COMPLETE:KAPLAN AND SADOCK'S SYNOPSIS OF PSYCHIATRY 11TH EDITION SADOCK TEST BANK|ALL CHAPTERS INCLUDED

Chapter 1: Neural Sciences

Test Bank MULTIPLE CHOICE

1. A patient with depression mentions to the nurse, My mother says depression is a chemical disorder. What does she mean? The nurses response is based on the theory that depression primarily involves which of the following neurotransmitters?

1. Cortisol and GABA
2. COMT and glutamate
3. Monamine and glycine
4. Serotonin and norepinephrine

2. A patient has experienced a stroke (cerebral vascular accident) that has resulted in damage to the Broca area. Which evaluation does the nurse conduct to reinforce this diagnosis?

1. Observing the patient pick up a spoon
2. Asking the patient to recite the alphabet
3. Monitoring the patients blood pressure
4. Comparing the patients grip strength in both hands

3. The patient diagnosed with schizophrenia asks why psychotropic medications are always prescribed by the doctor. The nurses answer will be based on information that the therapeutic action of psychotropic drugs is the result of their effect on:

1. The temporal lobe; especially Wernickes area
2. Dendrites and their ability to transmit electrical impulses
3. The regulation of neurotransmitters especially dopamine
4. The peripheral nervous system sensitivity to the psychotropic medications

4. A student nurse mutters that it seems entirely unnecessary to have to struggle with understanding the anatomy and physiology of the neurologic system. The mentor would base a response on the understanding that it is:

1. Necessary but generally for psychiatric nurses who focus primarily on behavioral interventions

1. A complex undertaking that advance practice psychiatric nurses frequently use in their practice

1. Important primarily for the nursing assessment of patients with brain traumacaused cognitive symptoms

1. Necessary for planning psychiatric care for all patients especially those experiencing psychiatric disorders

5. A patient asks the nurse, My wife has breast cancer. Could it be caused by her chronic depression? Which response is supported by research data? 1. Too much stress has been proven to cause all kinds of cancer.

2. There have been no research studies done on stress and disease yet.
3. Stress does cause the release of factors that suppress the immune system.
4. There appears to be little connection between stress and diseases of the body

6. A patient who has a parietal lobe injury is being evaluated for psychiatric rehabilitation needs.
Of the aspects of functioning listed, which will the nurse identify as a focus of nursing intervention?

1. Expression of emotion
2. Detecting auditory stimuli
3. Receiving visual images
4. Processing associations

7. At admission, the nurse learns that some time ago the patient had an infarct in the right cerebral cortex. During assessment, the nurse would expect to find that the patient:

1. Demonstrates major deficiencies in speech
2. Is unable to effectively hold a spoon in the left hand
3. Has difficulty explaining how to go about using the telephone

8. A patient with chronic schizophrenia had a stroke involving the hippocampus. The patient will be discharged on low doses of haloperidol. The nurse will need to individualize the patients medication teaching by:

1. Including the patients caregiver in the education
2. Being careful to stress the importance of taking the medication as prescribed 3. Providing the education at a time when the patient is emotionally calm and relaxed

1. Encouraging the patient to crush or dissolve the medication to help with swallowing

9. The physician tells the nurse, The medication Im prescribing for the patient enhances the gaminobutyric acid (GABA) system. Which patient behavior will provide evidence that the medication therapy is successful?

1. The patient is actively involved in playing cards with other patients.
2. The patient reports that, I dont feel as anxious as I did a couple of days ago.
3. The patient reports that both auditory and visual hallucinations have decreased.
4. The patient says that, I am much happier than before I came to the hospital.

10. The patients family asks whether a diagnosis of Parkinsons disease creates an increased risk for any mental health issues. What question would the nurse ask to assess for such a comorbid condition?

1. Has your father exhibited any signs of depression?
2. Does your father seem to experience mood swings?
3. Have you noticed your father talking about seeing things you cant see?
4. Is your dad preoccupied with behaviors that he needs to repeat over and over?

11. Which explanation for the prescription of donepezil (Aricept) would the nurse provide for a patient in the early stage of Alzheimers disease?

1. It will increase the metabolism of excess GABA.
2. Excess dopamine will be prevented from attaching to receptor sites.
3. Serotonin deficiency will be managed through a prolonged reuptake period.
4. The acetylcholine deficiency will be managed by inhibiting cholinesterase.

12. There remains a stigma attached to psychiatric illnesses. The psychiatric nurse makes the greatest impact on this sociological problem when:

1. Providing educational programming for patients and the public
2. Arranging for adequate and appropriate social support for the patient
3. Assisting the patient to achieve the maximum level of independent functioning 4. Regularly praising the patient for seeking and complying with appropriate treatment

13. The wife of a patient with paranoid schizophrenia tells the nurse, Ive learned that my husband has several close relatives with the same disorder. Does this problem run in families? The response based on recent discoveries in the field of genetics would be:

1. Your children should be monitored closely for the disorder.
2. Research tends to support a familiar tendency to schizophrenia.
3. There is no concrete evidence; it is just as likely a coincidence.
4. Only bipolar disorder has been identified to have a genetic component.

14. A patient whose symptoms of mild depression have been managed with antidepressants is concerned about the affect of accepting a promotion that will require working the night shift. What will be the basis of the response the nurse gives to address the patients concern?

1. The connection between a new job and possible depression does exist.
2. The medication can be adjusted to manage any increase in depression.
3. The interruption in normal wake-sleep patterns can influence mood disorders. 4. The change in sleep routine can be managed with a healthy sleep hygiene routine.

15. The nurse is discouraged because the patient exhibiting negative symptoms of schizophrenia has shown no improvement with the planned interventions to reduce the symptoms. The mentors remark that helps place the problem in perspective is:
1. You arent responsible for the behavior of any other person.
2. Patients can be perverse and cling to symptoms despite our efforts.
3. Negative symptoms have been associated with genetic pathology.
4. It will take several trail and error attempts to get the right combination care.

MULTIPLE RESPONSE

1. What assessment data would reinforce the diagnosis of temporal lobe injury in patient who experienced head trauma? Select all that apply.
1. Inability to balance a checkbook
2. Uncharacteristically aggressive
3. Affect fluctuates dramatically
4. Increased interest in sexual behaviors
5. Difficulty remembering the names of family members

2. A patient has begun experiencing dysfunction of the hypothalamus. What nursing interventions will the nurse include in the patients plan of care? Select all that apply.
1. Reinforcing clear physical boundaries
2. Assisting the patient with completing daily menus
3. Learning about healthy sleep hygiene habits
4. Monitoring and recording temperature every 4 hours
5. Monitoring and recording blood pressure every 4 hours

3. The nurse is preparing a patient for a positron emission tomography (PET) scan. Which instructions will the nurse include? Select all that apply.

