1. A male client with a history of schizophrenia comes to the emergency department, accompanied by his wife. What is the emergency department nurse's priority intervention?

1 Observing and evaluating his behavior

2 Writing a plan of care for the mental health team

3 Obtaining a copy of the client's past medical records

4 Meeting separately with his wife and exploring why he came to the hospital

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✓ Correct 1 Observing and evaluating his behavior

2 Writing a plan of care for the mental health team

3 Obtaining a copy of the client's past medical records

4 Meeting separately with his wife and exploring why he came to the hospital

The client and his needs are the priority, and assessment is the first step of the nursing process. Writing a plan of care for the mental health team is done after a thorough assessment is completed. The nurse must deal with the present, not the past. Although meeting separately with the wife should be done, it is not the priority.

2. On the afternoon of admission to a psychiatric unit, an adolescent boy with the diagnosis of schizophrenia exposes his genitals to a female nurse. What should the nurse's immediate therapeutic response be?

1 Ignoring the client at this time

2 Stating that this behavior is unacceptable

3 Moving him to his room for a short time-out

4 Telling the client to come to the office later to discuss the behavior

2. On the afternoon of admission to a psychiatric unit, an adolescent boy with the diagnosis of schizophrenia exposes his genitals to a female nurse. What should the nurse's immediate therapeutic response be?

1. Ignoring the client at this time
2. ✓ Correct — Stating that this behavior is unacceptable
3. Moving him to his room for a short time-out
4. Telling the client to come to the office later to discuss the behavior

When clients enter a new milieu, limits should be set on unacceptable behavior and acceptable behavior should be reinforced. Neither clients nor unacceptable behavior should ever be ignored. Moving the client to his room for a short time-out is punishment. Unacceptable attention-getting behavior must be addressed immediately; also, the focus should be on appropriate behavior.

Test-Taking Tip: If the question asks for an immediate action or response, all of the answers may be correct, so base your selection on identified priorities for action.

3. A client who uses a complex ritual says to the nurse, "I feel so guilty. None of this makes any sense. Everyone must really think I'm crazy." What is the most therapeutic response by the nurse?

1. "Your behavior is bizarre, but it serves a useful purpose."
2. "You're concerned about what other people are thinking about you."
3. "I am sure people understand that you can't help this behavior right now."
4. "Guilt serves no useful purpose. It just helps you stay stuck where you are."

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Paraphrasing encourages further ventilation of feelings and concerns by the client. Telling the client that the behavior is bizarre but that it serves a useful purpose is a negative response that may increase the client's fears about being "crazy." Saying "I'm sure people understand that you can't help this behavior right now" provides false reassurance and implies that the client is out of control, which may increase the fears. Telling the client that guilt serves no useful purpose and just helps the client stay stuck denies the client's feelings.

4. A client who was involved in a near-fatal automobile collision arrives at the mental health clinic with complaints of insomnia, anxiety, and flashbacks. The nurse determines that the client is experiencing symptoms of crisis. What is the nurse's initial intervention?

1. Focusing on the present
2. Identifying past stressors
3. Discussing a referral for psychotherapy
4. Exploring the client's history of mental health problems

4. A client who was involved in a near-fatal automobile collision arrives at the mental health clinic with complaints of insomnia, anxiety, and flashbacks. The nurse determines that the client is experiencing symptoms of crisis. What is the nurse's initial intervention?

✔ Correct

1. Focusing on the present
2. Identifying past stressors
3. Discussing a referral for psychotherapy
4. Exploring the client's history of mental health problems

Crisis intervention deals with the here and now; the past is not important except in building on client strengths. The client is anxious and uncomfortable because of the current situation; the focus is on the present, not the past. Psychotherapy is not appropriate for crisis intervention; psychotherapy focuses on the causes of current feelings and behavior and may be provided long term. Exploring the client's history of mental health problems is not significant to crisis intervention.

5. A client with the diagnosis of dementia of the Alzheimer type, stage 1, is living at home with an adult child. To best address the functional and behavioral changes associated with this stage, what should the nurse encourage the daughter to do?

1. Place the client in a long-term care facility.
2. Provide for the client's basic physical needs.
3. Post a schedule of the client's daily activities.
4. Perform care so the client does not need to make decisions.

5. A client with the diagnosis of dementia of the Alzheimer type, stage 1, is living at home with an adult child. To best address the functional and behavioral changes associated with this stage, what should the nurse encourage the daughter to do?

