ATI Mental Health Proctored Exam 2019

1.A client is fearful of driving and enters a **behavioral therapy program** to help him overcome his **anxiety**. Using systematic desensitization, he is able to drive down a familiar street without **experiencing a panic attack**. The nurse should recognize that to continue positive results, the client should participate in which of the following?

a. Biofeedback
b. Therapist modeling
c. Frequent pacing
d. Positive reinforcement

2. A nurse is counseling a client following the death of the client's partner **8 months ago.** Which of the following client statements indicates **maladaptive grieving**?

a. "I am so sorry for the times I was angry with my partner."
b. "I like looking at his personal items in the closet."
c. "I find myself thinking about my partner often."
d. "I still don't feel up to returning to work."

Rationale: 8 months too long Maladaptive Grief: . Distorted or exaggerated grief response - unable to perform activities of daily living.

RISK FACTORS FOR MALADAPTIVE GRIEVING

●● *Being dependent upon the deceased*
●● *Unexpected death at a young age, through violence, or by a socially unacceptable manner*
●● *Inadequate coping skills or lack of social support*
●● *Pre-existing mental health issues, such as depression or substance use disorder*

3./21 A nurse in an inpatient mental health facility is assessing a client who has **schizophrenia** and is taking **haloperidol** (anti-psychotic, 1st gen). Which of the following clinical findings is the nurse's priority?

a. Headache
b. Insomnia *(sedation)*
c. Urinary hesitancy *(Complication → ANTIcholinergic effects)*
d**. High fever** *(Complication → agranulocytosis)*

Other complications: Acute dystonia, Pseudoparkinsonism, Akathisia, Tardive dyskinesia, Neuroendocrine effects (Gynecomastia, Weight gain, Menstrual irregularities), NMS, Orthostatic Hypotension, Sedation, Sexual dysfunction, Skin effects, Liver impairment

4. A nurse is planning care for a client who has **obsessive compulsive disorder**. Which of the following recommendations should the nurse include in the client's plan of care?

a. Reality Orientation therapy *(re-orient to reality)*
b. Operant Conditioning *(receives positive rewards for positive behavior)*
c. Thought Stopping *(say "stop" when compulsive behaviors arise & substitute w/ positive thought)*
d. Validation Therapy *(acknowledging pt's feelings)*

4. A nurse is providing teaching to the daughter of an older client who has **obsessive-compulsive disorder.** Which of the following statements by the daughter indicates an understanding of the teaching?

a. "I will provide my mother with detailed instructions about how to perform self-care." *(Give simple directions)*
b. "I will limit my mother's clothing choices when she is getting dressed." *(If client is indecisive, limit the client's choices; if client still unable to make a decision, give client one outfit to wear)*
c. "I will wake my mother up a couple of times in the night to check on her."
d. "I will discourage my mother from talking about her physical complaints."

5. A nurse is caring for a client who is in the **manic phase of bipolar disorder**. Which of the following actions should the nurse take?

a. Provide in depth explanation of nursing expectations *(inability to focus - give concise explanations)*
b. Encourage the client to participate in group activities *(decrease stimulation)*
c. Avoid power struggles by remaining neutral *(do not react personally to pt's comments)*
d. Allow the client to set limits for his behavior *(nurse sets limits)*

6. A nurse is providing behavioral therapy for a client who has OCD. The client repeatedly checks that the doors are locked at night. Which of the following instructions should the nurse give the client when using **thought stopping technique**?

a. "Keep a journal of how often you check the locks each night."
b. "Ask a family member to check the locks for you at night."
c. "Focus on abdominal breathing whenever you go to check the locks."

d. “Snap a rubber band on your wrist when you think about checking the locks.”