1. There will likely be a 30 to 45 minute wait between the injection and the beginning of the scan.

1. A blindfold and earplugs may be used to help decrease reaction to the environment during the scan.

1. Make every attempt to lie still during the scan because movement will affect the imaging produced.

1. No food or fluids are to be ingested for at least 8 full hours before the scan and none during the scan.

1. Staying awake during the scan is important since the results are altered when the patient is in any phase of the sleep state.

4. A patient with schizophrenia is described as having difficulty with executive functions. What patient dysfunction can the nurse expect to assess behaviorally? Select all that apply.

1. Invades the personal space of others frequently
2. Consistently fails to bring money when going to buy snacks
3. Cannot remember the names of staff who often provide care
4. Requires repeated reinforcement on how to make a sandwich
5. Frequently speaks of hurting himself or of hurting other patients

5. The unit physicians have ordered magnetic resonance imaging (MRI) tests for the following patients. For which patients would the nurse decline to make test arrangements without further discussion with the physician? Select all that apply.

1. A patient who is claustrophobic
2. A patient who is breastfeeding
3. A patient who has an allergy to iodine
4. A patient who had a total knee replacement
5. A patient who is taking a neuroleptic medication

Chapter 2: Contributions of the Psychosocial Sciences

MULTIPLE CHOICE

1. Which understanding is the basis for the nursing actions focused on minimizing mental health promotion of families with chronically mentally ill members?

1. Family members are at an increased risk for mental illness.
2. The mental health care system is not prepared to deal with family crises.
3. Family members are seldom prepared to cope with a chronically ill individual.
4. The chronically mentally ill receive care best when delivered in a formal setting.

2. Which nursing activity shows the nurse actively engaged in the primary prevention of mental
disorders?

1. Providing a patient, whose depression is well managed, with medication on time 2. Making regular follow-up visits to a new mother at risk for post-partum depression

1. Providing the family of a patient, diagnosed with depression, information on suicide prevention

1. Assisting a patient who has obsessive compulsive tendencies prepare and practice for a job interview

3. Which intervention reflects attention being focused on the patients intentions regarding his diagnosis of severe depression? 1. Being placed on suicide precautions

2. Encouraging visits by his family members

3. Receiving a combination of medications to address his emotional needs
4. Being asked to decide where he will attend his prescribed therapy sessions

4. When a patients family asks why their chronically mentally ill adult child is being discharged to a community-based living facility, the nurse responds:
1. It is a way to meet the need for social support.
2. It is too expensive to keep stabilized patients in acute care settings.
3. This type of facility will provide the specialized care that is needed.
4. Being out in the community will help provide hope and purpose for living.

5. What is the best explanation to offer when the mother of a chronically ill teenage patient asks,
Under what circumstances would he be considered incompetent?
1. When you can provide the court with enough evidence to show that he is not able to care for himself safely.
1. It is not likely that someone his age would be determined to be incompetent regardless of his mental condition.
1. He would have to engage in behavior that would result in harm to himself or to someone else; like you or his siblings.
1. If the illness becomes so severe that his judgment is impaired to the point where the decisions he makes are harmful to himself or to others.

6. Which psychiatric nursing intervention shows an understanding of integrated care?
A chronically abused woman is assessed for anxiety.
A manic patient is taken to the gym to use the exercise equipment.
The older adult diagnosed with depression is monitored for suicidal ideations.
A teenager who refuses to obey the units rules is not allow to play video games.

7. What reason does the nurse give the patient for the emphasis and attention being paid to the recovery phase of their treatment plan?
1. Recovery care, even when intensive, is less expensive than acute psychiatric care.
1. Effective recovery care is likely to result in fewer relapses and subsequent hospitalizations.
1. Planning for recovery care is time consuming and involves dealing with many complicated details.
1. Recovery care is usually done on an outpatient basis and so is generally better accepted by patients.

8. The nurse is attending a neighborhood meeting where a half-way house is being proposed for

the neighborhood when a member of the community states, We dont want the facility; we especially dont want violent people living near us. The response by the nurse that best addresses the publics concern is:

1. In truth, most individuals with psychiatric disorder are passive and withdrawn and pose little threat to those around them.

1. The mentally ill seldom behave in the manner they are portrayed by movies; they are people just like the rest of us.

1. Patients with psychiatric disorder are so well medicated that they do not display violent behaviors.

1. The mentally ill deserve a safe, comfortable place to live among people who truly care for them.

9. Which activity shows that a therapeutic alliance has been established between the nurse and patient?

1. The nurse respects the patients right to privacy when visitors are spending time with the patient.

1. The patient is eagerly attending all group sessions and working independently on identifying their personal stressors.

1. The patient is freely describing their feelings related to the physical and emotional trauma they experienced as a child with the nurse.

1. The nurse dutifully administers the patients medications on time and with appropriate knowledge of the potential side effects.

10. Mental health care reform has called for parity between psychiatric and medical diagnoses.

Which is an example of such parity?

1. Depression treatment is not paid for as readily as is treatment for asthma.
2. The mentally ill patient will be protected by law against social stigma.
3. Medical practitioners are trained to be proficient at treating mental disorders.
4. Psychiatric service reimbursement will be equivalent to that of medical services.

MULTIPLE RESPONSE

1. Which assessment findings suggest to the nurse that this patient has characteristics seen in an individual who has reached self-actualization. Select all that apply.

