1. Despite repeated nursing interventions to improve reality orientation, a client insists that he is the commander of an alien spaceship. What is the client experiencing?

1 Illusion
2 Delusion
3 Confabulation
4 Hallucination

1. Despite repeated nursing interventions to improve reality orientation, a client insists that he is the commander of an alien spaceship. What is the client experiencing?

1 Illusion
✔ Correct 2 Delusion
3 Confabulation
4 Hallucination

A delusion is a fixed false belief. An illusion is a false sense interpretation of an external stimulus. Confabulation is the client's attempt to fill gaps in memory with imaginary events. A hallucination is a false sensory perception with no external stimulus.

Test-Taking Tip: Read every word of each question and option before responding to the item. Glossing over the questions just to get through the examination quickly can cause you to misread or misinterpret the real intent of the question.

2. A 65-year-old man is admitted to a mental health facility with a diagnosis of substance-induced persisting dementia resulting from chronic alcoholism. When conducting the admitting interview, the nurse determines that the client is using confabulation. What does the nurse recall precipitates the client's use of confabulation?

1 Ideas of grandeur
2 Need for attention
3 Marked memory loss
4 Difficulty in accepting the diagnosis

2. A 65-year-old man is admitted to a mental health facility with a diagnosis of substance-induced persisting dementia resulting from chronic alcoholism. When conducting the admitting interview, the nurse determines that the client is using confabulation. What does the nurse recall precipitates the client's use of confabulation?

1. Ideas of grandeur
2. Need for attention
3. Marked memory loss ✔ Correct
4. Difficulty in accepting the diagnosis

A client with this disorder has a loss of memory and adapts by filling in areas that cannot be remembered with made-up information. Ideas of grandeur do not occur with this type of dementia. The use of confabulation is not attention-seeking behavior; the individual is attempting to mask memory loss. This person is not coping with the diagnosis; when confabulating, the individual is attempting to mask memory loss.

STUDY TIP: A word of warning: do not expect to achieve the maximum benefits of this review tool by cramming a few days before the examination. It doesn't work! Instead, organize planned study sessions in an environment that you find relaxing, free of stress, and supportive of the learning process.

3. A client has been diagnosed with generalized anxiety disorder (GAD). Which behavior supports this diagnosis?

1. Making huge efforts to avoid "any kind of bug or spider"
2. Experiencing flashbacks to an event that involved a sexual attack
3. Spending hours each day worrying about something "bad happening"
4. Becoming suddenly tachycardic and diaphoretic for no apparent reason

3. A client has been diagnosed with generalized anxiety disorder (GAD). Which behavior supports this diagnosis?

1 Making huge efforts to avoid "any kind of bug or spider"

2 Experiencing flashbacks to an event that involved a sexual attack

✔ Correct 3 Spending hours each day worrying about something "bad happening"

4 Becoming suddenly tachycardic and diaphoretic for no apparent reason

Using worrying as a coping mechanism is a behavior characteristic of GAD. Experiencing an accelerated heart rate and perfuse sweating for no apparent reason is consistent with a panic attack. Avoiding bugs and spiders would indicate a phobia. Flashbacks to traumatic events are characteristic of posttraumatic stress disorder (PTSD).

Test-Taking Tip: After you have eliminated one or more choices, you may discover that two of the options are very similar. This can be very helpful, because it may mean that one of these look-alike answers is the best choice and the other is a very good distractor. Test both of these options against the stem. Ask yourself which one completes the incomplete statement grammatically and which one answers the question more fully and completely. The option that best completes or answers the stem is the one you should choose. Here, too, pause for a few seconds, give your brain time to reflect, and recall may occur.

4. To provide appropriate psychosocial support to clients, a nurse must understand development across the life span. What theory is the nurse using in considering relationships and resulting behaviors as the central factors that influence development?

1 Cognitive theory

2 Psychosocial theory

3 Interpersonal theory

4 Psychosexual theory

4. To provide appropriate psychosocial support to clients, a nurse must understand development across the life span. What theory is the nurse using in considering relationships and resulting behaviors as the central factors that influence development?

1 Cognitive theory

Incorrect 2 Psychosocial theory

✓ Correct 3 Interpersonal theory

4 Psychosexual theory

The interpersonal theory of human development by Harry Stack Sullivan highlights interpersonal behaviors and relationships as the central factors influencing child and adolescent development across six "eras"; the need to satisfy social attachments and a longing to meet biologic and psychological needs are two dimensions associated with this theory. Cognitive theory is associated with Jean Piaget; cognitive theory explains how thought processes develop, are structured, and influence behavior. Psychosocial theory is associated with Erik Erikson; psychosocial theory identifies social interaction as the source that influences human development. Erikson identified eight stages of human life, with each stage built on the previous stages and influenced by past experiences. Psychosexual theory is associated with Sigmund Freud; psychosexual theory views child development as a biologically driven series of conflicts and gratifying internal needs.

