- C. teaching the parents methods of discipline
- D. promoting parenteral attachment to the child
18. Jerry, 10 years old was brought to the ER. The nurse completes the initial assessment of Jerry who will be admitted to the mental health unit. The nurse analyzes the data obtained on assessment and determines that which of the following presents a priority concern?
- A. the presence of unexplainable bruises on the child's body**
- B. the client's report of not eating or sleeping
- C. the client's report of suicidal thoughts
- D. the significant other's disapproving of the treatment
19. A psychiatric nurse is planning a discharge teaching for Philles, a schizophrenic patient together with his family. It is important for the nurse to include the following in his discharge teaching:
- A. importance of maintaining prescribed medication regimen and regular follow-up**
- B. telling the client that it's ok to consume alcohol but in moderate amounts only
- C. informing the client that once stable and at home, the client may resume any diet preferred
- D. obtain a new and more complete family health history
20. After Lorena, a 3 year old child, was diagnosed as moderately retarded about a month ago, her parent's discussion of her future reflects plans for her normal independent functioning. The nurse recognizes that the parents:
- A. are using denial**
- B. accept the diagnosis
- C. are using intellectualization
- D. understand their child's limitations
21. Sam is a 70 year old war veteran and was admitted to the hospital because of a diagnosis of dementia. The client has agnosia, aphasia and is frequently agitated, confused, incontinent of urine and feces, and at times unaware of the presence of others. The question by the nurse that would best test the client's ability for abstract would be:
- A. "Can you give me today's complete date?"
- B. "How are a television set and a radio alike?"
- C. "What would you do if you fell and hurt yourself?"
- D. "Can you repeat the following numbers: 1,3,7,9, and 2?"**
22. A client has been admitted with a diagnosis of post traumatic stress disorder. The nurse tells the client that talking is part and important in her therapy. The client tells the nurse, "How can talking to you, possibly help me?" The nurse's appropriate response would be:
- A. "I can see how you would feel that way now, but hopefully you'll change your mind."**
- B. "You will never know whether or not it is helpful unless you are willing to give it a try."
- C. "The one-to-one relationship has proven itself very helpful to others. Why don't you give it a try?"
- D. " Hopefully, I can help you sort out your thoughts and feelings so you can better understand them."
23. Mr. Mercado, 21 years old, is diagnosed to have schizophrenia, paranoid type. He started to show unusual behaviour when his teacher hurled his report at him in front of the entire class. His family admitted him in the psychiatric hospital for treatment.
24. "I want to write, to write, to write, to write," said Mr. Mercado. This indicates what type of speech pattern of a client with schizophrenia?
- A. verbigeration**
- B. stilted language
- C. perseveration
- D. clang association
25. College student, Lina, attended a Halloween party at 11 pm and ends up being raped by one of her male friends. Due to his trauma, Lina developed a dissociative disorder. Which of the following best describes dissociative fugue?
- A. Lina has recurrent feelings of being detached from her mental processes
- B. Lina cannot remember important specific information about the rape
- C. Lina displays two distinct personality states that recurrently take control of her behaviour
- D. Lina leaves her work without explanation, goes to a new city, and assumes a new identity**
26. A 15-year old girl was admitted to the hospital with a history of increasingly bizarre behaviour. The client states, "I'm receiving signals from the sun and its minions and it informed me that my family is out to persecute me." The initial action by the admitting nurse that would be most therapeutic for this client would be:
- A. Asking the client "Tell me what you are thinking about that?"**
- B. Ensuring the client that the unit is safe and that the client will be protected from the family
- C. Telling the client that the door is locked and no one is permitted to enter the unit to harm any client
- D. Telling the client that the sun cannot send signals to you
27. Nurse Yasmin is assigned at one of the pavilion of National Center for Mental Health. She is caring for a client diagnosed with dementia and another diagnosed with delirium. How does dementia differ from delirium?
- A. dementia is confined to the elderly

- B. delirium only occurs with the substance abuse
 - C. delirium is an acute or subacute onset of confusion**
 - D. they aren't different; their defining characteristics are interchangeable
28. Robin, a long time drug user and abuser is unable to cope with the slightest stress and change in his environment. To enhance Robin's coping skills, the nurse should plan to:
- A. Allow time for compulsive behavior
 - B. Maintain a low level of environmental stimuli
 - C. Provide ample opportunities for intellectual activities
 - D. Schedule short independent tasks that are achievable**
29. You are caring for Mang Kiko, 73 years old, who was being abused at home. Which of the following assessment findings might indicate elder self-neglect?
- A. Missing valuables that are not misplaced
 - B. Unusual explanations for injuries
 - C. Inability to manage personal finances**
 - D. Hesitant to talk openly with nurse
30. A client has been admitted with a diagnosis of post traumatic stress disorder. The nurse tells the client that talking is part and important in her therapy. The client tells the nurse, "How can talking to you, possibly help me?" The nurse's appropriate response would be:
- A. "I can see how you would feel that way now, but hopefully you'll change your mind."**
 - B. "You will never know whether or not it is helpful unless you are willing to give it a try."
 - C. "The one-to-one relationship has proven itself very helpful to others. Why don't you give it a try?"
 - D. "Hopefully, I can help you sort out your thoughts and feelings so you can better understand them."
31. Manny, a 26-year old psychiatric patient, was talking with the nurse regularly for 4 days already. Manny expressed that he had lost 6 jobs within a year and 6 roommates within 6 months. When learning more about the client's issue when it comes to relationships with people, the nurse's most appropriate response would be:
- A. "Let's not talk about your past. It's better to talk about your future."
 - B. "That's a lot of changes. What happened in those jobs and roommates?"
 - C. "It must be so sad. How were you able to adapt to it? How did you do it?"
 - D. "Tell me more about some of the specific problem situations you've experience with these people."**
32. The nurse is talking with a mother to assess her child. A positive response to which question would indicate the child is in the anal stage of psychosexual development as described by Freud?
- a) "Does he put everything in his mouth?"
 - b) "Does he say 'No!' to everything you say?"**
 - c) "Does he like to dress up and pretend to be his father?"
 - d) "Does he seem jealous when you show affection to his father?"
33. The nurse is assessing a 70-year-old woman. Which statement by the client indicates that she has achieved integrity according to Erickson's stages of personality development?
- a) "My life has been wasted."
 - b) "My children no longer visit me. I am just waiting to die."
 - c) "I was a good nurse when I was younger, but now I am nothing."
 - d) "I have a good life and still enjoy it, but I feel ready to go when it's time."**
34. Which cognitive skill would the nurse expect a 6-year-old child to be in the process of developing?
- a) Understanding of basic rules.**
 - b) Ability to understand abstract concepts.
 - c) Recognition of object performance.
 - d) Imitation of others' actions.
35. The nurse is meeting a new client on the unit. Which action by the nurse is most effective in initiating the nurse-client relationship?
- a) Introduce self and explain the purpose and the plan for the relationship.**
 - b) Describe the nurse's family and ask the client to describe his family.
 - c) Wait until the client indicates a readiness to establish a relationship.
 - d) Ask the client why he was brought to the hospital.
36. An adult has just been brought to the psychiatric unit and is pacing up and down the hall. The nurse is to admit him to the hospital. To establish a nurse-client relationship, which approach should the nurse try first?
- a) Assign someone to watch him until he is calmer.
 - b) Ask him to sit down and orient him to the nurse's name and the need for information.**
 - c) Check his vital signs, ask him about allergies, and call the physician for sedation.
 - d) Explain the importance of accurate assessment data to him.
37. A woman has been referred for help in managing her children. The woman arrives late for appointments and focuses on her busy schedule, the difficulty in parking, and other reasons for being late. How would the nurse best interpret this behavior?
- a) Transference
 - b) Counter-transference
 - c) Identification
 - d) Rationalization**
 - e)
38. A woman has remained at the side of the nurse all day. When the nurse talked with other clients during dinner, the client tried to regain the nurse's attention and then began to shout, "You're just like my mother! You pay attention to everyone but me!" What is the best interpretation of this behavior?
- a) She is exhibiting sublimation.
 - b) She has been spoiled by her family.
 - c) The nurse has failed to meet her needs.
 - d) She is demonstrating transference.**
39. A nurse is part of a community task force on teenage suicide. The task force on teenage suicide. The task force is considering all of the following steps in an effort to reduce teen suicide. Which action represents primary prevention?
- a) Encourage emergency room staff to request psychiatric consultation for adolescents who overdose

- b) Educate teachers, counsellors, and school nurses in recognition and early intervention with suicidal teens.
 - c) **Provide community programs, such as scouts, which increase self-esteem for children and adolescents.**
 - d) Increase the number of inpatient adolescent psychiatric beds available in the community.
40. Two nurses are discussing plans for their client group. What should be in the plan to promote group cohesiveness?
- a) Let the group know which clients are behaving in ways approved by the nurses.
 - b) **Help the group identify group goals that are consistent with the individual members' goals.**
 - c) Make most decisions about the group in advance and make each group member aware of the nurses' decisions.
 - d) Seat the most talkative members nearest the nurses where they can be more clearly heard by the group.
41. The nurse is the leader of a client group. The members of the group test each other and the group's rules, as well as compete for the nurse's attention. This behavior is typical of which phase of the nurse-client relationship?
- a) **Orientation**
 - b) Working
 - c) Feedback
 - d) Termination
42. A family was referred to family therapy after their teenage son experienced behavioral problems in school. Which statement by the father indicates that he understands the purpose of family therapy?
- a) "Our son will realize the consequences of his actions and try harder to behave."
 - b) **"It will help us learn to communicate and problem-solve better as a group."**
 - c) "I expect the therapist to tell my wife how to discipline our son."
 - d) "The therapist will tell us how to make our son behave better in school."
43. A client walks in to the mental health outpatient center and states, "I've had it. I can't go on any longer. You've got to help me." The nurse asks the client to be seated in a private interview room. Which action should the nurse take next?
- a) Reassure the client that someone will help him soon.
 - b) Assess the client's insurance coverage.
 - c) **Find out more about what is happening to the client.**
 - d) Call the client's family to come and provide support.
44. The nurse is caring for a client with anorexia nervosa who is to be placed on behavior modification. Which is appropriate to include in the nursing care plan?
- a) Remind the client frequently to eat all the food served on the tray.
 - b) **Increase phone calls allowed the client by one per day for each pound gained.**
 - c) Include the family with the client in therapy sessions 2 times per week.
 - d) Reduce the client's TV time for any weight loss.
45. An adult is pacing about the unit and wringing his hands. He is breathing rapidly and complains of palpitations and nausea and he has difficulty focusing on what the nurse is saying. He says he is having a heart attack but refuses to rest. How would the nurse interpret his level of anxiety?
- a) Mild
 - b) Moderate
 - c) Severe
 - d) **Panic**
46. Each time a client is scheduled for a therapy session, she develops a headache and nausea. How would the nurse interpret this behavior?
- a) **Conversion**
 - b) Reaction Formation
 - c) Projection
 - d) Suppression
47. A man is admitted to the intensive care unit with chest pain, an abnormal ECG, and elevated enzymes. When the significance of this is explained to him, he says, "I can't be having a heart attack. No way. You must be mistaken." The nurse suspects the client is using which defense mechanism?
- a) Sublimation
 - b) Regression
 - c) Dissociation
 - d) **Denial**
48. An adult is admitted for panic attacks. He frequently experiences shortness of breath, palpitations, nausea, diaphoresis, and terror. What should the nurse include in the care plan when he is having a panic attack?
- a) **Calm reassurance, deep breathing, and medication as ordered.**
 - b) Teach him problem-solving in relation to his anxiety.
 - c) Explain the physiologic responses of anxiety
 - d) Explore alternate methods for dealing with the cause of his anxiety.
49. A client on an inpatient psychiatric unit refuses to eat and states that the staff is poisoning her food. Which action should the nurse include in the client's care plan?
- a) Explain to the client that the staff can be trusted
 - b) Show the client that others eat the food without harm
 - c) **Offer the client factory-sealed foods and beverages**
 - d) Institute behavior modification with privileges dependent on intake
50. A woman is being treated on the inpatient unit for depression. She tells the nurse, "I don't see how I can go on. I've been thinking of ways to kill myself. I can see several ways to do it." What is the best initial action for the nurse to perform?
- a) Notify her family about her statements.
 - b) Explain to the client the consequences of suicide on her family.
 - c) **See that someone is with the client at all times.**
 - d) Help the client identify the alternate means of coping.
51. An adult has been admitted to the inpatient unit with a diagnosis of depression. He states that he continues to think of suicide. Which is most essential for the nurse to include in his nursing care plan?
- a) Encourage the client to participate in all unit activities in all unit activities.
 - b) Ask the client if he has a knife.
 - c) Allow the client time alone to relax and think.
 - d) **Have someone stay with the client 24 hours a day.**

52. A 6-year-old has been diagnosed with enuresis after tests revealed no organic cause of bedwetting. The child's mother is upset and blames the problem on his father. "It's all his father's fault!" What is the initial response?
- "Why do you say that?"
 - "It's usually nobody's fault."
 - "You seem really upset by this."**
 - "Why are you blaming his father?"
53. An adolescent is admitted with anorexia nervosa. You have been assigned to sit with her while she eats her dinner. The client says to you, "My primary nurse trusts me. I don't see why you don't." What is your best response?
- "I do trust you, but I was assigned to be with you."
 - "I'd like to share this time with you."**
 - "OK. When I return, I'll check to see how much you have eaten."
 - "Who is your primary nurse?"
54. A teenager is hospitalized for the treatment of anorexia nervosa. She is 64 inches tall and weighs 100 pounds. What is the primary objective in the treatment of the hospitalized anorexic client?
- Decrease the client's anxiety.
 - Increase insight into the disorder.
 - Help the mother to relinquish control.
 - Get the client to eat and gain weight.**
55. A female adolescent is hospitalized for treatment of anorexia nervosa. While admitting the client, the nurse discovers a bottle of pills. She states they are antacids and she takes them because her stomach hurts. What would be the nurse's best initial response?
- "Tell me more about your stomach pain."**
 - "These do not look like antacids. I need to get an order for you to have them."
 - "Tell me more about your drug use."
 - "Some girls take pills to help them lose weight."
56. The nurse assesses an adolescent who has dropping grades, low motivation, somatic complaints, and dental caries. What disorder would the nurse suspect?
- Anxiety.
 - Depression.**
 - Acute mania.
 - Dissociative fugue.
57. An elderly client was recently admitted to a nursing home because of confusion, disorientation, and negativistic behavior. Her family states that she is in good health. The woman asks you, "Where am I?" What would be the best response from the nurse?
- "Don't worry. You're safe here."
 - "Where do you think you are?"
 - "What did your family tell you?"
 - "You're at the community nursing home."**
58. Which of the following would be an appropriate strategy in reorienting a confused client to where her room is?
- Place pictures of her family on the bedside stand.
 - Put her name in large letters on her wristband.
 - Remind the client where her room is.**
 - Let the other residents know where the client's room is.
59. An elderly client was admitted to a nursing home because of confusion, disorientation, and negativistic behavior. Which activity would you engage the client in the nursing home?
- Reminiscence groups.
 - Sing-alongs.
 - Discussion groups.
 - Exercise class.**
60. A 78-year-old was recently admitted to a nursing home because of confusion, disorientation, and negativistic behavior. She has had difficulty sleeping since admission. Which of the following would be the best intervention?
- Provide her with a glass of warm milk.
 - Ask the physician for a mild sedative.
 - Do not allow her to take naps during the day.
 - Ask her family what they prefer.**
61. A middle aged client is on the verge of losing his job because of a drinking problem. He voluntarily enters an alcohol detoxification program. Along with the amount and type, what information is most important that he needs to inform the staff?
- Time substances were taken over the past 24 hours.**
 - Frequency of substances taken over the past week.
 - Frequency of substances taken over the past 2 weeks.
 - Frequency of substances taken over the past month.
62. What is a characteristic common to most substance abusers that is difficult for them to achieve?
- Coping with stress and anxiety.**
 - Interacting socially.
 - Performing in work-related settings
 - Setting goals.
 -
63. A client is developing impending alcohol withdrawal delirium. Besides tremors, what others signs and symptoms would be present?
- Bradycardia and hypertension.
 - Bradycardia and hypotension.
 - Tachycardia and hypertension.**
 - Tachycardia and hypotension.
64. What is the most widely accepted treatment modality for substance abuse?
- Individual therapy with a psychodynamically oriented therapist.
 - Individual therapy with a systems-oriented therapist.
 - Group therapy with others with personality disorders.
 - Group therapy with other substance abusers.**
65. A client was voluntarily admitted to the inpatient unit with a diagnosis of schizophrenia. As the nurse approaches the client, he says, "If you come any closer, I'll die." Which disorder of perception does this client exhibit?
- Hallucination
 - Delusion**
 - Illusion
 - Ideas of reference
66. The nurse is approaching an adult client who is admitted with a diagnosis of paranoid schizophrenia. As the nurse approaches the client, he says, if you come any closer, I'll die." What is the best response for the nurse to make to this behaviour?
- "How can I hurt you?"
 - "I am your nurse today."**

- c) "Tell me more about this." d) "You're not going to die."
67. A young man admitted with a diagnosis of paranoid schizophrenia is pacing the halls and is agitated. The nurse hears him saying, "I have to get away from those doctors! They are trying to commit me to the state hospital!" The nurse's continued assessment should include:
- Clarifying intervention with the doctor
 - Observing the client for rising anxiety**
 - Reviewing history of involuntary commitment
 - Checking dosage of prescribed medication.
68. After 2 days in the hospital, the nurse assesses a client diagnosed with schizophrenia as exhibiting flat affect with little interest in other clients. What describes this characteristic of the schizophrenic process?
- Paranoia
 - Ambivalence**
 - Cyclothymic
 - Undifferentiated
69. What would be an appropriate activity for the nurse to recommend for a client who is extremely agitated?
- Competitive sports
 - Bingo
 - Trivial Pursuit
 - Daily walks**
70. A client who is diagnosed with a bipolar disorder is admitted to the hospital in the manic phase. What is the initial plan of care?
- Put the client in seclusion.
 - Put the client on one to one for safety.
 - Provide an environment for the client.**
 - Stabilize the client on medication.
71. A 34-year-old is hospitalized with bipolar disorder. At 2 AM, the nurse finds him phoning friends all across the country to discuss his new plan for eradicating world hunger. His excited explanations are keeping the entire unit awake, he won't quiet down. Which drug is most likely to be prescribed for this client?
- A tricyclic antidepressant
 - A MAOI antidepressant
 - Lithium carbonate (Eskalith)**
 - An antianxiety drug
72. Which supportive therapy for a client who is exhibiting manic behavior would be inappropriate to use as treatment?
- Psychoanalysis.**
 - Cognitive therapy.
 - Interpersonal therapy.
 - Problem-solving therapy.
73. A 38-year-old was admitted to the psychiatric service after a failed suicide attempt by drug overdose. The client sought help when her husband informed her of his decision to leave her and the children after 19 years of marriage. Her suicide attempt was made after she and her husband had had a fierce argument about property settlement. Upon initial contact with the nurse, the client looked exhausted, affect was sad, movements and responses were slowed, and self-care impairments were evident. She is convinced that a blemish on her face is a melanoma that is invading her brain and eating away at the tissue. What type of disorder is being shown?
- Bipolar disorder
 - Depression with melancholia
 - Dysthymic disorder
 - Major depression**
74. An adult is admitted to the psychiatric service after a failed suicide attempt by drug overdose. She presents with a sad affect and moves and responds slowly. Which nursing diagnosis is of the greatest priority at the time of her admission?
- Imbalanced nutrition: less than body requirements.
 - Ineffective coping.
 - Risk for violence: self-directed.**
 - Bathing/hygiene self-care deficit.
75. An adult is admitted following a suicide attempt. She took sleeping pills. She has been receiving therapy for depression since her husband left her after 23 years of marriage. Upon admission she looks very tired, has a sad affect, and moves slowly. What intervention would be a priority in helping to stabilize the client?
- Allow her to catch up on lost sleep for the first 3 days of her hospitalization.
 - Have her fully involved in all therapeutic activities.
 - Encourage her husband to visit for brief periods of time.
 - Schedule balanced periods of rest and therapeutic activity.**
76. When a client is experiencing severe anxiety, what would be the priority nursing intervention?
- Give the client medication immediately.
 - Offer the client psychotherapy to calm her down.
 - Isolate the client in a quiet environment.**
 - Put the client in seclusion temporarily.
- 77.
78. A client is admitted to the hospital because her family is unable to manage her constant hand washing rituals. Her family reports she washes her hands at least 30 times each day. The nurse noticed that the client's hands are reddened, scaly, and cracked. What is the main nursing goal?
- Decrease the number of hand washings a day.**
 - Provide a milder soap.
 - Provide good skin care.
 - Eliminate the hand washing rituals.
79. An adult admitted to the psychiatric hospital for hand washing rituals. The day after admission she is scheduled for lab tests. How will the nurse ensure that the client is there on time?
- Remind the client of her appointment several times.
 - Limit the number of hand washings.
 - Tell her it is her responsibility to be there on time.
 - Provide ample time for her to complete her rituals.**
80. An adult who is hospitalized with an obsessive-compulsive disorder washes her hands several times a day. Which of the following is an appropriate treatment for this client?
- An unstructured schedule of activities.
 - A structured schedule of activities.**
 - Intense counselling.
 - Negative reinforcement every time she performs the ritual.
81. A woman is admitted to the psychiatric hospital. She was found walking on a highway. She is unkempt and appears thin and dirty. What is the most thorough way to conduct a nursing assessment of her nutritional status?

