ATI MENTAL HEALTH
Those 100 questions

A nurse overhears a hospitalized client with mania telling another client, "I'm actually a journalist writing an article for a magazine — I'm just posing as a person with mental illness." How should the nurse respond?
Presenting the client with the actual situation

Rationale: When dealing with a delusional client, it is important for the nurse to state clearly that the nurse does not share the client's perceptions. All three of the other options — ignoring the delusion, taking the client to a quiet room, and supporting the client's denial of illness — do not focus on reality, and they ignore the issue. Presenting the client with the actual situation helps orient the client to reality.
A client who is hallucinating fearfully says to the nurse, "Please tell that demon to get out." How should the nurse respond to the client?
"I know you must be very upset by this, but I don't see a demon."

Rationale: If the client hallucinates, it is best to provide reality-based perceptions and not negate the client's experience, because this may lead to a regressive struggle with the client. Giving advice or false reassurance is incorrect because such techniques indicate that demons actually are present, which feeds into the client's hallucination and reinforces the client's behavior.
The mother of a 3-year-old says, "My child hit his teddy bear after being scolded for picking the neighbors' flowers." Which defense mechanism was the child using?
Displacement

Rationale: The defense mechanism of displacement involves the discharge of intense feelings for one person onto a less threatening substitute person or object to satisfy an impulse. Projection involves attributing an attitude, behavior, or impulse to someone else, such as that which occurs in blaming or scapegoating. Sublimation is rechanneling an impulse into a more socially acceptable object. Identification involves modeling behavior after someone else's.
A client says to the nurse, "Even though my husband and I keep telling them we don't want to have children, our parents are pressuring us to 'start a family.' What should we say to them?" Which of the following responses by the nurse is therapeutic?
"This must be very difficult for both of you."

Rationale: Childless families may elect not to have children or to postpone having them until they have established themselves occupationally or financially. Telling the client to tell the parents that the couple can't have children is incorrect because the client is being encouraged to lie about life decisions rather than helping the parents understand the couple's choices. Asking how they usually cope with such interference is incorrect because it indicates that the nurse is judgmental and has decided that the parents are interfering with the client and spouse. Saying, "Tell them to have more children if they want them so badly," is incorrect because it is sarcastic and ridicules the situation over which the client has expressed concerns.

A young adult client says, "I just can't seem to stop snapping at my parents. I know they work hard to support me, but what do I do when they're so overbearing?" Which responses by the nurse is therapeutic?
"Have you talked to your parents about your frustrations?"

Rationale: The correct response is focused on the client's concerns and encourages the therapeutic technique of formulating a plan of action. "It's important not to be rude to your parents" and "You need to be more patient with your parents" are both nontherapeutic, judgmental responses that do not encourage the client to further explore her feelings and problem-solve. "Snapping at your parents is childish. How could you?" is incorrect because it is sarcastic and condescending, which is nontherapeutic.
A client says, "I have so much trouble caring for my husband's child from his first marriage. I resent the money we have to pay for child support because we have to deprive my own child of things. How can I stop feeling this way?" Which response by the nurse is therapeutic?
"Have you shared your feelings with your husband?"

Rationale: Remarried individuals often encounter problems as a result of the stressors they bring into a marriage without prior discussion with the new partner. Bonding sometimes does always occur when a child is not one's biological offspring. The correct answer is focused on the client's feelings. "Your child benefits from having a sibling" is not facilitative. "I wonder why you married him, knowing that he wouldn't desert his biological child" is incorrect because it prejudges the client. "You need to take a second job to give your child what you think she deserves" is not open ended, does not facilitate feelings, and gives advice.

A client says to the nurse, "My wife retired last year from a lucrative law practice, and I'm really discouraged. I'll be working until I die, even though I helped pay for her education." Which response by the nurse is supportive?
"You sound very troubled by this."

Rationale: Saying that the situation is unfair is judgmental and does not encourage the client to express his feelings; nor does "That's such a tough break for you." Suggesting that the husband approach the spouse for help is incorrect because it prematurely gives advice, a nontherapeutic communication technique. The correct option is focused on the client's feelings.
A gay man is brought to the emergency department by the police. The client tells the nurse, "I was beaten up. I guess I just have to expect this kind of treatment for the rest of my life." Which statement by the nurse is therapeutic?
"You feel that being beaten up goes along with being gay?"

