TEST BANK FOR HESI COMPUTERIZED ADAPTIVE TESTING (CAT) 2023-2024 UPDATE QUESTIONS AND CORRECT ANSWERS INCLUSIVE OF THE RATIONALES ALREADY A GRADED

A client is admitted to the hospital with the diagnosis of severe anxiety. What should the nurse's plan of care for a client with an anxiety disorder include?

1

Promoting the suppression of anger by the client 2

Supporting the verbalization of feelings by the client 3

Encouraging the client to limit anxiety-related behaviors

4

Restricting the involvement of the client's family during the acute phase ✓ Ans- 2 Freedom to ventilate feelings serves as a safety valve to reduce anxiety. The suppression of anger may increase the client's anxiety. Encouraging the client to limit anxiety-related behaviors is not therapeutic; it may increase the anxiety that the client is feeling.

Restricting the involvement of the client's family during the acute phase may or may not be helpful; the client's family may provide support to the client.

Windows in the recreation room of the adolescent psychiatric unit have been broken on numerous occasions. After a group discussion one of the adolescents confides that another adolescent client broke them. What should the nurse do when using an assertive intervention instead of aggressive confrontation?

1

Confront the adolescent openly in the group, using a controlled voice and maintaining direct eye contact.

2

Knock on the door of the adolescent's room and ask whether the adolescent would come out to talk about the situation.

3

Approach the adolescent when the client is alone and, after making direct eye contact, inquire about the involvement in these incidents.

4

Use a trusting approach toward the adolescent and imply that the staff doubts the adolescent's involvement but requests a denial for the record. ✓ Ans- 3

A private confrontation with presentation of reported facts allows verification; a calm, direct manner is most assertive. Confronting the adolescent openly in the group, using a controlled voice and maintaining direct eye contact, is aggressive confrontation, not assertive intervention. Knocking on the door of the adolescent's room and asking whether the adolescent would come out to talk about the situation places control in the hands of the client rather than the nurse, and this may lead to aggressive confrontation. Using a trusting approach toward the adolescent and implying that the staff doubts the adolescent's involvement but requests a denial for the record is not assertive intervention; it is manipulation and is not truthful.

A 6-year-old child with autism is nonverbal and makes limited eye contact. What should the nurse do initially to promote social interaction?

1

Encourage the child to sing songs with the nurse.

2

Engage in parallel play while sitting next to the child.

3

Provide opportunities for the child to play with other children.

4

Use therapeutic holding when the child does not respond to verbal interactions. ✓ Ans- 2
Entering the child's world in a nonthreatening way helps promote trust and eventual interaction with the nurse. Using therapeutic holding may be necessary when a child initiates self-mutilating behaviors. Singing songs with the child participating or providing opportunities for the child to play with other children is unrealistic at this time; playing with others is a long-term objective.

What is an important aspect of nursing care for a client exhibiting psychotic patterns of thinking and behavior?

1

Helping keep the client oriented to reality 2

Involving the client in activities throughout the day

3

Helping the client understand that it is harmful to withdraw from situations
4

Encouraging the client to discuss why interacting with other people is being avoided ✓ Ans-
1

Keeping the withdrawn client oriented to reality prevents further withdrawal into a private world. A gradual involvement in selected activities is best. Helping the client understand that it is harmful to withdraw from situations is futile at this time. The psychotic client is unable to tell anyone the reason for avoiding interaction with others.

A nurse is volunteering on the community crisis hotline. What is the final objective of the counseling process?

1

Reducing anxiety

2

Exploring feelings

3

Developing constructive coping skills

4

Accomplishing the debriefing process ✓ Ans- 3

Past coping behaviors have been inadequate in resolving the current crisis; new coping skills are needed to manage anxiety-producing conflicts. Reduction of anxiety is an early objective. Exploration of feelings is an immediate objective. Accomplishment of the debriefing process is an early objective.

An infant is born with a bilateral cleft palate. Plans are made to begin reconstruction immediately. What nursing intervention should be included to promote parent-infant attachment?