1. Place the client in a long-term care facility.
2. Provide for the client's basic physical needs.
3. ✓ Correct — Post a schedule of the client's daily activities.
4. Perform care so the client does not need to make decisions.

In stage 1 of Alzheimer-type dementia [1] [2], clients have mild cognitive impairment with short-term memory loss; establishing a daily routine, posting it, and adhering to it provides a concrete, structured approach. Placing the client in a long-term care facility may be required during stage 3 or the end of stage 2 if the child is unable to cope with the client's functional and behavioral changes. In stage 1, clients can provide for their own basic activities of daily living such as bathing, dressing, and eating. Clients can make simple decisions in stage 1, and they have the right to make choices; an authoritarian approach may promote regression, anxiety, depression, or anger.

Test-Taking Tip: Be alert for details. Details provided in the stem of the item, such as behavioral changes or clinical changes (or both) within a certain time period, can provide a clue to the most appropriate response or, in some cases, responses.

6. A depressed client reports feelings of helplessness and hopelessness. The nurse hears the client tell another client, "I'll be feeling better soon." In light of this comment, what factor should the nurse assess?

1. Ability to sleep
2. Suicidal thinking
3. Current feelings of depression
4. Subjective ideas about treatment progress

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1. Ability to sleep
2. ✓ Correct — Suicidal thinking
3. Current feelings of depression
4. Incorrect — Subjective ideas about treatment progress

The client's comment reflects the possibility of suicide; further assessment and protection of the client are necessary. Although sleep is affected by depression, the overheard comment does not warrant this type of assessment at this time. Although feelings of depression and ideas regarding the progress of treatment are important, neither is the priority at this time.

7. Nurses working with clients who have a diagnosis of dementia should adopt a common approach of care, because these clients have a need to do what?

1. Relate in a consistent manner to staff
2. Learn that the staff cannot be manipulated
3. Accept controls that are concrete and fairly applied
4. Have sameness and consistency in their environment

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1. Relate in a consistent manner to staff
2. Learn that the staff cannot be manipulated
3. Accept controls that are concrete and fairly applied
4. ✔ Correct — Have sameness and consistency in their environment

A consistent approach and consistent communication from all members of the health team help the client who has dementia remain more reality oriented. It is the staff members who need to be consistent. Clients who have this disorder do not attempt to manipulate the staff. Acceptance of controls that are concrete and fairly applied is not needed when working with clients who have this disorder; consistency is most important.

8. What is most important for the nurse to do when caring for a client who is experiencing a paranoid delusion?

1. Touch the client's arm gently to convey concern.
2. Maintain eye contact when talking with the client.
3. Attempt to disprove the client's delusional thoughts.
4. Speak softly when talking with others near the client.

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Eye contact focuses the client's attention on the nurse; it also conveys caring and tells the client that the nurse considers the client important. The nurse should respect the client's personal space; touching the client, particularly without warning, may reinforce suspicious thoughts or precipitate agitation. Attempting to disprove the client's delusional thoughts is useless, because a delusion is real to the client. Whispering or laughing in the presence of a paranoid delusional client may reinforce the delusional state and further agitate the client.

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.

9. An older client's family tells the nurse that the client has suffered some memory loss in the past few years leading to a diagnosis of dementia with Lewy bodies (DLB). When attempting to increase the client's self-esteem, the nurse should try to avoid discussing events that require memory of what part of the client's life?

1 Married life

2 Work years

3 Recent days

4 Young adulthood

9. An older client's family tells the nurse that the client has suffered some memory loss in the past few years leading to a diagnosis of dementia with Lewy bodies (DLB). When attempting to increase the client's self-esteem, the nurse should try to avoid discussing events that require memory of what part of the client's life?

1 Married life

2 Work years

✓ Correct 3 Recent days

Incorrect 4 Young adulthood

Dementia with Lewy bodies (DLB) is characterized with short-term memory loss, unpredictable cognitive shifts, and sleep disturbances. Memory of remote events (e.g., married life, working years, young adulthood) usually remains fairly intact.

10. How should a nurse intervene when a confused and anxious client voids on the floor in the sitting room of the mental health unit?

1. Make the client mop the floor.
2. Restrict the client's fluids for the rest of the day.
3. Toilet the client more frequently with supervision.
4. Withhold the client's privileges each time the client voids on the floor.

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4. Withhold the client's privileges each time the client voids on the floor.