5. A nursing assistant interrupts the performance of a ritual by a client with obsessive-compulsive disorder. What is the most likely client reaction?

1 Anxiety

2 Hostility

3 Aggression

4 Withdrawal

5. A nursing assistant interrupts the performance of a ritual by a client with obsessive-compulsive disorder. What is the most likely client reaction?

✓ Correct 1 Anxiety

Incorrect 2 Hostility

3 Aggression

4 Withdrawal

Because the compulsive ritual is used to control anxiety, any attempt to prevent the action will increase anxiety. Underlying hostility is considered part of the disorder itself, not a reaction to an interruption of the ritual. Aggression is possible only if the anxiety reaches a panic level and causes the person to express anger overtly. Withdrawal is not a pattern of behavior associated with obsessive-compulsive disorder.

6. A nurse is assessing a child with suspected autism. At what age does the nurse determine that the signs of autism initially may be evident?

1. 2 years
2. 6 years
3. 6 months
4. 1 to 3 months

6. A nurse is assessing a child with suspected autism. At what age does the nurse determine that the signs of autism initially may be evident?

✔ Correct

1. 2 years
2. 6 years
3. 6 months
4. 1 to 3 months

By 2 years of age the child should demonstrate an interest in others, communicate verbally, and possess the ability to learn from the environment. Before the age when these skills develop, autism is difficult to diagnose. Usually by 3 years the signs of autism become more profound. Autism can be diagnosed long before a child is 6 years old. Infantile autism may occur in an infant of 1 to 3 months, but at this age it is difficult to diagnose.

7. A nurse is planning to teach a client about self-care. What level of anxiety will best enhance the client's learning abilities?

1. Mild
2. Panic
3. Severe
4. Moderate

7. A nurse is planning to teach a client about self-care. What level of anxiety will best enhance the client's learning abilities?

✔ Correct 1 Mild

2 Panic

3 Severe

4 Moderate

Mild anxiety motivates one to action, such as learning or making changes. Higher levels of anxiety tend to blur the individual's perceptions and interfere with functioning. Attention is severely reduced by panic. The perceptual field is greatly reduced with severe anxiety and narrowed with moderate anxiety.

Test-Taking Tip: Read the question carefully before looking at the answers: (1) Determine what the question is really asking; look for key words; (2) Read each answer thoroughly and see if it completely covers the material asked by the question; (3) Narrow the choices by immediately eliminating answers you know are incorrect.

8. During the first meeting of a therapy group, the members become quite uncomfortable. The nurse notes frequent periods of silence, tense laughter, and nervous movement in the group. What does the nurse conclude about these responses?

1 They require active leader intervention to relieve signs of obvious stress.

2 They indicate unhealthy group processes and an unwillingness to relate openly.

3 They are expected group behaviors because relationships are not yet established.

4 They should be addressed immediately so members will not become too uncomfortable.

8. During the first meeting of a therapy group, the members become quite uncomfortable. The nurse notes frequent periods of silence, tense laughter, and nervous movement in the group. What does the nurse conclude about these responses?

1 They require active leader intervention to relieve signs of obvious stress.

2 They indicate unhealthy group processes and an unwillingness to relate openly.

✔ Correct 3 They are expected group behaviors because relationships are not yet established.

4 They should be addressed immediately so members will not become too uncomfortable.

The members have not established trust and are hesitant to discuss problems; the behaviors observed reflect anxiety and insecurity. Requiring active leader intervention to relieve signs of obvious stress can add to the anxiety and insecurity of group members. These behaviors are expected in the early stage of group interaction and are not unhealthy. Immediately addressing them may add to the anxiety and insecurity of the group members.

9. A nurse is assessing a client for the use of defense mechanisms. In the presence of which defense mechanism does the client express emotional conflicts through motor, sensory, or somatic disabilities?

1 Projection
2 Conversion
3 Dissociation
4 Compensation

9. A nurse is assessing a client for the use of defense mechanisms. In the presence of which defense mechanism does the client express emotional conflicts through motor, sensory, or somatic disabilities?

1 Projection
✔ Correct 2 Conversion
3 Dissociation
4 Compensation

The defense mechanism is called conversion because the individual reduces emotional anxiety to a physical disability. Projection occurs when people assign their own unacceptable thoughts and feelings to others. With dissociation there is separation of certain mental processes from consciousness as though they belonged to another; a dissociative reaction is expressed as amnesia, fugue, multiple personality, aimless running, depersonalization, sleepwalking, and other behaviors. Compensation is a mechanism used to make up for a lack in one area by emphasizing capabilities in another.

10. A psychiatric nurse is hired to work in the psychiatric emergency department of a large teaching hospital. While reviewing the manuals, the nurse reads, "People with mental health emergencies shall be triaged within 5 minutes of entering the emergency department." What does the nurse consider this statement to represent?

