Chapter 1: Mental Health and Mental Illness

Multiple Choice
*Identify the letter of the choice that best completes the statement or answers the question.*

1. A nurse explaining the multiaxial *DSM-IV-TR* to a psychiatric technician can accurately say that it
   a. focuses on plans for treatment.
   b. includes nursing and medical diagnoses.
   c. includes assessments of several aspects of functioning.
   d. uses the framework of a specific biopsychosocial theory.

2. A 23-year-old college student wrote about herself, “Most of the time I’m happy and feel pretty good about myself. I’ve learned that what I get out of something is often proportional to the effort I put into it. My grades are OK.” Based on this information, what number on the mental health continuum should the nurse select as best reflecting the individual’s state of mental health/illness?

   ![Mental Health Continuum]

   a. 1  
   b. 2  
   c. 3  
   d. 4

3. A client has been admitted to the psychiatric hospital for assessment and evaluation. What behavior might indicate that the client has a mental disorder? The client
   a. is able to see the difference between the “as if” and the “for real.”
   b. describes her mood as consistently sad, discouraged, down in the dumps, and hopeless.
   c. responds to the rules, routines, and customs of any group to which she belongs.
   d. can perform tasks she attempts within the limits set by her abilities.

4. An outcome for a client is that he will demonstrate mentally healthy behavior. The behavior that indicates the outcome is being met is that the client
   a. behaves without considering the consequences of his actions.
   b. sees himself as approaching his ideals and as capable of meeting demands.
   c. passively allows others to assume responsibility for major areas of his life.
   d. is aggressive in meeting his own needs without considering the rights of others.

5. A float nurse working at a behavioral health clinic notes a diagnosis of a psychiatric disorder with which he is unfamiliar on a client’s insurance form. To discern the criteria used to establish this diagnosis, the nurse should consult the
   a. *DSM-IV-TR.*
b. *Nursing Diagnosis Manual.*
c. a psychiatric nursing textbook.
d. a behavioral health reference manual.

6. The nurse must assess the mental health/mental illness of several new clients at the mental health clinic. Conclusions about current functioning should be made on the basis of:
   a. the degree of conformity of the individual to society’s norms.
   b. the degree to which an individual is logical and rational.
   c. the rate of intellectual and emotional growth.
   d. a continuum from healthy to psychotic.

___ 7. A 22-year-old college student is highly confident of his own intellectual abilities and strives to excel to the point of always wanting to be first or better than others in academic standing, sports, and other endeavors. Peers find him aggressive, but he ignores this opinion, stating “Too bad. I’m happy when I’m getting ahead. I get my work done and don’t break any laws.” The nurse assessing this individual would be most concerned about the aspect of mental health known as:
   a. control over behavior.
   b. appraisal of reality.
   c. effectiveness in work.
   d. healthy self-concept.

___ 8. A 40-year-old woman who lives with her parents and works at a highly routine clerical job states “I’m as happy as the next person even though I don’t socialize much outside of work. My work is routine, but when new things come up my boss explains things a few times to make sure I catch on. At home, my parents make all the decisions for me and I go along with their ideas.” The nurse should identify interventions to increase this client’s:
   a. self-concept.
   b. overall happiness.
   c. appraisal of reality.
   d. control over behavior.

___ 9. A client tells the nurse, “I’m a real freak. I’m a psychiatric patient, in and out of hospitals all the time. None of my friends or relatives is crazy like this.” The reply that would help the client understand the prevalence of mental illness is:
   a. “Comparing yourself with others has no real advantages.”
   b. “Mental illness affects 50% of the adult population in any given year.”
   c. “Nearly 50% of all people aged 15 to 55 years have had a psychiatric disorder at some time in their lives.”
   d. “You are not to blame for having a psychiatric illness. The important thing is to recognize your need for treatment.”

10. The best response for the nurse who receives a query from another mental health professional seeking to understand the difference between a *DSM-IV-TR* diagnosis and a nursing diagnosis would be:
    a. “There is no functional difference between the two; both serve to identify a human deviance.”
    b. “The *DSM-IV-TR* diagnosis disregards culture, whereas the nursing diagnosis takes culture into account.”
    c. “The *DSM-IV-TR* diagnosis is associated with present distress or disability, whereas a nursing diagnosis considers past and present responses to actual mental health problems.”
d. “The DSM-IV-TR diagnosis affects the choice of medical treatment, whereas the nursing diagnosis offers a framework for identifying interventions for phenomena a client is experiencing.”

11. A client mentions to a nursing student, “I’d never want to be a nurse working with psychiatric clients because none of us ever gets well.” The reply by the nursing student that best addresses the stated bias is
   a. “People with mental disorders should not be stereotyped as hopeless cases.”
   b. “The media tend to focus on the sensational, so the public hears only about the poorest outcomes.”
   c. “Treatment of bipolar disorder has an 80% success rate, whereas angioplasty is successful 41% of the time.”
   d. “Some mental disorders such as panic disorder are highly treatable, whereas other disorders result in progressive deterioration.”

12. The nurse caring for a client finds the client uncommunicative about recent life events. The nurse suspects marital and perhaps economic problems exist. The social worker’s intake note has been dictated, but not typed, and is placed in the medical record. The most effective action the nurse could take is to
   a. focus questions on these two topics.
   b. ask the client who shares a room with this client.
   c. try to work around the lack of pertinent information.
   d. look at axis IV of the DSM-IV-TR in the medical record.

13. The nurse making an admission assessment notes the client is profoundly depressed to the point of being mute and motionless. The client has refused to bathe and eat for a week, according to her parents. The nurse should code the client’s global assessment of functioning as a. 100.
   b. 50.
   c. 25.
   d. 10.

14. The nurse tells a peer, “I’m assigned to an interdisciplinary team working with a group of depressed clients, half of whom are receiving supportive interventions and antidepressant medication. The others are receiving only antidepressants. We are concerned with treatment outcomes for each group.” The peer should identify the work described as a. analytical epidemiology.
   b. clinical epidemiology.
   c. descriptive epidemiology.
   d. experimental epidemiology.

15. The husband of a client with schizophrenia tells the nurse, “I simply don’t understand why how my wife was nurtured or toilet trained has anything to do with the incredibly disabling illness she has!” The response by the nurse that will help the husband better understand his wife’s condition is a. “It must be frustrating for you that your wife is sick so much of the time.”
   b. “You can count on the fact that her illness is the result of genetic factors.”
   c. “Although it seems impossible, psychological stress really is at the root of most mental disorders.”
   d. “New findings tell us that your wife’s condition is more likely biological than psychological in origin.”