Reports to have, found peace and security in my religious faith

Effectively changed occupations when a chronic vision problem worsened Has consistently earned a six-figure salary as an architect for the last 10 years Has been in a supportive, loving relationship with the same individual for 15 years

Provides free literacy tutoring help at the local homeless shelter 3 evenings a week

2. Which nursing activities represent the tertiary level of mental health care? Select all that apply.
   Providing a depression screening at a local college
   Helping a mental-challenged patient learn to make correct change
   Reporting an incidence of possible elder abuse to the appropriate legal agency
   Regularly assessing a patients understanding of their prescribed antidepressants
   Providing a 6-week parenting class to teenage parents through a local high school

3. Which nursing actions indicate an understanding of the priority issues currently facing psychiatric mental health nursing today? Select all that apply.
   1. Working on the facilitys Safe Use of Restraints Policy revision committee 2. Advocating for increased salaries for all levels of psychiatric mental health nurses
   1. Attending a political rally for increased state funding for mental health service providers 1. Offering an in-service to facility staff regarding the cultural implications of caring for the Hispanic patient
   1. Joining the state nursing committee working on the role and scope of practice of the advanced practice psychiatric nurse

4. Which assessment findings describe risk factors that increase the potential risk for mental illness? Select all that apply.
   1. Possesses high tolerance for stress
   2. Is very curious about how things work
   3. Admits to being a member of an ethnic gang
   4. Only practicing Jew among school classmates
   5. Has a younger sibling who is mentally challenged

5. Which nursing actions show a focus on the fundamental goals that guide psychiatric mental health nurses in providing patient care? Select all that apply.
   1. Offering an informational session of identifying signs of depression at a local senior center
   1. Attending a workshop on evidence practice interventions for the chronically depressed patient
   1. Keeping strict but appropriate boundaries with a patient diagnosed with a personality disorder
   1. Asking a parent who has just experienced the death of a child if they could consider talking with a grief counselor
   1. Identifying what help a patient diagnosed with Alzheimers disease will need with instrumental activities of daily living (IADLs)

Chapter 3: Contributions of the Sociocultural Sciences

MULTIPLE CHOICE

1. Which nursing action is a reflection of Hildegard Peplaus theoretic framework regarding psychiatric mental health nursing?

1. Basing patient outcomes on expected instinctual responses
2. Discussing a patients feelings regarding parents and siblings
3. Providing the patient with clean clothes and wholesome food
4. Centering professional practice in a state run psychiatric facility

2. The nurse is attempting to provide a safe environment for a patient at great risk for selfharm. Which intervention shows an understanding of evidence-based practice (EBP)? 1. Using physical restraints only after all other options have been proven ineffective 1. Referring to the facilitys policies manual for guidelines for applying physical restraints

1. Collecting data regarding the short-term effects of using physical restraints on an aggressive patient

1. Requiring constant monitoring of a patient whose inability to self-regulate anger has required the use of physical restraints

3. Which statement by the patient reflects patient education that was based on the concept of integrated patient care?

1. I know Im anxious when I get a tension headache.
2. My anxiety is a result of stressors I dont cope well with.
3. Medication has helped me tremendously with anxiety control.
4. Anxiety runs in my family; my entire family is trying to deal with it.

4. The nurse demonstrates objective patient care when:
5. Being sympathetic to the patients recent loss of a spouse
6. Protecting the anxious patient by eliminating stressors in the milieu
7. Responding to the patient by stating, I know exactly how you feel.
8. Facilitating the patients exploration of various stress reduction techniques

5. Which nursing intervention would be appropriately addressed during the orientation phase of the nursepatient relationship?

1. Self reflection by the nurse regarding personal biases and prejudices regarding the patient
1. Patient works at prioritizing personal needs and develops realistic expected outcomes
1. Establishing the contract between the nurse and the patient regarding mutual needs and expectations
1. Patient commits to the reinforcement of positive personal characteristics while working on problems and concerns

6. Which action on the part of a novice psychiatric mental health nurse shows a need for future development of altruism?

1. Excusing a patient from attending group because, all that talking makes me so anxious

1. Not permitting two patients who are physically attracted to each other to engage in public displays of affection

1. Placing a physically aggressive patient in restraints when they are unable to internally calm their anger

1. Self-reflecting on why I continue to work with patients who are so emotionally damaged they will never be normal

7. The greatest negative outcome resulting from a nurses fear of a mentally ill patient is that the:
8. Nurse will reinforce negative stereotyping of the mentally ill.
9. Patient will experience increased bias against the nursing staff.
10. Publics fearfulness of the mentally ill will continue to be exaggerated.
11. Therapeutic alliance between the nurse and patient will not develop effectively.

8. Which action on the part of a novice mental health nurse will best minimize fear related to effectively working with the psychotic patient?

1. Be knowledgeable about psychotropic medications and their affect on psychosis. 2. Always arrange for staff support when working one-on-one with a psychotic patient.

1. Take advantage of opportunities to attend workshops devoted to the care of the psychotic patient.

1. Recognize that the psychotic patient is not in control of their behaviors due to their altered though processes.

9. Which response by the nurse manager to a novice mental health nurse is most effective when the nurse asks, How do I justify not keeping a patients secret?

1. Never promise the patient that you will keep a secret for them.
2. Always stop the patient from telling you something as a secret.
3. Let the patient know that you will not keep a secret that could ultimately cause harm or affect their treatment.

1. Keep reminding yourself that you are not the patients friend but rather a professional mental health provider.

10. The nurse is effectively facilitating the nurse-patient relationship when:
11. Sharing with an angry patient who is verbally abusive that, Although I can accept that you are angry, I cannot and will not accept your verbal abuse.

1. Focusing on the patients life experience without relating to the similarities of ones own experiences

1. Objectively providing constructive criticism that is directed to helping the patient identify inappropriate behaviors

1. Refraining from abandoning the patient regardless of the frustration the interaction causes

11. An often expressed intrinsic reward of psychiatric mental health nursing is:
12. Seeing the seriously ill recover their health
13. Working with patients of all ages and walks of life
14. Working with well-trained, caring health care providers
15. Having time to really focus on the human who is the patient

12. Which statement is an example of an inference?
13. He is an alcoholic because his wife nags a lot.
14. He states he binges after arguing with his wife.
15. You say your alcohol intake exceeds a quart a day.
16. So you are saying that you were drinking earlier today.

MULTIPLE RESPONSE

1. Which interactions are likely outcomes of a well-established therapeutic alliance? Select all that apply.

1. The nurse states, Im not here to judge but rather to help.
2. The patient states, I really think I can handle this problem now.
3. The patient asks his abusive father to attend counseling with him.
4. The nurse sets boundaries for a patient who has few social skills.
5. The patient with anger issues voluntarily goes into the seclusion room.

2. Which nursing interventions are directly related to the principles on which a therapeutic alliance is based? Select all that apply.