The client is voiding on the floor not to express hostility but because of confusion. Taking the client to the toilet frequently reduces the risk of voiding in inappropriate places. Making the client mop the floor is a form of punishment for something the client cannot control. Restricting the client's fluids for the rest of the day is not realistic; it will have no effect on the problem and may lead to physiologic problems. If the client were doing this to express hostility, withholding privileges might be effective, but not when the client is unable to control the behavior.

11. How can a nurse minimize agitation in a disturbed client?

1. By ensuring constant staff contact
2. By increasing environmental sensory stimulation
3. By limiting unnecessary interactions with the client
4. By discussing the reasons for the client's suspicions

11. How can a nurse minimize agitation in a disturbed client?

1 By ensuring constant staff contact

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✔ Correct 3 By limiting unnecessary interactions with the client

4 By discussing the reasons for the client's suspicions

Limiting unnecessary interactions will decrease stimulation and therefore agitation. Constant client and staff contact increases stimulation and agitation. Increasing environmental sensory stimulation bombards the client's sensorium and increases agitation. Not all disturbed clients are suspicious. This client is unlikely to benefit from this discussion at this time.

12. What statement by a male client during a yearly physical examination indicates to a nurse that the client may have a sexual arousal disorder?

1 "I have no interest in sex."

2 "I don't get hard during sex anymore."

3 "I climax almost before we even get started."

4 "It takes forever before I finally have an orgasm."

12. What statement by a male client during a yearly physical examination indicates to a nurse that the client may have a sexual arousal disorder?

1 "I have no interest in sex."

✔ Correct 2 "I don't get hard during sex anymore."

3 "I climax almost before we even get started."

4 "It takes forever before I finally have an orgasm."

The statement "I don't get hard during sex anymore" indicates a sexual arousal disorder, which is a partial or complete failure to achieve a physiologic or psychological response to sexual activity. The statement "I have no interest in sex" may indicate a sexual desire disorder in which the individual has deficient or absent interest in, or extreme aversion to and avoidance of, sexual activity. "I climax almost before we even get started" and "It takes forever before I finally have an orgasm" are both indicative of an orgasmic disorder, which is a delay in or absence of an orgasm or premature ejaculation.

1. A client has just been admitted to the psychiatric unit on involuntary admission status. During the admission assessment the client tells the nurse, "I am the second son of God and need to say a prayer." What is the best response by the nurse?

1. Interrupting the client and continuing the assessment
2. Joining the client in the prayer and then refocusing on the assessment
3. Quietly leaving the client and coming back later to complete the assessment
4. Waiting until the client finishes the prayer and then completing the assessment

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4. ✓ Correct — Waiting until the client finishes the prayer and then completing the assessment

During the initial assessment it is important for the nurse to learn as much as possible about a client and to establish baseline data; therefore both direct and indirect assessment data are important. Interrupting the client may interfere with the nurse-client relationship and increase the client's anxiety; also, it may interfere with obtaining valuable information about the client. Joining the client in the prayer and then refocusing on the assessment is not therapeutic and may reinforce the client's delusional thinking. Quietly leaving the client and returning later to complete the assessment is not therapeutic and will not meet standards of care; it may precipitate feelings of abandonment.

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

2. Which suicide method is the least lethal?

1. Hanging
2. Ingesting pills
3. Jumping from a tall bridge
4. Poisoning with carbon monoxide

2. Which suicide method is the least lethal?

1 Hanging

✔ Correct 2 Ingesting pills

3 Jumping from a tall bridge

4 Poisoning with carbon monoxide

Ingesting pills is considered the least lethal of these suicide methods, because it is considered slower. Hanging, jumping, and carbon monoxide poisoning are all quicker and therefore more lethal methods.

3. An older adult is being admitted to a nursing home with the diagnosis of dementia. The history reveals confusion, difficulty recognizing family members, and nighttime wandering. What should the nurse include in the client's plan of care?

1 Ordering a vest restraint for the client to be applied at night

2 Obtaining a prescription for a sedative so the client will sleep better at night

3 Requesting that the family provide a companion to stay with the client at night

4 Assigning the client to a room near the nurses' station for closer supervision at night

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✔ Correct 4 Assigning the client to a room near the nurses' station for closer supervision at night

It is the nurse's responsibility to ensure the safety of clients; close supervision can help ensure that the client does not wander. Restraints should not be used without a primary healthcare provider's order; a restraint is too excessive an intervention to prevent wandering. The issue is not that the client does not sleep; the issue is that the client wanders. It is the responsibility of the facility, specifically the nurse, to meet the needs of and ensure the safety of clients.