1

Demonstrating positive acceptance of the infant

2

Placing the infant in a nursery away from view of the general public 3

Explaining to the parents that the infant will look normal after the surgery 4

Encouraging the parents to limit contact with the infant until after the surgery ✓ Ans- 1 By demonstrating acceptance of the infant, without regard for the defect, the nurse acts as a role model for the parents, thereby encouraging their acceptance. Infants with cleft palates can remain in the newborn nursery; they should not be hidden. Telling the parents that the child will look normal after surgery is false reassurance; it does not promote parent-infant attachment behaviors. Encouraging the parents to limit contact will delay attachment; the parents should be encouraged to have frequent contact with their infant.

A nurse is working with a client experiencing a major depressive episode. What is a longterm outcome for this client?

1

Talking openly about the depressed feelings 2

Identifying and using new defense mechanisms 3

Discussing the unconscious source of the anger 4

Verbalizing realistic perceptions of self and others ✓ Ans- 4

A major part of depression involves an inability to accept the self as is, which leads to making demands on others to meet unrealistic needs. Talking about the client's depressed feelings is a short-term goal; looking at what is causing those feelings is a long-term goal. Developing new defense mechanisms is not the priority, because they tend to help the client avoid reality. Discussing the unconscious source of the anger is not important or crucial to the client's recovery.

A nurse in the emergency department is assessing a client who has been physically and sexually assaulted. What is the nurse's priority during assessment?

1

The family's feelings about the attack

2

The client's feelings of social isolation

3

The client's ability to cope with the situation

4

Disturbance in the client's thought processes ✓ Ans- 3

The situation is so traumatic that the individual may be unable to use past coping behaviors to comprehend what has occurred. Assessing emotions that occur in response to news of the attack will occur later. The client should be the focus of care at this time. Social isolation is not an immediate concern. Coping skills, not thought processes, are challenged at this time.

A client is admitted to the psychiatric unit with the diagnosis of obsessive-compulsive disorder. The client washes her hands more than 20 times a day, and they are raw and bloody. What defense mechanism does the nurse conclude that the client is using to ease anxiety? 1

Undoing

2

Projection

3

Introjection

4

Displacement ✓ Ans- 1

Undoing is an act that partially negates a previous one; the client is using this defense mechanism to atone for unacceptable acts or wishes. The client is not attributing selfthoughts or impulses to another person or group, which is called projection. The client is not absorbing into the self a hated or loved object (introjection). Displacement is the

transferring of feelings from one person, object, or experience onto another, less threatening person, object, or experience.

The parents tell the nurse that their preschooler often awakes from sleep screaming in the middle of the night. The preschooler is not easily comforted and screams if the parents try to restrain the child. What does the nurse instruct the parents?

1

"Always read a story to the child before bedtime."

2

"Intervene only if necessary to protect the child from injury."

3

"Discuss counseling options with the primary health care provider." 4

"Try to wake the child and ask the child to describe the dream." ✓ Ans- 2

Waking up screaming from sleep at night indicates sleep terrors. The nurse should advise the parents to observe the child and intervene only if there is a risk for injury. Reading a story before bedtime helps to calm the child before sleeping, but it does not ensure that the child will not have a sleep terror. There is no need for professional counseling, because sleep terrors are a common phenomenon in preschool-age children. The child is not aware of anybody's presence during a sleep terror, so it is not appropriate to wake up the child; this may cause the child to scream and thrash more.

A client who was forced into early retirement is found to have severe depression. The client says, "I feel useless, and I've got nothing to do." What is the best initial response by the nurse?

1

"Tell me more about feeling useless."

2

"Volunteering can help you fill your time." 3

"Your illness is adding to your current feelings."

4

"Let's talk about what you'd like to be doing right now." ✓ Ans- 1

An open-ended response encourages further discussion and allows exploration of feelings. Telling the client that volunteering will help pass the time ignores the client's feelings. The depression is not adding to the feelings; the feelings are causing the depression. Asking the client to talk about what the client would rather be doing ignores the client's feelings.

What characteristic is most essential for the nurse caring for a client undergoing mental health care? 1

Empathy

2

Sympathy

3

Organization

4

Authoritarianism ✓ Ans- 1
Empathy—understanding and to some extent sharing the emotions of another—encourages the expression of feelings. Empathy is an essential tool in caring for emotionally ill clients. Sympathy, or feeling sorry for someone, may further decrease the client's feelings of self-worth. Although organization may help the client accept limits and organize activities, it is not as important as empathy. An authoritarian approach will emphasize the client's weak ego and lack of self-esteem.

