Chapter 01: Mental Health and Mental Illness

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A staff nurse completes orientation to a psychiatric unit. Which of the following would the nurse expect as an advanced practice intervention?

a. Conduct mental health assessments

b. Prescribe psychotropic medication

c. Establish therapeutic relationships

d. Individualize nursing care plans

ANS: B

Prescriptive privileges are granted to master's-prepared nurse practitioners who have taken special courses on prescribing medication; thus it is an advanced-practice intervention. The nurse prepared at the basic level is permitted to perform mental health assessments, establish relationships, and provide individualized care planning.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

2. When a nursing student expresses concerns about how mental health nurses "lose all their nursing skills," which of the following is the best response by the mental health nurse?

a. "Psychiatric nurses practise in safer environments than other specialties. Nurse-to-patient ratios must be better because of the nature of the patients' problems."

b. "Psychiatric nurses use complex communication skills as well as critical thinking to solve multidimensional problems. I am challenged by those situations."

c. "That's a misconception. Psychiatric nurses frequently use high-technology monitoring equipment and manage complex intravenous therapies."

d. "Psychiatric nurses do not have to deal with as much pain and suffering as medical–

surgical nurses do. That appeals to me.”

ANS: B

The practice of psychiatric nursing requires a different set of skills from medical–surgical nursing, though there is substantial overlap. Two domains relate specifically to psychiatric nursing: behavioural, including communication, coping, and education; and safety, covering crisis and risk management. Basic psychosocial nursing concepts are central to psychiatric nursing practice and increase your competency as a practitioner in all clinical settings. Whatever setting you choose to work in, you will have the opportunity to improve the lives of people who are experiencing mental illness as an additional challenge to their health.

Your experience in the mental health nursing rotation can help you gain insight into yourself and greatly increase your insight into the experiences of others. This part of nursing education can provide guidelines for and the opportunity to learn new skills for dealing with a variety of challenging behaviours.

Psychosocial pain and suffering are as real as physical pain and suffering.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

3. When a new bill introduced in Parliament reduces funding for care of people with mental illness, a group of people with mild mental illness write letters to their elected representatives in opposition to the legislation for all people with mental illness. Which role does this action portray?

a. Recovery

b. Self-care

c. Advocacy

d. Social action

ANS: C

An advocate defends or asserts another’s cause, particularly when the other person lacks the ability to do

that for himself or herself. On a community scale, advocacy includes political activity, public speaking, and publication in the interest of improving the human condition. Since funding is necessary to deliver quality programming for people with mental illness, the letter-writing campaign advocates for the cause for all people with mental illness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

4. Which of the following has been identified as a significant trend that will affect the future of psychiatric mental health nursing in Canada?

a. Decrease in the aging population

b. Increase in cultural diversity

c. Role of the advanced-practice nurse

d. Shortage of physicians in rural and urban areas

ANS: B

Four significant trends have been identified that will affect the future of psychiatric mental health nursing in Canada; these include an aging population, an increase in cultural diversity, expanding technology, and an increased awareness of the impact of the determinants of health on mental illness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

5. Which assessment finding most clearly indicates that a patient may be experiencing a mental illness?

a. The patient reports occasional sleeplessness and anxiety.

b. The patient reports a consistently sad, discouraged, and hopeless mood.

c. The patient is able to describe the difference between “as if” and “for real.”

d. The patient perceives difficulty making a decision about whether to change jobs.

ANS: B

The correct response describes a mood alteration, which reflects mental illness. Alterations in cognition, mood, or behaviour that are coupled with significant distress and impaired functioning characterize mental illness. The distracters describe behaviours that are mentally healthy or within the usual scope of

human experience.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. Which finding best indicates that the goal “Demonstrates mentally healthy behaviour” was achieved?

a. A patient sees self as capable of achieving ideals and meeting demands.

b. A patient behaves without considering the consequences of personal actions.

c. A patient aggressively meets own needs without considering the rights of others.

d. A patient seeks help from others when assuming responsibility for major areas of own life.

ANS: A

The correct response describes an adaptive, healthy behaviour. The WHO defines mental health as “a state of well-being in which each individual is able to realize his or her own potential, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to the community” (World Health Organization, 2010). The distracters describe maladaptive behaviours.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

7. A nurse encounters an unfamiliar psychiatric disorder on a new patient’s admission form. Which resource should the nurse consult to determine criteria used to establish this diagnosis?

a. International Statistical Classification of Diseases and Related Health Problems (ICD-10)

b. Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

c. A behavioural health reference manual

d. NurseOne online

ANS: B

The DSM-5 gives the criteria used to diagnose each mental disorder. The distracters may not contain diagnostic criteria for a psychiatric illness.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

8. A nurse wants to find a description of diagnostic criteria for anxiety disorders. Which resource would have the most complete information?

a. Nursing Outcomes Classification (NOC)

b. Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

c. The ANA's Psychiatric–Mental Health Nursing Scope and Standards of Practice

d. International Statistical Classification of Diseases and Related Health Problems (ICD-10)

ANS: B

The DSM-5 details the diagnostic criteria for psychiatric clinical conditions and is the official guide for diagnosing psychiatric disorders. The other references are good resources but do not define the diagnostic criteria.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

9. Which individual is demonstrating the highest level of resilience?

a. One who is able to repress stressors.

b. One who becomes depressed after the death of a spouse.

c. One who lives in a shelter for 2 years after his or her home is destroyed by fire.

d. One who is able to connect with their support systems and secure the resources they need to be well.

ANS: D

Resilience is closely associated with the process of adapting and helps people facing tragedies, loss, trauma, and severe stress. It is a process and outcome of complex cultural systems rather than simply an individual's ability to overcome adversity. Repression and depression are unhealthy. Living in a shelter for 2 years shows a failure to move forward after a tragedy. See related audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

10. Complete this analogy. NANDA: clinical judgement; NIC: _____

a. Patient outcomes

b. Nursing actions

c. Diagnoses

d. Symptoms

ANS: B

Analogies show parallel relationships. NANDA, the North American Nursing Diagnosis Association, identifies diagnostic statements regarding human responses to actual or potential health problems. These statements represent clinical judgements. NIC (Nursing Interventions Classification) identifies actions provided by nurses that enhance patient outcomes. Nursing care activities may be direct or indirect.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

11. A college student said, “Most of the time I’m happy and feel good about myself. I have learned that what I get out of something is proportional to the effort I put into it.” According to the Epp classification, which quadrant outcome should the nurse select?

a. Optimal mental health with mental illness

b. Poor mental health with mental illness

c. Optimal mental health without mental illness

d. Poor mental health without mental illness

ANS: C

The student is happy and has an adequate self-concept. The student is reality-oriented, works effectively, and has control over his or her own behaviour. Mental health does not mean that a person is always happy.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. Which disorder is a culture-bound syndrome?

a. Epilepsy

b. Schizophrenia

c. Running amok

d. Major depression

ANS: C

Culture-bound syndromes occur in specific sociocultural contexts and are easily recognized by people in those cultures. A syndrome recognized in parts of Southeast Asia is running amok, in which a person (usually a male) runs around engaging in furious, almost indiscriminate violent behaviour.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

13. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies which of the following?

a. Deviant behaviours

b. Present disability or distress

c. People with mental disorders

d. Mental disorders people have

ANS: D

The DSM-5 classifies disorders people have rather than people themselves. The terminology of the tool reflects this distinction by referring to individuals with a disorder rather than as a “schizophrenic” or “alcoholic,” for example. Deviant behaviour is not generally considered a mental disorder. Present disability or distress is only one aspect of the diagnosis.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

14. A visitor at a community health fair asks the nurse, “What is the most prevalent mental disorder in Canada?” Select the nurse’s best response.

a. Schizophrenia

b. Bipolar disorder

c. Generalized anxiety disorder

d. Major depression

ANS: D

The prevalence of major depressive disorder is 47%, and approximately 11.3% of adults will experience major depression at some time in their lives. The prevalence of schizophrenia is 1.3% per year. The prevalence of bipolar disorder is 1.5%. The prevalence for generalized anxiety disorder is about 2.6% annually.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

15. Which of the following represents an outcome domain of the Nursing Outcomes Classification (NOS)?

a. Mental health

b. Perceived health

c. Chronic illness

d. Mental illness

ANS: B

One of the seven outcome domains is perceived health; the other six are functional health, physiologic health, psychosocial health, health knowledge, family health, and community health.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. A patient's relationships are intense and unstable. The patient initially idealizes the significant other and then devalues him or her, resulting in frequent feelings of emptiness. This patient will benefit from interventions to develop which aspect of mental health?

a. Effectiveness in work

b. Communication skills

c. Productive activities

d. Fulfilling relationships

ANS: D

The information provided centres on relationships with others that are described as intense and unstable.

The relationships of mentally healthy individuals are stable, satisfying, and socially integrated. They have

rich social relationships. Data are not present to describe work effectiveness, communication skills, or activities.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. Which belief will best support a nurse's efforts to provide patient advocacy during a multidisciplinary patient care planning session?

a. All mental illnesses are culturally determined.

b. Schizophrenia and bipolar disorder are cross-cultural disorders.

c. Symptoms of mental disorders are unchanged from culture to culture.

d. Assessment findings in mental disorders reflect a person's cultural patterns.

ANS: D

A nurse who understands that a patient's symptoms are influenced by culture will be able to advocate for the patient to a greater degree than a nurse who believes that culture is of little relevance. The distracters are untrue statements.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A nurse is part of a multidisciplinary team working with groups of depressed patients. Half the patients receive supportive interventions and antidepressant medication. The other half receives only medication. The team measures outcomes for each group. Which type of study is evident?

a. Incidence

b. Prevalence

c. Comorbidity

d. Clinical epidemiology

ANS: D

Clinical epidemiology is a broad field that addresses studies of the natural history (or what happens if there is no treatment and the problem is left to run its course) of an illness, studies of diagnostic screening

tests, and observational and experimental studies of interventions used to treat people with the illness or

symptoms. Prevalence refers to numbers of new cases. Comorbidity refers to having more than one mental disorder at a time. Incidence refers to the number of new cases of mental disorders in a healthy population within a given period.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

19. The spouse of a patient diagnosed with schizophrenia says, "I don't understand how events from childhood have anything to do with this disabling illness." Which response by the nurse will best help the spouse understand the cause of this disorder?

a. "Psychological stress is the basis of most mental disorders."

b. "This illness results from developmental factors rather than stress."

c. "Research suggests that this condition more likely has a biological basis."

d. "It must be frustrating for you that your spouse is sick so much of the time."

ANS: C

Many of the most prevalent and disabling mental disorders have strong biological influences. Genetics is only one part of biological factors. Empathy does not address increasing the spouse's level of knowledge about the cause of the disorder. The other distracters are not established facts.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

20. A category 5 tornado occurred in a community of 400 people, resulting in the destruction of many homes and businesses. In the 2 years after this disaster, 140 individuals were diagnosed with post-traumatic stress disorder (PTSD). Which term best applies to these newly diagnosed cases?

a. Prevalence

b. Comorbidity

c. Incidence

d. Clinical epidemiology

ANS: C

Incidence refers to the number of new cases of mental disorders in a healthy population within a given

period of time. Prevalence describes the total number of cases, new and existing, in a given population during a specific period of time, regardless of when they became ill. Clinical epidemiology is a broad field that addresses what happens after people with illnesses are seen by clinical care providers. Comorbidity refers to having more than one mental disorder at a time.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Safe Effective Care Environment

21. Most psychiatric disorders are the result of which of the following?

a. Childhood trauma

b. Adverse life events

c. Multiple defective genes

d. Chronic medical conditions

ANS: C

Most psychiatric disorders are the result of multiple mutated or defective genes, each of which in combination may contribute to the disorder. Although disorders may be caused by childhood trauma, adverse live events, and chronic medical conditions, they are not the cause of the majority of psychiatric disorders.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

22. Select the best response for the nurse who receives a question from another health professional seeking to understand the difference between a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis and a nursing diagnosis.

a. “There is no functional difference between the two. Both identify human disorders.”

b. “The DSM-5 diagnosis disregards culture, whereas the nursing diagnosis takes culture into account.”

c. “The DSM-5 diagnosis describes causes of disorders, whereas a nursing diagnosis does not explore etiology.”

d. “The DSM-5 diagnosis guides medical treatment, whereas the nursing diagnosis

offers a framework for identifying interventions for issues a patient is

experiencing."

ANS: D

The medical diagnosis is concerned with the patient's disease state, causes, and cures, whereas the

nursing diagnosis focuses on the patient's response to stress and possible caring interventions. Both tools

consider culture. The DSM-5 is multiaxial. Nursing diagnoses also consider potential problems.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

23. Which nursing intervention below is part of the scope of an advanced-practice

psychiatric mental health nurse only?

a. Coordination of care

b. Health teaching

c. Milieu therapy

d. Psychotherapy

ANS: D

Psychotherapy is part of the scope of practice of an advanced-practice nurse. The distracters are within a

staff nurse's scope of practice.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

MULTIPLE RESPONSE

1. An experienced nurse says to a new graduate, "When you've practiced as long as I have,

you instantly know how to take care of psychotic patients." What information should the new

graduate consider when analyzing this comment? (Select all that apply.)

a. The experienced nurse may need to be reminded of the importance of standardized

classifications.

b. New research findings should be integrated continuously into a nurse's practice to

provide the most effective care.

c. Experience provides mental health nurses with the essential tools and skills needed for effective professional practice.

d. Experienced psychiatric nurses have learned the best ways to care for mentally ill patients through trial and error.

e. An intuitive sense of patients' needs guides effective psychiatric nurses.

ANS: A, B

Evidence-informed practice involves using research findings and standards of care to provide the most effective nursing care. Evidence is continuously emerging, so nurses cannot rely solely on experience. The effective nurse also maintains respect for each patient as an individual. Overgeneralization compromises that perspective. Intuition and trial and error are unsystematic approaches to care.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

2. Which findings are signs of a person who is mentally healthy? (Select all that apply.)

a. Says, "I have some weaknesses, but I feel I'm important to my family and friends."

b. Adheres strictly to religious beliefs of parents and family of origin

c. Spends all holidays alone watching old movies on television

d. Considers past experiences when deciding about the future

e. Experiences feelings of conflict related to changing jobs

ANS: A, D, E

Mental health is a state of well-being in which each individual is able to realize his or her own potential, cope with the normal stresses of life, work productively, and make a contribution to the community. Mental health provides people with the capacity for rational thinking, communication skills, learning, emotional growth, resilience, and self-esteem.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A patient in the emergency department says, "Voices say someone is stalking me. They want to kill me because I developed a cure for cancer. I have a knife and will stab anyone who is a threat." Which aspects of the patient's mental health have the greatest and most immediate concern

to the nurse? (Select all that apply.)

a. Happiness

b. Appraisal of reality

c. Control over behaviour

d. Effectiveness in work

e. Healthy self-concept

ANS: B, C, E

The aspects of mental health of greatest concern are the patient's appraisal of and control over behaviour.

Their appraisal of reality is inaccurate. There are auditory hallucinations, delusions of persecution, and delusions of grandeur. In addition, the patient's control over behaviour is tenuous, as evidenced by the plan to stab anyone who seems threatening. A healthy self-concept is lacking, as evidenced by the delusions of grandeur. Data are not present to suggest that the other aspects of mental health (happiness

and effectiveness in work) are of immediate concern.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 03: Overview of Psychiatric Mental Health Nursing Care Within Various Settings

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Inpatient hospitalization for persons with mental illness is generally reserved for which

of the following patients?

a. Patients who present a clear danger to self or others

b. Patients who are noncompliant with medication at home

c. Patients who have limited support systems in the community

d. Patients who develop new symptoms during the course of an illness

ANS: A

Hospitalization is justified when the patient is a danger to self or others or is unable to meet his or her

basic needs, placing the individual at imminent risk of harming self. The distracters do not necessarily describe patients who require inpatient treatment.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

2. A patient was hospitalized for 24 hours after a reaction to a psychotropic medication. While planning discharge, the nurse learned that the patient received a notice of eviction immediately prior to admission. Select the nurse's most appropriate action.

a. Postpone the patient's discharge from the hospital.

b. Contact the landlord who evicted the patient to further discuss the situation.

c. Arrange a temporary place for the patient to stay until new housing can be arranged.

d. Determine whether the adverse medication reaction was genuine because the patient had nowhere to live.

ANS: C

Poverty, stigma, unemployment, and lack of appropriate housing are identified as major barriers to recovery of mental health. The nurse needs to consider these gaps when planning discharge for patients from acute care settings as the gaps can delay discharge and increase the likelihood of readmission. None of the other options is a viable alternative.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

3. A patient diagnosed with schizophrenia had an exacerbation related to medication noncompliance and was hospitalized for 5 days. The patient's thoughts are now more organized, and discharge is planned. The patient's family says, "It's too soon for discharge. We will just go through all this again." Which of the following should the nurse do?

a. Ask the case manager to arrange a transfer to a long-term care facility.

b. Notify hospital security to handle the disturbance and escort the family off the unit.

c. Explain that the patient will continue to improve if the medication is taken regularly.

d. Contact the health care provider to meet with the family and explain the discharge

rationale.

ANS: C

Patients do not stay in a hospital until every symptom disappears. The nurse must assume responsibility to

advocate for the patient's right to the least restrictive setting as soon as the symptoms are under control

and for the right of citizens to control health care costs. The health care provider will use the same

rationale. Shifting blame will not change the discharge. Security is unnecessary. The nurse can handle this

matter.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

4. A nurse inspects an inpatient psychiatric unit and finds that exits are free of

obstructions, no one is smoking, and the janitor's closet is locked. These observations relate to

which of the following?

a. Coordinating care of patients

b. Management of milieu safety

c. Management of the interpersonal climate

d. Use of therapeutic intervention strategies

ANS: B

Nursing staff are responsible for all aspects of milieu management. The observations mentioned in this

question directly relate to the safety of the unit. The other options, although part of the nurse's concerns,

are unrelated to the observations cited.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

5. The patients below were evaluated in the emergency department. The psychiatric unit

has one bed available. Which patient should be admitted?

a. The patient who is feeling anxiety and a sad mood after separation from a spouse of

10 years.

b. The patient who self-inflicted a superficial cut on the forearm after a family argument.

c. The patient experiencing dry mouth and tremor related to taking haloperidol (Haldol).

d. The patient who is a new parent and hears voices saying, “Smother your baby.”

ANS: D

Admission to the hospital would be justified by the risk of patient danger to self or others. The other patients have issues that can be handled with less restrictive alternatives than hospitalization.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

6. A nurse surveys medical records. Which finding signals a violation of patients’ rights?

a. A patient was not allowed to send letters to family.

b. A patient’s belongings were searched at admission.

c. A patient with suicidal ideation was placed on continuous observation.

d. Physical restraint was used after a patient was assaultive toward a staff member.

ANS: A

The patient has the right to send and receive communication and encouraging patient autonomy and community connectedness will support patient recovery. Inspecting patients’ belongings is a safety measure. Patients have the right to a safe environment, including the right to be protected against impulses to harm self.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

7. Which principle has the highest priority when addressing a behavioural crisis in an inpatient setting?

a. Suspend the patients’ rights until the crisis is resolved.

b. Swift intervention is justified to maintain the integrity of a therapeutic milieu.

c. Rights of an individual patient are superseded by the rights of the majority of patients.

d.

Patients should have opportunities to regain control without intervention if the
safety of others is not compromised.

ANS: A

A patient's rights are suspended only in circumstances where protection of the patient or others is a priority. Planned interventions are nearly always preferable. Intervention may be necessary when the patient threatens harm to self.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care
Environment

8. Clinical pathways are used by the multidisciplinary team, in managed care settings, to
do which of the following?

a. Stabilize aggressive patients

b. Identify obstacles to effective care

c. Relieve nurses of planning responsibilities

d. Streamline the care process and improve outcomes

ANS: D

Clinical pathways provide guidelines for assessments, interventions, treatments, and outcomes, as well as
a designated timeline for accomplishment. Deviations from the timeline must be reported and investigated. Clinical pathways streamline the care process and improve outcomes. Care pathways do not identify obstacles or stabilize aggressive patients. Staff are responsible for the necessary interventions. Care pathways do not relieve nurses of the responsibility of planning; pathways may, however, make the task easier.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care
Environment

9. Which aspect of direct care is an experienced, inpatient registered nurse most likely to
provide for a patient?

a. Hygiene assistance

b. Diversional activities

c. Assistance with job hunting

d. Building assertiveness skills

ANS: D

Building assertiveness skills is provided by the psychoeducational skills of the nurse. Assistance with personal hygiene would usually be accomplished by a health care aide. Diversional activities are usually the province of recreational therapists. The patient would probably be assisted in job hunting by a social worker or occupational therapist.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

10. Which of the following scenarios best depicts a behavioural crisis?

a. A patient is waving fists, cursing, and shouting threats at a nurse.

b. A patient is curled up in a corner of the bathroom, wrapped in a towel.

c. A patient is crying hysterically after receiving a phone call from a family member.

d. A patient is performing push-ups in the middle of the hall, forcing others to walk around.

ANS: A

This behaviour constitutes a behavioural crisis because the patient is threatening harm to another individual. Intervention is called for to defuse the situation. The other options speak of behaviours that may require intervention of a less urgent nature because the patients in question are not threatening harm to self or others.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. A patient usually watches television all day, seldom going out in the community or socializing with others. The patient says, “I don’t know what to do with my free time.” Which member of the multidisciplinary treatment team would be most helpful to this patient?

a. Psychologist

b. Social worker

c. Recreational therapist

d. Occupational therapist

ANS: C

Recreational therapists help patients use leisure time to benefit their mental health. Occupational therapists assist with a broad range of skills, including those for employment. Psychologists conduct testing and provide other patient services. Social workers focus on the patient's support system.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

12. A nurse performed these actions while caring for patients in an inpatient psychiatric setting. Which action violated patients' rights?

a. Prohibited a patient from using the telephone

b. In patient's presence, opened a package mailed to patient

c. Remained within arm's length of patient with homicidal ideation

d. Permitted a patient with psychosis to refuse oral psychotropic medication

ANS: A

The patient has a right to use the telephone for communication with family members or to secure counsel.

The patient should be protected against possible harm to self or others. Patients have rights to send and receive mail and be present during package inspection. Patients have rights to refuse treatment.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

13. Select the response that is an example of tertiary prevention.

a. Helping a person diagnosed with a serious mental illness learn to manage money

b. Restraining an agitated patient who has become aggressive and assaultive

c. Teaching school-age children about the dangers of drugs and alcohol

d. Genetic counselling with a young couple expecting their first child

ANS: A

Tertiary prevention involves services that address residual impairments, with a goal of improved independent functioning. Restraint is a secondary prevention. Genetic counselling and teaching school-

age children about substance abuse and dependence are examples of primary prevention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

14. A suspicious, socially isolated patient lives alone, eats one meal a day at a local shelter, and spends the remaining daily food allowance on cigarettes. Select a community psychiatric nurse's best initial action.

a. Explore ways to help the patient stop smoking.

b. Report the situation to the manager of the shelter.

c. Assess the patient's weight; determine foods and amounts eaten.

d. Arrange hospitalization for the patient in order to formulate a new treatment plan.

ANS: C

Assessment of biopsychosocial needs and general ability to live in the community is called for before any other action is taken. Both nutritional status and income adequacy are critical assessment parameters. A patient may be able to maintain adequate nutrition while eating only one meal a day. The rule is to assess before taking action. Hospitalization may not be necessary. Smoking cessation strategies can be pursued later.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

15. A nurse receives the following three phone calls regarding a community patient.

· The psychiatrist wants to complete a follow-up assessment.

· An internist wants to schedule a physical examination.

· The patient's attorney wants an appointment with the patient.

The nurse schedules the activities for the patient. Which role has the nurse fulfilled?

a. Advocate

b. Case manager

c. Milieu manager

d. Provider of care

ANS: B

Case managers design individually tailored treatment services for patients and track outcomes of care. The new case management includes assessing patient needs, developing a plan for service, linking the patient with necessary services, monitoring the effectiveness of services, and advocating for the patient as needed. Nurses routinely coordinate patient services, serving as case managers as described in this scenario. The role of advocate would require the nurse to speak out on the patient's behalf. The role of milieu manager refers to maintaining a therapeutic environment. Provider of care refers to giving direct care to the patient.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

16. Which characteristic would be more applicable to a community mental health nurse than to a nurse working in an operating room?

a. Kindness

b. Autonomy

c. Compassion

d. Professionalism

ANS: B

A community mental health nurse often works autonomously. Kindness, compassion, and professionalism apply to both nurses.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

17. A patient with which of the following diagnoses would be most appropriate to refer for assertive community treatment (ACT)?

a. A phobic fear of crowded places.

b. A single episode of major depression.

c. A catastrophic reaction to a tornado in the community.

d. Schizophrenia and four hospitalizations in the past year.

ANS: D

ACT provides intensive case management for persons with serious persistent mental illness who live in the community. Repeated hospitalization is a frequent reason for this intervention. The distracters identify mental health problems of a more episodic nature.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

18. Select the response that is an example of primary prevention.

a. Assisting a person diagnosed with a serious mental illness to fill a pill-minder

b. Helping school-age children identify and describe normal emotions

c. Leading a psychoeducational group in a community care home

d. Medicating an acutely ill patient who assaulted a staff person

ANS: B

Primary preventions are directed at healthy populations with a goal of preventing health problems from occurring. Helping school-age children describe normal emotions people experience promotes coping, a skill that is needed throughout life. Assisting a person with serious and persistent mental illness to fill a pill-minder is an example of tertiary prevention. Medicating an acutely ill patient who assaulted a staff person is secondary prevention. Leading a psychoeducational group in a community care home is an example of tertiary prevention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

19. Which level of prevention activities would a nurse in an emergency department employ most often?

a. Primary

b. Secondary

c. Tertiary

ANS: B

An emergency department nurse would generally see patients in crisis or with acute illness, so secondary prevention is used. Primary prevention involves preventing a health problem from developing, and tertiary prevention applies to rehabilitative activities.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

20. The nurse assigned to assertive community treatment (ACT) should explain the program's treatment goal as which of the following?

a. Assisting patients to maintain abstinence from alcohol and other substances of abuse

b. Providing structure and a therapeutic milieu for mentally ill patients whose symptoms require stabilization

c. Maintaining medications and stable psychiatric status for incarcerated inmates who have a history of mental illness

d. Providing services for mentally ill individuals who require intensive treatment to continue to live in the community

ANS: D

An ACT program provides intensive community services to persons with serious, persistent mental illness, who live in the community, but require aggressive services to prevent repeated hospitalizations.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

21. The case manager plans to discuss the treatment plan with a patient's family. Select the case manager's first action.

a. Determine an appropriate location for the conference.

b. Support the discussion with examples of the patient's behaviour.

c. Obtain the patient's permission for the exchange of information.

d. Determine which family members should participate in the conference.

ANS: C

The case manager must respect the patient's right to privacy and confidentiality, which extends to

discussions with family. Talking to family members is part of the case manager's role, with the patient's consent. Actions identified in the distracters occur after the patient has given permission.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Safe Effective Care Environment

22. A patient diagnosed with schizophrenia has been stable for 2 months. Today the patient's spouse calls the nurse to report the patient has not taken prescribed medication and is having disorganized thinking. The patient forgot to refill the prescription. The nurse arranges a refill. Select the best outcome to add to the plan of care.

a. The patient's spouse will mark dates for prescription refills on the family calendar.

b. The nurse will obtain prescription refills every 90 days and deliver to the patient.

c. The patient will call the nurse weekly to discuss medication-related issues.

d. The patient will report to the clinic for medication follow-up every week.

ANS: A

The nurse will enhance the patient's support system to meet patient needs whenever possible. Delivery of

medication by the nurse should be unnecessary for the nurse to do if the patient or a significant other can

be responsible. The patient may not need more intensive follow-up as long as medication is taken as prescribed.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

23. A community mental health nurse has worked for months to establish a relationship with a delusional, suspicious patient. The patient recently lost employment and could no longer afford prescribed medications. The patient says, "Only a traitor would make me go to the hospital." Select the nurse's best initial intervention.

a. Collaborate with the patient to contact resources to provide medications without charge temporarily.

b. Arrange a bed in a local homeless shelter with nightly on-site supervision.

c. Hospitalize the patient until the symptoms have stabilized.

d. Ask the patient, “Do you feel like I am a traitor?”

ANS: A

Hospitalization may damage the nurse-patient relationship, even if it provides an opportunity for rapid stabilization. The treatment outcome is to stabilize and improve the patient’s level of functioning in the community. If medication is restarted, the patient may possibly be stabilized in the home setting, even if it

takes a little longer. This will aid in the patient’s long term recovery journey. Programs are available to help patients who are unable to afford their medications. A homeless shelter is inappropriate and unnecessary. Hospitalization may be necessary later, but a less restrictive solution should be tried first, since the patient is not dangerous. A yes/no question is non-therapeutic communication.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

24. Which activity is appropriate for a nurse engaged exclusively in community-based primary prevention?

a. Medication follow-up

b. Teaching parenting skills

c. Substance abuse counselling

d. Making a referral for family therapy

ANS: B

Primary prevention activities are directed to healthy populations to provide information for developing skills that promote mental health. The distracters represent secondary or tertiary prevention activities.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

25. A psychiatrist prescribed depot injections every 3 weeks at the clinic for a patient with a history of medication noncompliance. For this plan to be successful, which factor will be of critical importance?

a. The attitude of significant others toward the patient

b. Nutrition services in the patient’s neighbourhood

c. The level of trust between the patient and nurse

d. The availability of transportation to the clinic

ANS: D

The ability of the patient to get to the clinic is of paramount importance to the success of the plan. The depot medication relieves the patient of the necessity to take medication daily, but if he or she does not receive the injection at 3-week intervals, nonadherence will again be the issue. Attitude toward the patient, trusting relationships, and nutrition are important but not fundamental to this particular problem.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

26. Which assessment finding for a patient in the community deserves priority intervention by the psychiatric nurse?

a. The patient receives provincial disability income plus a small cheque from a trust fund every month.

b. The patient was absent from three of six planned Alcoholics Anonymous meetings in the past 2 weeks.

c. The patient lives in an apartment with two patients who attend partial hospitalization programs.

d. The patient has a sibling who was recently diagnosed with a mental illness.

ANS: B

Patients who use alcohol or illegal substances often become medication noncompliant. Medication noncompliance, along with the disorganizing influence of substances on cellular brain function, promotes relapse. The distracters do not suggest problems.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

27. The nurse should refer which of the following patients to a partial hospitalization program?

a. A patient who has a therapeutic lithium level and reports regularly for blood tests

and clinic follow-up.

b. A patient who needs psychoeducation for relaxation therapy related to agoraphobia and panic episodes.

c. A patient who spent yesterday in a supervised crisis care centre and continues to have active suicidal ideation.

d. A patient who states, “I’m not sure I can avoid using alcohol when my spouse goes to work every morning.”

ANS: D

This patient could profit from the structure and supervision provided by spending the day at the partial hospitalization program. During the evening, at night, and on weekends, the spouse could assume responsibility for supervision. A suicidal patient needs inpatient hospitalization. The other patients can be served in the community or with individual visits.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

28. A Category V tornado hits a community, destroying many homes and businesses. Which nursing intervention would best demonstrate compassion and caring?

a. Encouraging people to describe their memories and feelings about the event

b. Arranging transportation to the local community mental health centre

c. Referring a local resident to a community food bank

d. Coordinating psychiatric home care services

ANS: A

Disaster victims benefit from telling their story. Nurses show compassion by listening and offering hope. The distracters identify other aspects of psychological first aid and services on the mental health continuum.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

29. A nurse makes an initial visit to a homebound patient diagnosed with a serious mental illness. A family member offers the nurse a cup of coffee. Select the nurse’s best response.

a. “Thank you. I would enjoy having a cup of coffee with you.”

b. “Thank you, but I would prefer to proceed with the assessment.”

c. “No, but thank you. I never accept drinks from patients or families.”

d. “Our agency policy prohibits me from eating or drinking in patients’ homes.”

ANS: A

Accepting refreshments or chatting informally with the patient and family represent therapeutic use of self

and help to establish rapport. The distracters fail to help establish rapport.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. The health care team at an inpatient psychiatric facility drafts these criteria for

admission. Which criteria should be included in the final version of the admission policy? (Select

all that apply.)

a. Clear risk of danger to self or others

b. Adjustment needed for doses of psychotropic medication

c. Detoxification from long-term heavy alcohol consumption needed

d. Respite for caregivers of persons with serious and persistent mental illness

e. Failure of community-based treatment, demonstrating need for intensive treatment

ANS: A, C, E

Medication doses can be adjusted on an outpatient basis. The goal of caregiver respite can be

accomplished without hospitalizing the patient. The other options are acceptable, evidence-informed

criteria for admission of a patient to an inpatient service.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

2. A psychiatric nurse discusses rules of the therapeutic milieu and patients’ rights with a

newly admitted patient. Which rights should be included? (Select all that apply.)

a. The right to received information

b. The right to confidentiality

c. The right to retain legal counsel

d. The right to an independent panel review, if certified

e. The right to select the nurse assigned to their care

ANS: A, B, C, D

Patients' rights should be discussed shortly after admission. Patients have rights related to receiving information, confidentiality, to retain legal counsel and to an independent review of their certification status. Patients do not have a right to a private room or selecting which nurse will provide care.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

3. A nurse can best address factors of critical importance to successful community treatment by including making assessments relative to which of the following: (Select all that apply.)

a. Source of income

b. Family and support systems

c. Housing adequacy and stability

d. Early psychosocial development

e. Substance abuse history and current use

ANS: A, B, C, E

Early psychosocial developmental history is less relevant to successful outcomes in the community than the assessments listed in the other options. If a patient is homeless or fears homelessness, focusing on other treatment issues is impossible. Sufficient income for basic needs and medication is necessary. Adequate support is a requisite to community placement. Substance abuse undermines medication effectiveness and interferes with community adjustment.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. Which statements by patients diagnosed with a serious mental illness best demonstrate that the case manager has established an effective long-term relationship? (Select all that apply.)

a. "My case manager talks in language I can understand."

b. “My case manager helps me keep track of my medication.”

c. “My case manager gives me little gifts from time to time.”

d. “My case manager looks at me as a whole person with many needs.”

e. “My case manager lets me do whatever I choose without interfering.”

ANS: A, B, D

Each correct answer is an example of appropriate nursing foci: communicating at a level understandable to the patient, providing medication supervision, and using holistic principles to guide care. The distracters violate relationship boundaries or suggest a laissez faire attitude on the part of the nurse.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

5. Which statements most clearly reflect the stigma of mental illness? (Select all that apply.)

a. “Many mental illnesses are hereditary.”

b. “Mental illness can be evidence of a brain disorder.”

c. “People claim mental illness so they can get disability cheques.”

d. “Mental illness results from the breakdown of nuclear families.”

e. “If people with mental illness went to church, their symptoms would vanish.”

ANS: C, D, E

Stigma is represented by judgemental remarks that discount the reality and validity of mental illness. Many mental illnesses are genetically transmitted. Neuroimaging can show changes associated with some mental illnesses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

6. A person in the community asks, “People with mental illnesses went to isolated hospitals in earlier times. Why has that changed?” Select the nurse’s accurate responses. (Select all that apply.)

a. “Science has made significant improvements in drugs for mental illness, so now many people may live in their communities.”

b. “There’s now a better selection of less restrictive treatment options available in communities to care for people with mental illness.”

c. “National rates of mental illness have declined significantly. There actually is not a need for state institutions anymore.”

d. “Most psychiatric institutions were closed because of serious violations of patients’ rights and unsafe conditions.”

e. “Federal legislation and payment for treatment of mental illness has shifted the focus to community rather than institutional settings.”

ANS: A, B, E

The community is a less restrictive alternative than hospitals for treatment of people with mental illness. Funding for treatment of mental illness remains largely inadequate, but now focuses on community rather than institutional care. Antipsychotic medications improve more symptoms of mental illness; hence, management of psychiatric disorders has improved. Rates of mental illness have increased, not decreased.

Hospitals were closed because funding shifted to the community. Conditions in institutions have improved.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

7. A patient diagnosed with schizophrenia lives in the community. On a home visit, the community psychiatric nurse case manager learns the following:

· The patient wants to attend an activity group at the mental health outreach centre

· The patient is worried about being able to pay for the therapy

· The patient does not know how to get from home to the outreach centre

· The patient has an appointment to have blood work at the same time an activity group meets

· The patient wants to attend services at a church that is about a kilometre from the patient’s home

Which tasks are part of the role of a community mental health nurse? (Select all that apply.)

a. Rearranging conflicting care appointments

b. Negotiating the cost of therapy for the patient

c. Arranging transportation to the outreach centre

d. Accompanying the patient to church services weekly

e. Monitoring to ensure the patient's basic needs are met

ANS: A, C, E

The correct answers reflect the coordinating role of the community psychiatric nurse case manager. Negotiating the cost of therapy and accompanying the patient to church services are interventions the nurse would not be expected to undertake. The patient can walk to the church services; the nurse can provide encouragement.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

Chapter 04: Relevant Theories and Therapies for Nursing Practice

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A parent says, "My 2-year-old child refuses toilet training and shouts "No!" when given directions. What do you think is the challenge for the child in this situation?" Select the nurse's best reply.

a. "Your child needs firmer control. It is important to set limits now."

b. "This is normal for your child's age and developmental stage. The child is striving for independence."

c. "There may be developmental problems. Most children are toilet trained by age 2."

d. "Some undesirable attitudes are developing. A child psychologist can help you develop a plan."

ANS: B

This behaviour is typical of a child around the age of 2 years, whose developmental task is to develop autonomy. The distracters indicate the child's behaviour is abnormal.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. A 26-month-old displays negative behaviour, refuses toilet training, and often says,

“No!” Which stage of psychosexual development is evident?

a. Oral

b. Anal

c. Phallic

d. Genital

ANS: B

The anal stage occurs from age 1 to 3 years and has as its focus toilet training and learning to delay immediate gratification. The oral stage occurs between birth and 1 year. The phallic stage occurs between 3 and 5 years, and the genital stage occurs between age 13 and 20 years.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. A 26-month-old displays negative behaviour, refuses toilet training, and often says, “No!” Which psychosocial crisis is evident?

a. Trust versus mistrust

b. Initiative versus guilt

c. Industry versus inferiority

d. Autonomy versus shame and doubt

ANS: D

The crisis of autonomy versus shame and doubt relates to the developmental task of gaining control of self and environment, as exemplified by toilet training. This psychosocial crisis occurs during the period of early childhood. Trust versus mistrust is the crisis of the infant. Initiative versus guilt is the crisis of the preschool and early school-aged child. Industry versus inferiority is the crisis of the 6- to 12-year-old child.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. A 4-year-old grabs toys from siblings and says, “I want that now!” The siblings cry, and

the child's parent becomes upset with the behaviour. According to Freudian theory, this behaviour is a product of impulses originating in which system of the personality?

a. Id

b. Ego

c. Superego

d. Preconscious

ANS: A

The id operates on the pleasure principle, seeking immediate gratification of impulses. The ego acts as a mediator of behaviour and weighs the consequences of the action, perhaps determining that taking the toy is not worth the mother's wrath. The superego would oppose the impulsive behaviour as "not nice." The preconscious is a level of awareness. This item relates to an audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. The parent of a 4-year-old rewards and praises the child for helping a younger sibling, being polite, and using good manners. The nurse supports this use of praise related to these behaviours. These qualities are likely to be internalized and become part of which system of the personality?

a. Id

b. Ego

c. Superego

d. Preconscious

ANS: C

The superego contains the "should nots," or moral standards internalized from interactions with significant others. Praise fosters internalization of desirable behaviours. The id is the centre of basic instinctual drives, and the ego is the mediator. The ego is the problem-solving and reality-testing portion of the personality that negotiates solutions with the outside world. The preconscious is a level of awareness from which material can be retrieved easily with conscious effort. This item relates to an audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

6. A nurse supports a parent for praising a child behaving in a helpful way. When this child behaves with politeness and helpfulness in adulthood, which feeling will most likely result?

a. Guilt

b. Anxiety

c. Humility

d. Self-esteem

ANS: D

The individual will be living up to the ego ideal, which will result in positive feelings about self rather than feelings of inferiority. The other options are incorrect because each represents a negative feeling.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

7. An adult says, “I never know the answers,” and “My opinion doesn’t count.” Which psychosocial crisis was unsuccessfully resolved for this adult?

a. Initiative versus guilt

b. Trust versus mistrust

c. Autonomy versus shame and doubt

d. Generativity versus self-absorption

ANS: C

These statements show severe self-doubt, indicating that the crisis of gaining control over the environment was not met successfully. Unsuccessful resolution of the crisis of initiative versus guilt results in feelings of guilt. Unsuccessful resolution of the crisis of trust versus mistrust results in poor interpersonal relationships and suspicion of others. Unsuccessful resolution of the crisis of generativity versus self-absorption results in self-absorption that limits the ability to grow as a person.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

8. Which patient statement would lead the nurse to suspect unsuccessful completion of the developmental task of infancy?

a. “I have very warm and close friendships.”

b. “I’m afraid to allow anyone to really get to know me.”

c. “I’m always absolutely right, so don’t bother saying more.”

d. “I’m ashamed that I didn’t do things correctly in the first place.”

ANS: B

According to Erikson, the developmental task of infancy is the development of trust. The correct response is the only statement clearly showing lack of ability to trust others. Warm, close relationships suggest the developmental task of infancy was successfully completed; rigidity and self-absorption are reflected in the belief one is always right; and shame for past actions suggests failure to resolve the crisis of initiative versus guilt.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. A patient is suspicious and frequently manipulates others. To which psychosexual stage do these traits relate?

a. Oral

b. Anal

c. Phallic

d. Genital

ANS: A

The behaviours in the question develop as the result of attitudes formed during the oral stage, when an infant first learns to relate to the environment. Anal-stage traits include stinginess, stubbornness, orderliness, or their opposites. Phallic-stage traits include flirtatiousness, pride, vanity, difficulty with authority figures, and difficulties with sexual identity. Genital-stage traits include the ability to form satisfying sexual and emotional relationships with members of the opposite sex, emancipation from parents, a strong sense of personal identity, or the opposites of these traits.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. Which stage of psychosexual development is most relevant to the patient that expresses a desire to be cared for by others and often behaves in a helpless fashion?

a. Latency

b. Phallic

c. Anal

d. Oral

ANS: D

Fixation at the oral stage sometimes produces dependent infantile behaviours in adults. Latency fixations often result in difficulty identifying with others and developing social skills, resulting in a sense of inadequacy and inferiority. Phallic fixations result in having difficulty with authority figures and poor sexual identity. Anal fixation sometimes results in retentiveness, rigidity, messiness, destructiveness, and cruelty. This item relates to an audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

11. A nurse listens to a group of recent retirees. One says, “I volunteer with Meals on Wheels, coach teen sports, and do church visitation.” Another laughs and says, “I’m too busy taking care of myself to volunteer to help others.” Which developmental task do these statements contrast?

a. Trust and mistrust

b. Intimacy and isolation

c. Industry and inferiority

d. Generativity and self-absorption

ANS: D

Both retirees are in middle adulthood, when the developmental crisis to be resolved is generativity versus

self-absorption. One exemplifies generativity; the other embodies self-absorption. This developmental crisis would show a contrast between relating to others in a trusting fashion and being suspicious and lacking trust. Failure to negotiate this developmental crisis would result in a sense of inferiority or difficulty learning and working as opposed to the ability to work competently. Behaviours that would be contrasted are emotional isolation and the ability to love and commit oneself.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. Although ego defence mechanisms and security operations are mainly unconscious and designed to relieve anxiety, the major difference is which of the following?

a. Defence mechanisms are intrapsychic and not observable.

b. Defence mechanisms cause arrested personal development.

c. Security operations are masterminded by the id and superego.

d. Security operations address interpersonal relationship activities.

ANS: D

Sullivan's theory explains that security operations are interpersonal relationship activities designed to relieve anxiety. Because they are interpersonal, they are observable. Defence mechanisms are unconscious and automatic. Repression is entirely intrapsychic, but other mechanisms result in observable behaviours. Frequent, continued use of many defence mechanisms often results in reality distortion and interference with healthy adjustment and emotional development. Occasional use of defence mechanisms is normal and does not markedly interfere with development. Security operations are ego-centred. This item relates to an audience response question.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Analysis MSC: Client Needs: Health Promotion and Maintenance

13. A student nurse says, "I don't need to interact with my patients. I learn what I need to know by observation." An instructor can best interpret the nursing implications of Sullivan's theory to this student by responding with which of the following?

a. "Interactions are required in order to help you develop therapeutic communication

skills."

b. "Nurses cannot be isolated. We must interact to provide patients with opportunities

to practice interpersonal skills."

c.

"Observing patient interactions will help you formulate priority nursing diagnoses

and appropriate interventions."

d. "It is important to pay attention to patients' behavioural changes because these

signify adjustments in personality."

ANS: B

The nurse's role includes educating patients and assisting them in developing effective interpersonal

relationships. Mutuality, respect for the patient, unconditional acceptance, and empathy are cornerstones

of Sullivan's theory. The nurse who does not interact with the patient cannot demonstrate these

cornerstones. Observations provide only objective data. Priority nursing diagnoses usually cannot be

accurately established without subjective data from the patient. The other distracters relate to Maslow and

behavioural theory. This item relates to an audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and

Maintenance

14. A nurse consistently encourages a patient to do his or her own activities of daily living

(ADLs). If the patient is unable to complete an activity, the nurse helps until the patient is once

again independent. This nurse's practice is most influenced by which theorist?

a. Betty Neuman

b. Patricia Benner

c. Dorothea Orem

d. Joyce Travelbee

ANS: C

Orem emphasizes the role of the nurse in promoting self-care activities of the patient; this has relevance

to the seriously and persistently mentally ill patient.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. A nurse uses Maslow's hierarchy of needs to plan care for a patient with mental illness. Which problem will receive priority?

a. The patient refuses to eat or bathe.

b. The patient reports feelings of alienation from family.

c. The patient is reluctant to participate in unit social activities.

d. The patient is unaware of medication action and adverse effects.

ANS: A

The need for food and hygiene are physiological and therefore take priority over psychological or meta-needs in care planning.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Safe Effective Care Environment

16. Operant conditioning is part of the treatment plan to encourage speech in a child who is nearly mute. Which technique applies?

a. Encourage the child to observe others talking.

b. Include the child in small group activities.

c. Give the child a small treat for speaking.

d. Teach the child relaxation techniques.

ANS: C

Operant conditioning involves giving positive reinforcement for a desired behaviour. Treats are rewards and reinforce speech through positive reinforcement.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. The parent of a child diagnosed with schizophrenia tearfully asks the nurse, "What

could I have done differently to prevent this illness?" Select the nurse's best response.

a. "Although schizophrenia results from impaired family relationships, try not to feel guilty. No one can predict how a child will respond to parental guidance."

b. "Schizophrenia is a biological illness resulting from changes in how the brain and nervous system function. You are not to blame for your child's illness."

c. "There is still hope. Changing your parenting style can help your child learn to cope effectively with the environment."

d. "Most mental illnesses result from genetic inheritance. Your genes are more at fault than your parenting."

ANS: B

Patients and families need reassurance that the major mental disorders are biological in origin and are not the "fault" of parents. The parent's comment suggests feelings of guilt or inadequacy. The nurse's response should address these feelings as well as provide information. One distracter places the burden of having faulty genes on the shoulders of the parents. The other distracters are neither wholly accurate nor reassuring.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A nurse influenced by Peplau's interpersonal theory works with an anxious, withdrawn patient. Interventions should focus on which of the following?

a. Rewarding desired behaviours

b. Use of own capacities

c. Changing the patient's self-concept

d. Administering medications to relieve anxiety

ANS: B

The nurse-patient relationship is structured to provide a model for adaptive interpersonal relationships that can be generalized to others. The theory centres on helping the patient learn to use his or her capacities to live more productively. The distracters apply to theories of cognitive, behavioural, and biological therapy.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

19. A patient had psychotherapy weekly for 5 months. The therapist used free association, dream analysis, and facilitated transference to help the patient understand conflicts and foster change. Select the term that applies to this method.

a. Rational-emotive behaviour therapy

b. Psychodynamic therapy

c. Cognitive-behavioural therapy

d. Operant conditioning

ANS: B

The techniques are aspects of psychodynamic therapy. The distracters use other techniques.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. Consider this comment from a therapist: “The patient is homosexual but has kept this preference secret. Severe anxiety and depression occur when the patient anticipates family reactions to this sexual orientation.” Which perspective is evident in the speaker?

a. Theory of interpersonal relationships

b. Classical conditioning theory

c. Psychosexual theory

d. Behaviourism theory

ANS: A

The theory of interpersonal relationships recognizes the anxiety and depression as that which arises from social insecurity or that prevents biological needs from being satisfied. Behaviourism and classical conditioning theories do not apply. A psychosexual formulation would focus on uncovering unconscious material that relates to the patient problem.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. A psychotherapist works with an anxious, dependent patient. Which strategy is most

consistent with psychoanalytic psychotherapy?

a. Identifying the patient's strengths and assets

b. Praising the patient for describing feelings of isolation

c. Focusing on feelings developed by the patient toward the therapist

d. Providing psychoeducation and emphasizing medication adherence

ANS: C

Positive or negative feelings of the patient toward the therapist indicate transference. Transference is a psychoanalytic concept that can be used to explore previously unresolved conflicts. The distracters relate to biological therapy and supportive psychotherapy. Use of psychoeducational materials is a common "homework" assignment used in cognitive therapy.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

22. A person says, "I was the only survivor in a small plane crash. Three business associates died. I got depressed and saw a counsellor twice a week for 4 weeks. We talked about my feelings related to being a survivor, and I'm better now." Which type of therapy was used?

a. Milieu therapy

b. Psychoanalysis

c. Behaviour modification

d. Interpersonal psychotherapy

ANS: D

Interpersonal psychotherapy returned the patient to his former level of functioning by helping him come to terms with the loss of friends and guilt over being a survivor. Milieu therapy refers to environmental therapy. Psychoanalysis would call for a long period of exploration of unconscious material. Behaviour modification would focus on changing a behaviour rather than helping the patient understand what is going on in his life.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

23. Which technique is most applicable to aversion therapy?

a. Punishment

b. Desensitization

c. Role modeling

d. Positive reinforcement

ANS: A

Aversion therapy is akin to punishment. Aversive techniques include pairing of a maladaptive behaviour with a noxious stimulus, punishment, and avoidance training.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

24. A patient says to the nurse, “My father has been dead for over 10 years, but talking to you is almost as comforting as the talks he and I had when I was a child.” Which term applies to the patient’s comment?

a. Superego

b. Transference

c. Reality testing

d. Counter-transference

ANS: B

Transference refers to feelings a patient has toward the health care worker that were originally held toward significant others in his or her life. Counter-transference refers to unconscious feelings that the health care worker has toward the patient. The superego represents the moral component of personality; it seeks perfection.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

25. A college student received an invitation to attend the wedding of a close friend who lives across the country. The student is afraid of flying. Which type of therapy would be most helpful for this patient?

a. Psychoanalysis

b. Milieu therapy

c. Systematic desensitization

d. Short-term dynamic therapy

ANS: C

Systematic desensitization is a type of therapy aimed at extinguishing a specific behaviour, such as those associated with a fear of flying. Psychoanalysis and short-term dynamic therapy seek to uncover conflicts.

Milieu therapy involves environmental factors.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

26. Which approach would be best to provide therapy in which peers as well as staff have a voice in determining patients' privileges and psychoeducational topics?

a. Milieu therapy

b. Cognitive therapy

c. Short-term dynamic therapy

d. Systematic desensitization

ANS: A

Milieu therapy is based on the idea that all members of the environment contribute to the planning and functioning of the setting. The distracters are individual therapies that do not fit the description.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

27. A patient repeatedly stated, "I'm stupid." Which statement by that patient would show progress resulting from cognitive behavioural therapy?

a. "Sometimes I do stupid things."

b. "Things always go wrong for me."

c. "I always fail when I try new things."

d. "I'm disappointed in my lack of ability."

ANS: A

"I'm stupid" is a cognitive distortion. A more rational thought is "Sometimes I do stupid things." The latter thinking promotes emotional self-control. The distracters reflect irrational or distorted thinking. This item relates to an audience response question.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

28. A patient says, “All my life I’ve been surrounded by stupidity. Everything I buy breaks because the entire American workforce is incompetent.” Which of the following is this patient experiencing?

a. A self-esteem deficit

b. A cognitive distortion

c. A deficit in motivation

d. A deficit in love and belonging

ANS: B

Automatic thoughts, or cognitive distortions, are irrational and lead to false assumptions and misinterpretations. See related audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

29. A patient is fearful of riding on elevators. The therapist first rides an escalator with the patient. The therapist and patient then stand in an elevator with the door open for five minutes and later with the elevator door closed for five minutes. Which technique has the therapist used?

a. Classic psychoanalytic therapy

b. Systematic desensitization

c. Rational emotive therapy

d. Biofeedback

ANS: B

Systematic desensitization is a form of behaviour modification therapy that involves the development of behaviour tasks customized to the patient’s specific fears. These tasks are presented to the patient while using learned relaxation techniques. The patient is incrementally exposed to the fear.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

30. A patient says, “I always feel good when I wear a size 2 petite.” Which type of cognitive distortion is evident?

a. Disqualifying the positive

b. Overgeneralization

c. Catastrophizing

d. Personalization

ANS: B

Automatic thoughts, or cognitive distortions, are irrational and lead to false assumptions and misinterpretations. The question offers an example of overgeneralization. See related audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

31. Which comment best indicates a patient is self-actualized?

a. “I have succeeded despite a world filled with evil.”

b. “I have a plan for my life. If I follow it, everything will be fine.”

c. “I’m successful because I work hard. No one has ever given me anything.”

d. “My favourite leisure is walking on the beach, hearing soft sounds of rolling waves.”

ANS: D

The self-actualized personality is associated with high productivity and enjoyment of life. Self-actualized persons experience pleasure in being alone and an ability to reflect on events.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

32. A nurse and patient discuss a problem the patient has kept secret for many years. Afterward, the patient says, “I feel so relieved that I finally told somebody.” Which term best describes the patient’s feeling?

a. Catharsis

b. Superego

c. Cognitive distortion

d. Counter-transference

ANS: A

Freud initially used talk therapy, known as the cathartic method. Today we refer to catharsis as “getting

things off our chests.” The superego represents the moral component of personality.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

33. Which patient is the best candidate for brief psychodynamic therapy?

a. An accountant with a loving family and successful career who was involved in a

short extramarital affair

b. An adult with a long history of major depression who was charged with driving

under the influence (DUI)

c. A woman with a history of borderline personality disorder who recently cut both

wrists

d. An adult male recently diagnosed with anorexia nervosa

ANS: A

The best candidates for psychodynamic therapy are relatively healthy and well-functioning individuals, sometimes referred to as the “worried well,” who have a clearly circumscribed area of difficulty and are intelligent, psychologically minded, and well-motivated for change. Patients with psychosis, severe depression, borderline personality disorder, and severe character disorders are not appropriate candidates

for this type of treatment.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A patient states, “I’m starting cognitive-behavioural therapy. What can I expect from

the sessions?” Which responses by the nurse would be appropriate? (Select all that apply.)

a. “The therapist will be active and questioning.”

b. “You will be given some homework assignments.”

c. “The therapist will ask you to describe your dreams.”

d. “The therapist will help you look at your ideas and beliefs about yourself.”

e. “The goal is to increase subjectivity about thoughts that govern your behaviour.”

ANS: A, B, D

Cognitive therapists are active rather than passive during therapy sessions because they help patients

reality-test their thinking. Homework assignments are given and completed outside the therapy sessions. Homework is usually discussed at the next therapy session. The goal of cognitive therapy is to assist the patient in identifying inaccurate cognitions and in reality-testing and formulating new, accurate cognitions. One distracter applies to psychoanalysis. Increasing subjectivity is not desirable.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. Which comments by an elderly person best indicate successful completion of the developmental task? (Select all that apply.)

a. “I am proud of my children’s successes in life.”

b. “I should have given to community charities more often.”

c. “My relationship with my father made life more difficult for me.”

d. “My experiences in the war helped me appreciate the meaning of life.”

e. “I often wonder what would have happened if I had chosen a different career.”

ANS: A, D

The developmental crisis for an elderly person relates to integrity versus despair. Pride in one’s offspring indicates a sense of fulfillment. Recognition of the wisdom gained from difficult experiences (such as being in a war) indicates a sense of integrity. Blaming and regret indicate despair and unsuccessful resolution of the crisis.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which comments by an adult best indicate self-actualization? (Select all that apply.)

a. “I am content with a good book.”

b. “I often wonder if I chose the right career.”

c. “Sometimes I think about how my parents would have handled problems.”

d. “It’s important for our country to provide basic health care services for everyone.”

e. “When I was lost at sea for 2 days, I gained an understanding of what is important.”

ANS: A, D, E

Self-actualized persons enjoy privacy, have a sense of democracy, and show positive outcomes associated

with peak experiences. Self-doubt, defensiveness, and blaming are not consistent with self-actualization.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. Which activities represent the art of nursing? (Select all that apply.)

a. Administering medications on time to a group of patients

b. Listening to a new widow grieve her husband's death

c. Helping a patient obtain groceries from a food bank

d. Teaching a patient about a new medication

e. Holding the hand of a frightened patient

ANS: B, C, E

Peplau described the science and art of professional nursing practice. The art component of nursing consists of the care, compassion, and advocacy nurses provide to enhance patient comfort and well-being.

The science component of nursing involves the application of knowledge to understand a broad range of human problems and psychosocial phenomena, intervening to relieve patients' suffering and promote growth. See related audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

Chapter 05: Understanding Responses to Stress

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. The adult child of a patient diagnosed with major depression asks, "Do you think depression and physical illness are connected? Since my father's death, my mother has had shingles and the flu, but she's usually not one who gets sick." Which answer by the nurse best reflects current knowledge about psychoneuroimmunology?

a. "It is probably a coincidence. Emotions and physical responses travel on different tracts of the nervous system."

b. "You may be paying more attention to your mother since your father died and

noticing more things such as minor illnesses."

c. "So far, research on emotions or stress and becoming ill more easily is unclear. We do not know for sure if there is a link."

d. "Negative emotions and stress may interfere with the body's ability to protect itself and can increase the likelihood of infection."

ANS: D

This answer best explains the research. Research supports a link between negative emotions and/or prolonged stress and impaired immune system functioning. Activation of the immune system sends proinflammatory cytokines to the brain, and the brain in turn releases its own cytokines that signal the central nervous system to initiate myriad responses to stress. Prolonged stress suppresses the immune system and lowers resistance to infections. Although the adult child may be more aware of issues involving the mother, the pattern of illnesses described may be an increase from the mother's baseline.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

2. A patient diagnosed with emphysema has severe shortness of breath and needs portable oxygen when leaving home. Recently, the patient has reduced activity because of fear that breathing difficulty will occur. A nurse suggests using guided imagery. Which image should the patient be encouraged to visualize?

a. Engaging in activity without using any supplemental oxygen

b. Sleeping comfortably and soundly, without respiratory distress

c. Feeling relaxed and taking regular deep breaths when leaving home

d. Having a younger, healthier body that knows no exercise limitations

ANS: C

The patient has dysfunctional images of dyspnea. Guided imagery can help replace the dysfunctional image with a positive coping image. Athletes have found that picturing successful images can enhance performance. Encouraging the patient to imagine a regular breathing depth and rate will help improve oxygen-carbon dioxide exchange and help achieve further relaxation. Other options focus on unrealistic goals (being younger, not needing supplemental oxygen), or restrict her quality of life.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. A nurse leads a psychoeducational group for depressed patients. The nurse plans to implement an exercise regime for each patient. Which of the following rationales should the nurse use when presenting this plan to the treatment team?

a. Exercise can lead to protection from the harmful effects of stress.

b. Exercise prevents damage from overstimulation of the sympathetic nervous system.

c. Exercise detoxifies the body by removing metabolic wastes and other toxins.

d. Exercise improves mood stability for patients with bipolar disorders.

ANS: A

Physical exercise can lead to protection from the harmful effects of stress on both physical and mental states. Regular physical activity was associated with a lower incidence of all psychiatric disorders except bipolar disorder. The other options are not accurate.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

4. A recent immigrant from Honduras comes to the clinic with a family member who has been a Canadian resident for 10 years. The family member says, “The immigration to Canada has been very difficult.” Considering cultural background, which expression of stress by this patient would the nurse expect?

a. Motor restlessness

b. Somatic complaints

c. Memory deficiencies

d. Sensory perceptual alterations

ANS: B

Honduras is in Central America. Many people from Asia, Africa and Central America express distress in somatic terms. The other options are not specific to this patient’s cultural background and are less likely to be observed in people from Central America.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A patient nervously says, “Financial problems are stressing my marriage. I’ve heard rumours about cutbacks at work; I am afraid I might get laid off.” The patient’s pulse is 112 per

minute; respirations are 26 per minute; and blood pressure is 166/88. Which nursing intervention will the nurse implement?

a. Advise the patient, “Go to sleep 30 to 60 minutes earlier each night to increase rest.”

b. Direct the patient in slow and deep breathing via use of a positive, repeated word.

c. Suggest the patient consider that a new job might be better than the present one.

d. Tell the patient, “Relax by spending more time playing with your pet.”

ANS: B

The patient is responding to stress with increased arousal of the sympathetic nervous system, as evidenced by elevated vital signs. These will have a negative effect on his health and increase his perception of being anxious and stressed. Stimulating the parasympathetic nervous system will counter the sympathetic nervous system’s arousal, normalizing these vital-sign changes and reducing the physiological demands stress is placing on his body. Other options do not address his physiological response pattern as directly or immediately.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

6. According to the Recent Life Changes Questionnaire, which situation would most necessitate a complete assessment of a person’s stress status and coping abilities?

a. A person who has been assigned more responsibility at work

b. A parent whose job required relocation to a different city

c. A person returning to college after an employer ceased operations

d. A man who recently separated from his wife because of marital problems

ANS: C

A person returning to college after losing a job is dealing with two significant stressors simultaneously. Together, these stressors total more life change units than any of the single stressors cited in the other options.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. A patient newly diagnosed as HIV-positive seeks the nurse's advice on how to reduce the risk of infections. The patient says, "I used to go to church and I was in my best health then. Maybe I should start going to church again." Which response will the nurse offer?

a. "Religion does not usually affect health, but you were younger and stronger then."

b. "Contact with supportive people at church might help, but religion itself is not especially helpful."

c. "Studies show that spiritual practices can enhance immune system function and coping abilities."

d. "Going to church would expose you to many potential infections. Let's think about some other options."

ANS: C

Studies have shown a positive correlation between spiritual practices and enhanced immune system function and sense of well-being. The other options wrongly suggest that spiritual practices have little effect on the immune system or reject the patient's preferences regarding health management.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

8. When a nurse asks a newly admitted patient to describe social supports, the patient says, "My parents died last year, and I have no family. I am newly divorced, and my former in-laws blame me. I don't have many friends because most people my age just want to go out drinking." Which action will the nurse apply?

a. Advise the patient that being so particular about potential friends reduces social contact.

b. Suggest using the Internet as a way to find supportive others with similar values.

c. Encourage the patient to begin dating again, perhaps with members of the church.

d. Discuss how divorce support groups could increase coping and social support.

ANS: D

High-quality social support enhances mental and physical health and acts as a significant buffer against distress. Low-quality support relationships affect a person's coping negatively. Resuming dating soon after a divorce could place additional stress on the patient rather than help her cope with existing

stressors. Developing relationships on the Internet probably would not substitute fully for direct contact with other humans and could expose her to predators misrepresenting themselves to take advantage of vulnerable people.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

9. A patient experiencing significant stress associated with a disturbing new medical diagnosis asks the nurse, “Do you think saying a prayer would help?” Select the nurse’s best answer.

a. “It could be that prayer is your only hope.”

b. “You may find prayer gives comfort and lowers your stress.”

c. “I can help you feel calmer by teaching you meditation exercises.”

d. “We do not have evidence that prayer helps, but it wouldn’t hurt.”

ANS: B

Many patients find that spiritual measures, including prayer, are helpful in mediating stress. Studies have shown that spiritual practices can enhance the sense of well-being. When a patient suggests a viable means of reducing stress, it should be supported by the nurse. Indicating that prayer is the patient’s only hope is pessimistic and would cause further distress. Suggesting meditation or other alternatives to prayer implies that the nurse does not think prayer would be effective. Many patients find that spiritual measures, including prayer, are helpful in mediating stress.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. A patient is brought to the emergency department after a motorcycle accident. The patient is alert and responsive and is diagnosed with a broken leg. The patient’s vital signs are pulse (P) 72 and respiration (R) 16. After being informed surgery is required for the broken leg, which vital sign readings would be expected?

a. P 64, R 14

b. P 68, R 12

c. P 72, R 16

d. P 80, R 20

ANS: D

The patient would experience stress associated with anticipation of surgery. In times of stress, the sympathetic nervous system takes over (fight-or-flight response) and sends signals to the adrenal glands, thereby releasing norepinephrine. The circulating norepinephrine increases the heart rate. Respirations increase, bringing more oxygen to the lungs.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

11. A patient tells the nurse, "I know that I should reduce the stress in my life, but I have no idea where to start." What would be the best initial nursing response?

a. "Physical exercise works to elevate mood and reduce anxiety."

b. "Reading about stress and how to manage it might be a good place to start."

c. "Why not start by learning to meditate? That technique will cover everything."

d. "Let's talk about what is going on in your life and then look at possible options."

ANS: D

In this case, the nurse lacks information about what stressors the patient is coping with, and what coping skills the patient already possesses. Further assessment is indicated before potential solutions can be explored. Suggesting exploration of the stress facing the patient is the only option that involves further assessment rather than suggesting a particular intervention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. A patient tells the nurse, "My doctor thinks my problems with stress relate to the negative way I think about things and suggested I learn new ways of thinking." Which response by the nurse would support the recommendation?

a. Encourage the patient to imagine being in calm circumstances.

b. Provide the patient with a blank journal and guidance about journaling.

c. Teach the patient to recognize, reconsider, and reframe irrational thoughts.

d. Teach the patient to use instruments that give feedback about bodily functions.

ANS: C

Cognitive reframing focuses on recognizing and correcting maladaptive patterns of thinking that create stress or interfere with coping. Cognitive reframing involves recognizing the habit of thinking about a situation or issue in a fixed, irrational, and unquestioning manner. Helping the patient to recognize and reframe (reword) such thoughts so that they are realistic and accurate promotes coping and reduces stress.

Thinking about being in calming circumstances is a form of guided imagery. Instruments that give feedback about bodily functions are used in biofeedback. Journaling is effective for helping to increase self-awareness. However, none of these last three interventions is likely to alter the patient's manner of thinking.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

13. A patient who had been experiencing significant stress learned to use progressive muscle relaxation and deep breathing exercises. When the patient returns to the clinic 2 weeks later, which finding most clearly shows the patient is coping more effectively with stress?

a. The patient's systolic blood pressure has changed from the 140s to the 120s mm Hg.

b. The patient reports, "I feel better, and things are not bothering me as much."

c. The patient reports, "I spend more time napping or sitting quietly at home."

d. The patient's weight decreased by 3 pounds.

ANS: A

Objective measures tend to be the most reliable means of gauging progress. In this case, the patient's elevated blood pressure, an indication of the body's physiological response to stress, has diminished. The patient's report regarding activity level is subjective; sitting quietly could reflect depression rather than improvement. Appetite, mood, and energy levels are also subjective reports that do not necessarily reflect physiological changes from stress and may not reflect improved coping with stress. The patient's weight change could be a positive or negative indicator; the blood pressure change is the best answer.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

14. A patient tells the nurse, “I will never be happy until I’m as successful as my older sister.” The nurse asks the patient to reassess this statement and reframe it. Which reframed statement by the patient is most likely to promote coping?

a. “People should treat me as well as they treat my sister.”

b. “I can find contentment in succeeding at my own job level.”

c. “I won’t be happy until I make as much money as my sister.”

d. “Being as smart or clever as my sister isn’t really important.”

ANS: B

Finding contentment within one’s own work, even when it does not involve success as others might define it, is likely to lead to a reduced sense of distress about achievement level. It speaks to finding satisfaction and happiness without measuring the self against another person. Focusing on salary is simply a more specific way of being as successful as the sister, which would not promote coping. Expecting others to treat her as they do her sister is beyond her control. Dismissing the sister’s cleverness as unimportant indicates that the patient continues to feel inferior to the sibling.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

15. A patient says, “One result of my chronic stress is that I feel so tired. I usually sleep from 11 p.m. to 6:30 a.m. I started setting my alarm to give me an extra 30 minutes of sleep each morning, but I don’t feel any better and I’m rushed for work.” Which nursing response would best address the patient’s concerns?

a. “You may need to speak to your doctor about taking a sedative to help you sleep.”

b. “Perhaps going to bed a half-hour earlier would work better than sleeping later.”

c. “A glass of wine in the evening might take the edge off and help you to rest.”

d. “Exercising just before retiring for the night may help you to sleep better.”

ANS: B

Finding contentment within one’s own work, even when it does not involve success as others might define it, is likely to lead to a reduced sense of distress about achievement level. It speaks to finding

satisfaction and happiness without measuring the self against another person. Focusing on salary is simply

a more specific way of being as successful as the sister, which would not promote coping. Expecting

others to treat her as they do her sister is beyond her control. Dismissing the sister's cleverness as

unimportant indicates that the patient continues to feel inferior to the sibling.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Evaluation

MSC: Client Needs: Psychosocial Integrity

16. A patient reports, "I am overwhelmed by stress." Which question by the nurse would

be most important to use in the initial assessment of this patient?

a. "Tell me about your family history. Do you have any relatives who have problems

with stress?"

b. "Tell me about your exercise. How much activity do you typically get in a day?"

c. "Tell me about the kinds of things you do to reduce or cope with your stress."

d. "Stress can interfere with sleep. How much did you sleep last night?"

ANS: C

The most important data to collect during an initial assessment is that which reflects how stress is

affecting the patient and how he is coping with stress at present. This data would indicate whether or not

his distress is placing him in danger (e.g., by elevating his blood pressure dangerously, or via maladaptive

responses, such as drinking), and would help the nurse understand how he copes and how well his coping

strategies and resources serve him. Of the choices presented, the highest priority would be to determine

what he is doing to cope at present, preferably via an open-ended inquiry. Family history, the extent of his

use of exercise, and how much sleep he is getting are all helpful information but provide data that is less

of a priority. Also, the manner in which such data is sought here is likely to provide only brief responses

(e.g., how much sleep he got on one particular night is probably less important than how much he is

sleeping in general).

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. Which scenario best demonstrates an example of eustress?

a. An individual loses a beloved family pet.

b. An individual prepares to take a one-week vacation to a tropical island with a group of close friends.

c. An individual receives a bank notice that there were insufficient funds in his or her account for a recent rent payment.

d. An individual receives notification that his or her current employer is experiencing financial problems and some workers will be terminated.

ANS: B

Eustress is beneficial stress; it motivates people to develop skills they need to solve problems and meet personal goals. Positive life experiences produce eustress. Going on a tropical vacation is an exciting, relaxing experience and is an example of eustress. Losing the family pet, worrying about employment security, and having financial problems are examples of distress, a negative experience that drains energy and can lead to significant emotional problems. See related audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. A person with a fear of heights drives across a high bridge. Which structure will stimulate a response from the autonomic nervous system?

a. Thalamus

b. Parietal lobe

c. Hypothalamus

d. Pituitary gland

ANS: C

The individual will find this experience stressful. The hypothalamus functions as the command-and-control centre when receiving stressful signals. The hypothalamus responds to signals of stress by engaging the autonomic nervous system. The parietal lobe is responsible for interpretation of other

sensations. The thalamus processes messages associated with pain and wakefulness. The pituitary gland may be involved in other aspects of the person's response but would not stimulate the autonomic nervous system.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

19. A person with a fear of heights drives across a high bridge. Which division of the autonomic nervous system will be stimulated in response to this experience?

a. Limbic system

b. Peripheral nervous system

c. Sympathetic nervous system

d. Parasympathetic nervous system

ANS: C

The autonomic nervous system is comprised of the sympathetic (fight-or-flight response) and parasympathetic (relaxation response) nervous system. In times of stress, the sympathetic nervous system is stimulated. A person fearful of heights would experience stress associated with driving across a high bridge. The peripheral nervous system responds to messages from the sympathetic nervous system. The limbic system processes emotional responses but is not specifically part of the autonomic nervous system.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

MULTIPLE RESPONSE

1. Which changes reflect short-term physiological responses to stress? (Select all that apply.)

a. Muscular tension, blood pressure, and triglycerides increase.

b. Epinephrine is released, increasing heart and respiratory rates.

c. Corticosteroid release increases stamina and impedes digestion.

d. Cortisol is released, increasing glucogenesis and reducing fluid loss.

e. Immune system functioning decreases, and risk of cancer increases.

f. Risk for depression, autoimmune disorders, and heart disease increases.

ANS: A, B, C, D

These answers are all short-term physiological responses to stress. Increased risk for immune system dysfunction, cancer, cardiovascular disease, depression, and autoimmune disease are all long-term (chronic) effects of stress.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

2. Which nursing comments are likely to help a patient to cope, by addressing the mediators of stress? (Select all that apply.)

a. “A divorce, while stressful, can be the beginning of a new, better phase of life.”

b. “You said you used to jog; getting back to aerobic exercise could be helpful.”

c. “Journaling often promotes awareness of how experiences have affected people.”

d. “Slowing your breathing by counting to three between breaths will calm you.”

e. “Would a short-term loan make your finances less stressful?”

f. “There is a support group for newly divorced persons in your neighbourhood.”

ANS: A, C, E, F

Stress mediators are factors that can help people cope by influencing how they perceive and respond to stressors; they include personality, social support, perceptions, and culture. Suggesting that a divorce may have positive as well as negative aspects helps the patient to alter perceptions of the stressor. Journaling increases self-awareness regarding how life experiences may have shaped how we perceive and respond to stress (or how our personality affects how we respond to stressors). A loan could help the patient by reducing the financial pressures. Participation in support groups is an excellent way to expand one’s support network relative to specific issues. However, neither aerobic exercise nor breathing-control exercises, while helpful in other ways, affect stress mediators.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

3. The nurse wishes to use guided imagery to help a patient relax. Which comments would be appropriate to include in the guided imagery script? (Select all that apply.)

a. “Imagine others treating you the way they should, the way you want to be treated ...”

b. “With each breath, you feel calmer, more relaxed, almost as if you are floating ...”

c. “You are alone on a beach, the sun is warm, and you hear only the sound of the surf ...”

d. “You have taken control; nothing can hurt you now. Everything is going your way ...”

e. “You have grown calm; your mind is still; there is nothing to disturb your well-being ...”

f. “You will feel better as work calms down, as your boss becomes more understanding ...”

ANS: B, C, E

The intent of guided imagery to help patients manage stress is to lead the patient to envision images that are calming and health-enhancing. Statements that involve the patient calming progressively with breathing, feeling increasingly relaxed, being in a calm and pleasant location, being away from stressors, and having a peaceful and calm mind are therapeutic and should be included in the script. However, items that raise stressful images or memories or that involve unrealistic expectations or elements beyond the patient’s control (e.g., that others will treat the patient as he desires, that everything is going the patient’s way, that bosses are understanding) interfere with relaxation or do not promote effective coping (or both). Thus, these are not health-promoting and should not be included in the script.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

4. An individual says to the nurse, “I feel so stressed out lately. I think the stress is affecting my body, also.” Which somatic complaints are most likely to accompany this feeling? (Select all that apply.)

a. Headache

b. Muscle flaccidity

c. Ulcer

d. Arthritis

e. Myopia

ANS: A, C, D

When individuals feel “stressed-out,” they often have accompanying somatic complaints, including headache, ulcers, and arthritis, to name a few. Changes in vision, such as myopia, would not be expected.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 06: The Nursing Process and Standards of Care for Psychiatric Mental Health Nursing

Halter: Varcarolis’s Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. What is the nurse’s primary source for data collection?

a. The patient

b. The patients chart

c. The admission history and physical

d. The patient’s family or significant other

ANS: A

The nurse’s primary source of data is the patient; however, there may be times when it is necessary to supplement or rely completely on another for the assessment information. These secondary sources can be invaluable when caring for a patient experiencing psychosis, muteness, agitation, or catatonia. Such secondary sources may include members of the family, friends, neighbours, police, health care workers, and medical records.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

2. A newly admitted patient diagnosed with major depression has gained 10 kilograms

over a few months and has suicidal ideation. The patient has taken an antidepressant medication for

1 week without remission of symptoms. Select the priority nursing diagnosis.

a. Imbalanced nutrition; more than body requirements

b. Chronic low self-esteem

c. Risk for suicide

d. Hopelessness

ANS: C

Risk for suicide is the priority diagnosis when the patient has both suicidal ideation and a plan to carry out

the suicidal intent. Imbalanced nutrition, hopelessness, and chronic low self-esteem may be applicable

nursing diagnoses, but these problems do not affect patient safety as urgently as would a suicide attempt.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

3. A patient diagnosed with major depression has lost 9 kilograms in one month, has

chronic low self-esteem, and a plan for suicide. The patient has taken an antidepressant medication

for 1 week. Which nursing intervention has the highest priority?

a. Implement suicide precautions.

b. Offer high-calorie snacks and fluids frequently.

c. Assist the patient to identify three personal strengths.

d. Observe patient for therapeutic effects of antidepressant medication.

ANS: A

Implementing suicide precautions is the only option related to patient safety. The other options related to

nutrition, self-esteem, and medication therapy are important, but are not priorities.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Safe Effective Care Environment

4. The desired outcome for a patient experiencing insomnia is, “Patient will sleep for a minimum of 5 hours nightly within 7 days.” At the end of 7 days, review of sleep data shows the patient sleeps an average of 4 hours nightly and takes a 2-hour afternoon nap. The nurse will document the outcome as which of the following?

a. Consistently met

b. Often met

c. Sometimes met

d. Unmet

ANS: D

Although the patient is sleeping 6 hours daily, the total is not one uninterrupted session at night. Therefore, the outcome must be evaluated as unmet.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiological Integrity

5. The desired outcome for a patient experiencing insomnia is, “Patient will sleep for a minimum of 5 hours nightly within 7 days.” At the end of 7 days, review of sleep data shows the patient sleeps an average of 4 hours nightly and takes a 2-hour afternoon nap. What is the nurse’s next action?

a. Continue the current plan without changes.

b. Remove this nursing diagnosis from the plan of care.

c. Write a new nursing diagnosis that better reflects the problem.

d. Examine interventions for possible revision of the target date.

ANS: D

Sleeping a total of 5 hours at night remains a reasonable outcome. Extending the period for attaining the outcome may be appropriate. Examining interventions might result in planning an activity during the afternoon rather than having time for a nap. Continuing the current plan without changes is inappropriate.

Removing this nursing diagnosis from the plan of care would be correct when the outcome was met, and the problem resolved. Writing a new nursing diagnosis is inappropriate because no other nursing

diagnosis relates to the problem.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiological Integrity

6. A patient begins a new program to assist with building social skills. In which part of the plan of care should a nurse record the item, “Encourage patient to attend one psychoeducational group daily”?

a. Assessment

b. Analysis

c. Implementation

d. Evaluation

ANS: C

Interventions are the nursing prescriptions to achieve the outcomes. Interventions should be specific.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

7. Before assessing a new patient, a nurse is told by another health care worker, “I know that patient. No matter how hard we work, there isn’t much improvement by the time of discharge.” The nurse’s responsibility is to do which of the following?

a. Document the other worker’s assessment of the patient

b. Assess the patient based on data collected from all sources

c. Validate the worker’s impression by contacting the patient’s significant other

d. Discuss the worker’s impression with the patient during the assessment interview

ANS: B

Assessment should include data obtained from both the primary and reliable secondary sources. To gain an even clearer understanding of your patient, it is helpful to look to outside sources for information.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

8. A patient presents to the emergency department with mixed psychiatric symptoms. The admission nurse suspects the symptoms may be the result of a medical problem. Lab results show elevated BUN (blood urea nitrogen) and creatinine. What is the nurse’s next best action?

a. Report the findings to the health care provider.

b. Assess the patient for a history of renal problems.

c. Assess the patient's family history for cardiac problems.

d. Arrange for the patient's hospitalization on the psychiatric unit.

