

1. A client has approached the nurse asking for advice on how to deal with his alcohol addiction. The nurse should tell the client that the only effective treatment for alcoholism is:

- 1) psychotherapy.
- 2) total abstinence.
- 3) Alcoholics Anonymous (AA).
- 4) aversion therapy.

2. The nurse is providing care for a client undergoing opiate withdrawal. Opiate withdrawal causes severe physical discomfort and can be life-threatening. To minimize these effects, opiate users are commonly detoxified with:

- 1) barbiturates.
- 2) amphetamines.
- 3) methadone.
- 4) benzodiazepines.

3. The nurse is caring for a client who experiences false sensory perceptions with no basis in reality. These perceptions are known as:

- 1) delusions.
- 2) hallucinations.
- 3) loose associations.
- 4) neologisms.

4. The nurse is caring for a client who is suicidal. When accompanying the client to the bathroom, the nurse should:

- 1) give him privacy in the bathroom.
- 2) allow him to shave.
- 3) open the window and allow him to get some fresh air.
- 4) observe him.

5. The nurse is developing a care plan for a client with anorexia nervosa. Which action should the nurse include in the plan?

- 1) Restrict visits with the family until the client begins to eat.
- 2) Provide privacy during meals.
- 3) Set up a strict eating plan for the client.
- 4) Encourage the client to exercise, which will reduce her anxiety.

6. A client whose husband recently left her is admitted to the hospital with severe depression. The nurse suspects that the client is at risk for suicide. Which of the following questions would be most appropriate and helpful for the nurse to ask during an assessment for suicide risk?

- 1) "Are you sure you want to kill yourself?"
- 2) "I know if my husband left me, I'd want to kill myself. Is that what you think?"
- 3) "How do you think you would kill yourself?"

4) "Why don't you just look at the positives in your life?"

7. The nurse is caring for a client who she believes has been abusing opiates. Assessment findings in a client abusing opiates, such as morphine, include:

- 1) dilated pupils and slurred speech.
- 2) rapid speech and agitation.
- 3) dilated pupils and agitation.
- 4) euphoria and constricted pupils.

8. The nurse is caring for a client experiencing an anxiety attack. Appropriate nursing interventions include:

- 1) turning on the lights and opening the windows so that the client doesn't feel crowded.
- 2) leaving the client alone.
- 3) staying with the client and speaking in short sentences.
- 4) turning on stereo music.

9. The nurse is teaching a new group of mental health aides. The nurse should teach the aides that setting limits is most important for:

- 1) a depressed client.
- 2) a manic client.
- 3) a suicidal client.
- 4) an anxious client.

10. A client is admitted with a diagnosis of delusions of grandeur. This diagnosis reflects a belief that one is:

- 1) highly important or famous.
- 2) being persecuted.
- 3) connected to events unrelated to oneself.
- 4) responsible for the evil in the world.

11. The nurse is caring for a client, a Vietnam veteran, who exhibits signs and symptoms of posttraumatic stress disorder. Signs and symptoms of posttraumatic stress disorder include:

- 1) hyperalertness and sleep disturbances.
- 2) memory loss of traumatic event and somatic distress.
- 3) feelings of hostility and violent behavior.
- 4) sudden behavioral changes and anorexia.

12. The nurse is caring for a client with manic depression. The care plan for a client in a manic state would include:

- 1) offering high-calorie meals and strongly encouraging the client to finish all food.
- 2) insisting that the client remain active throughout the day so that he'll sleep at night.
- 3) allowing the client to exhibit hyperactive, demanding, manipulative behavior without setting limits.
- 4) listening attentively with a neutral attitude and avoiding power struggles.

13. A client is a Vietnam War veteran with a diagnosis of posttraumatic stress disorder. He has a history of nightmares, depression, hopelessness, and alcohol abuse. Which option offers the client the most lasting relief of his symptoms?

- 1) The opportunity to verbalize memories of trauma to a sympathetic listener
- 2) Family support
- 3) Prescribed medications taken as ordered
- 4) Alcoholics Anonymous (AA) meetings

14. A client is admitted for detoxification after a cocaine overdose. The client tells the nurse that he frequently uses cocaine but that he can control his use if he chooses. Which coping mechanism is he using?