1 Hospital policy
2 Standard of care
3 Hospital procedure
4 Mental Health Bill of Rights

10. A psychiatric nurse is hired to work in the psychiatric emergency department of a large teaching hospital. While reviewing the manuals, the nurse reads, "People with mental health emergencies shall be triaged within 5 minutes of entering the emergency department." What does the nurse consider this statement to represent?

✔ Correct 1 Hospital policy

Incorrect 2 Standard of care

3 Hospital procedure

4 Mental Health Bill of Rights

Policies are statements that help define a course of action; what is to be done is stated in policies, and how a task or skill is to be performed is defined in a procedure manual. Standards of care are published by the American Nurses Association; they reflect current knowledge and represent levels of practice agreed on by experts within the specialty; in legal terms, the standard of care is that level of practice that a reasonably prudent nurse would provide. A hospital procedure defines how a task or skill is to be performed. The Mental Health Bill of Rights states that all clients have the right to respectful care, confidentiality, continuity of care, relevant information, and refusal of treatment, except in an emergency or by law.

STUDY TIP: Do not change your pattern of study. It obviously has contributed to your being here, so it worked. If you have studied alone, continue to study alone. If you have studied in a group, form a study group.

11. A nurse in the mental health clinic concludes that a client is using confabulation when the client does what?

1 The flow of thoughts is interrupted.

2 Imagination is used to fill in memory gaps.

3 Speech flits from one topic to another with no apparent meaning.

4 Connections between statements are so loose that only the speaker understands them.

11. A nurse in the mental health clinic concludes that a client is using confabulation when the client does what?

1 The flow of thoughts is interrupted.

✔ Correct 2 Imagination is used to fill in memory gaps.

3 Speech flits from one topic to another with no apparent meaning.

4 Connections between statements are so loose that only the speaker understands them.

Using imagination to fill in memory gaps is the definition of confabulation; it is a defense mechanism used by people experiencing memory deficits. Interruption of the flow of thoughts is the definition of thought blocking. Flitting of speech from one topic to another with no apparent meaning is the definition of flight of ideas. The definition of associative looseness is connections between statements so loose that only the speaker understands them.

12. Three days after a stressful incident a client can no longer remember why it was stressful. The nurse, in relating to this client, can be most therapeutic by identifying that the inability to recall the situation is an example of what defense mechanism?

1 Denial
2 Regression
3 Repression
4 Dissociation

12. Three days after a stressful incident a client can no longer remember why it was stressful. The nurse, in relating to this client, can be most therapeutic by identifying that the inability to recall the situation is an example of what defense mechanism?

1 Denial
2 Regression
✔ Correct 3 Repression
4 Dissociation

The client's inability to recall is an example of repression, which is the unconscious and involuntary forgetting of painful events, ideas, and conflicts. There is nothing to demonstrate that denial, an unconscious refusal to admit an unacceptable situation, exists. There is nothing to demonstrate that regression, a return to an earlier, more comfortable developmental level, has occurred. There is nothing to demonstrate that dissociation, the separation and detachment of emotional affect and significance from a particular idea, situation, or incident, has occurred.

1. When a nurse is working with a client with psychiatric problems, a primary goal is the establishment of a therapeutic nurse-client relationship. What is the major purpose of this relationship?

1 Increasing nonverbal communication
2 Presenting an outlet for suppressed hostile feelings
3 Assisting the client in acquiring more effective behavior
4 Providing the client with someone who can make decisions

1. When a nurse is working with a client with psychiatric problems, a primary goal is the establishment of a therapeutic nurse-client relationship. What is the major purpose of this relationship?

1 Increasing nonverbal communication

2 Presenting an outlet for suppressed hostile feelings

✔ Correct 3 Assisting the client in acquiring more effective behavior

4 Providing the client with someone who can make decisions

The therapeutic nurse-client relationship provides an opportunity for the client to try out different behaviors in an accepting atmosphere and ultimately to replace pathologic responses with more effective responses. Verbal communication, not nonverbal communication, is the objective of the therapeutic relationship. The nurse, although accepting of the client's hostile feelings, uses the therapeutic relationship to redirect hostile feelings into more acceptable behaviors. The nurse provides the support and acceptance that encourage clients to make their own decisions.

2. A 17-year-old client is found to have anorexia nervosa. The psychiatrist, in conjunction with the client and the parents, decides to institute a behavior modification program. What does the nurse recall is a major component of behavior modification?

1 Rewarding positive behavior

2 Reducing necessary restrictions

3 Deconditioning fear of weight gain

4 Reducing anxiety-producing situations

2. A 17-year-old client is found to have anorexia nervosa. The psychiatrist, in conjunction with the client and the parents, decides to institute a behavior modification program. What does the nurse recall is a major component of behavior modification?

✔ Correct 1 Rewarding positive behavior

2 Reducing necessary restrictions

3 Deconditioning fear of weight gain

4 Reducing anxiety-producing situations

In behavior modification [1] [2] [3], positive behavior is reinforced, and negative behavior is not reinforced or punished. Reducing the number or complexity of necessary restrictions, deconditioning the fear of weight gain, and reducing the number of anxiety-producing situations may all be part of the program, but none is a major component.

