d. Experienced psychiatric nurses have learned the best ways to care for psychotic patients through trial and error.
e. Effective psychiatric nurses should be continually guided by an intuitive sense of patients' needs.

ANS: A, B
Evidence-based practice involves using research findings to provide the most effective nursing care. Evidence is continually emerging; therefore, nurses cannot rely solely on experience. The effective nurse also maintains respect for each patient as an individual. Overgeneralization compromises that perspective. Intuition and trial and error are unsystematic approaches to care.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe, Effective Care Environment

2. Which patient statements identify qualities of nursing practice with high therapeutic value? "My nurse: (*Select all that apply*.)
   a. "The nurses talk in language I can understand."
   b. "The nursing staff helps me keep track of my medications."
   c. "My nurse is willing to go to social activities with me."
   d. "The staff lets me do whatever I choose without interfering."
   e. "My nurses look at me as a whole person with different needs."

   ANS: A, B, E
   Each correct answer demonstrates caring is an example of appropriate nursing foci: communicating at a level understandable to the patient, using holistic principles to guide care, and providing medication supervision. The incorrect options suggest a laissez-faire attitude on the part of the nurse when the nurse should instead provide thoughtful feedback and help patients test alternative solutions or violate boundaries.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

Chapter 02: Mental Health and Mental Illness
Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 5e

MULTIPLE CHOICE

1. An 86 year old, previously healthy and independent, falls after an episode of vertigo. Which statement made by this patient best demonstrates resilience?
   a. "I knew this would happen eventually."
   b. "Attending my weekly water aerobics class is too risky."
   c. "I don't need that silly walker to get around by myself."
   d. "Maybe some physical therapy will help me with my balance."

   ANS: D

Resiliency is the ability to recover from or adjust to misfortune and change. The correct response indicates that the patient is hopeful and thinking positively about ways to adapt to the vertigo. Saying "I knew this would happen eventually" and discontinuing healthy activities suggest a hopeless perspective on the health change. Refusing to use a walker indicates denial.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

2. Which basic intervention should a psychiatric mental health nurse plan to provide for a patient diagnosed with a mood disorder?
   a. Sharing clinical expertise to enhance patient treatment
   b. Performing individual or group psychotherapy for the patient
   c. Using appropriate diagnostic tests to monitor patient condition
   d. Conducting stress reduction and health maintenance classes

   ANS: D
   Conducting stress reduction and health maintenance classes is the basic intervention that should be performed by a psychiatric mental health nurse. These classes will provide individualized guidance to patients to prevent or reduce mental illness and improve mental health. Community screenings and stress management classes are examples of health maintenance classes. Consulting nurses from other disciplines to share clinical expertise and enhance patient treatment is an advanced practice psychiatric mental health nursing intervention. Performing individual and group psychotherapy and performing diagnostic tests like blood pressure, etc., are also advanced practice psychiatric mental health nursing interventions.

   DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning
   MSC: NCLEX: Psychosocial Integrity

3. A patient is admitted to the psychiatric hospital. Which assessment finding best indicates that the patient has a mental illness? The patient:
   a. describes coping and relaxation strategies used when feeling anxious.
   b. describes mood as consistently sad, discouraged, and hopeless.
   c. can perform tasks attempted within the limits of own abilities.
   d. reports occasional problems with insomnia.

   ANS: B
   A patient who reports having a consistently negative mood is describing a mood alteration that affects the ability to function optimistically. The incorrect options describe mentally healthy behaviors and common problems that do not indicate mental illness.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

4. The goal for a patient is to increase resiliency. Which outcome should a nurse add to the plan of care to be achieved within 3 days?
   a. Patient describes feelings associated with loss and stress.
   b. Patient meet own needs before considering the rights of others.
   c. Patient will identify healthy coping behaviors in response to stressful events.
   d. Patient will allow others to assume responsibility for major areas of own life.