16. The understanding on the part of the nurse that should result in the nurse providing the highest degree of client advocacy during a multidisciplinary client care planning session is a. all mental illnesses are culturally determined.
b. schizophrenia and bipolar disorder are cross-cultural disorders.
c. symptoms of mental disorders are unchanged from culture to culture.
d. symptoms of mental disorders reflect a person’s cultural patterns.

17. The nurse reading a client’s medical record determines that the client’s relationships with both men and women tend to be intense and unstable, with the client initially idealizing the significant other and then devaluing him or her when the individual does not meet the client’s needs. Furthermore, the client experiences feelings of emptiness and resorts to self-mutilation. The aspect of mental health the nurse can assess as lacking is a. effectiveness in work.
b. communication skills.
c. productive activities.
d. fulfilling relationships.

18. In the majority culture of the United States, the individual at greatest risk for being labeled mentally ill is
a. one who is wealthy and goes around the city giving away $20 bills to needy individuals.
b. one who attends a charismatic church and describes hearing God’s voice speaking to her.
c. one who always has an optimistic viewpoint about her life situation and the possibility of having her needs met.
d. one who is usually pessimistic about possible outcomes but strives to meet personal goals.

19. To effectively use the *DSM-IV-TR* the nurse must be cognizant of the fact that this tool classifies a. deviant behavior.
b. people with mental disorders.
c. disorders that people have.
d. present disability or distress.

20. The psychiatric nurse addresses axis I of the *DSM-IV-TR* as the focus of treatment but must also consider the presence of a long-term disorder that affects treatment. This information is accessed by noting axis a. II.
b. III.
c. IV.
d. V.

21. For the psychiatric nurse whose client care focus is holistic, awareness of which *DSM-IV-TR* axes is most important? a. I and II
b. III and IV
c. V
d. I through V

22. When the nurse providing psychoeducation about mental disorders is asked “What is the most prevalent mental disorder in the United States?” the response should be a. “Why do you ask?”
b. schizophrenia.
c. affective disorders.
d. substance abuse.

Completion
Complete each sentence or statement.

23. A nurse visiting a U.S. senator’s office to lobby for greater insurance parity for psychobiological disorders can establish need for parity by accurately stating that approximately 1 in ___________________________ adults per year in the United States has a diagnosable mental disorder.

Other

24. A client asks the nurse, “The pamphlet I read about depression mentions that psychosocial factors influence depression. What does that mean?” Examples a nurse could cite to support the premise that a client’s depression can be influenced by psychosocial factors include (more than one answer may be correct)

A. having a hostile and overinvolved family.
B. having two first-degree relatives with bipolar disorder.
C. feeling strong guilt over having an abortion when one’s religion forbids it.
D. experiencing the death of a parent a month before the onset of depression.
E. experiencing symptom remission when treated with antidepressant medication.
25. A client comes to the emergency department with the chief symptom of “I’m hearing voices telling me that someone is stalking me. They want to kill me because I have developed a cure for cancer.” The client tells the nurse that he carries a knife and will stab anyone he thinks is a threat to him. Which aspects of mental health should be of greatest immediate concern to the nurse? (More than one answer may be correct.)

A. Happiness
B. Appraisal of reality
C. Control over behavior
D. Effectiveness in work
E. Healthy self-concept
Chapter 1
Answer Section

MULTIPLE CHOICE

1. **ANS: C**
   The use of five axes requires assessment beyond diagnosis of a mental disorder and includes relevant medical conditions, psychosocial and environmental problems, and global assessment of functioning. Option A: The *DSM-IV-TR* does not include a treatment plan. Option B: Nursing diagnoses are not included. Option D: The *DSM-IV-TR* does not use a specific biopsychosocial theory.


2. **ANS: D**
   The student states she’s happy. Her self-concept is adequate. She is reality oriented, effective in her work, and has control over her behavior. Option A would be appropriate for an individual with severe impairment of functioning. Option B would be appropriate for an individual with moderate impairment of functioning. Option C would be appropriate for an individual with mild impairment of functioning.


3. **ANS: B**
   Option B describes a mood alteration. Options A, C, and D describe mentally healthy behaviors.


4. **ANS: B**
   Option B describes an adaptive, healthy behavior. Options A, C, and D are considered maladaptive behaviors.


5. **ANS: A**
   The *DSM-IV-TR* gives the criteria used to diagnose each mental disorder. Option B focuses on nursing diagnoses. Options A and D may not contain diagnostic criteria.


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


7.  **ANS: A**

The individual accurately appraises reality, is effective in his work, and is self-confident. The trait of control over behavior is of greatest concern because he is not sensitive to the rules, routines, and customs of his peer group, and he violates the rights of others.


8.  **ANS: A**

The client sees herself as needing multiple explanations of new tasks at work and allows her parents to make decisions for her even though she is 40 years old. These behaviors indicate a poorly developed self-concept.


9.  **ANS: C**

The question calls for an answer relating to the prevalence of mental illness. Only options B and C address this, and option B is untrue.


10. **ANS: D**

The medical diagnosis is concerned with the client’s disease state, causes, and cures, whereas the nursing diagnosis focuses on the client’s response to stress and possible caring interventions. Options A and B are not true statements. Both consider culture. Option C: The *DSM-IV-TR* is multiaxial. Nursing diagnoses also consider potential problems.


11. **ANS: C**

Providing information about treatment efficacy is a concrete way to refute the myth that clients with mental disorders are untreatable. Option A does not provide information to refute the myth. Option B gives general information, whereas option C is more specific. Option D provides general information, some of which is discouraging.

12. The intake physician would use axis IV to note psychosocial and environmental problems pertinent to the client’s situation, providing another source of information for the nurse. Option A: Persistent questioning will likely result in client withdrawal. Option B violates client privacy rights. Option C is not an effective solution.

TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment;

13. The client is unable to maintain personal hygiene, oral intake, or verbal communication. She is a persistent danger to herself because she refuses to eat. Option A indicates high-level functioning. Options B and C suggest higher functional abilities than the client presently displays.

DIF: Cognitive Level: Analysis REF: Text Page: 10
TOP: Nursing Process: Assessment MSC: NCLEX: Safe, Effective Care Environment;

14. Clinical epidemiology is a broad field that addresses what happens to people with illnesses who are seen by providers of clinical care. This study is concerned with the effectiveness of various interventions. Option A explores the rates of variation in illness among different groups, seeking to identify risk factors contributing to development of the disorder. Option C provides estimates of the rates of disorders in a general population and its subgroups. Option D tests presumed assumptions between a risk factor and a disorder.

