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Chapter 01: Practicing the Science and the Art of Psychiatric Nursing

MULTIPLE CHOICE

1. Which outcome, focused on recovery, would be expected in the plan of care for a patient living in the community and diagnosed with serious and persistent mental illness? Within 3 months, the patient will: a. deny suicidal ideation. b. report a sense of well-being.

c. take medications as prescribed.

d. attend clinic appointments on time.

ANS: B

Recovery emphasizes managing symptoms, reducing psychosocial disability, and improving role performance. The goal of recovery is to empower the individual with mental illness to achieve a sense of meaning and satisfaction in life and to function at the highest possible level of wellness. The incorrect options focus on the classic medical model rather than recovery.

DIF: Cognitive Level: Application (Applying) REF: 2
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Health Promotion and Maintenance

2. In the shift-change report, an off-going nurse criticizes a patient who wears heavy makeup. Which comment by the nurse who receives the report best demonstrates advocacy?

a. This is a psychiatric hospital. Craziness is what we are all about.

b. Lets all show acceptance of this patient by wearing lots of makeup too.

c. Your comments are inconsiderate and inappropriate. Keep the report objective.

d. Our patients need our help to learn behaviors that will help them get along in society.

ANS: D

Accepting patients needs for self-expression and seeking to teach skills that will contribute to their well-being demonstrate respect and are important parts of advocacy. The on-coming nurse needs to take action to ensure that others are not prejudiced against the patient. Humor can be appropriate within the privacy of a shift report but not at the expense of respect for patients. Judging the off-going nurse in a critical way will create conflict. Nurses must show compassion for each other.

DIF: Cognitive Level: Application (Applying) REF: 8
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

3. A nurse assesses a newly admitted patient diagnosed with major depressive disorder. Which statement is an example of attending? a. We all have stress in life. Being in a psychiatric hospital isnt the end of the world.

b. Tell me why you felt you had to be hospitalized to receive treatment for your depression.

c. You will feel better after we get some antidepressant medication started for you.

d. Id like to sit with you a while so you may feel more comfortable talking with me.

ANS: D

Attending is a technique that demonstrates the nurses commitment to the relationship and reduces feelings of isolation. This technique shows respect for the patient and demonstrates caring. Generalizations, probing, and false reassurances are non-therapeutic.

DIF: Cognitive Level: Application (Applying) REF: 8
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

4. A patient is hospitalized for depression and suicidal ideation after their spouse asks for a divorce. Select the nurses most caring comment.

a. Lets discuss some means of coping other than suicide when you have these feelings.
b. I understand why youre so depressed. When I got divorced, I was devastated too.
c. You should forget about your marriage and move on with your life.
d. How did you get so depressed that hospitalization was necessary?

ANS: A
The nurses communication should evidence caring and a commitment to work with the patient. This commitment lets the patient know the nurse will help. Probing and advice are not helpful or therapeutic interventions.

DIF: Cognitive Level: Application (Applying) REF: 6
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

5. A patient shows the nurse an article from the Internet about a health problem. Which characteristic of the web sites address most alerts the nurse that the site may have biased and prejudiced information?

a. Address ends in .org.
b. Address ends in .com.
c. Address ends in .gov.
d. Address ends in .net.

ANS: B
Financial influences on a site are a clue that the information may be biased. .com at the end of the address indicates that the site is a commercial one. .gov indicates that the site is maintained by a government entity. .org indicates that the site is nonproprietary; the site may or may not have reliable information, but it does not profit from its activities. .net can have multiple meanings.

DIF: Cognitive Level: Comprehension (Understanding) REF: 5
TOP: Nursing Process: Evaluation MSC: NCLEX: Health Promotion and Maintenance

6. A nurse says, When I was in school, I learned to call upset patients by name to get their attention; however, I read a descriptive research study that says that this approach does not work. I plan to stop calling patients by name. Which statement is the best appraisal of this nurses comment?

a. One descriptive research study rarely provides enough evidence to change practice.
b. Staff nurses apply new research findings only with the help from clinical nurse specialists.
c. New research findings should be incorporated into clinical algorithms before using them in practice.
d. The nurse misinterpreted the results of the study. Classic tenets of practice do not change.

ANS: A
Descriptive research findings provide evidence for practice but must be viewed in relation to other studies before practice changes. One study is not enough. Descriptive studies are low on the hierarchy of evidence. Clinical algorithms use flow charts to manage problems and do not specify one response to a clinical problem. Classic tenets of practice should change as research findings provide evidence for change.