ANS: C
The patient's ability to identify healthy coping behaviors indicates adaptive, healthy behavior and demonstrates an increased ability to recover from severe stress. Describing feelings associated with loss and stress does not move the patient toward adaptation. The remaining options are maladaptive behaviors.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Outcomes Identification
MSC: NCLEX: Psychosocial Integrity

5. A nurse at a behavioral health clinic sees an unfamiliar psychiatric diagnosis on a patient's insurance form. Which resource should the nurse consult to discern the criteria used to establish this diagnosis?
   a. A psychiatric nursing textbook
   b. *NANDA International (NANDA-I)*
   c. A behavioral health reference manual
   d. *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*)

   ANS: D
   The *DSM-5* gives the criteria used to diagnose each mental disorder. The *NANDA-I* focuses on nursing diagnoses. A psychiatric nursing textbook or behavioral health reference manual may not contain diagnostic criteria.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Analysis | Nursing Process: Diagnosis
   MSC: NCLEX: Safe, Effective Care Environment

6. A nurse must assess several new patients at a community mental health center. Conclusions concerning current functioning should be made on the basis of what factor?
   a. The degree of conformity of the individual to society's norms.
   b. The degree to which an individual appears logical and rational.
   c. A continuum from mentally healthy to mentally unhealthy.
   d. The rate of their intellectual and emotional growth.

   ANS: C
   Because mental health and mental illness are relative concepts, assessment of functioning is made by using a continuum. Mental health is not based on conformity; some mentally healthy individuals do not conform to society's norms. Most individuals occasionally display illogical or irrational thinking. The rate of intellectual and emotional growth is not the most useful criterion to assess mental health or mental illness.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Diagnosis | Nursing Process: Analysis
   MSC: NCLEX: Psychosocial Integrity

7. A 40-year-old adult living with parents' states, "I'm happy but I don't socialize much. My work is routine. When new things come up, my boss explains them a few times to make sure I understand. At home, my parents make decisions for me, and I go along with them." A nurse should identify interventions to improve which patient characteristic?
   a. Self-concept
   b. Overall happiness

c. Appraisal of reality
d. Control over behavior

ANS: A
The patient feels the need for multiple explanations of new tasks at work and, despite being 40 years of age, allows both parents to make all decisions. These behaviors indicate a poorly developed self-concept. Although the patient reports being happy, the subsequent comments refute that self-appraisal. The patient's comments do not indicate that he/she is out of touch with reality. The patient's needs are broader than control over own behavior.

DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning
MSC: NCLEX: Psychosocial Integrity

8. A patient tells a nurse, "I have psychiatric problems and am in and out of hospitals all the time. Not one of my friends or relatives has these problems." What is the nurse's best response?
   a. "Comparing yourself with others has no real advantages."
   b. "Why do you blame yourself for having a psychiatric illness?"
   c. "Mental illness affects 50% of the adult population in any given year."
   d. "Are you are concerned that others don't experience the same challenges as you."

   ANS: D
   Mental illness affects many people at various times in their lives. No class, culture, or creed is immune to the challenges of mental illness. The correct response also demonstrates the use of reflection, a therapeutic communication technique. It is not true that mental illness affects 50% of the population in any given year. Asking patients if they blame themselves is an example of probing.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. A critical care nurse asks a psychiatric nurse about the difference between a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) and a nursing diagnosis. What is the psychiatric nurse's best response?
   a. "No functional difference exists between the two diagnoses. Both serve to identify a human deviance."
   b. "The *DSM-5* diagnosis disregards culture, whereas the nursing diagnosis includes cultural variables."
   c. "The *DSM-5* diagnosis profiles present distress or disability, whereas a nursing diagnosis considers past and present responses to actual mental health problems."
   d. "The *DSM-5* diagnosis influences the medical treatment; the nursing diagnosis offers a framework to identify interventions for problems a patient has or may experience."