3. A male college student who is smaller than average and unable to participate in sports becomes the life of the party and a stylish dresser. What defense mechanism does the nurse determine that the client is using?

1. Introjection
2. Sublimation
3. Compensation
4. Reaction formation

3. A male college student who is smaller than average and unable to participate in sports becomes the life of the party and a stylish dresser. What defense mechanism does the nurse determine that the client is using?

1. Introjection
2. Sublimation
3. Compensation ✔ Correct
4. Reaction formation

By developing skills in one area, the individual compensates for a real or imagined deficiency in another, thereby maintaining a positive self-image. Had the student incorporated the qualities of the college athlete, that would be introjection. Sublimation is related to unacceptable impulses that may pose a threat. This person is trying to make amends not for unacceptable feelings (reaction formation), but rather for a believed deficiency and an inadequate self-image.

4. A client with a history of drug abuse begins group therapy. After attending the first meeting the client says to the nurse, "It helps to know that I'm not the only one with this type of problem." What concept does this statement reflect?

1. Altruism
2. Catharsis
3. Universality
4. Transference

4. A client with a history of drug abuse begins group therapy. After attending the first meeting the client says to the nurse, "It helps to know that I'm not the only one with this type of problem." What concept does this statement reflect?

1. Altruism
2. Catharsis
3. Universality ✓ Correct
4. Transference

Universality is the sense that one is not alone in any situation; one purpose of group therapy is to share feelings and gain support from others with similar thoughts and feelings. Altruism in group therapy is giving support, insight, and reassurance to others, which eventually promotes self-knowledge and growth. Catharsis involves group members relating to one another through the verbal expression of negative and positive feelings. Transference occurs when a client unconsciously assigns to the therapist feelings and attitudes originally associated with another important person in the client's life.

STUDY TIP: Becoming a nursing student automatically increases stress levels because of the complexity of the information to be learned and applied and because of new constraints on time. One way to decrease stress associated with school is to become very organized so that assignment deadlines or tests do not come as sudden surprises. By following a consistent plan for studying and completing assignments, you can stay on top of requirements and thereby prevent added stress.

5. A nurse, understanding the possible cause of alcohol-induced amnestic disorder, should take into consideration that the client is probably experiencing which imbalance?

1. Thiamine deficiency
2. A reduced iron intake
3. An increase in serotonin
4. Riboflavin malabsorption

5. A nurse, understanding the possible cause of alcohol-induced amnestic disorder, should take into consideration that the client is probably experiencing which imbalance?

1. Thiamine deficiency ✓ Correct
2. A reduced iron intake
3. An increase in serotonin
4. Riboflavin malabsorption

The deficiency of thiamine (vitamin B_1) is thought to be a primary cause of alcohol-induced amnestic disorder. Reduced iron intake, increased serotonin, and riboflavin malabsorption are all unrelated to alcohol-induced amnestic disorder.

6. Addicted clients commonly expect discrimination and lack of empathy from others. How can the nurse best overcome these expectations?

1. Demonstrating a nonjudgmental attitude
2. Explaining that an addiction is a disease
3. Offering reassurance that the client is accepted
4. Confronting these attitudes when they are expressed

6. Addicted clients commonly expect discrimination and lack of empathy from others. How can the nurse best overcome these expectations?

✔ Correct

1. Demonstrating a nonjudgmental attitude
2. Explaining that an addiction is a disease
3. Offering reassurance that the client is accepted
4. Confronting these attitudes when they are expressed

Behaviors that reflect acceptance and consistency are the best approaches to overcoming these client expectations. What the nurse does is a better indicator of acceptance than the words or explanations that are verbalized. The nurse's actions over time are better indicators of acceptance than is verbal reassurance. Confrontational measures increase anxiety and are not therapeutic.

7. After a nurse works with an adolescent with anorexia nervosa for 1 week, the adolescent becomes hostile and says to the nurse, "You're just like my mother. I hate you." What concept does the client's statement reflect?

1. Insight
2. Universality
3. Transference
4. Identification

7. After a nurse works with an adolescent with anorexia nervosa for 1 week, the adolescent becomes hostile and says to the nurse, "You're just like my mother. I hate you." What concept does the client's statement reflect?

1 Insight

2 Universality

✓ Correct 3 Transference

4 Identification

Transference occurs when a client unconsciously assigns to the therapist feelings and attitudes originally associated with another important person in the client's life. This client's statement reflects a lack of insight. Universality is the sense that one is not alone in any situation. Identification is a defense mechanism that eases anxiety. The person takes on characteristics of someone who is viewed as admirable.