DIF: Cognitive Level: Analysis (Analyzing) REF: 3

TOP: Nursing Process: Evaluation MSC: NCLEX: Health Promotion and Maintenance

7. Two nursing students discuss career plans after graduation. One student wants to enter psychiatric nursing. The other student asks, Why would you want to be a psychiatric nurse? All they do is talk. You will lose your skills. Select the best response by the student interested in psychiatric nursing.

a. Psychiatric nurses practice in safer environments than other specialties. Nurse-to-patient ratios must bebetter because of the nature of patients problems.

b. Psychiatric nurses use complex communication skills, as well as critical thinking, to solve multidimensionalproblems. Im challenged by those situations.

c. I think I will be good in the mental health field. I do not like clinical rotations in school, so I do not want tocontinue them after I graduate.

d. Psychiatric nurses do not have to deal with as much pain and suffering as medical surgical nurses. Thatappeals to me.

ANS: B

The practice of psychiatric nursing requires a different set of skills than medical surgical nursing, although substantial overlap does exist. Psychiatric nurses must be able to help patients with medical and mental health problems, reflecting the holistic perspective these nurses must have. Nurse-patient ratios and workloads in psychiatric settings have increased, similar to other specialties. Psychiatric nursing involves clinical practice, not simply documentation. Psychosocial pain is real and can cause as much suffering as physical pain.

DIF: Cognitive Level: Application (Applying) REF: 3
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

8. Which research evidence would most influence a group of nurses to change their practice?

a. Expert committee report of recommendations for practice

b. Systematic review of randomized controlled trials

c. Nonexperimental descriptive study

d. Critical pathway

ANS: B

Research findings are graded using a hierarchy of evidence. A systematic review of randomized controlled trials is Level A and provides the strongest evidence for changing practice. Expert committee recommendations and descriptive studies lend less powerful and influential evidence. A critical pathway is not evidence; it incorporates research findings after they have been analyzed.

DIF: Cognitive Level: Comprehension (Understanding) REF: 3
TOP: Nursing Process: Planning MSC: NCLEX: Safe, Effective Care Environment

9. A bill introduced in Congress would reduce funding for the care of people diagnosed with mental illnesses. A group of nurses write letters to their elected representatives in opposition to the legislation. Which role have the nurses fulfilled? a. Advocacy b. Attending

c. Recovery

d. Evidence-based practice

ANS: A

An advocate defends or asserts anothers cause, particularly when the other person lacks the ability to do that for himself or herself. Examples of individual advocacy include helping patients understand their rights or make decisions. On a community scale, advocacy includes political activity, public speaking, and publication

in the interest of improving the individuals with mental illness; the letter-writing campaign advocates for that cause on behalf of patients who are unable to articulate their own needs.

DIF: Cognitive Level: Comprehension (Understanding) REF: 8
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. An informal group of patients discuss their perceptions of nursing care. Which comment best indicates a patients perception that his or her nurse is caring?
a. My nurse always asks me which type of juice I want to help me swallow my medication.
b. My nurse explained my treatment plan to me and asked for
my ideas about how to make it better.
c. My nurse told me that if I take all the medicines the doctor prescribes I will get discharged soon.
d. My nurse spends time listening to me talk about my problems.
That helps me feel like Im not alone.

ANS: D
Caring evidences empathic understanding, as well as competency. It helps change pain and suffering into a shared experience, creating a human connection that alleviates feelings of isolation. The incorrect options give examples of statements that demonstrate advocacy or giving advice.

DIF: Cognitive Level: Application (Applying) REF: 3
TOP: Nursing Process: Evaluation MSC: NCLEX: Psychosocial Integrity

11. A patient who immigrated to the United States from Honduras was diagnosed with schizophrenia. The patient took an antipsychotic medication for 3 weeks but showed no improvement. Which resource should the treatment team consult for information on more effective medications for this patient? a. Clinical algorithm b. Clinical pathway
c. Clinical practice guideline
d. International Statistical Classification of Diseases and Related Health Problems (ICD)

ANS: A
A clinical algorithm is a guideline that describes diagnostic and/or treatment approaches drawn from large databases of information. These guidelines help the treatment team make decisions cognizant of an individual patients needs, such as ethnic origin, age, or gender. A clinical pathway is a map of interventions and treatments related to a specific disorder. Clinical practice guidelines summarize best practices about specific health problems. The ICD classifies diseases.

DIF: Cognitive Level: Application (Applying) REF: 5
TOP: Nursing Process: Evaluation MSC: NCLEX: Safe, Effective Care Environment

12. Which historical nursing leader helped focus practice to recognize the importance of science in psychiatric nursing? a. Abraham Maslow
b. Hildegard Peplau
c. Kris Martinsen
d. Harriet Bailey

ANS: B
Although all these leaders included science as an important component of practice, Hildegard Peplau most influenced its development in psychiatric nursing. Maslow was not a nurse, but his theories influence how nurses prioritize problems and care. Bailey wrote a textbook in the

1930s on psychiatric nursing interventions. Kris Martinsen emphasized the importance of caring in nursing practice.