TOP: Nursing Process: N/A MSC: NCLEX: Safe, Effective Care Environment;

15. Many of the most prevalent and disabling mental disorders have been found to have strong biological influences. Option A is empathetic but does not address increasing the husband’s level of knowledge about the cause of his wife’s condition. Option B is not an established fact. Option C is not true.


16. A nurse who understands that a client’s symptoms are influenced by culture will be able to advocate for the client to a greater degree than a nurse who believes that culture is of little relevance. Option A is an untrue statement. Option B is a true statement but has little relevance to client advocacy. Option C is an untrue statement.

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment;

17. The information given 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 (options A, B, and C).
ANS: D


18.  ANS: B
Hearing voices is generally associated with mental illness; however, in charismatic religious groups, hearing the voice of God or a prophet is a desirable event. In this situation cultural norms vary, making it more difficult to make an accurate DSM-IV-TR diagnosis. The individuals described in the other options are less likely to be labeled as mentally ill.


19.  ANS: C
The DSM-IV-TR classifies disorders that people have rather than people themselves. The terminology of the tool reflects this distinction by referring to individuals with a disorder rather than as a “schizophrenic” or “alcoholic,” for example. Option A: Deviant behavior is generally not considered a mental disorder. Option D: Present disability or distress is associated with having a mental disorder.


20.  ANS: A
Axis II refers to personality disorders and mental retardation. Together they constitute the classification of abnormal behavior diagnosed in the individual. Option B: Axis III indicates any relevant general medical conditions. Option C: Axis IV reports psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis. Option D: Axis V is the global assessment of functioning.


21.  ANS: D
A holistic focus requires the nurse to be aware of the entire client, thus allowing more comprehensive and appropriate interventions.


22.  ANS: D
The prevalence for schizophrenia is 1.1% per year. The prevalence of all affective disorders (depression, dysthymia, bipolar) is 9.5%, and the prevalence of substance abuse is 11.3%. Option A does not provide an answer.


COMPLETION

23.  ANS:
  5
  five
Rationale: An estimated 21.1% of Americans aged 18 years and older have a diagnosable mental disorder each year. This statistic is roughly equivalent to 1 in 5 adults.


OTHER

24. ANS:
A, C, D
Rationale: Option A: Family influence is considered a psychosocial factor affecting a client’s mental health. A hostile, overinvolved family is critical of the client and contributes to low self-esteem. Option B: This example would be considered a genetic factor that influences the individual’s risk for mental disorder, not a psychosocial factor. Option C: Religious influences are considered psychosocial in nature. Option D: Life experiences, especially crises and losses, are considered psychosocial influences on mental health. Option 5: Treatment with a biological agent such as antidepressant medication is an example of a biological influence.


25. ANS:
B, C, E
Rationale: The aspects of mental health of greatest concern are the client’s appraisal of and his control over behavior. His appraisal of reality is inaccurate. He has auditory hallucinations, delusions of persecution, and delusions of grandeur. In addition, the client’s control over behavior is tenuous, as evidenced by his plan to stab anyone who seems threatening. A healthy self-concept is lacking, as evidenced by the delusion of grandeur. Data are not present to suggest that the other aspects of mental health (happiness [option A] and effectiveness in work [option D]) are of immediate concern.

Chapter 2

Multiple Choice
Identify the letter of the choice that best completes the statement or answers the question.

1. At the well-child clinic the nurse notices that a 26-month-old boy is displaying negative behavior. His mother relates that he refuses to have anything to do with toilet training and often shouts “no!” when given direction. His mother asks what might be the matter with her son. On the basis of knowledge of growth and development, the nurse should reply
   a. “He is behaving normally for his age. He is striving for independence.”
   b. “He needs firmer control. He should be scolded when he tells you ‘no’ and is defiant.”
   c. “I suspect he has a serious developmental problem because most children are toilet trained by the age of 2 years.”
   d. “He seems to be developing some undesirable attitudes. A child psychologist might be able to help you develop a remedial plan.”

2. A 26-month-old child often displays negative behavior, refuses to have anything to do with toilet training, and often shouts “no!” when given direction. By using Freud’s stages of psychosexual development, the nurse would assess the child’s behavior as being consistent with the stage of development termed
   a. oral.
   b. anal.
   c. phallic.
   d. genital.

3. A 26-month-old child often displays negative behavior, refuses to have anything to do with toilet training, and often shouts “no!” when given direction. His mother asks the nurse what might be the matter with the child. The counseling the nurse gives the mother should be based on the premise that the child is engaged in the psychosocial crisis of
   a. trust versus mistrust.
   b. initiative versus guilt.
   c. industry versus inferiority.
   d. autonomy versus shame and doubt.

4. A 4-year-old child seen at the well-child clinic is noted to grab toys from his sibling, saying, “I want that toy, now!” The sibling usually cries, and the child’s mother becomes upset with the behavior. By using Freudian theory the nurse can interpret this behavior to the mother as being as a product of impulses originating in the
   a. id.
   b. ego.
   c. superego.
   d. preconscious.
5. The mother of a 4-year-old child rewards and praises the child for helping his younger brother and for being polite and using good manners. The nurse supports the use of praise because the qualities of politeness and helpfulness will likely be internalized and become part of the child’s a.  
   b. ego.
   c. superego.
   d. preconscious.

6. The nurse who supports parental praise of a child who is behaving in a helpful way can hypothesize that in adulthood, when the individual behaves with politeness and helpfulness, she will feel a. guilt.
   b. anxiety.
   c. unsatisfied.
   d. positive self-esteem.

7. A client says, “I never know the answers” or “My opinion doesn’t count for much.” The nurse can correctly assess that, according to Erikson, the client has had difficulty resolving the crisis of a. initiative versus guilt.
   b. trust versus mistrust.
   c. autonomy versus shame and doubt.
   d. generativity versus self-absorption.

8. Which client statement would lead the nurse to suspect that the developmental task of infancy was not successfully completed by the client?
   a. “Andy and I are very warm and close friends.”
   b. “I’m afraid to allow anyone to really get to know me.”
   c. “I’m always absolutely right, so don’t bother saying more.”
   d. “I’m so ashamed because I didn’t do it correctly in the first place.”