- 1) Withdrawal
- 2) Logical thinking
- 3) Repression
- 4) Denial

15. A 22-year-old client is diagnosed with dependent personality disorder. Which behavior is most likely evidence of ineffective individual coping?

- 1) Inability to make choices and decisions without advice
- 2) Showing interest only in solitary activities
- 3) Avoiding developing relationships
- 4) Recurrent self-destructive behavior with history of depression

16. The major goal of therapy in crisis intervention is to:

- 1) withdraw from the stress.
- 2) resolve the immediate problem.
- 3) decrease anxiety.
- 4) provide documentation of events.

17. A 38-year-old client is admitted for alcohol withdrawal. The most common early sign or symptom that this client is likely to experience is:

- 1) impending coma.
- 2) manipulating behavior.
- 3) suppression.
- 4) perceptual disorders.

18. A client is admitted with a diagnosis of schizotypal personality disorder. Which signs would this client exhibit during social situations?

- 1) Aggressive behavior
- 2) Paranoid thoughts
- 3) Emotional affect
- 4) Independence needs

19. The nurse is caring for a client in an acute manic state. What's the most effective nursing action for this client?

- 1) Assigning him to group activities
- 2) Reducing his stimulation
- 3) Assisting him with self-care
- 4) Helping him express his feelings

20. The nurse is caring for a client diagnosed with bulimia. The most appropriate initial goal for a client diagnosed with bulimia is to:

- 1) avoid shopping for large amounts of food.
- 2) control eating impulses.
- 3) identify anxiety-causing situations.
- 4) eat only three meals per day.

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21. The nurse is caring for a 40-year-old client. Which behavior by the client indicates adult cognitive development?

- 1) Has perceptions based on reality
- 2) Assumes responsibility for actions
- 3) Generates new levels of awareness
- 4) Has maximum ability to solve problems and learn new skills

22. The nurse is assessing a client suffering from stress and anxiety. A common physiological response to stress and anxiety is:

- 1) sedation.
- 2) diarrhea.
- 3) vertigo.
- 4) urticaria.

23. The nurse is assessing a client for lifestyle factors that might affect normal coping. Which factor would the nurse most likely consider?

- 1) Inadequate diet
- 2) Divorce
- 3) Job promotion
- 4) Adopting a child

24. A client with bipolar disorder is being treated with lithium for the first time. The nurse should observe the client for which common adverse effect of lithium?

- 1) Sexual dysfunction
- 2) Constipation
- 3) Polyuria
- 4) Seizures

25. A client is admitted for an overdose of amphetamines. When assessing this client, the nurse should expect to see:

- 1) tension and irritability.

- 2) slow pulse.
- 3) hypotension.
- 4) constipation.

26. During a shift report, the nurse learns that she'll be providing care for a client who is vulnerable to panic attack. Treatment for panic attacks includes behavioral therapy, supportive psychotherapy, and medication such as:

- 1) barbiturates.
- 2) antianxiety drugs.
- 3) depressants.
- 4) amphetamines.

27. A client comes to the emergency department while experiencing a panic attack. The nurse can best respond to a client having a panic attack by:

- 1) staying with the client until the attack subsides.
- 2) telling the client everything is under control.
- 3) telling the client to lie down and rest.
- 4) talking continually to the client by explaining what's happening.

28. A 24-year-old client is experiencing an acute schizophrenic episode. He has vivid hallucinations that are making him agitated. The nurse's best response at this time would be to:

- 1) take the client's vital signs.
- 2) explore the content of the hallucinations.
- 3) tell him his fear is unrealistic.
- 4) engage the client in reality-oriented activities.

29. A client with paranoid type schizophrenia becomes angry and tells the nurse to leave him alone. The nurse should:

- 1) tell him that she'll leave for now but will return soon.
- 2) ask him if it's okay if she sits quietly with him.
- 3) ask him why he wants to be left alone.
- 4) tell him that she won't let anything happen to him.

30. A client begins taking haloperidol (Haldol). After a few days, he experiences severe tonic contractures of muscles in the neck, mouth, and tongue. The nurse should recognize this as:

- 1) psychotic symptoms.
- 2) parkinsonism.
- 3) akathisia.
- 4) dystonia.