ANS: B

Elevated BUN (blood urea nitrogen) and creatinine suggest renal problems. Renal dysfunction can often imitate psychiatric disorders. The nurse should further assess the patient's history for renal problems and then share the findings with the health care provider.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

9. A patient states, "I'm not worth anything. I have negative thoughts about myself. I feel anxious and shaky all the time. Sometimes I feel so sad that I want to go to sleep and never wake up." Which nursing intervention should have the highest priority?

a. Self-esteem-building activities

b. Anxiety self-control measures

c. Sleep enhancement activities

d. Suicide precautions

ANS: D

The nurse would place a priority on monitoring and reinforcing suicide self-restraint because it relates directly and immediately to patient safety. Patient safety is always a priority concern. The nurse needs to initiate suicide precautions (e.g., ongoing observations and monitoring of the patient, provision of a protective environment) for the person who is at serious risk for suicide. The nurse should monitor and reinforce all patient attempts to control anxiety, improve sleep patterns, and develop self-esteem, while giving priority attention to suicide self-restraint.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Safe Effective Care Environment

10. Select the best outcome for a patient with the nursing diagnosis Impaired social interaction related to sociocultural dissonance as evidenced by stating, "Although I'd like to, I don't join in because I don't speak the language very well."

a. Patient will show improved use of language.

b. Patient will demonstrate improved social skills.

c. Patient will become more independent in decision making.

d. Patient will select and participate in one group activity per day.

ANS: D

The outcome describes social involvement on the part of the patient. Neither cooperation nor independence has been an issue. The patient has already expressed a desire to interact with others. Outcomes must be measurable. Two of the distracters are not measurable.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Outcomes Identification

11. Nursing behaviours associated with the implementation phase of nursing process are concerned with which of the following?

a. Participating in mutual identification of patient outcomes

b. Gathering accurate and sufficient patient-centred data

c. Comparing patient responses and expected outcomes

d. Carrying out interventions and coordinating care

ANS: D

The psychiatric mental health nurse coordinates the implementation of the plan and provides documentation. Some registered nurses and registered psychiatric nurses are educationally and clinically prepared to conduct advanced interventions such as offering psychotherapy to individuals, couples, groups, and families and providing consultation to other disciplines using evidence-informed psychotherapeutic frameworks and nurse-patient therapeutic relationships.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

12. Which statement made by a patient during an initial assessment interview should serve as the priority focus for the plan of care?

a. “I can always trust my family.”

b. “It seems like I always have bad luck.”

c. “You never know who will turn against you.”

d. “I hear evil voices that tell me to do bad things.”

ANS: D

The statement regarding evil voices tells the nurse that the patient is experiencing auditory hallucinations

and represents the patient’s chief complaint. The other statements are vague and do not clearly identify

the patient’s chief symptom.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

13. Who is the best person to provide information about a 4-year-old’s behaviour, attitude,

and performance?

a. The child

b. The parent(s)

c. The family doctor

d. The psychologist

ANS: B

When assessing children, it is important to gather data from a variety of sources. Although the child is the

best source for determining emotions, the caregivers (parents or guardians) often can best describe the

behaviour, performance, and attitude of the child. Caregivers also are helpful in interpreting the child’s

words and responses.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

14. A nurse assesses an older adult patient brought to the emergency department by a

family member. The patient was wandering outside saying, “I can’t find my way home.” The

patient is confused and unable to answer questions. Select the nurse’s best action.

a. Record the patient’s answers to questions on the nursing assessment form.

b. Ask an advanced-practice nurse to perform the assessment interview.

c. Call for a mental health advocate to maintain the patient’s rights.

d. Obtain important information from the family member.

ANS: D

When the patient (primary source) is unable to provide information, secondary sources should be used, in

this case, the family member. Later, more data may be obtained from other information sources familiar

with the patient. An advanced-practice nurse is not needed for this assessment; it is within the scope of

practice of the staff nurse. Calling a mental health advocate is unnecessary.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

15. A nurse asks a patient, “If you had a fever and vomiting for 3 days, what would you

do?” Which aspect of the mental status examination is the nurse assessing?

a. Behaviour

b. Cognition

c. Affect and mood

d. Perceptual disturbances

ANS: B

Assessing cognition involves determining a patient’s judgement and decision making. In this case, the

nurse would expect a response of “Call my doctor” if the patient’s cognition and judgement are intact. If

the patient responds, “I would stop eating” or “I would just wait and see what happened,” the nurse would

conclude that judgement is impaired. The other options refer to other aspects of the examination.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. An adolescent asks a nurse conducting an assessment interview, “Why should I tell

you anything? You’ll just tell my parents whatever you find out.” Which response by the nurse is

appropriate?

a. “That isn’t true. What you tell us is private and held in strict confidence. Your

parents have no right to know.”

b. “Yes, your parents may find out what you say, but it is important that they know

about your problems."

c. "What you say about your feelings is private, but some things, like suicidal thinking, must be reported to the treatment team."

d. "It sounds as though you are not really ready to work on your problems and make changes."

ANS: C

Adolescents are very concerned with confidentiality. The patient has a right to know that most information will be held in confidence but that certain material must be reported or shared with the treatment team, such as threats of suicide, homicide, use of illegal drugs, or issues of abuse. The incorrect responses are not true, will not inspire the confidence of the patient, or are confrontational.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

17. A nurse wants to assess an adult patient's recent memory. Which question would best yield the desired information?

a. "Where did you go to elementary school?"

b. "What did you have for breakfast this morning?"

c. "Can you name the current president of the United States?"

d. "A few minutes ago, I told you my name. Can you remember it?"

ANS: B

The patient's recall of a meal provides evidence of recent memory. Two of the incorrect responses are useful to assess immediate and remote memory. The other distracter assesses the patient's fund of knowledge.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. When a nurse assesses an older adult patient, answers seem vague or unrelated to the questions. The patient also leans forward and frowns, listening intently to the nurse. Which of the following questions would be appropriate for the nurse to ask?

a. “Are you having difficulty hearing when I speak?”

b. “How can I make this assessment interview easier for you?”

c. “I notice you are frowning. Are you feeling annoyed with me?”

d. “You’re having trouble focusing on what I’m saying. What is distracting you?”

ANS: A

The patient’s behaviours may indicate difficulty hearing. Identifying any physical need that the patient may have at the onset of the interview, and making accommodations, are important considerations. By asking if the patient is annoyed, the nurse is jumping to conclusions. Asking how to make the interview easier for the patient may not elicit a concrete answer. Asking about distractions is a way of asking about auditory hallucinations, which is not appropriate because the nurse has observed that the patient seems to be listening intently.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

19. At what point in an assessment interview would a nurse ask, “How does your faith help you in stressful situations?”

a. During the assessment of childhood growth and development

b. During the assessment of substance use and abuse

c. During the assessment of educational background

d. During the assessment of coping strategies

ANS: D

When discussing coping strategies, the nurse might ask what the patient does when upset, what usually relieves stress, and to whom the patient goes to talk about problems. The question regarding whether the patient’s faith helps deal with stress fits well here. It would be out of place if introduced during exploration of the other topics.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. When a new patient is hospitalized, a nurse takes the patient on a tour, explains rules of the unit, and discusses the daily schedule. The nurse is engaged in which of the following?

a. Counselling

b. Health teaching

c. Milieu management

d. Psychobiological intervention

ANS: C

Milieu management provides a therapeutic environment in which the patient can feel comfortable and safe while engaging in activities that meet the patient's physical and mental health needs. Counselling refers to activities designed to promote problem solving and enhanced coping and includes interviewing, crisis intervention, stress management, and conflict resolution. Health teaching involves identifying health education needs and giving information about these needs. Psychobiological interventions involve medication administration and monitoring response to medications.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

21. After formulating the nursing diagnoses for a new patient, what is a nurse's next action?

a. Designing interventions to include in the plan of care

b. Determining the goals and outcome criteria

c. Implementing the nursing plan of care

d. Completing the spiritual assessment

ANS: B

The third step of the nursing process is outcomes identification. Outcomes cannot be determined until the nursing assessment is complete and nursing diagnoses have been formulated.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

22. Select the most appropriate label to complete this nursing diagnosis: _____

related to feelings of shyness and poorly developed social skills as evidenced by watching

television alone at home every evening.

a. Deficient knowledge

b. Ineffective coping

c. Social isolation

d. Powerlessness

ANS: C

A nursing diagnosis is a clinical judgement about a patient's response, needs, actual and potential

psychiatric disorders, mental health problems, and potential co-morbid physical illnesses. A well-chosen

and well-stated nursing diagnosis is the basis for selecting therapeutic outcomes and interventions. In this

instance, the evidence shows social isolation that is caused by shyness and poorly developed social skills.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

23. What does the nurse assess when completing the final "S" of the HEADSSS

Psychosocial Interview Technique?

a. Suicide risk

b. Savagery

c. Sexuality

d. Social support

ANS: B

The final S in the HEADSSS Psychosocial Interview Technique is to assess savagery, that is, violence or

abuse in the home environment or neighbourhood.

DIF: Cognitive Level: Remember (Knowledge) TOP: Nursing Process: N/A

MSC: Client Needs: Safe Effective Care Environment

24. A nurse documents, "Patient is mute despite repeated efforts to elicit speech. Makes no

eye contact. Inattentive to staff. Gazes off to the side or looks upward rather than at speaker."

Which nursing diagnosis should be considered?

a. Defensive coping

b. Decisional conflict

c. Risk for other-directed violence

d. Impaired verbal communication

ANS: D

The defining characteristics are more related to the nursing diagnosis of impaired verbal communication than to the other nursing diagnoses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

25. A nurse prepares to assess a new patient who moved to Canada from Central America three years ago. After introductions, what is the nurse's next comment?

a. "How did you get to Canada?"

b. "Would you like for a family member to help you talk with me?"

c. "An interpreter is available. Would you like for me to make a request for these services?"

d. "Are you comfortable conversing in English, or would you prefer to have a translator present?"

ANS: D

The nurse should determine whether a translator is needed by first assessing the patient for language barriers. Accuracy of the assessment depends on the ability to communicate in a language that is familiar to the patient. Family members are not always reliable translators. An interpreter may change the patient's responses; a translator is a better resource.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

26. The nurse records this entry in a patient's progress notes: Patient escorted to unit by ER nurse at 2130. Patient's clothing was dirty. In interview room, patient sat with hands over face, sobbing softly. Did not acknowledge nurse or reply to questions. After several minutes, abruptly

arose, ran to window, and pounded. Shouted repeatedly, “Let me out of here.” Verbal intervention unsuccessful. Order for stat dose 2 mg haloperidol PO obtained; medication administered at 2150.

By 2215, patient stopped shouting and returned to sit wordlessly in chair. Patient placed on one-to-one observation. How should this documentation be evaluated?

a. Uses unapproved abbreviations

b. Contains subjective material

c. Too brief to be of value

d. Excessively wordy

e. Meets standards

ANS: E

This narrative note describes patient appearance, behaviour, and conversation. It mentions that less-restrictive measures were attempted before administering medication and documents patient response to

medication. This note would probably meet standards. A complete nursing assessment would be in order as soon as the patient is able to participate. Subjective material is absent from the note. Abbreviations are

acceptable.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Evaluation

MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. A nurse assessed a patient who reluctantly participated in activities, answered questions with minimal responses, and rarely made eye contact. What information should be included when documenting the assessment? (Select all that apply.)

a. The patient was uncooperative

b. The patient’s subjective responses

c. Only data obtained from the patient's verbal responses

d. A description of the patient's behaviour during the interview

e. Analysis of why the patient was unresponsive during the interview

ANS: B, D

Both content and process of the interview should be documented. Providing only the patient's verbal responses would create a skewed picture of the patient. Writing that the patient was uncooperative is subjectively worded. An objective description of patient behaviour would be preferable. Analysis of the reasons for the patient's behaviour would be speculation, which is inappropriate.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

2. A nurse performing an assessment interview for a patient with a substance use disorder decides to use a standardized rating scale. Which scales are appropriate? (Select all that apply.)

a. Addiction Severity Index (ASI)

b. Brief Drug Abuse Screen Test (B-DAST)

c. Abnormal Involuntary Movement Scale (AIMS)

d. Cognitive Capacity Screening Examination (CCSE)

e. Recovery Attitude and Treatment Evaluator (RAATE)

ANS: A, B, E

Standardized scales are useful for obtaining data about substance use disorders. The ASI, B-DAST, and RAATE are scales related to substance abuse. AIMS assesses involuntary movements associated with antipsychotic medications. The CCSE assesses cognitive function.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. What information is conveyed by nursing diagnoses? (Select all that apply.)

a. Medical judgements about the disorder

b. Unmet patient needs currently present

c. Goals and outcomes for the plan of care

d. Supporting data that validate the diagnoses

e. Probable causes that will be targets for nursing interventions

ANS: B, D, E

Nursing diagnoses focus on phenomena of concern to nurses rather than on medical diagnoses.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

4. A patient is very suspicious and states, “The FBI has me under surveillance.” Which strategies should a nurse use when gathering initial assessment data about this patient? (Select all that apply.)

a. Tell the patient that medication will help this type of thinking.

b. Ask the patient, “Tell me about the problem as you see it.”

c. Seek information about when the problem began.

d. Tell the patient, “Your ideas are not realistic.”

e. Reassure the patient, “You are safe here.”

ANS: B, C, E

During the assessment interview, the nurse should listen attentively and accept the patient’s statements in a non-judgemental way. The psychosocial assessment collects information, in the patient’s own words, about what the patient’s chief complaint is that day. Because the patient is suspicious and fearful, reassuring safety may be helpful, although trust is unlikely so early in the relationship. Saying that medication will help or telling the patient that the ideas are not realistic will undermine development of trust between the nurse and patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 07: Ethical Responsibilities and Legal Obligations for Psychiatric Mental Health Nursing Practice

Halter: Varcarolis’s Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A psychiatric nurse best applies the ethical principle of autonomy by doing which of

the following?

a. Exploring alternative solutions with a patient, who then makes a choice.

b. Suggesting that two patients who were fighting be restricted to the unit.

c. Intervening when a self-mutilating patient attempts to harm self.

d. Staying with a patient demonstrating a high level of anxiety.

ANS: A

Autonomy is the right to self-determination, that is, to make one's own decisions. By exploring alternatives with the patient, the patient is better equipped to make an informed, autonomous decision. The distracters demonstrate beneficence, fidelity, and justice.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

2. A nurse finds a psychiatric advance directive in the medical record of a patient experiencing psychosis. The directive was executed during a period when the patient was stable and competent. The nurse should do which of the following?

a. Review the directive with the patient to ensure it is current.

b. Ensure that the directive is respected in treatment planning.

c. Consider the directive only if there is a cardiac or respiratory arrest.

d. Encourage the patient to revise the directive in light of the current health problem.

ANS: B

The nurse has an obligation to honour the right to self-determination. An advance psychiatric directive supports that goal. Since the patient is currently psychotic, the terms of the directive now apply.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

3. Two hospitalized patients fight whenever they are together. During a team meeting, a nurse asserts that safety is of paramount importance, so treatment plans should call for both patients to be secluded to keep them from injuring each other. This assertion does which of the following?

a. Reinforces the autonomy of the two patients

b. Violates the civil rights of both patients

c. Represents the intentional tort of battery

d. Correctly places emphasis on safety

ANS: B

Patients have a right to treatment in the least restrictive setting. Safety is important, but less restrictive measures should be tried first. Unnecessary seclusion may result in a charge of false imprisonment. Seclusion violates the patient's autonomy. The principle by which the nurse is motivated is beneficence, not justice. The tort represented is false imprisonment.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

4. In a team meeting a nurse says, "I'm concerned about whether we are behaving ethically by using restraint to prevent one patient from self-mutilation, while the care plan for another self-mutilating patient requires one-on-one supervision." Which ethical principle most clearly applies to this situation?

a. Beneficence

b. Autonomy

c. Fidelity

d. Justice

ANS: D

The nurse is concerned about justice, that is, fair distribution of care, which includes treatment with the least restrictive methods for both patients. Beneficence means promoting the good of others. Autonomy is the right to make one's own decisions. Fidelity is the observance of loyalty and commitment to the patient.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

5. Select the response that is an example of a tort.

a. The plan of care for a patient is not completed within 24 hours of the patient's admission.

b. A nurse gives a PRN dose of an antipsychotic drug to an agitated patient because the unit is short-staffed.

c. An advanced-practice nurse recommends hospitalization for a patient who is dangerous to self and others.

d. A patient's admission status change from involuntary to voluntary after the patient's hallucinations subside.

ANS: B

A tort is a civil wrong against a person that violates his or her rights. Giving unnecessary medication for the convenience of staff, controls behaviour in a manner similar to secluding a patient; thus, false imprisonment is a possible charge. The other options do not exemplify torts.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

6. What is the legal significance of a nurse's action when a patient verbally refuses medication and the nurse gives the medication over the patient's objection?

a. The nurse has been negligent.

b. The nurse has committed malpractice.

c. The nurse has fulfilled the standard of care.

d. The nurse can be charged with battery.

ANS: D

Battery is an intentional tort in which one individual violates the rights of another through touching without consent. Forcing a patient to take medication after the medication was refused constitutes battery.

The charge of battery can be brought against the nurse. The medication may not necessarily harm the patient; harm is a component of malpractice.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

7. Which nursing intervention demonstrates false imprisonment?

a.

A confused and combative patient says, “I’m getting out of here, and no one can stop me.” The nurse restrains this patient without a health care provider’s order and then promptly obtains an order.

b. A patient has been irritating and attention-seeking much of the day. A nurse escorts the patient down the hall saying, “Stay in your room, or you’ll be put in seclusion.”

c. An involuntarily hospitalized patient with suicidal ideation runs out of the psychiatric unit. The nurse rushes after the patient and convinces the patient to return to the unit.

d. An involuntarily hospitalized patient with homicidal ideation attempts to leave the facility. A nurse calls the security team and uses established protocols to prevent the patient from leaving.

ANS: D

False imprisonment involves holding a competent person against his or her will. Actual force is not a requirement of false imprisonment. The individual needs only to be placed in fear of imprisonment by someone who has the ability to carry out the threat. If a patient is not competent (confused), then the nurse should act with beneficence. Patients admitted involuntarily should not be allowed to leave without permission of the treatment team.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

8. Which of the following patients meets criteria for involuntary hospitalization for psychiatric treatment?

a. The patient who is noncompliant with the treatment regimen

b. The patient who fraudulently files for bankruptcy

c. The patient who sold and distributed illegal drugs

d. The patient who threatens to harm self and others

ANS: D

Involuntary hospitalization protects patients who are dangerous to themselves or others and cannot care for their own basic needs. Involuntary commitment also protects other individuals in society. The behaviours described in the other options are not sufficient to require involuntary hospitalization.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe Effective Care Environment

9. A nurse prepares to administer a scheduled injection of haloperidol decanoate (Haldol) to an outpatient with schizophrenia. As the nurse swabs the site, the patient shouts, “Stop! I don’t want to take that medicine anymore. I hate the side effects.” Select the nurse’s best action.

a. Assemble other staff for a show of force and proceed with the injection, using restraint if necessary.

b. Stop the medication administration procedure and say to the patient, “Tell me more about the side effects you’ve been having.”

c. Proceed with the injection but explain to the patient that there are medications that will help reduce the unpleasant side effects.

d. Say to the patient, “Since I’ve already drawn the medication in the syringe, I’m required to give it, but let’s talk to the doctor about delaying next month’s dose.”

ANS: B

Patients with mental illness retain their right to refuse treatment unless there is clear, cogent, and convincing evidence of harming themselves or harming others. The patient in this situation presents no evidence of harm. The nurse, as an advocate and educator, should seek more information about the patient’s decision and not force the medication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

10. A nurse is concerned that an agency’s policies are inadequate. Which understanding about the relationship between substandard institutional policies and individual nursing practice should guide nursing practice?

a. Agency policies do not exempt an individual nurse of responsibility to practice

according to professional standards of nursing care.

b. Agency policies are the legal standard by which a professional nurse must act and

therefore override other standards of care.

c. Faced with substandard policies, a nurse has a responsibility to inform the

supervisor and discontinue patient care immediately.

d. Interpretation of policies by the judicial system is rendered on an individual basis

and therefore cannot be predicted.

ANS: A

The weakness of individual institutions setting such criteria is that a particular hospital's policy may be

substandard. Substandard institutional policies, however, do not absolve the individual nurse of

responsibility to practise on the basis of professional standards of nursing care. Nurses are professionally

bound to uphold standards of practice regardless of lesser standards established by a health care agency or

a province/territory. Conversely, if the agency standards are higher than standards of practice, the agency

standards must be upheld. The courts may seek to establish the standard of care through the use of expert

witnesses when the issue is clouded.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

11. A newly admitted acutely psychotic patient is a private patient of the medical director

and has private medical insurance. To whom does the psychiatric nurse assigned to the patient

owe the duty of care?

a. Medical director

b. Hospital

c. Profession

d. Patient

ANS: D

Although the nurse is accountable to the health care provider, the agency, the patient, and the profession,

the duty of care is owed to the patient.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

12. Which action by a nurse constitutes a breach of a patient's right to privacy?

a. Documenting the patient's daily behaviour during hospitalization

b. Releasing information to the patient's employer without consent

c. Discussing the patient's history with other staff during care planning

d. Asking family to share information about a patient's pre-hospitalization behaviour

ANS: B

Release of information without patient authorization violates the patient's right to privacy. The other options are acceptable nursing practice and do not constitute a breach of the patient's right to privacy of information (confidentiality).

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

13. An adolescent hospitalized after a violent physical outburst tells the nurse, "I'm

going to kill my father, but you can't tell anyone." Select the nurse's best response.

a. "You are right. Federal law requires me to keep clinical information private."

b. "I am obligated to share that information with the treatment team."

c. "Those kinds of thoughts will make your hospitalization longer."

d. "You should share this thought with your psychiatrist."

ANS: B

Breach of nurse-patient confidentiality does not pose a legal dilemma for nurses in these circumstances because a team approach to delivery of psychiatric care presumes communication of patient information to other staff members to develop treatment plans and outcome criteria. The CNA's code of ethics

clarifies that the person's right to privacy is not absolute. In some situations, disclosure may be mandated

to protect the patient, other persons, or public health. The patient should also know that the team has a

duty to warn the father of the risk for harm.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

14. A voluntarily hospitalized patient tells the nurse, "Get me the forms for discharge. I

want to leave now." Select the nurse's best response.

a. "I will get the forms for you right now and bring them to your room."

b. "Since you signed your consent for treatment, you may leave if you desire."

c. "I will get them for you but let's talk about your decision to leave treatment."

d. "I cannot give you those forms without your health care provider's permission."

ANS: C

A voluntarily admitted patient has the right to decide to leave the hospital. However, as a patient

advocate, the nurse is responsible for weighing factors related to the patient's wishes and best interests.

By asking for information, the nurse may be able to help the patient reconsider the decision. Facilitating

discharge without consent is not in the patient's best interests before exploring the reason for the request.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

15. A registered nurse requests that the unlicensed health care worker give a patient his

or her medication at 1000 hours as the nurse will be at coffee break. This represents an example

of which of the following?

a. Malpractice

b. Intentional tort

c. Vicarious liability

d. Defamation of character

ANS: C

Vicarious liability, also known as supervisory liability, is demonstrated in the example, as the RN is inappropriately delegating medication administration to an unlicensed health care worker.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

16. Which individual with mental illness may need emergency or involuntary admission?

a. An individual who resumes using heroin while still taking naltrexone (ReVia).

b. An individual who reports hearing angels playing harps during thunderstorms.

c. An individual who does not keep an outpatient appointment with the mental health nurse.

d. An individual who throws a heavy plate at a waiter at the direction of command hallucinations.

ANS: D

Throwing a heavy plate is likely to harm the waiter and is evidence of the possibility of harming others. This behaviour meets the criteria for emergency or involuntary hospitalization for mental illness. The behaviours in the other options evidence mental illness but not imminent danger for harming self or others.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

17. A patient in alcohol rehabilitation reveals to the nurse, “I feel terrible guilt for sexually abusing my 6-year-old before I was admitted.” Select the nurse’s most important action.

a. Report the abuse to the local child welfare agency.

b. Reply, “I’m glad you feel comfortable talking to me about it.”

c. File a written report with the agency’s ethics committee.

d. Respect nurse-patient relationship confidentiality.

ANS: A

It is your legal and ethical responsibility to make a report of suspected abuse to your province’s or territories child welfare agency. Most statutes include the consequences of failure to report. Many

provinces and territories specifically require nurses to report cases of suspected abuse.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

18. A family member of a patient with delusions of persecution asks the nurse, “Are there any circumstances under which the treatment team is justified in violating a patient’s right to confidentiality?” The nurse should reply that confidentiality may be breached in which of the following circumstances, if any?

a. Under no circumstances

b. At the discretion of the psychiatrist

c. When questions are asked by law enforcement

d. If the patient threatens the life of another person

ANS: D

The duty to warn a person whose life has been threatened by a psychiatric patient overrides the patient’s right to confidentiality. The right to confidentiality is not suspended at the discretion of the therapist or for legal investigations.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

19. A new antidepressant is prescribed for an elderly patient with major depression, but the dose is more than the usual geriatric dose. What should the nurse do?

a. Consult a reliable drug reference.

b. Teach the patient about possible side effects and adverse effects.

c. Withhold the medication and confer with the health care provider.

d. Encourage the patient to increase oral fluids to reduce drug concentration.

ANS: C

The dose of antidepressants for elderly patients is often less than the usual adult dose. The nurse should withhold the medication and consult the health care provider who wrote the order. The nurse’s duty is to

practise according to professional standards as well as intervene and protect the patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

20. A patient diagnosed with schizophrenia believes a local minister stirred evil spirits. The patient threatens to bomb a local church. The psychiatrist notifies the minister. Select the answer with the correct rationale.

a. The psychiatrist released information without proper authorization.

b. The psychiatrist demonstrated the duty to warn and protect.

c. The psychiatrist violated the patient's confidentiality.

d. The psychiatrist avoided charges of malpractice.

ANS: B

It is the health care provider's duty to warn or notify an intended victim after a threat of harm has been made. Informing a potential victim of a threat is a legal responsibility of the health care provider. It is not a violation of confidentiality.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

21. A patient with psychosis became aggressive, struck another patient, and required seclusion. Select the best documentation.

a. Patient struck another patient who attempted to leave day room to go to bathroom. Seclusion necessary at 1415. Plan: Maintain seclusion for 8 hours and keep these two patients away from each other for 24 hours.

b. Seclusion ordered by physician at 1415 after command hallucinations told the patient to hit another patient. Careful monitoring of patient maintained during period of seclusion.

c. Seclusion ordered by physician for aggressive behaviour. Begun at 1415. Maintained for 2 hours without incident. Outcome: Patient calmer and apologized for outburst.

d. Patient pacing, shouting. Haloperidol 5 mg given PO at 1300. No effect by 1315. At 1415 patient yelled, “I’ll punch anyone who gets near me,” and struck another patient with fist. Physically placed in seclusion at 1420. Seclusion order obtained from physician at 1430.

ANS: D

Documentation must be specific and detail the key aspects of care. It should demonstrate implementation of the least restrictive alternative. Justification for why a patient was secluded should be recorded, along with interventions attempted in an effort to avoid seclusion. Documentation should include a description of behaviour and verbalizations, interventions tried and their outcomes, and the name of the health care provider ordering the use of seclusion.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

22. A person in the community asks, “Why aren’t people with mental illness kept in institutions anymore?” Select the nurse’s best response.

a. “Less restrictive settings are available now to care for individuals with mental illness.”

b. “There are fewer people with mental illness, so fewer hospital beds are needed.”

c. “Most people with mental illness are still in psychiatric institutions.”

d. “Psychiatric institutions violated patients’ rights.”

ANS: A

The community is a less restrictive alternative than hospitals for treatment of people with mental illness. Changes in the provincial/territorial acts over the years reflect a shift in emphasis from institutional care of people with mental illness to community-based care delivery models. The distracters are incorrect and part of the stigma of mental illness.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

23. A patient experiencing psychosis asks a psychiatric technician, “What’s the matter

with me?” The technician replies, “Nothing is wrong with you. You just need to use some self-control.” The nurse who overheard the exchange should take action based on which of the

following?

a. The technician’s unauthorized disclosure of confidential clinical information.

b. Violation of the patient’s right to be treated with dignity and respect.

c. The nurse’s obligation to report caregiver negligence.

d. The patient’s right to social interaction.

ANS: B

Patients have the right to be treated with dignity and respect. The technician’s comment disregards the seriousness of the patient’s illness. The Code of Ethics for Nurses requires intervention. Patient emotional

abuse has been demonstrated, not negligence. An interaction with the technician is not an aspect of social

interaction. The technician did not disclose clinical information.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

24. Which documentation of a patient’s behaviour best demonstrates a nurse’s

observations?

a. Isolates self from others. Frequently fell asleep during group. Vital signs stable.

b. Calmer; more cooperative. Participated actively in group. No evidence of psychotic

thinking.

c. Appeared to hallucinate. Frequently increased volume on television, causing

conflict with others.

d. Wore four layers of clothing. States, “I need protection from evil bacteria trying to

pierce my skin.”

ANS: D

The documentation states specific observations of the patient’s appearance and the exact statements made.

The other options are vague or subjective statements and can be interpreted in different ways.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

25. After leaving work, a nurse realizes documentation of administration of a PRN medication was omitted. This off-duty nurse phones the nurse on duty and says, "Please document administration of the medication for me. My password is alpha1." The nurse receiving the call should do which of the following?

a. Fulfill the request promptly.

b. Document the caller's password.

c. Refer the matter to the charge nurse to resolve.

d. Report the request to the patient's health care provider.

ANS: C

Fraudulent documentation may be grounds for discipline by provincial/territorial nursing associations or colleges. Referring the matter to the charge nurse will allow observance of hospital policy while ensuring that documentation occurs. Notifying the health care provider would be unnecessary when the charge nurse can resolve the problem. Nurses should not provide passwords to others.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

26. Which individual diagnosed with a mental illness may need involuntary hospitalization?

a. An individual who has a panic attack after her child gets lost in a shopping mall

b. An individual with visions of demons emerging from cemetery plots throughout the community

c. An individual who takes 38 acetaminophen tablets after his or her stock portfolio becomes worthless

d. An individual diagnosed with major depression who stops taking prescribed antidepressant medication

ANS: C

Involuntary hospitalization protects patients who are dangerous to themselves or others and cannot care for their own basic needs. Involuntary hospitalization also protects other individuals in society. An overdose of acetaminophen indicates dangerousness to self. The behaviours described in the other options are not sufficient to require involuntary hospitalization.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe Effective Care Environment

27. An unlicensed health care worker in a psychiatric hospital says to the nurse, "We don't have time every day to help each patient complete a menu selection. Let's tell dietary to prepare popular choices and send them to our unit." Select the nurse's best response.

a. "Thanks for the suggestion, but that idea may not work because so many patients take MAOI (monoamine oxidase inhibitor) antidepressants."

b. "Thanks for the idea, but it's important to treat patients as individuals. Giving choices is one way we can respect patients' individuality."

c. "Thank you for the suggestion, but the patients' bill of rights requires us to allow patients to select their own diet."

d. "Thank you. That is a very good idea. It will make meal preparation easier for the dietary department."

ANS: B

The nurse's response to the worker should recognize patients' rights to be treated with dignity and respect as well as promote autonomy. This response also shows respect for the worker and fulfills the nurse's obligation to provide supervision of unlicensed personnel. The incorrect responses have flawed rationale or do not respect patients as individuals.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

28. In order to release information to another health care facility or third party regarding

a patient diagnosed with a mental illness, the nurse must obtain which of the following?

a. A signed consent by the patient for release of information stating specific

information to be released.

b. A verbal consent for information release from the patient and the patient's guardian

or next of kin.

c. Permission from members of the health care team who participate in treatment

planning.

d. Approval from the attending psychiatrist to authorize the release of information.

ANS: A

Nurses have an obligation to protect patients' privacy and confidentiality. Clinical information should not

be released without the patient's signed consent for the release unless there is evidence of harm to self or

others.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. In which situations would a nurse have the duty to intervene and report? (Select all

that apply.)

a. A peer has difficulty writing measurable outcomes.

b. A health care provider gives a telephone order for medication.

c. A peer tries to provide patient care in an alcohol-impaired state.

d. A team member violates relationship boundaries with a patient.

e. A patient refuses medication prescribed by a licensed health care provider.

ANS: C, D

Both keyed answers are events that jeopardize patient safety. The distracters describe situations that may

be resolved with education or that are acceptable practices.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

2. Which actions violate the civil rights of a psychiatric patient? (Select all that apply.)

a. The nurse performs mouth checks after overhearing a patient say, “I’ve been

spitting out my medication.”

b. The nurse begins suicide precautions before a patient is assessed by the health care

provider.

c. The nurse opens and reads a letter a patient left at the nurse’s station to be mailed.

d. The nurse places a patient’s expensive watch in the hospital business office safe.

e. The nurse restrains a patient who uses profanity when speaking to the nurse.

ANS: C, E

The patient has the right to send and receive mail without interference. Restraint is not indicated because

a patient uses profanity; there are other less restrictive ways to deal with this behaviour. The other options

are examples of good nursing judgement and do not violate the patient’s civil rights.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

Chapter 08: Cultural Considerations for Psychiatric Mental Health Nursing

Halter: Varcarolis’s Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Which term refers to the sharing of common traits, customs, and race?

a. World view

b. Ethnicity

c. Ethnocentrism

d. Culture

ANS: B

Ethnicity refers to the sharing of common traits, customs, and race. World view is a major paradigm used to explain the world and its mysteries, inclusive of beliefs about health, illness, and the hereafter. Ethnocentrism is the perception that one's own values, beliefs, and behaviours are superior. Culture comprises the shared beliefs, values, and practices that guide a group's members in patterned ways of thinking and acting, and includes factors such as religion, geography, socioeconomic status, occupation, ability or disability, and sexual orientation.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

2. A patient who speaks limited English has gotten upset with the nurse when she gestured with her foot towards the washroom as her hands were full and wanted to help the patient find the washroom. What should the nurse do?

a. Contact a translator.

b. Apologize for upsetting the patient and ask what happened that upset the patient.

c. Explain to the patient that you were pointing to the washroom with your foot.

d. Research the patients' cultural background to assess what it was that may have been misinterpreted.

ANS: B

Nurses can become aware of signs of cultural pain (e.g., a patient's feeling of alienation, emotional upset) and recover trust and rapport by asking what has caused the offence, apologizing for insensitivity, and expressing willingness to provide culturally sensitive care.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

3. To provide culturally competent care, the nurse should do which of the following?

a. Accurately interpret the thinking of individual patients

b. Predict how a patient may perceive treatment interventions

c. Formulate interventions to reduce the patient's ethnocentrism

d. Identify strategies that fit within the cultural context of the patient

ANS: D

Cultural competence is the ability of nurses to apply knowledge and skill appropriately in cross-cultural

situations. Having cultural sensitivity or awareness is an essential component of cultural competence. Culturally competent care goes beyond culturally sensitive care by adapting care to meet the patient's cultural needs and preferences. Interpreting the thinking of individual patients does not ensure culturally competent care. Reducing a patient's ethnocentrism may not be a desired outcome.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

4. A patient of Asian descent has a diagnosis of depression. A colleague tells the nurse, "This patient often looks down and is reluctant to share feelings. However, I've observed the patient spontaneously interacting with other black patients." Select the nurse's best response.

a. "Black patients depend on the church for support. Have you consulted the patient's pastor?"

b. "Encourage the patient to talk in a group setting. It will be less intimidating than one-to-one interaction."

c. "Don't take it personally. Black patients often have a resentful attitude that takes a long time to overcome."

d. "The patient may have difficulty communicating in English. Have you considered using a cultural broker?"

ANS: D

Asian immigrants underutilized health care services due to language barriers and cultural beliefs about health and treatment options. The use of translators is one strategy for overcoming communication barriers. Society expects a culturally diverse patient to accommodate and use English. Feelings are abstract, which requires a greater command of the language. This may be especially difficult during episodes of high stress or mental illness. Cultural brokers can be helpful with language and help the nurse to understand the Asian world view and cultural nuances.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

5. A patient diagnosed with depression tells the nurse, "There's nothing you can do. This

is a punishment. The only thing I can do is see a healer." A religious world view perspective would indicate which of the following?

a. The patient has delusions of persecution.

b. The patient has likely been misdiagnosed with depression.

c. The patient may believe the distress is the result of a curse or spell.

d. The patient feels hopeless and helpless related to an unidentified cause.

ANS: C

Individuals of African, Haitian, and other cultures may hold fatalistic attitudes about illness, believe they are being punished for wrongdoing or are victims of witchcraft or voodoo. They may be reticent to share information about curses with therapists. No data are present in the scenario to support delusions. Misdiagnosis more often labels a patient with depression as having schizophrenia.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. A group activity on an inpatient psychiatric unit is scheduled to begin at 1000 hours. A patient, who was recently discharged from the Canadian Navy, arrives at 0945 hours. Which analysis best explains this behaviour?

a. The patient wants to lead the group and give directions to others.

b. The patient wants to secure a chair that will be close to the group leader.

c. The military culture values timeliness. The patient does not want to be late.

d. The behaviour indicates feelings of self-importance that the patient wants others to appreciate.

ANS: C

World views shape perceptions about time, as well as health and illness, rights and obligations in society, and acceptable ways of behaving in relation to others and nature. Culture is more than ethnicity and social norms. In this instance, the patient's military experience represents an aspect of the patient's behaviour. The military culture values timeliness. The distracters represent misinterpretation of the patient's behaviour and have no bearing on the situation.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. The nurse would increase the distance of personal space when interacting with a patient who is of which of the following origins?

a. Middle Eastern

b. Asian

c. Southern European

d. Latin American

ANS: B

When working with patients of Asian descent, it is important for the nurse to know that personal space is significantly further away than traditionally used in Western culture. People of Middle Eastern, Southern European, and Latin American descent generally have a closer personal space. Within these cultures, standing close indicates acceptance of the other.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. The sibling of an Asian Canadian patient tells the nurse, “My sister needs help for pain. She cries from the hurt.” Which understanding by the nurse will contribute to culturally competent care for this patient?

a. People of Asian descent often express emotional distress with physical symptoms.

b. People of Asian descent will probably respond best to a therapist who is impersonal.

c. People of Asian descent will require prolonged treatment to stabilize these symptoms.

d. People of Asian descent should be given direct information about the diagnosis and prognosis.

ANS: A

Among several cultures, body-mind-spirit is seen as a single entity. For example, such ideas predominate in Eastern world views, prevalent in many Asian Canadians, and are based on the ancient beliefs of Chinese and Indian philosophers and the spiritual traditions of Confucianism, Buddhism, and Taoism. Therefore the nurse may observe Asian Canadians expressing somatic complaints when there is a

psychological or spiritual problem. Treatment will likely be short. The patient will probably respond best to a therapist who is perceived as giving. Asian Canadians usually have strong family ties and value hope more than truth.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. Which communication techniques would be most effective for a nurse to use during an assessment interview with an adult Indigenous patient?

a. Open and friendly; ask direct questions; touch the patient's arm or hand occasionally for reassurance.

b. Frequent nonverbal behaviours, such as gestures and smiles; make an unemotional face to express negatives.

c. Soft voice; break eye contact occasionally; general leads and reflective techniques.

d. Stern voice; unbroken eye contact; minimal gestures; direct questions.

ANS: C

Indigenous culture stresses living in harmony with nature. Cooperative, sharing styles rather than competitive or intrusive approaches are preferred; thus, the more passive style described would be best received. The other options would be more effective to use with patients of a Western orientation.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. An Indigenous patient sadly describes a difficult childhood. The patient abused alcohol as a teenager but stopped 10 years ago. The patient now says, "I feel stupid and good for nothing. I don't help my people." How should the treatment team focus planning for this patient?

a. Psychopharmacological and somatic therapies should be central techniques.

b. Apply a psychoanalytic approach, focused on childhood trauma.

c. Depression and alcohol abuse should be treated concurrently.

d. Use a holistic approach, including mind, body, and spirit.

ANS: D

Indigenous peoples, because of their beliefs in the interrelatedness of parts and about being in harmony with nature, respond best to a holistic approach. No data are present to support a concurrent disorder

because the patient has resolved the problem of excessive alcohol use. Psychopharmacological and somatic therapies may be part of the treatment, but the focus should be more holistic. Psychoanalysis is a long-term, expensive therapy; cognitive therapy might be a better choice.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

11. A First Nations patient describes a difficult childhood and dropping out of high school. The patient used many recreational substances as a teenager to escape feelings of isolation but stopped 13 years ago. The patient now says, “I feel stupid. I’ve never had a good job. There is nothing that I am good enough at doing to be able to work.” Which nursing diagnosis applies?

a. Risk for other-directed violence

b. Chronic low self-esteem

c. Deficient knowledge

d. Social isolation

ANS: B

Living in poverty subjects people to bias and discrimination that diminishes self-esteem and self-efficacy, contributing to exclusion and marginalization. Relative poverty refers to inequities in material resources across segments of the population—that is, between “the haves” and “the have-nots.” In Canada, this gap is widening, which is cause for concern. One of the most impoverished groups is Indigenous peoples. The patient has given several indications of chronic low self-esteem. Forming a positive self-image is often difficult for Indigenous individuals because these indigenous people must blend together different world views. No defining characteristics are present for the other nursing diagnoses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

12. The nurse knows that the blueprint for guiding actions that impact care, health, and well-being is which of the following?

a. World view

b. Ethnicity

c. Ethnocentrism

d. Culture

ANS: D

Culture is the blueprint for guiding actions that impact care, health, and well-being.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

13. Which intervention best demonstrates that a nurse correctly understands the cultural needs of a hospitalized Asian Canadian patient diagnosed with a mental illness?

a. Encouraging the family to attend community support groups

b. Involving the patient's family to assist with activities of daily living

c. Providing educational pamphlets to explain the patient's mental illness

d. Restricting homemade herbal remedies the family brings to the hospital

ANS: B

The Asian community values the family in caring for each other. They view the family as central to one's identity, and family interdependence and group decision making are the norm. The Asian community uses traditional medicines and healers, including herbs for mental symptoms. The Asian community describes illness in somatic terms. The Asian community attaches a stigma to mental illness, so interfacing with the community would not be appealing.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

14. Which world view is predominant in Western culture?

a. Holistic

b. Biomedical

c. Religious

d. Natural laws

ANS: B

The predominant world view in Western culture is the biomedical or scientific world view. The holistic world view is predominantly practiced by Asian and Indigenous peoples and includes a belief about natural laws. Many Latino, African, Caribbean, and Middle Eastern cultures support the religious world view.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. A patient in the emergency department shows a variety of psychiatric symptoms, including restlessness and anxiety. The patient says, "I feel sad because evil spirits have overtaken my all of me—they think for me and they do things I would not normally do." Which world view is most applicable to this individual?

a. Religious

b. Holistic

c. Scientific

d. Biomedical

ANS: B

People with an indigenous, holistic world view believe balance and harmony must be present for health. They consider an explanation of disharmony and imbalance in the cosmos, resulting in illness. The holism of body-mind-spirit is a key component of this view.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. A nurse prepares to teach important medication information to a patient of Middle Eastern descent. How should the nurse manage the teaching environment?

a. Stand very close to the patient while teaching.

b. Maintain direct eye contact with the patient while teaching.

c. Maintain a neutral emotional tone during the teaching session.

d. Sit 4 feet or more from the patient during the teaching session.

ANS: A

Several cultures (Middle Eastern, Latin American, Southern European) use close personal space, closer than many other minority groups. Standing very close to the patient frequently indicates acceptance.

Direct eye contact should not be prolonged with this patient as it can be associated with rudeness, arrogance, challenge, or sexual interest.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

17. When caring for a patient of Western culture, the nurse is aware that the personal space of this patient is which of the following?

a. up to 0.5 m

b. 0.5 to 1.0 m

c. 1.0 to 1.5 m

d. 1.5 to 2.0 m

ANS: B

Personal space in Western society is considered to be 0.5 to 1.0 metre. Intimate space is 0 to 0.5 metre.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

18. An experienced psychiatric nurse plans to begin a new job in a community-based medication clinic. The clinic sees culturally diverse patients. Which action should the nurse take first to prepare for this position?

a. Investigate cultural differences in patients' responses to psychotropic medications.

b. Contact the clinical nurse specialist for guidelines regarding cultural competence.

c. Examine the literature on various health beliefs of members of diverse cultures.

d. Complete an online continuing education offering about psychopharmacology.

ANS: A

An experienced nurse working on a mental health inpatient unit would be familiar with the action and side effects of most commonly prescribed psychotropic medications. However, because the clinic serves a culturally diverse population, reviewing cultural differences in patients' responses to these medications is helpful and vital to patient safety as there are ethnic variations in psychotropic drug metabolism. The

distracters identify actions the nurse would take later.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Physiological Integrity

19. A psychoeducational session will discuss medication management for a culturally

diverse group of patients. Group participants are predominantly members of minority cultures. Of

the four staff nurses below, which nurse should lead this group?

a. Very young registered nurse

b. Older, mature registered nurse

c. Newly licensed registered nurse

d. A registered nurse who is very thin

ANS: B

People of minority cultures value age and wisdom. People with a Western world view tend to value

youth. An older, mature registered nurse would be the most credible leader of this group. The nurse's size

has no bearing on credibility.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

20. A nurse wants to engage a translator for a severely anxious 21-year-old male who

immigrated to Canada 2 years ago. Of the four translators below who are available and fluent in the

patient's language, which one should the nurse call?

a. A 65-year-old female professional translator

b. A 24-year-old male professional translator

c. A member of the patient's family

d. The patient's best friend

ANS: B

A professional translator will be most effective because he or she will be able to interpret both language and culture. When a translator is engaged, the translator should be matched to the patient as closely as possible in gender, age, social status, and religion. Translators should not be relatives or friends of the

patient. The stigma of mental illness may prevent the openness needed during the encounter.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

21. A patient who has been hospitalized for 3 days with a serious mental illness says, "I've got to get out of here and back to my job. I get 60 to 80 messages a day, and I'm getting behind on my email correspondence." What is this patient's perspective about health and illness?

a. Fateful, magical

b. Eastern, holistic

c. Western, biomedical

d. Harmonious, religious

ANS: C

The Western biomedical perspective holds the belief that sick people should be as independent and self-reliant as possible. Self-care is encouraged; one gets better by "getting up and getting going." An ability

to function at a high level is valued. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. When completing an admission assessment on a patient with a diagnosis of depression, the nurse discovers that the patient is taking an herb that is believed to treat depression in their culture but is contraindicated with the pharmacological treatment the patient is receiving. What is the nurses' initial action?

a. Respect the cultural need for the herb and alter the medication treatment.

b. Provide information to the patient as to why the herb is contraindicated.

c. Inform the patient that she or he will not be able to take this herb while in hospital.

d. Do not address this with the patient but report it to the health care provider in charge of care.

ANS: B

When cultural patterns are determined harmful (e.g., if a patient is taking an herb that is contraindicated

with the prescription medication), the nurse is responsible for alerting the patient and the mental health care team to these risks. The initial action would not include altering the medication treatment. Informing a patient that she or he cannot continue a cultural practice is not appropriate as the initial action. Although it is important that the health care team is aware of this information, the nurse would address it with the patient initially.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

23. A Vietnamese patient's family reports that the patient has wind illness. Which menu selection will be most helpful for this patient?

a. Iced tea

b. Ice cream

c. Warm broth

d. Gelatin dessert

ANS: C

Wind illness is a culture-bound syndrome found in the Chinese and Vietnamese population. It is characterized by a fear of cold, wind, or drafts. It is treated by keeping very warm and avoiding foods, drinks, and herbs that are cold. Warm broth would be most in sync with the patient's culture and provide the most comfort. The distracters are cold foods.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. A Mexican Canadian patient puts a picture of the Virgin Mary on the bedside table. What is the nurse's best action?

a. Move the picture so it is beside a window.

b. Send the picture to the business office safe.

c. Leave the picture where the patient placed it.

d. Send the picture home with the patient's family.

ANS: C

Cultural heritage is expressed through language, works of art, music, dance, customs, traditions, diet, and

expressions of spirituality. This patient's prominent placement of the picture is an example of expression

of cultural heritage and spirituality. Spiritual practices are important to preserving or regaining health.

The nurse should not move it unless the patient's safety is jeopardized.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

25. A nurse begins work in an agency that provides care to members of a minority ethnic

population. The nurse will be better able to demonstrate cultural competence after doing which of

the following?

a. Identifying culture-bound issues

b. Implementing scientifically proven interventions

c. Correcting inferior health practices of the population

d. Exploring commonly held beliefs and values of the population

ANS: D

Cultural competence is dependent on understanding the beliefs and values of members of a different

culture. A nurse who works with an individual or group of a culture different from his or her own must be

open to learning about the culture. The other options have little to do with cultural competence or

represent only a portion of the answer.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

26. A nurse cares for a first-generation Canadian whose family emigrated from Germany.

Which world view about the source of knowledge would this patient likely have?

a. Knowledge is acquired through use of affective or feeling senses.

b. Science is the foundation of knowledge and proves something exists.

c. Knowledge develops by striving for transcendence of the mind and body.

d. Knowledge evolves from an individual's relationship with a supreme being.

ANS: B

The Western world perspective of acquiring knowledge evolves from science. The distracters describe the

beliefs of other world views.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

27. The nurse administers medications to a culturally diverse group of patients on a psychiatric unit. What expectation should the nurse have about pharmacokinetics?

a. Patients of different cultural groups may metabolize medications at different rates.

b. Metabolism of psychotropic medication is consistent among various cultural groups.

c. Differences in hepatic enzymes will influence the rate of elimination of psychotropic medications.

d. It is important to provide patients with oral and written literature about their psychotropic medications.

ANS: A

Cytochrome enzyme systems, which vary among different cultural groups, influence the rate of metabolism of psychoactive drugs. Some genetic variations result in rapid metabolism, resulting in minimization of the therapeutic effects; others may result in poor metabolism. With slow metabolism, serum levels become high, increasing intolerable adverse effects. Current practice requires that nurses be aware of ethnic variations in drug metabolism and monitor for unwanted adverse effects. Renal function influences elimination of psychotropic medication; hepatic function influences metabolism rates. Information about medication is important but does not apply to pharmacokinetics.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

28. A nurse prepares to assess a newly hospitalized patient who moved to Canada 6 months ago from Somalia. The nurse should first determine which of the following?

a. If the patient's immunizations are current

b. The patient's religious preferences

c. The patient's specific ethnic group

d. Whether a translator is needed

ANS: D

The assessment depends on communication. The nurse should first determine whether a translator is needed. The other information can be subsequently assessed.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Which questions should the nurse ask to determine an individual's world view? (Select all that apply.)

a. What is more important: the needs of an individual or the needs of a community?

b. How would you describe an ideal relationship between individuals?

c. How long have you lived at your present residence?

d. Of what importance are possessions in your life?

e. Do you speak any foreign languages?

ANS: A, B, D

The answers provide information about cultural values related to the importance of individuality, material possessions, relational connectedness, community needs versus individual needs, and interconnectedness between humans and nature. These will assist the nurse to determine a patient's world view. Other follow-up questions are needed to validate findings.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Why is the study of culture so important for psychiatric nurses in Canada? (Select all that apply.)

a. Psychiatric nurses often practice in other countries.

b. Psychiatric nurses must advocate for the traditions of the Western culture.

c. Cultural competence helps protect patients from prejudice and discrimination.

d. Patients should receive information about their illness and treatment in terms they

understand.

e. Psychiatric nurses often interface with patients and their significant others over a long period of time.

ANS: C, D, E

One purpose of cultural competence is for the psychiatric nurse to relate and explain information about the patient's illness and treatment in an understandable way, incorporating the patient's own beliefs and values. A fundamental aspect of nursing practice is advocacy. Cultural knowledge helps nurses establish rapport, ask the right questions, avoid misunderstandings, and identify cultural variables that may need to be considered when planning nursing care. Psychiatric nurses often interface with patients and families over years and in community settings.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

3. The nurse should be particularly alert to somatization of psychological distress among patients whose cultural beliefs include which of the following? (Select all that apply.)

a. Mental illness reflects badly on the family.

b. Mental illness shows moral weakness.

c. Intergenerational conflict is common.

d. The mind and body are merged.

e. Food choices influence one's health.

ANS: A, B, D

Physical symptoms are seen as more acceptable in cultural groups in which interdependence and harmony of the group are emphasized. Mental illness is often perceived as reflecting a failure of the entire family. In groups in which mental illness is seen as a moral weakness and both the individual and family are stigmatized, somatization of mental distress is better accepted. In groups in which the mind and body are holistically perceived, somatization of psychological distress is common. Somatization and food are not commonly related. Intergenerational conflict has not been noted as a risk factor for somatization.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 09: Therapeutic Relationships

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A nurse assesses a confused older adult. The nurse experiences sadness and reflects, "The patient is like one of my grandparents-so helpless." Which response is the nurse demonstrating?

a. Transference

b. Counter-transference

c. Catastrophic reaction

d. Defensive coping reaction

ANS: B

Counter-transference is the nurse's transference or response to a patient that is based on the nurse's unconscious needs, conflicts, problems, or view of the world. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which statement shows a nurse has empathy for a patient who made a suicide attempt?

a. "You must have been very upset when you tried to hurt yourself."

b. "It makes me sad to see you going through such a difficult experience."

c. "If you tell me what is troubling you, I can help you solve your problems."

d. "Suicide is a drastic solution to a problem that may not be such a serious matter."

ANS: A

Empathy permits the nurse to see an event from the patient's perspective, understand the patient's feelings, and communicate this to the patient. The incorrect responses are nurse- centred (focusing on the

nurse's feelings rather than the patient's), belittling, and sympathetic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

3. After several therapeutic encounters with a patient who recently attempted suicide,

which occurrence should cause the nurse to consider the possibility of counter-transference?

a. The patient's reactions toward the nurse seem realistic and appropriate.

b. The patient states, "Talking to you feels like talking to my parents."

c. The nurse feels unusually happy when the patient's mood begins to lift.

d. The nurse develops a trusting relationship with the patient.

ANS: C

Strong positive or negative reactions toward a patient or over-identification with the patient indicate

possible counter-transference. Nurses must carefully monitor their own feelings and reactions to detect

counter-transference and then seek supervision. Realistic and appropriate reactions from a patient toward

a nurse are desirable. One incorrect response suggests transference. A trusting relationship with the

patient is desirable.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

4. A patient says, "Please don't share information about me with the other people." How

should the nurse respond?

a.

"I will not share information with your family or friends without your permission,

but I share information about you with other staff."

b. "A therapeutic relationship is just between the nurse and the patient. It is up to you

to tell others what you want them to know."

c. "It depends on what you choose to tell me. I will be glad to disclose at the end of

each session what I will report to others."

d. "I cannot tell anyone about you. It will be as though I am talking about my own

problems, and we can help each other by keeping it between us."

ANS: A

A patient has the right to know with whom the nurse will share information and that confidentiality will be protected. Although the relationship is primarily between the nurse and patient, other staff needs to know pertinent data. The other incorrect responses promote incomplete disclosure on the part of the patient, require daily renegotiation of an issue that should be resolved as the nurse-patient contract is established, and suggest mutual problem solving. The relationship must be patient centred.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

5. A nurse is talking with a patient, and 5 minutes remain in the session. The patient has been silent most of the session. Another patient comes to the door of the room, interrupts, and says to the nurse, “I really need to talk to you.” What should the nurse do?

a. Invite the interrupting patient to join in the session with the current patient.

b. Say to the interrupting patient, “I am not available to talk with you at the present time.”

c. End the unproductive session with the current patient and spend time with the interrupting patient.

d. Tell the interrupting patient, “This session is 5 more minutes; then I will talk with you.”

ANS: D

When a specific duration for sessions has been set, the nurse must adhere to the schedule. Leaving the first patient would be equivalent to abandonment and would destroy any trust the patient had in the nurse.

Adhering to the contract demonstrates that the nurse can be trusted and that the patient and the sessions are important. The incorrect responses preserve the nurse-patient relationship with the silent patient, but may seem abrupt to the interrupting patient, abandon the silent patient, or fail to observe the contract with the silent patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

6. Termination of a therapeutic nurse-patient relationship has been successful when the nurse does which of the following?

a. Avoids upsetting the patient by shifting focus to other patients before discharge.

b. Gives the patient a personal telephone number and permission to call after discharge.

c. Discusses with the patient changes that happened during the relationship and evaluates outcomes.

d. Offers to meet the patient for coffee and conversation three times a week after discharge.

ANS: C

Summarizing and evaluating progress help validate the experience for the patient and the nurse and facilitate closure. Termination must be discussed; avoiding discussion by spending little time with the patient promotes feelings of abandonment. Successful termination requires that the relationship be brought to closure without the possibility of dependency-producing ongoing contact.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

7. What is the desirable outcome for the orientation stage of a nurse-patient relationship? The patient will demonstrate behaviours that indicate which of the following?

a. Self-responsibility and autonomy

b. A greater sense of independence

c. Rapport and trust with the nurse

d. Resolved transference

ANS: C

Development of rapport and trust is necessary before the relationship can progress to the working phase.

Behaviours indicating a greater sense of independence, self-responsibility, and resolved transference

occur in the working phase.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

8. During which phase of the nurse-patient relationship can the nurse anticipate that identified patient issues will be explored and resolved?

a. Preorientation

b. Orientation

c. Working

d. Termination

ANS: C

During the working phase, the psychiatric nurse and patient together identify and explore areas that are causing problems in the patient's life. Often the patient's present ways of handling situations stem from earlier means of coping devised to survive in a chaotic and dysfunctional family environment.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

9. At what point in the nurse-patient relationship should a nurse plan to first address termination?

a. During the orientation phase

b. At the end of the working phase

c. Near the beginning of the termination phase

d. When the patient initially brings up the topic

ANS: A

The patient has a right to know the conditions of the nurse-patient relationship. If the relationship is to be time-limited, the patient should be informed of the number of sessions. If it is open-ended, the termination date will not be known at the outset, and the patient should know that the issue will be negotiated at a later date. The nurse is responsible for bringing up the topic of termination early in the relationship, usually during the orientation phase.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

10. A nurse introduces the matter of a contract during the first session with a new patient

because of which of the following?

a. Contracts specify what the nurse will do for the patient.

b. Contracts spell out the participation and responsibilities of each party.

c. Contracts indicate the feeling tone established between the participants.

d. Contracts are binding and prevent either party from prematurely ending the

relationship.

ANS: B

A contract emphasizes that the nurse works with the patient rather than doing something for the patient.

"Working with" is a process that suggests each party is expected to participate and share responsibility for

outcomes. Contracts do not, however, stipulate roles or feeling tone, and premature termination is

forbidden.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

11. As a nurse escorts a patient being discharged after treatment for major depression,

the patient gives the nurse a necklace with a heart pendant and says, "Thank you for helping

mend my broken heart." Which is the nurse's best response?

a. "Accepting gifts violates the policies and procedures of the facility."

b. "I'm glad you feel so much better now. Thank you for the beautiful necklace."

c. "I'm glad I could help you, but I can't accept the gift. My reward is seeing you with

a renewed sense of hope."

d. "Helping people is what nursing is all about. It's rewarding to me when patients

recognize how hard we work."

ANS: C

Accepting a gift creates a social rather than therapeutic relationship with the patient and blurs the boundaries of the relationship. A caring nurse will acknowledge the patient's gesture of appreciation, but the gift should not be accepted.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

12. Which remark by a patient indicates passage from orientation to the working phase of a nurse-patient relationship?

a. "I don't have any problems."

b. "It is so difficult for me to talk about problems."

c. "I don't know how it will help to talk to you about my problems."

d. "I want to find a way to deal with my anger without becoming violent."

ANS: D

Thinking about a more constructive approach to dealing with anger indicates a readiness to make a behavioural change. Behavioural change is associated with the working phase of the relationship. Denial is often seen in the orientation phase. It is common early in the relationship, before rapport and trust are firmly established, for a patient to express difficulty in talking about problems. Stating skepticism about the effectiveness of the nurse-patient relationship is a reaction that is more typical during the orientation phase.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

13. A nurse explains to the family of a mentally ill patient how a nurse-patient relationship differs from social relationships. Which is the best explanation?

a. "The focus is on the patient. Problems are discussed by the nurse and patient, but solutions are implemented by the patient."

b. "The focus shifts from nurse to patient as the relationship develops. Advice is given by both, and solutions are implemented."

c. “The focus of the relationship is socialization. Mutual needs are met, and feelings are shared openly.”

d. “The focus is creation of a partnership in which each member is concerned with growth and satisfaction of the other.”

ANS: A

The focus of the relationship is on the patient’s ideas, experiences, feelings, and personal issues introduced during the clinical interview, with the development of personal insight as a desired outcome. The nurse and the patient identify areas that need exploration and periodically evaluate the degree of change in the patient’s understanding of the stressors, and pinpoint strategies to manage them differently.

The remaining responses describe events that occur in social or intimate relationships.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

14. A nurse wants to demonstrate genuineness with a patient diagnosed with schizophrenia. Which of the following should the nurse do?

a. Restate what the patient says.

b. Use congruent communication strategies.

c. Use self-revelation in patient interactions.

d. Consistently interpret the patient’s behaviours.

ANS: B

Genuineness is a desirable characteristic involving awareness of one’s own feelings as they arise and the ability to communicate them when appropriate. The incorrect options are undesirable in a therapeutic relationship.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. A nurse caring for a withdrawn, suspicious patient recognizes development of feelings of anger toward the patient. Which of the following should the nurse do?

a. Suppress the angry feelings

b. Express the anger openly and directly with the patient

c. Tell the nurse manager to assign the patient to another nurse

d. Discuss the anger with a clinician during a supervisory session

ANS: D

The nurse is accountable for the relationship. Objectivity is threatened by strong positive or negative feelings toward a patient. Supervision is necessary to work through counter-transference feelings.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

16. A nurse wants to enhance growth of a patient by showing positive regard. The nurse's action most likely to help achieve this goal is which of the following?

a. Making rounds daily

b. Staying with a tearful patient

c. Administering medication as prescribed

d. Examining personal feelings about a patient

ANS: B

Staying with a crying patient offers support and shows positive regard. Administering daily medication and making rounds are tasks that could be part of an assignment and do not necessarily reflect positive regard. Examining feelings regarding a patient addresses the nurse's ability to be therapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. A patient says, "I've done a lot of cheating and manipulating in my relationships." Select a nonjudgemental response by the nurse.

a. "How do you feel about that?"

b. "I am glad that you realize this."

c. "That's not a good way to behave."

d. "Have you outgrown that type of behaviour?"

ANS: A

Asking a patient to reflect on feelings about his or her actions does not imply any judgement about those actions, and it encourages the patient to explore feelings and values. The remaining options offer negative judgements.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A patient says, “People should be allowed to commit suicide without interference from others.” A nurse replies, “You’re wrong. Nothing is bad enough to justify death.” What is the best analysis of this interchange?

a. The patient is correct.

b. The nurse is correct.

c. Congruent attitudes are implied.

d. Differing values are reflected.

ANS: D

Values guide beliefs and actions. The individuals stating their positions place different values on life and autonomy. Nurses must be aware of their own values and be sensitive to the values of others. When working with patients it is important for nurses to understand that their values and beliefs are not necessarily “right” and certainly are not right for everyone.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

19. Which issues should a nurse address during the first interview with a patient with a psychiatric disorder?

a. Trust, congruence, attitudes, and boundaries

b. Goals, resistance, unconscious motivations, and diversion

c. Relationship parameters, the contract, confidentiality, and termination

d. Transference, counter-transference, intimacy, and developing resources

ANS: C

Relationship parameters, the contract, confidentiality, and termination are issues that should be considered during the orientation phase of the relationship. The remaining options are issues that are

discussed later in the relationship.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

20. An advanced-practice nurse observes a novice nurse expressing irritability regarding

a patient with a long history of alcoholism and suspects the new nurse is experiencing counter-transference. Which comment by the new nurse confirms this suspicion?

a. “This patient continues to deny problems resulting from drinking.”

b. “My parents were alcoholics and often neglected our family.”

c. “The patient cannot identify any goals for improvement.”

d. “The patient said I have many traits like her mother.”

ANS: B

Counter-transference occurs when the nurse unconsciously and inappropriately displaces onto the patient

feelings and behaviours related to significant figures in the nurse’s past. In this instance, the new nurse’s irritability stems from relationships with the nurse’s parents. The distracters indicate transference or accurate analysis of the patient’s behaviour.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. Which of the following behaviours shows that a nurse values autonomy?

a. The nurse suggests one-on-one supervision for a patient who has suicidal thoughts.

b. The nurse informs a patient that the spouse will not be in during visiting hours.

c. The nurse discusses options and helps the patient weigh the consequences.

d. The nurse sets limits on a patient’s romantic overtures toward the nurse.

ANS: C

Autonomy is supported when the nurse helps a patient weigh alternatives and their consequences before

the patient makes a decision. A goal of the nurse-patient relationship is to help patients examine self-defeating behaviours and test alternatives. Autonomy or self-determination is not the issue in any of the

other behaviours.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

22. As a nurse discharges a patient, the patient gives the nurse a card of appreciation made in an arts and crafts group. What is the nurse's best action?

a. Recognize the effectiveness of the relationship and patient's thoughtfulness. Accept the card.

b. Inform the patient that accepting gifts violates policies of the facility. Decline the card.

c. Acknowledge the patient's transition through the termination phase, but decline the card.

d. Accept the card and invite the patient to return to participate in other arts and crafts groups.

ANS: A

The nurse must consider the meaning, timing, and value of the gift. In this instance, the nurse should accept the patient's expression of gratitude. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe Effective Care Environment

23. A patient says, "I'm still on restriction, but I want to attend some off-unit activities. Would you ask the doctor to change my privileges?" What is the nurse's best response?

a. "Why are you asking me when you're able to speak for yourself?"

b. "I will be glad to address it when I see your doctor later today."

c. "That's a good topic for you to discuss with your doctor."

d. "Do you think you can't speak to a doctor?"

ANS: C

Nurses should encourage patients to work at their optimal level of functioning. A nurse does not act for the patient unless it is necessary. Acting for a patient increases feelings of helplessness and dependency.
DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation
MSC: Client Needs: Safe Effective Care Environment
24. A community mental health nurse has worked with a patient for 3 years, but is moving out of the city and terminates the relationship. When a novice nurse begins work with this patient, what is the starting point for the relationship?
a. Begin at the orientation phase.
b. Resume the working relationship.
c. Initially establish a social relationship.
d. Return to the emotional catharsis phase.
ANS: A
After termination of a long-term relationship, the patient and new nurse usually have to begin at ground zero, the orientation phase, to build a new relationship. If termination is successfully completed, the orientation phase sometimes progresses quickly to the working phase. Other times, even after successful termination, the orientation phase may be prolonged.
DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity
25. As a patient diagnosed with a mental illness is being discharged from a facility, a nurse invites the patient to the annual staff picnic. What is the best analysis of this scenario?
a. The invitation facilitates dependency on the nurse.
b. The nurse's action blurs the boundaries of the therapeutic relationship.
c. The invitation is therapeutic for the patient's diversional activity deficit.
d. The nurse's action assists the patient's integration into community living.
ANS: B
The invitation creates a social relationship rather than a therapeutic relationship.
DIF: Cognitive Level: Analyze (Analysis)
TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

26. A nurse says, “I am the only one who truly understands this patient. Other staff

members are too critical.” The nurse’s statement indicates which of the following?

a. Boundary blurring

b. Sexual harassment

c. Positive regard

d. Advocacy

ANS: A

When the role of the nurse and the role of the patient shift, boundary blurring may arise. In this situation

the nurse is becoming over-involved with the patient as a probable result of unrecognized counter-

transference. When boundary issues occur, the need for supervision exists. The situation does not describe

sexual harassment. Data are not present to suggest positive regard or advocacy.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. Which descriptors exemplify consistency regarding nurse-patient relationships?

(Select all that apply.)

a. Encouraging a patient to share initial impressions of staff

b. Having the same nurse care for a patient on a daily basis

c. Providing a schedule of daily activities to a patient

d. Setting a time for regular sessions with a patient

e. Offering solutions to a patient’s problems

ANS: B, C, D

Consistency implies predictability. Having the same nurse see the patient daily, provide a daily schedule

of patient activities, and set a time for regular sessions will help a patient predict what will happen during

each day and develop a greater degree of security and comfort. Encouraging a patient to share initial impressions of staff and giving advice are not related to consistency and would not be considered therapeutic interventions.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A nurse ends a relationship with a patient. Which actions by the nurse should be included in the termination phase? (Select all that apply.)

a. Focus dialogues with the patient on problems that may occur in the future.

b. Help the patient express feelings about the relationship with the nurse.

c. Help the patient prioritize and modify socially unacceptable behaviours.

d. Reinforce expectations regarding the parameters of the relationship.

e. Help the patient to identify strengths, limitations, and problems.

ANS: A, B

Helping the patient express feelings about the relationship and prioritize and modify socially unacceptable behaviours are part of the termination phase. The other actions would be used in the working and orientation phases.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

3. A novice psychiatric nurse has a parent with bipolar disorder. This nurse angrily recalls feelings of embarrassment about the parent's behaviour in the community. Select the best ways for this nurse to cope with these feelings. (Select all that apply.)

a. Seek ways to use the understanding gained from childhood to help patients cope with their own illnesses.

b. Recognize that these feelings are unhealthy. The nurse should try to suppress them when working with patients.

c. Recognize that psychiatric nursing is not an appropriate career choice. Explore other nursing specialties.

d. The nurse should begin new patient relationships by saying, “My own parent had

mental illness, so I accept it without stigma.”

e. Recognize that the feelings may add sensitivity to the nurse’s practice, but

supervision is important.

ANS: A, E

The nurse needs support to explore these feelings. An experienced psychiatric nurse may be a helpful

resource. The knowledge and experience gained from the nurse’s relationship with a mentally ill parent

may contribute sensitivity to compassionate practice. It is important to explore the root of the anger. Self-

disclosure and suppression are not adaptive coping strategies. The nurse should not give up on this area of

practice without first seeking ways to cope with the memories.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

4. A novice nurse tells a mentor, “I want to convey to my patients that I am interested in

them and that I want to listen to what they have to say.” Which behaviours will be helpful in

meeting the nurse’s goal? (Select all that apply.)

a. Sitting behind a desk, facing the patient

b. Introducing self to a patient and identifying own role

c. Maintaining control of discussions by asking direct questions

d. Using facial expressions to convey interest and encouragement

e. Demonstrating attending behaviours

ANS: B, D, E

Trust is fostered when the nurse gives an introduction and identifies his or her role. Facial expressions

that convey interest and encouragement support the nurse’s verbal statements to that effect and strengthen

the message. Attending is a special kind of listening that refers to an intensity of presence, or of being

with the patient. At times, simply being with another person during a painful time can make a difference. A desk would place a physical barrier between the nurse and patient. A face-to-face stance should be avoided when possible, and a less intense 90- or 120-degree angle used to permit either party to look away without discomfort.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

Chapter 10: Communication and the Clinical Interview

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient says to the nurse, "I dreamed I was stoned. When I woke up, I felt emotionally drained, as though I hadn't rested well." Which response should the nurse use to clarify the patient's comment?

a. "It sounds as though you were uncomfortable with the content of your dream."

b. "I understand what you're saying. Bad dreams leave me feeling tired, too."

c. "So you feel as though you did not get enough quality sleep last night?"

d. "Can you give me an example of what you mean by 'stoned'?"

ANS: D

The technique of clarification is therapeutic and helps the nurse examine the meaning of the patient's statement. Asking for a definition of "stoned" directly asks for clarification. Restating that the patient is uncomfortable with the dream's content is parroting, a nontherapeutic technique. The other responses fail to clarify the meaning of the patient's comment.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A patient diagnosed with schizophrenia tells the nurse, "The CIA is monitoring us through the fluorescent lights in this room. Be careful what you say." Which response by the

nurse would be most therapeutic?

a. “Let’s talk about something other than the CIA.”

b. “It sounds like you’re concerned about your privacy.”

c. “The CIA is prohibited from operating in health care facilities.”

d. “You have lost touch with reality, which is a symptom of your illness.”

ANS: B

It is important not to challenge the patient’s beliefs, even if they are unrealistic. Challenging undermines the patient’s trust in the nurse. The nurse should try to understand the underlying feelings or thoughts the patient’s message conveys. The correct response uses the therapeutic technique of reflection. The other comments are nontherapeutic. Asking to talk about something other than the concern at hand is changing the subject. Saying that the CIA is prohibited from operating in health care facilities gives false reassurance. Stating that the patient has lost touch with reality is truthful, but uncompassionate.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

3. The patient says, “My marriage is just great. My spouse and I always agree.” The nurse observes the patient’s foot moving continuously as the patient twirls a shirt button. The conclusion the nurse can draw is that the patient’s communication is which of the following?

a. Clear

b. Mixed

c. Precise

d. Inadequate

ANS: B

Mixed messages involve the transmission of conflicting or incongruent messages by the speaker. The patient’s verbal message that all was well in the relationship was modified by the nonverbal behaviours denoting anxiety. Data are not present to support the choice of the verbal message being clear, explicit, or inadequate.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. A nurse interacts with a newly hospitalized patient. Select the nurse's comment that applies the communication technique of "offering self."

a. "I've also had traumatic life experiences. Maybe it would help if I told you about them."

b. "Why do you think you had so much difficulty adjusting to this change in your life?"

c. "I hope you will feel better after getting accustomed to how this unit operates."

d. "I'd like to sit with you for a while to help you get comfortable talking to me."

ANS: D

"Offering self" is a technique that should be used in the orientation phase of the nurse-patient relationship. Sitting with the patient, an example of "offering self," helps to build trust and convey that the nurse cares about the patient. Two incorrect responses are ineffective and nontherapeutic. The other incorrect response is therapeutic, but is an example of "offering hope."

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

5. Which technique will best communicate to a patient that the nurse is interested in listening?

a. Restating a feeling or thought the patient has expressed

b. Asking a direct question, such as "Did you feel angry?"

c. Making a judgement about the patient's problem

d. Saying, "I understand what you're saying."

ANS: A

Restating allows the patient to validate the nurse's understanding of what has been communicated. Restating is an active listening technique. Judgements should be suspended in a nurse-patient relationship.

Closed-ended questions such as "Did you feel angry?" ask for specific information rather than showing understanding. When the nurse simply states that he or she understands the patient's words, the patient

has no way of measuring the understanding.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

6. A patient discloses several concerns and associated feelings. If the nurse wants to seek

clarification, which comment would be appropriate?

a. “What are the common elements here?”

b. “Tell me again about your experiences.”

c. “Am I correct in understanding that . . .”

d. “Tell me everything from the beginning.”

ANS: C

Asking, “Am I correct in understanding that . . .” permits clarification to ensure that both the nurse and

patient share mutual understanding of the communication. Asking about common elements encourages

comparison rather than clarification. The remaining responses are questions that suggest the nurse was not

listening.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

7. A patient tells the nurse, “I don’t think I’ll ever get out of here.” Select the nurse’s

most therapeutic response.

a. “Don’t talk that way. Of course you will leave here!”

b. “Keep up the good work, and you certainly will.”

c. “You don’t think you’re making progress?”

d. “Everyone feels that way sometimes.”

ANS: C

By asking if the patient does not believe that progress has been made, the nurse is reflecting by putting

into words what the patient is hinting at. By making communication more explicit, issues are easier to

identify and resolve. The remaining options are nontherapeutic techniques. Telling the patient not to "talk

that way" is disapproving. Saying that "everyone feels that way sometimes" minimizes feelings. Telling the patient that good work will always result in success is falsely reassuring.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

8. Documentation in a patient's chart shows, "Throughout a 5-minute interaction, patient

fidgeted and tapped left foot, periodically covered face with hands, and looked under chair while stating, 'I enjoy spending time with you.'" Which analysis is most accurate?

a. The patient is giving positive feedback about the nurse's communication

techniques.

b. The nurse is viewing the patient's behaviour through a cultural filter.

c. The patient's verbal and nonverbal messages are incongruent.

d. The patient is demonstrating psychotic behaviours.

ANS: C

When a verbal message is not reinforced with nonverbal behaviour, the message is confusing and incongruent. Some clinicians call it a "mixed message." It is inaccurate to say that the patient is giving positive feedback about the nurse's communication techniques. The concept of a cultural filter is not relevant to the situation because a cultural filter determines what we will pay attention to and what we will ignore. Data are insufficient to draw the conclusion that the patient is demonstrating psychotic behaviours.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. While talking with a patient diagnosed with major depression, a nurse notices the

patient is unable to maintain eye contact. The patient's chin lowers to the chest, while the patient looks at the floor. Which aspect of communication has the nurse assessed?

a. Nonverbal communication

b. A message filter

c. A cultural barrier

d. Social skills

ANS: A

Eye contact and body movements are considered nonverbal communication. There are insufficient data to

determine the level of the patient's social skills or whether a cultural barrier exists.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

10. During the first interview with a parent whose child died in a car accident, the nurse

feels empathic and reaches out to take the patient's hand. Select the correct analysis of the nurse's

behaviour.

a. It shows empathy and compassion. It will encourage the patient to continue to

express feelings.

b. The gesture is premature. The patient's cultural and individual interpretation of

touch is unknown.

c. The patient will perceive the gesture as intrusive and overstepping boundaries.

d. The action is inappropriate. Psychiatric patients should not be touched.

ANS: B

Touch has various cultural and individual interpretations. Nurses should refrain from using touch until an assessment can be made regarding the way in which the patient will perceive touch. The other options present prematurely drawn conclusions.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

11. During a one-on-one interaction with the nurse, a patient frequently looks nervously

at the door. Select the best comment by the nurse regarding this nonverbal communication.

a. "I notice you keep looking toward the door."

b. "This is our time together. No one is going to interrupt us."

c. "It looks as if you are eager to end our discussion for today."

d. "If you are uncomfortable in this room, we can move someplace else."

ANS: A

Making observations and encouraging the patient to describe perceptions are useful therapeutic communication techniques for this situation. The other responses are assumptions made by the nurse.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. A black patient says to a white nurse, “There’s no sense talking. You wouldn’t understand because you live in a white world.” Which of the following would be the nurse’s best action?

a. Explain, “Yes, I do understand. Everyone goes through the same experiences.”

b. Say, “Please give an example of something you think I wouldn’t understand.”

c. Reassure the patient that nurses interact with people from all cultures.

d. Change the subject to one that is less emotionally disturbing.

ANS: B

Having the patient speak in specifics rather than globally will help the nurse understand the patient’s perspective. This will encourage a description of the patient’s perception that the nurse does not understand the patient. This approach will help the nurse engage the patient. Reassurance and changing the subject are not therapeutic techniques.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

13. An Indigenous patient had a nursing diagnosis of situational low self-esteem related to poor social skills as evidenced by lack of eye contact. Interventions were used to raise the patient’s self-esteem, but after 3 weeks, the patient’s eye contact did not improve. What is the most accurate analysis of this scenario?

a. The patient’s eye contact should have been directly addressed by role-playing to increase comfort with eye contact.

b. The nurse should not have independently embarked on assessment, diagnosis, and planning for this patient.

c. The patient’s poor eye contact is indicative of anger and hostility that were unaddressed.

d. The nurse should have assessed the patient's culture before making this diagnosis and plan.

ANS: D

The amount of eye contact a person engages in is often culturally determined. In some cultures, eye contact is considered insolent, whereas in others, eye contact is expected. Indigenous individuals have traditionally been taught to avoid eye contact with authority figures, including nurses, physicians, and other health care providers; avoidance of direct eye contact is seen as a sign of respect to those in authority, but it could be misinterpreted as a lack of interest or even as a lack of respect.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

14. When a female Indigenous patient and a female nurse sit together, the patient often holds the nurse's hand. The patient also links arms with the nurse when they walk. The nurse is uncomfortable with this behaviour. Which analysis is most accurate?

a. The patient is accustomed to touch during conversation, as are members of many Indigenous cultures.

b. The patient understands that touch makes the nurse uncomfortable and controls the relationship based on that factor.

c. The patient is afraid of being alone. When touching the nurse, the patient is reassured and comforted.

d. The patient is trying to manipulate the nurse using nonverbal techniques.

ANS: A

The most likely answer is that the patient's behaviour is culturally influenced. People from some cultures —Indigenous people, for example—are accustomed to frequent physical contact. Holding an Indigenous patient's hand in response to a distressing situation or giving the patient a reassuring pat on the shoulder may be experienced as supportive and thus help facilitate openness. Although the other options are possible, they are less likely.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. An Italian Canadian patient uses dramatic body language when describing emotional discomfort. Which analysis most likely explains the patient's behaviour?

a. The patient has a histrionic personality disorder.

b. The patient believes dramatic body language is sexually appealing.

c. The patient wishes to impress staff with the degree of emotional pain.

d. The patient belongs to a culture in which dramatic body language is the norm.