9. The nurse caring for a client makes the assessment that the client is suspicious of others and frequently engages in manipulation of others. To plan care, the nurse should consider these traits as being related to Freud’s a. oral stage.
   b. anal stage.
   c. phallic stage.
   d. genital stage.

10. The nurse notes that an assigned client expresses the wish to be taken care of and that the client often behaves in a helpless fashion. The client can be assessed as having needs related to the stage of psychosexual development termed the a. latency stage.
    b. phallic stage.
    c. anal stage.
    d. oral stage.

11. A is a 55-year-old retiree who volunteers 5 days a week helping with Meals on Wheels, coaching teen sports, and doing church visitation. B is a 58-year-old retiree who laughs at A and says, “I’m too busy taking care of myself to volunteer. I don’t care much about doing good for others.” These behaviors can be assessed as showing the difference between a. trust and mistrust.
    b. industry and inferiority.
    c. intimacy and isolation.
    d. generativity and self-absorption.
12. The student nurse notes that a client uses a number of behaviors designed to relieve anxiety. The student asks the coassigned staff nurse if ego defense mechanisms and security operations are identical. The nurse should explain that, although both are unconsciously determined and designed to relieve anxiety, the major difference is that
a. defense mechanisms are always intrapsychic and not observable.
b. defense mechanisms always lead to arrested personal development.
c. security operations are interpersonal relationship activities.
d. security operations are masterminded by the id and superego.

13. A student nurse tells the clinical instructor, “I’ve found that I do not need to interact with my assigned clients. I learn what I need to know simply by observing them.” The instructor can best interpret the nursing implications of Sullivan’s theory to the student by responding a. “Nurses cannot be isolated from the therapeutic situation. We need to interact with clients to provide opportunities for them to practice interpersonal skills.”
b. “Observing client interactions can provide sufficient data to formulate priority nursing diagnoses and appropriate interventions.”
c. “I wonder how accurate your assessment of the client’s needs hierarchy can be if you do not interact with the client.”
d. “It is important to note client behavioral changes because these signify changes in personality.”

14. A psychiatric technician mentions that little of what takes place on the behavioral health unit seems to be theory based. The nurse can enlighten the technician by citing the fact that many of Sullivan’s theoretic constructs are used in
a. the ongoing use of restraint and seclusion as behavior management tools.
b. the structure of the therapeutic milieu of most behavioral health units.
c. assessment tools based on age-appropriate versus arrested behaviors.
d. the method nurses use to determine the best sequence for nursing actions.

15. When the nurse uses Maslow’s hierarchy of needs to plan care for a client who is psychotic, which client problem below will receive priority? a. Refusal to eat
b. Feelings of alienation from family
c. Reluctance to participate in unit social activities
d. Need to be taught about medication action and side effects

16. Operant conditioning will be used to encourage speech in a child who is nearly mute. Which technique would the nurse include in the treatment plan? a. Spanking the child for silence
b. Having the child observe others talking
c. Giving the child a small candy for speaking
d. Teaching the child relaxation techniques, then coaxing speech

17. The mother of a young adult client who has schizophrenia tearfully asks the nurse what she could have done differently to prevent her child’s illness. The most reassuring response for the nurse would be
a. “Although schizophrenia is caused by impaired interpersonal relationships between parents and the child, try not to feel guilty. No one can predict how a child will respond to parental guidance.”
b. “Most of the damage is done, but there is still hope. By changing your parenting style, you can help your child learn to cope more effectively with the environment.”
c. “Schizophrenia is a biological illness not unlike diabetes and heart disease. You are not to blame for your child’s illness.”

d. “Most mental illnesses result from genetic inheritance. Your genes are more at fault than your parenting.”

18. A nurse using Peplau’s interpersonal therapy while working with an anxious, withdrawn client will plan interventions focusing on
a. changing the client’s cognitions about self.
b. improving the client’s interactional skills.
c. reinforcing specific behaviors.
d. liberally using medications to relieve anxiety.

19. A client tells the nurse she had psychotherapy weekly for 3 years. The client states the therapist used the techniques of free association, dream analysis, and facilitation of awareness of transference feelings to help her understand unconscious processes and foster personality change. The nurse can determine that the client was treated with a.
   a. short-term dynamic psychotherapy.
b. transactional analysis.
c. cognitive therapy.
d. psychoanalysis.

20. The nurse states “The patient is a lesbian and is experiencing severe anxiety and depression as she anticipates a problem with acceptance by her family when she reveals her sexual orientation.” The nurse has formulated the client’s problem from the vantage point of a therapist who uses a.
   a. cognitive therapy.
b. behavioral therapy.
c. interpersonal psychotherapy.
d. psychodynamic psychotherapy.

21. The nurse psychotherapist is working with an anxious, dependent client. The therapeutic strategy most consistent with the framework of psychodynamic or psychoanalytic psychotherapy would be
a. emphasizing medication compliance.
b. identifying client strengths and assets.
c. using psychoeducational materials.
d. focusing on feelings developed by the client toward the nurse.

22. A client tells the nurse, “I was the lone survivor in a small plane crash in which three of my business associates were killed. I got anxious and depressed and saw a counselor three times a week for 4 weeks. The therapist and I talked about my feelings about being a survivor. I’m OK now, back to being my old self.” The nurse can correctly conclude that the type of therapy the client underwent was
a. milieu therapy.
b. psychoanalysis.
c. behavior modification.
d. interpersonal psychotherapy.

23. A cognitive strategy the nurse could use to help an excessively dependent client would be to have the client
a. reveal his or her dreams.
b. take prescribed medications.
c. examine his or her thoughts about being independent.
d. choose an applicable diagnostic label from the DSM-IV-TR.
24. A 39-year-old businesswoman and single parent of three is experiencing many feelings of inadequacy in her job and family situation since her 16-year-old daughter ran away several weeks ago. She seeks the help of a therapist specializing in cognitive therapy. The nurse psychotherapist who uses cognitive therapy will treat the client by
a. focusing on unconscious mental processes.
b. negatively reinforcing an undesirable behavior.
c. discussing ego states.
d. helping her identify and change faulty thinking.

25. A college student has been invited to be the best man at the wedding of a college friend who lives across the country. The wedding is in 6 weeks. He must travel by plane but is afraid of flying. A nurse suggests seeing a therapist. What type of therapy would the nurse be most likely to recommend?
   a. Psychoanalysis
   b. Milieu therapy
   c. Systematic desensitization
   d. Short-term dynamic therapy

26. The advanced practice nurse concludes a client would profit from the type of therapy in which peers and interdisciplinary staff all have a voice in determining the level of client privileges. The nurse would arrange for
   a. milieu therapy.
   b. cognitive therapy.
   c. short-term dynamic therapy.
   d. systematic desensitization.