31. The nurse must administer a medication to reverse or prevent Parkinson-type symptoms in a client receiving an antipsychotic. The medication the client will likely receive is:

- 1) benztropine (Cogentin).
- 2) diphenhydramine (Benadryl).
- 3) propranolol (Inderal).
- 4) haloperidol (Haldol).

32. The nurse is providing care for a female client with a history of schizophrenia who is experiencing hallucinations. The physician orders 200 mg of haloperidol (Haldol) orally or I.M. every 4 hours as needed. What's the nurse's best action?

- 1) Administer the haloperidol orally if the client agrees to take it.
- 2) Call the physician to clarify whether the haloperidol should be given orally or I.M.
- 3) Call the physician to clarify the order because the dosage is too high.
- 4) Withhold haloperidol because it may worsen hallucinations.

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33. The nurse is providing care to a client with catatonic type of schizophrenia who exhibits extreme negativism. To help the client meet his basic needs, the nurse should:

- 1) ask the client which activity he would prefer to do first.
- 2) negotiate a time when the client will perform activities.
- 3) tell the client specifically and concisely what needs to be done.
- 4) prepare the client ahead of time for the activity.

34. Which information is most important for the nurse to include in a teaching plan for a schizophrenic client taking clozapine (Clozaril)?

- 1) Monthly blood tests will be necessary.
- 2) Report a sore throat or fever to the physician immediately.
- 3) Blood pressure must be monitored for hypertension.
- 4) Stop the medication when symptoms subside.

35. A client with manic episodes is taking lithium. Which electrolyte level should the nurse check before administering this medication?

- 1) Calcium
- 2) Sodium
- 3) Chloride
- 4) Potassium

36. A client is admitted to the inpatient unit of the mental health center with a diagnosis of paranoid schizophrenia. He's shouting that the government of France is trying to assassinate him. Which of the following responses is most appropriate?

- 1) "I think you're wrong. France is a friendly country and an ally of the United States. Their government wouldn't try to kill you."
- 2) "I find it hard to believe that a foreign government or anyone else is trying to hurt you. You must feel frightened by this."
- 3) "You're wrong. Nobody is trying to kill you."
- 4) "A foreign government is trying to kill you? Please tell me more about it."

37. A client has been receiving chlorpromazine (Thorazine), an antipsychotic, to treat his psychosis. Which finding should alert the nurse that the client is experiencing pseudoparkinsonism?

- 1) Restlessness, difficulty sitting still, pacing
- 2) Involuntary rolling of the eyes

- 3) Tremors, shuffling gait, masklike face
- 4) Extremity and neck spasms, facial grimacing, jerky movements

38. A 54-year-old female was found unconscious on the floor of her bathroom with self-inflicted wrist lacerations. An ambulance was called and the client was taken to the emergency department. When she was stable, the client was transferred to the inpatient psychiatric unit for observation and treatment with antidepressants. Now that the client is feeling better, which nursing intervention is most appropriate?

- 1) Observing for extrapyramidal symptoms
- 2) Beginning a therapeutic relationship
- 3) Canceling any no-suicide contracts
- 4) Continuing suicide precautions

39. A 26-year-old male reports losing his sight in both eyes. He's diagnosed as having a conversion disorder and is admitted to the psychiatric unit. Which nursing intervention would be most appropriate for this client?

- 1) Not focusing on his blindness
- 2) Providing self-care for him
- 3) Telling him that his blindness isn't real
- 4) Teaching eye exercises to strengthen his eyes

40. A client has a diagnosis of borderline personality disorder. She has attached herself to one nurse and refuses to speak with other staff members. She tells the nurse that the other nurses are mean, withhold her medication, and mistreat her. The staff is discussing this problem at their weekly conference. Which intervention would be most appropriate for the nursing staff to implement?

- 1) Provide an unstructured environment for the client.
- 2) Rotate the nurses who are assigned to the client.
- 3) Ignore the client's behaviors.
- 4) Bend unit rules to meet the client's needs.