4. A client who complains of memory loss, nervousness, insomnia, and fear of leaving the house is admitted to the hospital after several days of increasing incapacitation. What nursing action is the priority in light of this client's history?

1. Evaluating the client's adjustment to the unit
2. Providing the client with a sense of security and safety
3. Exploring the client's memory loss and fear of going out
4. Assessing the client's perception of reasons for the hospitalization

4. A client who complains of memory loss, nervousness, insomnia, and fear of leaving the house is admitted to the hospital after several days of increasing incapacitation. What nursing action is the priority in light of this client's history?

1. Evaluating the client's adjustment to the unit
2. ✔ Correct — Providing the client with a sense of security and safety
3. Exploring the client's memory loss and fear of going out
4. Assessing the client's perception of reasons for the hospitalization

The client is anxious and afraid of leaving home; the priority is the client's safety and security needs. Unless the client is provided with a sense of security, adjustment probably will be unsatisfactory, because the anxiety will most likely escalate. Exploring the client's memory loss and fear of going out cannot be done until anxiety is reduced. The client is experiencing memory loss and may not be able to remember what precipitated admission to the hospital; some memory loss may be a result of high anxiety and thought blocking.

Test-Taking Tip: Anxiety leading to an exam is normal. Reduce your stress by studying often, not long. Spend at least 15 minutes every day reviewing the "old" material. This action alone will greatly reduce anxiety. The more time you devote to reviewing past material, the more confident you will feel about your knowledge of the topics. Start this review process on the first day of the semester. Don't wait until the middle to end of the semester to try to cram information.

5. A nurse is caring for a client with a diagnosis of conversion disorder manifesting as paralysis of the legs. Which is the most therapeutic nursing intervention?

1. Encouraging the client to try to walk
2. Explaining to the client that there is nothing wrong
3. Avoiding focusing on the client's physical symptoms
4. Helping the client follow through with the physical therapy plan

5. A nurse is caring for a client with a diagnosis of conversion disorder manifesting as paralysis of the legs. Which is the most therapeutic nursing intervention?

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✔ Correct 3 Avoiding focusing on the client's physical symptoms

Incorrect 4 Helping the client follow through with the physical therapy plan

The physical symptoms are not the client's major problem and therefore should not be the focus of care. This is a psychological problem, and the focus should be in this domain. Encouraging the client to try to walk is focusing on the physical symptom of the conflict; the client is not ready to give up the symptom. The disorder operates on an unconscious level but is very real to the client; saying there is nothing wrong denies feelings. Psychotherapy, not physical therapy, is needed at this time.

Test-Taking Tip: Key words or phrases in the stem of the question such as first, primary, early, or best are important. Similarly, words such as only, always, never, and all in the alternatives are frequently evidence of a wrong response. As in life, no real absolutes exist in nursing; however, every rule has its exceptions, so answer with care.

6. A client with a history of obsessive-compulsive behaviors is attending a mental health day treatment center. Improvement is obvious, and the client applies for a part-time job. On the day of a job interview the client begins displaying compulsive behavior. How should the nurse respond?

1 "Going for your interview must be upsetting you. Describe what you're feeling now."

2 "It's important for you to overcome your anxiety. You should keep that appointment."

3 "Your actions indicate that you want to delay the interview. Do you really want the job?"

4 "Going to the interview seems to upset you. Do you think you should look for another kind of job?"

6. A client with a history of obsessive-compulsive behaviors is attending a mental health day treatment center. Improvement is obvious, and the client applies for a part-time job. On the day of a job interview the client begins displaying compulsive behavior. How should the nurse respond?

✔ Correct	1	"Going for your interview must be upsetting you. Describe what you're feeling now."
	2	"It's important for you to overcome your anxiety. You should keep that appointment."
	3	"Your actions indicate that you want to delay the interview. Do you really want the job?"
	4	"Going to the interview seems to upset you. Do you think you should look for another kind of job?"

The client's behaviors are a defense against anxiety resulting from decision-making, which triggers old fears; the client needs support. Noting that it is important for the client to overcome the anxiety and encouraging the client to keep the appointment denies the client's overwhelming anxiety and shows a lack of realistic support. Asking whether the client really wants the job is judgmental; an increase in anxiety does not necessarily mean that the client does not want to attain the goal. The client should be encouraged to work through symptoms, not to avoid risk.