27. A client expresses suicidal ideation and admits to having a plan for committing suicide. The advanced practice nurse assesses the client as being at risk for suicide. In arranging for the client’s admission to the inpatient unit, the nurse has used principles of
   a. a practice beyond the scope of nursing licensure.
   b. interpersonal relationship therapy.
   c. short-term dynamic therapy.
   d. milieu therapy.

28. A nurse sees the nursing theory of Dorothea Orem as providing a suitable framework for practice. This nurse would plan care to
   a. acknowledge the client’s suffering related to illness.
   b. support client coping strategies to enhance adaptation.
   c. assist the client to discover and use stress reduction strategies.
   d. promote self-care activities of the seriously and persistently mentally ill client.

29. The nurse providing cognitive therapy for a client who believes she is stupid would evaluate cognitive intervention as effective when the client states
   a. “I’m disappointed in my lack of ability.”
   b. “Sometimes I do stupid things.”
   c. “Things always go wrong for me.”
   d. “I always fail when I try new things.”

Other
30. Desired outcomes of a nurse assuming the role of participant observer during an interaction with a client would include (more than one answer may be correct)
   A. client anxiety level decreases
   B. nurse self-awareness is enhanced
   C. the nurse views the client as a unique individual
   D. the focus of the interaction remains client centered

31. A client states “I’m going to be engaging in cognitive therapy. What can I expect from the sessions?”
Which responses by the nurse would be appropriate? (More than one answer may be correct.)
   A. “The therapist will be active and questioning.”
   B. “You may be given homework assignments.”
   C. “The therapist will help you look at ideas and beliefs you have about yourself.”
   D. “The goal is to increase your subjectivity about the thoughts that govern your behavior.”
Chapter 2
Answer Section

MULTIPLE CHOICE

1. ANS: A
Options B, C, and D all indicate the child’s behavior is abnormal when, in fact, this behavior is typical of a child around the age of 2 years whose developmental task is to develop autonomy.

DIF: Cognitive Level: Application   REF: Text Page: 19
TOP: Nursing Process: Implementation   MSC: NCLEX: Health Promotion and Maintenance

2. ANS: B
The anal stage occurs from age 1 to 3 years and has as its focus toilet training and learning to delay immediate gratification. Option B: The oral stage occurs between birth and 1 year. Options C and D: The phallic stage occurs between 3 and 5 years, and the genital stage occurs between age 13 and 20 years.

DIF: Cognitive Level: Application   REF: Text Page: 18
TOP: Nursing Process: Assessment   MSC: NCLEX: Health Promotion and Maintenance

3. 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. Option A: Trust versus mistrust is the crisis of the infant. Option B: Initiative versus guilt is the crisis of the preschool and early school-aged child. Option C: Industry versus inferiority is the crisis of the 6- to 12-year-old child.

DIF: Cognitive Level: Application   REF: Text Page: 19
TOP: Nursing Process: Assessment   MSC: NCLEX: Health Promotion and Maintenance

4. ANS: A
The id operates on the pleasure principle, seeking immediate gratification of impulses. Option B: The ego acts as a mediator of behavior and would weigh the consequences of the action, perhaps determining that taking the toy is not worth the mother’s wrath. Option C: The superego would oppose the impulsive behavior as “not nice.” Option D: The preconscious is a level of awareness.

TOP: Nursing Process: Assessment   MSC: NCLEX: Health Promotion and Maintenance

5. ANS: C
The superego contains the “thou shalt’s,” or moral standards internalized from interactions with significant others. Praise fosters internalization of desirable behaviors. Option A: The id is the center of basic instinctual drives, and the ego is the mediator. Option B: The ego is the problem-solving and reality-testing portion of the personality that negotiates solutions with the outside world. Option D: The preconscious is a level of awareness from which material can be retrieved rather easily with conscious effort.

6. The individual will be living up to her ego ideal, which will result in positive feelings about herself. The other options are incorrect because each represents a negative feeling.


7. These statements show severe self-doubt, indicating that the crisis of gaining control over the environment was not successfully met. Option A: Unsuccessful resolution of the crisis of initiative versus guilt would result in feelings of guilt. Option B: Unsuccessful resolution of the crisis of trust versus mistrust results in poor interpersonal relationships and suspicion of others. Option D: 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  REF: Text Page: 19

8. According to Erikson the developmental task of infancy is the development of trust. Option B is the only statement clearly showing lack of ability to trust others. Option A suggests the developmental task of infancy was successfully completed. Option C suggests rigidity rather than mistrust. Option D suggests failure to resolve the crisis of initiative versus guilt.

DIF: Cognitive Level: Analysis  REF: Text Page: 19

9. 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. Option B: Anal stage traits include stinginess, stubbornness, orderliness, or their opposites. Option C: Phallic stage traits include flirtatiousness, pride, vanity, difficulty with authority figures, and difficulties with sexual identity. Option D: Genital stage traits include the ability to form satisfying sexual and emotional relationships with members of the opposite sex, emancipation from parents, a strong sense of personal identity, or the opposites of these traits.

DIF: Cognitive Level: Application  REF: Text Page: 18

10. Fixation at the oral stage sometimes produces dependent infantile behaviors in adults. Option A: Latency fixations often result in difficulty identifying with others and developing social skills, resulting in a sense of inadequacy and inferiority. Option B: Phallic fixations result in having difficulty with authority figures and poor sexual identity. Option C: Anal fixation sometimes results in retentiveness, rigidity, messiness, destructiveness, and cruelty.

DIF: Cognitive Level: Application  REF: Text Page: 18
Both men are in middle adulthood, when the developmental crisis to be resolved is generativity versus self-absorption. A exemplifies generativity; B embodies self-absorption. Option A: This developmental crisis would show a contrast between relating to others in a trusting fashion or being suspicious and lacking trust. Option B: Failure to negotiate this developmental crisis would result in a sense of inferiority or difficulty learning and working as opposed to the ability to work competently. Option C: Behaviors that would be contrasted would be emotional isolation and the ability to love and commit oneself.

DIF: Cognitive Level: Application REF: Text Page: 19
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance
ANS: C

Sullivan’s theory explains that security operations are interpersonal relationship activities designed to relieve anxiety. Because they are interpersonal in nature they can be observed. Option A: Defense mechanisms are unconscious and automatic. Repression is entirely intrapsychic, but other mechanisms result in observable behaviors. Option B: Frequent, continued use of many defense mechanisms often results in reality distortion and interference with healthy adjustment and emotional development. Occasional use of defense mechanisms is considered normal and does not markedly interfere with development. Option D: Security operations are ego centered.