   ANS: D
   The medical diagnosis, defined according to the *DSM-5*, is concerned with the patient's disease state, causes, and cures, whereas the nursing diagnosis focuses on the patient's response to stress and possible caring interventions. Both the *DSM-5* and a nursing diagnosis consider culture. Nursing diagnoses also consider potential problems.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

10. The partner of a patient diagnosed with schizophrenia says, "I don't understand why childhood experiences have anything to do with this disabling illness." Which nurse's response will best help the partner understand this condition?
    a. "Psychological stress is actually at the root of most mental disorders."
    b. "We now know that all mental illnesses are the result of genetic factors."
    c. "It must be frustrating for you that your spouse is sick so much of the time."
    d. "Research has shown schizophrenia has a biological rather than psychological origin."

    ANS: D
    Many of the most prevalent and disabling mental disorders have been found to have strong biological influences. Helping the partner understand the importance of his or her role as a caregiver is also important. Empathy is important but does not increase the spouse's level of knowledge about the cause of the patient's condition. Not all mental illnesses are the result of genetic factors. Psychological stress is not at the root of most mental disorders.

    DIF: Cognitive Level: Application (Applying)
    TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

11. Which belief by a nurse supports the highest degree of patient advocacy during a multidisciplinary patient care planning session?
    a. All mental illnesses are culturally determined.
    b. Schizophrenia and bipolar disorder are cross-cultural disorders.
    c. Symptoms of mental disorders are constant from culture to culture.
    d. Some symptoms of mental disorders may reflect a person's cultural patterns.

    ANS: D
    A nurse who understands that a patient's symptoms are influenced by culture will be able to advocate for the patient to a greater degree than a nurse who believes that culture is of little relevance. All mental illnesses are *not* culturally determined. Schizophrenia and bipolar disorder are cross-cultural disorders, but this understanding has little relevance to patient advocacy. Symptoms of mental disorders change from culture to culture.

    DIF: Cognitive Level: Application (Applying) TOP: Nursing Process: Planning
    MSC: NCLEX: Safe, Effective Care Environment

12. A patient's history shows intense and unstable relationships with others. The patient initially idealizes an individual and then devalues the person when the patient's needs are not met. Which aspect of mental health is a problem for this patient?
    a. Effectiveness in work
    b. Communication skills
    c. Productive activities
    d. Maintaining relationships

    ANS: D
    The information provided centers on relationships with others, which are described as intense and unstable. The relationships of mentally healthy individuals are stable, satisfying, and socially integrated. Data are not present to describe work effectiveness, communication skills, or activities.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

13. In the majority culture of the United States, which individual is at greatest risk to be incorrectly labeled mentally ill?
    a. Person who is usually pessimistic but strives to meet personal goals.
    b. Wealthy person who gives $20 bills to needy individuals in the community.
    c. Person with an optimistic viewpoint about getting his or her own needs met.
    d. Person who expresses strong beliefs about the existence of alien abductions.

    ANS: D
    Possessing and expressing unpopular or unsubstantiated beliefs often suggests an individual is mentally unstable. In this situation, cultural norms vary, making it more difficult to make an accurate *DSM-5* diagnosis. The individuals described in the other options are less likely to be labeled as mentally ill.

    DIF: Cognitive Level: Application (Applying)
    TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

14. A participant at a community education conference asks, "What is the most prevalent type of mental disorder in the United States?" What is the nurse's best response?
    a. "Why do you ask?"
    b. "Schizophrenia"
    c. "Affective disorders"
    d. "Anxiety disorders"

    ANS: D
    The prevalence for schizophrenia is 1.1% per year. The prevalence of all affective disorders (e.g., depression, dysthymic disorder, bipolar) is 9.5%. The prevalence of anxiety disorders is 18.1%.

    DIF: Cognitive Level: Comprehension (Understanding)
    TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

15. A nurse wants to find a description of diagnostic criteria for a person diagnosed with schizophrenia. Which resource should the nurse consult?
    a. U.S. Department of Health and Human Services
    b. *Journal of the American Psychiatric Association*
    c. *North American Nursing Diagnosis Association International* (NANDA-I)
    d. *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*)

    ANS: D
    The *DSM-5* identifies diagnostic criteria for psychiatric diagnoses. The other sources have useful information but are not the best resources for finding a description of the diagnostic criteria for a psychiatric disorder.