When visiting hours are over, a nurse approaches a client with paranoid schizophrenia, who shouts, "You're the one that made my lover leave me." What conclusion does the nurse make about the client?

1

The patient is disoriented.

2

The patient is actively hallucinating.

3

The patient feels a sense of vulnerability.

4

The patient needs to have limits set after calming down. ✓ Ans- 3
The client's low self-esteem precipitates doubt of the lover's feelings, creating a sense of vulnerability. This statement reflects the client's low self-esteem, which is projected onto the nurse as part of the delusion. The client's statements do not reflect disorientation but instead reflect false beliefs, which are common in clients with paranoid schizophrenia. The client's statements do not represent hallucinations because they are not false sensory perceptions. Setting limits after the fact is not effective in any situation; limits must be set when the problem occurs.

A nurse is counseling the spouse of a client who has a history of alcohol abuse. What does the nurse explain is the main reason for drinking alcohol in people with a long history of alcohol abuse?

1

They are dependent on it.

2

They lack the motivation to stop.

3

They use it for coping.

4

They enjoy the associated socialization. ✓ Ans- 1

Alcohol causes both physical and psychological dependence; the individual needs the alcohol to function. Alcoholism is a disorder that entails physical and psychological dependence. Because alcohol is so physiologically addictive, the client's body craves the alcohol, so most clients lack the motivation to stop because they will go into withdrawal. Clients who abuse alcohol have numbed their ability to utilize other coping mechanisms, so alcohol is used as an excuse for coping. People with alcoholism usually drink alone or feel alone in a crowd; socialization is not the prime reason for their drinking.

A clinic nurse observes a 2-year-old client sitting alone, rocking and staring at a small, shiny top that she is spinning. Later the father relates his concerns, stating, "She pushes me away. She doesn't speak, and she only shows feelings when I take her top away. Is it something I've done?" What is the most therapeutic initial response by the nurse?

1

Asking the father about his relationship with his wife

2

Asking the father how he held the child when she was an infant

3.Telling the father that it is nothing he has done and sharing the nurse's observations of the child

4

Telling the father not to be concerned and stressing that the child will outgrow this developmental phase ✓ Ans- 3

The nurse provides support in a nonjudgmental way by sharing information and observations about the child. This child exhibits symptoms of autism, which is not attributable to the actions of the parents. Asking the father about his relationship with his wife or how he held the child when she was an infant indirectly indicates that the parent may be at fault; it negates the father's need for support and increases his sense of guilt. Telling the father not to be concerned and stressing that the child will outgrow this developmental phase is false reassurance that does not provide support; the father recognizes that something is wrong.

What is most appropriate for a nurse to say when interviewing a newly admitted depressed client whose thoughts are focused on feelings of worthlessness and failure?

1

"Tell me how you feel about yourself."

2

"Tell me what has been bothering you."

3

"Why do you feel so bad about yourself?"

4

"What can we do to help you while you're here?" ✓ Ans- 1
Because major depression is a result of the client's feelings of self-rejection, it is important for the nurse to have the client initially identify these feelings before developing a plan of care. Later discussion should be focused on other topics to prevent reinforcement of negative thoughts and feelings. "Tell me what has been bothering you" is asking the client to draw a conclusion; the client may be unable to do so at this time. Also, depression may be related not to external events but instead to a client's psychobiology. Asking why does not let a client explore feelings; it usually elicits an "I don't know" response. "What can we do to help you while you're here?" is beyond the scope of the client's abilities at this time.

A client is admitted to the mental health unit with the diagnosis of major depressive disorder. Which statement alerts the nurse to the possibility of a suicide attempt?

1

"I don't feel too good today."

2."I feel much better; today is a lovely day."

3

"I feel a little better, but it probably won't last." 4

"I'm really tired today, so I'll take things a little slower." ✓ Ans- 2

A rapid mood upswing and psychomotor change may signal that the client has made a decision and has developed a plan for suicide. "I don't feel too good today"; "I feel a little better, but it probably won't last"; and "I'm really tired today, so I'll take things a little slower" are all typical of the depressed client; none of these statements signals a change in mood.

