NURSING PRACTICE V- Care of Clients with Physiologic and Psychosocial Alterations

1. Mr. Marquez reports of losing his job, not being able to sleep at night, and feeling upset with his wife. Nurse John responds to the client, “You may want to talk about your employment situation in group today.” The Nurse is using which therapeutic technique?
   a. Observations
   b. Restating
   c. Exploring
   d. Focusing

2. Tony refuses his evening dose of Haloperidol (Haldol), then becomes extremely agitated in the dayroom while other clients are watching television. He begins cursing and throwing furniture. Nurse Oliver first action is to:
   a. Check the client’s medical record for an order for an as-needed I.M. dose of medication for agitation.
   b. Place the client in full leather restraints.
   c. Call the attending physician and report the behavior.
   d. Remove all other clients from the dayroom.

3. Tina who is manic, but not yet on medication, comes to the drug treatment center. The nurse would not let this client join the group session because:
   a. The client is disruptive.
   b. The client is harmful to self.
   c. The client is harmful to others.
   d. The client needs to be on medication first.

4. Dervid, an adolescent boy was admitted for substance abuse and hallucinations. The client’s mother asks Nurse Armando to talk with his husband when he arrives at the hospital. The mother says that she is afraid of what the father might say to the boy. The most appropriate nursing intervention would be to:
   a. Inform the mother that she and the father can work through this problem themselves.
   b. Refer the mother to the hospital social worker.
   c. Agree to talk with the mother and the father together.
   d. Suggest that the father and son work things out.

5. What is Nurse John likely to note in a male client being admitted for alcohol withdrawal?
   a. Perceptual disorders.
   b. Impending coma.
   c. Recent alcohol intake.
   d. Depression with mutism.

6. Aira has taken amitriptyline HCL (Elavil) for 3 days, but now complains that it “doesn’t help” and refuses to take it. What should the nurse say or do?
   a. Withhold the drug.
   b. Record the client’s response.
   c. Encourage the client to tell the doctor.
   d. Suggest that it takes awhile before seeing the results.

7. Dervid, an adolescent has a history of truancy from school, running away from home and “barrowing” other people’s things without their permission. The adolescent denies stealing, rationalizing instead that as long as no one was using the items, it was all right to borrow them. It is important for the nurse to understand the psychodynamically, this behavior may be largely attributed to a developmental defect related to the:
   a. Id
   b. Ego
c. Superego
d. Oedipal complex

8. In preparing a female client for electroconvulsive therapy (ECT), Nurse Michelle knows that succinylcholine (Anectine) will be administered for which therapeutic effect?

a. Short-acting anesthesia
b. Decreased oral and respiratory secretions.
c. Skeletal muscle paralysis.
d. Analgesia.

9. Nurse Gina is aware that the dietary implications for a client in manic phase of bipolar disorder is:

a. Serve the client a bowl of soup, buttered French bread, and apple slices.
b. Increase calories, decrease fat, and decrease protein.
c. Give the client pieces of cut-up steak, carrots, and an apple.
d. Increase calories, carbohydrates, and protein.

10. What parental behavior toward a child during an admission procedure should cause Nurse Ron to suspect child abuse?

a. Flat affect
b. Expressing guilt
c. Acting overly solicitous toward the child.
d. Ignoring the child.

11. Nurse Lynnette notices that a female client with obsessive-compulsive disorder washes her hands for long periods each day. How should the nurse respond to this compulsive behavior?

a. By designating 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 attempting to prevent the behavior.
d. By discouraging the client from verbalizing anxieties.

12. After seeking help at an outpatient mental health clinic, Ruby who was raped while walking her dog is diagnosed with posttraumatic stress disorder (PTSD). Three months later, Ruby returns to the clinic, complaining of fear, loss of control, and helpless feelings. Which nursing intervention is most appropriate for Ruby?

a. Recommending a high-protein, low-fat diet.
b. Giving sleep medication, as prescribed, to restore a normal sleepwake cycle.
c. Allowing the client time to heal.
d. Exploring the meaning of the traumatic event with the client.

13. Meryl, age 19, is highly dependent on her parents and fears leaving home to go away to college. Shortly before the 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 her to the psychiatric unit where she is diagnosed with conversion disorder. Meryl asks the nurse, "Why has this happened to me?" What is the nurse's best response?

a. "You've developed this paralysis so you can stay with your parents. You must deal with this conflict if you want to walk again."
b. "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."
c. "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."
d. "It isn't uncommon for someone with your personality to develop a conversion disorder during times of stress."
14. Nurse Krina knows that the following drugs have been known to be effective in treating obsessive-compulsive disorder (OCD):

a. benztropine (Cogentin) and diphenhydramine (Benadryl).
b. chlordiazepoxide (Librium) and diazepam (Valium)
c. fluvoxamine (Luvox) and clomipramine (Anafranil)
d. divalproex (Depakote) and lithium (Lithobid)

15. Alfred was newly diagnosed with anxiety disorder. The physician prescribed buspirone (BuSpar). The nurse is aware that the teaching instructions for newly prescribed buspirone should include which of the following?

a. A warning about the drug’s delayed therapeutic effect, which is from 14 to 30 days.
b. A warning about the incidence of neuroleptic malignant syndrome (NMS).
c. A reminder of the need to schedule blood work in 1 week to check blood levels of the drug.
d. A warning that immediate sedation can occur with a resultant drop in pulse.

16. Richard with agoraphobia has been symptom-free for 4 months. Classic signs and symptoms of phobias include:

a. Insomnia and an inability to concentrate.
b. Severe anxiety and fear.
c. Depression and weight loss.
d. Withdrawal and failure to distinguish reality from fantasy.

17. Which medications have been found to help reduce or eliminate panic attacks?

a. Antidepressants
b. Anticholinergics
c. Antipsychotics
d. Mood stabilizers

18. A client seeks care because she feels depressed and has gained weight. To treat her atypical depression, the physician prescribes 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

19. A 65 years old client is in the first stage of Alzheimer's disease. Nurse Patricia 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 do together.

20. The nurse is assessing a client who has just been admitted to the emergency department. Which signs would suggest an overdose of an antianxiety agent?

a. Combativeness, sweating, and confusion
b. Agitation, hyperactivity, and grandiose ideation
c. Emotional lability, euphoria, and impaired memory
d. Suspiciousness, dilated pupils, and increased blood pressure
21. The nurse is caring for a client diagnosed with antisocial personality disorder. The client has a history of fighting, cruelty to animals, and stealing. Which of the following traits would the nurse be most 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

22. Nurse Amy is providing care for a male client undergoing opiate withdrawal. Opiate withdrawal causes severe physical discomfort and can be life-threatening. To minimize these effects, opiate users are commonly detoxified with:

a. Barbiturates  
b. Amphetamines  
c. Methadone  
d. Benzodiazepines

23. Nurse Cristina is caring for a client who experiences false sensory perceptions with no basis in reality. These perceptions are known as:

a. Delusions  
b. Hallucinations  
c. Loose associations  
d. Neologisms

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

a. Restricts visits with the family and friends until the client begins to eat.  
b. Provide privacy during meals.  
c. Set up a strict eating plan for the client.  
d. Encourage the client to exercise, which will reduce her anxiety.

25. Tim is admitted with a diagnosis of delusions of grandeur. The nurse is aware that this diagnosis reflects a belief that one is:

a. Highly important or famous.  
b. Being persecuted  
c. Connected to events unrelated to oneself  
d. Responsible for the evil in the world.

26. Nurse Jen is caring for a male client with manic depression. The plan of care for a client in a manic state would include:

a. Offering a high-calorie meal and strongly encouraging the client to finish all food.  
b. Insisting that the client remain active through the day so that he’ll sleep at night.  
c. Allowing the client to exhibit hyperactive, demanding, manipulative behavior without setting limits.  
d. Listening attentively with a neutral attitude and avoiding power struggles.