1. Graciously declining to, Come visit when I get discharged.
2. Establishing the topic to be discussed at each group session
3. Explaining to the patient the purpose of terminating the alliance
4. Sharing how the nurse also has experienced the same problems
5. Providing subjective feedback to the patients efforts at therapy

3. The nurse is attempting to minimize the groups display of resistance during a therapy session.
Which patients are at risk for displaying such behavior? Select all that apply

1. The patient who is cognitively impaired
2. The patient who is older and well educated
3. The patient who is aggressive and attention seeking
4. The patient who has attended similar therapy groups in the past
5. The patient who has been diagnosed with paranoid schizophrenia

Chapter 4: Theories of Personality and Psychopathology

Test Bank MULTIPLE CHOICE

1. The nurse leading parent education classes bases instruction on Eriksons developmental stages. It follows that the nurse will plan to instruct the parents that a helpful strategy to foster a childs initiative would be to:

1. Offer several different options for dressing and encourage the child to select one of them.
1. Allow the child to help wash the unbreakable dishes used to serve breakfast.
2. Provide one-on-one parentchild time each evening before bed.
3. Enroll the child in a weekend, age-appropriate sports program.

2. Which of the following responses would the nurse expect from a 12-year-old regarding stealing?

1. You are never allowed to steal.
2. You go to jail is you steal someone elses things.
3. My parents would punish me if I was caught stealing.
4. Stealing food when you dont have anything to eat is alright.

3. A nursing diagnosis of hopelessness would be considered for an individual who:
4. Was consistently overprotected by family members
5. Was raised by parents who were strict disciplinarians
6. Had inconsistent, unpredictable physical care as an infant
7. As a teenager always felt unaccepted by his social peers

4. An adolescent has been a consistently, poor academic student due to a learning disorder. Which statement overheard by the nurse would support the possibility of a problem with the developmental stage *competence versus inferiority*?

1. Its too hard to get good grades.
2. Ill never be able to get into a good college.
3. My parents are disappointed that I do so poorly in school.
4. I dont want people to know I can barely read or write.

5. A parent is concerned with the interpersonal skills of her 12-year-old son. Based on interpersonal theory, the nurse asks:

1. Does your son belong to team or club with friends or classmates?
2. Does he feel bad when he does something he knows he shouldnt do?
3. How does he tend to act when he doesnt get exactly what he wants?
4. How confident is he in situations that are generally unfamiliar for him?

6. The parents of an 8-year-old are attempting to help their child comprehend new information.
Which intervention suggested by the nurse shows an understanding of the cognitive development theory for this age group?

1. The use of drawing and illustrations
2. Comparing the childs experiences to the new material
3. Encouraging the child to talk about this new information
4. Asking the child to give a reason for how they feel about new information

7. According to Piaget, which of the following would the nurse consider normal when assessing a 6-year-old?

1. Playing with an imaginary friend
2. Talking about their best friend
3. Enjoying putting puzzles together
4. Knowing its wrong to tell a lie

8. Which developmental level would be characterized by a child being able to focus, to coordinate, and to imagine a series of events?

1. Preoperational
2. Concrete operational
3. Formal operational
4. Postoperational

9. Which strategy will the nurse include in the plan of care for a 6-year-old child for whom operant conditioning has been recommended?

1. Periodically asking the child to attempt to solve increasingly difficult puzzles
2. Consistently offering praise when the child puts his dirty clothes in the hamper
3. Expecting the child to rinse and to place his dirty dishes in the sink
4. Conditioning the child to expect punishment when he misbehaves

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10. A child who has been physically abused becomes emotionally distorted when told that the parent will no longer be allowed to visit. Which principle of social learning theory is most likely for the childs response?

1. The child views the abuse to be more desirable than the parent leaving.
2. The parent has fostered a fear in the child that increases when they are apart.
3. The child believes that he is responsible for the parent now being punished.
4. The parent has likely told the child that he deserved the abuse as a punishment.

11. Which nursing intervention supports the principles on which the cross-links theory of aging is based?

1. Applying an elastin sustaining moisturizer to an adult patients skin
2. Assessing a patients family history for genetic diseases and disorders

3. Questioning a patient regarding long-term exposure to environmental toxins
4. Assisting an adult patient is selecting foods that are high in vitamins A, C, and E

12. The nurse determines that a patient is showing a decline in explicit memory. Which characterizes such a deficiency?
1. Inability to remember how to operate a common kitchen appliance
2. Difficulty remembering the name of a place visited 20 years ago
3. Being unsuccessful at retaining new information
4. Forgetting the ingredients of a favorite recipe

13. A patient is experiencing distress with midlife transition. Which statement provides support that the patient is successfully managing this stressor?
1. I wont give up on my dream to be rich.
2. Being rich doesnt necessarily make a person happy.
3. Ill never be rich but I can save enough to live comfortably.
4. I wasnt being realistic when I set being rich as my lifes goal.

14. According to Maslows hierarchy of needs, the nursing strategies a psychiatric nurse would use to assist in meeting self-esteem needs of elderly patients would include:
1. Providing privacy when spouses are visiting
2. Arranging for the spouses to dine with the patients when visiting
3. Including both the patients and spouses in all educational sessions
4. Attending to patient hygiene and dress in preparation for spousal visits

15. A patient is involved in a smoking cessation program that encourages self-control therapy interventions. Which intervention would the nurse suggest to this patient? 1. Limiting the act of smoking to certain times of the day
2. Keeping a behavioral diary that tracks when the patient smokes
3. Identifying the factors that initially encouraged the patient to start smoking
4. Making plans that involve spending the money saved when the smoking stops

16. A 70-year-old male has the nursing diagnosis situational low self-esteem related to forced retirement. Using Maslows hierarchy of human needs, the nurse is confident the patient is meeting the outcome of experiencing self-worth when the patient:
1. Moves to a secure apartment building
2. Exercises regularly with friends at the gym
3. Attends his grandchildrens school functions
4. Volunteers at the local homeless shelter each week

17. The spouse of a patient recently diagnosed with early stage Alzheimers disease asks, Is there anything I can do to help delay the progression of this disease? Which strategy has the greatest potential for preserving the protective abilities of immune cells related to the disease?

1. Minimize contact with the public during cold and flu season.
2. Enroll the patient in an exercise program that meets regularly.
3. Provide supplements to enhance the patients immune system.
4. Identify creative ways to keep the patient mentally challenged.

MULTIPLE RESPONSE

1. A nurse is using Piagets model to assess a childs developmental stage. Which behaviors would determine that a child is successfully achieving the skills required of the formal operations level of development? Select all that apply.

1. Becomes sad when the family pet dies
2. Plans a trip to attend a basketball game
3. Identifies two different bowls that hold 1 cup
4. Selects the appropriate clothing for a ski trip
5. Enjoys solving what if types of word problems

2. The nurse is assessing a child according to Kohlbergs developmental theory. Which statement would support the belief the child is showing appropriate behaviors of the preconventional state? Select all that apply.