7. An adolescent with a long history of drug abuse, stealing, refusal to comply with rules, and inability to get along in any setting is admitted to an adolescent psychiatric unit for evaluation. What should the nurse include in the plan of care for this adolescent?

	1	Providing activities that ensure immediate gratification and social stimulation
	2	Allowing as much freedom as possible, setting few rules and minimal structure
	3	Serving as a role model for mature behavior while providing a structured setting
	4	Behaving in a punitive manner toward the adolescent when rules are not followed

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2. Allowing as much freedom as possible, setting few rules and minimal structure
3. ✓ Correct — Serving as a role model for mature behavior while providing a structured setting
4. Behaving in a punitive manner toward the adolescent when rules are not followed

The client is unable to control impulses at this time, so control must be provided for the client; the nurse's behavior provides a role model. Providing activities that ensure immediate gratification and social stimulation will probably provoke even more acting-out behavior. The client is not able to set self-controls; freedom may prove frightening to a client who is not in control. Behaving in a punitive manner toward the adolescent when rules are not followed could provoke even more acting-out behavior.

Test-Taking Tip: A psychological technique used to boost your test-taking confidence is to look into a mirror whenever you pass one and say out loud, "I know the material, and I'll do well on the test." Try it; many students have found that it works because it reduces "test anxiety."

8. A client exhibits physical symptoms in response to stress. What nursing intervention may help the client reduce this physiological response to stress?

1. Limiting discussions about the problem
2. Providing information regarding medical care
3. Teaching the client how to eliminate stress at home
4. Assisting the client in developing new coping mechanisms

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2. Providing information regarding medical care
3. Teaching the client how to eliminate stress at home
4. ✓ Correct — Assisting the client in developing new coping mechanisms

Until the client learns new ways of coping with stress and anxiety, this pattern of behavior will continue. Learning new ways of coping with stress will help break this physiological pattern. Limiting discussion will avoid the problem. Providing information about medical care will reinforce the sick role. A certain amount of stress is present in everyday family situations; the elimination of stress is impossible.

9. A client is admitted to the mental health unit because of a progressively increasing depression over the past month. What clinical finding does a nurse expect during the initial assessment of the client?

1. Elated affect related to reaction formation
2. Loose associations related to thought disorder
3. Physical exhaustion resulting from decreased physical activity
4. Diminished verbal expression caused by a slowed thought process

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1. Elated affect related to reaction formation
2. Loose associations related to thought disorder
3. Physical exhaustion resulting from decreased physical activity — Incorrect
4. Diminished verbal expression caused by a slowed thought process — ✓ Correct

As depression increases, the thought process becomes slower and verbal expression decreases. The affect of the depressed person is usually one of sadness, or it may be blank. Loose associations are characteristic of clients with schizophrenia, not depressed clients. Decreased physical activity does not produce physical exhaustion.

10. A client with a borderline personality disorder is admitted to the mental health unit. What should the nurse do to maintain a therapeutic relationship with the client?

1. Provide an unstructured environment to promote self-expression.
2. Be firm, consistent, and understanding and focus on specific target behaviors.
3. Use an authoritarian approach, because this type of client needs to learn to conform to the rules of society.
4. Record but ignore marked shifts in mood, suicidal threats, and temper displays, because these last only a few hours.

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Consistency, limit-setting, and supportive confrontation are essential nursing interventions designed to provide a secure, therapeutic environment for clients with borderline personality disorder. To be therapeutic, the environment needs structure, and the staff must help the client set short-term goals for behavioral changes. The use of an authoritarian approach will increase anxiety in this type of client, resulting in feelings of rejection and withdrawal. Ignoring the client's behavior is nontherapeutic and may reinforce underlying fears of abandonment.

11. The husband of a young mother who has attempted suicide tells the nurse that he told his wife he would bring their 26-month-old daughter to visit his wife and asks if that would be possible. What is the best response by the nurse?

1. "Probably so, but you'd better check with her primary healthcare provider first."
2. "Of course! Children of all ages are welcome to visit relatives."
3. "It could be very upsetting for your child to see her mother so depressed."
4. "Tell me what your wife said when you offered to bring your child for a visit."