Rationale: Many lesbians and gays encounter harassment or violence in the course of their lives. "I think you should take some self-defense classes" is incorrect because it advises the client, and giving advice is not therapeutic. "Maybe you should be more

discreet when you're in public" also gives advice and presumes that the client has been indiscreet. "Why not try counseling to change your sexual orientation?" is incorrect because it assumes that sexual orientation can or should be changed. The correct option indicates reflection and is focused on the client's feelings.

A client whose spouse recently died is experiencing dysfunctional grieving. Which intervention has priority in the plan of care?

Assessing the client's risk for violence toward self and others

Rationale: The priority intervention for a client with dysfunctional grieving is assessment of the client's risk for violence toward self and others. Although the nurse will assist the client in resolving the grief and monitor the client's sleep pattern, these are not the priority interventions of the options given. Obtaining a prescription for an antidepressant is not a priority.

A nurse develops a plan of care for a client in whom AIDS was recently diagnosed. The client is experiencing difficulty adjusting to the illness. Which interventions are appropriate for this client? Select all that apply.

Assisting the client in verbalizing fears
Helping the client identify sources of hope
Monitoring the client for signs of self-harm
Assisting the client with problem-solving and decision-making

Rationale: Assisting the client with problem-solving and decision-making, helping the client verbalize fears, helping the client identify sources of hope, and monitoring the client for signs of self-harm are all appropriate interventions. In planning care for a client having difficulty adjusting to an illness, the nurse develops interventions to promote social networking that will provide needed support and information to the client.

An emergency department nurse is caring for an older client who is a victim of physical abuse. List in order of priority the following nursing actions, with number 1 representing the first action and number 4 the last.

1. Checking the client for physical injuries
2. Contacting the appropriate state officials to report the abuse
3. Contacting a social worker to assist in planning care for the client
4. Calling a member of the clergy to address the client's spiritual needs

Rationale: The priority intervention in the event of physical abuse is to check the client for physical injuries. The nurse should then fulfill the legal obligation of reporting suspected elder abuse. The next action is to contact the social worker to obtain assistance in planning care for the client. The client may need the social worker's help with housing as well. Last, a referral to a member of the clergy is an appropriate intervention if the client desires it.

The parents of an 18-month-old arrive at the emergency department with their unconscious child. Physical examination reveals bruises on the child's upper arms that resemble grip marks. Which nursing intervention is the priority?

Stabilizing the child's physical condition

Rationale: In all child abuse cases, the primary concern is the physical condition of the

child. Although contacting appropriate state officials to report suspected abuse and securing a safe environment for the child are both interventions that need to be performed, this child is unconscious, so the priority is to stabilize the child's physical condition. Confronting the parents about the abuse at this time may cause resentment and conflict in the parents, and the parents might attempt to leave the emergency department with their child.

A nurse in a women's clinic develops a plan of care for abused women. Which tertiary prevention intervention should be included in the plan of care?

Assisting abused women in overcoming the physical and psychological effects of abuse

Rationale: Primary prevention intervention (here, identifying families at risk for abuse and changing societal views toward domestic abuse) is focused on risk identification and health promotion and prevention of disorders. Secondary prevention interventions (early case-finding and decisive intervention) are focused on early identification and treatment of a problem. Tertiary prevention intervention (helping abused women overcome the physical and psychological effects of abuse) is focused on reducing the residual effects of a disorder and rehabilitation.

A nurse assists in caring for victims of an explosion at a local industrial plant. The nurse plans to implement crisis interventions, knowing that this incident is characteristic of:

An adventitious crisis

Rationale: Adventitious crises are unpredictable tragedies that occur without warning. An individual may experience crisis, but there is no formal type of crisis known as "individual crisis." A situational crisis occurs when a specific external event disturbs an individual's psychological equilibrium. A maturational crisis involves the normal life transitions that produce changes in individuals and how they perceive themselves, their roles, and their status.

A nurse prepares equipment in the electroconvulsive therapy (ECT) suite for a client who will be arriving shortly for therapy. Which items are essential? Select all that apply.

Pulse oximeter
Suction device
Ventilation equipment

Rationale: In the ECT suite, blood pressure, cardiac, and electroencephalographic monitors are placed on the client to assess vital functions. Whenever ECT is administered, emergency equipment, including oxygen, suction, and ventilation equipment, must also be available. Bath blankets and a thermometer are not essential equipment.

A client with depression says, "I always make mistakes. I never do anything right." Which response by the nurse is therapeutic?

Identifying recent accomplishments that demonstrate the client's abilities

Rationale: Feelings of low self-esteem and worthlessness are common symptoms of the depressed client. Reminders of the client's recent accomplishments or personal successes are ways to interrupt the client's negative self-talk and distorted cognitive view of self. The incorrect options give advice and devalue the client's feelings.