1. If I pick up my toys, can I get an ice cream cone?
2. I cant watch cartoons when I dont pick up my toys.
3. I always pick up my toys because mommy needs my help.
4. When I pick up all of my toys I make mommy very happy.
5. If I dont pick up my toys, mommy could trip on them and fall.

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3. Which activities should the nurse evaluate in an assessment of an older patients functional status? Select all that apply.

1. Possessing the ability to prepare nutritious meals independently
2. Having the financial resources available to live independently
3. Performing regular, simple maintenance on their primary residence
4. Effectively toileting themselves for both bowel and bladder elimination
5. Safely moving around their residence without an increased risk for falls

4. Which older adult patients medical conditions appear to support the hypothesis upon which the immunologic theory of aging is based? Select all that apply. 1. Has, at age 64, been diagnosed with type 2 diabetes

2. Has been treated for multiple sclerosis since age 30
3. Is managing a 36-year history of chronic Graves disease

4. Has begun to experience symptoms of rheumatoid arthritis
5. Is experiencing a flare up of celiac disease, which was diagnosed at age 26

5. The nurse manages the care for several older adult patients. Which strategies shows an understanding of the effects of aging on cognitive function? Select all that apply.

1. Allowing ample time for completion of patient activities
2. Breaking complicated patient activities into single tasks
3. Planning patient activities that can be completed rather quickly
4. Excluding complex problem-solving patient activities in the daily routine
5. Planning for complex patient activities to be introduced early in the day

6. According to most biological theories of aging, predisposing factors create the affects seen in aging. Which behaviors are considered predisposing factors regarding aging? Select all that apply.

1. Diagnosis of a chronic genetic disease
2. Lack of healthy diet and regular exercise
3. Family history of several different cancers
4. Occupation that involved working with toxins
5. Radiation exposure from numerous diagnostic studies

7. The nurse is preparing to educate a group of middle-aged adults on longevity strategies. Which behaviors would the nurse stress? Select all that apply.

1. Having warm and caring people in your life
2. Engaging in age-appropriate exercise on a regular basis
3. Accepting the fact that aging negatively impacts your life
4. Seeking help if changes of aging cause depression or anxiety
5. Avoiding retirement for as long as possible in order to keep active

8. A nurse is working with a group of older adults attending a seminar on the physical and emotional effects of aging. Which patient statements are good predictors of positive well being and perceived mortality? Select all that apply.

1. Being satisfied with growing older
2. Feeling younger than my birthdays say I should
3. Retirement gives me time to do the things Ive put off doing.
4. Not having to deal with the stress of any major chronic illnesses 5. At least I dont have to worry about having enough money to retire.

Chapter 5: Examination and Diagnosis of the Psychiatric Patient

MULTIPLE CHOICE

1. A new staff nurse completes an orientation to the psychiatric unit. This nurse will expect to ask an advanced practice nurse to perform which action for patients?

1. Perform mental health assessment interviews.
2. Prescribe psychotropic medication.
3. Establish therapeutic relationships.
4. Individualize nursing care plans.

2. A newly admitted patient diagnosed with major depression has gained 20 pounds over a few months and has suicidal ideation. The patient has taken an antidepressant medication for 1 week without remission of symptoms. Select the priority nursing diagnosis.

1. Imbalanced nutrition: more than body requirements
2. Chronic low self-esteem
3. Risk for suicide
4. Hopelessness

3. A patient diagnosed with major depression has lost 20 pounds in one month, has chronic low self-esteem, and a plan for suicide. The patient has taken an antidepressant medication for 1 week. Which nursing intervention has the highest priority?

1. Implement suicide precautions.
2. Offer high-calorie snacks and fluids frequently.
3. Assist the patient to identify three personal strengths.
4. Observe patient for therapeutic effects of antidepressant medication.

4. The desired outcome for a patient experiencing insomnia is, Patient will sleep for a minimum
of 5 hours nightly within 7 days. At the end of 7 days, review of sleep data shows the patient sleeps an average of 4 hours nightly and takes a 2-hour afternoon nap. The nurse will document the outcome as:

1. consistently demonstrated. c. sometimes demonstrated.
2. often demonstrated.
3. d. never demonstrated.

5. The desired outcome for a patient experiencing insomnia is, Patient will sleep for a minimum
of 5 hours nightly within 7 days. At the end of 7 days, review of sleep data shows the patient sleeps an average of 4 hours nightly and takes a 2-hour afternoon nap. What is the nurses next action?

1. Continue the current plan without changes.
2. Remove this nursing diagnosis from the plan of care.
3. Write a new nursing diagnosis that better reflects the problem.
4. Examine interventions for possible revision of the target date.

6. A patient begins a new program to assist with building social skills. In which part of the plan of care should a nurse record the item, Encourage patient to attend one psychoeducational group daily?

A. Assessment
B. Implementation
C. Analysis
D. Evaluation

7. Before assessing a new patient, a nurse is told by another health care worker, I know that patient. No matter how hard we work, there isnt much improvement by the time of discharge. The nurses responsibility is to:

1. document the other workers assessment of the patient.
2. assess the patient based on data collected from all sources.
3. validate the workers impression by contacting the patients significant other.
4. discuss the workers impression with the patient during the assessment interview.

8. A patient presents to the emergency department with mixed psychiatric symptoms. The admission nurse suspects the symptoms may be the result of a medical problem. Lab results show elevated BUN (blood urea nitrogen) and creatinine. What is the nurses next best action?

1. Report the findings to the health care provider.
2. Assess the patient for a history of renal problems.
3. Assess the patients family history for cardiac problems.
4. Arrange for the patients hospitalization on the psychiatric unit.

9. A patient states, Im not worth anything. I have negative thoughts about myself. I feel anxious and shaky all the time. Sometimes I feel so sad that I want to go to sleep and never wake up.

Which nursing intervention should have the highest priority?

1. Self-esteembuilding activities c. Sleep enhancement activities
2. Anxiety self-control measures d. Suicide precautions

10. Select the best outcome for a patient with the nursing diagnosis: Impaired social interaction related to sociocultural dissonance as evidenced by stating, Although Id like to, I dont join in because I dont speak the language very well. Patient will:

1. show improved use of language.
2. demonstrate improved social skills.
3. become more independent in decision making.
4. select and participate in one group activity per day.

11. Nursing behaviors associated with the implementation phase of nursing process are concerned with:

1. participating in mutual identification of patient outcomes.
2. gathering accurate and sufficient patient-centered data.
3. comparing patient responses and expected outcomes.
4. carrying out interventions and coordinating care.