27. Ramon is admitted for detoxification after a cocaine overdose. The client tells the nurse that he frequently uses cocaine but that he can control his use if he chooses. Which coping mechanism is he using?

a. Withdrawal  
b. Logical thinking  
c. Repression  
d. Denial
28. Richard 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

29. Nurse Mickey is caring for a client diagnosed with bulimia. The most appropriate initial goal for a client diagnosed with bulimia is to:

a. Avoid shopping for large amounts of food.  
b. Control eating impulses.  
c. Identify anxiety-causing situations  
d. Eat only three meals per day.

30. Rudolf is admitted for an overdose of amphetamines. When assessing the client, the nurse should expect to see:

a. Tension and irritability  
b. Slow pulse  
c. Hypotension  
d. Constipation

31. Nicolas is experiencing hallucinations tells the nurse, “The voices are telling me I’m no good.” The client asks if the nurse hears the voices. The most appropriate response by the nurse would be:

a. “It is the voice of your conscience, which only you can control.”  
b. “No, I do not hear your voices, but I believe you can hear them”.  
c. “The voices are coming from within you and only you can hear them.”  
d. “Oh, the voices are a symptom of your illness; don’t pay any attention to them.”

32. The nurse is aware that the side effect of electroconvulsive therapy that a client may experience:

a. Loss of appetite  
b. Postural hypotension  
c. Confusion for a time after treatment  
d. Complete loss of memory for a time

33. A dying male client gradually moves toward resolution of feelings regarding impending death. Basing care on the theory of Kubler-Ross, Nurse Trish plans to use nonverbal interventions when assessment reveals that the client is in the:

a. Anger stage  
b. Denial stage  
c. Bargaining stage  
d. Acceptance stage

34. The outcome that is unrelated to a crisis state is:

a. Learning more constructive coping skills  
b. Decompensation to a lower level of functioning.  
c. Adaptation and a return to a prior level of functioning.  
d. A higher level of anxiety continuing for more than 3 months.

35. Miranda a psychiatric client is to be discharged with orders for haloperidol (haldol) therapy. When developing a teaching plan for discharge, the nurse should include cautioning the client against:
36. Jen, a nursing student, is anxious about the upcoming board examination but is able to study intently and does not become distracted by a roommate's talking and loud music. The student's ability to ignore distractions and to focus on studying demonstrates:

a. Mild-level anxiety
b. Panic-level anxiety
c. Severe-level anxiety
d. Moderate-level anxiety

37. When assessing a premorbid personality characteristics of a client with a major depression, it would be unusual for the nurse to find that this client demonstrated:

a. Rigidity
b. Stubbornness
c. Diverse interest
d. Over meticulousness

38. Nurse Krina recognizes that the suicidal risk for depressed client is greatest:

a. As their depression begins to improve
b. When their depression is most severe
c. Before any type of treatment is started
d. As they lose interest in the environment

39. Nurse Kate would expect that a client with vascular dementia would experience:

a. Loss of remote memory related to anoxia
b. Loss of abstract thinking related to emotional state
c. Inability to concentrate related to decreased stimuli
d. Disturbance in recalling recent events related to cerebral hypoxia.

40. Josefina is to be discharged on a regimen of lithium carbonate. In the teaching plan for discharge the nurse should include:

a. Advising the client to watch the diet carefully
b. Suggesting that the client take the pills with milk
c. Reminding the client that a CBC must be done once a month.
d. Encouraging the client to have blood levels checked as ordered.

41. The psychiatrist orders lithium carbonate 600 mg p.o t.i.d for a female client. Nurse Katrina would be aware that the teaching about the side effects of this drug were understood when the client states, “I will call my doctor immediately if I notice any:

a. Sensitivity to bright light or sun
b. Fine hand tremors or slurred speech
c. Sexual dysfunction or breast enlargement
d. Inability to urinate or difficulty when urinating

42. Nurse Mylene recognizes that the most important factor necessary for the establishment of trust in a critical care area is:

a. Privacy
b. Respect
c. Empathy
43. When establishing an initial nurse-client relationship, Nurse Hazel should explore with the client the:
   a. Client’s perception of the presenting problem.
   b. Occurrence of fantasies the client may experience.
   c. Details of any ritualistic acts carried out by the client.
   d. Client’s feelings when external controls are instituted.

44. Tranlcypromine sulfate (Parnate) is prescribed for a depressed client who has not responded to the tricyclic antidepressants. After teaching the client about the medication, Nurse Marian evaluates that learning has occurred when the client states, “I will avoid:
   a. Citrus fruit, tuna, and yellow vegetables.”
   b. Chocolate milk, aged cheese, and yogurt.”
   c. Green leafy vegetables, chicken, and milk.”
   d. Whole grains, red meats, and carbonated soda.”

45. Nurse John is aware that most crisis situations should resolve in about:
   a. 1 to 2 weeks
   b. 4 to 6 weeks
   c. 4 to 6 months
   d. 6 to 12 months

46. Nurse Judy knows that statistics show that in adolescent suicide behavior:
   a. Females use more dramatic methods than males
   b. Males account for more attempts than do females
   c. Females talk more about suicide before attempting it
   d. Males are more likely to use lethal methods than are females

47. Dervid with paranoid schizophrenia repeatedly uses profanity during an activity therapy session. Which response by the nurse would be most appropriate?
   a. “Your behavior won't be tolerated. Go to your room immediately.”
   b. “You're just doing this to get back at me for making you come to therapy.”
   c. “Your cursing is interrupting the activity. Take time out in your room for 10 minutes.”
   d. "I'm disappointed in you. You can't control yourself even for a few minutes.”

48. Nurse Maureen knows that the nonantipsychotic medication used to treat some clients with schizoaffective disorder is:
   a. phenelzine (Nardil)
   b. chlordiazepoxide (Librium)
   c. lithium carbonate (Lithane)
   d. imipramine (Tofranil)

49. Which information is most important for the nurse Trinity to include in a teaching plan for a male schizophrenic client taking clozapine (Clozaril)?
   a. Monthly blood tests will be necessary.
   b. Report a sore throat or fever to the physician immediately.
   c. Blood pressure must be monitored for hypertension.
   d. Stop the medication when symptoms subside.
50. Ricky with chronic schizophrenia takes neuroleptic medication is admitted to the psychiatric unit. Nursing assessment reveals rigidity, fever, hypertension, and diaphoresis. These findings suggest which lifethreatening reaction:

a. Tardive dyskinesia.
b. Dystonia.
c. Neuroleptic malignant syndrome.
d. Akathisia.

51. Which nursing intervention would be most appropriate if a male client develop orthostatic hypotension while taking amitriptyline (Elavil)?

a. Consulting with the physician about substituting a different type of antidepressant.
b. Advising the client to sit up for 1 minute before getting out of bed.
c. Instructing the client to double the dosage until the problem resolves.
d. Informing the client that this adverse reaction should disappear within 1 week.

52. Mr. Cruz visits the physician's office to seek treatment for depression, feelings of hopelessness, poor appetite, insomnia, fatigue, low selfesteem, poor concentration, and difficulty making decisions. The client states that these symptoms began at least 2 years ago. Based on this report, the nurse Tyfany suspects:

a. Cyclothymic disorder.
b. Atypical affective disorder.
c. Major depression.
d. Dysthymic disorder.