    DIF: Cognitive Level: Application (Applying)
    TOP: Nursing Process: Analysis | Nursing Process: Diagnosis
    MSC: NCLEX: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A patient in the emergency department reports, “I hear voices saying someone is stalking me. They want to kill me because I found the cure for cancer. I will stab anyone that threatens me.” Which aspects of mental health have the greatest immediate concern to a nurse? (*Select all that apply.*)
   a. Happiness
   b. Appraisal of reality
   c. Control over behavior
   d. Effectiveness in work
   e. Healthy self-concept

   ANS: B, C, E
   The aspects of mental health of greatest concern are the patient’s appraisal of and control over behavior. The patient’s appraisal of reality is inaccurate, and auditory hallucinations are evident, as well as delusions of persecution and grandeur. In addition, the patient’s control over behavior is tenuous, as evidenced by the plan to “stab” anyone who seems threatening. A healthy self-concept is lacking. Data are not present to suggest that the other aspects of mental health (happiness and effectiveness in work) are of immediate concern.

   DIF: Cognitive Level: Application (Applying)
   TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment

2. Which statements most clearly reflect the stigma of mental illness? (*Select all that apply.*)
   a. “Many mental illnesses are hereditary.”
   b. “Mental illness can be evidence of a brain disorder.”
   c. “People claim mental illness, so they can qualify for disability.”
   d. “If people with mental illness went to church, they would be fine.”
   e. “Mental illness is a result of the breakdown of the American family.”

   ANS: C, D, E
   Stigma is represented by judgmental remarks that discount the reality and validity of mental illness. Many mental illnesses are genetically transmitted. Neuroimaging can show changes associated with some mental illnesses.

   DIF: Cognitive Level: Analysis (Analyzing)
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment

Chapter 03: Theories and Therapies
Varcarolis: Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care, 5e

MULTIPLE CHOICE

1. A 26-month-old child displays negative behaviors. The parent says, “My child refuses toilet training and shouts, ‘No!’ when given direction. What do you think is wrong?” Select the nurse’s best reply.
   a. “This is normal for your child’s age. The child is striving for independence.”
   b. “The child needs firmer control. Punish the child for disobedience and say, ‘No.’”
   c. “There may be developmental problems. Most children are toilet trained by age 2 years.”

d. "Some undesirable attitudes are developing. A child psychologist can help you develop a remedial plan."

ANS: A
These negative behaviors are typical of a child around the age of 2 years whose developmental task is to develop autonomy. The incorrect options indicate the child's behavior is abnormal.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

2. A 26-month-old child displays negative behavior, refuses toilet training, and often shouts, "No!" when given directions. Using Freud's stages of psychosexual development, a nurse would assess the child's behavior is based on which stage?
   a. Oral
   b. Anal
   c. Phallic
   d. Genital

   ANS: B
   In Freud's stages of psychosexual development, the anal stage occurs from age 1 to 3 years and has, as its focus, toilet training and learning to delay immediate gratification. The oral stage occurs between birth and 1 year, the phallic stage occurs between 3 and 5 years, and the genital stage occurs between 13 and 20 years.

   DIF: Cognitive Level: Comprehension (Understanding)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

3. A 26-month-old child displays negative behavior, refuses toilet training, and often shouts, "No!" when given direction. The nurse's counseling with the parent should be based on the premise that the child is engaged in which of Erikson's psychosocial crises?
   a. Trust versus Mistrust
   b. Initiative versus Guilt
   c. Industry versus Inferiority
   d. Autonomy versus Shame and Doubt

   ANS: D
   The crisis of Autonomy versus Shame and Doubt is related to the developmental task of gaining control of self and environment, as exemplified by toilet training. This psychosocial crisis occurs during the period of early childhood. Trust versus Mistrust is the crisis of the infant, Initiative versus Guilt is the crisis of the preschool and early school-aged child, and Industry versus Inferiority is the crisis of the 6- to 12-year-old child.