TOP: Nursing Process: Implementation MSC: NCLEX: Health Promotion and Maintenance
ANS: A

Sullivan believed that the nurse’s role includes educating clients and assisting them in developing effective interpersonal relationships. Mutuality, respect for the client, unconditional acceptance, and empathy are cornerstones of Sullivan’s theory. These cornerstones cannot be demonstrated by the nurse who does not interact with the client. Option B: Observations provide only objective data. Priority nursing diagnoses usually cannot be accurately established without subjective data from the client. Option C: This response pertains to Maslow’s theory. Option D: This response pertains to behavioral theory.

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment;
ANS: B

The structure of the therapeutic environment has as foci an accepting atmosphere and provision of opportunities for practicing interpersonal skills. Both constructs are directly attributable to Sullivan’s theory of interpersonal relationships. Option A: Sullivan’s interpersonal theory did not specifically consider use of restraint or seclusion. Option C: Assessment based on developmental level is more the result of Erikson’s theories. Option D: Sequencing nursing actions based on client priority needs is related to Maslow’s hierarchy of needs.

TOP: Nursing Process: Implementation MSC: NCLEX: Safe, Effective Care Environment;
ANS: A

The need for food is a physiological need; therefore it takes priority over psychological or meta-needs in care planning.
16. Operant conditioning involves giving positive reinforcement for a desired behavior. Presuming the child likes candy, candy will reinforce speech. Option A describes an aversive therapy technique. Option B describes modeling. Option D is an example of systematic desensitization.

17. Clients and families need reassurance that the major mental disorders are biological in origin and are not the “fault” of parents. Knowing the biological nature of the disorder relieves feelings of guilt over being responsible for the illness. Option A is neither wholly accurate nor reassuring. Option B falls short of being reassuring. Option D places the burden of having faulty genes on the shoulders of the parents.

18. The nurse-client relationship is structured to provide a model for adaptive interpersonal relationships that can be generalized to others. Option A would be appropriate for cognitive therapy. Option C would be used in behavioral therapy. Option D would be the focus of biological therapy.

19. The client described traditional psychoanalysis. Option A: Short-term dynamic psychotherapy would last less than a year. Options B and C: Neither transactional analysis nor cognitive therapy makes use of the techniques described.

20. By using the interpersonal model, the therapist sees the anxiety and depression as resulting from unmet interpersonal security needs. Option A: A cognitive theory formulation would focus on faulty cognitions of the client. Option B: A behavioral formulation would focus on changing specific behaviors of the client. Option D: A psychodynamic formulation would focus on uncovering unconscious material that relates to the client problem.

21. Positive or negative feelings of the client toward the nurse or the therapist are called transference. Transference is a psychoanalytic concept. Transference can be used to explore previously unresolved conflicts. Option A would be more related to biological therapy. Option B would be
consistent with supportive psychotherapy. Option C: Use of psychoeducational materials is a common “homework” assignment used in cognitive therapy.

TOP: Nursing Process: Implementation   MSC: NCLEX: Psychosocial Integrity

ANS: D

22. Interpersonal psychotherapy returned the client to his former level of functioning by helping him come to terms with the loss of friends and guilt over being a survivor. Option A: Milieu therapy refers to environmental therapy. Option B: Psychoanalysis would call for a long period of exploration of unconscious material. Option 3C: Behavior modification would focus on changing a behavior rather than helping the client understand what is going on in his life.

DIF: Cognitive Level: Application   REF: Text Page: 26
TOP: Nursing Process: Assessment   MSC: NCLEX: Psychosocial Integrity

ANS: C

23. Cognitive theory suggests that one’s thought processes are the basis of emotions and behavior. Changing faulty learning makes development of new adaptive behaviors possible. Option A would be used in psychoanalytically oriented therapy. Option B is an intervention associated with biological therapy. Option D is not an appropriate intervention. Medical diagnosis is the prerogative of the medical practitioner or advanced practice registered nurse.

TOP: Nursing Process: Implementation   MSC: NCLEX: Psychosocial Integrity

ANS: D

24. Cognitive therapy emphasizes the importance of changing erroneous ways people think about themselves. Once faulty thinking is changed, the individual’s behavior changes. Option A describes a psychoanalytic approach. Option B describes behavior modification, and option C relates to transactional analysis.

TOP: Nursing Process: Implementation   MSC: NCLEX: Psychosocial Integrity

ANS: C

25. Systematic desensitization is a type of therapy aimed at extinguishing a specific behavior, such as the fear of flying. Options A and D: Psychoanalysis and short-term dynamic therapy are aimed at uncovering conflicts. Option B: Milieu therapy involves environmental factors. None of these would be likely to cause behavioral change in 6 weeks.

DIF: Cognitive Level: Analysis   REF: Text Page: 29
TOP: Nursing Process: Planning   MSC: NCLEX: Psychosocial Integrity

ANS: A

26. Milieu therapy is based on the idea that all members of the environment contribute to the planning and functioning of the setting. The other therapies are all individual therapies that do not fit the description given.

TOP: Nursing Process: Planning   MSC: NCLEX: Safe, Effective Care Environment;
27. **ANS: D**

One aspect of milieu therapy involves providing safe and effective care environments for clients. Option A: The nurse’s action is within the scope of nursing practice. Option B: The information provided is not sufficient to determine if principles of interpersonal relationship therapy were used. Option C: The information given does not describe short-term dynamic therapy.

**DIF:** Cognitive Level: Application  
**REF:** Text Page: 30, Text Page: 31  
**TOP:** Nursing Process: Implementation  
**MSC:** NCLEX: Safe, Effective Care Environment

28. **ANS: D**

The focus of Orem’s theory suggests that the goal of care for clients should be to maximize client self-care activities and abilities. Option A is associated with Benner’s caring theory. Option B is emphasized in the adaptation theory of Sister Calista Roy. Option C: Betty Neuman’s theory focuses on the impact of internal and external stressors of the equilibrium of the client.

**DIF:** Cognitive Level: Analysis  
**REF:** Text Page: 25  
**TOP:** Nursing Process: Planning  
**MSC:** NCLEX: Psychosocial Integrity

29. **ANS: B**

“I’m stupid” is an irrational thought. A more rational thought is “Sometimes I do stupid things.” The latter thinking promotes emotional self-control. Options A, C, and D reflect irrational thinking.