DIF: Cognitive Level: Knowledge (Remembering) REF: 4
TOP: Nursing Process: N/A MSC: NCLEX: Psychosocial Integrity

13. A nurse consistently strives to demonstrate caring behaviors during interactions with patients. Which reaction by a patient indicates this nurse is effective? A patient reports feeling: a. distrustful of others.
b. connected with others.
c. uneasy about the future.
d. discouraged with efforts to improve.

ANS: B
A patient is likely to respond to caring with a sense of connectedness with others. The absence of caring can make patients feel distrustful, disconnected, uneasy, and discouraged.
DIF: Cognitive Level: Comprehension (Understanding) REF: 7
TOP: Nursing Process: Evaluation MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. An experienced nurse says to a new graduate, When youve practiced as long as I have, you will instantly know how to take care of psychotic patients. What is the new graduates best analysis of this comment? Select all that apply.
a. The experienced nurse may have lost sight of patients individuality, which may compromise the integrity ofpractice.
b. New research findings must be continually integrated into a nurses practice to provide the most effectivecare.
c. Experience provides mental health nurses with the tools and skills needed for effective professional practice.
d. Experienced psychiatric nurses have learned the best ways to care for psychotic patients through trial anderror.
e. Effective psychiatric nurses should be continually guided by an intuitive sense of patients needs.

ANS: A, B
Evidence-based practice involves using research findings to provide the most effective nursing care. Evidence is continually emerging; therefore, nurses cannot rely solely on experience. The effective nurse also maintains respect for each patient as an individual. Overgeneralization compromises that perspective. Intuition and trial and error are unsystematic approaches to care.

DIF: Cognitive Level: Application (Applying) REF: 2
TOP: Nursing Process: Evaluation MSC: NCLEX: Safe, Effective Care Environment

2. Which patient statements identify qualities of nursing practice with high therapeutic value? (Select all that apply.) My nurse: a. talks in language I can understand.
b. helps me keep track of my medications.
c. is willing to go to social activities with me.
d. lets me do whatever I choose without interfering.
e. looks at me as a whole person with different needs.

ANS: A, B, E
Each correct answer demonstrates caring is an example of appropriate nursing foci: communicating at a level understandable to the patient, using holistic principles to guide care, and providing medication supervision. The incorrect options suggest a laissez-faire attitude on the part of the nurse, when the nurse should instead provide thoughtful feedback and help patients test alternative solutions or violate boundaries.

DIF: Cognitive Level: Application (Applying) REF: 6
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

Chapter 02: Mental Health and Mental Illness

MULTIPLE CHOICE

1. An 86-year-old, previously healthy and independent, falls after an episode of vertigo. Which behavior by this patient best demonstrates resilience?
The patient: a. says, I knew this would happen eventually. b. stops attending her weekly water aerobics class.
c. refuses to use a walker and says, I dont need that silly thing.
d. says, Maybe some physical therapy will help me with my balance.

ANS: D
Resiliency is the ability to recover from or adjust to misfortune and change. The correct response indicates that the patient is hopeful and thinking positively about ways to adapt to the vertigo. Saying I knew this would happen eventually and discontinuing healthy activities suggest a hopeless perspective on the health change. Refusing to use a walker indicates denial.

DIF: Cognitive Level: Comprehension (Understanding) REF: 14
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

2. A patient is admitted to the psychiatric hospital. Which assessment finding best indicates that the patient has a mental illness? The patient:
a. describes coping and relaxation strategies used when feeling anxious.
b. describes mood as consistently sad, discouraged, and hopeless.
c. can perform tasks attempted within the limits of own abilities.
d. reports occasional problems with insomnia.

ANS: B
A patient who reports having a consistently negative mood is describing a mood alteration. The incorrect options describe mentally healthy behaviors and common problems that do not indicate mental illness.

DIF: Cognitive Level: Application (Applying) REF: 11
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

3. The goal for a patient is to increase resiliency. Which outcome should a nurse add to the plan of care? Within 3 days, the patient will:
a. describe feelings associated with loss and stress.
b. meet own needs without considering the rights of others.
c. identify healthy coping behaviors in response to stressful events.
d. allow others to assume responsibility for major areas of own life.

ANS: C

The patients ability to identify healthy coping behaviors indicates adaptive, healthy behavior and demonstrates an increased ability to recover from severe stress. Describing feelings associated with loss and stress does not move the patient toward adaptation. The remaining options are maladaptive behaviors.