8. What does a nurse expect to determine about a child with a diagnosis of reactive attachment disorder?

1 Has been physically abused

2 Tries to cling to the mother on separation

3 Is able to develop just superficial relationships with others

4 Has a more positive relationship with the father than with the mother

8. What does a nurse expect to determine about a child with a diagnosis of reactive attachment disorder?

1 Has been physically abused

2 Tries to cling to the mother on separation

✓ Correct 3 Is able to develop just superficial relationships with others

4 Has a more positive relationship with the father than with the mother

Children who have experienced attachment difficulties with primary caregivers are not able to trust others and therefore relate superficially. Physical abuse is a possibility but not a necessity for this diagnosis. The child probably will not cling or react when separated from the mother. Attachment will not occur with either parent.

9. A nurse is assessing a client with major depression. Which clinical manifestation reflects a disturbance in affect related to depression?

1 Echolalia
2 Delusions
3 Confusion
4 Hopelessness

9. A nurse is assessing a client with major depression. Which clinical manifestation reflects a disturbance in affect related to depression?

1 Echolalia
2 Delusions
3 Confusion
✔ Correct
4 Hopelessness

Feelings of hopelessness are symptomatic of depression; the individual feels unable to find any solution to problems and therefore feels overwhelmed. Echolalia, the pathological meaningless repetition of another's words or phrases, is associated with schizophrenia, not with depression. Delusions are associated with psychotic disorders such as schizophrenia, not depression. Confusion is not common because these individuals are in contact with reality.

10. While caring for an older adult client, what symptom requires an immediate reassessment of the client's needs and plan of care?

1 Memory loss or confusion
2 Neglect of self-care
3 Increased daily fatigue
4 Withdrawal from usual activities

10. While caring for an older adult client, what symptom requires an immediate reassessment of the client's needs and plan of care?

✓ Correct	1	Memory loss or confusion
	2	Neglect of self-care
	3	Increased daily fatigue
Incorrect	4	Withdrawal from usual activities

All are common signs of depression due to the aging process, however, memory loss or confusion may require immediate intervention. The development of confusion indicates that the client's ability to maintain equilibrium has not been achieved and that further disequilibrium is occurring, setting the client up for safety issues. Confusion may also be related to more serious physical conditions that can occur which require medical intervention.

11. What is most important for the nurse to do to assist a couple to cope with their feelings about the husband's terminal illness?

	1	Referring the husband to a psychotherapist for help in dealing with his anger
	2	Placing the couple in a couples' therapy group that addresses terminal illness
	3	Helping the couple express to each other their feelings about his terminal illness
	4	Encouraging the wife to verbalize her feelings to a therapist during individual therapy sessions

11. What is most important for the nurse to do to assist a couple to cope with their feelings about the husband's terminal illness?

	1	Referring the husband to a psychotherapist for help in dealing with his anger
	2	Placing the couple in a couples' therapy group that addresses terminal illness
✓ Correct	3	Helping the couple express to each other their feelings about his terminal illness
	4	Encouraging the wife to verbalize her feelings to a therapist during individual therapy sessions

It is important for the couple to discuss their feelings to maintain open communication and support each other. Referring the husband to the psychotherapist for help in dealing with his anger will not meet the needs of this couple because it focuses only on the client's needs and ignores the partner's needs; in addition, most psychotherapy is a long-term process. Placing the couple in a couples' therapy group that addresses terminal illness may be useful in the future, but at this time it is premature; clients need to work through their own feelings first. Encouraging the wife to verbalize her feelings to a therapist during individual therapy sessions may elicit feelings but will not improve communication between the husband and wife; this is a long-term goal.

STUDY TIP: The old standbys of enough sleep and adequate nutritional intake also help keep excessive stress at bay. Although nursing students learn about the body's energy needs in anatomy and physiology classes, somehow they tend to forget that glucose is necessary for brain cells to work. Skipping breakfast or lunch or surviving on junk food puts the brain at a disadvantage.

12. A 24-year-old woman states that she no longer enjoys any of the activities that she once found fun and pleasurable, such as socializing, sports, and hobbies. What term should the nurse use to describe this condition?

1 Anergia

2 Anhedonia

3 Grandiosity

4 Learned helplessness

12. A 24-year-old woman states that she no longer enjoys any of the activities that she once found fun and pleasurable, such as socializing, sports, and hobbies. What term should the nurse use to describe this condition?

1 Anergia

✔ Correct 2 Anhedonia

3 Grandiosity

4 Learned helplessness

Anhedonia is the inability to experience pleasure in events or activities that once were enjoyable. Anergia is lethargy and a decreased level of energy. Grandiosity is a symptom seen during manic episodes in which an individual displays an inflated self-esteem. Learned helplessness is a theory proposing that depression occurs when an individual believes that he or she has no control over life situations. This results in the individual's giving up and becoming passive and dependent.

Test-Taking Tip: Being emotionally prepared for an examination is key to your success. Proper use of resources over an extended period of time ensures your understanding and increases your confidence about your nursing knowledge. Your lifelong dream of becoming a nurse is now within your reach! You are excited, yet anxious. This feeling is normal. A little anxiety can be good because it increases awareness of reality; but excessive anxiety has the opposite effect, acting as a barrier and keeping you from reaching your goal. Your attitude about yourself and your goals will help keep you focused, adding to your strength and inner conviction to achieve success.