- a) Observe her at mealtime.
 - b) Request a medical consult.
 - c) Explore her recent dietary intake.
 - d) **Compare current weight with her usual weight.**
82. A client is admitted to the psychiatric unit. She was found wandering on a major four-lane highway and cannot recall her activities from the past 3 days. During the assessment, the nurse observes that her face and hands are very red and excoriated, her hair is matted and dirty, and she is quite thin. When the client asked to be excused, she went directly to her room, and washed her hands and face washing was quite repetitive and ritualistic. However, she refused to bathe or wash her clothing. Which nursing diagnosis describes the most prominent difficulty that the client is experiencing?
- a) Impaired skin integrity
 - b) Disturbed thought processes
 - c) **Ineffective coping**
 - d) Social isolation
83. An adult is admitted because of ritualistic behavior. She is also constipated and dehydrated. Which nursing intervention would the client be most likely to comply with?
- a) Drinking ensure between meals.
 - b) Drinking extra fluids with meals.
 - c) **Drinking 8 oz water every hour between meals.**
 - d) Drinking adequate amounts of fluid during the day.
84. An adult is admitted because of excessive hand and face washing rituals. What would be the most effective way for the nurse to intervene with her hand and face washing?
- a) **Allow her a certain amount of time each shift to engage in this behavior.**
 - b) Interrupt the activity briefly and frequently.
 - c) Lock the door to her room and restrict access to the bathroom.
 - d) Tell her to stop each time she is observed doing it.
85. A client is admitted for ritualistic behavior involving frequent hand and face washing. Upon admission, the client was also dehydrated and underweight. When will the nurse know to initiate discharge planning for this client?
- a) The client's normal body weight is regained.
 - b) The client will express a desire to leave the hospital.
 - c) The client is able to start talking about her guilt and anxiety.
 - d) **The client limits her hand and face washing to a few times a day.**
84. A young adult was admitted on a voluntary basis to psychiatric services. During the last 3 years, he has been under psychiatric services. During the last 3 years he has been under psychiatric care and has a long history of petty crimes. Once on the unit, the client is difficult to manage because he is arrogant and manipulative. When a scheduled group therapy session is announced, he refuses to go. He uses other clients to his own ends and often pioneers causes that are disruptive to the milieu. What diagnostic title best describes his behavior?
- a) **Antisocial personality disorder.**
 - b) Borderline personality disorder.
 - c) Somatisation disorder.
 - d) Bipolar disorder.
85. An adult is admitted to a psychiatric unit with a diagnosis of antisocial personality disorder. In planning care for the client, which of the following would be least likely to occur?
- a) **Staff and client agree when setting treatment goals.**
 - b) Staff and client are in a constant struggle for control of the milieu.
 - c) Allow client to set limits.
 - d) Staff and client use the same defense mechanisms when interacting.
86. A client is admitted with an antisocial personality disorder. Which key intervention would be contraindicated with this client?
- a) Assisting him to identify and clarify his feelings.
 - b) **Changing staff assigned to a client at his request.**
 - c) Making expectations about his behavior clear as well as consequences for the same.
 - d) Setting firm limits with clear consequences.
87. A client has been hospitalized with an antisocial personality disorder on a voluntary basis as an alternative to serving a jail sentence? Following discharge, what will be the most likely result of the client?
- a) Be committed to another facility for a longer length of stay.
 - b) Be committed to a virtuous and socially acceptable lifestyle.
 - c) Continue to use sublimation.
 - d) **Revert to pre-hospitalization behaviors.**
88. A 28-year-old is admitted to the psychiatric unit under an involuntary petition after a perceived suicide attempt. Initially, she presented as very tearful and highly anxious. As the staff became more familiar with her, it became apparent that she had many episodes of self-mutilation and would do so "so I can feel something." While he could appear quite intact most of the time,, when stressed she would respond very impulsively, express anger, report hearing voices of a depreciative nature, and require a high level of observation. This client's symptoms can be best described as fitting which of the following diagnostic categories?
- a) Antisocial personality disorder.
 - b) **Borderline personality disorder.**
 - c) Generalized Anxiety Disorder
 - d) Post-traumatic Stress Disorder
89. A client is admitted to the psychiatric unit with a diagnosis of borderline personality disorder. Which of the following components would be needless to obtain for the history/ data base?
- a) Ego-strength assessment
 - b) Social history
 - c) **Cognitive aspect of mental status exam.**
 - d) Past psychiatric treatment history.
90. An adult was admitted to the psychiatric unit after cutting herself on the forearm. She has numerous scars which are from prior self-mutilation. Should the client attempt self-mutilation while in the hospital, which implementation should the nurse execute?
- a) Focus on the how, when, and where of the injury
 - b) **Care for the injury and explore the client's activities and feelings immediately before the episode.**
 - c) Care for the injury and leave the client alone for awhile to let her settle down.
 - d) Care for the injury and seclude, and possibly restrain, the client to prevent further injury.
91. A female client was admitted with a borderline personality disorder following an episode of self-mutilation. Her husband recently left her and she reports that she has injured herself in the past so she could feel something. Which of the following would be excluded during the discharge planning?

- a) **Cognition.**
b) Identity.
- c) Dealing with anger.
d) Separation/individualization.
92. While collecting data about a 7-year-old boy, the school nurse has learned that he has minimal verbal skills and expresses his needs by acting out behaviors. The communication capabilities of this boy indicate which of the following levels of mental retardation?
a) Mild.
b) Moderate.
c) **Severe.**
d) Profound.
93. What nursing care would be included for a 4-year-old boy with severe autistic disorder?
a) Psychotropic medications.
b) Social skills training.
c) **Play therapy.**
d) Group therapy.
94. The nurse makes the following assessment of a 14-year-old gymnast: underweight, hair loss, yellowish skin, facial lanugo, and peripheral edema. These findings are suggestive of which of the following disorders?
a) **Anorexia nervosa**
b) Bulimia nervosa
c) Acquired immunodeficiency
d) Ulcerative colitis.
95. An adolescent gymnast presents in the eating disorders clinic severely emaciated, with sallow skin color, 20% body weight loss, amenorrhea for the past 12 months, and facial lanugo. Based on these findings, which one of the following nursing diagnoses, would be most appropriate for the nurse to make.
a) **Impaired nutrition: less than body requirements**
b) Impaired tissue integrity
c) ineffective individual coping
d) Deficient knowledge, nutritional
96. Which observation of the client with anorexia indicates the client is improving?
a) The client eats meals in the dining room.
b) **The client gains 1 pound per week.**
c) The client attends group therapy sessions.
d) The client has a more realistic self-concept.
97. A client with severe Alzheimer's disease has violent outbursts, wanders, and is incontinent. He can no longer identify familiar people or objects. In developing the nursing care plan, the nurse would give highest priority to which nursing diagnosis?
a) **High risk for injury**
b) Impaired verbal communication
c) Self-care deficits
d) Altered pattern of urinary elimination: incontinence
98. A client with Alzheimer's disease has a self-care deficit related to his cognitive impairment. Because the client has difficulty dressing himself, what would be the best action for the nurse to take?
a) Have the client wear hospital gowns.
b) Explain to the client why he should dress himself.
c) **Give the client step-by-step instructions for dressing himself.**
d) Allow enough time for the client to dress himself.
99. Which question made by the family of a client with Alzheimer's disease indicates to the nurse an understanding of the prognosis?
a) "Does another hospital have a better treatment?"
b) "Will a change in diet help his memory?"
c) "Won't his new medicine cure him?"
d) **"What supports are available for the future."**
100. A 75-year-old man was brought to the emergency room confused, incoherent, and agitated after painting his lawn furniture earlier in the day. He has no concurrent history of illness. Which of the following interpretations would be appropriate for the nurse to make about his condition?
a) Depression r/t aging.
b) Dementia r/t organic illness.
c) **Delirium r/t toxin exposure.**
d) Distress r/t unaccomplished tasks.



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n) **Set 7**

o)

1. A student with a history of barbiturate addiction is brought to the infirmary with suspected overdose. Which of the following assessments is the nurse likely to make?
a) Watery eyes, slow and shallow breathing clammy skin.
b) **Dilated pupils, shallow respirations, weak and rapid pulse.**
c) Constricted pupils, respirations depressed nausea.
d) Responsive pupils, increased respirations, increased pulse and BP.
2. A teenage girl is admitted to a detoxification unit with a history of cocaine abuse. Her pupils are dilated and she complains of nausea and feeling cold. She states that she is not addicted, but uses cocaine occasionally with friends. Which of the following nursing diagnoses is appropriate for the nurse to make?
a) Impaired verbal communication r/t substance use as evidenced by giving untrue information.
b) Altered growth and development r/t substance use as evidenced by age of client.
c) Perceptual alteration r/t substance use as evidenced by distortion of reality.
d) **Ineffective denial r/t substance use as evidenced in refusal to admit problem.**
3. The nurse is caring for a client in early alcohol withdrawal. What would most likely be included in the nursing care plan?
a) Using physical restraints.
b) Providing environmental stimulation.
c) **Taking pulse and BP.**
d) Administering antipsychotic medications.
4. A client in a detox program is being manipulative by trying to split staff. The client tells the nurse that he is the "best" staff member on the unit. What would be the best response from the nurse?

- a) Thank the client for the compliment.
 - b) Identify the client's manipulative behavior.**
 - c) Ignore the client's comment.
 - d) Ask the client's why he feels that way.
5. In developing a teaching plan for adolescents on the topic of cocaine abuse, the nurse would highlight which of the following?
- a) Cocaine is a naturally occurring depressant.
 - b) Cocaine's physical effects differ according to the method of ingestion.
 - c) The body's peak reaction occurs 30 minutes after it is taken.
 - d) Smoking cocaine is particularly dangerous to the cardiovascular system.**
6. A 14-year-old male client is admitted to the emergency room after ingesting a high dose of PCP and subsequently injuring himself in a fall. What would be an effective action for the nurse to take?
- a) Attempt to talk the client down.
 - b) Withhold fluids.
 - c) Place the client in a quiet, dimly lit room.**
 - d) Administer a prn phenothiazine.
7. The nurse on a medical unit smells alcohol and notices that the relief nurse's words are slurred and she is giggling inappropriately. What is the best initial action for the nurse to take?
- a) Double assign the nurse's clients.
 - b) Ask the relief nurse if she has been drinking.**
 - c) Report the nurse to the licensing board.
 - d) Refer the nurse to an employee assistance program.
8. A nurse's co-worker is argumentative and resistant to change. Her appearance has become sloppy over the last 6 months; she is frequently late for work and often calls in sick. When she is at work, she complains about everything. Which of the following is the most likely cause of these problems?
- a) The nurse is dissatisfied with her job.
 - b) The nurse is having problems at home.
 - c) The nurse may be abusing drugs or alcohol.**
 - d) The nurse realizes she is in the wrong profession.
9. A nurse is evaluating an adult client from the substance abuse unit. Which statement by the client reveals that the client may be ready for discharge?
- a) "I'll take my Antabuse when I need it."
 - b) "I can't wait to hang out with my old buddies."
 - c) "I'll drink in moderation and only on the weekend."
 - d) "Attending daily AA meetings will help me not to drink again."**
10. Which of the following assessment findings would the nurse observe in a client with schizophrenia?
- a) Associate looseness, affect disturbance, ambivalence, autistic thinking.**
 - b) Euphoria, distractibility, dramatic mannerisms, energetic.
 - c) Argumentative, anhedonia, poor judgment, manipulative.
 - d) Psychomotor retardation, intense sadness, loss of energy, suicidal.
11. A client with a diagnosis of paranoid schizophrenia reports to the nurse that he hears a voice that says, "Don't take those poisoned pills from that nurse!" Which one of the following nursing diagnoses would it be appropriate for the nurse to make regarding this statement?
- a) Disturbed sensory perceptual: auditory, r/t anxiety as evidenced by auditory hallucination.**
 - b) Disturbed thought processes r/t anxiety as evidenced by delusions of persecution.
 - c) Defensive coping r/t impaired reality testing as evidenced by paranoid ideation.
 - d) Impaired verbal communication r/t disturbances in form of thinking as evidenced by use of symbolic references.
- 12.
13. An adult is admitted with a diagnosis of catatonic schizophrenia, excited phase. She shouts and paces continuously and seems to be responding to internal stimuli. What would be a short-term goal for the nurse to formulate?
- a) The client will groom self daily.
 - b) The client will maintain adequate nutrition.**
 - c) The client will sleep 8 hours per night.
 - d) The client will attend unit social activities.
14. A client with schizophrenia stops talking mid sentence and tilts her head to one side. The nurse suspects that the client is experiencing auditory hallucinations. What is an appropriate response from the nurse?
- a) Ask the client what she is experiencing.**
 - b) Change the topic of conversation.
 - c) Explain the hallucinations are not real.
 - d) Deny that she hears anything.
15. In teaching a client for whom clozapine (Clozaril) has been prescribed, the nurse would include which of the following?
- a) The drug will be given every 4 weeks by intramuscular injection.
 - b) The drug will probably cause weight reduction.
 - c) There is a high incidence of extrapyramidal side effects.
 - d) Blood work may be required weekly.**
16. An adult is to go on a 3-day pass and has his maintenance supply of chlorpromazine (Thorazine) which statement indicates to the nurse that he understands instructions regarding his medication?
- a) "I'll take my pills when I hear those voices."
 - b) "I'll drink beer but no wine while I'm away."
 - c) "I'll cover up when I go to the beach."**
 - d) "I'll stop taking it if my mouth stays dry."
17. Which of the following behaviors indicates to the nurse that the client's antipsychotic medication is having a desired effect?
- a) The client states that her "voices" are not as threatening.**
 - b) The client reports having inner feelings of restlessness.
 - c) The client sleeps all day.
 - d) The client reports muscular stiffening in her face and arms.

18. A client taking trifluoperazine (Stelazine) exhibits severe extrapyramidal symptoms, a temperature of 40.5°C (105°F), and diaphoresis. The nurse suspects neuroleptic malignant syndrome. What is the nurse's best action?
 - a) Administer an antiparkinson medication
 - b) **Stop the neuroleptic medication.**
 - c) Withhold fluids.
 - d) Administer an antianxiety medication.
19. A client with paranoid schizophrenia has a delusion of persecution. He tells the nurse, "The CIA is out to get me. They're spying on me." What is the nurse's best initial response?
 - a) **"I don't want to hurt you."**
 - b) "How would they spy on you here?"
 - c) "Tell me how they're trying to get you."
 - d) "I know the CIA wouldn't want to hurt you."
20. Which of the following statement indicates to the nurse that a client with obsessive-compulsive disorder has developed insight into her problem?
 - a) **"I realize that the dangers are more in my mind."**
 - b) "I don't hear the voices anymore."
 - c) "I check on my family 12 times every day."
 - d) "I slept 8 hours last night."
21. An adult is brought to the emergency room after he attempted to walk across the roof of a building in an attempt to "fly like a jet plane." In addition to impulsiveness, which of the following behaviors would the nurse assess in a client diagnosed as bipolar, manic type?
 - a) Hallucinations and delusions.
 - b) **Euphoria and increased motor activity.**
 - c) Paranoia and ideas of reference.
 - d) Splitting and manipulation.
22. During the focused assessment of a client with major depression, the nurse may ask which of the following questions?
 - a) "You seem to have a lot of energy; when did you last have 6 or more hours of sleep?"
 - b) "You seem to be angry with your family now; when was it that you last got along?"
 - c) **"Have you had any thoughts of harming yourself?"**
 - d) "You seem to be listening to something. Could you tell me about it?"
23. Which of the following nursing diagnoses would be most appropriate for a client who is diagnosed as bipolar I disorder, single manic episode and is intrusive, argumentative, and severely critical peers?
 - a) Impaired social interaction r/t narcissistic behavior as evidenced by inability to sustain relationships."
 - b) **Risk for injury r/t extreme hyperactivity as evidenced by increased agitation and lack of control over behavior.**
 - c) Social isolation r/t feelings of inadequacy in social interaction as evidenced by problematic interaction with others.
 - d) Defensive coping r/t social learning patterns as evidenced by difficulty interacting with others.
24. An adult is in an acute manic phase of bipolar disorder. He talks and paces incessantly, frequently shouting and threatening other clients. The nurse expects the client's care plan to include which of the following?
 - a) **Monitor blood lithium levels.**
 - b) Monitor client during phototherapy.
 - c) Monitor client after electroconvulsive therapy.
 - d) Teach client to avoid foods with tyramine.
25. The nurse is preparing to administer lithium (Eskalith) to client with bipolar disorder. The client complains of nausea and muscle weakness, and his speech is slurred. His lithium level is 1.6 mEq/Liter. What would be the nurse's best action?
 - a) Chart the client's symptoms after giving the lithium.
 - b) Explain that these are common side effects
 - c) **Withhold the client's lithium.**
 - d) Administer a prn antiparkinsonism drug.
26. Which of the following behaviors indicate to the nurse that the client understands teaching related to lithium treatment?
 - a) Taking lithium 1 hour after meals.
 - b) Stopping taking her lithium when her mania subsides.
 - c) Going on a low-salt diet to counter weight.
 - d) **Withholding her lithium if episodes of diarrhea, vomiting, and diaphoresis occur.**
27. An adult is recovering from a severe depression. Which of the following behaviors alerts the nurse to a risk for suicide?
 - a) The client sleeps most of the day.
 - b) **The client has a plan to kill herself.**
 - c) The client loses 5 pounds.
 - d) The client does not attend unit activities.
28. A man has been severely depressed for 2 weeks. He had mentioned "Ending it all" prior to admission. Which of the following questions should the nurse ask during the pre-screen assessment?
 - a) "Have long have you thought about harming yourself?"
 - b) "What is it that makes you think about harming yourself?"
 - c) "How has your concentration been?"
 - d) **"What specifically have you thought about doing to harm yourself?"**
29. A 19-year-old recently broke off her engagement. Her mother states, "She does nothing but cry and sit and stare into space. I can't get her to eat or anything!" She feels she can't go on without her boyfriend. The nurse should make which priority nursing diagnosis?
 - a) Impaired nutrition: less than body requirements.
 - b) Dysfunctional grieving.
 - c) **Risk for self-directed violence.**
 - d) Social isolation.
30. A client is admitted for treatment of a major depression. She is withdrawn, appears disheveled, and states, "No one could ever love me." What would the nurse expect to be ordered for this client?
 - a) Antiparkinsonism medication.
 - b) **Suicide precautions.**
 - c) A low-salt diet.
 - d) Phototherapy.
31. A man's wife complains that her husband's depression isn't any better after 1 week on amitriptyline (Elavil). What is the nurse's best response?
 - a) Tell her she will contact the physician.
 - b) Question the wife about what response she expects.