ANS: D

Members of some cultures tend to use high affect and dramatic body language as they communicate. French and Italian Canadians typically use animated facial expressions and expressive hand gestures during communication, which can be misinterpreted by others. The other options are more remote possibilities.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. During an interview, a patient attempts to shift the focus from self to the student nurse by asking personal questions. The student nurse should respond by saying:

a. "Why do you keep asking about me?"

b. "Nurses direct the interviews with patients."

c. "Do not ask questions about my personal life."

d. "The time we spend together is to discuss your concerns."

ANS: D

When a patient tries to focus on the student nurse, the student should refocus the discussion back onto the patient. Telling the patient that interview time should be used to discuss patient concerns refocuses the discussion in a neutral way. Telling patients not to ask about the student nurse's personal life shows indignation. Saying that student nurses prefer to direct the interview reflects superiority. "Why" questions are probing and nontherapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

17. Which principle should guide the nurse in determining the extent of silence to use during patient interview sessions?

a. A nurse is responsible for breaking silences.

b. Patients withdraw if silences are prolonged.

c. Silence can provide meaningful moments for reflection.

d. Silence helps patients know that what they said was understood.

ANS: C

Silence can be helpful to both participants by giving each an opportunity to contemplate what has transpired, weigh alternatives, and formulate ideas. A nurse breaking silences is not a principle related to silences. It is inaccurate to say that patients withdraw during long silences or that silence helps patients know that they are understood. Feedback helps patients know they have been understood.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

18. A patient is having difficulty making a decision. The nurse has mixed feelings about whether to provide advice. Which principle usually applies?

a. Giving advice is rarely helpful.

b. Giving advice fosters independence.

c. Giving advice lifts the burden of personal decision making.

d. Giving advice helps the patient develop feelings of personal adequacy.

ANS: A

Giving advice fosters dependence on the nurse and interferes with the patient's right to make personal decisions. It robs patients of the opportunity to weigh alternatives and develop problem-solving skills. Furthermore, it contributes to patient feelings of personal inadequacy. It also keeps the nurse in control and feeling powerful.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

19. A school-age child tells the school nurse, "Other kids call me mean names and will not sit with me at lunch. Nobody likes me." Select the nurse's most therapeutic response.

a. “Just ignore them and they will leave you alone.”

b. “You should make friends with other children.”

c. “Call them names if they do that to you.”

d. “Tell me more about how you feel.”

ANS: D

The correct response uses exploring, a therapeutic technique. The distracters give advice, a nontherapeutic

technique.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

20. A patient with acute depression states, “God is punishing me for my past sins.” What

is the nurse’s most therapeutic response?

a. “You sound very upset about this.”

b. “God always forgives us for our sins.”

c. “Why do you think you are being punished?”

d. “If you feel this way, you should talk to your minister.”

ANS: A

The nurse reflects the patient’s comment, a therapeutic technique to encourage sharing for perceptions and feelings. The incorrect responses reflect probing, closed-ended comments, and giving advice, all of which are nontherapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

MULTIPLE RESPONSE

1. A patient cries as the nurse explores the patient’s feelings about the death of a close

friend. The patient sobs, “I shouldn’t be crying like this. It happened a long time ago.” Which

responses by the nurse facilitate communication? (Select all that apply.)

a. “Why do you think you are so upset?”

b. “I can see that you feel sad about this situation.”

c. “The loss of a close friend is very painful for you.”

d. “Crying is a way of expressing the hurt you are experiencing.”

e. “Let’s talk about something else because this subject is upsetting you.”

ANS: B, C, D

Reflecting (“I can see that you feel sad”; “This is very painful for you”) and giving information (“Crying is a way of expressing hurt”) are therapeutic techniques. “Why” questions often imply criticism or seem intrusive or judgemental. They are difficult to answer. Changing the subject is a barrier to communication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. During the initial patient interview, which of the following are reasons that the patient may be reluctant to speak? (Select all that apply.)

a. Feelings of distrust

b. The nurse is a health care provider

c. Feelings of embarrassment

d. Repetitive nature of the situation

e. Shyness

ANS: A, C, E

In the initial interview, patients may be reluctant to speak because of the newness of the situation, the fact that the nurse is a stranger, or feelings of distrust, self-consciousness, embarrassment, or shyness. The nurse must recognize and respect individual differences in styles and tempos of responding. It would be the newness of the situation, not the repetitive nature of the situation that may cause a patient to be reluctant to speak. The nurse being a health care provider does not directly cause the patient to be reluctant to speak, but rather the fact that the nurse is a stranger.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

3. Which comments by a nurse demonstrate use of therapeutic communication techniques? (Select all that apply.)

a. “Why do you think these events have happened to you?”

b. “There are people with problems much worse than yours.”

c. “I’m glad you were able to tell me how you felt about your loss.”

d. “I noticed your hands trembling when you told me about your accident.”

e. “You look very nice today. I’m proud you took more time with your appearance.”

ANS: C, D

These responses demonstrate use of the therapeutic techniques of making an observation and showing empathy. The incorrect responses demonstrate minimizing feelings, probing, and giving approval, which are nontherapeutic techniques.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. A nurse is interacting with patients in a psychiatric unit. Which statements reflect use of therapeutic communication? (Select all that apply.)

a. “Tell me more about that situation.”

b. “Let’s talk about something else.”

c. “I notice you are pacing a lot.”

d. “I’ll stay with you a while.”

e. “Why did you do that?”

ANS: A, C, D

The correct responses demonstrate use of the therapeutic techniques of making an observation and showing empathy. The incorrect responses demonstrate changing the subject and probing, which are nontherapeutic techniques.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

Chapter 11: Psychotropic Drugs

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient asks, "What are neurotransmitters? The doctor said mine are imbalanced."

Select the nurse's best response.

a. "How do you feel about having imbalanced neurotransmitters?"

b. "Neurotransmitters protect us from harmful effects of free radicals."

c. "Neurotransmitters are substances we consume that influence memory and mood."

d. "Neurotransmitters are natural chemicals that pass messages between brain cells."

ANS: D

The patient asked for information, and the correct response is most accurate. Neurotransmitters are

chemical substances that function as messengers in the central nervous system. They are released from the

axon terminal, diffuse across the synapse, and attach to specialized receptors on the postsynaptic neuron.

The distracters either do not answer the patient's question or provide untrue, misleading information.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological

Integrity

2. The parent of an adolescent diagnosed with schizophrenia asks the nurse, "My child's

doctor ordered a PET. What kind of test is that?" Select the nurse's best reply.

a. "This test uses a magnetic field and gamma waves to identify problem areas in the

brain. Does your teenager have any metal implants?"

b. "PET means positron emission tomography. It is a special type of scan that shows

blood flow and activity in the brain."

c. "A PET scan passes an electrical current through the brain and shows brain-wave

activity. It can help diagnose seizures."

d. "It's a special X-ray that shows structures of the brain and whether there has ever

been a brain injury."

ANS: B

The parent is seeking information about PET scans. It is important to use terms the parent can understand,

so the nurse should identify what the initials mean. The correct response is the only option that provides information relevant to PET scans. The distracters describe MRI, CT scans, and EEG.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological

Integrity

3. A patient with a long history of hypertension and diabetes now develops confusion.

The health care provider wants to make a differential diagnosis between Alzheimer's disease and multiple infarcts. Which diagnostic procedure should the nurse expect to prepare the patient for first?

a. Skull X-rays

b. Computed tomography (CT) scan

c. Positron emission tomography (PET)

d. Single-photon emission computed tomography (SPECT)

ANS: B

A CT scan shows the presence or absence of structural changes, including cortical atrophy, ventricular enlargement, and areas of infarct, information that would be helpful to the health care provider. PET and SPECT show brain activity rather than structure and may occur later. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

4. A patient's history shows drinking 4 to 6 litres of fluid and eating more than 6,000 calories per day. Which part of the central nervous system is most likely dysfunctional for this patient?

a. Amygdala

b. Parietal lobe

c. Hippocampus

d. Hypothalamus

ANS: D

The hypothalamus, a small area in the ventral superior portion of the brain stem, plays a vital role in such

basic drives as hunger, thirst, and sex.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

5. The nurse prepares to assess a patient diagnosed with major depression for

disturbances in circadian rhythms. Which question should the nurse ask this patient?

a. “Have you ever seen or heard things that others do not?”

b. “What are your worst and best times of the day?”

c. “How would you describe your thinking?”

d. “Do you think your memory is failing?”

ANS: B

Mood changes throughout the day may be related to circadian rhythm disturbances. Questions about sleep

pattern are also relevant to circadian rhythms. The distracters apply to assessment for illusions and

hallucinations, thought processes, and memory.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. The nurse administers a medication that potentiates the action of gamma-aminobutyric

acid (GABA). Which effect would be expected?

a. Reduced anxiety

b. Improved memory

c. More organized thinking

d. Fewer sensory perceptual alterations

ANS: A

Increased levels of GABA reduce anxiety. Acetylcholine and substance P are associated with memory

enhancement. Thought disorganization is associated with dopamine. GABA is not associated with sensory

perceptual alterations. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Evaluation MSC: Client Needs: Physiological Integrity

7. A nurse would anticipate that treatment for a patient with memory difficulties might include medications designed to have which of the following effects?

a. Inhibit gamma-aminobutyric acid (GABA)

b. Prevent destruction of acetylcholine

c. Reduce serotonin metabolism

d. Increase dopamine activity

ANS: B

Increased acetylcholine plays a role in learning and memory. Preventing destruction of acetylcholine by acetylcholinesterase would result in higher levels of acetylcholine, with the potential for improved memory. GABA affects anxiety rather than memory. Increased dopamine would cause symptoms associated with schizophrenia or mania rather than improve memory. Decreasing dopamine at receptor sites is associated with Parkinson's disease rather than improving memory.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

8. A patient has disorganized thinking associated with schizophrenia. Neuroimaging would likely show dysfunction in which part of the brain?

a. Hippocampus

b. Frontal lobe

c. Cerebellum

d. Brain stem

ANS: B

The frontal lobe is responsible for intellectual functioning. The hippocampus is involved in emotions and learning. The cerebellum regulates skeletal muscle coordination and equilibrium. The brain stem regulates internal organs.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

9. The nurse should assess a patient taking a drug with anticholinergic properties for

inhibited function of which of the following?

a. Parasympathetic nervous system

b. Sympathetic nervous system

c. Reticular activating system

d. Medulla oblongata

ANS: A

Acetylcholine is the neurotransmitter found in high concentration in the parasympathetic nervous system.

When anticholinergic drugs inhibit acetylcholine action, blurred vision, dry mouth, constipation, and

urinary retention commonly occur.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

10. The therapeutic action of neurotransmitter inhibitors that block reuptake cause which

of the following effects?

a. Decreased concentration of the blocked neurotransmitter in the central nervous

system

b. Increased concentration of the blocked neurotransmitter in the synaptic gap

c. Destruction of receptor sites specific to the blocked neurotransmitter

d. Limbic system stimulation

ANS: B

If the reuptake of a substance is inhibited, it accumulates in the synaptic gap, and its concentration

increases, permitting ease of transmission of impulses across the synaptic gap. Normal transmission of

impulses across synaptic gaps is consistent with normal rather than depressed mood. The other options are

not associated with blocking neurotransmitter reuptake.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological

Integrity

11. A patient taking medication for mental illness develops restlessness and an uncontrollable need to be in motion. Which drug action causes these symptoms to develop?

a. Anticholinergic effects

b. Dopamine-blocking effects

c. Endocrine-stimulating effects

d. Ability to stimulate spinal nerves

ANS: B

Medication that blocks dopamine often produces disturbances of movement, such as akathisia, because dopamine affects neurons involved in both thought processes and movement regulation. Anticholinergic effects include dry mouth, blurred vision, urinary retention, and constipation. Akathisia is not caused by endocrine stimulation or spinal nerve stimulation.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

12. A patient shows signs of fear as well as increased heart rate and blood pressure. The nurse suspects increased activity of which neurotransmitter?

a. Gamma-aminobutyric acid (GABA)

b. Norepinephrine

c. Acetylcholine

d. Histamine

ANS: B

Norepinephrine is the neurotransmitter associated with sympathetic nervous system stimulation, preparing the individual for “fight or flight.” GABA is a mediator of anxiety level. A high concentration of histamine is associated with an inflammatory response. A high concentration of acetylcholine is associated with parasympathetic nervous system stimulation.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

13. A patient has acute anxiety related to an automobile accident 2 hours ago. The nurse should teach the patient about medication from which group?

a. Tricyclic antidepressants

b. Antipsychotic drugs

c. Antimanic drugs

d. Benzodiazepines

ANS: D

Benzodiazepines provide anxiety relief. Tricyclic antidepressants are used to treat symptoms of depression. Antimanic drugs are used to treat bipolar disorder. Antipsychotic drugs are used to treat psychosis.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

14. A patient is hospitalized for severe depression. Of the medications listed below, the nurse can expect to provide the patient with teaching about which of the following?

a. Chlordiazepoxide (Librium)

b. Clozapine (Clozaril)

c. Sertraline (Zoloft)

d. Tacrine (Cognex)

ANS: C

Sertraline (Zoloft) is a selective serotonin reuptake inhibitor (SSRI). This antidepressant blocks the reuptake of serotonin, with few anticholinergic and sedating adverse effects. Clozapine is an antipsychotic. Chlordiazepoxide is an anxiolytic. Tacrine treats Alzheimer's disease.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

15. A patient diagnosed with bipolar disorder has an unstable mood, aggressiveness, agitation, talkativeness, and irritability. The nurse expects the health care provider to prescribe a medication from which group?

a. Psychostimulants

b. Mood stabilizers

c. Anticholinergics

d. Antidepressants

ANS: B

The symptoms describe mania, which is effectively treated by mood stabilizers, such as lithium, and selected anticonvulsants (carbamazepine, valproic acid, and lamotrigine). Drugs from the other classifications listed are not effective in the treatment of mania.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

16. A drug causes muscarinic receptor blockade. The nurse will assess the patient for which of the following?

a. Dry mouth

b. Gynecomastia

c. Pseudoparkinsonism

d. Orthostatic hypotension

ANS: A

Muscarinic receptor blockade includes atropine-like adverse effects, such as dry mouth, blurred vision, and constipation. Gynecomastia is associated with decreased prolactin levels. Movement defects are associated with dopamine blockade. Orthostatic hypotension is associated with á1 antagonism.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

17. A patient begins therapy with a phenothiazine medication. What teaching should the nurse provide related to the drug's strong dopaminergic effect?

a. Chew sugarless gum.

b. Increase dietary fiber.

c. Arise slowly from bed.

d. Report changes in muscle movement.

ANS: D

Phenothiazines block dopamine receptors in both the limbic system and basal ganglia. Movement disorders and motor abnormalities (extrapyramidal side effects), such as parkinsonism, akinesia, akathisia, dyskinesia, and tardive dyskinesia, are likely to occur early in the course of treatment. They are often heralded by sensations of muscle stiffness. Early intervention with antiparkinson medication can increase the patient's comfort and prevent dystonic reactions. The distracters are related to anticholinergic

effects.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

18. A patient tells the nurse, “My doctor prescribed Paxil (paroxetine) for my depression. I assume I’ll have side effects like I had when I was taking Tofranil (imipramine).” The nurse’s reply should be based on what information about the drug?

a. Paroxetine is a selective norepinephrine reuptake inhibitor.

b. Paroxetine is a tricyclic antidepressant.

c. Paroxetine is an MAO inhibitor.

d. Paroxetine is an SSRI.

ANS: D

Paroxetine is an SSRI and will not produce the same adverse effects as imipramine, a tricyclic antidepressant. The patient will probably not experience dry mouth, constipation, or orthostatic hypotension.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

19. A nurse can anticipate anticholinergic adverse effects are likely when a patient takes which of the following:

a. Lithium carbonate (Carbolith)

b. Buspirone hydrochloride (Bustab)

c. Imipramine hydrochloride (Impril)

d. Risperidone (Risperdal)

ANS: C

Imipramine hydrochloride (Impril) is a tricyclic antidepressant with strong anticholinergic properties, resulting in dry mouth, blurred vision, constipation, and urinary retention.

Lithium therapy is more often associated with fluid-balance problems, including polydipsia, polyuria, and edema. Risperidone therapy is more often associated with movement disorders, orthostatic hypotension,

and sedation. Buspirone is associated with anxiety reduction without major adverse effects.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

20. Which instruction has priority when teaching a patient about clozapine (Clozaril)?

a. “Avoid unprotected sex.”

b. “Report sore throat and fever immediately.”

c. “Reduce foods high in polyunsaturated fats.”

d. “Use over-the-counter preparations for rashes.”

ANS: B

Clozapine therapy may produce agranulocytosis; therefore signs of infection should be immediately

reported to the health care provider. In addition, the patient should have white blood cell levels measured

weekly. The other options are not relevant to clozapine.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

21. A nurse cares for a group of patients receiving various medications, including

haloperidol (Haldol), carbamazepine (Tegretol), trazodone (Oleptro), and phenelzine (Nardil).

The nurse will order a special diet for the patient who takes which of the following?

a. Carbamazepine

b. Haloperidol

c. Phenelzine

d. Trazodone

ANS: C

Patients taking phenelzine, a MAO inhibitor, must be on a low tyramine diet to prevent hypertensive

crisis. There are no specific dietary precautions associated with carbamazepine, haloperidol or trazodone.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

22. A nurse instructs a patient taking a drug that inhibits monoamine oxidase (MAO) to

avoid certain foods and drugs because of the risk of which of the following?

a. Cardiac dysrhythmia

b. Hypotensive shock

c. Hypertensive crisis

d. Hypoglycemia

ANS: C

Patients taking MAO-inhibiting drugs must be on a low tyramine diet to prevent hypertensive crisis. In the presence of MAO inhibitors, tyramine is not destroyed by the liver and in high levels produces intense vasoconstriction, resulting in elevated blood pressure.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

23. A nurse caring for a patient taking a selective serotonin reuptake inhibitor (SSRI) will develop outcome criteria related to which of the following?

a. Coherent thought processes

b. Improvement in depression

c. Reduced levels of motor activity

d. Decreased extrapyramidal symptoms

ANS: B

SSRIs affect mood, relieving depression in many cases. SSRIs do not act to reduce thought disorders. SSRIs reduce depression but have little effect on motor hyperactivity. SSRIs do not reduce extrapyramidal symptoms.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

24. By which mechanism do selective serotonin reuptake inhibitors (SSRI) improve depression?

a. Destroying increased amounts of serotonin

b. Making more serotonin available at the synaptic gap

c. Increasing production of acetylcholine and dopamine

d. Blocking muscarinic and a1 norepinephrine receptors

ANS: B

Depression is thought to be related to lowered availability of the neurotransmitter serotonin. SSRIs act by

blocking reuptake of serotonin, leaving a higher concentration available at the synaptic cleft. SSRIs

prevent destruction of serotonin. SSRIs have little or no effect on acetylcholine and dopamine production.

SSRIs do not produce muscarinic or a1 norepinephrine blockade.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological

Integrity

25. The laboratory report for a patient taking clozapine (Clozaril) shows a white blood

cell count of 3 000 mm3

. Select the nurse's best action.

a. Report the results to the health care provider immediately.

b. Administer the next dose as prescribed.

c. Give aspirin and force fluids.

d. Repeat the laboratory test.

ANS: A

These laboratory values indicate the possibility of agranulocytosis, a serious adverse effect of clozapine

therapy. These results must be immediately reported to the health care provider, and the drug should be

withheld. The health care provider may repeat the test, but in the meantime, the drug should be withheld.

Caution: This question requires students to apply previous learning regarding normal and abnormal values

of white blood cell counts.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological

Integrity

26. A drug blocks the attachment of norepinephrine to a1 receptors. The patient may experience which of the following?

a. Hypertensive crisis

b. Orthostatic hypotension

c. Severe appetite disturbance

d. An increase in psychotic symptoms

ANS: B

Sympathetic-mediated vasoconstriction is essential for maintaining normal blood pressure in the upright position. Blockage of a1 receptors leads to vasodilation and orthostatic hypotension. Orthostatic hypotension may cause fainting and falls. Nurses should teach patients ways of minimizing this phenomenon.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

27. A nurse cares for four patients who are receiving clozapine, lithium, fluoxetine, and venlafaxine, respectively. The nurse should be most alert for problems associated with fluid and electrolyte imbalance with the patient receiving which drug?

a. Lithium

b. Clozapine (Clozaril)

c. Fluoxetine (Prozac)

d. Venlafaxine (Effexor)

ANS: A

Lithium is a salt and known to alter fluid and electrolyte balance, producing polyuria, edema, and other symptoms of imbalance. Patients receiving clozapine should be monitored for agranulocytosis. Patients receiving fluoxetine should be monitored for acetylcholine block. Patients receiving venlafaxine should be monitored for heightened feelings of anxiety

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

28. An obese patient has a diagnosis of schizophrenia. Medications that block which receptors would contribute to further weight gain?

a. H1

b. 5 HT2

c. Acetylcholine

d. Gamma-aminobutyric acid (GABA)

ANS: A

H1 receptor blockade results in weight gain, which is undesirable for an obese patient. Blocking of the other receptors would have little or no effect on the patient's weight.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

29. An individual hiking in the forest encounters a large poisonous snake on the path.

Which change in this individual's vital signs is most likely?

a. Pulse rate changes from 90 to 72.

b. Respiratory rate changes from 22 to 18.

c. Complaints of intestinal cramping begin.

d. Blood pressure changes from 114/62 to 136/78.

ANS: D

This frightening experience would stimulate the sympathetic nervous system, causing a release of norepinephrine, an excitatory neurotransmitter. It prepares the body for fight or flight. Increased blood pressure, pupil size, respiratory rate, and pulse rate signify release of norepinephrine. Intestinal cramping

would be associated with stimulation of the parasympathetic nervous system.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

30. Consider these medications: carbamazepine (Tegretol), lamotrigine (Lamictal), gabapentin (Neurontin). Which medication below also belongs with this group?

a. Galantamine hydrobromide (Reminyl)

b. Valproate (Depakene)

c. Buspirone hydrochloride (Bustab)

d. Rivastigmine hydrogen tartrate (Exelon)

ANS: B

The medications listed in the question are mood stabilizers, anticonvulsant types. Valproate (Depakene) is

also a member of this group. The distracters are drugs for treatment of Alzheimer's disease and anxiety.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

31. A professional football player is seen in the emergency department after losing

consciousness from an illegal block. Prior to discharge, the nurse assists the patient to schedule

an outpatient computed tomography (CT) scan for the next day. Which strategy should the nurse

use to ensure the patient remembers the appointment?

a. Write the appointment day, time, and location on a piece of paper and give it to the

player.

b. Log the appointment day, time, and location into the player's cell phone calendar

feature.

c. Ask the health care provider to admit the patient to the hospital overnight.

d. Verbally inform the patient of the appointment day, time, and location.

ANS: B

This player may have suffered repeated head injuries with damage to the hippocampus. The hippocampus

has a significant role in maintaining memory. Logging the appointment into the player's cell phone

calendar will remind him of the appointment the next day. Paper will be lost, and the patient is unlikely to

remember verbal instruction. Hospitalization is unnecessary.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. A nurse prepares to administer a second-generation antipsychotic medication to a

patient diagnosed with schizophrenia. Additional monitoring for adverse effects will be most

important if the patient has which co-morbid health problems? (Select all that apply.)

a. Parkinson's disease

b. Grave's disease

c. Hyperlipidemia

d. Osteoarthritis

e. Diabetes

ANS: A, C, E

Antipsychotic medications may produce weight gain, which would complicate care of a patient with diabetes, and increase serum triglycerides, which would complicate care of a patient with hyperlipidemia.

Parkinson's disease involves changes in transmission of dopamine and acetylcholine, so these drugs would also complicate care of this patient. Osteoarthritis and Grave's disease should have no synergistic effect with this medication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

2. Questions the nurse could ask that would be nonjudgemental when obtaining information about patient use of herbal remedies include which of the following? (Select all that apply.)

a. "You don't regularly take herbal remedies, do you?"

b. "What herbal medicines have you used to relieve your symptoms?"

c. "What over-the-counter medicines and nutritional supplements do you use?"

d. "What differences in your symptoms do you notice when you take herbal supplements?"

e. "Have you experienced problems from using herbal and prescription drugs at the same time?"

ANS: B, C, D, E

The correct responses are neutral in tone and do not express bias for or against the use of herbal medicines. The distracter, worded in a negative way, makes the nurse's bias evident.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. An individual is experiencing problems with memory. Which of these structures are

most likely to be involved in this deficit? (Select all that apply.)

a. Amygdala

b. Hippocampus

c. Occipital lobe

d. Reticular activating system (RAS)

e. Basal ganglia

ANS: A, B

The amygdala and hippocampus play roles in memory. The occipital lobe is predominantly involved with vision. The reticular activating system (RAS) regulates the sleep-wake cycle. The basal ganglia influence integration of physical movement, as well as some thoughts and emotions.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

4. A patient's sibling says, "My brother has a mental illness, but the doctor ordered a functional magnetic resonance image (fMRI) test. That seems unnecessary and wasteful." Select the nurse's best responses. (Select all that apply.)

a. "Sometimes there are physical causes for psychiatric symptoms. This test will help us understand whether that is the situation."

b. "Some mental illnesses are evident on fMRIs. This test will give information to help us plan the best care for your brother."

c. "Tell me more about what is concerning you about the testing."

d. "It sounds like you do not truly believe your brother had a mental illness."

e. "It would be better for you to discuss your concerns with the doctor."

ANS: A, B, C

The correct responses provide information to the sibling. Modern imaging techniques are important tools in assessing molecular changes in mental disease and marking the receptor sites of drug action, which can help in treatment planning. Psychiatric symptoms can be caused by anatomical or physiologic abnormalities. There is no evidence of denial in the sibling's comment. The nurse can answer this

question rather than referring it to the physician. It would be inappropriate to discuss finances with the patient's sibling.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

Chapter 12: Anxiety and Related Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A nurse wants to teach alternative coping strategies to a patient experiencing severe anxiety. Which action should the nurse perform first?

a. Verify the patient's learning style.

b. Lower the patient's current anxiety.

c. Create outcomes and a teaching plan.

d. Assess how the patient uses defence mechanisms.

ANS: B

A patient experiencing severe anxiety has a markedly narrowed perceptual field and difficulty attending to events in the environment. A patient experiencing severe anxiety will not learn readily. Determining preferred modes of learning, devising outcomes, and constructing teaching plans are relevant to the task, but are not the priority measure. The nurse has already assessed the patient's anxiety level. Use of defence mechanisms does not apply.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. Which is an intermediate indicator of the nursing outcome of anxiety self-control?

a. Maintains adequate sleep

b. Monitors intensity of anxiety

c. Controls anxiety response

d. Uses relaxation techniques to lower anxiety

ANS: C

Intermediate indicators of the nursing outcome anxiety self-control are controls anxiety response and maintains role performance. Maintains adequate sleep, monitors intensity of anxiety and uses relaxation techniques to lower anxiety, are short term indicators of the outcomes of anxiety self-control.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A patient experiencing moderate anxiety says, "I feel undone." An appropriate response for the nurse would be which of the following?

a. "What would you like me to do to help you?"

b. "Why do you suppose you are feeling anxious?"

c. "I'm not sure I understand. Give me an example."

d. "You must get your feelings under control before we can continue."

ANS: C

Increased anxiety results in scattered thoughts and an inability to articulate clearly. Clarifying helps the patient identify thoughts and feelings. Asking the patient why he or she feels anxious is nontherapeutic; the patient likely does not have an answer. The patient may be unable to determine what he or she would like the nurse to do in order to help. Telling the patient to get his or her feelings under control is a directive the patient is probably unable to accomplish.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. A patient fearfully runs from chair to chair, crying, "They're coming! They're coming!" The patient does not follow the staff's directions or respond to verbal interventions. The initial nursing intervention of highest priority is to do which of the following?

a. Provide for the patient's safety

b. Encourage clarification of feelings

c. Respect the patient's personal space

d. Offer an outlet for the patient's energy

ANS: A

Safety is of highest priority because the patient experiencing panic is at high risk for self-injury related to increased nongoal-directed motor activity, distorted perceptions, and disordered thoughts. Offering an outlet for the patient's energy can occur when the current panic level subsides. Respecting the patient's personal space is a lower priority than safety. Clarification of feelings cannot take place until the level of anxiety is lowered.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

5. A patient fearfully runs from chair to chair, crying, "They're coming! They're coming!" The patient does not follow the staff's directions or respond to verbal interventions. Which nursing diagnosis has the highest priority?

a. Fear

b. Risk for injury

c. Self-care deficit

d. Disturbed thought processes

ANS: B

A patient experiencing panic-level anxiety is at high risk for injury related to increased nongoal-directed motor activity, distorted perceptions, and disordered thoughts. Data are not present to support a nursing diagnosis of self-care deficit or disturbed thought processes. The patient may have fear, but the risk for injury has a higher priority.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

6. A patient checks and rechecks electrical cords related to an obsessive thought that the house may burn down. The nurse and patient explore the likelihood of an actual fire. The patient states this event is not likely. This counselling demonstrates principles of which of the following?

a. Flooding

b. Desensitization

c. Relaxation technique

d. Cognitive restructuring

ANS: D

Cognitive restructuring involves the patient in testing automatic thoughts and drawing new conclusions. Desensitization involves graduated exposure to a feared object. Relaxation training teaches the patient to produce the opposite of the stress response. Flooding exposes the patient to a large amount of an undesirable stimulus in an effort to extinguish the anxiety response.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

7. A patient undergoing diagnostic tests says, “Nothing is wrong with me except a stubborn chest cold.” The spouse reports the patient smokes, coughs daily, lost 15 pounds, and is easily fatigued. Which defence mechanism is the patient using?

a. Displacement

b. Regression

c. Projection

d. Denial

ANS: D

Denial is an unconscious blocking of threatening or painful information or feelings. Regression involves using behaviours appropriate at an earlier stage of psychosexual development. Displacement shifts feelings to a more neutral person or object. Projection attributes one’s own unacceptable thoughts or feelings to another.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A patient with an abdominal mass is scheduled for a biopsy. The patient has difficulty understanding the nurse’s comments and asks, “What do you mean? What are they going to do?”

Assessment findings include tremulous voice, respirations 28, and pulse 110. What is the patient's level of anxiety?

a. Mild

b. Moderate

c. Severe

d. Panic

ANS: B

Moderate anxiety causes the individual to grasp less information and reduces problem-solving ability to a less-than-optimal level. Mild anxiety heightens attention and enhances problem solving. Severe anxiety causes great reduction in the perceptual field. Panic-level anxiety results in disorganized behaviour.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

9. A patient preparing for surgery has moderate anxiety and is unable to understand preoperative information. Which nursing intervention is most appropriate?

a. Reassure the patient that all nurses are skilled in providing postoperative care.

b. Present the information again in a calm manner using simple language.

c. Tell the patient that staff is prepared to promote recovery.

d. Encourage the patient to express feelings to family.

ANS: B

Giving information in a calm, simple manner will help the patient grasp the important facts. Introducing extraneous topics as described in the distracters will further scatter the patient's attention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. A patient is experiencing moderate anxiety. The nurse encourages the patient to talk about feelings and concerns. What is the rationale for this intervention?

a. Offering hope allays and defuses the patient's anxiety.

b. Concerns stated aloud become less overwhelming and help problem solving begin.

c. Anxiety is reduced by focusing on and validating what is occurring in the

environment.

d. Encouraging patients to explore alternatives increases the sense of control and

lessens anxiety.

ANS: B

All principles listed are valid, but the only rationale directly related to the intervention of assisting the

patient to talk about feelings and concerns is the one that states that concerns spoken aloud become less

overwhelming and help problem solving begin.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

11. A nurse assesses a patient with a tentative diagnosis of generalized anxiety disorder.

Which question would be most appropriate for the nurse to ask?

a. “Have you been a victim of a crime or seen someone badly injured or killed?”

b. “Do you feel especially uncomfortable in social situations involving people?”

c. “Do you repeatedly do certain things over and over again?”

d. “Do you find it difficult to control your worrying?”

ANS: D

Patients with generalized anxiety disorder frequently engage in excessive worrying. They are less likely

to engage in ritualistic behaviour, fear social situations, or have been involved in a highly traumatic event.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. A patient in the emergency department shows disorganized behaviour and

incoherence after a friend suggested a homosexual encounter. In which room should the nurse

place the patient?

a. An interview room furnished with a desk and two chairs

b. A small, empty storage room with no windows or furniture

c. A room with an examining table, instrument cabinets, desk, and chair

d. The nurse's office, furnished with chairs, files, magazines, and bookcases

ANS: A

Individuals experiencing severe to panic-level anxiety require a safe environment that is quiet, nonstimulating, structured, and simple. A room with a desk and two chairs provides simplicity, few objects with which the patient could cause self-harm, and a small floor space in which the patient can move about. A small, empty storage room without windows or furniture would feel like a jail cell. The nurse's office or a room with an examining table and instrument cabinets may be overstimulating and unsafe.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

13. A person has minor physical injuries after an auto accident. The person is unable to focus and says, "I feel like something awful is going to happen." This person has nausea, dizziness, tachycardia, and hyperventilation. What is the person's level of anxiety?

a. Mild

b. Moderate

c. Severe

d. Panic

ANS: C

The person whose anxiety is severe is unable to solve problems and may have a poor grasp of what is happening in the environment. Somatic symptoms such as those described are usually present. The individual with mild anxiety is only mildly uncomfortable and may even find his or her performance enhanced. The individual with moderate anxiety grasps less information about a situation and has some difficulty with problem solving. The individual in panic will demonstrate markedly disturbed behaviour and may lose touch with reality.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. Two staff nurses applied for a charge nurse position. After the promotion was announced, the nurse who was not promoted said, "The nurse manager had a headache the day I

was interviewed." Which defence mechanism is evident?

a. Introjection

b. Conversion

c. Projection

d. Splitting

ANS: C

Projection is the hallmark of blaming, scapegoating, prejudicial thinking, and stigmatizing others. Conversion involves the unconscious transformation of anxiety into a physical symptom. Introjection involves intense, unconscious identification with another person. Splitting is the inability to integrate the positive and negative qualities of oneself or others into a cohesive image.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. A patient tells a nurse, "I was not able to write my final exam as I had a pounding headache and I was not able to read." This patient is demonstrating which of the following?

a. Denial

b. Projection

c. Compensation

d. Conversion

ANS: D

Conversion is the unconscious transformation of anxiety into a physical symptom with no organic cause. Often, the symptom functions to gain attention or provide an excuse. Compensation would result in the patient unconsciously attempting to make up for a perceived weakness by emphasizing a strong point. Denial is an unconscious process that would call for the nurse to ignore the existence of the situation. Projection operates unconsciously and would result in blaming behaviour.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. A patient experiences a sudden episode of severe anxiety. Of these medications in the patient's medical record, which is most appropriate to give as a prn anxiolytic?

a. Buspirone (Bustab)

b. Lorazepam (Ativan)

c. Phenelzine sulfate (Nardil)

d. Tranylcypromine sulfate (Parnate)

ANS: B

Lorazepam is a benzodiazepine used to treat anxiety. It may be given as a prn medication. Buspirone is long acting and is not useful as a prn drug. Phenelzine and tranylcypromine are monoamine oxidase inhibitors.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

17. Two staff nurses applied for promotion to nurse manager. The day of the job interviews, one nurse was told by her boyfriend that he wanted to end the relationship. Although visibly upset, the nurse does not think about what her boyfriend has said and prepares for the interview. Which term best describes the nurse's response?

a. Altruism

b. Suppression

c. Intellectualization

d. Reaction formation

ANS: B

Suppression is the conscious denial of a disturbing situation or feeling. There is no evidence of altruism. Intellectualization is a process in which events are analyzed based on remote, cold facts and without passion, rather than incorporating feeling and emotion into the processing. Reaction formation is when unacceptable feelings or behaviours are controlled and kept out of awareness by developing the opposite behaviour or emotion.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. A person who feels unattractive repeatedly says, "Although I'm not beautiful, I am smart." This is an example of which of the following?

a. Repression

b. Devaluation

c. Identification

d. Compensation

ANS: D

Compensation is an unconscious process that allows us to make up for deficits in one area by excelling in another area to raise self-esteem. Repression unconsciously puts an idea, event, or feeling out of awareness. Identification is an unconscious mechanism calling for imitation of mannerisms or behaviours of another. Devaluation occurs when the individual attributes negative qualities to self or others.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

19. A person speaking about a rival for a significant other's affection says in an emotional, syrupy voice, "What a lovely person. That's someone I simply adore." The individual is demonstrating which of the following?

a. Reaction formation

b. Repression

c. Projection

d. Denial

ANS: A

Reaction formation is an unconscious mechanism that keeps unacceptable feelings out of awareness by using the opposite behaviour. Instead of expressing hatred for the other person, the individual gives praise. Denial operates unconsciously to allow an anxiety-producing idea, feeling, or situation to be ignored. Projection involves unconsciously disowning an unacceptable idea, feeling, or behaviour by attributing it to another. Repression involves unconsciously placing an idea, feeling, or event out of awareness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. An individual experiences sexual dysfunction and blames it on a partner by calling the person unattractive and unromantic. Which defence mechanism is evident?

a. Rationalization

b. Compensation

c. Introjection

d. Regression

ANS: A

Rationalization involves unconsciously making excuses for one's behaviour, inadequacies, or feelings. Regression involves the unconscious use of a behaviour from an earlier stage of emotional development. Compensation involves making up for deficits in one area by excelling in another area. Introjection is an unconscious, intense identification with another person.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. A student says, "Before taking a test, I feel very alert and a little restless." The nurse can correctly assess the student's experience as which of the following?

a. Culturally influenced

b. Displacement

c. Trait anxiety

d. Mild anxiety

ANS: D

Mild anxiety is rarely obstructive to the task at hand. It may be helpful to the patient because it promotes study and increases awareness of the nuances of questions. The incorrect responses have different symptoms. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. A student says, "Before taking a test, I feel very alert and a little restless." Which nursing intervention is most appropriate to assist the student?

a. Explain that the symptoms result from mild anxiety and discuss the helpful aspects.

b. Advise the student to discuss this experience with a health care provider.

c. Encourage the student to begin antioxidant vitamin supplements.

d. Listen attentively, using silence in a therapeutic way.

ANS: A

Teaching about symptoms of anxiety, their relation to precipitating stressors, and, in this case, the positive

effects of anxiety will serve to reassure the patient. Advising the patient to discuss the experience with a

health care provider implies that the patient has a serious problem. Listening without comment will do no

harm but deprives the patient of health teaching. Antioxidant vitamin supplements are not useful in this

scenario.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

23. A cruel and abusive person often uses rationalization to explain the behaviour. Which

comment demonstrates use of this defence mechanism?

a. “I don’t know why I do mean things.”

b. “I have always had poor impulse control.”

c. “That person should not have provoked me.”

d. “I’m really a coward who is afraid of being hurt.”

ANS: C

Rationalization consists of justifying one’s unacceptable behaviour by developing explanations that

satisfy the teller and attempt to satisfy the listener. The abuser is suggesting that the abuse is not his or her

fault; it would not have occurred except for the provocation by the other person. The distracters indicate

some measure of acceptance of responsibility for the behaviour.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. A patient experiencing panic suddenly began running and shouting, “I’m going to

explode!” Select the nurse’s best action.

a. Ask, “I’m not sure what you mean. Give me an example.”

b. Capture the patient in a basket-hold to increase feelings of control.

c. Tell the patient, “Stop running and take a deep breath. I will help you.”

d. Assemble several staff members and say, “We will take you to seclusion to help

you regain control."

ANS: C

Safety needs of the patient and other patients are a priority. Comments to the patient should be simple and

neutral and give direction to help the patient regain control. Running after the patient will increase the patient's anxiety. More than one staff member may be needed to provide physical limits but using seclusion or physically restraining the patient prematurely is unjustified. Asking the patient to give an example would be futile; a patient in panic processes information poorly.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

25. A person who has been unable to leave home for more than a week because of severe anxiety says, "I know it does not make sense, but I just can't bring myself to leave my apartment alone." Which nursing intervention is appropriate?

a. Help the person use online video calls to provide interaction with others.

b. Advise the person to accept the situation and use a companion.

c. Ask the person to explain why the fear is so disabling.

d. Teach the person to use positive self-talk techniques.

ANS: D

Positive self-talk, a form of cognitive restructuring, replaces negative thoughts such as "I can't leave my apartment" with positive thoughts such as "I can control my anxiety." This technique helps the patient gain mastery over the symptoms. The other options reinforce the sick role.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

26. A nurse assesses an individual who commonly experiences anxiety. Which comment by this person indicates the possibility of obsessive-compulsive disorder?

a. "I check where my car keys are eight times."

b. "My legs often feel weak and spastic."

c. "I'm embarrassed to go out in public."

d. “I keep reliving a car accident.”

ANS: A

Recurring doubt (obsessive thinking) and the need to check (compulsive behaviour) suggest obsessive-compulsive disorder. The repetitive behaviour is designed to decrease anxiety, but fails and must be

repeated. Stating “My legs feel weak most of the time” is more in keeping with a somatic disorder. Being embarrassed to go out in public is associated with an avoidant personality disorder. Reliving a traumatic event is associated with post-traumatic stress disorder.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

27. When alprazolam (Xanax) is prescribed for a patient who experiences acute anxiety, health teaching should include instructions to do which of the following?

a. Report drowsiness

b. Eat a tyramine-free diet

c. Avoid alcoholic beverages

d. Adjust dose and frequency based on anxiety level

ANS: C

Drinking alcohol or taking other anxiolytics along with the prescribed benzodiazepine should be avoided because depressant effects of both drugs will be potentiated. Tyramine-free diets are necessary only with

monoamine oxidase inhibitors (MAOIs). Drowsiness is an expected effect and needs to be reported only if it is excessive. Patients should be taught not to deviate from the prescribed dose and schedule for administration.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

28. The nurse assesses a patient who complains of loneliness and episodes of anxiety. Which statement by the patient is mostly likely if this patient also has agoraphobia?

a. “I’m sure I will get over not wanting to leave home soon. It takes time.”

b. “Being afraid to go out seems ridiculous, but I can’t go out the door.”

c. “My family says they like it now that I stay home most of the time.”

d. “When I have a good incentive to go out, I can do it.”

ANS: B

Individuals who are agoraphobic generally acknowledge that the behaviour is not constructive and that they do not really like it. The symptom is ego-dystonic. However, patients will state they are unable to change the behaviour. Agoraphobics are not optimistic about change. Most families are dissatisfied when family members refuse to leave the house.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

29. A patient diagnosed with obsessive-compulsive disorder has this nursing diagnosis:

Anxiety related to _____ as evidenced by inability to control compulsive cleaning. Which phrase correctly completes the etiological portion of the diagnosis?

a. Feelings of responsibility for the health of family members

b. Approval-seeking behaviour from friends and family

c. Persistent thoughts about bacteria, germs, and dirt

d. Needs to avoid interactions with others

ANS: C

Many compulsive rituals accompany obsessive thoughts. The patient uses these rituals for anxiety relief. Unfortunately, the anxiety relief is short-lived, and the patient must frequently repeat the ritual. The other

options are unrelated to the dynamics of compulsive behaviour.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

30. A patient performs ritualistic handwashing. Which action should the nurse implement to help the patient develop more effective coping?

a. Displacement

b. Reflection

c. Systematic desensitization

d. Reaction formation

ANS: B

Systematic desensitization will assist the patient to develop more effective coping. The patient is gradually introduced to a feared object or experience through a series of steps, from the least frightening to the most frightening (graduated exposure). The patient is taught to use a relaxation technique at each step when anxiety becomes overwhelming. Displacement, reflection and reaction formation are defence mechanisms, not a form of behavioural therapy.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

31. For a patient experiencing panic, which nursing intervention should be implemented first?

a. Teach relaxation techniques.

b. Administer an anxiolytic medication.

c. Prepare to implement physical controls.

d. Provide calm, brief, directive communication.

ANS: D

Calm, brief, directive verbal interaction can help the patient gain control of overwhelming feelings and impulses related to anxiety. Patients experiencing panic-level anxiety are unable to focus on reality; thus, learning relaxation techniques is virtually impossible. Administering anxiolytic medication should be considered if providing calm, brief, directive communication is ineffective. Although the patient is disorganized, violence may not be imminent, ruling out the intervention of preparing for physical control until other less-restrictive measures are proven ineffective.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

32. Which assessment data would help the health care team distinguish symptoms of conversion (functional neurological) disorder from symptoms of illness anxiety disorder

(hypochondriasis)?

a. Voluntary control of symptoms

b. Patient's style of presentation

c. Results of diagnostic testing

d. The role of secondary gains

ANS: B

Patients with illness anxiety disorder (hypochondriasis) tend to be more anxious about their concerns and

display more obsessive attention to detail, whereas patients with conversion (functional neurological)

disorder often exhibit less concern with the symptom they are presenting than would be expected. Neither

disorder involves voluntary control of the symptoms. Results of diagnostic testing for both would be

negative (i.e., no physiological basis would be found for the symptoms). Secondary gains can occur in

both disorders but are not necessary to either.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

33. Which prescription medication would the nurse expect to be prescribed for a patient

diagnosed with a somatic symptom disorder?

a. Narcotic analgesics for use as needed for acute pain

b. Antidepressant medications to treat underlying depression

c. Long-term use of benzodiazepines to support coping with anxiety

d. Conventional antipsychotic medications to correct cognitive distortions

ANS: B

Various types of antidepressants may be helpful in somatic disorders directly by reducing depressive

symptoms and hence somatic responses, but also indirectly by affecting nerve circuits that affect not only

mood, but also fatigue, pain perception, GI distress, and other somatic symptoms. Patients may benefit

from short-term use of antianxiety medication (benzodiazepines), but require careful monitoring because

of risks of dependence. Conventional antipsychotic medications would not be used, although selected

atypical antipsychotics may be useful. Narcotic analgesics are not indicated.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

34. A medical-surgical nurse works with a patient diagnosed with a somatic symptom disorder. Care planning is facilitated by understanding which of the following?

a. The patient will probably readily seek psychiatric counselling.

b. The patient will probably be resistant to accepting psychiatric help.

c. The patient will probably attend psychotherapy sessions without encouragement.

d. The patient will probably be eager to discover the true reasons for physical symptoms.

ANS: B

Patients with somatic symptom disorders go from one health care provider to another trying to establish a physical cause for their symptoms, referred to as “doctor shopping.” When a psychological basis is suggested and a referral for counselling offered, these patients reject both.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

35. A patient has blindness related to conversion (functional neurological) disorder, but is unconcerned about this problem. Which understanding should guide the nurse’s planning for this patient?

a. The patient is suppressing accurate feelings regarding the problem.

b. The patient’s anxiety is relieved through the physical symptom.

c. The patient’s optic nerve transmission has been impaired.

d. The patient will not disclose genuine fears.

ANS: B

Psychoanalytical theory suggests conversion reduces anxiety through production of a physical symptom symbolically linked to an underlying conflict. Conversion, not suppression, is the operative defence mechanism in this disorder. While some MRI studies suggest that patients with conversion disorder have an abnormal pattern of cerebral activation, there is no actual alternation of nerve transmission. The other

distracters oversimplify the dynamics, suggesting that only dependency needs are of concern, or suggesting conscious motivation (conversion operates unconsciously).

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

36. A patient has blindness related to conversion (functional neurological) disorder.

Which of the following should the nurse do to help the patient eat?

a. Establish a "buddy system" with other patients who can feed the patient at each meal

b. Expect the patient to feed self after explaining arrangement of the food on the plate

c. Direct the patient to locate items on the tray independently and feed self

d. Address needs of other patients in the dining room, and then feed this patient

ANS: B

The patient is expected to maintain some level of independence by feeding self, while the nurse is supportive in a matter-of-fact way. The patient experiencing blindness can be told at what numbers on an imaginary clock the food is located on the plate. The distracters support dependency or offer too little support.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

37. A patient with blindness related to conversion (functional neurological) disorder says, "All the doctors and nurses in the hospital stop by often to check on me. Too bad people outside the hospital don't find me as interesting." Which nursing diagnosis is most relevant?

a. Social isolation

b. Chronic low self-esteem

c. Interrupted family processes

d. Ineffective health maintenance

ANS: B

The patient mentions that the symptoms make people more interested. This indicates that the patient feels

uninteresting and unpopular without the symptoms, thus supporting the nursing diagnosis of chronic low

self-esteem. Defining characteristics for the other nursing diagnoses are not present in the scenario.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

38. To assist patients diagnosed with somatic symptom disorders, nursing interventions

of high priority do which of the following?

a. Explain the pathophysiology of symptoms

b. Help these patients suppress feelings of anger

c. Shift focus from somatic symptoms to feelings

d. Investigate each physical symptom as it is reported

ANS: C

Shifting the focus from somatic symptoms to feelings or to neutral topics conveys interest in the patient as

a person rather than as a condition. The need to gain attention with the use of symptoms is reduced over

the long term. A desired outcome would be that the patient would express feelings, including anger if it is

present. Once physical symptoms are investigated, they do not need to be reinvestigated each time the

patient reports them.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

39. A patient with fears of serious heart disease was referred to the mental health centre

by a cardiologist. Extensive diagnostic evaluation showed no physical illness. The patient says,

“My chest is tight, and my heart misses beats. I’m often absent from work. I don’t go out much

because I need to rest.” Which health problem is most likely?

a. Dysthymic disorder

b. Somatic symptom disorder

c. Antisocial personality disorder

d. Illness anxiety disorder (hypochondriasis)

ANS: D

Illness anxiety disorder (hypochondriasis) involves preoccupation with fears of having a serious disease even when evidence to the contrary is available. The preoccupation causes impairment in social or occupational functioning. Somatic symptom disorder involves fewer symptoms. Dysthymic disorder is a disorder of lowered mood. Antisocial disorder applies to a personality disorder in which the individual has little regard for the rights of others. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

40. A nurse assessing a patient diagnosed with a somatic symptom disorder is most likely to note which of the following?

a. The patient sees a relationship between symptoms and interpersonal conflicts.

b. The patient has little difficulty communicating emotional needs to others.

c. The patient rarely derives personal benefit from the symptoms.

d. The patient has altered comfort and activity needs.

ANS: D

The patient frequently has altered comfort and activity needs associated with the symptoms displayed (fatigue, insomnia, weakness, tension, pain). In addition, hygiene, safety, and security needs may also be compromised. The patient is rarely able to see a relation between symptoms and events in his or her life, which is readily discernible to health professionals. Patients with somatic symptom disorders often derive secondary gain from their symptoms and/or have considerable difficulty identifying feelings and conveying emotional needs to others.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

41. To plan effective care for patients diagnosed with somatic symptom disorders, the nurse should understand that patients have difficulty giving up the symptoms because of which of the following?

a. The symptoms are generally chronic.

b. The symptoms have a physiological basis.

c. The symptoms can be voluntarily controlled.

d. The symptoms provide relief from health anxiety.

ANS: D

At the unconscious level, the patient's primary gain from the symptoms is anxiety relief. Considering that the symptoms actually make the patient more psychologically comfortable and may also provide secondary gain, patients frequently fiercely cling to the symptoms. The symptoms tend to be chronic, but that does not explain why they are difficult to give up. The symptoms are not under voluntary control; nor are they physiologically based.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

42. A patient with a somatic symptom disorder has the nursing diagnosis Interrupted family processes related to patient's disabling symptoms as evidenced by spouse and children assuming roles and tasks that previously belonged to the patient. An appropriate outcome is that the patient will do which of the following?

a. Assume roles and functions of other family members

b. Demonstrate performance of former roles and tasks

c. Focus energy on problems occurring in the family

d. Rely on family members to meet personal needs

ANS: B

The patient with a somatic symptom disorder has typically adopted a sick role in the family, characterized by dependence. Increasing independence and resumption of former roles are necessary to change this pattern. An appropriate outcome is that the patient will resume performance of work, family, and social role behaviours. The distracters are inappropriate outcomes.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

43. A nurse assesses a patient diagnosed with conversion (functional neurological) disorder. Which comment is most likely from this patient?

a. “Since my father died, I’ve been short of breath and had sharp pains that go down my left arm, but I think it’s just indigestion.”

b. “I have daily problems with nausea, vomiting, and diarrhea. My skin is very dry, and I think I’m getting seriously dehydrated.”

c.

“Sexual intercourse is painful. I pretend I’m asleep so I can avoid it. I think it’s starting to cause problems with my marriage.”

d. “I choke very easily and have trouble swallowing when I eat. I think I might have cancer of the esophagus.”

ANS: A

Patients with conversion (functional neurological) disorder demonstrate a lack of concern regarding the seriousness of symptoms. This lack of concern is termed “la belle indifférence.” There is also a specific, identifiable cause for the development of the symptoms; in this instance, the death of a parent would have precipitated stress. The distracters relate to sexual dysfunction and illness anxiety disorder.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

44. A patient who experienced a myocardial infarction was transferred from critical care to a step-down unit. The patient then used the call bell every 15 minutes for minor requests and complaints. Staff nurses reported feeling inadequate and unable to satisfy the patient’s needs. When the nurse manager intervenes directly with this patient, which comment would be most therapeutic?

a. “I’m wondering if you’re feeling anxious about your illness and being left alone.”

b. “The staff are concerned that you are not satisfied with the care you are receiving.”

c. “Let’s talk about why you use your call bell so frequently. It is a problem.”

d. “You frustrate the staff by calling them so often. Why are you doing that?”

ANS: A

This patient is experiencing anxiety associated with a serious medical condition. Verbalization is an effective outlet for anxiety. “I’m wondering if you’re anxious . . .” focuses on the emotions underlying the behaviour rather than the behaviour itself. This opening conveys the nurse’s willingness to listen to the patient’s feelings and an understanding of the commonly seen concern about not having a nurse always nearby as in the critical care unit. The other options focus on the behaviour or its impact on nursing and do not help the patient with her emotional needs.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

45. A patient reports fears of having cervical cancer and says to the nurse, “I’ve had Pap smears by six different doctors. The results were normal, but I’m sure that’s because of errors in the laboratory.” Which disorder would the nurse suspect?

a. Conversion (functional neurological) disorder

b. Illness anxiety disorder (hypochondriasis)

c. Somatic symptom disorder

d. Factitious disorder

ANS: B

Patients with illness anxiety disorder have fears of serious medical problems, such as cancer or heart disease. These fears persist despite medical evaluations and interfere with daily functioning. There are no complaints of pain. There is no evidence of factitious or conversion disorder.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

46. A patient diagnosed with a somatic symptom disorder says, “My pain is from an undiagnosed injury. I can’t take care of myself. I need pain medicine six or seven times a day. I feel like a baby because my family has to help me so much.” It is important for the nurse to assess which of the following?

a. Mood

b. Cognitive style

c. Secondary gains

d. Identity and memory

ANS: C

Secondary gains should be assessed. The patient's dependency needs may be met through care from the family. When secondary gains are prominent, the patient is more resistant to giving up the symptom. The scenario does not allude to a problem of mood. Cognitive style and identity and memory assessment are of lesser concern because the patient's diagnosis has been established.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

47. What is an essential difference between somatic symptom disorders and factitious disorders?

a. Somatic symptom disorders are under voluntary control, whereas factitious disorders are unconscious and automatic.

b. Factitious disorders are precipitated by psychological factors, whereas somatic symptom disorders are related to stress.

c. Factitious disorders are individually determined and related to childhood sexual abuse, whereas somatic symptom disorders are culture bound.

d. Factitious disorders are under voluntary control, whereas somatic symptom disorders involve expression of psychological stress through somatization.

ANS: D

Factitious disorders are under voluntary control, whereas somatic symptom disorders involve expression of psychological stress through somatization is the only fully accurate statement. Somatic symptom disorders involve expression of stress through bodily symptoms and are not under voluntary control or culture bound. Factitious disorders are under voluntary control. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

48. A patient says, "I know I have a brain tumor despite the results of the MRI. The radiologist is wrong. People who have brain tumors vomit, and yesterday I vomited all day." Which response by the nurse fosters cognitive reframing?

a. “You do not have a brain tumor. The more you talk about it, the more it reinforces

your belief.”

b. “Let’s see if there are any other possible explanations for your vomiting.”

c. “You seem so worried. Let’s talk about how you’re feeling.”

d. “We need to talk about something else.”

ANS: B

Questioning the evidence is a cognitive reframing technique. Reattribution treatment, which can help the

patient identify causes other than the feared disease, can be helpful in changing distorted perceptions.

Distraction by changing the subject will not be effective.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

49. Which treatment modality should a nurse recommend to help a patient diagnosed

with a somatic symptom disorder to cope more effectively?

a. Flooding

b. Response prevention

c. Relaxation techniques

d. Systematic desensitization

ANS: C

Somatic symptom disorders are commonly associated with complicated reactions to stress. These

reactions are accompanied by muscle tension and pain. Relaxation can diminish the patient’s perceptions

of pain and reduce muscle tension. The distracters are modalities useful in treating selected anxiety

disorders.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

50. Which assessment question could a nurse ask to help identify secondary gains

associated with a somatic symptom disorder?

a. “What are you unable to do now but were previously able to do?”

b. “How many doctors have you seen in the last year?”

c. “Who do you talk to when you’re upset?”

d. “Did you experience abuse as a child?”

ANS: A

Secondary gains should be assessed. Secondary gains reinforce maladaptive behaviour. The patient’s dependency needs may be evident through losses of abilities. When secondary gains are prominent, the patient is more resistant to giving up the symptom. There may be a history of abuse or doctor shopping, but the question does not assess the associated gains.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

51. A patient diagnosed with a somatic symptom disorder has been in treatment for 4 weeks. The patient says, “Although I’m still having pain, I notice it less and am able to perform more activities.” The nurse should evaluate the treatment plan as which of the following?

a. Marginally successful

b. Minimally successful

c. Partially successful

d. Totally achieved

ANS: C

Decreased preoccupation with symptoms and increased ability to perform activities of daily living suggest partial success of the treatment plan. Total success is rare because of patient resistance.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A child was placed in a foster home after being removed from abusive parents. The child is apprehensive and overreacts to environmental stimuli. The foster parents ask the nurse how to help the child. Which interventions should the nurse suggest? (Select all that apply.)

a. Use a calm manner and low voice.

b. Maintain simplicity in the environment.

c. Avoid repetition in what is said to the child.

d. Minimize opportunities for exercise and play.

e. Explain and reinforce reality to avoid distortions.

ANS: A, B, E

The child has moderate anxiety. A calm manner will calm the child. A simple, structured, predictable environment is desirable to decrease anxiety and reduce stimuli. Calm, simple explanations that reinforce reality validate the environment. Repetition is often needed when the individual is unable to concentrate because of elevated levels of anxiety. Opportunities for play and exercise should be provided as avenues to reduce anxiety. Physical movement helps channel and lower anxiety. Play helps by allowing the child to act out concerns.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A nurse plans health teaching for a patient with generalized anxiety disorder who begins a new prescription for lorazepam (Ativan). What information should be included? (Select all that apply.)

a. Caution in use of machinery

b. Foods allowed on a tyramine-free diet

c. The importance of caffeine restriction

d. Avoidance of alcohol and other sedatives

e. The need to take the medication on an empty stomach

ANS: A, C, D

Caffeine is a central nervous system stimulant that acts as an antagonist to the benzodiazepine lorazepam.

Daily caffeine intake should be reduced to the amount contained in one cup of coffee. Benzodiazepines are sedatives, thus the importance of exercising caution when driving or using machinery and the importance of not using other central nervous system depressants such as alcohol or sedatives to avoid potentiation. Benzodiazepines do not require a special diet. Food will reduce gastric irritation from the

medication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

3. Which assessment questions would be most appropriate for the nurse to ask a patient with possible obsessive-compulsive disorder? (Select all that apply.)

a. “Are there certain social situations that cause you to feel especially uncomfortable?”

b. “Are there others in your family who must do things in a certain way to feel comfortable?”

c. “Have you been a victim of a crime or seen someone badly injured or killed?”

d. “Is it difficult to keep certain thoughts out of your awareness?”

e. “Do you do certain things over and over again?”

ANS: B, D, E

The correct questions refer to obsessive thinking and compulsive behaviours. There is likely a genetic correlation to the disorder. The incorrect responses are more pertinent to a patient with suspected post-traumatic stress disorder or with suspected social phobia. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. The nurse assesses an adult who is socially withdrawn and hoards. Which nursing diagnoses most likely apply to this individual? (Select all that apply.)

a. Ineffective home maintenance

b. Situational low self-esteem

c. Chronic low self-esteem

d. Disturbed body image

e. Risk for injury

ANS: A, C, E

Shame regarding the appearance of one's home is associated with hoarding. The behaviour is usually associated with chronic low self-esteem. Hoarding results in problems of home maintenance, which may precipitate injury. The self-concept may be affected, but not body image.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Psychosocial Integrity

5. Which presentations suggest the possibility of a factitious disorder, self-directed type?

(Select all that apply.)

a. History of multiple hospitalizations without findings of physical illness

b. History of multiple medical procedures or exploratory surgeries

c. Going from one doctor to another seeking the desired response

d. Claims of illness to obtain financial benefit or other incentive

e. Difficulty describing symptoms

ANS: A, B

People with factitious disorders, self-directed type, typically have a history of multiple hospitalizations and medical workups, with negative findings from workups. Sometimes they have even had multiple surgeries seeking the origin of the physical complaints. If they do not receive the desired response from a

hospitalization, they may elope or accuse staff of incompetence. Such people usually seek treatment through a consistent health care provider rather than doctor shopping, are not motivated by financial gain

or other external incentives, and present symptoms in a very detailed, plausible manner, indicating considerable understanding of the disorder or presentation they are mimicking. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

6. A patient diagnosed with a factitious disorder says, "Why has God chosen me to be

sick all the time and unable to provide for my family? The burden on my family is worse than the pain I bear." Which nursing diagnoses apply to this patient? (Select all that apply.)

a. Spiritual distress

b. Decisional conflict

c. Adult failure to thrive

d. Impaired social interaction

e. Ineffective role performance

ANS: A, E

The patient's verbalization is consistent with spiritual distress. The patient's description of being unable

to provide for and burdening the family indicates ineffective role performance. No data support diagnoses

of adult failure to thrive, impaired social interaction, or decisional conflict.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

7. A nurse assesses a patient suspected of having somatic symptom disorder. Which

assessment findings regarding this patient support the suspected diagnosis? (Select all that apply.)

a. Female

b. Reports frequent syncope

c. Rates pain as "1" on a scale of "10"

d. First diagnosed with psoriasis at age 12

e. Reports insomnia often results from back pain

ANS: A, B, E

There is no chronic disease to explain the symptoms for patients with somatic symptom disorder. Patients

report multiple symptoms; gastrointestinal and pseudoneurological symptoms are common. This disorder

is more common in women than in men. Patients with conversion disorder would have a tendency to

underrate pain.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A nurse's neighbour says, "I saw a news story about a man without any known illness

who died suddenly after his ex-wife committed suicide. Was that a coincidence, or can emotional shock be fatal?" The nurse should respond by noting that some serious medical conditions may be complicated by emotional stress, including which of the following? (Select all that apply.)

a. Cancer

b. Hip fractures

c. Hypertension

d. Immune disorders

e. Cardiovascular disease

ANS: A, C, D, E

A number of diseases can be worsened or brought to awareness by intense emotional stress. Immune disorders can be complicated when associated with the detrimental effects of stress on the immune system. Others can be brought about indirectly, such as cardiovascular disease due to acute or chronic hypertension. Hip fractures are not in this group.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

Chapter 13: Depressive Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient became severely depressed when the last of the family's six children moved out of the home 4 months ago. The patient repeatedly says, "No one cares about me. I'm not worth anything." Which response by the nurse would be the most helpful?

a. "Things will look brighter soon. Everyone feels down once in a while."

b. "Our staff members care about you and want to try to help you get better."

c. "It is difficult for others to care about you when you repeatedly say the same negative things."

d. "I'll sit with you for 10 minutes now and 10 minutes after lunch to help you feel that I care about you."

ANS: D

Spending time with the patient at intervals throughout the day shows acceptance by the nurse and will help the patient establish a relationship with the nurse. The therapeutic technique is “offering self.” Setting definite times for the therapeutic contacts and keeping the appointments show predictability on the

part of the nurse, an element that fosters trust building. The incorrect responses would be difficult for a person with profound depression to believe, provide false reassurance, and are counterproductive. The patient is unable to say positive things at this point.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A patient became depressed after the last of the family’s six children moved out of the

home 4 months ago. Select the best initial outcome for the nursing diagnosis Situational low self-esteem related to feelings of abandonment.

a. The patient will verbalize realistic positive characteristics about self by (date).

b. The patient will agree to take an antidepressant medication regularly by (date).

c. The patient will initiate social interaction with another person daily by (date).

d. The patient will identify two personal behaviours that alienate others by (date).

ANS: A

Low self-esteem is reflected by making consistently negative statements about self and self-worth. Replacing negative cognitions with more realistic appraisals of self is an appropriate intermediate outcome. The incorrect options are not as clearly related to the nursing diagnosis. Outcomes are best when framed positively; identifying two personal behaviours that might alienate others is a negative concept.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

3. A patient diagnosed with major depression says, “No one cares about me anymore. I’m not worth anything.” Today the patient is wearing a new shirt and has neat, clean hair. Which

remark by the nurse supports building a positive self-esteem for this patient?

a. “You look nice this morning.”

b. “You’re wearing a new shirt.”

c. “I like the shirt you are wearing.”

d. “You must be feeling better today.”

ANS: B

Patients with depression usually see the negative side of things. The meaning of compliments may be altered to “I didn’t look nice yesterday” or “They didn’t like my other shirt.” Neutral comments such as making an observation avoid negative interpretations. Saying, “You look nice” or “I like your shirt” gives approval (nontherapeutic techniques). Saying “You must be feeling better today” is an assumption, which

is nontherapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. An adult diagnosed with major depression was treated with medication and cognitive-behavioural therapy. The patient now recognizes how passivity contributed to the depression.

Which intervention should the nurse suggest?

a. Social skills training

b. Relaxation training classes

c. Desensitization techniques

d. Use of complementary therapy

ANS: A

Social skills training is helpful in treating and preventing the recurrence of depression. Training focuses on assertiveness and coping skills that lead to positive reinforcement from others and development of a patient’s support system. Use of complementary therapy refers to adjunctive therapies such as herbals, which would be less helpful than social skill training. Assertiveness would be of greater value than relaxation training because passivity was a concern. Desensitization is used in the treatment of phobias.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

5. Priority interventions for a patient diagnosed with major depression and feelings of

worthlessness should include which of the following?

a. Distracting the patient from self-absorption

b. Careful, unobtrusive observation around the clock

c. Allowing the patient to spend long periods alone in meditation

d. Opportunities to assume a leadership role in the therapeutic milieu

ANS: B

Approximately two-thirds of people with depression contemplate suicide. Patients with depression who

exhibit feelings of worthlessness are at higher risk. Regular, planned observations of the patient diagnosed

with depression may prevent a suicide attempt on the unit.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

6. When counselling patients diagnosed with major depression, an advanced practice nurse

will address the negative thought patterns by using which of the following?

a. Psychoanalytic therapy

b. Desensitization therapy

c. Cognitive-behavioural therapy

d. Alternative and complementary therapies

ANS: C

Cognitive-behavioural therapy attempts to alter the patient's dysfunctional beliefs by focusing on positive

outcomes rather than negative attributions. The patient is also taught the connection between thoughts and

resultant feelings. Research shows that cognitive-behavioural therapy involves the formation of new

connections between nerve cells in the brain and that it is at least as effective as medication. Evidence is

not present to support superior outcomes for the other psychotherapeutic modalities mentioned.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

7. A patient says to the nurse, “My life doesn’t have any happiness in it anymore. I once enjoyed holidays, but now they’re just another day.” The nurse documents this report as an example of which of the following?

a. Dysthymia

b. Anhedonia

c. Euphoria

d. Anergia

ANS: B

Anhedonia is a common finding in many types of depression. It refers to feelings of a loss of pleasure in formerly pleasurable activities. Dysthymia is a diagnosis. Euphoria refers to an elated mood. Anergia means “without energy.”

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A patient diagnosed with major depression began taking a tricyclic antidepressant 1 week ago. Today the patient says, “I don’t think I can keep taking these pills. They make me so dizzy, especially when I stand up.” The nurse will do which of the following?

a. Limit the patient’s activities to those that can be performed in a sitting position

b. Withhold the drug, force oral fluids, and notify the health care provider

c. Teach the patient strategies to manage postural hypotension

d. Update the patient’s mental status examination

ANS: C

Drowsiness, dizziness, and postural hypotension usually subside after the first few weeks of therapy with tricyclic antidepressants. Postural hypotension can be managed by teaching the patient to stay well hydrated and rise slowly. Knowing this information may convince the patient to continue the medication. Activity is an important aspect of the patient’s treatment plan and should not be limited to activities that can be done in a sitting position. Withholding the drug, forcing oral fluids, and notifying the health care provider are unnecessary actions. Independent nursing action is called for. Updating a mental status examination is unnecessary.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

9. A patient diagnosed with depression is receiving amitriptyline (Elavil) 50 mg qhs. Which assessment finding would prompt the nurse to collaborate with the health care provider regarding potentially hazardous side effects of this drug?

a. Dry mouth

b. Blurred vision

c. Nasal congestion

d. Urinary retention

ANS: D

All the side effects mentioned are the result of the anticholinergic effects of the drug. Only urinary retention and severe constipation warrant immediate medical attention. Dry mouth, blurred vision, and nasal congestion may be less troublesome as therapy continues.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

10. A patient diagnosed with major depression tells the nurse, “Bad things that happen are always my fault.” Which response by the nurse will best assist the patient to reframe this overgeneralization?

a. “I really doubt that one person can be blamed for all the bad things that happen.”

b. “Let’s look at one bad thing that happened to see if another explanation exists.”

c. “You are being extremely hard on yourself. Try to have a positive focus.”

d. “Are you saying that you don’t have any good things happen?”

ANS: B

By questioning a faulty assumption, the nurse can help the patient look at the premise more objectively and reframe it as a more accurate representation of fact. The incorrect responses cast doubt but do not require the patient to evaluate the statement.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

11. A nurse worked with a patient diagnosed with major depression, severe withdrawal,

and psychomotor retardation. After 3 weeks, the patient did not improve. The nurse is most at risk for which of the following?

a. Feelings of guilt and despair

b. Feelings of over-involvement

c. Feelings of interest and pleasure

d. Feelings of ineffectiveness and frustration

ANS: D

Nurses may have expectations for self and patients that are not wholly realistic, especially regarding the patient's progress toward health. Unmet expectations result in feelings of ineffectiveness, anger, or frustration. Nurses rarely become over-involved with patients with depression because of the patient's resistance. Guilt and despair might be seen when the nurse experiences the patient's feelings because of empathy. Interest is possible, but not the most likely result.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

12. A patient diagnosed with depression begins selective serotonin reuptake inhibitor (SSRI) antidepressant therapy. The nurse should provide information to the patient and family about which of the following?

a. Restricting sodium intake to 1 gram daily

b. Minimizing exposure to bright sunlight

c. Reporting increased suicidal thoughts

d. Maintaining a tyramine-free diet

ANS: C

Some evidence indicates that suicidal ideation may worsen at the beginning of antidepressant therapy; thus, close monitoring is necessary. Avoiding exposure to bright sunlight and restricting sodium intake are unnecessary. Tyramine restriction is associated with monoamine oxidase inhibitor (MAOI) therapy.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

13. A nurse taught a patient about a tyramine-restricted diet. Which menu selection would the nurse approve?

a. Macaroni and cheese, hot dogs, banana bread, caffeinated coffee

b. Mashed potatoes, ground beef patty, corn, green beans, apple pie

c. Avocado salad, ham, creamed potatoes, asparagus, chocolate cake

d. Noodles with cheddar cheese sauce, smoked sausage, lettuce salad, yeast rolls

ANS: B

The correct answer describes a meal that contains little tyramine. Vegetables and fruits contain little or no

tyramine. Fresh ground beef and apple pie are safe. The other meals contain various amounts of tyramine-

rich foods or foods that contain vasopressors: avocados, ripe bananas (banana bread), sausages/hot dogs,

smoked meat (ham), cheddar cheese, yeast, caffeine drinks, and chocolate.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiological Integrity

14. What is the focus of priority nursing interventions for the period immediately after

electroconvulsive therapy treatment?

a. Nutrition and hydration

b. Supporting physiological stability

c. Reducing disorientation and confusion

d. Assisting the patient to identify and test negative thoughts

ANS: B

During the immediate post-treatment period, the patient is recovering from general anesthesia; hence, the

priority need is to establish and support physiological stability. Reducing disorientation and confusion is

an acceptable intervention, but not the priority. Assisting the patient in identifying and testing negative

thoughts is inappropriate in the immediate post-treatment period because the patient may be confused.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

15. A nurse provided medication education for a patient diagnosed with major depression

who began a new prescription for phenelzine (Nardil). Which behaviour indicates effective learning?

a. The patient monitors sodium intake and weight daily.

b. The patient wears support stockings and elevates the legs when sitting.

c. The patient can identify foods with high selenium content that should be avoided.

d. The patient confers with a pharmacist when selecting over-the-counter medications.

ANS: D

Over-the-counter medicines may contain vasopressor agents or tyramine, a substance that must be avoided when the patient takes MAOI antidepressants. Medications for colds, allergies, or congestion or any preparation that contains ephedrine or phenylpropanolamine may precipitate a hypertensive crisis. MAOI antidepressant therapy is unrelated to the need for sodium limitation, support stockings, or leg elevation. MAOIs interact with tyramine-containing foods, not selenium, to produce dangerously high blood pressure.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiological Integrity

16. Major depression resulted after a patient's employment was terminated. The patient now says to the nurse, "I'm not worth the time you spend with me. I am the most useless person in the world." Which nursing diagnosis applies?

a. Powerlessness

b. Defensive coping

c. Situational low self-esteem

d. Disturbed personal identity

ANS: C

The patient's statements express feelings of worthlessness and most clearly relate to the nursing diagnosis of situational low self-esteem. Insufficient information exists to lead to other diagnoses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

17. A patient diagnosed with major depression does not interact with others except when

addressed, and then only in monosyllables. The nurse wants to show nonjudgemental acceptance and support for the patient. Which communication technique will be effective?

a. Make observations.

b. Ask the patient direct questions.

c. Phrase questions to require yes or no answers.

d. Frequently reassure the patient to reduce guilt feelings.

ANS: A

Making observations about neutral topics such as the environment draws the patient into the reality around him or her but places no burdensome expectations for answers on the patient. Acceptance and support are shown by the nurse's presence. Direct questions may make the patient feel that the encounter is an interrogation. Open-ended questions are preferable if the patient is able to participate in dialogue. Platitudes are never acceptable. They minimize patient feelings and can increase feelings of worthlessness.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A patient being treated for depression has taken 300 mg amitriptyline (Elavil) daily for a year. The patient calls the case manager at the clinic and says, "I stopped taking my antidepressant 2 days ago. Now I am having cold sweats, nausea, a rapid heartbeat, and nightmares." What will the nurse advise the patient to do?

a. "Go to the nearest emergency department immediately."

b. "Do not be alarmed. Take two aspirin and drink plenty of fluids."

c. "Take a dose of your antidepressant now and come to the clinic to see the health care provider."

d. "Resume taking your antidepressants for 2 more weeks and then discontinue them again."

ANS: C

The patient has symptoms associated with abrupt withdrawal of the tricyclic antidepressant. Taking a dose of the drug will ameliorate the symptoms. Seeing the health care provider will allow the patient to

discuss the advisability of going off the medication and to be given a gradual withdrawal schedule if discontinuation is the decision. This situation is not a medical emergency, although it calls for medical advice. Resuming taking the antidepressant for 2 more weeks and then discontinuing again would produce the same symptoms the patient is experiencing.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

19. Which documentation for a patient diagnosed with major depression indicates the treatment plan was effective?

a. Slept 6 hours uninterrupted. Sang with activity group. Anticipates seeing grandchild.

b. Slept 10 hours uninterrupted. Attended craft group; stated "project was a failure, just like me."

c. Slept 5 hours with brief interruptions. Personal hygiene adequate with assistance. Weight loss of 1 pound.

d. Slept 7 hours uninterrupted. Preoccupied with perceived inadequacies. States, "I feel tired all the time."

ANS: A

Sleeping 6 hours, participating with a group, and anticipating an event are all positive events. All the other options show at least one negative finding.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

20. A patient was diagnosed with seasonal affective disorder (SAD). During which month would this patient's symptoms be most acute?

a. January

b. April

c. June

d. September

ANS: A

The days are short in January, so the patient would have the least exposure to sunlight. Seasonal affective

disorder is associated with disturbances in circadian rhythm and most often occur in the fall or winter and

remit in the spring. Days are longer in spring, summer, and fall.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. A patient diagnosed with depression repeatedly tells staff, “I have cancer. It’s my

punishment for being a bad person.” Diagnostic tests reveal no cancer. Select the priority nursing

diagnosis.

a. Powerlessness

b. Risk for suicide

c. Stress overload

d. Spiritual distress

ANS: B

A patient diagnosed with depression who feels so worthless as to believe cancer is deserved is at risk for

suicide. Safety concerns take priority over the other diagnoses listed.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

22. A patient diagnosed with major depression takes a monoamine oxidase inhibitor and

refuses solid foods. In order to meet nutritional needs, which beverage will the nurse offer to this

patient?

a. Imported beer

b. Protein dietary supplement beverage

c. Hot tea

d. Milk

ANS: D

Milk is the only beverage listed that provides protein, fat, and carbohydrates and is not contraindicated

when taking a monoamine oxidase inhibitor. In addition, milk is fortified with vitamins.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

23. During a psychiatric assessment, the nurse observes a patient's facial expression is

without emotion. The patient says, "Life feels so hopeless to me. I've been feeling sad for several

months." How will the nurse document the patient's affect and mood?

a. Affect depressed; mood flat

b. Affect flat; mood depressed

c. Affect labile; mood euphoric

d. Affect and mood incongruent

ANS: B

Mood refers to a person's self-reported emotional feeling state. Affect is the emotional feeling state that is

outwardly observable by others. When there is no evidence of emotion in a person's expression, the affect

is flat.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. A disheveled patient with severe depression and psychomotor retardation has not

showered for several days. What will the nurse do?

a. Bring up the issue at the community meeting.

b.

Calmly tell the patient, "You must bathe daily."

c. Avoid forcing the issue in order to minimize stress.

d. Firmly and neutrally assist the patient with showering.

ANS: D

When patients are unable to perform self-care activities, staff must assist them rather than ignore the

issue. Better grooming increases self-esteem. Calmly telling the patient to bathe daily and bringing up the

issue at a community meeting are punitive.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

25. A patient diagnosed with major depression began taking escitalopram (Cipralex) 5 days ago. The patient now says, “This medicine isn’t working.” The nurse’s best intervention would be which of the following?

a. Discuss with the health care provider the need to increase the dose

b. Reassure the patient that the medication will be effective soon

c. Explain the time lag before antidepressants relieve symptoms

d. Critically assess the patient for symptoms of improvement

ANS: C

Escitalopram is an SSRI antidepressant. One to three weeks of treatment is usually necessary before symptom relief occurs. This information is important to share with patients.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

26. A nurse is caring for a patient with low self-esteem. Which nonverbal communication should the nurse anticipate from this patient?

a. Arms crossed

b. Staring at the nurse

c. Smiling inappropriately

d. Eyes pointed downward

ANS: D

Nonverbal communication is usually considered more powerful than verbal communication. Downward-casted eyes suggest feelings of worthlessness or hopelessness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

27. How long after a patient stops a monoamine oxidase inhibitor does he or she need to maintain the dietary restrictions followed when taking this medication?

a. Can resume normal diet immediately

b. 48 hours after the last dose

c. 1 week after the last dose

d. 2 weeks after the last dose

ANS: D

Patients who stop MAOIs need to maintain the dietary restrictions for 14 days after the last dose. The other answer time frames are incorrect.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

28. A nurse instructs a patient taking a medication that inhibits the action of monoamine oxidase (MAO) to avoid certain foods and drugs because of the risk for which of the following?

a. Hypotensive shock

b. Hypertensive crisis

c. Cardiac dysrhythmia

d. Cardiogenic shock

ANS: B

Patients taking MAO-inhibiting drugs must be on a tyramine-free diet to prevent hypertensive crisis. In the presence of MAOIs, tyramine is not destroyed by the liver and, in high levels, produces intense vasoconstriction, resulting in elevated blood pressure.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

29. Which falls within the parameters of the normal course of treatment of depression with ECT?

a. Daily for 7 days

b. Three times per week for 10 weeks

c. Once a week for 8 weeks

d. Twice a week for 4 weeks

ANS: B

Two to three treatments per week for 6 to 12 weeks is the normal course of treatment; therefore the only

answer choice that falls within this parameter is three times per week for 10 weeks.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiological Integrity

MULTIPLE RESPONSE

1. The admission note indicates a patient diagnosed with major depression has anergia and

anhedonia. For which measures should the nurse plan? (Select all that apply.)

a. Channeling excessive energy

b. Reducing guilty ruminations

c. Instilling a sense of hopefulness

d. Assisting with self-care activities

e. Accommodating psychomotor retardation

ANS: C, D, E

Anergia refers to a lack of energy. Anhedonia refers to the inability to find pleasure or meaning in life;

thus, planning should include measures to accommodate psychomotor retardation, assist with activities of

daily living, and instill hopefulness. Anergia is lack of energy, not excessive energy. Anhedonia does not

necessarily imply the presence of guilty ruminations.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

2. A student nurse caring for a patient diagnosed with depression reads in the patient's

medical record, "This patient shows vegetative signs of depression." Which nursing diagnoses most

clearly relate to the vegetative signs? (Select all that apply.)

a. Imbalanced nutrition: less than body requirements

b. Chronic low self-esteem

c. Sexual dysfunction

d. Self-care deficit

e. Powerlessness

f. Insomnia

ANS: A, C, D, F

Vegetative signs of depression are alterations in body processes necessary to support life and growth, such as eating, sleeping, elimination, and sexual activity. These diagnoses are more closely related to vegetative signs than diagnoses associated with feelings about self. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

3. A patient diagnosed with major depression shows vegetative signs of depression. Which nursing actions should be implemented? (Select all that apply.)

a. Offer laxatives if needed.

b. Monitor food and fluid intake.

c. Provide a quiet sleep environment.

d. Eliminate all daily caffeine intake.

e. Restrict intake of processed foods.