   DIF: Cognitive Level: Comprehension (Understanding)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

4. A 4-year-old child grabs toys from siblings, saying, "I want that toy now!" The siblings cry, and the child's parent becomes upset with the behavior. Using the Freudian theory, a nurse can interpret the child's behavior as a product of impulses originating in the:
   a. id.
   b. ego.

c. superego.
d. preconscious.

ANS: A
The id operates on the pleasure principle, seeking immediate gratification of impulses. The ego acts as a mediator of behavior and weighs the consequences of the action, perhaps determining that taking the toy is not worth the parent's wrath. The superego would oppose the impulsive behavior as "not nice." The preconscious is a level of awareness.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

5. The parent of a 4 year old rewards and praises the child for helping a younger sibling, being polite, and using good manners. A nurse supports the use of praise because, according to the Freudian theory, these qualities will likely be internalized and become what part of the child's personality?
a. Id
b. Ego
c. Superego
d. Preconscious

ANS: C
In the Freudian theory, the superego contains the "thou shalts" or moral standards internalized from interactions with significant others. Praise fosters internalization of desirable behaviors. The id is the center of basic instinctual drives, and the ego is the mediator. The ego is the problem-solving and reality-testing portion of the personality that negotiates solutions with the outside world. The preconscious is a level of awareness from which material can be easily retrieved with conscious effort.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

6. A nurse supports parental praise of a child who is behaving in a helpful way. When the individual behaves with politeness and helpfulness in adulthood, which ego ideal will most likely result?
a. Curiosity
b. Awareness
c. Honesty
d. Self-esteem

ANS: D
The individual will be living up to the ego ideal, which will result in positive feelings about self. None of the other characteristics are as closely associated with the ego.

DIF: Cognitive Level: Comprehension (Understanding)
TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance

7. A patient comments, "I never know the right answer" and "My opinion is not important." Using Erikson's theory, which psychosocial crisis did the patient have difficulty resolving?
a. Initiative versus Guilt
b. Trust versus Mistrust
c. Autonomy versus Shame and Doubt
d. Generativity versus Self-Absorption

ANS: C
These statements show severe self-doubt, indicating that the crisis of gaining control over the environment is not being successfully met. Unsuccessful resolution of the crisis of Initiative versus Guilt results in feelings of guilt. Unsuccessful resolution of the crisis of Trust versus Mistrust results in poor interpersonal relationships and suspicion of others. Unsuccessful resolution of the crisis of Generativity versus Self-Absorption results in self-absorption that limits the ability to grow as a person.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

8. Which patient statement would lead a nurse to suspect that the developmental task of infancy was not successfully completed?
   a. "I have very warm and close friendships."
   b. "I'm afraid to let anyone really get to know me."
   c. "I am always right and confident about my decisions."
   d. "I'm ashamed that I didn't do it correctly in the first place."

ANS: B
According to Erikson, the developmental task of infancy is the development of trust. The patient's statement that he or she is afraid of becoming acquainted with others clearly shows a lack of ability to trust other people. Having warm and close friendships suggests the developmental task of infancy was successfully completed. Believing one is always right suggests rigidity rather than mistrust. Feelings of shame suggest failure to resolve the crisis of Initiative versus Guilt.

DIF: Cognitive Level: Analysis (Analyzing)
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

9. A nurse assesses that a patient is suspicious and frequently manipulates others. Using the Freudian theory, these traits are related to which psychosexual stage?
   a. Oral
   b. Anal
   c. Phallic
   d. Genital

ANS: A
According to Freud, each of the behaviors mentioned develops as the result of attitudes formed during the oral stage, when an infant first learns to relate to the environment. Anal stage traits include stinginess, stubbornness, orderliness, or their opposites. Phallic stage traits include flirtatiousness, pride, vanity, difficulty with authority figures, and difficulties with sexual identity. Genital stage traits include the ability to form satisfying sexual and emotional relationships with members of the opposite sex, emancipation from parents, and a strong sense of personal identity.

DIF: Cognitive Level: Application (Applying)
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

10. An adult expresses the wish to be taken care of and often behaves in a helpless fashion. This adult has needs related to which of Freud's stages of psychosexual development?
    a. Latency