- c) **Explain that it may take 1 to 3 weeks to see any improved.**
 d) Suggest that the client change antidepressants.
32. Which of the following behaviors indicates to the nurse that a client's major depression is improving?
 a) Displaying a blunted effect.
 b) Losing an additional 2 pounds.
 c) **Stating one "good" thing about himself.**
 d) Sleeping about 16 hours a day.
33. An adult is hospitalized for treatment of obsessive-compulsive disorder (OCD). The nurse recognizes which of the following as an indication that the client's sertraline (Zoloft) is having the desired effect?
 a) The client experiences nervousness and drowsiness.
 b) The client's delusions are less entrenched.
 c) **The client engages in fewer rituals.**
 d) The client sleeps 4 hours per night.
34. A client with major depression is scheduled for electroconvulsive therapy (ECT) tomorrow. The nurse would plan for which of the following activities?
 a) Force fluids 6 to 8 hours before treatment.
 b) Administer succinylcholine (Inestine, Anectine) during pre-treatment care.
 c) Encourage the client's spouse to accompany him.
 d) **Reorient the client frequently during post treatment care.**
35. A severely depressed client received ECT this morning. Which of the findings listed below would the nurse least expect to assess post treatment?
 a) Headache.
 b) Memory loss.
 c) **Paralytic ileus.**
 d) Disorientation.
36. A client for whom Nardil was prescribed for depression is brought to the ER with severe occipital headaches after eating pepperoni pizza for lunch. Which of the following interpretations is it important for the nurse to make regarding these findings?
 a) Allergic reaction r/t ingestion of processed food.
 b) Hypertensive crisis r/t drug and food reaction.
 c) Panic anxiety r/t unresolved issues.
 d) **Conversion disorder r/t uncontrolled anxiety.**
37. The nurse explains the major difference between neurotic and psychotic disorders. What is a major difference in clients with psychotic disorders?
 a) The clients are aware that their behaviors are maladaptive.
 b) The clients are aware they are experiencing distress.
 c) The clients experience no loss of contact with reality.
 d) **The clients exhibit a flight from reality.**
38. A client is prescribed buspirone (BuSpar). Which statement alerts the nurse that additional medication teaching is required?
 a) **"I'll take my drugs as soon as I feel anxious."**
 b) "I won't drink any alcohol."
 c) "I'll report any troubles with my heart or seeing."
 d) "I'll have my blood checked every month."
39. In teaching a client about her new anti-anxiety medication alprazolam (Xanax), the nurse should include which of the following?
 a) Caution the client to avoid foods with tyramine.
 b) **Caution the client not to drink alcoholic beverages.**
 c) Instruct the client to take Xanax 1 hour after meals.
 d) Instruct the client to double up a dose if she forgets to take her medication.
40. A client experiencing thanatophobia is afraid to leave her aging, ailing husband alone for any reason. She has not left her husband alone since her mother and sister died 4 years ago. Which of the following statements would be appropriate for the nurse to make during the initial assessment of this client?
 a) **"Are you afraid that your husband might die while you are away from him?"**
 b) "There must be someone you are able to trust to stay with your husband."
 c) "Don't you have children who are willing to stay with your husband when you need to be away."
 d) "It must be very confining to have constantly attended to your husband so long."
41. A newly admitted client is fearful of elevators. She needs to take one in 10 minutes to attend therapy on the 10th floor. Which of the following actions would be best for the nurse to take?
 a) Explain to her that she needs to attend therapy.
 b) Have another client go with her.
 c) **Accompany her to the 10th floor.**
 d) Explore with her why she is afraid of elevators.
42. A man with a family of five was recently laid off and now has financial concerns. He is experiencing muscle tension, breathlessness, and sleep disturbances. Which one of the following nursing diagnoses would be appropriate for the nurse to make regarding his condition?
 a) Post-trauma response r/t loss of economic support as evidenced by job loss.
 b) **Parental role conflict related to perceived inability to meet his family's economic and physical needs as evidenced by job loss.**
 c) Ineffective individual coping r/t recent unemployment as evidenced by physical manifestations.
 d) Powerlessness r/t inability to deal with anxiety as evidenced by physical manifestations.
43. A woman appears to be having a panic attack during group therapy. She is agitated, pacing rapidly, and not responding to verbal stimuli. What would be the nurse's initial intervention?
 a) **Remove her from the group.**
 b) Encourage her to express her feelings.
 c) Facilitate her recognizing her anxiety.
 d) Ignore her.
44. The nurse is assessing a client who presents with OCD. In addition to gathering information about the client's anxiety and rituals, the nurse should assess for which of the following?

- a) Handwringing and foot-tapping behaviors.
 - b) Use of abusive substances and gambling.
 - c) Tics, stuttering or other unusual speech patterns.**
 - d) Diaphoresis and rapid breathing.
45. Which of the following statements by a client with delusions indicates to the nurse that the client is improving?
- a) "I don't feel those crawling bugs anymore."
 - b) "I won't talk about my crazy thoughts at work."**
 - c) "I feel less jumpy inside."
 - d) "I must check my room for bugs."
46. During the assessment phase of the nurse-client interaction, which of the following statements made by the client is suggestive of post-traumatic stress disorder?
- a) "My dad had trouble swallowing before he died and I always feel as if I have a lump in my throat."
 - b) "After I contacted meningitis on vacation last summer, I can't control this horrible thought that all people who work in park restaurants are dirty."
 - c) "I continue to have the same dream over and over again."
 - d) "I had another horrible nightmare last night and went through the same trauma and anxiety all over again."**
47. A client with OCD has an elaborate hand washing and touching ritual that interferes with her activities of daily living. She misses meals and therapy sessions. What effective strategy could the nurse initiate to limit her ritual?
- a) Teach thought stopping techniques.**
 - b) Prevent the ritualistic behavior.
 - c) Use adjunctive therapies for distraction.
 - d) Facilitate insight regarding the need for the ritual.
48. A client with OCD has checking rituals and thoughts that her family will be harmed. Which of the following indicates to the nurse that the client is improving?
- a) Obsessing about her family's health.
 - b) Adhering to the unit schedule.**
 - c) Losing 2 pounds in 1 week.
 - d) Awakening 8 times during the night.
49. A 4-year-old girl, who is a victim of a bomb blast that demolished the building which housed her day care, constantly builds block houses and blows them up. She also has nightmares frequently.
- a) Post-trauma response r/t terrorist attack as evidenced by destructive behaviors and sleep disturbances.**
 - b) Explosive disorder r/t dysfunctional personality as evidenced by destructive behaviors.
 - c) Sleep disturbance r/t emotional trauma as evidenced by nightmares.
 - d) Ineffective individual coping r/t internal stressors as evidenced by destructive behaviors and nightmares.
50. The nurse recognizes that the client with post-traumatic stress disorder (PTSD) is improving when which of the following occurs?
- a) States he feels "numb" most of the time.
 - b) Drinks alcohol to cope with his feelings.
 - c) Talks about a benefit of the traumatic experience.**
 - d) Attends weekly group therapy.
51. A young man is found wandering on campus after a fraternity party. She is dishevelled and does not know who she is. She has no recollection of the evening. At the student health service she is diagnosed with dissociative amnesia subsequent to a rape. What is the most appropriate nursing diagnosis for the nurse to formulate?
- a) Ineffective individual coping.
 - b) Personal identity disturbance.**
 - c) Anxiety r/t alteration in memory.
 - d) Risk for violence, self-directed
52. The nurse finds during the initial assessment of the star player on the basketball team that he is not concerned about the sudden paralysis of his "shooting arm". What is this behavior known as?
- a) Secondary gain
 - b) La belle indifference**
 - c) Malingering
 - d) Hypochondriasis
53. A man's family brought him into the hospital because of his many somatic complaints. He has been seen by many medical specialists in the past without discovery of organic pathology. The nurse assesses that the client is probably experiencing which of the following problems?
- a) Conversion disorder
 - b) Body dysmorphic disorder
 - c) Malingering
 - d) Hypochondriasis**
54. An adult is hospitalized for treatment of a conversion disorder. She complained of paralysis of her right side after her husband threatened to leave her and their children. She seems unconcerned about her paralysis. What would be an appropriate long-term goal for the nurse to formulate for the client?
- a) Cope effectively with stress without using conversion**
 - b) Identity stressors
 - c) Express feelings about the conflict
 - d) Develop an increased sense of relatedness to others.
55. An adult has hypochondriasis—believing he is dying of stomach cancer despite repeated and extensive diagnostic testing that has all been negative. He has become reclusive and is preoccupied with his physical complaints. The nurse would include which of the following in the nursing care plan as a client outcome?
- a) Focus on the signs and symptoms of stomach cancer.
 - b) Attend a support group for persons with cancer.
 - c) Complete a contract to attend social and diversional activities daily.**
 - d) Receive secondary gain from his physical symptoms.
56. A man is brought into the police station after he ran toward a boy who resembled his son. At the police station he was unable to recall any personal information. The pre-screening nurse inferred that the man has which one of the following dissociative disorders?
- a) Amnesia.**
 - b) Fugue.
 - c) Personality disorder.
 - d) Stress disorder.

57. Which of the behaviors listed below would assist the nurse in establishing the diagnosis of borderline personality disorder?
- Impulsivity.
 - Hallucination.
 - Self-mutilation.**
 - Narcissism.
58. A woman is admitted to the unit with a diagnosis of borderline personality disorder. She has angry outbursts and is impulsive and manipulative. She has lacerations on her arm from self-mutilation. Which of the following would be a priority nursing diagnosis?
- Ineffective individual coping.
 - Disturbed body image.
 - Disturbed personality disorder.
 - Risk for violence to self.**
59. A client with borderline personality disorder tells the nurse she hates the doctor because he denied her a pass because she returned "high" from her last pass. What would be the nurse's best action?
- Ask the client why she is feeling so angry.
 - Suggest that the client bring it up in community meeting.
 - Offer to contact the doctor and discuss the situation.
 - Set limits and point out that the denial is a consequence of her inappropriate behavior.**
60. The nurse would formulate which of the following outcome criteria for a client with borderline personality disorder?
- Displays anger frequently.
 - Acts out neediness.
 - Experiences troubling thoughts without self-mutilation.**
 - Idolizes assigned nurse.
61. A client with antisocial personality disorder is charming, seductive, and highly manipulative. He has a history of multiple jobs and marriages, which have all failed, and problems with the law. Which of the following is an appropriate short-term goal for the nurse to formulate in relation to a nursing diagnosis of ineffective individual coping?
- The client will avoid situations that provoke aggressive acts.
 - The client will adhere to unit rules.
 - The client will assume a leadership role in unit governance.
 - The client will acknowledge manipulative behaviors pointed out by staff.**
62. Which of the following indicates to the nurse that a client with antisocial personality disorder is improving?
- Complimenting the nurse for an outstanding job on the unit.
 - Testing the limits on personal behavior.
 - Acknowledging some manipulative behavior.**
 - Sleeping 8 hours per night.
63. An 18-month-old has been admitted for second-degree burns surrounding the genital area. Her mother told the nurse that the child grabbed for the hot coffee cup and spilled it on herself. Legally, what is the nurse required to do?
- Testify in court on the injuries.
 - Report suspected child abuse.**
 - Have the mother arrested.
 - Refer the mother to counselling.
64. A toddler was admitted for second-degree burns surrounding the genital area. An 18-month-old has been admitted for second-degree burns surrounding the genital area. Her mother told the nurse that the child grabbed for the hot coffee cup and spilled it on herself. The toddler's mother is 17 years old. In which of the areas would the nurse provide health teaching?
- Normal growth and development.
 - Bonding techniques.
 - How to childproof the apartment.
 - Parenting skills.**
65. A young woman was returning home from work late and was sexually assaulted. She was brought to the emergency room upset and crying. What is the nurse's main goal?
- Assist her in crisis.**
 - Notify the police of the alleged assault.
 - Understand she will have a long recovery period.
 - Provide support and comfort.
66. The nurse is caring for a young woman who was sexually assaulted. Which of the following is indicative of successful adjustment to the trauma?
- She moves to another city.
 - She resumes her work and activities.**
 - She takes classes in the martial arts.
 - She remains silent about the assault.
67. A young man has recently begun experiencing forgetfulness, disorientation, and occasional lapses in memory. The client was diagnosed with AIDS dementia. His family began sobbing on hearing the diagnosis. What would be an appropriate response from the nurse?
- "You must never give up hope."
 - "He was in a high-risk group for AIDS."
 - "I can understand your grief."
 - "This must be very difficult for you."**
68. The nurse is planning care for a young man who has AIDS dementia. What is the primary goal in his care?
- Enhance the quality of life.**
 - Teach him about AIDS.
 - Discuss his future goals.
 - Provide him with comfort and support.
69. What is one of the major fears experienced by people with AIDS?
- Dying.
 - Debilitation.**
 - Stigma.
 - Poverty.
70. A school nurse is assessing second-grade child for symptoms of sexual abuse. Which of the following behavioral symptoms would support the possibility of sexual abuse?
- Enuresis, impulsivity, decline in school performance.
 - Thumb sucking, isolating self from peers on playground, excessive fearfulness.**
 - Hyperactivity, rocking, isolating self from peers on playground.
 - Stuttering, rocking, impulsivity.
71. A 21-year-old college student is seen in the ER following an incident of date rape. During the nursing assessment, the client describes the entire chain of events with a blank facial expression. She ends her comments by saying, "It's like it didn't happen to me at all." Which of the following statements most accurately explains that patient's reaction?

- a) **This client is using dissociation/isolation as a defense mechanism to cope with the attack.**
 - b) This client is using denial as a defense mechanism to cope with the attack.
 - c) This client is in the shock phase of a crisis and is repressing feelings associated with the traumatic event.
 - d) This client is using reaction formation to manage the hostility she feels toward the attacker.
72. A 38-year-old mother of three children is seen in the medical clinic with complaints of chronic fatigue. The woman looks sad, makes only brief eye contact, and startles easily. The nurse acknowledges these observations and the woman says, "My husband has started to hold a gun to my head when I don't do exactly what he wants." Which of the following is the most appropriate response by the nurse?
- a) "What is it you won't do that makes him do this?"
 - b) "Tell me what has influenced your decision to stay with your husband?"
 - c) **"That is abusive behavior; there are resources which can help you."**
 - d) "How often does this happen?"
73. Which of the following statements made by a victim of spouse abuse would indicate to the nurse that the woman was admitting that she was a victim of spousal abuse?
- a) "It would be nice to be out of the situation, but I cannot afford to leave. I have no skills."
 - b) "My husband has never visited me when I've been in the hospital. He even said he will take me out more often."
 - c) "Last time it happened I tried to talk to his mother. She said he was never like this growing up."
 - d) **"I have the shelter number and I've decided to work on my high school diploma while the kids are in school each day."**
74. A 78-year-old male with a history of cancer of the prostate is admitted to the medical unit for the fourth time in 6 weeks. On admission, the client is confused and has a decubitus ulcer the size of a fifty-cent piece on the sacral area. The client did not have this breakdown on discharge 10 days ago. The nurse also notes what appear to be friction burns on both wrists. Which of the following nursing diagnosis statements takes priority in the care of his patient?
- a) Impaired skin integrity.
 - b) Disturbed thought processes.
 - c) Ineffective health maintenance.
 - d) **Risk for injury.**
- 75.
- 76.
- 77.
- 78.
79. A 27-year-old is admitted to the medical unit with severe abdominal pain, dehydration, and renal insufficiency associated with substance abuse. The patient's admitting chest x-ray shows diffuse interstitial infiltrates and the physician asks that the client give consent for HIV testing. The client consents and the test returns positive. After learning of the positive results, the client says to the nurse, "I never thought this would happen to me. I don't know if I can go through this." Which of the following nursing diagnosis statements takes priority in the care of his patient?
- a) Anticipatory grieving.
 - b) Risk for infection.
 - c) **Risk for self-directed violence.**
 - d) Thought process, altered.
80. The nurse is changing the dressing on a client who has had a modified radical mastectomy 2 days ago. The client refuses to look in the direction of the nurse or the operative site. The nurse notices a tear running down the client's cheek. Which of the following responses would most appropriately facilitate the client's grief resolution?
- a) **"You look very sad; it might help you feel better if you let yourself cry."**
 - b) "Tell me what the worst part about losing your breast is."
 - c) "Everything is going to be all right; you can be fitted for a new bra and no one will notice."
 - d) Are you crying because you are concerned about how your partner will respond?
81. A 42-year-old male is admitted to the medical unit for insertion of an access site for haemodialysis. The client relates that his transplant graft failed, he has lost his job due to corporate downsizing, and his wife left him recently. He has now moved back into his parents' home. Which of the following nursing diagnosis statements takes priority in planning nursing care for this client?
- a) Fluid volume deficit.
 - b) Ineffective denial.
 - c) Ineffective tissue perfusion.
 - d) **Powerlessness.**
82. The condition of a client diagnosed with chronic obstructive pulmonary disease (COPD) and cor pulmonale is deteriorating. The client is very hypoxemic, obtunded, and easily fatigued by any activity. The nurse who has been working with this client throughout this hospitalization is repositioning the client. Which of the following remarks made by the client indicates that the client has come to terms with death?
- a) "It is finally spring and that is my favourite time of year."
 - b) "Am I going to die"
 - c) **"I'm very tired, but content and ready to go."**
 - d) "I'm feeling stronger by the moment today."
83. A family member whose mother is terminally ill asks to speak to the nurse. Which of the following statements made by this family member understands the emotional response to death and dying?
- a) **"Mother seems very comfortable; so we're to recall some of our good times spent together."**
 - b) "My mother is irate because she says you all told her she had to have an advanced directive."
 - c) "My mother is talking about redoing her bedroom when she's discharged. Doesn't she know she's dying?"
 - d) "My mother is crying so much these days. Where's all this sadness coming from?"
84. Mark, a 26 year old psychiatric patient, was talking with the nurse regularly for 4 days already. Mark expresses that he had lost 6 jobs within a year and 6 roommates within 6 months. When learning more about the client's issue when it comes to relationships with people, the nurse's most appropriate response would be:
- A. "Let's not talk about your past. It's better to talk about your future."
 - B. "That's a lot of changes. What happened in those jobs and roommates?"
 - C. "It must be so sad. How were you able to adapt to it? How did you do it?"

D. "Tell me more about some of the specific problem situations you've experience with these people."

85. Juan is a patient admitted to the Psychiatric ward. He keeps on repeating the words other patients in the ward says. Based on your knowledge in Psychiatry, this type of speech is called:
- A. **Echolalia**
 - B. Dyslexia
 - C. Echopraxia
 - D. Word salad
86. In a health care setting, clients are often faced with stressful situations. As nurse, it is essential that we know how to apply the nursing process to these clients, whether their anxiety is normal or is in excess.
87. 24-year old Mrs. Alano is diagnosed to have obsessive-compulsive disorder. For this client, which intervention should Nurse Nancy include when developing plan of care?
- A. Increase environmental stimulation
 - B. Set limits on compulsive behaviour
 - C. Prevent ritualistic behaviour
 - D. **Give client adequate time to perform rituals**
88. A client who has been orphaned has been diagnosed with severe anxiety. When planning for the discharge of the client, the nurse directs at promoting a safe environment at home. The most appropriate maintenance goal should focus on which of the following?
- A. continued contact with crisis counsellor
 - B. **identifying anxiety-producing situation**
 - C. ignoring feeling of anxiety
 - D. eliminating all anxiety from daily situations
89. Mr. Go has an incapacitating obsessive-compulsive behaviour. The statement that best describes how clients with obsessive-compulsive behaviour view this disorder would be:
- A. "The devil makes me do this things, it's not my fault."
 - B. **"I know these are irrational but I cannot help it."**
 - C. "The things I do take a little time, but they make me a productive person."
 - D. "There is nothing wrong with what I do, I don't know why people are telling me otherwise."
90. Based on what you have learned in textbooks and in institutions, which one of the following neurotransmitters is altered in depression?
- A. Acetylcholine
 - B. **Serotonin**
 - C. Dopamine
 - D. Histamine
- 91.
92. Archie is assigned as the nurse sounselor in a community mental health clinic and is working with a couple and their two kids. One son has been in trouble in school because of fighting and poor grades. The other daughter appears quiet and withdrawn. But the parents report no problems. They have severe been in and out of jobs in the last 3 years and the mother works as a waitress. The priority nursing diagnosis for this family at this time would be:
- A. **Impaired parenting related to marital problems**
 - B. Impaired adjustment related to children growing older
 - C. Disabled family coping related to the son's school problems
 - D. Impaired social interaction related to an inability to form relationships
93. Ms. Sanchez has been admitted to the hospital due to severe anxiety. The nurse plans to teach a client to use healthier coping behaviours. These include:
- A. dissociation, intellectualization, fixation
 - B. intellectualization, fantasy, rationalization
 - C. **Exercise, talking to friends, suppression**
 - D. Repression, regression, smoking
94. Johnny, a 20 year old jeepney driver was brought to the hospital by the police because of reckless driving. Johnny reports having alcoholic blackouts. The nurse recognizes that an alcoholic blackout is best described as:
- A. A fatigue state resembling absence seizures
 - B. fainting spells followed by loss of memory
 - C. **absence of memory to drinking episodes**
 - D. loss of consciousness lasting less than 10 minutes
95. Susan was admitted to the mental health facility because of bulimia nervosa. The nurse is aware that the priority nursing intervention for her would be to:
- A. monitor the client continuously
 - B. **observe the client following meals and snacks for 1 to 2 hours**
 - C. teach the client to measure intake and output
 - D. involve the client in developing a daily meal plan
96. 89. A popular pop singer was admitted to the hospital due to excessive weight loss. The singer was diagnosed with anorexia nervosa. After the patient stabilized from her condition, the parents, the client and the psychiatrist decided to initiate a behaviour modification program to assist her in her recovery. The nurse knows that a major component of behaviour modification program is that:
- 97. A. punishes negative reactions
 - 98. B. deconditions the patient to fear to gaining weight
 - 99. **C. rewards positive behaviour**
 - 100. D. control the behaviour of the patient
90. A 43-year old client was diagnosed with amyotropic lateral sclerosis and has progressed rapidly. The client commented "I have been good all my life and still I got this disease, there are so many bad and rotten people around and they are the ones who should be infected with this illness." The nurse could best respond by saying:
- A. **"I can understand you are afraid of death."**
 - B. "It's really unfair that you have the disease."
 - C. "Do not say that because other people might be mad at you."
 - D. "Have you thought of selling all your possessions?"
91. Nurse Cath is assessing a client suspected of having vascular dementia. Which of the following helps confirm the diagnosis?
- A. drug screen for toxicology
 - B. finding upon autopsy
 - C. **MRI**
 - D. response to electroconvulsive therapy

