**Psychiatric Mental Health Nursing**

**1**. **A client complains of experiencing an overwhelming urge to sleep. He states that he’s been falling asleep while working at his desk. He reports that these episodes occur about five times daily. This client is most likely experiencing which sleep disorder?**

1. Breathing-related sleep disorder

2. Narcolepsy

3. Primary hypersomnia

4. Circadian rhythm disorder

*Answer:* 2. Narcolepsy is characterized by irresistible attacks of refreshing sleep that occur two to six times per day and last for 5 to 20 minutes. The client with breathing-related sleep disorder suffers interruptions in sleep that leave the client with excess sleepiness. In hypersomnia, the client suffers excess sleepiness and reports prolonged periods of nighttime sleep or daytime napping. With circadian rhythm disorder, the client has periods of insomnia followed by periods of increased sleepiness.

**2. A nurse is caring for a client who complains of fatigue, inability to concentrate, and palpitations. The client states that she has been experiencing these symptoms for the past 6 months. The nurse suspects that the client is experiencing circadian rhythm sleep disturbance related to which factor?**

1. History of recent fever

2. Shift work

3. Hyperthyroidism

4. Pheochromocytoma

Answer: 2. The client is experiencing circadian rhythm sleep disorder (palpitations, GI disturbances, fatigue, haggard appearance,

and poor concentration), which is typically caused by shift work, jet lag, or a delayed sleep phase. Fever is a contributing factor in parasomnias. Hyperthyroidism and pheochromocytoma are causative factors for primary

insomnia.

**3. A client comes to the clinic complaining of the inability to sleep over the past 2 months. He states that his inability to sleep is ruining his life because “getting sleep” is all he can think about. This client is most likely experiencing which sleep disorder?**

1. Circadian rhythm sleep disorder

2. Breathing-related sleep disorder

3. Primary insomnia

4. Primary hypersomnia

Answer: 3. The client with primary insomnia experiences difficulty initiating or maintaining sleep. A key symptom of primary insomnia is

the client’s intense focus and anxiety about not getting to sleep. The client diagnosed with circadian rhythm sleep disorder reports periods of insomnia at particular times during a 24-hour period and excessive sleepiness

**4. A nurse is preparing a teaching plan for a client diagnosed with primary insomnia. Which teaching topic should be included?**

1. Eating unlimited spicy foods and limiting caffeine and alcohol

2. Exercising 1 hour before bedtime to promote sleep

3. Importance of sleeping whenever the client tires

4. Drinking warm milk before bed to induce sleep

Answer: 4. Clients diagnosed with primary insomnia should be taught that drinking warm milk before bedtime can help induce sleep. They should also be taught the importance of limiting spicy foods, alcohol, and caffeine;

A voiding exercise within 3 hours before bedtime; establishing a routine bedtime; and avoiding napping.

**5. A nurse is caring for a client hospitalized on numerous occasions for complaints of chest pain and fainting spells, which she attributes to her deteriorating heart condition. No relatives or friends report ever actually**

**seeing a fainting spell. After undergoing an extensive cardiac, pulmonary, GI, and neurologic work-up, she’s told that all test results are completely negative. The client remains persistent in her belief that she has a serious**

**illness. What diagnosis is appropriate for this client?**

1. Exhibitionism

2. Somatoform disorder

3. Degenerative dementia

4. Echolalia

Answer: 2. Somatoform disorders are characterized by recurrent and multiple physical symptoms that have no organic or physiologic base. Exhibitionism involves public exposure of genitals. Degenerative dementia is characterized by deterioration of mental capacities. Echolalia is a repetition of words or phrases.

**6. A client is prescribed sertraline (Zoloft), a selective serotonin reuptake inhibitor. Which adverse effects about this drug should the nurse include when creating a medication teaching plan? Select all that apply.**

1. Agitation

2. Agranulocytosis

3. Sleep disturbance

4. Intermittent tachycardia

5. Dry mouth

6. Seizures

Answer: 1, 3, 5. Common adverse effects of sertraline are agitation, sleep disturbance, and dry mouth. Agranulocytosis, intermittent tachycardia, and seizures are adverse effects of clonazepam (Klonopin).

**7. A nurse is caring for a client who exhibits signs of somatization. Which statement is most relevant?**

1. Clients with somatization are cognitively impaired.

2. Anxiety rarely coexists with somatization.

3. Somatization exists when medical evidence supports the symptoms.

4. Clients with somatization often have lengthy medical records.

Answer: 4. Clients with somatization are prone to “physician shop” and have extensive medical records as a result of their multiple procedures and tests. Clients with somatization aren’t usually cognitively impaired.

**8. A nurse is caring for a client who displays gait disturbances, paralysis, pseudoseizures, and tremors. These symptoms may be manifestations of what psychiatric disorder?**

1. Pain disorder

2. Adjustment disorder

3. Delirium

4. Conversion disorder

Answer: 4. Conversion disorders are most frequently associated with psychologically mediated neurologic deficits, such as gait disturbances, paralysis, pseudo-seizures, and tremors. Pain disorders and adjustment

disorders aren’t generally expressed in terms of neurologic deficits. Delirium is associated with cognitive impairment.