**DIF:** Cognitive Level: Evaluation  
**REF:** Text Page: 27  
**TOP:** Nursing Process: Evaluation  
**MSC:** NCLEX: Psychosocial Integrity

**OTHER**

30. **ANS:**  
B, C, D

Rationale: Option B is a desirable outcome. Being a participant observer involves participating in an interaction with a client and simultaneously being aware of both the client’s reactions and one’s own reactions. Self-awareness promotes true mutuality. Option C: Participant observation promotes viewing the client as a person with unique attributes. Seeing the client as a unique individual diminishes distortions and stereotyping. Option D: Participant observation promotes self-awareness. The nurse who has self-awareness is able to separate his or her own needs from those of the client and remain client focused. Option A: Although anxiety reduction would be a desirable outcome, it cannot be seen as resulting from the nurse acting as a participant observer. Other interventions would probably be necessary.

**DIF:** Cognitive Level: Analysis  
**REF:** Text Page: 24  
**TOP:** Nursing Process: Planning (Outcome Identification)  
**MSC:** NCLEX: Psychosocial Integrity
ANS:
A, B, C
Rationale: Option A: Cognitive therapists are active rather than passive during therapy sessions because they help clients reality test their thinking. Option B: Homework assignments are given and are completed outside the therapy sessions. Homework is usually discussed at the next therapy session. Option C: The goal of cognitive therapy is to assist the client in identifying inaccurate cognitions and in reality testing and formulating new, accurate cognitions. Option D: The desired outcome of cognitive therapy is to assist the client in increasing his or her objectivity, not subjectivity, about the cognitions that influence behavior.

DIF: Cognitive Level: Application
REF: Text Page: 26, Text Page: 27
TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity
Chapter 3

Multiple Choice

Identify the letter of the choice that best completes the statement or answers the question.

____ 1. A client asks the nurse, “What are neurotransmitters? My doctor says they are at the root of my problem.” The best reply would be
   a. “You must feel relieved to know that your problem has a physical basis.”
   b. “It is a rather high-level concept to explain. Perhaps you should ask the doctor to tell you more.”
   c. “Neurotransmitters are substances we eat daily that influence the brain functions of memory and mood.”
   d. “Neurotransmitters are chemicals manufactured in the brain that are responsible for passing messages between brain cells.”

____ 2. The mother of an adolescent client with obsessive-compulsive disorder tells the nurse, “My daughter’s doctor wants her to be in a research study and to have a PET [positron emission tomography] scan. I do not want her to have to go through any tests that are painful. What should I do?” The best reply for the nurse would be
   a. “The doctor has made the diagnosis, but having a PET scan would confirm it.”
   b. “You might want to ask who will pay for the PET scan because they are very expensive.”
   c. “PET scans involve an injection and lying still while a machine visualizes brain activity.”
   d. “PET scans involve passing an electrical current through the brain and can be uncomfortable.”

____ 3. The physician mentions that a client’s dementia may be associated with either Alzheimer’s disease or multiple infarcts. For the physician to make a differential diagnosis with the least expensive test, the nurse should expect to prepare the client for a
   a. computed tomography (CT) scan.
   b. magnetic resonance imaging (MRI) scan.
   c. PET scan.
   d. single-photon emission computed tomography (SPECT) scan.

____ 4. A client has delusions and hallucinations. Before beginning treatment with psychotropic drugs, the physician wishes to rule out the presence of a brain tumor. For which test will the nurse need to prepare the client?
   a. CT or MRI scan
   b. PET or SPECT scan
   c. Cerebral arteriogram
   d. Neuronal depolarization

____ 5. A client who is being admitted for depression should be assessed for disturbances in circadian rhythms. The question that best implements this assessment is
   a. “What time of day do you feel worst and when do you feel best?”
b. “Do you ever see or hear things that others do not?”
c. “How would you describe your thinking?”
d. “Would you say your memory is failing?”

6. When the wife of a client with schizophrenia asks which neurotransmitter is implicated in the development of schizophrenia, the nurse should state “The current thinking is that the thought disturbances are related to a. excess dopamine.”
b. serotonin deficiency.”
c. histamine decrease.”
d. increased γ-aminobutyric acid [GABA].”

7. Ongoing assessment and outcome planning for a client with schizophrenia are facilitated if the nurse understands that the medication prescribed to reduce the client’s symptoms targets the neurotransmitter a. dopamine.
b. serotonin.
c. norepinephrine.
d. acetylcholine.

8. The nurse should provide ongoing assessment for a client receiving medication that potentiates the action of GABA relative to a. reduced anxiety.
b. improved memory.
c. more organized thinking.
d. fewer sensory perceptual alterations.

9. On the basis of current knowledge of neurotransmitter effects, the nurse could anticipate that the treatment plan for a client with memory difficulties might include orders to administer medication designed to
a. inhibit GABA.
b. increase dopamine at receptor sites.
c. decrease dopamine at receptor sites.
d. prevent destruction of acetylcholine.

10. A client demonstrates disorganized and delusional thinking. The tentative diagnosis is schizophrenia. The nurse can anticipate that a PET scan would be most likely to show dysfunction in the part of the brain called the a. temporal lobe.
b. cerebellum.
c. brainstem.
d. frontal lobe.

11. The nurse should assess clients taking a drug known to have anticholinergic properties for symptoms of inhibition of function of the
a. parasympathetic nervous system.
b. sympathetic nervous system.
c. reticular activating system.
d. medulla oblongata.
12. The nurse can explain the therapeutic action of monoamine oxidase (MAO) inhibitors as blocking neurotransmitter reuptake, causing
   a. increased concentration of neurotransmitter in the synaptic gap.
   b. decreased concentration of neurotransmitter in the synaptic gap.
   c. destruction of receptor sites.
   d. limbic system stimulation.

___ 13. A client taking medication for his mental illness develops a profound sense of restlessness and an uncontrollable need to be in motion. The nurse can correctly hypothesize that these symptoms are related to the drug’s
   a. dopamine-blocking effects.
   b. anticholinergic effects.
   c. endocrine-stimulating effects.
   d. ability to stimulate spinal nerves.

___ 14. A nurse makes the assessment that the client demonstrates anxiety and a number of responses consistent with sympathetic nervous system stimulation. The nurse would suspect the presence of a high concentration of brain
   a. GABA.
   b. histamine.
   c. acetylcholine.
   d. norepinephrine.