41. A client is being admitted to the substance abuse unit for alcohol detoxification. As part of the intake interview, the nurse asks him when he had his last alcoholic drink. He says that he had his last drink 6 hours before admission. Based on this response, the nurse should expect early withdrawal symptoms to:

- 1) not occur at all because the time period for their occurrence has passed.
- 2) begin anytime within the next 1 to 2 days.
- 3) begin within 2 to 7 days.
- 4) begin after 7 days.

42. The nurse in the substance abuse unit is trying to encourage a client to attend Alcoholics Anonymous (AA) meetings. When the client asks the nurse what he must do to become a member, the nurse should respond:

- 1) You must first stop drinking.
- 2) Your physician must refer you to this program.
- 3) Admit you're powerless over alcohol and that you need help.
- 4) You must bring along a friend who will support you.

43. The nurse is assessing a 15-year-old female who is being admitted for treatment of anorexia nervosa. Which clinical manifestation is the nurse most likely to find?

- 1) Tachycardia
- 2) Warm, flushed extremities
- 3) Parotid gland tenderness
- 4) Coarse hair growth

44. The nurse is assessing an adult's developmental stage. The nurse should consider:

- 1) height and weight.
- 2) blood pressure.
- 3) previous problem-solving strategies.
- 4) pulse rate.

45. Which of the following factors would have the most influence on the outcome of a crisis situation?

- 1) Age
- 2) Previous coping skills
- 3) Self-esteem
- 4) Perception of the problem

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46. The nurse is caring for an elderly client in a long-term care facility. The client has a history of attempted suicide. The nurse observes the client giving away personal belongings and has heard the client express feelings of hopelessness to other residents. Which intervention should the nurse perform first?

- 1) Setting aside time to listen to the client
- 2) Removing items that the client could use in a suicide attempt
- 3) Communicating a nonjudgmental attitude
- 4) Referring the client to a mental health professional

47. The nurse is caring for an adolescent female who reports amenorrhea, weight loss, and depression. Which additional assessment finding would suggest that the woman has an eating disorder?

- 1) Wearing tight-fitting clothing
- 2) Increased blood pressure
- 3) Oily skin
- 4) Excessive and ritualized exercise

48. A high school student is referred to the school nurse for suspected substance abuse. Following the nurse's assessment and interventions, what would be the most desirable outcome?

- 1) The student discusses conflicts over drug use.
- 2) The student accepts a referral to a substance abuse counselor.
- 3) The student agrees to inform his parents of the problem.
- 4) The student reports increased comfort with making choices.



49. The nurse is using drawing, puppetry, and other forms of play therapy while treating a terminally ill, school-age child. The purpose of these techniques is to help the child:

- 1) internalize his feelings about death and dying.
- 2) accept responsibility for his situation.
- 3) express feelings that he can't articulate.
- 4) have a good time while he's in the hospital.

50. The nurse is working with a client who abuses alcohol. Which of the following facts should the nurse communicate to the client?

- 1) Abstinence is the basis for successful treatment.
- 2) Attendance at Alcoholics Anonymous (AA) meetings every day will cure alcoholism.
- 3) For treatment to be successful, family members must participate.
- 4) An occasional social drink is acceptable behavior for the alcoholic.

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51. A client exhibits the following defining characteristics: denial of problems that are evident to others, expressions of shame or guilt, perceptions of self as being unable to deal with events, and projection of blame or responsibility for problems onto others. How would a nurse diagnose this client?

- 1) Anxiety
- 2) Chronic low self-esteem
- 3) Ineffective denial
- 4) Ineffective individual coping

52. What herbal medication for depression, widely used in Europe, is now being prescribed in the United States?

- 1) Ginkgo biloba
- 2) Echinacea
- 3) St. John's wort
- 4) Ephedra

53. The nurse is caring for a client with bulimia. Strict management of dietary intake is necessary. Which intervention is also important?

- 1) Fill out the client's menu and make sure she eats at least half of what's on her tray.
- 2) Let the client eat her meals in private then engage her in social activities for at least 2 hours after each meal.
- 3) Let the client choose her own food. If she eats everything she orders, then stay with her for 1 hour after each meal.
- 4) Let the client eat food brought in by the family if she chooses, but keep a strict calorie count.