1. A client with alcoholism was admitted a few hours ago for pancreatitis. For which symptoms should the nurse carefully monitor this client?

1 Irritability and tremors

2 Yawning and convulsions

3 Disorientation and paranoia

4 Fever and profuse diaphoresis

1. A client with alcoholism was admitted a few hours ago for pancreatitis. For which symptoms should the nurse carefully monitor this client?

✓ Correct
1 Irritability and tremors
2 Yawning and convulsions
3 Disorientation and paranoia
4 Fever and profuse diaphoresis

The nurse should carefully monitor a client with alcoholism and pancreatitis for irritability and tremors when it has been a few hours since admission. Alcohol is a central nervous system depressant, and irritability and tremors are the body's neurologic adaptation during withdrawal of alcohol. Tachycardia, irritability, and tremors are the early signs of withdrawal and will appear 24 to 48 hours after the last alcoholic drink has been consumed. Although it has only been a few hours since admission, it is unknown how long it has been since the client last had an alcoholic drink or how much time was spent during transportation to the hospital, waiting to be seen, or in observation in the emergency department before admission. Yawning occurs with heroin withdrawal. Convulsions (delirium tremens, or DTs) are a later sign of severe withdrawal that occurs with alcohol withdrawal delirium. Delirium (paranoia and disorientation) is not an early sign of alcohol withdrawal and occurs 48 to 72 hours after abstinence. Fever and diaphoresis may occur during prolonged periods of delirium and are due to autonomic hyperactivity.

STUDY TIP: When forming a study group, carefully select members for your group. Choose students who have abilities and motivation similar to your own. Look for students who have a different learning style than you. Exchange names, email addresses, and phone numbers. Plan a schedule for when and how often you will meet. Plan an agenda for each meeting. You may exchange lecture notes and discuss content for clarity or quiz one another on the material. You could also create your own practice tests or make flash cards that review key vocabulary terms.

2. What is it imperative for a mental health nurse to prevent clients from doing?

1 Breaking contracts
2 Using delusional thinking
3 Harming themselves or others
4 Engaging further in hallucinatory thoughts or behaviors

2. What is it imperative for a mental health nurse to prevent clients from doing?

1 Breaking contracts
2 Using delusional thinking
✓ Correct
3 Harming themselves or others
4 Engaging further in hallucinatory thoughts or behaviors

The physical safety of the client and others is the priority. Although it is important for clients to avoid breaking contracts, it is not imperative and cannot always be prevented. The nurse cannot control clients' thinking and perceptions.

3. A client who is to be discharged from an inpatient mental health facility is referred to a mental health daycare center in the community. What should the nurse identify as the primary reason for this referral?

1. Improving social skills
2. Getting out of the house for a few hours daily
3. Maintaining gains achieved during hospitalization
4. Avoiding direct confrontation with the community

3. A client who is to be discharged from an inpatient mental health facility is referred to a mental health daycare center in the community. What should the nurse identify as the primary reason for this referral?

1. Improving social skills
2. Getting out of the house for a few hours daily
✔ Correct 3. Maintaining gains achieved during hospitalization
4. Avoiding direct confrontation with the community

The daycare center provides the client with a therapeutic setting for a few hours each day during the transitional stage between hospital and total discharge. The goal is to maintain and enhance progress made during inpatient treatment. Daycare treatment may improve social skills or allow the client to get out of the house for a few hours, but neither is its primary purpose. Avoiding direct confrontation with the community may help during the transition stage, but it is not the primary goal of daycare.

STUDY TIP: Record the information you find to be most difficult to remember on 3-inch by 5-inch index cards and carry them with you in your pocket or purse. When you are waiting in traffic or for an appointment, just pull out the cards and review again. This "found" time may add points to your test scores that you have lost in the past.

4. A nurse is counseling a recently widowed client, who says, "His death has complicated my life even more than the hassles he caused when he was alive!" The nurse realizes the client is having difficulty with the grieving process and concludes that the relationship with the husband was probably what?

1. Loving
2. Long-term
3. Ambivalent
4. Subservient

4. A nurse is counseling a recently widowed client, who says, "His death has complicated my life even more than the hassles he caused when he was alive!" The nurse realizes the client is having difficulty with the grieving process and concludes that the relationship with the husband was probably what?

1 Loving

2 Long-term

✔ Correct 3 Ambivalent

Incorrect 4 Subservient

If the relationship was ambivalent, the surviving spouse now has feelings of both anger and guilt to resolve. A loving relationship evokes fewer feelings of guilt and is followed by a less complicated grieving process. The length of the relationship seems to have little to do with the ease or difficulty in completing the grieving process. Individuals in the subservient role usually have learned to accept directions and either find a new director or are relieved to have a chance to express their own feelings.

