Child Maltreatment & Eating Disorders Practice Questions – Unit 3

1. A 3-month-old infant presents to the Emergency Department with subdural and retinal hemorrhages but no external signs of trauma, and dies after arriving. What would the nurse suspect?

   A. Plant poisoning
   B. Abusive head trauma
   C. Sudden infant death syndrome
   D. Congenital neurologic disease

   Rationale:

   The correct answer is B. These are classic signs of Abusive Head Trauma or Shaken-baby Syndrome. Plant poisoning, SIDS and congenial neurologic disorders would not present this way.

2. What is the most important criterion on which to base the decision to report suspected child abuse?

   A. Inappropriate parental concern for the degree of injury
   B. Absence of parents for questioning about the child's injuries
   C. Inappropriate response of the child
   D. Incompatibility between the history and injury observed

   Rationale:

   The correct answer is D. When the injury does not fit with the history, it is considered a "red flag" of suspected abuse. Inappropriate response of the caregiver or child may be present, but are more subjective. The parents and child should be questioned as well as the child to look for inconsistencies in the history as well conflicting histories.

3. Which are common characteristics of those who sexually abuse children? Select all that apply.

   A. Pressure the victim into secrecy
   B. Are usually unemployed and unmarried
   C. Typically a man whom the victim knows
   D. Have many victims that are abused once only
   E. Typically have a poor criminal record

Rationale:

The correct answers are A and C. The perpetrator typically pressures the victim into not telling others by offering them gifts or telling them that there will be negative consequences if they tell. They are also often someone the victim know, often a family member.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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

   ATI Nursing Education Content Mastery Series Review Modules -
   RN Mental Health Nursing Edition 10.0
   RN Nursing Care of Children Edition 10.0

   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

Hockenberry, M. J., Wilson, D. & Rodgers, C.C. (2022). *Wong's essentials of pediatric nursing* (11th ed.). St. Louis, MO: Mosby/Elsevier.