**9. A nurse is caring for a client who is experiencing a panic attack. Which intervention is most appropriate?**

1. Tell the client that there’s no need to panic.

2. Speak in short, simple sentences.

3. Explain that there’s no need to worry.

4. Give the client a detailed explanation of his panic reaction.

Answer: 2. The client experiencing a panic attack is unable to focus and his ability to relate to others is diminished; therefore, short, simple sentences are the most effective means of communication. Telling the client that there’s no need to panic or that he’s safe, or offering detailed explanations invalidates

the client’s feelings of anxiety.

**10. A client is experiencing acute confusion due to poisoning from an accidental exposure to toxic chemicals in the workplace.**

**What type of behavior should the nurse expect this client to demonstrate upon admission to the nursing unit?**

1. Inability to eat without experiencing nausea

2. Frequently verbalizing ambivalent feelings

3. Difficulty expressing ideas and needs

4. Despondency in the presence of family members

Answer: 3. A client with delirium has disorganized thinking and has difficulty expressing his ideas and needs to the nurse. A client in a state of confusion can usually eat without experiencing nausea, doesn’t tend to verbalize feelings of ambivalence, and doesn’t demonstrate irritability in the presence of others.

**11. A client with posttraumatic stress disorder (PTSD) is preparing** **for a family meeting. The nurse who’s working with the client should encourage him to share which topic with family members?**

1. Struggling to stop engaging in people-pleasing behaviors

2. Using medications to help cope with feelings of survivor guilt

3. Difficulty being emotionally attached to people

4. Difficulty handling the hallucinations experienced after a trauma

Answer: 3. Clients who suffer from PTSD tend to avoid emotional attachments as a way to protect themselves from the trauma they’ve experienced. Clients with PTSD don’t tend to engage in people-pleasing behaviors or experience hallucinations after the experience of extreme trauma and loss. Although clients with PTSD may be prescribed medications to assist in symptom reduction, there aren’t any drugs used specifically to help clients handle their feelings of survivor guilt.

**12. A nurse is assessing a client who struggles with social phobia. Which assessment question does the nurse need to ask?**

1. “Do you drink alcohol or use illicit drugs?”

2. “Do you use physical outlets to handle anger?”

3. “Do you often struggle to control your impulses?

4. “Do you have a history of being an underachiever?”

Answer: 1. Clients with social phobia are highly likely to consume alcohol or use or abuse other substances to control the fear they experience in specific social situations. Clients with social phobia don’t tend to be angry or aggressive, struggle to control their impulses, or have a history of underachievement.

**13. A nurse is observing a client on a medical unit who’s pacing the room, shaking his head from side to side, and clasping and unclasping his hands. As the nurse reviews the client’s health history, she should be alert for information about which medication that could be linked to the client’s**

**behavior?**

1. Anticholinergics

2. Vasodilators

3. Antiemetics

4. Steroids

Answer: 4. Clients who have taken steroids can experience a manic episode. Anticholinergic, vasodilator, and antiemetic drugs don’t induce a manic episode.

**14. A nurse is caring for a client who has generalized anxiety disorder. Which statement about this client is true?**

1. The client has regular obsessions.

2. Relaxation techniques are necessary for cure.

3. Nightmares and flashbacks are common in this client.

4. His anxiety lasts longer than 6 months.

Answer: 4. Constant patterns of anxiety that affect the client for more than 6 months and interfere with normal activities are characteristic of generalized anxiety disorder. Pharmaceutical therapy with benzodiaze pines can help. Clients having regular obsessions are probably suffering from obsessivecompulsive disorder. Nightmares and flashbacks are typical symptoms of posttraumatic stress disorder.

**15. A client with the nursing diagnosis of fear related to being embarrassed in the presence of others exhibits symptoms of social phobia. What should be the goals for this client? Select all that apply.**

1. Manage his fear in group situations.

2. Develop a plan to avoid situations that may cause stress.

3. Verbalize feelings that occur in stressful situations.

4. Develop a plan for responding to stressful situations.

5. Deny feelings that may contribute to irrational fears.

6. Use suppression to deal with underlying fears.

Answer: 1, 3, 4. Improving stress management skills, verbalizing feelings, and

anticipating and planning for stressful situations should be goals for this client. Avoidance, denial, and suppression are maladaptive

defense mechanisms.

**16. A nurse is caring for a client who suffers from depression. She tells the client that he must avoid cheese, yogurt, preserved meats, and vegetables. Based on this information, the client is most likely receiving which drug**

**therapy to treat his depression?**

1. Monoamine oxidase inhibitor (MAOI)

2. Benzodiazepine

3. Selective serotonin reuptake inhibitor (SSRI)

4. Tricyclic antidepressant (TCA)

Answer: 1. This client is receiving an MAOI, which requires the client to avoid tyramine rich foods, such as cheese, beer, wine, yogurt, and preserved fruits, vegetables, and meats. Benzodiazepines, SSRIs, and TCAs don’t require dietary restrictions except avoiding alcoholic beverages.