During a group discussion it is learned that a group member hid suicidal urges and committed suicide several days ago. What should the nurse leading the group be prepared to manage?

1

Guilt of the co-leaders for failing to anticipate and prevent the suicide 2

Guilt of group members because they could not prevent another's suicide 3

Lack of concern over the suicide expressed by several of the members in the group

4.Fear by some members that their own suicidal urges may go unnoticed and that they may go unprotected ✓ Ans- 4

Ambivalence about life and death, plus the introspection commonly found in clients with emotional problems, can lead to increased anxiety and fear among the group members.

These feelings must be handled within the support and supervisory systems for the staff; the group members are the primary concern. Guilt that the group's leaders or members might feel because they could not prevent another's suicide will probably be a secondary concern of the group leader. Lack of concern over the suicide expressed by several of the members in the group is not a primary concern, but this should be explored later to determine the reason for such apparent indifference, which may be a mask to cover true feelings.

Which screening report will help the nurse determine skeletal growth in a child?

1

Electroencephalogram reports

2.Radiographs of the hand and wrist

3

Magnetic resonance imaging (MRI)

4

Denver Developmental Screening Test ✓ Ans- 2

Skeletal growth in a child can be determined from the ossification centers. At 5 to 6 months of age, the capitate and hamate bones in the wrist are the earliest centers. Therefore radiographs of the hand and wrist will help determine skeletal growth in the child. Electroencephalogram reports will help assess a child's brain activity. MRI is used to scan the internal structures of a client. The Denver Developmental Screening Test is used to understand developmental issues of a child.

A client describes his delusions in minute detail to the nurse. How should the nurse respond?

1.Changing the topic to reality-based events

2

Continuing to discuss the delusion with the client 3

Getting the client involved in a social project with peers

4

Disputing the perceptions with the use of logical thinking ✓ Ans- 1

Decreasing time spent on delusions prevents reinforcement of psychotic thinking. Discussing reality-based events improves contact with reality. Encouraging discussion will give validity to the delusion. The client will have difficulty getting involved in a social activity; the activity will not stop the delusion. Challenging the client may increase anxiety.

A nurse working on a mental health unit is caring for several clients who are at risk for suicide. Which client is at the greatest risk for successful suicide?

1

Young adult who is acutely psychotic

2

Adolescent who was recently sexually abused

3.Older single man just found to have pancreatic cancer

4

Middle-age woman experiencing dysfunctional grieving ✓ Ans- 3

Older single men with chronic health problems are at the highest risk of suicide. This is because men have fewer social supports than women do. (Men are less social then women in general.) Less social support at times of stress can increase the risk of suicide. Also, chronic health problems can lead to learned helplessness, which can lead to depression. People who are acutely psychotic as a group are at higher risk for suicide, but they do not have the suicide rate of older single adult men with chronic health problems. An adolescent who was recently sexually abused, although severely traumatized, does not have the risk of suicide of an older single man with chronic health problems. Dysfunctional grieving is prolonged grieving that is characterized by greater disability and dysfunctional patterns of behavior. Although people with complicated dysfunctional grieving may be at risk for selfdirected violence, they do not have the suicide risk of older single men with chronic health problems.

Which stages would the nurse explain that a toddler goes through, according to Freud's theory? Select all that apply.

1

Oral

2

Anal

3

Phallic

4

Genital

5

Latency ✓ Ans- 1,2

According to Freud's theory, a toddler goes through the oral and anal stages. The phallic stage is seen in children between the ages of 3 to 6 years. The genital stage is seen during puberty through adulthood. The latency stage is seen in children ages 6 to 12 years of age.

A client is found to have a borderline personality disorder. What behavior does the nurse consider is most typical of these clients?

1

Inept

2

Eccentric

3

Impulsive

4

Dependent ✓ Ans- 3

Impulsive, potentially self-damaging behaviors are typical of clients with this personality disorder. Inept behavior, by itself, is not typical of clients with any specific personality disorder. Eccentric behavior is more typical of the client with a schizotypal personality disorder. Dependent behavior is more typical of the client with a dependent personality disorder.