ANS: A, B, C

The correct options promote a normal elimination pattern. Although excessive intake of stimulants such as caffeine may make the patient feel jittery and anxious, small amounts may provide useful stimulation. No indication exists that processed foods should be restricted. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. A patient being treated with paroxetine (Paxil) 50 mg po daily for depression reports to the clinic nurse, “I took a few extra tablets earlier today and now I feel bad.” Which assessments are most critical? (Select all that apply.)

a. Vital signs

b. Urinary frequency

c. Psychomotor retardation

d. Presence of abdominal pain and diarrhea

e. Hyperactivity or feelings of restlessness

ANS: A, D, E

The patient is taking the maximum dose of this SSRI and has ingested an additional unknown amount of the drug. Central serotonin syndrome must be considered. Symptoms include abdominal pain, diarrhea, tachycardia, elevated blood pressure, hyperpyrexia, increased motor activity, and muscle spasms. Central serotonin syndrome may progress to a full medical emergency if not treated early. The patient may have urinary retention, but frequency would not be expected.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

Chapter 14: Bipolar Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A person was online continuously for over 24 hours, posting rhymes on official government Web sites and inviting politicians to join social networks. The person has not slept or eaten for 3 days. What features of mania are evident?

a. Increased muscle tension and anxiety

b. Vegetative signs and poor grooming

c. Poor judgement and hyperactivity

d. Cognitive deficits and paranoia

ANS: C

Hyperactivity (activity without sleep) and poor judgement (posting rhymes on government Web sites) are characteristic of manic episodes. The distracters do not specifically apply to mania.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. A patient diagnosed with bipolar disorder is dressed in a red leotard and bright scarves.

The patient twirls and shadow boxes. The patient says gaily, “Do you like my scarves? Here; they are my gift to you.” How should the nurse document the patient’s mood?

a. Euphoric

b. Irritable

c. Suspicious

d. Confident

ANS: A

The patient has demonstrated clang associations and pleasant, happy behaviour. Excessive happiness indicates euphoria. Irritability and confidence are not the best terms for the patient’s mood. Suspiciousness is not evident.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A person was directing traffic on a busy street, rapidly shouting, “To work, you jerk, for perks” and making obscene gestures at cars. The person has not slept or eaten for 3 days. Which assessment findings will have priority concern for this patient’s plan of care?

a. Insulting, aggressive behaviour

b. Pressured speech and grandiosity

c. Hyperactivity; not eating and sleeping

d. Poor concentration and decision making

ANS: C

Hyperactivity, poor nutrition, poor hydration, and not sleeping take priority in terms of the needs listed above because they threaten the physical integrity of the patient. The other behaviours are less threatening to the patient’s life.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

4. A patient diagnosed with acute mania has distributed pamphlets about a new business venture on a street corner for 2 days. Which nursing diagnosis has priority?

a. Risk for injury

b. Ineffective coping

c. Impaired social interaction

d. Ineffective therapeutic regimen management

ANS: A

Although each of the nursing diagnoses listed is appropriate for a patient having a manic episode, the priority lies with the patient's physiological safety. Hyperactivity and poor judgement put the patient at risk for injury.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

5. A patient diagnosed with bipolar disorder becomes hyperactive after discontinuing lithium. The patient threatens to hit another patient. Which comment by the nurse is appropriate?

a. "Stop that! No one did anything to provoke an attack by you."

b. "If you do that one more time, you will be secluded immediately."

c. "Do not hit anyone. If you are unable to control yourself, we will help you."

d. "You know we will not let you hit anyone. Why do you continue this behaviour?"

ANS: C

When the patient is unable to control his or her behaviour and violates or threatens to violate the rights of others, limits must be set in an effort to de-escalate the situation. Limits should be set in simple, concrete terms. The incorrect responses do not offer appropriate assistance to the patient, threaten the patient with seclusion as punishment, and ask a rhetorical question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

6. This nursing diagnosis applies to a patient with acute mania: Imbalanced nutrition: less than body requirements related to insufficient caloric intake and hyperactivity as evidenced by 5-pound weight loss in 4 days. Select an appropriate outcome.

a. The patient will ask staff for assistance with feeding within 4 days.

b. The patient will drink six servings of a high-calorie, high-protein drink each day.

c. The patient will consistently sit with others for at least 30 minutes at meal time

within 1 week.

d. The patient will consistently wear appropriate attire for age and sex within 1 week

while on the psychiatric unit.

ANS: B

High-calorie, high-protein food supplements will provide the additional calories needed to offset the

patient's extreme hyperactivity. Sitting with others or asking for assistance does not mean the patient eats

or drinks. The other indicator is unrelated to the nursing diagnosis.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Physiological Integrity

7. A patient demonstrating characteristics of acute mania relapsed after discontinuing

lithium. New orders are written to resume lithium twice daily and begin olanzapine (Zyprexa).

What is the rationale for the addition of olanzapine to the medication regimen?

a. It minimizes the side effects of lithium.

b. It brings hyperactivity under rapid control.

c. It enhances the antimanic actions of lithium.

d. It is used for long-term control of hyperactivity.

ANS: B

Manic symptoms are controlled by lithium only after a therapeutic serum level is attained. Because this

takes several days to accomplish, a drug with rapid onset is necessary to reduce the hyperactivity initially.

Antipsychotic drugs neither enhance lithium's antimanic activity nor minimize the side effects. Lithium is

used for long-term control.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Physiological Integrity

8. A patient diagnosed with bipolar disorder has rapidly changing mood cycles. The health

care provider prescribes an anticonvulsant medication. To prepare teaching materials, which drug

should the nurse anticipate will be prescribed?

a. Phenytoin (Dilantin)

b. Gabapentin (Neurontin)

c. Risperidone (Risperdal)

d. Carbamazepine (Tegretol)

ANS: D

Some patients with bipolar disorder, especially those who have only short periods between episodes, have

a favourable response to the anticonvulsants carbamazepine and valproate. Carbamazepine seems to work

better in patients with rapid cycling and in severely paranoid, angry manic patients. Phenytoin is also an

anticonvulsant but not used for mood stabilization. Risperidone is not an anticonvulsant. Gabapentin is an

anticonvulsant that is used primarily for maintenance treatment of bipolar disorder.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

9. The exact cause of bipolar disorder has not been determined; however, for most

patients, which of the following is true?

a. Several factors, including genetics, are implicated.

b. Brain structures were altered by stress early in life.

c. Excess sensitivity in dopamine receptors may trigger episodes.

d. Inadequate norepinephrine reuptake disturbs circadian rhythms.

ANS: A

The best explanation at this time is that bipolar disorder is most likely caused by interplay of complex

independent variables. Various theories implicate genetics, endocrine imbalance, environmental stressors,

and neurotransmitter imbalances.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and

Maintenance

10. The spouse of a patient diagnosed with bipolar disorder asks what evidence supports the possibility of genetic transmission of bipolar disorders. Which response should the nurse provide?

a. “A high proportion of patients with bipolar disorders are found among creative writers.”

b. “A higher rate of relatives with bipolar disorder is found among patients with bipolar disorder.”

c. “Patients with bipolar disorder have higher rates of relatives who respond in an exaggerated way to daily stress.”

d. “More individuals with bipolar disorder come from high socioeconomic and educational backgrounds.”

ANS: B

Evidence of genetic transmission is supported when twins or relatives of patients with a particular disorder also show an incidence of the disorder that is higher than the incidence in the general public. The incorrect options do not support the theory of genetic transmission and other factors involved in the etiology of bipolar disorder.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

11. A patient diagnosed with bipolar disorder commands other patients, “Get me a book. Take this stuff out of here,” and other similar demands. The nurse wants to interrupt this behaviour without entering into a power struggle. Which initial approach should the nurse select?

a. Distraction: “Let’s go to the dining room for a snack.”

b. Humor: “How much are you paying servants these days?”

c. Limit setting: “You must stop ordering other patients around.”

d. Honest feedback: “Your controlling behaviour is annoying others.”

ANS: A

The distractibility characteristic of manic episodes can assist the nurse to direct the patient toward more appropriate, constructive activities without entering into power struggles. Humor usually backfires by

either encouraging the patient or inciting anger. Limit setting and honest feedback may seem heavy-handed and may incite anger.

DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity
12. The nurse receives a laboratory report indicating a patient's serum lithium level is 1 mEq/L. The patient's last dose of lithium was 8 hours ago. How should the nurse interpret this result?
a. This result is within therapeutic limits.
b. This result is below therapeutic limits.
c. This result is above therapeutic limits.
d. This result is invalid because of the time lapse since the last dose.
ANS: A
Normal range for a blood sample taken 8 to 12 hours after the last dose of lithium is 0.4 to 1 mEq/L.
DIF: Cognitive Level: Understand (Comprehension)
TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity
13. Consider these three anticonvulsant medications used in mood stabilization: divalproex sodium (Epival), carbamazepine (Tegretol), and gabapentin (Neurontin). Which of the following medications also belongs to this classification?
a. Clonazepam (Rivotril)
b. Risperidone (Risperdal)
c. Lamotrigine (Lamictal)
d. Aripiprazole (Abilify)
ANS: C
The three drugs in the question are all anticonvulsants. Lamotrigine is also an anticonvulsant. Clonazepam is an anxiolytic; aripiprazole and risperidone are antipsychotic drugs.
DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

14. When a hyperactive patient diagnosed with acute mania is hospitalized, what is the initial nursing intervention?

a. Allow the patient to act out feelings.

b. Set limits on patient behaviour as necessary.

c. Provide verbal instructions to the patient to remain calm.

d. Restrain the patient to reduce hyperactivity and aggression.

ANS: B

This intervention provides support through the nurse's presence and provides structure as necessary while the patient's control is tenuous. Acting out may lead to loss of behavioural control. The patient will probably be unable to focus on instructions and comply. Restraint is used only after other interventions have proved ineffective.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

15. At a unit meeting, the staff discusses decor for a special room for patients with acute mania. Which suggestion is appropriate?

a. An extra-large window with a view of the street

b. Neutral walls with pale, simple accessories

c. Brightly coloured walls and print drapes

d. Deep colours for walls and upholstery

ANS: B

The environment for a manic patient should be as simple and nonstimulating as possible. Manic patients are highly sensitive to environmental distractions and stimulation.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

16. A patient demonstrating behaviours associated with acute mania has exhausted the staff by noon. Staff members are feeling defensive and fatigued. Which action will the staff take initially?

a. Confer with the health care provider to consider use of seclusion for this patient.

b. Hold a staff meeting to discuss consistency and limit-setting approaches.

c. Conduct a meeting with all staff and patients to discuss the behaviour.

d. Explain to the patient that the behaviour is unacceptable.

ANS: B

When staff members are at their wits' end, the patient has succeeded in keeping the environment unsettled

and avoided outside controls on behaviour. Staff meetings can help minimize staff splitting and feelings

of anger, helplessness, confusion, and frustration.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

17. A patient experiencing acute mania undresses in the group room and dances. The nurse

intervenes initially by doing which of the following?

a. Quietly asking the patient, "Why don't you put your clothes on?"

b. Firmly telling the patient, "Stop dancing and put on your clothing."

c. Putting a blanket around the patient and walking with the patient to a quiet room

d. Letting the patient stay in the group room and moving the other patients to a

different area

ANS: C

Patients must be protected from the embarrassing consequences of their poor judgement whenever possible. Protecting the patient from public exposure by matter-of-factly covering the patient and removing him or her from the area with a sufficient number of staff to avoid argument and provide control is an effective approach.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A patient waves a newspaper and says, "I must have my credit card and use the

computer right now. A store is having a big sale, and I need to order 10 dresses and 4 pairs of

shoes." Select the nurse's appropriate intervention.

a. Suggest the patient have a friend do the shopping and bring purchases to the unit

b. Invite the patient to sit together and look at new fashion magazines

c. Tell the patient computer use is not allowed until self-control improves

d. Ask whether the patient has enough money to pay for the purchases

ANS: B

Situations such as this offer an opportunity to use the patient's distractibility to staff's advantage. Patients

become frustrated when staff deny requests that the patient sees as entirely reasonable. Distracting the

patient can avoid power struggles. Suggesting that a friend do the shopping would not satisfy the patient's

need for immediacy and would ultimately result in the extravagant expenditure. Asking whether the

patient has enough money would likely precipitate an angry response.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

19. An outpatient diagnosed with bipolar disorder takes lithium carbonate 300 mg three

times daily. The patient reports nausea. To reduce the nausea most effectively, the nurse suggests

that the lithium be taken with which of the following?

a. Meals

b. An antacid

c. An antiemetic

d. A large glass of juice

ANS: A

Some patients find that taking lithium with meals diminishes nausea. The incorrect options are less

helpful.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

20. A health teaching plan for a patient taking lithium should include instructions to do

which of the following?

a. Maintain normal salt and fluids in the diet

b. Drink twice the usual daily amount of fluid

c. Double the lithium dose if diarrhea or vomiting occurs

d. Avoid eating aged cheese, processed meats, and red wine

ANS: A

Sodium depletion and dehydration increase the chance for development of lithium toxicity. The other options offer inappropriate information.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

21. Which nursing diagnosis would most likely apply to both a patient diagnosed with major depression and one experiencing acute mania?

a. Deficient diversional activity

b. Disturbed sleep pattern

c. Fluid volume excess

d. Defensive coping

ANS: B

Patients with mood disorders, both depression and mania, experience sleep pattern disturbances. Assessment data should be routinely gathered about this possible problem. Deficient diversional activity is more relevant for patients with depression. Defensive coping is more relevant for patients with mania. Fluid volume excess is less relevant for patients with mood disorders than is Deficient fluid volume.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

22. Which dinner menu is best suited for a patient with acute mania?

a. Spaghetti and meatballs, salad, and a banana

b. Beef and vegetable stew, a roll, and chocolate pudding

c. Broiled chicken breast on a roll, an ear of corn, and an apple

d. Chicken casserole, green beans, and flavoured gelatin with whipped cream

ANS: C

These foods provide adequate nutrition, but more importantly, they are finger foods that the hyperactive patient could “eat on the run.” The foods in the incorrect options cannot be eaten without utensils.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

23. Outcome identification for the treatment plan of a patient experiencing grandiose

thinking associated with acute mania will focus on which of the following?

a. Development of an optimistic outlook

b. Distorted thought self-control

c. Interest in the environment

d. Sleep pattern stabilization

ANS: B

The desired outcome is that the patient will be able to control the grandiose thinking associated with acute

mania as evidenced by making realistic comments about self, abilities, and plans. Patients with acute

mania are already unduly optimistic as a result of their use of denial, and they are overly interested in

their environment. Sleep stability is a desired outcome but is not related to distorted thought processes.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

24. Which documentation indicates that the treatment plan for a patient diagnosed with

acute mania has been effective?

a. “Converses with few interruptions; clothing matches; participates in activities.”

b. “Irritable, suggestible, distractible; napped for 10 minutes in afternoon.”

c. “Attention span short; writing copious notes; intrudes in conversations.”

d. “Heavy makeup; seductive toward staff; pressured speech.”

ANS: A

The descriptors given indicate the patient is functioning at an optimal level, using appropriate behaviour,

and thinking without becoming overstimulated by unit activities. The incorrect options reflect manic

behaviour.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

25. A patient experiencing acute mania dances around the unit, seldom sits, monopolizes

conversations, interrupts, and intrudes. Which nursing intervention will best assist the patient with energy conservation?

a. Monitor physiological functioning.

b. Provide a subdued environment.

c. Supervise personal hygiene.

d. Observe for mood changes.

ANS: B

All the options are reasonable interventions with a patient with acute mania, but providing a subdued environment directly relates to the outcome of energy conservation by decreasing stimulation and helping to balance activity and rest.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

26. A patient with diagnosed bipolar disorder was hospitalized 7 days ago and has been taking lithium 600 mg tid. Staff observes increased agitation, pressured speech, poor personal hygiene, and hyperactivity. Which action demonstrates that the nurse understands the most likely cause of the patient's behaviour?

a. Educate the patient about the proper ways to perform personal hygiene and coordinate clothing.

b. Continue to monitor and document the patient's speech patterns and motor activity.

c. Ask the health care provider to prescribe an increased dose and frequency of lithium.

d. Consider the need to check the lithium level. The patient may not be swallowing medications.

ANS: D

The patient is continuing to exhibit manic symptoms. The lithium level may be low from "cheeking" (not swallowing) the medication. The prescribed dose is high, so one would not expect a need for the dose to be increased. Monitoring the patient does not address the problem.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Evaluation

MSC: Client Needs: Physiological Integrity

27. A patient with acute mania has disrobed in the hall three times in 2 hours. Which of the

following should the nurse do?

a. Direct the patient to wear clothes at all times.

b. Ask if the patient finds clothes bothersome.

c. Tell the patient that others feel embarrassed.

d. Arrange for one-on-one supervision.

ANS: D

A patient who repeatedly disrobes despite verbal limit setting needs more structure. One-on-one

supervision may provide the necessary structure. Directing the patient to wear clothes at all times has not

proven successful, considering the behaviour has continued. Asking if the patient is bothered by clothing

serves no purpose. Telling the patient that others are embarrassed will not make a difference to the patient

whose grasp of social behaviours is impaired by the illness.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

28. A patient experiencing acute mania is dancing atop a pool table in the recreation room.

The patient waves a cue in one hand and says, “I’ll throw the pool balls if anyone comes near me.”

To best assure safety, the nurse’s first intervention is to do which of the following?

a. Tell the patient, “You need to be secluded.”

b. Clear the room of all other patients.

c. Help the patient down from the table.

d. Assemble a show of force.

ANS: B

Safety is of primary importance. Once other patients are out of the room, a plan for managing this patient

can be implemented.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

29. A patient diagnosed with bipolar disorder will be discharged tomorrow. The patient is taking a mood stabilizing medication. What is the priority nursing intervention for the patient as well as the patient's family during this phase of treatment?

a. Attending psychoeducation sessions

b. Decreasing physical activity

c. Increasing food and fluids

d. Meeting self-care needs

ANS: A

During the continuation phase of treatment for bipolar disorder, the physical needs of the patient are not as important an issue as they were during the acute episode. After hospital discharge, treatment focuses on maintaining medication compliance and preventing relapse, both of which are fostered by ongoing psychoeducation.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

30. A nurse assesses a patient who takes lithium. Which findings demonstrate evidence of complications?

a. Pharyngitis, mydriasis, and dystonia

b. Alopecia, purpura, and drowsiness

c. Polyuria, weakness, and nausea

d. Ascites, dyspnea, and edema

ANS: C

Nausea, vomiting, diarrhea, thirst, polyuria, lethargy, slurred speech, muscle weakness, and fine hand tremors are early signs of lithium toxicity. Problems mentioned in the incorrect options are unrelated to lithium therapy.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

31. A patient diagnosed with bipolar disorder is in the maintenance phase of treatment. The patient asks, “Do I have to keep taking this lithium even though my mood is stable now?” Select the nurse’s appropriate response.

a. “You will be able to stop the medication in about 1 month.”

b. “Taking the medication every day helps reduce the risk of a relapse.”

c. “Usually patients take medication for approximately 6 months after discharge.”

d. “It’s unusual that the health care provider hasn’t already stopped your medication.”

ANS: B

Patients diagnosed with bipolar disorder may be maintained on lithium indefinitely to prevent recurrences. Helping the patient understand this need will promote medication compliance.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

32. An outpatient diagnosed with bipolar disorder is prescribed lithium. The patient telephones the nurse to say, “I’ve had severe diarrhea for 4 days. I feel very weak and unsteady when I walk. My usual hand tremor has gotten worse. What should I do?” The nurse will advise the patient to which of the following?

a. Restrict food and fluids for 24 hours and stay in bed

b. Have someone bring the patient to the clinic immediately

c. Drink a large glass of water with 1 teaspoon of salt added

d. Take one dose of an over-the-counter antidiarrheal medication now

ANS: B

The symptoms described suggest lithium toxicity. The patient should have a lithium level drawn and may require further treatment. Because neurological symptoms are present, the patient should not drive and should be accompanied by another person. The incorrect options will not ameliorate the patient’s symptoms.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

33. A newly diagnosed patient is prescribed lithium. Which information from the patient’s history indicates that monitoring of serum concentrations of the drug will be challenging and

critical?

a. Arthritis

b. Epilepsy

c. Psoriasis

d. Heart failure

ANS: D

The patient with heart failure will likely need diuretic drugs, which are contraindicated and will complicate the maintenance of the fluid balance necessary to avoid lithium toxicity.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

34. Four new patients were admitted to the behavioural health unit in the past 12 hours. The nurse directs a psychiatric technician to monitor these patients for safety. A patient with which of the following diagnoses will need the most watchful supervision?

a. Bipolar I disorder

b. Bipolar II disorder

c. Dysthymic disorder

d. Cyclothymic disorder

ANS: A

Bipolar I is a mood disorder characterized by excessive activity and energy. Psychosis (hallucinations, delusions, and dramatically disturbed thoughts) may occur during manic episodes. A patient with bipolar I disorder is more unstable than a patient diagnosed with bipolar II, cyclothymic disorder, or dysthymic disorder.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. Which suggestions are appropriate for the family of a patient diagnosed with bipolar disorder who is being treated as an outpatient during a hypomanic episode? (Select all that apply.)

a. Limit credit card access.

b. Provide a structured environment.

c. Encourage group social interaction.

d. Suggest limiting work to half-days.

e. Monitor the patient's sleep patterns.

ANS: A, B, E

A patient with hypomania is expansive, grandiose, and labile; uses poor judgement; spends inappropriately; and is over-stimulated by a busy environment. Providing structure would help the patient maintain appropriate behaviour. Financial irresponsibility may be avoided by limiting access to cash and credit cards. Continued decline in sleep patterns may indicate the condition has evolved to full mania. Group socialization should be kept to a minimum to reduce stimulation. A full leave of absence from work will be necessary to limit stimuli and prevent problems associated with poor judgement and inappropriate decision making that accompany hypomania.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

2. A nurse prepares the plan of care for a patient experiencing an acute manic episode.

Which nursing diagnoses are most likely? (Select all that apply.)

a. Imbalanced nutrition: more than body requirements

b. Disturbed thought processes

c. Sleep deprivation

d. Chronic confusion

e. Social isolation

ANS: B, C

People with mania are hyperactive and often do not take time to eat and drink properly. Their high levels of activity consume calories, so deficits in nutrition may occur. Sleep is reduced. Their socialization is impaired but not isolated. Confusion may be acute but not chronic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

3. A patient tells the nurse, "I'm ashamed of being bipolar. When I'm manic, my

behaviour embarrasses everyone. Even if I take my medication, there are no guarantees. I'm a burden to my family." These statements support which nursing diagnoses? (Select all that apply.)

a. Powerlessness

b. Defensive coping

c. Chronic low self-esteem

d. Impaired social interaction

e. Risk-prone health behaviour

ANS: A, C

Chronic low self-esteem and powerlessness are interwoven in the patient's statements. No data support the other diagnoses.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

4. The plan of care for a patient in the manic state of bipolar disorder should include which of the following interventions? (Select all that apply.)

a. Touch the patient to provide reassurance.

b. Invite the patient to lead a community meeting.

c. Provide a structured environment for the patient.

d. Ensure that the patient's nutritional needs are met.

e. Design activities that require the patient's concentration.

ANS: C, D

People with mania are hyperactive, grandiose, and distractible. It's most important to ensure the patient receives adequate nutrition. Structure will support a safe environment. Touching the patient may precipitate aggressive behaviour. Leading a community meeting would be appropriate when the patient's behaviour is less grandiose. Activities that require concentration will produce frustration.

Chapter 15: Schizophrenia Spectrum and Other Psychotic Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A person has had difficulty keeping a job because of arguing with co-workers and accusing them of conspiracy. Today the person shouts, “They’re all plotting to destroy me. Isn’t that true?” Select the nurse’s most therapeutic response.

a. “Everyone here is trying to help you. No one wants to harm you.”

b. “Feeling that people want to destroy you must be very frightening.”

c. “That is not true. People here are trying to help you if you will let them.”

d. “Staff members are health care providers who are qualified to help you.”

ANS: B

Resist focusing on content; instead, focus on the feelings the patient is expressing. This strategy prevents arguing about the reality of delusional beliefs. Such arguments increase patient anxiety and the tenacity with which the patient holds to the delusion. The other options focus on content and provide opportunity for argument.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A newly admitted patient diagnosed with schizophrenia is hypervigilant and constantly scans the environment. The patient states, “I saw two doctors talking in the hall. They were plotting to kill me.” The nurse may correctly assess this behaviour as which of the following?

a. Echolalia

b. An idea of reference

c. A delusion of infidelity

d. An auditory hallucination

ANS: B

Ideas of reference are misinterpretations of the verbalizations or actions of others that give special personal meanings to these behaviours; for example, when seeing two people talking, the individual assumes they are talking about him or her. The other terms do not correspond with the scenario.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A patient diagnosed with schizophrenia says, “My co-workers are out to get me. I also

saw two doctors plotting to kill me." How does this patient perceive the environment?

a. Disorganized

b. Dangerous

c. Supportive

d. Bizarre

ANS: B

The patient sees the world as hostile and dangerous. This assessment is important because the nurse can be more effective by using empathy to respond to the patient. Data are not present to support any of the other options.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. When a patient diagnosed with schizophrenia was discharged 6 months ago, haloperidol (Haldol) was prescribed. The patient now says, "I stopped taking those pills. They made me feel like a robot." What are common side effects the nurse should validate with the patient?

a. Sedation and muscle stiffness

b. Sweating, nausea, and diarrhea

c. Mild fever, sore throat, and skin rash

d. Headache, watery eyes, and runny nose

ANS: A

Conventional antipsychotic drugs often produce sedation and extrapyramidal side effects such as stiffness and gait disturbance, effects the patient might describe as making him or her "feel like a robot." The side effects mentioned in the other options are usually not associated with typical antipsychotic therapy or would not have the effect described by the patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

5. Which of the following patient statements implies a hallucination that requires the nurse to implement safety measures?

a. "I hear angels playing harps."

b. “The voices say everyone is trying to kill me.”

c. “My dead father tells me I am a good person.”

d. “The voices talk only at night when I’m trying to sleep.”

ANS: B

The correct response indicates the patient is experiencing paranoia. Paranoia often leads to fearfulness, and the patient may attempt to strike out at others to protect self. The distracters are comforting hallucinations or do not indicate paranoia.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

6. A patient’s care plan includes monitoring for auditory hallucinations. Which assessment findings suggest the patient may be hallucinating?

a. Detachment and overconfidence

b. Darting eyes, tilted head, mumbling to self

c. Euphoric mood, hyperactivity, distractibility

d. Foot tapping and repeatedly writing the same phrase

ANS: B

Clues to hallucinations include eyes looking around the room as though to find the speaker, tilting the head to one side as though listening intently, and grimacing, mumbling, or talking aloud as though responding conversationally to someone.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. A health care provider considers which antipsychotic medication to prescribe for a patient diagnosed with schizophrenia who has auditory hallucinations and poor social function. The patient is also overweight and hypertensive. Which drug should the nurse advocate?

a. Clozapine (Clozaril)

b. Ziprasidone (Zeldox)

c. Olanzapine (Zyprexa)

d. Aripiprazole (Abilify)

ANS: D

Aripiprazole is a third-generation atypical antipsychotic effective against both positive and negative

symptoms of schizophrenia. It causes little or no weight gain and no increase in glucose, high- or low-

density lipoprotein cholesterol, or triglycerides, making it a reasonable choice for a patient with obesity or

heart disease. Clozapine may produce agranulocytosis, making it a poor choice as a first-line agent.

Ziprasidone may prolong the QT interval, making it a poor choice for a patient with cardiac disease.

Olanzapine fosters weight gain.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Physiological Integrity

8. A patient diagnosed with schizophrenia tells the nurse, “I eat skiller. Tend to end.

Easter. It blows away. Get it?” Select the nurse’s best response.

a. “Nothing you are saying is clear.”

b. “Your thoughts are very disconnected.”

c. “Try to organize your thoughts and then tell me again.”

d. “I am having difficulty understanding what you are saying.”

ANS: D

When a patient’s speech is loosely associated, confused, and disorganized, pretending to understand is

useless. The nurse should tell the patient that he or she is having difficulty understanding what the patient

is saying. Clear messages and honesty are a vital part of working effectively in psychiatric mental health

nursing. An honest response lets the person know that the nurse does not understand, would like to

understand, and can be trusted to be honest. If a theme is discernible, ask the patient to talk about the

theme. The incorrect options tend to place blame for the poor communication with the patient. The correct

response places the difficulty with the nurse rather than being accusatory.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

9. A patient diagnosed with schizophrenia exhibits little spontaneous movement and demonstrates waxy flexibility. Which patient needs are of priority importance?

a. Self-esteem

b. Psychosocial

c. Physiological

d. Self-actualization

ANS: C

Physiological needs must be met to preserve life. A patient with waxy flexibility must be fed by hand or tube, toileted, given range-of-motion exercises, and so forth to preserve physiological integrity. Higher level needs are of lesser concern.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

10. A patient diagnosed with schizophrenia demonstrates little spontaneous movement and has waxy flexibility. The patient's activities of daily living are severely compromised. An appropriate outcome would be which of the following?

a. The patient demonstrates increased interest in the environment by the end of week 1.

b. The patient performs self-care activities with coaching by the end of day 3.

c. The patient gradually takes the initiative for self-care by the end of week 2.

d. The patient accepts tube feeding without objection by day 2.

ANS: B

Outcomes related to self-care deficit nursing diagnoses should deal with increasing ability to perform self-care tasks independently, such as feeding, bathing, dressing, and toileting. Performing the tasks with coaching by nursing staff denotes improvement over the complete inability to perform the tasks. The incorrect options are not directly related to self-care activities, difficult to measure, or describe total care versus maintenance of self-care.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Physiological Integrity

11. A nurse observes a catatonic patient standing immobile, facing the wall with one arm extended in a salute. The patient remains immobile in this position for 15 minutes, moving only when the nurse gently lowers the arm. What is the name of this phenomenon?

a. Echolalia

b. Waxy flexibility

c. Depersonalization

d. Thought withdrawal

ANS: B

Waxy flexibility is the ability to hold distorted postures for extended periods of time, as though the patient were molded in wax. Echolalia is a speech pattern. Depersonalization refers to a feeling state. Thought withdrawal refers to an alteration in thinking.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. A patient is experiencing delusions of persecution about being poisoned. The patient has refused all hospital meals for 3 days. Which intervention is most likely to be acceptable to the patient?

a. Allowing the patient supervised access to food vending machines

b. Allowing the patient to phone a local restaurant to deliver meals

c. Offering to taste each portion on the tray for the patient

d. Providing tube feedings or total parenteral nutrition

ANS: A

The patient who is delusional about food being poisoned is likely to believe restaurant food might still be poisoned and to say that the staff member tasting the food has taken an antidote to the poison before tasting. Attempts to tube feed or give nutrition intravenously are seen as aggressive and usually promote violence. Patients perceive foods in sealed containers, packages, or natural shells as being safer.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

13. A community mental health nurse wants to establish a relationship with a very withdrawn patient diagnosed with schizophrenia. The patient lives at home with a supportive family. Select the nurse's best plan.

a. Visit daily for 4 days, then every other day for 1 week; stay with patient for 20 minutes, accept silence; state when the nurse will return.

b. Arrange to spend 1 hour each day with the patient; focus on asking questions about what the patient is thinking or experiencing; avoid silences.

c. Visit twice daily; sit beside the patient with a hand on the patient's arm; leave if the patient does not respond within 10 minutes.

d. Visit every other day; remind the patient of the nurse's identity; encourage the patient to talk while the nurse works on reports.

ANS: A

Severe constraints on the community mental health nurse's time will probably not allow more time than what is mentioned in the correct option; yet, important principles can be used. A severely withdrawn patient should be met "at the patient's own level," with silence accepted. Short periods of contact are helpful to minimize both the patient's and the nurse's anxiety. Predictability in returning as stated will help build trust. An hour may be too long to sustain a home visit with a withdrawn patient, especially if the nurse persists in levelling a barrage of questions at the patient. Twice-daily visits are probably not possible and leaving after 10 minutes would be premature. Touch may be threatening. Working on reports

suggests the nurse is not interested in the patient.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

14. Which of the following is true for withdrawn patients diagnosed with schizophrenia?

a. They are usually violent toward caregivers.

b. They universally fear sexual involvement with therapists.

c. They exhibit a high degree of hostility as evidenced by rejecting behaviour.

d. They avoid relationships because they become anxious with emotional closeness.

ANS: D

When an individual is suspicious and distrustful and perceives the world and the people in it as potentially

dangerous, withdrawal into an inner world can be a defence against uncomfortable levels of anxiety.

When someone attempts to establish a relationship with such a patient, the patient's anxiety rises until

trust is established. There is no evidence that withdrawn patients with schizophrenia universally fear

sexual involvement with therapists. In most cases, it is untrue that withdrawn patients with schizophrenia

are commonly violent or exhibit a high degree of hostility by demonstrating rejecting behaviour.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

15. A newly admitted patient diagnosed with schizophrenia says, "The voices are

bothering me. They yell and tell me I am bad. I have got to get away from them." Select the nurse's

most helpful reply.

a. "Do you hear the voices often?"

b. "Do you have a plan for getting away from the voices?"

c. "I'll stay with you. Focus on what we are talking about, not the voices. "

d. "Forget the voices and ask some other patients to play cards with you."

ANS: C

Staying with a distraught patient who is hearing voices serves several purposes: ongoing observation, the opportunity to provide reality orientation, a means of helping to dismiss the voices, the opportunity of forestalling an action that would result in self-injury, and general support to reduce anxiety. Asking if the patient hears voices is not particularly relevant at this point. Asking if the patient plans to "get away from the voices" is relevant for assessment purposes but is less helpful than offering to stay with the patient, while encouraging a focus on their discussion. Suggesting playing cards with other patients shifts responsibility for intervention from the nurse to the patient and other patients.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

16. A patient diagnosed with schizophrenia has taken fluphenazine (Modecate) 5 mg po

bid for 3 weeks. The nurse now observes a shuffling propulsive gait, a masklike face, and drooling. Which term applies to these symptoms?

a. Neuroleptic malignant syndrome

b. Hepatocellular effects

c. Pseudoparkinsonism

d. Akathisia

ANS: C

Pseudoparkinsonism induced by antipsychotic medication mimics the symptoms of Parkinson's disease. It frequently appears within the first month of treatment and is more common with first-generation antipsychotic drugs. Hepatocellular effects would produce abnormal liver test results. Neuroleptic malignant syndrome is characterized by autonomic instability. Akathisia produces motor restlessness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

17. A patient diagnosed with schizophrenia is very disturbed and violent. After several doses of haloperidol (Haldol), the patient is calm. Two hours later the nurse sees the patient's head rotated to one side in a stiff position, the lower jaw thrust forward, and drooling. Which problem is most likely?

a. An acute dystonic reaction

b. Tardive dyskinesia

c. Waxy flexibility

d. Akathisia

ANS: A

Acute dystonic reactions involve painful contractions of the tongue, face, neck, and back. Opisthotonos and oculogyric crisis may be observed. Dystonic reactions are considered emergencies requiring immediate intervention. Tardive dyskinesia involves involuntary spasmodic muscular contractions that involve the tongue, fingers, toes, neck, trunk, or pelvis. It appears after prolonged treatment. Waxy flexibility is a symptom seen in catatonic schizophrenia. Internal and external restlessness, pacing, and fidgeting are characteristics of akathisia.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

18. An acutely violent patient diagnosed with schizophrenia receives several doses of haloperidol (Haldol). Two hours later, the nurse notices the patient's head rotated to one side in a stiffly fixed position, the lower jaw thrust forward, and drooling. Which intervention by the nurse is indicated?

a. Administer diphenhydramine (Benadryl) 50 mg IM from the prn medication administration record.

b. Reassure the patient that the symptoms will subside. Practice relaxation exercises with the patient.

c. Give trihexyphenidyl (Artane) 5 mg orally at the next regularly scheduled medication administration time.

d. Administer atropine sulfate 2 mg subcut from the prn medication administration record.

ANS: A

Diphenhydramine, trihexyphenidyl, benztropine, and other anticholinergic medications may be used to treat dystonias. Swallowing will be difficult or impossible; therefore oral medication is not an option. Medication should be administered immediately, so the intramuscular route is best. In this case, the best option given is diphenhydramine.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

19. A patient took trifluoperazine 30 mg po daily for 3 years. The clinic nurse notes that the patient grimaces and constantly smacks both lips. The patient's neck and shoulders twist in a slow, snakelike motion. Which problem would the nurse suspect?

a. Agranulocytosis

b. Tardive dyskinesia

c. Tourette's syndrome

d. Anticholinergic effects

ANS: B

Tardive dyskinesia is a neuroleptic-induced condition involving the face, trunk, and limbs. Involuntary

movements, such as tongue thrusting; licking; blowing; irregular movements of the arms, neck, and shoulders; rocking; hip jerks; and pelvic thrusts are seen. These symptoms are frequently not reversible even when the drug is discontinued. The scenario does not present evidence consistent with the other disorders mentioned: agranulocytosis is a blood disorder; Tourette's syndrome is a condition in which tics are present; and anticholinergic effects include dry mouth, blurred vision, flushing, constipation, and dry eyes.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Evaluation

MSC: Client Needs: Physiological Integrity

20. A nurse sits with a patient diagnosed with schizophrenia. The patient starts to laugh uncontrollably, although the nurse has not said anything funny. Select the nurse's best response.

a. "Why are you laughing?"

b. "Please share the joke with me."

c. "I don't think I said anything funny."

d. "You're laughing. Tell me what's happening."

ANS: D

The patient is likely laughing in response to inner stimuli, such as hallucinations or fantasy. Focus on the hallucinatory clue (the patient's laughter) and then elicit the patient's observation. The incorrect options are less useful in eliciting a response: no joke may be involved, "why" questions are difficult to answer, and the patient is probably not focusing on what the nurse said in the first place.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

21. The nurse assesses a patient diagnosed with schizophrenia. Which assessment finding would the nurse regard as a negative symptom of schizophrenia?

a. Auditory hallucinations

b. Delusions of grandeur

c. Poor personal hygiene

d. Psychomotor agitation

ANS: C

Negative symptoms include apathy, anhedonia, poor social functioning, and poverty of thought. Poor personal hygiene is an example of poor social functioning. The distracters are positive symptoms of schizophrenia.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. What assessment findings mark the prodromal stage of schizophrenia?

a. Withdrawal, misinterpreting, poor concentration, and preoccupation with religion

b. Auditory hallucinations, ideas of reference, thought insertion, and broadcasting

c. Stereotyped behaviour, echopraxia, echolalia, and waxy flexibility

d. Loose associations, concrete thinking, and echolalia neologisms

ANS: A

Withdrawal, misinterpreting, poor concentration, and preoccupation with religion are prodromal symptoms, the symptoms that are present before the development of florid symptoms. The incorrect options list the positive symptoms of schizophrenia that might be apparent during the acute stage of the illness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

23. A patient diagnosed with schizophrenia says, “Contagious bacteria are everywhere. When they get in your body, you will be locked up with other infected people.” Which problem is evident?

a. Poverty of content

b. Concrete thinking

c. Neologisms

d. Paranoia

ANS: D

The patient’s unrealistic fear of harm indicates paranoia. Neologisms are invented words. Concrete thinking involves literal interpretation. Poverty of content refers to an inadequate fund of information.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. A patient diagnosed with schizophrenia begins a new prescription for lurasidone (Latuda). The patient is 168 cm and currently weighs 95 kg. Which topic is most important for the nurse to include in the teaching plan related to this medication?

a. How to recognize tardive dyskinesia

b. Weight management strategies

c. Ways to manage constipation

d. Sleep hygiene measures

ANS: B

Lurasidone HCL (Latuda) is a second-generation antipsychotic medication. The incidence of weight gain, diabetes, and high cholesterol is high with this medication. The patient is overweight now, so weight management will be especially important. The incidence of tardive dyskinesia is low with second-generation antipsychotic medications. Constipation may occur, but it is less important than weight management. This drug usually produces drowsiness.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

25. A patient diagnosed with schizophrenia says, "It's beat. Time to eat. No room for the cat." What type of verbalization is evident?

a. Neologism

b. Idea of reference

c. Thought broadcasting

d. Associative looseness

ANS: D

Looseness of association refers to jumbled thoughts incoherently expressed to the listener. Neologisms are newly coined words. Ideas of reference are a type of delusion. Thought broadcasting is the belief that others can hear one's thoughts.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

26. A patient diagnosed with schizophrenia has taken a conventional antipsychotic medication for a year. Hallucinations are less intrusive, but the patient continues to have apathy, poverty of thought, and social isolation. The nurse would expect a change to which medication?

a. Haloperidol (Haldol)

b. Olanzapine (Zyprexa)

c. Chlorpromazine (Thorazine)

d. Diphenhydramine (Benadryl)

ANS: B

Olanzapine is a second-generation atypical antipsychotic that targets both positive and negative symptoms of schizophrenia. Haloperidol and chlorpromazine are conventional antipsychotics that target only positive symptoms. Diphenhydramine is an antihistamine. See relationship to audience response question.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

27. The family of a patient diagnosed with schizophrenia is unfamiliar with the illness and family's role in recovery. Which type of therapy should the nurse recommend?

a. Psychoeducational

b. Psychoanalytic

c. Transactional

d. Family

ANS: A

A psychoeducational group explores the causes of schizophrenia, the role of medication, the importance of medication compliance, support for the ill member, and hints for living with a person with schizophrenia. Such a group can be of immeasurable practical assistance to the family. The other types of therapy do not focus on psychoeducation.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and

Maintenance

28. A patient diagnosed with schizophrenia has been stable for a year; however, the family now reports the patient is tense, sleeps 3 to 4 hours per night, and has difficulty concentrating. The patient says, “My computer is sending out infected radiation beams.” The nurse assesses this information as an indication of which of the following?

a. The need for psychoeducation

b. Medication noncompliance

c. Chronic deterioration

d. Relapse

ANS: D

Signs of potential relapse include feeling tense, difficulty concentrating, trouble sleeping, increased withdrawal, and increased bizarre or magical thinking. Medication noncompliance may not be implicated.

Relapse can occur even when the patient is taking medication regularly. Psychoeducation is more effective when the patient’s symptoms are stable. Chronic deterioration is not the best explanation.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

29. A patient diagnosed with schizophrenia begins to talk about “macnabs” hiding in the warehouse at work. The term macnabs should be documented as which of the following?

a. A neologism

b. Concrete thinking

c. Thought insertion

d. An idea of reference

ANS: A

A neologism is a newly coined word having special meaning to the patient. Macnabs is not a known common word. Concrete thinking refers to the inability to think abstractly. Thought insertion refers to the belief that the thoughts of others are implanted in one’s mind. Ideas of reference are a type of delusion in which trivial events are given personal significance.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

30. A patient diagnosed with schizophrenia anxiously says, “I can see the left side of my body merging with the wall. Then my face appears and disappears in the mirror.” While listening, the nurse should do which of the following?

a. Sit close to the patient

b. Place an arm protectively around the patient’s shoulders

c. Place a hand on the patient’s arm and exert light pressure

d. Maintain a normal social interaction distance from the patient

ANS: D

The patient is describing phenomena that indicate personal boundary difficulties and depersonalization. The nurse should maintain appropriate social distance and not touch the patient because the patient is anxious about the inability to maintain ego boundaries and merging or being swallowed by the environment. Physical closeness or touch could precipitate panic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

31. A patient diagnosed with schizophrenia and auditory hallucinations anxiously tells the nurse, “The voice is telling me to do things.” Select the nurse’s priority assessment question.

a. “How long has the voice been directing your behaviour?”

b. “Does what the voice tells you to do frighten you?”

c. “Do you recognize the voice speaking to you?”

d. “What is the voice telling you to do?”

ANS: D

Learning what a command hallucination is telling the patient to do is important because the command often places the patient or others at risk for harm. Command hallucinations can be terrifying and may pose a psychiatric emergency. The incorrect answers are of lesser importance than identifying the command.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

32. A patient receiving risperidone (Risperdal) reports severe muscle stiffness at 1030. By

1200, the patient has difficulty swallowing and is drooling. By 1600, vital signs are 38.6°C; pulse 110; respirations 26; and blood pressure 150/90. The patient is diaphoretic. Select the nurse's best analysis and action.

a. Agranulocytosis; institute reverse isolation.

b. Tardive dyskinesia; withhold the next dose of medication.

c. Cholestatic jaundice; begin a high-protein, high-cholesterol diet.

d. Neuroleptic malignant syndrome; notify health care provider stat.

ANS: D

Taking an antipsychotic medication coupled with the presence of extrapyramidal symptoms, such as severe muscle stiffness and difficulty swallowing, hyperpyrexia, and autonomic symptoms (pulse elevation), suggests neuroleptic malignant syndrome, which is a medical emergency. The symptoms given in the scenario are not consistent with the medical problems listed in the incorrect options.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

33. A nurse asks a patient diagnosed with schizophrenia, "What is meant by the old saying 'You can't judge a book by its cover'?" Which response by the patient indicates concrete thinking?

a. "The table of contents tells what a book is about."

b. "You can't judge a book by looking at the cover."

c. "Things are not always as they first appear."

d. "Why are you asking me about books?"

ANS: A

Concrete thinking refers to an impaired ability to think abstractly. Concreteness is often assessed through the patient's interpretation of proverbs. Concreteness reduces one's ability to understand and address abstract concepts such as love or the passage of time. The incorrect options illustrate echolalia, an unrelated question, and abstract thinking.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

34. The nurse is developing a plan for psychoeducational sessions for several adults diagnosed with schizophrenia. Which goal is best for this group?

a. Members will gain insight into unconscious factors that contribute to their illness.

b. Members will explore situations that trigger hostility and anger.

c. Members will learn to manage delusional thinking.

d. Members will demonstrate improved social skills.

ANS: D

Improved social skills help patients maintain relationships with others. These relationships are important to management of the disorder. Most patients with schizophrenia think concretely, so insight development is unlikely. Not all patients with schizophrenia experience delusions.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

35. A client says, “Facebook has a new tracking capacity. If I use the Internet, Homeland Security will detain me as a terrorist.” Select the nurse’s best initial action.

a. Tell the client, “Facebook is a safe Web site. You don’t need to worry about Homeland Security.”

b. Tell the client, “You are in a safe place where you will be helped.”

c. Administer a prn dose of an antipsychotic medication.

d. Tell the client, “You don’t need to worry about that.”

ANS: B

The patient is experiencing paranoia and delusional thinking, which leads to fear. Explaining that the patient is in a safe place will help relieve the fear. It is not therapeutic to disagree or give advice. Medication will not relieve the immediate concern.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

36. Which finding constitutes a negative symptom associated with schizophrenia?

a. Hostility

b. Bizarre behaviour

c. Poverty of thought

d. Auditory hallucinations

ANS: C

Negative symptoms include apathy, anhedonia, poor social functioning, and poverty of thought. The distracters are positive symptoms of schizophrenia. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

37. A patient insistently indicates that she cannot take her hat off because then the aliens will be able to put thoughts into her brain. Which problem is evident?

a. Visual hallucinations

b. Thought withdrawal

c. Idea of reference

d. Thought insertion

ANS: D

Thought insertion is believing that another person, group of people, or external force controls one`s thoughts. There is no evidence of the distracters.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

38. A newly hospitalized patient experiencing psychosis says, “Red chair out town board.” Which term should the nurse use to document this finding?

a. Word salad

b. Neologism

c. Anhedonia

d. Echolalia

ANS: A

Word salad (schizophasia) is a jumble of words that is meaningless to the listener and perhaps to the speaker as well, because of an extreme level of disorganization.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse at the mental health clinic plans a series of psychoeducational groups for

persons newly diagnosed with schizophrenia. Which two topics take priority? (Select all that apply.)

a. “The importance of taking your medication correctly”

b. “How to complete an application for employment”

c. “How to dress when attending community events”

d. “How to give and receive compliments”

e. “Ways to quit smoking”

ANS: A, E

Stabilization is maximized by adherence to the antipsychotic medication regimen. Because so many persons with schizophrenia smoke cigarettes, this topic relates directly to the patients’ physiological well-being. The other topics are also important but are not priority topics.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Health Promotion and Maintenance

2. A patient diagnosed with schizophrenia was hospitalized after arguing with co-workers and threatening to harm them. The patient is aloof and suspicious and says, “Two staff members I saw talking were plotting to kill me.” Based on data gathered at this point, which nursing diagnoses relate? (Select all that apply.)

a. Risk for other-directed violence

b. Disturbed thought processes

c. Risk for loneliness

d. Spiritual distress

e. Social isolation

ANS: A, B

Delusions of persecution and ideas of reference support the nursing diagnosis of disturbed thought processes. Risk for other-directed violence is substantiated by the patient’s feeling endangered by persecutors. Fearful individuals may strike out at perceived persecutors or attempt self-harm to get away from persecutors. Data are not present to support the other diagnoses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

Chapter 16: Eating and Feeding Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Over the past year, a woman has cooked gourmet meals for her family, but eats only tiny servings. This person wears layered loose clothing. Her current weight is 42 kg, a loss of 14 kg. Which medical diagnosis is most likely?

a. Binge eating

b. Bulimia nervosa

c. Anorexia nervosa

d. Eating disorder not otherwise specified

ANS: C

Overly controlled eating behaviours, extreme weight loss, preoccupation with food, and wearing several layers of loose clothing to appear larger are part of the clinical picture of an individual with anorexia nervosa. The individual with bulimia usually is near normal weight. The binge eater is often overweight. The patient with eating disorder not otherwise specified may be obese. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

2. Disturbed body image is a nursing diagnosis established for a patient diagnosed with an eating disorder. Which outcome indicator is most appropriate to monitor?

a. Weight, muscle, and fat congruence with height, frame, age, and sex

b. Calorie intake is within required parameters of treatment plan

c. Weight reaches established normal range for the patient

d. Patient expresses satisfaction with body appearance

ANS: D

Body image disturbances are considered improved or resolved when the patient is consistently satisfied with his or her own appearance and body function. This is a subjective consideration. The other indicators are more objective but less related to the nursing diagnosis.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

3. A patient referred to the eating disorders clinic has lost 15 kg during the past 3 months. To assess eating patterns, which of the following should the nurse should ask the patient?

a. “Do you often feel fat?”

b. “Who plans the family meals?”

c. “What do you eat in a typical day?”

d. “What do you think about your present weight?”

ANS: C

Although all the questions might be appropriate to ask, only “What do you eat in a typical day?” focuses on the eating patterns. Asking if the patient often feels fat focuses on distortions in body image. Questions about family meal planning are unrelated to eating patterns. Asking for the patient’s thoughts on present weight explores the patient’s feelings about weight.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

4. A patient diagnosed with anorexia nervosa virtually stopped eating 5 months ago and lost 25% of body weight. A nurse asks, “Describe what you think about your present weight and how you look.” Which response by the patient is most consistent with the diagnosis?

a. “I am fat and ugly.”

b. “What I think about myself is my business.”

c. “I’m grossly underweight, but that’s what I want.”

d. “I’m a few pounds overweight, but I can live with it.”

ANS: A

Untreated patients with anorexia nervosa do not recognize their thinness. They perceive themselves to be

overweight and unattractive. The patient with anorexia will usually tell people perceptions of self. The

patient with anorexia does not recognize his or her thinness and will persist in trying to lose more weight.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A patient was diagnosed with anorexia nervosa. The history shows the patient virtually

stopped eating 5 months ago and lost 25% of body weight. The serum potassium is currently 2.7

mg/dL. Which nursing diagnosis applies?

a. Adult failure to thrive related to abuse of laxatives as evidenced by electrolyte

imbalances and weight loss

b. Disturbed energy field related to physical exertion in excess of energy produced

through caloric intake as evidenced by weight loss and hyperkalemia

c. Ineffective health maintenance related to self-induced vomiting as evidenced by

swollen parotid glands and hyperkalemia

d. Imbalanced nutrition: less than body requirements related to reduced oral intake as

evidenced by loss of 25% of body weight and hypokalemia

ANS: D

The patient's history and lab result support the nursing diagnosis Imbalanced nutrition: less than body

requirements. Data are not present that the patient uses laxatives, induces vomiting, or exercises

excessively. The patient has hypokalemia rather than hyperkalemia.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Physiological Integrity

6. Outpatient treatment is planned for a patient diagnosed with anorexia nervosa. Select the

most important desired outcome related to the nursing diagnosis Imbalanced nutrition: less than

body requirements. Within 1 week, which of the following will the patient do?

a. Weigh self accurately using balanced scales

b. Limit exercise to less than 2 hours daily

c. Select clothing that fits properly

d. Gain 1 to 1.5 kg

ANS: D

Only the outcome of a gain of 1 to 1.5 kg can be accomplished within 1 week when the patient is an outpatient. The focus of an outcome would not be on the patient weighing self. Limiting exercise and selecting proper clothing are important, but weight gain takes priority.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Physiological Integrity

7. Which nursing intervention has the highest priority as a patient diagnosed with anorexia nervosa begins to gain weight?

a. Assess for depression and anxiety.

b. Observe for adverse effects of refeeding.

c. Communicate empathy for the patient's feelings.

d. Help the patient balance energy expenditures with caloric intake.

ANS: B

The nursing intervention of observing for adverse effects of refeeding most directly relates to weight gain and is a priority. Assessing for depression and anxiety, as well as communicating empathy, relate to coping. Helping the patient achieve balance between energy expenditure and caloric intake is an inappropriate intervention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

8. A patient diagnosed with anorexia nervosa is resistant to weight gain. What is the rationale for establishing a contract with the patient to participate in measures designed to produce a specified weekly weight gain?

a. Because severe anxiety concerning eating is expected, objective and subjective data may be unreliable.

b. Patient involvement in decision making increases sense of control and promotes compliance with treatment.

c. Because of increased risk of physical problems with refeeding, the patient's

permission is needed.

d. A team approach to planning the diet ensures that physical and emotional needs will

be met.

ANS: B

A sense of control for the patient is vital to the success of therapy. A diet that controls weight gain can allay patient fears of too-rapid weight gain. Data collection is not the reason for contracting. A team approach is wise but is not a guarantee that needs will be met. Permission for treatment is a separate issue.

The contract for weight gain is an additional aspect of treatment.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

9. The nursing care plan for a patient diagnosed with anorexia nervosa includes the

intervention "monitor for complications of refeeding." Which system should a nurse closely

monitor for dysfunction?

a. Renal

b. Endocrine

c. Integumentary

d. Cardiovascular

ANS: D

Refeeding resulting in too-rapid weight gain can overwhelm the heart, resulting in cardiovascular collapse. Focused assessment is a necessity to ensure the patient's physiological integrity. The other body

systems are not initially involved in refeeding syndrome.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

10. A psychiatric clinical nurse specialist uses cognitive-behavioural therapy for a patient

diagnosed with anorexia nervosa. Which statement by the staff nurse supports this type of therapy?

a. "What are your feelings about not eating foods that you prepare?"

b. "You seem to feel much better about yourself when you eat something."

c. “It must be difficult to talk about private matters to someone you just met.”

d. “Being thin doesn’t seem to solve your problems. You are thin now but still unhappy.”

ANS: D

The correct response is the only strategy that attempts to question the patient’s distorted thinking. As patients begin to eat again, they ideally participate in milieu therapy, in which the cognitive distortions (errors in thinking) that perpetuate the illness are consistently addressed by all members of the interdisciplinary team.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

11. An appropriate intervention for a patient diagnosed with bulimia nervosa who binges and purges is to teach the patient which of the following?

a. To eat a small meal after purging

b. Not to skip meals or restrict food

c. To increase oral intake after 4 p.m. daily.

d. The value of reading journal entries aloud to others

ANS: B

One goal of health teaching is normalization of eating habits. Food restriction and skipping meals lead to rebound bingeing. Teaching the patient to eat a small meal after purging will probably perpetuate the need to induce vomiting. Teaching the patient to eat a large breakfast but no lunch and increase intake after 4 p.m. will lead to late-day bingeing. Journal entries are private.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

12. A nurse provides care for an adolescent patient diagnosed with an eating disorder. Which behaviour by this nurse indicates that additional clinical supervision is needed?

a. The nurse interacts with the patient in a protective fashion.

b. The nurse’s comments to the patient are compassionate and nonjudgemental.

c. The nurse teaches the patient to recognize signs of increasing anxiety and ways to

intervene.

d. The nurse refers the patient to a self-help group for individuals with eating

disorders.

ANS: A

In the effort to motivate the patient and take advantage of the decision to seek help and be healthier, the

nurse must take care not to cross the line toward authoritarianism and assumption of a parental role.

Protective behaviours are part of the parent's role. The helpful nurse uses a problem-solving approach and

focuses on the patient's feelings of shame and low self-esteem. Referring a patient to a self-help group is

an appropriate intervention.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

13. A nursing diagnosis for a patient diagnosed with bulimia nervosa is Ineffective coping

related to feelings of loneliness as evidenced by overeating to comfort self, followed by self-

induced vomiting. The best outcome related to this diagnosis is that within 2 weeks the patient will

do which of the following?

a. Appropriately express angry feelings

b. Verbalize two positive things about self

c. Verbalize the importance of eating a balanced diet

d. Identify two alternative methods of coping with loneliness

ANS: D

The outcome of identifying alternative coping strategies is most directly related to the diagnosis of

Ineffective coping. Verbalizing positive characteristics of self and verbalizing the importance of eating a

balanced diet are outcomes that might be used for other nursing diagnoses. Appropriately expressing

angry feelings is not measurable.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

14. Which nursing intervention has the highest priority for a patient diagnosed with bulimia nervosa?

a. Assist the patient to identify triggers to binge eating.

b. Provide corrective consequences for weight loss.

c. Assess for signs of impulsive eating.

d. Explore needs for health teaching.

ANS: A

For most patients with bulimia nervosa, certain situations trigger the urge to binge; purging then follows. Often the triggers are anxiety-producing situations. Identification of triggers makes it possible to break the binge-purge cycle. Because binge eating and purging directly affect physical status, the need to promote physical safety assumes highest priority.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. One bed is available on the inpatient eating disorders unit. The patient with which of the following weight decrease should be admitted to this bed?

a. From 70 to 45 kg over a 4-month period. Vital signs are temperature, 35.9°C; pulse, 38 beats/min; blood pressure 60/40 mm Hg

b. From 55 to 40 kg over a 3-month period. Vital signs are temperature, 36°C; pulse, 50 beats/min; blood pressure 70/50 mm Hg

c. From 50 to 32 kg over a 4-month period. Vital signs are temperature 36.5°C; pulse, 60 beats/min; blood pressure 80/66 mm Hg

d. From 40 to 35 kg over a 5-month period. Vital signs are temperature, 36.7°C; pulse, 62 beats/min; blood pressure 74/48 mm Hg

ANS: A

Physical criteria for hospitalization include weight loss less than 85% of ideal weight or rapid decline in weight and food refusal, temperature below 36°C (hypothermia), heart rate less than 40 beats/min, and blood pressure less than 90/60 mm Hg.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

16. A nurse provides health teaching for a patient diagnosed with binge-purge bulimia.

Priority information the nurse should provide relates to which of the following?

a. Self-monitoring of daily food and fluid intake

b. Establishing the desired daily weight gain

c. How to recognize hypokalemia

d. Self-esteem maintenance

ANS: C

Hypokalemia results from potassium loss associated with vomiting. Physiological integrity can be maintained if the patient can self-diagnose potassium deficiency and adjust the diet or seek medical assistance. Self-monitoring of daily food and fluid intake is not useful if the patient purges. Daily weight gain may not be desirable for a patient with bulimia nervosa. Self-esteem is an identifiable problem but is

of lesser priority than the dangers associated with hypokalemia.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

17. As a patient admitted to the eating disorders unit undresses, a nurse observes that the patient's body is covered by fine, downy hair. The patient weighs 32 kg and is 162 cm. Which term should be documented?

a. Amenorrhea

b. Alopecia

c. Lanugo

d. Stupor

ANS: C

The fine, downy hair noted by the nurse is called lanugo. It is frequently seen in patients with anorexia nervosa. None of the other conditions can be supported by the data the nurse has gathered.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

18. A patient being admitted to the eating disorders unit has a yellow cast to the skin and fine, downy hair over the trunk. The patient weighs 32 kg; height is 172 cm. The patient says, “I won’t eat until I look thin.” Select the priority initial nursing diagnosis.

a. Anxiety related to fear of weight gain

b. Disturbed body image related to weight loss

c. Ineffective coping related to lack of conflict resolution skills

d. Imbalanced nutrition: less than body requirements related to self-starvation

ANS: D

The physical assessment shows hypercarotenemia and lanugo, which indicate imbalanced nutrition. Addressing the patient’s self-starvation is the priority.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Physiological Integrity

19. A nurse conducting group therapy on the eating disorders unit schedules the sessions immediately after meals for which primary purpose?

a. Maintaining patients’ concentration and attention

b. Shifting the patients’ focus from food to psychotherapy

c. Promoting processing of anxiety associated with eating

d. Focusing on weight control mechanisms and food preparation

ANS: C

Eating produces high anxiety for patients with eating disorders. Anxiety levels must be lowered if the patient is to be successful in attaining therapeutic goals. Shifting the patients’ focus from food to psychotherapy and focusing on weight control mechanisms and food preparation are not desirable. Maintaining patients’ concentration and attention is important, but not the primary purpose of the schedule.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

20. Physical assessment of a patient diagnosed with bulimia often reveals which of the following:

a. Prominent parotid glands

b. Peripheral edema

c. Thin, brittle hair

d. Twenty-five percent underweight

ANS: A

Prominent parotid glands are associated with repeated vomiting. The other options are signs of anorexia nervosa and not usually seen in bulimia.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

21. Which personality characteristic is a nurse most likely to assess in a patient diagnosed with anorexia nervosa?

a. Carefree flexibility

b. Rigidity, perfectionism

c. Open displays of emotion

d. High spirits and optimism

ANS: B

Rigid thinking, inability to demonstrate flexibility, and difficulty changing cognitions are characteristic of patients with eating disorders. The incorrect options are rare in a patient with an eating disorder. Inflexibility, controlled emotions, and pessimism are more the rule.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. Which assessment finding for a patient diagnosed with an eating disorder meets criteria for hospitalization?

a. Urine output 40 mL/hr

b. Pulse rate 58 beats/min

c. Serum potassium 3.4 mEq/L

d. Blood pressure 78/58 mm Hg

ANS: D

Blood pressure less than 90/60 mm Hg is an indicator for inpatient care. Many people without eating

disorders have bradycardia (pulse less than 60 beats/min). Urine output should be more than 30 mL/hr. A

potassium level of 3.4 mEq/L is within the normal range.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

23. A nurse finds a patient diagnosed with anorexia nervosa vigorously exercising before

gaining the agreed-upon weekly weight. Which response by the nurse is appropriate?

a. “You and I will have to sit down and discuss this problem.”

b. “It bothers me to see you exercising. I am afraid you will lose more weight.”

c. “Let’s discuss the relationship between exercise, weight loss, and the effects on

your body.”

d. “According to our agreement, no exercising is permitted until you have gained a

specific amount of weight.”

ANS: D

A matter-of-fact statement that the nurse’s perceptions are different will help to avoid a power struggle. Treatment plans have specific goals for weight restoration. Exercise is limited to promote weight gain. Patients must be held accountable for required behaviours.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. Which nursing diagnosis is more appropriate for a patient diagnosed with anorexia

nervosa who restricts intake and is 20% below normal weight than for a patient diagnosed with

bulimia nervosa who weighs 60 kg and who purges?

a. Powerlessness

b. Ineffective coping

c. Disturbed body image

d. Imbalanced nutrition: less than body requirements

ANS: D

The patient with bulimia nervosa usually maintains a close to normal weight, whereas the patient with anorexia nervosa may approach starvation. The incorrect options may be appropriate for patients with either anorexia nervosa or bulimia nervosa.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Physiological Integrity

25. Two years ago, a patient was diagnosed with bulimia nervosa, and she has weighed 90 kg for the past 12 months. The patient is generally happy with her life and indicates that she has no resistance to weight gain. Which is the best medication to help control the obsessive-compulsive behaviour, now that the patient has reached a maintenance weight?

a. Olanzapine (Zyprexa)

b. Fluoxetine (Prozac)

c. Chlorpromazine (Thorazine)

d. Fat soluble vitamins

ANS: B

The selective serotonin reuptake inhibitor (SSRI) fluoxetine (Prozac) has been found clinically useful in reducing obsessive-compulsive behaviour after the patient has reached a maintenance weight. Conventional antipsychotics such as chlorpromazine (Thorazine) may be helpful for delusional or overactive patients (Halmi, 2008). Atypical antipsychotic agents such as olanzapine (Zyprexa) are helpful in improving mood and decreasing obsessional behaviours and resistance to weight gain; although this may be a choice, it is not the best choice because the patient is not experiencing mood problems or resistance to weight gain.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiological Integrity

26. Which of the following is a complication of bulimia nervosa?

a. Tachycardia

b. Hyperchloremia

c. Hyperkalemia

d. Esophageal tears

ANS: D

A complication of bulimia nervosa is esophageal tears caused by self-induced vomiting. Others include bradycardia, hypochloremia, and hypokalemia.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

MULTIPLE RESPONSE

1. A patient referred to the eating disorders clinic has lost 16 kg in 3 months. For which physical manifestations of anorexia nervosa should a nurse assess? (Select all that apply.)

a. Peripheral edema

b. Parotid swelling

c. Constipation

d. Hypotension

e. Dental caries

f. Lanugo

ANS: A, C, D, F

Peripheral edema is often present because of hypoalbuminemia. Constipation related to starvation is often present. Hypotension is often present because of dehydration. Lanugo is often present and is related to starvation. Parotid swelling is associated with bulimia. Dental caries are associated with bulimia. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

2. A patient diagnosed with anorexia nervosa is hospitalized for treatment. What features should the milieu provide? (Select all that apply.)

a. Flexible mealtimes

b. Unscheduled weight checks

c. Adherence to a selected menu

d. Observation during and after meals

e. Monitoring during bathroom trips

f. Privileges correlated with emotional expression

ANS: C, D, E

Priority milieu interventions support restoration of weight and normalization of eating patterns. This

requires close supervision of the patient's eating and prevention of exercise, purging, and other activities.

There is strict adherence to menus. Patients are observed during and after meals to prevent throwing away

food or purging. All trips to the bathroom are monitored. Mealtimes are structured, not flexible. Weighing

is performed on a regular schedule. Privileges are correlated with weight gain and treatment plan

compliance.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

Chapter 17: Neurocognitive Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. An older adult patient takes multiple medications daily. Over 2 days, the patient

developed confusion, incoherent speech, an unsteady gait, and fluctuating levels of orientation.

These findings are most characteristic of which of the following?

a. Delirium

b. Dementia

c. Amnestic syndrome

d. Alzheimer's disease

ANS: A

Delirium is characterized by inattention, disorganized thinking, and a fluctuating mental status. The onset

of dementia or Alzheimer's disease-a type of dementia-is more insidious. Amnestic syndrome involves

memory impairment without other cognitive problems.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

2. A patient with fluctuating levels of awareness, confusion, and disturbed orientation

shouts, "Bugs are crawling on my legs. Get them off!" Which problem is the patient experiencing?

a. Aphasia

b. Dystonia

c. Hallucinations

d. Mnemonic disturbance

ANS: C

The patient feels bugs crawling on both legs, even though no sensory stimulus is actually present. This description meets the definition of a hallucination, a false sensory perception. Hallucinations may be part of the symptom constellation of delirium. Aphasia refers to a language disorder. Dystonia refers to excessive muscle tonus. Mnemonic disturbance is associated with dementia rather than delirium.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A patient with fluctuating levels of consciousness, disturbed orientation, and perceptual alteration begs, “Someone get these bugs off me.” What is the nurse’s best response?

a. “No bugs are on your legs. You are having hallucinations.”

b. “I will have someone stay here and brush off the bugs for you.”

c. “Try to relax. The crawling sensation will go away sooner if you can relax.”

d. “I don’t see any bugs, but I can tell you are frightened. I will stay with you.”

ANS: D

When hallucinations are present, the nurse should acknowledge the patient’s feelings and state the nurse’s perception of reality, but not argue. Staying with the patient increases feelings of security, reduces anxiety, offers the opportunity for reinforcing reality, and provides a measure of physical safety. Denying the patient’s perception without offering help does not support the patient emotionally. Telling the patient to relax makes the patient responsible for self-soothing. Telling the patient that someone will brush the bugs away supports the perceptual distortions.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. What is the priority nursing diagnosis for a patient with fluctuating levels of consciousness, disturbed orientation, and hallucinations?

a. Risk for injury related to altered cerebral function, fluctuating levels of

consciousness, disturbed orientation, and misperception of the environment

b. Bathing/hygiene self-care deficit related to cerebral dysfunction, as evidenced by

confusion and inability to perform personal hygiene tasks

c. Disturbed thought processes related to medication intoxication, as evidenced by

confusion, disorientation, and hallucinations

d. Fear related to sensory perceptual alterations as evidenced by visual and tactile

hallucinations

ANS: A

The physical safety of the patient is of highest priority among the diagnoses given. Many opportunities

for injury exist when a patient misperceives the environment as distorted, threatening, or harmful or when

the patient exercises poor judgement or when the patient's sensorium is clouded. The other diagnoses may

be concerns but are lower priorities.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

5. What is the priority intervention for a patient diagnosed with delirium who has

fluctuating levels of consciousness, disturbed orientation, and perceptual alterations?

a. Distraction using sensory stimulation

b. Careful observation and supervision

c. Avoidance of physical contact

d. Activation of the bed alarm

ANS: B

Careful observation and supervision are of ultimate importance because an appropriate outcome would be

that the patient will remain safe and free from injury. Physical contact during care cannot be avoided.

Activating a bed alarm is only one aspect of providing for the patient's safety.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

6. A patient diagnosed with delirium is experiencing perceptual alterations. Which environmental adjustment should the nurse make for this patient?

a. Provide a well-lit room without glare or shadows. Limit noise and stimulation.

b. Maintain soft lighting day and night. Keep a radio on low volume continuously.

c. Light the room brightly day and night. Awaken the patient hourly to assess mental status.

d. Keep the patient by the nurse's desk while awake. Provide rest periods in a room with a television on.

ANS: A

A quiet, shadow-free room offers an environment that produces the fewest sensory perceptual distortions for a patient with cognitive impairment associated with delirium. The other options have the potential to produce increased perceptual alterations.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

7. Which assessment finding would be likely for a patient experiencing a hallucination?

a. The patient looks at shadows on a wall and says, "I see scary faces."

b. The patient states, "I feel bugs crawling on my legs and biting me."

c. The patient reports telepathic messages from the television.

d. The patient speaks in rhymes.

ANS: B

A hallucination is a false sensory perception occurring without a corresponding sensory stimulus. Feeling bugs on the body when none are present is a hallucination. Misinterpreting shadows as faces is an illusion. An illusion is a misinterpreted sensory perception. The other incorrect options apply to thought insertion and clang associations.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. Consider these health problems: Lewy body disease, frontal-temporal lobar degeneration, and Huntington's disease. Which term unifies these problems?

a. Cyclothymia

b. Dementia

c. Delirium

d. Amnesia

ANS: B

The listed health problems are all forms of dementia.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

9. Which medication prescribed to patients diagnosed with Alzheimer's disease normalizes levels of glutamate rather than antagonizes cholinesterase?

a. Donepezil (Aricept)

b. Rivastigmine (Exelon)

c. Memantine (Ebixa)

d. Galantamine (Reminyl)

ANS: C

Memantine (Ebixa) normalizes levels of glutamate, a neurotransmitter that may contribute to neurodegeneration, and is used in moderate-to-severe stages of the disease. Donepezil, rivastigmine, and galantamine are all cholinesterase inhibitors. These drugs increase the availability of acetylcholine and are most often used to treat mild-to-moderate Alzheimer's disease.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

10. An older adult was stopped by police for driving through a red light. When asked for a driver's license, the adult hands the police officer a pair of sunglasses. What sign of dementia is evident?

a. Aphasia

b. Apraxia

c. Agnosia

d. Anhedonia

ANS: C

Agnosia refers to the loss of sensory ability to recognize objects. Aphasia refers to the loss of language ability. Apraxia refers to the loss of purposeful movement. Anhedonia refers to a loss of joy in life.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. An older adult drove to a nearby store but was unable to remember how to get home or state an address. When police intervened, they found that this adult was wearing a heavy coat and hat, even though it was July. Which stage of Alzheimer's disease is evident?

a. Preclinical Alzheimer's disease

b. Mild cognitive decline

c. Moderately severe cognitive decline

d. Severe cognitive decline

ANS: C

In the moderately severe stage, deterioration is evident. Memory loss may include the inability to remember addresses or the date. Activities such as driving may become hazardous, and the person may experience frustration by the increasing difficulty of performing ordinary tasks. The individual has difficulty with clothing selection. Mild cognitive decline (early-stage) Alzheimer's can be diagnosed in some, but not all, individuals with the disease. Symptoms include misplacing items and misuse of words. In the stage of severe cognitive decline, personality changes may take place, and the patient needs extensive help with daily activities. This patient has symptoms, so the preclinical stage does not apply.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. Consider these diagnostic findings: apolipoprotein E (apoE) malfunction, neurofibrillary tangles, neuronal degeneration in the hippocampus, and brain atrophy. Which health problem corresponds to these diagnostic findings?

a. Huntington's disease

b. Alzheimer's disease

c. Parkinson’s disease

d. Vascular dementia

ANS: B

All of the options have associated dementias; however, the pathophysiological phenomena described apply to Alzheimer’s disease. Parkinson’s disease is associated with dopamine dysregulation. Huntington’s disease is genetic. Vascular dementia is the consequence of circulatory changes.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

13. A patient with stage 3 Alzheimer’s disease tires easily and prefers to stay home rather than attend social activities. The spouse does the grocery shopping because the patient cannot remember what to buy. Which nursing diagnosis applies at this time?

a. Self-care deficit

b. Impaired memory

c. Caregiver role strain

d. Adult failure to thrive

ANS: B

Memory impairment begins at stage 2 and progresses in stage 3. This patient is able to perform most self-care activities. Caregiver role strain and adult failure to thrive occur later.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

14. A patient has progressive memory deficits associated with dementia. Which nursing intervention would best help the individual function in the environment?

a. Assist the patient to perform simple tasks by giving step-by-step directions.

b. Reduce frustration by performing activities of daily living for the patient.

c. Stimulate intellectual function by discussing new topics with the patient.

d. Read one story from the newspaper to the patient every day.

ANS: A

Patients with cognitive impairment should perform all tasks of which they are capable. When simple directions are given in a systematic fashion, the patient is better able to process information and perform simple tasks. Stimulating intellectual functioning by discussing new topics is likely to prove frustrating for the patient. Patients with cognitive deficits may enjoy the attention of someone reading to them, but this activity does not promote their function in the environment.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

15. Two patients in a residential care facility have dementia. One shouts to the other, "Move along, you're blocking the road." The other patient turns, shakes a fist, and shouts, "You're trying to steal my car." What is the nurse's best action?

a. Administer one dose of an antipsychotic medication to both patients.

b. Reinforce reality. Say to the patients, "Walk along in the hall. This is not a traffic intersection."

c. Separate and distract the patients. Take one to the day room and the other to an activities area.

d. Step between the two patients and say, "Please quiet down. We do not allow violence here."

ANS: C

Separating and distracting prevents escalation from verbal to physical acting out. Neither patient loses self-esteem during this intervention. Medication probably is not necessary. Stepping between two angry, threatening patients is an unsafe action, and trying to reinforce reality during an angry outburst will probably not be successful when the patients are cognitively impaired.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

16. An older adult patient in the intensive care unit has visual and auditory illusions. Which intervention will be most helpful?

a. Using the patient's glasses and hearing aids

b. Placing personally meaningful objects in view

c. Placing large clocks and calendars on the wall

d. Assuring that the room is brightly lit but very quiet at all times

ANS: A

Illusions are sensory misperceptions. Glasses and hearing aids help clarify sensory perceptions. Without glasses, clocks, calendars, and personal objects are meaningless. Round-the-clock lighting promotes sensory overload and sensory perceptual alterations.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. A patient diagnosed with Alzheimer's disease calls the fire department saying, "My smoke detectors are going off." Firefighters investigate and discover that the patient misinterpreted the telephone ringing. Which problem is this patient experiencing?

a. Hyperorality

b. Aphasia

c. Apraxia

d. Agnosia

ANS: D

Agnosia is the inability to recognize familiar objects, parts of one's body, or one's own reflection in a mirror. Hyperorality refers to placing objects in the mouth. Aphasia refers to the loss of language ability. Apraxia refers to the loss of purposeful movements, such as being unable to dress.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. During morning care, a nurse asks a patient diagnosed with dementia, "How was your night?" The patient replies, "It was lovely. I went out to dinner and a movie with my friend." Which term applies to the patient's response?

a. Sundown syndrome

b. Confabulation

c. Perseveration

d. Delirium

ANS: B

Confabulation refers to making up stories or answers to questions by a person who does not remember. It is a defensive tactic to protect self-esteem and prevent others from noticing the memory loss. The patient's response was not sundown syndrome. Perseveration refers to repeating a word or phrase over and over. Delirium is not present in this scenario.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

19. A nurse counsels the family of a patient diagnosed with Alzheimer's disease who lives at home and wanders at night. Which action is most important for the nurse to recommend to enhance safety?

a. Apply a medical alert bracelet to the patient.

b. Place locks at the tops of doors.

c. Discourage daytime napping.

d. Obtain a bed with side rails.

ANS: B

Placing door locks at the top of the door makes it more difficult for the patient with dementia to unlock the door because the ability to look up and reach upward is diminished. The patient will try to climb over side rails, increasing the risk for injury and falls. Avoiding daytime naps may improve the patient's sleep pattern but does not assure safety. A medical alert bracelet will be helpful if the patient leaves the home, but it does not prevent wandering or assure the patient's safety.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

20. Which of the following will be the focus for goals of care for an older adult patient diagnosed with delirium caused by fever and dehydration?

a. Returning to premorbid levels of function

b. Identifying stressors negatively affecting self

c. Demonstrating motor responses to noxious stimuli

d. Exerting control over responses to perceptual distortions

ANS: A

The desired overall goal is that the delirious patient will return to the level of functioning held before the development of delirium. Demonstrating motor response to noxious stimuli is an indicator appropriate for a patient whose arousal is compromised. Identifying stressors that negatively affect the self is too nonspecific to be useful for a patient with delirium. Exerting control over responses to perceptual distortions is an unrealistic indicator for a patient with sensorium problems related to delirium.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Physiological Integrity

21. An older adult with moderately severe dementia forgets where the bathroom is and has episodes of incontinence. Which intervention should the nurse suggest to the patient's family?

a. Label the bathroom door.

b. Take the older adult to the bathroom hourly.

c. Place the older adult in disposable adult briefs.

d. Limit the intake of oral fluids to 1000 mL per day.