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1. "Probably so, but you'd better check with her primary healthcare provider first."
2. "Of course! Children of all ages are welcome to visit relatives."
3. "It could be very upsetting for your child to see her mother so depressed." Incorrect
4. "Tell me what your wife said when you offered to bring your child for a visit." ✔ Correct

The nurse should determine whether the spouse has discussed the child visiting with the client before commenting further. The responses "Probably so, but you'd better check with her primary healthcare provider first" and "Of course! Children of all ages are welcome to visit relatives" assume that the client has consented to the visit; this assumption may be incorrect. The response "It may be very upsetting for your child to see her mother so depressed" makes an assumption that requires more data and discussion to validate.

12. A nurse has been assigned to work with a depressed client on a one-on-one basis. The next morning the client refuses to get out of bed, saying, "I'm too sick to be helped and I don't want to be bothered." What is the best response by the nurse?

1. "You won't feel better unless you make the effort to get up and get dressed."
2. "I know you'll feel better again if you just make an attempt to help yourself."
3. "Everyone feels this way in the beginning as they confront their feelings."
4. "I know you don't feel like getting up, but you might feel better if you did. Let me help you get started."

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3. "Everyone feels this way in the beginning as they confront their feelings."

✔ Correct

4. "I know you don't feel like getting up, but you might feel better if you did. Let me help you get started."

The statement, "I know you don't feel like getting up, but you might feel better if you did. Let me help you get started," acknowledges the client's feelings, offers hope, and helps the client to a higher level of function. The statement, "You won't feel better unless you make the effort to get up and get dressed," ignores the client's feelings and may not be true. The statement, "I know you'll feel better again if you just make an attempt to help yourself," denies the client's feelings and feeling better cannot be guaranteed. The statement, "Everyone feels this way in the beginning as they confront their feelings," minimizes the client's feelings; also the client is not interested in how others feel.

1. The nurse is caring for an Asian-American client with a diagnosis of depression. While interviewing this client the nurse notes that the client maintains traditional cultural beliefs and values. What is the most important information for the nurse to obtain about the client?

1. Dietary practices
2. Concept of space
3. Immigration status
4. Role within the family

1. The nurse is caring for an Asian-American client with a diagnosis of depression. While interviewing this client the nurse notes that the client maintains traditional cultural beliefs and values. What is the most important information for the nurse to obtain about the client?

Incorrect
1 Dietary practices
2 Concept of space
3 Immigration status
✔ Correct
4 Role within the family

If an Asian-American client adheres to traditional Asian practices, the nurse must recognize that the family is the central and most important social force acting on the individual. Dietary practices, concept of space, and immigration status are not as significant as family dynamics.

2. What should the nurse do when implementing a tertiary preventive program for cognitively impaired individuals?

1 Teach children how to feed themselves.
2 Encourage the use of birth control by women.
3 Refer children for evaluation if they fail to meet developmental milestones.
4 Use the Denver Developmental Screening Test to evaluate children attending well-child clinics.

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Incorrect
3 Refer children for evaluation if they fail to meet developmental milestones.
4 Use the Denver Developmental Screening Test to evaluate children attending well-child clinics.

Tertiary prevention is focused on interventions that prevent complete disability or reduce the severity of a disorder or its associated disabilities. Referring children for evaluation if they fail to meet developmental milestones is secondary prevention aimed at case-finding and early intervention. Encouraging the use of birth control by women who are cognitively impaired is primary prevention. Using the Denver Developmental Screening Test to evaluate children attending well-child clinics is secondary prevention aimed at case-finding and early intervention.

3. A client's severe anxiety and panic are often considered "contagious." What action should be taken when a nurse's personal feelings of anxiety are increasing?

1. Refocusing the conversation to more pleasant topics
2. Saying to the client, "Calm down. You're making me anxious, too."
3. Saying, "Another staff member is coming in. I'll leave and come back later."
4. Remaining quiet so personal feelings of anxiety do not become apparent to the client

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2. Saying to the client, "Calm down. You're making me anxious, too."
3. Saying, "Another staff member is coming in. I'll leave and come back later." — Correct
4. Remaining quiet so personal feelings of anxiety do not become apparent to the client — Incorrect

The nurse who is anxious should leave the situation after ensuring continuity of care; the client will be aware of the nurse's anxiety, and the nurse's presence will be nonproductive and nontherapeutic. The client will probably sense the nurse's anxiety through nonverbal channels, if not through verbal responses. Refocusing and asking the client to calm down both meet the nurse's need; this response may make the client feel guilty that something was said that upset the nurse. The client will be aware of the nurse's anxiety, which will increase the client's own anxiety.

