VERSION 2

ATI MENTAL HEALTH PROCTORED EXAM

1. A charge nurse is discussing mental status examinations with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching? (select all that apply.)

   A. "To assess cognitive ability, I should ask the client to count backward by sevens." counting backward by 7s is an appropriate technique to assess a client's cognitive ability.

   B. "To assess affect, I should observe the client's facial expression." Observing a client's facial expression is appropriate when assessing affect.

C. “To assess language ability, I should instruct the client to write a sentence.” Writing a sentence is an indication of language ability.

2. A nurse is planning care for a client who has a mental health disorder. Which of the following actions should the nurse include as a psychobiological intervention?

   D. Monitor the client for adverse effects of medications. Monitoring for adverse effects of medications is an example of a psychobiological intervention.

3. A nurse in an outpatient mental health clinic is preparing to conduct an initial client interview. When conducting the interview, which of the following actions should the nurse identify as the priority?
   B. Identify the client’s perception of her mental health status. assessment is the priority action when using the nursing process approach to client care. identifying the client’s perception of her mental health status provides important information about the client’s psychosocial history.

4. A nurse is told during change-of-shift report that a client is stuporous. When assessing the client, which of the following findings should the nurse expect?
   A. The client arouses briefly in response to a sternal rub. A client who is stuporous requires vigorous or painful stimuli to elicit a response.

5. A nurse is planning a peer group discussion about the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DsM-5). Which of the following information is appropriate to include in the discussion? (select all that apply.)
   B. the DSM-5 establishes diagnostic criteria for individual mental health disorders.
   D. the DSM-5 assists nurses in planning care for client’s who have mental health disorders.
   E. the DSM-5 indicates expected assessment findings of mental health disorders.

Chapter 2

1. A nurse in an emergency mental health facility is caring for a group of clients. the nurse should identify that which of the following clients requires a temporary emergency admission?
   C. A client who has borderline personality disorder and assaulted a homeless man with a metal rod. A client who is a current danger to self or others is a candidate for a temporary emergency admission.

2. A nurse decides to put a client who has a psychotic disorder in seclusion overnight because the unit is very short-staffed, and the client frequently fights with other clients.

the nurse’s actions are an example of which of the following torts?
B. False imprisonment. A civil wrong that violates a client’s civil rights is a tort. in this case, it is false imprisonment, which is the confining of a client to a specific area, such as a seclusion room, if the reason for such confinement is for the convenience of staff.

3. A client tells a nurse, “don’t tell anyone, but i hid a sharp knife under my mattress in order to protect myself from my roommate, who is always yelling at me and threatening me.” Which of the following actions should the nurse take?
   C. Tell the client that this must be reported to the health care team because it concerns the health and safety of the client and others. The information presented by the client is a serious safety issue that the nurse must report to the health care team. using the ethical principle of veracity, the student tells the client truthfully what must be done regarding the issue.

4. A nurse is caring for a client who is in mechanical restraints. Which of the following statements should the nurse include in the documentation? (select all that apply.)
   B. “Client was offered 8 oz of water every hr.” how much water was offered and how often it was offered is objective data that the nurse should document when caring for a client in mechanical restraints.
   C. “Client shouted obscenities at assistive personnel.” A description of the client’s verbal communication is objective data that the nurse should document when caring for a client in mechanical restraints.
   D. “Client received chlorpromazine 15 mg by mouth at 1000.” The dosage and time of medication administration is objective data that the nurse should document when caring for a client in mechanical restraints

5. A nurse hears a newly licensed nurse discussing a client’s hallucinations in the hallway with another nurse. Which of the following actions should the nurse take first?
   B. tell the nurse to stop discussing the behavior. The greatest risk to this client is an invasion of privacy through the sharing of confidential information in a public place. the first action the nurse should take is to tell the newly licensed nurse to stop discussing the client’s hallucinations in a public location.

   Chapter 3

   1. A charge nurse is conducting a class on therapeutic communication to a group of newly licensed nurses. Which of the following aspects of communication should the nurse identify as a component of verbal communication?
      D. intonation. The nurse should identify intonation as a component of verbal communication. intonation is the tone of one’s voice and can communicate a variety of feelings.

2. A nurse in an acute mental health facility is communicating with a client. the client states, “I can’t sleep. I stay up all night.” the nurse responds, “You are having difficulty sleeping?” Which of the following therapeutic communication techniques is the nurse demonstrating?
   D. Restating. Restating allows the nurse to repeat the main idea expressed.

3. A nurse is communicating with a client who was just admitted for treatment of a substance use disorder. Which of the following communication techniques should the nurse identify as a barrier to therapeutic communication?
   A. Offering advice. Offering advice to a client is a barrier to therapeutic communication that the nurse should avoid using. advice tends to interfere with the client’s ability to make personal decisions and choices.

4. A nurse caring for a client who has anorexia nervosa. Which of the following examples demonstrates the nurse’s use of interpersonal communication?
   C. the nurse asks the client about her body image perception. The nurse’s one-on-one communication with the client is an example of interpersonal communication.