ANS: A

The patient with moderately severe dementia has memory loss that begins to interfere with activities. This patient may be able to use environmental cues such as labels on doors to compensate for memory loss. Regular toileting may be helpful, but a 2-hour schedule is often more reasonable. Placing the patient in disposable briefs is more appropriate at a later stage. Severely limiting oral fluid intake would predispose the patient to a urinary tract infection.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

22. An older patient diagnosed with severe, late-stage dementia no longer recognizes family members. The family asks how long it will be before this patient recognizes them when they

visit. What is the nurse's best reply?

a. "Your family member will never again be able to identify you."

b. "I think that is a question the health care provider should answer."

c. "One never knows. Consciousness fluctuates in persons with dementia."

d. "It is disappointing when someone you love no longer recognizes you."

ANS: D

Therapeutic communication techniques can assist the family to come to terms with the losses and irreversibility dementia imposes on both the loved one and themselves. Two incorrect responses close communication. The nurse should take the opportunity to foster communication. Consciousness does not fluctuate in patients with dementia.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

23. A patient with severe dementia no longer recognizes family members and becomes anxious and agitated when they attempt reorientation. Which alternative could the nurse suggest to the family members?

a. Wear large name tags.

b. Focus interaction on familiar topics.

c. Frequently repeat the reorientation strategies.

d. Place large clocks and calendars strategically.

ANS: B

Validating, talking with the patient about familiar, meaningful things, and reminiscing give meaning to existence both for the patient and family members. The option that suggests using validating techniques when communicating is the only option that addresses an interactional strategy. Wearing large name tags and placing large clocks and calendars strategically are reorientation strategies. Frequently repeating the reorientation strategies is inadvisable because patients with dementia sometimes become more agitated with reorientation.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. What is the priority need for a patient with late-stage dementia?

a. Promotion of self-care activities

b. Meaningful verbal communication

c. Preventing the patient from wandering

d. Maintenance of nutrition and hydration

ANS: D

In late-stage dementia, the patient often seems to have forgotten how to eat, chew, and swallow. Nutrition

and hydration needs must be met if the patient is to live. The patient is incapable of self-care, ambulation,

or verbal communication.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

25. An older adult is prescribed digoxin (Lanoxin) and hydrochlorothiazide daily as well

as lorazepam (Ativan) as needed for anxiety. Over 2 days, the patient developed confusion, slurred

speech, an unsteady gait, and fluctuating levels of orientation. What is the most likely reason for

the patient's change in mental status?

a. Drug actions and interactions

b. Benzodiazepine withdrawal

c. Hypotensive episodes

d. Renal failure

ANS: A

Drug actions and interactions are common among elderly persons and predispose this population to delirium. Medications should always be suspected as a potential cause of delirium. To recognize drug reactions or anticipate potential interactions before delirium actually occurs, health care providers must assess all medications or other substances that a patient is taking. Delirium is characterized by an abrupt onset of fluctuating levels of awareness, clouded consciousness, perceptual disturbances, and disturbed memory and orientation. The patient takes lorazepam on a prn basis, so withdrawal is unlikely. Hypotensive episodes or problems with renal function may occur, associated with the patient's drug

regime, but interactions are more likely the problem.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

26. A hospitalized patient diagnosed with delirium misinterprets reality, while a patient diagnosed with dementia wanders about the home. Which outcome is the priority in both scenarios?

a. The patient will remain safe in the environment.

b. The patient will participate actively in self-care.

c. The patient will communicate verbally.

d. The patient will acknowledge reality.

ANS: A

Risk for injury is the nurse's priority concern. Safety maintenance is the desired outcome. The other outcomes are lower priorities and may not be realistic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Safe Effective Care Environment

27. An elderly patient is admitted with delirium secondary to a urinary tract infection. The family asks whether the patient will ever recover. Select the nurse's best response.

a. "The health care provider is the best person to answer your question."

b. "The confusion will probably get better as we treat the infection."

c. "Unfortunately, delirium is a progressively disabling disorder."

d. "I will be glad to contact the chaplain to talk with you."

ANS: B

Usually, as the underlying cause of the delirium is treated, the symptoms of delirium clear. The distracters mislead the family.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

28. An elderly person presents with symptoms of delirium. The family reports, "Everything was fine until yesterday." What is the most important assessment information for the

nurse to gather?

a. A list of all medications the person currently takes

b. Whether the person has experienced any recent losses

c. Whether the person has ingested aged or fermented foods

d. The person's recent personality characteristics and changes

ANS: A

Delirium is often the result of medication interactions or toxicity. The distracters relate to MAOI therapy and depression.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

29. A nurse gives anticipatory guidance to the family of a patient diagnosed with mild cognitive decline Alzheimer's disease. Which problem common to that stage should the nurse address?

a. Violent outbursts

b. Emotional disinhibition

c. Communication deficits

d. Inability to feed or bathe self

ANS: C

Families should be made aware that the patient will have difficulty concentrating and following or carrying on in-depth or lengthy conversations. The other symptoms are usually seen at later stages of the disease.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A patient diagnosed with moderately severe Alzheimer's disease has a self-care deficit of dressing and grooming. Designate appropriate interventions to include in the patient's plan of care. (Select all that apply.)

a. Provide clothing with elastic and Velcro closures.

b. Label clothing with the patient's name and name of the item.

c. Administer anti-anxiety medication before bathing and dressing.

d. Provide necessary items and direct the patient to proceed independently.

e. If the patient resists dressing, use distraction and try again after a short interval.

ANS: A, B, E

Providing clothing with elastic and Velcro closures facilitates patient independence. Labelling clothing with the patient's name and the name of the item maintains patient identity and dignity (provides information if the patient has agnosia). When a patient resists, it is appropriate to use distraction and try again after a short interval because patient moods are often labile. The patient may be willing to cooperate given a later opportunity. Providing the necessary items for grooming and directing the patient to proceed independently are inappropriate. Be prepared to coach by giving step-by-step directions for each task as it occurs. Administering anxiolytic medication before bathing and dressing is inappropriate. This measure would result in unnecessary overmedication.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. Which assessment findings would the nurse expect in a patient experiencing delirium?

(Select all that apply.)

a. Impaired level of consciousness

b. Disorientation to place, time

c. Wandering attention

d. Apathy

e. Agnosia

ANS: A, B, C

Disorientation to place and time is an expected finding. Orientation to person (self) usually remains intact.

Attention span is short, and difficulty focusing or shifting attention as directed is often noted. Patients with delirium commonly experience illusions and hallucinations. Fluctuating levels of consciousness are expected. Agnosia occurs with dementia. Apathy is associated with depression.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which nursing diagnoses are most applicable for a confused patient diagnosed with

severe Alzheimer's disease? (Select all that apply.)

a. Acute confusion

b. Anticipatory grieving

c. Urinary incontinence

d. Disturbed sleep pattern

e. Risk for caregiver role strain

ANS: C, D, E

The correct answers are consistent with problems frequently identified for patients with confusion in late-

stage Alzheimer's disease. Confusion is chronic, not acute. The patient's cognition is too impaired for the

patient to grieve.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

Chapter 18: Psychoactive Substance Use and Treatment

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient diagnosed with alcoholism asks, "How will Alcoholics Anonymous (AA) help

me?" Select the nurse's best response.

a. "The goal of AA is for members to learn controlled drinking with the support of a

higher power."

b. "An individual is supported by peers while working through a 12-step plan."

c. "You must make a commitment to permanently abstain from alcohol and other

drugs.”

d. “You will be assigned a sponsor who will plan your treatment program.”

ANS: B

Using the 12 steps, often referred to as “working the steps,” helps a person refrain from addictive behaviours, while fostering individual change and growth. Peer support, accomplished by obtaining a sponsor prior to discharge, can increase the patient’s likelihood of attendance at 12-step meetings. The other options are incorrect.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A nurse reviews vital signs for a patient admitted with an injury sustained while intoxicated. The medical record shows these blood pressure and pulse readings at the times listed: 0200: 118/78 mm Hg and 72 beats/min; 0400: 126/80 mm Hg and76 beats/min; 0600: 128/82 mm Hg and 72 beats/min; 0800: 132/88 mm Hg and 80 beats/min;1000: 148/94 mm Hg and 96 beats/min. What is the nurse’s priority action?

a. Force fluids.

b. Consult the health care provider.

c. Obtain a clean-catch urine sample.

d. Place the patient in a vest-type restraint.

ANS: B

Elevated pulse and blood pressure may indicate impending alcohol withdrawal and the need for medical intervention. No indication is present that the patient may have a urinary tract infection or that the patient is presently in need of restraint. Hydration will not resolve the problem.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

3. A nurse cares for a patient diagnosed with an opioid overdose. Which focused assessment has the highest priority?

a. Cardiovascular

b. Respiratory

c. Neurologic

d. Hepatic

ANS: B

Opioid overdose causes respiratory depression. Respiratory depression is the primary cause of death among opioid abusers. The assessment of the other body systems is relevant but not the priority. See relationship to audience response question.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

4. A patient admitted for injuries sustained while intoxicated has been hospitalized for 48 hours. The patient is now shaky, irritable, anxious, and diaphoretic and reports nightmares. The pulse rate is 130 beats/min. The patient shouts, “Bugs are crawling on my bed. I’ve got to get out of here.” Select the most accurate assessment of this situation.

a. The patient is attempting to obtain attention by manipulating staff.

b. The patient may have sustained a head injury before admission.

c. The patient has symptoms of alcohol-withdrawal delirium.

d. The patient is having an acute psychosis.

ANS: C

Symptoms of agitation, elevated pulse, and perceptual distortions indicate alcohol withdrawal delirium. The findings are inconsistent with manipulative attempts, head injury, or functional psychosis.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

5. A patient admitted yesterday for injuries sustained while intoxicated believes bugs are crawling on the bed. The patient is anxious, agitated, and diaphoretic. What is the priority nursing diagnosis?

a. Disturbed sensory perception

b. Ineffective coping

c. Ineffective denial

d. Risk for injury

ANS: D

The patient's clouded sensorium, sensory perceptual distortions, and poor judgement predispose a risk for

injury. Safety is the nurse's priority. The other diagnoses may apply but are not the priorities of care.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

6. A hospitalized patient diagnosed with an alcohol abuse disorder believes the window

blinds are snakes trying to get in the room. The patient is anxious, agitated, and diaphoretic. The

nurse can anticipate the health care provider will prescribe which of the following?

a. A narcotic analgesic, such as hydromorphone (Dilaudid)

b. A benzodiazepine, such as lorazepam (Ativan) or chlordiazepoxide (Librium)

c. An antipsychotic, such as olanzapine (Zyprexa) or thioridazine (Mellaril)

d. A monoamine oxidase inhibitor antidepressant, such as phenelzine (Nardil)

ANS: B

Sedation allows for safe withdrawal from alcohol. Benzodiazepines are the drugs of choice in most

regions because of their high therapeutic safety index and anticonvulsant properties.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

7. A hospitalized patient diagnosed with an alcohol abuse disorder believes spiders are

spinning entrapping webs in the room. The patient is fearful, agitated, and diaphoretic. Which

nursing intervention is indicated?

a. Check the patient every 15 minutes

b. One-on-one supervision

c. Keep the room dimly lit

d. Force fluids

ANS: B

Immediate medical attention, ongoing assessment and supervised treatment is necessary to promote physical safety until sedation reduces the patient's feelings of terror. Checks every 15 minutes would not be sufficient to provide for safety. A dimly lit room promotes perceptual disturbances. Excessive fluid

intake can cause overhydration, because fluid retention normally occurs when blood alcohol levels fall.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

8. A patient diagnosed with an alcohol abuse disorder says, “Drinking helps me cope with

being a single parent.” Which therapeutic response by the nurse would help the patient

conceptualize the drinking objectively?

a. “Sooner or later, alcohol will kill you. Then what will happen to your children?”

b. “I hear a lot of defensiveness in your voice. Do you really believe this?”

c. “If you were coping so well, why were you hospitalized again?”

d. “Tell me what happened the last time you drank.”

ANS: D

The correct response will help the patient see alcohol as a cause of the problems, not a solution, and begin

to take responsibility. This approach can help the patient become receptive to the possibility of change.

The other responses directly confront and attack defences against anxiety that the patient still needs. They

reflect the nurse’s frustration with the patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

9. A patient asks for information about Alcoholics Anonymous. Select the nurse’s best

response.

a. “Alcoholics Anonymous is a form of group therapy led by a psychiatrist.”

b. “Alcoholics Anonymous is a self-help group for which the goal is sobriety.”

c. “Alcoholics Anonymous is a group that learns about drinking from a group leader.”

d. “Alcoholics Anonymous is a network that advocates strong punishment for drunk

drivers.”

ANS: B

Alcoholics Anonymous (AA) is a peer support group for recovering alcoholics. Neither professional nor

peer leaders are appointed.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. Police bring a patient to the emergency department after an automobile accident. The patient demonstrates ataxia and slurred speech. The blood alcohol level is 0.50 mg%. Considering the relationship between the behaviour and blood alcohol level, which conclusion is most probable?

a. The patient rarely drinks alcohol.

b. The patient has a high tolerance to alcohol.

c. The patient has been treated with disulfiram (Antabuse).

d. The patient has ingested both alcohol and sedative drugs recently.

ANS: B

A nontolerant drinker would be in coma with a blood alcohol level of 0.50 mg%. The fact that the patient is moving and talking shows a discrepancy between blood alcohol level and expected behaviour and strongly indicates that the patient's body is tolerant. If disulfiram and alcohol are ingested together, an entirely different clinical picture would result. The blood alcohol level gives no information about ingestion of other drugs.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

11. A patient admitted to an alcoholism rehabilitation program tells the nurse, "I'm actually just a social drinker. I usually have a drink at lunch, two in the afternoon, wine with dinner, and a few drinks during the evening." The patient is using which defence mechanism?

a. Denial

b. Projection

c. Introjection

d. Rationalization

ANS: A

Minimizing one's drinking is a form of denial of alcoholism. The patient is more than a social drinker. Projection involves blaming another for one's faults or problems. Rationalization involves making excuses. Introjection involves incorporating a quality of another person or group into one's own personality.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. Which medication to maintain abstinence would most likely be prescribed for patients with an addiction to either alcohol or opioids?

a. Naloxone (Targin)

b. Methadone (Metadol)

c. Disulfiram (Antabuse)

d. Naltrexone (ReVia)

ANS: D

Naltrexone (ReVia) is useful for treating both opioid and alcohol addiction. An opioid antagonist blocks the action of opioids and the mechanism of reinforcement. It also reduces or eliminates alcohol craving.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

13. During the third week of treatment, the spouse of a patient in a rehabilitation program for substance abuse says, “After this treatment program, I think everything will be all right.” Which remark by the nurse will be most helpful to the spouse?

a. “While sobriety solves some problems, new ones may emerge as one adjusts to living without drugs and alcohol.”

b. “It will be important for you to structure life to avoid as much stress as you can and provide social protection.”

c. “Addiction is a lifelong disease of self-destruction. You will need to observe your spouse’s behaviour carefully.”

d. “It is good that you are supportive of your spouse’s sobriety and want to help maintain it.”

ANS: A

During recovery, patients identify and use alternative coping mechanisms to reduce reliance on substances. Physical adaptations must occur. Emotional responses were previously dulled by alcohol but are now fully experienced and may cause considerable anxiety. These changes inevitably have an effect on the spouse and children, who need anticipatory guidance and accurate information.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

14. The treatment team discusses the plan of care for a patient with concurrent disorders of schizophrenia and daily cannabis abuse who is having increased hallucinations and delusions. To plan effective treatment, which of the following should the team do?

a. Provide long-term care for the patient in a residential facility

b. Withdraw the patient from cannabis, and then treat the schizophrenia

c. Consider each diagnosis primary and provide simultaneous treatment

d. First treat the schizophrenia, and then establish goals for substance abuse treatment

ANS: C

Patients with concurrent disorders need to receive simultaneous treatment. Patients with co-occurring disorders require longer treatment and progress is slower, but treatment may occur in the community.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. Select the most therapeutic manner for a nurse to work with a patient who is beginning treatment for alcohol addiction.

a. Empathetic, supportive

b. Skeptical, guarded

c. Cool, distant

d. Confrontational

ANS: A

Support and empathy assist the patient to feel safe enough to start looking at problems. Counselling during the early stage of treatment needs to be direct, open, and honest. The other approaches will increase patient anxiety and cause the patient to cling to defences.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

16. Which features should be present in a therapeutic milieu for a patient with a hallucinogen overdose?

a. Simple and safe

b. Active and bright

c. Stimulating and colourful

d. Confrontational and challenging

ANS: A

Because the individual who has ingested a hallucinogen is probably experiencing feelings of unreality and

altered sensory perceptions, the best environment is one that does not add to the stimulation. A simple,

safe environment is a better choice than an environment with any of the characteristics listed in the other

options. The other options would contribute to a “bad trip.”

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

17. When a patient first began using alcohol, two drinks produced relaxation and

drowsiness. After 1 year, four drinks are needed to achieve the same response. Why has this change

occurred?

a. Tolerance has developed.

b. Antagonistic effects are evident.

c. Metabolism of the alcohol is now delayed.

d. The pharmacokinetics of the alcohol has changed.

ANS: A

Tolerance refers to needing higher and higher doses of a drug to produce the desired effect. The potency

of the alcohol is stable. Neither delayed metabolism nor antagonistic effects account for this change.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

18. At a meeting for family members of alcoholics, a spouse says, “I did everything I

could to help. I even requested sick leave when my partner was too drunk to go to work.” The

nurse assesses these comments as which of the following?

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Which personality dimension is reflective of the behaviours of absorption, dissociation, eccentricity, openness to experience, and perceptual cognitive distortion?

a. Emotional dysregulation versus emotional stability

b. Constraint versus impulsivity

c. Antagonism versus compliance

d. Unconventionality versus closedness to experience

ANS: D

The personality dimension of unconventionality versus closedness to experience includes the following attitudes and behaviours: absorption, dissociation, eccentric perceptions, eccentricity, openness to experience, perceptual cognitive distortion, rigidity, spiritual acceptance, thought disorder, and transpersonal identification.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which intervention is appropriate for an individual diagnosed with antisocial personality disorder who frequently manipulates others?

a. Ensure limits are adhered to by all staff.

b. Encourage the patient to discuss feelings of fear and inferiority.

c. Provide negative reinforcement for acting-out behaviour.

d. Ignore, rather than confront, inappropriate behaviour.

ANS: A

Manipulative people frequently make requests of many different staff, hoping one will give in. Therefore, it is important that all staff adhere to the limits that have been set. Positive reinforcement of appropriate behaviours is more effective than negative reinforcement. The behaviour should not be ignored; judicious use of confrontation is necessary. Patients with antisocial personality disorders rarely have feelings of fear and inferiority.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

3. As a nurse prepares to administer medication to a patient diagnosed with borderline personality disorder, the patient says, “Just leave it on the table. I’ll take it when I finish combing my hair.” What is the nurse‘s best response?

a. Reinforce this assertive action by the patient. Leave the medication on the table as requested.

b. Respond to the patient, “I’m worried that you might not take it. I’ll come back later.”

c. Say to the patient, “I must watch you take the medication. Please take it now.”

d. Ask the patient, “Why don’t you want to take your medication now?”

ANS: C

The individual with borderline personality disorder characteristically demonstrates manipulative, splitting, and self-destructive behaviours. Clear and consistent boundaries and limits are vital for the patient’s safety, but also to prevent splitting of other staff. “Why” questions are not therapeutic. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

4. What is an appropriate initial outcome for a patient diagnosed with a personality disorder who has impulse control interferences?

a. The patient will identify when feeling angry.

b. The patient will use impulsive behaviours only to get legitimate needs met.

c. The patient will identify harmful impulsive behaviours.

d. The patient will accept fulfillment of his or her requests within an hour rather than immediately.

ANS: C

Identifying impulsive behaviours is an early outcome that paves the way for later taking greater

responsibility for controlling impulsive behaviours. Identifying anger relates to anger and aggression control. Using manipulation to get legitimate needs is an inappropriate outcome—the patient would ideally use assertive behaviour to promote need fulfillment. Accepting fulfillment of requests within an hour rather than immediately relates to impulsivity control.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

5. Consider this comment to three different nurses by a patient diagnosed with antisocial personality disorder. “Another nurse said you don’t do your job right.” Collectively, these interactions can be assessed as which of the following?

a. Seductive

b. Detached

c. Manipulative

d. Guilt-producing

ANS: C

Patients manipulate and control staff in various ways. By keeping staff off balance or fighting among themselves, the person with antisocial personality disorder is left to operate as he or she pleases. Seductive behaviour has sexual connotations. The patient is displaying the opposite of detached behaviour. Guilt is not evident in the comments.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. A nurse reports to the treatment team that a patient diagnosed with antisocial personality disorder has displayed the behaviours below. This patient is detached and superficial during counselling sessions. Which behaviour by the patient most clearly warrants limit setting?

a. Flattering the nurse

b. Lying to other patients

c. Verbal abuse of another patient

d. Detached superficiality during counselling

ANS: C

Limits must be set in areas in which the patient’s behaviour affects the rights of others. Limiting verbal

abuse of another patient is a priority intervention and particularly relevant when interacting with a patient

diagnosed with antisocial personality disorder. The other concerns should be addressed during therapeutic

encounters.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Safe Effective Care Environment

7. A patient diagnosed with borderline personality disorder has a history of self-mutilation

and suicide attempts. The patient reveals feelings of depression and anger with life. Which type of

medication would the nurse expect to be prescribed?

a. A benzodiazepine

b. A mood-stabilizing medication

c. A monoamine oxidase inhibitor (MAOI)

d. A serotonin norepinephrine reuptake inhibitor (SNRI)

ANS: B

Mood stabilizing medications have been effective for many patients with borderline personality disorder. The use of serotonin norepinephrine reuptake inhibitors (SNRI) or anxiolytics is not supported by data given in the scenario. MAOIs require great diligence in adherence to a restricted diet and are rarely used for patients who are impulsive.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

8. A patient's spouse filed charges after repeatedly being battered. The patient sarcastically

says, "I'm sorry for what I did. I need psychiatric help." Which statement by the patient supports

antisocial personality disorder?

a. "I have a quick temper, but I can usually keep it under control."

b. "I've done some stupid things in my life, but I've learned a lesson."

c. "I'm feeling terrible about the way my behaviour has hurt my family."

d. "I hit because I am tired of being nagged. My spouse deserves the beating."

ANS: D

The patient with antisocial personality disorder often impulsively acts out feelings of anger and feels no guilt or remorse. Patients with antisocial personality disorders rarely seem to learn from experience or feel true remorse. Problems with anger management and impulse control are common.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. What is the priority nursing diagnosis for a patient diagnosed with antisocial personality disorder who has made threats against staff, ripped art off the walls, and thrown objects?

a. Risk for other-directed violence

b. Risk for self-directed violence

c. Impaired social interaction

d. Ineffective denial

ANS: A

Violence against property, along with threats to harm staff, makes this diagnosis the priority. Patients with antisocial personality disorders have impaired social interactions, but the risk for harming others is a higher priority. They direct violence toward others; not self. When patients with antisocial personality disorders use denial, they use it effectively.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

10. When a patient diagnosed with a personality disorder uses manipulation to get needs met, the staff applies limit-setting interventions. What is the correct rationale for this action?

a. It provides an outlet for feelings of anger and frustration.

b. It respects the patient's wishes, so assertiveness will develop.

c. External controls are necessary due to failure of internal control.

d. Anxiety is reduced when staff assumes responsibility for the patient's behaviour.

ANS: C

A lack of internal controls leads to manipulative behaviours such as lying, cheating, conning, and

flattering. To protect the rights of others, external controls must be consistently maintained until the patient is able to behave appropriately.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

11. One month ago, a patient diagnosed with borderline personality disorder and a history of self-mutilation began dialectical behaviour therapy. Today, the patient phones to say, "I feel empty and want to hurt myself." What should the nurse do?

a. Arrange for emergency inpatient hospitalization.

b. Send the patient to the crisis intervention unit for 8 to 12 hours.

c. Assist the patient to choose coping strategies for triggering situations.

d. Advise the patient to take an anti-anxiety medication to decrease the anxiety level.

ANS: C

The patient has responded appropriately to the urge for self-harm by calling a helping individual. A component of dialectical behaviour therapy is telephone access to the therapist for "coaching" during crises. The nurse can assist the patient to choose an alternative to self-mutilation. The need for a protective environment may not be necessary if the patient is able to use cognitive strategies to determine a coping strategy that will reduce the urge to mutilate. Taking a sedative and going to sleep should not be the first-line intervention because sedation may reduce the patient's ability to weigh alternatives to mutilating behaviour.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

12. What is the most challenging nursing intervention with patients diagnosed with personality disorders who use manipulation?

a. Supporting behavioural change

b. Maintaining consistent limits

c. Monitoring suicide attempts

d. Using aversive therapy

ANS: B

Maintaining consistent limits is by far the most difficult intervention because of the patient's superior skills at manipulation. Supporting behavioural change and monitoring patient safety are less difficult tasks. Aversive therapy would probably not be part of the care plan because positive reinforcement strategies for acceptable behaviour seem to be more effective than aversive techniques. See relationship to

audience response question.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

13. The history shows that a newly admitted patient is impulsive. The nurse would expect behaviour to be characterized by which of the following?

a. Adherence to a strict moral code

b. Manipulative, controlling strategies

c. Acting without thought on urges or desires

d. Postponing gratification to an appropriate time

ANS: C

The impulsive individual acts in haste without taking time to consider the consequences of the action. None of the other options describes impulsivity.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. A patient says, "I get in trouble sometimes because I make quick decisions and act on them." Select the nurse's most therapeutic response.

a. "Let's consider the advantages of being able to stop and think before acting."

b. "It sounds as though you've developed some insight into your situation."

c. "I bet you have some interesting stories to share about overreacting."

d. "It's good that you're showing readiness for behavioural change."

ANS: A

The patient is showing openness to learning techniques for impulse control. One technique is to teach the

patient to stop and think before acting impulsively. The patient can then be taught to evaluate outcomes of

possible actions and choose an effective action. The incorrect responses shift the encounter to a social

level or are judgemental.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. A patient diagnosed with borderline personality disorder was hospitalized several times

after self-mutilating episodes. The patient remains impulsive. Which nursing diagnosis is the initial

focus of this therapy?

a. Risk for self-directed violence

b. Impaired skin integrity

c. Risk for injury

d. Powerlessness

ANS: A

Risk for self-mutilation is a nursing diagnosis relating to patient safety needs and is therefore of high

priority. Impaired skin integrity and powerlessness may be appropriate foci for care but are not the

priority related to this therapy. Risk for injury implies accidental injury, which is not the case for the

patient with borderline personality disorder.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

16. Which statement made by a patient diagnosed with borderline personality disorder

indicates the treatment plan is effective?

a. “I think you are the best nurse on the unit.”

b. “I’m never going to get high on drugs again.”

c. “I felt empty and wanted to hurt myself, so I called you.”

d. “I hate my mother. I called her today, and she wasn’t home.”

ANS: C

Seeking a staff member instead of impulsively self-mutilating shows an adaptive coping strategy. The incorrect responses demonstrate idealization, devaluation, and wishful thinking.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:
Evaluation
MSC: Client Needs: Psychosocial Integrity

17. When preparing to interview a patient diagnosed with narcissistic personality disorder, a nurse can anticipate the assessment findings will include which of the following?

a. Preoccupation with minute details; perfectionist
b. Charm, drama, seductiveness; seeking admiration
c. Difficulty being alone; indecisive, submissiveness
d. Grandiosity, self-importance, and a sense of entitlement

ANS: D

The characteristics of grandiosity, self-importance, and entitlement are consistent with narcissistic personality disorder. Charm, drama, seductiveness, and admiration-seeking are seen in patients with histrionic personality disorder. Preoccupation with minute details and perfectionism are seen in individuals with obsessive-compulsive personality disorder. Patients with dependent personality disorder often express difficulty being alone and are indecisive and submissive.

DIF: Cognitive Level: Understand (Comprehension)
TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. For which behaviour would limit setting be most essential?

a. The patient who clings to the nurse and asks for advice about inconsequential matters
b. The patient who is flirtatious and provocative with staff members of the opposite sex
c. The patient who is hypervigilant and refuses to attend unit activities
d. The patient who urges a suspicious patient to hit anyone who stares

ANS: D

This is a manipulative behaviour. Because manipulation violates the rights of others, limit setting is

absolutely necessary. Furthermore, limit setting is necessary in this case because the safety of at least two

other patients is at risk. Limit setting may occasionally be used with dependent behaviour (clinging to the nurse) and histrionic behaviour (flirting with staff members), but other therapeutic techniques are also useful. Limit setting is not needed for a patient who is hypervigilant and refuses to attend unit activities; rather, the need to develop trust is central to patient compliance.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Safe Effective Care Environment

19. Others describe a worker as very shy and lacking in self-confidence. This worker stays

in an office cubicle all day, never coming out for breaks or lunch. Which term best describes this behaviour?

a. Narcissistic

b. Histrionic

c. Avoidant

d. Paranoid

ANS: C

Patients with avoidant personality disorder are timid, socially uncomfortable, withdrawn, and avoid situations in which they might fail. They believe themselves to be inferior and unappealing. Individuals with histrionic personality disorder are seductive, flamboyant, shallow, and attention-seeking. Paranoia and narcissism are not evident.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. What is the priority intervention for a nurse beginning to work with a patient diagnosed

with a schizotypal personality disorder?

a. Respect the patient's need for periods of social isolation.

b. Prevent the patient from violating the nurse's rights.

c. Teach the patient how to select clothing for outings.

d. Engage the patient in community activities.

ANS: A

Patients with schizotypal personality disorder are eccentric and often display perceptual and cognitive distortions. They are suspicious of others and have considerable difficulty trusting. They become highly anxious and frightened in social situations, thus the need to respect their desire for social isolation. Teaching the patient to match clothing is not the priority intervention. Patients with schizotypal personality disorder rarely engage in behaviours that violate the nurse's rights or exploit the nurse.
DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning
MSC: Client Needs: Psychosocial Integrity

21. After gaining new privileges on the unit, a patient diagnosed with borderline personality disorder self-inflicted wrist lacerations. In this case, the self-mutilation may have been due to which of the following?
a. An inherited disorder that manifests itself as an incapacity to tolerate stress
b. Use of projective identification and splitting to bring anxiety to manageable levels
c. A constitutional inability to regulate affect, predisposing to psychic disorganization
d. Fear of abandonment associated with progress toward autonomy and independence
ANS: D
Fear of abandonment is a central theme for most patients with borderline personality disorder. This fear is often exacerbated when patients with borderline personality disorder experience success or growth.
DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Evaluation
MSC: Client Needs: Safe Effective Care Environment

22. A patient diagnosed with borderline personality disorder has self-inflicted wrist lacerations. The health care provider prescribes daily dressing changes. The nurse performing this care should do which of the following?
a. Maintain a stern and authoritarian affect
b. Provide care in a matter-of-fact manner
c. Encourage the patient to express anger
d. Be very rigid and challenging
ANS: B
A matter-of-fact approach does not provide the patient with positive reinforcement for self-mutilation.

The goal of providing emotional consistency is supported by this approach. The distracters provide positive reinforcement of the behaviour or fail to show compassion.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

23. A nurse set limits while interacting with a patient demonstrating behaviours associated with borderline personality disorder. The patient tells the nurse, “You used to care about me. I thought you were wonderful. Now I can see I was wrong. You’re evil.” This outburst can be assessed as which of the following?

a. Denial

b. Splitting

c. Defensive

d. Reaction formation

ANS: B

Splitting involves loving a person, then hating the person because the patient is unable to recognize that an individual can have both positive and negative qualities. Denial is unconsciously motivated refusal to believe something. Reaction formation involves unconsciously doing the opposite of a forbidden impulse.

The scenario does not indicate defensiveness. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. Which characteristic of personality disorders makes it most necessary for staff to schedule frequent team meetings in order to address the patient’s needs and maintain a therapeutic milieu?

a. Ability to achieve true intimacy

b. Flexibility and adaptability to stress

c. Ability to provoke interpersonal conflict

d. Inability to develop trusting relationships

ANS: C

Frequent team meetings are held to counteract the effects of the patient’s attempts to split staff and set

them against one another, causing interpersonal conflict. Patients with personality disorders are inflexible

and demonstrate maladaptive responses to stress. They are usually unable to develop true intimacy with others and are unable to develop trusting relationships. Although problems with trust may exist, it is not the characteristic that requires frequent staff meetings. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

25. Which of the following nursing diagnoses is appropriate to consider for a patient

diagnosed with any of the personality disorders?

a. Noncompliance

b. Impaired social interaction

c. Disturbed personal identity

d. Diversional activity deficit

ANS: B

Without exception, individuals with personality disorders have problems with social interaction with others; hence, the diagnosis of Impaired social interaction. For example, some individuals are suspicious and lack trust, others are avoidant, and still others are manipulative. None of the other diagnoses are universally applicable to patients with personality disorders; each might apply to select clinical diagnoses,

but not to others.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

26. A new psychiatric technician says, “Schizophrenia . . . schizotypal! What’s the

difference?” The nurse’s response should include which information?

a. A patient diagnosed with schizophrenia is not usually overtly psychotic.

b. In schizotypal personality disorder, the patient remains psychotic much longer.

c. With schizotypal personality disorder, the person can be made aware of

misinterpretations of reality.

d. Schizotypal personality disorder causes more frequent and more prolonged

hospitalizations than schizophrenia.

ANS: C

The patient with schizotypal personality disorder might have problems thinking, perceiving, and communicating and might have an odd, eccentric appearance; however, the person can be made aware of misinterpretations, and overtly psychotic symptoms are usually absent. The individual with schizophrenia is more likely to display psychotic symptoms, remain ill for longer periods, and have more frequent and prolonged hospitalizations.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

27. Which personality traits are most likely to be documented regarding a patient demonstrating characteristics of an obsessive-compulsive personality disorder?

a. Affable, generous

b. Perfectionist, inflexible

c. Suspicious, holds grudges

d. Dramatic speech, impulsive

ANS: B

The individual with obsessive-compulsive personality disorder (OCPD) is perfectionist, rigid, preoccupied with rules and procedures, and afraid of making mistakes. The other options refer to behaviours or traits not usually associated with OCPD. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

28. A nurse determines desired outcomes for a patient diagnosed with schizotypal personality disorder. Select the best outcome.

a. The patient will adhere willingly to unit norms.

b. The patient will report decreased incidence of self-mutilative thoughts.

c. The patient will demonstrate fewer attempts at splitting or manipulating staff.

d. The patient will demonstrate the ability to introduce self to a stranger in a social situation.

ANS: D

Schizotypal individuals have poor social skills. Social situations are uncomfortable for them. It is desirable for the individual to develop the ability to meet and socialize with others. Individuals with

schizotypal personality disorder usually have no issues with adherence to unit norms, nor are they self-mutilative or manipulative.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

29. A patient says, “The other nurses won’t give me my medication early, but you know what it’s like to be in pain and don’t let your patients suffer. Could you get me my pill now? I won’t tell anyone.” Which response by the nurse would be most therapeutic?

a. “I’m not comfortable doing that,” and then ignore subsequent requests for early medication.

b. “I understand that you have pain, but giving medicine too soon would not be safe.”

c. “I’ll have to check with your doctor about that; I will get back to you after I do.”

d. “It would be unsafe to give the medicine early; none of us will do that.”

ANS: B

The patient is attempting to manipulate the nurse. Empathetic mirroring reflects back to the patient the nurse’s understanding of the patient’s distress or situation in a neutral manner that does not judge it and helps elicit a more positive response to the limit that is being set. The other options would be nontherapeutic; they lack the empathic mirroring component that tends to elicit a more positive response

from the patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse plans care for an individual diagnosed with antisocial personality disorder. Which characteristic behaviours will the nurse expect? (Select all that apply.)

a. Reclusive behaviour

b. Callous attitude

c. Perfectionism

d. Aggression

e. Clinginess

f. Anxiety

ANS: B, D

Individuals with antisocial personality disorders characteristically demonstrate manipulative, exploitative,

aggressive, callous, and guilt-instilling behaviours. Individuals with antisocial personality disorders are more extroverted than reclusive, rarely show anxiety, and rarely demonstrate clinging or dependent behaviours. Individuals with antisocial personality disorders are more likely to be impulsive than to be perfectionists.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. For which patients diagnosed with personality disorders would a family history of

similar problems be most likely? (Select all that apply.)

a. Obsessive-compulsive

b. Antisocial

c. Borderline

d. Schizotypal

e. Narcissistic

ANS: A, B, C, D

Some personality disorders have evidence of genetic links, so the family history would show other

members with similar traits. Heredity plays a role in schizotypal, antisocial, borderline, and obsessive-compulsive personality disorder.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

Chapter 20: Sleep–Wake Disorders

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A nurse cares for the following four patients. Which patient has the highest risk for problems with sleep physiology?

a. Retiree who volunteers twice a week at Habitat for Humanity

b. Corporate accountant who travels frequently

c. Parent with three teenagers

d. Lawn care worker

ANS: B

The corporate accountant is likely to work long hours and have significant stress associated with work demands. Compounded by travel, these factors are likely to precipitate unstable sleep patterns and inadequate sleep time. The retiree and lawn care worker engage in physical activity during the day, which will promote natural fatigue and sleep. The parent's sleep is unlikely to be disturbed; teenagers sleep through the night.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

2. Which comment is most likely from a patient with chronic sleep deprivation?

a. "I turn on the television every night to get to sleep. I set the timer so it goes off in 30 minutes."

b. "I have diarrhea frequently and not much energy, so I stay at home most of the time."

c. "I sleep only about 5 hours a night, but I know I should sleep 7 or 8 hours."

d. "When my alarm clock goes off every morning, it seems like I am dreaming."

ANS: C

A discrepancy between hours of sleep obtained and hours required leads to sleep deprivation. Adults with

less than 6 hours of sleep per night often suffer from chronic sleep deprivation. Common complaints include poor general health, physical and mental distress, limitations in ADLs, depressive or anxious symptoms, and pain. One distracter indicates a problem with sleep hygiene [television]. The remaining distracters do not indicate a sleep problem.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

3. The nurse provides health education for an adult experiencing sleep deprivation.

Which instruction has the highest priority?

a. “It’s important to limit your driving to short periods. Sleep deprivation increases

your risks for serious accidents.”

b. “Sleep deprivation is usually self-limiting. See your health care provider if it lasts

more than a year.”

c. “Turn the radio on with a soft volume as you prepare for bed each evening. It will

help you relax.”

d. “Three glasses of wine each evening helps many patients who suffer from sleep

deprivation.”

ANS: A

Safety is the highest priority for this patient. Sleep deprivation causes psychomotor deficits. Driver drowsiness and fatigue lead to many automobile injuries and fatalities. Alcohol compounds problems associated with sleep deprivation. Sleep deprivation should be evaluated and treated; a 1-year delay is too

long.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

4. A nurse provides health education for an adult with sleep deprivation. It is most

important for the nurse to encourage caution when the patient engages in which of the following?

a. Using a vacuum cleaner

b. Cooking a meal

c. Driving a car

d. Bathing

ANS: C

Safety is the highest priority for this patient. Sleep deprivation causes psychomotor deficits. Driver drowsiness and fatigue lead to many automobile injuries and fatalities. The distracters are less likely to be associated with serious injury.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

5. A patient needs diagnostic evaluation of sleep problems. Which test will evaluate the patient for possible sleep-related problems?

a. Skull X-rays

b. Electroencephalogram (EEG)

c. Positron emission tomography

d. Single-photon emission computed tomography

ANS: B

EEG measures NREM and REM sleep. The distracters represent ways to diagnose structural and metabolic problems.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

6. A patient says, “It takes me about 15 minutes to go to sleep each night.” Which of the following does this comment describe?

a. Delta sleep

b. Parasomnia

c. Sleep latency

d. Rapid eye movement sleep

ANS: C

Sleep latency refers to the amount of time it takes a person to fall asleep. The distracters represent other phases of the sleep cycle or a sleep disorder.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

7. A person says, “I often feel like I have been dreaming just before I awake in the morning.” Which rationale correctly explains the comment?

a.

Sleep architecture changes during the sleep period, resulting in increased slow-wave sleep at the end of the cycle.

b. Cycles of rapid eye movement sleep increase in the second half of sleep and occupy longer periods.

c. Dreams occur more frequently when a person is experiencing unresolved conflicts or depression.

d. Dream content relates directly to developmental tasks. The person is likely feeling autonomous.

ANS: B

Cycles of rapid eye movement (REM) sleep increase in the second half of sleep and occupy longer periods, up to 1 hour. Dreaming occurs during REM sleep. The question relates to sleep architecture rather than dream content.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

8. Which person would be most likely to experience sleep fragmentation?

a. An obese adult

b. A toddler who attends day care

c. A person diagnosed with mild osteoarthritis

d. An adolescent diagnosed with anorexia nervosa

ANS: A

Obese adults experience more disruption of sleep stages, resulting in fragmentation. Obesity is the leading

factor for obstructive sleep apnea, which causes sleep fragmentation. These changes are also associated

with illness and some medications. The changes are evident on a hypnogram. An adolescent with

anorexia nervosa would have a low body weight and therefore decreased risk for sleep fragmentation.

People with arthritis have pain that may sometimes interrupt sleep, but arthritis would not have as high a

risk as obesity would. Toddlers do not generally experience sleep fragmentation.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

9. A person is prescribed lorazepam (Ativan) 2 mg po bid prn for anxiety. When the

person takes this medication, which change in sleep is anticipated?

a. The patient will have fewer dreams.

b. The patient will have less slow-wave sleep.

c. The patient will experience extended sleep latency.

d. The patient will enter sleep through rapid eye movement (REM) sleep.

ANS: B

Lorazepam is a benzodiazepine, which reduces slow-wave sleep. REM sleep would likely increase.

People with narcolepsy often enter sleep through REM.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

10. A person is prescribed a selective serotonin reuptake inhibitor (SSRI). Which change

in sleep is likely to be secondary to this medication?

a. The patient will have more dreams.

b. The patient will have excessive sleepiness.

c. The patient will have less slow-wave sleep.

d. The patient will have less rapid eye movement (REM) sleep.

ANS: D

A person prescribed a selective SSRI would have suppressed REM sleep as this medication is a serotonergic drug. Dreams would decrease because they occur during REM. Benzodiazepines reduce slow-wave sleep. SSRIs have a side effect of insomnia.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

11. Which season would be most associated with increased periods of wakefulness in the general population?

a. Summer

b. Winter

c. Spring

d. Fall

ANS: A

Circadian drive is associated with physiology. Light is the main exogenous factor that drives wakefulness. Days are longest in summer.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

12. Normally, most people sleep at night. What is the physiological rationale?

a. The master biological clock responds to darkness with sleep.

b. Darkness stimulates histamine release, which promotes sleep.

c. Cooler environmental temperatures stimulate retinal messages.

d. Stimulation of the sympathetic nervous system promotes sleep.

ANS: A

The master biological clock in the suprachiasmatic nucleus (SCN) of the hypothalamus regulates sleep as well as other physiological processes. Darkness cues the clock for sleep. Light cues it for wakefulness. Light stimulates retinal messages. Histamine release is associated with wakefulness. Stimulation of the sympathetic nervous system promotes alertness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

13. A nurse counsels a patient on ways to determine the person's total sleep requirement.

Which instruction would produce the most accurate results?

a. “For 1 full week, record what you remember about your dream content and related feelings as soon as you wake up. Bring the record to your next appointment.”

b. “While off work for 1 week, go to bed at your usual time and wake up without an alarm. Record how many hours you sleep and then average the findings.”

c. “For 2 full weeks, record how much time you sleep each night and rate your daytime alertness on a scale of 1 to 10. Calculate your average alertness score.”

d. “All adults need 7 or 8 hours of sleep to function properly. Let’s design ways to help you reach that goal.”

ANS: B

Sleep requirements are most accurately determined by going to bed at the usual time and waking up without an alarm for several nights, ideally on vacation. The average of these findings indicates the estimated requirements. Two distracters relate to dream content and daytime alertness. Some adults are long sleepers or short sleepers with different requirements for sleep from the general population.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

14. A home care nurse assesses a very demanding patient with chronic obstructive pulmonary disease (COPD). Afterward, the nurse talks with the spouse, who has provided this patient’s care for 6 years. The spouse says, “I don’t need much sleep anymore. I might need to help him during the night.” Select the nurse’s most therapeutic response.

a. “It sounds like you are very devoted to your spouse.”

b. “I noticed you fell asleep while I was assessing your spouse. I’m concerned about you.”

c. “Your spouse is lucky to have you to provide care rather than being placed in a nursing home.”

d. “If you keep going like this, your health will be impaired also. Then who will take care of both of you?”

ANS: B

Sleep deprivation can cause accidents. The correct answer makes an observation, gives important information about safety, and communicates care and compassion for the spouse. The distracters do not invite further dialogue with the spouse.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

15. A patient with rheumatoid arthritis reports, “For the past month I’ve been having a lot of trouble falling asleep. When I finally get to sleep, I wake up several times during the night.” Which information should the nurse seek initially?

a. “What have you done to try to improve your sleep?”

b. “What would be a good sleep pattern for you?”

c. “How much exercise are you getting?”

d. “Do you have pain at night?”

ANS: D

Patients with diseases such as arthritis may have sleep disturbance related to nightly pain. Because the pain is chronic, the patient may fail to realize it is the reason for the inability to sleep. The other options do not follow the patient’s lead or begin problem solving without an adequate baseline.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

16. A 76-year-old man tells the nurse at the sleep disorder clinic, “I awaken almost nightly in the midst of violent dreams in which I am defending myself against multiple attackers. Then I realize I have been hitting and kicking my wife. She has bruises.” Which health problem is most likely?

a. Sleep paralysis

b. Night terror disorder

c. Sleep-related bruxism

d. Rapid eye movement (REM) sleep behaviour disorder

ANS: D

The scenario describes REM sleep behaviour disorder, in which the patient engages in violent and complex behaviours during REM sleep as though acting out his dreams. Older men have a higher

incidence of this problem. Sleep paralysis refers to the sudden inability to perform voluntary movement either at sleep onset or on awakening from sleep. Bruxism refers to grinding teeth during stage 2 sleep. Night terror disorder occurs as arousal in the first third of the night during non-REM sleep, accompanied by feelings of panic.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

17. A patient reports, “Nearly every night I awaken feeling frightened after a bad dream. The dream usually involves being hunted by people trying to hurt me. It usually happens between 4 and 5 a.m.” The nurse assesses this disorder as most consistent with criteria for which problem?

a. Sleep deprivation

b. Nightmare disorder

c. Night terror disorder

d. REM sleep behaviour disorder

ANS: B

Nightmares are long, frightening dreams from which people awaken in a frightened state. They occur during REM sleep late in the night. Night terror disorder occurs as arousal in the first third of the night during non-REM sleep and is accompanied by feelings of panic. REM sleep behaviour disorder involves acting out a violent dream during REM sleep. Nightmare disorder may lead to sleep deprivation.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. A nurse who works night shift says, “I am exhausted most of the time. I sleep through my alarm. Sometimes my brain does not seem to work right. I am worried that I might make a practice error.” Which question should the nursing supervisor ask first?

a. “What stress are you experiencing in your life?”

b. “How much sleep do you get in a 24-hour period?”

c. “Would it help if you do some exercises just before going to bed?”

d. “Have you considered using a hypnotic medication to help you sleep?”

ANS: B

Total sleep hours should be ascertained before seeking to correct a sleep disorder. In this case, the nurse

describes sleep deprivation symptoms rather than a sleep disorder. The correct response is the only option

that addresses total sleep hours.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

19. A patient reports, “The medicine prescribed to help me get to sleep worked well for

about a month, but I don’t have any more of those pills, and now my insomnia is worse than ever.

I had nightmares the last 2 nights.” Which type of medication did the health care provider most

likely prescribe?

a. Hypnotic

b. Tricyclic antidepressant

c. Conventional antipsychotic

d. Central nervous system stimulant

ANS: A

Hypnotics can worsen existing sleep disturbances when they induce drug-dependency insomnia. Once the

drug is discontinued, the individual may have rebound insomnia and nightmares. CNS stimulants worsen

insomnia while they are in use. Tricyclic antidepressants and atypical antipsychotics may help insomnia

but would not be used for initial therapy.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Evaluation MSC: Client Needs: Physiological Integrity

20. A patient experiencing primary insomnia says she takes a nap during the day and

asks the nurse, “Doesn’t that make up for a lost night’s sleep?” Select the nurse’s best reply.

a. “Circadian drives give daytime naps a structure different from nighttime sleep.”

b. “The body clock operates on a 24-hour cycle, making nap effectiveness

unpredictable.”

c. “It is a matter of habit and expectation. We expect to be more refreshed from a

night’s sleep.”

d. “Sleep restores homeostasis but works more efficiently when aided by melatonin

secreted at night."

ANS: A

Regular sleep cycles occur with nighttime sleep, with progression through two distinct physiological states: four stages of non-rapid eye movement and a period of REM sleep. Naps often contain different amounts of REM sleep, thus changing the physiology of sleep as well as the psychological and behavioural effects of sleep.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

21. A patient tells the nurse, "Everyone says we should sleep 8 hours a night. I can only sleep 6 hours, no matter how hard I try. Am I doing harm to my body?" Select the nurse's best response.

a. "Tell me about strategies you have tried to increase your total sleep hours."

b. "Lack of sleep acts as a stressor on the body and can cause physical changes."

c. "If you have really tried to sleep more, maybe you should consult your health care provider."

d. "If you function well with 6 hours of sleep, you are a short sleeper. That's normal for some people."

ANS: D

Some individuals require less sleep than others do. Those who need less are called short sleepers (less than 5 hours per night), while long sleepers require 10 or more hours of sleep per night. The distracters do not provide information the patient is seeking or are untrue.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

22. A patient says, "I have trouble falling asleep at night and might lie awake until 3 or 4 a.m. before falling sleep." Which medication would the nurse expect a health care provider to prescribe for this patient?

a. Triazolam

b. Flurazepam (Dalmane)

c. Risperidone (Risperdal)

d. Methylphenidate (Ritalin)

ANS: A

Triazolam is a benzodiazepine that has a short duration of action and is often prescribed for patients with insomnia. Methylphenidate is a central nervous system stimulant. Flurazepam is a long-acting hypnotic that will produce hangover drowsiness during the next day. Risperidone is an antipsychotic and not likely to be useful in this scenario. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

23. A young adult says to the nurse, "I go to sleep without any problem, but I often wake up during the night because it feels like there are rubber bands in my legs." Which assessment question should the nurse ask to assess for restless legs syndrome (RLS)?

a. "What type of birth control do you use?"

b. "How much caffeine do you use every day?"

c. "How much exercise do you get in a typical day?"

d. "Is the sensation relieved by stretching or flexing your legs?"

ANS: D

RLS is a sensory and movement disorder characterized by an unpleasant, uncomfortable sensation in the legs accompanied by an urge to move. Symptoms begin or worsen during periods of inactivity, such as sleep and are relieved or reduced by physical activity such as walking, stretching, or flexing. Therefore, assessing whether or not this occurs for the young adult will offer the nurse further indication of restless legs syndrome. Symptoms can have a significant impact on the individual's ability to fall asleep and stay asleep.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

MULTIPLE RESPONSE

1. Which neurotransmitters are most responsible for wakefulness? (Select all that apply.)

a. Gamma-aminobutyric acid (GABA)

b. Norepinephrine

c. Acetylcholine

d. Dopamine

e. Galanin

ANS: B, C, D

GABA and galanin are sleep-promoting neurotransmitters.

DIF: Cognitive Level: Remember (Knowledge)

TOP: Nursing Process: N/A

MSC: Client Needs: Health Promotion and Maintenance

2. A night shift worker reports, "I'm having trouble getting to sleep after a night's work. I have a hearty breakfast with coffee, read the paper, do my exercises, and then go to bed. However, I just lie awake until it is nearly time to get up to be with my family for dinner." What changes should the nurse suggest? (Select all that apply.)

a. Drink juice with breakfast rather than coffee.

b. Exercise after awakening rather than before.

c. Turn on the television when going to bed.

d. Do not read the paper.

e. Eat a light breakfast.

ANS: A, B, E

Sleep can be disrupted by caffeine (a central nervous system stimulant), exercise performed just before trying to sleep, and a heavy meal before retiring. Reading the newspaper is not likely to be so stimulating that it disrupts the patient's ability to sleep. Television will be disruptive to sleep.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

3. A new patient at the sleep disorders clinic tells the nurse, "I have not slept well in a year, so I never feel good. I do not expect things will ever improve or be any different." Which of the following interventions should the nurse consider doing? (Select all that apply.)

a. Suggest using alcohol as a sedative

b. Provide instruction in relaxation techniques

c. Counsel the patient to address cognitive distortions

d. Teach the patient about factors that influence sleep

e. Teach fatigue-producing activities to become overtired

f. Encourage long, daytime naps to compensate for sleep deprivation

ANS: B, C, D

Interventions that could be helpful include teaching relaxation techniques, such as meditation or progressive relaxation, to relieve the tension that sometimes prevents initiation of sleep. Reviewing factors that influence sleep can assist the patient to diagnose and remove barriers to sleep. Cognitive therapy could be helpful in combating the hopelessness verbalized by the patient. Alcohol consumption actually disrupts sleep. Becoming overtired may be a barrier to nighttime sleep. Naps may help replace lost sleep, but lengthy daytime sleep will prevent the patient from sleeping well at night.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

Chapter 21: Crisis and Disaster

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient comes to the crisis clinic after an unexpected job termination. The patient paces around the room sobbing, cringes when approached, and responds to questions with only shrugs or monosyllables. Choose the nurse's best initial comment to this patient.

a. "Everything is going to be all right. You are here at the clinic, and the staff will keep you safe."

b. "I see you are feeling upset. I'm going to stay and talk with you to help you feel better."

c. "You need to try to stop crying and pacing so we can talk about your problems."

d. “Let’s set some guidelines and goals for your visit here.”

ANS: B

This patient is experiencing a crisis. The two primary thrusts of crisis intervention are to provide for the safety of the individual and to use anxiety-reduction techniques to facilitate use of inner resources. The nurse offers therapeutic presence, which provides caring, ongoing observation relative to the patient’s safety, and interpersonal reassurance.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A patient being seen in the clinic for superficial cuts on both wrists is pacing and sobbing. After a few minutes, the patient is calmer. The nurse attempts to determine the patient’s perception of the precipitating event by saying which of the following?

a. “Tell me why you were crying.”

b. “How did your wrists get injured?”

c. “How can I help you feel more comfortable?”

d. “What was happening just before you started to feel this way?”

ANS: D

A clear definition of the immediate problem provides the best opportunity to find a solution. Asking about recent upsetting events permits assessment of the precipitating event. “Why” questions are nontherapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A patient comes to the crisis centre saying, “I’m in a terrible situation. I don’t know what to do.” The triage nurse can initially assume that the patient is which of the following?

a. Suicidal

b. Anxious and fearful

c. Misperceiving reality

d. Potentially homicidal

ANS: B

Individuals in crisis are universally anxious. They are often frightened and may be mildly confused. Perceptions are often narrowed with anxiety.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

4. An adolescent comes to the crisis clinic and reports sexual abuse by an uncle. The adolescent told both parents about the uncle's behaviour, but the parents did not believe the adolescent. What type of crisis exists?

a. Maturational

b. Adventitious

c. Situational

d. Organic

ANS: B

An adventitious crisis is a crisis of disaster that is not a part of everyday life. It is unplanned or accidental. Adventitious crises include natural disasters and crimes of violence. Sexual molestation falls within this classification. A maturational crisis occurs as an individual arrives at a new stage of development and old coping styles become ineffective. A situational crisis arises from an external source such as a job loss, divorce, or other loss affecting self-concept or self-esteem. Organic is not a type of crisis.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. While conducting the initial interview with a patient in crisis, the nurse should do which of the following?

a. Listen carefully and summarize often

b. Convey a sense of urgency to the patient

c. Be forthright about time limits of the interview

d. Let the patient know the nurse controls the interview

ANS: A

Severe anxiety narrows perceptions and concentration. The nurse should listen carefully and summarize what the patient is saying to ensure correct meaning. Conveying urgency will increase the patient's

anxiety. Letting the patient know who controls the interview or stating that time is limited is nontherapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

6. An adult seeks counselling after the spouse was murdered. The adult angrily says, "I hate the beast that did this. It has ruined my life. During the trial, I don't know what I'll do if the jury doesn't return a guilty verdict." What is the nurse's highest priority response?

a. "Would you like to talk to a psychiatrist about some medication to help you cope during the trial?"

b. "What resources do you need to help you cope with this situation?"

c. "Do you have enough support from your family and friends?"

d. "Are you having thoughts of hurting yourself or others?"

ANS: D

The highest nursing priority is safety. The nurse should assess suicidal and homicidal potential. The distracters are options, but the highest priority is safety.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. Six months ago, a woman had a prophylactic double mastectomy because of a family history of breast cancer. One week ago, this woman learned her husband was involved in an extramarital affair. The woman tearfully says to the nurse, "What else can happen?" What type of crisis is this person experiencing?

a. Maturational

b. Adventitious

c. Situational

d. Recurring

ANS: C

A situational crisis arises from an external source and involves a loss of self-concept or self-esteem. An adventitious crisis is a crisis of disaster, such as a natural disaster or crime of violence. A maturational

crisis occurs as an individual arrives at a new stage of development, when old coping styles may be ineffective. No classification of a recurring crisis exists.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A woman said, “I can’t take anymore! Last year my husband had an affair, and now we don’t communicate. Three months ago, I found a lump in my breast. Yesterday my daughter said she’s quitting college.” What is the nurse’s priority assessment?

a. Identify measures useful to help improve the couple’s communication.

b. The patient’s feelings about the possibility of having a mastectomy

c. Whether the husband is still engaged in an extramarital affair

d. Clarify what the patient means by “I can’t take anymore.”

ANS: D

During crisis intervention, the priority concern is patient safety. This question helps assess personal coping skills. The other options are incorrect because the focus of crisis intervention is on the event that occurred immediately before the patient sought help.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. Six months ago, a woman had a prophylactic double mastectomy because of a family history of breast cancer. One week ago, this woman learned her husband was involved in an extramarital affair. The woman tearfully says, “What else can happen?” If the woman’s immediate family is unable to provide sufficient support, which of the following should the nurse do?

a. Suggest hospitalization for a short period

b. Ask what other relatives or friends are available for support

c. Tell the patient, “You are a strong person. You can get through this crisis”

d. Foster insight by relating the present situation to earlier situations involving loss

ANS: B

The assessment of situational supports should continue. Even though the patient’s nuclear family may not

be supportive, other situational supports may be available. If they are adequate, admission to an inpatient

unit will be unnecessary. Psychotherapy is not appropriate for crisis intervention. Advice is usually

nontherapeutic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

10. A woman says, “I can’t take anymore. Last year my husband had an affair, and now

we do not communicate. Three months ago, I found a lump in my breast. Yesterday my daughter

said she’s quitting college and moving in with her boyfriend.” Which issue should the nurse

focus on during crisis intervention?

a. The possible mastectomy

b. The disordered family communication

c. The effects of the husband’s extramarital affair

d. Coping with the reaction to the daughter’s events

ANS: D

The focus of crisis intervention is on the most recent problem: “the straw that broke the camel’s back.”

The patient had coped with the breast lesion, the husband’s infidelity, and the disordered communication.

Disequilibrium occurred only with the introduction of the daughter leaving college and moving.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

11. A patient who is visiting the crisis clinic for the first time asks, “How long will I be

coming here?” The nurse’s reply should consider that the usual duration of crisis intervention is

how long?

a. 1 to 2 weeks

b. 3 to 4 weeks

c. 4 to 6 weeks

d. 6 to 8 weeks

ANS: C

The disorganization associated with crisis is so distressing that it usually cannot be tolerated for more than

4 to 6 weeks. If it is not resolved by that time, the individual usually adopts dysfunctional behaviours that reduce anxiety without solving the problem. Crisis intervention can shorten the duration.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

12. A student falsely accused a college professor of sexual intimidation. The professor

tells the nurse, “I cannot teach nor do any research. My mind is totally preoccupied with these

false accusations.” What is the priority nursing diagnosis?

a. Ineffective denial related to threats to professional identity

b. Deficient knowledge related to sexual harassment protocols

c. Impaired social interaction related to loss of teaching abilities

d. Ineffective role performance related to distress from false accusations

ANS: D

This nursing diagnosis is the priority because it reflects the consequences of the precipitating event associated with the professor’s crisis. There is no evidence of denial. Deficient knowledge may apply, but it is not the priority. Data are not present to diagnose impaired social interaction.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

13. Which communication technique will the nurse use more in crisis intervention than

in traditional counselling?

a. Role modeling

b. Giving direction

c. Information giving

d. Empathic listening

ANS: B

The nurse working in crisis intervention must be creative and flexible in looking at the patient’s situation and suggesting possible solutions to the patient. Giving direction is part of the active role a crisis

intervention therapist takes. The other options are used equally in crisis intervention and traditional counselling roles.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

14. Which situation demonstrates use of primary care related to crisis intervention?

a. Implementation of suicide precautions for a depressed patient

b. Teaching stress reduction techniques to a first-year college student

c. Assessing coping strategies used by a patient who attempted suicide

d. Referring a patient with schizophrenia to a partial hospitalization program

ANS: B

Primary care-related crisis intervention promotes mental health and reduces mental illness. The incorrect options are examples of secondary or tertiary care.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

15. A victim of spousal violence comes to the crisis centre seeking help. Which of the following crisis intervention strategy will be the nurse's focus?

a. Supporting emotional security and re-establishing equilibrium

b. Long-term resolution of issues precipitating the crisis

c. Promoting growth of the individual

d. Providing legal assistance

ANS: A

Strategies of crisis intervention address the immediate cause of the crisis and restoration of emotional security and equilibrium. The goal is to return the individual to the pre-crisis level of function. Crisis intervention is, by definition, short term. The correct response is the most global answer. Promoting growth is a focus of long-term therapy. Providing legal assistance might or might not be applicable.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

16. After celebrating their fortieth birthday, an individual becomes concerned with the loss of their youthful appearance. What type of crisis has occurred?

a. Reactive

b. Situational

c. Maturational

d. Adventitious

ANS: C

Maturational crises occur when a person arrives at a new stage of development and finds that old coping styles are ineffective but has not yet developed new strategies. Situational crises arise from sources external to the individual, such as divorce and job loss. There is no classification called reactive. Adventitious crises occur when calamities, such as natural disasters (e.g., floods, hurricanes), war, or violent crimes, disrupt coping.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance

17. Which scenario is an example of an adventitious crisis?

a. The death of a child from sudden infant death syndrome

b. Being fired from a job because of company downsizing

c. Retirement of a 55-year-old person

d. A riot at a rock concert

ANS: D

The rock concert riot is unplanned, accidental, violent, and not a part of everyday life. The incorrect options are examples of situational or maturational crises.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. Which agency plays a major role in mass disaster planning and prevention?

a. National Emergency Response System

b. Provincial or territorial disaster management agencies

c. National Incident Management System

d. Federal Emergency Management Agency

ANS: A

The Canadian National Emergency Response System plays a major role in mass disaster planning and prevention. The National Incident Management System is a US based organization.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

19. During the initial interview at the crisis centre, a patient says, “I’ve been served with divorce papers. I’m so upset and anxious that I can’t think clearly.” Which comment should the nurse use to assess personal coping skills?

a. “In the past, how have you handled difficult or stressful situations?”

b. “What would you like us to do to help you feel more relaxed?”

c. “Tell me more about how it feels to be anxious and upset.”

d. “Can you describe your role in the marital relationship?”

ANS: A

The correct answer is the only option that assesses coping skills. The incorrect options are concerned with self-esteem, ask the patient to decide on treatment at a time when he or she cannot think clearly, and seek to explore issues tangential to the crisis.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment

20. An adult has cared for a debilitated parent for 10 years. The parent’s condition recently declined, and the health care provider recommended placement in a nursing home. The adult says, “I’ve always been able to care for my parents. Nursing home placement goes against everything I believe.” Successful resolution of this person’s crisis will most closely relate to which of the following?

a. Resolving the feelings associated with the threat to the person’s self-concept

b. Ability of the person to identify situational supports in the community

c. Reliance on assistance from role models within the person’s culture

d. Mobilization of automatic relief behaviours by the person

ANS: A

The patient's crisis clearly relates to a loss of (or threatened change in) self-concept. Her capacity to care for her parents, regardless of the deteriorating condition, has been challenged. Crisis resolution will involve coming to terms with the feelings associated with this loss. As in all crises, the stressful event involves loss or change that threatens the person's self-concept, self-esteem, and sense of security.

Identifying situational supports is relevant, but less so than coming to terms with the threat to self-concept. Reliance on lessons from role models can be helpful but is not the primary factor associated with

resolution in this case. Automatic relief behaviours will not be helpful; these are part of the fourth phase of crisis.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

21. The principle most useful to a nurse planning crisis intervention for any patient is which of the following?

a. That the patient is experiencing a state of disequilibrium

b. That the patient is experiencing a type of mental illness

c. That the patient poses a threat of violence to others

d. That the patient has high potential for self-injury

ANS: A

Disequilibrium is the only universally true answer for all patients in crisis. A crisis represents a struggle for equilibrium when problems seem unsolvable. Crisis does not reflect mental illness. Potential for self-violence or other-directed violence may or may not be a factor in crisis.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

22. A nurse assesses a patient in crisis. Select the most appropriate question for the nurse to ask to assess this patient's situational support.

a. "Has anything upsetting occurred in the past few days?"

b. "Who can be helpful to you during this time?"

c. "How does this problem affect your life?"

d. "What led you to seek help at this time?"

ANS: B

Only the correct answer focuses on situational support. The incorrect options focus on the patient's perception of the precipitating event.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

23. An adult comes to the crisis clinic after termination from a job of 15 years. The patient says, "I don't know what to do. How can I get another job? Who will pay the bills? How will I feed my family?" Which nursing diagnosis applies?

a. Hopelessness

b. Powerlessness

c. Chronic low self-esteem

d. Disturbed thought processes

ANS: B

The patient describes feelings of lack of control over life events. No direct mention is made of hopelessness or chronic low self-esteem. The patient's thought processes are not altered at this point.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

24. A patient that has recently survived a plane crash has returned to work and reports being able to sleep well at night. The nurse meets with the patient once a month to provide ongoing support and encouragement. Which type of crisis intervention is the nurse performing?

a. Primary

b. Secondary

c. Tertiary

d. Critical incident stress debriefing

ANS: C

Tertiary care provides support for those who have experienced a severe crisis and are now recovering from a disabling mental state. Primary goals are to facilitate optimal levels of functioning and prevent further emotional disruptions.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

25. At the last contracted visit in the crisis intervention clinic, an adult says, "I've emerged from this a stronger person. You helped me get my life back in balance." The nurse responds, "I think we should have two more sessions to explore why your reactions were so intense." Which analysis applies?

a. The patient is experiencing transference.

b. The patient demonstrates need for continuing support.

c. The nurse is having difficulty terminating the relationship.

d. The nurse is empathizing with the patient's feelings of dependency.

ANS: C

The nurse's remark is clearly an invitation to work on other problems and prolong contact with the patient. The focus of crisis intervention is the problem that precipitated the crisis, not other issues. The scenario does not describe transference. The patient shows no need for continuing support. The scenario does not describe dependency needs.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

26. Which health care worker should be referred for critical incident stress debriefing?

a. A nurse who works at an oncology clinic where patients receive chemotherapy

b. A case manager whose patients have serious mental illness and are cared for at home

c. A health care employee who worked 12 hours at the information desk of a critical

care unit

d. An emergency medical technician (EMT) who treated victims of a car bombing at a

mall

ANS: D

Although each of the individuals mentioned experience job-related stress on a daily basis, the person most

in need of critical incident stress debriefing is the EMT, who experienced an adventitious crisis event by

responding to a bombing and provided care to trauma victims.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse driving home after work comes upon a serious automobile accident. The

driver gets out of the car with no apparent physical injuries. Which assessment findings would

the nurse expect from the driver immediately after this event? (Select all that apply.)

a. Difficulty using a cell phone

b. Long-term memory losses

c. Fecal incontinence

d. Rapid speech

e. Trembling

ANS: A, D, E

Signs and symptoms may include denial, exaggerated startle response, flashbacks, horror, hypervigilance,

intrusive thoughts and dreams, panic attacks, feeling numb, substance abuse, confusion, and incoherence.

Immediate responses to crisis commonly include shock, and the person may have difficulty using a cell

phone, be talking fast and incoherently, and be shaking or trembling. Incontinence and long-term memory

losses would not be expected.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which are characteristics of a mental health emergency? (Select all that apply.)

a. Self-care limitations

b. Depression

c. Effective coping strategies

d. Behavioural disturbances

e. Collective self-efficacy

ANS: A, B, D

A mental health emergency is a state of overwhelming anxiety that can lead to serious personality disorganization, depression, confusion, and behavioural disturbances. In a mental health emergency, there are urgent issues of safety, potentially because of risk for self-care limitations (e.g., lack of nutrition, exposure to physical risks), self-harm behaviour (e.g., substance abuse, risk of suicide), or violence against others.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

Chapter 22: Suicide and Nonsuicidal Self-Injury

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. An adult outpatient diagnosed with major depression has a history of several suicide attempts by overdose. Given this patient's history and diagnosis, which antidepressant medication would the nurse expect to be prescribed?

a. Amitriptyline (Elavil), a sedating tricyclic medication

b. Fluoxetine (Prozac), a selective serotonin reuptake inhibitor

c. Desipramine (Norpramin), a stimulating tricyclic medication

d. Tranylcypromine sulfate (Parnate), a monoamine oxidase inhibitor

ANS: B

Selective serotonin reuptake inhibitor antidepressants (SSRIs) are very safe in overdose situations, which

is not true of the other medications listed. Lethal overdose is nearly impossible with SSRIs. Given this patient's history of overdosing, it is important that the medication be as safe as possible in case she takes

an overdose of her prescribed medication.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

2. Four individuals have given information about their suicide plans. Which plan

evidences the highest suicide risk?

a. Turning on the oven and letting gas escape into the apartment during the night

b. Cutting the wrists in the bathroom while the spouse reads in the next room

c. Overdosing on aspirin with codeine while the spouse is out with friends

d. Shooting in the head with a firearm that spouse keeps in the bedroom

ANS: D

This is a highly lethal method with little opportunity for rescue. A risk factor for suicide is easy access to firearms. The other options are lower lethality methods with higher rescue potential.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which measure would be considered a form of primary intervention for suicide?

a. Psychiatric hospitalization of a suicidal patient

b. Referral of a formerly suicidal patient to a support group

c. Suicide precautions for 24 hours for newly admitted patients

d. Helping school children learn to manage stress and be resilient

ANS: D

This measure promotes effective coping and reduces the likelihood that such children will become suicidal later in life. Admissions and suicide precautions are secondary intervention measures. Support group referral is a tertiary prevention measure.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

4. Which change in the brain's biochemical function is most associated with suicidal

behaviour?

a. Dopamine excess

b. Serotonin deficiency

c. Acetylcholine excess

d. Gamma-aminobutyric acid deficiency

ANS: B

Research suggests that low levels of serotonin may play a role in the decision to commit suicide. Evidence suggests a potentially causal association between suicidal behaviour and the serotonin neurotransmission system. The other neurotransmitter alterations have not been implicated in suicidality.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

5. A college student who failed two tests cried for hours and then tried to telephone a parent but got no answer. The student then gave several expensive sweaters to a roommate and asked to be left alone for a few hours. Which behaviour provides the strongest clue of an impending suicide attempt?

a. Calling parents

b. Excessive crying

c. Remaining in a dorm room alone

d. Giving away sweaters to her roommate.

ANS: D

A behaviour such as giving away prized objects possibly indicates she is considering suicide. Calling parents, remaining in a dorm, and crying do not provide direct clues to suicide.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. A nurse uses the SAD PERSONS scale to interview a patient. This tool provides data relevant to which of the following?

a. Current stress level

b. Mood disturbance

c. Suicide potential

d. Level of anxiety

ANS: C

The SAD PERSONS tool evaluates 10 major risk factors in suicide potential: sex, age, depression, previous attempt, ethanol use, rational thinking loss, social supports lacking, organized plan, no spouse, and sickness. The tool does not have categories to provide information on the other options listed.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. A person intentionally overdosed on antidepressants. Which nursing diagnosis has the highest priority?

a. Powerlessness

b. Social isolation

c. Risk for suicide

d. Compromised family coping

ANS: C

This diagnosis is the only one with life-or-death ramifications and is therefore of higher priority than the other options.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

8. A person who attempted suicide by overdose was treated in the emergency department and then hospitalized. The initial outcome is that the patient will do which of the following?

a. Verbalize a will to live by the end of the second hospital day

b. Describe two new coping mechanisms by the end of the third hospital day

c. Accurately delineate personal strengths by the end of the first week of hospitalization

d. Refrain from attempts to harm self for 24 hours

ANS: D

Having the patient refrain from attempts to self-harm most directly addresses the priority problem of risk

for self-directed violence. The other outcomes are related to hope, coping, and self-esteem.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

9. A college student who attempted suicide by overdose was hospitalized. When the

parents were contacted, they responded, “We should have seen this coming. We did not do

enough.” The parents’ reaction reflects which of the following?

a. Guilt

b. Denial

c. Shame

d. Rescue feelings

ANS: A

The parents’ statements indicate guilt. Guilt is evident from the parents’ self-chastisement. The feelings

suggested in the distracters are not clearly described in the scenario.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

10. Select the most critical question for the nurse to ask an adolescent who has

threatened to take an overdose of pills.

a. “Why do you want to kill yourself?”

b. “Do you have access to medications?”

c. “Have you been taking drugs and alcohol?”

d. “Did something happen with your parents?”

ANS: B

The nurse must assess the patient’s access to a means to carry out the plan and, if there is access, alert the

parents to remove the means from the home and take additional actions to assure the patient’s safety. The

information in the other questions may be important to ask but are not the most critical.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe Effective Care Environment

11. It has been 3 days since a suicidal patient was hospitalized and prescribed an antidepressant medication. The patient is now more talkative and shows increased energy. Select the highest priority nursing intervention.

a. Supervise the patient 24 hours a day.

b. Begin discharge planning for the patient.

c. Refer the patient to art and music therapists.

d. Consider discontinuation of suicide precautions.

ANS: A

The patient now has more energy and may have decided on suicide, especially given the prior suicide attempt history. The patient must be supervised 24 hours per day. The patient is still a suicide risk.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe Effective Care Environment

12. What is the key element when the nurse is providing follow-up counselling to a patient who has been discharged to home following a suicide attempt?

a. Maintain 24-hour observation.

b. Administer antidepressant medication as ordered.

c. Establish a working alliance to encourage realistic problem solving.

d. Offer solutions to problems related to the stigma associated with a suicide attempt.

ANS: C

The key element is establishing a working alliance to encourage the patient to engage in more realistic problem solving. Helpful staff characteristics include warmth, sensitivity, interest, and consistency.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

13. A tearful, anxious patient at the outpatient clinic reports, “I should be dead.” The initial task of the nurse conducting the assessment interview is to do which of the following?

a. Assess lethality of suicide plan

b. Encourage expression of anger

c. Establish rapport with the patient

d. Determine risk factors for suicide

ANS: C

The foundation of any intervention for suicide or suicidal behaviours is establishing a therapeutic relationship. Understanding and appreciating clients' unique situations and treating individuals with respect and openness are essential. Establishing rapport facilitates a therapeutic alliance that will allow the nurse to obtain relevant assessment data such as the presence of a suicide plan, lethality of any plan, and the presence of risk factors for suicide.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

14. A nurse interacts with an outpatient who has a history of multiple suicide attempts.

Select the most helpful response for a nurse to make when the patient states, "I am considering committing suicide."

a. "I'm glad you shared this. Please do not worry. We will handle it together."

b. "I think you should admit yourself to the hospital to keep you safe."

c. "Bringing up these feelings is a very positive action on your part."

d. "We need to talk about the good things you have to live for."

ANS: C

The correct response gives the patient reinforcement, recognition, and validation for making a positive response rather than acting out the suicidal impulse. It gives neither advice nor false reassurance, and it does not imply stereotypes such as "You have a lot to live for." It uses the patient's ambivalence and sets the stage for more realistic problem solving.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. Which intervention will the nurse recommend for the distressed family and friends of someone who has committed suicide?

a. Participating in reminiscence therapy

b. Psychological postmortem assessment

c. Attending a self-help group for survivors

d. Contracting for at least two sessions of group therapy

ANS: C

Survivors need outlets for their feelings about the loss of the deceased person. Self-help groups provide peer support while survivors work through feelings of loss, anger, and guilt. Psychological postmortem assessment would not provide the support necessary to work through feelings of loss associated with the suicide. Reminiscence therapy is not geared to loss resolution. Contracting for two sessions of group therapy would not provide sufficient time to work through the issues associated with a death by suicide.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

16. Which statement provides the best rationale for closely monitoring a severely depressed patient during antidepressant medication therapy?

a. As depression lifts, physical energy becomes available to carry out suicide.

b. Patients who previously had suicidal thoughts need to discuss their feelings.

c. For most patients, antidepressant medication results in increased suicidal thinking.

d. Suicide is an impulsive act. Antidepressant medication does not alter impulsivity.

ANS: A

Antidepressant medication has the objective of relieving depression. Risk for suicide is greater with dramatic mood changes, primarily because the patient has more physical energy at a time when he or she may still have suicidal ideation. The other options have little to do with nursing interventions relating to antidepressant medication therapy.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

17. A nurse assesses a patient who reports a 3-week history of depression and periods of uncontrolled crying. The patient says, “My business is bankrupt, and I was served with divorce papers.” Which subsequent statement by the patient alerts the nurse to a concealed suicidal message?

a. “I wish I were dead.”

b. “Life is not worth living.”

c. “I have a plan that will fix everything.”

d. “My family will be better off without me.”

ANS: C

Verbal clues to suicide may be overt or covert. The incorrect options are overt references to suicide. The correct option is more veiled. It alludes to the patient’s suicide as being a way to “fix everything” but does not say it outright.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. A depressed patient says, “Nothing matters anymore.” What is the most appropriate response by the nurse?

a. “Are you having thoughts of suicide?”

b. “I am not sure I understand what you are trying to say.”

c. “Try to stay hopeful. Things have a way of working out.”

d. “Tell me more about what interested you before you became depressed.”

ANS: A

The nurse must make overt what is covert; that is, the possibility of suicide must be openly addressed. The patient often feels relieved to be able to talk about suicidal ideation.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

19. A nurse counsels a patient with recent suicidal ideation. Which is the nurse’s most therapeutic comment?

a. “Let’s make a list of all your problems and think of solutions for each one.”

b. “I’m happy you’re taking control of your problems and trying to find solutions.”

c. “When you have bad feelings, try to focus on positive experiences from your life.”

d. “Let’s consider which problems are very important and which are less important.”

ANS: D

The nurse helps the patient develop effective coping skills. Assist the patient to reduce the overwhelming

effects of problems by prioritizing them. Talking openly leads to a decrease in isolation and can increase problem-solving alternatives for living. The incorrect options continue to present overwhelming approaches to problem solving.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

20. When assessing a patient’s plan for suicide, what aspect has priority?

a. Patient’s financial and educational status

b. Patient’s insight into suicidal motivation

c. Availability of means and lethality of method

d. Quality and availability of patient’s social support

ANS: C

If a person has plans that include choosing a readily available method of suicide and if the method is one that is lethal (i.e., will cause the person to die with little probability for intervention), the suicide risk is high. These areas provide a better indication of risk than the areas mentioned in the other options. See relationship to audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe Effective Care Environment

21. The feeling experienced by a patient that should be assessed by the nurse as most predictive of elevated suicide risk is:

a. Hopelessness

b. Sadness

c. Elation

d. Anger

ANS: A

Of the feelings listed, hopelessness is most closely associated with increased suicide risk. Depression, aggression, impulsivity, and shame are other feelings noted as risk factors for suicide.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. Which statement by a depressed patient will alert the nurse to the patient's need for immediate, active intervention?

a. "I am mixed up, but I know I need help."

b. "I have no one to turn to for help or support."

c. "It is worse when you are a person of colour."

d. "I tried to get attention before I cut myself last time."