54. A 15-year-old client is brought to the clinic by her mother. Her mother expresses concern about her daughter's weight loss and constant dieting. The nurse conducts a health history interview.

Which of the following comments indicates that the client may be suffering from anorexia nervosa?

- 1) "I like the way I look. I just need to keep my weight down because I'm a cheerleader."
- 2) "I don't like the food my mother cooks. I eat plenty of fast food when I'm out with my friends."

- 3) "I just can't seem to get down to the weight I want to be. I'm so fat compared to other girls."
- 4) "I do diet around my periods, otherwise I just get so bloated."

55. Which psychological or personality factors are most likely to predispose an individual to medication abuse?

- 1) Low self-esteem and unresolved rage
- 2) Desire to inflict pain upon oneself
- 3) Obsessive-compulsive disorder
- 4) Codependency

56. A client chronically complains of being unappreciated and misunderstood by others. She's argumentative and sullen. She always blames others for her failure to complete work assignments. She expresses feelings of envy toward people she perceives as more fortunate. She voices exaggerated complaints of personal misfortune. The client most likely suffers from which of the following personality disorders?

- 1) Dependent personality
- 2) Passive-aggressive personality
- 3) Avoidant personality disorder
- 4) Obsessive-compulsive disorder

57. A client diagnosed with depression tells the nurse, "I won't allow myself to cry because it upsets the whole family when I cry." This is an example of:

- 1) manipulation.
- 2) insight.
- 3) rationalization.
- 4) repression.

58. A client diagnosed with major depression has started taking amitriptyline (Elavil), a tricyclic antidepressant. What's a common adverse effect of this drug?

- 1) Weight loss
- 2) Dry mouth
- 3) Increased blood pressure
- 4) Muscle spasms

59. A client has received treatment for depression for 3 weeks. Which behavior suggests that the client is recovering from depression?

- 1) The client talks about the difficulties of returning to college after discharge.
- 2) The client spends most of the day sitting alone in the corner of the room.
- 3) The client wears a hospital gown instead of street clothes.
- 4) The client shows no emotion when visitors leave.

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60. A client in the manic phase of bipolar disorder constantly belittles other clients and demands special favors from the nurses. Which nursing intervention would be most appropriate for this client?

- 1) Ask other clients and staff members to ignore the client's behavior.

- 2) Set limits with consequences for belittling or demanding behavior.
- 3) Offer the client an anti-anxiety drug when belittling or demanding behavior occurs.
- 4) Offer the client a variety of stimulating activities to distract him from belittling or making demands of others.

61. The nurse is caring for a client with hypochondriasis. Which behavior would the nurse most likely encounter?

- 1) Ready acceptance of the physician's explanation that all medical and laboratory tests are normal
- 2) Expression of fear of dying after being diagnosed with advanced breast cancer
- 3) Expression of fear of colorectal cancer following 3 days of constipation
- 4) Lack of concern about having a serious disease

62. The nurse is caring for a client who has been diagnosed with hypochondriasis. The client attributes his cough to tuberculosis. A chest X-ray and skin test are negative for tuberculosis. The client begins to complain about the sudden onset of chest pain. How should the nurse react initially?

- 1) Let the client know the nurse understands his fears of serious illness.
- 2) Encourage the client to discuss his fear of having a serious illness.
- 3) Report the complaint of chest pain to the physician.
- 4) Determine if the illness is fulfilling a psychological need for the client.

63. The nurse is talking with a client who recently attempted suicide. The client asks her not to tell anyone one about their conversation. How should the nurse respond?

- 1) I'll need to share information with the rest of your health care team if it's important to your care.
- 2) I promise I won't tell anyone about the information you share with me today.
- 3) I promise I won't tell anyone about the information you share with me today unless you give me permission to do so.
- 4) Please don't tell me anything that you wouldn't want others on your health care team to know.

64. The nurse is administering atropine sulfate to a client about to undergo electroconvulsive therapy. Which assessment indicates that the medication is effective? 1) The client's heart rate is 48 beats/minute.

- 2) The client states that his mouth is dry.
- 3) The client appears calm and relaxed.
- 4) The client falls asleep.