DIF: Cognitive Level: Analysis (Analyzing) REF: 14
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

4. Which organization actively seeks to reduce the stigma associated with mental illness through public presentations such as In Our Own Voice (IOOV)? a. American Psychiatric Association (APA) b. National Alliance on Mental Illness (NAMI)

c. United States Department of Health and Human Services (USDHHS)
d. North American Nursing Diagnosis Association International (NANDA-I)

ANS: B
Stigma represents the bias and prejudice commonly held regarding mental illness. NAMI actively seeks to dispel misconceptions about mental illness. NANDA-I defines approved nursing diagnoses. The APA publishes the DSM 5. The USDHHS regulates and administers health policies.

DIF: Cognitive Level: Knowledge (Remembering) REF: 19
TOP: Nursing Process: Evaluation MSC: NCLEX: Safe, Effective Care Environment

5. A nurse must assess several new patients at a community mental health center. Conclusions concerning current functioning should be made on the basis of:

a. the degree of conformity of the individual to societys norms.
b. the degree to which an individual is logical and rational.
c. a continuum from mentally healthy to unhealthy.
d. the rate of intellectual and emotional growth.

ANS: C
Becausemental health and mental illness are relative concepts, assessment of functioning is made by using a continuum. Mental health is not based on conformity; some mentally healthy individuals do not conform to societys norms. Most individuals occasionally display illogical or irrational thinking. The rate of intellectual and emotional growth is not the most useful criterion to assess mental health or mental illness.

DIF: Cognitive Level: Application (Applying) REF: 11 TOP: Nursing Process: Diagnosis| Nursing Process: Analysis MSC: NCLEX: Psychosocial Integrity

6. A nurse at a behavioral health clinic sees an unfamiliar psychiatric diagnosis on a patients insurance form. Which resource should the nurse consult to discern the criteria used to establish this diagnosis? a. A psychiatric nursing textbook b. NANDA International (NANDA-I)

c. A behavioral health reference manual
d. Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

ANS: D
The DSM-5 gives the criteria used to diagnose each mental disorder. The NANDA-I focuses on nursing diagnoses. A psychiatric nursing textbook or behavioral health reference manual may not contain diagnostic criteria.

DIF: Cognitive Level: Application (Applying) REF: 12 TOP: Nursing Process: Analysis| Nursing Process: Diagnosis MSC: NCLEX: Safe, Effective

Care Environment

7. A 40-year-old adult living with parents states, Im happy but I dont socialize much. My work is routine. When new things come up, my boss explains them a few times to make sure I understand. At home, my parents make decisions for me, and I go along with them. A nurse should identify interventions to improve this patients:

a. self-concept.
b. overall happiness.
c. appraisal of reality.
d. control over behavior.

ANS: A

The patient feels the need for multiple explanations of new tasks at work and, despite being 40 years of age, allows both parents to make all decisions. These behaviors indicate a poorly developed self-concept. Although the patient reports being happy, the subsequent comments refute that self-appraisal. The patients comments do not indicate that he/she is out of touch with reality. The patients needs are broader than control over own behavior.

DIF: Cognitive Level: Application (Applying) REF: 11
TOP: Nursing Process: Planning MSC: NCLEX: Psychosocial Integrity

8. A patient tells a nurse, I have psychiatric problems and am in and out of hospitals all the time. Not one of my friends or relatives has these problems. Select the nurses best response. a. Comparing yourself with others has no real advantages.

b. Why do you blame yourself for having a psychiatric illness?
c. Mental illness affects 50% of the adult population in any given year.
d. It sounds like you are concerned that others dont experience the same challenges as you.

ANS: D

Mental illness affects many people at various times in their lives. No class, culture, or creed is immune to the challenges of mental illness. The correct response also demonstrates the use of reflection, a therapeutic communication technique. It is not true that mental illness affects 50% of the population in any given year. Asking patients if they blame themselves is an example of probing.

DIF: Cognitive Level: Application (Applying) REF: 11
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. A critical care nurse asks a psychiatric nurse about the difference between a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and a nursing diagnosis. Select the psychiatric nurses best response.

a. No functional difference exists between the two diagnoses. Both serve to identify a human deviance.
b. The DSM-5 diagnosis disregards culture, whereas the nursing diagnosis includes cultural variables.
c. The DSM-5 diagnosis profiles present distress or disability, whereas a nursing diagnosis considers past andpresent responses to actual mental health problems.
d. The DSM-5 diagnosis influences the medical treatment; the nursing diagnosis offers a framework to identifyinterventions for problems a patient has or may experience.

ANS: D

The medical diagnosis, defined according to the DSM-5, is concerned with the patients disease state, causes, and cures, whereas the nursing diagnosis focuses on the patients response to stress and possible caring

interventions. Both the DSM-5 and a nursing diagnosis consider culture. Nursing diagnoses also consider potential problems.