An older adult, accompanied by family members, is admitted to a long-term care facility with symptoms of dementia. What initial statement by the nurse during the admission procedure would be most helpful to this client? 1

"You're a little disoriented now, but don't worry. You'll be all right in a few days." 2

"Don't be afraid. I'm your nurse, and everyone here in the hospital is here to help you." 3

"I'm the nurse on duty today. You're in the hospital. Your family can stay with you for a while."

4

"Let me introduce you to the staff here first. In a little while I'll get you acquainted with our unit routine." ✓ Ans- 2

Familiarity with the environment and a self-introduction may help promote security and feelings of trust. Telling the client "You're a little disoriented now, but don't worry. You'll be all right in a few days" denies the client's feelings and provides false reassurance. A selfintroducing one's self followed by telling the client that of being in the hospital and that the family may stay for a while denies the client's feelings but does provide self-introduction and orientation regarding the client's location. A person under stress cannot assimilate much information; verbiage could lead to more confusion.

Which identity may fail to develop if the adolescent fails to feel a sense of belonging and acceptance?
1

Sexual identity

2

Group identity

3

Family identity

4

Health identity ✓ Ans- 2
Failure to feel acceptance and belonging results in failure to establish a group identity. A lack of physical evidence of maturity can predispose the adolescent to fail to establish a sexual identity. Adolescents depend on these physical cues because they want assurance of maleness or femaleness and do not wish to be different from their peers. If an adolescent fails to foster independence and balance in the family structure, it may hamper family identity. Healthy adolescents evaluate their own health on the basis of feelings of wellbeing, ability to function normally, and absence of symptoms.

In her eighth month of pregnancy, a 24-year-old client is brought to the hospital by the police, who were called when she barricaded herself in a ladies' restroom of a restaurant. During admission the client shouts, "Don't come near me! My stomach is filled with bombs, and I'll blow up this place if anyone comes near me." What does the nurse conclude that the client is exhibiting?
1

Ideas of reference

2

Loose associations

3

Delusional thinking

4

Tactile hallucinations ✓ Ans- 3
Delusions are false fixed beliefs that have a minimal basis in reality. This is a somatic delusion. Ideas of reference are false beliefs that every statement or action of others relates to the individual. Loose associations are verbalizations that sound disjointed to the listener. Tactile hallucinations are false sensory perceptions of touch without external stimuli.

Which should the nurse encourage for a school-age client diagnosed with a chronic illness to enhance a sense of accomplishment?
1

Wearing make-up
2
Making up missed work
3
Participating in sports activities
4
Participating in creative activities ✓ Ans- 2
Making up missed work is an activity the nurse can encourage to enhance a sense of accomplishment for a school-age client who is diagnosed with a chronic illness. Wearing make-up is often encouraged for an adolescent client. Participation in sports activities enhances the development of peer relationship in the school-age child. Participating in creative activities allows the school-age child to learn through concrete operations.

A nurse is caring for a client exhibiting compulsive behaviors. The nurse concludes that the compulsive behavior usually incorporates the use of which defense mechanism? 1
Projection
2
Regression
3
Displacement
4
Rationalization ✓ Ans- 3
Displacement is the unconscious redirection of an emotion from a threatening source to a nonthreatening source. Projection is the attribution of one's unacceptable feelings and thoughts to someone else. Regression is the return to an earlier, more comfortable level of behavior; it is a retreat from the present. Rationalization is the attempt to make unacceptable behavior or feelings acceptable by justifying the reasons for them.

A client is admitted for a biopsy of a tumor in her left breast. The client states, "I know it can't be cancer, because it doesn't hurt." What is the nurse's most therapeutic response?
1
"Let's hope that it isn't malignant."
2
"What do you know about breast cancer?" 3
"Most lumps in the breast are not malignant."
4
"Has your primary healthcare provider told you that it wasn't cancer?" ✓ Ans- 2 Asking what the client knows about breast cancer allows the nurse to assess the client's understanding of breast cancer and to clarify any misconceptions. Saying that they should

hope that the growth isn't malignant avoids an opportunity to teach, and it is a type of false reassurance. The statement may actually increase feelings of hopelessness if the lesion is determined to be malignant. Although correct, stating that most lesions are benign provides a false sense of security and avoids an opportunity to teach. Asking whether the primary healthcare provider has told the client that it wasn't cancer focuses on what the primary healthcare provider said rather than on what the client knows and may limit further communication of feelings and beliefs.