Test-Taking Tip: Stay away from other nervous students before the test. Stop reviewing at least 30 minutes before the test. Take a walk, go to the library and read a magazine, listen to music, or do something else that is relaxing. Go to the test room a few minutes before class time so that you are not rushed in settling down in your seat. Tune out what others are saying. Crowd tension is contagious, so stay away from it.

5. A parent of a 13-year-old adolescent with recently diagnosed Hodgkin disease tells a nurse, "I don't want my child to know about the diagnosis." How should the nurse respond?

1 "It's best for your child to know the diagnosis."

2 "Did you know that the cure rate for Hodgkin disease is high?"

3 "Would you like someone with Hodgkin disease to talk with you?"

4 "Let's talk about how you're feeling about your child's diagnosis."

5. A parent of a 13-year-old adolescent with recently diagnosed Hodgkin disease tells a nurse, "I don't want my child to know about the diagnosis." How should the nurse respond?

1 "It's best for your child to know the diagnosis."

2 "Did you know that the cure rate for Hodgkin disease is high?"

3 "Would you like someone with Hodgkin disease to talk with you?"

✓ Correct 4 "Let's talk about how you're feeling about your child's diagnosis."

Initiating a conversation about the client's feelings does not prejudge the parent; it encourages communication. Stating that it is best for the child to know the diagnosis disregards the parent's feelings and cuts off further communication. Asking the client about the cure rate may stop communication and does not recognize the parent's concerns. Offering to have someone with Hodgkin disease speak to the client is premature and does not recognize the parent's concerns.

STUDY TIP: Record the information you find to be most difficult to remember on 3" × 5" cards and carry them with you in your pocket or purse. When you are waiting in traffic or for an appointment, just pull out the cards and review again. This "found" time may add points to your test scores that you have lost in the past.

6. A mother brings her 7-year-old son into an outpatient clinic for a follow-up appointment. The mother appears angry and agitated with the boy. Looking at the boy's medical chart, the nurse notes that the boy has a diagnosis of encopresis. What is the primary symptom of encopresis?

1 Practicing self-mutilation

2 Practicing self-induced vomiting

3 Passing feces either voluntarily or involuntarily into inappropriate places

4 Passing urine either voluntarily or involuntarily into inappropriate places

6. A mother brings her 7-year-old son into an outpatient clinic for a follow-up appointment. The mother appears angry and agitated with the boy. Looking at the boy's medical chart, the nurse notes that the boy has a diagnosis of encopresis. What is the primary symptom of encopresis?

1 Practicing self-mutilation

2 Practicing self-induced vomiting

✓ Correct 3 Passing feces either voluntarily or involuntarily into inappropriate places

4 Passing urine either voluntarily or involuntarily into inappropriate places

Encopresis is the passage of feces into inappropriate places such as clothing, closets, floors, or toy boxes, either voluntarily or involuntarily. It may severely limit a child's social development and results in parental disapproval and rejection. Encopresis does not involve self-induced vomiting or self-mutilation. The passage of urine into inappropriate places is called enuresis.

7. A nursing assistant is frequently late for work and often tells the nurse manager that although he leaves his apartment early, he is delayed by heavy traffic. What defense mechanism is being used by the nursing assistant?

1. Undoing
2. Repression
3. Rationalization
4. Overcompensation

7. A nursing assistant is frequently late for work and often tells the nurse manager that although he leaves his apartment early, he is delayed by heavy traffic. What defense mechanism is being used by the nursing assistant?

1. Undoing
2. Repression
✓ Correct 3. Rationalization
4. Overcompensation

Rationalization is the use of contrived, socially acceptable, and logical explanations to justify unacceptable behavior and thus keep it out of the consciousness. Undoing is an attempt to compensate for an action or communication that is considered unacceptable—for instance, by giving a gift after a disagreement. Repression is the unconscious and involuntary forgetting of painful ideas, events, or behaviors. Reaction formation, also known as overcompensation, is defined as a conscious behavior that is the opposite of an unconscious feeling.

8. A nurse is caring for a newly admitted client with obsessive-compulsive disorder. When should the nurse anticipate that the client's anxiety level will increase?

1. As the day progresses
2. When family members visit
3. During a physical assessment by the nurse
4. When limits are set on the performance of a ritual

8. A nurse is caring for a newly admitted client with obsessive-compulsive disorder. When should the nurse anticipate that the client's anxiety level will increase?

1 As the day progresses

2 When family members visit

3 During a physical assessment by the nurse

✔ Correct 4 When limits are set on the performance of a ritual

Setting limits on the performance of a ritual will increase the client's anxiety. The ritual is a defense that the client needs at this time to control anxiety. The client needs time to develop other defenses before the ritual can be limited. The precipitation of anxiety in a client with obsessive-compulsive disorder is usually unrelated to the time of day. Visits from family members may or may not precipitate anxiety. Researchers have implicated trauma to the basal ganglia or cortical connections or a genetic predisposition as the origin of obsessive-compulsive disorder. A physical assessment by the nurse may or may not precipitate anxiety. The presentation of a nonjudgmental, supportive attitude by the nurse should decrease, not increase, anxiety.