**17. A nurse is teaching the wife of a client who has mild symptoms of dementia how to more effectively communicate with her spouse. The teaching would be considered successful if the nurse observed the wife:**

1. having a face-to-face conversation with her husband.

2. talking quietly into her husband’s ear.

3. discussing only events related to their past.

4. speaking loudly and enunciating each word.

Answer: 1. Speaking face-to-face is the most effective strategy to use when communicating with a cognitively impaired client because it allows the client to pick up visual cues to assist him in understanding his wife. Talking directly into the client’s ear prohibits the client from having access to the reinforcement of non-verbal communication. It isn’t good practice to assume that all recent memory is gone; it is better to stay current, explain things, and orient as necessary. There’s no need to speak loudly and enunciate each word

to a client with mild dementia unless he has a hearing impairment.

**18. A nurse is planning care for a client with substance abuse delirium. When the nurse implements care that addresses the client’s hygiene needs, which action should be taken?**

1. Provide an electric shaver instead of a razor.

2. Administer medication before starting care.

3. Set limits for staff involvement in the client’s daily care.

4. Bathe the client, but permit the client’s family to dress him.

Answer: 1. For a client with delirium, using an electric shaver is preferable because the client may be predisposed to injury if a standard razor is used. Medication is administered to promote comfort and address illness

issues, not to promote the client’s participation in self-hygiene. The client requires assistance during the recovery process, not limits for staff involvement. Bathing the client facilitates dependency; the goal is to

provide optimal functioning and self-care ability.

**20. A nurse is caring for a client who is diagnosed with delirium. What must the nurse provide for the client?**

1. A safe environment

2. An opportunity to release frustration

3. Prescribed medications

4. Medications, as needed, judiciously

Answer: 1. Keeping the client with delirium safe is the most important aspect of care. All other choices are logical and appropriate, but safety issues and meeting the client’s basic physiologic needs are of primary importance.

**21. A nurse is caring for a client who was found huddled in her apartment by the police. The client stares toward one corner of the room and seems to be responding to something not visible to others. She appears hyperalert and scared. How should the nurse assess the situation?**

1. The client may be hallucinating.

2. The client is suicidal.

3. Nothing is wrong because the client isn’t a threat to society.

4. The client is malingering.

Answer: 1. The scenario is typical of a client who’s hallucinating. Not enough information is available to suggest that she’s a threat to society or to herself. Malingering refers to a medically unproven symptom that’s consciously motivated.

**22. A nurse is caring for a client who’s experiencing auditory hallucinations. What should be most crucial for the nurse to assess?**

1. Possible hearing impairment

2. Family history of psychosis

3. Content of the hallucinations

4. Possible sella turcica tumors

Answer: 3. To prevent the client from harming himself or others, the nurse should encourage him to reveal the content of auditory hallucinations. Assessing for hearing impairment would be inappropriate. Family history, although important because of a possible genetic component, isn’t an immediate concern. Olfactory hallucinations, not auditory hallucinations.

**23. A nurse is caring for a client with disorganized schizophrenia. The client is responding well to therapy but has had limited social contact with others. Which of the following interventions is most appropriate?**

1. Discourage the client from interacting with others because, if his

efforts fail, it will be too traumatic for him.

2. Encourage the client to attend a party thrown for the residents of the

facility.

3. Encourage the client to participate in one-on-one interactions.

4. Encourage the client to place a personal advertisement in the local

newspaper but not to reveal his mental disability.

Answer: 3. First, encourage the client to participate in one-on-one interactions, and then progress to small groups to enable

the client to practice newly acquired social skills.

**24- A client with schizophrenia is taking the atypical antipsychotic medication clozapine (Clozaril). Which signs and symptoms indicate the presence of adverse effects associated with this medication? Select all that apply.**

1. Sore throat

2. Pill-rolling movements

3. Polyuria

4. Fever

5. Flulike symptoms

6. Orthostatic hypotension

Answer: 1, 4, 5. Sore throat, fever, and a sudden onset of other flulike symptoms are signs of agranulocytosis. The condition is caused by a lack of sufficient granulocytes (a type of white blood cell [WBC]), which causes the individual to be susceptible to infection. The client’s WBC count should be

monitored at least weekly throughout the course of treatment. Pill-rolling movements can occur in those experiencing extrapyramidal adverse effects associated with antipsychotic medication that has been prescribed for much longer than a medication such as clozapine. Polyuria (increased urine) is a

common adverse effect of lithium. Orthostatic hypotension is an adverse effect of tricyclic antidepressants.

**25- After 10 days of lithium therapy, the clients lithium level is 1.0 mEq\L this value indicates which of the following?**

1. A laboratory error.
2. An anticipated therapeutic blood level of therapy.
3. An atypical client response to the drug.
4. A toxic level.

Answer: 2 the therapeutic blood level range from lithium between 0.6 and 1.2 mEq\L for adults. A level 1.0 mEq\L can be anticipated after 10 days of treatment.