Child & Adolescent Disorders/Eating Disorders Practice Questions

1. A nurse is providing instruction to the teacher of a child who has attention deficit/hyperactivity disorder (ADHD). Which of the following classroom strategies should the nurse include in the teaching? Select all that apply.

   A. Eliminate testing.
   B. Allow for regular breaks.
   C. Combine verbal instruction with visual cues.
   D. Establish consistent classroom rules.
   E. Increase stimuli in the environment.

   Rationale:

   A. Allowing for added time when testing can assist the client who has ADHD to be successful.
   B. CORRECT: Allowing for regular breaks will assist the client who has ADHD to focus on the required tasks.
   C. CORRECT: Combining verbal instruction with verbal cues will assist the client who has ADHD with learning information.
   D. CORRECT: Providing consistent classroom rules will assist the client who has ADHD to become successful.
   E. Stimuli in the environment distract the client who has ADHD, so it should be decreased.

2. A nurse is performing an admission assessment of a client who has bulimia nervosa with purging behavior. Which of the following is an expected finding? Select all that apply.

   A. Amenorrhea
   B. Hypokalemia
   C. Mottling of the skin
   D. Slightly elevated body weight
   E. Presence of lanugo on the face

   Rationale:

   A. Amenorrhea is an expected finding of anorexia nervosa rather than bulimia nervosa.
   B. CORRECT: Hypokalemia is an expected finding of purging-type bulimia nervosa.
   C. Mottling of the skin is an expected finding of anorexia nervosa rather than bulimia nervosa.
   D. CORRECT: Most clients who have bulimia nervosa maintain a weight within a normal range or slightly higher.
   E. Lanugo is an expected finding of anorexia nervosa rather than bulimia nervosa.

3. A nurse on an acute care unit is planning care for a client who has anorexia nervosa with binge-eating and purging behavior. Which of the following nursing actions should the nurse include in the client's plan of care?

   A. Allow the client to select preferred meal times.
   B. Establish consequences for purging behavior.
   C. Provide the client with a high-fat diet at the start of treatment.
   D. Implement one-to-one observation during and after meals.

   Rationale:

   A. The nurse should provide a highly structured milieu, including meal times, for the client requiring acute care for the treatment of anorexia nervosa.
   B. The nurse should use a positive approach to client care that includes rewards rather than consequences.
   C. The nurse should limit high-fat and gas-producing foods at the start of treatment.
   D. CORRECT: The nurse should closely monitor the client during and after meals to prevent purging.

4. A nurse is assisting the parents of a school-age child who has oppositional defiant disorder in identifying strategies to promote positive behavior. Which of the following is an appropriate strategy for the nurses to recommend? Select all that apply.

   A. Allow the child to choose consequences for negative behavior.
   B. Use role-playing to act out unacceptable behavior.
   C. Develop a reward system for acceptable behavior.
   D. Encourage the child to participate in school sports.
   E. Be consistent when addressing unacceptable behavior.

   Rationale:

   A. The parents should set clear limits on unacceptable behavior.
   B. The parents should focus on acceptable behavior and demonstrate through modeling.
   C. CORRECT: The parents should have a method to reward the child for acceptable behavior.
   D. CORRECT: The parents should encourage physical activity through which the child can use energy and obtain success.
   E. CORRECT: The parents should set clear limits on unacceptable behavior and should be consistent.

5. A nurse is obtaining a health history from the parents of a 12-year-old client who has conduct disorder. Which of the following findings should the nurse expect? Select all that apply.

   A. Bullying of others
   B. Threats of suicide
   C. Law-breaking activities
   D. Narcissistic behavior
   E. Flat affect

   Rationale:

   A. CORRECT: Bullying behavior is an expected finding of conduct disorder.
   B. CORRECT: Suicide ideation is an expected finding of conduct disorder.
   C. CORRECT: Law- and/or rule-breaking behavior is an expected finding of conduct disorder.
   D. Low self-esteem, rather than narcissism, is an expected finding of conduct disorder.
   E. Irritability and temper outbursts, rather than a flat affect, are expected findings of conduct disorder.

6. A nurse in a pediatric clinic is caring for a preschool-age child who has a new diagnosis of ADHD. When teaching the parent about this disorder, which of the following statements should the nurse include in the teaching?

   A. “Behaviors associated with ADHD are present prior to age 3.”
   B. “This disorder is characterized by argumentativeness.”
   C. “Below-average intellectual functioning is associated with ADHD.”
   D. “Because of this disorder, your child is at increased risk for injury.”

   Rationale:

   A. Behaviors associated with ADHD are present before the age of 12.
   B. Argumentativeness is associated with oppositional defiant disorder rather than ADHD.
   C. Below average intellectual functioning is associated with intellectual developmental disorder rather than ADHD.
   D. CORRECT: Inattentive or impulsive disorder behavior increases the risk for injury in a child who has ADHD.

7. A nurse is assessing a 4-year-old child for indications of autism spectrum disorder. For which of the following manifestations should the nurse assess?