65. The nurse is documenting a care plan for a client who has undergone electroconvulsive therapy. Which intervention should the nurse include?

- 1) Monitoring the client's vital signs every hour for 4 hours
- 2) Placing the client in Trendelenburg's position
- 3) Encouraging early ambulation
- 4) Reorienting the client to time and place

66. The nurse is caring for a client in the manic phase of bipolar disorder who is ready for discharge from the psychiatric unit. As the nurse begins to terminate the nurse-client relationship, which client response is most appropriate?

- 1) Expressing feelings of anxiety
- 2) Displaying anger, shouting, and banging the table.
- 3) Withdrawing from the nurse in silence
- 4) Rationalizing the termination, saying that everything comes to an end

67. A client with a borderline personality disorder has been playing one staff member against another. In formulating a care plan for this client, the nursing staff should include which intervention?

- 1) Assigning the same staff members to work with the client
- 2) Avoiding setting limits
- 3) Rotating staff members who work with the client
- 4) Avoiding interaction with the client until splitting behaviors stop

68. The nurse is planning care for a client admitted to the psychiatric unit with a diagnosis of paranoid schizophrenia. Which nursing diagnosis should receive the highest priority?

- 1) Risk for self- or other-directed violence
- 2) Imbalanced nutrition
- 3) Ineffective coping
- 4) Impaired verbal communication

69. The nurse is teaching a psychiatric client about her prescribed drugs, chlorpromazine and benztropine. Why is benztropine administered?

- 1) To reduce psychotic symptoms
- 2) To reduce extrapyramidal symptoms
- 3) To control nausea and vomiting
- 4) To relieve anxiety

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70. The nurse is leading group therapy with psychiatric clients. During the working phase, what should the nurse do?

- 1) Explain the purposes and goals of the group.
- 2) Offer advice to help resolve conflicts.
- 3) Encourage group cohesiveness.
- 4) Encourage a discussion of feelings of loss regarding termination of the group.

71. A client is admitted to the substance abuse unit for alcohol detoxification. Which of the following medications is the nurse most likely to administer to reduce the symptoms of alcohol withdrawal?

- 1) Naloxone (Narcan)
- 2) Haloperidol (Haldol)
- 3) Magnesium sulfate
- 4) Chlordiazepoxide (Librium)

72. The client tells the nurse he was involved in a car accident while he was intoxicated. What would be the most therapeutic response from the nurse?

- 1) Why didn't you get someone else to drive you?
- 2) Tell me how you feel about the accident.
- 3) You should know better than to drink and drive.
- 4) I recommend that you attend an Alcoholics Anonymous meeting.

73. A client suffers from depression after the accidental death of her daughter. After a suicide attempt, the client is admitted to the psychiatric unit. During the admission interview, the client tells the nurse that she no longer wants to die. The nurse should:

- 1) suggest that the client no longer requires close observation.
- 2) place the client in a private room, away from the nurses' station, so that she has privacy to work through the stages of the grieving process.
- 3) inspect the client's personal belongings for potentially dangerous objects.
- 4) avoid any further discussion of suicide, unless the client brings up the topic.

74. The nurse is caring for a client diagnosed with panic disorder. The client begins to hyperventilate. How should the nurse respond initially?

- 1) Stay with the client during the panic attack.
- 2) Shout for help and obtain assistance.
- 3) Teach the client relaxation exercises.
- 4) Help the client explore the reason for the anxiety.

75. The nurse is caring for a client with panic disorder who has difficulty sleeping. Which nursing intervention would best help the client achieve healthy long-term sleeping habits? 1) Administering sleeping pills

- 2) Encouraging the use of relaxation exercises
- 3) Suggesting he talk with other clients until he feels ready to sleep
- 4) Telling him to play ping-pong in the day room

76. A teenager was driving a car that slipped off an icy road, killing two of his friends. He repeatedly tells the nurse that he should be dead instead of his friends. The client's behavior is an example of:

- 1) survivor's guilt.
- 2) denial.
- 3) anticipatory grief.
- 4) repression.

77. The nurse is caring for a client with schizophrenia. Which of the following outcomes is least desirable?

- 1) The client spends more time by himself.
- 2) The client doesn't engage in delusional thinking.
- 3) The client doesn't harm himself or others.
- 4) The client demonstrates the ability to meet his own self-care needs.