DIF: Cognitive Level: Application (Applying) REF: 16
TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. The spouse of a patient diagnosed with schizophrenia says, I dont understand why childhood experiences have anything to do with this disabling illness. Select the nurses response that will best help the spouse understand this condition.
a. Psychological stress is actually at the root of most mental disorders. b. We now know that all mental illnesses are the result of genetic factors.
c. It must be frustrating for you that your spouse is sick so much of the time.
d. Although this disorder more likely has a biological rather than psychological origin, the support andinvolvement of caregivers is very important.

ANS: D
Many of the most prevalent and disabling mental disorders have been found to have strong biological influences. Helping the spouse understand the importance of his or her role as a caregiver is also important. Empathy is important but does not increase the spouses level of knowledge about the cause of the patients condition. Not all mental illnesses are the result of genetic factors. Psychological stress is not at the root of most mental disorders.

DIF: Cognitive Level: Application (Applying) REF: 14
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

11. Which belief by a nurse supports the highest degree of patient advocacy during a multidisciplinary patient care planning session? a. All mental illnesses are culturally determined.
b. Schizophrenia and bipolar disorder are cross-cultural disorders.
c. Symptoms of mental disorders are constant from culture to culture.
d. Some symptoms of mental disorders may reflect a persons cultural patterns. ANS: D A nurse who understands that a patients symptoms are influenced by culture will be able to advocate for the patient to a greater degree than a nurse who believes that culture is of little relevance.
All mental illnesses are not culturally determined. Schizophrenia and bipolar disorder are cross-cultural disorders, but this understanding has little relevance to patient advocacy. Symptoms of mental disorders change from culture to culture.
DIF: Cognitive Level: Application (Applying) REF: 18
TOP: Nursing Process: Planning MSC: NCLEX: Safe, Effective Care Environment

12. A patients history shows intense and unstable relationships with others. The patient initially idealizes an individual and then devalues the person when the patients needs are not met. Which aspect of mental health is a problem?
a. Effectiveness in work b. Communication skills c. Productive activities
d. Fulfilling relationships

ANS: D
The information provided centers on relationships with others, which are described as intense and unstable. The relationships of mentally healthy individuals are stable, satisfying, and socially integrated. Data are not present to describe work effectiveness, communication skills, or activities.

DIF: Cognitive Level: Application (Applying) REF: 12

TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

13. In the majority culture of the United States, which individual is at greatest risk to be incorrectly labeled mentally ill?

a. Person who is usually pessimistic but strives to meet personal goals
b. Wealthy person who gives $20 bills to needy individuals in the community
c. Person with an optimistic viewpoint about life and getting his or her own needs met
d. Person who attends a charismatic church and describes hearing Gods voice

ANS: D
Hearing voices is generally associated with mental illness; however, in charismatic religious groups, hearing the voice of God or a prophet is a desirable event. In this situation, cultural norms vary, making it more difficult to make an accurate DSM-5 diagnosis. The individuals described in the other options are less likely to be labeled as mentally ill.

DIF: Cognitive Level: Application (Applying) REF: 17
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

14. A participant at a community education conference asks, What is the most prevalent type of mental disorder in the United States? Select the nurses best response. a. Why do you ask?

b. Schizophrenia
c. Affective disorders
d. Anxiety disorders

ANS: D
The prevalence for schizophrenia is 1.1% per year. The prevalence of all affective disorders (e.g., depression, dysthymic disorder, bipolar) is 9.5%. The prevalence of anxiety disorders is 13.3%.
DIF: Cognitive Level: Comprehension (Understanding) REF: 15
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

15. A nurse wants to find a description of diagnostic criteria for a person diagnosed with schizophrenia. Which resource should the nurse consult? a. U.S. Department of Health and Human Services

b. Journal of the American Psychiatric Association
c. North American Nursing Diagnosis Association International (NANDA-I)
d. Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

ANS: D
The DSM-5 identifies diagnostic criteria for psychiatric diagnoses. The other sources have useful information but are not the best resources for finding a description of the diagnostic criteria for a psychiatric disorder.

DIF: Cognitive Level: Application (Applying) REF: 12
TOP: Nursing Process: Analysis| Nursing Process: Diagnosis MSC: NCLEX: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A patient in the emergency department reports, I hear voices saying someone is stalking me. They want to kill me because I found the cure for cancer. I will stab anyone that threatens me. Which aspects of mental

health have the greatest immediate concern to a nurse? Select all that apply. a. Happiness b. Appraisal of reality

c. Control over behavior

d. Effectiveness in work

e. Healthy self-concept

ANS: B, C, E

The aspects of mental health of greatest concern are the patients appraisal of and control over behavior. The patients appraisal of reality is inaccurate, and auditory hallucinations are evident, as well as delusions of persecution and grandeur. In addition, the patients control over behavior is tenuous, as evidenced by the plan to stab anyone who seems threatening. A healthy self-concept is lacking. Data are not present to suggest that the other aspects of mental health (happiness and effectiveness in work) are of immediate concern.