53. After taking an overdose of phenobarbital (Barbita), Mario is admitted to the emergency department. Dr. Trinidad prescribes activated charcoal (Charcocaps) to be administered by mouth immediately. Before administering the dose, the nurse verifies the dosage ordered. What is the usual minimum dose of activated charcoal?

a. 5 g mixed in 250 ml of water
b. 15 g mixed in 500 ml of water
c. 30 g mixed in 250 ml of water
d. 60 g mixed in 500 ml of water

54. What herbal medication for depression, widely used in Europe, is now being prescribed in the United States?

a. Ginkgo biloba
b. Echinacea
c. St. John's wort
d. Ephedra

55. Cely with manic episodes is taking lithium. Which electrolyte level should the nurse check before administering this medication?

a. Calcium
b. Sodium
c. Chloride
d. Potassium

56. Nurse Josefina 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.
57. Edward, a 66 year old client with slight memory impairment and poor concentration is diagnosed with primary degenerative dementia of the Alzheimer's type. Early signs of this dementia include subtle personality changes and withdrawal from social interactions. To assess for progression to the middle stage of Alzheimer's disease, the nurse should observe the client for:

a. Occasional irritable outbursts.
b. Impaired communication.
c. Lack of spontaneity.
d. Inability to perform self-care activities.

58. Isabel with a diagnosis of depression is started on imipramine (Tofranil), 75 mg by mouth at bedtime. The nurse should tell the client that:

a. This medication may be habit forming and will be discontinued as soon as the client feels better.
b. This medication has no serious adverse effects.
c. The client should avoid eating such foods as aged cheeses, yogurt, and chicken livers while taking the medication.
d. This medication may initially cause tiredness, which should become less bothersome over time.

59. Kathleen is admitted to the psychiatric clinic for treatment of anorexia nervosa. To promote the client's physical health, the nurse should plan to:

a. Severely restrict the client's physical activities.
b. Weigh the client daily, after the evening meal.
c. Monitor vital signs, serum electrolyte levels, and acid-base balance.
d. Instruct the client to keep an accurate record of food and fluid intake.

60. Celia with a history of polysubstance abuse is admitted to the facility. She complains of nausea and vomiting 24 hours after admission. The nurse assesses the client and notes piloerection, pupillary dilation, and lacrimation. The nurse suspects that the client is going through which of the following withdrawals?

a. Alcohol withdrawal
b. Cannabis withdrawal
c. Cocaine withdrawal
d. Opioid withdrawal

61. Mr. Garcia, an attorney who throws books and furniture around the office after losing a case is referred to the psychiatric nurse in the law firm's employee assistance program. Nurse Beatriz knows that the client's behavior most likely represents the use of which defense mechanism?

a. Regression
b. Projection
c. Reaction-formation
d. Intellectualization

62. Nurse Anne is caring for a client who has been treated long term with antipsychotic medication. During the assessment, Nurse Anne checks the client for tardive dyskinesia. If tardive dyskinesia is present, Nurse Anne would most likely observe:

a. Abnormal movements and involuntary movements of the mouth, tongue, and face.
b. Abnormal breathing through the nostrils accompanied by a “thrill.”
c. Severe headache, flushing, tremors, and ataxia.
d. Severe hypertension, migraine headache,

63. Dennis has a lithium level of 2.4 mEq/L. The nurse immediately would assess the client for which of the following signs or symptoms?
64. Nurse Jannah is monitoring a male client who has been placed in restraints because of violent behavior. Nurse determines that it will be safe to remove the restraints when:

a. The client verbalizes the reasons for the violent behavior.
b. The client apologizes and tells the nurse that it will never happen again.
c. No acts of aggression have been observed within 1 hour after the release of two of the extremity restraints.
d. The administered medication has taken effect.

65. Nurse Irish is aware that Ritalin is the drug of choice for a child with ADHD. The side effects of the following may be noted by the nurse:

a. Increased attention span and concentration
b. Increase in appetite
c. Sleepiness and lethargy
d. Bradycardia and diarrhea

66. Kitty, a 9 year old child has very limited vocabulary and interaction skills. She has an I.Q. of 45. She is diagnosed to have Mental retardation of this classification:

a. Profound
b. Mild
c. Moderate
d. Severe

67. The therapeutic approach in the care of Armand an autistic child include the following EXCEPT:

a. Engage in diversionary activities when acting-out
b. Provide an atmosphere of acceptance
c. Provide safety measures
d. Rearrange the environment to activate the child

68. Jeremy is brought to the emergency room by friends who state that he took something an hour ago. He is actively hallucinating, agitated, with irritated nasal septum.

a. Heroin
b. Cocaine
c. LSD
d. Marijuana

69. Nurse Pauline is aware that Dementia unlike delirium is characterized by:

a. Slurred speech
b. Insidious onset
c. Clouding of consciousness
d. Sensory perceptual change

70. A 35 year old female has intense fear of riding an elevator. She claims “ As if I will die inside.” The client is suffering from:

a. Agoraphobia
b. Social phobia
c. Claustrophobia
d. Xenophobia
71. Nurse Myrna develops a counter-transference reaction. This is evidenced by:

a. Revealing personal information to the client  
b. Focusing on the feelings of the client.  
c. Confronting the client about discrepancies in verbal or non-verbal behavior  
d. The client feels angry towards the nurse who resembles his mother.

72. Tristan is on Lithium has suffered from diarrhea and vomiting. What should the nurse in-charge do first:

a. Recognize this as a drug interaction  
b. Give the client Cogentin  
c. Reassure the client that these are common side effects of lithium therapy  
d. Hold the next dose and obtain an order for a stat serum lithium level

73. Nurse Sarah ensures a therapeutic environment for all the client. Which of the following best describes a therapeutic milieu?

a. A therapy that rewards adaptive behavior  
b. A cognitive approach to change behavior  
c. A living, learning or working environment.  
d. A permissive and congenial environment

74. Anthony is very hostile toward one of the staff for no apparent reason. He is manifesting:

a. Splitting  
b. Transference  
c. Countertransference  
d. Resistance

75. Marielle, 17 years old was sexually attacked while on her way home from school. She is brought to the hospital by her mother. Rape is an example of which type of crisis:

a. Situational  
b. Adventitious  
c. Developmental  
d. Internal

76. Nurse Greta is aware that the following is classified as an Axis I disorder by the Diagnosis and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR) is:

a. Obesity  
b. Borderline personality disorder  
c. Major depression  
d. Hypertension

77. Katrina, a newly admitted is extremely hostile toward a staff member she has just met, without apparent reason. According to Freudian theory, the nurse should suspect that the client is experiencing which of the following phenomena?

a. Intellectualization  
b. Transference  
c. Triangulation  
d. Splitting

78. An 83 year-old male client is in extended care facility is anxious most of the time and frequently complains of a number of vague symptoms that interfere with his ability to eat. These symptoms indicate which of the following disorders?
79. Charina, a college student who frequently visited the health center during the past year with multiple vague complaints of GI symptoms before course examinations. Although physical causes have been eliminated, the student continues to express her belief that she has a serious illness. These symptoms are typically of which of the following disorders?

a. Conversion disorder  
b. Depersonalization  
c. Hypochondriasis  
d. Somatization disorder

80. Nurse Daisy is aware that the following pharmacologic agents are sedativehypnotic medication is used to induce sleep for a client experiencing a sleep disorder is:

a. Triazolam (Halcion)  
b. Paroxetine (Paxil)  
c. Fluoxetine (Prozac)  
d. Risperidone (Risperdal)

81. Aldo, with a somatoform pain disorder may obtain secondary gain. Which of the following statement refers to a secondary gain?

a. It brings some stability to the family  
b. It decreases the preoccupation with the physical illness  
c. It enables the client to avoid some unpleasant activity  
d. It promotes emotional support or attention for the client

82. Dervid is diagnosed with panic disorder with agoraphobia is talking with the nurse in-charge about the progress made in treatment. Which of the following statements indicates a positive client response?

a. “I went to the mall with my friends last Saturday”  
b. “I’m hyperventilating only when I have a panic attack”  
c. “Today I decided that I can stop taking my medication”  
d. “Last night I decided to eat more than a bowl of cereal”

83. The effectiveness of monoamine oxidase (MAO) inhibitor drug therapy in client with posttraumatic stress disorder can be demonstrated by which of the following client self-reports?