78. The nurse is caring for a client with schizophrenia who experiences auditory hallucinations. The client appears to be listening to someone who isn't visible. He gestures, shouts angrily, and stops shouting in mid-sentence. Which nursing intervention is the most appropriate?

- 1) Approach the client and touch him to get his attention.
- 2) Encourage the client to go to his room where he'll experience fewer distractions.
- 3) Acknowledge that the client is hearing voices, but make it clear that the nurse doesn't hear these voices.
- 4) Ask the client to describe what the voices are saying.

79. A client with schizophrenia who receives fluphenazine (Prolixin) develops pseudoparkinsonism and akinesia. What drug would the nurse administer to minimize extrapyramidal symptoms?

- 1) Benztropine (Cogentin)
- 2) Dantrolene (Dantrium)
- 3) Clonazepam (Klonopin)
- 4) Diazepam (Valium)

80. The nurse is caring for a client being treated for alcoholism. Before initiating therapy with disulfiram (Antabuse), the nurse teaches the client that he must read labels carefully on which of the following products?

- 1) Carbonated beverages
- 2) Aftershave lotion
- 3) Toothpaste
- 4) Cheese

81. Which statement about somatoform pain disorder is accurate?

- 1) The pain is intentionally fabricated by the client in order to receive attention.
- 2) The pain is real to the client, even though there may not be an organic etiology for the pain.
- 3) The pain is less than would be expected from what the client identifies as the underlying disorder.
- 4) The pain is what would be expected from what the client identifies as the underlying disorder.

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82. The nurse is caring for a client diagnosed with antisocial personality disorder. The client has a history of fighting, cruelty to animals, and stealing. Which of the following traits would the nurse be most likely to uncover during assessment?

- 1) History of gainful employment
- 2) Frequent expression of guilt regarding antisocial behavior
- 3) Demonstrated ability to maintain close, stable relationships
- 4) A low tolerance for frustration

83. The nurse is caring for a client with antisocial personality disorder. Which of the following statements is most appropriate for the nurse to make when explaining unit rules and expectations to the client?

- 1) "I and other members of the health care team would like you to attend group therapy each day."
- 2) "You'll find your condition will improve much faster if you attend group therapy each day."

- 3) "You'll be expected to attend group therapy each day."
- 4) "Please try to attend group therapy each day."

84. A 58-year-old client on a mental health unit has lost control, despite having been properly medicated, and is threatening to harm himself and others. He has been placed in four-point restraints. Which nursing measure should be taken next?

- 1) Release one restraint every 15 minutes.
- 2) Have a staff member stay with the client at all times.
- 3) Leave the client alone to reduce his sensory stimulation and allow him to regain control.
- 4) Restrict fluids until the restraint period is over.

85. Which nursing assessment has priority while a client's extremities are restrained?

- 1) Measuring urine output
- 2) Checking circulation in extremities
- 3) Assessing pupillary responses
- 4) Noting respiratory pattern

86. A psychiatric client who was voluntarily admitted now wishes to be discharged from the hospital, against medical advice. What's the most important assessment the nurse should make of the client?

- 1) Ability to care for himself
- 2) Degree of danger to self and others
- 3) Level of psychosis
- 4) Intended compliance with aftercare

87. The nurse should determine that restraints are no longer needed when the client:

- 1) falls asleep.
- 2) ceases verbalizing threats.
- 3) is calm verbally and nonverbally.
- 4) expresses being okay.

88. A client on an inpatient psychiatric unit at a community mental health center is pacing up and down the hallway. The client has a history of aggression. Which response by the nurse would be best when approaching the client?

- 1) "If you can't relax, you could go to your room."
- 2) "Would you like your antianxiety medication now?"
- 3) "You're pacing. What's going on?"
- 4) "Let's go play a game of pool."

89. A 37-year-old male with a history of schizophrenia is having auditory hallucinations. The physician orders 200 mg of haloperidol (Haldol) orally or I.M. every 4 hours as needed. What's the nurse's best action?