92. Romy, a 33-year old client admitted due to a substance abuse, is having symptoms of opiod withdrawal. Clonidine (Catapres) is prescribed. Nurse Aura is aware that important nursing assessment before giving a dose of the medication includes:
- A. determine when Romy last took opiate
 - B. check for breath sounds
 - C. **assess Romy's blood pressure**
 - D. check for sore throat
93. A 20-year old male client has recently graduated college and is exoeriening crisis because he has to leave home to become independent. In relation to crisis theory, this clinet's stressful event can be seen as:
- A. experiential crises
 - B. adventitious crises
 - C. situational crises
 - D. **developmental crises**
94. A newly licensed nurse on the psychiatric unit is assigned to work with a client who appears negative and mistrustful to everyone. The nurse can help the client to develop trust by:
- A. **attempting to be prompt for their scheduled meetings**
 - B. stating simply and sincerely that the nurse cares about the client's feelings
 - C. listening attentively to the client's positive feelings and ignoring negative feelings
 - D. handling the client's medication and not watching to see whether it is swallowed
95. A client has experienced visual hallucinations and says that he sees the Virgin Mary. To deal with a client's hallucinations therapeutically, the nurse plans to:
- A. Reinforce the perceptual distortions until the client develops new defences
 - B. **Engage the client in an reality-based activity**
 - C. Avoid helping the client make connections between anxiety-producing situations and hallucinations
 - D. Distract the client's attention by providing a completing stimulus that is stronger than the hallucinations
96. A client was admitted with a diagnosis of schizophrenia. The nurse is assessing for negative symptoms or soft symptoms of schizophrenia. What should the nurse assess for?
- A. delusions
 - B. disorganized speech
 - C. hallucinations
 - D. **flat affect**
- 97.
98. A nurse has taught Jimmy, a client who is experiencing panic attacks, of thought-stopping techniques. He has also taught him to counter his negative thoughts of "I'm a failure. I will never pass the tests" with sentences like "I have passed lots of exams, I will pass the next test." This is an example of:
- A. psychoeducation
 - B. distraction
 - C. **positive self-talk**
 - D. panic control treatment
99. Ms. Donna is diagnosed to have bulimia. Which of the following is an initial goal of Nurse Patricia of Ms. Donna?
- A. refrain from buying large amounts of food
 - B. control the sudden urge to eat
 - C. **recognize situations that cause anxiety**
 - D. strictly eta 3 meals per day
100. James, a 7 year-old male has recently been diagnosed with an attention-deficit disorder with hyperactivity. Methylphenidate (Ritalin) has been prescribed. In discussing their child's treatment with the parents, the nurse emphasizes the fact that it would be important for them to:
- A. tutor their son in the subjects that are troublesome
 - B. **monitor the effect of the medication on their son's behaviour**
 - C. point out to their son that he can control his behaviour if he desires
 - D. avoid imposing too many rules because they would frustrate their son
101. Nurse Patricia, a psychiatric nurse knows that the distinguishing features of anorexia nervosa from bulimia are:
- A. **earlier age of onset and below normal body weight**
 - B. later age of onset and near normal body weight
 - C. earlier age of onset and near normal body weight
 - D. later age of onset and below normal body weight

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150. **A1 PASSERS TRAINING, RESEARCH, REVIEW AND DEVELOPMENT COMPANY**
151. PSYCHIATRIC NURSING
152. SET 8

153.

154.

approached Nurse Trish asking for advice on how to deal with his alcohol addiction. Nurse Trish should tell the client that the only effective treatment for alcoholism is:

- | | |
|---|---------------------|
| 155. a. Psychotherapy | 158. |
| 156. b. Alcoholics anonymous (A.A.) | d. Aversion Therapy |
| 157. c. Total abstinence | |

159.

Hazel is caring for a male client who experience false sensory perceptions with no basis in reality. This perception is known as:

- | | |
|-----------------------------------|---------------|
| 160. a. Hallucinations | 163. |
| 161. b. Delusions | d. Neologisms |
| 162. c. Loose associations | |

164.

Monet is caring for a female client who has suicidal tendency. When accompanying the client to the restroom, Nurse Monet should...

- | | |
|---|-----------------------|
| 165. a. Give her privacy | 168. |
| 166. b. Allow her to urinate | d. Observe her |
| 167. c. Open the window and allow her to get some fresh air | |

169.

Maureen is developing a plan of care for a female client with anorexia nervosa. Which action should the nurse include in the plan?

- | | |
|---|---|
| 170. a. Provide privacy during meals | 172. |
| 171. b. Set-up a strict eating plan for the client | c. Encourage client to exercise to reduce anxiety |
| | 173. |

174.

experiencing anxiety attack. The most appropriate nursing intervention should include?

- | | |
|--|--|
| 175. a. Turning on the television | 178. |
| 176. b. Leaving the client alone | d. Ask the client to play with other clients |
| 177. c. Staying with the client and speaking in short sentences | |

179.

client is admitted with a diagnosis of delusions of GRANDEUR. This diagnosis reflects a belief that one is:

- | | |
|--|---|
| 180. a. Being Killed | 183. |
| 181. b. Highly famous and important | d. Connected to client unrelated to oneself |
| 182. c. Responsible for evil world | |

184.

old client was diagnosed with dependent personality disorder. Which behavior is not most likely to be evidence of ineffective individual coping?

- | | |
|---|--|
| 185. a. Recurrent self-destructive behavior | 187. |
| 186. b. Avoiding relationship | c. Showing interest in solitary activities |

188. d. Inability to make choices and decision without advise

189. client is diagnosed with schizotypal personality disorder. Which signs would this client exhibit during social situation? 8. A male
190. **a. Paranoid thoughts** 193.
191. b. Emotional affect d. Aggressive behavior
192. c. Independence need
194. Claire is caring for a client diagnosed with bulimia. The most appropriate initial goal for a client diagnosed with bulimia is? 9. Nurse
195. a. Encourage to avoid foods 197.
196. **b. Identify anxiety causing situations** c. Eat only three meals a day
- 198.
199. Tony was caring for a 41 year old female client. Which behavior by the client indicates adult cognitive development? 10. Nurse
200. **a. Generates new levels of awareness** 202.
201. b. Assumes responsibility for her actions c. Has maximum ability to solve problems and learn new skills
- 203.
204. neuromuscular blocking agent is administered to a client before ECT therapy. The Nurse should carefully observe the client for? 11. A
205. **a. Respiratory difficulties** 208.
206. b. Nausea and vomiting d. Seizures
207. c. Dizziness
209. year old client is admitted to the hospital with the diagnosis of dementia of the Alzheimer's type and depression. The symptom that is unrelated to depression would be? 12. A 75
210. a. Apathetic response to the environment **212. c. Shallow of labile effect**
211. b. "I don't know" answer to questions 213.
214. Trish is working in a mental health facility; the nurse priority nursing intervention for a newly admitted client with bulimia nervosa would be to? 13. Nurse
215. a. Teach client to measure I & O **218. d. Monitor client continuously**
216. b. Involve client in planning daily meal
217. c. Observe client during meals
219. Patricia is aware that the major health complication associated with intractable anorexia nervosa would be? 14. Nurse
220. **a. Cardiac**
221. b. Glucose
222. c.
223. d.
224. Anna can minimize agitation in a disturbed client by? 15. Nurse
225. a. Increasing stimulation 228.
226. **b. limiting unnecessary interaction** d. ensuring constant client and staff contact
227. c. increasing appropriate sensory perception
229. year old mother with obsessive-compulsive disorder has become immobilized by her elaborate hand washing and walking rituals. Nurse Trish recognizes that the basis of O.C. disorder is often: 16. A 39
230. a. Problems with being too conscientious **232. c. Feelings of guilt and inadequacy**
231. b. Problems with anger and remorse 233.
234. complaining to other clients about not being allowed by staff to keep food in his room. Which of the following interventions would be most appropriate? 17. Mario is
235. a. Allowing a snack to be kept in his room 237.
236. b. Reprimanding the client **238. c. Ignoring the clients behavior**

239. 18. Conney
with borderline personality disorder who is to be discharge soon threatens to “do something” to herself if discharged. Which of the following actions by the nurse would be most important?
240. a. Ask a family member to stay with the client at home temporarily
241. **b. Discuss the meaning of the client’s statement with her**
242. c. Request an immediate extension for the client
243. d. Ignore the clients statement because it’s a sign of manipulation
244. 19. Joey a
client with antisocial personality disorder belches loudly. A staff member asks Joey, “Do you know why people find you repulsive?” this statement most likely would elicit which of the following client reaction?
245. **a. Depensiveness**
246. b. Embarrassment
247. c. Shame
248. d. Remorsefulness
249. 20. Which
of the following approaches would be most appropriate to use with a client suffering from narcissistic personality disorder when discrepancies exist between what the client states and what actually exist?
250. a. Rationalization
251. **b. Supportive confrontation**
252. c. Limit setting
253. d. Consistency
254. 21. Cely is
experiencing alcohol withdrawal exhibits tremors, diaphoresis and hyperactivity. Blood pressure is 190/87 mmhg and pulse is 92 bpm. Which of the medications would the nurse expect to administer?
255. a. Naloxone (Narcan)
256. b. Benzlropine (Cogentin)
257. **c. Lorazepam (Ativan)**
258. d. Haloperidol (Haldol)
259. 22. Which
of the following foods would the nurse Trish eliminate from the diet of a client in alcohol withdrawal?
260. a. Milk
261. b. Orange Juice
262. c. Soda
263. **d. Regular Coffee**
264. 23. Which
of the following would Nurse Hazel expect to assess for a client who is exhibiting late signs of heroin withdrawal?
265. a. Yawning & diaphoresis
266. b. Restlessness & Irritability
267. c. Constipation & steatorrhea
268. **d. Vomiting and Diarrhea**
269. 24. To
establish open and trusting relationship with a female client who has been hospitalized with severe anxiety, the nurse in charge should?
270. a. Encourage the staff to have frequent interaction with the client
271. b. Share an activity with the client
272. c. Give client feedback about behavior
273. **d. Respect client’s need for personal space**
274. 25. Nurse
Monette recognizes that the focus of environmental (MILIEU) therapy is to:
275. **a. Manipulate the environment to bring about positive changes in behavior**
276. b. Allow the client’s freedom to determine whether or not they will be involved in activities
277. c. Role play life events to meet individual needs
278. d. Use natural remedies rather than drugs to control behavior
279. 26. Nurse
Trish would expect a child with a diagnosis of reactive attachment disorder to:
280. a. Have more positive relation with the father than the mother
281. b. Cling to mother & cry on separation
282. **c. Be able to develop only superficial relation with the others**
283. d. Have been physically abuse

284. teaching parents about childhood depression Nurse Trina should say?
285. appear acting out behavior
286. respond to conventional treatment
 287. duration & resolves easily
 288. almost identical to adult depression
289. Perry is aware that language development in autistic child resembles:
 290. a. Scanning speech
 291. b. Speech lag
294. year old female client who lives alone tells the nurse at the community health center "I really don't need anyone to talk to". The TV is my best friend. The nurse recognizes that the client is using the defense mechanism known as?
 295. a. Displacement
 296. b. Projection
 297. c. Sublimation
299. working with a male client suffering phobia about black cats, Nurse Trish should anticipate that a problem for this client would be?
300. a. Anxiety when discussing phobia
 301. b. Anger toward the feared object
 302. c. Denying that the phobia exist
304. pacing the floor and appears extremely anxious. The duty nurse approaches in an attempt to alleviate Linda's anxiety. The most therapeutic question by the nurse would be?
 305. a. Would you like to watch TV?
306. b. Would you like me to talk with you?
309. Penny is aware that the symptoms that distinguish post traumatic stress disorder from other anxiety disorder would be:
 310. Avoidance of situation & certain activities that resemble the stress
 311. Depression and a blunted affect when discussing the traumatic situation
 312. interest in family & others
313. experiencing the trauma in dreams or flashback
314. Benjie is communicating with a male client with substance-induced persisting dementia; the client cannot remember facts and fills in the gaps with imaginary information. Nurse Benjie is aware that this is typical of?
 315. a. Flight of ideas
 316. b. Associative looseness
 317. c. Confabulation
319. Joey is aware that the signs & symptoms that would be most specific for diagnosis anorexia are?
320. Excessive weight loss, amenorrhea & abdominal distension
 321. pulse, 10% weight loss & alopecia
 322. Compulsive behavior, excessive fears & nausea
 323. Excessive activity, memory lapses & and increased pulse
324. characteristic that would suggest to Nurse Anne that an adolescent may have bulimia would be:
 325. a. Frequent regurgitation & re-swallowing of food
 326. b. Previous history of gastritis
329. Monette is aware that extremely depressed clients seem to do best in settings where they have:
 330. a. Multiple stimuli
331. b. Routine Activities
27. When
a. It may
 b. Does not
 c. Is short in
 d. Looks
28. Nurse
29. A 60
298. d. Denial
30. When
 303.
 d. Distortion of reality when completing daily routines
31. Linda is
32. Nurse
 a.
 b.
 c. Lack of
d. Re-
33. Nurse
34. Nurse
a.
 b. Slow
 c.
 d.
35. A
36. Nurse
327.
 c. Badly stained teeth
328.
 332.
 c. Minimal decision making
 333.

334. further assess a client's suicidal potential. Nurse Katrina should be especially alert to the client
335. of: 37. To expression
336. a. Frustration & fear of death
337. b. Anger & resentment
338. c. Anxiety & loneliness
339. **d. Helplessness & hopelessness**
340. nursing care plan for a male client with bipolar I disorder should include: 38. A
341. **Providing a structured environment**
342. Designing activities that will require the client to maintain contact with reality
343. the client in conversing about current affairs
344. the client provide assurance
345. planning care for a female client using ritualistic behavior, Nurse Gina must recognize that the ritual: 38. A
346. client focus on the inability to deal with reality
347. **the client control the anxiety**
348. the client's conscious control
349. by the client primarily for secondary gains
39. When
350. year old male graduate student, who has become increasingly withdrawn and neglectful of his work and personal hygiene, is brought to the psychiatric hospital by his parents. After detailed assessment, a diagnosis of schizophrenia is made. It is unlikely that the client will demonstrate: 39. When
351. a. Low self esteem
352. b. Concrete thinking
353. **c. Effective self boundaries**
354. d. Weak ego
40. A 32
355. year old client has been admitted with a diagnosis of schizophrenia says to the nurse "Yes, its march, March is little woman". That's literal you know". These statements illustrate: 40. A 32
356. a. Neologisms
357. b. Echolalia
358. c. Flight of ideas
359. **d. Loosening of association**
360. term goal for a paranoid male client who has unjustifiably accused his wife of having many extramarital affairs would be to help the client develop: 41. A 23
361. a. Insight into his behavior
362. b. Better self control
363. **c. Feeling of self worth**
364. d. Faith in his wife
42. A long
365. client who is experiencing disordered thinking about food being poisoned is admitted to the mental health unit. The nurse uses which communication technique to encourage the client to eat dinner? 42. A long
366. on self-disclosure of own food preference
367. **open ended question and silence**
368. opinion about the need to eat
369. Verbalizing reasons that the client may not choose to eat
43. A male
370. Nina is assigned to care for a client diagnosed with Catatonic Stupor. When Nurse Nina enters the client's room, the client is found lying on the bed with a body pulled into a fetal position. Nurse Nina should? 43. A male
371. client direct questions to encourage talking
372. client into the dayroom to be with other clients
373. **beside the client in silence and occasionally ask open-ended question**
374. the client alone and continue with providing care to the other clients
44. Nurse
375. Tina is caring for a client with delirium and states that "look at the spiders on the wall". What should the nurse respond to the client? 44. Nurse
45. Nurse

376. having hallucination, there are no spiders in this room at all a. "You're
377. see the spiders on the wall, but they are not going to hurt you" b. "I can
378. you like me to kill the spiders" c. "Would
379. **d. "I know**
you are frightened, but I do not see spiders on the wall"
380. 46. Nurse
Jonel is providing information to a community group about violence in the family.
381. Which
statement by a group member would indicate a need to provide additional information?
382. a. **"Abuse occurs more in low-income families"**
383. b. "Abuser Are often jealous or selfcentered"
384. c. "Abuser use fear and intimidation"
385. d. "Abuser usually have poor self-esteem"
386. 47. During
electroconvulsive therapy (ECT) the client receives oxygen by mask via positive pressure ventilation. The nurse assisting with this procedure knows that positive pressure ventilation is necessary because?
387. a.
388. b. Decrease
oxygen to the brain increases confusion and disorientation
389. c. Grand
mal seizure activity depresses respirations
390. **d. Muscle**
relaxations given to prevent injury during seizure activity depress respirations.
391. 48. When
planning the discharge of a client with chronic anxiety, Nurse Chris evaluates achievement of the discharge maintenance goals. Which goal would be most appropriately having been included in the plan of care requiring evaluation?
392. a. The
393. b. The
client eliminates all anxiety from daily situations
client ignores feelings of anxiety
394. **c. The**
client identifies anxiety producing situations
395. d. The
client maintains contact with a crisis counselor
396. 49. Nurse
Tina is caring for a client with depression who has not responded to antidepressant medication. The nurse anticipates that what treatment procedure may be prescribed?
397. a. Neuroleptic medication
398. b. Short term seclusion
399. c. Psychosurgery
400. **d. Electroconvulsive therapy**
401. 50. Mario is
admitted to the emergency room with drug-induced anxiety related to over ingestion of prescribed antipsychotic medication. The most important piece of information the nurse in charge should obtain initially is the:
402. a. Length of
time on the med.
403. **b. Name of**
the ingested medication & the amount ingested
404. c. Reason
for the suicide attempt
405. d. Name of
the nearest relative & their phone number
406. 51. Nurse Tony should first discuss terminating the nurse client relationship with a client during the:
407. a. Termination phase when discharge plans are being made.
408. b. Working phase when the client shows some progress.
409. **c. Orientation phase when a contract is established.**
410. d. Working phase when the client brings it up.
411. 52. Malou is diagnosed with major depression spends majority of the day lying in bed with the sheet pulled over his head. Which of the following approaches by the nurse would be the most therapeutic?
412. a. Question the client until he responds
413. **b. Initiate contact with the client frequently**
414. c. Sit outside the clients room
415. d. Wait for the client to begin the conversation
416. 53. Joe who is very depressed exhibits psychomotor retardation, a flat affect and apathy. The nurse in charge observes Joe to be in need of grooming and hygiene. Which of the following nursing actions would be most appropriate?
417. a. Waiting until the client's family can participate in the client's care
418. b. Asking the client if he is ready to take shower
419. c. Explaining the importance of hygiene to the client
420. **d. Stating to the client that it's time for him to take a shower**

421. 54. When teaching Mario with a typical depression about foods to avoid while taking phenelzine(Nardil), which of the following would the nurse in charge include?
422. a. Roasted chicken
423. b. Fresh fish
424. c. Salami
425. d. Hamburger
426. 55. When assessing a female client who is receiving tricyclic antidepressant therapy, which of the following would
427. alert the nurse to the possibility that the client is experiencing anticholinergic effects?
428. a. Urine retention and blurred vision
429. b. Respiratory depression and convulsion
430. c. Delirium and Sedation
431. d. Tremors and cardiac arrhythmias
432. 56. For a male client with dysthymic disorder, which of the following approaches would the nurse expect to implement?
433. a. ECT
434. b. Psychotherapeutic approach
435. c. Psychoanalysis
436. d. Antidepressant therapy
437. 57. Danny who is diagnosed with bipolar disorder and acute mania, states the nurse, "Where is my daughter? I love Louis. Rain, rain go away. Dogs eat dirt." The nurse interprets these statements as indicating which of the following?
438. a. Echolalia
439. b. Neologism
440. c. Clang associations
441. d. Flight of ideas
442. 58. Terry with mania is skipping up and down the hallway practically running into other clients. Which of the following activities would the nurse in charge expect to include in Terry's plan of care?
443. a. Watching TV
444. b. Cleaning dayroom tables
445. c. Leading group activity
446. d. Reading a book
447. 59. When assessing a male client for suicidal risk, which of the following methods of suicide would the nurse identify as most lethal?
448. a. Wrist cutting
449. b. Head banging
450. c. Use of gun
451. d. Aspirin overdose
452. 60. Jun has been hospitalized for major depression and suicidal ideation. Which of the following statements indicates to the nurse that the client is improving?
453. a. "I'm of no use to anyone anymore."
454. b. "I know my kids don't need me anymore since they're grown."
455. c. "I couldn't kill myself because I don't want to go to hell."
456. d. "I don't think about killing myself as much as I used to."
457. 61. Which of the following activities would Nurse Trish recommend to the client who becomes very anxious when thoughts of suicide occur?
458. a. Using exercise bicycle
459. b. Meditating
460. c. Watching TV
461. d. Reading comics
- 462.
463. 62. When developing the plan of care for a client receiving haloperidol, which of the following medications would nurse Monet anticipate administering if the client developed extra pyramidal side effects?
464. a. Olanzapine (Zyprexa)
465. b. Paroxetine (Paxil)
466. c. Benztropine mesylate (Cogentin)
467. d. Lorazepam (Ativan)
468. 63. Jon a suspicious client states that "I know you nurses are spraying my food with poison as you take it out of the cart." Which of the following would be the best response of the nurse?
469. a. Giving the client canned supplements until the delusion subsides
470. b. Asking what kind of poison the client suspects is being used
471. c. Serving foods that come in sealed packages
472. d. Allowing the client to be the first to open the cart and get a tray
473. 64. A client is suffering from catatonic behaviors. Which of the following would the nurse use to determine that the medication administered PRN have been most effective?
474. a. The client responds to verbal directions to eat
475. b. The client initiates simple activities without direction
476. c. The client walks with the nurse to her room
477. d. The client is able to move all extremities occasionally
478. 65. Nurse Hazel invites new client's parents to attend the psycho educational program for families of the chronically mentally ill. The program would be most likely to help the family with which of the following issues?
479. a. Developing a support network with other families
480. b. Feeling more guilty about the client's illness
481. c. Recognizing the client's weakness
482. d. Managing their financial concern and problems
483. 66. When planning care for Dory with schizotypal personality disorder, which of the following would help the client become involved with others?
484. a. Attending an activity with the nurse
485. b. Leading a sing a long in the afternoon
486. c. Participating solely in group activities
487. d. Being involved with primarily one to one activities
488. 67. Which statement about an individual with a personality disorder is true?
489. a. Psychotic behavior is common during acute episodes
490. b. Prognosis for recovery is good with therapeutic intervention
491. c. The individual typically remains in the mainstream of society, although he has problems in social and occupational roles
492. d. The individual usually seeks treatment willingly for symptoms that are personally distressful.