   A. Impulsive behavior
   B. Repetitive counting
   C. Destructiveness
   D. Somatic problems

   Rationale:

   A. Impulsive behavior is an indication of ADHD rather than autism spectrum disorder.
   B. CORRECT: Repetitive actions and strict routines are an indication of autism spectrum disorder.
   C. Destructiveness is an indication of conduct disorder rather than autism spectrum disorder.
   D. Somatic problems are an indication of posttraumatic stress disorder rather than autism spectrum disorder.

8. A nurse is caring for a child who has depression. Which of the following findings should the nurse expect? Select all that apply.

   A. Preferring being with peers
   B. Weight loss or gain
   C. Report of low self-esteem
   D. Sleeping more than usual
   E. Hyperactivity

   Rationale:

   A. A preference for being alone is a finding associated with depression
   B. CORRECT: Weight loss or gain are findings.
   C. CORRECT: Low self-esteem is a finding associated with depression
   D. CORRECT: Sleeping more than usual is a finding associated with depression.
   E. Fatigue is a finding associated with depression

9. A nurse is caring for a client who has bulimia nervosa and has stopped their purging behavior. The client tells the nurse that she is afraid she is going to gain weight. Which of the following response should the nurse make?

   A. "Many of the clients are concerned about their weight. However, the dietician will ensure that you don't get too many calories in your diet."
   B. Instead of worrying about your weight, try to focus on your other problems at this time."
   C. "I understand you have concerns about your weight, but first, let's talk about your recent accomplishments."
   D. "You are not overweight, and the staff will ensure that you do not gain weight while you are in the hospital. We know that is important to you."

   Rationale:

   A. This statement minimizes and generalizes the client's concern and is therefore a nontherapeutic response.
   B. This statement minimizes the client's concern and is therefore a nontherapeutic response.
   C. CORRECT: This statement acknowledges the client's concern and then focuses the conversation on the client's accomplishments, which can promote self-esteem and self-image.
   D. This statement minimizes the client's concern and is therefore a nontherapeutic response.

10. A nurse is performing an admission assessment on an adolescent client who has depression. Which of the following manifestations should the nurse expect? Select all that apply.
    A. Fear of being alone
    B. Substance use
    C. Weight gain or loss
    D. Irritability
    E. Aggressiveness

    Rationale:

    A. Solitary play or work, rather than the fear of being alone, is an expected finding associated with depression.
    B. CORRECT: Substance use is an expected finding associated with depression.
    C. Loss of appetite and weight loss, or weight gain, are expected findings associated with depression.
    D. CORRECT: Irritability is an expected finding associated with depression.
    E. CORRECT: Aggressiveness is an expected finding associated with depression.

11. A very thin individual describes herself as “positively obese”. She states that she “has to keep dieting.” Which statement by the nurse is the best response to this patient regarding her distorted body image?
    A. “ I think it will be important for you to attend group to get some feedback about your weight from peers.”
    B. “You really are quite thin. Trust me on this. I am a health professional.”
    C. “What makes you think that you are obese?”
    D. “I am concerned about your health. Let’s consider some ways to help you stay healthy.”

    Rationale: A significant symptom of anorexia nervosa is a distorted body image. This irrational belief (sometimes understood to be delusional) does not usually lessen with the use of logic or the opinion of others (A, B, and C.). In fact, these comments can sometimes lead to defensiveness on the part of the patient. Answer D focuses away from appearance and on health which the person may more readily accept.

12. A nursing assistant is asked to provide continual observation for 2 hours following dinner for a patient admitted with a diagnosis of anorexia nervosa. The RN provides the following explanation for this intervention.
    A. Patients with this disorder can get very sleepy and fall following a meal.
    B. Patients with this disorder may vomit following a meal.
    C. Patients with this disorder usually become combative following a meal.
    D. Patients with this disorder sometimes need a companion after dinner.

    Rationale:

    A. Sleepiness following a meal is not a symptom of this illness.
    B. Patients with this disorder may vomit after eating to prevent weight gain.
    C. Combativeness following a meal is not a symptom of this illness.
    D. Continuous observation is used for safety or to prevent harmful behaviors.

13. Symptoms associated with a diagnosis of anorexia nervosa include: (Select SATA)
    A. Extreme fear of gaining weight
    B. A happy disposition when not eating
    C. Excessive exercise
    D. Slightly overweight appearance
    E. Hiding laxative use
    F. Self-harm behaviors like “cutting”

Rationale:

A. Extreme fear of gaining weight – This is an important symptom of the formal diagnosis of AN
B. A happy disposition when not eating – Mood is usually depressed or anxious with this disease
C. Excessive exercise – This is a commonly seen behavior in an attempt to keep weight down
D. Slightly overweight appearance – The most common appearance is thin to emaciated
E. Hiding laxative use – This is a commonly seen behavior in an attempt to keep weight down
F. Self-harm behaviors like “cutting” – This is a co-morbid dysfunctional behavior frequently seen with this diagnosis

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Keith RN:
Giddens, J. F. (2013). *Concepts for nursing practice*. St. Louis, MO: Mosby/Elsevier
Varcarolis, E. M. (2017). *Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence Based Care* (3rd ed.). St. Louis, MO: Mosby/Elsevier