5. A nurse is caring for the parents of a child who has demonstrated recent changes in behavior and mood. When the mother of the child asks the nurse for reassurance about her son’s condition, which of the following responses should the nurse make?
   D. “I understand you’re concerned. Let’s discuss what concerns you specifically.” The therapeutic response reflects upon, and accepts, the parents’ feelings, and it allows them to clarify what they are feeling.

Chapter 4

1. A nurse is caring for a client who smokes and has lung cancer. the client reports, “I’m coughing because I have that cold that everyone has been getting.” The nurse should identify that the client is using which of the following defense mechanisms?
   B. denial. This is an example of denial, which is pretending the truth is not reality to manage the anxiety of acknowledging what is real.

2. A nurse is providing preoperative teaching for a client who was just informed that she requires emergency surgery. the client, has a respiratory rate 30/min, and says,

“this is difficult to comprehend. I feel shaky and nervous.” the nurse should identify that the client is experiencing which of the following levels of anxiety?
B. Moderate anxiety decreases problem-solving and may hamper the client’s ability to understand information. Vital signs may increase somewhat, and the client is visibly anxious.

3. A nurse is caring for a client who is experiencing moderate anxiety. Which of the following actions should the nurse take when trying to give necessary information to the client? (Select all that apply.)
   B. Discuss prior use of coping mechanisms with the client. This assists the client in identifying ways of effectively coping with the current stressor.
   D. Demonstrate a calm manner while using simple and clear directions. Providing a calm presence assists the client in feeling secure and promotes relaxation. clients experiencing moderate levels of anxiety often bene t from the direction of others.

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Chapter 5

1. A nurse is talking with a client who is at risk for suicide following the death of his spouse. Which of the following statements should the nurse make?
   C. “Losing someone close to you must be very upsetting.” This statement is an empathetic response that attempts to understand the client’s feelings.

2. A charge nurse is discussing the characteristics of a nurse-client relationship with a newly licensed nurse. Which of the following characteristics should the nurse include in the discussion? (Select all that apply.)
   C. It is goal-directed. A therapeutic nurse-client relationship is goal-directed.

   D. Behavioral change is encouraged. A therapeutic nurse-client relationship encourages positive behavioral change.
   E. A termination date is established. A therapeutic nurse-client relationship has an established termination date.

3. A nurse is in the working phase of a therapeutic relationship with a client who has methamphetamine use disorder. Which of the following actions indicates transference behavior?
   B. The client accuses the nurse of telling him what to do just like his ex-girlfriend. When a client views the nurse as having characteristics of another person who has been significant to his personal life, such as his ex-girlfriend, this indicates transference.

4. A nurse is planning care for the termination phase of a nurse-client relationship. Which of the following actions should the nurse include in the plan of care?
   A. Discussing ways to use new behaviors into life is an appropriate task for the termination phase.

5. A nurse is orienting a new client to a mental health unit. When explaining the unit's community meetings, which of the following statements should the nurse make?
   C. "You and the other clients will meet with staff to discuss common problems." Community meetings are an opportunity for clients to discuss common problems or issues affecting all members of the unit.

Chapter 6

1. A nurse is caring for several clients who are attending community-based mental health programs. Which of the following clients should the nurse plan to visit first?
   C. A client who says he is hearing a voice that tells him he is not worthy of living anymore. A client who hears a voice telling him he is not worthy is at greatest risk for self-harm, and the nurse should visit this client first.

2. A community mental health nurse is planning care to address the issue of depression among older adult clients in the community. Which of the following interventions should the nurse plan as a method of tertiary prevention?
   C. establishing rehabilitation programs to decrease the effects of depression. Rehabilitation programs are an example of tertiary prevention. tertiary prevention deals with prevention of further problems in clients already diagnosed with mental illness.

3. A nurse is working in a community mental health facility. Which of the following services does this type of program provide? (select all that apply.)
   A. educational groups
   B. Medication dispensing programs
   C. individual counseling programs
   E. Family therapy

4. A nurse in an acute mental health facility is assisting with discharge planning for a client who has a severe mental illness and requires supervision much of the time. the client's wife works all day but is home by late afternoon. Which of the following strategies should the nurse suggest as appropriate follow-up care?

C. attending a partial hospitalization program. A partial hospitalization program can provide treatment during the day while allowing the client to spend nights at home, as long as a responsible family member is present.

5. A nurse is caring for a group of clients. Which of the following clients should a nurse consider for referral to an assertive community treatment (act) group?
1. B. a client who lives at home and keeps "forgetting" to come in for his monthly antipsychotic injection for schizophrenia. An ACT group works with clients who are nonadherent with traditional therapy, such as the client in a home setting who keeps "forgetting" his injection.

Chapter 7

1. A nurse is teaching a client who has an anxiety disorder and is scheduled to begin classical psychoanalysis. Which of the following client statements indicates an understanding of this form of therapy?
2. B. "The therapist will focus on my past relationships during our sessions." Classical psychoanalysis places a common focus on past relationships to identify the cause of the anxiety disorder.

2. A nurse is discussing free association as a therapeutic tool with a client who has major depressive disorder. Which of the following client statements indicates understanding of this technique?
   D. "I should say the first thing that comes to my mind." Free association is the spontaneous, uncensored verbalization of whatever comes to a client's mind.