493. 68. Nurse John is talking with a client who has been diagnosed with antisocial personality about how to socialize during activities without being seductive. Nurse John would focus the discussion on which of the following areas?
494. a. Discussing his relationship with his mother
495. b. Asking him to explain reasons for his seductive behavior
496. c. Suggesting to apologize to others for his behavior
- 497. d. Explaining the negative reactions of others toward his behavior**
498. 69. Tina with a histrionic personality disorder is melodramatic and responds to others and situations in an exaggerated manner. Nurse Trish would recommend which of the following activities for Tina?
499. a. Baking class
500. **b. Role playing**
501. c. Scrap book making
502. d. Music group
503. 70. Joy has entered the chemical dependency unit for treatment of alcohol dependency. Which of the following client's possession will the nurse most likely place in a locked area?
504. a. Toothpaste
505. b. Shampoo
- 506. c. Antiseptic mouthwash**
507. d. Moisturizer
508. 71. Which of the following assessment would provide the best information about the client's physiologic response and the effectiveness of the medication prescribed specifically for alcohol withdrawal?
509. a. Sleeping pattern
510. b. Mental alertness
511. c. Nutritional status
- 512. d. Vital signs**
513. 72. After administering naloxone (Narcan), an opioid antagonist, Nurse Ronald should monitor the female client carefully for which of the following?
- 514. a. Respiratory depression**
515. b. Epilepsy
516. c. Kidney failure
517. d. Cerebral edema
518. 73. Which of the following would nurse Ronald use as the best measure to determine a client's progress in rehabilitation?
519. a. The way he gets along with his parents
- 520. b. The number of drug-free days he has**
521. c. The kinds of friends he makes
522. d. The amount of responsibility his job entails
523. 74. A female client is brought by ambulance to the hospital emergency room after taking an overdose of barbiturates is comatose. Nurse Trish would be especially alert for which of the following?
524. a. Epilepsy
525. b. Myocardial Infarction
526. c. Renal failure
- 527. d. Respiratory failure**
528. 75. Joey who has a chronic user of cocaine reports that he feels like he has cockroaches crawling under his skin. His arms are red because of scratching. The nurse in charge interprets these findings as possibly indicating which of the following?
529. a. Delusion
- 530. b. Formication**
531. c. Flash back
532. d. Confusion
533. 76. Jose is diagnosed with amphetamine psychosis and was admitted in the emergency room. Nurse Ronald would most likely prepare to administer which of the following medication?
534. a. Librium
535. b. Valium
536. c. Ativan
- 537. d. Haldol**
538. 77. Which of the following liquids would nurse Leng administer to a female client who is intoxicated with phencyclidine (PCP) to hasten excretion of the chemical?
539. a. Shake
540. b. Tea
- 541. c. Cranberry Juice**
542. d. Grape juice
543. 78. When developing a plan of care for a female client with acute stress disorder who lost her sister in a car accident. Which of the following would the nurse expect to initiate?
- 544. a. Facilitating progressive review of the accident and its consequences**
545. b. Postponing discussion of the accident until the client brings it up
546. c. Telling the client to avoid details of the accident
547. d. Helping the client to evaluate her sister's behavior
548. 79. The nursing assistant tells nurse Ronald that the client is not in the dining room for lunch. Nurse Ronald would direct the nursing assistant to do which of the following?
549. a. Tell the client he'll need to wait until supper to eat if he misses lunch
- 550. b. Invite the client to lunch and accompany him to the dining room**
551. c. Inform the client that he has 10 minutes to get to the dining room for lunch
552. d. Take the client a lunch tray and let the client eat in his room
553. 80. The initial nursing intervention for the significant others during shock phase of a grief reaction should be focused on:
554. a. Presenting full reality of the loss of the individuals
555. b. Directing the individual's activities at this time
- 556. c. Staying with the individuals involved**
557. d. Mobilizing the individual's support system
558. 81. Joy's stream of consciousness is occupied exclusively with thoughts of her father's death. Nurse Ronald should plan to help Joy through this stage of grieving, which is known as:
559. a. Shock and disbelief
560. b. Developing awareness
- 561. c. Resolving the loss**
562. d. Restitution
563. 82. When taking a health history from a female client who has a moderate level of cognitive impairment due to dementia, the nurse would expect to note the presence of:
- 564. a. Accentuated premorbid traits**
565. b. Enhance intelligence
566. c. Increased inhibitions
567. d. Hyper vigilance
568. 83. What is the priority care for a client with a dementia resulting from AIDS?
569. a. Planning for remotivational therapy
570. b. Arranging for long term custodial care

571. **c. Providing basic intellectual stimulation**
572. d. Assessing pain frequently
573. 84. Jerome who has eating disorder often exhibits similar symptoms. Nurse Lhey would expect an adolescent client with anorexia to exhibit:
574. **a. Affective instability**
575. b. Dishered, unkempt physical appearance
576. c. Depersonalization and derealization
577. d. Repetitive motor mechanisms
578. 85. The primary nursing diagnosis for a female client with a medical diagnosis of major depression would be:
579. a. Situational low self-esteem related to altered role
580. b. Powerlessness related to the loss of idealized self
581. c. Spiritual distress related to depression
582. **d. Impaired verbal communication related to depression**
583. 86. When developing an initial nursing care plan for a male client with a Bipolar I disorder (manic episode) nurse Ron should plan to?
584. a. Isolate his gym time
585. b. Encourage his active participation in unit programs
586. **c. Provide foods, fluids and rest**
587. d. Encourage his participation in programs
588. 87. Grace is exhibiting withdrawn patterns of behavior. Nurse Johnny is aware that this type of behavior eventually produces feeling of:
589. a. Repression
590. **b. Loneliness**
591. c. Anger
592. d. Paranoia
593. 88. One morning a female client on the inpatient psychiatric service complains to nurse Hazel that she has been waiting for over an hour for someone to accompany her to activities. Nurse Hazel replies to the client "We're doing the best we can. There are a lot of other people on the unit who needs attention too." This statement shows that the nurse's use of:
594. **a. Defensive behavior**
595. b. Reality reinforcement
596. c. Limit-setting behavior
597. d. Impulse control
598. 89. A nursing diagnosis for a male client with a diagnosed multiple personality disorder is chronic low self-esteem probably related to childhood abuse. The most appropriate short term client outcome would be:
599. a. Verbalizing the need for anxiety medications
600. **b. Recognizing each existing personality**
601. c. Engaging in object-oriented activities
602. d. Eliminating defense mechanisms and phobia
603. 90. A 25 year old male is admitted to a mental health facility because of inappropriate behavior. The client has been hearing voices, responding to imaginary companions and withdrawing to his room for several days at a time. Nurse Monette understands that the withdrawal is a defense against the client's fear of:
604. a. Phobia
605. b. Powerlessness
606. c. Punishment
607. **d. Rejection**
- 608.
609. 91. When asking the parents about the onset of problems in young client with the diagnosis of schizophrenia, Nurse Linda would expect that they would relate the client's difficulties began in:
610. a. Early childhood
611. b. Late childhood
612. **c. Adolescence**
613. d. Puberty
614. 92. Jose who has been hospitalized with schizophrenia tells Nurse Ron, "My heart has stopped and my veins have turned to glass!" Nurse Ron is aware that this is an example of:
615. **a. Somatic delusions**
616. b. Depersonalization
617. c. Hypochondriasis
618. d. Echolalia
619. 93. In recognizing common behaviors exhibited by male client who has a diagnosis of schizophrenia, nurse Josie can anticipate:
620. a. Slumped posture, pessimistic out look and flight of ideas
621. b. Grandiosity, arrogance and distractibility
622. **c. Withdrawal, regressed behavior and lack of social skills**
623. d. Disorientation, forgetfulness and anxiety
624. 94. One morning, nurse Diane finds a disturbed client curled up in the fetal position in the corner of the dayroom. The most accurate initial evaluation of the behavior would be that the client is:
625. a. Physically ill and experiencing abdominal discomfort
626. b. Tired and probably did not sleep well last night
627. c. Attempting to hide from the nurse
628. **d. Feeling more anxious today**
629. 95. Nurse Bea notices a female client sitting alone in the corner smiling and talking to herself. Realizing that the client is hallucinating. Nurse Bea should:
630. a. Invite the client to help decorate the dayroom
631. **b. Leave the client alone until he stops talking**
632. c. Ask the client why he is smiling and talking
633. d. Tell the client it is not good for him to talk to himself
634. 96. When being admitted to a mental health facility, a young female adult tells Nurse Mylene that the voices she hears frighten her. Nurse Mylene understands that the client tends to hallucinate more vividly:
635. a. While watching TV
636. b. During meal time
637. c. During group activities
638. **d. After going to bed**
639. 97. Nurse John recognizes that paranoid delusions usually are related to the defense mechanism of:
640. **a. Projection**
641. b. Identification
642. c. Repression

643. d. Regression
644. 98. When planning care for a male client using paranoid ideation, nurse Jasmin should realize the importance of:
645. a. Giving the client difficult tasks to provide stimulation
- 646. b. Providing the client with activities in which success can be achieved**
647. c. Removing stress so that the client can relax
648. d. Not placing any demands on the client
649. 99. Nurse Gerry is aware that the defense mechanism commonly used by clients who are alcoholics is:
650. a. Displacement
- 651. b. Denial**
652. c. Projection
653. d. Compensation
654. 100. Within a few hours of alcohol withdrawal, nurse John should assess the male client for the presence of:
655. a. Disorientation, paranoia, tachycardia
656. b. Tremors, fever, profuse diaphoresis
- 657. c. Irritability, heightened alertness, jerky movements**
658. d. Yawning, anxiety, convulsions



663. 1. Nancy takes maintenance dosage of lithium carbonate for a history of bipolar disorder. She has come to the community health clinic stating that she "has had flu for over a week." She describes her symptoms as coughing runny nose, chest congestion, fever and gastrointestinal
- She has consumed some of foods high in tyramine
 - She has stopped taking her lithium carbonate
 - She has probably developed a tolerance to the lithium
 - She may have become toxic on lithium carbonate**
2. Joey, age 8, takes methylphenidate for attention – deficit – hyperactivity disorder. His mother complains to the nurse that Joey has a very poor appetite, and she struggles to help him gain weight. Which of the following would be appropriate for the nurse to advise Joey's mother?
- Administer Joey's medication immediately after meals**
 - Administer Joey's medication at bedtime
 - Skip a dose of the medication when Joey doesn't eat anything
 - Assure Joey's mother that Joey will eat when he is hungry
664. SITUATION: Sarah, age 70, is a client on the psychiatric unit with a diagnosis of major depression. She has been seeing her psychiatrist on an outpatient basis for several months and has been taking an antidepressant medication, with no improvement in her symptoms. Her physician has suggested hospitalization for a series of electroconvulsive therapy (ECT) treatments.
3. The nurse is doing some pretreatment teaching with Sarah and her family. Sarah's daughter asks, "Isn't this treatment dangerous?" which of the following is the most appropriate response by the nurse?
- "No, this treatment is absolutely safe."
 - "there are some risks involved, but in your mother's case, the benefits outweigh the risks."
 - "There are some risks involved, but your mother will have a thorough examination in advance to ensure that she is a good candidate for the treatment."**
 - "There are some side effects to the treatment, but they are not life – threatening."
4. Which of the following statements is true regarding ECT?
- Electrical stimulation to the brain produces a grand mal seizure**
 - Maximal muscle movement is required to ensure efficacy of the treatment
 - The client will sleep for about 12 hours following a treatment
 - The client will have full recall of what has occurred during the treatment
5. In explaining to the client and family what to expect immediately following an ECT treatment, which of the following statement is true?
- The client will most likely wake up right away and no longer be depressed
 - The client will likely be confused and somewhat disoriented**
 - The client will be sleepy and very likely sleep for a number of hours
 - The client may experience some soreness in her muscles and joints
6. The nurse tells the client that an injection of medication called atropine sulfate will be administered about 30 minutes prior to the ECT treatment. The nurse explains to the client that this is for:
- Alleviating her anxiety
 - Relaxing her muscles
 - Decreasing secretions**
 - Putting her to sleep
7. The nurse constructs a plan of care for the hospital stay of a client receiving a series of ECT treatments, and it includes the following nursing diagnoses. Which must receive priority attentions?
- Anxiety related to receiving ECT
 - Knowledge deficit related to ECT
 - Confusion related to side effects of ECT
 - Risk for injury related to risks and side effects of ECT**
8. Situation: Carol went to the community mental health clinic because she was feeling depressed. She told the therapist that she had broken up with her boyfriend 6 weeks ago, and she has been feeling depressed since that time.
9. She wants to feel better, but she does not want to take medication. She told therapist she would be willing to take herbal medication if there was something that might help her feel. The therapist may suggest which of the following for Carol?
- Chamomile
 - Echinacea
 - St. John's wort**
 - Feverfew
10. Carol decided to see a chiropractor for a recurring pain in her lower back. The chiropractor took x-rays and told Carol that he saw some displacement of vertebrae in her spine. In chiropractic medicine, these displacements are called:
- Maladjustments
 - Manipulations
 - Meridians
 - Subluxations**
11. The therapist suggested that Carol see a physician for a complete physical examination. Part of the examination included a health risk assessment. Carol's medical history revealed that her father had died of colon cancer and that her mother has had surgery for breast cancer, both of which may have link to high – fat diet. The nurse does health teaching about diet with Carol. In terms of her risk factors, which of the following food groups should Carol modify her intake of?
- Fruit and grain
 - Meat and cheese**
 - Meat and starches
 - Milk and cereal
12. Which of the following herbal medicines is thought to improve memory and blood circulation?
- Ginkgo**
 - Ginseng
 - Kava kava
 - St. John's wort
13. The technique of yoga uses which of the following?
- Deep breathing
 - Meditation
 - Balanced body postures
 - All of the above**

14. Glenda diagnosed as mentally retarded, scored 47 on recent IQ testing. Her parents have called a local agency that serves the developmentally disabled and asked for advice regarding Glenda's potential. Which of the following statements from the nurse who counsels them is the best estimate of Glenda's eventual level of development?
 - a. "Glenda may develop minimal verbal skills
 - b. Glenda may be able to work at an unskilled job**
 - c. Glenda may eventually function at about a sixth – grade level
 - d. Glenda will require constant supervision and care
15. Tommy, age 9, has been diagnosed with autistic disorder. The cause of this disorder is thought to be:
 - a. Refrigerator parents
 - b. Fragile syndrome
 - c. Increased glucose metabolism
 - d. Unknown**
16. Tommy, age 9, has been diagnosed with autistic disorder. A psychiatric nurse frequently visits Tommy and his family, who also has a second son, Ronnie, age 3. Which of the following behaviors would the nurse regard as age – appropriate and not indicative of autistic disorder?
 - a. Intense fascination with fans
 - b. Parallel play**
 - c. Lack of eye contact
 - d. Drinking large quantities of fluid
17. Mrs. Smith tells the psychiatric nurse that her son, Ronnie, age 3, is in constant motion and is unable to sit still long enough to listen to a story or even watch TV. She asks the nurse if she thinks he could be "hyperactive". The nurse's best response is:
 - a. "I wouldn't worry about it."
 - b. "It's certainly possible."
 - c. **"It's hard to tell with a 3 year old."**
 - d. "Why would you think that?"
18. Mrs. Smith tells the psychiatric nurse that her son, Ronnie, age 3, is in constant motion and is unable to sit still long enough to listen to a story or even to watch TV. She asks the nurse if she thinks she could be "hyperactive." Which of the following factors would prompt the nurse to continue to evaluate Ronnie for ADHD?
 - a. Ronnie's father smoke
 - b. Ronnie was born 7 weeks prematurely**
 - c. Ronnie develops hives when he eats foods with red food coloring added
 - d. Ronnie has a cousin on his father's side who has ADHD
19. Calming effects on hyperactive children have been found to occur with the administration of which of the following classifications of medications?
 - a. Central nervous stimulants**
 - b. CNS depressant
 - c. Nonsteroidal anti – inflammatory drugs
 - d. Antimanic drugs, such as lithium
20. A potential side effect from prolonged use of methylphenidate (Ritalin) is which of the following?
 - a. Psychosis
 - b. Decreased intelligence
 - c. Dry mouth and sore throat
 - d. Decrease in rate of growth and development**
21. The primary nursing intervention in working with a child with conduct disorder is to:
 - a. Plan activities that provide opportunities for success
 - b. Give the child unconditional acceptance for good behaviors that occur
 - c. Recognize behaviors that precede the onset of aggression and intervene before violence occurs**
 - d. Provide immediate positive feedback for acceptable and unacceptable behaviors
22. Which of the following classes of medication is effective in the treatment of Tourette's syndrome?
 - a. Neuroleptics**
 - b. Antimanics
 - c. Tricyclic antidepressant
 - d. MAOI's
23. In providing care for the adolescent with an overanxious disorder, the primary goal of the nurse is:
 - a. To set very strict limits on what behavior can be tolerated
 - b. To make the adolescent aware of the outcomes of his or her desire to excel
 - c. To establish an atmosphere of calm, trust and unconditional acceptance**
 - d. To accept all "nervous habit" behavior and extinguish somatic symptoms
24. The essential feature that distinguishes oppositional defiant disorder from other disorders is:
 - a. Gender ratio
 - b. Passive – aggressiveness**
 - c. Violence toward others
 - d. Role of genetic predisposition
- 25.
- 26.
27. SITUATION: Gloria visits her Aunt Naomi about twice a year. Naomi is 74 years old and lives in a city about 300 miles away from Gloria. During her most recent visit, Gloria notices that her aunt has become quite forgetful. Two days worth of mail is still in the mailbox, and Naomi has forgotten to have her prescription for her antihypertensive medication refilled. There is very little food in the house, and Naomi is unable to tell Gloria when or what she last ate. Gloria calls Naomi's physician, who has Naomi hospitalized for evaluation. The physician diagnoses Naomi with dementia.
- 28.
29. From the information given, which of the following types of dementia does Naomi probably have?
 - a. Dementia of the Alzheimer's type
 - b. Vascular dementia**
 - c. Dementia due to head trauma
 - d. Dementia due to Parkinson's disease
- 30.
31. Which of the following statement is true about vascular dementia
 - a. It is reversible
 - b. It is characterized by plaques and tangles in the brain
 - c. It exhibits gradual, progressive deterioration
 - d. It exhibits a fluctuating pattern of deterioration**
32. The physician orders cyclandelate (Cyclan) for a client with dementia. The rationale for this order is:

- a. **To enhance circulation to the brain**
 - b. To elevate levels of acetylcholine in the brain
 - c. To control aggressive behavior
 - d. To prevent depression
33. Which of the following nursing diagnoses would be a priority for the nurse caring of the client with dementia?
- a. Altered thought process
 - b. Self – care deficit
 - c. **Risk for trauma**
 - d. Risk for violence toward others
34. Naomi can no longer live alone. Arrangements are made for her to move into nursing home, where she becomes very depressed and withdrawn. The physician believes Naomi would benefit from an antidepressant medication. Which of the following is an example of an antidepressant that the physician may prescribe for Naomi?
- a. Haloperidol (Haldol)
 - b. Tacrine (Cognex)
 - c. **Amitriptyline (Elavil)**
 - d. Diazepam (Valium)
- e. Situation: Michael, a 47 year – old salesman, is brought to the emergency department at midnight by the police because of aggressive, uninhibited behavior; slurred speech; and impaired motor coordination. His blood alcohol level is 347 mg/dl.
35. He is admitted to the alcohol and drug treatment unit for detoxification. At what minimum blood alcohol level is an individual considered to be intoxicated?
- a. 50 mg/dl
 - b. **100 mg/dl**
 - c. 200 mg/dl
 - d. 300 mg/dl
36. Michael's wife reports to the admitting nurse that Michael's drinking has increased over the last several years. Lately, Michael has been drinking a pint of bourbon a day, mostly in the evening but sometimes also during the day. "He usually just comes home from work and drinks until he passes out." She stated yesterday Michael's boss told him if he didn't increase his sales, he would be fired. Michael started drinking in the early afternoon and drank continuously into the night. She didn't know what time he left the house. It is now 2 AM. When might the nurse expect withdrawal symptoms begin?
- a. **Around 4 to 6 AM**
 - b. Around 10 AM
 - c. In 2 to 3 days
 - d. Around 4 to 6 PM
37. For what initial symptoms should the nurse be alert with a client who is withdrawing from alcohol?
- a. Suicidal ideation, increased appetite
 - b. Lacrimation, rhinorrhea, piloerection
 - c. **Tremors, tachycardia, sweating**
 - d. Belligerence, assaultiveness
38. What would be expected treatment for a client who is withdrawing from alcohol?
- a. Tricyclic antidepressant
 - b. A long – acting barbiturate, such as Phenobarbital
 - c. Alcohol deterrent therapy, such as disulfiram
 - d. **Substitution therapy with chlordiazepoxide**
39. The physician orders daily administration of thiamine for Michael, a chronic alcoholic who has been hospitalized for alcohol withdrawal. What is the rationale behind this order?
- a. To restore nutritional balance
 - b. To prevent pancreatitis
 - c. To prevent alcoholic hepatitis
 - d. **To prevent Wernicke's encephalopathy**
40. Which of the following describes symptoms of Wernicke's encephalopathy?
- a. Peripheral neuropathy and pain
 - b. Epigastric pain and nausea and/or vomiting
 - c. **Diplopia, ataxia, somnolence**
 - d. Inflammation and necrosis of the liver
41. Although Michael denies that he is an alcoholic, the nurse encourages him to seek rehabilitative treatment. The nurse understands that for Michael to be successful in treatment, he must first:
- a. Identify someone to whom he can go for support
 - b. Give up his old drinking buddies
 - c. Understands the dynamics of alcohol on the body
 - d. **Correlate life problems to his drinking of alcohol**
42. SITUATION: Frankie, a 20 year old college student, has become increasingly suspicious and isolated over the last few months. He has begun accusing his roommate and other students of conspiring against him. Last night, he charged after his roommate with a knife in his hands. He was taken to the local hospital by police, where he was admitted to the psychiatric unit. The psychiatrist diagnosed Frankie with paranoid schizophrenia.
43. Based on this information, what initial nursing diagnosis would the nurse make?
- a. Risk for self – directed violence
 - b. Sensory perceptual alteration
 - c. **Risk for violence directed toward others**
 - d. Altered thought process
44. Based on the background knowledge, in what stage of development would the nurse place her new client Frankie?
- a. **Trust versus mistrust**
 - b. Autonomy versus shame and doubt
 - c. Identity versus role confusion
 - d. Intimacy versus isolation
45. Because of the developmental level, what must be an initial intervention for the nurse who is working with a paranoid schizophrenic client?
- a. Allowing the client to take the charge of his self – care independently
 - b. Putting the client in the first group therapy session with an opening
 - c. Helping the client decide where he wants to go in his life from here
 - d. **Helping the client to decrease his anxiety and establish trust**
46. The physician orders 100 mg chlorpromazine (Thorazine) bid and 2 mg benztropine (Cogentin) bid p.r.n. the rationale for chlorpromazine order is:
- a. To ensure that Frankie can get enough sleep
 - b. **To reduce psychotic symptoms**
 - c. To decrease Frankie's aggressiveness
 - d. To prevent tardive dyskinesia
47. The physician orders 100 mg chlorpromazine (Thorazine) bid and 2 mg benztropine (Cogentin) bid p.r.n. under what circumstances would the nurse administer a p.r.n. dose of Cogentin?
- a. When Frankie becomes aggressive
 - b. When Frankie needs to be calmed down before bedtime
 - c. **When Frankie exhibits tremors and shuffling gait**
 - d. When Frankie complains of constipation

48. Frankie says, "I find that hard to believe, Frankies" plotting with others to have "Blondie" killed." The most appropriate response by the nurse would be:
- a. "Why would anyone do that thing?"
 - b. "I might feel the same way if you came after me with a knife!"
 - c. "I find that hard to believe, Frankies" plotting with others to have "Blondie" killed." The most appropriate response by the nurse would be:
 - d. "I might feel the same way if you came after me with a knife!"
49. The nurse notices that Frankie is stopping in midsentence when they are talking. He tilts his head to the side as if listening to something. The most appropriate intervention by the nurse would be:
- a. Call and report the behavior to the physician
 - b. Give Frankie PRN dose of benzotropine
 - c. **Say to Frankie, "what are the voices saying to you, Frankie?"**
 - d. Say to Frankie, "well, I see you are distracted right now. We'll talk more later."
50. SITUATION: Janet, age 28, was diagnosed at age 24 with bipolar I disorder. She had been taking lithium carbonate 300 mg tid for maintenance therapy. Today she was brought to the emergency department (ED) by police called to a local department store when she became belligerent and aggressive after being confronted for shoplifting. Janet lives with her mother, who is summoned to the hospital, and who reports that Janet quit taking her lithium about 3 months ago because it caused her to gain weight. On the psychiatric unit, Janet is agitated, pacing, talking loudly and abusively as if in response to an unseen person, and flailing her arms in exaggerated gestures. She is begun on lithium carbonate and haloperidol (Haldol) immediately.
51. What is the rationale for the haloperidol order?
- a. Haloperidol cures manic symptoms
 - b. Haloperidol prevents extrapyramidal side effects
 - c. Haloperidol will ensure that she gets a good night's sleep
 - d. **Haloperidol will calm hyperactivity until the lithium takes effect**
52. In the initial stages of caring for a client experiencing an acute manic episode, what must the nurse consider to be the priority nursing diagnosis?
- a. **Risk for injury related to excessive hyperactivity**
 - b. Sleep pattern disturbance related to manic hyperactivity
 - c. Alteration in nutrition, less than body requirements related to inadequate intake
 - d. Self – esteem disturbance related to embarrassment from being arrested for shoplifting
53. Janet, whose diagnosis is bipolar disorder, current episode manic, tells the physician that she does not want to take lithium carbonate because she has gained a lot of weight on this medication. She says that if he sends her home on this drug, she will just stop taking it. The physician decides to change her medication in hopes that she will be more compliant. Which of the following medications might the physician choose to prescribe for Janet?
- a. Sertraline (Zoloft)
 - b. **Valproic acid (Depakote)**
 - c. Trazodone (Desyrel)
 - d. Proxetine (Paxil)
- e.
- f. SITUATION: Janet is stabilized on her medication and the hyperactivity subsides. She is discharged from the hospital to her parent's home. She apologizes to her boss for her behavior and is rehired. However, 10 months later, because of cutbacks and downsizing, Janet is laid off. She becomes very depressed, refuses to look for another job, stays in her room, eats very little and neglects her personal hygiene. She tells her mother, "What's the use of trying? I fail at everything I do, anyway. Nothing ever works out for me." The next morning, when Janet's mother went into check on her, she found Janet unconscious, but still breathing, with an empty bottle of sertraline (Zoloft) beside her. She called an ambulance and had Janet transported to the hospital ED. Janet was stabilized in the ED and admitted to the psychiatric unit. Her diagnosis is bipolar I disorder: current episode depressed.
54. Why does the physician give Janet this diagnosis rather than major depression?
- a. Because he does not feel she is that severely depressed
 - b. **Because she has experienced a full manic episode in the past**
 - c. Because he needs to make a more extensive assessment before he decided
 - d. Because she has no history of major depression in her family
55. What would be the priority nursing diagnosis for Janet at this time?
- a. Alteration in nutrition, less than body requirements, related to refusal to eat
 - b. Anxiety (Severe) related to threat to self- esteem
 - c. **Risk for self – directed violence related to depressed mood**
 - d. Dysfunctional grieving related to loss of employment
56. The physician prescribes paroxetine (Paxil) for Janet. She is encouraged to participate in unit activities and to talk about her feelings. Despite all efforts, her depression becomes profound. She is in total despair and in a vegetative state. The physician obtains consent from her parents to perform electroconvulsive therapy (ECT). What is the rationale behind this treatment for profound depression?
- a. The client is made to forget painful memories from the past and go on with his or her life
 - b. The treatment causes stimulation of the central nervous system (CNS) similar to CNS stimulant medication, thereby lifting mood.
 - c. The treatment satisfies the need for punishment that severely depressed clients sometimes think they deserve.
 - d. **The treatment is thought to increase levels of norepinephrine and serotonin, resulting in mood elevation.**
57. The physician orders a medication to be administered by the nurse 30 minutes prior to each ECT treatment that will decrease secretions and maintain heart rate during the convulsion. Which of the following medications would the physician prescribe for this purpose?
- a. Thiopental sodium (Pentotal)
 - b. **Atropine sulfate**
 - c. Succinylcholine (Anectine)
 - d. Clonazepam (Klonopin)
58. Which of the following currently receives the most credibility as etiologically implicated in the development of bipolar disorder?
- a. **Genetics and biochemical alterations**
 - b. Poor mother – child relationship
 - c. Evidence of lesion in temporal lobe

- d. Learned helplessness within a dysfunctional family system

E.

f. **SITUATION:** Sharon is a 25 – year – old graduate student working on a doctorate in pharmacy. She is very bright and very achievement oriented. She works very hard and pushes herself to excel. Lately, she has been very upset because she is not studying as much as she usually does, and she is afraid she will fail some of her courses. She has begun cleaning out her drawers and closets incessantly. If she notices one thing out of place, she removes the entire contents and begins to rearrange them. Many times during the ritual, she gets interrupted and starts all over again. She knows that the behavior is not normal, but she feels powerless to change. She has been admitted to the psychiatric unit with the diagnosis of obsessive compulsive disorder.

59. After her initial assessment and introduction to the unit, Sharon goes to her room to unpack her suitcase. She begins to arrange her belongings in the drawers and closet. Forty – five minutes later, when the nurse comes to check for her, Sharon is still unfolding her clothes and arranging and rearranging them in the drawers. What is the appropriate nursing intervention at this time?
- Explain to Sharon that she must come out of her room and join the others in the dayroom at this time
 - Give Sharon a task to complete, to get her mind off the ritual
 - Allow Sharon as much time as she wants to perform the ritual**
 - Take Sharon by the hand and state, "It is time to go to group therapy"
60. The most likely reason Sharon arranges and rearranges her clothing so often is:
- Relieves her anxiety**
 - Her mother taught her to be very neat
 - It provides her with a feeling of control over her life
 - It makes her feel good about herself
61. The physician writes an order for medication for Sharon. Which of the following is an appropriate prescription for OCD?
- Diazepam (Valium)
 - Fluvoxamine (Luvox)**
 - Propanolol (Inderal)
 - Alprazolam (Xanax)
62. Which of the following would be an appropriate nursing intervention with Sharon?
- Distract Sharon with other activities whenever she tries to clean out her drawers
 - Report the behavior to the physician each time she begins the ritual
 - Lock Sharon's room so that she cannot engage in the ritualistic behavior
 - Help Sharon identify what is causing the anxiety that leads to the ritualistic behavior**
 -
63. As Sharon becomes more comfortable on the unit and begins to interact with others, what change, if any, should the nurse make in her plan of care?
- Begin to set limits on the amount of time Sharon may engage in the ritual**
 - Give negative reinforcement to the behavior by pointing out its inappropriateness
 - Establish firm consequences if Sharon performs the ritualistic behavior
 - No change should be made in the plan of care
64. Recently, the biochemical theory of etiology of OCD has been given an increasing amount of credibility. Which neurotransmitter has been associated with this disorder?
- Norepinephrine
 - Dopamine
 - Serotonin**
 - Acetylcholine
65. Louise has just moved to a new city and sees her new primary care practitioner (PCP) for the first time because of gastrointestinal distress. When she takes Louise's history, the PCP suspects some type of somatoform disorder. What is the next step necessary to confirm a diagnosis in this category?
- Gastrointestinal work up
 - Thorough physical examination**
 - Review of old medical records
 - Referral to a psychiatrist
66. The PCP diagnoses Louise with somatization disorder. Which of the following data enables the physician to distinguish between hypochondriasis and somatization disorder in arriving at a diagnosis for Louise?
- Pain
 - Gender distribution
 - Persistent fear**
 - Impaired functioning
67. Tyler, a 25 year old law school graduate who has worked in his first job with a private law firm for a year, makes an appointment with his PCP because of weakness in his right hand and arm that he discovered when he awoke yesterday morning. He delayed making the appointment because he thought "he slept on it wrong," but it has not improved. He is unable to hold a pen or use his computer. He plays racquetball twice a week and it last played 4 days ago, but he denies recent injury. Other extremities are normal, and he shows no other evidence of neurological impairment. Tyler says he enjoys the challenge of his job and has gotten used to the hectic pace and stress. He is scheduled to take the bar examination in 10 days for the second time, but he seems philosophical about his inability to use his hand. Which of these data, taken together, form the basis for a diagnosis of conversion disorder?
- Sudden onset
 - The specific functional loss
 - Negative neurological findings
 - Upcoming bar examination
 - Philosophical attitude
- 1 & 2
 - 3 only
 - 4 only
 - All of the above**
68. The psychodynamic theory underlying Tyler's symptoms is:
- Relief from despair
 - Repression anger
 - Unconscious resolution of conflict**
 - Cognitive deficit
69. Tommy, age 9, has begun sleepwalking, and his parents are afraid for his safety. He has begun getting up and wandering around outside their house in the middle of the night. Which of the following interventions might the practitioner prescribe for Tommy?

- a. **Low dose alprazolam (Xanax) and bell on side of bed**
 - b. Methyphenidate (Ritalin) and biofeedback
 - c. Temazepam (Restoril) and relaxation therapy
 - d. Sertraline (Zoloft) and phototherapy
70. Edith, 69 – year – old widow, is very troubled by increasing difficulty sleeping well at night. She wakes frequently during the night, and feels tired when she wakes early in the morning. What is the outcome that best indicates that treatment of Edith's sleep disorder is successful?
- a. Is compliant with medications
 - b. Has not yet experienced injury
 - c. Verbalizes understanding of the sleep disorder
 - d. **Reports increased sense of well being and feeling rested**
71. Tracy is a 27 year old woman who, after being diagnosed as having major depression, borderline personality disorder, and antisocial personality disorder in previous contacts with the mental health care system, has recently been diagnosed with DID. She has been hospitalized because of one of her personalities attempted suicide. What is the primary consideration in planning care for Tracy?
- a. **Safety**
 - b. Establishing trust
 - c. Awareness of all personalities
 - d. Recognition of events that trigger transition between personalities
72. The primary nursing diagnosis for Tracy during this hospitalization is:
- a. Personal identity disorder
 - b. Sensory perceptual alteration
 - c. Altered thought process
 - d. **Risk for self – directed violence**
73. Anxiety is involved in understanding the problem of dissociative amnesia. The defense mechanism used in this psychologic process is:
- a. Suppression
 - b. Denial
 - c. **Regression**
 - d. Rationalization
74. Bill C. has been diagnosed with a dissociative disorder that is identified as a fugue state. Which of the following best behaviors best illustrates this diagnosis?
- a. Seeking privacy in his office
 - b. Driving a long distance to visit a friend
 - c. **Sudden unexpected travel away from home**
 - d. Taking a vacation to a place he would not usually go
75. Bill's unusual activity (from question number 4) may have occurred in response to which of the following?
- a. Severe psychological process
 - b. Excessive alcohol use
 - c. Psychogenic amnesia
 - d. **A or B**
76. Which of the following is an example of systematized amnesia?
- a. George has no memory of his entire lifetime, including his personal identity
 - b. **AnnMarie knows she was beaten by her mother as a child, but cannot remember the details of any of the beatings**
 - c. Nancy, who was driving the car in which her bestfriend was killed, cannot recall the accident of events since the accident
 - d. Sarah, whose home was destroyed in a tornado, only remembers hearing the tornado hit, the ambulance siren, and waking up in the hospital
77. Tom and Susan are seeking treatment at the sex therapy clinic. They have been married for 3 years. Susan was a virgin when they married. She admits she has never enjoyed sex, but lately developed an aversion to it. They have not had sexual intercourse for about 5 months. Sexual history reveals that Susan grew up in a family who were very closed about sexual issues, and with the implication that sex was sinful and dirty. The physician would most likely assign which of the following diagnoses to Susan?
- a. Dyspareunia
 - b. Vaginismus
 - c. Anorgasmia
 - d. **Sexual aversion disorder**
78. The most appropriate nursing diagnosis for Susan would be:
- a. Pain related to vaginal constriction
 - b. **Sexual dysfunction related to negative teachings about sex**
 - c. Altered sexual patterns related to lack of desire for sex
 - d. Self- esteem disturbance related to inability to please her husband sexually
79. Which of the following interventions by the nurse may initiate treatment for Tom and Susan?
- a. **An explanation of the diagnosis**
 - b. Initiating sensate focus exercises
 - c. Initiating directed masturbation training
 - d. Teaching the "squeeze" technique
80. The sex therapist assigned to the case would likely choose which of the following therapies for Susan?
- a. Sensate focus exercise
 - b. **Systematic desensitization**
 - c. Hypnotherapy
 - d. Gradual dilation of the vagina
81. Additional therapy may include:
- a. Minor tranquilizers
 - b. Group therapy
 - c. **Tricyclic antidepressant**
 - d. Injections of testosterone
- e. SITUATION: Staphanie, age 23, calls the eating disorders clinic for an appointment. She tells the nurse who does the assessment interview that she was hospitalized and diagnosed with anorexia nervosa when she was 14 years old. Since that time, she has seen a therapist periodically when she feels her anxiety is increasing and the fear of eating starts to take hold. She recently graduated from college and moved to this city, where she began a new job as a production assistant at a local TV station. She is nervous about starting the new job, and wants to "do a perfect job, so I can move up quickly to a more challenging position." She tells the nurse that she has been taking laxative everyday, and some days after eating, she will self- induce vomiting. She knows this is not good, but feels powerless to stop. She is 5'6" tall and weighs 105 lb.
82. What other physical manifestations might the nurse expect to find upon assessment?
- a. High blood pressure, fever
 - b. **Low blood pressure, low temperature**
 - c. Slow heart rate, fever
 - d. Fast heart rate, low blood pressure
83. The primary nursing diagnosis on which the nurse will base her plan of care is:

- a. Ineffective denial
 - b. Body image disturbance
 - c. Self-esteem disturbance
84. What other therapy might the physician prescribe?
- a. **Fluoxetine (Prozac)**
 - b. Diazepam (Valium)
 - c. Fenfluramine (Pondimin)
 - d. Meprobamate (Equanil)
- e.
- f. SITUATION: Betty, a 38 year old woman, is also being followed in the eating disorders clinic. Betty is 5'4" and weighs 250 pounds. When she first came to the clinic two years ago, she weighed 347 pounds. Her diagnosis at that time was Morbid Obesity. The dietitian put her on a 1500 calorie/day diet and the physician at the clinic prescribed fencluramine and phentermine, the "fen – fen" drugs that were so popular at that time. Since then, fenfluramine has been taken off the market because it caused pulmonary hypertension in a number of individuals Betty says to the nurse, "I don't know what to do! I know I can't lose weight without those drugs. That's the only reason I lost any at all. And I've already gained back some back since I quit taking them!"
85. Fenfluramine and phentamine are part of which of the following classifications of drugs?
- a. Antidepressants
 - b. **Anorexigenics**
 - c. Antianxiety
 - d. Anticonvulsants
86. The nurse explains to Betty that the physician may be able to prescribed another medication to help her lose weight. Which of the following might the nurse expect the physician to prescribe?
- a. Diazepam (Valium)
 - b. Dexfenfluramine (Redux)
 - c. **Sibutramine (Meridia)**
 - d. Pemoine (Cylert)
- e. SITUATION: Tommy T., age 6, has been admitted to the child psychiatric unit. His parents report that until the last 6 months Tommy has never presented a problem for them. However, since his baby sister was born 6 months ago, they have been unable to control his behavior. Normally a very bright outgoing student, Tommy's teachers report that he is bullying other student's, and this week he threw a rock at a classmate, causing a laceration on the other child's forehead. At home, when he cannot have his way, Tommy resorts to temper tantrums, and yesterday swung his fists at his Mom for not allowing him to ride his bike after dinner. This morning, Mr. and Mrs. T became fearful when they heard the baby screaming and coughing, and found Tommy flinging baby powder all over the baby and the nursery. The physician has assigned the diagnosis of adjustment disorder with Mixed disturbances of emotions and conduct. The following questions relate to Tommy.
87. The primary nursing diagnosis for Tommy would be:
- a. **Dysfunctional grieving related to perceived loss of parental love**
 - b. Impaired adjustment related to birth of baby sister
 - c. Ineffective individual coping related to loss of only – child status
 - d. Risk for violence directed at others related to anger at birth of sister
88. The category of Adjustment Disorder with Mixed Disturbance of Emotions and Conduct identifies the individual who:
- a. Expresses symptoms that reveal a panic level of anxiety
 - b. Expresses feelings of suicidal ideation
 - c. **Violates rights of others to feel better**
 - d. Exhibits severe social isolation and withdrawal
89. The most likely treatment modality for Tommy would be:
- a. Family therapy
 - b. Group therapy
 - c. Behavior therapy
 - d. **Individual psychotherapy**
90. Related to the correct answer in question #3, the focus of therapy with Tommy would be:
- a. To treat dysfunctional family system
 - b. To allow input from his peer group in an effort to gain insight
 - c. To keep him from hurting others
 - d. **To focus on his anger at baby's birth and fear of parental abandonment**
91. Tommy's predisposition to adjustment disorder is most likely related to which of the following?
- a. Mental retardation
 - b. **Temperamental characteristics at birth that promote vulnerability**
 - c. Retarded superego development
 - d. Presence of psychiatric illness
- 92.
93. SITUATION: the following questions relate to impulse control disorders
94. What is the identifying dysfunction in all impulse control disorders
- a. **Disinhibition**
 - b. Thought disorder
 - c. Mood disorder
 - d. Loss of memory
95. Which of the following impulse control disorders has the strongest genetic predisposing factor?
- a. Kleptomania
 - b. pyromania
 - c. **Pathological gambling**
 - d. Trichotolomania
96. Which of the following psychosocial influences has been correlated with the predisposition to asthma?
- a. Unresolved Oedipus complex
 - b. Underdeveloped ego
 - c. Punitive superego
 - d. **Unresolved dependence on the mother**
97. Type C personality characteristics include all of the following except:
- a. Exhibits a calm, placid exterior
 - b. Puts others' needs before their own
 - c. **Has a strong competitive drive**
 - d. Holds resentment toward others for perceived "wrongs."
98. Friedman and Rosenman identified two major character traits common to individuals with Type A personality. They are:
- a. **Excessive competitive drive and chronic sense of time urgency**
 - b. Unmet dependency needs and low self – esteem
 - c. Chronic depression and tendency toward self – pity
 - d. Self- sacrificing and perfectionist

99. Which of the following statements is true about type B personality?
- Their personalities are the exact opposite of type A's
 - They lack the need for competition and comparison as to Type A's**
 - They are usually less successful than Type A's
 - They do not perform as well under pressure as Type A's
100. Which of the following has not been implicated in the etiology of peptic ulcer disease?
- Genetics
 - Cigarettes smoking
 - c. Allergies**
 - Unfulfilled dependency
101. The individual with essential hypertension is thought to:
- a. Suppress anger and hostility**
 - Fear social interactions with others
 - Project feelings onto the environment
 - Deny responsibility for own behavior
102. The "migraine personality" includes which of the following sets of characteristics?
- a. Compulsive, perfectionistic, and somewhat inflexible**
 - Excessive ambitious, easily aroused hostility and highly competitive
 - Highly extroverted, impulsive and expresses anger inappropriately
 - Chronic feelings of depression and despair, and has a tendency toward self – pity
103. The individual who suffers from migraine headaches is thought to have:
- a. Repressed anger**
 - Suppressed anxiety
 - Unresolved dependency needs
 - Displaced aggression
104. The individual with ulcerative colitis has been found to have which of the following types of personality characteristics?
- Passive – aggressive
 - b. Obsessive – compulsive**
 - Antisocial – suspicious
 - Hostile – aggressive
105. Individuals with ulcerative colitis and rheumatoid arthritis share which of the following personality characteristics?
- Highly negativistic
 - Strongly independent
 - Excessively introverted
 - d. Unable to express anger directly**
106. Situation: Claudia is a 27-year-old woman who has been married and divorced four times. She is admitted to the psychiatric unit with a diagnosis of borderline personality disorder.
107. Which of the following behavior patterns best describes someone with borderline personality disorder?
- Social isolation
 - Suspiciousness of others
 - Belligerent and argumentative
 - d. Emotional instability**
108. As Nancy Nurse starts to leave the unit at the end of her shift, Claudia runs up to her, puts her arms around her, and yells, "Please don't go! You're the only one who understands me. If you go, I won't have anyone!" This is an example of what type of behavior common to individuals with borderline personality disorder?
- Splitting
 - Manipulation
 - c. Clinging**
 - Impulsivity
109. Which of the following nursing interventions is appropriate to help the client with borderline personality disorder extinguish clinging behaviors?
- Put the client on room restriction each time it happens
 - Ignore such behaviors so that they will be extinguished for lack of reinforcement
 - Secure a verbal contract with the client that he or she will discontinue this type of behavior
 - d. Ensure that various staff members are rotated to work with the client he or she is in the hospital**
110. Joe is a client of the psychiatric day treatment program. He has been referred by his probation officer for treatment after an arrest for driving under the influence of substances. Joe has a history of many arrests for assault, grand larceny, and other serious crimes and has served two prison sentences. His diagnosis is antisocial personality disorder. Which of the following quotes is Joe's most probable comment on his past behavior?
- a. "It's not my fault."**
 - "I'm too ashamed to talk about it."
 - "I just don't remember doing it."
 - "I'm really sorry about all the people I've hurt."
111. The physician prescribes an additional medication for a client on antipsychotic medication, with the order for it to be administered "p.r.n. for EPS." When should the nurse give this medication?
- When the client's white cell count falls below 3000 mm <sup>³
 - b. When the client exhibits tremors and shuffling gait**
 - When the client complains of dry mouth
 - When the client experiences a seizure
- 112.



1. When an individual's stress response is sustained over a long time, the endocrine system involvement results in:
 - a. **Decreased resistance to disease**
 - b. Increased libido
 - c. Decreased blood pressure
 - d. Increased inflammatory response
2. Which of the following symptoms would the nurse identify as typical of the "fight-or-flight" response?
 - a. Papillary constriction
 - b. **Increased heart rate**
 - c. Increased salivation
 - d. Increased peristalsis
3. Research undertaken by Holmes and Rahe in 1967 demonstrated a correlation between the effects of life change and illness. In the development of the Social Readjustment Rating Scale, which of the following concepts limits its effectiveness?
 - a. Stress overload always precipitate illness.
 - b. Individual abilities are activated.
 - c. Stress is viewed as a physiological response.
 - d. **Personal perception of the event is excluded.**
4. In the transactional model of stress/adaptation, secondary appraisal takes place if the individual judges an event to be:
 - a. Benign
 - b. Irrelevant
 - c. **Challenging**
 - d. Pleasurable
5. Diseases of adaptation occur when:
 - a. Individuals have not had to face stress in the past
 - b. Individuals inherit maladaptive genes
 - c. Predisposing factors fail
 - d. **Physiological and psychological resources become depleted**
6. Meditation has been shown to be an effective stress-management technique. Meditation works by:
 - a. **Producing a state of relaxation**
 - b. Providing insight into one's feeling
 - c. Promoting more appropriate role behaviors
 - d. Facilitating problem-solving ability
7. John, a 39-year-old Italian-American, lives in an ethnic community of Italian immigrants. He and most of his peers are of the lower socioeconomic class. Recently John was charged with an act of voyeurism. Which of the following individuals would be most likely to label John's behavior as mental illness?
 - a. John's parents, who are ashamed of his behavior
 - b. John's friend from his "Sons of Italy" social club
 - c. **Johns employer who owns the company where he works**
 - d. John's wife, who feels she must protect their children
8. Which of the following best describe the characteristics of panic-level anxiety?
 - a. Decreased attention span, hypotension, mild muscle tension
 - b. Frequent body changes, feeling of nervousness, enhanced learning
 - c. Narrow perceptual field, problem solving, mild gastric upset
 - d. **Feeling of losing control, misperceptions of the environment**
9. Anne tends to use the defense mechanism of displacement. Her husband, whom she loves very much, yells at her for not having dinner ready when he comes home from work. She is most likely to react by:
 - a. Telling her husband he has no right to yell at her.
 - b. **Yelling at their son for slouching in his chair.**
 - c. Burning dinner.
 - d. Saying to her husband, "I'll try to do better tomorrow."
10. Nancy hates her mother, who paid little attention to Nancy when she was growing up. Nancy uses the defense mechanism of reaction formation. Which of the following statements represents this defense mechanism?
 - a. "I don't like to talk about my relationship with my mother."
 - b. "It's my mother's fault that I feel this way."
 - c. **"I have a very wonderful mother whom I love very much."**
 - d. "My mom always loved my sister more than she loved me."
11. Jack and Jill were recently divorced. Jill was devastated by the divorce and became very depressed. She sought counseling at the community mental health center. Which of the following statements by Jill would indicate that she has resolved the grief over loss of her marriage?
 - a. "I know things would be different if we could only try again."
 - b. "He will be back. I know he will."
 - c. "I'm sure I did lots of things to provoke his anger."
 - d. **"Yes, it was a difficult relationship, and he abused the children and me."**
12. Sarah's husband Frank died 23 years ago. She has not changed a thing in their house since he died. She still has all of Frank's clothing in his closet, and his house slippers are still beside the bed where they were when he died. Sarah talks about Frank unceasingly to anyone who will listen. Which of the following pathological grief responses is Sarah exhibiting?
 - a. Inhibited
 - b. **Prolonged**
 - c. Delayed
 - d. Distorted
13. The main difference between neurotic and psychotic behavior is that people experiencing neuroses
 - a. Are unaware that they are experiencing distress
 - b. Are unaware that their behaviors are maladaptive
 - c. Are aware of possible psychological causes of their behavior
 - d. **Experience no loss of contact with reality**

15. Situation: Mrs. K is 78 years old. She has been admitted to the psychiatric unit of a large hospital because she is depressed and told her daughter she no longer had anything to live for. She threatened to swallow her whole bottle of antihypertensive medication.
16. . Theoretically, in which level of psychological development (according to Erikson) would you place Mrs. K?
 - a. Trust versus mistrust
 - b. Industry versus inferiority
 - c. Generativity versus stagnation
 - d. **Ego integrity versus despair**
17. Mrs. K lives alone. She has been married and divorced five times. She told the nurse, "Every time I got married, I thought it was for the rest of my life; but every time, we just couldn't get along. I like to be independent. I want to do what I want to do, when I want to do it, and I don't want some man getting in my way! Men are all alike. They think they own their wives. Well, not me!" According to Erikson's theory, where would you place Mrs. K. based on her behavior/
 - a. Trust versus mistrust, based on suspiciousness of others
 - b. **Industry versus inferiority, based on difficulty in interpersonal relationship due to feelings of inadequacy**
 - c. Generativity versus stagnation, based on lack of concern for the welfare of others
 - d. Ego integrity versus despair, based on sense of self-contempt and disgust with how life has progressed
18. On the unit, she is quarrelsome with the other clients. She changes the TV channel to what she wants to watch without consulting the group; she interrupts in group therapy to discuss her own situation when the focus is on another person; and most of the time, she prefers to stay in her room alone, rather than interact with the other clients. In what stage of development is Mrs. K fixed according to Sullivan's interpersonal theory/
 - a. Infancy: She relieves anxiety through oral gratification.
 - b. **Childhood: She has not learned to delay gratification.**
 - c. Early adolescence: She is struggling to form an identity.
 - d. Late adolescent: She is working to develop a lasting relationship.
19. . Which of the following describes the psychoanalytical structure of Mrs. K's personality/
 - a. Weak id, strong ego, weak superego
 - b. Strong id, weak ego, weak superego
 - c. Weak id, weak ego, punitive superego
 - d. **Strong id, weak ego, punitive superego**
18. Which of the following cerebral structures is sometimes referred to as the "emotional brain?"
 - a. The cerebellum
 - b. **The limbic system**
 - c. The cortex
 - d. The left temporal lobe
19. Carl's wife of 34 years died unexpectedly 2 months ago. He is very depressed and is visited at home weekly by a community mental health nurse. The nurse encourages Carl to talk about his wife, their life together, and what he's lost with her death. In addition, at each visit she strongly reinforces the need for Carl to eat properly and get daily exercise and adequate rest. She emphasizes these self-care activities primarily because:
 - a. The nurse is substituting for Carl's wife
 - b. Carl has developed bad habits since his wife's death
 - c. It is routine practice to remind patients about nutrition, exercise, and rest
 - d. **Carl is more susceptible to illness because of his depression**
20. Increased dopamine may play a significant role in which of the following illnesses?
 - a. Alzheimer's disease
 - b. **Schizophrenia**
 - c. Anxiety disorders
 - d. Depression
21. Decreased norepinephrine may play a significant role in which of the following illnesses?
 - a. Alzheimer's disease
 - b. Schizophrenia
 - c. Anxiety disorders
 - d. **Depression**
22. Decreased gamma-aminobutyric acid (GABA) may play a significant role in which of the following illnesses?
 - a. Alzheimer's disease
 - b. Schizophrenia
 - c. **Anxiety disorders**
 - d. Depression
23. Decreased acetylcholine may play a significant role in which of the following illnesses?
 - a. **Alzheimer's disease**
 - b. Schizophrenia
 - c. Anxiety disorders
 - d. Depression
24. Elevated levels of the cortisol may play a role in which of the following illnesses?
 - a. Acute mania
 - b. Schizophrenia
 - c. **Anorexia nervosa**
 - d. Alzheimer's disease
25. Elevated levels of thyroxine hormone may play a role in which of the following illnesses?
 - a. **Acute mania**
 - b. Schizophrenia
 - c. Anorexia nervosa
 - d. Alzheimer's disease
26. Decreased levels of hormones prolactin may play a role in which of the following illnesses?
 - a. Acute mania
 - b. **Schizophrenia**
 - c. Anorexia nervosa
 - d. Alzheimer's disease
27. When there is congruence between what the nurse is feeling and what is being expressed, the nurse is conveying
 - a. Respect
 - b. **Genuineness**
 - c. Sympathy
 - d. Rapport
28. Which of the following tasks takes place during the working phase of relationship development?
 - a. Establishing a contract for intervention
 - b. Examining feelings about working with a particular client
 - c. Establishing a plan for continuing aftercare
 - d. **Promoting the client's insight and perception of reality**
29. The Johari Window is a representation of the self and a tool that can be used to increase self-awareness. Because Nurse J. suppresses painful memories of an abortion, she would prefer not to discuss these issues with anyone. However, she volunteers her time to counsel potential abortion clients at the women's clinic. In the Johari Window, this is an example of:
 - a. The Open or Public Self
 - b. The Unknowing Self
 - c. **The Private Self**
 - d. The Unknown Self

- e.
 - f. Situation: Roy is a client on the psychiatric unit. He has a diagnosis of antisocial personality disorder. Jack is assigned as Roy's nurse
30. Occasionally, Roy loses his temper and expresses his anger inappropriately. Which of the following statements would be appropriate feedback for Roy's angry outbursts?
 - a. "You were very rude to interrupt the group the way you did."
 - b. "You accomplish nothing when you lose your temper like that."
 - c. "Showing your anger in that manner is very childish and insensitive"
 - d. **"You became angry in group, raised your voice, stomped out, and slammed the door."**
 31. Roy says to Jack, "I don't belong in this place with all these loonies. My doctor must be crazy!" Which of the following responses by Jack is most appropriate?
 - a. **"You are here for a psychological evaluation."**
 - b. "I'm sure your doctor has your best interests in mind."
 - c. "Why do you think you don't belong here?"
 - d. "Just bide your time. You'll be out of here soon."
 32. Nancy, a pregnant adolescent, asks the nurse on the psychiatric unit, "Do you think I should give my baby up for adoption?" Which of the following statements by the nurse is most appropriate?
 - a. "It would probably be best for you and the baby."
 - b. "Why would you want to give it up for adoption?"
 - c. **"What do you think would be the best thing for you to do?"**
 - d. "I'm afraid you would feel very guilty afterward if you gave your baby away."
 33. The purpose of providing feedback is to:
 - a. Give the patient good advice
 - b. Tell the patient how to behave
 - c. Evaluate the patient's behavior
 - d. **Give the patient information**
 34. When interviewing a psychiatric client, which of the following nonverbal behaviors should the nurse be careful to avoid?
 - a. Maintaining eye contact
 - b. **Leaning back with arms crossed**
 - c. Sitting directly facing the client
 - d. Smiling
 35. Laura is a nurse on an inpatient psychiatric unit. Much of her time is spent observing client activity, talking with clients, and striving to maintain a therapeutic environment in collaboration with other health care providers. This specific example of the implementation step of the nursing process is called:
 - a. Health teaching
 - b. Case management
 - c. **Milieu therapy**
 - d. Self-care activities
 36. Which of the following statements about nursing diagnosis is true?
 - a. Nursing diagnosis is a brand new concept.
 - b. All nurse are required by law to write nursing diagnoses
 - c. All nursing diagnoses must be approved by North American Nursing Diagnosis Association
 - d. **Nursing diagnoses are client responses to actual or potential health problems.**
 37. Which of the following statements is not true about outcomes?
 - a. **Expected outcomes are specifically formulated by the nurse.**
 - b. Expected outcomes are derived from the nursing diagnosis.
 - c. Expected outcomes must be measureable and estimate a time for attainment.
 - d. Expected outcomes must be realistic for the client's capabilities.
 38. Nursing diagnoses are prioritized according to:
 - a. The established goal of care
 - b. **The life-threatening potential**
 - c. The nurse's priority of care
 - d. The specific focus of problem resolution
 39. The purpose of case management is to attempt to:
 - a. Improve the medical welfare system
 - b. Ensure that all individuals have medical coverage
 - c. **Maintain a balance between costs and quality of care**
 - d. Increase hospital lengths of stay for chronically ill individuals
 40. Situation: Jane, a psychiatric nurse, leads a supportive-therapeutic group on the psychiatric unit.
 41. It is an open group, and clients come and go within the group as they are admitted to and discharged from the unit. Members discuss unresolved issues and ways to cope with stress in their lives. One evening when the group was breaking up, Jane heard one client say to another, "I never thought that other people had the same problems that I have." This statement represents which of Yalom's curative factors?
 - a. Catharsis
 - b. Group cohesiveness
 - c. **Universality**
 - d. Imitative behavior
 42. Meredith has been in a supportive-therapeutic group on the psychiatric unit for 2 weeks now. She dominates the conversation and does not permit other to participate. Meredith is assuming which of the following roles within the group?
 - a. Aggressor
 - b. Dominator
 - c. Recognition seeker
 - d. **Monopolizer**
 43. One evening, several of the group members spoke up in group and expressed their satisfaction that Meredith, a group member, had been dominating the conversation and not permitting others to participate. They encouraged others in the group to express their feelings as well. Together, they decided that from then on all members who wished to do so would get a turn to talk in group, and time would be monitor so that everyone would get their turn. Jane remained silent during this group interaction. Which type of leadership style does Jane demonstrate?
 - a. Autocratic
 - b. Democratic
 - c. **Laissez-faire**
 - d. None of the above