- 1) Administer the haloperidol orally if the client agrees to take it.
- 2) Call the physician to clarify whether the haloperidol should be given orally or I.M.
- 3) Call the physician to clarify the order because the dosage is too high.
- 4) Withhold haloperidol because it may cause hallucinations.

90. An inpatient psychiatric client suddenly becomes loud and visibly anxious. What's the best action for the nurse to take?

- 1) Summon help and escort the client to his room.
- 2) Face the client squarely and say, "You must be quiet."
- 3) Say, "Calm down; you're safe here."
- 4) Say, "Let's go talk in your room."

91. A voluntary client on an inpatient psychiatric unit has a history of auditory hallucinations and self-aggression. The nurse is talking with the client when the client suddenly jumps up and says, to no one in particular, "Get away from me." What's the nurse's best response?

- 1) Escort the client to his room.
- 2) Say, "I won't let them harm you."
- 3) Sit quietly until the client becomes calm.
- 4) Ask, "Who are you talking to?"

92. A 35-year-old voluntary client suddenly begins yelling, throws a chair, and exhibits extreme agitation. Which of the following would be most important for the nurse to consider when planning an intervention?

- 1) Because the client is a voluntary admission, restraints can't be used.
- 2) The family must be called for permission to restrain the client.
- 3) Restraint should be used as a last resort.
- 4) Restraint can't be initiated until the physician is called.

93. Before forcing a client to take a medication, the nurse should give priority to:

- 1) the client's danger to self or others.
- 2) what the "voices" are saying to the client.
- 3) whether the client's admission was voluntary.
- 4) the client's insight into the illness.

94. A client was admitted to the hospital 2 days ago for disrupting a town meeting, shouting religious delusions, and fighting with police. The client now refuses to take prescribed haloperidol (Haldol), saying, "I don't want it." Which response by the nurse would be best?

- 1) "It will help you feel better."
- 2) "You must take it or get an injection."
- 3) "What are you afraid of?"
- 4) "You sound concerned."

95. A client has been prescribed 75 mg of amitriptyline (Elavil) at bedtime and 15 mg of phenelzine (Nardil) three times per day. Which nursing action takes priority?

- 1) Teaching the client about the adverse effects
- 2) Calling the physician and questioning the order
- 3) Instituting dietary restrictions
- 4) Taking baseline vital signs



96. A client on an inpatient psychiatric unit has been taking a tricyclic antidepressant without satisfactory results, so the physician changes to a monoamine oxidase (MAO) inhibitor. In evaluating the physician's order, the nurse must first be sure:

- 1) adequate time has elapsed between discontinuing the first medication and beginning the second.
- 2) the MAO inhibitor is begun at the same dosage as the tricyclic antidepressant.
- 3) the client isn't suicidal.
- 4) the client isn't allergic to cheese.

97. A client reports no improvement in mood since beginning a regimen of 15 mg of tranylcypromine (Parnate) twice per day 1 week ago. Which of the following is the best nursing action?

- 1) Say to the client, "The medication may need up to 4 weeks to take effect."
- 2) Say to the client, "You should feel the effects any day now."
- 3) Consult with the physician about a dosage adjustment.
- 4) Consult with the physician about a change of medication.

98. A client who has been hospitalized with depression is about to be discharged with a prescription of phenelzine (Nardil). In planning for discharge, the nurse should have a teaching plan that emphasizes:

- 1) getting adequate rest.
- 2) avoiding smoking.
- 3) avoiding red wine.
- 4) taking the drug with food or milk.

99. The physician prescribes a monoamine oxidase (MAO) inhibitor for a client. Which of the following nursing diagnostic categories would be most appropriate to focus on during client teaching?

- 1) Risk for injury
- 2) Disturbed thought processes
- 3) Deficient fluid volume
- 4) Disturbed sleep pattern

100. A nurse is teaching clients in an outpatient clinic about monoamine oxidase (MAO) inhibitors. The nurse would best evaluate the clients' understanding of how their medications work by noting:

- 1) food selections.
- 2) fluid intake.
- 3) potential for self-harm.
- 4) level of anxiety.

More information regarding Psychiatric Cases in the Blue Book of Psychiatric Nursing by Aaron Tuesca Untalan