ANS: B

Hopelessness is evident. Lack of social support and social isolation increases the suicide risk. Willingness to seek help lowers risk. Being a person of colour does not suggest higher risk because more White people commit suicide than individuals of other racial groups do. Attention-seeking is not correlated with higher suicide risk.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

23. A patient hospitalized for 2 weeks committed suicide during the night. Which initial nursing measure will be most important regarding this event?

a. Ask the information technology manager to verify that the hospital information system is secure.

b. Hold a staff meeting to express feelings and plan care for the other patients.

c. Ask the patient's roommate not to discuss the event with other patients.

d. Prepare a report of a sentinel event.

ANS: B

Interventions should help the staff and patients come to terms with the loss and learn from the incident. Then, a community meeting should occur to allow other patients to express their feelings and request help. Staff should be prepared to provide additional support and reassurance to patients and should seek opportunities for peer support. A sentinel event report can be prepared later. The other incorrect options will not control information or would result in unsafe care.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

24. After one of their identical twin daughters commits suicide, the parents express concern that the other twin may also have suicidal tendencies. Which reply should the nurse provide?

a. “Genetics are associated with suicide risk. Monitoring and support are important.”

b. “Apathy underlies suicide. Instilling motivation is the key to health maintenance.”

c. “Your child is unlikely to act out suicide when identifying with a suicide victim.”

d. “Fraternal twins are at higher risk for suicide than identical twins.”

ANS: A

Family history of suicide is a suicide risk factor. Therefore, the second daughter would be at risk and should be monitored. Primary interventions can be helpful in promoting and maintaining health and possibly counteracting genetic load. The incorrect options are untrue statements or an oversimplification.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

25. Which individual in the emergency department should be considered at highest risk for completing suicide?

a. An adolescent girl with superior athletic and academic skills who has asthma

b. A 38-year-old single female church member with fibrocystic breast disease

c. A 60-year-old married man with twelve grandchildren who has type 2 diabetes

d. A 79-year-old single, male diagnosed recently with terminal cancer of the prostate

ANS: D

High-risk factors include being an older adult, single, male, and having a co-occurring medical illness.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse assesses five newly hospitalized patients. Which patients have the highest suicide risk? (Select all that apply.)

a. 82-year-old White male

b. 17-year-old White female

c. 22-year-old Hispanic male

d. 19-year-old Inuit male

e. 39-year-old African Canadian male

ANS: A, B, D

White people have suicide rates almost twice those of non-Whites, and the rate is particularly high for older adult males, adolescents, and young adults. Other high-risk groups include Inuit and Aboriginal people.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which nursing interventions will be implemented for a patient who is actively suicidal? (Select all that apply.)

a. Maintain arm's-length, one-on-one direct observation at all times.

b. Check all items brought by visitors and remove risk items.

c. Use finger foods, plastic utensils, and drinkware; count utensils upon collection.

d. Remove the patient's eyeglasses to prevent self-injury.

e. Interact with the patient every 15 minutes.

ANS: A, B, C

One-on-one observation is necessary for anyone who has limited or unreliable control over suicidal

impulses. Finger foods allow the patient to eat without silverware; “no silver or glassware” orders restrict

access to a potential means of self-harm. Every-15-minute checks are inadequate to assure the safety of an

actively suicidal person. Placement in a public area is not a substitute for arm’s-length direct observation; some patients will attempt suicide even when others are nearby. Vision impairment requires eyeglasses (or contacts); although they could be used dangerously, watching the patient from arm’s length at all times would allow enough time to interrupt such an attempt and would prevent the disorientation and isolation that uncorrected visual impairment could create.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

3. A college student is extremely upset after failing two examinations. The student said, “No one understands how this will hurt my chances of getting into medical school.” The student then suspends access to his social networking website and turns off his cell phone. Which suicide risk factors are evident? (Select all that apply.)

a. Shame

b. Panic attack

c. Humiliation

d. Self-imposed isolation

e. Recent stressful life event

ANS: A, C, D, E

Failing examinations in the academic major constitutes a recent stressful life event. Shame and humiliation related to the failure can be hypothesized. The statement, “No one can understand,” can be seen as recent lack of social support. Terminating access to one’s social networking site and turning off the cell phone represent self-imposed isolation. The scenario does not provide evidence of panic attack.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 23: Anger, Aggression, and Violence

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Which behaviour best demonstrates aggression?

a. Stomping away from the nurses' station, going to the hallway, and grabbing a tray from the meal cart.

b. Bursting into tears, leaving the community meeting, and sitting on a bed hugging a pillow and sobbing.

c. Telling the primary nurse, "I felt angry when you said I could not have a second helping at lunch."

d. Telling the medication nurse, "I am not going to take that or any other medication you try to give me."

ANS: A

Aggression is an emotion that results in harsh physical or verbal action that reflects rage, hostility, and potential for physical or verbal destructiveness. Aggressive behaviour violates the rights of others. Refusing medication is a patient's right and may be appropriate. The other incorrect options do not feature violation of another's rights.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which scenario predicts the highest risk for directing violent behaviour toward others?

a. Major depression with delusions of worthlessness

b. Obsessive-compulsive disorder; performs many rituals

c. Paranoid delusions of being followed by alien monsters

d. Completed alcohol withdrawal; beginning a rehabilitation program

ANS: C

Patients who are delusional, hyperactive, impulsive, or predisposed to irritability are at higher risk for violence. The patient in the correct response has the greatest disruption of ability to perceive reality accurately. People who feel persecuted may strike out against those believed to be persecutors. The other

patients have better reality-testing ability.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Safe Effective Care Environment

3. A patient was arrested for breaking windows in the home of a former domestic partner. The patient's history also reveals childhood abuse by a punitive parent, torturing family pets, and an arrest for disorderly conduct. Which nursing diagnosis has priority?

a. Risk for injury

b. Ineffective coping

c. Impaired social interaction

d. Risk for other-directed violence

ANS: D

Defining characteristics for risk for other-directed violence include a history of being abused as a child, having committed violent acts in the past, and demonstrating poor impulse control. There is no indicator that the patient will experience injury. Ineffective coping and impaired social interaction have lower priorities.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Psychosocial Integrity

4. A confused older adult patient in a nursing home was asleep when unlicensed assistive personnel (UAP) entered the room quietly and touched the bed to see if it was wet. The patient awakened and hit the UAP in the face. Which statement best explains the patient's action?

a. Older adult patients often demonstrate exaggerations of behaviours used earlier in life.

b. Crowding in nursing homes increases an individual's tendency toward violence.

c. The patient learned violent behaviour by watching other patients act out.

d. The patient interpreted the UAP's behaviour as potentially harmful.

ANS: D

Confused patients are not always able to evaluate the actions of others accurately. This patient behaved as

though provoked by the intrusive actions of the staff.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A patient is pacing the hall near the nurses' station, swearing loudly. An appropriate

initial intervention for the nurse would be to address the patient by name and say which of the

following?

a. "What is going on?"

b. "Please be quiet and sit down in this chair immediately."

c. "I'd like to talk with you about how you're feeling right now."

d. "You must go to your room and try to get control of yourself."

ANS: C

Intervention should begin with analysis of the patient and the situation. When anger is escalating, a

patient's ability to process decreases. It is important to speak to the patient slowly and in short sentences,

using a low and calm voice. Use open-ended statements designed to hear the patient's feelings and

concerns. This leads to the next step of planning an intervention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

6. A patient who was responding to auditory hallucinations earlier in the morning now

approaches the nurse shaking a fist and shouts, "Back off!" and then goes to the day room. While

following the patient into the day room, the nurse should do which of the following?

a. Make sure there is adequate physical space between the nurse and patient

b. Move into a position that places the patient close to the door

c. Maintain one arm's-length distance from the patient

d. Begin talking to the patient about appropriate behaviour

ANS: A

Making sure space is present between the nurse and the patient avoids invading the patient's personal

space. Personal space needs increase when a patient feels anxious and threatened. Allowing the patient to

block the nurse's exit from the room may result in injury to the nurse. Closeness may be threatening to the

patient and provoke aggression. Sitting is inadvisable until further assessment suggests the patient's

aggression is abating. One arm's length is inadequate space.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

7. An intramuscular dose of antipsychotic medication needs to be administered to a

patient who is becoming increasingly more aggressive and refusing to leave the day room. Which

of the following should the nurse do?

a. Enter the day room and say, "Would you like to come to your room and take some

medication your health care provider prescribed for you?"

b. Enter the day room accompanied by three staff members and say, "Please come to

your room so I can give you some medication that will help you regain control."

c. Enter the day room and place the patient in a basket hold and then say, "I am going

to take you to your room to give you an injection of medication to calm you."

d. Enter the day room accompanied by a male security guard and tell the patient,

"Come to your room willingly so I can give you this medication, or the guard and I

will take you there."

ANS: B

A patient gains feelings of security if he or she sees others are present to help with control. The nurse

gives a simple direction, honestly states what is going to happen, and reassures the patient that the

intervention will be helpful. This positive approach assumes the patient can act responsibly and will

maintain control. Physical control measures are used only as a last resort.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

8. After an assault by a patient, a nurse has difficulty sleeping, startles easily, and is preoccupied with the incident. The nurse says, “That patient should not be allowed to get away with that behaviour.” Which of the following responses poses the greatest barrier to the nurse’s ability to provide therapeutic care?

a. Startle reactions

b. Difficulty sleeping

c. A wish for revenge

d. Preoccupation with the incident

ANS: C

The desire for revenge signals an urgent need for professional supervision to work through anger and counter the aggressive feelings. Feelings of revenge create a risk for harm to the patient. The distracters are normal in a person who was assaulted. They usually are relieved with crisis intervention that helps the individual regain a sense of control and make sense of the event.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Evaluation MSC: Client Needs: Psychosocial Integrity

9. The staff development coordinator plans to teach physical management techniques for use when patients become assaultive. Which topic should the coordinator emphasize?

a. Practice and teamwork

b. Spontaneity and surprise

c. Caution and superior size

d. Diversion and physical outlets

ANS: A

Staff must work as a team when secluding a patient. Intervention techniques are learned behaviours and must be practised to be used in a smooth, organized fashion. Before beginning the intervention, every member of the intervention team should be assigned a specific task to carry out. The other options are useless if the staff does not know how to use physical techniques and how to apply them in an organized fashion.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

10. An adult patient assaulted another patient and was then restrained. One hour later, which statement by the restrained patient requires the nurse's immediate attention?

The patient's threat to kill others with the knife he possessed constituted a clear and present danger to others. The distracters are not sufficient reasons for seclusion.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

14. A patient sat in silence for 20 minutes after a therapy appointment, appearing tense and vigilant. The patient abruptly stood, paced back and forth, clenched and unclenched fists, and then stopped and stared in the face of a staff member. Which of the following is the patient doing?

a. Demonstrating withdrawal

b. Working though angry feelings

c. Attempting to use relaxation strategies

d. Exhibiting clues to potential aggression

ANS: D

The description of the patient's behaviour shows the classic signs of someone whose potential for aggression is increasing.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. A patient with multi-infarct dementia lashes out and kicks at people who walk past in the hall of a nursing home. Intervention by the nurse should begin by which of the following?

a. Gently touching the patient's arm

b. Asking the patient, "What do you need?"

c. Saying to the patient, "This is a safe place."

d. Directing the patient to cease the behaviour

ANS: C

Striking out usually signals fear or that the patient perceives the environment to be out of control. Getting

the patient's attention is fundamental to intervention. The nurse should make eye contact and assure the

patient of safety. Once the nurse has the patient's attention, gently touching the patient, asking what he or

she needs, or directing the patient to discontinue the behaviour may be appropriate.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

16. A cognitively impaired patient has been a widow for 30 years. This patient frantically

tries to leave the facility, saying, "I have to go home to cook dinner before my husband arrives

from work." To intervene with validation therapy, the nurse will say which of the following?

a. "You must come away from the door."

b. "You have been a widow for many years."

c. "You want to go home to prepare your husband's dinner?"

d. "Your husband gets angry if you do not have dinner ready on time?"

ANS: C

Validation therapy meets the patient "where she or he is at the moment" and acknowledges the patient's

wishes. Validation does not seek to redirect, reorient, or probe. The distracters do not validate the

patient's feelings.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

17. A patient with a history of anger and impulsivity was hospitalized after an accident

resulting in injuries. When in pain, the patient loudly scolded nursing staff for "not knowing

enough to give me pain medicine when I need it." Which nursing intervention would best address

this problem?

a. Teach the patient to use coping strategies such as deep breathing and progressive

relaxation to reduce the pain.

b. Talk with the health care provider about changing the pain medication from pro re nata (PRN) to patient-controlled analgesia.

c. Tell the patient that verbal assaults on nurses will not shorten the wait for analgesic medication.

d. Talk with the patient about the risks of dependency associated with overuse of analgesic medication.

ANS: B

Encourage the individual to assume responsibility for choices and being independent. Use of patient-controlled analgesia will help the patient manage the pain by taking control of the management. This intervention will help reduce the patient's anxiety and anger. Dependency is not an important concern related to acute pain.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

18. A patient has a history of impulsively acting out anger by striking others. Select the most appropriate intervention for avoiding similar incidents.

a. Teach the patient about herbal preparations that reduce anger.

b. Help the patient identify incidents that trigger impulsive anger.

c. Explain that restraint and seclusion will be used if violence occurs.

d. Offer one-on-one supervision to help the patient maintain control.

ANS: B

Identification of trigger incidents allows the patient and nurse to plan interventions to reduce irritation and frustration, which lead to acting out anger, and eventually to put into practice more adaptive coping strategies.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

19. A patient with severe injuries is irritable and angry and belittles the nurses. As a

nurse changes a dressing, the patient screams, “Don’t touch me! You are so stupid. You will make it worse!” Which intervention uses a cognitive technique to help the patient?

a. Wordlessly discontinue the dressing change and then leave the room.

b. Stop the dressing change, saying, “Perhaps you would like to change your own dressing.”

c. Continue the dressing change, saying, “This dressing change is needed so your wound will not get infected.”

d. Continue the dressing change, saying, “Unfortunately, you have no choice in this because your health care provider ordered this dressing change.”

ANS: C

As uncomfortable as this kind of communication may make you feel, you cannot take the patient’s words personally or respond in kind. During an escalating situation is not the time to forbid the patient to communicate in this way or to end the conversation because of the patient’s verbal abusiveness. The patient who is about to lose emotional control should not be abandoned. The answer helps the patient test his cognitions and may lead to lowering his anger. The incorrect options will escalate the patient’s anger by belittling or escalating the patient’s sense of powerlessness.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

20. Which medication from the medication administration record should a nurse administer to provide immediate intervention for a psychotic patient whose aggressive behaviour continues to escalate despite verbal intervention?

a. Lithium

b. Lorazepam (Ativan)

c. Olanzapine (Zyprexa)

d. Alprazolam (Xanax)

ANS: C

Olanzapine is a short-acting antipsychotic useful in calming angry, aggressive patients regardless of

diagnosis. Lithium is for bipolar patients. Lorazepam and alprazolam are anti-anxiety medications.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological

Integrity

21. An emergency department nurse realizes that the spouse of a patient is becoming

increasingly irritable while waiting. Which intervention should the nurse use to prevent further

escalation of the spouse's anger?

a. Offer the waiting spouse a cup of coffee.

b. Explain that the patient's condition is not life threatening.

c. Periodically provide an update and progress report on the patient.

d. Suggest that the spouse return home until the patient's treatment is complete.

ANS: C

Periodic updates reduce anxiety and defuse anger. This strategy acknowledges the spouse's presence and

concern. A cup of coffee is a nice gesture, but it does not address the spouse's feelings. The other

incorrect options would be likely to increase anger because they imply that the anxiety is inappropriate.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial

Integrity

22. Which information from a patient's record would indicate marginal coping skills and

the need for careful assessment of the risk for violence?

a. A history of academic problems

b. A history of family involvement

c. A history of childhood trauma

d. A history of substance abuse

ANS: D

The nurse should suspect marginal coping skills in a patient with substance abuse. The potential for

violence is especially true for hospitalized patients with chemical dependence, who may be anxious about

being cut off from the substance to which they are addicted. They are often anxious, may be concerned

about inadequate pain relief, and may have personality styles that externalize blame. The incorrect options

do not signal as high a degree of risk as substance abuse.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

23. Family members describe the patient as “a difficult person who finds fault with

others.” The patient verbally abuses nurses for their poor care. The most likely explanation lies in

which of the following?

a. Poor childrearing that did not teach respect for others

b. Automatic thinking leading to cognitive distortions

c. A personality style that externalizes problems

d. Delusions that others wish to deliver harm

ANS: C

Patients whose personality style causes them to externalize blame see the source of their discomfort and anxiety as being outside themselves. They displace anger and are often unable to self-soothe. The incorrect options are less likely to have a bearing on this behaviour.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. A new patient acts out so aggressively that seclusion is required before the admission

assessment is completed or orders written. Immediately after safely secluding the patient, which

action is the nurse’s priority?

a. Complete the physical assessment.

b. Notify the health care provider to obtain a seclusion order.

c. Document the incident objectively in the patient’s medical record.

d. Explain to the patient that seclusion will be discontinued when self-control is

regained

ANS: B

Emergency seclusion can be effected by a credentialed nurse but must be followed by an appropriate health care provider’s signature according to provincial and territorial law. The incorrect options are not

immediately necessary from a legal standpoint. See related audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. Which indications warrant the use of seclusion? (Select all that apply.)

a. To protect from self-harm

b. To increase self-isolation

c. To decrease environmental stimulation

d. To prevent assault

e. To encourage self-reflection

ANS: A, D

There are only two indications for the use of seclusion: to protect the patient from self-harm and to prevent the patient from assaulting others. To increase self-isolation is not an indication. To decrease environmental stimulation is not an indication. To encourage self-reflection is not an indication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe Effective Care Environment

2. A nurse directs the intervention team that is placing an aggressive patient in seclusion. Before approaching the patient, which actions will the nurse direct team members to take? (Select all that apply.)

a. Appoint a person to clear a path and open, close, or lock doors.

b. Quickly approach the patient and take the closest extremity.

c. Select the person who will communicate with the patient.

d. Move behind the patient when the patient is not looking.

e. Remove jewelry, glasses, and harmful items.

ANS: A, C, E

Injury to staff and the patient should be prevented. Only one person should explain what will happen and

direct the patient. This may be the nurse or a staff member with a good relationship with the patient. A clear pathway is essential because those restraining a limb cannot use keys, move furniture, or open doors. The nurse is usually responsible for administering medication once the patient is restrained. Each staff member should have an assigned limb rather than just grabbing the closest. This system could leave one or two limbs unrestrained. Approaching in full view of the patient reduces suspicion.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

3. Which central nervous system structures are most associated with anger and aggression? (Select all that apply.)

a. Amygdala

b. Cerebellum

c. Basal ganglia

d. Temporal lobe

e. Prefrontal cortex

ANS: A, D, E

The amygdala and prefrontal cortex mediate anger experiences and help a person judge an event as either rewarding or aversive. The temporal lobe, which is part of the limbic system, also plays a role in aggressive behaviour. The basal ganglia are involved in movement. The cerebellum manages equilibrium, muscle tone, and movement.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning MSC: Client Needs: Physiological Integrity

4. Because an intervention was required to control a patient's aggressive behaviour, the nurse plans a critical-incident debriefing with staff members. Which topics should be the primary focus of this discussion? (Select all that apply.)

a. Patient behaviours associated with the incident

b. Genetic factors associated with aggression

c. Intervention techniques used by the staff

d. Effects of environmental factors

e. Theories of aggression

ANS: A, C, D

The patient's behaviour, the intervention techniques used, and the environment in which the incident occurred are important to establish realistic outcomes and effective nursing interventions. Discussing views about the theoretical origins of aggression would be less effective and relevant.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

Chapter 24: Interpersonal Violence: Child, Older Adult, and Intimate Partner Abuse

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Which comment by the nurse would best support relationship building with a survivor of intimate partner abuse?

a. "You are feeling violated because you thought you could trust your partner."

b. "I'm here for you. I want you to tell me about the bad things that happened to you."

c. "I was very worried about you. I knew you were living in a potentially violent situation."

d. "Abusers often target people who are passive. I will refer you to an assertiveness class."

ANS: A

Offering hope, identifying strengths, and displaying confidence that the person can take care of him- or herself are important aspects of nursing care. The correct option uses the therapeutic technique of reflection. It shows empathy, an important nursing attribute for establishing rapport and building a relationship. None of the other options would help the patient feel accepted.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. An 11-year-old reluctantly tells the nurse, "My parents don't like me. They said they wish I was never born." Which type of violence is likely?

a. Sexual

b. Physical

c. Emotional

d. Economic

ANS: C

Examples of emotional violence include having an adult demean a child's worth, frequently criticize, or belittle the child. No data support physical battering or endangerment, sexual abuse, or economic abuse.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. What feelings are most commonly experienced by nurses working with abusive families?

a. Outrage toward the victim and discouragement regarding the abuser

b. Helplessness regarding the victim and anger toward the abuser

c. Unconcern for the victim and dislike for the abuser

d. Vulnerability for self and empathy with the abuser

ANS: B

Intense protective feelings, helplessness, and sympathy for the victim are common emotions of a nurse working with an abusive family. Anger and outrage toward the abuser are also common emotions of a nurse working with an abusive family.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. Which rationale best explains why a nurse should be aware of personal feelings while working with a family experiencing family violence?

a. Self-awareness enhances the nurse's advocacy role.

b. Strong negative feelings interfere with assessment and judgement.

c. Strong positive feelings lead to healthy transference with the victim.

d. Positive feelings promote the development of sympathy for patients.

ANS: B

Strong negative feelings cloud the nurse's judgement and interfere with assessment and intervention, no

matter how hard the nurse tries to cover or deny those feelings. Strong positive feelings lead to over involvement with victims rather than healthy transference.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

5. The parents of a 15-year-old seek to have this teen declared a delinquent because of excessive drinking, habitually running away, and prostitution. The nurse interviewing the teen should recognize that these behaviours often occur in which of the following adolescents?

a. Adolescents who have been abused

b. Adolescents who are attention-seeking

c. Adolescents who have eating disorders

d. Adolescents who are developmentally delayed

ANS: A

Failing grades, alcohol and drug abuse, increased incidence of theft and violent behaviours, running away

from home, and unstable and unsatisfactory relationships are frequently seen in teens who are abused. These behaviours are not as closely aligned with any of the other options.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. What is a nurse's legal responsibility if child abuse or neglect is suspected?

a. Discuss the findings with the child's parent and health care provider.

b. Document the observation and suspicion in the medical record.

c. Report the suspicion according to provincial or territorial regulations.

d. Continue the assessment.

ANS: C

According to provincial or territorial legislation, any suspected or actual cases of child abuse must be reported to the official social service agency. The nurse is a mandated reporter. The reporter does not need to be sure that abuse or neglect occurred, only that it is suspected. Speculation should not be documented, only the facts.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

7. Several children are seen in the emergency department for treatment of various illnesses and injuries. Which assessment finding would create the most suspicion for child abuse?

a. The child with complaints of abdominal pain

b. The child who has repeated middle ear infections

c. The child with bruises on extremities

d. The child with diarrhea

ANS: C

Determine whether a child demonstrates signs of physical abuse, including numerous injuries in various stages of healing; unexplained bruises and welts; unexplained pattern, immersion, and friction burns; facial, spiral, shaft, or multiple fractures; unexplained facial lacerations and abrasions. In older children, vague complaints such as back pain may also be suspicious. Ear infections, diarrhea, and abdominal pain are problems that were unlikely to have resulted from violence.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

8. An 11-year-old says, “My parents don’t like me. They call me stupid and say they wish I was never born. It doesn’t matter what they think because I already know I’m dumb.” Which nursing diagnosis applies to this child?

a. Chronic low self-esteem related to negative feedback from parents

b. Deficient knowledge related to interpersonal skills with parents

c. Disturbed personal identity related to negative self-evaluation

d. Complicated grieving related to poor academic performance

ANS: A

The child has indicated a belief in being too dumb to learn. The child receives negative and demeaning feedback from the parents. The child has internalized these messages, resulting in a low self-esteem. Deficient knowledge refers to knowledge of health care measures. Disturbed personal identity refers to an alteration in the ability to distinguish between self and non-self. Grieving may apply, but a specific loss is not evident in the scenario. Low self-esteem is more relevant to the child’s statements.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

9. An adult has recently been absent from work for 3-day periods on several occasions.

Each time, the individual returned wearing dark glasses. Facial and body bruises were apparent.

What is the occupational health nurse's priority assessment?

a. Interpersonal relationships

b. Work responsibilities

c. Socialization skills

d. Physical injuries

ANS: D

The individual should be assessed for possible battering. Physical injuries are abuse indicators and are the

primary focus for assessment. No data support the other options.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

10. A young adult has recently had multiple absences from work. After each absence, this

adult returned to work wearing dark glasses and a long-sleeved shirt. During an interview with the

occupational health nurse, this adult says, "My partner beat me, but it was because I did not do the

laundry." What is the nurse's next action?

a. Call the police.

b. Arrange for hospitalization.

c. Call the relevant social services agency.

d. Document injuries with a body map.

ANS: D

Documentation of injuries provides a basis for possible legal intervention. In most provinces and

territories, the abused adult needs to make the decision to involve the police, unless there are issues of age

or competency. Because the worker is not a child and is competent, a provincial or territorial social

services agency is unable to assist. Admission to the hospital is not necessary.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

11. A patient tells the nurse, “My husband lost his job. He’s abusive only when he drinks too much. His family was like that when he was growing up. He always apologizes and regrets hurting me.” What risk factor was most predictive for the husband to become abusive?

a. History of family violence

b. Loss of employment

c. Abuse of alcohol

d. Poverty

ANS: A

An abuse-prone individual is an individual who has experienced family violence and was often abused as a child. This phenomenon is part of the cycle of violence. The other options may be present but are not as predictive.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. An adult tells the nurse, “My partner abuses me when I make mistakes, but I always get an apology and a gift afterward. I’ve considered leaving but haven’t been able to bring myself to actually do it.” Which phase in the cycle of violence prevents this adult from leaving?

a. Tension-building

b. Acute battering

c. Honeymoon

d. Stabilization

ANS: C

The honeymoon stage is characterized by kind, loving behaviours toward the abused spouse when the perpetrator feels remorseful. The victim believes the promises and drops plans to leave or seek legal help.

The tension-building stage is characterized by minor violence in the form of abusive verbalization or

pushing. The acute battering stage involves the abuser beating the victim. The violence cycle does not include a stabilization stage.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

13. After treatment for a detached retina, a survivor of intimate partner abuse says, “My partner only abuses me when I make mistakes. I’ve considered leaving, but I was brought up to believe you stay together, no matter what happens.” Which diagnosis should be the focus of the nurse’s initial actions?

a. Risk for injury related to physical abuse from partner

b. Social isolation related to lack of a community support system

c. Ineffective coping related to uneven distribution of power within a relationship

d. Deficient knowledge related to resources for escape from an abusive relationship

ANS: A

Risk for injury is the priority diagnosis because the partner has already inflicted physical injury during violent episodes. The other diagnoses are applicable, but the nurse must first address the patient’s safety.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

14. A survivor of physical spousal abuse was treated in the emergency department for a broken wrist. This patient said, “I’ve considered leaving, but I made a vow and I must keep it no matter what happens.” Which outcome should be met before discharge?

a. Staff will lay charges against the abuser with police.

b. The patient will name two community resources for help.

c. The patient will demonstrate insight into the abusive relationship.

d. The patient will re-examine cultural beliefs about marital commitment.

ANS: B

The only outcome indicator clearly attainable within this time is for staff to provide the victim with information about community resources that can be contacted. Development of insight into the abusive

relationship and re-examining cultural beliefs will require time. The patient may or may not press charges

against the abuser with the police; however, this is not an outcome to be met before discharge.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Safe Effective Care Environment

15. An older adult with Lewy body dementia lives with family and attends a day care

centre. A nurse there noticed the adult had a disheveled appearance, strong odour of urine, and

bruises on the limbs and back. What type of violence might be occurring?

a. Psychological

b. Financial

c. Physical

d. Sexual

ANS: C

Lewy body dementia results in cognitive impairment. The assessment of physical abuse would be supported by the nurse's observation of bruises. Physical violence includes evidence of improper care as well as physical endangerment behaviours, such as reckless behaviour toward a vulnerable person that could lead to serious injury. No data substantiate the other options.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

16. An older adult with Alzheimer's disease lives with family in a rural area. During the

week, the person attends a day care centre while the family is at work. In the evenings, members of the family provide care. Which factor makes this patient most vulnerable to abuse?

a. Multiple caregivers

b. Alzheimer's disease

c. Living in a rural area

d. Being part of a busy family

ANS: B

Older adults are at high risk for violence, particularly those with cognitive impairments. The other

characteristics are not identified as placing an individual at high risk.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

17. An older adult with Lewy body dementia lives with family. After observing multiple bruises, the home health nurse talked with the daughter, who became defensive and said, “My mother often wanders at night. Last night she fell down the stairs.” Which nursing diagnosis has priority?

a. Risk for injury related to poor judgement, cognitive impairments, and inadequate supervision

b. Wandering related to confusion and disorientation as evidenced by sleepwalking and falls

c. Chronic confusion related to degenerative changes in brain tissue as evidenced by nighttime wandering

d. Insomnia related to sleep disruptions associated with cognitive impairment as evidenced by wandering at night

ANS: A

The patient is at high risk for injury because of her confusion. The risk increases when caregivers are unable to give constant supervision. Insomnia, chronic confusion, and wandering apply to this patient; however, the risk for injury is a higher priority.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Safe Effective Care Environment

18. An older woman diagnosed with Alzheimer’s disease lives with family and attends day care. After observing poor hygiene, the nurse talked with the caregiver. This caregiver became defensive and said, “It takes all my energy to care for my mother. She’s awake all night. I never get any sleep.” Which nursing intervention has priority?

a. Teach the caregiver about the effects of sundown syndrome.

b. Secure additional resources for the mother’s evening and night care.

c. Support the caregiver to grieve the loss of the mother’s cognitive abilities.

d. Teach the family how to give physical care more effectively and efficiently.

ANS: B

The patient's caregivers were coping with care until the patient began to stay awake at night. The family needs assistance with evening and night care to resume their pre-crisis state of functioning. Secondary prevention calls for the nurse to mobilize community resources to relieve overwhelming stress. The other interventions may then be accomplished.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

19. An adult has a history of physical violence against family when frustrated, followed by periods of remorse after each outburst. Which finding indicates a successful plan of care?

a. The adult expresses frustration verbally instead of physically.

b. The adult explains the rationale for behaviours to the victim.

c. The adult identifies three personal strengths.

d. The adult agrees to seek counselling.

ANS: A

The patient will have developed a healthier way of coping with frustration if it is expressed verbally instead of physically. The incorrect options do not confirm achievement of outcomes.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

20. Which referral will be most helpful for a woman who was severely beaten by her intimate partner, has no relatives or friends in the community, is afraid to return home, and has limited financial resources?

a. A support group

b. A mental health centre

c. A women's shelter

d. Vocational counselling

ANS: C

Because the woman has no safe place to go, referral to a shelter is necessary. The shelter will provide other referrals as necessary.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

MULTIPLE RESPONSE

1. A 10-year-old cares for siblings while the parents work because the family cannot afford a babysitter. This child says, “My father doesn’t like me. He calls me stupid all the time.” The mother says the father is easily frustrated and has trouble disciplining the children. The community health nurse should consider which resources as priorities to stabilize the home situation? (Select all that apply.)

a. Parental sessions to teach childrearing practices

b. Anger management counselling for the father

c. Continuing home visits to give support

d. A safety plan for the wife and children

e. Placing the children in foster care

ANS: A, B, C

Anger management counselling for the father is appropriate. Support for this family will be an important component of treatment. By the wife’s admission, the family has deficient knowledge of parenting practices. Whenever possible, the goal of intervention should be to keep the family together; thus, removing the children from the home should be considered a last resort. Physical abuse is not suspected,

so a safety plan would not be a priority at this time.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

2. A nurse assists a victim of intimate partner abuse to create a plan for escape if it becomes necessary. Which components should the plan include? (Select all that apply.)

a. Keep a cell phone fully charged

b. Hide money with which to buy new clothes

c. Have the phone number for the nearest shelter

d. Take enough toys to amuse the children for 2 days

e. Secure a supply of current medications for self and children

f. Assemble birth certificates, passports, and other identification and licences

g. Determine a code word to signal children when it is time to leave

ANS: A, C, E, F, G

The victim must prepare for a quick exit and so should assemble necessary items. Keeping a cell phone fully charged will help with access to support persons or agencies. Taking a large supply of toys would be cumbersome and might compromise the plan. People are advised to take one favourite small toy or security object for each child, but most shelters have toys to further engage the children. Accumulating enough money to purchase clothing may be difficult.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

3. A community health nurse visits a family with four children. The father behaves angrily, finds fault with the oldest child, and asks twice, “Why are you such a stupid kid?” The wife says, “I have difficulty disciplining the children. It’s so frustrating.” Which comments by the nurse will facilitate an interview with these parents? (Select all that apply.)

a. “Tell me how you discipline your children.”

b. “How do you stop your baby from crying?”

c. “Caring for four small children must be difficult.”

d. “Do you or your husband ever spank your children?”

e. “Calling children ‘stupid’ injures their self-esteem.”

ANS: A, B, C

An interview with possible abusing individuals should be built on concern and carried out in a nonthreatening, non-judgemental way. Empathetic remarks are helpful in creating rapport. Questions requiring a descriptive response are less threatening and elicit more relevant information than questions that can be answered by yes or no.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

Chapter 25: Sexual Assault

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. The nurse at a university health centre leads a dialogue with female freshmen about rape and sexual assault. One student says, "If I avoid strangers or situations where I am alone outside at night, I'll be safe from sexual attacks." Choose the nurse's best response.

a. "Your plan is not adequate. You could still be raped or sexually assaulted."

b. "I am glad you have this excellent safety plan. Would others like to comment?"

c. "It's better to walk with someone or call security when you enter or leave a building."

d. "Sexual assaults are more often perpetrated by acquaintances. Let's discuss ways to prevent that."

ANS: D

The majority (82%) of the sexual assaults reported involved an offender who was a friend or acquaintance of the victim, with stranger assaults accounting for 18% of incidents. The nurse should share this information along with encouraging discussion of safety measures. The distracters fail to provide adequate information or encourage discussion.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. A woman was found confused and disoriented after being abducted and raped at gunpoint by an unknown assailant. The emergency department nurse makes these observations about the woman: talking rapidly in disjointed phrases, unable to concentrate, indecisive when asked to make simple decisions. What is the woman's level of anxiety?

a. Weak

b. Mild

c. Moderate

d. Severe

ANS: D

Acute anxiety results from the personal threat to the victim's safety and security. In this case, the patient's

symptoms of rapid, dissociated speech, inability to concentrate, and indecisiveness indicate severe

anxiety. Weak is not a level of anxiety. Mild and moderate levels of anxiety would allow the patient to

function at a higher level.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. After an abduction and rape at gunpoint by an unknown assailant, which assessment

finding best indicates that a patient is in the acute phase of the rape-trauma syndrome?

a. Decreased motor activity

b. Confusion and disorientation

c. Flashbacks and dreams

d. Fears and phobias

ANS: B

Reactions of the acute phase of the rape-trauma syndrome are shock, emotional numbness, confusion,

disorientation, restlessness, and agitated motor activity. Flashbacks, dreams, fears, and phobias are seen in

the long-term reorganization phase of the rape-trauma syndrome. Decreased motor activity by itself is not

indicative of any particular phase.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. A nurse interviews a patient who was abducted and raped at gunpoint by an unknown

assailant. The patient says, "I can't talk about it. Nothing happened. I have to forget." What is the

patient's present coping strategy?

a. Compensation

b. Somatization

c. Projection

d. Denial

ANS: D

The patient's statements reflect use of denial, an ego defence mechanism. This mechanism may be used unconsciously to protect the person from the emotionally overwhelming reality of the rape. The patient's statements do not reflect somatization, compensation, or projection.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. An emergency department nurse prepares to assist with evidence collection for a sexual assault victim. Prior to photographs and pelvic examination, what documentation is important?

a. The patient's vital signs

b. Consent signed by the patient

c. Supervision and credentials of the examiner

d. Storage location of the patient's personal effects

ANS: B

Patients have the right to refuse legal and medical examination. Consent forms are required to proceed with these steps.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

6. A nurse in the emergency department assesses an unresponsive victim of rape. The victim's friend reports, "That guy gave her salty water before he raped her." Which question is most important for the nurse to ask of the victim's friend?

a. "Does the victim have any kidney disease?"

b. "Has the victim consumed any alcohol?"

c. "What time was she given salty water?"

d. "Did you witness the rape?"

ANS: B

Salty water is a slang/street name for GHB (g-hydroxybutyric acid), a Schedule III central nervous system depressant associated with rape. Use of alcohol would produce an increased risk for respiratory depression. GHB has a duration of 1-12 hours, but the duration is less important than the potential for respiratory depression. Seeking evidence is less important than the victim's physiologic stability.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

7. A rape victim says to the nurse, “I always try to be so careful. I know I should not have walked to my car alone. Was this attack my fault?” Which communication by the nurse is most therapeutic?

a. Support the victim to separate issues of vulnerability from blame.

b. Emphasize the importance of using a buddy system in public places.

c. Reassure the victim that the outcome of the situation will be positive.

d. Pose questions about the rape and help the patient explore why it happened.

ANS: A

Although the victim may have made choices that made her vulnerable, she is not to blame for the rape. Correcting this distortion in thinking allows the victim to begin to restore a sense of control. This is a positive response to victimization. The distracters do not permit the victim to begin to restore a sense of control or offer use of nontherapeutic communication techniques. In this interaction, the victim needs to talk about feelings rather than prevention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

8. A rape victim tells the nurse, “I should not have been out on the street alone.” Select the nurse’s most therapeutic response.

a. “Rape can happen anywhere.”

b. “Blaming yourself increases your anxiety and discomfort.”

c. “You are right. You should not have been alone on the street at night.”

d. “You feel as though this would not have happened if you had not been alone.”

ANS: D

A reflective communication technique is most helpful. Looking at one’s role in the event serves to explain events that the victim would otherwise find incomprehensible. The distracters discount the victim’s perceived role and interfere with further discussion.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

9. The nursing diagnosis Rape-trauma syndrome applies to a rape victim in the emergency department. Select the most appropriate outcome to achieve before discharging the patient.

a. The memory of the rape is less vivid and less frightening.

b. The patient is able to describe feelings of safety and relaxation.

c. Symptoms of pain, discomfort, and anxiety are no longer present.

d. The patient agrees to a follow-up appointment with a rape victim advocate.

ANS: D

Agreeing to keep a follow-up appointment is a realistic short-term outcome. The victim is in the acute phase; the distracters are unlikely to be achieved during the limited time the victim is in an emergency department.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

10. A rape victim visited a rape crisis counsellor weekly for 8 weeks. At the end of this counselling period, which comment by the victim best demonstrates that reorganization was successful?

a. “I have a rash on my buttocks. It itches all the time.”

b. “Now I know what I did that triggered the attack on me.”

c. “I’m sleeping better although I still have an occasional nightmare.”

d. “I have lost 8 pounds since the attack, but I needed to lose some weight.”

ANS: C

Rape-trauma syndrome is a variant of post-traumatic stress disorder. The absence of signs and symptoms of post-traumatic stress disorder suggests that the long-term reorganization phase was successfully completed. The victim’s sleep has stabilized; occasional nightmares occur, even in reorganization. The distracters suggest somatic symptoms, appetite disturbances, and self-blame, all of which are indicators that the process is ongoing.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

11. A nurse interviews a 17-year-old male victim of sexual assault. The victim is reluctant

to talk about the experience. Which comment should the nurse offer to this victim?

a. “Male victims of sexual assault are usually better equipped than women to deal with the emotional pain that occurs.”

b. “Male victims of sexual assault often experience physical injuries and are assaulted by more than one person.”

c. “Do you have any male friends who have also been victims of sexual assault?”

d. “Why do you think you became a victim of sexual assault?”

ANS: B

Few rape survivors seek help, even with serious injury; so, it is important for the nurse to help the victim discuss the experience. The correct response therapeutically gives information to this victim. A male rape victim is more likely to experience physical trauma and to have been victimized by several assailants. Males experience the same devastation, physical injury, and emotional consequences as females. Although they may cover their responses, they too benefit from care and treatment. “Why” questions represent probing, which is a nontherapeutic communication technique. The victim may or may not have friends who have had this experience, but it’s important to talk about his feelings rather than theirs.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. Where do the majority of sexual assaults occur?

a. Private home

b. City street at night

c. Commercial establishment

d. Person’s own motor vehicle

ANS: C

Just over half (51%) of sexual assault incidents occurred in a commercial establishment; 31% in a residence or surrounding location; 12% in a street or other public place; and 6% in another location.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

13. A nurse cares for a rape victim who was given a drink that contained GHB (g-hydroxybutyric acid) by an assailant. Which intervention has priority?

a. Monitoring for coma

b. Monitoring for seizures

c. Monitoring for hypotonia

d. Monitoring for respiratory depression

ANS: D

Monitoring for respiratory depression takes priority over hypotonia, seizures, or coma.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Intervention MSC: Client Needs: Physiological Integrity

14. Which situation describes consensual sex rather than rape?

a. A husband forces vaginal sex when he comes home intoxicated from a party. The wife objects.

b. A woman's lover pleads with her to have oral sex. She gives in but later regrets the decision.

c. A person is beaten, robbed, and forcibly subjected to anal penetration by an assailant.

d. A dentist gives anesthesia for a procedure and then has intercourse with the unconscious patient.

ANS: B

Only the correct option describes a scenario in which the sexual contact is consensual. Consensual sex is not considered rape if the participants are of legal age.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. Before a victim of sexual assault is discharged from the emergency department, which of the following should the nurse do?

a. Notify the victim's family to provide emotional support

b. Offer to stay with the patient until stability is regained

c. Advise the patient to try not to think about the assault

d. Provide referral information verbally and in writing

ANS: D

Immediately after the assault, rape victims are often disorganized and unable to think well or remember instructions. Written information acknowledges this fact and provides a solution. The distracters violate the patient's right to privacy, evidence a rescue fantasy, and offer a platitude that is neither therapeutic nor effective.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

16. A victim of a sexual assault who sits in the emergency department is rocking back and forth and repeatedly saying, "I can't believe I've been raped." This behaviour is characteristic of which stage of rape-trauma syndrome?

a. The acute phase

b. The long-term phase

c. A delayed reaction

d. The angry stage

ANS: A

The victim's response is typical of the acute phase and shows cognitive, affective, and behavioural disruptions. This response is immediate and does not include a display of behaviours suggestive of the long-term (reorganization) phase, anger, or a delayed reaction.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. A victim of a sexual assault comes to the hospital for treatment but abruptly decides to decline treatment and leaves the facility. While respecting the person's rights, which of the following should the nurse do?

a. Say, "You may not leave until you receive prophylactic treatment for sexually transmitted diseases."

b. Provide written information about physical and emotional reactions the person may experience.

c. Explain the need and importance of infectious disease and pregnancy tests.

d. Give verbal information about legal resources in the community.

ANS: B

All information given to a patient before he or she leaves the emergency department should be in writing.

Patients who are anxious are unable to concentrate and therefore cannot retain much of what is verbally

imparted. Written information can be read and referred to later. Patients may not be kept against their will

or coerced into treatment. This constitutes false imprisonment.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. An unconscious teenager is treated in the emergency department. The teenager's

friends suspect a rape occurred at a party and tell the nurse the teenager received ketamine. Priority

action by the nurse should focus on which of the following?

a. Preserving rape evidence

b. Maintaining physiologic stability

c. Determining what drugs were ingested

d. Obtaining a description of the rape from a friend

ANS: B

Because the patient is unconscious, the risk for airway obstruction is present. Treatment for ketamine is

airway maintenance. The nurse's priority will focus on maintaining physiologic stability. The distracters

are of lower priority than preserving physiological functioning.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Physiological Integrity

19. A victim of a violent rape was treated in the emergency department. As discharge

preparation begins, the victim says softly, "I will never be the same again. I can't face my friends.

There is no reason to go on." Select the nurse's most appropriate response.

a. "Are you thinking of harming yourself?"

b. "It will take time, but you will feel the same as before the attack."

c. “Your friends will understand when you explain it was not your fault.”

d. “You will be able to find meaning from this experience as time goes on.”

ANS: A

The patient’s words suggest hopelessness. Whenever hopelessness is present, so is suicide risk. The nurse

should directly address the possibility of suicidal ideation with the patient. The other options attempt to

offer reassurance before making an assessment.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. When an emergency department nurse teaches a victim of rape-trauma syndrome about

reactions that may occur during the long-term phase of reorganization, which symptoms should be

included? (Select all that apply.)

a. Development of fears and phobias

b. Decreased motor activity

c. Feelings of numbness

d. Flashbacks, dreams

e. Syncopal episodes

ANS: A, C, D

These reactions are common to the long-term phase. Victims of rape frequently have a period of increased

motor activity rather than decreased motor activity during the long-term reorganization phase. Syncopal

episodes would not be expected.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A patient was abducted and raped at gunpoint by an unknown assailant. Which nursing

interventions are appropriate while caring for the patient in the emergency department? (Select all

that apply.)

a. Allow the patient to talk at a comfortable pace.

b. Place the patient in a private room with a caregiver.

c. Pose questions in nonjudgemental, empathetic ways.

d. Invite the patient's family members to the examination room.

e. Put an arm around the patient to demonstrate support and compassion.

ANS: A, B, C

Neutral, nonjudgemental care and emotional support are critical to crisis management for the rape victim.

The rape victim should have privacy but not be left alone. The rape victim's anxiety may escalate when touched by a stranger, even when the stranger is a nurse. Some rape victims prefer not to have family involved. The patient's privacy may be compromised by family presence.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

3. An emergency department nurse prepares to assist with examination of a sexual assault victim. What equipment will be needed to collect and document forensic evidence? (Select all that apply.)

a. Camera

b. Body map

c. DNA swabs

d. Pulse oximeter

e. Sphygmomanometer

ANS: A, B, C

Body maps, DNA swabs, and photographs are used to collect and preserve body fluids and other forensic evidence.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

4. Which aspects of assessment have priority when a nurse interviews a rape victim in an acute setting? (Select all that apply.)

a. Coping mechanisms the patient is using

b. The patient's previous sexual experiences

c. The patient's history of sexually transmitted diseases

d. Signs and symptoms of emotional and physical trauma

e. Adequacy and availability of the patient's support system

ANS: A, D, E

The nurse assesses the victim's level of anxiety, coping mechanisms, available support systems, signs and symptoms of emotional trauma, and signs and symptoms of physical trauma. The history of STDs or previous sexual experiences has little relevance.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A rape victim tells the emergency nurse, "I feel so dirty. Help me take a shower before I get examined." Which of the following should the nurse do? (Select all that apply.)

a. Arrange for the victim to shower.

b. Explain that bathing destroys evidence.

c. Give the victim a basin of water and towels.

d. Offer the victim a shower after evidence is collected.

e. Explain that bathing facilities are not available in the emergency department.

ANS: B, D

As uncomfortable as the victim may be, she should not bathe until the examination is completed. Collection of evidence is critical for prosecution of the attacker. A shower and fresh clothing should be made available to the survivor as soon as possible after the examination and collection of specimens. Showering after the examination will provide comfort to the victim. The distracters will result in destruction of evidence or are untrue.

Chapter 26: Sexuality and Gender

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A new staff nurse tells the clinical nurse specialist, "I am unsure about my role when patients bring up sexual problems." The clinical nurse specialist should give clarification by saying which of the following?

a. "All nurses qualify as sexual counsellors. Nurses have knowledge about the

biopsychosocial aspects of sexuality throughout the life cycle."

b. "All nurses should be able to screen for sexual dysfunction and give basic information about sexual feelings, behaviours, and myths."

c. "All nurses should defer questions about sex to other health care professionals because of their limited knowledge of sexuality."

d. "All nurses who are interested in sexual dysfunction can provide sex therapy for individuals and couples."

ANS: B

The basic education of nurses provides information sufficient to qualify the generalist to take a sexual history, assess for sexual dysfunction, and perform health teaching. A registered nurse may provide basic information about sexual function, but complex questions may require referral.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. A nurse is performing an assessment for a 59-year-old man who has hypertension. What is the rationale for including questions about prescribed medications and their effects on sexual function in the assessment?

a. Sexual dysfunction may result from use of prescription medications for management of hypertension.

b. Such questions are an indirect way of learning about the patient's medication adherence.

c. These questions ease the transition to questions about sexual practices in general.

d. Sexual dysfunction can cause stress and contribute to increased blood pressure.

ANS: A

Some of the drugs used to treat hypertension can interfere with normal sexual functioning and lead to sexual disorders. Hypertension itself can lead to acquired erectile dysfunction. It would not be appropriate or necessary to use such inquiries as a lead-in to other sexual health topics. Sexual dysfunction, while stressful, does not cause hypertension.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

3. An adult experienced a myocardial infarction 6 months ago. At a follow-up visit, he says, “I haven’t had much interest in sex since my heart attack. I finished my rehabilitation program, but having sex strains my heart. I don’t know if my heart is strong enough.” Which nursing diagnosis applies?

a. Deficient knowledge related to faulty perception of health status

b. Disturbed self-concept related to required lifestyle changes

c. Disturbed body image related to treatment side effects

d. Sexual dysfunction related to self-esteem disturbance

ANS: A

Patients who have had a myocardial infarction often believe sexual intercourse will cause another heart attack. The patient has completed the rehabilitation, but education is needed regarding sexual activity. These patients should receive information about when sexual activity may begin, positions that conserve energy, and so forth. The scenario does not suggest self-concept or body image disturbance.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Health Promotion and Maintenance

4. Which nursing action should occur first regarding a patient who has a problem of sexual dysfunction or sexual disorder?

a. The nurse should develop an understanding of human sexual response.

b. The nurse should assess the patient’s sexual functioning and needs.

c. The nurse should acquire knowledge of the patient’s sexual roles.

d. The nurse should clarify his or her own personal values about sexuality.

ANS: D

Before a nurse can be helpful to patients with sexual dysfunctions or disorders, the nurse must be aware of his or her own feelings and values about sex and sexuality. Nurses must keep their personal beliefs separate from their patient care in order to remain objective, professional, and effective. Nurses must be comfortable with the idea that patients have a right to their own values and must avoid criticism and

censure. The other options are indicated as well, but self-awareness must precede them to provide the best

care.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A patient tells the nurse that his sexual functioning is normal when his wife wears short, red camisole-style nightgowns. He states, “Without the red teddies, I am not interested in sex.” The nurse can assess this as consistent with which of the following?

a. Exhibitionism

b. Voyeurism

c. Frotteurism

d. Fetishism

ANS: D

To be sexually satisfied, a person with a sexual fetish finds it necessary to have some external object present, in fantasy or in reality. Frotteurism involves deriving sexual pleasure from rubbing against others surreptitiously. Exhibitionism is the intentional display of the genitalia in a public place. Voyeurism refers to viewing others in intimate situations.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. While performing an assessment, the nurse says to a patient, “While growing up, most of us heard some half-truths about sexual matters that continue to puzzle us as adults. Do any come to your mind now?” What is the purpose of this question?

a. To identify areas of sexual dysfunction for treatment

b. To determine possible homosexual urges

c. To introduce the topic of masturbation

d. To identify sexual misinformation

ANS: D

Misinformation about normal sex and sexuality is common. Lack of knowledge may affect an individual’s sexual adjustment. Once myths have been identified, the nurse can give information to dispel the myth.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

7. A woman tells the nurse, “My partner is frustrated with me. I don’t have any natural lubrication when we have sex.” What type of sexual disorder is evident?

a. Genito-pelvic pain/penetration disorder

b. Female sexual interest/arousal disorder

c. Hypoactive sexual desire disorder

d. Female orgasmic disorder

ANS: B

One feature of female sexual interest/arousal disorder relates to the inability to maintain physiologic requirements for intercourse. For women, this includes problems with lubrication and swelling. The patient’s description does not meet criteria for diagnoses in the distracters.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

8. An indigenous patient describes being conflicted about the presence of both a female and male energy in her body. The patient is referring to which indigenous cultural perspective on sexuality?

a. Homosexuality

b. Cisgender

c. Two-spirit

d. Bisexuality

ANS: D

Two-spirit is used by some Indigenous people to describe their gender, sexual or spiritual identity and refers to a person who embodies both a male and female spirit. Those who identity as homosexual are sexually attracted to people of the same sex. Cisgender refers to one’s gender identity being aligned with their gender assigned at birth. People who are attracted to both men and women use the term bisexual to describe their sexual orientation.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. A woman consults the nurse practitioner because she has not achieved orgasm for 2 years, despite having been sexually active. The nurse may initially explore with the patient, which of the following?

a. Discomfort with sexual activity

b. Prior history of sexual abuse

c. A comprehensive sexual health assessment

d. Nature of sexual orientation and preference

ANS: B

The persistent inhibition of orgasm is a form of sexual dysfunction. Conducting a comprehensive sexual health assessment will allow for open exploration of the patient's concern. All other options are areas that may be discussed once the comprehensive exam is completed.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

10. An adult consulted a nurse practitioner because of an inability to achieve orgasm for 2 years, despite having been sexually active. This adult was frustrated and expressed concerns about the relationship with the sexual partner. Which nursing diagnosis is most appropriate for this scenario?

a. Defensive coping

b. Sexual dysfunction

c. Ineffective sexuality pattern

d. Disturbed sensory perception, tactile

ANS: B

Sexual dysfunction is the most appropriate nursing diagnosis for a patient who is experiencing a problem affecting one or more phases of arousal. This is the primary problem reported by this patient. Ineffective sexuality pattern, since it is due to sexual dysfunction, is secondary to the absence of orgasms and is indicated by expressions of concern regarding one's own sexuality. The patient has not indicated not

becoming aroused, just the inability to achieve orgasm. Disturbed sensory perception may be part of the etiology, but the problem is sexual dysfunction. There is no evidence of Defensive coping.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

11. An adult consulted a nurse practitioner because of an inability to achieve orgasm for 2 years, despite having been sexually active. This adult was frustrated and expressed concerns about the relationship with the sexual partner. Which documentation best indicates the treatment was successful?

a. “No complaints related to sexual function; to return next week.”

b. “Patient reports achieving orgasm last week; seems very happy.”

c. “Reports satisfaction with sexual encounters; feels partner is supportive.”

d. “Reports achieving orgasm occasionally; relationship with partner is adequate.”

ANS: C

Human sexuality, sexual expression, and expectations related to sexuality vary tremendously from person to person and across cultures. Therefore, the best indication of satisfactory treatment is that the patient is satisfied with what has been achieved. In this instance, “Patient reports satisfaction with sexual encounters; feels partner is supportive” best indicates that the patient is satisfied, and both presenting issues are progressing in a positive manner. Achieving orgasm once or occasionally may or may not represent satisfactory progress to the patient. “No complaints” does not necessarily mean that the person is satisfied.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

12. Which characteristic fits the usual profile of an individual diagnosed with gender dysphoria?

a. Aggression

b. Persistent low mood

c. Promiscuous

d. Attention seeking

ANS: B

People with gender dysphoria, prior to gender reassignment, medical and/or psychological support, suffer

from a pervasive and sustained low mood. The other characteristics are not seen in a usual case of gender

dysphoria

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

13. A nurse is anxious about assessing the sexual history of a patient who is considerably

older than the nurse is. Which statement would be most appropriate for obtaining information about

the patient's sexual practices?

a. "Some people are not sexually active, others have a partner, and some have several

partners. What has been your pattern?"

b. "Sexual health can reflect a number of medical problems, so I'd like to ask if you

have any sexual problems you think we should know about."

c. "It's your own business, of course, but it might be helpful for us to have some

information about your sexual history. Could you tell me about that, please?"

d. "I would appreciate it if you could share your sexual history with me, so I can share

it with your health care provider. It might be helpful in planning your treatment."

ANS: A

Explaining that sexual practices vary helps reduce patient anxiety about the topic by normalizing the full

range of sexual practices so that whatever his situation, the patient can feel comfortable sharing it. "It's

your business of course . . ." implies the nurse does not have a valid reason to seek the information and in

effect suggests that the patient perhaps should not answer the question. "It might be helpful . . ." makes

the information seem less valid or important for the nurse to pursue and, again, could discourage the

patient from responding fully. Asking if the patient has any sexual problems that staff should know about

is not unprofessional, but it is a very broad question that may increase a patient's uncertainty about what

the nurse wants to hear, thus increasing his anxiety. Defining or giving an example of "sexual problem"

would make this inquiry more effective.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

14. A man says, "I enjoy watching women when I am out in public. I like to go to places

where I can observe women crossing their legs in hopes of seeing something good." Which

statement about this behaviour is most accurate?

a. It is a sexual disorder. The behaviour is socially atypical. It could disrupt

relationships and could be insulting to others.

b. It is not a sexual disorder. These events occur in public, where those he observes do

not have a reasonable expectation of privacy.

c. It is not a sexual disorder. Because it occurs in public areas, this behaviour does not

hurt others or involve intrusion into the personal space of those observed.

d. An action is or is not a sexual disorder depending on applicable local laws, so

whether this meets the definition of a sexual disorder depends on the location.

ANS: A

A sexual disorder is defined as an activity that is socially atypical, has the potential to disrupt significant

relationships, and may result in insult or injury to others. The behaviour described constitutes a sexual

disorder (voyeurism). Many of the people involved in nonstandard sexual practices find no need for

therapy because their sexual activities are carried out with a consenting adult partner, and they are neither

illegal nor physically nor emotionally harmful to either partner. If, however, the person is experiencing

relationship difficulties, wishes to change the sexual behaviours, becomes involved in illegal activity, or

is physically or emotionally harming others or being harmed, therapy is indicated.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. A parent who is very concerned about a 3-year-old son says, "He likes to play with

girls' toys. Do you think he is homosexual or mentally ill?" Which response by the nurse most professionally describes the current understanding of gender identity?

a. "A child's interest in the activities of the opposite gender is not unusual or related to sexuality. Most children do not carry cross-gender interests into adulthood."

b. "It's difficult to say for sure because the research is incomplete so far, but chances are that he will grow up to be a normal adult."

c. "The research is incomplete, but many boys play with girls' toys and turn out normal as adults."

d. "I am sure that whatever happens, he will be a loving son, and you will be a proud parent."

ANS: A

The parent's inquiry is really two questions: (1) whether the child's behaviour suggests an increased risk of developing mental illness and (2) what the child's future sexual preference will be. The psychiatric disorder that most directly addresses gender preferences and cross-gender activities is gender identity disorder. Pointing out that cross-gender activities are not necessarily related to gender identity and not likely to be carried into adulthood is supported by current research. Saying the child will grow up to be "normal" implies that to be homosexual is to be abnormal, which reflects a cultural perspective that most professionals would believe to be inappropriate to share in a professional setting. Research provides information about the relationship between cross-gender interests in childhood and adulthood, so a comment that "research is incomplete" is not entirely accurate. Stating that the child is a wonderful boy the parent will be proud of, whatever happens, evades the parent's question and suggests that parental bonds should not be affected by gender issues. The nurse has a professional obligation to maintain an objective, therapeutic relationship.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

16. Which statement about intersex is accurate?

a. Intersexed individuals fail to integrate their gender identity effectively

b. People with intersex rarely experience shame and are not distressed by their condition.

c. People with intersex would be described as being overly dependant personalities.

d. Intersex is not uncommon and people with the disorder are likely to receive adequate treatment to resolve the disorder.

ANS: D

Intersex is a set of medical conditions that feature a congenital anomaly of the reproductive system or genitals. Intersex individuals are born with chromosomes, external genitalia, or internal reproductive systems that are not considered either male or female. The remaining distractors do not address the foundation of what defines Intersex.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. A respected university coach was arrested after a student reported the coach attempted to have sexual contact. Which nursing action has priority in the period immediately following the coach's arrest?

a. Determine the nature and extent of the coach's sexual disorder.

b. Assess the coach's potential for suicide or other self-harm.

c. Assess the coach's self-perception of problem and needs.

d. Determine whether other students were harmed.

ANS: B

Individuals with internalized sexual dysfunction may be at increased risk of self-harm associated with the guilt, shame, and anger they feel about their behaviour, and its effect on their families, victims, and victims' families. These individuals also face considerable losses, such as the end of their careers or the loss of freedom due to imprisonment. Thus, safety is the priority issue for assessment. Determining the nature and extent of the patient's disorder and related patient perceptions would be appropriate but not the highest priority for assessment. Investigating whether other victims exist is a matter for law enforcement rather than health care providers. See relationship to audience response question.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. An adult seeks treatment for homosexual desires. The adult has not acted on these urges but feels shame. Which finding best indicates that this adult is making progress in understanding and accepting the desires?

a. The adult consistently avoids opportunities to explore the homosexual desires.

b. The adult indicates sexual drive and enjoyment from sex have decreased.

c. The adult reports an active and satisfying sex life with a heterosexual partner.

d. The adult begins to talk about a history of these desires dating back to early childhood and can see the progression in sexual identity.

ANS: D

Reconciling one's sexual identity as a by-product of genetic expression that is outside of the individual's control is an important step in accepting and acknowledging the desire as a part of who the person is. A diminished sex drive or a healthy sex life with an appropriate heterosexual partner does not normally reduce the desire for a homosexual relationship in individuals who have these desires.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

19. A patient's medical record documents gender as unknown. This patient may be addressed in which of the following ways?

a. Initially assume the gender related to the most obvious physical traits

b. Begin by asking questions about their sexual health history

c. Allow the patient to tell you when they are ready

d. Approach the patient with the name listed on the document and ask if this is their preferred name

ANS: D

By asking the patient their preferred name you are opening up the dialogue on gender identification and how they would feel most comfortable in being addressed. Asking questions about sexual health history or waiting for the patient to provide gender information when ready may establish a situation where assumptions are being made by the nurse in terms of how the patient currently identifies.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. A man presents to the nurse stating, “Intercourse with my new bride is painful for her and she seems disinterested in doing this with me.” How may you address the patient’s complaint?

a. “Can you tell me more about your relationship?”

b. “Do you feel she is disinterested in sex?”

c. “Tell me about her sexual health history.”

d. Discuss the stress of a new marriage as the likely reason for this issue.

ANS: A

Asking and answering questions related to sexual experiences and enjoyment can be challenging. Beginning the interaction by asking for a narrative on how the man feels the relationship is functioning may allow for a more natural exploration of these the current challenges. Making assumptions about the stress of a new marriage or delving into the wife’s sexual health history are not the immediate priorities or helpful strategies.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

21. A man who regularly experiences premature ejaculation tells the nurse, “I feel like such a failure. It’s so awful for both me and my partner.” Select the nurse’s most therapeutic response.

a. “I sense you are feeling frustrated and upset.”

b. “Tell me more about feeling like a failure.”

c. “You are too hard on yourself.”

d. “What do you mean by awful?”

ANS: A

Using reflection and empathy promotes trust and conveys concern to the patient. The distracters do not offer empathy, probe, or offer premature reassurance.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

22. A man who reports experiencing frequent premature ejaculation tells the nurse, “I feel like such a failure. It’s so awful for both me and my partner. Can you help me?” Select the nurse’s

best response.

a. “Have you discussed this problem with your partner?”

b. “I can refer you to a practitioner who can help you with this problem.”

c. “Have you asked your health care provider for prescription medication?”

d. “There are several techniques described in this pamphlet that might be helpful.”

ANS: B

The primary role of the nurse is to perform basic assessment and make appropriate referrals. The other options do not clarify the nurse’s role.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

23. A 10-year-old boy is diagnosed with gender dysphoria. Which assessment finding would the nurse expect?

a. Having tea parties with dolls

b. A compromised sexual response cycle

c. Identifying with boys who are athletic

d. Intense urges to watch his parents have sex

ANS: A

An individual with gender dysphoria feels at odds with the roles associated with their gender. A child with this diagnosis is likely to engage in play associated with the opposite gender. The other options are not age appropriate or characteristically seen in children with gender dysphoria.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. A patient approaches the nurse in the clinic waiting room and says, “I want to talk to you about a sexual matter.” The nurse can best facilitate the discussion by doing which of the following?

a. Saying, “Let’s go to my office.”

b. Responding, “I want to help. Go ahead; I’m listening.”

c. Telling the patient, “Let’s schedule another appointment.”

d. Offering to sit in a corner of the waiting room with the patient.

ANS: A

A discussion of sexual concerns requires privacy. Suggesting use of office space is preferable to using the waiting room, where others cannot help but overhear sensitive material. The distracters block communication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Health disparities in the LGBTQ population have been linked to higher rates of which of the following? (Select all that apply.)

a. Depression

b. Sexual dysfunction

c. Self-Harm

d.

Suicide

e. Substance Abuse

ANS: A, C, D, E

When considering the social determinates of health as they relate to the LGBTQ community, marginalization, discrimination, and stigma can all lead to inadequate access to health care resources/education, social isolation that can play a significant role in the development of depression, suicidality, and substance abuse. Sexual dysfunction, if present, would not be directly related to health disparities.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 27: Disorders of Children and Adolescents

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Which factor presents the highest risk for a child to develop a psychiatric disorder?

a. Having an uncle with schizophrenia

b. Being the oldest child in a family

c. Living with a depressed parent

d. Being an only child

ANS: C

A child with a parent with depression is at risk for developing an anxiety disorder, mood disorder, conduct disorder, or substance abuse disorder. The parent's inability to model effective coping strategies can lead to learned helplessness, the creation of anxiety or apathy, and an inability to master the environment. Being in a middle-income family and being the oldest child do not represent psychosocial adversity. Having a family history of schizophrenia presents a risk, but a depressed parent in the family offers a greater risk.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which nursing diagnosis is universally applicable for children diagnosed with autism spectrum disorders?

a. Impaired social interaction related to difficulty relating to others

b. Chronic low self-esteem related to excessive negative feedback

c. Deficient fluid volume related to abnormal eating habits

d. Anxiety related to nightmares and repetitive activities

ANS: A

This disorder affects the normal development of the brain in social interaction and communication skills. People with autism spectrum disorder (ASD) typically have difficulties in verbal and nonverbal communication, social interactions, and leisure or play activities. Language is often delayed and deviant, further complicating relationship issues. The other nursing diagnoses might not be appropriate in all cases.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Psychosocial Integrity

3. Which behaviour indicates that the treatment plan for a child diagnosed with an autism spectrum disorder was effective?

a. The child plays with one toy for 30 minutes.

b. The child repeats words spoken by a parent.

c. The child holds the parent's hand while walking.

d. The child spins around and claps hands while walking.

ANS: C

A characteristic of a child with autism spectrum disorder (ASD) is an indifference or aversion to affection and physical contact. Holding the hand of another person suggests relatedness. Usually, a child with ASD would resist holding someone's hand and stand or walk alone, perhaps flapping arms or moving in a stereotyped pattern. The incorrect options reflect behaviours that are consistent with ASDs.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

4. A kindergartener is disruptive in class. This child is unable to sit for expected lengths of time, is inattentive to the teacher, screams while the teacher is talking, and is aggressive toward other children. The nurse plans interventions designed to do which of the following?

a. Promote integration of self-concept

b. Provide inpatient treatment for the child

c. Reduce loneliness and increase self-esteem

d. Improve language and communication skills

ANS: C

Because of their disruptive behaviours, children with attention deficit-hyperactivity disorder (ADHD) often receive negative feedback from parents, teachers, and peers, leading to self-esteem disturbance. These behaviours also cause peers to avoid the child with ADHD, leaving the child with ADHD vulnerable to loneliness. The child does not need inpatient treatment at this time. The incorrect options may or may not be relevant.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

5. A nurse will prepare teaching materials for the parents of a child newly diagnosed with attention deficit-hyperactivity disorder. Which medication will the information focus on?

a. Paroxetine (Paxil)

b. Citalopram (Celexa)

c. Methylphenidate (Ritalin)

d. Carbamazepine (Tegretol)

ANS: C

CNS stimulants are the drugs of choice for treating children with attention deficit-hyperactivity disorder (ADHD): Ritalin and Dexedrine are commonly used. None of the other drugs are psychostimulants used to treat ADHD.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

6. What is the nurse's priority focused assessment for adverse effects in a child taking methylphenidate (Ritalin) for attention deficit-hyperactivity disorder (ADHD)?

a. Dystonia, akinesia, and extrapyramidal symptoms

b. Bradycardia and hypotensive episodes

c. Sleep disturbances and weight loss

d. Neuroleptic malignant syndrome

ANS: C

The most common side effects are gastrointestinal disturbances, reduced appetite, weight loss, urinary retention, dizziness, fatigue, and insomnia. Weight loss has the potential to interfere with the child's growth and development. The distracters relate to adverse effects of conventional antipsychotic medications.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

7. A desired outcome for a 12-year-old diagnosed with attention deficit-hyperactivity disorder is to improve relationships with other children. Which treatment modality should the nurse suggest for the plan of care?

a. Reality therapy

b. Simple restitution

c. Social skills group

d. Insight-oriented group therapy

ANS: C

Development of problem solving, conflict resolution, empathy, and social skills are important treatment modalities for the nurse to consider when planning care. Social skills training teaches the child to recognize the impact of his or her behaviour on others. It uses instruction, role-playing, and positive reinforcement to enhance social outcomes. The other therapies would have a lesser or no impact on peer

relationships.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

8. The parent of a 6-year-old says, “My child is in constant motion and talks all the time. My child isn’t interested in toys but is out of bed every morning before me.” The child’s behaviour is most consistent with diagnostic criteria for which of the following?

a. Communication disorder

b. Stereotypic movement disorder

c. Intellectual development disorder

d. Attention deficit-hyperactivity disorder

ANS: D

Excessive motion, distractibility, and excessive talkativeness are seen in attention deficit-hyperactivity disorder (ADHD). The behaviours presented in the scenario do not suggest intellectual development, stereotypic, or communication disorders.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. A child diagnosed with attention deficit-hyperactivity disorder had this nursing diagnosis: Impaired social interaction related to excessive neuronal activity as evidenced by aggression and demanding behaviour with others. Which finding indicates the plan of care was effective?

a. The child has an improved ability to identify anxiety and use self-control strategies.

b. The child has increased expressiveness in communication with others.

c. The child shows increased responsiveness to authority figures.

d. The child engages in cooperative play with other children.

ANS: D

The goal should be directly related to the defining characteristics of the nursing diagnosis, in this case, improvement in the child's aggressiveness and play. The distracters are more relevant for a child with autism spectrum or anxiety disorder.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

10. When a 5-year-old diagnosed with attention deficit-hyperactivity disorder bounces out of a chair and runs over and slaps another child, what is the nurse's best action?

a. Instruct the parents to take the aggressive child home.

b. Direct the aggressive child to stop immediately.

c. Call for emergency assistance from other staff.

d. Take the aggressive child to another room.

ANS: D

The nurse should manage the milieu with structure and limit-setting. Removing the aggressive child to another room is an appropriate consequence for the aggressiveness. Directing the child to stop will not be effective. This is not an emergency. Intervention is needed rather than sending the child home.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

11. A child diagnosed with attention deficit-hyperactivity disorder will begin medication therapy. The nurse should prepare a plan to teach the family about which classification of medications?

a. Psychostimulants

b. Tricyclic antidepressants

c. Antipsychotics

d. Anxiolytics

ANS: A

Psychostimulants, such as methylphenidate and pemoline (Cylert), increase blood flow to the brain and have proved helpful in reducing hyperactivity in children and adolescents with attention deficit-hyperactivity disorder. The other medication categories listed would not be appropriate.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning
MSC: Client Needs: Physiological Integrity

12. Soon after parents announced they were divorcing, their child stopped participating in sports, sat alone at lunch, and avoided former friends. The child told the school nurse, "If my parents loved me, they would work out their problems." Which nursing diagnosis has the highest priority?

a. Social isolation
b. Decisional conflict
c. Chronic low self-esteem
d. Disturbed personal identity

ANS: A

This child shows difficulty coping with problems associated with the family. Social isolation refers to aloneness that the patient perceives negatively, even when self-imposed. The other options are not supported by data in the scenario.

DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Analysis/Diagnosis
MSC: Client Needs: Psychosocial Integrity

13. A nurse works with a child who is sad and irritable because the child's parents are divorcing. Why is establishing a therapeutic alliance with this child a priority?

a. Therapeutic relationships provide an outlet for tension.
b. Focusing on the strengths increases a person's self-esteem.
c. Acceptance and trust convey feelings of security to the child.
d. The child should express feelings rather than internalize them.

ANS: C

The initial interview is key to building trust and rapport. Trust is frequently an issue because the child

may question his or her trusting relationship with the parents. In this situation, the trust the child once had

in the parents has been disrupted, reducing feelings of security. This answer is the most global response.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

14. A nurse assesses a 3-year-old diagnosed with an autism spectrum disorder. Which

finding is most associated with the child's disorder?

a. The child has occasional toileting accidents.

b. The child is unable to read children's books.

c. The child cries when separated from a parent.

d. The child continuously rocks in place for 30 minutes.

ANS: D

Autism spectrum disorder (ASD) involves distortions in development of social skills and language that include perception, motor movement, attention, and reality testing. Body rocking for extended periods suggests ASD. The distracters are expected findings for a 3-year-old.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. A 4-year-old cries for 5 minutes when the parents leave the child at preschool. The

parents ask the nurse, "What should we do?" Select the nurse's best response.

a. "Ask the teacher to let the child call you at play time."

b. "Withdraw the child from preschool until maturity increases."

c. "Remain with your child for the first hour of preschool time."

d. "Give your child a kiss before you leave the preschool program."

ANS: D

The child demonstrates age-appropriate behaviour for a 4-year-old. The nurse should reassure the parents.

The distracters are over-reactions.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and

Maintenance

16. Which assessment finding would cause the nurse to consider a child to be most at risk for the development of mental illness?

a. The child has been raised by a parent with chronic major depression.

b. The child's best friend was absent from the child's birthday party.

c. The child was not promoted to the next grade one year.

d. The child moved to three new homes over a 2-year period.

ANS: A

Children raised by a depressed parent have an increased risk of developing an emotional disorder. Familial risk factors correlate with child psychiatric disorders, including severe marital discord, low socioeconomic status, large families and overcrowding, parental criminality, maternal psychiatric disorders, and foster-care placement. The chronicity of the parent's depression means it has been a consistent stressor. The other factors are not as risk-enhancing.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. The child who has been prescribed an antipsychotic medication to manage violent behaviour was most likely diagnosed with which of the following?

a. Attention deficit-hyperactivity disorder

b. Post-traumatic stress disorder

c. Communication disorder

d. An anxiety disorder

ANS: A

Antipsychotic medication is useful for managing aggressive or violent behaviour in some children diagnosed with attention deficit-hyperactivity disorder. If medication was prescribed for a child with an anxiety disorder, it would be a benzodiazepine. Medications are generally not needed for children with communication disorder. Treatment of post-traumatic stress disorder is more often associated with SSRI medications.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

18. A child reports to the school nurse that he was verbally bullied by an aggressive

classmate. What is the nurse's best first action?

a. Give notice to the chief administrator at the school regarding the events.

b. Encourage the victimized child to share feelings about the experience.

c. Encourage the victimized child to ignore the bullying behaviour.

d. Discuss the events with the aggressive classmate.

ANS: B

The behaviours by the bullying child create emotional pain and present the risk for physical pain. The nurse should first listen to the child's complaints and validate the child for reporting the events. Later, school authorities should be notified. School administrators are the most appropriate personnel to deal with the bullying child. The behaviour should not be ignored; it will only get worse.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

19. Assessment data for a 7-year-old reveals an inability to take turns, blurting out answers to questions before a question is complete, and frequently interrupting others' conversations. How should the nurse document these behaviours?

a. Defiance

b. Hyperactivity

c. Impulsivity

d. Anxiety

ANS: C

These behaviours are most directly related to impulsivity. Hyperactive behaviours are more physical in nature, such as running, pushing, and the inability to sit. Defiance is demonstrated by willfully doing what an authority figure has said not to do. Anxiety behaviours in children are typically more withdrawn and avoidant than expressive.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. A child diagnosed with attention deficit-hyperactivity disorder (ADHD) shows hyperactivity, aggression, and impaired play. The health care provider prescribed amphetamine

(Adderall XR). For which desired behaviour should the nurse monitor?

a. Increased expressiveness in communication with others

b. Abilities to identify anxiety and implement self-control strategies

c. Improved ability to participate in cooperative play with other children

d. Ability to tolerate social interactions for short periods without disruption or frustration

ANS: C

The goal is improvement in the child's symptoms of ADHD, for example, hyperactivity, aggression, and play. The remaining options are more relevant for a child with intellectual development disorder or an anxiety disorder.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

21. When group therapy is prescribed as a treatment modality, the nurse would suggest placement of a 9-year-old in a group that uses which of the following?

a. Guided imagery

b. Talk focused on a specific issue

c. Play and talk about a play activity

d. Group discussion about selected topics

ANS: C

Group therapy for young children takes the form of play. For elementary school children, therapy combines play and talk about the activity. For adolescents, group therapy involves more talking.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

22. Which child demonstrates behaviours indicative of a neurodevelopmental disorder?

a. A 4-year-old who stuttered for 3 weeks after the birth of a sibling

b. A 9-month-old who does not eat vegetables and likes to be rocked

c. A 3-month-old who cries after feeding until burped, then sucks a thumb

d. A 3-year-old who is mute, passive toward adults, and twirls while walking

ANS: D

Symptoms consistent with autistic spectrum disorders (ASD) are evident in this answer. ASD is one type of neurodevelopmental disorder. The behaviours of the other children are within normal ranges.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

23. The parent of a child diagnosed with Tourette's disorder says to the nurse, "I think my child is faking the tics because they come and go." Which response by the nurse is accurate?

a. "Perhaps your child was misdiagnosed."

b. "Your observation indicates the medication is effective."

c. "Tics often change frequency or severity. That doesn't mean they aren't real."

d. "This finding is unexpected. How have you been administering your child's medication?"

ANS: C

Tics are sudden, rapid, involuntary, repetitive movements or vocalizations characteristic of Tourette's disorder. They often fluctuate in frequency and severity and are reduced or absent during sleep.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. When a 5-year-old is disruptive, the nurse says, "You must take a time out." The expectation is that the child will do which of the following?

a. Go to a quiet room until called for the next activity

b. Slowly count to 20 before returning to the group activity

c. Sit on the edge of the activity until able to regain self-control

d. Sit quietly on the lap of a staff member until able to apologize for the behaviour

ANS: C

A time out is designed so that staff can be consistent in their interventions. A time out may require going to a designated room or sitting on the periphery of an activity until the child gains self-control and reviews the episode with a staff member. A time out may not require going to a designated room and does not involve special attention such as holding. Counting to 10 or 20 is not sufficient.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

25. A parent diagnosed with schizophrenia and a 13-year-old child live in a homeless shelter. The child formed a trusting relationship with a shelter volunteer. The child says, “My three friends and I got an A on our school science project.” What does this allow the nurse to assess about the child?

a. That the child displays resiliency

b. That the child has a passive temperament

c. That the child is at risk for post-traumatic stress disorder

d. That the child uses intellectualization to deal with problems

ANS: A

Resiliency enables a child to handle the stresses of a difficult childhood. Resilient children can adapt to changes in the environment, take advantage of nurturing relationships with adults other than parents, distance themselves from emotional chaos occurring within the family, learn, and use problem-solving skills.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse prepares to lead a discussion at a community health centre regarding children’s health problems. The nurse wants to use current terminology when discussing these issues. Which terms are appropriate for the nurse to use? (Select all that apply.)

a. Autism

b. Bullying

c. Mental retardation

d. Autism spectrum disorder

e. Intellectual development disorder

ANS: B, D, E

Some dated terminology contributes to the stigma of mental illness and misconceptions about mental

illness. It's important for the nurse to use current terminology.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A nurse prepares the plan of care for a 15-year-old diagnosed with moderate intellectual developmental disorder. What are the highest outcomes that are realistic for this patient? Within 5 years, the patient will be able to do which of the following? (Select all that apply.)

a. Graduate from high school

b. Live independently in an apartment

c. Independently perform own personal hygiene

d. Obtain employment in a local sheltered workshop

e. Correctly use public buses to travel in the community

ANS: C, D, E

Individuals with moderate intellectual developmental disorder progress academically to about the second grade. These people can learn to travel in familiar areas and perform unskilled or semiskilled work. With supervision, the person can function in the community, but independent living is not likely.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

3. At the time of a home visit, the nurse notices that each parent and child in a family has his or her own personal online communication device. Each member of the family is in a different area of the home. Which nursing actions are appropriate? (Select all that apply.)

a. Report the finding to the official child protection social services agency.

b. Educate all members of the family about risks associated with cyberbullying.

c. Talk with the parents about parental controls on the children's communication devices.

d. Encourage the family to schedule daily time together without communication devices.

e. Obtain the family's network password and examine online sites family members have visited.