Thought stopping: *teach pt to say “stop” when negative thoughts/compulsive behaviors arise & substitute positive thought - goal for pt use command silently over time*

7. A nurse is caring for a client who has a **cocaine use disorder**. Which of the following manifestations should the nurse expect the client to have during **withdrawal**?

a. Hand tremors *(Intoxication)*
b. Fatigue
c. Seizures *(Intoxication)*
d. Rapid speech

Rationale: Pg: 97 WITHDRAWAL MANIFESTATIONS● Depression, ***fatigue****, craving, excess sleeping or insomnia, dramatic unpleasant dreams, psychomotor retardation, agitation● Not life-threatening, but possible occurrence of suicidal ideation*
Cocaine = STIMULANT → OPPOSITE of HEROIN
● Withdrawal = opposite effects

8. A nurse is reviewing the medical record of a client who is taking **clozapine.** For which of the following findings should the nurse withhold the medication and notify the provider?

a. WBC count
b. Heart rate
c. Report of photosensitivity
d. Blood glucose level

9./59. A nurse is creating a plan of care for a client who has **major depressive disorder**. Which of the following **interventions** should the nurse include in the plan?

a. Keep the ring light on in the client’s room at night
b. Encourage physical activity for the client during the day
c. Identity and schedule alternative group activities for the client
d. Discourage the client from expressing feeling of anger

10. A nurse is assessing a client who is experiencing **acute alcohol withdrawal**. Which of the following findings should the nurse expect?

a. Diminished reflexes
b. Hypotension - increased BP
c. Insomnia
d. Bradycardia

11. A nurse is caring for a client who has **schizophrenia and displays severe symptoms** of the disorder. Which of the following actions should the nurse take?

a. Use medication to decrease frequency of auditory and visual hallucinations
b. Assist the client to identify somatic and thought broadcast delusion
(Identify symptom triggers, such as loud noises (can trigger auditory hallucinations in certain clients) and situations that seem to trigger conversations about the client's delusions.
c. Manage the client's loud, rambling, and incoherent communication patterns
d. Direct the client to perform her own daily hygiene and grooming tasks
Somatic delusions - believes that his body is changing in an unusual way, such as growing a third arm.
Thought broadcasting - believes that her thoughts are heard by others.
Schizophrenia: The client has psychotic thinking or behavior present for at least 6 months. Areas of functioning, including school or work, self-care, and interpersonal relationships, are significantly impaired.

12. A nurse is caring for a client who was **involuntarily committed** and is scheduled to receive **electroconvulsive therapy**. The client refuses the treatment and will discuss why with the healthcare team. Which of the following actions should the nurse take?

a**. Document the client's refusal of the treatment in the medication record**
b. Tell the client he cannot refuse the treatment because he was involuntarily committed
c. Inform the client the ECT does not require client consent
d. Ask the client family to encourage the client to receive ECT
Clients admitted under involuntary commitment are still considered competent and have the right to refuse TX,.

13. A nurse is providing crisis intervention for a client who was involved in a violent mass casualty situation in the community. Which of the following actions should the nurse take during the initial session with the client?

a. Identify the client's usual coping style.
b. Encourage the client to display anger toward the cause of the crisis. (Reduce stress-related manifestations, such as using techniques to alleviate a panic attack)
c. Tell the client that this life will soon return to normal *(False assurance)*
d. Help the client focus on a wide variety of topics regarding the crisis. *(Reduce stress)*

14. A nurse in the emergency department is caring for a client who reports feeling sad, worthless, and hopeless 9 months after the death of her son. Which of the following actions should the nurse take first?

a. Encourage the client to attend a grief support group
b. Discuss the client's coping skills
c. Request a mental health consult for the client
d. Ask the client if she has thought about harming herself given - *she's showing signs of depression and no reason to live so we asked if she's going to commit suicide. Feelings of powerlessness and isolation and death of a loved one are risk factors.*

15. A nurse is planning care for an adolescent who has **autism spectrum disorder**. Which of the following outcomes should the nurse include in the plan of care?

a. Acknowledges that his delusions are not real
b. Changes behavior as a result of peer pressure
c. Initiate social interactions with caregiver *pl with autism have a problem with communicating and interacting with others. They also have an inability to make eye contact .*
d. Meets own needs without manipulating others.

16. A nurse is caring for a client who is experiencing **active auditory hallucination**. Which of the following should the nurse take?