DIF: Cognitive Level: Application (Applying) REF: 12

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

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

a. Many mental illnesses are hereditary.

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

c. People claim mental illness so they can get disability checks.

d. If people with mental illness went to church, they would be fine.

e. Mental illness is a result of the breakdown of the American family.

ANS: C, D, E

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

DIF: Cognitive Level: Analysis (Analyzing) REF: 19

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

Chapter 03: Theories and Therapies

MULTIPLE CHOICE

1. A 26-month-old child displays negative behaviors. The parent says, My child refuses toilet training and shouts, No! when given direction. What do you think is wrong? Select the nurses best reply. a. This is normal for your childs age. The child is striving for independence.

b. The child needs firmer control. Punish the child for disobedience and say, No.

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

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

ANS: A

These negative behaviors are typical of a child around the age of 2 years whose developmental task is to develop autonomy. The incorrect options indicate the childs behavior is abnormal.

DIF: Cognitive Level: Application (Applying) REF: 22

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

2. A 26-month-old child displays negative behavior, refuses toilet training, and often shouts, No! when given directions. Using Freuds stages of psychosexual development, a nurse would assess the childs behavior is based on which stage? a. Oral b. Anal

c. Phallic

d. Genital

ANS: B

In Freuds stages of psychosexual development, the anal stage occurs from age 1 to 3 years and has, as its focus, toilet training and

learning to delay immediate gratification. The oral stage occurs between birth and 1 year, the phallic stage occurs between 3 and 5 years, and the genital stage occurs between 13 and 20 years.

DIF: Cognitive Level: Comprehension (Understanding) REF: 20

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

3. A 26-month-old child displays negative behavior, refuses toilet training, and often shouts, No! when given direction. The nurses counseling with the parent should be based on the premise that the child is

engaged in which of Eriksons psychosocial crises? a. Trust versus

Mistrust

b. Initiative versus Guilt

c. Industry versus Inferiority

d. Autonomy versus Shame and Doubt

ANS: D

The crisis of Autonomy versus Shame and Doubt is related to the developmental task of gaining control of self and environment, as exemplified by toilet training. This psychosocial crisis occurs during the period of early childhood. Trust versus Mistrust is the crisis of the infant, Initiative versus Guilt is the crisis of the preschool and early school-aged child, and Industry versus Inferiority is the crisis of the 6- to 12-year-old child.

DIF: Cognitive Level: Comprehension (Understanding) REF: 22

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

4. A 4-year-old child grabs toys from siblings, saying, I want that toy now! The siblings cry, and the childs parent becomes upset with the behavior. Using the Freudian theory, a nurse can interpret the childs behavior as a product of impulses originating in the: a. id. b. ego. c. superego.

d. preconscious.

ANS: A

The id operates on the pleasure principle, seeking immediate gratification of impulses. The ego acts as a mediator of behavior and weighs the consequences of the action, perhaps determining that taking the toy is not worth the parents wrath. The superego would oppose the impulsive behavior as not nice. The preconscious is a level of awareness.

DIF: Cognitive Level: Application (Applying) REF: 20

TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

5. The parent of a 4-year-old rewards and praises the child for helping a younger sibling, being polite, and using good manners. A nurse supports the use of praise because, according to the

Freudian theory, these qualities will likely be internalized and become part of the childs: a. id. b. ego.

c. superego.

d. preconscious.

ANS: C
In the Freudian theory, the superego contains the thou shalts or moral standards internalized from interactions with significant others. Praise fosters internalization of desirable behaviors. The id is the center of basic instinctual drives, and the ego is the mediator. The ego is
the problem-solving and reality-testing portion of the personality that negotiates solutions with the outside world. The preconscious is a level of awareness from which material can be easily retrieved with conscious effort.
DIF: Cognitive Level: Comprehension (Understanding) REF: 20
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and
Maintenance

6. A nurse supports parental praise of a child who is behaving in a helpful way. When the individual behaves with politeness and helpfulness in adulthood, which feeling will most likely result? a. Guilt b. Anxiety
c. Loneliness
d. Self-esteem

ANS: D
The individual will be living up to the ego ideal, which will
result in positive feelings about self. The other options are incorrect; each represents a negative feeling.

DIF: Cognitive Level: Comprehension (Understanding) REF: 22
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and
Maintenance

7. A patient comments, I never know the right answer and My
opinion is not important. Using Eriksons theory, which psychosocial crisis did the patient have difficulty resolving? a. Initiative versus Guilt b. Trust versus Mistrust
c. Autonomy versus Shame and Doubt
d. Generativity versus Self-Absorption

ANS: C
These statements show severe self-doubt, indicating that the crisis of gaining control over the environment is not being successfully met. Unsuccessful resolution of the crisis of Initiative versus Guilt results in feelings of guilt. Unsuccessful resolution of the crisis of Trust versus Mistrust results in poor interpersonal relationships and suspicion of others.
Unsuccessful resolution of the crisis of Generativity versus Self-Absorption results in self-absorption that limits the ability to grow as a person.