ANS: B, C, D

Education and awareness-based approaches have a chance of effectively reducing harmful online behaviour, including risks associated with cyberbullying. Parental controls on the children's devices will support safe Internet use. Family time will promote healthy bonding and a sense of security among family

members. There is no evidence of danger to the children, so a report to a child protective agency is unnecessary. It would be inappropriate to seek the family's network password and an invasion of privacy to inspect sites family members have visited.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

Chapter 28: Psychosocial Needs of the Older Adult

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A student nurse visiting a seniors centre says, "It's depressing to see these old people. They are weak and frail. I doubt any of them can engage in a discussion." The student is expressing which of the following?

a. Reality

b. Ageism

c. Empathy

d. Vulnerability

ANS: B

Ageism is a bias against older people because of their age. None of the other options applies to the ideas expressed by the student.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. A nurse plans an educational program for staff of a home health agency specializing in

care of the elderly. Which topic is the highest priority to include?

a. Pain assessment techniques for older adults

b. Psychosocial stimulation for those who live alone

c. Preparation of psychiatric advance directives in the elderly

d. Ways to manage disinhibition in elderly persons with dementia

ANS: A

The topic of greatest immediacy is the assessment of pain in older adults. Unmanaged pain can precipitate

other problems, such as substance abuse and depression. Elderly patients are less likely to be accurately

diagnosed and adequately treated for pain. The distracters are unrelated or of lesser importance.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Physiological Integrity

3. Select the best comment for a nurse to begin an interview with an elderly patient.

a. “I am a nurse. Are you familiar with what nurses do?”

b. “Hello. I am going to ask you some questions to get to know you better.”

c. “You look comfortable and ready to participate in an admission interview. Shall we

get started?”

d. “Hello. My name is _____ and I am a nurse. How you would like to be addressed

by staff?”

ANS: D

The opening that identifies the nurse’s role and politely seeks direction for addressing the patient in a way

that will make him or her comfortable is most appropriate. This is particularly important when a

considerable age difference exists between the nurse and the patient. The nurse should address patients by

name and not assume patients want to be called by a first name. The nurse should always introduce

himself or herself.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. Which information is most important to obtain during assessment of an older adult

diagnosed with a mental disorder?

a. Functional ability and emotional status

b. Chronological age and sexual function

c. Economic status and sources of income

d. Developmental history, interests, and activities

ANS: A

Information related to functional ability and emotional status provides an overview of patient problems and abilities. It guides selection of interventions and services to meet identified needs. The distracters reflect information of relevance but are not of highest priority.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

5. A 75-year-old patient comes to the clinic reporting frequent headaches. As the nurse begins the interaction, which action is most important?

a. Complete a neurological assessment.

b. Determine whether the patient can hear as the nurse speaks.

c. Suggest that the patient lie down in a darkened room for a few minutes.

d. Administer medication to relieve the patient's pain before continuing the assessment.

ANS: B

Before proceeding with any further assessment, the nurse should assess the patient's ability to hear questions. Impaired hearing could lead to inaccurate answers.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Which statement about aging provides the best rationale for focused assessment of elderly patients?

a. The elderly are usually socially isolated and lonely.

b. Vision, hearing, touch, taste, and smell decline with age.

c. The majority of elderly patients have some form of early dementia.

d. As people age, thinking becomes more rigid and learning is impaired.

ANS: B

Option B is the only true statement. It cues the nurse to assess sensory function in the elderly patient.

Correcting vision and hearing are critical to providing safe care. The distracters are myths about aging.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. A nurse assesses an elderly patient. The nurse should complete the Geriatric Depression

Scale if the patient answers which question affirmatively?

a. “Would you say your mood is often sad”

b. “Are you having any trouble with your memory?”

c. “Have you noticed an increase in your alcohol use?”

d. “Do you often experience moderate to severe pain?”

ANS: A

Feeling low may be a symptom of depression. Low moods occurring with regularity should signal the

need for further assessment for other symptoms of depression. The other options do not focus on mood.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A health-care provider writes these new orders for a resident in a nursing home: 2 G

sodium diet, Restraint as needed, Limit fluids to 1800 mL daily, Continue antihypertensive

medication, Milk of Magnesia 30 mL PO once if no bowel movement for 3 days. What should the

nurse do?

a. Question the fluid restriction

b. Question the order for restraint

c. Transcribe the prescriptions as written

d. Assess the resident’s bowel elimination

ANS: B

Restraints may be imposed but the nurse should question the indications for use with this patient as well

as the time frame of use. The other orders are appropriate and specific.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

9. An elderly patient must be physically restrained. Who is responsible for the patient's safety?

a. The nurse assigned to care for the patient

b. Unlicensed assistive personnel who apply the restraint

c. Family member who agrees to application of the restraint

d. Health care provider who prescribed application of restraint

ANS: A

Although restraint is prescribed by a health care provider, the restraint is a measure carried out by nursing staff. The nurse caring for the patient is responsible for safe application of restraining devices and for providing safe care while the patient is restrained. Even when family agree to restraint, nurses are responsible for providing safe outcomes.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

10. A new nurse says, "My elderly patient has Lewy body disease. What should I do about assessing for pain?" Select the best response from the nurse manager.

a. "Ask the patient's family if they think the patient is experiencing pain."

b. "Use a visual analog scale to help the patient determine the presence and severity of pain."

c. "There are special scales for assessing patients with dementia. Let's review how to use them."

d. "The perception of pain is diminished by this type of dementia. Focus your assessment on the patient's mental status."

ANS: C

Lewy body disease is a form of dementia. There are special scales to assess the presence and severity of

pain in patients with dementia. The Pain Assessment in Advanced Dementia Scale (PAINAD) evaluates breathing, negative vocalizations, body language, and consolability. A patient with dementia would be unable to use a visual analog scale. The family may be able to help the nurse gain perspective about the pain, but this strategy alone is inadequate. The other distracter is a myth.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

11. What is considered the most common mental health disorder in the elderly?

a. Depression

b. Anxiety

c. Chronic pain

d. Sleep disorders

ANS: B

Anxiety disorders in late life are twice as prevalent as dementia and four to eight times as common as major depressive disorders.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

12. For which of the following reasons is it difficult to diagnosis alcohol abuse in the older adult?

a. They have built up an alcohol tolerance.

b. They remain alone a lot of time.

c. Personality changes are frequently unrecognized.

d. It is usually masked by mental illness.

ANS: C

Identifying alcohol and substance abuse is often difficult because personality and behavioural changes frequently go unrecognized in older adults.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

13. A physically frail elderly patient with mild cognitive impairments needs the services of

a facility that can provide supervision and safety as well as recreation and social interaction. The family cares for this patient during the evening and night. Which type of facility should the nurse suggest to meet this patient's needs?

a. Adult day program

b. Nursing home

c. Partial hospitalization

d. Group home

ANS: A

A day program provides recreation and social interaction as well as supervision in a safe environment. Nursing, medical, and rehabilitative care are usually not provided. Nursing homes go beyond meeting recreational and social needs by providing medical interventions and nursing and rehabilitation services on a 24-hour basis. Partial hospitalization provides acute psychiatric hospital programs. A group home is inappropriate and would not meet the patient's needs.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

14. A 79-year-old white male tells a nurse, "I have felt very sad lately. I do not have much to live for. My family and friends are all dead, and my own health is failing." The nurse should analyze this comment as which of the following?

a. Normal pessimism of the elderly

b. Evidence of risks for suicide

c. A call for sympathy

d. Normal grieving

ANS: B

The patient describes loss of significant others, economic security, and health. He describes mood alteration and voices the thought that he has little to live for. Combined with his age, sex, and single status, each is a risk factor for suicide. Elderly white males have the highest risk for completed suicide.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Psychosocial Integrity

15. In a sad voice, an elderly patient tells the nurse of the recent deaths of a spouse and close friend. The patient has no other family and only a few acquaintances in the community. The nurse's priority is to determine which nursing diagnosis applies to this patient?

a. Risk for suicide related to recent deaths of significant others

b. Anxiety related to sudden and abrupt lifestyle changes

c. Social isolation related to loss of existing family

d. Spiritual distress related to anger with God

ANS: A

The patient appears to be experiencing normal grief related to the loss of her family, but because of age and social isolation, the risk for suicide should be determined and has high priority. No defining characteristics exist for the diagnoses of anxiety or spiritual distress. The patient's social isolation is important, but the risk for suicide has higher priority.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Analysis/Diagnosis

MSC: Client Needs: Psychosocial Integrity

16. When determining whether an elderly patient's confusion is related to delirium or another problem, what information would be of particular value?

a. Evidence of spasticity or flaccidity

b. The patient's level of motor activity

c. Medications the patient has recently taken

d. The patient's level of preoccupation with somatic symptoms

ANS: C

Delirium in the elderly produces symptoms of confusion. Medication interactions or adverse reactions are often a cause. The distracters do not give information important for delirium.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

17. An 85-year-old has difficulty walking after a knee replacement. The patient tells the nurse, "It's awful to be old. Every day is a struggle. No one cares about old people." Select the nurse's best response.

a. “Everyone here cares about old people. That’s why we work here.”

b. “It sounds like you’re having a difficult time. Tell me about it.”

c. “Let’s not focus on the negative. Tell me something good.”

d. “You are still able to get around, and your mind is alert.”

ANS: B

The nurse uses empathic understanding to permit the patient to express frustration and clarify her “struggle” for the nurse. The distracters block communication.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A 76-year-old is regressed, indifferent, and responds to others only when they initiate an interaction. What form of group therapy would be most useful to promote resocialization?

a. Remotivation

b. Activity group

c. Psychotherapy

d. Reminiscence (life review)

ANS: A

Remotivation therapy helps to resocialize regressed and apathetic patients by focusing on a single topic, creating a bridge to reality as group members talk about the world in which they live and work and hobbies related to the topic. Group leaders give members acceptance and appreciation. Group psychotherapy would not be effective for this patient. An activity group does not address the patient’s problem.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

19. A nurse assesses four patients between the ages of 70 and 80 years. Which patient has the highest risk for alcohol abuse?

a. The patient who consumed one glass of wine nightly with dinner

b. The patient who began drinking alcohol daily after retirement and says, “A few drinks keep my mind off my arthritis.”

c. The patient who drank socially throughout adult life and continues this pattern,

saying “I’ve earned the right to do as I please.”

d. The patient who abused alcohol between the ages of 25 and 40 years but now

abstains and occasionally attends Alcoholics Anonymous (AA)

ANS: B

Alcohol abuse and dependence can develop at any age, and the geriatric population is particularly at risk.

Losses, such as retirement, widowhood, and loneliness, are often related. The distracters describe patients

with a lower risk for alcohol abuse.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. A nurse wants to assess for suicidal ideation in an elderly patient. Select the best

question to begin this assessment.

a. “Are there any things going on in your life that would cause you to consider

suicide?”

b. “What are your beliefs about a person’s right to take his or her own life?”

c. “Do you think you are vulnerable to developing a depressed mood?”

d. “If you felt suicidal, would you tell someone about your feelings?”

ANS: B

This question is clear, direct, and respectful. It will produce information relative to the acceptability of

suicide as an option to the patient. If the patient deems suicide unacceptable, no further assessment is

necessary. If the patient deems suicide acceptable, the nurse can continue to assess intent, plan, means to

carry out the plan, lethality of the chosen method, and so forth. The other options are less direct, may

produce responses that may be unclear, or are appropriate for use later in this discussion.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. A community health nurse visits an elderly person whose spouse died 6 months ago.

Two vodka bottles are in the trash. When the nurse asks about alcohol use, this person says, “I get

lonely and drink a little to help me forget.” Select the nurse’s most therapeutic intervention.

a. Assess whether this patient is drinking and driving.

b. Advise the person not to drink alone because the risks for injury increase.

c. Teach the person about risks for alcoholism and suggest other coping strategies.

d. Arrange for the person to attend an Alcoholics Anonymous meeting for older

adults.

ANS: D

Treatment plans should emphasize social therapies. Older adults who abuse alcohol tend to be more passive than younger adults who abuse alcohol and may benefit from interpersonal involvement with professional health care personnel. Older people respond well to emotional and social support, and family

therapy should be encouraged. Group therapy with other middle-aged and older adults with alcoholism, as

well as self-help groups like Alcoholics Anonymous, can also be effective. The distracters will not be therapeutic in this instance.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

22. Discharge planning begins for an elderly patient hospitalized for 2 weeks and

diagnosed with major depression. The patient needs ongoing assessment and socialization opportunities as well as education about medication and relapse prevention. The patient lives with a daughter, who works during the week. Select the best referral for this patient.

a. Behavioural health home care

b. A nursing home

c. Partial hospitalization

d. A halfway house

ANS: C

Partial hospitalization will provide services the patient needs as well as give supervision and meals to the patient while the daughter is at work. Home care would not provide socialization. The patient does not need the intensity of a nursing home. A halfway house provides 24-hour care and usually expects involvement in off-campus programs.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

23. A patient living in community housing for the elderly says, “I don’t go to the senior citizens club. They play cards and talk about the past because that’s all they can do.” The nurse analyzes these remarks to represent which of the following:

a. Failure to achieve developmental tasks

b. Thinking associated with ageism

c. Hypercritical behaviour

d. Paranoid thinking

ANS: B

Ageism is negative stereotyping and devaluation of people based on their age. Older adults might be as guilty of ageism as younger individuals. The other options are not substantiated by the information given in the scenario.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. A nurse plans a staff education program for employees of a senior living community. Which topic has priority?

a. Late-onset schizophrenia

b. Depression and suicide

c. Dementia

d. Delirium

ANS: B

Older adults frequently experience undiagnosed depression and are disproportionately more likely to commit suicide. Educating staff about signs and symptoms of high-risk patients and early intervention strategies will decrease morbidity and mortality. The other conditions have a lower prevalence.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

25. An older adult patient was diagnosed with schizophrenia at age 18. A nurse at the outpatient medication clinic interviews this patient. Which communication strategy will be most helpful?

a. Ask questions that can be answered with “yes” or “no.”

b. Ask clear, simple questions using concrete language.

c. Use silence often and let the patient take the lead.

d. Use open-ended, indirect questions.

ANS: B

Communication with individuals who have schizophrenia might be difficult because of the individual’s various thought disorders. The nurse can be most effective by using simple language, keeping to concrete concepts, and clarifying and validating as needed. The nurse needs more information than “yes” or “no” questions will provide.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

26. An elderly patient brings a bag of medications to the clinic. The nurse finds a bottle labelled “Ativan” and one labelled “lorazepam,” both of which are to be taken BID. There are also bottles labelled “hydrochlorothiazide,” “Inderal,” and “rofecoxib,” each to be taken once daily. Which conclusion is accurate?

a. Rofecoxib should not be taken with Ativan.

b. Lorazepam interferes with the action of Inderal.

c. The patient should not self-administer medication.

d. Lorazepam and Ativan are the same drug, so the dose is excessive.

ANS: D

Lorazepam and Ativan are generic and trade names for the same drug, creating an accidental misuse situation. The patient needs medication education and help with proper, consistent labelling of bottles; there is no evidence that the patient cannot self-administer medication. The other distracters are not factual statements.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

27. Which of the following is the highest priority for assessment by nurses caring for older adults who self-administer medications?

a. Use of multiple drugs with anticholinergic effects

b. Overuse of medications for erectile dysfunction

c. Missed doses of medications for arthritis

d. Trading medications with acquaintances

ANS: A

Anticholinergic effects are cumulative in older adults, causing confusion, and they often have adverse consequences related to accidents and injuries. The distracters may be relevant but are not the highest priority.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

28. A nurse and social worker co-lead a reminiscence group for eight elite-old adults.

Which activity is appropriate to include in the group?

a. Mild aerobic exercise

b. Singing a song from World War II

c. Discussing national leadership during the Vietnam War

d. Identifying the most troubling story in today's newspaper

ANS: B

Elite-old adults are 100+ years of age. They were young people during World War II. Reminiscence groups share memories of the past. The other options are less relevant to this age group.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

29. A nurse and social worker co-lead a reminiscence group for eight young-old adults.

Which activity is most appropriate to include in the group?

a. Mild aerobic exercise

b. Singing a song from World War II

c. Discussing national leadership during the Vietnam War

d. Identifying the most troubling story in today's newspaper

ANS: C

Young-old adults are persons 65 to 75 years of age. These adults were attuned to conflicts in national

leadership associated with the Vietnam War. Reminiscence groups share memories of the past. The other

options are less relevant to this age group.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse leads a staff development session about ageism among health care workers.

What information should the nurse include about the consequences of ageism? (Select all that

apply.)

a. Failure of the elderly to receive necessary medical information

b. Development of public policy that discriminates against the elderly

c. Staff shortages because caregivers prefer working with younger adults

d. The perception that elderly consume a smaller share of medical resources

e. More ancillary than professional personnel discriminate with regard to age

ANS: A, B, C

Because of society's negative stereotyping of the elderly as having little to offer, some people avoid working with older patients. Staff shortages in long-term care are common. Elderly patients are often provided less information about their conditions and fewer treatment options than younger patients are because some health care staff members perceive them as less able to understand. This problem exists equally among both professional and ancillary personnel. Public policy discriminates against programs for the elderly. Anger exists because the elderly are perceived to consume a disproportionately large share

of medical resources.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

2. A nurse assessing an elderly patient for depression and suicide potential should include

questions about mood as well as which of the following? (Select all that apply.)

a. Apathy

b. Increased appetite

c. Sleep pattern changes

d. Evidence of grandiosity

e. Neck and back pain

ANS: A, C, E

There are three categories of depressive symptoms: emotional (mood, motivation, apathy, anxiety), cognitive (concentration, memory), and physical (insomnia, fatigue, headache, and stomach, back, and neck pain). These responses relate to symptoms often noted in elderly patients with depression. Somatic symptoms are often present but missed by nurses as related to depression. Anorexia, rather than hyperphagia, occurs in major depression. Grandiosity is associated with bipolar disorder.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which assessment findings would alert the nurse that an older patient may have an increased risk for development of geriatric alcohol abuse? (Select all that apply.)

a. Mild recent memory impairment

b. Chronic pain

c. Death of spouse

d. Retirement

e. Loneliness

ANS: B, C, D, E

The geriatric problem drinker begins drinking in later life, often in response to stressors such as retirement, loss of spouse, and loneliness. Once the demands of job, career, and care of a family and household are gone, the structure of daily life is disrupted. Mild cognitive impairment is not a predisposing factor in the development of geriatric problem drinking. Other risk factors include less than a high school education, smoking, low income, and male gender.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. Which remarks by a 72-year-old patient should prompt the nurse to assess for depression? (Select all that apply.)

a. “Lately I have had a lot of aches and pains and just haven’t felt very well.”

b. “I cannot seem to remember anything at all anymore.”

c. “Don’t ask me to eat. I can’t because my stomach is upset all the time.”

d. “I’m eating more than usual, and I am sleeping about 6 hours a night.”

e. “Life seems more organized now that I don’t live in my own home.”

ANS: A, B, C

Any of the remarks listed should be enough to trigger use of an assessment tool for depression. There are

three categories of depressive symptoms: emotional (mood, motivation, apathy, anxiety), cognitive

(concentration, memory), and physical (insomnia, fatigue, headache, and stomach, back, and neck pain).

The distracters do not suggest symptoms of depression.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. Which beliefs by a nurse facilitate provision of safe, effective care for older adult

patients? (Select all that apply.)

a. Sexual interest declines with aging.

b. Older adults are able to learn new tasks.

c. Aging results in a decline in restorative sleep.

d. Older adults are prone to become crime victims.

e. Older adults are usually lonely and socially isolated.

ANS: B, C, D

Myths about aging are common and can negatively impact the quality of care older patients receive. Older

individuals are more prone to become crime victims. A decline in restorative sleep occurs as one ages.

Learning continues long into life. These factors affect care delivery.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

Chapter 29: Living With Recurrent and Persistent Mental Illness

Halter: Varcarolis’s Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. After 5 years in a psychiatric hospital, an adult diagnosed with schizophrenia was discharged to the community. This patient now requires persistent direction to accomplish activities of daily living and expects others to provide meals and do laundry. The nurse assesses this behaviour as the probable result of which of the following?

a. Side effects of antipsychotic medications

b. Dependency caused by institutionalization

c. Cognitive deterioration from schizophrenia

d. Stress associated with acclimation to the community

ANS: B

Institutions tend to impede independent functioning. For example, daily activities are planned and directed by staff; others provide meals and only at set times. Over time, patients become dependent on the institution to meet their needs and adapt to being cared for rather than caring for themselves. When these patients return to the community, many continue to demonstrate passive behaviours despite efforts to promote their independence. Cognitive dysfunction and antipsychotic side effects can make planning and carrying out activities more difficult, but the question is more suggestive of adjustment to institutional care and difficulty readjusting to independence instead.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. An adult diagnosed with a serious mental illness says, “I do not need help with money management. I have excellent ideas about investments.” This patient usually does not have money to buy groceries by the middle of the month. The nurse assesses the patient as demonstrating which of the following?

a. Rationalization

b. Identification

c. Anosognosia

d. Projection

ANS: C

The patient scenario describes anosognosia, the inability to recognize one's deficits because of one's illness. The patient is not projecting an undesirable thought or emotion onto others. He is not justifying his behaviour via rationalization and is not identifying with another.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which service would be expected to provide resources 24 hours a day, 7 days a week, if needed, for persons with serious mental illness?

a. Clubhouse model

b. Cognitive Behavioural Therapy (CBT)

c. Assertive Community Treatment (ACT)

d. Cognitive Enhancement Therapy (CET)

ANS: C

ACT involves consumers working with a multidisciplinary team that provides a comprehensive array of services. At least one member of the team is available 24 hours a day for crisis needs, and the emphasis is on treating the patient within his own environment.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. An outpatient diagnosed with schizophrenia tells the nurse, "I am here to save the world. I threw away the pills because they make God go away." The nurse identifies the patient's reason for medication nonadherence as which of the following?

a. Poor alliance with clinicians

b. Inadequate discharge planning

c. Dislike of medication adverse effects

d. Lack of insight associated with the illness

ANS: D

The patient's nonadherence is most closely related to lack of insight into his illness. The patient believes he is an exalted personage who hears God's voice rather than an individual with a serious mental disorder

who needs medication to control his symptoms. While the distracters may play a part in the patient's nonadherence, this response is the most likely one.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. An outpatient diagnosed with schizophrenia attends programming at a community mental health centre. The patient says, "I threw away the pills because they keep me from hearing God." Which response by the nurse would most likely benefit this patient?

a. "You need your medicine. Your schizophrenia will get worse without it."

b. "Do you want to be hospitalized again? You must take your medication."

c. "I would like you to come to the medication education group every Thursday."

d. "I noticed that when you take the medicine, you have been able to hold the job you wanted."

ANS: D

The patient appears not to understand that he has an illness. He has stopped his medication because it interferes with a symptom that he finds desirable (auditory hallucinations—the voice of God). Connecting medication adherence to one of the patient's goals (the job) can serve to motivate the patient to take the medication and override concerns about losing the hallucinations. Exhorting a patient to take medication because it is needed to control his illness is unlikely to be successful; he does not believe he has an illness. Medication psychoeducation would be appropriate if the cause of nonadherence was a knowledge deficit.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. A homeless individual diagnosed with serious mental illness, anosognosia, and a history of persistent treatment nonadherence is persuaded to come to the day program at a community mental health centre. Which intervention should be the team's initial focus?

a. Teach appropriate health maintenance and prevention practices.

b. Educate the patient about the importance of treatment adherence.

c. Help the patient obtain employment in a local sheltered workshop.

d. Interact regularly and supportively without trying to change the patient.

ANS: D

Given the individual's history of treatment nonadherence and the difficulty achieving other goals until psychiatrically stable and adherent, getting the patient to accept and adhere to treatment is the fundamental goal to address. At this stage, the intervention most likely to help meet that goal is developing a trusting relationship with the patient. Interacting regularly, supportively, and without demands is likely to build the necessary trust and relationships that will be the foundation for all later interventions. No data here suggest the patient is in crisis, so it is possible to proceed slowly and build this

foundation of trust.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

7. A patient diagnosed with schizophrenia has had multiple relapses. The patient usually responds quickly to antipsychotic medication but soon discontinues the medication. Discharge plans include follow-up at the mental health centre, group home placement, and a psychosocial day program. Which strategy should apply as the patient transitions from hospital to community?

a. Administer a second-generation antipsychotic to help negative symptoms.

b. Use a quick-dissolving medication formulation to reduce "cheeking."

c. Prescribe a long-acting intramuscular antipsychotic medication.

d. Involve the patient in decisions about which medication is best.

ANS: D

People with schizophrenia are at high risk for treatment nonadherence, so the strategy needs to primarily

address that risk. Of the options here, involving the patient in the decision is best because it will build trust and help establish a therapeutic alliance with care providers, an essential foundation to adherence. Intramuscular depot medications can be helpful for promoting adherence if other alternatives have been unsuccessful, but IM medications are painful and may jeopardize the patient's acceptance. All the other strategies also apply but are secondary to trust and bonding with providers.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

8. The sibling of a patient diagnosed with a serious mental illness asks why a case manager has been assigned. The nurse's reply should cite which of the following as the major advantage of the use of case management?

a. "The case manager can modify traditional psychotherapy for patients so that it is more flexible."

b. "Case managers coordinate services and help with accessing them, making sure the patient's needs are met."

c. "The case manager can focus on social skills training and esteem building in the real world where the patient lives."

d. "Having a case manager has been shown to reduce hospitalizations, which prevents disruption and saves money."

ANS: B

The case manager helps the patient gain entrance into the system of care, can coordinate multiple referrals that so often confuse the seriously mentally ill person and his family, and can help overcome obstacles to access and treatment participation. Case managers do not usually possess the credentials needed to provide psychotherapy or function as therapists. Case management promotes efficient use of services in general, but only Assertive Community Treatment (ACT) programming has been shown to reduce hospitalization (which the sibling might see as a disadvantage). Case managers operate in the community, but this is not the primary advantage of their services.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

9. A family discusses the impact of having a seriously mentally ill member. Insurance partially covered treatment expenses, but the family spent much of their savings for care. The patient's sibling says, "My parents have no time for me." The parents are concerned that when they are older, there will be no one to care for the patient. Which response by the nurse would be most

helpful?

a. Acknowledge their concerns and consult with the treatment team about ways to bring the patient's symptoms under better control.

b. Give them names of financial advisors that could help them save or borrow sufficient funds to leave a trust fund to care for their loved one.

c. Refer them to crisis intervention services to learn ways to manage caregiver stress and provide titles of some helpful books for families.

d.

Educate the family about caregiver burden and ways to help the patient become more independent.

ANS: D

Coping with the persistent and challenging needs of people with serious mental illness (SMI) can be extremely challenging and requires significant emotional, physical, and, at times, financial resources. Caregivers also age, become ill, and may require care themselves, depleting their ability to provide support for the person with SMI. When caregivers are no longer able to provide the needed support for the person with SMI, they become anxious. Education and awareness are key to assisting this family. The family will need more than financial planning; their issues go beyond financial. The family is distressed but not in crisis. Crisis intervention is not an appropriate resource for the longer-term issues and needs affecting this family.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning/Implementation

MSC: Client Needs: Psychosocial Integrity

10. A patient diagnosed with a serious mental illness lives independently and attends a psychosocial rehabilitation program. The patient presents at the emergency department seeking hospitalization. The patient has no acute symptoms but says, "I have no money to pay my rent or refill my prescription." Select the nurse's best action.

a. Involve the patient's case manager to provide crisis intervention.

b. Send the patient to a homeless shelter until housing can be arranged.

c. Arrange for a short inpatient admission and begin discharge planning.

d. Explain that one must have active psychiatric symptoms to be admitted.

ANS: A

Impaired stress tolerance and problem-solving abilities can cause people with serious mental illness to experience relatively minor stressors as crises. This patient has run out of money, and this has overwhelmed her ability to cope, resulting in a crisis for which crisis intervention would be an appropriate response. Inpatient care is not clinically indicated nor is the patient homeless (although she may fear she is). Telling the patient that she is not symptomatic enough to be admitted may prompt malingering.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

11. The nurse wants to enroll a patient with poor social skills in a training program for patients diagnosed with schizophrenia. Which description accurately describes social skills training?

a. Patients learn to improve their attention and concentration.

b. Group leaders provide support without challenging patients to change.

c. Complex interpersonal skills are taught by breaking them into simpler behaviours.

d. Patients learn social skills by practising them in a supported employment setting.

ANS: C

In social skills training, complex interpersonal skills are taught by breaking them down into component behaviours that are covered in a stepwise fashion. Social skills training is not based in employment settings, although such skills can be addressed as part of supported employment services. The other distracters are less relevant to social skills training.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. A patient diagnosed with a serious mental illness died suddenly at age 52. The patient lived in the community for 5 years without relapse and held supported employment the past 6 months. The distressed family asks, “How could this happen?” Which response by the nurse accurately reflects research and addresses the family’s question?

a.

“A certain number of people die young from undetected diseases, and it’s just one

of those sad things that sometimes happen.”

b. “Mentally ill people tend to die much younger than others, perhaps because they

struggle to maintain their health, often smoke more, or are overweight.”

c. “We will have to wait for the autopsy to know what happened. There were some

medical problems, but we were not expecting death.”

d. “We are all surprised. The patient had been doing so well and saw the nurse every

other week.”

ANS: B

The family is in distress. Because they do not understand his death, they are less able to accept it and seek

specific information to help them understand what happened. People with serious mental illness die an

average of 25 years prematurely. Contributing factors include failing to provide for their own health needs

(e.g., forgetting to take medicine), inability to access or pay for care, higher rates of smoking, poor diet,

criminal victimization, and stigma. The most accurate answer indicates that seriously mentally ill people

are at much higher risk of premature death for a variety of reasons. Staff would not have been surprised

that the patient died prematurely, and they would not attribute his death to random, undetected medical

problems. Although the cause of death will not be reliably established until the autopsy, this response fails

to address the family’s need for information.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

13. Many people brought before a criminal court have mental illness, have committed

minor offences, and are off medications. The judge consults the nurse at the local community

mental health centre for guidance about how to respond when handling such cases. Which advice

from the nurse would be most appropriate?

a. “Sometimes a little time in jail makes people rethink what they’ve been doing and

puts them back on the right track.”

b. “Sentencing such people to participate in treatment instead of incarcerating them has been shown to reduce repeat offences.”

c. “Arresting these people helps them in the long run. Sometimes we cannot hospitalize them, but in jail they will get their medication.”

d. “Research suggests that special mental health courts do not make much difference so far, but outpatient commitment does seem to help.”

ANS: B

Research supports the use of special mental health courts that can sentence mentally ill persons to treatment instead of jail. Jail exposes vulnerable mentally ill people to criminals, victimization, and high levels of stimulation and stress. Incarceration can also interrupt eligibility for benefits or lead to the loss of housing and often provides lower-quality mental health treatment than in other settings. Recidivism rates for both mentally ill and nonmentally ill offenders are relatively high, so it does not appear that incarceration necessarily leads people to behave more appropriately. In addition, a criminal record can leave them more desperate and with fewer options after release. Research indicates that outpatient commitment is less effective at improving the mental health of mentally ill people than was expected.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

14. A nurse’s neighbour says, “My sister has been diagnosed with bipolar disorder but will not take her medication. I have tried to help her for over 20 years, but it seems like everything I do fails. Do you have any suggestions?” Select the nurse’s best response.

a. “The Schizophrenia Society of Canada offers a family education series that you might find helpful.”

b. “Since your sister is noncompliant, perhaps it’s time for her to be changed to injectable medication.”

c. “You have done all you can. Now it’s time to put yourself first and move on with your life.”

d. “You cannot help her. Would it be better for you to discontinue your relationship?”

ANS: A

Support groups such as the Schizophrenia Society of Canada expose the patient and caregiver to members

who “have been there.” In addition to providing support and socialization opportunities, such groups often

have practical suggestions for issues and problems that patients and significant others face. Involvement

in support groups is often empowering for the patient and the family. The nurse should not give advice

about injectable medication or encourage the family member to give up on the patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. Serious mental illness is characterized as which of the following?

a. Any mental illness of more than 2 weeks’ duration

b. A major long-term mental illness marked by significant functional impairments

c. A mental illness accompanied by physical impairment and severe social problems

d. A major mental illness that cannot be treated to prevent deterioration of cognitive

and social abilities

ANS: B

Individuals with serious mental illness (SMI) usually have difficulties in multiple areas, including

activities of daily living, relationships, social interaction, task completion, communication, leisure

activities, safe movement about the community, finances and budgeting, health maintenance, vocational

and academic activities, and coping with stressors. SMI can be treated, but remissions and exacerbations

are part of the course of the illness.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

16. Which nursing diagnosis is likely to apply to an individual diagnosed with a serious

mental illness who is homeless?

a. Insomnia

b. Substance abuse

c. Chronic low self-esteem

d. Impaired environmental interpretation syndrome

ANS: C

Many individuals with serious mental illness do not live with their families and become homeless. Life on the street or in a shelter has a negative influence on the individual's self-esteem, making this nursing diagnosis one that should be considered. Substance abuse is not an approved NANDA-International diagnosis. Insomnia may be noted in some patients but is not a universal problem. Impaired environmental interpretation syndrome refers to persistent disorientation, which is not seen in a majority of the homeless.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Nursing Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

17. A patient diagnosed with schizophrenia tells the community mental health nurse, "I threw away my pills because they interfere with God's voice." The nurse identifies the etiology of the patient's ineffective management of the medication regime as which of the following?

a. Inadequate discharge planning

b. Poor therapeutic alliance with clinicians

c. Dislike of antipsychotic medication side effects

d. Lack of insight secondary to the schizophrenia

ANS: D

To improve patient insight and motivation, provide psychoeducation (an approach to care that emphasizes helping a person gain knowledge necessary to manage the illness) about serious mental illness (SMI) and the role of treatment in recovery. Take care not to assume that nonadherence means the patient does not understand. There are many reasons for nonadherence; applying psychoeducation when the problem is something other than a lack of knowledge is unlikely to succeed. The patient believes in being an exalted personage who hears God's voice, rather than an individual with an SMI who needs medication to control symptoms. Data do not suggest any of the other factors often related to medication nonadherence.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

18. A patient living independently had command hallucinations to shout warnings to neighbours. After a short hospitalization, the patient was prohibited from returning to the apartment. The landlord said, “You cause too much trouble.” What problem is the patient experiencing?

a. Grief

b. Stigma

c. Homelessness

d. Nonadherence

ANS: B

The inability to obtain shelter because of negative attitudes about mental illness is an example of stigma. Stigma is defined as damage to reputation, shame, and ridicule that society places on mental illness. Data are not present to identify grief as a patient problem. Data do not suggest that the patient is homeless. See relationship to audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

19. A person diagnosed with a serious mental illness enters a shelter for the homeless. Which intervention should be the nurse’s initial priority?

a. Find supported employment.

b. Develop a therapeutic alliance.

c. Administer prescribed medication.

d. Teach appropriate health care practices.

ANS: B

The nurse-patient relationship stresses empathic understanding, a nonjudgemental attitude, and the development of a therapeutic alliance. Basic psychosocial needs do not change because a person is homeless. The first step in meeting mental health needs is establishing rapport. Once a trusting relationship is established, the nurse can pursue other interventions.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

20. A homeless patient diagnosed with a serious mental illness became suspicious and delusional. Depot antipsychotic medication began, and housing was obtained in a local shelter. One month later, which statement by the patient indicates significant improvement?

a. “They will not let me drink. They have many rules in the shelter.”

b. “I take the bus each week to buy my own groceries.”

c. “Those shots make my arm very sore.”

d. “Those people watch me a lot.”

ANS: B

Evaluation of a patient’s progress is made based on patient satisfaction with the new health status and the health care team’s estimation of improvement. An intermediate indicator is the ability to manage money, and short-term indicators, in this scenario, are grocery shopping and using public transit. For a formerly delusional patient to admit to feeling comfortable and free of being “bothered” by others denotes improvement in the patient’s condition. The other options suggest that the patient is in danger of relapse.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

21. For patients diagnosed with serious mental illness, what is the major advantage of case management?

a. The case manager can modify traditional psychotherapy.

b. With one coordinator of services, resources can be more efficiently used.

c. The case manager can focus on social skills training and esteem building.

d. Case managers bring groups of patients together to discuss common problems.

ANS: B

The case manager coordinates the care and multiple referrals that so often confuse the seriously mentally ill patient and the patient’s family. Case management promotes efficient use of services. The other options are lesser advantages or are irrelevant.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

22. The parent of a seriously mentally ill adult asks the nurse, “Why are you making a referral to a vocational rehabilitation program? My child won’t ever be able to hold a job.” Which is the nurse’s best reply?

a. “We make this referral to continue eligibility for federal funding.”

b. “Are you concerned that we’re trying to make your child too independent?”

c. “If you think the program would be detrimental, we can postpone it for a time.”

d. “Most patients are capable of employment at some level, competitive or supported.”

ANS: D

Studies have shown that most patients who complete vocational rehabilitation programs are capable of some level of employment. They also demonstrate significant improvement in assertiveness and work behaviours as well as decreased depression.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

23. A consumer at a rehabilitative psychosocial program says to the nurse, “People are not cleaning up behind themselves in the bathrooms. The building is dirty and cluttered.” How should the nurse respond?

a. Encourage the consumer to discuss it at a meeting with everyone.

b. Hire a professional cleaning service to clean the restrooms.

c. Address the complaint at the next staff meeting.

d. Tell the consumer, “That’s not my problem.”

ANS: A

Consumer-run programs range from informal “clubhouses,” which offer socialization and recreation, to competitive businesses, such as snack bars or janitorial services, which provide needed services and consumer employment while encouraging independence and building vocational skills. Consumers engage in problem solving under the leadership of staff. See related audience response question.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. During the day, a person diagnosed with a serious mental illness (SMI) was punched, pushed to the ground, and robbed of $7 on a public street near home. Which statements about violence and SMI in general are accurate? (Select all that apply.)

a. People with SMI are more likely to be violent.

b. People with SMI are more likely to commit crimes than to be the victims of crime.

c. Impaired judgement and social skills can provoke hostile or assaultive behaviour.

d. Lower incomes force people with SMI to live in high-crime areas, increasing risk.

e. People with SMI experience higher rates of sexual assault and victimization than others.

f. Criminals may believe people with SMI are less likely to resist or testify against them.

ANS: C, D, E, F

Mentally ill people are more likely to be victims of crime than perpetrators of criminal acts. They are often victims of criminal behaviour, including sexual crimes, at a higher rate than others. When a mentally ill person commits a crime, it is usually nonviolent. Mental illnesses interfere with employment and are associated with poverty, limiting people with SMI to living in inexpensive areas that also tend to be higher-crime areas. People with SMI may inadvertently provoke others because of poor judgement or socially inappropriate behaviour, or they may be victimized because they are perceived as passive, less likely to resist, and less likely to be believed as witnesses. See related audience response question.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Planning/Implementation

MSC: Client Needs: Safe Effective Care Environment

2. The nurse manager of a mental health centre wants to improve medication adherence among the seriously mentally ill persons treated there. Which interventions are likely to help achieve this goal? (Select all that apply.)

a. Maintain stable and consistent staff.

b. Increase the length of medication education groups.

c. Stress that without treatment, illnesses will worsen.

d. Prescribe drugs in smaller but more frequent dosages.

e. Actively manage adverse medication effects.

f. Require adherence to participate in programming.

ANS: A, E

Trust in one's providers is a key factor in treatment adherence, and mentally ill people can sometimes take a very long time to develop such trust; therefore, interventions that stabilize staffing allow patients to have more time with staff to develop these bonds. Actively manage adverse effects to avert or minimize patient distress, which could result in nonadherence. Many patients with SMI have anosognosia and do not adhere to treatment because they believe they are not ill; telling them nonadherence will worsen an illness they do not believe they have is unlikely to be helpful. Increasing medication education is helpful only when the cause of nonadherence is a knowledge deficit. Other issues that reduce adherence, particularly anosognosia and adverse effects, are seldom helped by longer medication education. Requiring medication adherence to participate in other programs is coercive and unethical. Smaller, more frequent doses do not reduce adverse effects and make the regimen more difficult for the patient to remember.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

3. A person diagnosed with serious mental illness has frequent relapses, usually precipitated by situational stressors such as running out of money or the absence of key staff at the mental health centre. Which interventions would the nurse suggest to reduce the risk of stressors to cause relapse? (Select all that apply.)

a. Discourage potentially stressful activities such as groups or volunteer work.

b. Develop plans that will help the patient remember what to do in a crisis.

c. Help the patient identify and anticipate events that are likely to be overwhelming.

d. Encourage health-promoting activities such as exercise and getting adequate rest.

e. Accompany the patient to a support group meeting.

ANS: B, C, D, E

Basic interventions for coping with crises involve anticipating crises where possible and then developing a plan with specific actions to take when faced with an overwhelming stressor. Health-promoting activities enhance a person's ability to cope with stress. As the name suggests, support groups help a person develop a support system, and they provide practical guidance from peers who learned from experience how to deal with issues the patient may be facing. Groups and volunteer work may involve a measure of stress but also provide benefits that help persons cope and should not be discouraged unless they are being done to excess.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

4. A patient diagnosed with serious mental illness was living successfully in a group home but wanted an apartment. The prospective landlord said, "People like you have trouble getting along and paying their rent." The patient and nurse meet for a problem-solving session. Which options should the nurse endorse? (Select all that apply.)

a. Coach the patient in ways to control symptoms effectively.

b. Seek out landlords less affected by the stigma associated with mental illness.

c. Threaten the landlord with legal action because of the discriminatory actions.

d. Encourage the patient to remain in the group home until the illness is less obvious.

e. Suggest that the patient list a false current address in the rental application.

f. Have the case manager meet with the landlord to provide education about mental illness.

ANS: A, B, F

Managing symptoms so that they are less obvious or socially disruptive can reduce negative reactions and reduce rejection due to stigma. Seeking a more receptive landlord might be the most expeditious route to housing for this patient. Educating the landlord to reduce stigma might make the patient more receptive and give the case manager an opportunity to address some of his concerns (e.g., the case manager could arrange a payee to assure that the rent is paid each month). However, threatening a lawsuit would increase the landlord's defensiveness and would likely be a long and expensive undertaking. Delaying the patient's

efforts to become more independent is not clinically necessary according to the data noted here; the problem is the landlord's bias and response, not the patient's illness. It would be unethical to encourage falsification and poor role modeling to do so; further, if falsification is discovered, it could permit the landlord to refuse or cancel the patient's lease. See related audience response question.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

5. An adult patient tells the case manager, "I don't have bipolar disorder anymore, so I don't need medicine. After I was in the hospital last year, you helped me get an apartment and disability cheques. Now I'm bored and don't have any friends." Where should the nurse refer the patient? (Select all that apply.)

a. Psychoeducational classes

b. Vocational rehabilitation

c. Social skills training

d. A homeless shelter

e. Crisis intervention

ANS: A, B, C

The patient does not understand the illness or the need for adherence to the medication regimen. Psychoeducation for the patient (and family) can address this lack of knowledge. The patient, who is considered friendless, could also profit from social skills training to improve the quality of interpersonal relationships. Many patients with serious mental illness have such poor communication skills that other people feel uncomfortable interacting with them. Interactional skills can be effectively taught by breaking the skill down into smaller verbal and nonverbal components. Work gives meaning and purpose to life, so vocational rehabilitation can assist with this aspect of care. The nurse case manager will function in the role of crisis stabilizer, so no related referral is needed. The patient presently has a home and does not require a homeless shelter.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

6. Which statements most clearly indicate that the speaker views mental illness with stigma? (Select all that apply.)

a. “We are all a little bit crazy.”

b. “If people with mental illness would go to church, their problems would be solved.”

c. “Many mental illnesses are genetically transmitted. It’s no one’s fault that the illness occurs.”

d. “Anyone can have a mental illness. War or natural disasters can be too stressful for healthy people.”

e. “People with mental illness are lazy. They get government disability cheques instead of working.”

ANS: A, B, E

Stigma is represented by judgemental remarks that discount the reality and validity of mental illness. It is evidenced in stereotypical statements, by oversimplification, and by other messages of guilt or shame. See related audience response question.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

Chapter 30: Psychological Needs of Patients With Medical Conditions

Halter: Varcarolis’s Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A diabetic patient is to have a mid-thigh amputation of his left leg. He tells the nurse, “I guess I’ll be called ‘Gimpy’ after the surgery. My life is really going to change when I can’t carry out my exercise program anymore. It sure won’t be the same.” What do these comments suggest the patient is experiencing?

a. Loss and grief

b. Fear and denial

c. Depression

d. Spiritual distress

ANS: A

The nature of the surgery, which involves the loss of a major portion of his body and the potential for major changes in his mobility, creates a major loss for the patient. When there is a significant loss, the patient experiences a grief response, which is what is beginning to be addressed here. There are no data to support denial, depression, or spiritual distress.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. A woman whose sister-in-law died of cancer is herself diagnosed with breast cancer after a mammogram. Her doctor has advised a lumpectomy followed by radiation and chemotherapy. The patient is awaiting surgery, oncology, and radiation consults and is scheduled for surgery the day after tomorrow. She tearfully tells the nurse, "I keep thinking about how there is something growing inside me that could kill me. It's like living with a bomb inside you, and you don't know if or when it's going to go off." Which nursing intervention is most likely to be helpful?

a. Interact frequently with the patient and provide books and games to help her stay busy and distract her from her negative thinking.

b. Validate her feelings and, with her permission, have a member of a breast cancer survivors' support group visit her in her hospital room.

c. Provide support and validate her feelings, and then offer to have the hospital chaplain stop by to talk with her.

d. Sympathize with her concerns but remind the patient that she has not even had the surgery yet, and the treatments may well rid her of cancer.

ANS: B

The patient is just beginning to cope with a very serious and potentially fatal diagnosis and is dealing with a variety of thoughts and concerns. It is likely that others who have dealt personally with breast cancer, had similar experiences, and can validate the patient's feelings and discuss her concerns in a genuine

manner. Distraction can be helpful for reducing anxiety temporarily but does not help the patient process

or cope with her questions and fears. Suggesting the chaplain would be appropriate if the patient had spiritual needs, but that is not clearly indicated here; further, the patient might perceive this as indicating

that staff believe her disorder will prove fatal. Sympathy is rarely therapeutic and noting that treatment has not yet begun implies that she should not be distressed, at least until the results of treatment are known. This is a disconfirming, nontherapeutic response that in essence tells her that her feelings are wrong.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. A woman whose sister-in-law died of cancer is diagnosed with breast cancer after a mammogram. Her doctor has advised a lumpectomy followed by radiation and chemotherapy. The patient is awaiting surgery, oncology, and radiation consults and is scheduled for surgery the day after tomorrow. She tearfully tells the nurse, “I keep thinking about how there is something growing inside me that could kill me. It’s like living with a bomb inside you, and you don’t know if or when it’s going to go off.” Which observation noted in the patient’s chart would most suggest that nursing interventions had been helpful?

a. “Less tearful today, denies having questions or concerns, pain rating = 0, up ad lib.”

b. “Reading and talking with visitors, smiles readily, says she feels better since talking.”

c. “States she is less worried after looking at her glass as half full instead of half empty.”

d. “Met with oncologist, reports she is not going to think about it until they know more.”

ANS: C

The patient’s comment about seeing the glass as half full instead of half empty suggests that she has reframed her situation and is less anxious. Being less tearful or saying she feels better are possible indicators of improvement but are less specific and more ambiguous. For example, patients may suppress

tearfulness if embarrassed by crying earlier, or they may indicate they are “feeling better” even though they are still distressed. Saying she is “not going to think about it” suggests avoidance, which is generally a less effective coping approach.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Evaluation

MSC: Client Needs: Psychosocial Integrity

4. Which comment by the patient indicates use of a maladaptive or ineffective coping

strategy?

a. “That heart attack was no fun, but at least it woke me up to my need for a better diet

and more exercise.”

b. “My family and God will see me through this. It won’t be easy, but I’ll never be

alone.”

c. “I definitely have cancer. Now I need to look at the effects of treatment and decide

whether I will be able to work daily.”

d. “I wouldn’t be in this position if the company had better health benefits. If they paid

for health club memberships, maybe I wouldn’t be here now.”

ANS: D

Blaming someone else and rationalizing one’s failure to exercise are not usually considered to be adaptive

coping strategies. Seeing the glass as half full, using social and religious supports, and confronting one’s situation are seen as more effective strategies.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A staff nurse tells the clinical nurse leader, “I am at a total loss as to how to deal with

this patient. He has so many physical needs since his head and neck surgery! Those needs have to

be my primary focus, but sometimes it seems he’s crying and in emotional pain, too, and I don’t

know how to help with that.” Which resource would likely be the best choice to help this nurse?

a. Psychiatric consultation liaison nurse

b. On-call psychiatrist

c. Unit social worker

d. Hospital chaplain

ANS: A

The psychiatric consultation liaison nurse is an advanced-practice nurse who provides patient care consultation to nurses outside of psychiatry and would be an ideal resource to help a nurse caring for a patient with emotional health needs. The other professionals might also be helpful, but problems such as these are the specialty of the liaison nurse.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

6. A patient is recovering from a severe myocardial infarction (MI). He tells his nurse, to whom he is very close, "I will be fine once I get home. All that 'watch your cholesterol, watch your calories, watch your stress' stuff is bull; if your time is up, your time is up." Which response would be most therapeutic?

a. "You've had a very serious heart attack and are lucky to be getting a second chance that many don't get; what you do with it is up to you."

b. "It sounds as if you would be just as happy with dying sooner as later. I wonder if those cute grandkids would feel the same way."

c. "Well, when you are home you can do as you wish, but until then you are on a low-sodium, low-fat diet and will be walking 30 minutes per shift."

d. "Research has shown that diet changes and stress control can at least double how long a person lives after a heart attack like yours."

ANS: B

The patient is in denial and is exhibiting ineffective coping behaviours. This statement by the nurse is to help the patient to redefine the situation. Rationalizing that he has little control over what will happen and therefore need not worry so much about it could also be his way of coping with the fact that his life is in a precarious state at the moment. Focusing him on how his family might feel about his fatalistic comments

is designed to get him to consider his life from another perspective that might be more important than continuing his unhealthy lifestyle or avoiding dealing with his mortality. The response is indirectly confrontational, which is acceptable given that they are in the working phase of the nurse-patient relationship; it is designed to lead him toward cognitive reframing of his beliefs about how to live after a severe MI. The "when you are home you can do as you wish" comment suggests anger about the patient's seeming disregard of his health and devaluing of life and is nontherapeutic. Dictating diet and exercise while the patient is hospitalized does not address his anxiety and other emotional responses to how the MI will affect his lifestyle. If the patient had a knowledge deficit related to recommended post-MI lifestyle changes, providing information about research on health practices and outcomes after MI might be of value, but he seems to have at least some awareness that the practices mentioned are recommended.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation

MSC: Client Needs: Psychosocial Integrity/Health Promotion and Maintenance/Physiological Integrity

7. A patient hospitalized after an MI is restlessly moving about in bed. Her pulse, blood pressure, and respiratory rate are elevated. In a shaky voice, she tells the nurse, "I think I am going to die. The pain is gone, but it could come back anytime. Where is the doctor? Why isn't the doctor here with me?" The nurse should analyze this behaviour as suggesting which of the following nursing diagnoses?

a. Spiritual distress

b. Ineffective breathing pattern

c. Nonadherence

d. Anxiety

ANS: D

The clinical picture is typical of anxiety. The patient is experiencing uneasy feelings arising from her insecurity about her health. Anxiety typically produces elevated vital signs. Data do not support the other nursing diagnoses.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Nursing Diagnosis

MSC: Client Needs: Psychosocial Integrity

8. A man was brought to the emergency room for treatment of minor injuries after an accident in which his life partner, a transvestite, was killed. He refuses care, paces, screams, “Why, why, why!” repeatedly, and scratches at his arms as if trying to tear the flesh. A nurse says, “Geez, he’s going to hurt himself. We’d better admit him to psych.” Which explanation for the nurse’s response is most likely?

a. The nurse’s experience tells her that the patient is developing a psychotic reaction to the stress of the accident and death.

b. She is stigmatizing the patient due to his sexuality, dramatic grief response, and connection to a transvestite person.

c. The nurse is unsure how to handle a person presenting in this manner, is anxious as a result, and copes by wanting to shift the patient to another unit.

d. Medical nurses usually have less skill in managing emotional problems, and psychiatric staff are more appropriate to deal with people who are grieving.

ANS: B

The patient’s sexuality and romantic involvement with a transvestite person subject him to stigma, even from health care professionals who should be self-aware enough to recognize and intercept such inappropriate and nontherapeutic responses. The patient’s grief response, perhaps unusual from the cultural perspective of many people, also is stigmatizing and as a result is incorrectly attributed to a mental illness. There are no data to suggest that the patient is not in touch with reality; he is simply expressing his acute grief in a dramatic fashion (which may be a culturally-mediated response). The nurse may be anxious, be unsure how to help the patient, or believe that medical nurses have less skill in managing emotional problems, but all nurses should be capable of helping patients with both emotional and physical health needs and should consult with other staff if they are not. This nurse’s exclamation of “Geez” suggests that the primary issue underlying the response is countertransference related to stigma.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. An unconscious patient is brought to the emergency department by ambulance for

trauma treatment. The patient is wearing a sweat-stained John Deere cap, a denim shirt worn out in the elbows, dirty bib overalls covered with patches, work boots worn thin, and ragged underclothes. Several staff laugh as they stabilize the patient, and one remarks, “Farmer John must have fallen off the tractor.” The most appropriate action for the charge nurse is to say which of the following?

a. “So he’s a farmer—get over it. Thank him for your food and move on.”

b. “You are violating this man’s right to be treated with respect, and it stops now.”

c. “Grow up and do your jobs; I think you have all seen poor people before.”

d. “Perhaps you could find an outlet for humour that’s not at a patient’s expense.”

ANS: B

The scenario is an example of a stigmatization of a medically ill patient based on cultural differences such as a possible agrarian vocation and poverty. People tend to stigmatize those who are most unlike themselves, who they least understand, whom they are most anxious about, or who are most disenfranchised. As professionals, nurses should recognize and correct behaviour based on stigma, but those laughing at the patient have not done so and are not behaving professionally. They are also violating the patient’s human right to dignity. The behaviour is grossly unprofessional and carries a risk of compromised patient care; it merits direct and firm confrontation. This response labels the comment for what it is, with firm limits set thereafter. Stating that the staff’s behaviour is violating the patient’s right to be treated with respect clearly communicates that their behaviour is unacceptable and will not be tolerated. The other options all redirect the staff but do not carry the gravitas needed to indicate clearly how unacceptable their behaviour is or set firm limits on it.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. A patient has a disorder that causes progressive, severe muscle pain and weakness, and she has curtailed physical and social activities to accommodate her condition. She tells the nurse “I cannot do anything. I have to depend on other people to help me. I do not enjoy much of anything anymore; even food does not taste good. I cannot see that my situation will change, so I feel pretty hopeless.” Which of the following is the priority action the nurse should take?

a. Point out that there is always room for hope

b. Discuss the importance of physical exercise

c. Inquire about her support system and coping plans

d. Assess for signs of depression

ANS: D

The patient is at risk for depression due to having a chronic, deteriorating illness and resulting accumulating losses. She also displays hopelessness. These factors make the need for a thorough assessment for depression essential. Depression that goes unrecognized and untreated is often responsible for worsening the medical condition and diminishing functional abilities. The other options are not priorities or are nontherapeutic (or both).

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

11. A patient who has been diagnosed with breast cancer has many questions related to surgery, radiation therapy, and chemotherapy. The nurse provides education about the disease and treatments but perceives that the patient has further questions about coping with day-to-day situations. Which of the following actions would be of greatest benefit to the patient?

a. Suggesting cognitive behavioural therapy with a counsellor

b. Teaching her to monitor her stress level while at home

c. Suggesting she enroll in a pain-management program

d. Referring her to a support group for people with breast cancer

ANS: D

Patients with breast cancer are often helped by the comradery, support, and knowledge shared in support group meetings. Techniques for coping can be learned from women who have had similar experiences. There is no indication that the patient is demonstrating negative or distorted cognitions. Monitoring stress level is insufficient in that it is assessment but not intervention—it does nothing to reduce anxiety or promote coping. The patient would also need to be taught stress-management techniques. Pain-management needs are not evident.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. A college student is a patient on a medical unit for treatment of Guillain-Barré syndrome, a rare disorder that produces ascending paralysis and can be fatal if respiratory function is compromised. She is very anxious and frequently calls for staff. Staff direct her to try to calm down and explain that her sensation of being short of breath is due to her anxiety causing her to hyperventilate. Her family becomes increasingly concerned as the patient moves from being anxious to panic-stricken, saying she cannot breathe. Her resident doctor is called and reinforces the need for the patient to slow and deepen her breathing to control anxiety. Away from the patient, staff talk about how histrionic and whiny she is. Soon afterwards, the patient goes into respiratory arrest. She is left in a permanent vegetative state from hypoxia. Which of the following is the primary cause of this tragic outcome?

a. The paralysis had impaired respiration.

b. Her disorder was not adequately treated.

c. Staff stigmatized the patient as a whiner.

d. Her doctor was negligent in his response.

ANS: C

Although the cause of the respiratory arrest was the Guillain-Barré syndrome, an objective assessment would have correctly led to identifying the patient's symptoms as representing the onset of respiratory distress, and the hypoxia would have been averted via use of oxygen and mechanical ventilation. The reason staff did not perform an objective, accurate assessment is that they had labelled—stigmatized—the patient as "histrionic and whiny" and as a result, they did not fully investigate her somatic complaints. The doctor may have been negligent, and there may have been better treatment available, but the primary problem was a failure to identify the impending respiratory arrest until it was too late, and the root cause of this was that the patient had been stigmatized.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment/Implementation

MSC: Client Needs: Physiological Integrity/Safe Effective Care Environment

13. A patient being treated for an MI has been transferred to a step-down unit from the intensive care unit. She uses the call bell as often as every 15 minutes. Each time a staff member responds, the patient complains about her care or makes a seemingly small request. Several staff tell the primary nurse that the patient is “obnoxious” and that they feel inadequate because they can never seem to satisfy her needs. The primary nurse can be most helpful by doing which of the following?

a. Explaining that the demanding behaviour is due to the patient’s increasing anxiety

b. “Laying down the law” to the patient, limiting use of the call light to once per hour

c. Rotating caregivers to give each person a much-needed respite from the patient’s complaints

d. Asking the patient’s family to sit with her and help meet her need for attention

ANS: A

Teaching staff the probable basis for the behaviour will change their perspective. They will realize that anxiety is increasing the patient’s neediness and that she is hurting emotionally and not simply a difficult person. If staff reduce the anxiety, the patient’s insecurity will decrease, and she will not summon staff so frequently. Setting limits on calling for staff does not help the cause of the behaviour and will only increase the patient’s distress and desperation. Rotating caregivers and asking the family to help provide care benefits the staff but not the patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation

MSC: Client Needs: Psychosocial Integrity/Safe Effective Care Environment

14. A patient being treated for an MI has been transferred from the intensive care unit to a step-down unit. She uses the call bell as often as every 15 minutes. She makes a seemingly small request or complains each time a staff member is summoned. Several staff tell the primary nurse that the patient is “obnoxious” and that they feel inadequate because they can never seem to satisfy her needs. The primary nurse decides to intervene directly with the patient. Which response would be most therapeutic?

a. “I’m wondering if you are feeling anxious about your illness and being left alone.”

b. “The staff are concerned that you are not satisfied with the care you are receiving.”

c. “Let’s talk about why you use your call light so frequently; it’s a bit of a problem.”

d. “You are frustrating the staff by calling them so often; any idea why you do that?”

ANS: A

“I’m wondering if you are anxious . . . ” focuses on the emotions underlying the behaviour rather than the

behaviour itself. This opening conveys the nurse’s willingness to listen to the patient’s feelings and an understanding of the commonly seen concern about not having a nurse always nearby as in the intensive care unit. Verbalization is an effective outlet for anxiety. Also, knowing that staff understand her anxiety and will meet her needs without being summoned so frequently can reduce the patient’s anxiety level from severe to moderate or lower. The other options focus on the behaviour or its impact on nursing and do not help the patient with her emotional needs.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. A patient being treated for an MI has been transferred from the intensive care unit to a step-down unit. She is anxious and uses the call bell as often as every 15 minutes, complaining or making a seemingly small request each time the staff member enters the room. Which indicator should staff focus on to monitor for the outcome of “anxiety self-control”?

a. Patient monitors duration of anxiety episodes

b. Patient sleeps 7 or more hours each night

c. Patient has stopped using the call button

d. Uses call button not more than once per hour

ANS: D

Using the button less frequently suggests that the patient is less needy because she is more secure and less

anxious. Not using the call button at all suggests that she is reluctant to bother staff, which is not desirable

if she truly needs assistance. Monitoring her own anxiety does not necessarily indicate improvement, and

sleep duration does not necessarily reflect one's level of anxiety.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

16. A patient has just learned that all possible treatments for his disease have been exhausted, and it will likely claim his life within the next month. He is alert, has full control of his motor abilities, and is comfortable. He tells the nurse he cannot bear to leave his 11- and 13-year-old children when they are so young, that they seem so upset by his condition they change the topic when he brings it up, that he does not know how to talk with them, and yet he has so many things he has to say to them while there is still time. Which option would be most helpful for the nurse to endorse?

a. Writing down his feelings and thoughts in a journal

b. Talking with a minister, priest, or hospice social worker

c. Telling the children that there is no time, they must face this

d. Praying for guidance and strength to deal with this challenge

ANS: A

Writing down thoughts and feelings can be a very helpful means of expressing oneself when speaking them aloud is difficult. It allows one to carefully compose and edit them until they truly reflect what is going on inside the person and to contemplate and adjust them over time. The act of writing down feelings can also help one process them and reduce the anxiety present about sharing these feelings aloud.

In this situation, even if the patient's time ends before he can communicate his thoughts and feelings to the children orally, the journals will serve to pass along important reflections and give the children an opportunity to reread them when they are older and more mature. The other options may be of value as well but lack the benefits noted with journaling. Pressing the children to talk may increase their anxiety and distress, leading to further withdrawal at a time when there is so little time remaining to be together.

Prayer is a culturally sensitive intervention that may or may not be acceptable to the patient's sensibilities

and may or may not lead to the answers he seeks.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Which modality would be helpful to include in the standard plan of care for patients who are being treated for severe, chronic low back pain? (Select all that apply.)

a. Biofeedback to promote muscular relaxation relief of tension that aggravates pain

b. Guided imagery to deepen relaxation and desensitize the patient to pain

c. Hypnosis for a state of restful alertness and blocking out painful sensations

d. Acupuncture and transcendental meditation for relaxation and direct pain relief

e. Psychotherapy to address emotional issues that can aggravate tension and pain

f. Spiritual healing via prayer and other spiritual practices to help what man cannot

ANS: A, B, C, E

All the therapies listed might be of value to at least some chronic pain sufferers, but for a standard care plan, only those with fairly universal application and acceptance and not likely to be affected by cultural beliefs should be included. This would generally exclude religious practices and might exclude holistic or alternative practices that are less clearly supported by research, such as transcendentalism and acupuncture.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Physiological Integrity

2. A 32-year-old patient experiences an intestinal perforation and requires emergency surgery. The surgeon first meets the patient just before anesthesia is to be given and explains that peritonitis and intestinal inflammation may make a colostomy necessary. The patient is still quite groggy when stepped down to a postoperative unit and does not yet know that he has a colostomy. Which initial response(s) should his nurse anticipate when the patient discovers that this procedure has been necessary? (Select all that apply.)

a. Distress that he has been disfigured and will be repugnant to others

b. Thankfulness that the surgery was successful and that he will live

c. Concerns about how he will do all the things he is used to doing

d. Anger that this has happened to him and that it has ruined his life

e. Depression related to changes in body image and perceived losses

f. Curiosity about how colostomies work and how one cares for them

ANS: A, C, D, E

This patient had no time to prepare emotionally or intellectually for the significant changes in function and appearance that follow a colostomy. It is likely that he will experience a wide range of strong emotional responses: fear about being repugnant to others or being rejected, anger that this has happened to him and changed his life for the worse, concerns about his appearance and how (or if) he will be able do the things he is used to doing, and depression as the breadth and gravity of the changes and possible losses he is facing begin to register. In time, it is likely that he will adjust to the changes in appearance and function, finding ways to adapt so the great majority of his previous activities will remain possible. At this stage, however, he is likely to be quite distressed emotionally. It is unlikely that thankfulness or curiosity will be major or immediate responses relative to these stronger emotions.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. A nurse's brother mentions that he saw on the news that a man without any known illnesses died suddenly just after hearing that his ex-wife had committed suicide. He asks if this was coincidence or if an emotional shock can kill someone. The nurse should respond by noting that a number of serious medical conditions may be precipitated by anxiety, including which of the following? (Select all that apply.)

a. Cancer

b. Lung disease

c. Hypertension

d. Certain headaches

e. Myocardial infarction

f. Cardiovascular disease

g. Peptic ulcer

ANS: A, C, D, E, F, G

A number of diseases can be worsened or brought to awareness by anxiety as a result of intense emotional

experiences or by chronic or acute anxiety. Others can be brought about indirectly, such as cardiovascular

disease due to acute or chronic hypertension. Lung diseases, other than cancer, are not in this group.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

Chapter 31: Care for the Dying and for Those Who Grieve

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. Which is a pathological intensification of death and outcry?

a. Anxiety

b. Reactive psychoses

c. Self-punitive feelings

d. Inappropriate hostile feelings

ANS: B

Panic, dissociative reactions, and reactive psychoses are all pathological intensifications of death and

outcry. Self-punitive feelings is a pathological intensification of dying, not death. Inappropriate hostile

feelings is a pathological intensification of dying, not death.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Four teenagers died in an automobile accident. One week later, which behaviour by

parents indicates adaptive mourning?

a. The parents who isolate themselves at home.

b. The parents who return immediately to employment.

c. The parents who forbid other teens in the household to drive a car.

d. The parents who create a scholarship fund at their child's high school.

ANS: D

Loss of a child is among the highest-risk situations for maladaptive grieving. The parents who create a scholarship fund or organize support networks in the child's name are openly expressing their feelings and memorializing their child. The other parents in this question are isolating themselves or denying their feelings, or both.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. After a spouse's death, a patient repeatedly says, "I should have recognized what was happening and been more helpful." This individual is experiencing which of the following?

a. Preoccupation with the image of the deceased

b. Sensations of somatic distress

c. Anger

d. Guilt

ANS: D

Guilt is expressed by the bereaved person's self-reproach. Preoccupation with the image of the deceased is not evident here. Somatic distress would involve bodily symptoms. Anger cannot be assessed from the data given in the scenario.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. A widower tells friends, "I am going to take my neighbour out for dinner. It's time for me to be more sociable again." Which phenomenon of bereavement is evident?

a. Anger

b. Preoccupation with the image of the deceased

c. Change in behaviour; depression, disorganization, restlessness

d. Reorganization of behaviour directed toward a new object or activity

ANS: D

Toward the end of bereavement, the person renews interest in people and activities. At the same time, the person is released from the relationship with the deceased. The patient is seeking to move into new

relationships.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. After the death of his wife, a man says, “I can’t live without her . . . she was my whole life.” Select the nurse’s most therapeutic reply.

a. “Each day will get a little better.”

b. “Her death is a terrible loss for you.”

c. “It’s important to recognize that she is no longer suffering.”

d. “Your friends will help you cope with this change in your life.”

ANS: B

A statement that validates the bereaved person’s loss is more helpful than banal clichés. It signifies understanding. The other options are clichés.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

6. A patient has just died and the spouse has just received notification. The nurse who most recently cared for the patient is approached by the bereaved spouse who says angrily, “My spouse would still be alive if you had given your undivided attention.” Which analysis applies?

a. The comment warns of a malpractice suit.

b. Anger is a phenomenon experienced during grieving.

c. The patient had ambivalent feelings about the spouse.

d. In some cultures, grief is expressed solely through anger.

ANS: B

Anger may protect the bereaved from facing the devastating reality of loss. Anger expressed during mourning is not directed toward the nurse personally, even though accusations and blame may make the nurse feel as though it is.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

7. A wife received news that her husband died of heart failure, and she called her family to come to the hospital. She angrily tells the nurse who cared for him, “He would still be alive if you had given him your undivided attention.” Select the nurse’s best response.

a. “Most people go through periods of anger when their loved one dies. Are you

feeling angry now?”

b. “Your husband’s heart was so severely damaged that it could no longer pump.”

c. “I will call my supervisor to discuss this matter with you.”

d. Hold the spouse’s hand in silence until the family arrives.

ANS: A

When a bereaved family member behaves in a disturbed manner, the nurse should show patience and tact,

while offering sympathy and warmth. The distracters are defensive, evasive, or placating.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

8. A patient who was widowed 18 months ago says, “I can remember good times we had

without getting upset. Sometimes I even think about the disappointments. I am still trying to

become accustomed to sleeping in the bed all alone.”

a. The work of mourning is beginning.

b. The work of mourning has not begun.

c. The work of mourning is at or near completion.

d. The work of mourning is progressing abnormally.

ANS: C

The work of mourning has been successfully completed when the bereaved can acknowledge both

positive and negative memories about the deceased and when the task of restructuring the relationship

with the deceased is completed.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. When is the grieving process more difficult?

a. When a person has experienced many previous losses in life

b. When a person was emotionally independent of the deceased

c. When a person had few unresolved conflicts with the deceased

d. When a person recognizes the deceased was an elderly person, so it was time for

death

ANS: A

The following factors can complicate bereavement: high dependency on the deceased, ambivalence toward the deceased, a poor or absent support system, a high number of past losses or other recent losses,

poor physical or mental health, and young age of the deceased. Data do not support the other options.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

10. A patient with a new diagnosis of cancer says, “My father died of pancreatic cancer. I took care of him during his illness, so I know what is ahead for me.” Which nursing diagnosis applies?

a. Anticipatory grieving

b. Ineffective coping

c. Ineffective denial

d. Spiritual distress

ANS: A

The patient’s experience demonstrates anticipatory grieving. The other diagnoses may apply but are not supported by the comment.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Nursing Diagnosis

MSC: Client Needs: Psychosocial Integrity

11. A nurse talks with a woman who recently learned that her husband died while jogging. Select the appropriate statement for the nurse.

a. “At least your husband did not suffer.”

b. “It’s better to go quickly as your husband did.”

c. “Your husband’s loss must be very painful for you.”

d. “You will begin to feel better after you get over the shock.”

ANS: C

The most helpful responses by others validate the bereaved person’s experience of loss. Avoid clichés because they are ineffective.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. A recently widowed patient tells the nurse, “I am having epigastric discomfort. I think I have developed an ulcer.” Diagnostic tests are negative. Which phenomenon of bereavement is evident?

a. Preoccupation with the image of the deceased

b.

Disorganization, depression, and restlessness

c. Sensations of somatic distress

d. Reorganization of behaviour

ANS: C

Sensations of somatic distress are often experienced during the acute stage of grieving. They include tightness in the throat, shortness of breath, exhaustion, and pain or sensations such as those experienced by the dead person.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

13. Which finding indicates successful completion of an individual’s grieving process?

a. For 2 years after her husband’s death, a widow has kept her husband’s belongings in their usual places.

b. After 15 months, a widower realistically remembers both the pleasures and disappointments of his relationship with his wife.

c. Three years after her husband’s death, a widow talks about her husband as if he is alive and weeps when others mention his name.

d. Eighteen months after a spouse’s death, a person says, “I have never cried or had feelings of loss, even though we were very close.”

ANS: B

The work of grieving is over when the bereaved can remember the individual realistically and

acknowledge both the pleasure and disappointments associated with the loved one. The individual is then

free to enter into new relationships and activities. The other options suggest maladaptive grief.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

14. A child drowned while swimming in a local lake 2 years ago. Which behaviour

indicates the child's parents are mourning in an effective way?

a. The parents who forbid their other children to go swimming

b. The parents who keep a place set for the dead child at the family dinner table

c. The parents who sealed their child's room exactly as the child left it 2 years ago

d. The parents who throw flowers on the lake at each anniversary date of the accident

ANS: D

Loss of a child is among the highest-risk situations for maladaptive grieving. The parents who throw flowers on the lake on each anniversary date of the accident are openly expressing their feelings. The other behaviours indicate the parents are isolating themselves or denying their feelings, or both.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Evaluation

MSC: Client Needs: Psychosocial Integrity

15. A patient with pancreatic cancer says, "I know I am dying, but I am still alive. I want

to be in control as long as I can." Which reply by the nurse shows active listening?

a. "Our staff will do their best to manage your pain."

b. "Your mind and spirit are healthy, although your body is frail."

c. "Most people do not know how to help. Try not to be hard on them."

d. "Are you saying you want people to stop focusing on your diagnosis?"

ANS: B

The patient has strengths and capabilities and is asking for acknowledgment that he is not incapacitated, even though the diagnosis is likely terminal. It is important for the nurse to provide the patient with ways to have control over decisions affecting health and living situations. This answer provides that acknowledgment. The other responses are tangential.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

16. A terminally ill patient says, “I know I will never get well, but . . . ” and the patient’s voice trails off. Select the most therapeutic response by the nurse.

a. What do you hope for?”

b. “Do you have questions about what is happening?”

c. “You are not going to get well. It is healthy that you accept that.”

d. “When you have questions, it is best to talk to the health care provider.”

ANS: A

This open-ended response is an example of following the patient’s lead. It provides an opportunity for the patient to speak about whatever is on his mind. The distracters are not therapeutic; they block further communication, refocus the conversation, give advice, or suggest the nurse is uncomfortable with the topic.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. A husband whose wife is terminally ill says, “I don’t want to cry in front of her. I need to be strong for her.” Select the nurse’s most therapeutic response.

a. “She might find comfort in your tears.”

b. “You should be honest about your feelings.”

c. “You need to consider the fact that time is running out.”

d. “You are right to protect her at a time when she is so vulnerable.”

ANS: A

Many people try to protect the dying person from experiencing emotions; however, emotional honesty is important to both the patient and the family. The patient may be reassured knowing that the family is facing the inevitable. Giving advice and making judgemental statements are not helpful.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. Family members of a dying patient ask the nurse, “What can we say when our loved one says, ‘Death is coming soon?’” To promote communication, which response could the nurse

suggest for family members?

a. “We feel sad when we think about life without you.”

b. “We have not given up on getting you well.”

c. “We think you will be around for a long time yet.”

d. “Let’s talk about the good memories we have.”

ANS: A

This response is emotionally honest. It allows the family opportunities to express emotions, address issues

in the relationship, and say farewell. The distracters are evasive.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

19. As death approaches, a patient with AIDS says, “I do not have enough energy for

many visitors anymore, and I am embarrassed about how I look. I only want to see my parents and

sister.” What action should the nurse take?

a. Support the patient to share the request with the parents and sister. Suggest that they

inform the patient’s friends of the request.

b. Encourage the patient to reconsider this decision. Interested and caring friends can

be sources of support.

c. Suggest that the patient discuss these wishes with the health care provider.

d. Place a “No Visitors” sign on the patient’s door.

ANS: A

This response empowers the patient. As some patients approach death, they begin to withdraw. In the

stage of acceptance, many patients are exhausted, and interactions of a social nature are a burden. Many

prefer to have someone present at the bedside who will sit without talking constantly.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care

Environment

20. Nursing staff spend minimal time with a patient terminally ill with AIDS. The patient

confides in the nurse leader, “I am having many confusing emotions. Sometimes I feel angry,

sometimes afraid, sometimes abandoned.” What is the most likely reason for the staff’s avoidance

of this patient?

a. The need to use extra infection control precautions

b. Disapproval of the patient’s former high-risk lifestyle

c. Feelings of inadequacy in dealing with complex emotional needs

d. Wisdom that the patient needs time alone with significant others and for meditation

ANS: C

Supporting patients at the end of life, as they grow weaker, sicker, and ultimately die, can be

overwhelming, challenging the nurse’s sense of competency and professionalism. Many nurses tend to be

more comfortable with meeting physical needs than in focusing on emotional needs. Standard precautions

are necessary for all patients. The patient’s lifestyle is irrelevant.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. A hospice patient tells the nurse, “Life has been good. I am proud of being self-

educated. I overcame adversity and always gave my best. I intend to die as I lived: optimistic.” The

nurse planning care for this patient would recognize the importance of which of the following?

a. Providing aggressive pain and symptom management

b. Helping the patient reassess and explore existing conflicts

c. Assisting the patient to focus on the meaning in life and death

d. Supporting the patient’s use of own resources to meet challenges

ANS: D

The patient whose intrinsic strength and endurance have been a hallmark often wishes to approach dying

by staying optimistic and in control. Helping such patients use their own resources to meet challenges

would be appropriate.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

22. The spouse of a patient being cared for at home by hospice angrily tells the nurse, "Care provided by the aide is inadequate, so I must do everything myself. Why is this happening? Can't someone help?" The hospice nurse should do which of the following?

a. Provide teaching about anticipatory grieving

b. Assign new hospice personnel to the case

c. Refer the spouse for crisis intervention

d. Arrange hospitalization for the patient

ANS: A

The behaviours described in the scenario are consistent with anticipatory grieving. The spouse needs education about the process of anticipatory grieving and counselling to validate her feelings and to improve coping with the physical, emotional, and cognitive symptoms she is experiencing. The other options are not appropriate to the situation.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

23. A bystander was killed during a robbery 2 weeks ago. His widow, who has schizoaffective disorder, cries spontaneously when talking about his death. Select the nurse's most therapeutic response.

a. "Are you hearing voices at night?"

b. "I am worried about how much you are crying. Your grief over your husband's death has gone on too long."

c. "This loss is harder to accept because of your mental illness. I will refer you to a partial hospitalization program."

d. "The unexpected death of your husband must be very painful. I am glad you are able to talk to me about your feelings."

ANS: D

The patient is expressing feelings related to the loss, and this is an expected and healthy behaviour. This

patient is at risk for dysfunctional grieving because of the history of a severe psychiatric illness, but the nurse's priority intervention is to form a therapeutic alliance and support the patient's expression of feelings. The crying 2 weeks after his death is expected and normal.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. Children of a widow confer with the nurse because their mother is depressed and lonely. Her days are filled with aimless activities. Family members are concerned about her and ask, "What can we do? It`s been over 6 months since Dad died." What should the nurse counsel the family?

a. That they should offer to move in with their mother to help with loneliness

b. That they should encourage their mother to talk about her life as a widow with other women who have had the same experience

c. That loneliness and aimlessness are most pronounced 6 to 9 months after the death

d. That retelling of negative memories is expected as part of the aging process

ANS: C

Loneliness and aimlessness are most pronounced 6 to 9 months after the death. The nurse should provide information to the children to assure them that this is not abnormal behaviour at this stage of bereavement. Offering to move in would not address her need to grieve. She is not yet ready to provide support to other widows. Retelling of positive rather than negative memories can be helpful.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

25. A woman grieving her husband's sudden death tells the nurse, "Yesterday, I saw my husband walk through the door and smile at me, but then he just faded away." Select the nurse's most appropriate action.

a. Assess for substance use and abuse.

b. Assess the patient's psychiatric history.

c. Refer the patient to the mental health centre.

d. Counsel the patient that visualizations are a normal part of grieving.

ANS: D

Grieving persons often dream about, visualize, think about, or search for the lost loved one. Inform the person that this experience is a normal phenomenon. Visualization does not suggest substance use or mental illness in this case.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

26. A father and son have a long history of hostility and conflict. As the father dies, he finally expresses his love, but the son is unable to respond verbally. Which gift of resolving relationships is most important to address with the son?

a. Guilt

b. Anger

c. Gratitude

d. Forgiveness

ANS: D

The son is unable to express the hurt and pain associated with the relationship with his father. Assisting him to forgive the father and admit the wrongs in the relationship will help resolve the conflict. Guilt and anger are not gifts. Expressing gratitude is not the priority for the son.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

27. A nurse cared for a terminally ill patient for over a month and looked forward to spending time with this patient. After the patient died, the nurse began to sleep poorly, lacked energy, and felt depressed. Eventually the nurse explained these feelings to a mentor. How should the mentor counsel the nurse?

a. About stress-reduction strategies

b. To seek therapy for dysfunctional grief

c. About the experience of disenfranchised grief

d. To consider taking a leave of absence to pursue healing

ANS: C

The nurse is experiencing disenfranchised grief. Nurses often incur loss that is not openly acknowledged or publicly mourned. Loss of a patient may not be recognized or acknowledged by others, so the grief is

solitary and uncomforted and may be difficult to resolve.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

28. A nurse asks a hospice palliative care nurse, “Who should be referred for hospice palliative care?” Select the correct reply.

a. “Hospice is for terminally ill patients with cancer.”

b. “Patients with a life-threatening illness.”

c. “We are best equipped to care for patients with end-stage renal disease.”

d. “Patients with degenerative neurological disease are eligible after respiration is affected.”