12. Which statement made by a patient during an initial assessment interview should serve as the priority focus for the plan of care?

1. I can always trust my family.
2. It seems like I always have bad luck.
3. You never know who will turn against you.
4. I hear evil voices that tell me to do bad things.

13. Which entry in the medical record best meets the requirement for problem-oriented charting?

14. A: Pacing and muttering to self. P: Sensory perceptual alteration related to internal auditory stimulation. I: Given fluphenazine HCL (Prolixin) 2.5 mg po at 0900 and went to room to lie down. E: Calmer by 0930. Returned to lounge to watch TV.

1. S: States, I feel like Im ready to blow up. O: Pacing hall, mumbling to self. A: Auditory hallucinations. P: Offer haloperidol (Haldol) 2 mg po. I: Haloperidol (Haldol) 2 mg po given at 0900. E: Returned to lounge at 0930 and quietly watched TV.
1. Agitated behavior. D: Patient muttering to self as though answering an unseen person. A: Given haloperidol (Haldol) 2 mg po and went to room to lie down. E: Patient calmer. Returned to lounge to watch TV.
1. Pacing hall and muttering to self as though answering an unseen person. haloperidol (Haldol) 2 mg po administered at 0900 with calming effect in 30 minutes. Stated, Im no longer bothered by the voices.

14. A nurse assesses an older adult patient brought to the emergency department by a family member. The patient was wandering outside saying, I cant find my way home. The patient is confused and unable to answer questions. Select the nurses best action.

1. Record the patients answers to questions on the nursing assessment form.
2. Ask an advanced practice nurse to perform the assessment interview.
3. Call for a mental health advocate to maintain the patients rights.
4. Obtain important information from the family member.

15. A nurse asks a patient, If you had fever and vomiting for 3 days, what would you do? Which aspect of the mental status examination is the nurse assessing?

1. Behavior c. Affect and mood
2. Cognition d. Perceptual disturbances

16. An adolescent asks a nurse conducting an assessment interview, Why should I tell you anything? Youll just tell my parents whatever you find out. Which response by the nurse is appropriate?

1. That isnt true. What you tell us is private and held in strict confidence. Your parents have no right to know.
1. Yes, your parents may find out what you say, but it is important that they know about your problems.
1. What you say about feelings is private, but some things, like suicidal thinking, must be reported to the treatment team.
1. It sounds as though you are not really ready to work on your problems and make changes.

17. A nurse wants to assess an adult patients recent memory. Which question would best yield the desired information?

1. Where did you go to elementary school?
2. What did you have for breakfast this morning?
3. Can you name the current president of the United States?
4. A few minutes ago, I told you my name. Can you remember it?

18. When a nurse assesses an older adult patient, answers seem vague or unrelated to the questions. The patient also leans forward and frowns, listening intently to the nurse. An appropriate question for the nurse to ask would be:

1. Are you having difficulty hearing when I speak?
2. How can I make this assessment interview easier for you?
3. I notice you are frowning. Are you feeling annoyed with me?
4. Youre having trouble focusing on what Im saying. What is distracting you?

19. At what point in an assessment interview would a nurse ask, How does your faith help you in stressful situations? During the assessment of:

1. childhood growth and development c. educational background
2. substance use and abuse d. coping strategies

20. When a new patient is hospitalized, a nurse takes the patient on a tour, explains rules of the unit, and discusses the daily schedule. The nurse is engaged in:

1. counseling. c. milieu management.
2. health teaching. d. psychobiological intervention.

21. After formulating the nursing diagnoses for a new patient, what is a nurses next action?
22. Designing interventions to include in the plan of care
23. Determining the goals and outcome criteria
24. Implementing the nursing plan of care
25. Completing the spiritual assessment

22. Select the most appropriate label to complete this nursing diagnosis: _____ related to feelings of shyness and poorly developed social skills as evidenced by watching television alone at home every evening. 1. Deficient knowledge c. Social isolation

2. Ineffective coping d. Powerlessness

23. QSEN refers to:
24. Qualitative Standardized Excellence in Nursing
25. Quality and Safety Education for Nurses
26. Quantitative Effectiveness in Nursing
27. Quick Standards Essential for Nurses

24. A nurse documents: Patient is mute despite repeated efforts to elicit speech. Makes no eye contact. Inattentive to staff. Gazes off to the side or looks upward rather than at speaker. Which nursing diagnosis should be considered?

1. Defensive coping c. Risk for other-directed violence
2. Decisional conflict d. Impaired verbal communication

25. A nurse prepares to assess a new patient who moved to the United States from Central America three years ago. After introductions, what is the nurses next comment?

1. How did you get to the United States?
2. Would you like for a family member to help you talk with me?
3. An interpreter is available. Would you like for me to make a request for these services?
    1. Are you comfortable conversing in English, or would you prefer to have a translator present?

26. The nurse records this entry in a patients progress notes:

Patient escorted to unit by ER nurse at 2130. Patients clothing was dirty. In interview room, patient sat with hands over face, sobbing softly. Did not acknowledge nurse or reply to questions. After several minutes, abruptly arose, ran to window, and pounded. Shouted repeatedly, Let me out of here. Verbal intervention unsuccessful. Order for stat dose 2 mg haloperidol PO obtained; medication administered at 2150. By 2215, patient stopped shouting and returned to sit wordlessly in chair. Patient placed on one-to-one observation.

How should this documentation be evaluated?

1. Uses unapproved abbreviations
2. Contains subjective material
3. Too brief to be of value
4. Excessively wordy
5. Meets standards

MULTIPLE RESPONSE

1. A nurse assessed a patient who reluctantly participated in activities, answered questions with minimal responses, and rarely made eye contact. What information should be included when documenting the assessment? *Select all that apply.*

1. The patient was uncooperative
2. The patients subjective responses
3. Only data obtained from the patients verbal responses
4. A description of the patients behavior during the interview
5. Analysis of why the patient was unresponsive during the interview

2. A nurse performing an assessment interview for a patient with a substance use disorder decides to use a standardized rating scale. Which scales are appropriate? *Select all that apply.*

1. Addiction Severity Index (ASI)
2. Brief Drug Abuse Screen Test (B-DAST)
3. Abnormal Involuntary Movement Scale (AIMS)
4. Cognitive Capacity Screening Examination (CCSE)
5. Recovery Attitude and Treatment Evaluator (RAATE)

3. What information is conveyed by nursing diagnoses? *Select all that apply.*

4. Medical judgments about the disorder
5. Unmet patient needs currently present
6. Goals and outcomes for the plan of care
7. Supporting data that validate the diagnoses
8. Probable causes that will be targets for nursing interventions

4. A patient is very suspicious and states, The FBI has me under surveillance. Which strategies should a nurse use when gathering initial assessment data about this patient?
Select all that apply.