a. “I’m sleeping better and don’t have nightmares”  
b. “I’m not losing my temper as much”  
c. “I’ve lost my craving for alcohol”  
d. “I’ve lost my phobia for water”

84. Mark, with a diagnosis of generalized anxiety disorder wants to stop taking his lorazepam (Ativan). Which of the following important facts should nurse Betty discuss with the client about discontinuing the medication?

a. Stopping the drug may cause depression  
b. Stopping the drug increases cognitive abilities  
c. Stopping the drug decreases sleeping difficulties  
d. Stopping the drug can cause withdrawal symptoms

85. Jennifer, an adolescent who is depressed and reported by his parents as having difficulty in school is brought to the community mental health center to be evaluated. Which of the following other health problems would the nurse suspect?
a. Anxiety disorder  
b. Behavioral difficulties  
c. Cognitive impairment  
d. Labile moods

86. Ricardo, an outpatient in psychiatric facility is diagnosed with dysthymic disorder. Which of the following statement about dysthymic disorder is true?

a. It involves a mood range from moderate depression to hypomania  
b. It involves a single manic depression  
c. It’s a form of depression that occurs in the fall and winter  
d. It’s a mood disorder similar to major depression but of mild to moderate severity

87. The nurse is aware that the following ways in vascular dementia different from Alzheimer’s disease is:

a. Vascular dementia has more abrupt onset  
b. The duration of vascular dementia is usually brief  
c. Personality change is common in vascular dementia  
d. The inability to perform motor activities occurs in vascular dementia

88. Loretta, a newly admitted client was diagnosed with delirium and has history of hypertension and anxiety. She had been taking digoxin, furosemide (Lasix), and diazepam (Valium) for anxiety. This client’s impairment may be related to which of the following conditions?

a. Infection  
b. Metabolic acidosis  
c. Drug intoxication  
d. Hepatic encephalopathy

89. Nurse Ron enters a client’s room, the client says, “They’re crawling on my sheets! Get them off my bed!” Which of the following assessment is the most accurate?

a. The client is experiencing aphasia  
b. The client is experiencing dysarthria  
c. The client is experiencing a flight of ideas  
d. The client is experiencing visual hallucination

90. Which of the following descriptions of a client’s experience and behavior can be assessed as an illusion?

a. The client tries to hit the nurse when vital signs must be taken  
b. The client says, “I keep hearing a voice telling me to run away”  
c. The client becomes anxious whenever the nurse leaves the bedside  
d. The client looks at the shadow on a wall and tells the nurse she sees frightening faces on the wall.

91. During conversation of Nurse John with a client, he observes that the client shift from one topic to the next on a regular basis. Which of the following terms describes this disorder?

a. Flight of ideas  
b. Concrete thinking  
c. Ideas of reference  
d. Loose association

92. Francis tells the nurse that her coworkers are sabotaging the computer. When the nurse asks questions, the client becomes argumentative. This behavior shows personality traits associated with which of the following personality disorder?
a. Antisocial  
b. Histrionic  
c. Paranoid  
d. Schizotypal

93. Which of the following interventions is important for a Cely experiencing with paranoid personality disorder taking olanzapine (Zyprexa)?

a. Explain effects of serotonin syndrome  
b. Teach the client to watch for extrapyramidal adverse reaction  
c. Explain that the drug is less effective if the client smokes  
d. Discuss the need to report paradoxical effects such as euphoria

94. Nurse Alexandra notices other clients on the unit avoiding a client diagnosed with antisocial personality disorder. When discussing appropriate behavior in group therapy, which of the following comments is expected about this client by his peers?

a. Lack of honesty  
b. Belief in superstition  
c. Show of temper tantrums  
d. Constant need for attention

95. Tommy, with dependent personality disorder is working to increase his self-esteem. Which of the following statements by the Tommy shows teaching was successful?

a. “I’m not going to look just at the negative things about myself”  
b. “I’m most concerned about my level of competence and progress”  
c. “I’m not as envious of the things other people have as I used to be”  
d. “I find I can’t stop myself from taking over things other should be doing”

96. Norma, a 42-year-old client with a diagnosis of chronic undifferentiated schizophrenia lives in a rooming house that has a weekly nursing clinic. She scratches while she tells the nurse she feels creatures eating away at her skin. Which of the following interventions should be done first?

a. Talk about his hallucinations and fears  
b. Refer him for anticholinergic adverse reactions  
c. Assess for possible physical problems such as rash  
d. Call his physician to get his medication increased to control his psychosis

97. Ivy, who is on the psychiatric unit is copying and imitating the movements of her primary nurse. During recovery, she says, “I thought the nurse was my mirror. I felt connected only when I saw my nurse.” This behavior is known by which of the following terms?

a. Modeling  
b. Echopraxia  
c. Ego-syntonicity  
d. Ritualism

98. Jun approaches the nurse and tells that he hears a voice telling him that he’s evil and deserves to die. Which of the following terms describes the client’s perception?

a. Delusion  
b. Disorganized speech  
c. Hallucination  
d. Idea of reference

99. Mike is admitted to a psychiatric unit with a diagnosis of undifferentiated schizophrenia. Which of the following defense mechanisms is probably used by mike?

a. Projection
100. Rocky has started taking haloperidol (Haldol). Which of the following instructions is most appropriate for Rocky before taking haloperidol?

a. Should report feelings of restlessness or agitation at once
b. Use a sunscreen outdoors on a year-round basis
c. Be aware you’ll feel increased energy taking this drug
d. This drug will indirectly control essential hypertension

1. Answer: (D) Focusing
Rationale: The nurse is using focusing by suggesting that the client discuss a specific issue. The nurse didn’t restate the question, make observation, or ask further question (exploring).

2. Answer: (D) Remove all other clients from the dayroom.
Rationale: The nurse’s first priority is to consider the safety of the clients in the therapeutic setting. The other actions are appropriate responses after ensuring the safety of other clients.

3. Answer: (A) The client is disruptive.
Rationale: Group activity provides too much stimulation, which the client will not be able to handle (harmful to self) and as a result will be disruptive to others.

4. Answer: (C) Agree to talk with the mother and the father together.
Rationale: By agreeing to talk with both parents, the nurse can provide emotional support and further assess and validate the family’s needs.

5. Answer: (A) Perceptual disorders.
Rationale: Frightening visual hallucinations are especially common in clients experiencing alcohol withdrawal.

6. Answer: (D) Suggest that it takes awhile before seeing the results.
Rationale: The client needs a specific response; that it takes 2 to 3 weeks (a delayed effect) until the therapeutic blood level is reached.

7. Answer: (C) Superego
Rationale: This behavior shows a weak sense of moral consciousness. According to Freudian theory, personality disorders stem from a weak superego.

8. Answer: (C) Skeletal muscle paralysis.
Rationale: Anectine is a depolarizing muscle relaxant causing paralysis. It is used to reduce the intensity of muscle contractions during the convulsive stage, thereby reducing the risk of bone fractures or dislocation.

9. Answer: (D) Increase calories, carbohydrates, and protein.
Rationale: This client increased protein for tissue building and increased calories to replace what is burned up (usually via carbohydrates).

10. Answer: (C) Acting overly solicitous toward the child.
Rationale: This behavior is an example of reaction formation, a coping mechanism.

11. Answer: (A) By designating times during which the client can focus on the behavior.
Rationale: The nurse should designate times during which the client can focus on the compulsive behavior or obsessive thoughts. The nurse should urge the client to reduce the frequency of the compulsive behavior gradually, not rapidly. She shouldn't call attention to or try to prevent the behavior. Trying to prevent the behavior may cause pain and terror in the client. The nurse should encourage the client to verbalize anxieties to help distract attention from the compulsive behavior.