3. A nurse is preparing to implement cognitive reframing techniques for a client who has an anxiety disorder. Which of the following techniques should the nurse include in the plan of care? (select all that apply.)
   A. Priority restructuring
   B. Monitoring thoughts
   D. Journal keeping

4. A nurse is caring for a client who has a new prescription for disulfiram for treatment of alcohol use disorder. The nurse informs the client that this medication can cause nausea and vomiting if he drinks alcohol. Which of the following types of treatment is this method an example?
   A. Aversion therapy pairs a maladaptive behavior with unpleasant stimuli to promote a change in behavior.

   B. A nurse is assisting with systematic desensitization for a client who has an extreme fear of elevators. Which of the following actions should the nurse implement with this form of therapy?
   C. Gradually expose the client to an elevator while practicing relaxation techniques. systematic desensitization is the planned, progressive exposure to anxiety-provoking stimuli. during this exposure, relaxation techniques suppress the anxiety response.

Chapter 8 – Group and Family Therapy

1. A nurse wants to use democratic leadership with a group whose purpose is to learn appropriate conflict resolution techniques. The nurse is correct in implementing this form of group leadership when she demonstrates which of the following actions?
   C. asks for group suggestions of techniques and then supports discussion. Democratic leadership supports group interaction and decision making to solve problems

2. A nurse is planning group therapy for clients dealing with bereavement. Which of the following activities should the nurse include in the initial phase? (Select all that apply.)
   B. Define the purpose of the group.
   C. Discuss termination of the group.
   E. Establish an expectation of confidentiality within the group.

3. A nurse working on an acute mental health unit forms a group to focus on self-management of medications. at each of the meetings, two of the members use the opportunity to discuss their common interest in gambling on sports. This is an example of which of the following concepts?
   D. hidden agenda is when some group members have a different goal than the stated group goals. The hidden agenda is often disruptive to the effective functioning of the group.

4. A nurse is conducting a family therapy session. The adolescent son tells the nurse that he plans ways to make his sister look bad so his parents will think he's the better sibling, which he believes will give him more privileges. The nurse should identify this dysfunctional behavior as which of the following?
   B. manipulation is the dysfunctional behavior of using dishonesty to support an individual agenda.

5. A nurse is working with an established group and identifies various member roles. Which of the following should the nurse identify as an individual role?
   C. A member who brags about accomplishments. An individual who brags about accomplishments is acting in an individual role that does not promote the progression of the group toward meeting goals.

Chapter 9 – Stress Management

1. A nurse is preparing to provide an educational seminar on stress to other nursing staff. Which of the following information should the nurse include in the discussion?
   A. excessive stressors cause the client to experience distress. Distress is the result of excessive or damaging stressors, such as anxiety or anger.

2. A nurse is discussing acute vs. prolonged stress with a client. Which of the following effects should the nurse identify as an acute stress response? (Select all that apply.)
   B. Depressed immune system
   C. Increased blood pressure
   E. Unhappiness

3. A nurse is teaching a client about stress-reduction techniques. Which of the following client statements indicates understanding of the teaching?
   A. "Cognitive reframing will help me change my irrational thoughts to something positive." Cognitive reframing helps the client look at irrational cognitions (thoughts) in a more realistic light and to restructure those thoughts in a more positive way.

4. A client says she is experiencing increased stress because her significant other is "pressuring me and my kids to go live with him. I love him, but I'm not ready to do that." Which of the following recommendations should the nurse make to promote a change in the client's situation?
   B. Use assertiveness techniques. Assertive communication allows the client to assert her feelings and then make a change in the situation.

5. A nurse is caring for a client who states, “I’m so stressed at work because of my coworker. He expects me to finish his work because he’s too lazy!” When discussing effective communication, which of the following statements by the client to his coworker indicates client understanding?
   D. “When I have to pick up extra work, I feel very overwhelmed. I need to focus on my own responsibilities.” This response demonstrates assertive communication, which allows the client to state his feelings about the behavior and then promote a change.

Chapter 10 – Brain stimulation Therapies

1. A nurse is providing teaching for a client who is scheduled to receive eCt for the treatment of major depressive disorder. Which of the following client statements indicates understanding of the teaching?
   D. “I will receive a muscle relaxant to protect me from injury during ECT.” A muscle relaxant, such as succinylcholine, is administered to reduce the risk for injury during induced seizure activity.

2. A charge nurse is discussing TMS with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching?
   D. “I will schedule the client for daily TMS treatments for the first several weeks.” TMS is commonly prescribed daily for a period of 4 to 6 weeks.

3. A nurse is assessing a client immediately following an ECT procedure. Which of the following findings should the nurse expect? (Select all that apply.)
   C. memory loss
   D. nausea
   e. Confusion

4. A nurse is leading a peer group discussion about the indications for ECT. Which of the following indications should the nurse include in the discussion?
   C. Bipolar disorder with rapid cycling

5. A nurse is planning care for a client following surgical implantation of a VNS device. the nurse should plan to monitor for which of the following adverse effects? (Select all that apply.)