DIF: Cognitive Level: Application (Applying) REF: 22
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and
Maintenance

8. Which patient statement would lead a nurse to suspect that the developmental task of infancy was not successfully completed? a. I have very warm and close friendships.
b. Im afraid to let anyone really get to know me.
c. I am always right and confident about my decisions.
d. Im ashamed that I didnt do it correctly in the first place. ANS: B

According to Erikson, the developmental task of infancy is the development of trust. The patients statement that he or she is afraid of becoming acquainted with others clearly shows a lack of ability to trust other people.
Having warm and close friendships suggests the developmental task of infancy was successfully completed.
Believing one is always right suggests
Both retirees are in middle adulthood, when the developmental crisis to be resolved is Generativity versus Self-
Absorption. One exemplifies generativity; the other embodies self-absorption. The developmental crisis of Trust versus Mistrust would show a contrast between relating to others in a trusting fashion and being suspicious and lacking trust. Failure to negotiate the developmental crisis of Industry versus Inferiority would result in a sense of inferiority or difficulty learning and working as opposed to the ability to work competently. Behaviors that would be contrasted in the crisis of Intimacy versus Isolation would be emotional isolation and the ability to love and commit to oneself.

DIF: Cognitive Level: Application (Applying) REF: 22
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

12. Cognitive therapy was provided for a patient who frequently said, Im stupid. Which statement by the patient indicates the therapy was effective?
a. Im disappointed in my lack of ability.
b. I always fail when I try new things.
c. Things always go wrong for me.
d. Sometimes I do stupid things.

ANS: D
Im stupid is a cognitive distortion or irrational thought. A more rational thought is, Sometimes I do stupid things. The latter thinking promotes emotional self-control. The incorrect options reflect irrational thinking.

DIF: Cognitive Level: Application (Applying) REF: 26
TOP: Nursing Process: Evaluation MSC: NCLEX: Psychosocial Integrity

13. A student nurse tells the instructor, I dont need to interact with my patients. I learn what I need to know by observation. The instructor can best interpret the nursing implications of Sullivans theory to the student by responding:
a. Nurses cannot be isolated. We must interact to provide patients with opportunities to practice interpersonalskills.
b. Observing patient interactions can help you formulate priority nursing diagnoses and appropriateinterventions.
c. I wonder how accurate your assessment of the patients needs can be if you do not interact with the patient.
d. Noting patient behavioral changes is important because these signify changes in personality. ANS: A

Sullivanbelieved that the nurses role includes educating patients and assisting them in developing effective interpersonal relationships. Mutuality, respect for the patient, unconditional acceptance, and empathy are cornerstones of Sullivans theory. The nurse who does not interact with the patient cannot demonstrate these cornerstones. Observations provide only objective data. Priority nursing diagnoses usually cannot be accurately established without subjective data from the patient. The third response pertains to Maslows theory. The fourth response pertains to behavioral theory.

DIF: Cognitive Level: Application (Applying) REF: 21
child who is nearly mute. Which technique would a nurse include in the treatment plan? a. Ignore the child for using silence. b. Have the child observe others talking.
c. Give the child a small treat for speaking.
d. Teach the child relaxation techniques, then coax speech.

ANS: C
Operant conditioning involves giving positive reinforcement for a desired behavior. Treats are rewards to reinforce speech. Ignoring the child will not change the behavior. Having the child observe others describes modeling. Teaching relaxation techniques and then coaxing speech is an example of systematic desensitization.

DIF: Cognitive Level: Application (Applying) REF: 25
TOP: NursingProcess: Planning MSC: NCLEX: Psychosocial Integrity

17. The parent of a child diagnosed with schizophrenia tearfully asks a nurse, What could I have done differently to prevent this illness?
Select the nurses most caring response.
a. Although schizophrenia is caused by impaired family relationships, try
not to feel guilty. No one can predicthow a child will respond to parental guidance.
b. Most of the damage is done, but there is still hope. Changing your parenting style can help your child learnto cope more effectively with the environment.
c. Schizophrenia is a biological illness with similarities to diabetes and heart disease. You are not to blame foryour childs illness.
d. Most mental illnesses result from genetic inheritance. Your genes are more at
fault than your parenting.

ANS: C
Patients and families need reassurance that the major mental disorders are biological in origin and are not the fault of parents. Knowing the biological nature of the disorder relieves feelings of guilt over being responsible for the illness. The incorrect responses are neither wholly accurate nor reassuring; they fall short of being reassuring and place the burden of having faulty genes on the shoulders of the parents.