12. Answer: (D) Exploring the meaning of the traumatic event with the client.
Rationale: The client with PTSD needs encouragement to examine and understand the meaning of the traumatic event and consequent losses. Otherwise, symptoms may worsen and the client may become depressed or engage in self-destructive behavior such as substance abuse. The client must explore the meaning of the event and won't heal without this, no matter how much time passes. Behavioral techniques, such as relaxation therapy, may help
decrease the client's anxiety and induce sleep. The physician may prescribe antianxiety agents or antidepressants cautiously to avoid dependence; sleep medication is rarely appropriate. A special diet isn't indicated unless the client also has an eating disorder or a nutritional problem.

13. Answer: (C) "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."
Rationale: The nurse must be honest with the client by telling her that the paralysis has no physiologic cause while also conveying empathy and acknowledging that her symptoms are real. The client will benefit from psychiatric treatment, which will help her understand the underlying cause of her symptoms. After the psychological conflict is resolved, her symptoms will disappear. Saying that it must be awful not to be able to move her legs wouldn't answer the client's question; knowing that the cause is psychological wouldn't necessarily make her feel better. Telling her that she has developed paralysis to avoid leaving her parents or that her personality caused her disorder wouldn't help her understand and resolve the underlying conflict.

14. Answer: (C) fluvoxamine (Luvox) and clomipramine (Anafranil)
Rationale: The antidepressants fluvoxamine and clomipramine have been effective in the treatment of OCD. Librium and Valium may be helpful in treating anxiety related to OCD but aren't drugs of choice to treat the illness. The other medications mentioned aren't effective in the treatment of OCD.

15. Answer: (A) A warning about the drugs delayed therapeutic effect, which is from 14 to 30 days.
Rationale: The client should be informed that the drug's therapeutic effect might not be reached for 14 to 30 days. The client must be instructed to continue taking the drug as directed. Blood level checks aren't necessary. NMS hasn't been reported with this drug, but tachycardia is frequently reported.

16. Answer: (B) Severe anxiety and fear.
Rationale: Phobias cause severe anxiety (such as a panic attack) that is out of proportion to the threat of the feared object or situation. Physical signs and symptoms of phobias include profuse sweating, poor motor control, tachycardia, and elevated blood pressure. Insomnia, an inability to concentrate, and weight loss are common in depression. Withdrawal and failure to distinguish reality from fantasy occur in schizophrenia.

17. Answer: (A) Antidepressants
Rationale: Tricyclic and monoamine oxidase (MAO) inhibitor antidepressants have been found to be effective in treating clients with panic attacks. Why these drugs help control panic attacks isn't clearly understood. Anticholinergic agents, which are smooth-muscle relaxants, relieve physical symptoms of anxiety but don't relieve the anxiety itself. Antipsychotic drugs are inappropriate because clients who experience panic attacks aren't psychotic. Mood stabilizers aren't indicated because panic attacks are rarely associated with mood changes.

18. Answer: (B) 3 to 5 days
Rationale: Monoamine oxidase inhibitors, such as tranylcypromine, have an onset of action of approximately 3 to 5 days. A full clinical response may be delayed for 3 to 4 weeks. The therapeutic effects may continue for 1 to 2 weeks after discontinuation.

19. Answer: (B) Providing emotional support and individual counseling.
Rationale: Clients in the first stage of Alzheimer's disease are aware that something is happening to them and may become overwhelmed and frightened. Therefore, nursing care typically focuses on providing emotional support and individual counseling. The other options are appropriate during the second stage of Alzheimer's disease, when the client needs continuous monitoring to prevent minor illnesses from progressing into major problems and when maintaining adequate nutrition may become a challenge. During this stage, offering nourishing finger foods helps clients to feed themselves and maintain adequate nutrition.

20. Answer: (C) Emotional lability, euphoria, and impaired memory
Rationale: Signs of antianxiety agent overdose include emotional lability, euphoria, and impaired memory. Phencyclidine overdose can cause combativeness, sweating, and confusion. Amphetamine overdose can result in agitation, hyperactivity, and grandiose ideation. Hallucinogen overdose can produce suspiciousness, dilated pupils, and increased blood pressure.

21. Answer: (D) A low tolerance for frustration
Rationale: Clients with an antisocial personality disorder exhibit a low tolerance for frustration, emotional immaturity, and a lack of impulse control. They commonly have a history of unemployment, miss
work repeatedly, and quit work without other plans for employment. They don't feel guilt about their behavior and commonly perceive themselves as victims. They also display a lack of responsibility for the outcome of their actions. Because of a lack of trust in others, clients with antisocial personality disorder commonly have difficulty developing stable, close relationships.

22. Answer: (C) Methadone
Rationale: Methadone is used to detoxify opiate users because it binds with opioid receptors at many sites in the central nervous system but doesn’t have the same deterious effects as other opiates, such as cocaine, heroin, and morphine. Barbiturates, amphetamines, and benzodiazepines are highly addictive and would require detoxification treatment.

23. Answer: (B) Hallucinations
Rationale: Hallucinations are visual, auditory, gustatory, tactile, or olfactory perceptions that have no basis in reality. Delusions are false beliefs, rather than perceptions, that the client accepts as real. Loose associations are rapid shifts among unrelated ideas. Neologisms are bizarre words that have meaning only to the client.

24. Answer: (C) Set up a strict eating plan for the client.
Rationale: Establishing a consistent eating plan and monitoring the client’s weight are very important in this disorder. The family and friends should be included in the client’s care. The client should be monitored during meals—not given privacy. Exercise must be limited and supervised.

25. Answer: (A) Highly important or famous.
Rationale: A delusion of grandeur is a false belief that one is highly important or famous. A delusion of persecution is a false belief that one is being persecuted. A delusion of reference is a false belief that one is connected to events unrelated to oneself or a belief that one is responsible for the evil in the world.

26. Answer: (D) Listening attentively with a neutral attitude and avoiding power struggles.
Rationale: The nurse should listen to the client’s requests, express willingness to seriously consider the request, and respond later. The nurse should encourage the client to take short daytime naps because he expends so much energy. The nurse shouldn’t try to restrain the client when he feels the need to move around as long as his activity isn’t harmful. High calorie finger foods should be offered to supplement the client’s diet, if he can’t remain seated long enough to eat a complete meal. The nurse shouldn’t be forced to stay seated at the table to finish a meal. The nurse should set limits in a calm, clear, and self-confident tone of voice.

27. Answer: (D) Denial
Rationale: Denial is unconscious defense mechanism in which emotional conflict and anxiety is avoided by refusing to acknowledge feelings, desires, impulses, or external facts that are consciously intolerable.Withdrawal is a common response to stress, characterized by apathy. Logical thinking is the ability to think rationally and make responsible decisions, which would lead the client admitting the problem and seeking help. Repression is suppressing past events from the consciousness because of guilty association.

28. Answer: (B) Paranoid thoughts
Rationale: Clients with schizotypal personality disorder experience excessive social anxiety that can lead to paranoid thoughts. Aggressive behavior is uncommon, although these clients may experience agitation with anxiety. Their behavior is emotionally cold with a flattened affect, regardless of the situation. These clients demonstrate a reduced capacity for close or dependent relationships.

29. Answer: (C) Identify anxiety-causing situations
Rationale: Bulimic behavior is generally a maladaptive coping response to stress and underlying issues. The client must identify anxiety-causing situations that stimulate the bulimic behavior and then learn new ways of coping with the anxiety.

30. Answer: (A) Tension and irritability
Rationale: An amphetamine is a nervous system stimulant that is subject to abuse because of its ability to produce wakefulness and euphoria. An overdose increases tension and irritability. Options B and C are incorrect because amphetamines stimulate norepinephrine, which increase the heart rate and blood flow. Diarrhea is a common adverse effect so option D in is incorrect.