A hospitalized client with a diagnosis of delirium often becomes disoriented and confused during the night. Which intervention does the nurse implement?
Ensuring a low-stimulation environment at night

Rationale: It is important to provide a consistent daily routine and a low-stimulation environment when a client is confused. Noise, including that from radios and televisions, may add to the client's confusion and disorientation. Lighting is an environmental stimulus that helps maintain and improve orientation.
A psychiatric nurse assists victims of a nightclub fire and their families. Which actions on the part of the nurse is the most important intervention in the immediate post disaster period?
Talking to people seeking assistance from the American Red Cross

Rationale: In the immediate post disaster period, it is important that the nurse is present in places, such as morgues, hospitals, and shelters, where victims are likely to gather. Rather than wait for people to identify themselves publicly as being unable to cope with stress, it is suggested that nurses work with the American Red Cross, talk to people waiting in line to apply for assistance, go door to door, or visit a relocation site. The nurse should ask individuals how they are managing their affairs and explore their reactions to the stress.

A psychiatric nurse who is a member of a mobile crisis team is called to deal with a person who is threatening to jump off a bridge in a suicide attempt. On arrival at the site, the nurse immediately:
Tries to communicate with the client and develop a therapeutic relationship

Rationale: When someone is in the act of preparing to commit suicide, the most appropriate action on the part of the nurse is to communicate with the client in an attempt to develop a therapeutic relationship. The nurse should communicate hope, and hope is often the most therapeutic element in any nursing intervention with a suicidal client. Telling the client he is making a mistake is inappropriate. The other incorrect options are also inappropriate and could prompt the client to follow through with the suicide attempt.
A client tells the nurse, "I did my hair just like my favorite math teacher wears hers. I hope I can be a good teacher, too." Which defense mechanism is the client using?
Identification

Rationale: Identification is the process in which a person tries to become like someone he or she admires by taking on the thoughts, mannerisms, or tastes of that person. Projection is attributing one's thoughts or impulses to another person. Regression is retreating to behavior characteristic of an earlier level of development. Intellectualization is the use of excessive reasoning or logic in an attempt to avoid disturbed feelings.
A nurse assesses a new client hospitalized on the mental health unit. The client is experiencing negative thinking and says, "I'm doomed to failure." The nurse recognizes that the client's announcement indicates problems with:

Self-esteem

Rationale: Direct expressions of low self-esteem may include self-criticism. The client exhibits negative thinking and believes that he or she is doomed to failure. The underlying goal of the client is to demoralize himself. The client may describe himself as "stupid," "no good," or a "born loser." The client will view the normal stressors of life as impossible barriers and become preoccupied with self-pity. A body image problem involves the expression of dislike of one's physical appearance. A problem with personal identity involves the expression of dislike of one's characteristics. A problem with role performance involves one's inability to fulfill expected responsibilities.
A psychiatric nurse is sitting with several clients in the day room. A client who has been experiencing delusions and hallucinations says to the nurse, "That television is sending special messages to me." Which of the following responses by the nurse is therapeutic?
"The television is on for everyone."

Rationale: The therapeutic response is the one that provides reality for the client. In the incorrect options, the nurse feeds into the client's delusions or hallucinations and denies the client the opportunity to see reality.
A client with depression says, "My children hate me." Which response by the nurse is therapeutic?
"It sounds like you're having a difficult time with your children."

Rationale: The nurse should use therapeutic communication techniques when responding to a client's comment. In saying, "Your children don't hate you," the nurse is disagreeing with the client's comment. In the other incorrect options, the nurse criticizes the client's children. The correct option is an example of the therapeutic response of reflection.
A client with depression says to the nurse, "My child is dead, and I don't want to live anymore." Which comment by the nurse is therapeutic?
"Tell me more about how you're feeling."

Rationale: In the correct option, the nurse encourages the client to continue expressing her feelings. The incorrect options are nontherapeutic responses in which the nurse does not encourage the client's self-expression.
A client on the mental health unit says to the evening nurse, "The staff on the day shift let me smoke two cigarettes. You only let me smoke one." Which response by the nurse is therapeutic?
"The policy is one cigarette. We'll follow the policy."