DIF: Cognitive Level: Application (Applying) REF: 30
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

18. A nurse uses Peplaus interpersonal therapy while working with an anxious, withdrawn patient. Interventions should focus on:
a. changing the patients perceptions about self.
b. improving the patients interactional skills.
c. using medications to relieve anxiety.
d. reinforcing specific behaviors.
ANS: B
The nurse-patient relationship is structured to provide a model for adaptive interpersonal relationships that can be generalized to others. Changing the patients perceptions about his- or herself would be appropriate for cognitive therapy. Reinforcing specific behaviors would be used in behavioral
b. Transactional analysis
c. Cognitive therapy
d. Psychoanalysis

ANS: D
The therapy described is traditional psychoanalysis. Short-term dynamic psychotherapy would last less than 1 year. Neither transactional analysis nor cognitive therapy makes use of the techniques described.

DIF: Cognitive Level: Comprehension (Understanding) REF: 20
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity 20. An advanced practice nurse determines a group of patients would benefit from therapy in which peers and interdisciplinary staff all have a voice in determining the level of the patients privileges. The nurse would arrange for:

a. milieu therapy
b. cognitive therapy
c. short-term dynamic therapy
d. systematic desensitization

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

DIF: Cognitive Level: Comprehension (Understanding) REF: 36
TOP: Nursing Process: Planning MSC: NCLEX: Psychosocial Integrity 21. A nurse psychotherapist works with an anxious, dependent
ANS: D

b. focusing on unconscious mental processes.
c. negatively reinforcing an undesirable behavior.
d. helping the patient identify and change faulty thinking.

ANS: D
Cognitive therapy emphasizes the importance of changing erroneous ways people think about themselves. Once faulty thinking changes, the individuals behavior changes. Focusing on unconscious mental processes is a psychoanalytic approach. Negatively reinforcing undesirable behaviors is behavior modification, and discussing ego states relates to transactional analysis.

DIF: Cognitive Level: Comprehension (Understanding) REF: 26
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

25. A person received an invitation to be in the
wedding of a friend who lives across the country. The individual is afraid of flying. What type of therapy should the nurse recommend? a. Psychoanalysis b. Milieu therapy

c. Systematic desensitization
d. Short-term dynamic therapy

nurse. Advanced practice registered nurses provide family therapy and psychotherapy.

DIF: Cognitive Level: Application (Applying) REF: 34
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and
Maintenance

2. A patient states, Im starting cognitive behavioral therapy. What can I expect from the sessions? Which responses by the nurse are appropriate? Select all that apply.

a. The therapist will be active and questioning.
b. You may be given homework assignments.

c. The therapist will ask you to describe your dreams.
d. The therapist will help you look at ideas and beliefs you have about yourself.
e. The goal is to increase your subjectivity about thoughts that govern your behavior.

ANS: A, B, D
Cognitive therapists are active rather than passive during therapy sessions because they help patients to reality test their thinking. Homework assignments are given and completed outside the therapy sessions. Homework is usually discussed at the next therapy session. The goals of cognitive therapy are to assist the patient to identify inaccurate cognitions, to reality test their thinking, and to formulate new, accurate cognitions. Dream describing applies to psychoanalysis, not cognitive behavioral therapy. The desired outcome of cognitive therapy is to assist patients in increasing their objectivity, not subjectivity, about the cognitions that influence behavior.

DIF: Cognitive Level: Application (Applying) REF: 26
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

Chapter 04: Biological Basis for Understanding Psychopharmacology

MULTIPLE CHOICE

1. A patient asks a nurse, What are neurotransmitters? My doctor says mine are out of balance. The best reply would be:
a. You must feel relieved to know that your problem has a physical basis.
b. Neurotransmitters are chemicals that pass messages between brain cells.
c. It is a high-level concept to explain. You should ask the doctor to tell you more.
d. Neurotransmitters are substances we eat daily that influence memory and mood.

ANS: B
Stating that neurotransmitters are chemicals that pass messages between brain cells gives the most accurate information. Neurotransmitters are messengers in the central nervous system. They are released from the axon terminal, diffuse across the synapse, and attach to specialized receptors on the postsynaptic neuron. The incorrect responses do not answer the patients question, are demeaning, and provide untrue and misleading information.

DIF: Cognitive Level: Comprehension (Understanding) REF: 39
TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

2. The parent of an adolescent diagnosed with schizophrenia asks a nurse, My childs doctor ordered a positronemission tomography (PET) scan. What is that? Select the nurses best reply.
a. PET uses a magnetic field and gamma waves to identify problems areas in the brain. Does your teenagerhave any metal implants?
b. Its a special type of x-ray image that shows structures of the brain and whether a brain injury has everoccurred.
c. PET is a scan that passes an electrical current through the brain and shows brain wave activity. PET can helpdiagnose seizures.