31. Answer: (B) “No, I do not hear your voices, but I believe you can hear them”.
Rationale: The nurse, demonstrating knowledge and understanding, accepts the client’s perceptions even though they are hallucinatory.
32. Answer: (C) Confusion for a time after treatment
Rationale: The electrical energy passing through the cerebral cortex during ECT results in a temporary state of confusion after treatment.

33. Answer: (D) Acceptance stage
Rationale: Communication and intervention during this stage are mainly nonverbal, as when the client gestures to hold the nurse’s hand.

34. Answer: (D) A higher level of anxiety continuing for more than 3 months.
Rationale: This is not an expected outcome of a crisis because by definition a crisis would be resolved in 6 weeks.

35. Answer: (B) Staying in the sun
Rationale: Haldol causes photosensitivity. Severe sunburn can occur on exposure to the sun.

36. Answer: (D) Moderate-level anxiety
Rationale: A moderately anxious person can ignore peripheral events and focuses on central concerns.

37. Answer: (C) Diverse interest
Rationale: Before onset of depression, these clients usually have very narrow, limited interest.

38. Answer: (A) As their depression begins to improve
Rationale: At this point the client may have enough energy to plan and execute an attempt.

39. Answer: (D) Disturbance in recalling recent events related to cerebral hypoxia.
Rationale: Cell damage seems to interfere with registering input stimuli, which affects the ability to register and recall recent events; vascular dementia is related to multiple vascular lesions of the cerebral cortex and subcortical structure.

40. Answer: (D) Encouraging the client to have blood levels checked as ordered.
Rationale: Blood levels must be checked monthly or bimonthly when the client is on maintenance therapy because there is only a small range between therapeutic and toxic levels.

41. Answer: (B) Fine hand tremors or slurred speech
Rationale: These are common side effects of lithium carbonate.

42. Answer: (D) Presence
Rationale: The constant presence of a nurse provides emotional support because the client knows that someone is attentive and available in case of an emergency.

43. Answer: (A) Client’s perception of the presenting problem.
Rationale: The nurse can be most therapeutic by starting where the client is, because it is the client’s concept of the problem that serves as the starting point of the relationship.

44. Answer: (B) Chocolate milk, aged cheese, and yogurt”
Rationale: These high-tyramine foods, when ingested in the presence of an MAO inhibitor, cause a severe hypertensive response.

45. Answer: (B) 4 to 6 weeks
Rationale: Crisis is self-limiting and lasts from 4 to 6 weeks.

46. Answer: (D) Males are more likely to use lethal methods than are females
Rationale: This finding is supported by research; females account for 90% of suicide attempts but males are three times more successful because of methods used.

47. Answer: (C) "Your cursing is interrupting the activity. Take time out in your room for 10 minutes."
Rationale: The nurse should set limits on client behavior to ensure a comfortable environment for all clients. The nurse should accept hostile or quarrelsome client outbursts within limits without becoming personally offended, as in option A. Option B is incorrect because it implies that the client's actions reflect feelings toward the staff instead of the client's own misery. Judgmental remarks, such as option D, may decrease the client's self-esteem.
48. Answer: (C) lithium carbonate (Lithane)
Rationale: Lithium carbonate, an antimania drug, is used to treat clients with cyclical schizoaffective disorder, a psychotic disorder once classified under schizophrenia that causes affective symptoms, including maniclike activity. Lithium helps control the affective component of this disorder. Phenelzine is a monoamine oxidase inhibitor prescribed for clients who don't respond to other antidepressant drugs such as imipramine. Chlordiazepoxide, an antianxiety agent, generally is contraindicated in psychotic clients. Imipramine, primarily considered an antidepressant agent, is also used to treat clients with agoraphobia and that undergoing cocaine detoxification.

49. Answer: (B) Report a sore throat or fever to the physician immediately.
Rationale: A sore throat and fever are indications of an infection caused by agranulocytosis, a potentially life-threatening complication of clozapine. Because of the risk of agranulocytosis, white blood cell (WBC) counts are necessary weekly, not monthly. If the WBC count drops below 3,000/μl, the medication must be stopped. Hypotension may occur in clients taking this medication. Warn the client to stand up slowly to avoid dizziness from orthostatic hypotension. The medication should be continued, even when symptoms have been controlled. If the medication must be stopped, it should be slowly tapered over 1 to 2 weeks and only under the supervision of a physician.

50. Answer: (C) Neuroleptic malignant syndrome.
Rationale: The client's signs and symptoms suggest neuroleptic malignant syndrome, a life-threatening reaction to neuroleptic medication that requires immediate treatment. Tardive dyskinesia causes involuntary movements of the tongue, mouth, facial muscles, and arm and leg muscles. Dystonia is characterized by cramps and rigidity of the tongue, face, neck, and back muscles. Akathisia causes restlessness, anxiety, and jitteriness.

51. Answer: (B) Advising the client to sit up for 1 minute before getting out of bed.
Rationale: To minimize the effects of amitriptyline-induced orthostatic hypotension, the nurse should advise the client to sit up for 1 minute before getting out of bed. Orthostatic hypotension commonly occurs with tricyclic antidepressant therapy. In these cases, the dosage may be reduced or the physician may prescribe nortriptyline, another tricyclic antidepressant. Orthostatic hypotension disappears only when the drug is discontinued.

52. Answer: (D) Dysthymic disorder.
Rationale: Dysthymic disorder is marked by feelings of depression lasting at least 2 years, accompanied by at least two of the following symptoms: sleep disturbance, appetite disturbance, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and hopelessness. These symptoms may be relatively continuous or separated by intervening periods of normal mood that last a few days to a few weeks. Cyclothymic disorder is a chronic mood disturbance of at least 2 years' duration marked by numerous periods of depression and hypomania. Atypical affective disorder is characterized by manic signs and symptoms. Major depression is a recurring, persistent sadness or loss of interest or pleasure in almost all activities, with signs and symptoms recurring for at least 2 weeks.

53. Answer: (C) 30 g mixed in 250 ml of water
Rationale: The usual adult dosage of activated charcoal is 5 to 10 times the estimated weight of the drug or chemical ingested, or a minimum dose of 30 g, mixed in 250 ml of water. Doses less than this will be ineffective; doses greater than this can increase the risk of adverse reactions, although toxicity doesn't occur with activated charcoal, even at the maximum dose.

54. Answer: (C) St. John's wort
Rationale: St. John's wort has been found to have serotonin-elevating properties, similar to prescription antidepressants. Ginkgo biloba is prescribed to enhance mental acuity. Echinacea has immune-stimulating properties. Ephedra is a naturally occurring stimulant that is similar to ephedrine.

55. Answer: (B) Sodium
Rationale: Lithium is chemically similar to sodium. If sodium levels are reduced, such as from sweating or diuresis, lithium will be reabsorbed by the kidneys, increasing the risk of toxicity. Clients taking lithium shouldn't restrict their intake of sodium and should drink adequate amounts of fluid each day. The other electrolytes are important for normal body functions but sodium is most important to the absorption of lithium.

56. Answer: (D) It's characterized by an acute onset and lasts hours to a number of days
Rationale: Delirium has an acute onset and typically can last from several hours to several days.

57. Answer: (B) Impaired communication.  
Rationale: Initially, memory impairment may be the only cognitive deficit in a client with Alzheimer's disease. During the early stage of this disease, subtle personality changes may also be present. However, other than occasional irritable outbursts and lack of spontaneity, the client is usually cooperative and exhibits socially appropriate behavior. Signs of advancement to the middle stage of Alzheimer's disease include exacerbated cognitive impairment with obvious personality changes and impaired communication, such as inappropriate conversation, actions, and responses. During the late stage, the client can't perform self-care activities and may become mute.