Rationale: The correct option is therapeutic because it provides the client with a clear and direct response regarding the policy on the unit. In the incorrect options, the nurse criticizes the day shift staff.
A nurse seeks to deescalate aggressive behavior by a client with schizophrenia. Which actions by the nurse are appropriate in this situation? Select all that apply.
Being assertive with the client
Maintaining a nonaggressive posture

Notifying other staff of the client's behavior

Rationale: To deescalate aggressive behavior, the nurse should maintain a calm demeanor and nonaggressive posture. The nurse should give the client clear instructions that are brief and assertive, but threatening the client with restraint is inappropriate. The nurse should maintain personal space and not stand closer than about 8 feet (2.4 meters) from the client. Standing close to the client will convey a threatening message. For the sake of safety, it is important to notify other staff members of the client's behavior.

A nurse prepares a client for electroconvulsive therapy (ECT). Which concern is of the highest priority?

Risk for aspiration

Rationale: The risk for aspiration is reduced by keeping the client on nothing-by-mouth status for 6 to 8 hours before the procedure, removing dentures, and administering medications as prescribed to diminish oral secretions. Although fear and anxiety may also be concerns, they are of lower priority. Confusion is likely to be a concern after the treatment.

A nurse discovers a hospitalized client with depression wrapping long shreds of torn sheets around his neck. What is the priority nursing concern for this client?

Self-inflicted injury

Rationale: Because the client is depressed and has been found with long shreds of torn sheets hanging around his neck, the nurse must conclude that a risk for self-inflicted injury exists. Safety is always a priority concern. Self-esteem, loss of hope, and coping abilities may also be concerns in this case but are not the priority.

A nurse analyzes assessment findings in a client with physical injuries that are suspected by the staff of having been inflicted during family-related violence. Which factor should the nurse first consider?

The client's vital signs

Rationale: When data obtained from a client who may have been involved in family violence are being analyzed, the physiological well-being of the client is the first concern. The correct option is the only one that directly addresses physiological assessment.

A nurse is caring for a victim of sexual assault. The client's physical assessment is complete. The client's psychological reaction to the assault includes fear, confusion, disorganization, and restlessness. How should the nurse interpret these behaviors?

Normal reactions to a traumatic event

Rationale: During the acute phase following the sexual assault, the client may display any of a wide range of emotional and somatic responses. All of the symptoms noted in the question are part of a normal reaction to an intensely difficult crisis. Although the client's initial reactions may be predictive of later problems, they do not constitute an abnormal initial response. Therefore the remaining options are incorrect.

The wife of an alcoholic client began attending Al-Anon groups three weeks ago. The nurse determines that the wife is benefiting from the group when she states:
"Now I realize that I didn't deserve the beatings my husband inflicted on me."

Rationale: Al-Anon support groups specifically help families of alcoholics cope with the problems that arise from living with an alcoholic. The wife's recognition that the beatings were not deserved is the healthiest response, identifying an understanding that the client (husband) is responsible for his behavior and cannot be allowed to blame family members for loss of control. The nonalcoholic partner should not feel responsible when the spouse loses control. Codependency is not a healthy response. The group is a place to work on issues rather than an escape.
A client says, "I've had so many crying spells over the past several weeks. My doctor says it's probably depression." The nurse sees that the client is sitting slumped in the chair and that the client's clothing is baggy. Further assessment of this client should be focused on:
Weight loss

Rationale: All of the options are problems that should be addressed; however, the weight loss is the priority, because the obvious ill fit of clothing could signify a substantial problem with nutrition. The client has already told the nurse that the crying spells have been a problem. The need for medication was not addressed in the question. Sleep is affected by depression and should be addressed; however, weight loss is the most important item requiring further assessment.
A client says, "I spend hours each evening reviewing my day to see whether I behaved appropriately or should have done something differently. I tell myself to snap out of it, but I'm still doing it! It takes me 2 or 3 hours each morning to get dressed, because I want my clothes to be just right." Which problem is evident in these statements?
Obsessive-compulsive disorder

Rationale: Obsessions are persistent intrusive thoughts that the affected person tries to ignore or suppress. This client wants to "snap out of" this daily review, but the thoughts continue for hours. Compulsions are repetitive behaviors that the client feels driven to perform, such as changing clothes frequently until they are "just right." Agoraphobia, major depression, and attention deficit-hyperactivity disorder are not associated with the characteristics described in the question.
A phlebotomist prepares to draw blood from a client experiencing delusions. While in the laboratory, the client begins shouting, "You're all bloodsuckers. Get me out of here." Which response by the nurse is therapeutic?
"It must be scary to think others want to hurt you."