During a survey, the community nurse meets a client who has not visited a gynecologist after the birth of her second child. The client says that her mother or sister never had annual gynecologic examinations. Which factor is influencing the client's health practice? 1

Spiritual belief

2

Family practices

3

Emotional factors

4

Cultural background ✓ Ans- 2
Family practices influence the client's perception of the seriousness of diseases. The client does not feel the need to seek preventive care measures because no family member practices preventive care. The client is not influenced by spiritual beliefs in this instance. An individual's spiritual beliefs and religious practices may restrict the use of certain forms of medical treatment. Emotional factors such as stress, depression, or fear may influence an individual's health practice; however, this client does not show signs of being affected by emotional factors. The client is said to be influenced by cultural background if he or she follows certain beliefs about the causes of illness and uses customary practices to restore health.

A client tells the nurse, "A man is speaking to me from the corner of the room. Can you hear him?" How should the nurse respond?

1

"What's he saying to you? Does it make any sense?" 2

"Yes, I hear him, but I can't understand what he's saying." 3

"I don't hear him. There's no one in the corner of the room."

4

"No, I don't hear him, but is it making you uncomfortable to hear him?" ✓ Ans- 4 The statement "No, I don't hear him, but is it making you uncomfortable to hear him?" points out reality, identifies potential feelings, and prevents the nurse from supporting the hallucination. Asking what the man is saying to the client and whether it makes any sense is nontherapeutic because it supports and focuses on the hallucination. "Yes, I hear him, but I can't understand what he is saying" is nontherapeutic because it supports and focuses on the hallucination; also, it is not truthful. Although denying hearing the voice and pointing out that there is no one else in the room points out reality, this statement does not focus on the client's feelings.

What is the priority nursing objective of the therapeutic psychiatric environment for a confused client?

1

Helping the client relate to others

2

Making the hospital atmosphere more homelike

3

Helping the client become accepted in a controlled setting

4

Maintaining the highest level of safe, independent function ✓ Ans- 4

The therapeutic milieu is directed toward helping the client develop effective ways of functioning safely and independently. Helping the client relate to others is one small part of the overall objectives. The therapeutic milieu allows some items from home to make the client less anxious; however, the objective is not to duplicate a home situation. Helping the client become accepted in a controlled setting is a worthwhile objective but not as important as working toward the maximal degree of safe, independent function.

Before an amniocentesis, both parents express anxiety about the fetus's safety during the test. Which nursing intervention is most appropriate in promoting the parents' ability to cope?

1

Initiating a parent-primary healthcare provider conference

2

Reassuring them that the procedure is safe

3

Explaining the procedure, step by step

4

Arranging for the father to be present during the test ✓ Ans- 3
Giving the parents information about what to expect during the procedure will help allay their fears and encourage their cooperation. The nurse should be able to provide information and interpretation of procedures for clients; a delay in answering questions may increase a client's concerns. Amniocentesis is a low-risk procedure; however, some complications may occur. If the father is uninformed, viewing the procedure may increase his anxiety, even though his presence may be comforting to the mother.

A young client who has just lost her first job comes to the mental health clinic very upset and says, "I just start crying without any reason and without any warning." How should the nurse respond initially?

1

"Do you know what makes you cry?" 2
"Most of us need to cry from time to time." 3

"Crying unexpectedly can be very upsetting."

4

"Are you having any other problems at this time?" ✓ Ans- 3
The response "Crying unexpectedly can be very upsetting" identifies the client's feelings. Asking, "Do you know what makes you cry?" is an unrealistic question; the cause of anxiety may not be known. "Most of us need to cry from time to time" moves the focus away from the client. "Are you having any other problems at this time?" disregards the client's comment; it is a direct question that may impede communication.

The nurse finds a client with schizophrenia lying under a bench in the hall. The client says, "God told me to lie here." What is the best response by the nurse?

1