9. A nurse is counseling clients who are attending an alcohol rehabilitation program. Which substance poses the greatest risk of addiction for these clients?

1 Heroin

2 Cocaine

3 Nicotine

4 Marijuana

9. A nurse is counseling clients who are attending an alcohol rehabilitation program. Which substance poses the greatest risk of addiction for these clients?

1 Heroin

2 Cocaine

✔ Correct 3 Nicotine

4 Marijuana

Although polysubstance abuse is common, clients undergoing rehabilitation from alcohol dependence are more likely to use or develop a dependence on nicotine, another legal substance, than on an illegal substance such as heroin, cocaine, or marijuana.

STUDY TIP: A helpful method for decreasing test stress is to practice self-affirmation. After you have adequately studied and really know the material, start looking in the mirror each time you pass one and say to yourself—preferably out loud—"I know this material, and I will do well on the test." After several times of watching and hearing yourself reaffirm your knowledge, you will gain inner confidence and be able to perform much better during the test period. This technique really works for students who are adventurous enough to use it. It may feel silly at first, but if it works, who cares? It will work for performing skills in clinical as well, as long as you have practiced the skill sufficiently.

10. A client has had repeated hospitalizations for aggressive, violent behavior. While on the mental health service, the client becomes very angry, starts screaming at the nurse, and pounds the table. What is the priority nursing assessment at this time?

1 Range of expressed anger

2 Extent of orientation to reality

3 Degree of control over the behavior

4 Determination of whether the anger is justified

10. A client has had repeated hospitalizations for aggressive, violent behavior. While on the mental health service, the client becomes very angry, starts screaming at the nurse, and pounds the table. What is the priority nursing assessment at this time?

1 Range of expressed anger

2 Extent of orientation to reality

✔ Correct 3 Degree of control over the behavior

4 Determination of whether the anger is justified

Degree of control over the behavior is the most important assessment because it will influence the nurse's intervention. Depending on the extent of the client's control, the nurse may or may not need assistance. It is not the degree of anger but instead the behavior it precipitates that is important to assess. The extent of orientation to reality may or may not influence the ability to control behavior. Anger is always justifiable to the person; the determination of whether the anger is justified will not help the nurse address the client's behavior.

11. A 68-year-old client who has metastatic carcinoma is told by the practitioner that death will occur within a month or two. Later the nurse enters the client's room and finds the client crying. Before responding, which factor should the nurse consider?

1 Crying relieves depression and helps the client face reality.

2 Crying releases tension and frees psychic energy for coping.

3 Nurses should not interfere with a client's behavior and defenses.

4 Accepting a client's tears maintains and strengthens the nurse-client bond.

11. A 68-year-old client who has metastatic carcinoma is told by the practitioner that death will occur within a month or two. Later the nurse enters the client's room and finds the client crying. Before responding, which factor should the nurse consider?

1. Crying relieves depression and helps the client face reality.
2. Crying releases tension and frees psychic energy for coping. ✔ Correct
3. Nurses should not interfere with a client's behavior and defenses.
4. Accepting a client's tears maintains and strengthens the nurse-client bond. Incorrect

Crying is an expression of an emotion that, if not expressed, increases anxiety and tension; the increased anxiety and tension use additional psychic energy and hinder coping. Crying does not relieve depression, nor does it help a client face reality. It is not universally true that nurses should not interfere with a client's behavior and defenses. In most instances the client's defenses should not be taken away until they can be replaced by more healthy defenses. The nurse must interfere with behavior and defenses that may place the client in danger, but the client's current behavior poses no threat to the client. It is not always true that accepting a client's crying maintains and strengthens the nurse-client bond. Many clients are embarrassed by what they consider a "show of weakness" and have difficulty relating to the individual who witnessed it. The nurse must do more than just accept the crying to strengthen the nurse-client relationship.

12. After a cocaine binge an individual is found unconscious and is admitted to the hospital with acute cocaine toxicity. What should the initial nursing action be directed toward?

1. Being understanding
2. Establishing a patent airway
3. Maintaining a drug-free environment
4. Establishing a therapeutic relationship

12. After a cocaine binge an individual is found unconscious and is admitted to the hospital with acute cocaine toxicity. What should the initial nursing action be directed toward?

1. Being understanding
2. Establishing a patent airway ✔ Correct
3. Maintaining a drug-free environment
4. Establishing a therapeutic relationship

The client is unconscious and unable to meet physical needs; a patent airway, breathing, and circulation are essential needs. Understanding and support are important once the client's physical condition has stabilized. Maintaining a drug-free environment will be a priority later in the treatment program. Establishment of a therapeutic relationship will increase in importance once the client's physical condition has stabilized.

STUDY TIP: Identify your problem areas that need attention. Do not waste time on restudying information you know.