4. Which intervention will the nurse implement when assisting a child with a history of aggressive behavior to regain control in the triggering phase of an assault cycle?

1. Discuss alternative behaviors to substitute for aggression.
2. Provide the child with a quiet, low-stimulus environment.
3. Speak to the child in a calm but firm manner.
4. Administer medication as needed (PRN) to facilitate de-escalation.

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Incorrect 3 Speak to the child in a calm but firm manner.

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In the triggering phase, the client's behavior is nonthreatening and poses no danger to others. Minimizing environmental stimuli and providing a calm, nonthreatening environment likely will serve to help the client de-escalate and regain control. Discussion of substitute behaviors is effective only once the crisis is over (postcrisis phase). As the client escalates, the nurse needs to begin to assume control by presenting a calm but firm tone of voice and demeanor. It is at this time that appropriate oral PRN medications may be helpful.

Test-Taking Tip: The computerized NCLEX exam is an individualized testing experience in which the computer chooses your next question based on the ability and competency you have demonstrated on previous questions. The minimum number of questions will be 75 and the maximum 265. You must answer each question before the computer will present the next question, and you cannot go back to any previously answered questions. Remember that you do not have to answer all of the questions correctly to pass.

5. A child has been hospitalized repeatedly for illnesses of unknown origin. Finally the primary healthcare provider makes the diagnosis of Munchausen syndrome by proxy. What is the most therapeutic approach by the nurse to the involved parent?

1 Confrontation

2 Open communication

3 Health teaching about child-rearing

4 Validation of the child's physical status

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3 Health teaching about child-rearing

4 Validation of the child's physical status

Maintaining open communication is important for any therapeutic nurse-client relationship. Confrontation will put the parent on the defensive and close off communication. Health teaching at this time is premature; the parent is not ready for this approach. Validation of the child's physical status focuses on the physical symptoms, which will reinforce the parent's behavior.

6. A nurse is planning health teaching for a 14-year-old girl hospitalized with the diagnosis of anorexia nervosa. What does the nurse assume is likely true of the client?

1. Is somewhat concerned that the eating behavior may threaten life
2. Has some understanding of anorexia nervosa because of media publicity
3. Has minimal awareness that reduced caloric intake has lethal implications
4. Is demonstrating an unconscious desire for death by selecting refusal of food as the method

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3. Has minimal awareness that reduced caloric intake has lethal implications — ✓ Correct
4. Is demonstrating an unconscious desire for death by selecting refusal of food as the method

Even though anorexia nervosa is a popular media topic and people with the disorder may intellectually understand the lethal implications of not eating, they do not recognize it as their problem even when they are dying of starvation. People with anorexia nervosa are unconcerned with the physiologic danger of the consequences of their behavior and focus only on being fat. Adolescents typically feel indestructible and immortal; also, individuals with anorexia nervosa believe being fat is unhealthy and must be avoided at any cost.

7. A nurse is caring for a newly admitted client with anorexia nervosa. What is the priority treatment for the client at this time?

1. Medications to reduce anxiety
2. Family psychotherapy sessions
3. Separation from family members
4. Correction of electrolyte imbalances

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✓ Correct 4 Correction of electrolyte imbalances

Starvation or inadequate/inappropriate nutrition can lead to electrolyte imbalances, which are life threatening. Medication and therapy will be prescribed later and are not the priority at this time. Client independence, not separation from family members, is supported.

Test-Taking Tip: Do not read information into questions, and avoid speculating. Reading into questions creates errors in judgment.

8. A clinically depressed client on a psychiatric unit of a local hospital uses embroidery scissors to cut the wrists. After treatment, when the nurse approaches, the client is tearful and silent. What is the best initial intervention by the nurse?

1 Note the client's behavior, record it, and notify the primary healthcare provider.

2 Sit quietly next to the client and wait until the client begins to speak.

3 Say, "You're crying. I guess that means you feel bad about attempting suicide and really want to live."

4 Comment, "I notice that you seem sad. Tell me what it's like for you and perhaps we can begin to work it out together."

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Noting that the client seems sad and asking for a description of the feelings so the nurse and client can begin to work it out together recognizes feelings and behavior; it encourages the client to share feelings and promotes trust, which is essential for a therapeutic relationship. Although noting, recording, and notifying the primary healthcare provider of the client's behavior are important actions, they are not enough; nursing intervention with the client must be included. Without verbal encouragement, the depressed client will not respond to the nurse sitting quietly and waiting. Saying that crying means the client must feel bad about attempting suicide and really wants to live assumes too much and may be inaccurate; an indirect approach should be used.