1. Tell the patient that medication will help this type of thinking.
2. Ask the patient, Tell me about the problem as you see it.
3. Seek information about when the problem began.
4. Tell the patient, Your ideas are not realistic.
5. Reassure the patient, You are safe here.

Chapter 6: Classification in Psychiatry

Test Bank MULTIPLE CHOICE

1. The patient asks the nurse, Ive heard the student nurses talk about the nursing process. Why is there so much emphasis on using the nursing process? The response that explains the need for nurses to understand and use the nursing process is:

1. Do you think you have a better method we might use?

2. The nursing process is a systematic problem-solving method encompassing all components necessary to care for patients.

1. Using the nursing process is a way of legitimizing our profession and placing us on an equal footing with the pure sciences.

1. The nursing process is a unidimensional, static, linear approach used to guide nurses as they make clinical judgments.

2. When preparing to conduct a nursing history and assessment on a patient transferred from the emergency department (ED) whose family believes the patient to be a questionable historian due to cognitive impairment, the nurse initially begins the interview by:

1. Reviewing the ED chart
2. Contacting the admitting physician
3. Directing the questions to the family members
4. Establishing a line of communication with the patient

3. The nurse shows the ability to effectively state a nursing diagnosis reflective of the implications of depression on a patients life processes when stating in the patients plan of care that:

1. Patient outcomes were partially attained. Implementation of present plan to continue.

1. Patient will initiate and support conversation with nurse therapist by (date 3 weeks in future).

1. Oral medication for anxiety should be administered when depression is assessed to be at the moderate level.

1. Impaired verbal communication r/t impoverished thoughts secondary to depression as evidenced by monosyllabic responses.

4. When engaging in outcomes identification, the nurse:

5. Interviews and collects patient-focused data
6. Re-assesses the patients physical and emotional status evaluation
7. Reviews the patients existing problems and projects the results of the nursing care

1. Considers the patients presenting symptoms and identifies nursing-related problems

5. While discussing assessment of suicidal patients, a novice nurse mentions, I was taught to always base my care on concrete, evidence-based scientific reasoning and never to rely on intuition. Which response by the experienced nurse shows understanding of intuitive reasoning?

1. Thats wise, because intuition went out of favor with the scientific revolution. 2. Critical thinking and intuition are at opposite poles. Keep relying on your expertise.

Its possible that intuition about suicidality is generated by transfer of feelings from the patient to the nurse.

1. Its been determined that intuition is nothing more that extrasensory perception, so some folks have it, and some dont.

6. A nurse shows effective critical thinking skills directed towards nursing care of a cognitively impaired patient who continues to socially isolate by: 1. Clearly stating that the patient must socially interact once daily
2. Documenting that the patient continues to resist socialization
3. Asking the patient to identify which unit activity they are willing to attend
4. Suggesting that staff take the patient with them when running errands off the unit

7. A depressed patient shares with the nurse that he, has been thinking about ending it all. Based on NANDA recommendations, the nurse:
1. Implements suicide precautions for this patient
2. Includes Risk for Self Harm to the patients care plan
3. Documents regarding the patients safety every 15 minutes
4. Reviews the patients chart for references to past incidences of hopeless

8. The nurse shows an understanding of the appropriate use of nursing outcomes regarding triggers for a patient diagnosed with chronic alcohol abuse when stating:
1. Can you work on identifying three situations that cause you to abuse alcohol?
2. Ill help you to identify three triggers for your drinking during todays session.
3. Im pleased youve identified three situations that trigger your abuse of alcohol.
4. Do you think you will be able to avoid the three triggers that cause you to drink?

9. When a patient experiencing acute depression asks what the difference is between a medical and a nursing diagnosis, the nurse responds best when stating:
1. Actually they are very similar in that they both are concerned with helping you get better and lead a happier life.
1. Medical diagnoses are focused on why you are depressed whereas nursing diagnoses are concerned about making your life less sad.
1. Nursing diagnoses are more directed at caring for you, unlike medical diagnoses that focus on finding the cause for your problem.
1. The medical diagnosis identifies that you are experiencing depression whereas the nursing diagnosis identifies how the depression is affecting you.

10. A nurse best shows an understanding of the role of evidence-based research in achieving therapeutic patient care outcomes when:
1. Subscribing to and reading a monthly psychiatric research nursing journal 2. Working on a committee to revise current facility policies regarding the use of chemical restraints

1. Registering to attend a psychiatric workshop on newly developed psychotropic medication therapies
1. Asking an experienced staff member to review the interventions being proposed for a newly admitted patient

11. When caring for a patient admitted with a diagnosis if bipolar disorder, managed care regulations is the driving force behind the nurses use of:
1. NANDA nursing diagnoses
2. Short-term stress management therapy
3. A specialized clinical pathway for such patients
4. Generic instead of brand name medications

12. A benefit of the implementation of clinical pathways is evidenced when the patient states:
13. I know my doctors and nurses really care about me.
14. My medication has really helped lessen my symptoms.
15. I have hopes that I will be able to lead a productive, healthy life.
16. My care team has really helped me manage most of my problems.

13. A nurse shows the best understanding of the legal importance of the patients chart when stating:
1. You always document in ink and never erase or use white out in the nursing notes. 1. Its a document that shows proof that the patient received care that met the expected standards.
1. Patient charts are carefully protected from unlawful access by inappropriate individuals or institutions.
1. The patient has a legal right to the information contained in the chart but not the original documentation itself.

14. The nurse best fulfills the obligation to be accountable for providing care that meets the expected standards of care when:
1. Developing a therapeutic relations with the patient
2. Applying evidence-based nursing practice to the plan of care
3. Providing appropriate discharge planning to meet the patients needs
4. Evaluating the effectiveness of interventions through achievement of outcomes

15. The nurse assesses a patients judgment by asking:
16. Why did you run away?
17. When did you first start hearing voices?
18. What would you do if you smelled smoke in your home?
19. Do you believe you hear voices, or do you think it is in your mind?