ANS: B

Using an interdisciplinary approach, the national hospice palliative care (HPC) model is appropriate for patients and families of all ages living with or at risk for developing a life-threatening illness of any kind or magnitude, for whom HPC may complement therapy or be the total focus of care.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

29. Which is considered the hallmark of hospice palliative care?

a. Available in the patient’s home.

b. Excellent symptom management.

c. Family-centred approach to health decisions.

d. Based on culturally sensitive nursing care.

ANS: B

Excellent symptom management is a hallmark of hospice palliative care (HPC) nursing. Although HPC is available in the home, is family centred, and is culturally sensitive, these are not considered to be the hallmark of HPC.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Which actions by a nurse are most appropriate when caring for a hospice patient?

(Select all that apply.)

a. Giving choices

b. Fostering personal control

c. Explaining curative options

d. Supporting the patient's spirituality

e. Offering interventions that convey respect

f. Providing answers to the patient's questions about spirituality

ANS: A, B, D, E

These answers support the rights and choices of the dying individual. Acting on false information robs a patient of the opportunity for honest dialogue and places barriers to achieving end-of-life developmental opportunities. The nurse supports the patient's spirituality but does not have the answers to all questions.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. Which statements demonstrate aspects of spirituality in end-of-life care? (Select all that apply.)

a. Expressing an inner peace

b. The desire to talk about hopes and fears

c. Reciprocal sharing with the nurse

d. Attending to the meaning in suffering

e. Trust in the health care provider for symptom relief

ANS: A, B, C

Part of spirituality is that patients want to feel genuinely cared about and have the opportunity to talk about their fears, hopes, issues, and despair. Nurses must focus on presence, listening, connecting, creating openings, and engaging in reciprocal sharing as they make the journey with their patients. Time spent with the patient and family is considered essential for successful outcomes. Symptom relief is the hallmark of hospice palliative care rather than an aspect of spirituality.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which patients meet criteria for hospice services? (Select all that apply.)

a. A 92-year-old with pneumonia and late-stage Alzheimer's disease

b. A 74-year-old with advanced COPD self-managed at home.

c. A 54-year-old with glioblastoma and life expectancy of 8 to 10 weeks

d. A 16-year-old with type 1 diabetes, multiple infections, and substance abuse

e. A 36-year-old with multiple sclerosis complicated by depression and pain associated with muscle spasms

ANS: A, C

A hospice palliative care model is appropriate for patients and families of all ages living with or at risk for developing a life-threatening illness of any kind or magnitude. Although patients with other health problems may experience complications, treatments focusing on cure would exclude them from hospice services.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Safe Effective Care Environment

4. A woman was awakened one morning by a police officer after her husband died while jogging. For the next 3 days, the widow stoically went through the funeral ritual in a state of numbness. Friends tried to get her to vent her feelings by crying. Which statements offer likely explanations regarding the widow's inability to cry? (Select all that apply.)

a. Psychologically unhealthy individuals are likely to have atypical grief reactions.

b. The acute stage of grief involves shock and disbelief that may last for several days.

c. Culture influences grief responses. Some groups view emotional displays negatively.

d. The widow had anticipated her husband's death long before it occurred and completed her mourning.

e. The unconscious use of denial is normal for several days after a loss. It protects the individual from the intolerable pain of loss.

ANS: B, C, E

These answers are true relative to the scenario. Psychologically unhealthy individuals may have more complex reactions but not necessarily atypical ones. Anticipating death and completing mourning would

not be an expectation related to the death of a man healthy enough to jog.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. A child drowned while swimming in a local lake 2 years ago. Which behaviours show the child's parents are mourning in an effective way? (Select all that apply.)

a. The parents maintain a place setting for the dead child at the family dinner table.

b. The parents throw flowers on the lake at each anniversary date of the accident.

c. The parents keep their child's room exactly as the child left it 2 years ago.

d. The parents purchase life vests for children at a local group home.

e. The parents enroll their other children in swimming lessons.

ANS: B, D, E

Loss of a child is among the highest-risk situations for maladaptive grieving. The parents who throw flowers on the lake on each anniversary date of the accident are openly expressing their feelings. Enrolling their other children in swimming lessons shows the parents' love of the surviving children and interest in their safety. Purchasing life vests for other children is a way of memorializing their child who drowned. The other behaviours indicate the parents are isolating themselves or denying their feelings or both.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

Chapter 32: Forensic Psychiatric Nursing

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A person diagnosed with bipolar disorder ran out of money, did not refill a lithium prescription, and then relapsed. After assaulting several people in the community, this person was convicted and sentenced. Prior to parole, which outcome has priority for the correctional nurse to achieve?

a. The person agrees in writing to continue lithium therapy.

b. The person is re-established on an appropriate dose of lithium.

c. The person lists community resources for prescription assistance.

d. The person agrees to a follow-up appointment in an outpatient clinic.

ANS: C

To increase medication adherence, reduce the risk of relapse, and prevent further criminal activity due to

mental illness, the person's awareness of community resources for medication refills and medication-related services is the most important outcome. Agreeing to take lithium, being re-established on

medication in jail, and agreeing to follow-up mental health care are important, but none of these will address the primary reason for the criminal behaviour—the relapse caused by inability to access medication in the community.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Health Promotion and Maintenance

2. An inmate was diagnosed with post-traumatic stress disorder (PTSD) caused by severe sexual abuse. One day this inmate sees a person with characteristics similar to the perpetrator, has a flashback, and then attacks the person. Correctional officers place the inmate in restraint. In what way should the correctional nurse anticipate that the inmate would react to restraint?

a. By committing to counselling to reduce the incidence of flashbacks

b. By becoming less likely to assault others during future flashbacks

c. By gradually calming and returning from the flashback to reality

d. By becoming more frightened, agitated, and combative

ANS: D

The correctional nurse recognizes that events occurring in the present reality are likely to be incorporated

into a flashback, leading the inmate to become more frightened and desperate to escape. Even if no longer

experiencing a flashback, people will likely re-experience their original trauma if restrained, including the emotions experienced during that trauma, leading to increased fearfulness and resistance to the jail

restraints. Restraints are not likely to calm the individual or reduce aggressiveness but instead increase the

sense of helplessness and desperation.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. An inmate was diagnosed with post-traumatic stress disorder (PTSD) caused by severe

sexual abuse. One day this inmate sees a person with similar characteristics to the perpetrator, has a

flashback, and then attacks the person. Correctional officers place the inmate in restraint. Which

action by the correctional nurse is most appropriate?

a. Plan to meet with the inmate for debriefing after release from the required period of

restraint.

b. Support the use of restraints as needed to control violent outbursts and assure the

safety of all inmates.

c. Contact a supervisor authorized to make an exception to the restraint policy and

explain why an alternate response is needed.

d.

Confront the correctional officers who initiated the restraint, explain the

inappropriateness of this action, and request the inmate's release.

ANS: C

Nurses have advocacy responsibilities, regardless of the setting. The optimum outcome in this situation

would be to minimize the duration of the restraint episode. The inmate and others are at risk of injury

until the inmate is calm. The restraints will likely worsen and extend the inmate's distress and agitation.

Supporting the use of restraints ignores the need of select inmates for alternate responses that do not

paradoxically worsen the situation instead of help it. Meeting with and calming the patient after release

would be the second most helpful response, but it does not shorten the duration of the patient's restraint.

Confronting the officers is unlikely to be successful, since they are following proper procedures; accusing

them of improper actions will likely increase defensiveness rather than expedite the inmate's release from

restraint.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. The correctional nurse assesses a new prisoner beginning incarceration after committing a sex crime. The prisoner speaks in a low voice and tearfully tells the nurse, “My life might as well be over. There is no hope I will ever fit into society after I get out of prison. My family disowned me.” Select the nurse’s priority action.

a. Advise guards to place the inmate in solitary confinement.

b. Offer to contact the inmate’s family to convey these feelings of remorse.

c. Alert the guards of the risk for suicide and implement suicide precautions.

d. Meet with the inmate weekly to discuss these feelings and explore coping strategies.

ANS: C

The inmate is experiencing significant shame and self-loathing, facing many significant losses (freedom, status in the community, perhaps his career), separated from his support system, and evidences hopelessness. Patients with mental illness that are incarcerated are four times more likely to commit suicide than other prisoners. These all suggest a significant risk of suicide. The priority response would be to alert the guards of the inmate’s risk to self and implement suicide precautions. Safety is the primary issue; none of the other options is appropriate relative to suicide prevention.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

5. A correctional nurse working in a county jail assesses all new inmates who report taking psychotropic medication or have symptoms of psychiatric disorders. Because of the high volume of newly incarcerated individuals, which skill is most essential for this nurse?

a. Documenting information that could be used as trial evidence

b. Quickly and skillfully assessing risks for suicide and violence

c. Having a comprehensive understanding of community resources

d. Counselling inmates to promote successful adaptation to incarceration

ANS: B

Newly incarcerated prisoners are often in crisis and may be suicidal. Others may be mentally ill and

experiencing relapse. Therefore, being able to quickly and skillfully assess for risk of suicide and violence is an essential skill for the correctional nurse. Documenting potential evidence may occur but is not typically the primary or priority role of a correctional nurse. Community resources and counselling are helpful but would not be a priority compared to risk assessment and reduction.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

6. A psychiatric clinical nurse specialist works with a defendant as a competency evaluator. A staff member asks, "Why are you spending so much time with that defendant? You spend one-to-one time and write volumes. Usually, we give defendants some medication and return them to court." Select the clinical nurse specialist's most appropriate response.

a. "My role is to be an advocate for the defendant, so I have to know him well and build a trusting relationship."

b. "My focus is providing intensive psychotherapy to ensure the defendant becomes competent before returning to court."

c. "The specialized assessments I make on behalf of the court require very lengthy and detailed interviews, so it takes a lot of time."

d. "I spend the time observing, assessing, and documenting competency, writing a report, and preparing expert testimony for the court."

ANS: D

The competency evaluator must determine the patient's current competence to act on his own behalf during his trial; without competency, the inmate cannot stand trial. Determining competency goes well beyond the mental status, functional, and risk assessments most psychiatric nurses are accustomed to and are very complex and time-consuming. A complete formal report is prepared for the court and all pertinent details addressed in anticipation of questioning by officers of the court. The evaluator represents the court, not the patient. Interviews of the inmate are only a portion of the evaluator's work. Evaluators help the court determine competency but do not intervene to increase the patient's competency.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

7. During arraignment, a defendant behaves bizarrely, fails to respond to the judge's questions, and shouts obscenities. The judge orders an evaluation by a forensic nurse examiner. Which information provided by the examiner will be most important to the court at this time?

a. The defendant's mental state at the time of the crime

b. The defendant's competence to proceed with trial

c. The cause of the defendant's courtroom behaviour

d. The defendant's history and cognitive abilities

ANS: B

Competence to proceed refers to one's capacity to assist the attorney and understand legal proceedings. Evidence is collected by a careful evaluation of a forensic client's mental status at the time of the offence.

This evaluation aids in determining the individual's fitness to stand trial and may later influence the sentence. Forensic psychiatric nurses may spend many hours with an accused individual collecting evidence and carefully documenting the dialogue. In this capacity, the role of the forensic psychiatric nurse is not to determine guilt or innocence but to provide assessment data that can help make a final diagnosis within the multidisciplinary forensic team. Canadian law specifies that a person cannot be tried for a criminal offence if because of a mental disorder he or she is unable to provide a defence. An incompetent individual is remanded to a locked facility for treatment to regain competency. The court will desire a full assessment of the patient's present mental state related to his ability to assist in his own defence, but at this time, the court is not interested in his state of mind at the time of the original crime, nor his history.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A psychiatric forensic nurse examiner was asked by a defendant's attorney to determine the defendant's fitness to stand trial. What is the priority task of the nurse examiner?

a. Determine if the defendant understands the charges and can assist the attorney with

the defence.

b. Complete a risk assessment to determine if the defendant is a danger to self or others.

c. Complete a court-ordered evaluation of criminal responsibility.

d. Collect and compile evidence to determine whether a crime occurred.

ANS: C

It is the accused individual's capacity at the time of trial that is in question in determining fitness to stand trial. The court may decide that an individual found unfit to stand trial is to be treated for the purpose of making the individual fit to stand trial. The nurse would be conducting a court-ordered evaluation of criminal responsibility. The defendant's ability to understand the charges and assist in his defence is pertinent to an evaluation of competency. Unless the court has specifically asked for a risk assessment (which would be unusual), the risk assessment is the responsibility of clinical staff caring for the patient, not the forensic nurse examiner. Police collect evidence about the crime, and the prosecutor compiles it. A forensic nurse examiner does not participate in evidence collection other than that related to the assessment of the patient's state of mind at the time of the alleged crime.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. Select the best question for a psychiatric forensic nurse examiner to ask when assessing the fitness to stand trial of an individual charged with a crime.

a. "Tell me about what you were thinking at the time of the alleged crime."

b. "What would you do if you heard a fire alarm going off where you live?"

c. "At this time, are you having any experiences that others might think strange?"

d. "Do you feel as though you would like to harm yourself or anyone else at the present time?"

ANS: A

Evidence collection is central to the role of the forensic psychiatric nurse. For example, evidence is collected by a careful evaluation of a forensic client's mental status at the time of the offence. This evaluation aids in determining the individual's fitness to stand trial and may later influence the sentence. Criminal responsibility refers to the mental state of a defendant at the time of the offence. A person is

“not criminally responsible” (NCR) if he or she has a mental disorder that makes the person unable to judge the nature or quality of the criminal act or to understand that the act was wrong at the time it was committed. Assessing what the patient was thinking at the time of the alleged crime will provide insight into the person’s mental status. The distracters apply to other parts of a mental status assessment and do not assess the patient’s state at the time of the alleged crime.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

10. In which circumstance would a psychiatric forensic nurse examiner determine it appropriate for a defendant and attorney to consider a “not criminally responsible” defence? At the time of the crime, the defendant did which of the following?

a. Shot a drug dealer who tried to overcharge for cocaine

b. Acted on auditory hallucinations of the voice of God commanding, “Kill the children.”

c. Tampered with the brakes on his wife’s car after discovering she had an extramarital affair

d. Was frightened because of a home robbery the preceding night, assumed a family member was another burglar, and shot him

ANS: B

A person is “not criminally responsible” (NCR) if he or she has a mental disorder that makes the person unable to judge the nature or quality of the criminal act or to understand that the act was wrong at the time it was committed. The defendant, demonstrating symptoms of psychosis and acting on the direction of command hallucinations, could use the defence of “not criminally responsible” because he was unable to recognize his action as wrong due to a psychiatric illness. The other options suggest the defendant knew right from wrong, had the capacity to know the nature and quality of the act, and had the capacity to form intent to commit the crime.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. A nurse testifies about care provided to a patient in the 8 hours before a successful suicide. The nurse responds to questions about observations regarding the patient's behaviour. In what capacity was this nurse testifying?

a. Forensic nurse examiner

b. Expert witness

c. Hostile witness

d. Consultant

ANS: B

Forensic psychiatric nurses may function as a forensic nurse examiner, expert witness, and consultant to the criminal justice system, law enforcement, or health care agencies. An expert witness shares professional expertise about the defendant or elements of the crime and testifies on behalf of the prosecution or defendant. Forensic nurse examiners conduct court-ordered examinations and provide written reports and court testimony regarding the findings of the examinations, but they do not give direct patient care. Consultants are neutral experts who educate or advise the court or its officers on technical matters such as standards of nursing care.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. The highest degree of credibility is required by a nurse who provides testimony before the court as which of the following?

a. Hostile witness

b. Expert witness

c. Correctional nurse

d. Critical care nurse

ANS: B

An expert witness is recognized by the court as having a high level of skill or expertise in a specific area. In addition to testifying about involvement with the individual and documentation of the interactions, an expert witness is permitted by the court to give a professional opinion. A hostile witness does not apply in

this situation. Correctional and critical care nurses may testify as fact witnesses.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

13. What chronic condition is an individual that is incarcerated in a Canadian federal institution more likely to have than someone in the general population?

a. COPD

b. Diabetes

c. Multiple sclerosis

d. Cystic fibrosis

ANS: B

Chronic conditions more common in incarcerated individuals as compared to the general population are diabetes, asthma, and cardiovascular disorders. There is no evidence to suggest that COPD, multiple sclerosis, or cystic fibrosis is more likely to occur in the incarcerated population.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: N/A

14. A correctional nurse plans a health education series for male prison inmates based upon the greatest likelihood of experiencing which mental health disorder while incarcerated?

a. Mood disorder

b. Schizophrenia

c. Hallucinations

d. Bipolar disease

ANS: A

The most common mental health disorder experienced by male inmates is mood disorders. They are four times more likely to have a mood disorder than individuals that are not incarcerated. Although they are three times more likely to experience schizophrenia, the greatest likelihood is that they will experience a mood disorder.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. Health problems most commonly encountered by correctional nurses are which of the following?

a. Routine infections and minor trauma

b. Chronic medical and psychiatric disorders

c. Similar to the non-incarcerated population

d. Injuries acquired during arrest or incarceration

ANS: B

Correctional nurses provide care for inmates who have disproportionately high rates of mental illness, substance abuse, tuberculosis, AIDS, hepatitis, diabetes, and other chronic disorders and infections. The health problems of inmates are more complex and chronic, not similar to their non-incarcerated peers. Trauma is an important issue that affects inmate health, but it is not the primary health issue for this population.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

16. A guard tells an inmate diagnosed with schizophrenia to ask the desk officer for a mop and bucket, and then get some water from the shower area and mop the kitchen and hall. The inmate does not comply. The guard becomes angry and cancels the inmate's recreation time. Which action by the correctional nurse is most appropriate?

a. Document the inmate's response as indicative of resistance and psychopathology.

b. Do not intervene. Intervention is not part of a correctional nurse's scope of practice.

c. Confer with the prison psychiatrist regarding re-evaluation of this inmate's antipsychotic medication regime.

d. Explain to the guard that this inmate has difficulty following multiple-step instructions. Suggest stating one idea at a time.

ANS: D

Correctional nurses, like most direct-care nurses outside of corrections, have a professional responsibility to advocate for inmates regarding needed care. A psychiatric nurse would understand schizophrenia and recognize that the inmate's ability to process multistep instructions was impaired. Advocacy for the inmate is evident by educating the guard so he would not misperceive the reason the inmate did not

respond. Documentation is needed for all nursing activities. Involving the psychiatrist might be of some value but is at best a passive form of advocacy, and again, as worded here, suggests that the nurse does not understand how schizophrenia contributed to the inmate's not responding to complex instructions.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. Which Correctional Service Canada treatment setting would necessitate the most restrictive care environment?

a. Institutional health unit

b. Reception centre

c. Regional treatment centre

d. Regional hospital

ANS: D

A Correctional Service Canada (CSC) regional hospital is located within the compound of a multi-level or maximum security level institution that provides more specialized or comprehensive health care services on a 24-hour basis, making it the most restrictive care environment. Services include but are not limited to postoperative care, trauma care, observation, dialysis, palliative care, or any condition requiring 24-hour nursing services. An institutional health unit has varying hours of operation based on factors such as level of security and proximity to community services. A reception centre conducts the CSC standardized admission process (both health and security) for all newly sentenced federal offenders. A regional treatment centre provides treatment to inmates with psychiatric disorders that are too severe to allow them to remain in the general inmate population of an institution.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

18. Which statement about the practice of correctional nursing is accurate?

a. Because the majority of inmates are younger than 40 years of age, most have lower rates of chronic illnesses than the general population.

b. Correctional nurses work primarily with medically ill people rather than people

with psychiatric or substance abuse disorders.

c. Individuals with mental illness are over-represented in the Canadian criminal justice

system.

d. Correctional nurses commonly provide holistic and comprehensive care for the

incarcerated population.

ANS: C

Individuals living with mental health challenges are over-represented in the Canadian criminal justice

system, with more than 45% of the total male inmate population and 69% of the female inmate population

receiving mental health care services in 2010-2011. Correctional facilities carry a disproportionate share

of the burden for the provision of mental health services. Rates of chronic illness are higher among

inmates than in the general population due to factors such as higher rates of poverty, lower educational

status, higher rates of trauma, institutional living when incarcerated, reduced access to health care, poor

health habits, and higher rates of high-risk behaviours such as IV drug abuse. Correctional settings

provide adequate care of inmates, but it is rarely holistic or comprehensive.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: N/A

MSC: Client Needs: Safe Effective Care Environment

19. Which credential would be expected of forensic psychiatric nursing?

a. Three years of experience in an inpatient psychiatric facility

b. Ten years of experience in community health nursing

c. Educational preparation in theories of violence and victimology

d. Publication of five articles in peer-reviewed psychiatric nursing journals

ANS: C

The forensic nurse possesses expertise in assessment and treatment roles related to competency, risk, and

danger. Forensic nurses are educated in nursing science and take additional courses in theories of violence

and victimology, and legal issues that enable them to objectively assess the circumstances of the case. An

understanding of both the victim and the offender enhances evidence collection. Forensic nurses may

apply medical-surgical knowledge to the care of victims and offenders, and they may function in the legal role as they collect evidence, testify in court, or collaborate with law practitioners with relationship to a forensic client. If the expert has conducted research and published in the area, it is an added strength, but is not a requirement. Expert testimony is based on evidence-informed practice.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: N/A

MSC: Client Needs: Safe Effective Care Environment

MULTIPLE RESPONSE

1. Which specific task-oriented areas apply to the psychiatric forensic nurse's role? (Select all that apply.)

a. Hostage negotiation

b. Management of violent behaviour

c. Administration of first aid

d. Therapeutic use of self

e. Pharmacological treatment orders

ANS: A, B, C

Specific task-oriented areas that apply to the forensic nurse's role include hostage negotiation, management of violent behaviour, and administration of first aid. Therapeutic use of self is important, but it is not a specific task-oriented area. Nurses assess and monitor medication administration but do not write medication orders for inmates.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

2. Which characteristics best qualify a nurse for employment as a forensic psychiatric nurse? (Select all that apply.)

a. Ability to be non-judgemental

b. Ability to be detached

c. Desire to punish perpetrators of crime

d. Ability to appear calm and relaxed

e. Ability to make decisions effectively

f. Critical care skills

ANS: A, B, D, E

Forensic nursing requires the ability to address the issues and provide care in a truly neutral manner. All forensic nurses, whatever their specific title or responsibilities, must therefore be objective and not be motivated by any personal beliefs about what should or should not happen to patients involved in the criminal justice system. Personal qualities include the ability to be non-judgemental, be detached, appear

calm and relaxed, and make decisions effectively. Forensic nurses do not need critical care skills.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: N/A

MSC: Client Needs: N/A

Chapter 33: Therapeutic Groups

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient tells members of a therapy group, "I hear voices saying my doctor is

poisoning me." Another patient replies, "I used to hear voices too. They sounded real, but I found out later they were not. The voices you hear are not real either." Which therapeutic factor is exemplified in this interchange?

a. Catharsis

b. Universality

c. Imitative behaviour

d. Interpersonal learning

ANS: D

Here, a member gains insight into his own experiences from hearing about the experiences of others through interpersonal learning. Catharsis refers to a therapeutic discharge of emotions. Universality refers to members realizing their feelings are common to most people and not abnormal. Imitative behaviour involves copying or borrowing the adaptive behaviour of others.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. A leader plans to start a new self-esteem building group. Which intervention would be most helpful for assuring mutual respect within the group?

a. Describe the importance of mutual respect in the first session and make it a group norm.

b. Exclude potential members whose behaviour suggests they are likely to be disrespectful.

c. Give members a brochure describing the purpose, norms, and expectations of the group.

d. Explain that mutual respect is expected and confront those who are not respectful.

ANS: A

It is helpful to motivate members to behave respectfully by describing how mutual respect benefits all members and is necessary for the group to be fully therapeutic. Setting a tone and expectation of mutual respect from the outset is the most helpful intervention listed. Excluding members because of how they might behave could exclude members who would have been appropriate, depriving them of the potential benefits of the group. Conveying expectations by brochure is less effective than doing so orally, because it lacks the connection to each member that a skilled leader can create to motivate members and impart the expectation of respect. Confronting inappropriate behaviour is therapeutic but only addresses existing behaviour rather than preventing all such undesired behaviour.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning MSC: Client Needs: Psychosocial Integrity

3. A young female member in a therapy group says to an older female member, “You are just like my mother, always trying to control me with your observations and suggestions.” Which therapeutic factor of a group is evident by this behaviour?

a. Instillation of hope

b. Existential resolution

c. Development of socializing techniques

d. Corrective recapitulation of the primary family group

ANS: D

The younger patient is demonstrating an emotional attachment to the older patient that mirrors patterns within her own family of origin, a phenomenon called corrective recapitulation of the primary family group. Feedback from the group then helps the member gain insight about this behaviour and leads to more effective ways of relating to her family members. Instillation of hope involves conveying optimism and sharing progress. Existential resolution refers to the realization that certain existential experiences such as death are part of life, aiding the adjustment to such realities. Development of socializing techniques involves gaining social skills through the group's feedback and practice within the group.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. During group therapy, one patient says to another, "When I first started in this group, you were unable to make a decision, but now you can. You've made a lot of progress. I am beginning to think that maybe I can conquer my fears too." Which therapeutic factor is evident by this statement?

a. Hope

b. Altruism

c. Catharsis

d. Cohesiveness

ANS: A

The patient's professing that he may be able to learn to cope more effectively reflects hope. Groups can instill hope in individuals who are demoralized or pessimistic. Altruism refers to doing good for others, which can result in positive feelings about oneself. Catharsis refers to venting of strong emotions. Cohesion refers to coming together and developing a connection with other group members.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. During a group therapy session, a newly admitted patient suddenly says to the nurse, "How old are you? You seem too young to be leading a group." Select the nurse's most appropriate response.

a. "I am wondering what leads you to ask. Please tell me more."

b. “I am old enough to be a nurse, which qualifies me to lead this group.”

c. “My age is not pertinent to why we are here and should not concern you.”

d. “You are wondering whether I have enough experience to lead this group?”

ANS: D

A question such as this is common in the initial phase of group development when members are getting to

know one another, dealing with trust issues, and testing the leader. Opening the topic of the nurse’s

experience and leadership makes the implied explicit, serves to role model more effective

communication, and prompts further discussion of the patient’s concern. Asking the patient to tell the

leader more about the question focuses on the reason for the member’s concern rather than on the issue

raised (the experience and ability of the leader) and is a less helpful response. “I am old enough to be a

nurse” and “age is not pertinent” are defensive responses and fail to address the patient’s valid concern.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

6. A patient in a group therapy session listens to others and then remarks, “I used to think I

was the only one who felt afraid. I guess I’m not as alone as I thought.” This comment is an

example of which of the following?

a. Altruism

b. Ventilation

c. Universality

d. Group cohesiveness

ANS: C

Realizing that one is not alone and that others share the same problems and feelings is called universality.

Ventilation refers to expressing emotions. Altruism refers to benefiting by being of help to others. Group

cohesiveness refers to the degree of bonding among members of the group.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. A nurse at the well-child clinic realizes that many parents have misconceptions about

effective ways of disciplining their children. The nurse decides to form a group to address this problem. What should be the focus of the group?

a. Support

b. Socialization

c. Health education

d. Symptom management

ANS: C

The nurse has diagnosed a knowledge deficit. The focus of the group should be education. Support and socialization are beneficial but should not be the primary focus of the group, and symptoms requiring intervention are not identified here.

DIF: Cognitive Level: Understand (Comprehension) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. Which outcome would be most appropriate for a symptom-management group for persons with schizophrenia?

a. Group members will state the names of their medications.

b. Group members will resolve conflicts within their families.

c. Group members will rate anxiety at least two points lower.

d. Group members will describe ways to cope with their illness.

ANS: D

An appropriate psychoeducational focus for patients with schizophrenia is managing their symptoms; coping with symptoms such as impaired memory or impaired reality testing can improve functioning and enhance their quality of life. Names of medications might be appropriate for a medication education group but would be a low priority for symptom management. Addressing intra-family issues would be more appropriate within a family therapy group or possibly a support group. Rating anxiety lower would be an expected outcome for a stress-management group.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Planning/Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

9. A patient has talked constantly throughout the group therapy session, often repeating the same comments. Other members were initially attentive but then became bored, inattentive, and

finally sullen. Which comment by the nurse leader would be most effective?

a. Say to everyone, “Most of you have become quiet. I wonder if it might be related to concerns you may have about how the group is progressing today.”

b. Say to everyone, “One person has done most of the talking. I think it would be helpful for everyone to say how that has affected your experience of the group.”

c. Say to everyone, “I noticed that as our group progressed, most members became quiet and then disinterested, and now seem almost angry. What is going on?”

d. Say to the talkative patient, “You have been doing most of the talking, and others have not had a chance to speak as a result. Could you please yield to others now?”

ANS: A

The most effective action the nurse leader can take will be the one that encourages the group to solve its own problem. Pointing out changes in the group and asking members to respond to them lays the foundation for a discussion of group dynamics. Asking members to respond to the talkative patient puts that patient in an awkward position and will likely increase anxiety. As anxiety increases, monopolizing behaviour tends to increase as well, so this response would be self-defeating. Asking members what is going on is a broader opening and might lead to responses unrelated to the issue that bears addressing; narrowing the focus to the group process more directly addresses what is occurring in the group. Focusing on the talkative patient would be less effective and involves the leader addressing the issue instead of members first attempting to do so themselves (giving them a chance to practise skills such as assertive communication).

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. Guidelines followed by the leader of a therapeutic group include focusing on recognizing dysfunctional behaviour and thinking patterns, followed by identifying and practising more adaptive alternate behaviours and thinking. Which theory is evident by this approach?

a. Behavioural

b. Interpersonal

c. Psychodynamic

d. Cognitive behavioural

ANS: D

The characteristics described are those of cognitive behavioural therapy, in which patients learn to reframe dysfunctional thoughts and extinguish maladaptive behaviours. Behavioural therapy focuses solely on changing behaviour rather than thoughts, feelings, and behaviours together. Interpersonal theory focuses on interactions and relationships. Psychodynamic groups focus on developing insight to resolve unconscious conflicts.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

11. The nurse has been working with a large group of patients and has noticed that there are six members who have experienced sexual abuse and tend to talk only amongst themselves. Which type of group does this reflect?

a. Subgroup

b. Open group

c. Closed group

d. Heterogeneous group

ANS: A

A subgroup is a small group that is isolated within a larger group and functions separately. Members of a subgroup may have greater loyalty, more similar goals, or more perceived similarities to one another than they do to the larger group.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Safe Effective Care Environment

12. Which remark by a group participant would the nurse expect during the working phase of group therapy?

a. “My problems are very personal and private. How do I know people in this group will not tell others what they hear?”

b. “I have enjoyed this group. It’s hard to believe that a few weeks ago I couldn’t even bring myself to talk here.”

c. “One thing everyone seems to have in common is that sometimes it’s hard to be

honest with those you love most."

d. "I don't think I agree with your action. It might help you, but it seems like it would upset your family."

ANS: D

In the working stage, members actively interact to help each other accomplish goals, and because trust has developed, conflict and disagreement can be expressed. Focusing on trust and confidentiality typically occur in the orientation phase as part of establishing group norms. Commonality and universality are also themes typically expressed in the orientation phase, whereas reflecting on progress is a task addressed in the termination phase.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

13. Three members of a therapy group share covert glances as other members of the group describe problems. When one makes a statement that subtly criticizes another speaker, the others nod in agreement. Which group dynamic should the leader suspect?

a. Some members are acting as a subgroup instead of as members of the main group.

b. Some of the members have become bored and are disregarding others.

c. Three members are showing their frustration with slower members.

d. The leadership of the group has been ineffective.

ANS: A

Subgroups, small groups isolated within a larger group and functioning separately from it, sometimes form within therapy groups. When this occurs, subgroup members are cohesive with other subgroup members but not with the members of the larger group. Members of the subgroup may be bored or frustrated or may express passive aggression, but the primary dynamic is the splitting off from the main group.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. A therapy group adds new members as others leave. What type of group is evident?

a. Open

b. Closed

c. Homogeneous

d. Heterogeneous

ANS: A

An open group is a group that adds members throughout the life of the group as other members leave and

as more persons who would benefit from the group become available. A closed group does not add new members; the membership is established at the beginning and, except for the occasional losses as some members leave, does not change thereafter. A homogeneous group includes members who are similar, and a heterogeneous group includes dissimilar members; not enough data are provided here to determine

which applies in this case.

DIF: Cognitive Level: Remember (Knowledge)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. During a therapy group that uses existential/Gestalt theory, patients shared feelings that occurred at the time of their admission. After a brief silence, one member says, “Several people have described feeling angry. I would like to hear from members who had other feelings.” Which group role is evident by this comment?

a. Energizer

b. Encourager

c. Compromiser

d. Self-confessor

ANS: B

The member is filling the role of encourager by acknowledging those who have contributed and encouraging input from others. An energizer encourages the group to make decisions or take an action. The compromiser focuses on reducing or resolving conflict to preserve harmony. A self-confessor verbalizes feelings or observations unrelated to the group.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. A group begins the working phase. One member has a childhood history of neglect and ridicule by parents. Which comment would the group leader expect from this member?

a. “My boss is always expecting more of me than the others but talking to him would only make it worse.”

b. “I’m sorry for talking all the time, but there is so much going on in my life. I can’t remember what I already said.”

c. “Thanks for the suggestions, everyone. Maybe some of them will help. It won’t hurt to give them a try.”

d. “This group is stupid. Nobody here can help anybody else because we are all so confused. It’s a waste.”

ANS: A

People who frequently complain, yet reject help or suggestions when offered, tend to have histories of severe deprivation as children, often accompanied by neglect or abuse. The other comments reflect dynamics other than the help-rejecting complainer, such as the monopolizer who apologizes for talking too much, the person who is insightful and agrees to try a peer’s suggestion, and the demoralizing member.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. A group is in the working phase. One member says, “That is the stupidest thing I’ve ever heard. Everyone whines and tells everyone else what to do. This group is a total waste of my time.” Which comment by the group leader would be most therapeutic?

a. “You seem to think you know a lot already. Since you know so much, perhaps you can tell everyone why you are back in the hospital?”

b. “I think you have made your views clear, but I wonder if others feel the same way. How does everyone else feel about our group?”

c. “It must be hard to be so angry.” Direct this comment to another group member, “You were also angry at first, but you are not now. What has helped you?”

d. “I would like to remind you that one of our group rules is that everyone is to offer only positive responses to the comments of others.”

ANS: C

The member's comments demean the group and its members and suggest that the member is very angry.

Labelling the emotion and conveying empathy would be therapeutic. Focusing on members who are likely to be more positive can balance the influence of demoralizing members. "You seem to know a lot . . ." conveys hostility from the leader, who confronts and challenges the member to explain how he came to be readmitted if he was so knowledgeable, implying that he is less knowledgeable than he claims. This comment suggests countertransference and is nontherapeutic. Shifting away from the complaining member to see if others agree seeks to have others express disagreement with this member, but that might not happen. In the face of anger, they might be quiet or afraid to oppose the member, or they could respond in kind by expressing hostility themselves. A rule that only positive exchanges are permitted would suppress conflict, reducing the effectiveness of the therapy group.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. A group is in the working phase. One member states, "That is the stupidest thing I've ever heard. Everyone whines and tells everyone else what to do. This group is a waste of my time." Which initial action by the group leader would be most therapeutic?

a. Advise the member that hostility is inappropriate. Remove the member if it continues.

b. Keep the group's focus on this member, so the person can express the anger.

c. Meet privately with the member outside of group to discuss the anger.

d. Change to a more positive topic of discussion in this group session.

ANS: C

Meeting privately with the member can convey interest and help defuse the anger so that it is less disruptive to the group. Removing the member would be a last resort and used only when the behaviour is intolerably disruptive to the group process and all other interventions have failed. Decreasing the focus on the hostile member and focusing more on positive members can help soften the anger. Angry members

often hide considerable vulnerability by using anger to keep others at a distance and intimidated.

Changing the subject fails to respond to the behaviour.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

19. A group has two more sessions before it ends. One member was previously vocal and

has shown much progress but has now grown silent. What explanation most likely underlies this

behaviour?

a. The silent member has participated in the group and now has nothing more to offer.

b. The silent member is having trouble dealing with feelings about termination of this

group.

c. The silent member wants to give quieter members a chance to talk in the remaining

sessions.

d. The silent member is engaging in attention-seeking behaviour aimed at continuation

of the group.

ANS: B

A chief task during the termination phase of a group is to take what has been learned in group and

transition to life without the group. The end of a group can be a significant loss for members, who may

experience loss and grief and respond with sadness or anger. It is unlikely he would have nothing to say;

at the very least, he could be responding to the comments of others even if not focusing on his own issues.

He may wish to give quieter members a chance to talk, but again, this would not require or explain his

complete silence. Some members, faced with only two remaining sessions, may be becoming more

dominant under this pressure of time, but this, too, is unlikely to lead a previously active participant to fall

completely silent. The member is not attention-seeking.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

20. A patient in a support group says, “I’m tired of being sick. Everyone always helps me,

but I will be glad when I can help someone else.” This statement reflects which of the following?

a. Altruism

b. Universality

c. Cohesiveness

d. Corrective recapitulation

ANS: A

Altruism refers to the experience of being helpful or useful to others, a condition that the patient anticipates will happen. The other options are also therapeutic factors identified by Irving Yalom.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. During a support group, a patient diagnosed with schizophrenia says, “Sometimes I feel sad that I will never have a good job like my brother. Then I dwell on it and maybe I should not.” Select the nurse leader’s best comment to facilitate discussion of this issue.

a. “It is often better to focus on our successes rather than our failures.”

b. “How have others in the group handled painful feelings like these?”

c. “Grieving for what is lost is a normal part of having a mental disorder.”

d. “I wonder if you might also experience feelings of anger and helplessness.”

ANS: B

Asking others to share their experiences will facilitate discussion of an issue. Giving information may serve to close discussion of the issue because it sounds final. Suggesting a focus on the positives implies a discussion of the issue is not appropriate. Suggesting other possible feelings is inappropriate at this point, considering the patient has identified feelings of sadness and seems to have a desire to explore this feeling. Focusing on other feelings will derail discussion of the patient’s grief for his perceived lost potential.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

22. A nurse leads a psychoeducational group for patients in the community diagnosed with schizophrenia. A realistic outcome for group members is that they will do which of the following?

a. Discuss ways to manage their illness

b. Develop a high level of trust and cohesiveness

c. Understand unconscious motivation for behaviour

d. Demonstrate insight about development of their illness

ANS: A

Patients with schizophrenia almost universally have problems associated with everyday living in the community, so discussing ways to manage the illness would be an important aspect of psychoeducation. Discussing concerns about daily life would be a goal to which each could relate. Developing trust and cohesion is desirable but is not the priority outcome of a psychoeducational group. Understanding unconscious motivation would not be addressed. Insight would be difficult for a patient with residual schizophrenia because of the tendency toward concrete thinking.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

23. A patient in a detoxification unit asks, “What good will it do to go to Alcoholics Anonymous and talk to other people with the same problem?” The nurse’s best response would be to explain that self-help groups such as AA provide opportunities for which of the following?

a. Newly discharged alcoholics to learn about the disease of alcoholism

b. People with common problems to share their experiences with alcoholism and recovery

c. Patients with alcoholism to receive insight-oriented treatment about the etiology of their disease

d. Professional counsellors to provide guidance to individuals recovering from alcoholism

ANS: B

The patient needs basic information about the purpose of a self-help group. The basis of self-help groups is sharing by individuals with similar problems. Self-help is based on the belief that an individual with a problem can be truly understood and helped only by others who have the same problem. The other options fail to address this or provide incorrect information.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

24. Which type of group is a staff nurse with 2 months' psychiatric experience best qualified to conduct?

a. Psychodynamic/psychoanalytic group

b. Medication education group

c. Existential/Gestalt group

d. Family therapy group

ANS: B

All nurses receive information about patient teaching strategies and basic information about psychotropic medications, making a medication education group a logical group for a beginner to conduct. The other groups would need a leader with more education and experience.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. The next-to-last meeting of an interpersonal therapy group is taking place. The leader should take which actions? (Select all that apply.)

a. Support appropriate expressions of disagreement by the group's members.

b. Facilitate discussion and resolution of feelings about the end of the group.

c. Encourage members to reflect on their progress and that of the group itself.

d. Remind members of the group's norms and rules, emphasizing confidentiality.

e. Help members identify goals they would like to accomplish after the group ends.

f. Promote the identification and development of new options for solving problems.

ANS: B, C, E

The goals for the termination phase of groups are to prepare the group for separation, resolve related feelings, and prepare each member for the future. Contributions and accomplishments of members are elicited, post-group goals are identified, and feelings about the group's ending are discussed. Group norms are the focus of the orientation phase, and conflict and problem solving are emphasized in the

working phase.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

2. A leader begins the discussion at the first meeting of a new group. Which comments should be included? (Select all that apply.)

a. “We use groups to provide treatment because it’s a more cost-effective use of staff in this time of budget constraints.”

b. “When someone shares a personal experience, it’s important to keep the information confidential.”

c. “Talking to family members about our group discussions will help us achieve our goals.”

d. “Everyone is expected to share a personal experience at each group meeting.”

e. “It is important for everyone to arrive on time for our group.”

ANS: B, E

The leader must set ground rules for the group before members can effectively participate. Confidentiality of personal experiences should be maintained. Arriving on time is important to the group process. Talking to family members would jeopardize confidentiality. While groups are cost-effective, blaming the budget would not help members feel valued. Setting an expectation to share may be intimidating for a withdrawn patient.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

Chapter 34: Family Interventions

Halter: Varcarolis’s Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A married couple has two biological children who live with them, as well as a child

from the wife's first marriage. What type of family is evident?

a. Homogeneous

b. Extended

c. Blended

d. Nuclear

ANS: C

A blended family is made up of members from two or more unrelated families. It is not a nuclear family

because a stepchild is present. It is not an extended family because there are only two generations present.

Homogeneous is not a family type.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

2. A married couple has two children living in the home. Recently, the wife's mother

moved in. They should be assessed as which type of family?

a. Nuclear

b. Blended

c. Extended

d. Alternative

ANS: C

An extended family has members from three or more generations living together. Nuclear family refers to

a couple and their children. A blended family is one made up of members from two or more unrelated

families. An alternative family can consist of a same-sex couple or an unmarried couple and children.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and

Maintenance

3. When a nurse assesses a family, which family function is the highest priority?

a. Allocation of family resources

b. Physical maintenance and safety

c. Maintenance of order and authority

d. Reproduction of new family members

ANS: B

Physical care and maintenance of family members must be met to provide the other functions, including love and nurturance, socialization of children, and social control of members. Physical and safety needs have greater priority than other needs.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. Which finding of family assessment indicates a healthy and functional family?

a. Members provide nurturance

b. Power is distributed equally among all members

c. Members believe there are specific causes for events

d. Under stress, members turn inward and become enmeshed

ANS: A

Healthy family functions are providing love and nurturance, socialization of children, and social control of members, production and consumption of goods and services, addition of new family members through birth or adoption, and physical care and maintenance of family members. The distracters are unrelated or incorrect.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. A 15-year-old is hospitalized after a suicide attempt. This adolescent lives with her mother, stepfather, and several siblings. When performing a family assessment, which of the following must the nurse first determine?

a. How the family expresses and manages emotion

b. Names and relationships of the family's members

c. The communication patterns between the patient and parents

d. The meaning that the patient's suicide attempt has for family members

ANS: B

The identity of the members of the family is the most fundamental information and should be obtained first. When working with families, nurses must be sensitive and honour the client's identification of family. Without this, the nurse cannot fully process the other responses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Which information is the nurse most likely to find when assessing the family of a patient with a serious mental illness?

a. The family exhibits many characteristics of dysfunctional families.

b. Several family members have serious problems with their physical and emotional health.

c. Power in the family is maintained in the parental dyad and rarely delegated.

d. Stress from growing up with a mentally ill parent has contributed to a young adult's emotional health problems.

ANS: D

Children growing up in families where there is mental health illness, high stress, historical oppression, and intergenerational trauma may have emotional problems both in childhood and later in their adult lives. Stress does not necessarily mean the family has become dysfunctional or lacks shared power, nor does it necessarily cause other physical or emotional health concerns.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. The parent of an adolescent diagnosed with mental illness asks the nurse, "Why do you want to do a family assessment? My teenager is the patient, not the rest of us." Select the nurse's best response.

a. "Family dysfunction might have caused the mental illness."

b. "Family members provide more accurate information than the patient."

c. “Family assessment is part of the protocol for care of all patients with mental illness.”

d. “Every family member’s perception of events is different and adds to the total picture.”

ANS: D

The identified patient usually bears most of the family system’s anxiety and may have come to the attention of parents, teachers, or law enforcement because of poor coping skills. The correct response helps the family understand that the opinions of each will be valued. It allows the nurse to assess individual coping and prepares the family for the experience of working together to set goals and solve problems. The other responses are either incorrect or evasive.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

8. An adult diagnosed with schizophrenia lives with elderly parents. The patient was recently hospitalized with acute psychosis. One parent is very anxious, and the other is ill because of the stress. Which nursing diagnosis is most applicable to this scenario?

a. Ineffective family coping related to parental role conflict

b. Caregiver role strain related to the stress of chronic illness

c. Impaired parenting related to patient’s repeated hospitalizations

d. Interrupted family processes related to relapse of acute psychosis

ANS: B

Caregiver role strain refers to a caregiver’s felt or exhibited difficulty in performing a family caregiver role. In this case, one parent exhibits stress-related illness and the other exhibits increased anxiety. The other nursing diagnoses are not substantiated by the information given and are incorrectly formatted. (One nursing diagnosis should not be the etiology for another.)

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

9. An adult recently diagnosed with AIDS is hospitalized with pneumonia. The patient and

family are very anxious. Select the best outcome to add to the plan of care for this family.

a. Describe the stages of the anticipatory grieving process.

b. Identify and describe effective methods for coping with anxiety.

c. Recognize ways dysfunctional communication is expressed in the family.

d. Examine previously unexpressed feelings related to the patient's sexuality.

ANS: B

Desired outcomes might be set for the family or for individuals within the family. The outcome most closely associated with the anxiety that each member is experiencing is to focus on identifying and describing ways of coping with the anxiety. The other options are not appropriate at this time.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification

MSC: Client Needs: Psychosocial Integrity

10. A parent is admitted to a chemical dependency treatment unit. The patient's spouse and adolescent children participate in a family session. What is the most important aspect of this family's assessment?

a. Spouse's codependent behaviours

b. Interactions among family members

c. Patient's reaction to the family's anger

d. Children's responses to the family sessions

ANS: B

Interactions among all family members are the raw material for family problem-solving. By observing interactions, the nurse can help the family make its own assessments of strengths and deficits. The other options are narrower in scope when compared with the correct option.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. A parent is admitted to a chemical dependency treatment unit. The patient's spouse and adolescent children attend a family session. Which initial assessment question should the nurse ask of family members?

a. "What changes are most important to you?"

b. “How are feelings expressed in your family?”

c. “What types of family education would benefit your family?”

d. “Can you identify a long-term goal for improved functioning?”

ANS: B

It is important to understand family characteristics, particularly in a family under stress. Expression of feelings is an important aspect of assessment of the family’s function (or dysfunction). The distracters relate more to outcome identification and planning interventions, both of which should be delayed until the assessment is complete.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

12. A nurse interviews a homeless parent with two teenage children. To best assess the family’s use of resources, which of the following should the nurse ask?

a. “Can you describe a problem your family has successfully resolved?”

b. “What community agencies have you found helpful in the past?”

c. “What aspect of being homeless is most frightening for you?”

d. “Do you feel you have adequate resources to survive?”

ANS: B

The correct option asks about use of resources in an open, direct fashion. It will give information about choices the family has made regarding use of resources in the community. The other questions do not address prior use of resources or focus on other aspects of coping.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

13. Two divorced people plan to marry. The man has a teenager, and the woman has a toddler. This family will benefit most from which of the following?

a. Role-playing opportunities for conflict resolution regarding discipline

b. Guidance about parenting children at two developmental levels

c. Formal teaching about problem-solving skills

d. Referral to a family therapist

ANS: B

The newly formed family will be coping with tasks associated with the stage of rearing preschool children

and teenagers. These stages require different knowledge and skills. There is no evidence of a problem, so the distracters are not indicated.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

14. Parents of a teenager recently diagnosed with a serious mental illness express dismay. One parent says, “Our hopes for our child’s future are ruined. We probably won’t ever have grandchildren.” The nurse will use interventions to assist with which of the following?

a. Denial

b. Grieving

c. Acting out

d. Manipulation

ANS: B

Grief is a common reaction to having a family member diagnosed with a mental illness. The grief stems from actual or potential losses, such as the family’s ability to function, financial well-being, and altered future. Data do not support choosing any of the other options.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. Parents of a teenager recently diagnosed with a serious mental illness express dismay. One parent says, “Our child acts so strangely that we don’t invite friends to our home. We quit taking vacations. Sometimes we don’t get any sleep.” Which nursing diagnosis best applies?

a. Impaired parenting

b. Dysfunctional grieving

c. Impaired social interaction

d. Interrupted family processes

ANS: D

Interrupted family processes are evident in the face of disruptions in family functioning as a result of having a mentally ill member. Assessment data best support this diagnosis. Data are insufficient to support the other diagnoses.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Psychosocial Integrity

16. A family expresses helplessness related to dealing with a mentally ill member's odd behaviours, mood swings, and argumentativeness. Which of the following would be an effective nursing intervention for this family?

a. To express sympathy for their situation

b. To involve local social service agencies

c. To explain symptoms of relapse

d. To role-play difficult situations

ANS: D

The nurse is to encourage adaptive family problem-solving behaviours, and this can be accomplished through role-playing situations, which give family members the opportunity to try new, more effective approaches. The other options would not provide learning opportunities.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. Parents of a mentally ill teenager say, "We have never known anyone who was mentally ill. We have no one to talk to because none of our friends understand the problems we are facing." Select the nurse's most helpful intervention.

a. Refer the parents to a support group.

b. Build the parents' self-concept as coping parents.

c. Teach the parents techniques of therapeutic communication.

d. Facilitate achievement of normal developmental tasks of the family.

ANS: A

The need for support is evident. Referrals are made when working with families whose needs are unmet. A support group, such as through the Canadian Mental Health Association (CMHA), Al-Anon, Schizophrenia Society, and others, will provide the parents with support from others with similar experiences and with whom they can share feelings and experiences. The distracters are less relevant to providing a network of support.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

18. Select the best question for the nurse to ask to assess a family's ability to cope.

a. "What strengths does your family have?"

b. "Do you think your family copes effectively?"

c. "Describe how you successfully handled one family problem."

d. "How do you think the current family problem should be resolved?"

ANS: C

The correct option is the only statement that addresses coping strategies used by the family. The distracters seek opinions or use closed-ended communication techniques.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. Which scenario best illustrates scapegoating within a family?

a. The identified patient sends messages of aggression to selected family members.

b. Family members project problems of the family onto one particular family member.

c. The identified patient threatens separation from the family to induce feelings of isolation and despair.

d. Family members give the identified patient nonverbal messages that conflict with verbal messages.

ANS: B

Scapegoating projects blame for family problems onto a member who is less powerful. The purpose of this projection is to distract from issues or dysfunctional behaviours in the members of the family.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. A parent became unemployed 6 months ago. The parent has subsequently been verbally abusive toward the spouse and oldest child. The child ran away twice, and the spouse has become depressed. What is the most appropriate nursing diagnosis for this family?

a. Impaired parenting related to verbal abuse of oldest child

b. Impaired social interaction related to disruption of family bonds

c. Ineffective community coping related to fears about economic stability

d. Interrupted family processes related to insecurity secondary to loss of family

income

ANS: D

Interrupted family processes refers to the behaviour of a significant family member that disables his or her own capacity as well as another's capacity to perform tasks essential to adaptation. The distracters are

inaccurate because the stressors influence more than one individual.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Health Promotion and Maintenance

21. A parent says, "My son and I argue constantly since he started using drugs. When I

talk to him about not using drugs, he tells me to stay out of his business." What is the nurse's most

appropriate first action?

a. Educate the parent about stages of family development.

b. Report the son to law enforcement authorities.

c. Refer the son for substance abuse treatment.

d. Make a referral for family therapy.

ANS: D

Family therapy is indicated, and the nurse should provide a referral. Family therapy aims to decrease emotional reactivity and to encourage differentiation among family members. Reporting the child to law enforcement would undermine trust and violate confidentiality. The other distracters may occur later.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

22. Which scenario best demonstrates a healthy family?

a. One parent takes care of the children. The other parent earns income and maintains

the home.

b. A family has strict boundaries that require members to address problems within the

family.

c. A couple requires their adolescent children to attend church services three times a week.

d. A couple renews their marital relationship after their children become adults.

ANS: D

Revamping the marital relationship after children move out of the family of origin indicates the family is moving through its stages of development. Strict family boundaries or roles interfere with flexibility and use of outside resources. Adolescents should have some input into deciding their activities.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

23. Which comment by a mother during a family therapy session shows evidence of scapegoating?

a. “Our youngest child always starts arguments and upsets everyone else.”

b. “We all express our feelings openly, except when we think it might upset my husband.”

c. “Our oldest child knows that my husband and I are doing all we can for the others.”

d. “After my husband has been drinking, I have to get everyone up and ready for school.”

ANS: A

Scapegoating is blaming family problems on a member of the family who is not very powerful. The purpose of the blaming is to keep the focus off painful issues and off the blamers themselves. A double-bind message such as “We all express our feelings openly except when . . .” involves giving instructions that are inherently contradictory or that place the person in a no-win situation. “Our oldest child knows that . . .” is an example of triangulation, wherein a third party is engaged to help stabilize an unstable pair within the family. A child assuming parental responsibilities (e.g., caring for siblings) because a parent fails to do so is an example of enabling.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. Which example of behaviour in a family system demonstrates double-bind communication?

a. A mother tells her daughter, “You make me so mad that sometimes I wish I had never had you.”

b. A teenager tells her father, “You are treating me like a baby when you tell me I must be home by 10 p.m. on a school night.”

c. A son tells his mother, “You worry too much about what might happen. Nothing has happened yet, so why worry?”

d. A wife tells her husband, “You go ahead with your bowling trip. Try not to worry about me falling on my crutches while I’m alone at home.”

ANS: D

A double-bind communication is one that is inherently contradictory. That is, a comment that gives conflicting directions. In this case, the wife on crutches suggests that her husband should go bowling but then indicates that she will be at greater risk if he does. In effect, this tells him “go ahead” and “don’t do it” at the same time. This remark places the husband in a double bind, a situation in which no acceptable response exists. The distracters are clear, direct communications.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

25. A wife believes her husband is having an affair. Lately, he has been disinterested in romance and has been working late. The husband has an important, demanding project at work. The mother asks her teen, “What have you noticed about your father?” The teen later mentions this to the father, who says, “Tell your mother that I can’t deal with her insecurities right now.” Which family dynamic is evident?

a. Multigenerational dysfunction

b. Triangulation

c. Enmeshment

d. Blaming

ANS: B

Triangulation is a family dynamic wherein a pair relationship (usually the parents) is under stress and copes by drawing in a third person (usually a child) to align with one or the other members of the pair relationship. Multigenerational dysfunction is any dysfunction that exists within or across multiple generations of a family, such as child abuse or alcoholism. Blaming is distracting attention from one's own dysfunction or reducing one's own anxiety by blaming another person. Enmeshment refers to blurred

family boundaries or blending together of the thoughts, feelings, or family roles of the individuals so that clear distinctions among members fail to emerge.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

26. A 16-year-old wants to drive, but the parents will not allow it. The 14-year-old sibling

was invited to several sleepovers, but the parents found reasons to deny permission. Both teens are annoyed because the parents buy clothes for them that are more suitable for younger children. The parents say, "We don't want our kids to grow up too fast." Which term best describes this family's boundaries?

a. Rigid

b. Clear

c. Enmeshed

d. Differentiated

ANS: A

Rigid boundaries are those that do not change or flex with changing circumstances, as indicated here by parents who are reluctant to revise their roles and expectations about their children as the children mature.

Enmeshed boundaries are those that have failed to differentiate or develop individually; the family shares

roles and thoughts to an excessive degree, without a healthy degree of individuality. Clear boundaries are

not enmeshed; they are appropriate and well maintained. Differentiated boundaries is not a term that is used. Differentiation of self occurs when a person has clear boundaries.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. A wife believes her husband is having an affair. Lately, he has been disinterested in romance and working late. The husband has an important, demanding project at work. The mother asks her teen, “What have you noticed about your father?” The teen later mentions this to the father, who says, “Tell your mother that I can’t deal with her insecurities right now.” Family therapy should focus on which of the following? (Select all that apply.)

a. Identifying and reducing the cognitive distortion in each parent’s perceptions

b. Confronting the family with the need for honest, direct, assertive communication

c. Helping the parents find ways to cope more effectively with their stress and fears

d. Supporting the teen to redirect the parents when they try to communicate through her

e. Convincing the mother that her fear of an affair is due to her own insecurities and is unfounded

f. Helping the husband understand how others might misinterpret the changes in his behaviour

ANS: A, C, D, F

The aim of strategic therapy is to change the patterns, rules, and meaning of family interactions. Each parent is seeing the other’s behaviour in a possibly distorted manner, which the nurse would explore and help the parents correct. The nurse would guide the parents to communicate more effectively, but confrontation would likely be nontherapeutic because it would increase the tension and triangulation. Since fear and anxiety contribute to triangulation, increasing the parent’s coping abilities as well as reducing anxiety and fear would be areas for intervention. Teaching the adolescent how to protect herself from triangulation, when done in conjunction with interventions to help the parents reduce this behaviour, would be protective of the adolescent and would assist the parents in their efforts to change this pattern of communication. The nurse has no facts about whether or not the husband is having an affair; therefore,

the nurse should not convince the wife that her fear is due only to her insecurities. Her fears may be well-

founded. Helping the husband understand how his wife might see the changes in behaviour differently can

help him to respond helpfully instead of accusing her of being insecure.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process:

Planning

MSC: Client Needs: Psychosocial Integrity

2. A parent was recently hospitalized with severe depression. Family members say, “We’re

falling apart. Nobody knows what to expect, who should make decisions, or how to keep the family

together.” Which interventions should the nurse use when working with this family? (Select all that

apply.)

a. Help the family set realistic expectations.

b. Provide empathy, acceptance, and support.

c. Empower the family by teaching problem solving.

d. Negotiate role flexibility amongst family members.

e. Focus planning on the family rather than on the patient.

ANS: A, B, C, D

Issues include reorganizing family roles related to a newly diagnosed serious mental illness, dealing with potential family member feelings of guilt, dealing with concerns about the future, formulating realistic expectations, coping with feelings of loss for what was and what was hoped for, and maintaining the spousal subsystem. The correct answers address expressed needs of the family. The distracter is inappropriate.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

3. Which situations are most likely to place severe, disabling stress on a family? (Select all

that apply.)

a. A parent needs long-term care after sustaining a severe brain injury.

b. The youngest child in a family leaves for college in another state.

c. A spouse is diagnosed with liver failure and needs a transplant.

d. Parents of three children, aged 9, 7, and 2 years, get a divorce.

e. A parent retires after working at the same job for 28 years.

ANS: A, C, D

Major illnesses and divorce place severe, potentially disabling stress on families. The distracters identify normal milestones in a family's development.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

Chapter 35: Integrative and Complimentary Therapies

Halter: Varcarolis's Canadian Psychiatric Mental Health Nursing, 2nd Edition

MULTIPLE CHOICE

1. A patient tells the nurse, "I've been having problems with my memory. I read some information on the Internet and started taking ginkgo." Select the nurse's best response.

a. "The Internet does not have reliable health information for consumers."

b. "More recent studies indicate ginkgo does not help memory problems."

c. "Valerian has been shown to have better effects for treating memory problems."

d. "Your memory problems are related to your circulation problems. Herbs will not help."

ANS: B

Recent studies indicate ginkgo biloba may not help with cognition or memory problems but may play a role in prevention and treatment of cognitive decline, depression, and memory loss associated with electroconvulsive therapy. Valerian is useful for treating mild depression or anxiety. The other distracters are misleading.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. A patient shows a nurse this advertisement: "Our product is a scientific breakthrough helpful for depression, anxiety, and sleeplessness. Made from an ancient formula, it stimulates

circulation and excretes toxins. Satisfaction guaranteed or your money back." Select the nurse's best response.

a. "Over-the-counter products for sleep problems are ineffective."

b. "Do not take anything unless it's prescribed by your doctor."

c. "Let's do some additional investigation of that product."

d. "It sounds like you are trying to self-medicate."

ANS: C

Helping consumers actively evaluate the quality of information available to them is important. It is important for the nurse to work with the patient and include the patient's preferences regarding management of health. Advertisements indicating scientific breakthroughs or promising miracles for multiple ailments are usually for products that are useless and being fraudulently marketed. Some may even be harmful. Some over-the-counter products can be useful, and patients do not need a prescription for these products. The broader issue is safety and efficacy, rather than whether the patient is trying to self-medicate.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Safe Effective Care Environment

3. A patient wants to learn more about integrative therapies. Which resource should the nurse suggest for the most reliable information?

a. The Internet

b. The Canadian Nurses Association (CNA)

c. Health Canada's Natural and Non-prescription Health Products Directorate (NNHPD)

d. National Center for Complementary and Integrative Health (NCCIH)

ANS: C

Health Canada's Natural and Non-prescription Health Products Directorate (NNHPD) has a clearinghouse from which individuals may obtain information. The National Center for Complementary and Integrative Health (NCCIH) is a reliable resource; however, it is based in the USA. The Internet has many resources, but some are unreliable. The CNA does not provide extensive information about this topic.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. A patient with a history of asthma says, “I’ve been very nervous lately. I think aromatherapy will help. I am ordering $250 worth of oils from an Internet site that promised swift results.” Select the nurse’s best action.

a. Support the patient’s efforts to become informed and to find health solutions.

b. Suggest the patient check with friends who have tried aromatherapy for treatment of anxiety.

c. Remind the patient, “If you spend that much on oils, you may not be able to buy your prescribed medication.”

d. Tell the patient, “Aromatherapy can complicate respiratory problems such as asthma. Let’s consider some other options.”

ANS: D

Some individuals, particularly those with pulmonary disease, may be sensitive or allergic to essential oils when they come into contact with the skin or are inhaled. Safety is paramount, and aromatherapy may cause complications for a patient with asthma. The nurse should view alternative treatments with an open mind and try to recognize the importance of the treatment to the patient while trying to give the patient accurate, reliable information about the treatment. Although efforts to become health literate should be supported, educating the patient about the pitfalls of relying on the Internet is essential. The opinions of others, whether they are positive or negative, lack a scientific basis, and are subject to confounding variables such as the placebo effect and individual factors such as age and health history. Admonishing the patient may jeopardize the relationship.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

5. A patient says, “I have taken megadoses of vitamin E for 3 months to improve my circulation, but I think I feel worse.” Which action should the nurse take first?

a. Explain to the patient that megadoses may be harmful and advise caution.

b. Assess the patient for symptoms and signs of toxicity from excess vitamin

exposure.

c. Assess for signs of circulatory integrity to determine whether improvement has

occurred.

d. Educate the patient that research has not shown that megadoses of vitamins produce

benefits.

ANS: B

Megadoses of many vitamins, especially when taken over long periods, may produce dangerous adverse

effects or toxicity. The priority for the nurse is to assess for signs of any dangerous consequences of the

patient's use of such a regimen. Secondary interventions would include patient education about research

findings related to the practice, along with any benefits and undesired effects associated with the practice.

A health care provider should also assess the patient for cardiovascular concerns.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

6. Acupuncture is a traditional Chinese medical treatment based on which of the following

beliefs?

a. That insertion of needles in key locations will drain toxic energies

b. That pressure on meridian points will correct problems in energy flow

c. That insertion of needles modulates the flow of energy along body meridians

d. That taking small doses of noxious substances will alleviate specific symptoms

ANS: C

Acupuncture involves the insertion of needles to modulate the flow of body energy (chi) along specific

body pathways called meridians. Acupressure uses pressure to effect energy flow. Homeopathy involves

the use of microdosages of specific substances to effect health improvement. Traditional Chinese

medicine is more concerned with energy and life force balance, and acupuncture is not predicated on the

removal of toxic energies.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

7. A patient reports good results from taking an herb to manage migraine headache pain. The nurse confirms there are no hazardous interactions between the herb and the patient's current prescription drugs. Select the nurse's best comment to the patient.

a. "Thanks for telling me. I'll make a note in your medical record that you take it."

b. "You are experiencing a placebo effect. When we believe something will help, it usually does."

c. "Self-management of health problems can be dangerous. You should have notified me sooner."

d. "Research studies show that herbals actually increase migraine pain by inflaming nerve cells in the brain."

ANS: A

People who use TCAM therapies often do so without informing their conventional health care providers, which poses some risk. The nurse should reinforce the patient for reporting use of the herb. If it poses no danger, the nurse can document the use. The patient may also get a placebo effect from the herb, but it is not necessary for the nurse to point out that information. The distracters are judgemental and may discourage the patient from openly sharing in the future.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

8. A patient diagnosed with depression tells the nurse, "I want to try supplementing my selective serotonin reuptake inhibitor with St. John's wort." Which action should the nurse take first?

a. Advise the patient of the danger of serotonin syndrome.

b. Suggest that aromatherapy may produce better results.

c. Assess the patient for depression and risk for suicide.

d. Suggest the patient decrease the antidepressant dose.

ANS: A

Results are inconclusive in relation to severe depression, prompting ongoing research. St. John's wort should not be taken in tandem with antidepressant pharmaceuticals due to its serotonergic effects. Caution is also warranted with bipolar disorder as cases of mania have been reported with use of St. John's wort. Assessing the depression would be a secondary intervention. Aromatherapy has not been shown to be an effective adjunct or treatment for depression. Although a dosage reduction in her SSRI medication might reduce the risk of serotonin syndrome, this intervention is not in the nurse's scope of practice.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

9. A patient tells the nurse, "I have a hard time sleeping and find that my sleeping pill only works when I take valerian as well." How should the nurse respond?

a. "That's great that they work so well together for you."

b. "Thanks for telling me about this combination, I will note it on your medical chart."

c. "The use of valerian is contraindicated when taking other medication to help you sleep."

d. "What other medications have you tried to help you sleep in the past?"

ANS: C

Valerian is used as an anti-anxiety agent and has also been reported to have antidepressant and sedative properties. Results about its efficacy are mixed, but it is generally recognized as safe for the short-term treatment of insomnia when taken at the recommended dosages and not taken in combination with other sedative medications. Indicating that it is great that it works well for this patient would be disregarding the current evidence related to contraindications. Documenting the information without informing the patient of the contradiction is not correct. There is no need to explore other medication usage at this point; the priority is to ensure that the patient is aware of the contradiction in using the two at the same time.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

10. A patient asks, "What is the major difference between conventional health care and

traditional, complementary, and alternative medicine (TCAM)?" Which of the following is the nurse's best reply?

a. Conventional health care focuses on what is done to the patient, whereas TCAM focuses on mind-body interaction with an actively involved patient.

b. Conventional health care has been tested by research so less regulation is needed, but TCAM is religiously based and highly regulated.

c. Conventional health care is controlled by the health care industry, but TCAM is the people's medicine and not motivated by profit.

d. Conventional health care is holistic and focused on health promotion, whereas TCAM treats illnesses and is symptom- specific.

ANS: A

Conventional health care is based largely on highly controlled, evidence-informed scientific research and focuses primarily on curative actions implemented on a mostly passive patient, whereas TCAM focuses more on the mind-body aspects of health, along with the active involvement of the patient. Conventional health care is largely grounded in scientific research; the opposite tends to be true of TCAM. Some forms of TCAM have their roots in religious or cultural practices, but this is not characteristic of TCAM as a whole. Both conventional health care and TCAM can focus on health promotion and treatment of illness. Although critics express concern about the role of profit in conventional health care, the profit motive can also apply in TCAM.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

11. A patient has tried a variety of traditional, complementary, and alternative medicine (TCAM) approaches to manage health concerns. The nurse asks, "How is going to TCAM practitioners different from seeing your medical doctors?" How is the patient most likely to respond?

a. "The TCAM practitioners usually prescribe a course of invasive and sometimes painful treatments."

b. “The TCAM practitioners spend more time talking with me and not just about my symptoms.”

c. “The TCAM practitioners say I need to become much more spiritual to be well.”

d. “The TCAM practitioners order many tests to determine my diagnoses.”

ANS: B

TCAM is relationship-based, holistic care. TCAM practitioners often spend considerable time assessing the person in a holistic way. Visits typically involve lengthy discussions, in contrast to traditional physician visits, where contact is often brief. TCAM remedies can sometimes be invasive or slightly painful, but usually they are noninvasive and well tolerated. Some TCAM practices are very spiritually focused, but most do not have overt religious elements. Conventional health care involves more diagnostic testing than TCAM.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. What is the term used in Canada to describe energy drinks?

a. Stimulant

b. Homeopathy

c. Natural health product

d. Probiotic

ANS: C

The term natural health product (NHP) is used in Canada to describe substances such as vitamins and minerals, herbal medicines, homeopathic preparations, energy drinks, probiotics, and many alternative and traditional medicines.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

13. For patients with which co-morbid diagnosis would it be most important for the nurse to urge immediate discontinuation of kava kava?

a. Cirrhosis

b. Osteoarthritis

c. Multiple sclerosis

d. Chronic back pain

ANS: A

New research has demonstrated that cases of liver failure were associated with a processing error in the production of a single batch of kava. In response to the above controversial information, much confusion has arisen as to its legal status in Canada. However, kava kava is currently not legal for sale through Canadian businesses.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

14. A patient tells the nurse, "I prefer to treat my physical problems with herbs and vitamins. They are natural substances, and natural products are safe." Which response by the nurse would be most appropriate?

a. "Natural substances tend to be safer than conventional medical remedies."

b. "Natural remedies give you the idea that you are controlling your treatment."

c. "The word natural can be a marketing term used to imply a product is healthy, but that's not always true."

d. "You should not treat your own physical problems. You should see your health care provider for these problems."

ANS: C

Some patients may believe that if they purchase a natural substance at a health food store, it must be safe and effective; however, natural does not mean harmless. Herbal products and supplements may contain powerful active ingredients that can cause damage if taken inappropriately or in combination with pharmaceutical preparations. This is the most important message for the nurse to convey to the patient. So-called natural substances can have a number of significant adverse effects. Natural substances may give the patient the belief that he is controlling his own treatment, but that is not the message that most needs to be communicated here. Many patients can safely self-manage minor physical problems.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and

Maintenance

15. An immigrant from China needs a colonic resection but is anxious and reluctant about surgery. This patient usually follows traditional Chinese health practices. Which comment by the nurse would most likely reduce the patient's anxiety and reluctance?

a. "Surgery will help rebalance the yin and yang forces and return you to harmony."

b. "The surgery we are recommending will help you achieve final transformation."

c. "I know this is new to you, but you can trust us to take very good care of you."

d. "If you would like, we could investigate using acupuncture to help control pain."

ANS: D

It would be helpful to incorporate elements of traditional Chinese medicine (TCM) as appropriate, such as acupuncture for pain control. TCM has the goal of healing in harmony with one's environment and all of creation in mind, body, and spirit, as well as balance of yin and yang energies and a state of transition. However, it would not be helpful to suggest that surgery will balance the yin and the yang, since this is not how balance is achieved in TCM. Transformation is recognized as a stage of healing occurring when mutual, creative, active participation occurs between healers and the patient toward changes in the mind, body, and spirit; but "final transformation" could imply the end of corporeal life and might be perceived as hastening the patient's demise. Appealing to the patient to trust people whose practices are foreign to him conflicts with the patient's values and would not likely be effective.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

16. Which traditional, complementary, and alternative medicine (TCAM) method is associated with using allergy injections of small amounts of an allergen in solution?

a. Naturopathy

b. Homeopathy

c. Chiropractic

d. Shiatsu

ANS: B

Homeopathy uses small doses of a substance to stimulate the body's defences and healing mechanisms to

treat illness. Naturopathy emphasizes health restoration rather than disease. Chiropractic uses

manipulation of the body to restore health. Shiatsu is a type of massage.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

17. A nurse plans health education for a patient who is having difficulty sleeping and

wants to try a natural supplement. Which substance should the nurse recommend to the patient?

a. Ginkgo biloba

b. St. John's wort

c. Valerian

d. Kava kava

ANS: C

Valerian has calming, sleep-inducing effects. Ginkgo biloba has been used in the treatment of cognitive

decline, depression, and memory loss associated with electroconvulsive therapy. St. John's wort has been

used for centuries to improve mood and alleviate pain. Kava kava is considered to have analgesic

properties but is not available in Canada.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

18. A patient reports, "Last night I had several mixed drinks at a party. When I got home, I

had difficulty falling sleep. I made two cups of herbal tea with valerian. This morning, I feel very

groggy and have a headache." The nurse should explain which of the following?

a. That valerian should be delayed at least 1 hour after using alcohol to avoid side

effects

b. That valerian may increase sedation from other central nervous system depressants

c. That herbal teas often cause nervous system adverse effects such as headaches

d. That these feelings are actually a hangover from excessive alcohol intake

ANS: B

Valerian has sedative properties that are potentiated when used in combination with other central nervous

system depressants. Headaches are another possible adverse effect of this herbal medicine. The nurse should advise caution in ingesting alcohol and valerian for these reasons. Taking valerian an hour after alcohol will not prevent these interactions, and it is likely that the valerian played a role in the patient feeling perhaps worse than usual after this episode of drinking. Herbal teas cause headaches in some cases, but it is not characteristic of this group of herbal remedies.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

19. A patient has just completed 6 weeks of electroconvulsive therapy. When visiting the clinic for a follow-up visit, the patient reports taking ginkgo for memory enhancement. Which nursing diagnosis applies?

a. Impaired memory related to neurological changes

b. Deficient knowledge related to potentially harmful drug interactions

c. Ineffective denial related to consequences of mismanagement of therapeutic regime

d. Effective management of the therapeutic regime related to improvement of memory loss associated with electroconvulsive therapy

ANS: D

Ginkgo is purported to improve cognitive decline, depression, and memory loss associated with electroconvulsive therapy. Thus, Effective management of the therapeutic regime related to improvement

of memory loss associated with electroconvulsive therapy is an appropriate nursing diagnosis.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Diagnosis/Analysis

MSC: Client Needs: Physiological Integrity

20. Select the best desired outcome for a patient who uses valerian.

a. The patient will report that stress level is lower.

b. The patient will report undisturbed sleep throughout the night.

c. The patient will report increased interest in recreational activities.

d. The patient will report early morning waking without an alarm clock.

ANS: B

Results about valerian's efficacy are mixed, but it is generally recognized as safe for the short-term

treatment of insomnia when taken at the recommended dosages and not taken in combination with other

sedative medications. Sleeping through the night is the best indicator that the herb was effective.

Although the patient's stress level may be lowered by use of valerian, the problem is insomnia; outcomes

should relate to the problem. Early morning waking is indicative of depression or anxiety.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Outcomes Identification/Planning

MSC: Client Needs: Physiological Integrity

21. Which patient would most likely benefit from taking St. John's wort?

a. A patient with mood swings

b. A patient with hypomanic symptoms

c. A patient with mild depressive symptoms

d. A patient with panic disorder with agoraphobia

ANS: C

Research has found St. John's wort to be effective in treating mild to moderate depression. St. John's wort

has not been found to be effective in the treatment of cyclothymic, bipolar, or anxiety disorders.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. During an assessment interview, a patient who reports a high level of pain says, "I've

been using St. John's wort in small doses for about a week." When the nurse assesses the patient

what would the expected findings be?

a. Decreased pain

b. Mental confusion

c. High anxiety level

d. Slurred speech

ANS: A

St. John's wort has been used for centuries to improve mood and to alleviate pain. It does not usually produce the effects cited in the distracters.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

23. Which traditional, complementary, and alternative therapy may be safely combined with traditional Western medicine in the treatment of anxiety disorder?

a. Electroconvulsive therapy

b. Megadoses of vitamins

c. Meditative practices

d. Herbal therapy

ANS: C

Yoga, meditation, and prayer are considered to be beneficial adjuncts to treatment for anxiety disorder. Research supports this with findings of lower catecholamine levels following meditation. Patient self-reports suggest patient satisfaction, with increased ability to relax. Meditation and spiritual practices have no associated untoward side effects. Herbal therapy and megadoses of vitamins have potential associated adverse effects and interactions. Electroconvulsive therapy is not TCAM.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Outcomes Identification/Planning

MSC: Client Needs: Physiological Integrity

24. Which vitamin is thought to improve anxiety and depression?

a. Vitamin A

b. Vitamin B

c. Vitamin C

d. Vitamin D

ANS: B

B vitamins, especially vitamin B6 and folic acid appear to improve anxiety and depression.

DIF: Cognitive Level: Analyze (Analysis)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

MULTIPLE RESPONSE

1. A patient in good health and without any major health needs says, “I want to try some nutritional supplements I read about on the Internet.” What information would be appropriate for the nurse to include in a response? (Select all that apply.)

a. “Most healthy people who eat a balanced diet do not need nutritional supplements.”

b. “Research has not supported claims that various nutritional supplements create significant benefits in healthy people.”

c. “Some nutritional supplements are proven to significantly delay aging and reduce the incidence of age-related diseases like cancer.”

d. “I am glad you are actively engaged in managing your health by trusting information from the Internet.”

e. “Researchers are still studying the benefits and side effects of many supplements. We should know more in the years to come.”

ANS: A, B, E

Nutritional therapies are used to treat a variety of mental health disorders, including depression, anxiety, ADHD, menopausal symptoms, dementia, and addictions. Open discussions and ongoing literature reviews in relation to the associated risks and benefits are a must within the nurse-patient relationship. Claims for clear health benefits from exceeding the recommended intake of nutrients are generally not supported by science. Research is limited to date, and future findings may show more support as our understanding of the body’s nutritional needs expands. Taken at levels supported by most health care practitioners, supplements are probably safe. Occasionally, research suggests that supplements thought to be safe can contribute to health problems under some circumstances. There is no evidence that supplements slow aging or prevent cancer. It is important for nurses to caution patients about reliability of information on the Internet.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. A patient who emigrated from India is hospitalized. The patient and family use Ayurvedic medicine. The nurse wants to alter this patient's care so that it is more comfortable and familiar. What changes from usual Western practice should be considered? (Select all that apply.)

a. In preparation for discharge, include a significant focus on preventive practices.

b. Spend time exploring the patient's life overall, focusing on broader issues than health.

c. Involve the patient's entire family and treatment team in decisions about treatment options.

d. Anticipate that because the patient's traditions are steeped in history, there may be distrust in high-tech interventions.

e. Provide relevant health-related information, and then allow the patient to determine which course of action to pursue.

ANS: A, B, D, E

Ayurvedic medicine, an ancient practice that originated in India, stresses individual responsibility for health, is holistic, promotes prevention, recognizes the uniqueness of the individual, and offers natural methods of treatment. Ayurvedic medicine does not require spiritual cleansing or the involvement of family and the treatment team in all decisions.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. Which important points should the nurse teach a patient about using herbal preparations? (Select all that apply.)

a. Check active and inactive ingredients.

b. Discontinue use if adverse effects occur.

c. Avoid herbals during pregnancy and breastfeeding.

d. Buying from online sources is preferable and cheaper.

e. Inform your health care provider about the use of herbals.

ANS: A, B, C, E

As with dietary and nutritional supplements, health care providers need to be aware of their patients' use

of herbal therapies and any potential adverse effects, interactions, and benefits. All of the instruction is

correct except regarding purchase of herbals. Herbals should be purchased from a reputable firm. Internet

purchasing might not be the best plan, unless the reputation of the firm can be confirmed.

DIF: Cognitive Level: Apply (Application)

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

4. A patient reports frequent sleep disturbances. Which interventions could be considered

to help improve the patient's sleep pattern? (Select all that apply.)

a. Aromatherapy

b. Chamomile

c. Vitamin C

d. Valerian

e. SAM-e

ANS: A, B, D

Chamomile and valerian have relaxant effects that help sleep. Aromatherapy has sedating properties that

may improve sleep. SAM-e may help with mild depression. Vitamin C has no effect on sleep.

DIF: Cognitive Level: Understand (Comprehension)

TOP: Nursing Process: Outcomes Identification/Planning

MSC: Client Needs: Physiological Integrity