- e.
44. Although Meredith, talks a lot in group, Jane, the psychiatric nurse group leader, notices that much of her expression are kept on a superficial level. Jane decides that Meredith might benefit from psychodrama. She makes a referral for Meredith to the psychodramatist. Which of the following statements is not true about psychodrama?
- It provides a safe setting in which to discuss painful issues.
 - Peers will act out roles that represent individuals with whom Meredith has unresolved conflicts.
 - Meredith can choose who will play the role of her, while she observes the interaction from the audience.**
 - After the drama has been completed, a discussion will be held with members of the audience.
45. Michael, a registered nurse with 3 years experience on a psychiatric inpatient unit, has taken a position in a day treatment program, where he will be leading some groups. Which of the following groups is Michael qualified to lead?
- A parenting group**
 - A psychotherapy group
 - A psychodrama group
 - A family therapy group
- e.
- f. Situation: Sam and Carla have been married for 18 years. They have two children: a boy, Franklin, age 17, and a girl, Natalie, age 15. Natalie recently took an overdose of Aprazolam that she found in her parents' medicine cabinet. She was in the hospital for a week and diagnosed with depression. This family seeks counseling at the community mental health center.
46. Natalie says to the nurse, "I just want to go out and do things like all the rest of the kids. Mom says it's okay, but Dad says I'm too young." In the structural model of family therapy, which of the following has occurred?
- Multigenerational transmission
 - Disengagement
 - Mother-daughter subsystem**
 - Emotional cutoff
47. Sam and Natalie start to argue, and Sam states, "Your brother never gave us this kind of trouble. Why can't you be more like him?" This is an example of:
- Triangulation**
 - Pseudohostility
 - Double-bind communication
 - Pseudomutuality
- 48.
49. As the nurse continues to take notes of the initial family visit, she writes, "marital schism." What does this mean?
- Sam and Carla have a compatible marriage relationship
 - Sam has a dominant relationship over Carla
 - Sam and Carla have an enmeshed relationship
 - Sam and Carla have an incompatible marriage relationship**
50. Sam says to Carla, "What you need to do is spend more time with the family!" Carla responds, "Okay, I'll turn in my resignation at the office tomorrow." To this Sam replies, "Just as I thought! You've always been a quitter!" This is an example of:
- Emotional cutoff
 - Double-bind communication**
 - Indirect messages
 - Avoidance
51. Carla says to the nurse, "Every time we start to discuss rules for the children, we get into shouting matches. We can't ever settle on anything. We just shout at each other." The nurse instruct Sam and Carla to shout at each other for the next 2 weeks on Tuesdays and Thursday from 6:30 to 7 PM This intervention is called:
- Reframing
 - Restructuring the family
 - Expressive psychotherapy
 - Paradoxical intervention**
52. Which of the following statements is true about milieu therapy?
- Punishments are used to eliminate negative behaviors.
 - Interpersonal therapy is the foundation for the program of treatment.
 - Staff performs all activities of care for the clients.
 - The environment is structured so that stresses are used as opportunities for learning.**
53. To reinforce the democratic form of self-government on a milieu unit
- Clients are allowed to set forth the type of punishment for a peer who violates the rules
 - Clients may choose whether or not to attend daily community meetings
 - Clients participate in decision making that affects management of the unit**
 - Professional staff does not attend community meetings
- e.
- f. Situation: Jack is a client on the psychiatric unit. At community meeting, Jack expressed which movie he wanted to see that night. His choice was denied due to majority. At movie time that evening, Jack put the tape he wanted to view into the VCR. He was reprimanded by his peers, who removed the tape and put in the voted on by the majority.
54. This is an example of which basic assumption of milieu therapy?
- Every interaction is an opportunity for therapeutic intervention
 - Peer pressure is a useful and powerful tool**
 - Restrictions and punishment are to be avoided
 - The client owns his or her own environment
55. The psychiatrist decides to have Jack undergo psychological testing. Which of the following members of the interdisciplinary team would Jack's psychiatrist consult for this purpose?
- The occupational therapist
 - The psychiatrist social worker
 - The clinical psychologist**
 - The clinical nurse specialist
56. Which of the following best describes the role of the nurse in the therapeutic milieu of a psychiatric unit?
- The treatment team member who is responsible for management of the therapeutic milieu**
 - The treatment team member who develops the medical diagnosis for all clients on the unit
 - The treatment team member who provides for the spiritual and comfort needs of the client and his or her family

- d. The treatment team member who conducts individual, group, and family therapy after an in-depth psychosocial history.
 - e.
57. Situation: On Thursday, Camille, a college junior, is accompanied to the student health center by her roommate, Nancy. Nancy explains to the nurse that for 3 days Camille has been unable to attend her classes, has cried constantly, and has become panicky whenever Nancy leaves to go to classes and meals. The nurse performs an assessment and finds that Camille does not know the date and has difficulty with short-term memory. Nancy is not aware that Camille has received any bad news recently, but she offers that Camille is a good student and has been spending long hours at the computer center for nearly 2 weeks working on a major class project, usually returning to the dorm after Nancy is asleep. This is the strategy she has successfully used when working on projects in the past and was the strategy employed through Monday of this week.
58. What crucial information is missing that will most assist the nurse to plan interventions that will be helpful for Camille?
- a. **Precipitating stressor**
 - b. Camille's usual ability to cope with stress
 - c. How far away Camille's home and parents are
 - d. The due date of Camille's project
59. Camille reports to the student health nurse that she was nearly raped on Monday night when she took a shortcut on her way from the computer center to her dorm. She is referred to a nurse who is trained as a rape crisis counselor, who schedules appointments three times a week for 3 weeks. At the first session, Camille announces that she has decided to quit school and return home. What is the most therapeutic response for the counselor to make?
- a. "I'm confident you know what's best for you."
 - b. **"This is not a good time for you to make such an important decision."**
 - c. "Your mother and father will be terribly disappointment."
 - d. "What will you do if you go home?"
60. This is an example of which of the following types of crises?
- a. A psychiatric emergency
 - b. A crisis of anticipated life transition
 - c. A crisis reflecting psychopathology
 - d. **A crisis resulting from traumatic stress**
61. Camille reports to the student health nurse that she was nearly raped on Monday night when she took a shortcut on her way from the computer center to her dorm. She is referred to a nurse who is trained as a rape crisis counselor, who schedules appointments three times a week for 3 weeks. In her interventions with Camille, which of the following therapeutic approaches would best be implemented by the nurse?
- a. A psychoanalytic approach
 - b. A psychodynamic approach
 - c. **A reality-oriented approach**
 - d. A family-oriented approach
62. She is referred to a nurse who is trained as a rape crisis counselor, who schedules appointments three times a week for 3 weeks. During the final two sessions, Camille and the counselor review the work they have done together. Which of the following statements by Camille would most clearly suggest that the goals of crisis intervention have been met?
- a. "Thanks a lot. You've really been helpful. I'll miss working with you."
 - b. "My instructor gave me a 3-week extension on my project."
 - c. "I'm really glad I didn't go home. It would have been hard to come back."
 - d. **"I'm wearing the whistle my dad gave me when I go out walking. I've practiced using it, too."**
63. Which of the following is known to be a physiological manifestation of relaxation?
- a. Increased levels of norepinephrine
 - b. Pupil dilation
 - c. **Reduced metabolic rate**
 - d. Increased blood sugar level
64. Ellen is a registered nurse who works in an employee health facility for a large corporation. She teaches many kinds of preventive health care strategies to the employees, among them relaxation therapy. Which of the following is Ellen likely to teach as a beginning technique and is useful in conjunction with many other forms of relaxation therapy?
- a. **Deep-breathing exercise**
 - b. Mental imagery
 - c. Biofeedback
 - d. Meditation
65. Physical exercises is an effective relaxation technique because it
- a. Stresses and strengthen the cardiovascular system
 - b. Decreases the metabolic rate
 - c. Decreases levels of norepinephrine into the brain
 - d. **Provides a natural outlet for release of muscle tension**
66. Which of the following relaxation techniques is thought to improve concentration and attention?
- a. Biofeedback
 - b. Physical exercise
 - c. **Meditation**
 - d. Mental imagery
- e. Situation: Tracy, a registered nurse and new graduate from the local university, is beginning her first position in a medical-surgical unit where clients from the psychiatric unit often receive care.
67. Which of the following best describes Tracy's use of assertiveness behavior?
- a. Tracy attempts to please others and apologizes for her awkwardness in her new role.
 - b. Tracy frequently stands up for herself by defending her behavior to the nurse manager.
 - c. Tracy has some problems making decisions and has a tendency to procrastinate with the work.
 - d. **Tracy is open and direct with the nurse manager when asked to complete her assignments.**
68. Tracy is working with a male client who is complaining about the attention he is receiving. She responds to him calmly and nondefensively, "You are very angry right now. I don't want to discuss this with you while you

are so upset. I will be back in 1 hour to meet with you, and we will talk about it then.” This is an example of which of the following assertive techniques?

- f. **a. Defusing**
- b. Clouding or fogging
- c. Responding as a broken record
- d. Shifting from content to process

69. Tracy works with her clients to teach assertiveness and ways in which they can improve their communication. Which of the following nursing diagnoses is selected for clients needing assistance with assertiveness?

- a. Impaired adjustment
- b. Altered thought process
- c. **Defensive coping**
- d. Impaired verbal communication

70. The goal of assertive skills training is to:

- a. Help clients explain themselves and their life-cycle events, and to assist them in resolving problems
- b. Give reliable, expert information so that clients may correct faulty behaviors
- c. Clarify misconceptions and misperceptions that have caused clients to distort reality
- d. **Improve communication skill in an effort to improve interpersonal relationship**

71. Tracy has worked 10 days straight when her nurse manager approaches her with a request to stay on the 3 to 11 shift and work a double shift. Which of the following represents a passive-aggressive response on Tracy's part?

- a. “Get someone else to work 3 to 11! I’ve been working 10 days straight and I need a break!”
- b. **“Okay. I’ll do it,” then purposefully leaving tasks undone when she leaves the unit at 11 pm**
- c. “I have worked 10 days straight and I cannot work tonight. I will work for you tomorrow if you need me.”
- d. “Yes, I’ll do it. Anything to keep peace with the staff is a good thing, I guess.”

72. 69. Before initiating a psychopharmacological treatment, a thorough evaluation includes the following except;

- 73. **a. Family History**
- 74. b. Medication
- 75. c. Mental status evaluation
- 76. d. Coping mechanism

77. Situation: Allen is a 37-year-old man who has never married and has remained at home with his aging mother. He has not worked since he had a paper route as a teenager so that he can remain at home to care for his mother. She gives him a weekly allowance out of an estate left to her by her late husband, who died when Allen was 15 years old. A community health nurse visits the family once a month to administer vitamin B 12 injections to the mother. On one of these visits, Allen confides to the nurse that he is terrified of what will happen to him should his mother die.

70. The nurse recognizes that Allen has low self-esteem related to failure at which of Erikson's developmental tasks?

- a. Trust versus mistrust
- b. Initiative versus guilt
- c. **Identity versus role confusion**
- d. Ego integrity versus despair

71. . She notices that Allen demonstrates certain behaviors consistent with low self-esteem. Which of the following behaviors is Allen not likely to exhibit?

- a. Hostility
- b. **Meticulous grooming**
- c. Rumination about his situation
- d. Complaints of various aches and pains

72. What kind of boundaries does Allen appear to have relative to his mother?

- a. Loose
- b. Rigid
- c. Flexible
- d. **Enmeshed**

73. Although Allen's mother is the community health nurse's primary client, the nurse identifies Allen's need for intervention regarding his low-esteem. The nursing diagnosis she selects from which to identify goals and interventions is:

- a. Self-esteem disturbance
- b. **Chronic low self-esteem**
- c. Situational low self-esteem
- d. Social isolation

74. Allen has been diagnosed with chronic low self-esteem and is seeing a psychotherapist. After several months, the community health nurse who had made the referral notices some changes in Allen's behavior. Which of the following behaviors most clearly indicates improvement in Allen's self-esteem?

- a. He decides to save his money to buy a dog
- b. He asks his mother for permission to buy a dog
- c. **He tells his mother he plans to buy a dog**
- d. He buys a dog and hides it in the garage

78.

75. Anna is the charge nurse on a psychiatric unit in a large inner-city hospital. She carefully reviews clients' histories when making assignments so that the most experienced staff is assigned to clients who may become violent. Which of the following risk factors does Anna recognize as the most reliable indicator for a client becoming violent?

- a. Diagnosis of schizophrenia
- b. **Past history of violence**
- c. Family history of violence
- d. Tense posture and agitation

76. John, who has a diagnosis of paranoid schizophrenia, is admitted to Anna's unit after attempting to injure his father with a butcher knife. The nurse who writes John care's plan gives him the priority nursing diagnosis of Risk for violence towards others. Which of the following is the priority goal for John during his hospitalization?
- The client will not verbalize anger or hit anyone
 - The client will verbalize anger rather than hit others
 - The client will not harm self or others**
 - The client will be restrained if he becomes verbally or physically abusive
77. Because of the frequency with which they deal with violent clients, nurses on psychiatric units commonly have violence intervention protocols. Which of the following interventions would be contraindicated as part of such a protocol?
- Administration of psychotropic medication
 - Soothing the client by stroking an arm or shoulder**
 - Application of leather restraints
 - Observation for symptoms of the preassaultive tension state
78. A client with a history of violence begins to lose control of his anger, and the nurse decides intervention must occur. The client cannot be "talked down," and he refuses medication. The nurse should then:
- Call for assistance from the assault team**
 - Ask the ward clerk to put in a call for the physician
 - Make the client go to his room
 - Tell the client if he doesn't calm down, he will be placed in restraints
79. A client who becomes violent is placed in restraints, after which the nurse administers the p.r.n. dose of neuroleptics medication that the client had previously refused. Which of the following statements is true regarding this intervention?
- The physician must leave a standing order for this intervention to be appropriate
 - The nurse who intervenes in this manner is setting himself or herself up for a lawsuit, because the client always has a right to refuse medication
 - The physician must write an order to cover the nurse's actions after the intervention has taken place.
 - Most states consider this intervention appropriate in emergency situations or if a client would likely harm self or others,**
79. Situation: Edward is a 67 – year – old white lawyer who has been diagnosed with major depression. He was widowed 3 years ago and has had no interest in attending synagogue services since that time. He has taken fluoxetine (Prozac) for several years. He had made a suicide attempt 45 years ago during his first year in law school. He has been transported to the emergency department by ambulance after telling his son he was thinking of swallowing his whole bottle of flouxetine.
80. How many risk factors for suicide will the triage nurse document?
- Three
 - Five
 - Seven**
 - Nine
81. The nurse initiates suicidal precautions for Edward. She understands that which of the following statements regarding suicide is correct?
- The more specific the plan is, the more likely the client will attempt suicide**
 - Client who talk about suicide never actually commit it
 - The client who fails to complete a suicide attempt will not try again
 - The nurse should refrain from actually saying the word "suicide", because they may give client ideas
82. In creating the care plan for Edward, which of the following would be priority nursing diagnosis?
- Risk for self – mutilation related to low self – esteem
 - Risk for self – directed violence related to depressed mood**
 - Dysfunctional grieving related to unresolved loss
 - Powerlessness related to dysfunctional grieving process
83. What is the most immediate outcome criterion for a suicidal client?
- The client will not physically harm himself**
 - The client will express hope for the future
 - The client will reveal his suicide plan
 - The client will establish a trusting relationship with the nurse
84. Which of the following interventions is not consistent with the outcome criteria for a suicidal client?
- Accept the client with unconditional positive regard
 - Encourage the client to talk about his or her pain
 - Provide the client with tasks to occupy himself or herself
 - Provide the client with ample privacy**
85. Edward says to the nurse, "There's nothing to live for anymore." What is the nurse's most therapeutic response?
- "Now, Edward, , I you know that isn't true."
 - "In your situation, I might feel the same way."
 - "Things will look better in the morning."
 - "It sounds like you are feeling pretty hopeless."**
86. Gloria a single mother has been attending parenting classes with her 9 year old son, Phil. She wants him to begin doing some chores and asks him to clean his room. When she checks on him, she discovers she has picked up everything on the floor and tossed it on a chair. She says, "You've done a nice job of picking up things off the floor." This is consistent with which technique of behavior modification?
- Shaping**
 - Modeling
 - Contracting
 - Premack principle

87. Gloria responds to an advertisement in the local newspaper soliciting subjects for a research program to investigate effective ways to stop smoking. She is told that she will be assigned to a group that will use a reciprocal inhibition technique. Which of the following exercises is based on reciprocal inhibition?
- Before she can smoke, she must first take a half – hour walk
 - When she has the urge to smoke, she is to imagine herself as short of breath
 - She will be paid \$1 for each cigarette she does not smoke and must forfeit \$2 for each cigarette that she does not smoke
 - When she has the urge to smoke, she must first hold her breath to a count of 30, then perform a rhythmic breathing exercise to a count of 100**
80. Situation: Claudia has been seeing a psychotherapist for treatment of phobia of spiders.
88. Her therapist has begun a program of systematic desensitization. Which of the following interventions would not be a part of this behavior modification technique?
- Breathing exercises
 - One – hour audiotope describing being in a room full of spiders**
 - A visit to an insect zoo with the psychotherapist
 - Self – paced computer program presenting progressively more anxiety – producing scenarios regarding spiders
89. Her therapist decides to use the technique of “flooding”. Which of the following interventions describes use of this technique?
- A system of rewards for demonstrating decrease in fear of spiders
 - Use of a 1 – hour audiotope describing being in a room full of spiders**
 - A visit to an insect zoo with the psychotherapist
 - Self – paced computer program presenting progressively more anxiety – producing scenarios regarding spiders
90. Tony is a 20 – year old with a history of suicide attempts of low – to – moderate lethality. He has been seeing Norman, a nurse psychotherapist, for 4 years. Late one Friday evening Norman receives a telephone call from Tony, who informs Norman that he has ingested half a bottle of aspirin. Norman advises Tony call 911 for emergency assistance and says that he (Norman) will be available to reschedule a psychotherapy appointment when Tony has recovered. What is the explanation for Norman’s behavior?
- Norman is using an aversive stimulus in response to Tony’s suicide attempt
 - Norman is using negative reinforcement in response to Tony’s suicide attempt
 - Norman is minimizing reinforcement of Tony’s suicidal behavior with the goal of extinction**
 - Norman lacks empathy for Tony’s recurring suicidal behavior
81. SITUATION: Nancy is an 18 – year – old highschool senior. She has dreamed of attending a large Ivy League college when she graduates. She has received rejection letters from all such colleges to which she has applied because of inadequate GPA and SAT scores. She is devastated and becomes depressed. She is referred to Carol, a nurse psychotherapist. Nancy says to Carol, “I guess I’ll just have to forget about going to college. I’m just not good enough.”
91. This is an example of:
- Arbitrary inference
 - Overgeneralization**
 - Dichotomous thinking
 - Personalization
92. Carol responds to Nancy’s statement, “I thought you had received a scholarship to the local university.” To this, Nancy replies, “Oh, that doesn’t count.” This is an example of:
- Magnification
 - Minimization
 - Selective abstraction**
 - Catastrophic thinking
93. Carol wants to help Nancy by using problem solving. Which of the following represents intervention with this technique?
- “Let’s look at what your alternatives are.”**
 - “I know you are feeling unhappy now, but things will get better.”
 - “Tell me what you are thinking now.”
 - “When you start to think about rejections, I want you to switch thinking about something else.”
94. Carol, a nurse psychotherapist, uses cognitive therapy with her depressed clients. She asks them to keep a daily record of dysfunctional thoughts. The purpose of this tool in cognitive therapy is to:
- Identify automatic thoughts
 - Modify automatic thoughts**
 - Identify rational alternatives
 - All of the above
95. The nursing diagnosis that Carol would most likely choose to work with Nancy during this period would be:
- Chronic low self – esteem
 - Risk for self – directed violence
 - Powerlessness
 - Situational low self – esteem**
96. Carol has made an appointment to see her primary care provider because of increased anxiety. She sees a nurse practitioner who does a physical examination and takes a detailed history. The psychiatrist diagnoses Carol with anxiety disorder. Which of the following medications is prescribed for anxiety?
- Chlorpromazine (Thorazine)
 - Imipramine (Elavil)
 - Diazepam (Valium)**
 - Methylphenidate (Ritalin)
97. Which of the following data would suggest that caution is necessary in prescribing a benzodiazepine to an anxious client?
- The client has a history of alcohol independence**
 - The client has a history of diabetes mellitus
 - The client has a history of schizophrenia

- d. The client has a history of hypertension
98. Peter has been diagnosed with major depression. His psychiatrist prescribes imipramine (Tofranil). What information is specifically related to this class of antidepressants and should be included in client and family education?
- a. The medication may cause dry mouth
 - b. The medication may cause constipation
 - c. The medication should not be discontinued abruptly
 - d. **The medication may cause photosensitivity**
99. A psychiatrist prescribes monoamine oxidase inhibitor for a client. When teaching the client about the effects of tyramine, which of the following foods and/or medications will the nurse caution the client not to consume?
- a. **Pepperoni pizza and red wine**
 - b. Bagels with cream cheese and tea
 - c. Apple pie and coffee
 - d. Potato chips and diet coke
100. Alex, a 24 – year – old graduate student, is taken to the ED by one of his classmates because of increased suspiciousness and auditory hallucinations. He keeps asking others what they are whispering about him. The nurse who takes his history discovers that he has a history of depression and has been taking desipramine (Norpramine) for 3 years. He is in good physical health but has allergies to penicillin, prochlorperazine (Compazine), and bee stings. Although a definitive diagnosis is not made, it is clear that Alex is experiencing a psychotic episode. Using the assessment data gathered on admission, which of the following antipsychotic medications would be contraindicated for Alex?
- a. Haloperidol, because it is intended for use only with elderly patients and would not be effective for Alex
 - b. Clozapine, because it is incompatible with desipramine
 - c. Risperidone, because it exacerbates symptoms of depression
 - d. **Thioridazine, because of cross- sensitivity among phenothiazines**
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- 102.

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