Rationale: The correct option recognizes the client's feelings and helps the client focus on the emotion underlying the delusion but does not argue with it. One danger in directly attempting to change the client's mind is that the client may cling more strongly to the delusion. The inappropriate responses deny or argue with the client's beliefs, which may jeopardize the nurse-client relationship

A drunken client is awaiting treatment in the emergency department. The client becomes loud and aggressive when told that there will be a short delay before treatment. Which response by the nurse is therapeutic?
Offering to take the client to an examination room until treatment can be started

Rationale: Safety of the client, other clients, and staff is of priority concern. Offering to take the client to an examination room until she is treated separates the client from others and provides a less stimulating environment where the client can maintain her dignity. Waiting until the behavior escalates before intervening is incorrect because it allows the client to become even more agitated and a threat to others. Attempting to talk with the client to deescalate behavior is not likely to be productive, because the client is intoxicated and her reasoning impaired. Informing the client that she will be asked to leave if the behavior continues would only further aggravate an already agitated individual.
As the nurse prepares a client for a coronary artery bypass graft, the client asks, "Will I be OK?" Which response by the nurse is therapeutic?
"Let's talk about how you're feeling."

Rationale: The correct response offers self and encourages the client to share feelings and fears. The incorrect options block communication and may increase the client's anxiety. False reassurance is nontherapeutic. The client needs an opportunity to talk about the impending surgery.
A nurse prepares to care for a client with a diagnosis of Tourette syndrome. The medical record indicates that the client experiences motor tics. Which finding would the nurse expect to note during assessment of this client?
Tongue protrusion

Rationale: Tourette syndrome involves motor and verbal tics that cause marked distress and significant impairment of social and occupational function. Motor tics usually involve the head but may also involve the torso and limbs. The most common first symptom is a single tic, such as eye-blinking. Other motor tics include tongue protrusion, touching, squatting, hopping, skipping, retracing of steps, and twirling when walking. Vocal tics include words and sounds such as barks, grunts, yelps, clicks, snorts, sniffs, and coughs. Coprolalia, the uttering of obscenities, is present in some individuals with this disorder.
A nurse assesses a client with early-onset Alzheimer's disease. The nurse asks the client, "How was your weekend?" The client responds by saying, "It was great. I discussed war campaigns with the president and had dinner at the White House." Which defense mechanism is evident?
Confabulation

Rationale: Confabulation is a defense mechanism and an unconscious attempt to maintain self-esteem by providing information that is not true about an event or situation. Hiding is a form of denial and an unconscious protective defense against the terrifying possibility of losing one's place in the world. Apraxia is characterized by the

loss of purposeful movement in the absence of motor or sensory impairment. Perseveration is the repetition of phrases or behaviors.

A nurse reviews the record of a client and notes that the client experiences flashbacks. Which of the following conditions is most often associated with flashbacks?

Hallucinogenic drug use

Rationale: Flashbacks, a common effect of hallucinogenic drugs, are transitory recurrences in perceptual disturbance caused by a person's earlier hallucinogenic drug experiences. They occur when the person is in a drug-free state. Visual distortions, time expansion, loss of ego boundaries, and intense emotions may occur. The experience of flashbacks is also characteristic of posttraumatic stress disorder. They do not occur in schizophrenia or obsessive-compulsive disorder. Anxiety disorder is a term that encompasses posttraumatic stress disorder as one of its components.

After an attack in a park while jogging, a client experiences posttraumatic stress disorder. The client, visibly anxious, tells the nurse that she now avoids all exercise and parks but says, "I don't want to feel this way." Which response by the nurse is appropriate?

"I can see that you're upset about this. Let's talk some more about it."

Rationale: The therapeutic response encourages the client's expressions of feelings by indicating that the nurse is aware of the client's feelings and promoting continued communication. Each of the incorrect options neither acknowledges the client's concerns nor encourages further communication. Giving advice and false reassurance are not therapeutic techniques.

A client hospitalized in a mental health unit is restrained after becoming extremely violent. Which finding indicates to the nurse that the client can be removed from the restraints?

The client initiates no aggressive acts for 30 minutes after the release of two leg restraints

Rationale: The best indicator that the client's behavior is under control is when the client refrains from aggression after partial release from the restraints. Generally a structured reintegration, begun by reducing a client's four-point restraints to two-point restraints, is initiated. If the client continues to exhibit nonaggressive behavior, the remaining restraints are removed. The incorrect options are not indicators that the client's behavior is under control.

A client with bipolar disorder has been hospitalized for 4 days. Today in group therapy the client offered helpful suggestions in regard to another client's problem. The nurse concludes that the client's behavior is representative of

Improvement

Rationale: The behavior demonstrated by the client is appropriate during hospitalization. There is no evidence in the question that the client is acting out (which is an attention-seeking behavior), being manipulative, or seeking attention.