16. The nurse responsible for the care plan of a patient diagnosed with cognitive impairment includes rationales for the nursing interventions primarily to:

1. Provide a means for outcome evaluation
2. Account for the reasoning that drives the nursing action
3. Support the patients success in achieving the expected outcome
4. Provide information to aide in the implementation of the nursing action

17. A patient who has a nursing diagnosis of ineffective coping related to ineffective problem solving has been involved in treatment for 6 months. The nurse determines that the planned interventions require revision when the patient states:

1. I really dont think my psychiatrist actually helps me.
2. I cant decide if I should get my own apartment or not.
3. I cant accept that I will never be able to comfortably make decisions.
4. I dont think Im liked well enough to seek election as a committee chairperson.

18. To best facilitate interdisciplinary communication regarding the plan of care for a patient diagnosed with paranoid schizophrenia, the nurse: 1. Requires weekly meetings of the care team

2. Ensures the team includes members from all appropriate disciplines
3. Uses the standardized NIC classification system of care interventions
4. Recognizes the need for team access to patient records and makes them available

19. When reviewing the history of a newly admitted patient diagnosed with severe chronic depression, the nurse is most concerned about patient safety issues when noting:

1. The patients Axis II includes a diagnosis of mental retardation
2. Documentation that the patient has been noncompliant regarding medications
3. The patients current Global Assessment of Functioning (GAF) Scale rating is 9 4. Reference to a recent physical injury resulting from the patients impulsive behavior

20. An appropriate nursing diagnosis for a patient who manifests a psychological problem through frequent expressions of unfounded or excessive guilt or shame, states that he is unable to deal with situations, and has a hesitation to try new things would be:

1. Hopelessness
2. Powerlessness
3. Ineffective coping
4. Chronic low self-esteem

21. A well-stated outcome criteria for a patient with a nursing diagnosis of risk for loneliness related to social isolation would include The patient will:

1. No longer experience loneliness by the end of the fifth day of hospitalization.
2. Agree to attend two on-unit, staff-directed group sessions daily.
3. Continue to maintain social solitude 50% of the time.
4. Interact with a peer on a daily basis by discharge.

22. Care planning for a patient diagnosed with paranoid schizophrenia will include:
23. Analyzing effectiveness of care provided
24. Determining the patients needs and problems
25. Establishing realistic patient-focused outcome criteria
26. Identifying priorities of care based on the patients condition

23. The expert nurse is confident that the novice nurse understands the principles that guide the planning of patient care interventions when the:

1. Novice nurse asks the patient to identify their primary concerns
2. Patient successfully achieves the agreed upon nursing outcomes
3. Expert nurse requests that the novice nurse observe several care planning sessions 1. Novice nurse includes interventions that are supported by evidence-based practices

Chapter 7: Schizophrenia Spectrum and Other Psychotic Disorders

MULTIPLE CHOICE

1. A newly admitted patient has the diagnosis of catatonic schizophrenia. Which behavior observed in the patient supports that diagnosis? 1. Uses a rhyming form of speech
2. Refuses to eat any unwrapped foods
3. Laughs when watching a sad movie
4. Maintains an immobilized state for hours

2. What would be an appropriate short-term outcome for a patient diagnosed with residual schizophrenia who exhibits ambivalence?

1. Decide their own daily schedule.
2. Decide which unit groups they will attend.
3. Choose which clinic staff member to work with.
4. Choose between two outfits to wear each morning.

3. What is the priority nursing diagnosis for a catatonic patient?
4. Ineffective coping
5. Impaired physical mobility

6. Impaired social interaction
7. Risk for deficient fluid volume

4. Which nursing diagnosis is appropriate for a patient who insists being called Your Highness and demonstrates loosely associated thoughts?
1. Risk for violence
2. Defensive coping
3. Impaired memory
4. Disturbed thought processes

Which initial short-term outcome would be appropriate for a patient who was admitted expressing delusional thoughts?
1. Accept that delusion is illogical.
2. Distinguish external boundaries.
3. Explain the basis for the delusions.
4. Engage in reality-oriented conversation.

6. Which of the following interventions should the nurse plan to use to reduce patient focus on delusional thinking?
1. Confronting the delusion
2. Refuting the delusion with logic
3. Exploring reasons the patient has the delusion
4. Focusing on feelings suggested by the delusion

7. Which assessment observation supports a patients diagnosis of disorganized schizophrenia?
8. Reports suicidal ideations
9. Last relapse was 6 years ago
10. Consistent inappropriate laughing
11. Believes that the government is out to get me

8. A patient tried to gouge out his eye in response to auditory hallucinations commanding, If thine eye offends thee, pluck it out. The nurse would analyze this behavior as indicating:
1. Derealization
2. Inappropriate affect
3. Impaired impulse control
4. Inability to manage anger

9. An appropriate intervention for a patient with an identified nursing diagnosis of situational low self-esteem would be:
1. Providing large muscle activities to relieve stress

2. Attempting to determine triggers to hallucinations
3. Engaging patient in activities designed to permit success
4. Encouraging verbalization of feelings in a safe environment

10. A 19-year-old patient is admitted for the second time in 9 months and is acutely psychotic with a diagnosis of undifferentiated schizophrenia. The patient sits alone rubbing her arms and smiling. She tells the nurse her thoughts cause earthquakes and that the world is burning. The nurse assesses the primary deficit associated with the patients condition as:
1. Social isolation
2. Disturbed thinking
3. Altered mood states
4. Poor impulse control

11. A patient has been admitted with disorganized type schizophrenia. The nurse observes blunted affect and social isolation. He occasionally curses or calls another patient a jerk without provocation. The nurse asks the patient how he is feeling, and he responds, Everybody picks on
1. They frobitz me. The patients communication exhibits:
2. A neologism
3. Loose associations
4. Delusional thinking
5. Circumstantial speech

12. A patient has been admitted with disorganized type schizophrenia. The nurse asks the patient how he is feeling, and he responds, Everybody picks on me. They frobitz me. The best response for the nurse to make would be:
1. Thats really too bad that you are being treated that way.
2. Who do you mean when you say everybody?
3. What difference does frobitzing make?
4. Why do they frobitz?

13. Which patient behavior would support the diagnosis of residual schizophrenia with negative symptoms?
1. Communicating using only rhyming phases
2. Claims that worms are crawling in my brain
3. Maintaining both arms suspended awkwardly overhead
4. Shows no emotion when telling the story of a sisters recent death

14. By discharge, which outcome is appropriate for a patient who hears voices telling him he is evil?
1. Respond verbally to the voices.
2. Verbalize the reason the voices say he is evil.