58. Answer: (D) This medication may initially cause tiredness, which should become less bothersome over time.  
Rationale: Sedation is a common early adverse effect of imipramine, a tricyclic antidepressant, and usually decreases as tolerance develops. Antidepressants aren't habit forming and don't cause physical or psychological dependence. However, after a long course of high-dose therapy, the dosage should be decreased gradually to avoid mild withdrawal symptoms. Serious adverse effects, although rare, include myocardial infarction, heart failure, and tachycardia. Dietary restrictions, such as avoiding aged cheeses, yogurt, and chicken livers, are necessary for a client taking a monoamine oxidase inhibitor, not a tricyclic antidepressant.

59. Answer: (C) Monitor vital signs, serum electrolyte levels, and acid-base balance.  
Rationale: An anorexic client who requires hospitalization is in poor physical condition from starvation and may die as a result of arrhythmias, hypothermia, malnutrition, infection, or cardiac abnormalities secondary to electrolyte imbalances. Therefore, monitoring the client's vital signs, serum electrolyte level, and acid base balance is crucial. Option A may worsen anxiety. Option B is incorrect because a weight obtained after breakfast is more accurate than one obtained after the evening meal. Option D would reward the client with attention for not eating and reinforce the control issues that are central to the underlying psychological problem; also, the client may record food and fluid intake inaccurately.

60. Answer: (D) Opioid withdrawal  
Rationale: The symptoms listed are specific to opioid withdrawal. Alcohol withdrawal would show elevated vital signs. There is no real withdrawal from cannabis. Symptoms of cocaine withdrawal include depression, anxiety, and agitation.

61. Answer: (A) Regression  
Rationale: An adult who throws temper tantrums, such as this one, is displaying regressive behavior, or behavior that is appropriate at a younger age. In projection, the client blames someone or something other than the source. In reaction formation, the client acts in opposition to his feelings. In intellectualization, the client overuses rational explanations or abstract thinking to decrease the significance of a feeling or event.

62. Answer: (A) Abnormal movements and involuntary movements of the mouth, tongue, and face.  
Rationale: Tardive dyskinesia is a severe reaction associated with long term use of antipsychotic medication. The clinical manifestations include abnormal movements (dyskinesia) and involuntary movements of the mouth, tongue (fly catcher tongue), and face.

63. Answer: (C) Blurred vision  
Rationale: At lithium levels of 2 to 2.5 mEq/L the client will experienced blurred vision, muscle twitching, severe hypotension, and persistent nausea and vomiting. With levels between 1.5 and 2 mEq/L the client experiencing vomiting, diarrhea, muscle weakness, ataxia, dizziness, slurred speech, and confusion. At lithium levels of 2.5 to 3 mEq/L or higher, urinary and fecal incontinence occurs, as well as seizures, cardiac dysrhythmias, peripheral vascular collapse, and death.

64. Answer: (C) No acts of aggression have been observed within 1 hour after the release of two of the extremity restraints.  
Rationale: The best indicator that the behavior is controlled, if the client exhibits no signs of aggression after partial release of restraints. Options A, B, and D do not ensure that the client has controlled the behavior.

65. Answer: (A) increased attention span and concentration  
Rationale: The medication has a paradoxical effect that decrease hyperactivity and impulsivity among children with ADHD. B, C, D. Side effects of Ritalin include anorexia, insomnia, diarrhea and irritability.

66. Answer: (C) Moderate
Rationale: The child with moderate mental retardation has an I.Q. of 35-50. Profound mental retardation has an I.Q. of below 20; Mild mental retardation 50-70 and Severe mental retardation has an I.Q. of 20-35.

67. Answer: (D) Rearrange the environment to activate the child
Rationale: The child with autistic disorder does not want change. Maintaining a consistent environment is therapeutic. A. Angry outburst can be re-channeling through safe activities. B. Acceptance enhances a trusting relationship. C. Ensure safety from self-destructive behaviors like head banging and hair pulling.

68. Answer: (B) cocaine
Rationale: The manifestations indicate intoxication with cocaine, a CNS stimulant. A. Intoxication with heroine is manifested by euphoria then impairment in judgment, attention and the presence of papillary constriction. C. Intoxication with hallucinogen like LSD is manifested by grandiosity, hallucinations, synesthesia and increase in vital signs. D. Intoxication with Marijuana, a cannabinoid is manifested by sensation of slowed time, conjunctival redness, social withdrawal, impaired judgment and hallucinations.

69. Answer: (B) insidious onset
Rationale: Dementia has a gradual onset and progressive deterioration. It causes pronounced memory and cognitive disturbances. A, C and D are all characteristics of delirium.

70. Answer: (C) Claustrophobia
Rationale: Claustrophobia is fear of closed space. A. Agoraphobia is fear of open space or being a situation where escape is difficult. B. Social phobia is fear of performing in the presence of others in a way that will be humiliating or embarrassing. D. Xenophobia is fear of strangers.

71. Answer: (B) Transference
Rationale: Transference is the unconscious assignment of negative or positive feelings evoked by a significant person in the client’s past to another. A. Splitting is a defense mechanism commonly seen in a client with personality disorder in which the world is perceived as all good or all bad. C. Countertransference is a phenomenon where the nurse shifts feelings assigned to someone in her past to the patient. D. Resistance is the client’s refusal to submit himself to the care of the nurse.

72. Answer: (D) Hold the next dose and obtain an order for a stat serum lithium level
Rationale: Diarrhea and vomiting are manifestations of Lithium toxicity. The next dose of lithium should be withheld and test is done to validate the observation. A. The manifestations are not due to drug interaction. B. Cogentin is used to manage the extra pyramidal symptom side effects of antipsychotics. C. The common side effects of Lithium are fine hand tremors, nausea, polyuria and polydipsia.

73. Answer: (C) A living, learning or working environment.
Rationale: A therapeutic milieu refers to a broad conceptual approach in which all aspects of the environment are channeled to provide a therapeutic environment for the client. The six environmental elements include structure, safety, norms; limit setting, balance and unit modification. A. Behavioral approach in psychiatric care is based on the premise that behavior can be learned or unlearned through the use of reward and punishment. B. Cognitive approach to change behavior is done by correcting distorted perceptions and irrational beliefs to correct maladaptive behaviors. D. This is not congruent with therapeutic milieu.

74. Answer: (B) Transference
Rationale: Transference is a positive or negative feeling associated with a significant person in the client’s past that are unconsciously assigned to another. A. Splitting is a defense mechanism commonly seen in a client with personality disorder in which the world is perceived as all good or all bad. C. Countertransference is a phenomenon where the nurse shifts feelings assigned to someone in her past to the patient. D. Resistance is the client’s refusal to submit himself to the care of the nurse.

75. Answer: (B) Adventitious
Rationale: Adventitious crisis is a crisis involving a traumatic event. It is not part of everyday life. A. Situational crisis is from an external source that upset ones psychological equilibrium. C and D. Are the same. They are transitional or developmental periods in life.

76. Answer: (C) Major depression
Rationale: The DSM-IV-TR classifies major depression as an Axis I disorder. Borderline personality disorder as an Axis II; obesity and hypertension, Axis III.

77. Answer: (B) Transference
Rationale: Transference is the unconscious assignment of negative or positive feelings evoked by a significant person in the client’s past to another person. Intellectualization is a defense mechanism in which the client
avoids dealing with emotions by focusing on facts. Triangulation refers to conflicts involving three family members. Splitting is a defense mechanism commonly seen in clients with personality disorder in which the world is perceived as all good or all bad.

78. Answer: (B) Hypochondriasis
Rationale: Complains of vague physical symptoms that have no apparent medical causes are characteristic of clients with hypochondriasis. In many cases, the GI system is affected. Conversion disorders are characterized by one or more neurologic symptoms. The client’s symptoms don’t suggest severe anxiety. A client experiencing sublimation channels maladaptive feelings or impulses into socially acceptable behavior.