___ 15. A client’s laboratory reports show marked deficiencies of both serum sodium and potassium. On the basis of this finding, the nurse should assess the client for symptoms of electrical conduction problems
   a. throughout the body.
   b. in skeletal muscle function only.
   c. in the central nervous system only.
   d. in the cardiac conduction system only.

___ 16. A client is seen in the emergency department for symptoms of acute anxiety related to the death of her mother in an automobile accident 2 hours ago. To prepare a care plan, the nurse must correctly hypothesize that the client will need teaching about a drug from the group called a. tricyclic antidepressants.
   b. antimanic drugs.
   c. benzodiazepines.
   d. neuroleptic drugs.

___ 17. A client is hospitalized for severe depression. Of the medications listed below, the nurse can expect to provide the client with teaching about a. clozapine (Clozaril).
   b. chlordiazepoxide (Librium).
c. tacrine (Cognex).
d. fluoxetine (Prozac).

18. A client hospitalized with a mood disorder displays an elevated, unstable mood, aggressiveness, agitation, talkativeness, and irritability. The nurse can begin care planning based on the expectation that the psychiatrist is most likely to prescribe a medication classified as a(n) a. anticholinergic.
b. mood stabilizer.
c. psychostimulant.
d. antidepressant.

19. The Physician’s Desk Reference gives the nurse information that a certain drug causes muscarinic receptor blockade. This alerts the nurse to assess the client for a. gynecomastia.
b. pseudoparkinsonism.
c. orthostatic hypotension.
d. dry mouth.

20. When the nurse understands that clozapine preferentially blocks dopamine receptors in the limbic system rather than in the basal ganglia, the nurse will plan to assess the client for a. seizures.
b. marked motor disturbances.
c. strong suicidal tendencies.
d. greatly increased appetite.

21. A client has begun phenothiazine therapy. What teaching should the nurse provide related to the drug’s strong dopaminergic effect? a. Chew sugarless gum
b. Eat plenty of roughage
c. Arise slowly from bed
d. Report muscle stiffness

22. During the administration of the abnormal involuntary movement scale, the nurse should
a. have the client sit with hands over the head.
b. ask the client to protrude the tongue.
c. have the client lie prone on the floor.
d. direct the client to touch the nose with the tip of each finger.

23. The client tells the nurse “My doctor prescribed Prozac [fluoxetine]. I suppose I’ll have to get used to the side effects like the ones I experienced when I was taking Tofranil [imipramine].” The nurse’s reply should be based on the knowledge that fluoxetine is a(n) a. tricyclic antidepressant.
b. MAO inhibitor.
c. SSRI.
d. selective norepinephrine reuptake inhibitor.

24. A nurse can anticipate that anticholinergic side effects may occur when a client is taking a. lithium.
b. risperidone.
c. buspirone.
d. fluphenazine.

25. The teaching plan for a client taking clozapine should include which of the following instructions?  
a. Report sore throat and fever immediately.
b. Avoid foods high in polyunsaturated fats.
c. Practice unprotected sex.
d. Use over-the-counter preparations for rashes.

26. The nurse is caring for clients taking various medications, including buspirone (Buspar), haloperidol (Haldol), carbamazepine (Tegretol), trazodone (Desyrel), phenelzine (Nardil), and risperidone (Risperdal). The nurse must check to ensure that a special diet has been ordered for each client receiving
   a. buspirone and haloperidol.
b. trazodone and carbamazepine.
c. phenelzine.
d. risperidone.

27. The nurse must tell a client taking a drug that acts by inhibiting MAO to avoid certain foods and drugs or risk
   a. hypotensive shock.
b. hypertensive crisis.
c. cardiac dysrhythmia.
d. cardiogenic shock.

28. The nurse caring for a client taking SSRIs will develop evaluation parameters and outcome criteria related to
   a. mood improvement.
b. logical thought processes.
c. reduced levels of motor activity.
d. increased extrapyramidal symptoms.

29. A client’s husband is a chemist. He asks the nurse the action by which SSRIs lift depression. The nurse should explain that SSRIs
   a. make more serotonin available at the synaptic gap.
b. destroy increased amounts of neurotransmitter.
c. increase production of acetylcholine and dopamine.
d. block muscarinic and α₁ norepinephrine receptors.

30. A client has taken a number of conventional and standard antipsychotic drugs over the years. The physician, concerned about the client’s lack of response to these drugs and the development of
tardive dyskinesia, has prescribed risperidone. The nurse planning care for the client must consider that atypical antipsychotics
a. are more readily available.
b. are of higher potency.
c. are less costly.
d. produce fewer motor side effects.

31. The laboratory reports for a client who is taking clozapine show a white blood cell count of 3000 mm$^3$ and a granulocyte count of 1500 mm$^3$. The nurse should
a. give the next dose as ordered.
b. report the laboratory results to the physician.
c. repeat the laboratory tests.
d. give aspirin and force fluids.

32. The nurse administering psychotropic medications should be prepared to intervene when giving a drug that blocks the attachment of norepinephrine to $\alpha_1$ receptors because the client may experience
a. an increase in psychotic symptoms.
b. hypertensive crisis.
c. orthostatic hypotension.
d. severe appetite disturbance.

33. A nurse is caring for four clients who are receiving clozapine, lithium, fluoxetine, and venlafaxine, respectively. In which client should the nurse be most alert for alterations in cardiac or cerebral electrical conductivity and fluid and electrolyte imbalance?
   a. The client receiving lithium (Lithobid)
b. The client receiving clozapine (Clozaril)
c. The client receiving fluoxetine (Prozac)
d. The client receiving venlafaxine (Effexor)

34. To evaluate the efficacy of tacrine (Cognex), the nurse would consider outcome criteria related to
   a. improvement in mood.
b. memory improvement.
c. reduction of hyperactivity.
d. absence of auditory hallucinations.

35. During a care planning meeting for an obese client who has been diagnosed with schizophrenia, the nurse suggests to the physician that it would be appropriate to select a medication that does not block the receptors for
   a. $H_1$.
b. GABA.
c. Acetylcholine.
d. $5HT_2$. 
36. A client who has had excellent symptom reduction as a result of taking a conventional/standard antipsychotic tells the nurse that his medication makes him so sleepy that he is concerned his supervisor may terminate his employment. A solution the nurse should discuss with the physician is:
   a. reducing the dose by half.
   b. discontinuing the medication.
   c. having the client take the medication at bedtime.
   d. switching from the conventional antipsychotic to risperidone (Risperdal).