9. During the first month in a nursing home, an older client with dementia demonstrates numerous disruptive behaviors related to disorientation and cognitive impairment. What should the nurse take into consideration when planning care?

1. Client's orientation to time, place, and person
2. Ability to perform daily activities without assistance from others
3. Stressors that appear to precipitate the client's disruptive behavior
4. That cognitive impairments will increase until adjustment to the home is accomplished

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2. Ability to perform daily activities without assistance from others

✔ Correct

3. Stressors that appear to precipitate the client's disruptive behavior
4. That cognitive impairments will increase until adjustment to the home is accomplished

Additional information must be collected to determine what may be precipitating the disruptive behavior. Clients with cognitive impairment may have difficulty controlling behaviors and may need the environment to provide the structure needed to act appropriately. The client's disorientation is documented and will not change, although some day-to-day variations may occur. Disorientation alone usually does not lead to disruptive behavior. The client's ability to perform daily activities is important, but it is not necessarily related to disruptive behavior. The client may never achieve adjustment to the nursing home.

10. When selecting a room for a client with the diagnosis of bipolar I disorder who is hyperactive and talking nonstop in a loud, demanding voice, the nurse determines that what is the most important factor regarding the room?

1. A pleasant view
2. A quiet and restful atmosphere
3. Location close to the nurses' desk
4. Roommates with similar diagnoses and behaviors

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4 Roommates with similar diagnoses and behaviors

During the manic phase of the illness, the client responds to everything in the environment; therefore it is important that the room be quiet and restful to decrease stimulation. A room with a pleasant view is not an important consideration at this time for this client. A room close to the nurse's desk is too stimulating because of its location. Roommates with similar diagnoses and behaviors will probably increase both the client's and the roommates' behavioral acting out.

11. The nurse manager is evaluating a primary nurse who is working with a hospitalized adolescent client with the diagnosis of conduct disorder. Which intervention by the primary nurse should the nurse manager question?

1 Discussing unit rules

2 Giving the client choices

3 Explaining the consequences of not following unit regulations

4 Encouraging the verbalization of negative feelings toward others

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✓ Correct 4 Encouraging the verbalization of negative feelings toward others

Verbalization of negative feelings to others may escalate and result in antisocial or acting-out behavior. The environment must be consistent and predictable to limit manipulative behavior. Allowing opportunities for choices provides opportunities for the client to have some control. Consequences for unacceptable behavior can motivate individuals to act appropriately.

12. A woman who gave birth to a second child 3 weeks ago is depressed and having difficulty caring for her children. At the end of the day both of the children are dirty, wet, and crying. The woman tells her husband that she "just can't take this anymore." The husband calls the women's health clinic and asks what he should do. What is the best response by the nurse?

1 Telling him that his wife may be suffering from depression and needs emergency care

2 Telling him that fatigue is expected and that his wife needs to take rest periods during the day

3 Reassuring him that his wife is experiencing postpartum blues that will lessen in several days

4 Advising him to make an appointment for his wife to see her primary healthcare provider if the problem continues

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The mother's inability to care for herself or her children is an ominous sign that postpartum depression is reaching a critical level. The woman needs immediate care to meet her needs and ensure the safety of the children. Between 10% and 15% of new mothers have postpartum depression within 4 weeks of the birth of an infant. Telling the husband that fatigue is expected and that his wife needs to take rest periods during the day ignores the severity of the situation. The client's behavior is indicative of postpartum depression, not postpartum blues. Approximately 80% of women experience postpartum blues ("baby blues"), which peak around the fifth postpartum day and usually subside by the tenth postpartum day. The condition is characterized by a combination of emotional lability, restlessness, depression, let-down feeling, fatigue, insomnia, anxiety, sadness, and anger. Advising the husband to make an appointment for his wife to see her primary healthcare provider if the problem continues ignores the severity of the situation.

Test-Taking Tip: The night before the examination you may wish to review some key concepts that you believe need additional time, but then relax and get a good night's sleep. Remember to set your alarm, allowing yourself plenty of time to dress comfortably (preferably in layers, depending on the weather), have a good breakfast, and arrive at the testing site at least 15 to 30 minutes early.