79. Answer: (C) Hypochondriasis
Rationale: Hypochondriasis in this case is shown by the client’s belief that she has a serious illness, although pathologic causes have been eliminated. The disturbance usually lasts at least 6 with identifiable life stressor such as, in this case, course examinations. Conversion disorders are characterized by one or more neurologic symptoms. Depersonalization refers to persistent recurrent episodes of feeling detached from one’s self or body. Somatoform disorders generally have a chronic course with few remissions.

80. Answer: (A) Triazolam (Halcion)
Rationale: Triazolam is one of a group of sedative hypnotic medication that can be used for a limited time because of the risk of dependence. Paroxetine is a serotonin-specific reuptake inhibitor used for treatment of depression panic disorder, and obsessive-compulsive disorder. Fluoxetine is a serotonin-specific reuptake inhibitor used for depressive disorders and obsessive-compulsive disorders. Risperidone is indicated for psychotic disorders.

81. Answer: (D) It promotes emotional support or attention for the client
Rationale: Secondary gain refers to the benefits of the illness that allow the client to receive emotional support or attention. Primary gain enables the client to avoid some unpleasant activity. A dysfunctional family may disregard the real issue, although some conflict is relieved. Somatoform pain disorder is a preoccupation with pain in the absence of physical disease.

82. Answer: (A) “I went to the mall with my friends last Saturday”
Rationale: Clients with panic disorder tend to be socially withdrawn. Going to the mall is a sign of working on avoidance behaviors. Hyperventilating is a key symptom of panic disorder. Teaching breathing control is a major intervention for clients with panic disorder. The client taking medications for panic disorder; such as tricyclic antidepressants and benzodiazepines, must be weaned off these drugs. Most clients with panic disorder with agoraphobia don’t have nutritional problems.

83. Answer: (A) “I’m sleeping better and don’t have nightmares”
Rationale: MAO inhibitors are used to treat sleep problems, nightmares, and intrusive daytime thoughts in individuals with posttraumatic stress disorder. MAO inhibitors aren’t used to help control flashbacks or phobias or to decrease the craving for alcohol.

84. Answer: (D) Stopping the drug can cause withdrawal symptoms
Rationale: Stopping antianxiety drugs such as benzodiazepines can cause the client to have withdrawal symptoms. Stopping a benzodiazepine doesn’t tend to cause depression, increase cognitive abilities, or decrease sleeping difficulties.

85. Answer: (B) Behavioral difficulties
Rationale: Adolescents tend to demonstrate severe irritability and behavioral problems rather than simply a depressed mood. Anxiety disorder is more commonly associated with small children rather than with adolescents. Cognitive impairment is typically associated with delirium or dementia. Labile mood is more characteristic of a client with cognitive impairment or bipolar disorder.

86. Answer: (D) It’s a mood disorder similar to major depression but of mild to moderate severity
Rationale: Dysthymic disorder is a mood disorder similar to major depression but it remains mild to moderate in severity. Cyclothymic disorder is a mood disorder characterized by a mood range from moderate depression to hypomania. Bipolar I disorder is characterized by a single manic episode with no past major depressive episodes. Seasonal affective disorder is a form of depression occurring in the fall and winter.

87. Answer: (A) Vascular dementia has more abrupt onset
Rationale: Vascular dementia differs from Alzheimer’s disease in that it has a more abrupt onset and runs a highly variable course. Personally change is common in Alzheimer’s disease. The duration of delirium is usually brief. The inability to carry out motor activities is common in Alzheimer’s disease.

88. Answer: (C) Drug intoxication
Rationale: This client was taking several medications that have a propensity for producing delirium; digoxin (a digitalis glycoxide), furosemide (a thiazide diuretic), and diazepam (a benzodiazepine). Sufficient supporting data don’t exist to suspect the other options as causes.

89. Answer: (D) The client is experiencing visual hallucination
Rationale: The presence of a sensory stimulus correlates with the definition of a hallucination, which is a false sensory perception. Aphasia refers to a communication problem. Dysarthria is difficulty in speech production. Flight of ideas is rapid shifting from one topic to another.

90. Answer: (D) The client looks at the shadow on a wall and tells the nurse she sees frightening faces on the wall.
Rationale: Minor memory problems are distinguished from dementia by their minor severity and their lack of significant interference with the client’s social or occupational lifestyle. Other options would be included in the history data but don’t directly correlate with the client’s lifestyle.

91. Answer: (D) Loose association
Rationale: Loose associations are conversations that constantly shift in topic. Concrete thinking implies highly definitive thought processes. Flight of ideas is characterized by conversation that’s disorganized from the onset. Loose associations don’t necessarily start in a cogently, then becomes loose.

92. Answer: (C) Paranoid
Rationale: Because of their suspiciousness, paranoid personalities ascribe malevolent activities to others and tent to be defensive, becoming quarrelsome and argumentative. Clients with antisocial personality disorder can also be antagonistic and argumentative but are less suspicious than paranoid personalities. Clients with histrionic personality disorder are dramatic, not suspicious and argumentative. Clients with schizoid personality disorder are usually detached from other and tend to have eccentric behavior.

93. Answer: (C) Explain that the drug is less affective if the client smokes
Rationale: Olanzapine (Zyprexa) is less effective for clients who smoke cigarettes. Serotonin syndrome occurs with clients who take a combination of antidepressant medications. Olanzapine doesn’t cause euphoria, and extrapyramidal adverse reactions aren’t a problem. However, the client should be aware of adverse effects such as tardive dyskinesia.

94. Answer: (A) Lack of honesty
Rationale: Clients with antisocial personality disorder tent to engage in acts of dishonesty, shown by lying. Clients with schizotypal personality disorder tend to be superstitious. Clients with histrionic personality disorders tend to overreact to frustrations and disappointments, have temper tantrums, and seek attention.

95. Answer: (A) “I’m not going to look just at the negative things about myself”
Rationale: As the clients makes progress on improving self-esteem, selfblame and negative self evaluation will decrease. Clients with dependent personality disorder tend to feel fragile and inadequate and would be extremely unlikely to discuss their level of competence and progress. These clients focus on self and aren’t envious or jealous. Individuals with dependent personality disorders don’t take over situations because they see themselves as inept and inadequate.

96. Answer: (C) Assess for possible physical problems such as rash
Rationale: Clients with schizophrenia generally have poor visceral recognition because they live so fully in their fantasy world. They need to have as in-depth assessment of physical complaints that may spill over into their delusional symptoms. Talking with the client won’t provide as assessment of his itching, and itching isn’t as adverse reaction of antipsychotic drugs, calling the physician to get the client’s medication increased doesn’t address his physical complaints.

97. Answer: (B) Echopraxia
Rationale: Echopraxia is the copying of another’s behaviors and is the result of the loss of ego boundaries. Modeling is the conscious copying of someone’s behaviors. Ego-syntonicity refers to behaviors that correspond with the individual’s sense of self. Ritualism behaviors are repetitive and compulsive.
98. Answer: (C) Hallucination
Rationale: Hallucinations are sensory experiences that are misrepresentations of reality or have no basis in reality. Delusions are beliefs not based in reality. Disorganized speech is characterized by jumping from one topic to the next or using unrelated words. An idea of reference is a belief that an unrelated situation holds special meaning for the client.

99. Answer: (C) Regression
Rationale: Regression, a return to earlier behavior to reduce anxiety, is the basic defense mechanism in schizophrenia. Projection is a defense mechanism in which one blames others and attempts to justify actions; it’s used primarily by people with paranoid schizophrenia and delusional disorder. Rationalization is a defense mechanism used to justify one’s action. Repression is the basic defense mechanism in the neuroses; it’s an involuntary exclusion of painful thoughts, feelings, or experiences from awareness.

100. Answer: (A) Should report feelings of restlessness or agitation at once
Rationale: Agitation and restlessness are adverse effect of haloperidol and can be treated with anticholinergic drugs. Haloperidol isn’t likely to cause photosensitivity or control essential hypertension. Although the client may experience increased concentration and activity, these effects are due to a decreased in symptoms, not the drug itself.